



Centre for excellence
for Children's Care and Protection

CHILDREN'S SERVICES REFORM RESEARCH: CASE STUDIES OF TRANSFORMATIONAL REFORM

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CELCIS is a leading improvement and innovation centre in Scotland. We improve children's lives by supporting people and organisations to drive long-lasting change in the services they need, and the practices used by people responsible for their care.

How to read this report

Thank you for reading this report. We recognise that the report, plus the six case studies included in the appendix, is long and you may not have the time to read it cover to cover. This page explains the report structure and helps you to get to the sections that will interest you.

The report is for everyone

We appreciate that some people reading this report may feel that they need to have some prior knowledge of public services in Finland, the Netherlands, New Zealand, Northern Ireland, the Republic of Ireland or of policing in Scotland. This is not the case and we have tried to present the information for each case study so that it is accessible to anyone who is interested.

The report brings together the main points of learning from across the case studies into one place and is organised in sections with self-explanatory titles. The individual case studies (Appendix 1) we looked at go into more detail on the rationales behind the reforms in each case study, the changes that the reforms brought about, the progress and impact of the reforms, and the potential learning there is for Scotland. There is also a summary of this report available, which gives an overview of our key findings.

Throughout the report, examples from the case studies have been highlighted in boxes with a country flag to show where these examples are from. These examples provide detail on a particular issue or highlight a specific challenge or innovation.

Flexibility

Many people may be coming to this report with particular questions or priorities. We have tried to make it as easy as possible to find the things that are of interest by giving the sections what we hope are self-explanatory titles, which tell you what information you will find there. While reading all of the report will help you understand the evidence as a whole, if you have a particular question or issue you want to read about, please go straight to the section or case study that you are interested in.

The language used in this report

The case studies this part of the research study looks at consider services, systems, structures, and people in different parts of the world. Consequently, language differs, and some terms are used to reflect the legislative and statutory language applied to the support in place for children, young people and families. Where the language is of a particular system in a particular place, we have made this clear and it has been necessary to use these terms for accuracy.

Alternative care

Alternative care is the term used by the United Nations (UN) and others internationally to describe different settings and arrangements for the care of children when their

parents are unable to care for them. This can include being cared for in foster care, kinship care, residential care and many more approaches to care.

Care proceedings

Care proceedings refers to the legal measures, processes, and structures where children's health, wellbeing, safety and rights are not being met by their parents and/or where they live, and support arrangements within their family home, or alternative living arrangements are being considered. Working under the principle of what is in the child's best interests, children may be moved to live somewhere else (for example, in a children's home or with a different family member) or may continue to live where they do but with additional support for the household.

The care system

The care system is a term used to refer in general to the structures, services and arrangements in place under a statutory responsibility for the care of children and young people who are unable to be cared for by their parents without the support of the state.

Case

In the context of the examples we looked at, the word case is used to refer to two distinct things: a legal case (a matter brought before courts), and a social work case which is the circumstances and actions involving the needs of an individual child or young person.

Child protection

Child protection refers to the statutory measures, processes and structures that respond to the harm, abuse, neglect, exploitation of children. Child protection is a statutory activity in the case study countries, which means that it is a legal requirement for national, regional and/or local government and agencies to provide it. In some countries (such as Finland) the terminology used is child welfare rather than child protection but encompasses the same activities.

Family support

Family support refers to providing a range of supports and services to children and families at an early stage and before any needs require child protection or care proceedings. Family support services are often delivered in communities and can span parenting, health, financial, housing and other supports that meet families' needs.

Locality

Locality is used to refer to the community level.

Looked after

The term looked after is used in some places to describe the circumstances where a child is under the care of the state, where there is a legal order in place to meet the needs of

the child. In this study report, this applies in Northern Ireland and 'looked after' is also the term in statute in Scotland, and it is often used as a measure for official data collection.

People needing the support of services

This research study uses the phrase 'people needing the support of services' or 'children needing the support of services' to identify any and all who may at any time need the support of public services, which might include social care services, or social work services, or health services, for example. There are many different terms used as an alternative to this form of words such as 'service user' or 'client' and some of these will be more commonly used in different contexts and places including by the services and systems we looked at for these case studies.

Placement/s

When care needs to be provided to children who are at risk of harm, neglect or abuse away from their family home, the place and arrangements made for their care is sometimes referred to as a placement. This is a catch-all term and can mean being cared for in foster care, kinship care, residential care or another form of care.

Removal

The decision to take action when children are at risk of harm, neglect or abuse is a challenging one. Separating children from their parents or carers in such circumstances is described in some places as removing a child from their home or parents/carers.

Social care services

In the context of this report and research study, the phrases social care and social care services can be understood as the care and services designed to meet the needs of children, young people or adults who need extra support. This might take the form of personal care or other practical assistance. Worldwide, social care is provided through public services, not for profit organisations, and commercial providers. It should be noted that outside Scotland, the phrases social care and social care services are also used to refer to social work services with children and families.

Social work services

In the context of this report and research study, the phrases social work and social work services can be understood as the specialist services that operate at a local and/or regional government level that have a statutory responsibility to meet the welfare needs of children, young people and adults who need support. Their responsibilities are discharged in line with the relevant national and local laws and policies where the services are located.

Vulnerable

The word vulnerable is often used to describe to children, young people, families, or adults as a generalising term to reflect that they are more at risk of or to circumstances than the general population or their peers.

Readers should also note that:

1. The term 'national' has been used when referring to Northern Ireland-wide policies, structures and facilities but that these are widely referred to as 'regional' in Northern Ireland publications.
2. The term 'local authorities' has been used when referring to local government in the Netherlands but these are widely referred to as 'municipalities' in Netherlands publications.
3. In the Netherlands case study, the word children has been used but in the Netherlands the term 'youth' is applied to children and young people from age 0 to 25 – for example, the Youth Act 2015 applies to children and young people.

Overview of Children's Services Reform Research

This is a Scotland-based research study being undertaken by CELCIS, the Centre for Excellence for Children's Care and Protection. CELCIS was asked by the Scottish Government to carry out this research study with the aim of gathering evidence to inform decision-making about how best to deliver children's services in Scotland in light of the proposed introduction of the National Care Service, and its commitment to keep The Promise of the Independent Care Review.

The purpose of the research is to answer the question: "**What is needed to ensure that children, young people and families get the help they need, when they need it?**".

The [Children's Services Reform Research](#) study has four separate strands of work, which together aim to provide a comprehensive and holistic approach to answering this question. The findings of each strand of work will be published separately, in a full research report and a shorter summary report. We hope that this overview acts as a guide to help you to navigate through each strand of the research, and the different evidence that these will present. A final report will be published at the end of the study which will draw together and synthesise all four strands of the findings to address the research question.

This report is Strand 2: Case studies of Transformational Reform Programmes, and all strands of the research study are outlined below:

Strand 1: Rapid Evidence Review is a review of existing published national and international research evidence focused on better understanding the evidence associated with different models of integration of children's services with health and/or adult social care services in high income countries, as defined by the World Bank. The research questions which this review seeks to address are:

What models of integration exist for the delivery of children's social work services with health and/or adult social care services in high income countries, and what is the strength of evidence about their effectiveness in improving services, experiences and outcomes for children, young people and their families?

Strand 2: Case studies of transformational reform programmes is examining a range of approaches to the delivery of children's services, from national to highly decentralised structures and modes of delivery, in five high-income countries: Finland, Northern Ireland, the Netherlands, New Zealand and the Republic of Ireland. A sixth case study is drawing on learning from Scotland's experiences of national service reorganisation through the development of Police Scotland. These country case studies will be brought together in one report to consider the key learning and messages for Scotland.

Strand 3: Mapping integration in Scotland: A statistical analysis is mapping the range of different approaches to integrated service delivery across Scotland's 32 local authority areas and investigating, through the statistical modelling of administrative data, any potential effects of integration on a range of outcomes over time for people being supported by public services. In doing this, we are also taking into account different factors such as geography, poverty and the impact of the COVID-19 pandemic, to increase the likelihood that any findings are directly about integration rather than as a result of other factors.

Strand 4: Children's services workforce experiences of supporting children, young people and families is exploring, through an online survey, interviews and focus groups, the opportunities, challenges, barriers and facilitators that are found to bring about high quality experiences and outcomes for children, young people and families using services; close multi-agency working between professionals across different services; continuity of support when young people transition to adult services; and high quality support for the workforce and transformational change in services. This strand of work will also aim to produce additional insights regarding workforce perceptions of the association between integration and outcomes for children, young people and families and the wellbeing of the workforce that will complement and contextualise emerging findings from Strand 3.

An [Independent Steering Group](#) chaired by Professor Brigid Daniel, Professor Emerita at Queen Margaret University, Edinburgh, has supported the design, implementation and delivery of this research study. Their remit has been to provide independent support and oversight to the research team, and to ensure the research is robust and will provide the best possible evidence.

Throughout the Children's Services Reform Research study, we have taken very careful account of existing evidence which details the views that children, young people and their families have already shared about their experiences, the support and services they have identified as being needed, and what matters to them. This information has been taken from relevant research and reviews of services for children, including the Independent Care Review in Scotland (2020), and is included in a range of ways within the different strand reports. In this research report, examples of where children's views have formed part of the design and planning of the transformational reform programmes, and where children's views are sought in planning and decisions about their lives, have been included, albeit we found limited examples of this.

Introduction

Background

In September 2020, Scotland's First Minister announced an Independent Review of Adult Social Care in Scotland with the principal aim to recommend improvements to adult social care. The report was published in February 2021 and recommended the creation of a National Care Service for adult social care, to be delivered locally through reformed Integrated Joint Boards (Feeley, 2021).

In August 2021, Scottish Government launched a consultation on the National Care Service, which included a proposal that children's social work and social care services should be included within the National Care Service (Scottish Government, 2021). In the National Care Service Statement of Benefits report produced by Scottish Government in June 2022, the proposal that the National Care Service could include children's social work and social care services was considered in more detail, with a recognition that further evidence is required to inform future decisions around inclusion or exclusion of these services (Scottish Government, 2022a). In Scotland, children, young people, families, carers and those working to support them, have shared their experiences of what helps them and what they need, with a broad recognition and agreement that improvement is needed in children's services in response to this, as evidenced in the conclusions of the Independent Care Review (ICR, 2020), the Morgan Review (Morgan, 2020), and other areas of focus on the health, care and protection needs of Scotland's children and young people (Brock and Everingham 2018; Christie 2011).

Further details on the legal and policy context regarding the integration of health and social care in Scotland, and the proposals for the National Care Service, can be found in this research study's Rapid Evidence Review (Porter et al., 2023).

Rationale for the case studies

Whether or not to integrate systems, processes, services, or agencies is a big decision. When the systems in question include the nationwide delivery of support through children's social work and social care services, the implications are even wider. For Scotland, such a decision will impact on the lives of thousands of families each year, affecting their wellbeing, health, and education, among other aspects of their lives. It is important to note that this is true regardless of whether changes are made. A decision to take no action is a decision with consequences as much as a decision to make a change. In this context, it is important that any decision is made with the fullest understanding of all the available evidence and information.

There are many sources of such information and evidence which we have accessed across the different strands of the research. The case studies of transformational reform programmes we have developed in this second strand of work provide real world illustrations of structural reforms designed to bring about more integrated services. These then complement the analysis of how integration is understood and evidenced in

the mostly academic research papers that were reviewed within the first strand of our work: the Rapid Evidence Review.

A similar exercise was conducted as part of Scotland's Independent Care Review, with a review of international models of care (McCauley, 2019) commissioned. Drawing on cross-country studies (for example, Gilbert et al., 2011 and Katz et al., 2016), McCauley (2019) found that there was a coming together of systems previously categorised as having a child protection orientation versus those with a family support service orientation. Child protection-oriented systems were characterised by adversarial relationships between parents and the state, and family service-oriented systems characterised by a partnership-based approach with parents (Gilbert, 1997).

When Gilbert et al. (2011) carried out a follow-up study 14 years later they found that the two orientations were converging in different ways. Some countries (including England and the USA), which had previously had a child protection orientation, had been adopting elements of family-service orientation in terms of the emphasis on preventative approaches and early family support. Conversely, other countries that were previously orientated more to family support services, including Finland, Germany and Denmark, had adopted increasingly adversarial approaches to intervention which focused on issues such as increasing compulsory measures of intervention (Denmark) and mandatory reporting of child abuse (Germany and Finland).

Irrespective of their previous orientation, McCauley (2019) found that countries had experienced a similar range of issues. These included increases in levels of need among children and families, rising service costs, issues with workforce morale, recruitment and retention, and media scrutiny into high profile cases of child protection which had generated new or refined child protection laws. While there were common developments and challenges, it was also apparent that there was a lack of robust evidence around the impact of models and the outcomes achieved. McCauley (2019) concluded their review by stating that no one country has a system that is able to ensure the present or future wellbeing of children and, consequently, there is a need to reflect on and learn from system elements in a number of countries.

In light of the importance of learning from a number of countries, this research consists of six case studies, all of which are from high income countries and broadly comparable to Scotland on population, economic and/or child wellbeing measures. These have been purposefully selected because each set of structural reforms have led to different models of delivery. By understanding the rationales, experiences, and outcomes, of each of these transformational reform programmes, these collectively offer the opportunity to learn from and apply what has worked in other countries and settings and, equally, to understand and circumvent what has not worked.

Understanding what we already know is a key step both for decision making now, and for knowing what we need to understand in the future. Looking at these case studies of transformational reform programmes is one contribution to this process.

Methodology

In the development of the case studies, one overarching research question with eight more specific sub-questions were identified by the research team. The eight sub-questions are designed to complement and 'flesh out' the overarching question, and to provide focus for the analysis and synthesis of the data included in the case studies. The numbering or sequencing of the sub-questions does not denote any priority or relative importance.

Overarching research question

What transformational reform programmes have been introduced to enhance the delivery of children's social work services through closer working with health and/or adult social care services in the case study countries, and what has been the impact of these on children, families, services and practice?

Sub-questions

1. How are children's health, social care and education services organised, delivered and governed in each country?
2. What evidence exists around the availability, quality, timeliness and cost of health and social care services for children and their families?
3. What evidence exists about the satisfaction with these services in each country?
4. What evidence exists around the outcomes achieved by health and social care services for children and their families?
5. What evidence exists around the impact of each country's service structure and delivery on the health and social care workforce?
6. How are children, young people and families' views sought and listened to in the development of health and social care services?
7. Has there been any movement towards integration of adult and children's social care services? What has been the experience and learning from this?
8. Has there been any movement towards a national social care service? What has been the experience and learning from this?

Case study research

Case study research is an investigation and analysis of single or multiple examples of something in order to explore and understand the object of study. Case studies are a widely used method for generating knowledge of complex subject areas, provided the case studies are strategically and purposefully selected (Yin, 2003). Consistent with this, the following two overriding design features were adopted for our research here. First, more than one case study was used, as multiple cases and the opportunity to find commonalities between them enables more robust knowledge generation. Second, the case studies we selected would span different transformational reform programmes because if common features and issues are identified across different programmes, then

the findings can be more justifiably generalised as these have been found in diverse contexts and examples (Yin, 2003).

Case study selection

With the decision to produce multiple case studies spanning different transformational reform programmes, we adopted some further inclusion criteria:

- To help ensure the findings are grounded on real experience, the case study would need to have engaged in, or was in the process of engaging in, a transformational reform programme.
- The case study is broadly geographically comparable to Scotland, for example in relation to population size, urban-rural geography, and socio-economic strengths and challenges, so that there is increased opportunity for Scotland to learn from and potentially apply some of the findings from the case study.
- To help to ensure the evidence from the case study is understood and interpreted accurately by the English-speaking research team without relying on translation software, the case study would need to offer sufficient breadth of relevant documents written in English, including policy documents, evaluations and academic research.

Initial list of case study options

An initial list of options for possible case studies to consider was produced drawing on some of the emerging findings from this study's Rapid Evidence Review (Porter et al., 2023) and suggestions from the independent steering group and wider stakeholders. Options on our initial list were the health and social care systems of Australia, Finland, the Netherlands, New Zealand, Northern Ireland, Norway, the Republic of Ireland, Spain and Sweden. A further suggestion was to learn from outside the focus of children's services too and to look at experience within Scotland of public service reform in the formation of Police Scotland and/or the Scottish Fire and Rescue Service.

Scoping exercise

A scoping exercise was then undertaken to explore each of the case study options in greater depth, with the options assessed using the inclusion criteria. The findings from the scoping exercise were then put to the Steering Committee and there was collective agreement on the selection of Finland, the Netherlands, New Zealand, Northern Ireland, the Republic of Ireland and the formation of Police Scotland as the six case studies.

Australia, Norway, Spain and Sweden were not selected as our case study countries. The rationales for their exclusion were:



Australia was not selected as a case study on account of it:

- Being a much larger country than Scotland – both in terms of population and landmass
- Having a federal political system that differs from Scotland's government structure
- Having a strong policy focus on redress for, and supporting and the empowering of, indigenous communities. Similar important learning would be captured through the New Zealand case study and the empowerment of Māori communities



Norway was not selected as a case study on account of it:

- Having a much more decentralised model than Scotland and similar learning would be taken from the Netherlands case study as it too has a decentralised model as a core feature
- Having a Nordic family support-oriented system, but similar learning would be provided by the Finland case study
- Having no evidence of a recent reorganisation of children's social care services



Spain was not selected as a case study on account of it:

- Having a limited information about the reform programme that was available in the English language
- Having a much more decentralised model of children's services than Scotland, with 50 provinces and 8,131 municipalities at the local level
- Having a family-oriented 'Mediterranean' model of care that places greater onus on family responsibility relative to Scotland's approach
- Having no evidence of a recent reorganisation of children's social care services





Sweden was not selected as a case study on account of it:

- Having a much more decentralised model of children's services than Scotland, with responsibilities lying with Sweden's 290 municipalities, and the Netherlands case study has a decentralised model as a core feature
- Having a Nordic family support-oriented system, but similar learning would be provided by the Finland case study
- Having no evidence of recent reorganisation of children's social care services

Case study development

Desk-based research methods were used to develop and analyse the six case studies and we have outlined the process taken by the research team.

| | |
|---|--|
| <p>Preparation of a Draft Case Study</p>  | <ul style="list-style-type: none"> • Internet search for the available documents written in English, including policy documents, evaluations and academic research, relating to the transformational reform programmes in each case study. This also included literature identified through 'snowballing', such as identifying additional sources from the references of the literature reviewed • Review of the identified policy, academic, research and evaluation literature, with the aim of extracting information related to the Strand 2 research questions • Prepare a full draft of each case study for sending to identified country expert(s) |
| <p>Review of Draft Case Study by Country Experts</p>  | <ul style="list-style-type: none"> • Identify and approach one or more country experts to review each case study • Send the draft case study to the country expert(s) for comments on the draft and suggestions of further readings • Hold a meeting (virtual meeting or telephone call) with the country expert(s) to explore and clarify the comments received, and to consider the potential learning for Scotland's children's health and social care services |
| <p>Finalising of Case Study</p> | <ul style="list-style-type: none"> • Incorporate the feedback from country expert(s) • Review and incorporate the additional readings suggested by the country expert(s) • Complete the final version of each case study |

Role of the country experts

As a methodology, case studies benefit from a mixed methods approach whereby different types of data can be triangulated. A common mixed methods approach used within case studies is to bring together secondary (for example, documentary or statistical) data with primary (for example, interviews or focus groups) data. However, the tight timeframe of this research study meant the emphasis has been on the available secondary data. A full mixed methods approach was not possible, but the research team put in place a process of having external reading of each case study from at least one academic expert in each country. Their review would help to ensure the case study was accurate and had not omitted any key developments, literature or points of learning.

The country experts were identified after the review of the source material had been completed. At that juncture, and based on their research outputs and interests, a decision was made on which academics and experts would most likely offer important insights into each country's transformational reform programme, its implementation and/or impacts. Every country expert who was approached agreed to support the research and provided feedback on the drafts sent to them.

Across the six case studies, twelve country experts provided feedback on the case studies, either through written comments on the draft case study, online meetings or both.

Limitations

The six case studies have been developed so that these each provide the rationale, content, implementation and impact of the transformational reform programmes in each country, with the aim of answering the research questions. Due to time and resource constraints, the focus was on the available policy-related, academic research and evaluation source material, and specifically the material available in the English language. This means there are two limitations:

- There may not have been material available on a specific area of interest. This means it has not been possible to fully answer all of the research's eight sub-questions for each case study
- Key material may not have been produced in English. This has most affected the Finland and Netherlands case studies and meant that the research team has potentially not had access to an evidence base as comprehensive as there was for the other case studies.

The contributions of the country experts were designed to mitigate against these two limitations by ensuring any significant inaccuracies or gaps were identified and rectified. The experience of working with the country experts included one or more stages of review, signposting to research or other experts, and answering any queries or information gaps that the research team had. For the Finland and the Netherlands case studies, the experts also helped clarify the names and function of key structures, reform programmes and organisations, which varied across the different English language publications. They also provided verbal summaries of recent developments and publications that were not published in English. This dialogue was extremely constructive and the written case studies have benefited from this wide-ranging knowledge and expertise.


Notwithstanding the potential for some information gaps, the real value is in the collective knowledge produced. By reading across the six case studies, a more robust evidence base is offered that can inform future planning and decision-making regarding Scotland's children's services and be of potential use in other countries and contexts too.


Introducing the case studies


The six case studies have been purposefully selected because these transformational reform programmes offer different models and experiences for Scotland to learn from. Collectively they offer examples of:


- The integration of health and social care services for all ages (cradle to grave) but with movement towards a national children and families social care agency (Northern Ireland)
- A decentralisation of many adults' and children's health and social care services to local authorities (the Netherlands)
- A regionalisation of health and social care services (Finland)
- A national approach to children and family services (Republic of Ireland)
- The impacts of a series of reforms in a nationalised child welfare system, of which multi-agency working across national ministries has been core (New Zealand)
- The experience in Scotland of a national organisation formed from existing regional and local structures being established (Police Scotland).



Each of these transformational reform programmes are introduced in Figure 1, alongside information about the headline population, economic and child wellbeing data of the country (sourced from OECD (2021) Government at a Glance report, the World Bank and the UNICEF Innocenti Report Card 16 report). This information provides some context to each case study and helps to understand how Scotland compares to the case study countries on key population and socio-economic measures. The UNICEF Innocenti Report Card 16 report ranks three of the case study countries in the top 10 countries worldwide on child wellbeing and the conditions for child wellbeing (specifically Finland and the Netherlands on both policy rankings, and the Republic of Ireland on the rankings for conditions of child wellbeing). Northern Ireland and the Netherlands may not be directly geographically comparable to Scotland, but they offer particularly helpful learning for Scotland in terms of the Netherlands' decentralisation of children social care services and Northern Ireland's national approach to health and social care services combined with their very recent review of children's social care (Jones, 2023).

| | | |
|---|---|-----------------|
|  | FINLAND – Regionalisation and integration of children's services in two key reforms | |
| Population | Total Population, 2021 | 5,500,000 |
| | % Rural Population, 2021 | 14% rural |
| Economy | Density (People per sq km, 2020) | 18 / sq km |
| | Gross Domestic Product per capita (US\$, 2021) | \$53,700 |
| | Government expenditure on 'Family and Children' social protection (% of GDP, 2021) | 3.0% |
| | Child Wellbeing ranking | 5 th |

| | | |
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| UNICEF Innocenti Report Card 16 | Conditions for Child Wellbeing ranking | 3 rd |
| Description of Transformational Reform Programme(s) | <p>Finland has been undergoing several reform programmes, including structural changes to shift governance of health and social care from local municipalities to regional counties, with education remaining under governance of local municipalities; and to reform children's services so that they are more child and family centred.</p> <p>The LAPE programme (Lapsi ja perhepalveluiden muutosohjelma) commenced in 2016, and is reforming services and practice to be more child and family-centred, for example through the development of the Family Centre model to better link health, social care, and education services; while the SOTE (Sosiaali ja terveydenhuollon ja pelastustoimen uudistus) reforms legislated for in 2020 involve the transfer of governance of adult and children's health and social care services from what was 448 municipalities in Finland to 21 (plus the city of Helsinki) newly established wellbeing service counties.</p> | |
|  | THE NETHERLANDS – A decentralisation of children's services | |
| Population | Total Population, 2021 | 17,500,000 |
| | % Rural Population, 2021 | 7% rural |
| | Density (People per sq km, 2020) | 518 / sq km |
| Economy | Gross Domestic Product per capita (US\$, 2021) | \$57,800 |
| | Government expenditure on 'Family and Children' social protection (% of GDP, 2021) | 1.4% |
| UNICEF Innocenti Report Card 16 | Child Wellbeing ranking | 1 st |
| | Conditions for Child Wellbeing ranking | 9 th |
| Description of Transformational Reform Programme(s) | <p>The Youth (Care) Act 2015 aimed to remove children's social care services from the Netherlands' 12 provinces/regions and instead legislate for most children's health and social care responsibilities (children's social care, primary and mental health, youth and family support services) to be delegated to the Netherlands' 342 local authorities. Adult health and social care, employability and welfare services were also delegated to local authorities.</p> | |

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| | <p>Despite this decentralisation, national and regional levels have retained important functions. Specialist care and health services, along with education and police, are organised at the regional level – albeit in differing regional arrangements. At the national level, the national Child Care and Protection Board is a key institution as it undertakes child protection and care processes and decision-making.</p> | |
|  | <p>NEW ZEALAND – Multiple stages of reform to national children’s services</p> | |
| Population | Total Population, 2021 | 5,100,000 |
| | % Rural Population, 2021 | 13% rural |
| | Density (People per sq km, 2020) | 19 / sq km |
| Economy | Gross Domestic Product per capita (US\$, 2021) | \$48,800 |
| | Government expenditure on ‘Family and Children’ social protection (% of GDP, 2021) | 2.5% |
| UNICEF Innocenti Report Card 16 | Child Wellbeing ranking | 35 th |
| | Conditions for Child Wellbeing ranking | 20 th |
| Description of Transformational Reform Programme(s) | <p>There have been a number of significant policy changes in New Zealand over the last two decades, reflecting changes in governance, political values and ethos around child welfare. Some policy changes have had a considerable impact on children’s lives, including periods of increasing child protection referrals and contentious ‘removals’ from birth families, which Māori communities had disproportionate experiences of. Alongside periods of increased press coverage and public concern, there have been a range of reforms aiming to change practice, improve children’s and families’ welfare, and address inequalities.</p> <p>New Zealand has had a national child welfare system in place for a number of decades and the case study focuses on the reforms made to the system in the last 20 years. For example, a reform in 2015 saw the establishment of a new national agency governing child welfare, Oranga Tamariki from 2017, and new duties for inter-agency co-operation. Monitoring of the impact of changes to support inter-agency working has been overshadowed by multiple stages of reform focused on addressing child welfare issues, and reducing inequalities</p> | |

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| | <p>experienced by Māori children (tamariki). Family Group Conferencing is an important aspect of support for children and families and, originating in New Zealand, these were included in legislation there in 1989. Recent reviews have called for improvements to the involvement and experience of families in conferences (Waitangi Tribunal Report 2021).</p> | |
|  | <p>NORTHERN IRELAND – All-age health and social care integration but with movement towards a national children and families social care agency</p> | |
| Population | Total Population, 2021 | 1,900,000 |
| | % Rural Population, 2021 | 36% rural |
| | Density (People per sq km, 2020) | 113 / sq km |
| Economy | Gross Domestic Product per capita (US\$, 2021) | \$46,500 (UK) |
| | Government expenditure on 'Family and Children' social protection (% of GDP, 2021) | 1.2% (UK) |
| UNICEF Innocenti Report Card 16 | Child Wellbeing ranking | 27 th (UK) |
| | Conditions for Child Wellbeing ranking | 27 th (UK) |
| Description of Transformational Reform Programme(s) | <p>Adults' and children's health, social care and social work have been collectively planned in Northern Ireland since the 1970s and operate within a unifying governance and delivery structure of national, regional and local bodies. The main structures are the (national) Department of Health, five (regional) Health and Social Care Trusts, and the 29 (local) Family Support Hubs. Northern Ireland's 11 local authorities do not hold responsibilities for adult or children's health, social care and social work.</p> <p>The Bengoa Review - System, Not Structures – Changing Health and Social Care: Expert Panel Report - in 2016 brought a renewed focus on strengthening integration between national, regional and local levels and across different disciplines. However, The Independent Review of Children's Social Care Services in Northern Ireland (Jones, 2023) has found that children's social care does not attract sufficient attention in Northern Ireland's health and social care system for all ages and is proposing the setting up of a 'children and families social care arms-length body'. The arms-length body would be separate from the Northern Ireland Executive and government departments and have the lead strategic role in promoting the</p> | |

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| | multi-professional and multi-agency integration of services for children and families. | |
|  | REPUBLIC OF IRELAND – A national approach to children and families' services | |
| Population | Total Population, 2021 | 5,000,000 |
| | % Rural Population, 2021 | 36% rural |
| | Density (People per sq km, 2020) | 72 / sq km |
| Economy | Gross Domestic Product per capita (US\$, 2021) | \$100,200 |
| | Government expenditure on 'Family and Children' social protection (% of GDP, 2021) | 1.3% |
| | UNICEF Innocenti Report Card 16 | |
| | Child Wellbeing ranking | 12 th |
| | Conditions for Child Wellbeing ranking | 8 th |
| Description of Transformational Reform Programme(s) | <p>Following long-held criticisms that children's services in the Republic of Ireland were marginalised within a national health and social care system for all ages, allied to a desire to shift practice towards a more preventative and community-based approach, it was decided that a new approach was needed to support children and families. This led to the formation in 2014 of a new national child and family agency – Tusla – with responsibilities for child protection and welfare, family support, early years services, domestic violence and educational welfare services.</p> <p>Since its formation, Tusla has put in place a number of mechanisms to support more consistent and integrated practice with children and families, including national standards, national practice models and a national IT system.</p> | |
|  | POLICE SCOTLAND – The reform of policing in Scotland and the formation of Police Scotland | |
| Population | Total Population, 2021 | 5,500,000 |
| | % Rural Population, 2021 | 17% rural |
| | Density (People per sq km, 2020) | 70 / sq km |
| Economy | Gross Domestic Product per capita (US\$, 2021) | \$46,500 (UK) |

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| UNICEF Innocenti Report Card 16 | Government expenditure on 'Family and Children' social protection (% of GDP, 2021) | 1.2% (UK) |
| | Child Wellbeing ranking | 27 th (UK) |
| | Conditions for Child Wellbeing ranking | 27 th (UK) |
| Description of Transformational Reform Programme(s) | <p>In the context of financial austerity and policing changing due to the rise of cybercrime, terrorism and other threats, the Police and Fire Reform (Scotland) Act 2012 legislated for the transformation of Scotland's police service. The creation of Police Scotland involved the merger of eight regional police services, the national-level Scottish Crime and Drug Enforcement Agency and Scottish Police Services Authority into a single, national force.</p> <p>The experience of Police Scotland provides valuable learning about the implementation of a national transformational reform programme as, a decade on since the legislation, the reform process continues. Ongoing areas of development include the governance of Police Scotland by the (newly established) Scottish Police Authority and national-to-local relationships with local authorities and communities.</p> | |

Figure 1: Transformational reform programmes offering different models and experiences for Scotland to learn from

Rationales for transformational reform programmes

There were a number of factors evident in the case studies that provided the impetus or need for the transformational reform programmes. These factors have been grouped into 'push factors' which relate to the deficiencies in the previous service and system landscape, and 'pull factors' which relate to the vision, aims or objectives of the transformational reform programmes. Many of the 'push' and 'pull' factors will resonate with people in Scotland interested in public services and the reform agenda as these echo the findings, recommendations of and/or policy objectives behind The Christie Commission on the Future Delivery of Public Services (Scottish Government, 2011); the intention to incorporate the UN Convention on the Rights of the Child (UNCRC) into Scots law; the Getting It Right For Every Child (GIRFEC) approach (Scottish Government, 2022b); and The Promise (Independent Care Review, 2020).

Push Factors

The main 'push factors' that acted as a catalyst to initiate the transformational reform programmes have been set out. The focus of this discussion is predominantly on the five health and social care reform case studies, as opposed to the Police Scotland reforms.

Illustrative examples from the case studies give greater detail on a particular issue or highlight a specific challenge or innovation.

Fragmentation of children's health and social care services across national, regional and local structures

This led to a complex and confusing governance, funding and delivery landscape for children, young people, families and professionals alike. This was most apparent in Finland, New Zealand and the Netherlands, and the fragmentation also acted as a barrier to practitioners from different services working together.






In the **Netherlands**, prior to the Youth Care Act 2015, the children's health and social care system had its management, funding and delivery across national, regional and local administrative levels.

- National level: statutory child protection, children's care and legal proceedings
- Regional level: children's social care, children's acute healthcare and mental health services
- Local level: youth services, family support, children's primary healthcare (for example, vaccinations and health visiting)



In **New Zealand**, a central tenet of the 2015 review by the Expert Panel on Modernising Child Youth and Family was a need to address fragmentation between agencies. The review found that agencies were not clear on their

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| | <p>roles in meeting commitments under existing legislation to support children and families. As the agency with responsibility for children’s services did not have a mandate to direct services from the wider sector, a “negotiation and best efforts” approach across different agencies had failed, and a lack of interagency working had direct consequences on the ability to provide early support to families (the Expert Panel on Modernising Child Youth and Family 2015; page 64).</p> <p>The reforms have not, however, led to families having greater access to early support. O’Brien (2016) and Hyslop and Keddell (2019) found that there was a need to address a range of factors in addition to fragmented services, such as practice change, workforce support and attention to structural factors, such as poverty.</p> |
|  | <p>In Finland, the LAPE reforms to children’s services were developed to address the fragmentation of services. Services for children were dispersed between different sectors, teams or offices; children’s data was captured across different databases; and too often support would depend on administrative or organisational capacity rather than the needs of a child or family.</p> |

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| <p>Children’s social care services being marginalised within a larger all-age health and social care system</p> <p>Adult and acute hospital care tended to dominate planning and funding. This was most apparent in Northern Ireland and the Republic of Ireland where children’s health and social care were part of a health and social care service and/or system for all ages. In both cases, a ‘national children’s agency’ has been seen as a key means of addressing this imbalance (Burns and McGregor, 2019; Jones, 2023).</p> | |
|  | <p>In the Republic of Ireland, there were long-held criticisms that children’s social care services were a secondary focus of the national, Health Service Executive designed to provide services to all ages, compared to the primary focus it had on its hospitals (Burns and McGregor, 2019).</p> |
|  | <p>In Northern Ireland, a key recommendation of the Independent Review of Children’s Social Care Services (Jones, 2023 p223) is that, in the context of “well founded and long-standing concerns that children’s social care is marginal within organisations and arrangements understandably and necessarily focussed on the significant difficulties within health services”, a children and families social care arm’s length body be established.</p> <p>Under this proposed arrangement, the five Health and Social Care Trusts would retain their children’s health and social care remit but would work</p> |

with the national children and families social care body to best meet children, young people and families' needs.

Risk-oriented, deficit-based and centred on crisis management practice

Practice described as risk-oriented, deficit-based and centred on crisis management was present across all the case studies and often highlighted in the media through the experiences of high-profile children's cases or from the publications of reports into institutional historical abuse. Across the case study countries, the issue of practice was most apparent in New Zealand where the legacy of colonialism, along with the exclusion of structural factors such as poverty in child welfare approaches, led to greater intervention with Māori families and detrimental experiences and outcomes for Māori children and young people.

Limited participation of children, young people and families

Limited participation in decisions and planning that affect children, young people and their families' lives was seen across all case studies, and reflected the risk-oriented, deficit-based culture also seen. There were experiences of children and families not being listened to and decisions being made by professionals with limited child and family involvement.



In **the Netherlands**, children and families did not feel heard, professionals were found to overrule parents (Rap et al., 2019), and the ethos of professionals was described as having a 'patronizing tone' (De Vries and Wollbank, 2018 p101).



In **New Zealand**, and despite legislation since 1989 setting out duties to support participatory practices with Māori whānau, hapū and iwi (families, and larger subdivisions and units in Māori society), there had been significant barriers to the implementation of these duties (Healy 2009; Hyslop and Keddell, 2019). Following an inquiry by the Waitangi Tribunal in 2021, the devolution of power to Māori communities has been a key component of reforms.

An imbalance in service funding and provision towards specialist and reactive services

This was a focus rather than early help and preventative services. In turn, this was leading to ever-increasing costs as the needs of many children and families were not being met at an early stage. Instead, the support they then needed increased, requiring more costly specialist services to help them. This was apparent across all the country case studies we looked at, including in Finland with its (Nordic) family-service oriented model of care, where the number of children who require support from child

protection measures has been increasing and there are a proportionately high number of children in out-of-home care. The Child Welfare Act 2007, Social Welfare Act 2014 and LAPE programme aimed to ensure earlier support to families and gave families the right to request preventative support.

A programme of austerity aimed at reducing or constraining public expenditure

Another 'push factor' that was evident from the case studies, and particularly the formation of Police Scotland, was the financial impact of the 2008 global economic recession which led to or forced some governments to adopt a programme of austerity aimed at reducing or constraining public expenditure. The programme of austerity was also influenced by the New Public Management values of economy, effectiveness and efficiency (Hood, 1991). Opportunities to achieve cost savings through more efficient structures and streamlined services were prominent in the formations of Police Scotland, and Tusla in the Republic of Ireland (Moggré et al., 2018; Power and Burke, 2021).



In **Finland**, the SOTE reforms of health and social services designed for all ages had the explicit target of reducing annual expenditure by €3billion per annum through greater efficiencies, privatisation and marketisation of the system.



In **New Zealand**, its social welfare and child welfare policy of the early 2010s was strongly influenced by what has been described as a prevailing neoliberal political context that led to the emphasis being placed on smaller government, reducing government expenditure but also investing to achieve outcomes (particularly positive outcomes among high risk or 'vulnerable' children and families), and underlying the importance of individual responsibility. However, the resulting outcome of this policy approach was that many families experienced increased poverty (Keddell 2016).



In the case of **Police Scotland**, the Scottish Government stated in its support for the formation of a single national police force that "economies of scale and reduced duplication associated with the creation of a single police force would save 10% of the police budget per year without any reduction in the numbers of police officers" (Terpstra and Fyfe, 2019 p103).

Pull Factors

In many ways a mirror image of the 'push factors', each of the transformational reform programmes had a number of 'pull factors'.

A vision of what reforms would achieve

The 'pull factors' offered a 'vision' of what the reforms would achieve. The word 'vision' is important because these 'pull factors' relate to the aims and aspirations of the reform programmes as set out within national policy and legislative documentation. Often there was limited detail on what these visionary 'pull factors' would entail and, therefore, fewer illustrative examples are given here. In this report we consider the extent to which these aims and aspirations have been delivered.

A 'new' or a 'fresh' start

Indicative of the visionary nature of the transformational reform programmes, an overriding sentiment that came through strongly in all of the case studies was the importance of the transformational reforms signifying a 'new' or a 'fresh' start. This consequently reflects the sentiment across the case studies that the 'do nothing' option would not address the 'push factors'. A new approach was seen as necessary, and this sense of purpose and optimism was central to the support for the transformational reform programmes.



In **the Republic of Ireland**, the name Tusla was chosen to reflect the agency offering a new beginning and new identity to the children's services sector. Tusla is a completely new word, created by combining the Irish Gaelic words 'tús' and 'lá', which translate as 'start' and 'day' respectively.



In **Northern Ireland**, the Independent Review of Children's Social Care Services has recommended that "a single region-wide organisation be created for statutory children and families social care services [...] It would have a lead responsibility to promote the multi-professional and multi-agency integration of services for children and families [...and...] with its dedicated and single remit and focus on children and families it will be well placed to take on this strategic role" (Jones, 2023 p215).



In **New Zealand**, reforms led to the establishment of Oranga Tamariki in 2017 to replace the statutory social work organisation 'Child, Youth and Family' and to separate this Ministry from the Ministry of Social Development, along with a range of other changes.



In **the Netherlands**, the Youth (Care) Act 2015 led to the city of Utrecht establishing a new means of delivery – Child and Family Neighbourhood Teams – with this multi-agency service called Lokalis. This being a new service was seen to be an advantage as partners had permission to design

the service from scratch and not be tied to existing approaches and arrangements.

The sense of a new, fresh start not only related to the setting up of new structures but also reflected a fundamental change in service provision and practice. Across all the country health and social care case studies we looked at, 'pull factors' of this nature were:

Closer integration of national, regional and local organisations to enable more joined up planning, funding and delivery of children's health and social care services

This includes the opportunities for locally effective approaches and models to be scaled up or to influence national and regional provision so that more children and families benefit.

Re-balancing of service funding and provision towards early help and preventative services with the aim of improving children's outcomes

This in turn has the aim of reducing the demand for more costly specialist and reactive services. However, while improving children's outcomes were widely reported as the stated aims of the reforms, there was very little evidence of what specific outcomes, measures or indicators were being aspired to.



Improved access to services for children and families needing support

The aim of improved access to services particularly sought to deliver enhanced or seamless transitions between different services and increased equity of service provision irrespective of where children and families live, for example, in terms of meeting the needs of more rural communities and in accessing more specialist (such as mental health and disability) services.




In **Finland**, a key motivation of the SOTE reforms was to overcome the substantial variation in the size of Finland's municipalities (from 105 people in the smallest municipality to 658,457 people in Helsinki), which had in turn impacted on service provision. Smaller municipalities faced particular challenges in relation to financing, managerial capacity, and the coordination of services, leading to inequalities in access to services across local areas.

As well as overcoming local variations in service provision, a further development was to introduce low threshold mental health and substance misuse services to support children and families at an earlier stage.

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|  | <p>In the Netherlands, subsidiarity (that is, decisions being taken at the level closest to citizens) is a strong policy ethos. The decentralisation of adult and children's social care services would bring local service decisions and delivery to the most local level, therefore helping to ensure services were available locally that met that the needs of the local populations.</p> |
|  | <p>In the case of Police Scotland, a key aim in establishing Police Scotland was that it would create more equal access to specialist support and national capacity – such as murder investigation and firearms teams – where and when these are needed, as opposed to each regional force having these specialist resources and/or negotiating with other regional forces to access the specialist resources they have.</p> |

Embedding of children's rights in health and social care services

The countries of all the case studies had committed to uphold and implement the UN Convention on the Rights of the Child, and every country had a position of a Children's Commissioner or equivalent. There has also been a movement towards involving children in the design and development of the transformational reform programmes and ensuring their voices and participation are central to the planning and decisions that affect individual children's lives.

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|  | <p>In Finland, the LAPE programme set out to reorganise services so that these would be able to meet a child's individual needs. This was based on the principles of children's rights and best interests; strengthening children's, young people's and families' own resources; child- and family-centredness; and the diversity of families. Examples of the approach taken were the development of:</p> <ul style="list-style-type: none"> • Family Centres • Evaluations focused on the impact on children and their rights • Tools for child-centred budgeting • Tools to monitor the health and wellbeing of children. |
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Building a new relationship between services and children and families

There has been an emphasis placed on embedding relationship-based practice across children's health and social care services, with professionals practicing in a positive, strengths-based, and empowering manner. Children, young people and families would therefore experience and benefit from a more equal working relationship with professionals and services.

Enhanced working between practitioners from different services

Enhanced working between practitioners from different services has been central to the ambitions of the reforms, so that provision is flexible, responsive and holistic to the needs of individual children, young people and families. To facilitate this, reforms aim to help break down the professional boundaries between disciplines, encourage a more generalist skillset among children's practitioners, and enable practitioners to have more autonomy in their jobs to work in the best ways that meet the needs of children and families.

Improved workforce career and development opportunities

Recognising the importance of recruiting and retaining staff, there has been a drive towards professionalising the children's social care workforce, opening up career development and progression opportunities within a more coherent and integrated structure, and promoting the health and social care sector as an employer of choice.

Time to consider and develop the new approach

The opportunity for key stakeholders in the case studies to stop and consider the different 'push' and 'pull' factors and, above all, what would be the best way to respond to these was critical. This period was a time where different options were developed and appraised, and subsequently led to the formulation of the transformational reform programme.

This important time of reflection, appraisal and development took the form of independent reviews of the national health and social care system (for example, the Expert Panel on Modernising Child and Family Youth in New Zealand and the Independent Review of Children's Social Care Services in Northern Ireland) or, in the case of Police Scotland, the formation of a dedicated project team made up of key stakeholders.



In the case of **Police Scotland**, to consider and review options for policing reforms, the Scottish Government established the Sustainable Policing Project. The Sustainable Policing Project team consisted of civil servants and police officers, and they worked together at the Scottish Police College rather than at Scottish Government offices. "Symbolically and substantively this was important in allowing the police to have a strong voice in exploring the options for reform. It suggested a cultural shift in the centre of gravity of the reform process: rather than reform being 'done' to the police by government, reform was now being done 'with' the police" (Fyfe, 2019 p7).

The Sustainable Policing Project team explored three options: 1) to maintain the eight regional forces but with increased collaboration; 2) further regionalisation to, for example, three or four forces; and 3) a single

national service. In appraising the three options, the resulting report was clear in its support for a national police force, concluding that “The single force model represents the most significant change ...but it also... provides the greatest opportunity to manage change, drive efficiency and in delivering operations when the change is complete. The eight-force model represents the opposite” (Scottish Government, 2011, p5). The key benefits of a national police force were reported to be more equal access to specialist teams and functions, more streamlined command and leadership arrangements, and long-term financial sustainability (Scottish Government, 2011).

The respective independent reviews of the countries’ children’s health and social care systems instigated the reform programmes. However, these independent reviews were widely found to follow a number of similar reviews into the ‘system’ or parts of it. In Northern Ireland, this led to a sense of ‘review fatigue’ as each review identified similar weaknesses and put forward similar recommendations, with a sentiment that there was a need to move beyond these reviews and implement the reforms needed. Conversely, in New Zealand, successive reviews and reforms attempted to rectify crucial omissions or faults of previous reforms. Whilst this was often essential in this specific context, it is likely that these reviews brought disruption to the reform programmes.




Summary

Across the five health and social care system case studies, including those that rank highly on international measures of child wellbeing, each were found to face the same set of ‘push’ factors. To address these, the ‘do nothing’ option appears to have been dismissed and there was a clear desire within each country to take a new and different approach. The resulting transformational reform programmes – each of which took a different form – offered the optimism of delivering more preventative, integrated and person-centred health and social care for children, young people and families. However, the reform ambitions as articulated by the ‘pull factors’ were wide and expansive. These included not only structural changes, for example, new agencies, the transfer of functions between organisations, and enhanced transitions between services but also practice and cultural changes, such as towards strengths-based and participative practice as well as addressing workforce recruitment, retention and support challenges. This raises the question of whether the transformational reform programmes alone, particularly if primarily focused on system restructure, can deliver on all fronts.

Structural Developments

The transformational reform programmes within the case studies have led to children's health and social care services being the responsibility of national, regional, local authority and locality structures. Locality refers to the structures in place at the community level. While each case study differs, there are nonetheless some common features across them.

In Figure 2, the arrows suggest a two-way flow of influence between upper and lower levels of the system. However, the case study evidence finds that the flow of influence is typically top-down with locality needs rarely influencing the regional and national levels.

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| <p>National</p>  | <p>The features at this level are:</p> <ul style="list-style-type: none"> • Lead government ministry and/or national children and family agency that sets national children's health and social care policy and legislation, and is the main source of service funding • Lead government ministry and/or national children and family agency works in partnership with other government ministries and relevant national agencies – for example, a national inspectorate, children and young people's commissioner, social care workforce councils • Lead government ministry and/or national children and family agency leads and is responsible for the implementation of transformational reform programmes • Lead government ministry and/or national children and family agency has the opportunity to articulate national standards, practice models, and outcome indicators |
| <p>Regional</p>  | <p>The features at this level are:</p> <ul style="list-style-type: none"> • Strategic planning, commissioning and delivery of health and social care services • Health-led • Can be dominated by hospital and adult care, with children and family needs marginalised |
| <p>Local</p>  | <p>The features at this level are:</p> <ul style="list-style-type: none"> • Strategic planning of children and family support services at a 'local authority area' level via a partnership of, for example, social work, health, education and third sector partners • Oversight and coordination of locality level structures • A main focus on preventative and early intervention support services and the interface with statutory child protection and care |

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| | processes and specialist health services, particularly where these services are delivered at a national or regional level |
| Locality | <p>The features at this level are:</p> <ul style="list-style-type: none"> • Branded multi-agency hubs or teams (for example, Family Support Hubs or Family Centres) serving a population size of 40,000 – 60,000 people • Co-location of multi-agency practitioners working together in an integrated and responsive manner around children and families • The main area of activity is preventative and early intervention support services, but with access to more specialist and statutory services • Practice is welcoming, non-stigmatising, strengths- and relationship-based |

Figure 2: Commonalities across national, regional, local and locality structures

National structures

There were two structures that were found across all of the health and social care system case studies we looked at: a lead government ministry and a national inspectorate body, albeit with some variance in these structures' remits in each country.

The lead government ministry for children's health and social care varied between a 'health and social affairs' ministry in Finland, the Netherlands and Northern Ireland, whereas a 'children and youth' ministry was the lead ministry in the Republic of Ireland and New Zealand. The lead ministry held ultimate accountability for the children and/or adult health and social care system, strategic planning, setting of policy and legislation, and implementation of the transformational reform programmes. It was also the main source of funding for children's health and social care services, albeit the commissioning of services was widely delegated to regional and increasingly local authority partnership structures as the sub-national level was understood to be more attuned to local levels of need and service priorities.

The lead ministry works with other government ministries (such as education, health, social development, crime and justice, and housing) to ensure the holistic needs of children were being addressed. In New Zealand, the ministry for children, Oranga Tamariki, leads on work to support children, but there is also a collective commitment established in statute for six ministries to work together to achieve the outcomes of the national Child and Youth Wellbeing Strategy 2021.

As a comparison for this Children Services Research Reform study, the Scottish Government's structure means there is not a single distinct lead government department or ministerial responsibility for children's health and social care. Outcomes for children and their wellbeing is one of a number of National Outcomes in the National Performance Framework and this is shared across government. Lead responsibility for children's social

care sits within the directorates and Ministers working under the umbrella of Education, and lead responsibility for children's health sits within the health directorates, the Ministers working to the Health portfolios and the national health service in Scotland, and the chief professional officers including the Chief Medical Officer for Scotland. There are also directorates and Ministers with responsibilities for communities, justice and social security with policies that affect the day-to-day lives of Scotland's children and their families. among the case studies.

In the Republic of Ireland, Tusla's remit includes educational welfare services but this is seen to be a 'bolt on' service area and governance of educational welfare services recently transferred from the Department of Children, Equality, Disability, Integration and Youth to the Department of Education.

A national inspectorate body was responsible for scrutinising the functioning and performance of the health and social care system and its constituent providers. This body was independent but reported to the lead government ministry. While Scotland's health and social care inspectorate functions are sub-divided between Healthcare Improvement Scotland and the Care Inspectorate, these functions were held by single inspectorate bodies in most of the case studies. In the Netherlands, there was a merger of its Health Care Inspectorate and Youth Care Inspectorate. In the Republic of Ireland, Tusla currently inspects and regulates private and voluntary residential care settings. However, there are proposals to transfer these functions to the Health Improvement and Quality Authority due to concerns over conflict of interests as Tusla is both funder and inspector of the care settings.

A number of other national structures and bodies were found to operate across the case studies. Providing a summary analysis of these is difficult due to their number but some countries had adopted, or were adopting, a national child and family agency approach, some had national child protection boards, many had the equivalent of a children's commissioner to uphold their rights, and some had a professionals' council to advance the workforce needs of the sector.

- In the Republic of Ireland, Tusla: the Child and Family Agency was established in 2014 as a new national state agency responsible for improving children's lives and wellbeing. Tusla services include child protection and welfare, family support, early years services, and domestic violence. Previously these services were part of Ireland's national health system (specifically the Health Service Executive).
- In Northern Ireland, a national children and families' social care body is proposed and this would work with the five regional Health and Social Care Trusts to advance and meet children, young people and families' needs.
- In the Netherlands and Northern Ireland, a national child protection or safeguarding board is responsible for statutory child protection and care decision-making. In the Netherlands, the Child Care and Protection Board was responsible to the Ministry of Justice; in Northern Ireland, the Safeguarding Board is responsible to the Department of Health. On the matter of the mandatory reporting of child protection concerns, approaches varied across the case studies.

- In Finland and the Republic of Ireland, mandatory reporting by practitioners is set out in (Finland's) Child Welfare Act 2007 and the (Republic of Ireland's) Children First Act 2015. In the Netherlands and New Zealand, it is mandatory for organisations that worked with children to have a child protection policy or protocol for practitioners to follow. In Northern Ireland, the Criminal Law (Northern Ireland) Act (1967) provides for a criminal offence of failing to disclose an arrestable offence to the police which would include most offences against children. However, this legislation exists as a technicality for all offences, rather than a concerted effort to target the issue of child maltreatment.
- In Finland, Northern Ireland, the Republic of Ireland and New Zealand, there are national bodies to uphold the rights of the child. In New Zealand this is the Office of the Children's Commissioner; in Finland and the Republic of Ireland, these are ombudsmen who held the equivalent function to the Children and Young People's Commissioner Scotland. In Northern Ireland, The Children's Court Guardian Agency for Northern Ireland provides support so that the voices of children involved in public law and adoption proceedings are heard. Similarly, VOYCE (Voice Of the Young and Care Experienced) was established in New Zealand in 2017 to ensure children and young people have the opportunity to express their views in decisions that affect their lives.
- In Northern Ireland and the Republic of Ireland, there are professionals' councils (the NI Social Care Council and CORU: Health and Social Care Professionals Council respectively) for professional registration and to advance the workforce development needs of the sector.
- In the Netherlands, the Netherlands Youth Institute is a government-funded children's research centre. Commissioned and financed by the Ministry of Health, Welfare and Sport, it collects and shares knowledge and research about child and youth matters that can support professionals and local authorities in their service delivery. In a similar development, an independent evaluation team (the consortium of the Scottish Institute for Policing Research, ScotCen Social Research and What Works Scotland) was commissioned by the Scottish Government to capture and share the learning from the early years of the Police Scotland reform process.
- In New Zealand where all local children's social care is delivered through a commissioning model, the Whānau Ora Commissioning Agency is a national commissioning agency for child and adult services. The aim of the agency is to support the wellbeing of whānau (extended family group) by building on their strengths and capabilities and arranging culturally appropriate services and support in areas such as health, education, housing, employment, improved standards of living and cultural identity. This includes national programmes to provide direct financial support to families, and navigator programmes to support access to integrated care as well as local programmes.

Across the five health and social care case study examples, there was no evidence of a move to forming a dedicated national adult and children's social care agency or service.

In the Republic of Ireland and Northern Ireland, there have been moves to create a national children's social care agency in response to experiences of children's needs being marginalised in a health and social care system that is for all ages.

Regional structures

The main service area that was planned, commissioned and delivered at the regional level was health, so mirroring how health is delivered in Scotland and with its NHS boards, many of which operate at a regional level.

- In Finland and Northern Ireland, the regional health structures are responsible for adult and children's health and social care services. Furthermore, these regional structures are found to be coterminous with other key public administrative boundaries.
- In New Zealand and the Republic of Ireland, reforms of their health system have each led to a reduction in the number of regional health structures, with remits to plan, fund and deliver adult health and social care, and children's health care.
- In the Netherlands, its public health boards are responsible for child health care but not social care, as this resides with local authorities.



In **Scotland**, there are 14 NHS health boards that are responsible for primary and acute health and medical care covering an average population of 390,000. These regional structures vary in average population they serve from 380,000 to 1,250,000 people.



In **Finland**, 21 Wellbeing Services Counties (plus Helsinki city) serve populations that vary from under 30,000 in Åland, to 400,000 in more populous counties. The city of Helsinki is an exception to the regional governance structure, with a population of 658,457 people, and slight variations in governance responsibility.



In **the Netherlands**, there are 25 Public Health Boards serving an average population of 700,000 people.



In **New Zealand**, recent health reforms have led to an ending of its 22 regional district health boards and these have been replaced by four new health regions. The four health regions serve an average population of 1,250,000 people.



In **Northern Ireland**, there are five Health and Social Care Trusts serving an average population of 380,000 people.



In **the Republic of Ireland**, recent (Slaintecare) reforms have led to six Regional Health Areas being established rather than the nine Community Health Organisations that previously operated. The six Regional Health Areas serve an average population of 830,000 people.

Health was not the only health and social care service area managed at the regional level, albeit the regions in the other service domains (such as education or social care) often differed from the health regions. The two main examples come from the Netherlands and the Republic of Ireland where there were regional strategic planning arrangements for children's social care:

- The Netherlands has a number of regional structures and arrangements (for example, for primary school education, secondary school education, police and safety), many of which had different and overlapping administrative boundaries. In relation to children's social care, the 42 Regional Youth Care Alliances enabled the Netherlands' 342 local authorities to collaborate in regional strategic planning of children's social care services, though these regional arrangements did not extend to delivery or commissioning of services. These functions remained at the local level.
- In the Republic of Ireland, Tusla has 17 Integrated Service Areas to manage the delivery of services, with each having its own management structure and a Child Protection and Welfare department.

Local structures

The planning of early help and preventative services to children, young people and families was mainly found to be at the local authority level. In the Netherlands, the Youth (Care) Act 2015 and other social welfare reforms led to adult and children's social care being delegated to its 342 local authorities but with variation in how each local authority delivered these services.



In **the Netherlands**, there were three main models adopted for delivering children's social care services:

- Services delivered through dedicated child and family neighbourhood teams
- Services delivered through child and family centres
- Services delivered through an all-age service

Examples of each (Lokalis – Utrecht's Child and Family Neighbourhood Teams; Voorschoten's Child and Family Centre; and WIJEindhoven's All Age Service) are provided in our Netherlands case study but no evidence was found of the respective strengths and weaknesses of each approach, nor whether different models were found in different types of local authority areas.

Local authorities in Northern Ireland and the Republic of Ireland did not have adult or children's social care responsibilities, with local government's role focused on functions such as planning, roads, and economic development. However, while local authorities did not have children's social care responsibilities, both countries had multi-agency children's services planning structures at a similar geographical scale to Scotland's local authorities. New Zealand is seeking to adopt a similar approach through its 'Localities', which are local population health networks that aim to join up care services and help ensure decisions and planning to meet the needs of local communities. The funding for these and the third sector come from national government and via Whānau Ora, the Māori Commissioning agency, which supports the devolution of power and resources to Māori (Hyslop, 2022).

Across these different arrangements, there are parallels to the relationship between Police Scotland and Scotland's local authorities. While Police Scotland has national priorities, arrangements are in place to ensure local policing needs are heard and met. Specifically, Scotland's local authorities and other local partner organisations are responsible for approving and scrutinising Police Scotland's 32 Local Policing Plans (one for each of Scotland's local authorities). They do so as members of 32 Local Scrutiny Panels, with these existing within local community planning partnership structures.



In **Northern Ireland**, 25 Locality Planning Groups focus on identifying and understanding need at the local community level, and then engaging with communities to discuss how organisations can work together more effectively to meet local need.



In **the Republic of Ireland**, 26 Children and Young People's Services Committees bring together all relevant stakeholders in the statutory, community and voluntary sectors at a managerial level to jointly plan and co-ordinate services for children, young people and their families. Their age remit spans all children and young people aged from 0 to 24 years and their purpose is to ensure effective inter-agency co-ordination and collaboration to achieve the best outcomes for all children and young people in their area.








In **Finland**, whilst health and social care is co-ordinated at a regional level, education services, including early years education and youth work, have remained under the governance of local municipalities. The impact of this change in governance on multi-agency working has been monitored by regional wellbeing counties, with measures in development to reduce any detriment to co-ordinated working.

Locality structures

The planning of children's social care can be seen at the equivalent of local authority area level but the delivery of children and family services, particularly preventative and early intervention services, was found to be at a more localised, community level.

Whether termed 'Family Centres' in Finland, 'child and family neighbourhood teams' or 'child and family centres' in the Netherlands, 'Family Support Hubs' in Northern Ireland or 'Family Resource Centres' in the Republic of Ireland, there was a consistent form and function to these locality delivery structures:

- These consisted of multi-agency and co-located child and family teams or centres. Professionals from different disciplines (for example, parenting support, social work, mental health, financial inclusion, early childcare and education professionals) work together to tailor service delivery to the individual needs of children, young people and families.
- They had clear branding – for example, as 'Family Centres', 'Family Support Hubs' or 'Family Resource Centres' – that ensured the centres were recognised by children and families needing support as credible places of local child and family support within a coherent national structure.
- In terms of values, they were found to be community-based, welcoming, non-stigmatising, relationship-based and able to provide a co-ordinated response to people's needs. However, research in Northern Ireland and the Republic of Ireland that captured the views of families, found that family support services were closely associated with statutory child protection services and that this can deter the engagement of families with these services, particularly where families can draw on an informal (such as extended family or community) network (Mason et al., 2021; McGregor et al., 2020; Rodriguez et al., 2018). This has also been the experience in New Zealand, which has led to increased commissioning of local service through the Māori-led Whānau Ora Commissioning agency. Families have since reported very high levels of satisfaction: 97% of 5,685 families reported positive experiences of Whānau Direct, a service that provides resources to individuals and whānau (families) directly, and 81% of 2,007 families reported positive experiences of the Kaiārahi service, which provides advocacy and supports access to integrated, wraparound support from multiple agencies (Whānau Ora Commissioning Agency 2021).
- Where specialist or statutory levels of support or intervention were needed, referrals were then made to the relevant services, such as child and adolescent mental health, disability, or speech and language provision.
- These structures served an average population of between 41,000 and 66,000 people. In relation to the Republic of Ireland's Family Resource Centres, an aim was that each delivered to a population of 30,000 to 50,000 people (Rodriguez et al., 2018). A similar sentiment into the rationale for the decentralisation of services to the 342 local authorities in the Netherlands was expressed by the Netherlands country expert we consulted.

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|  | In Finland , 116 Family Centres serve an average population of 47,000 people. It should be noted that since 2023 there has been a change to the governance of family centres from local municipalities to regional wellbeing service counties. There are now Family Centres established across all counties. |
|  | In the Netherlands , there are child and family neighbourhood teams, child and family centres or services for all ages in each of its 342 local authorities serving an average population of 51,000 people. |
|  | In New Zealand , and under its health system reforms, there are plans to establish a new network of 60-80 Localities. Taking a mid-point of 70 Localities, each would serve an average population of 71,000 people. |
|  | In Northern Ireland , 29 Family Support Hubs serve an average population of 66,000 people. |
|  | In the Republic of Ireland , 121 Family Resource Centres serve an average population of 41,000 people. |

While there were many similarities in the form and function of the locality delivery structures we looked at, the service mix differed. The combination of different 'catchment' populations who would access the support, different third sector provision, and different local planning, commissioning and funding arrangements meant that no two locality delivery structures were the same. Locality service provision was therefore responsive to local opportunities and needs, and this was widely viewed to be a strength of these localised arrangements. Differences in locality structures across the case studies include:

- In the Netherlands and the Republic of Ireland, the localised structures were physical centres of co-located services for children and families to attend.
- In Finland there are five types of family centres; multidisciplinary family centres based at one location; multidisciplinary family centre across different locations; welfare health care clinics; open services for early childhood education and care; and specialised family support centres. 'Electronic family centres' are being developed which include an online service for families and professionals, with information about services and advice, as well as a directory of other professionals, and information about services, tools, and guidance for professionals.

- In Northern Ireland, the Family Support Hubs were virtual, multi-agency structures where referrals for support are screened and then directed to the most appropriate local support.

Summary

Despite their common aims and aspirations, the transformational reform programmes we looked at appear very different. They ranged from a national approach to a highly localised approach. None had moved towards forming a dedicated national adult and children's social care agency or service. However, on closer inspection, there were commonalities in the structures and functions that exist at each level:

- At the national level, there is a lead government ministry and/or national children and family agency that sets national policy and legislation, is responsible for implementing the transformational reform programmes, working in partnership with multiple stakeholder organisations to do so. Also at the national level are the inspectorate and children and young people's commissioner functions.
- At the regional level, adult and children's health services are widely planned and delivered.
- At the local (authority) level, there is joint planning, management and, increasingly, commissioning of children and family services.
- At the locality level, branded, multi-agency teams and hubs operate, often in co-located sites, to provide prevention and early intervention support. Services and joint-working at this level were found to be most impactful on the lives of children and families.

Progress, challenges and outcomes

For this study, we have considered the progress, challenges and outcomes that the transformational reform programmes have had to date. We begin with an overview of the extent to which the transformational reform programmes are being, or have been, implemented, with this setting the context for the level of progress and outcomes achieved.

Implementing the Reforms

Across all the transformational reform programmes we looked at, the clear finding is that reforms of this magnitude take multiple years to implement. A number of the new or reformed structures stem from legislation passed approximately 10 years ago (for example, the Child and Family Agency Act 2013 in the Republic of Ireland; the Vulnerable Children Act 2014 in New Zealand; and the Police and Fire Reform (Scotland) Act 2012). Rather than being a single event, the learning from the case studies is that transformational change is a complex and prolonged process.

There were features within the case studies that appeared to facilitate the implementation of the reforms:

- In the Netherlands, the importance of cross-party political support was highlighted as critical in driving forward the decentralisation of adult and children's social care services.
- In the Republic of Ireland, albeit drawing on the reforms to its national health system, a 'programme office' had been established. The Slaintecare Programme Office, reporting to the Department of Health and Health Service Executive, has been tasked with developing a strategic and programmatic approach to implementation and develop detailed action plans, deliverables, costs and timelines for each area of reform.
- In Finland, significant preparatory activity had been undertaken to manage the transfer of health and social care responsibilities from municipalities to the new regional wellbeing service counties. This activity included:
 - The transfer and integration of staff on existing terms and conditions
 - Development of new IT systems
 - Development of new regulations and guidance
 - Requirement for monthly implementation reporting by each wellbeing county so that progress can be understood, and challenges identified and acted on.
- From the Police Scotland experience, some flexibility and discretion in the reform legislation was found to be helpful in recognition of the difficulty of being prescriptive within the legislation for all aspects and details of the reform.

However, the overriding finding from the case studies is that implementation of the transformational reform programmes has been challenging. A number of factors have been identified which contributed to the challenges:

- Changes in government, with Finland's reform programmes in particular affected by changes in political leadership across the 2016-2019 and 2019-2023 parliamentary terms. The different agendas of each prime minister have altered the scope of reforms, meaning that reform programmes have been limited to each parliamentary term. An exception to this is the National Child Strategy 2021 which gained a 40-year commitment across different government terms and agreement to permanent funding. In New Zealand, fluctuations in political viewpoints and the ethos of children's social welfare resulted in contrasting stages of review and reform, resulting in an often-contradictory legislative landscape and inconsistent approach to implementation.
- External events, and especially the COVID-19 pandemic and its impact, lengthened reform timeframes because attention became focused on responding to the public health crisis.
- In New Zealand, a swell of public opinion, media attention and reviews tied to children and families' experiences of poor practice in providing support resulted in a third stage of reforms to children's services, shortly after a previous reform had commenced.
- In Finland, aspects of the SOTE reform aiming to increase the marketisation and privatisation of services (where the high rate of for-profit residential childcare has is especially high compared to other countries (Pålsson et al., 2022)) were particularly contentious and attempts to legislate these changes in 2018 failed.
- In the Netherlands and Police Scotland case studies, transformational leadership was found to be lacking, either due to leaders not having the skills and experience of bringing about transformational change, or due to other operational issues (such as an increasing demand for services) diverting their attention.



In the case of **Police Scotland**, the leadership of Police Scotland's reform process within Police Scotland, the Scottish Government and Scottish Police Authority was highlighted as a key challenge:

- Leaders did not communicate the rationales and benefits of reforms (Scottish Police Authority, 2022b). Too much of their communication was centred on the 'what' and 'how' of reform, rather than communicating 'why' changes were needed and the 'big picture' of what the new organisation wanted to achieve (Fyfe et al., 2021). Furthermore, much of the communication was internally focused, meaning wider partner organisations had less understanding of the implications and impact of reforms.
- Leaders did not have the range of skills and expertise to deliver and implement complex, transformational change. To overcome this, greater consideration of bringing in specialist skills sets from experienced, external professionals was proposed (SIPR, 2016).

- Leaders did not have a clear theory of change which would articulate the impact of policing reform, both at the national level but also at the local level (Fyfe, 2019).

- An underpinning theory of change was lacking across the case studies' transformational reform programmes that clearly articulated the aims, key changes, projected outcomes and impacts of the reforms, and the connections between these. This was a key gap that would have helped to communicate the transformational reform programmes and helped explain how the stated aim of improving children, young people and families' outcomes would be achieved. Furthermore, there was very limited evidence of indicators in place to monitor the implementation and impact of the transformational reform programmes. The few measures identified from the national health and social care system case studies were:

- In the Netherlands, the number of children receiving child and family support, the number of children involved in child protection and care proceedings, and the number of children and young people involved in youth justice cases.
- In Northern Ireland, the number of children on the Child Protection Register, and the number of children who are 'looked after'.

Even with these, and perhaps due to a lack of a theory of change, there was limited insights on how these indicators are being analysed and to what extent the changes recorded are being attributed to the reforms.

- Insufficient time was allocated for the implementation of projects and actions. In Finland, an evaluation of the LAPE programme found that whilst there has been good progression of the Family Centre model, the allocated time for implementation was not sufficient to achieve all goals of the model (Owal Group, 2019).
- Newly created organisations and structures take time to become fully operational. In the Republic of Ireland, it has taken many years for Tusla to develop its corporate (for example, IT, financial, procurement, human resources and estates services) infrastructure, with it entering a Memorandum of Understanding with the Health Service Executive so that it could use the Health Service Executive's infrastructure in the interim (Tusla, 2023). In Scotland, the newly created Scottish Police Authority that was set up as arms-length body to provide strategic direction and oversight of Police Scotland took time to develop and fulfil its functions, which impacted on its level of influence on Police Scotland and the Scottish Government given that both had existing resources and personnel (HMICS, 2019; Murray and Malik, 2019).
- While not referred to as having a direct impact on the transformational change programmes, it was apparent that there were other transformational change programmes taking place in the countries at the same time (for example, the

national health system reforms in New Zealand and in the Republic of Ireland, mergers and restructuring of local government in the Netherlands, and several interlinked and concurrent reforms in Finland).

Areas of progress

Having considered the factors related to the implementation of transformational reform programmes, we focused on the progress made towards delivering on the core aims of the reforms. In particular, we considered the extent to which the case studies have seen the visionary 'pull' factors of more integrated services, including re-balancing to preventative and early intervention services, and an embedding of children's rights realised. In doing so, it is important to reiterate that none of these reform programmes can be described as complete. Each continues to evolve and embed, which in turn means that the changes and impacts aspired to will only fully emerge and be understood in future years.

With the caveat that the areas of progress are best described as indicative areas of progress, the experience from Northern Ireland, the Netherlands and Finland points to an increase in collaborative working at the local level through the multi-agency, co-located teams at the locality level. In the Republic of Ireland there appears to have been a move to more consistent practice across the country through the availability of national resources. In New Zealand, it is too soon to understand the impact of the reforms but there does appear to be in terms of strengths-based practice leading to less children entering care, staff retention levels stabilising and increased commissioning to Māori communities.



In **Northern Ireland**, the drive towards health and social care integration has increased the levels of collaborative working at the locality level. We saw that with:

- The multi-agency Family Support Hubs and Early Intervention Support Service at the local level.
- The role of 'co-ordinators' or 'interface officers' who have in depth knowledge of the different services available in their local area, match services to the needs of people requiring support, facilitate seamless transitions between services, and identify and address service barriers and constraints in their local area.
- Co-location of workers from different services, with examples of social workers based in schools to support children, young people and school staff with trauma and attachment difficulties and (age) 16+ teams having social work, mental health and disability practitioners working together.

An evaluation of the Early Intervention Support Service found that it was well received by families on account of it being welcoming, non-judgemental, relationship-based and flexible to their needs. These features

contributed to a low drop-out rate among families and, from the Outcomes Star being used as a participatory tool for children and families to measure changes in different aspects of their lives (www.outcomesstar.org.uk), evidence of improved family wellbeing and increased confidence in parenting (Winter et al., 2018). Similarly, an evaluation of the Family Support Hubs found 93% of families involved experienced positive change in at least one of the outcome areas including improved parenting skills/capacity; improved family relationships; increased participation/involvement in education/training/employment or improved emotional wellbeing (Social Care Institute for Excellence, 2021).

The Northern Ireland Independent Review of Children's Social Care Services (Jones, 2023) highlighted that whilst the roll-out of Multi-Disciplinary Teams in primary health care was a welcome development, it was noted that this was often a partial co-location, with different professionals and workers being in the same building, but without a team structure, shared co-ordination or leadership. The social work staff usually undertook brief time-limited programmes of work with children and their families for 6-8 weeks, and an unintended consequence for local areas had been the loss of some of their most experienced staff and managers to these new teams.



In **the Republic of Ireland**, a more consistent, national approach to delivery has been brought about through the development of national standards (for example, in foster care, residential care and specialist care) and implementation of two national practice models:

- The Meitheal practice model on preventative and early intervention services (which is similar to the Getting It Right For Every Child approach in Scotland)
- The Signs of Safety model for child protection practice (which is also used in some Scottish local authorities).

Rodriguez et al. (2018) found that Family Resource Centres and their local service networks have increased collaboration between different sectors and services, and there has been an embedding of the 'No Wrong Door' principle into practice, which helps to ensure children and families are referred to the most appropriate services for them, irrespective of how they first engage with services.

There has also been investment in management information systems to boost the consistency of recording and information sharing:

- The National Child Care Information System is a single integrated management information system to manage child protection cases.



- The new Tusla Case Management System supports the management of all Tusla services and improve information sharing between professionals.

In **the Netherlands**, the co-location of generalist children and family workers with specialist services (for example, child and youth psychology, special education, psychotherapy, child and youth psychiatry) has facilitated joint discussion in supporting children and young people and enabled practitioners to learn from and be supported by practitioners from different disciplines.



In **Finland**, the successes of the LAPE reform include the development of new models of practice, and new structures and information systems to support multi-agency collaboration.

- Shared principles and goals have played a key role in practice, and effective communication, and information sharing has been critical to the success of changes (Yliruka 2022).
- One example of a model that has been developed to support integration of multi-agency services is the Family Centre model, of which the Ombudsman for Children has commented has been the primary area of progress within the 2016-2019 LAPE programme.

As the SOTE reform only began in 2023, it is too soon to have evidence of positive impacts. The same is true for other changes, such as the extension of the age at which young care experienced people are entitled to aftercare services, which was 18 and is now 25.



In **New Zealand**, too little time has passed since the most recent reforms in 2021 and 2022 for adequate evidence of the impact success of these reforms. However, there have been positive signs of change in terms of reductions in the number of children, including Māori children, entering care, staff retention levels stabilising, and an increase in the commissioning of services to Māori and iwi partners (Oranga Tamariki 2022).

Areas of challenge

Notwithstanding the indicative areas of progress, the main discourse that emerges from the analysis of our case studies is the persistence or worsening of longstanding challenges in children's health and social care. Many of these are continuations of the 'push factors' that provided the impetus for the transformational reform programmes.

In relation to the ambitions of more integrated working, enhanced access to and seamless transitions between services, there was widespread evidence of:

- Difficulties accessing specialist children's health and disability services, particularly for disabled children and for children with mental health difficulties. Across the

case studies, a key factor appears to be that specialist health services are planned and commissioned at a regional health structural level, thus quite separate from the multi-agency children's services planning at the local authority structural level. However, it is also important to acknowledge that these specialist services were widely experiencing staff recruitment and retention difficulties which, combined with rising levels of need, were leading to longer waiting lists.

- Unsupported transitions from children's services to adult services, such as limited throughcare and aftercare support for young people leaving the care of statutory services. Across the case studies, New Zealand appears to have taken the strongest action to help address this through its setting up of the Transition Support Service.



In **New Zealand**, the Transition Support Service was set up by Oranga Tamariki in 2019 as a relationship-based support service for young people to transition to independence when they leave care or custody. Delivered by iwi (the largest social units in Māori society, with political and social power to organise services) and community partners, the service includes the following new types of support:

- Support for young people from a 'transition worker' up to the age of 21, with this support including life skills, obtaining ID documents, goal setting, and help with work, education and training
- The ability for a young person to remain living with, or return to living with, a caregiver until they reach the age of 21
- Advice and assistance for young people until they reach the age of 25
- Access for young people to a National Contact Centre for phone-based support

Though survey responses from young people have been positive on the whole, a need for continued improvement of the service has also been identified, such as improvements to the number of young people who are able to stay in their home after the age of 18 (Malatest International 2021, Oranga Tamariki 2022).

- Children living in more rural areas are continuing to face difficulties accessing services. This was particularly the case where children lived in small, remote localities as these areas do not have the scale and level of need to provide specialist services locally. Children and families therefore need to travel lengthy distances to access specialist services. In Northern Ireland, for example, many of the specialist services are centred in Belfast Health and Social Care Trust as national centres.
- Risk- or deficits-based practice continue to be experienced by children and families, as too is the experience of children, young people and families having to tell and retell their stories to different professionals.



In **New Zealand**, the Independent Children's Monitor found that whilst there has been significant progress in the reform of Oranga Tamariki relating to children in care, there is still a need for improvement. Key issues identified were:

- A need for extended support for caregivers and social workers, including support to develop cultural competencies, for social workers to spend time with children, whānau, caregivers and communities, and for caregivers of children with disabilities to be adequately supported.
- A need to improve how children and young people are supported to express and share their opinions, to be involved in decision-making and to know their rights.
- A need to be better understanding of why there is a disproportionately high number of children with disabilities in the care system.

Despite successive efforts to integrate agencies since 2014, collaborative inter-agency working between Oranga Tamariki, health and education is often inadequate and does not translate to positive outcomes or experiences for children and young people, particularly for mental health provision (Hyslop 2022).

- We observed from the case studies the inconsistent participation of children and families in the decisions and planning that affects their lives. All of countries where our case studies were had ratified the UN Convention on the Rights of the Child (UNCRC) and made extensive reference to the UNCRC in their national policy and legislation documentation. However, its implementation into planning arrangements and practice was limited. For example, there was little evidence of the views of children and families being sought as part of the development and design of the transformational reform programmes. At a practice level, there continued to be examples of practitioners not working in an inclusive, relationship-based manner (particularly specialist health and legal practitioners). There were, however, exceptions and examples of where children's rights and participation were becoming core ways of working:
 - The position of a Children's Commissioner or equivalent in all case study countries.
 - In New Zealand, Oranga Tamariki established in 2019 the National Care Standards that help ensure children and young people understand their rights and that these are upheld; while a Youth Advisory Panel was put in place to help inform Oranga Tamariki.
 - In Northern Ireland, the Independent Review of Children's Social Care Services ensured that children and families with lived experience were a key group the review engaged with.

- In the locality structures of all the case study countries, multi-agency practice at the level of the 'team around the child' were responsive to and inclusive of children's and families' individual needs.

There were a number of organisational and systems factors contributing to these challenges. Many of these factors pre-dated the transformational reform programmes and, despite ambitions to address them, the case studies have again shown that these challenges are difficult to resolve. However, some factors have increased in prominence over time, not least the increasing demand for children's services and deepening workforce recruitment and retention difficulties. The contributory factors included:

- Different organisational and professional cultures between services and disciplines, which meant practitioners from different services were not working cohesively together in a shared manner.



In **Finland**, the SOTE reforms and the establishment of new regional wellbeing service counties changed how children's services were planned and managed. In particular, this is felt to have negatively impacted on the relationship between education and health services, to the detriment of children. Before the reforms, the workforce had rated co-operation between health and education services more highly than between other sectors (Kanste et al., 2013). Education, health and social care had all previously been managed at the local municipality level. Indeed, prior to the SOTE reforms, the vast majority of funding allocated to the governance of services for children, young people and families was within the education sector of local municipalities.

The SOTE reforms changed the children's services landscape, with health and social welfare services transferred to the regional level; and education (early childhood education, preschool, basic education, youth work) remaining at the local level. In light of children's day-to-day interaction with education services, the changes within the SOTE reforms can be argued to have resulted in more change for children than for any other age group. Although the need to balance involvement and funding of health, social welfare and education in children's lives appear justified, such an enormous change may not account for the primacy of the role of education in children's day-to-day lives, including the strong relationships that develop between the education workforce, children and their families. The Ombudsman for Children commented that the SOTE reforms fragmented the services which the LAPE programme aimed to integrate, namely education, social welfare and health (Ombudsman for Children 2022; page 24).

To help address this, there have been concerted efforts to strengthen the links between education and child welfare services. There are currently local and regional projects in development with an explicit aim of supporting information exchange between schools and child welfare services, foster

shared understanding of the needs and rights of children, and to create new practices between education and child welfare services.



In **the Netherlands**, the Child Care and Protection Board was found not to work with families in the same relationship and strengths-based approach that local authority child and family services do.



In **Northern Ireland**, legal and medical professionals were found to exert greater power, status and voice than social work professionals (Fargas-Malet and McSherry, 2018; 2020)



In the case of **Police Scotland**, the (at least initial) dominance of the former Strathclyde Police Force's culture of performance management and empowerment in Police Scotland led to a sense of cultural loss among staff from the other legacy forces (SIPR, 2016). There was also a reported 'us and them' culture developing between specialist teams operating at a national level and officers in local police stations (SIPR, 2017).

- National models and tools not being used consistently within and across service workforces, was most apparent in the Northern Ireland and the Republic of Ireland case studies where common assessment and referral forms were, for example, being inconsistently used. In New Zealand, there was a strong policy emphasis on trauma-informed approaches, but there was no shared understanding of what this meant in practice and, in particular, what this meant for Māori communities.
- Infrastructural challenges that inhibit joint working, in particular the lack of integrated IT systems that enable information sharing and joint approaches to recording across different services. Police Scotland, for example, had to contend with 125 legacy IT systems in navigating the merger of eight regional forces. Similarly, a growing challenge in the Netherlands following decentralisation is that local authorities' management, procurement and administrative systems are becoming more complex and demanding of practitioners' time.



In **New Zealand**, there have been attempts to use data algorithms to predict and identify children who are at high risk of harm and their families. The Vulnerable Kids Information System (VIKI) would record interactions, share information, manage plans, and monitor children's progress. Using large national data sets, VIKI would employ tools for risk-prediction and algorithms to identify "high-risk" children and families to enable the targeting of support to them (Stanley and Monod de Froideville, 2020). Amidst ethical concerns, including the use of data collected for one reason for a different purpose without consent (especially the use of an algorithm to identify "high risk" children), and the potential for stigmatisation of children and families,

the use of data in the VIKI information systems was paused (Ballantyne, 2019; Jørgensen et al., 2021; Keddell, 2015; Keddell, 2019b).

- There has been an increase in demand for children's services, as well as an increase in the complexity in the circumstances of children's and families' lives that make up this demand. This increased demand and increased complexity is linked to the impact of the COVID-19 pandemic and increasing levels of child poverty. In Northern Ireland, where there have been increases in the number of children on the child protection register and needing the support of care services, multiple factors are thought to have contributed to this situation. In relation to people needing support, the lives of children, young people and families are becoming more complex, presenting services with an increasing intensity of need (Department of Health, 2018; 2022d; RQIA, 2018). Families are also experiencing increasing levels of poverty and inequality (Teggart et al., 2022), while McCartan et al. (2021) found that Northern Ireland has the highest prevalence of parent mental health issues in the UK, with similarly high levels among Northern Ireland's children and young people.
- The case studies also reflected the context of pressures and cuts to children's services budgets, coming at a time when the demand for services is increasing. In the Netherlands, the lack of funding was a significant point of tension between the national government and the local authorities with responsibility for children's services. In New Zealand, where all services are commissioned from the third sector, there was a detrimental impact on reform agendas due to the underfunding of services. In particular, a delay in awarding additional funding to services to enable them to meet increases in costs due to the of living crisis affected service provision and implementation of reform agendas.
- Widespread and deepening workforce recruitment and retention challenges, thus placing demands on staff to meet immediate service demands rather than engage in more collaborative exercises. Importantly, these challenges were found across the children's services sector (for example among social workers, mental health, and children's disability staff). A reported weakness across the case studies was the lack of effective workforce planning (including a lack of workforce data) to respond and address these challenges and, in the case of Police Scotland, the support and opportunities for the workforce was reported to have been impacted by the move from eight regional forces to a single national force. While it too lacks a workforce strategy, developments led by Tusla in the Republic of Ireland do offer some examples of the actions that could be taken to address these challenges.



In **Northern Ireland**, there was reported to be a tension caused by 'transformation' posts being established to advance health and social care integration. These posts were filled by more experienced colleagues, for example, management, team leader and supervisory level, which then



impacted on the services' ability to respond to immediate service demands and to support less experienced staff.

In the case of **Police Scotland**, a core performance target for Police Scotland has been to maintain police officer numbers in Scotland and it has achieved this. However, the support and opportunities for the workforce is reported to have been impacted by the move from eight regional forces to a single national force. Issues reported by officers included (Fyfe et al., 2021; Terpstra et al., 2019):

- Reduced access to and interaction with senior officers.
- Reduced supervision as the new structure means sergeants have more officers under their management. Rural officers are also more likely to be based in a different location from their sergeant.
- Supervision changing in nature from "direct, personal and context-dependent forms of supervision" to "increasingly abstract quantitative targets" (Terpstra et al., 2019 p346).
- Reduced training opportunities for local officers, as training was now largely 'role-based' and orientated to those in specialist functions. Local officers saw this as limiting the range of work that they can be involved in and restricting their career opportunities to move to specialist teams (SIPR, 2017).
- Reduced career development and promotion opportunities as there were fewer supervisory, for example, sergeant positions within Police Scotland and taking up an opportunity in a specialist, national team may require relocating. However, an opposite view was also held by some that being part of a national police force increased the range of opportunities available.
- Greater reliance on email to communicate announcements across the organisation, and local officers feeling 'bombarded' with emails and information.



In **the Republic of Ireland**, Tusla have recognised the recruitment and retention challenges facing the sector and are taking forward a number of actions, including (HIQA, 2022; Tusla, 2021; 2023):

- In conjunction with the Department of Children, Equality, Disability, Integration and Youth, working with and seeking to influence universities to increase the supply of Social Work and Social Care professional graduates.
- Supporting graduate placements in Tusla.
- Championing Tusla's services and communicating the agency as an employer of choice.
- Employing other professional groups and using social care staff to complete tasks traditionally completed by social workers.

- Implementing retention initiatives to retain existing staff, including:
 - A new induction policy for new staff
 - A buddy programme for staff in their first year
 - Working with senior managers to develop Local Retention Plans, and
 - Seeking feedback from staff on their experiences of starting work at Tusla, and using this feedback to make future improvements.

Another area of challenge that is more directly related to structures is that of governance, particularly when a new national structure has been established. The experiences of Tusla in the Republic of Ireland and in the Police Scotland case study show that governance arrangements take time to evolve and embed, and this becomes a longer process if the key governance bodies are themselves new structures (as in the case of the Scottish Policy Authority and the 32 Local Scrutiny Panels). The governance arrangements of Police Scotland have been a consistent theme of HM Inspectorate of Constabulary in Scotland reports and these highlight the need for:

- Absolute clarity and understanding of relative roles, responsibilities and accountability of organisations and in particular where the boundaries lie between organisations
- Governance bodies having appropriate capacity, capability and competence to exercise their functions
- Exercise of effective support and scrutiny of the organisation, and
- Balanced democratic representation and input.



In **the Republic of Ireland**, Tusla continues to experience changes in how its services are governed. The government's Department of Children, Equality, Disability, Integration and Youth continues to be its sponsor government department but:

- Governance of Tusla's two educational welfare services have transferred to the Department of Education.
- Tusla's domestic, sexual and gender-based violence services are moving to a new national service in January 2024 with the governance of these transferred to the Department of Justice.



In **New Zealand**, Oranga Tamariki was established in 2017 to replace the previous statutory social work organisation 'Child, Youth and Family' and offer a new way of working with children and families. However, change has been protracted and further reviews of activity have been undertaken. One of these was the Ministerial Advisory Board's (2021) 'Te Kahu Aroha' report which recommended that a National Oranga Tamariki Governance Board be established to oversee the diversity and depth of changes needed.



In the case of **Police Scotland**, Police Scotland's national and local governance arrangements have taken time to become established as key governance structures were also newly established by the Police and Fire Reform (Scotland) Act 2012:

- At a national level, it is intended that Police Scotland, the Scottish Government and the Scottish Police Authority work together in a tripartite relationship, but such a balanced three-way relationship has taken time to achieve. This is mainly due to the Scottish Police Authority also being a new organisation (established in 2014) that has taken time to become fully operational. With the Scottish Police Authority having an initially limited role, there were concerns that relationships between senior leaders in Police Scotland and the Scottish Government "became much closer than previously, raising questions about the risks of politicisation of the police" (Terpstra and Fyfe, 2019 pp103).
- At a local level, it is intended that Police Scotland, the Scottish Police Authority and the 32 Local Scrutiny Panels work together in another tripartite relationship, yet the form and function of the Local Scrutiny Panels were found to vary due to a lack of detail concerning their operation in the Police and Fire Reform (Scotland) Act 2012. Partly on account of Local Scrutiny Panels taking time to form and develop, Loveday (2018) found that national direction from Police Scotland overrode previously agreed local commitments and described local accountability as symbolic rather than real.

Evidence of outcomes

In the review of international models of care as part of the Independent Care Review in Scotland, McCaulay (2019) found that all the countries considered had a lack of robust evidence around the impact of models adopted and the outcomes achieved. The findings from our case studies indicate that this remains the case. For example, there was no evidence of a theory of change being developed that depicted how the transformational reform programme is understood to impact on short- and longer-term outcomes and impacts. Similarly, there was no evidence of a national set of measures or indicators in place to monitor the implementation and/or impact of the reforms. This includes workforce measures that, if in place, could support workforce planning activities.

While there were not indicators specifically tied to the reforms, there were examples of indicators or tools being used. These included:

- Child and family support indicators – for example, the number of children and young people receiving child and family support; and the number of children referred to Northern Ireland's Family Support Hubs.

- Child protection or care indicators – for example, the number of children on the Child Protection Register; the number of children ‘looked after’; and the number of children involved in youth justice.
- Child- and family-centred data capture tools – for example, the Strengths and Difficulties Questionnaire (Goodman, 1997), the General Health Questionnaire (Goldberg, 1972), and the Outcomes Star Assessment Tool (MacKeith, 2011) – were being used in Northern Ireland’s Family Support Hubs and Early Intervention Support Service.



In **the Republic of Ireland**, there has been significant investment made by Tusla in the agency’s data and IT infrastructure, with the catalyst being an external hacking of its data systems in 2021 where the personal data of 20,000 people was compromised. Its data infrastructure includes (HIQA, 2022):

- The Tusla Data Hub that is an interactive dashboard that presents monthly referral and case data for its 17 regional Integrated Service Areas across the themes of: child protection and welfare; alternative care and adoption; prevention, partnership and family support; education support service; and regulatory services
- A new integrated National Child Care Information System to manage information regarding children and families involved in child protection, and
- A new Tusla Case Management System to support the management of all Tusla services and information sharing between practitioners.

However, the need for better data collection and data sharing among agencies is still highlighted (O’Leary and Lyons, 2023). Across children’s services, the Ombudsman for Children (2022) has identified deficits in the systematic collection of comprehensive disaggregated data regarding ‘vulnerable children’, including children with disabilities, homeless children, children in care (including informal kinship care arrangements), Roma children, and children with a migrant background.

Particular problems were found within CAMHS’ (Children and Adolescent Mental Health Services) IT and management information systems, with the Mental Health Commission stating that most services do not have an IT system that manages appointments, schedules rotas for staff, maintains clinical files and provides reports on activity (Mental Health Commission, 2023). This highlights the need for investments in data infrastructure across all services.



In **New Zealand**, changes to data, insights and evidence were one of five core tenets of Oranga Tamariki’s (2021) Future Direction Plan. This aspect of the Future Direction plan included the continued roll-out of new performance reporting tools; development of options for the replacement of the current

case management system; centralisation of data collection to enable the analysis of this data to inform monitoring and decision-making; the embedding of evidence-based decision-making from sites to the national office; and deployment of the Social Wellbeing Agency's Data Exchange.

The Oranga Tamariki Action Plan and its associated Implementation Plan requires agencies to monitor improvements to the outcomes for children and young people who are viewed as having the greatest needs (including children and young people who are currently, or are at risk of being, involved with Oranga Tamariki or youth justice systems). Agencies must self-report every six months on progress in meeting the actions they have committed to, although no further detail has been found about the measures or indicators that ought to be used.

More detail is available around the monitoring of the National Care Standards. The Independent Children's Monitor reports on how Oranga Tamariki is upholding the National Care Standards, including: assessments; support plans; how well children's needs are met; how children are supported to express their views and how these views influence their care experience; and support during care transitions. At the moment (2023) this relates to the experiences of children in care but will soon be extended to all children who need to be supported by Oranga Tamariki. There are ambitions to extend this to the assessment of how the six national government ministries responsible for meeting children's wellbeing needs are upholding this duty (Oranga Tamariki, 2021; Implementing the Oranga Tamariki Action Plan).

Within New Zealand's health system, a key strength is its early adoption and extended use of information technology, particularly in primary care. All New Zealand residents have a unique health index number, and all GPs use electronic medical records. The government is now undertaking a Digital Health Work Programme, which includes the Integrated Data Infrastructure that links national datasets including health, education, housing, social services and justice. This is designed to provide more comprehensive data to help answer more complex research and evaluation questions.

Using the data that the available indicators and measures provide, in the Netherlands, New Zealand, and Republic of Ireland, there have been reductions in the number of children involved in child protection and care processes. In Finland, there has been a reduction in the number of children 'who cannot safely stay with their families'. In New Zealand, there has been a large reduction in the number of all children entering care, including Māori children going into care (Oranga Tamariki, 2020). Reporting by Oranga Tamariki in 2022 shows the lowest number of reports of concern, referrals for assessment, and children going into care since 2017, as well as a slight reduction in the disparity between the rate of Māori and non-Māori children's entry into care (Oranga

Tamariki, 2022). Measures to support the workforce, including addressing the gender pay gap and providing staff wellbeing services, are likely to be contributing to stabilisation of staff retainment and an increase to the commissioning of services to Māori and iwi partners, with appropriate funding (Oranga Tamariki, 2022).

In general, it is difficult to attribute these encouraging trends to the reform programmes in these countries, particularly in the Republic of Ireland where the national economy has experienced a strong period of economic growth and child poverty levels have decreased. Nevertheless, and even in the context of rising demand for services linked to the impact of the COVID-19 pandemic and increasing poverty, interpretation of the data from the Netherlands is that children's needs are being met sooner through local preventative services and this is beginning to mean there are less children requiring statutory care and justice interventions (Meiloo et al., 2022).

Summary

We have considered the evidence on the progress, challenges and outcomes of the transformational reform programmes. This has been a challenge because transformational reform programmes take multiple years to be implemented. Realising and understanding the outcomes of these reforms takes longer still. Notwithstanding these caveats, there are emerging lessons to be taken from our case studies in relation to implementation, the areas of progress, the (persistent) challenges, and the measurement of indicative of outcomes. Our discussion considers the learning concerning the implementation of transformational reform programmes and the features that contribute to integrated children's health and social care systems.

Discussion

Our case studies of transformational reform programmes are the second strand of work within the Children's Services Reform Research study, which is addressing the overarching research question 'What is needed to ensure that children, young people and families receive the support they need, when they need it?'. This second strand builds on our first strand of work, the Rapid Evidence Review (Porter et al., 2023), and McCauley's (2019) finding as part of the Independent Care Review (2020) that no one country has a system that can ensure the present or future wellbeing of children. Consequently, there is a need to reflect on and learn from the experiences of transformational reform within different country contexts and systems.

The primary research question this strand of work has sought to answer is:

What transformational reform programmes have been introduced to enhance the delivery of children's social work services through closer working with health and/or adult social care services in the case study countries, and what has been the impact of these on children, families, services and practice?

To help us answer this question we developed a series of sub-questions ([Methodology](#)), which were designed to help us access the breadth of knowledge required and the depth needed to answer the overarching research question as fully as possible.

The findings outlined in this report analyse the evidence from the six case studies we have produced. These focus on three aspects which together aimed to address the overarching research question for this study: the rationales for transformational reform programmes (the push and pull factors); the types of structures present; the progress in, and the challenges and outcomes of, transformational reform. Together they offer valuable learning into:

- a. The implementation of transformational reform programmes; and
- b. Key features of integrated children's health and social care systems.

For our discussion here we have synthesised our findings into several thematic areas which together address the overarching research question for this strand of work. Whilst each case study offers valuable insights and learning, the real value comes in bringing these together to understand some of things which may be needed to ensure that children, young people and families receive the support they need when they need it, which is the overall focus of the Children's Services Reform Research study. Subsequent reports from our study will continue to build this story, which will be presented in a final report once each strand of work is completed.

Rationales for transformational reform programmes

There were a number of common factors that provided the impetus for the transformational reform programmes. Many of these factors will be familiar to Scottish readers as they echo the findings and/or aspirations of The Christie Commission on the Future Delivery of Public Services (Scottish Government, 2011); incorporation of the UN Convention on the Rights of the Child (UNCRC); the Getting It Right For Every Child (GIRFEC) (Scottish Government, 2022) approach; and The Promise (Independent Care Review, 2020).

Organising these factors into 'push' and 'pull factors', the 'push factors' relate to persistent challenges in the previous children's health and social care system and service landscape:

- Children's health and social care services were:
 - Fragmented across national, regional and local structures; and
 - Marginalised within a larger all-age health and social care system.
- Practice was described as risk-oriented, deficit-based and centred on crisis management.
- There was limited participation of children, young people and families in decisions and planning that affect their lives.
- There was an imbalance in service funding and provision towards specialist and reactive services rather than early help and preventative services.

A new, fresh and/or different approach was needed to address these push factors, and a number of 'pull factors' were identified, offering a positive and ambitious 'vision' of what the reforms would achieve. Spanning not only structural changes but also wider changes to practice, service cultures and workforce supports, the pull factors were:

- A closer integration of national, regional and local organisations to enable more joined up planning, funding and delivery of children's health and social care services.
- Re-balancing service funding and provision towards early help and preventative services which, in turn, aim to improve children's outcomes.
- Improved access to services for children and families, including enhanced or seamless transitions between different services.
- Embedding of children's rights and building a new relationship between services and children and families – one characterised by professionals practicing in a positive, strengths-based, and empowering manner.
- Enhanced working between practitioners from different services.
- Improved workforce supports through professionalising the children's social care workforce and opening up career development and progression opportunities.

Implementation of transformational reform programmes

Implementation is a complex, prolonged and challenging process

Transformational reform programmes are a long-term commitment and expectations must be managed accordingly. Across all six case studies, there was a recognition that transformational change is not a single event but is instead a complex and prolonged process. In keeping with the implementation of The Promise following the Independent Care Review in Scotland (2020), a 10-year timeframe from the initial change announcement or legislation is widely referred to as the length of time is needed to:

- Create a new structure or agency and its associated governance arrangements, data and IT infrastructure
- Build a shared organisational or multi-agency culture
- Establish national practice models and implement new ways of working, and
- Build constructive relationships with children, families and partner organisations

Transformational reform programmes are also complex because they involve multiple systems and factors, and there is a need to understand how these interact with one another. In relation to children's health and social care services, structural reforms are one aspect but the success of these are dependent on, for example, changes in organisational and professional cultures and practice, public expenditure levels, and workforce recruitment and retention levels. Without attention to these, the 'push factors' that helped instigate the reform programmes will continue.

A clearly articulated theory of change is a vital stage in the transformational reform process. A theory of change should include clearly articulated aims (or vision), the key changes needed, the outcomes that will be expected and how they will be measured, and what the overall impacts of the reform are intended to be. In communicating the theory of change, it is important that clear connections are made between these different aspects of the theory of change to ensure there is coherence across the transformational reform programme. Examples of theories of change within the children's services settings being used in other countries include the Capacity Building Center for States (2018) in the United States and the National Centre for Family Hubs (www.nationalcentreforfamilyhubs.org.uk/toolkits/theory-of-change/#5) in England.

Implementation of the transformational reform programmes was also a challenging process, and there is limited evidence to date of the impact of these reforms on children, families and practitioners. Some indicative areas of progress were identified, such as more collaborative working at the locality level and more consistent practice across the country through the availability of national resources. However, many of the 'push factors' remained as persistent challenges. Some of these are related to structural change (for example, children and families' access to services and transitions between services) and may be addressed in time as the reforms continue to be implemented. Others are related to non-structural factors such as the difficulties changing practice and organisational cultures, recruitment and retention difficulties, changes in governments,

constraints to public expenditure, and the impact of the COVID-19 pandemic. This highlights the need for reforms to engage with wider systems and factors if the wide-ranging aspirational 'pull factors' are to be achieved.

A conducive and settled domestic environment is required

Given their long-term nature, any transformational reform programme will be subject to external, unanticipated events. The case studies we have considered have, for example, been affected by the impact of the COVID-19 pandemic and increasing levels of child and family poverty due to the cost-of-living crisis and economic impact of the pandemic, energy prices rises and the impact of the invasion of Ukraine on the world economy. Notwithstanding these, at a domestic political level, a conducive and settled domestic environment should be sought when introducing and implementing major transformational reform programmes. Conditions for a conducive environment can be achieved through:

- Cross-party political support for the transformational reform programme, thus enabling continuity of support should there be electoral change
- Creating 'buy-in' and support for the reforms from the public
- Providing long-term budgetary stability that can ensure the required investment levels are available over the reform programme's multi-year timeframe
- Keeping the number of transformational change programmes progressed at any one time to a minimum.

Transformational reform programmes require transformational leadership

Transformational reform programmes require transformational leadership and from the case studies we identified the key characteristics of such leadership as including:

- An understanding of complex, multi-disciplinary systems and how to bring about changes in such systems
- Recognition of the need to have a theory of change that sets out the structural, process and/or practice change(s) involved and the expected outcomes and impacts of these, and
- Effective and inclusive communication of the reforms to internal and external stakeholders and audiences, explaining clearly what the change is, how it will be brought about, and why it is needed. Of these, explaining the 'bigger picture' or the 'why' for the change was found to be particularly important.

Importantly, if these transformational change skills and expertise are not held by senior leaders within the health and social care system, then these skills and expertise should be brought in from external experts.

These leadership skills are specialist but equally generalist in that they can be applied across different service areas. In addition, more specific to leaders within health and social care reforms and integration, there is the need for leadership that:

- Empowers practitioners, giving them autonomy in how they work with children, young people and families
- Builds the capacity needed for meaningful participatory practice with children, families and communities, and
- Actively promotes joint the development of shared understanding and culture across different services and disciplines.

Successful implementation needs strong foundations

The findings from the case studies highlight the need for a series of inter-related foundations to be in place for the successful implementation of transformational reform programmes (Figure 3). Driven by transformational leadership, the foundations encompass the need at the inception stage for thorough planning and appraisal of the reform programme, through to the importance of having long-term political and implementation support for the reform.

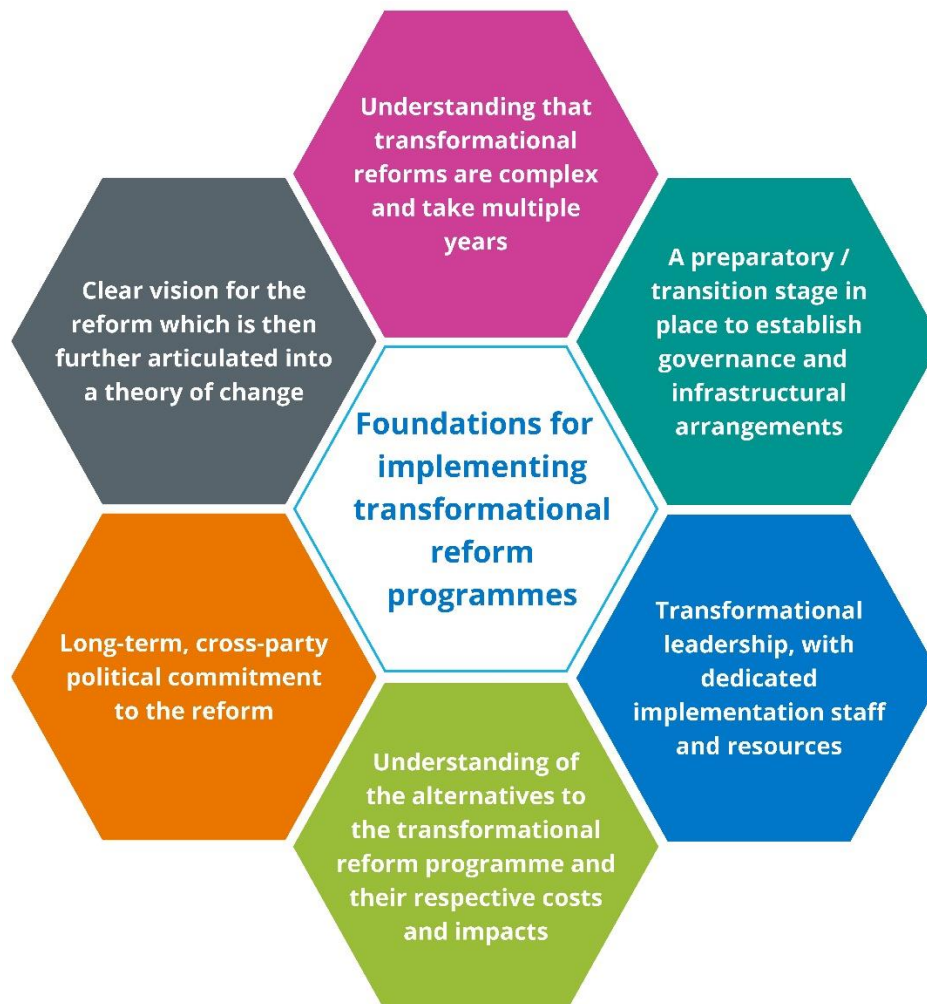


Figure 3: Implementation learning and experiences from the case studies

Integration of children's health and social care

There were commonalities in the structures and functions present at the national, regional, local and locality levels

In their ambitions to address the longstanding push factors, all five of the children's health and social care case studies examples sought to design and implement a new approach to delivering and integrating children's health and social care services.

However, despite their common 'push' and 'pull' factors, the respective approaches differed and reflected the historical, political, societal, cultural and economic contexts of the countries in which these reform programmes were developed. These ranged from a predominantly national approach to the country's children's health and social care system (New Zealand and Republic of Ireland) through to a regional (Finland) or local approach (the Netherlands). Northern Ireland offered a hybrid national-regional-local approach, albeit with movement towards a national children and families social care agency. The formation of Police Scotland was another example of a national approach being taken.

Each transformational reform programme was different but, crucially, there were commonalities in what structures and functions existed across these different examples at the national, regional, local authority and locality level:

- At the national level, there was a lead government ministry and/or national children and family agency that set national policy and legislation, and was responsible for implementing the transformational reform programmes, working in partnership with multiple stakeholder organisations to do so. Also at the national level were the children's services inspectorate and children's rights commissioner functions.
- At the regional level, health services for children and adults were widely planned and delivered.
- At the local (authority) level, children and families' social care services were jointly planned for, managed and increasingly commissioned.
- At the locality level, branded, multi-agency teams and hubs operated (often in co-located sites) to provide prevention and early intervention support. Services and joint working at this level were found to be most impactful on the lives of children and families.

The common features of the emerging and/or resulting structures offer valuable learning into what can potentially applied elsewhere.

Strong national leadership and investment is required for the design and implementation of transformational reform

Across the case studies, at the national level, and irrespective of the regional, local and locality structures, stakeholders had asked for stronger national direction, leadership and investment in a range of areas:

- National leadership and commitment to ensure children's health and social care needs receive dedicated policy attention and resources in the face of other pressures on public services and, particularly, the pressure stemming from increasing health and social care needs among adults.
- National practice guidance, standards, models and tools that provide clarity to multi-agency practitioners on what is expected of them and, in turn, can support inter-agency working. National workforce planning to address recruitment and retention challenges, which necessarily includes national consistency and collation of children's health and social work workforce data.
- Integrated IT systems that can support information sharing and recording.
- The standardisation of procurement processes and requirements within children's health and social care to help reduce administrative burden on commissioners and uncertainty for providers.
- National measures or indicators of children's outcomes that national, regional and local providers can all work towards, and a national data information system that supports consistent recording and reporting of these.

The locality level is the main setting for integrated working

Irrespective of the national, regional or local authority structures, the crucial level of delivery is at the locality level. It is at this level that horizontal integration, in other words working between services at the same system level, is most evident. It is characterised by co-located, multi-agency staff working flexibly together to listen to and meet the needs of children, young people and families' before they require more specialist and statutory support. While the service mix of each local centre or team varies according to local need and organisations operating locally, the learning from the case studies is that these structures benefit from having a consistent public recognition across the country and operate at a level where they each serve an average catchment size of 40,000-60,000 people.

Continued attention needs to be paid to the interfaces between services

To bring about more integrated children's health and social care services, there is a need to consider how services can work cohesively together to best meet the needs of children, young people and families. We have seen that for family support services this is achieved through the co-located, multi-agency teams and hubs at a locality level. However, across the case studies, persistent challenges were evident in how children, young people and families can access more specialist services, such as disability and mental health services, and how to support young people's transitions to adult services.

It is difficult to pinpoint why these challenges persist but, from these case studies, specialist health services (for example, for disability and mental health) are often organised at a regional level within the health system structure rather than being able to work responsively to local multi-agency children and family structures. Similarly, adult services were a peripheral partner in the local multi-agency children and family structures, which therefore has an impact on the quality of transitions young people experience.

Continued attention needs to be paid to workforce recruitment and retention

The impact of worsening workforce recruitment and retention challenges must also be understood. These have a direct impact on staffing and resource levels, waiting lists for services, and impede opportunities for more strategic planning and developments. If children's health and social care is not seen as a career of choice, the progress made in enhancing and integrating children's health and social care services at the national and locality level is compromised.

Wider policy agendas influence - and must be influenced by - the experiences of children and families

Across the case studies, services were reporting increasing and more complex needs among children and families, with rising poverty levels and the impact of the COVID-19 pandemic contributing to this. There was recognition that the children's health and social care system and services alone cannot tackle these wider economic and societal challenges. Other government departments, such as housing, welfare and social security departments, need to listen to the circumstances that children, young people and families are experiencing and actively consider how their policy and funding decisions can play their part in supporting and contributing to the transformational reforms of children's health and social care.

Integrated children's health and social care systems require a range of features to be in place

Figure 4 captures six common features identified from the case studies that integrated children's health and social care services need to have in place. The features closely align with the components identified in this study's Rapid Evidence Review (Porter et al., 2023). Using the learning from the case studies, Figure 4 helps to demonstrate how and at what structural level the different components from the Rapid Evidence Review's 'Components of integration' model interact.



Figure 4: Six common features identified from the case studies that integrated children's health and social care services need to have in place

Areas for future research and development

Children's rights and participation

Our research found that the UNCRC has been ratified in each of the countries where the case studies are and the Convention is widely referred to in national policy documentation and legislation. However, it has been unclear from the evidence we reviewed if and how children's rights have been enacted. In particular, there is a need to understand how children can be meaningfully involved in the design, development and governance of large-scale service reforms and restructures, and what impact their involvement has on the quality of the resulting services. From the case studies, there may be opportunities to learn from New Zealand's Youth Advisory Panel which was established to help inform Oranga Tamariki. Engaging with and listening to children, young people and families with lived experience of care and social work and social care services has been at the forefront of The Independent Review of Children's Social Care Services in Northern Ireland, and this commitment was also at the heart of the Independent Care Review (2020) in Scotland and in shaping the conclusions of The Promise. While it is important that we utilise the information gathered and stored from existing sources such as the Independent Care Review (2020) in Scotland and relevant academic research before we seek out new information, the evaluation of future integration efforts should prioritise the consistent and systematic gathering of feedback from people who use services on their experiences, before and after any change, and how these could be improved.

Children's outcome indicators

A common aim of the transformational reform programmes we looked at was to improve children's outcomes. While improving children's outcomes is an admirable 'vision', our research found very limited articulation of what improved children's outcomes meant in practice and how this was to be measured. For such reforms then, there is a task for children's services partners to come together to develop and agree a set of outcome indicators that multi-agency partners work towards. This is a task we hope that our study's Mapping Integration and Outcomes across Scotland report, due to be published in July 2023, can contribute to. Where possible, these indicators should have clear connections to the child wellbeing data measurement work evident in some of the locality structures identified in our case studies. Children and young people should be involved in the development of these, so helping to ensure the data collected about them by services is data that matters to them.

Timescales and attribution

The research has highlighted the multi-year timeframe that transformational reform programmes require for implementation. Undertaking research into the impacts of such reforms therefore needs to be carefully planned for. Indeed, we found that it was extremely difficult to evidence any impacts of the Finland and New Zealand reforms

given their recent introduction. However, if time is given for the reforms to be implemented and have effect, there is then the challenge of when to assess for impact and how to attribute any potential impacts to the reforms, as opposed to other factors, such as periods of economic growth or recessions, or changes in government.

Health and social care integration, but what role for education?

A final observation is that across the health and social care case studies we looked at, the focus of the transformational reform programmes has been on the closer integration of health, social care, social work and family support services. While gaps with mental health and disability services have been widely reported, the connection with education services – early learning and childcare, school education, educational psychology and learning support – very rarely came up as part of this integrated offer, aside from being a partner within local children’s services planning partnerships. In the Republic of Ireland, Tusla took on educational welfare services, but this is understood to have been an uneasy relationship and indeed governance of these services has now transferred to the Department of Education, thus hinting at this being seen as a discrete service area. In Finland, where connections between education, health and social care were previously very strong, the SOTE reforms have disrupted these working relationships with health and social care now managed at a regional level and education remaining at the local municipality level. Remedial measures to address the impact of this change on children are currently being explored in local and regional services. The question arising from this is whether the closer integration of children’s health and social care comes at the expense of the relationship with education.

Contribution of the case studies of transformational reform programmes

The international review of models for the Independent Care Review in Scotland concluded that no one country has a system that is able to ensure the present or future wellbeing of children (McCauley, 2019). The same conclusion can be reached from our case studies. Despite selecting countries that perform highly on international child wellbeing measures and who have engaged in transformational reform programmes to enhance their health and social services for children and families, there is no one approach that can be recommended for implementation in Scotland. However, there is learning to derive from the case studies, not least the consensus around the functions that require national leadership, investment and development; the critical importance of facilitating multi-agency working at the most local level to support children and their families; and the need to attend to the factors that support effective implementation of reforms.

While the case studies have been developed to contribute to decision-making around the future delivery of children's services in Scotland, we have identified issues which are relevant to policy makers, commissioners, service managers, and practitioners outside Scotland. This information can help inform all services that work with children, young people, and their families, whether these are still being designed or are well-established, specialist or universal. This knowledge may impact upon funding, staffing, aims and objectives, measurement of success, management structure, and more.

Finally, the case studies are the second strand in a series of four, collectively known as the Children's Services Reform Research Study. The findings from the case studies will be combined and synthesised with their findings for the final research report, due to be published later in 2023.

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Appendix 1

Regionalisation of health and social care Services in Finland

Introduction

Finland offers a valuable comparator country for Scotland on account of its high international ranking on child wellbeing, some similarities in geography, and its experience of reforms to its children's health and social care system. The UNICEF Innocenti study ranked Finland 3rd out of 41 high income countries in providing the conditions that support child wellbeing, including social, education and health policies, while the UK is rated 27th. Geographically, Finland has a population of approximately 5.5 million (United Nations Population Division, 2022), with 72% of people living in urban areas and 27% in rural areas, which is comparable to Scotland where 83% of the population live in urban areas and 17% in rural areas (Scottish Government, 2021; United Nations Population Division, 2018; Finnish Environment Institute, 2020). However, Finland occupies a significantly larger landmass than Scotland, so there is a greater degree of differentiation between those living in rural and urban populations.

Finland is organised into 309 local municipalities, and 108 of these are classed as cities. There is a vast difference in the size of the populations of smaller municipalities and cities; the smallest population of a municipality in mainland Finland is 703 people, in Luhanka (and 105 people in Sottunga in the Åland Islands). The population of the smallest city in Finland is 1,289 people in Kaskinen, and 658,457 people in the capital city Helsinki. Nine cities in Finland have more than 100,000 inhabitants and 1.2 million people live in a metropolitan area made up of the cities of Helsinki, Espoo, Vantaa and Kauniainen. Economically, Finland has a higher economic output per capita of US\$53,700, which is above the UK figure of US\$46,500 (World Bank, 2020).

Health and social services in Finland are offered by public, private and third sector providers. Nationalised insurance schemes mean that while the public is required to pay for healthcare to some extent, there is a cap on cost of this, with an annual maximum cost in 2023 of €692. Local authorities have decision making powers over whether there are charges for health and social care services, and usually there is no charge for children under the age of 18. Social welfare services for children and adults are provided by public, private and third sector services on behalf of local government.

Child protection in Finland is defined in terms of services provided to families to support the welfare of their children, with a focus on preventing maltreatment or providing early support to families (Poso et al., 2011). The services include care at maternity and child health clinics, daycare services, family centres, youth work, as well as assessment of whether a child needs child welfare measures, "open care" in their family home, or care

outside their family home. Reporting of any concerns about a child's welfare by any professional in contact with them, is mandatory in Finland, as set out in the Child Welfare Act 2007.

Along with other Nordic countries, Finland's approach to children's health and social care had been generalised as family service-oriented, where the state-parent relationship is based on partnership and support, occurring at an earlier point of need for a child or family and with a low threshold for offering support before children's needs escalate into higher or more complex needs (Gilbert, 1997). In this typology, family service-oriented systems are contrasted with child protection-oriented systems, of which Scotland and other countries in the United Kingdom are included (Gilbert, 1997; Falconer, 2019). However, there has been a merging of these different approaches over time (McCauley, 2019) and the evidence on the experiences of children and families involved in child welfare services in Finland shows that the categorisation of 'family service-oriented systems' cannot uncritically be applied to the Finnish context.

Over the last thirty years there has been extensive privatisation and marketisation of children's services in Finland. This is especially true for residential child care (Porko et al., 2018; Pålsson et al., 2022; Shanks et al., 2021) 80-90% of which is run by for-profit businesses (Shanks et al., 2021). This has led to an increase in cost for private residential child care and child protection services (Toikko, 2017). The number of children and families who are supported with child protection measures varies between each local area and is influenced by local differences such as the proportion of the population under 18 years, as well as the number of people in the local population who require support for particular needs from health and/or social welfare services (Harrikari, 2014). Finland offers support to children in their family home, known as "open care", such as through intensive family support, as well as support through out-of-home care, which includes short and emergency support as well as longer care outside a child's family home. Though open care services are an integral part of Finland's approach to child welfare, the number of children in out-of-home care is particularly high in Finland, and this has been consistent over several decades (Burns et al., 2017). Where out-of-home care is necessary, this predominantly occurs on a voluntary basis with the consent from parents (Pösö et al., 2014). However, research with parents has contested the degree to which they are able, and feel able, to consent to voluntary arrangements (Pösö et al., 2018) and data on the child welfare system has shown a steady increase in the number of children who require support from child protection measures (Pösö et al., 2016; Hiilamo, 2009; Pösö et al., 2014).

In addition to these concerns, there was growing concern and evidence that Finnish children's life experiences and experiences of adversity were becoming more unequal. Whilst the majority of children were growing up with positive and nurturing experiences, some children were having disproportionate experiences of adversity in comparison to their peers, including violence, poverty, parental substance or alcohol misuse, bullying or loneliness (Sosiaali -Ja Terveysministeriö, 2016; Finnish Student Health Service, 2012). Finland started a programme of change for children's services (the LAPE programme) in

2016. A second reform – SOTE - with closely related aims to the LAPE programme, and with a significant impact on children’s services, has followed. Whilst planning for the SOTE reform predated the LAPE programme, the implementation of this reform began in 2021. The SOTE reform involves a regionalisation of health and wellbeing services from Finland’s 448 local municipalities to a structure of 22 regional bodies, consisting of 21 regional wellbeing service counties and Helsinki city.

This case study sets out rationales behind the regionalisation of children’s health and social care services, the function of national government in this arrangement, and insights into the implementation of these two programmes of change.

Setting the context

At a national level, Finland’s Ministry of Social Affairs and Health, the National Child Strategy 2021 and the Ombudsman of Children set out and enact the foundations of policy for children and families, including for child protection. The National Child Strategy 2021 is the overarching policy framework to support children and families in Finland, and agreement has recently been reached to have this permanently funded (Ministry of Education and Culture, Ministry of Social Affairs and Health 2022). This strategy builds on two pieces of national legislation, the Child Welfare Act 2007 and the Social Welfare Act 2014.

The Child Welfare Act 2007

The Child Welfare Act 2007 sets the legislation for children’s welfare and protection in Finland (Ministry of Social Affairs and Health, 2007). Building on previous versions that included the principles of support for children and families in Finland and underscored the importance of social workers in this support, the purpose of the 2007 Act was to secure the right of the child to an upbringing in a safe environment, to harmonious development and to special protection. The Finnish Constitution includes provision that all legislation must be interpreted in relation to the human rights treaties that have been ratified by Finland, including the United Nations Convention on the Rights of the Child (UNCRC) as well as the European Convention on Human Rights (ECHR). This means that there is an obligation in statute for public authorities to guarantee that these rights treaties are upheld (Hakalehto, 2019).

The Child Welfare Act 2007 can be understood as framework legislation, defining the general principles and positions around child welfare, and the actions that should be taken by relevant parties. These include:

- The guiding principle that the child’s best interests must inform all decisions, measures or services around them.
- The support, assistance and services that should be provided to parents.
- The services and/or activities public authorities must provide. For example, providing support to families when they first need help.
- Requirements of how parents should act towards their children, and the legal reasons for changing the care or custody of children when this is necessary.

- The tasks that municipal child protection authorities should provide, including:
 - An investigation of any need for child welfare measures;
 - Providing support in “open care” services, at the child’s home;
 - Emergency placements for a child; and
 - Moving a child into care, or providing substitute care or after-care (Pösö, 2011).
- The participation of all children in matters that affect them.

In supporting participation, the European Commission has praised the role of the Child Welfare Act 2007, albeit its evaluation stated that improvements are still required to support the participation children they identified as ‘quieter’ children, such as “immigrant children” and children in alternative care whose voices are less heard by services (Ecorys UK Ltd 2015, p1). The participation of children, particularly children who use children’s welfare services has been a central tenet of the LAPE programme.

Social Welfare Act 2014

The Social Welfare Act 2014 is the overarching legislation stipulating how all social services should work in Finland. Prior to the 2014 Act, all duties to support the health and wellbeing of children by social welfare agencies were contained within the Child Welfare Act 2007. Children and families could only be supported through child protection measures. The changes in 2014 aimed to reduce the number of children who require support from child protection measures, as these could be stigmatising to children and families, and offer support to more children and families when they first need help, at a lower threshold of need. The Act enables families to request preventative support outside of formal child welfare processes, from community or universal supports (Tanninen, 2015; Falconer, 2019). The Social Welfare Act also encourages multi-agency and multi-professional working, stating that services should work in co-operation with primary health care, counselling and other relevant services when providing advice and guidance. There is also stipulation that local authorities must co-operate with each other to monitor and promote the welfare of adults, children and young people who require special support, and work to prevent or address poor service. Multi-agency services established as a result of this act include (but are not limited to) Family Centres (Box 1).

Some country experts for our study commented that there is a need for more research on the impact of the Social Welfare Act, particularly on multi-agency working and access to services, though some statistics shows that this legislative change has had an impact, for example, a reduction in the number of children who cannot safely stay with their families (Finnish Institute for Health and Welfare, 2022). However, there is a lack of clarity between definitions of child and family services under the Social Welfare Act and “open care” services defined by the Child Welfare Act 2007 resulting in different interpretations across local areas (Yliruka et al., 2022). Variation in the availability of universal or family support services provided under the Social Welfare Act across local areas also has an impact on the aims the Act. Our country experts discussed how a delay in, or the inability for children and families to access, support from universal services, for

example non-specialised mental health support, could lead to an escalation of need for that child, young person or family. This may result in child protection measures under the Child Welfare Act being required if that need remains unmet.

The National Child Strategy 2021 is the current overarching policy framework, is based on the UNCRC and aims to reduce fragmentation in policy to improve the consistency in how Finland upholds children's human rights. This policy applies to all children and young people under the age of 18, but there is also explicit direction that extensive consideration should be given to young people and young people's families in young people's transitions between childhood and adulthood. The key policies in the National Child Strategy set out to:

- Combat discrimination and inequality affecting children.
- Safeguard the rights of vulnerable children.
- Protect children from all forms of violence.
- Deliver health and social services that meet the needs of children and families.
- Secure an adequate standard of living and social security for families with children, and reconcile work and family life, with this an action of the government's Working Group on Social Security and Services for Children and Families.
- Provide for children's hobbies and other recreational activities.

The strategy plans to achieve these by:

- Actively implementing the principle that a child's best interests is a primary consideration in all decisions.
- Organising early childhood education and care and education to meet children's individual needs.
- Supporting children's relationships with family, friends and peers.
- Listening to children to promote their inclusion and participation.
- Coordinating data collection and training for children's affairs that are aligned to the rights of the child.
- Multi-agency working, with explicit direction around the need for integrated approaches between child welfare and education services.
- Influencing wider health and social care provision so that they best meet children and families' needs. This includes health services that are offered by both public and private providers.

Structural developments

Under the policy and legislative umbrellas of the Child Welfare Act 2007, Social Welfare Act 2014 and the National Child Strategy 2021, Finland has begun three programmes of change since 2016 that have impacted on children's services. The first was a programme of change for children's services (the LAPE programme) in 2016, which was followed by a second modified stage of the LAPE reforms, and third, the SOTE reform which involved a regionalisation of health and wellbeing services from Finland's 448 local municipalities to

a structure of 22 regional bodies, consisting of 21 regional wellbeing service counties and one for Helsinki city.

The LAPE Programme (Lapsi ja perhepalveluiden muutosohjelma)

LAPE, the programme to address reform in child and family services' or Lapsi ja perhepalveluiden muutosohjelma (LAPE programme) started in 2016 during the Finnish Parliamentary term of Prime Minister Juha Sipilä, and was renewed in the subsequent parliamentary term of Prime Minister Sanna Marin, albeit with changes to the focus and remit. The LAPE programme set out changes to organise services into child-focused services that would be able to meet a child's individual needs and was based on the following principles:

- Children's rights and best interests
- Strengthening of children's, young people's and families' own resources
- Child- and family-centredness, and
- Diversity of families. (The Ministry of Social Affairs and Health, 2016)

The LAPE programme aimed to reorganise services for children. Many services at that time were dispersed between different sectors, teams or offices. Data was spread amongst different databases, and too often support would depend on administrative or organisational capacity rather than need. The programme also aimed to shift the focus of service provision to preventative services that are accessed by all (universal services), as well as early support and intervention (Prime Minister's Office Finland, 2017). This included more support for parenting and measures to increase access to low-threshold services. A budget of €40 million was allocated for the LAPE programme between 2016-2018 (another €40 million was later allocated for the 2019-2023 parliamentary term).

The 2016-2018 LAPE programme involved:

- Projects to develop services for children and families that work across the boundaries of social welfare, health care and education services.
 - The development of Family Centres that would provide a range of low-threshold services to promote wellbeing for children and families at one location in the local area.
 - Services that would be linked with a child's early childhood education, school and/or formal care provision.
 - A team-based approach to supporting a child and their family where there are child protection concerns.
 - Specialist services at a local setting where these are needed by a child or family.
 - Multi-professional centres that offer specialist services for children and families with especially complex needs (Ombudsman for Children, 2022).
- Tools and guidelines for new child-friendly operating models for municipalities and regions, including a budgeting model.

- An operating culture, practices and service structures that are child and family oriented, rather than oriented based on current organisational or administrative systems. These include the development of:
 - evaluations of impacts on children that are based children’s rights
 - tools for child-centred budgeting
 - tools for monitoring health and wellbeing of children to support service design and decision making.

The LAPE programme was renewed in the parliamentary term 2020-2023, with alignment to the National Child Strategy 2021. In addition to the continued development of the Family Centre Model, low-threshold, multi-agency ‘Health and Social Services Centres’ are being developed. The focus of these multi-agency services will be to offer accessible mental health and/or substance use support to children and young people, and have children and young people participate in the development of these services (Huikko et al., 2023).

Box 1: The Finnish Family Centre Model

The Finnish family centre model plays a key role in offering child- and family-centred support. In 2021 there were 116 Family Centres across Finland (Eurochild 2021). As the LAPE programme and SOTE reform progresses, there has been significant development of Family Centres over the last few years, including changes to the governance of these services from local municipalities to regional ‘wellbeing service counties’. The country experts we consulted for this study confirmed that in 2023, there are Family Centres in all of the 21 welfare services counties as well as one for the city of Helsinki.

Family Centres support the integration of health, social welfare and early education services for families with children, as well as the services provided by non-governmental organisations. Family Centres aim to identify the needs children and families have at an early stage, provide co-ordinated support, and reduce inequalities.

There are five types of Family Centres:

- Multidisciplinary family centres (based at a single location)
- Multidisciplinary family centres (network-based)
- Welfare health care clinics
- Open services for early childhood education and care, and
- Specialised family support centres (Kekkonen 2017).

The establishment of a national model for multidisciplinary Family Centres was a core component of the 2016-2019 LAPE programme (Klavus et al. 2021). A sixth type – an electronic Family Centre - is currently being developed by the recent LAPE programme, and will be an online service for families to access information about services and advice, as well as facilitate professionals’ access to information they need for practice, such as a directory of other professionals, and information about services, tools, and guidance.

Preliminary research has shown that whilst practitioners share the aims and rationale of the Family Centres, there have been challenges to the implementation these aims. These include difficulties in the shift to services that are tailored to the individual needs of children and their families, as well as high staff turnover affecting services. The lack of permanent spaces for Family Centres has affected awareness and uptake of services by families, and a need to increase public information about Family Centres has been identified, as well as a need to increase the participation of children and families in planning services for them at Family Centres (The Family Research Centre 2019). Research on the impacts of Family Centres varies, with some research finding there has been a reduction in need for specialised support, when viewed through data held by municipalities on populations with specialised support needs (Joronen et al. 2022). However, other research indicates that there have been increases in referrals to specialist support after the establishment of Family Centres, which may be due to the likelihood of improvements in support in turn leading to improvements in the identification of needs (Joronen et al. 2022). There is currently insufficient research available in English on the experiences and outcomes of children and families engaging in Family Centres to be able to draw more substantive conclusions.

Reform of health and social care services (sosiaali ja terveydenhuollon ja pelastustoimen uudistus / SOTE reform)

The second significant programme of change is the reform of health and social care services or sosiaali ja terveydenhuollon ja pelastustoimen uudistus (SOTE reform). This is a reform of all health and social services and is not specific to services for children. Described by Finland's Ombudsman for Children as "the most significant socio-political reform in Finland in recent years" (2022, p24), it aims to:

- Improve the equity, access and effectiveness of services
- Reduce inequalities in health and wellbeing across Finland's children and families (Sote-Uudistus, 2023), and,
- In the context of an ageing population and decreasing income from taxation, reduce expenditure on Finland's health and social care system, with an explicit target of reducing expenditure by €3 billion by 2029 (Sote-Uudistus, 2023).

The SOTE reforms have been planned for over a 10-year period. There have been many stages in the reform process, and the country experts we consulted discussed how tension had arisen in public and political discourse at earlier stages around the extent of privatisation and marketisation of services. A government bill in 2018 failed due to concerns around substantial increases to the marketisation of care services. These issues, and other factors driving the reform, had been highlighted in a pre-review of the SOTE reform proposals carried out by a panel of experts on European and international health systems in 2016 (Expert Pre-Review) (Couffinhall et al., 2016). This review identified that there was an ambition to incentivise public sector providers in order to stimulate innovation and responsiveness. It was believed that increasing competition

between providers and freedom of choice for the public who access these services would bring about increased efficiency and reduce costs (Sote-Uudistus 2023). There was also a related need to address the variation in IT systems across municipal areas, as most municipal information systems are incompatible with one another (Vuorenkoski et al., 2008). That was subsequently noted to have delayed the roll-out of track and trace systems Finland required during the COVID-19 pandemic (Finnish Government, 2021). The Expert Pre-Review cautioned that an explicit aim of reducing health and social care expenditure by €3 billion by 2029 may jeopardise the reform's success and have a detrimental impact on the access to care and quality of care required by people needing support.

The review also highlighted the plans for structural reforms to local governance. Responsibility for health and social care was held by 448 municipalities. With considerable variation in the population municipalities, smaller municipalities faced particular challenges to financing, managerial capacity and the co-ordination of services, leading to inequalities in access to services across local areas.

In 2020, legislation on the health and social care reforms was passed, and these reforms were enacted in early 2023. Alongside the strengthening of national governance, these reforms transferred governance responsibility for health and social care services from 448 local municipalities to newly established regional 'wellbeing service counties', with 21 counties as well as one for the city of Helsinki. As the city of Helsinki has a population of over 660 000 people, it is significantly larger than any other wellbeing service county.

The wellbeing service counties have become the organiser and purchaser of health and social care services. Their establishment included the transfer and integration of staff from municipal administrations into new county administrations, new information systems, regulations, guidance and support between central agencies and the new counties, such as agreements and plans for the management of care, and responsibility for the Family Centres. The transfer of staff into the new wellbeing service counties has been on their existing contractual terms, retaining the rights and obligations related to the employment or public service relationship at the time of the transfer, that is, retaining the same duties (Sote-uudistus, 2022). There is some evidence from frontline social workers at this early stage of implementation who have said that, in general terms, there has been a high degree of preparation across local areas that has facilitated the transfer of responsibilities (Tammelin and Mänttari-Van der Kuip, 2022).

The early planning of the SOTE reforms aimed to change funding allocation protocols, with funding to the wellbeing service counties allocated by national government based on a needs-based resource allocation formula. The proposed change to this formula was identified by the Expert Pre-Review as a change with the greatest potential impact, and one that commanded broad consensus across Finland, and therefore had a high priority for implementation. Though there has been a commitment to adjust funding based on changes to population levels (Sote-uudistus, 2022 slide 48), there has been a high degree of complexity in ascertaining and agreement on demographic information on local

population's health and social care needs, which has been much more challenging, and is taking more time and resource than originally anticipated.

In addition to the provision of funding, the Expert Pre-Review also highlighted the need for national government to provide other supportive measures to the wellbeing service counties. Examples put forward by the Expert Pre-Review of the sustained supports required were:

- Investments in strategic purchasing, such as payment incentives to motivate providers and support care co-ordination
- Regulations to prevent unintended consequences such as service providers only providing services to people with less complex needs, and
- Sustained resourcing for new IT systems as these are essential but unlikely to deliver savings over the short-term.

Planning for SOTE reform implementation included the development of a Roadmap for National Actors 2022–2024, which aimed to support ministries, agencies and institutions to prepare for the transfer of responsibility of services to wellbeing service counties on 1 January 2023, and to support and monitor implementation afterwards. This includes planning of implementation reporting via Situation Reports by regional wellbeing counties to ministries. These are part of the overall assessment of the implementation of the reform and aim to show the progress and degree of completion of regional implementation. The intention of the situation report is to provide information on the progress of the implementation of the reform at various levels. It is planned for this reporting to be completed monthly, with regular discussions that aim to identify challenges and emerging issues, as well as increase trust, cooperation and interaction between counties and ministries (Sote-uudistus, 2022 slide 76).

Available publications give some information about the timeline of the reform measures, with the final measure listed as the Transfer of duties to wellbeing services counties on 1 January 2023 (Sote-uudistus, 2022 slide 6), and reference in the Roadmap for National Actors 2022–2024 to the completion of actions up to 2024. The Expert Pre-Review was concerned about the intended pace of implementation outlined in earlier stages of reform planning, warning that the timeframe may be too optimistic, as the highly complex and context specific changes meant there was potential for misalignment between some areas. To manage the programme of change, the Expert Pre-Review recommended (Couffinhal et al., 2016):

- A phased approach, with timings tailored to each area of the reform
- Context specific aspects of the reform, such as health and social care integration, should be tested through a piloting approach first. Indeed, the Expert Pre-Review highlighted the value of building on pilots that were already in progress, especially those related to the horizontal integration of health and social services (Box 2).
and

- The development of national level guidance setting strategic and operational directions for information systems, contracting and purchasing, which it was acknowledged will take time.

It is not clear from available documents we were able to consider as of June 2023 whether the current timeline for reform implementation has addressed these concerns.

Box 2: Health and Social Care Pilot: The Better Everyday Life project

The Better Everyday Life (BEL) project was a pilot project which occurred from 2015-2016 in advance of the SOTE reforms (Oksman et al 2017). It aimed to implement the principles of the reform by supporting practitioners to develop integrated and person-centred care to support clients who required specialist support from health and social care services. Professionals from primary care, secondary care, social care and the education sector were recruited to collaborate in many different local, multi-sectoral teams established specifically for this pilot project, each working to support a different client group.

The Help Team

The Help Team was a team within the Better Everyday Life Project. It aimed to provide an accessible service for children who have multiple needs, better co-ordinating the care they receive to identify and prevent problems at an early stage and to providing co-ordinated support from different professionals. The Help Team worked by gathering a multi-disciplinary team of professionals to support the child and their family in a co-ordinated way.

The Help Team was developed by those from education, primary care, specialised care and social care. It included a school welfare officer, a school nurse, a school doctor, a social worker for families with children, a youth psychiatrist, a psychiatric nurse for adults' specialised care and a dental hygienist.

An evaluation of the pilot showed that practitioner understanding of clients' needs increased, as did their understanding of the roles and work of other practitioners. Collaborative working across different sectors enabled practitioners to better meet the needs of children and families. This was underlined by the development of a common understanding and practice principles that no individual professional can effectively support a client with specialised or high needs on their own, and that the inclusion of education was particularly important to getting this support right. There was a need for flexibility to bring in other services when necessary, such as employment support for working families.

The evaluation proposed that this model of small-scale pilots within a broader project offers a mechanism for practitioners and clients to shape practices that support integration, improving the implementation of integration reforms. This is in contrast to models of integration that occur solely at a macro level, such as national or regional policy.

Source: Tuominen, T., Harju, M., Oksman, E., Hujala, A (2019) 'Co-designing integrated care for high-needs clients: the Help Team for school-aged children' *Journal of Integrated Care*, 27(2) pp 123 - 130

With the caveat that the ongoing SOTE reforms may lead to future changes in how health and social care services are governed in Finland, we have set out how responsibilities are currently organised across national, regional and local levels.

National

The Finnish government's Ministry of Social Affairs and Health holds primary responsibility for co-ordinating national child welfare legislation and guidance, and joint responsibility for the LAPE programme and SOTE reforms with other ministries. Areas of responsibility include preparedness; insurance; income security; EU and international co-operation; gender equality; working life; promotion of welfare and social and health services.

Social welfare and health services include a responsibility for children, young people and families. This portfolio comprises of:

- Financial assistance for families with children
- Family life and work
- Services and benefits for families such as: early childhood education and care; maternity and child health clinics; child guidance and family counselling; child welfare; adoption; health services; custody, maintenance, acknowledgement of paternity; family centres.

A key body within the Ministry of Social Affairs and Health is the National Child Strategy Unit, which co-ordinates the key policies of the National Child Strategy and works across government ministries and the wellbeing services counties to implement it.

Other national government ministries with a key role in Finland's children's health and social care system are:

- The Ministry of Finance which is responsible for drafting and implementation of legislation to facilitate the SOTE reform. This includes the establishment, administration, funding and personnel of the new wellbeing services counties
- The Ministry of Education and Culture which has responsibility for: early childhood education and care; general education; vocational education and training; higher education and research; student financial aid; culture; libraries; religious affairs; youth and sports and physical activity. The ministry was a key partner, alongside the Ministry of Social Affairs and Health, in the LAPE programme, and
- The Ministry of Justice which has responsibility over fundamental rights; crime and punishment; the rule of law and legal protection; international and EU

affairs; democracy and elections; development of law drafting; daily life; international legal assistance. The ministry was a supporting partner in the LAPE programme.

The Ombudsman for Children is an autonomous and independent body that promotes, monitors and assesses the implementation of the rights of the child in Finland.

Regional

Finland has a structure of regional government, consisting of 21 counties plus the City of Helsinki. The SOTE reforms have led to an increase in their responsibilities relating to health and social care, with responsibilities for health, social care and rescue services (such as fire and ambulance services) transferred from the 448 local municipalities to newly established wellbeing services counties. Specifically, their responsibilities span:

- Primary healthcare
- Specialised healthcare
- Hospital services
- Dental care
- Mental health and substance misuse services
- Maternity and child health clinics
- Social work for adults
- Child welfare
- Services for people with disabilities
- Housing services for older people
- Home care
- Rehabilitation

National legislation (The Act on Wellbeing Services Counties, 2021) sets out the duties of the wellbeing services counties in relation to financial management and auditing, and the participation of citizens in planning, preparation, implementation and monitoring of services. For example, the Act states that wellbeing service counties must provide effective opportunities for participation through:

- Youth councils (Box 3)
- Older people's councils
- Disability councils (Sote-uudistus, 2022 slide 29)

The Finnish Family Centre model has been included within the SOTE reforms, with Family Centres organised on a regional basis, and all wellbeing services counties having Family Centres.

Local

Finland has over 300 municipalities that provide local services and functions (aside from the health and social welfare functions that have recently been transferred to wellbeing service counties). The services and functions provided for children, young people and families include:

- early childhood education
- basic education
- upper secondary education
- library services, and
- youth work

Each municipality has a municipal council, a local executive and an auditing committee for auditing municipal administration and finance. Other decision-making bodies may also be established, such as a school management board, or an equality commission. Every municipality must be a member of a regional council.

Box 3: Vantaa Youth Council

Vantaa's youth council has operated in Vantaa since 2000, and Vantaa city has been granted recognition as a Youth Council Friendly City by The Union of Local Youth Councils in Finland. Working in partnership with other youth groups, for example student associations from schools and colleges, the youth council is tasked with bringing the perspective of young people into decision-making, to make the voice of young people heard, to take a stand on current issues. For the current council (2023), these include the quality of school meals, as well as violence and safety at schools.

The changes as part of the SOTE reform mean that a new youth council will be established for the Vantaa-Kerava wellbeing services county. Vantaa Youth Council has put forward representatives for this new council (Vantaa Youth Council 2022).

Progress and impacts

There has been a rigorous programme of change to support integrated multi-agency working between services for children, primarily between social welfare and health. These have included models of new practice and structures for collaboration, the development of new systems, communication and leadership, including the participation of children, parents and others with lived experience. Shared principles and goals have played a key role in practice, and effective communication, and information sharing have been critical to the success of changes (Yliruka, 2022). One example of a model that has been developed to support integration of multi-agency services is the Family Centre model, which the Ombudsman for Children commented has been the primary area of progress within the 2016-2019 LAPE programme.

However, an unintended impact of the reforms, and particularly the SOTE reforms, has been a weakening of the relationship between social care and education. The structural changes of the SOTE reform to establish regional wellbeing service counties changed the operational environment of health and social welfare services. Though health and social care is now governed by regional wellbeing service counties, education services (including early childhood education, preschool, basic education and education within residential care homes) remain under the governance responsibility of local municipalities. Before the SOTE reform, education services had a dominant role in children's lives in comparison with social welfare and health services that in general, played a secondary role in children's lives. Correspondingly, the vast majority of funding allocated to the governance of services for children, young people and families was within the education sector of local municipalities, in comparison to funding for children's health and social services. Therefore, the change in governance brought about by the SOTE reforms resulted in a reduction in funding to education services in local municipalities.

A country expert we consulted commented that the proportion of budgets for children's health and social welfare services in wellbeing service counties remains low in comparison to budgets for adults, bringing questions about the profile and prioritisation of children's services. The Ombudsman for Children has said that the LAPE programme was effective in raising the profile of children's issues during the planning for the SOTE reforms (Ombudsman for Children, 2022). However, the Ombudsman also expressed concern that some aspects of the SOTE reform "worked poorly" for children's services, with SOTE reform fragmenting the services which the LAPE programme aimed to integrate (namely education, social welfare and health) (Ombudsman for Children, 2022 p24). There were also concerns that the LAPE reforms were not adequately integrated into SOTE reforms, with insufficient and vague information about how the services for children and families would be organised in the new wellbeing service counties (Ombudsman for Children, 2022).

As the SOTE reforms only began in 2023, there is not yet evidence on the impact of these changes on children. The country experts we consulted reflected that in light of children's day-to-day interaction with education services, changes in governance of education, social care and health services are likely to have an impact on children. However, they also highlighted that challenges supporting multi-agency working between professionals across sectors (including between teachers and social work teams, for example) predate the SOTE reforms. As plans for the SOTE reforms have progressed, there have been concerted efforts to strengthen the links between education and child welfare services. Country experts told us that there are currently local and regional projects in development with an explicit aim of supporting information exchange between schools and child welfare services, fostering shared understanding of the needs and rights of children, and creating new practices between education and child welfare services, though information about these developments is not yet published.

A further ambition of the reforms was to improve young people's transitions from care to adulthood. In January 2023 there was a change to the Child Welfare Act 2007 to enable children and young people in 'substitute care' (cared for outside of their family home) to be entitled to aftercare services up until they are 25, which had previously only extended to 18 years of age. Though it is too soon to draw any conclusions about the impact of this change, evidence shows that children and young people had been reporting inconsistent experiences of support as they grow up and leave care, with a need for improvement of these services, despite measures to improve support (Häggman-Laitila et al., 2020).

Finally, children's rights to participate in matters that affect them is included within the Finnish Constitution: "Children shall be treated equally and as individuals and they shall be allowed to influence matters concerning themselves according to their level of development" (The Constitution of Finland, Section 6, Chapter 2). As human rights treaties, including the UNCRC, are binding in Finnish law, this means that public authorities have a responsibility to support children's participation (Hakalehto, 2019). This commitment is echoed in the Finnish Government's Action Plan for Open Government (from 2015-2017), which stated that the inclusion of children and young people in service planning, preparation for decision-making and in the development, implementation and evaluation of services must be promoted (Open Government Partnership 2015).

Supporting children's participation, especially the participation of children, young people and families who use child welfare services was an integral "starting point" of the LAPE programme (Sosiaali - Ja Terveysministeriö, 2016 p7). This included an intention to develop co-production approaches with children and families with lived experiences of using services. An example given about the involvement of people with lived experience of using services was the establishment of "client panels" in a local municipality (Sosiaali - Ja Terveysministeriö 2016, p18). This involvement extended through all stages of planning, implementation and development of services, but also extended to the planning and decision-making of individual services for the child, young person or family themselves. Evidence about the implementation of this aspect of the LAPE reform, and of the role and impact of participation of children, young people or their families in these reforms is not, however, not yet available in English.

In conclusion, Finland's health and social care services are undergoing two significant programmes of change and the impacts of these are yet to be realised. The structural changes in SOTE reforms began in January 2023, and the LAPE programme continues to develop alongside, and in response to, the SOTE reform. There are also other changes and reforms planned which will have a considerable impact on the progress of the reform, and the changes the reforms seek to affect. A major renewal of the Child Welfare Act 2007 is planned in the near future. The Future Health and Social Services Centres programme has recently started alongside side other reforms. Where SOTE reform has been focused on structural changes, this programme will support the establishment of health and social services centres across Finland, aiming to shift provision from

specialised healthcare to primary healthcare and preventive work, and the provision of continuous and individualised services to people, including a greater integration of social welfare services within healthcare. Sharing similar aims for people of all ages as the LAPE programme does for children, this programme is closely co-ordinated with other reforms.

It is important to acknowledge that as all reforms are in the early stages of implementation or have finished only recently, there is a shortage of research on the outcomes of these reforms. There is some commentary from key national actors such as the Ombudsman for Children (Ombudsman for Children, 2022). The country experts we consulted have discussed anecdotal evidence from the workforce, and that local studies focusing on individual projects are currently in progress, all of which offer valuable information. However, these do not provide conclusions about the efficacy of reforms and their impact on the quality of service or learning that is emerging from the development of reforms.

A further challenge in understanding the impact of these reforms is the lack of evidence and information available in English, especially evaluation or policy material relating to detailed policy provision rather than overarching policy, of which there is excellent range of information English already. Evidence, comment and reflection from the country experts we consulted has been particularly important for us to gain an accurate understanding of the progress of several reforms to date as well as future developments.

Potential learning for Scotland

Overlap of ambitions in Scotland and Finland

There are a number of overlaps in the ethos, drivers, ambitions and timings of reforms to children's services in both Scotland and Finland, albeit key differences, such as the high level of privatisation of children's care services in Finland. The aims of LAPE and SOTE reforms are similar to Scotland's key policy programmes such as GIRFEC (Getting It Right For Every Child) and The Promise, and fit with the shared aim of ensuring that children's services retain a high profile in wider reform planning. However, there are also differences including Finland's explicit aim to cut expenditure and the country's related use of privatisation.

Changes to governance at local, regional and national levels

While it is too early to assess the impact of the reforms, Finland has decided that health and social care services are best governed and delivered at regional level by 22 wellbeing services counties. The national level still retains an important role through the provision of national legislation, guidance, and IT systems. Similarly, the local level has responsibility for key mechanisms for supporting the needs of children and families, through the provision of education and youth services. As reforms progress, there is likely to be more evidence about the impact of these changes on children, young people and families, particularly of the interaction between local and regional services, and of national government. For instance, though Family Centres are governed at a regional level by wellbeing service counties, other multi-agency services providing low-threshold support for children and families are offered at a local level, which will have interaction between practitioners in health, education and social work, for example.

Participation of children, young people and families

The importance of participation by children, young people and their parents and carers is prominent in Finnish and Scottish policy and reforms, with similar intentions in both countries to embed participatory practices in policy for large-scale change and local change, as well as individual decision-making. However, there is scant evidence available in English so far on how these aspirations have been translated into practice in Finland, and little evidence available in either English or Finnish yet on the impact of participatory practice on reform agendas, as these reforms are still in progress.

Time allocation for reforms and sustaining change

There is emerging learning that the projected timescales for completion of the reforms in Finland have been insufficient. A country expert commented that allocating too little time for the development of projects has been a barrier to sustaining change, and this has meant that initial evidence shows weak results, as not enough time has passed to measure change. An evaluation of the LAPE programme found that whilst there has been good progression of the Family Centre model in all areas, the allocated time for

implementation was not sufficient to achieve all goals of the model (OwalGroup, 2019).

Changes in government administrations and political leadership have also had a huge impact on reforms, with the different agendas of each government altering the scope of reforms, and meaning that reform programmes are limited to a three-year parliamentary term, which is insufficient to carry out these reforms. However, the National Child Strategy 2021 gained a 40-year commitment across different government terms and permanent funding for this period, which should enable long term plans to be implemented.

The coordination of changes to children's services

There is a need for further evidence on the impact of structural changes on the outcomes and experiences of children, young people and families. Particularly where structural changes have an impact on the co-ordination of services and thus the integration of services, as was the case with education, health and social welfare services. The focus on co-ordinating education services with other services for children in the recent stages of SOTE reforms may bring about crucial learning on the importance of reform agendas that are sustained over the time required, but are also responsive to emerging learning as the reform progresses.

Changes to funding allocation for regional areas

Planning for the SOTE reform had stated that there would be changes to funding allocation by central government to regional organisations, where funding would be based on a needs-based resource allocation formula (Couffinhal et al., 2016). The country experts we consulted commented that there have been significant challenges in implementing this area of the reform. The level of complexity in ascertaining and agreeing on demographic information about a local population's health and social care needs has been much more challenging than originally anticipated, and this reform measure is still progressing.

The potential to allocate funding based on the needs of the local population is likely to be appeal to the Scottish context, but there is relevant learning about the time and expertise required to undertake this. In Finland, this has been further complicated by the emergence of deficits in regional wellbeing service counties; budgets, as well as plans for a reduction of spending in wellbeing service counties by €6 billion due to national budget deficits. Budgetary constraints are not unique to Finland, and there is critical learning for Scotland about the need for accurate budgeting that can be sustained throughout any unforeseen changes to national finances.

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Decentralisation of children's services in the Netherlands

Introduction

The Netherlands has a population three times that of Scotland (17.5 million population compared to Scotland's 5.5 million population) and has a higher population density (518 people per km sq to Scotland's 70 per km sq). Economically, it is wealthier (US\$58,100 GDP per capita to the UK's US\$47,300) but only spends a marginally higher proportion of its total income on children and family social protection services than in the UK (1.4% of GDP compared to 1.2% in the UK). Of most interest in the context of this study is the fact that the Netherlands scores highest of all countries for child wellbeing (UNICEF Innocenti Report Card 16). However, despite its international standing, 1 in 7.5 children in the Netherlands were being supported by child and family support services in 2021 (Statistics Netherlands, 2022) and it is this scale of need that has led the country to use its Youth (Care) Act 2015 to transform its children's health and social care system to better meet children's needs.

In contrast to the other case study countries we looked at, transformation in the Netherlands has involved the decentralisation of children's health and social care powers to its 342 local authorities; with this happening at the same time as a restructure of local government with the number of local authorities decreasing from 450 to 342. Most children's health and social care responsibilities have been delegated to the local level, but national and regional delivery and structures do still form part of the system and, seven years on since the Youth (Care) Act 2015, implementation of many of the transformational aims are yet to be realised. There is some emerging evidence that suggests change is starting to have an impact but the overriding conclusion from the Netherlands case study is that stakeholders are continuing to grapple to understand what the most effective children's health and social care structural and governance arrangements are.

Authors' note

The term 'local authorities' has been used when referring to local government in the Netherlands but these are widely referred to as 'municipalities' in Netherlands publications.

'Children' has been used in this case study but in the Netherlands the term 'youth' is applied to children and young people from age 0 to 25 – e.g. the Youth Act 2015 applies to children and young people.

Setting the context

The Youth (Care) Act 2015 was designed to address a number of longstanding issues that have led to the Netherlands' children's health and social care system being viewed as inefficient and ineffective (de Vries and Wolbink, 2018). These issues included:

- Critiques of service orientation being risk-oriented, reactive, deficits-based and agency-led (Coussee et al., 2012; de Vries and Wolbink, 2018).
- An imbalance of funding towards specialist services rather than early help and preventative services (Hilverdink et al., 2015; National Youth Institute, 2019).
- Fragmentation of services across national, regional and local structures, with services before the Youth (Care) Act 2015 taking the following structure:
 - National level responsible for child protection, children's care and legal proceedings
 - Regional (provincial) level responsible for children's social care, children's acute healthcare¹ and mental health services, and
 - Local authority level responsible for children and youth services, family support, and children's primary health (for example vaccinations and health visiting).

This fragmentation brought confusion to children, young people and families in how they access and navigate services; and acted as a barrier to practitioners from different services working together (Hilverdink et al., 2015; Mieloo et al., 2022; National Youth Institute, 2019; de Vries and Wolbink, 2018).

- The management and funding of the children's health and social care system being divided and fragmented across regional and local administrative systems (Coussee et al., 2012; Knijn et al., 2011; Van Nijnatten et al., 2014; de Vries and Wolbink, 2018).
- Limited participation of children and young people in the decisions and planning that affected their lives, with children and families not feeling heard, professionals overruling parents, and the professional ethos being described as having a 'patronizing tone' (Rap et al., 2019; de Vries and Wolbink, 2018).
- Rising demand for specialist services, as evidenced by increasing numbers of children accessing social care support, entering foster care and/or needing mental health services (Hilverdink et al., 2015; Knijn et al.; 2011; National Youth Institute, 2019). Expenditures on children's health and social care services rose as a result (National Youth Institute, 2019; de Vries and Wolbink, 2018).

With all-party support in the Dutch Parliament, the Youth (Care) Act 2015 was passed to overcome these issues. The main structural change was to remove children's social care

¹ Universal health care provision is free to children in the Netherlands, although more specialist treatments are only available free of charge to children if their parents/carers have a high level of health insurance. Adults are required to take out mandatory health care insurance with approved private health providers, with lower level insurance providing universal care and higher level insurance providing more specialist health care.

services from the Netherlands' 12 provinces and legislate for most children's health and social care responsibilities (that is, children's social care, primary and mental health, youth and family support services) to be delegated to the Netherlands' 342 local authorities. This was done with the aims of:

- Aligning with the strong policy ethos within the Netherlands of decisions being best taken at the level closest to citizens (subsidiarity). Local and regional levels enjoy autonomy and may act in any way as long as these are in line with national law (Knijn et al., 2018). Decision-making is therefore as close as possible to the people and only when needed should decision-making be brought to a higher level.
- Bringing multi-agency services together to build integrated local service offers that are tailored to the needs of local communities and neighbourhoods. Local authorities were viewed as the best scale at which to plan, deliver and manage an integrated service offer (Hilverdink et al., 2015; Mieloo et al., 2022; Rap et al., 2019; de Vries and Wolbink, 2018).
- Under the mantra of 'One Family, One Plan, One Coordinator', offering flexible and timely services that respond to the individual strengths and needs of children, young people and families (Helderman et al., 2020; Mieloo et al., 2022; National Youth Institute, 2019; de Vries and Wolbink, 2018).
- Reinforcing the value of a positive, strengths-based approach to practice that is non-stigmatising, empowers families, and builds on family and community assets (Coussee et al., 2012; Hilverdink et al., 2015; Mieloo et al., 2022; Rap et al., 2019; Trappenburg and van Beek, 2019; Van Nijnatten et al., 2014).
- Prioritising open dialogue and shared responsibilities between practitioners and families, and indeed between practitioners, as opposed to decisions being determined according to hierarchical structures and relationships (Coussee et al., 2012).
- Reconnecting practice to societal values of positive and participatory parenting and active citizenship (Coussee et al., 2012; Hilverdink et al., 2015; Knijn et al., 2018; Trappenburg and van Beek, 2019).
- Re-balancing resources towards early intervention and preventative services, yet also ensuring better connections with specialised care (Coussee et al., 2012; Hilverdink et al., 2015). This requires generalists (that is, practitioners with a wide grounding of skills and expertise) being able to call upon and work closely with specialist roles (de Vries and Wolbink, 2018; Helderman et al., 2020).
- Giving practitioners more autonomy and work more closely with families and other practitioners, with the reduction of administrative demands supporting this (Mieloo et al., 2022).
- As a consequence of these different ways of working and having less demand for specialist services, reducing the cost of children's health and social care (Hilverdink et al., 2015; de Vries and Wolbink, 2018).

The reforms stemming from the Youth (Care) Act 2015 were not the only transition of responsibilities to local authorities in the Netherlands in 2015. The Social Support Act 2015 saw adult health and social care responsibilities also being decentralised with the aim of achieving more integrated approaches across adult and children's care and support (Hilverdink et al., 2015). In addition, the Participation Act 2015 placed employability services and welfare payments under local authority responsibilities.

Structural developments

The Youth (Care) Act 2015 legislated for the local governance, design and delivery of most children's health and social care services. Table 1 sets out the key structures as these exist and operate in 2023.

National

- The Ministry of Health, Welfare and Sport is responsible at the national level for children's and youth policy and for most of the specialist services for children and families. Other important national ministries are:
 - The Ministry of Justice and Security which has responsibility for child protection, adoption, youth justice and probationary services:
 - The Child Care and Protection Board is a national organisation with 18 area teams spread across the country. Its remit is to first investigate and assess concerns raised. Based on this investigation, the Board decides whether an involuntary care and protection measure is necessary. If a child protection measure is not needed, they refer the family to a local authority.
 - The Ministry of Education, Culture and Science which has responsibility for schools, other educational institutes and cultural education, and
 - The Ministry of Social Affairs and Employment which has responsibility for preschool care, leisure, employability and income.

Collectively, these four government ministries hold and allocate public expenditure for children's health and social care services, with the Ministry of Health, Welfare and Sport and the Ministry of Justice and Security being the main sources of funding. Their key function is to allocate annual funding to the 342 local authorities, with each local authority's allocation dependent on a range of indicators (such as population size, number of children and young people, and number of people entitled to receive benefits).

- The Health and Youth Care Inspectorate is the supervisory authority responsible for monitoring the quality and safety of healthcare and youth care services in the Netherlands. This body is the result of a merger between the Health Care Inspectorate and the Youth Care Inspectorate.
- The Netherlands Youth Institute is commissioned and financed by the Ministry of Health, Welfare and Sport for collecting and sharing knowledge about child and

youth matters that can support professionals and local authorities in their service delivery.

Regional

- While the 342 local authorities are responsible for child and youth care, the small size of many means they co-operate on some matters. In particular, they have come together to form 42 regional youth care alliances where they undertake strategic service planning across:
 - Child protection
 - Residential care, foster care and crisis care, and
 - Specialised and secure care.
- Child health care is also the responsibility of local authorities but is organised and delivered through 25 public health boards. Through multi-disciplinary health teams, provision includes early years assessments and vaccinations, primary and secondary school assessments, and health and child development information. These teams then work closely with GPs and other specialist medical professionals.
- Other related regional arrangements between local authorities are:
 - 26 child abuse and domestic violence regions / centres (Veilig Thuis), which are the agencies where anyone can and should contact for advice or to report a concern of child abuse or risk. Staff assess concerns received to escalate to the Child Care and Protection Board, refer to local children's multi-disciplinary teams, or take no further action
 - 25 safety regions through which police, youth justice and other services are organised
 - 76 primary school education regions
 - 74 secondary school education regions, and
 - 40 specialist school regions.

Local

- Since 2015, the Netherlands' 342 local authorities have been responsible for most children's health and social care services. Their delivery of this responsibility include:
 - Providing universal and preventative services to specialised (both voluntary and compulsory) care, including mental health services, for children and young people up to the age of 18. Care arrangements can be extended to a young person's 23rd birthday where it is in the young person's interests to do so.
 - Operating local, multi-disciplinary teams to provide a holistic range of supports to children and families under the mantra of '*one family, one plan, one coordinator*'. Roles include health care workers, mental health staff, social workers, parenting support workers, educational psychologists, welfare and financial inclusion workers.

- Some local authorities organising their multi-disciplinary teams as neighbourhood teams, while others do so within a 'one stop shop' child and family centre.
- Children's social care services mainly being contracted out to external providers, for example, third sector organisations, but some local authorities deliver services in house. Procurement to external providers is typically organised by a service level agreement with funding tied to outcome measures.
- Local authorities having the discretion on how they spend their annual 'Youth Care Act' budget provided to them by the Ministry of Health, Welfare and Sport.
- Local authorities are also responsible for:
 - Child and youth policy and services such as child and youth work, free time activities and sports
 - Child poverty measures, including preventing and tackling financial problems and debt among families, and increasing the disposable income of parents on low incomes, and
 - Adult social welfare and measures to help the unemployed, people with disabilities and the elderly (including holding responsibilities for the Social Support Act 2015).

Local authorities are not directly responsible for schools. This is the overarching responsibility of the Ministry of Education and delegated to schoolboards. However, local authorities have a direct say in school boards of public schools and a delegated role for schools based on an ideological concept or religion. Local authorities are responsible for the infrastructure and maintenance of school buildings and they also are involved in care structures at schools.

Sources: Bouma et al. (2016); European Committee of the Regions (2022); Europe Encyclopaedia of National Youth Policies (Youth Wiki); Hilverdink et al. (2015); Knijn et al. (2011); Mieloo et al. (2022); Netherlands Government (2022); Netherlands Youth Institute (2007; 2019); Rap et al. (2019); Vanneste et al. (2022).

Reflecting on how children's services are organised in the Netherlands, the commitment to subsidiarity and local autonomy is evident, with local authorities responsible for children's health, social care and education, as well as for adult public health, social care, housing and employability. This has led to variations in what services are available locally for children and families (Hilverdink et al., 2015; Rap et al., 2019; Trappenburg and van Beek, 2019). Examples include whether local authorities have neighbourhood teams, child and family centre or a service for all ages; what services are available to all children and families, and which are available for those with specific needs; and whether services are delivered in-house or contracted out (de Vries and Wolbink, 2018). Focusing on the means of delivery, there are three ways in which children and family services are delivered at the local level in the Netherlands:

- Lokalis in Utrecht (Box 1) which is an example of a child and family neighbourhood team.
- Voorschoten local authority has a child and family centre (Box 2), and
- WIJeindhoven in the city of Eindhoven is an all-age service (Box 3).

Box 1: Lokalis, Utrecht's Child and Family Neighbourhood Teams

The city of Utrecht, with a population of 565,000 people, has placed responsibility for its children and families support in one organisation. This organisation, called Lokalis, delivers its services through 18 neighbourhood teams and two teams associated with secondary education and secondary vocational education. Its guiding principles closely align with those outlined via the Youth Care Act 2015 and are:

- Self-direction, responsibility, freedom of choice and reciprocity
- Normalising and starting from the possibilities: children, young people and families in everyday life form the starting point
- Customisation, so that services are tailored to the individual needs of children, young people and families
- High-quality generalist professionals at the front, but with room for professional considerations and decisions
- A simpler system with less bureaucracy – so meaning that the content leads, and not the system, and
- Child safety is always the bottom line.

Where children and families require additional support, Lokalis then works with and refers to other specialist teams within Utrecht (for example, child protection, child and youth psychology, and child and youth psychiatry teams). Referrals to specialist teams are agreed through joint case discussion with relevant professionals.

Key success factors of Utrecht's approach include:

- Lokalis was a newly established organisation and this helped to bring a fresh approach to service (re)design, rather than being tied to historic approaches and arrangements.
- The long-term funding that Lokalis receives supports longer-term planning focused on preventative and early intervention services.
- The composition of each neighbourhood team varies according to the needs of that neighbourhood. Specialist roles that make up teams include child and youth psychology, special education, psychotherapy, child and youth psychiatry, and systemic therapy.
- Having both neighbourhood teams and the two education teams has supported joint working across social work and education professionals.
- Joint case discussion between the generalist neighbourhood teams and specialist teams supports an integrated way of working, whereby each practitioner can learn from and be supported by others.
- The professionalism of the workforce is highly valued. This is done through:

- Articulating the competencies and skills that underpin the organisation's services, and then supporting its staff through learning and development opportunities
- Continuous learning is central to the organisation, with learning from casework and real experience valued more than training courses, and
- Limiting the administrative burden on staff, so prioritising time working with children and families.

Opportunities for further development still exist, with key areas identified by Helderma et al. (2020) as:

- Lokalis's interface with child protection, in particular ensuring that decisions made locally about a child or family that lead to referrals to the Child Protection Board are carefully explained, substantiated and documented.
- Family Plans – the means through which collaborative actions between families and professionals are discussed, articulated and monitored – can take a more consistent format (particularly around the inclusion of family assessment information and measures for monitoring families' progress), and are written in a family-friendly manner to boost families' use and understanding of these.
- A management information / IT system that can also be used by families rather than a system for professionals only.

More widely, Utrecht's development of services has been described as a gradual process of reflection and evolution rather than the result of one (or more) transformational decision. There is not, for example, a 'Utrecht model' but instead a design that has evolved, and will continue to evolve, over time through dialogue and discussion.

Source: Helderma et al. (2020); www.lokalis.nl

Box 2: Child and Family Centre, Voorschoten

Voorschoten is a small local authority with a population of around 25,000 in the province of South Holland. It operates a Youth and Family Centre to support children aged between nine months and 23 years and their families. Different services work together in the centre, including:

- Child and youth nurses and a paediatrician.
- Social workers and school social workers (noting these are contracted through a national third sector organisation: Kwadraad).
- Disability advisors and social workers (via the disability third sector organisation: the MEE Foundation).

The centre is open to all children, young people and families to provide advice and support around growing up, parenting (for example delivering the Triple P programme), care and available forms of assistance. Where staff in the centre cannot provide the level of support needed, they ensure referrals are made to appropriate

specialist providers. Across all its services, a positive approach to practice is taken whereby the strengths of children, their families and networks are identified and built upon.

Source: www.voorschoten.nl/youth-and-family-centre; www.cjgvoorschoten.nl/

Box 3: WIJeindhoven, Eindhoven's All Age Service

WIJeindhoven is an example of a service for all ages (0-100 years) whose remit has grown to take on welfare, employability, children and youth assistance, and social care supports for the city of Eindhoven, which has a population of 365,000. A key focus of WIJeindhoven's work is also to help build strengths and capacity within Eindhoven's neighbourhoods.

In terms of scale and structure, WIJeindhoven has approximately 350 staff working with around 25,000 Eindhoven residents. Delivery across the city is structured under eight district teams. To support integration, 35 connectors work to strengthen networks and partnership working with other services.

Staff are presented as 'generalists' who are able to work with residents on a holistic basis and tailor support to their strengths and needs. However, while staff are 'generalists', they are not tasked with working with all age groups. For children and families, there are 'Generalist Youth' staff who are experienced in working with children and families, understand key legislation and policy, and can support other WIJeindhoven colleagues in their work with children and families.

Source: www.wijeindhoven.nl

In seeking to compare these three models, there does not appear to exist research and evaluation evidence that has appraised the respective strengths and weaknesses of each approach, or whether different models are found in different types of local authority areas. However, there are commonalities across the three examples, not least the emphasis placed on having a generalist workforce (Trappenburg and van Beek, 2019). This wider, generalist skillset is understood to be less stigmatising for children, young people and families needing support and more supportive of integrated working as a more holistic child and family perspective is taken. Trappenburg and van Beek (2019) found Netherlands' social workers were positive about working in this manner, in multi-disciplinary teams, as it helps to address families' different needs simultaneously. Indeed, older workers reflected that this way of working reminded them of practice during their early careers. Where concerns were raised about working in these examples, these related to practitioners' lack of knowledge on specific matters (for example, tax or legal issues) and around the ability for children and families to access specialist support when they need it.

While many services have been decentralised to local authorities, national and regional structures do remain as part of the Netherlands' children's health and social care system. At a national level, the Ministry of Justice and Security has lobbied hard for the national Child Care and Protection Board to continue to hold responsibility for child protection and care assessments and legal decision-making. However, it is felt that the Child Care and Protection Board does not work with families in the same relationship- and strengths-based approach that local authority child and family services do. Indeed, there are widely reported cases in the media around the voice of children and families not being heard in legal proceedings, and of children and families having to tell and retell their stories across different agencies and professionals.

In relation to reporting of child protection concerns, there is no mandatory reporting requirement of practitioners. However, there is a national requirement to have a 'model protocol for child abuse and domestic violence' that illustrates the Netherlands' preference towards a policy-based reporting duty. The protocol has five steps to it: note the signs of child abuse or domestic violence; consult a colleague; speak to the parent or guardian; determine the severity of the abuse; and then take the decision of reporting to Veilig Thuis (the child abuse and domestic violence regions/centres) or that the practitioner can organise or provide assistance themselves. The protocol is obligatory for healthcare, education, childcare, social work, youth care, and criminal justice system organisations, with organisations having to ensure their workforces are aware of it.

There are then a number of youth care, health, safety, and education regional groupings in place, including one relating to child protection and alternative care, and one relating to child and youth health. These regional groupings have been set up by local authorities because some are "too small to perform all tasks themselves, are not able to deal with fluctuations in the demand of expensive care, do not have the specific expertise needed, or have important partners that operate on a regional level...(Local authorities) have therefore formed regional alliances to organize residential care, foster care, child protection measures, youth probation, certain types of specialised care and/or secure care" (Hilverdink et al., 2015 pp7). However, the regional groupings have varied and overlapping boundaries, so leaving a highly complex service landscape. Coterminous administrative boundaries across these different service domains only exist in the Netherlands' largest cities.

Progress and impacts

The Youth (Care) Act 2015, along with the Social Support Act 2015 and Participation Act 2015 covering adults, represents "one of the most far-reaching reforms of the Dutch welfare state in recent decades" (Helderman et al., 2020 p6). Such transformation takes time to achieve but there is some emerging evidence that these aspirations are beginning to take hold. Meiloo et al. (2022), for example, studied the impact of the reforms in Rotterdam between 2015 and 2018 and found that:

- The demand for preventative care increased from 2.2% to 8.5% of the children's population, but...

- ...the demand for specialist health and social care decreased from 7.2% to 6.4% of the children's population.

In seeking to explain Rotterdam's data, Meiloo et al. (2022) point to the impact of the Youth (Care) Act 2015 and associated reforms in Rotterdam. Specifically, they refer to Rotterdam's implementation of an integrated preventive child policy programme and community-based support teams: "An important part of this (Rotterdam's) programme is collaborative planning of preventive measures and interventions at the neighbourhood level focusing on an increased use of evidence-based preventive interventions especially on the domain of mental health promotion. Furthermore, the community-based support teams may have increased the availability, accessibility and acceptability for primary (preventative) youth care, which may have resulted in a reduced gap between those in need for care and actually receiving care" (Meiloo et al., 2022 p8). Linked to this, they also consider whether the trends could be due to "an increased competence of community-based [for example neighbourhood] teams or an increased familiarity of these teams in the communities they serve" (p8).

At the national level, a similar trend to that of Rotterdam's can be seen. The Annual Youth Monitor Report 2022 (Statistics Netherlands, 2022) finds that:

- More children and young people in the Netherlands are receiving child and family support: from 1 in 10 children in 2015 to 1 in 7.5 in 2021, and
- There has been a small reduction (1%) in child protection and care cases and a larger reduction (29%) in youth justice cases.

These trends are viewed positively as showing that children's needs are being met sooner through local preventative services, with less children requiring statutory care and justice interventions. However, the wider narrative is that the transformation in services and delivery has been complex and contested and the ambition of "providing effective, timely and coherent support for [children], young people and their families at local and regional levels is far from being achieved" (Helderman et al., 2020 p6).

Budgetary pressures have been a key factor. Local authorities have had to implement these transformational changes at a time of cuts to local authority budgets and when demand for services has been increasing (National Youth Institute, 2019). Statistics Netherlands (2022) reports that local authorities are spending more money on children's health and social care than they are receiving from central government and the resulting budgetary pressures have led local authorities to make cuts to preventative services.

Beyond budgetary pressures, other factors identified include:

- The availability of informal supports (for example from family members, friends and community groups) being less than expected, thus impacting on the family- and/or community-based supports to children and families (European Committee of the Regions, 2022; Trappenburg and van Beek, 2019).
- Disconnects between generalist children's social care (for example services provided by neighbourhood teams) and specialist health, care and education provision (Helderman et al., 2020; National Youth Institute, 2019). Mental health

care for children is a particular concern, with some waiting lists exceeding one year (OECD, 2021).

- Transitions for young people turning 18 years old remaining difficult (National Youth Institute, 2019). While the Youth (Care) Act 2015 provides a wide range of supports and services, there is less support for adults under the Social Support Act 2015 and more onus is placed on the young person. Under certain conditions local authorities can extend the duration of care until young people are 23 years of age and, since 2018, foster care automatically lasts until their 21st birthday, but still the transition is challenging (European Committee of the Regions, 2022).
- Workforce shortages, with Statistics Netherlands (2022 p161) reporting “employees in the [child health and social] care domain are relatively young, female (84 percent) and highly educated, work more hours than average in the health and well-being sector, experience a high workload more often and experience more aggression by patients or clients than average in the health and well-being sector[...] [child and] youth care workers are the most likely to leave the care and well-being sector”.
- Local authorities’ management, procurement and administration of children’s health and social care services are becoming more complex, requiring large bureaucracies and limiting the autonomy of practitioners (National Youth Institute, 2019; de Vries and Wolbink, 2018). The procurement culture is also contributing to increased competition between potential providers, rather than collaborative working (National Youth Institute, 2019).
- To meet contractual criteria and ensure accountability, increasing manager and practitioner attention is being paid to recording and evidencing staff time, caseloads, and children and families outcomes (de Vries and Wollbink, 2018).
- Limited training and education for children’s health and social care managers, meaning they have been struggling with the new roles and responsibilities (de Vries and Wollbink, 2018).

De Vries and Wollbink (2018) highlight the need for a transformational style of leadership, one characterised by leaders:

- Encouraging practitioners to focus on the ‘common good’ and achieving positive health and wellbeing outcomes for children, young people and families
- Empowering practitioners to have autonomy in working with children, young people and families
- Promoting co-operation between practitioners and within teams, and by
- Providing coaching and mentoring to practitioners to help support new ways of working.

Such transformational leadership is, however, difficult when leadership and service attention is focused on meeting increasing demand for children’s social work and specialist medical care, tackling growing waiting lists, and attending to rising costs (Helderman et al., 2020; Vanneste et al. (2022)). The conditions in which to bring about planned and sustainable transformation of services are not therefore in place. The

national government appears to be recognising this challenge and is “heed[ing] the call from the sector to give it plenty of time to expand on existing best practices, instead of [the national government] introducing new policies” (Ministry of Health, Welfare and Sport, 2022).

Beyond the role of local leadership, the role of national government has to be considered. To boost the consistency and professionalism of children’s health and social care services, there are calls for enhanced national guidance, greater standardisation of procurement within children’s health and social care, and national children’s services performance indicators for local authorities to use (National Youth Institute, 2019; Statistics Netherlands, 2022). Vanneste et al. (2022 p8743) for example, report that child health and wellbeing data is collected regionally but without the consistency to allow collation and analysis at the national level. The authors advocate that national data can provide “more insight into the health and well-being of children and young adults...in order to prioritise children in the greatest need of care, to demonstrate the effects of the child and youth health and to support the implementation of effective child and youth healthcare policy”.

However, the most pressing ask of national government has been the calls for increased funding for local authorities. Some additional funding has been made available, for example in April 2021 an additional €1billion were provided to local authorities to address bottlenecks in children’s health and social care services (European Committee of the Regions, 2022) but this has not addressed the funding gap given rising levels of demand. The relationship between national and local government is highly strained and impacting on service planning and delivery.

Potential learning for Scotland

Compared to the other case studies we have looked at, the Netherlands has taken a different approach to transforming its children's health and social care system as it has delegated many responsibilities to its 342 local authorities. This was done so that services are designed at the level closest to children and families, with their needs then met through local multi-disciplinary teams. Key to the effectiveness of these teams is their accessibility; the extent of joint service working, dialogue and responsibility around child and family needs; and a value placed on generalist skills that support a holistic view of the family to be taken.

Despite decentralisation, national and regional levels of structures have retained important functions. Specialist care and health services, along with education and police, are organised at the regional level – albeit in differing regional arrangements. At the national level, the national Child Care and Protection Board is a key institution as it undertakes child protection and care processes and decision-making. Collectively, the national-regional-local structures have led to a complex governance and delivery landscape. Key issues identified include the linkages between more generalist and specialist services, and transitions to adult services.

Notwithstanding the complex landscape, there is some early statistical data that indicates that the greater emphasis on local preventative and early intervention services is beginning to reduce the demand for more specialist services. However, the wider narrative is that implementation of the Youth (Care) Act 2015 will take more time and resources.

For local authorities, there have been challenges stemming from decentralisation. With 342 local authorities commissioning or managing services, there have been increased procurement and administrative demands across the sector, which are seen to have limited the time practitioners can spend working with children and families. Local authorities have also struggled to reform children's health and social care services when the demand for these services has been increasing, budgets are being increasingly squeezed, and other reforms, for example, local government restructure, and the Social Support Act 2015 and Participation Act 2015 were being implemented at the same time.

National government still has an important role to play in a decentralised system through the support it can provide to local authorities. Key areas of support include providing funding to local authorities, articulating expectations of practice, simplifying or rationalising procurement requirements, setting performance measures, and sharing high quality practice.

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Reforms of children's services in Aotearoa New Zealand

Introduction

New Zealand has a comparable size of population and geography to Scotland, with a slightly smaller population of approximately 5 million but with a significantly lower population density of 18 people per square kilometre (compared to 70 people per square kilometre in Scotland) (United Nations Population Division, 2022), as well as a slightly higher GDP of US\$48,780 per capita. There are some similarities in the geographic challenges arising from reaching rural communities over significant distances. In UNICEF's Innocenti Report Card 16, while the UK is ranked 27th, New Zealand scores 35th out of 38 high income countries for children's wellbeing across mental wellbeing, physical health and skills, scoring 38th for mental wellbeing. In a ranking of policy and context, New Zealand ranks 20th out of 41 countries, ranking 37th for social policies.

In 1938 New Zealand was one of the first countries to establish a universal, tax-funded national health service, and equitable access remains a guiding principle underpinning its public health service (Goodyear-Smith and Ashton, 2019). Children therefore access health services free of charge, ranging from midwifery, health visiting, general practice, dental, emergency, and hospital care.

There have been a series reforms and reviews of child welfare services in New Zealand over the last decade making changes to how services are organised and delivered. We looked at three distinct reforms to child welfare:

- The Vulnerable Child Reforms from 2012 to 2014
- A review by the Expert Panel on Modernising Child Youth and Family in 2015, which set out a second stage of reform, the Modernising Child Protection Reforms, and
- A third stage of reform in 2021 that followed a series of six reviews, and associated media coverage, in 2019 of children's and families' negative experiences of the children's social care system.

Among these reforms, structurally, a key reform has been the establishment of Oranga Tamariki, the government's Ministry for Children, in 2017. Oranga Tamariki acts in partnership with the ministries for health, police, justice and social development to commission children's services across New Zealand, noting that the Ministry of Health is responsible for children's health and there are currently (2023) also significant reforms of New Zealand's health system underway. Neither regional nor local government have responsibility for children's social care.

Cross-cutting many of the reforms has been how to ensure Māori communities are empowered, that the strengths of whānau (family, and extended family groups) are supported, addressing marginalisation, structural inequalities and disproportionate

experiences of adversity and poor outcomes for children and families. Scotland and New Zealand both have diverse communities of children, young people and families, some of whom experience marginalisation, stigma and adversity due to structural factors such as poverty or racism (Pihama et al., 2017; Atwool, 2019; and Keddell et al., 2022). There is no direct comparator between Māori communities and any community in Scotland, as Māori have a distinct history and culture as indigenous people who have experienced colonisation. However, many aspects of reforms to support Māori rights and culture have relevance to Scotland, such as supporting the strengths of whānau through early and preventative support, as well as supporting their participation and voices.

Authors' note

There is good availability of research and policy about reforms in New Zealand that is published in English. It should be noted that English language publications of government policy includes Māori language words that more accurately convey meanings in Māori culture. Whilst some words have equivalents in English, these are often simplified translations. For ease of reading in Scotland, a summary of key terms and close equivalent terms in English are listed below.

Key Māori words relating to children's services are:

- *Tamariki* - children
- *Rangatahi* - teenagers or young adults
- *Whānau* - family and extended family groups, though this has a more complex meaning incorporating culture and spirituality
- *Iwi* - the largest social units in Māori society, i.e. people, nation, tribe
- *Kaupapa* - a principle or policy
- *Hapū* - a division of a Māori people or community
- *Mahi* - to work, do, perform, make, accomplish, practise
- *Mana* - authority, prestige, status

Setting the context

From the 1980s, there had been increasing awareness of the high rates of child abuse and neglect, increasing notifications to the child protection system, and poor outcomes for children in care which prompted a period of significant legislative activity in New Zealand (Office of the Chief Social Worker, 2014). In particular, Māori children and their families had, and continue to have, disproportionate experiences of abuse, neglect and adversity, and are over-represented in data on children needing care services including residential care (Atwool, 2019; Hyslop 2017). In addition to the impact of marginalisation, there are arguments that colonialism impacted children's wellbeing, as traditional whānau structures are thought to have acted as a crucial protective factor for Māori children's wellbeing, were significantly disrupted (Keddell et al., 2022).

After a report by Māori leaders Puao-te-Ata-tu (Daybreak), legislation was progressed in 1989 with extensive requirements to support the rights of children and their families and promote participatory practice with Māori whānau, hapū and iwi. As well as setting out the definition of a child or young person in need of care or protection as an individual experiencing or likely to experience significant harm (detailing a range of related factors), the Oranga Tamariki Act 1989 (or the Children's and Young People's Well-being Act 1989) included the principle that, where possible, the primary role in caring for and protecting a child or young person lies with their family, whānau, hapū, iwi and family group. As part of this approach, directions on the use of 'Family Group Conferencing' within family support and decision-making was included this Act. Where it is not safe for a child to stay with their family, the child should be cared for in "an appropriate family-like setting" and with a person who is a member of the child's hapū or iwi should be prioritised.

There has been a significant gap between policy, practice and the aspirations in this Act. For instance, whilst the number of Family Group Conferences have been recorded by the Ministry or Department responsible for children's social work, and the number of conferences has been relatively stable, reviews of children's social work raised that Māori tamariki and whānau could often find these "pre-determined", manipulative and disempowering (Waitangi Tribunal Report, 2021 p103). This has been attributed to a wider policy context that did not acknowledge the role of structural factors such as poverty, discrimination, and inequalities on the wellbeing of some whānau; as well as the inconsistent and unsustainable funding of family support services and a risk averse practice culture (Healy, 2009; Hyslop and Keddell, 2019).

A prevailing political context in New Zealand that has been described as neoliberal (Hyslop and Keddell, 2019), impacted social welfare policy and child welfare policy specifically. This included a move to smaller government, a focus on investing in outcomes, specifically for children and families classified as "vulnerable" or "high-risk", and a focus on individual responsibility over matters such as welfare payments or child protection, with an aim of reducing government expenditure (Hyslop, 2017; O'Brien, 2016). Changes to welfare benefits in the 1990s led to many families experiencing increased poverty. Despite some remedial policy measures for working families, policy framed payment of welfare negatively, linking this to long-term poor outcomes for families and risks to children in these families (Keddell et al., 2022). There was also a shift in government responsibility for welfare, from the sole responsibility of a Ministry of Social Development to a remit spread across wider government departments, employers and communities, and particularly a responsibility on individuals themselves with support from social welfare.

Amidst this neoliberal political context, notifications of child protection concerns and occurrences of child abuse increased, and this is thought likely in part to be connected to the impact of policy choices on families and increasing poverty (Keddell, 2016). These trends led to the first stage of reforms to child welfare services – the 2012-2014 Vulnerable Children Reforms – but, despite evidence from New Zealand correlating with

international evidence linking experiences of poverty and contact with the child protection system, poverty was explicitly excluded as a driver of child abuse or neglect (Bywaters et al., 2016), and support to address poverty was not considered in policy responses to support children and their families until 2019.

2012–2014: the vulnerable children reforms

The Children's Act 2014, The Vulnerable Children's Act 2014 and Children's Action Plan were framed as child-focused and trauma-informed but also described as "tough new laws to protect children" (Keddell, 2016 p244). This included measures to support the reporting of concerns to statutory agencies earlier, and a focus on meeting the needs of children who have experienced abuse or are at risk of doing so (Keddell, 2016).

Whilst New Zealand does not have blanket mandatory reporting requirements on all professionals who interact with children (only police and social workers are mandated to report any concerns), the Children's Act 2014 included provision that all organisations in contact with children must have a child protection policy setting out how professionals should report concerns.

The Vulnerable Children Act 2014 and the Children's Act 2014

This legislation introduced a range of measures, including:

- An increase in the screening and checks on professionals in central or local government, prohibiting people with serious convictions from working closely with children (unless granted an exception).
- Requiring all agencies in contact with children to have child protection and reporting policies.
- Improvements to training of the children's workforce, and development of "core competencies".
- The establishment of the Vulnerable Children's Board which would have responsibility for cross-agency governance and oversight of the implementation of the Act and Action Plan.
- Changes that increased the burden of proof of parents whose children had been placed into care, for decisions about the care of their other children (in the Children, Young Persons, and Their Families (Vulnerable Children) Amendment Act 2014).
- Changes to curtail the guardianship rights of birth parents.
- An increase to the resources available for children in long-term foster care and an increase to the legal protection for permanent foster carers.
- The strengthening of 'the paramountcy principle' that a child's best interests are paramount over all other considerations, and the introduction of 'predictive risk modelling'.
- The creation of a child protection phonenumber outside the primacy child protection agency.
- The introduction of 'vulnerable kids information system', which facilitated information sharing between government agencies and Non-Governmental Organisations (NGOs) as well as the tracking high-risk adults and offenders. (Keddell 2016).

The Children's Act 2014 also made changes that designated five government departments would have accountability for the protection and welfare of vulnerable children: the ministries of Health, Education, Justice, Social Development and Oranga Tamariki (children); and the police.

A further development of these reforms was the planning of a new approach to information sharing, recording and analysis, though this was not implemented. The Vulnerable Kids Information System (VIKI) would record interactions, share information, manage plans, and monitor children's progress. Using large national data sets, VIKI would employ tools for risk-prediction and algorithms to identify "high-risk" children and families to enable the targeting of support to them (Stanley and Monod de Froideville, 2020). The framing of the reform as protecting "vulnerable children" justified the retention and sharing of information to mitigate future risk. Amidst ethical concerns, including the use of data collected for one reason for a different purpose without consent (especially the use of an algorithm to identify "high risk" children), and the potential for stigmatisation of children and families, the use of data in the VIKI information systems was paused in 2017 (Keddell 2019b; Jørgensen et al., 2021; Keddell, 2015; Ballantyne, 2019).

The overall impact of the 2012-2014 reforms were an increase in the surveillance of children; an increase in the number of children for whom a decision was taken for them to live in care; and an increase in the inequalities between children, especially Māori children (Hyslop and Keddell, 2019). The significant rise in notification rate (of children at risk of harm and abuse) led to a subsequent reduction in the criteria for a notification, with responsibility for the support for these children shifted to the third sector. This in turn resulted in tension between these services and agencies, as funding rarely met the increased demand for services, nor did it enable preventative actions to meet support needs before they escalated (Keddell, 2016). Indeed, limited family support was available, except services for children already in care. This meant that in practice prevention was solely enacted as the early identification and reporting of abuse to the national and statutory Child, Youth and Family agency.

2015-2019: the modernising child protection reforms

Given the adverse effects of the 2012-2014 reforms, the Minister of Social Development set out the need for a further reform of services that would better meet the needs of children rather than the needs of the system (Hyslop and Keddell, 2019). The Modernising Child, Youth and Family Expert Panel was established to undertake a review in 2015 of New Zealand's care and protection system, leading to recommendations to be implemented over five years.

Final Report of the Expert Panel on Modernising Child Youth and Family (2015)

The Expert Panel on Modernising Child Youth and Family identified that the current care system in 2015 did not meet the needs of children and young people, because it was fragmented, lacked accountability, and was not well-established around a common purpose. The review found that children in care not only experienced unacceptable levels of harm and abuse but also had poor long-term outcomes in health, education, employment and involvement with offending. The system as a whole was seen as ineffective in preventing further harm, and there was a particular need to address the over-representation of Māori children in the system.

The review suggested that the complex needs of children and families required a co-ordinated response across organisational boundaries, but that the current system was disjointed and fragmented. Agencies were not clear on their roles in meeting commitments under the Oranga Tamariki Act 1989. Additionally, the agency with responsibility for children's services did not have a mandate to direct services from the wider sector (such as housing or health services, for example), and a "negotiation and best efforts" approach across the system had failed. The lack of inter-agency working had direct consequences on the ability to provide early support to families. Five areas of change were identified:

- Prevention of harm through early intervention
- Intensive intervention when concerns escalate
- Care support when children are unable to live with their birth families
- Youth justice services for young people who offend, and
- Transition support for young people entering adulthood.

The review recommended a sweeping structural change to governance as well as other changes, organising these into changes that could be carried out immediately (such as the structural changes to the Ministry for Children), and a second stage of more complex and transformational changes, such as changes to working cultures, that would take longer. Key recommendations were:

- The establishment of a new Ministry, Oranga Tamariki, to replace the statutory social work organisation 'Child, Youth and Family' and separate this subdivision of the Ministry of Social Development into a distinct Ministry. Oranga Tamariki would have a significantly expanded mandate, funding and governance
- Culture and leadership change, including a fundamental change in values and ways of working with the sector, communities, families or whānau, hapū, and iwi
- Oranga Tamariki would provide a single point of accountability for "vulnerable" children in order to address fragmentation and the need to navigate multiple agencies for them to get support
- The development of new practice models, including development of guidance and training on common technical tools, to identify vulnerability to be used by

all agencies that interact with children and families, including health, education, police, housing etc (Hyslop, 2022)

- The use of a social investment model, with long term funding that recognised and prioritised long-term outcomes, expanding the focus of children’s services from statutory concerns to prevention activities
- Strategic partnering to broker the “right services for the right families at the right time”, with a mandate and funding for the children’s services department to purchase services, and
- Independent monitoring, including an independent advocacy service, and a permanent Youth Advisory Panel.

Source: The Modernising Child, Youth and Family Panel (2015) [Expert Panel Final Report Investing in New Zealand’s Children and their Families](#)

Understanding the implementation and impact of the Expert Panel Review’s recommendations is complicated by the third stage of reforms in 2021, which brought further changes to policy and disrupted the review’s implementation timescales. We have provided an overview of available information on known changes, and evidence on the efficacy of these changes. Three key developments are highlighted: the establishment of Oranga Tamariki; the introduction of National Care Standards; and the development of the Transition Support Service.

The primary structural change, alongside the formation of an independent advocacy service and a permanent Youth Advisory Panel, was the establishment of Oranga Tamariki in 2017. There is, however, a lack of evidence on the impact of this structural change or changes to working across Ministries. Hyslop comments that by 2021 little progress had been made in the development of shared working practices across the agencies that support a child and/or family, and that “much of the Expert Panel vision had largely imploded” (2022 p141).

One of Oranga Tamariki’s key developments was the introduction of National Care Standards in 2019 to ensure that children and young people in care understand their rights and that these are upheld, as well as that their caregivers are well supported. The standards consist of six parts:

- Part 1: that children and young people in care are entitled to a holistic needs assessment and support plan that reflects their views, wishes, aspirations and strengths, as well as that the views of their whānau or family, hapū and iwi are heard and taken into account, and the plan must be maintained and reviewed regularly.
- Part 2: that the needs of children in care are met, for example financial support, support to maintain whānau or family connections.
- Part 3: that there are assessments, planning and support for caregivers.

- Part 4: that children are supported to express their views and contribute to their care experience.
- Part 5: that children are supported during care transitions.
- Part 6: sets duties for the monitoring and reporting on compliance of the National Care Standards, including self-reporting as well as independent monitoring.

The compliance of Oranga Tamariki with the National Care Standards is monitored by Aroturuki Tamariki, The Independent Children's Monitor, who have reported since 2019.

The Transition Support Service was established at the latter stages of the reforms. Though fitting within the scope of this reform to focus on the needs of children and young people already in care, with sustained development and improvement to the service, including the participation of young people, it represents a crucial step in ensuring care experienced young people receive support as they grow up.

The Transition Support Service

The Transition Support Service was set up by Oranga Tamariki in 2019 as a relationship-based support service for young people to transition to independence when they are old enough to leave care or custody and is delivered by iwi and community partners, including a National Contact Centre offering phone support as well as local services. The service includes three main aspects of support all of which are new types of support available for young people and rangatahi (young Māori people).

- Support from a 'transition worker' up to the age of 21, including life skills and becoming independent, obtaining ID documents, goal setting and help with work, education and training
- The ability to remain living with, or return to live with a caregiver, until they are 21 years of age
- Advice and assistance until they are 25 years of age.

There are plans to expand the number of young people who will be eligible for support going forward.

An annual survey is conducted to ascertain the views of young people who are eligible for support from a transition worker, with surveys published in 2021 and 2022 so far. These show that support from transition workers met the needs of young people, with 81% of young people saying that their transition worker understood their needs more than their social worker.

Several ways of improving the service were identified. For example, increasing the consistency in pre-transition planning with young people, as 38% wanted to stay living in the same place when they left care, and 28% be able to do so. It should be considered that young people who are homeless were not included in survey responses, so the overall numbers of young people wanting to stay at home after leaving care and doing so is likely to be lower.

Source: *Malatest International (2021) First Synthesis Evaluation Report: Oranga Tamariki Transition Support June 2021*, and *Oranga Tamariki (2022) Transitions Support Service evaluation*

In commenting on the reforms, some research has claimed that despite the structural and other changes made, there was a perhaps inadvertent retention of several aspects of the earlier policy agendas, with a claim that in practice, there was little change to the core role of Oranga Tamariki in comparison to the previous, 'Child, Youth and Family' department (Hyslop and Keddell, 2019). This included:

- A retention of the focus on the identification of children experiencing or at risk of abuse or neglect, followed by initial work with their family, and then progression to the decision that the children would need to go into care if this was not successful.
- A focus in policy on improving support to children already in care, with insufficient resource to support the families of children before care proceedings were required.
- A focus on individual circumstances rather than on structural drivers such as poverty or racism (O'Brien, 2016).
- Despite a strong emphasis on trauma-informed approaches, a lack of shared understanding by professionals of what this meant for practice, and in particular, an understanding of what this meant for Māori, for whom practice must incorporate an understanding and action to address the cultural trauma of colonialism, and this meant that policy did not translate into the necessary practice changes (Pihama et al., 2017; Atwool, 2019).

The partial implementation of some of the changes recommended by the Expert Panel, alongside previous changes made in the Vulnerable Child Reforms, led to an inconsistent legislative landscape.

Two amendments to the Oranga Tamariki Act 1989 were passed in 2016 and 2017. In 2016, amendments to sections 18A to 18D were introduced to add restrictions (by reversing the onus of proof) on decisions around the future children of parents who had previously had a child to into care for safety reasons, or parents who were responsible for the death of a child. Initially proposed as part of the Vulnerable Child Reforms, this amendment was revoked in 2019 (Oranga Tamariki, 2019b). In comparison, section 7AA of the Oranga Tamariki Act was passed in 2017. This amendment set out requirements for Family Court decisions to reflect the principles of the Treaty of Waitangi to protect the familial structures of whānau, hapū and iwi, as well as a duty on the Chief Executive of Oranga Tamariki to enter into partnerships with iwi and to monitor and report on disparities for Māori. Although Section 7AA did not come into force until 2019, with implementation carried out in the context of a series of initial reviews into Oranga Tamariki, these two amendments demonstrate the divergence of legislation. Without sufficient planning and delivery of the structures needed to enable these agendas to be met concurrently, such as the provision of early or intensive support to families, this legislative agenda appeared confusing, with later reviews of practice finding that there was limited understanding of legislation (Oranga Tamariki, 2019a).

Notwithstanding the implementation issues outlined above, a wider development that stemmed from a change in national government was a new remit to address child poverty. The Child Poverty Reduction Act 2018 set three- and 10-year targets on a set of child poverty measures, as well as reporting duties. Amendments to the Children's Act 2014, via the Children's Amendment Act 2018, required successive governments to develop and publish a strategy to improve the wellbeing of all children and young people, with a particular focus on child poverty and those with greater needs. Addressing the impact of poverty was now factored into policy on children's wellbeing, and measures to address child poverty could be planned alongside wider policy on children's welfare and support for whānau. This change was a key support to the implementation of existing legislation to that set out the duty to support families and whānau, which had been argued to be ineffective without consideration of the structural impact of poverty (Healy, 2009).

Despite the critiques of the Expert Panel Review, the implementation of some of its recommendations, and the difficulty in collecting evidence on the impact of the changes made at this stage of reform, there is evidence of a reduction in the number of children going into the care system, including Māori children, in the years since this review was undertaken, and this change begins with the establishment of Oranga Tamariki in 2017 (Oranga Tamariki, 2020). It is possible that though there was an urgent need for change to child welfare services, the changes made at this stage had some positive impact on the lives of children, young people and their families.

Third stage of reforms: heightened media attention and reviews

In 2019, concerns around the level of intervention by child welfare services into family life, especially increases to the rate of orders for babies to go into care reached a culmination around a "sentinel event" which involved the removal of a baby from their birth family at a hospital (Keddell et al., 2022). This provoked public and media outrage, large-scale protests and an array of reviews. We have outlined these reviews, concluding with a range of findings relating to both the individual child protection case that spurred these events as well the as systemic issues. For the purposes of this report, we have described the changes that ensued after these reviews as a third stage of reforms.

Oranga Tamariki (2019) Practice Review: Professional Practice Group Review into the Hastings case

This was a review into one case in Hastings, Hawkes Bay. The review found that although concerns about the welfare of the baby concerned meant that involvement of social workers was necessary, there were significant issues with their subsequent practice, including:

- Relying on inaccurate, out of date information
- Limited assessment of the baby's parents and their supports, with the parents' experiences of childhood trauma disproportionately used to justify assessments of these parents as high risk
- There was insufficient understanding of relevant legislation
- No Family Group Conference was held before the order was made
- The views of other professionals working with the family were not gathered.

There was not sufficient resourcing of local offices, and a culture of focusing on the removal of children as early as possible to support the permanency of care.

Whānau Ora Commissioning Agency, Ko Te Wā Whakawhiti, It's Time For Change, A Māori Inquiry into Oranga Tamariki 2020

This was a Māori-led investigation into Oranga Tamariki which found that there had been unprecedented breaches of human rights and inhumane treatment of Māori women.

Office of the Children's Commissioner, Te Kuku O Te Manawa, A review of what needs to change to enable pēpi Māori aged 0-3 months to remain in the care of their whānau in situations where Oranga Tamariki-Ministry for Children is notified of care and protection concerns 2020

A two part review was carried out by the Children's Commissioner and found that there were discriminatory and racist practices from statutory social workers, and an organisational culture of deception and bullying that was harmful to mothers and their babies. Three overarching recommendations were issued:

- The development of new approaches based on Māori self-determination
- Practice that would connect Māori children and families back to their hapū and iwi, and
- The provision of wraparound support.

Ombudsman, He Take Kōhukihuki, A Matter of Urgency 2020

The Ombudsman's investigation focused on whether there were systemic issues with the Ministry's practices around the removal of newborn babies and as part of the investigation he reviewed the case files of 74 infant (and unborn) children. He found that the circumstances of removals at birth without notice to the parents were not exceptional; 94% of the newborn babies who were placed into care by social workers were placed through the use of emergency court orders and without consultation with whānau (parents). The Ombudsman noted that this was a departure from the spirit of

the legislation, where such orders should only be given when there are no other options to ensure the child's safety. Systemic issues were evident in the lack of engagement with families prior to the birth, which would have provided an opportunity for early engagement, and a lack of capacity to follow processes in a timely and effective way once the infant had been removed.

The Waitangi Tribunal, Urgent inquiry into Oranga Tamariki 2021

This inquiry focused on the disparity between the number of Māori and non-Māori children going into state care, whether the changes of the 2017 reforms would address these disparities if fully implemented, and if changes to legislation, policy or practice were required. The inquiry made a series of recommendations, centred around the adoption of the principles of partnership, active protection, and equity, as outlined in Te Tiriti Waitangi, especially the underlying factors that negatively impact whānau, such as poverty, poor housing, poor mental health, substance misuse, family violence, or lack of support for children with "high needs".

The tribunal found that the government had infringed on the Treaty of Waitangi and recommended the appointment of a 'Transition Authority', with a mandate to design and reform the care and protection system for Māori children, which would have authority to independently monitor all partnerships between Oranga Tamariki and Māori and iwi organisations (established under section 7AA amendments to the Oranga Tamariki Act 1989), and to advocate for devolution of power to iwi and Māori organisations at the highest structural level, with an aim that no Māori children would be in state care.

The current context: the 2021 reforms

The 2019-2021 reviews of Oranga Tamariki resulted in some immediate changes, as well as medium- and longer-term changes to policy and service provision.

There was an immediate restriction in access to the legal orders used to remove babies from their families (Cook, 2020), and a significant reduction in children going into care. There was also a reduction in disparities between the number of Māori and non-Māori children removed from their families over a short time period. It has been argued that the primary cause of this immediate reduction was due to management changes around access to legal orders, before other long-term changes could be implemented that, crucially, addressed the cause of disparities in children going into care, such as partnership with and funding to Māori and iwi organisations (Keddell et al., 2022). Though there was a subsequent increase in the commissioning of services to the third sector and iwi organisations (as set out in the Section 7AA amendment of the Oranga Tamariki Act) 1989, the underfunding of these services, particularly the delay of additional funding needed to meet an increase to the cost of living, was detrimental to services and a barrier to implementation of this policy intention.

In addition to these immediate changes, there was a notable re-evaluation by Oranga Tamariki of wider policy, legislation and practice. We have described this as a 'third' stage of reviewing. These changes are currently (2023) occurring, so there is especially limited evidence on the efficacy and impact of the changes.

In response to these reviews, Oranga Tamariki appointed a Ministerial Advisory Board, who published the report 'Te Kahu Aroha' in 2021 to make a full response to this series of reviews and set out recommendations to Oranga Tamariki. Their report made three overarching recommendations for change:

1. Māori and community collectives must be strengthened, restored and empowered to lead prevention of harm for children, rangatahi and their whānau
2. The purpose of Oranga Tamariki must be clarified and the mana of the core social work function rebuilt and properly supported, and
3. A National Oranga Tamariki Governance Board should be established to oversee the diversity and depth of changes needed.

The Future Direction Plan was set out by Oranga Tamariki in 2021 to respond to recommendations of Ministerial Advisory Board Report, the Waitangi Tribunal and other reviews. The plan set out five key areas of transformation that would occur over five years:

1. Organisational Blueprint: changes to the structure and function of services, developing a new operating model. This includes a reset of regional boundaries so that these align across agencies, and new complaints and feedback mechanisms. There are also plans to close some residential children's homes and replace them services that enable more tailored care for children with high and complex needs.
2. People and Culture: aims to create culture change and increase support for staff. This includes the development of a model to inform allocation and resourcing decisions at regional and national level; development of a workforce strategy to clarify the role of social work, support social worker recruitment and retention; frontline leadership development and; the establishment of specialised caregiving roles for children with high or complex needs.
3. Relationships, Partnering and Decision-making: working with iwi, partners, and communities to co-design and co-locate services, build required levels of trust and capability and alignment, including early, preventative and transition support as well as approaches to support family and whānau decision-making.
4. Social Work Practice: a range of measures to support social workers and to develop areas of practice such as assessment, planning and restraint practices.
5. Data, Insights and Evidence: here measures include continuing the roll-out of new performance reporting tools; the development of options for replacement of the current case management system; centralising collected data to enable analysis to inform monitoring and decision-making; and embedding evidence-based decision-making from sites to national office. A 'Social Wellbeing Agency's Data Exchange' would be deployed in the second year of implementation to allow the secure

sharing of data between Oranga Tamariki and partners (Social Wellbeing Agency, 2023). This tool has been developed with community engagement (Innovation GPS, 2023), and appears to remedy the high level of contention over previous attempts by the child welfare agency to collect, utilise and store data through the Vulnerable Kids Information System (Ballantyne, 2019; Jørgensen et al., 2021; Keddell 2015; Keddell, 2019b).

The Oranga Tamariki Action Plan was launched in 2023. It focuses on improving outcomes for children and young people 'with the greatest needs', including children and young people who are currently involved with, or are at risk of being involved with, Oranga Tamariki or youth justice systems. There are existing statutory duties for six government agencies in the Children's Act 2014 which are drawn on for them to work collaboratively to enact the Action Plan. The Action plan includes a range of actions:

1. Engagement with frontline decision-makers and operational staff to identify practical, high impact actions
2. An in-depth assessment of needs in housing, education and health agencies, who will respond to the findings and recommendations of these at later stages of implementation
3. Development of an evidence and indicator dashboard and the provision of evidence and data to regional leaders to inform planning
4. Continuation of joint work between the Ministry of Education and Oranga Tamariki to respond to key reviews
5. Building a high-level cross-agency picture of early support/prevention investment to identify gaps and opportunities, to support decision making on future investment in prevention. There will be an initial focus on the National Strategy to Eliminate Family Violence and Sexual Violence
6. The Social Wellbeing Board will drive further collective cross-agency effort to develop and test an integrated network of health, social services and informal supports for children and whānau in the first 1000 days, through a localised learning system approach
7. Agencies will support and respond to local prevention plans developed by iwi and communities.

To help guide and drive delivery of the Action Plan, an Implementation Plan sets out four areas in which impact can be measured: healthcare, housing, education, and supporting young people to transition to independence. The Implementation Plan sets out specific actions that agencies have committed to, with reporting occurring every six months.

Structural developments

There have been a number of structural developments in New Zealand over the course of the three stages of reforms. We have outlined these, and have made the distinction between children's social work and social care structures, and children's health

structures. The two systems are distinct and, indeed, there are substantial reforms of New Zealand's health system concurrently underway.

National Structures for Children's Welfare

Several national ministries (and agencies) have a direct role in children's services. These are named under the 2014 Children's Act, legislating their collective commitment to work together to achieve the outcomes in the Child and Youth Wellbeing Strategy 2019 and promote the best interests and wellbeing of children and young people with the greatest needs. These are:

- The New Zealand Police
- The Ministry of Education
- The Ministry of Social Development
- The Ministry of Health
- The Ministry of Justice
- Oranga Tamariki (Ministry for Children)

Other agencies that have a role in supporting children and families in addition these are the Ministry of Business, Innovation and Employment; Statistics New Zealand; the Ministry for Pacific Peoples, Te Puni Kōkiri; and the Department of the Prime Minister and Cabinet.

Oranga Tamariki is the Ministry for Children and was established in 2017. It integrates children's agencies, as defined by the Children's Act 2014, to support children, young people and families who require it, delivering the Treaty of Waitangi and the Oranga Tamariki Action Plan.

Whānau Ora Commissioning Agency is a national agency, established in 2014 (serving the North Island) and commissions services to non-governmental organisations in local communities. It aims to support the wellbeing of whānau by building on the strengths and capabilities of whānau and arranging culturally- appropriate services and support in areas such as health, education, housing, employment, improved standards of living and cultural identity. This includes national programmes to provide direct financial support to families, and navigator programmes to support access to integrated care, as well as local programmes.

The Ministerial Advisory Board was appointed in 2021 and it is planned to operate until 2023. The board provides independent advice to the Minister on the performance of Oranga Tamariki on fulfilling the recommendations in Te Kahu Aroha and progressing the actions in the Future Direction Plan.

The Office of the Children's Commissioner has a role in raising awareness monitoring and reporting on the implementation of the UNCRC. The Strategic Priorities of the office in 2022 were: education, mental wellbeing, ending family violence, and monitoring places of detention.

Aroturuki Tamariki, The Independent Children's Monitor was established in 2019 to monitor compliance of Oranga Tamariki with the National Care Standards Regulations.

The Monitor is being established in three phases to support effective implementation. The first phase prioritised assessment of regulations relating to allegations of harm or neglect for children in care. In the second phase, all care standards were monitored. The third phase started on the 1 May 2023 and will extend monitoring duties beyond children in care to the entire Oranga Tamariki system. This will include all children who interact with the care system, including those who are supported at prevention or early-intervention stages. Reports of the Independent Monitor will also be tabled in Parliament at this stage.

The Ombudsman New Zealand has the powers to receive complaints about the State care system, including Oranga Tamariki and other government agencies. There are plans to extend this remit to complaints about non-government organisations that care for children. The Ombudsman has enhanced oversight of complaints for all children and young people in care or custody.

VOYCE – Whakarongo Mai was established in 2017 as an independent “connection and advocacy service” across New Zealand, and met new requirements set in legislation (The Children Young Persons and their Families (Advocacy, Workforce and Age Settings) Amendment Act (2016), which made changes to the Oranga Tamariki Act 1989) for services to be made available to ensure that children and young people have the opportunity to express their views, as well as duties on decision-makers to support participation and take views into account. This independent organisation provides advocacy for care experienced children and young people up to the age of 25, across New Zealand. VOYCE has established a National Youth Council - ‘Tau Tuatahi’ that promotes the voices of care experienced young people to talk about the issues they experience.

The Waitangi Tribunal was established in 1975 as a permanent commission of inquiry, enabling any Māori person to bring forward a claim that the government has breached the Treaty of Waitangi.

Regional and Local Structures for Children’s Welfare

There is no governance responsibility for children’s social welfare at a regional or local level in New Zealand.

Services are delivered by the NGO sector at a local level through a commissioning model. This enables the Whānau Ora commissioning agency to support the development of culturally-appropriate services for Māori children, young people and families, as well as the devolution of power and resources to Māori (Hyslop, 2022).

New Zealand’s health system

The health in New Zealand system has very recently undergone significant reform, stemming from the Health and Disability System Review (2020). The review was commissioned with the aim of proposing system-level changes that address the increasing pressures on the health system and offer a more sustainable, equitable

system that would shift the balance from treatment of illness towards health and wellbeing. The pressures faced by the health system included:

- Persistent health inequalities experienced by Māori communities.
- An ageing population.
- An increasing number of disabled people.
- A rural population whose needs are not prioritised by urban decision-makers.
- A district health board structure that was seen to have brought unnecessary complexity and duplication, particularly in relation to procurement, IT systems and asset management.
- Workforce stress, retention and recruitment challenges.
- Funding pressures, as investment has not kept in line with cost increases, and opportunities to cut costs have largely been exhausted (Goodyear-Smith and Ashton, 2019).

There has been a longstanding national government policy interest in achieving integrated care for adults and children, albeit with limited national drive, blueprint or co-ordination around what integration should look like or how it was to be achieved.

Integrated health care could take multiple different forms:

- Horizontal integration in primary care.
- Vertical integration between primary and secondary care.
- Population health integration between health care and public health.
- Health and social services integration between health care and disability support and older people's support services.
- Intersectoral integration between health and other social development services (such as housing, employability, etc) (Goodyear-Smith and Ashton, 2019).

Without national direction, the onus was on localities to design their own responses (Goodyear-Smith and Ashton, 2019). This approach led to a number of local initiatives, but the majority only reached pilot stage and very few were scaled-up. Such local initiatives took the form of information sharing, service co-location, case management or care co-ordination, multi-disciplinary teamwork, shared planning and/or budgeting (including developing a shared vision, agreed care pathways, and agreed resource allocations) (Goodyear-Smith and Ashton, 2019). In the face of the pressures on the health system and the experiences of integration to date, the Health and Disability System Review 2020 found a lack of structured planning within the current health system and a lack of leadership (Health and Disability System Review, 2020). To address this, a 20-year national Health Plan was recommended by the review to provide long-term direction and a more integrated system where health services are more connected (including digitally connected) to other services (such as the other agencies and ministries responsible for supporting an individual) and the communities these serve.

In response to the Health and Disability Review, the New Zealand government committed to the creation of a health system that is more (Department of the Prime Minister and Cabinet, 2021):

- People-centred: bringing together the voice of all communities
- Equitable: focusing on working in partnership with Māori communities
- Accessible: offering more equitable, convenient and integrated access to services, irrespective of where someone lives. This includes the use of modern technology and innovative ways of working
- Cohesive: characterised by a unified culture across professions with shared expectations, ways of working, and clinical pathways, that also delivers at a local level, supported by co-ordinated planning and oversight, and
- Efficient: reducing duplication of functions and bureaucracy, with improved planning, including workforce planning, as well as clear standards agreed between all relevant stakeholders about the quality of care that can be expected.

To deliver on this vision, the most significant structural change has been the ending of New Zealand's 22 (regional) district health boards and the setting up in 2022 of four new regional health structures. To bring about and manage these structural changes, the Health Reform Transition Unit was established in September 2020 to run until September 2022. The Transition Unit's role was to:

- Develop the policy response and design of the system operating model
- Provide advice on the establishment of new entities and legislative change, and
- Develop an implementation plan and work programme for the reforms.

National Structures for Healthcare

Governed by the Ministry of Health, there are four structures of a nationalised health system:

- Public Health Agency – which leads and strengthens population and public health, placing a greater emphasis on equity and the wider determinants of health such as income, education and housing.
- Health New Zealand – which is responsible for planning and commissioning hospital, primary and community health services, and oversees delivery at local, regional and national levels. In terms of planning and purchasing:
 - Hospital and specialist services are planned nationally, and
 - Primary health, wellbeing and community-based services are planned and then purchased through four regional divisions (Northern, Te Manawa Taki, Central, and Te Waipounamu). Each region then works with their local district offices to develop and implement plans based on local needs.
- Māori Health Authority - working in partnership with both the Ministry of Health and Health New Zealand, the authority it is responsible for ensuring the health system works well for Māori.
- Ministry of Disabled People – which is tasked with driving the transformation of the disability support system.

Local Structures for Healthcare

The development of 'localities' across New Zealand is a fundamental part of the reform of the country's health system, embedding a stronger population health focus across the health system by joining up care services and helping to ensure decisions and planning meet the needs of local communities. As such, localities are to be networks that are expected to go beyond traditional GP (general practice) services and to achieve more co-ordinated care for patients and citizens.

The exact geographic size, or population a locality serves will vary and be determined through engagement with the community. The area boundary lines may or may not align with existing local government boundaries. The roll-out of localities is taking place over 2022 to 2024, with every area across the country expected to have its own locality by July 2024. By April 2022, nine localities had been established and ranged in size from 8,000 residents to 96,000 residents.

Once established, each locality will develop a three-year locality plan in collaboration with the locality partnership, iwi Partnership Boards, Health New Zealand, and the Māori Health Authority. The locality plans will:

- Set out local health goals and how they will be achieved
- Drive procurement of services by Health New Zealand and the Māori Health Authority, and
- Provide the basis for monitoring progress.

Source: Cummings et al. (2021); Health New Zealand (2022) Localities Update for the Health Sector

The focus of the reforms has been on establishing national structures that support more cohesive ways of working across the health system. Local structures are, however, still an integral part of New Zealand's health system and a new network of 60-80 'localities' in place to cover New Zealand is in development. While the localities are being established, the interim arrangement sees district offices working with local communities to jointly develop and implement local health plans. Other key children's health services are set out in Box 1.

Box 1: Child health services: disability and mental health

If a child has a serious health condition or disability, they may be entitled to support from the local Needs Assessment and Service Coordination service, which is managed by the Ministry of Disabled People. This may include help from Child Development Services (also managed by the Ministry of Disabled People) and the Infant, Child and Adolescent Mental Health Service, managed by Health New Zealand, who support children with disabilities and children who are not reaching their developmental milestones.

- Child Development Services are a team of allied health professionals (spanning physiotherapy, speech and language therapy, occupational therapy, psychology

and social work) who can provide community-based support and work with children and families to support their achievement of development goals.

- Infant, Child and Adolescent Mental Health Service is a multidisciplinary clinical team consisting of psychiatrists, clinical psychologists, psychiatric registrars, medical officers (specialist scale), social workers, community mental health nurses, alcohol and drug clinicians, and occupational therapists.

Plunket Centres are delivered by the third sector and provide health and wellbeing services for children under the age of five and their families. The service provides a health visitor service, free health and development checks, a 24/7 parenting helpline, and a range of local services.

Youth One Stop Shops aim to provide a range of 'wraparound' health and social services to young people aged about 12–24 years old across New Zealand. There are currently 10 operating across the country, but the model has been operational in New Zealand since 1994. Evaluations have found that though these services do not provide unique services, service design that is focused on young people's needs increases their access to services. These aspects of service design include young person friendly settings or opening hours, or the integration of services to respond to an individual's needs.

Source: Cummings et al. (2021); New Zealand Ministry of Health (2009)

Progress and impacts of children's social care reforms

The United Nations Convention on the Rights of the Child (UNCRC) was ratified in New Zealand in 1993, albeit with reservations relating to children who are not resident or citizens of New Zealand, child prisoners in adult prisons, and the protection of children in employment. The UNCRC can be seen as an extension of the concept of Whakapapa – valuing and respecting the mana (authority, prestige, status) of people and ancestors through recognising whanaungatanga (kinship). Te Tiriti o Waitangi (Treaty of Waitangi) was signed in 1840 and is considered the founding legal document for New Zealand. It gave a framework for Māori governance and self-determination, and co-existence with the Crown. It is regarded as crucial to children's rights and wellbeing in New Zealand (Office of the Children's Commissioner, 2022).

The UNCRC itself is not incorporated into law but is embedded into the Child and Youth Wellbeing Strategy 2019. In addition to raising awareness of children's rights under the UNCRC, the Office of the Children's Commissioner monitors implementation and convenes the Convention Monitoring Group, which has been responsible for implementation since 2011. The group is made up of the Children's Convention Deputy Chief Executives and meets bi-annually to discuss findings and report on the progress of implementation. It consists of representatives from 11 government agencies, including Ministries for social development) health, education, justice, police and Oranga Tamariki.

In reporting to the United Nations Committee on the Rights of the Child, the Office of the Children's Commissioner gives insight on the experiences of children and the impact of reforms to services for children's care and protection to date. Despite improvements, the Office of the Children's Commissioner (2022, p. 29) found that there are still ongoing reports of abuse and harm of children in care, including poor treatment and conditions in residential care or custody, over-representation of Māori, Pacific, and disabled children, and forced removals of Māori babies from their parents.

There are also variations in social work practice and inadequate support, training and supervision of social workers and care staff. This is especially critical with regard to the high use of seclusion and restrictive practices, with reports of concerning staff behaviour, extended length of stay, age-mixing, poor transition planning, a "flawed and biased" complaints procedures. There had been concerns from the Commissioner about the persistence of assumptions and ethos of previous models (such as of the 'child rescue' model) in policy and practice, with a need for radical transformation and systematic change strongly advised (Office of the Children's Commissioner, 2022).

Many of these recommendations align with those of the Waitangi Tribunal Inquiry (2021) and Te Kahu Aroha, such as the devolution of power and resources to Māori to care successfully for their own children; addressing the inequities experienced by Māori children in the care and protection system by resourcing by Māori, for Māori approaches; and protecting the wellbeing of children before they go into the care and protection system (Office of the Children's Commissioner 2022, p32). This highlights that current reforms are in their early stages and not complete, with a need for attention to the adherence of reforms to these overarching recommendations.

However, despite these concerns, it should be noted that there has been a large reduction in the number of all children going into care in New Zealand. A reduction in the number of Māori children going into care was noted by Oranga Tamariki in 2020 and reporting by Oranga Tamariki in 2022 shows the lowest number of reports of concern, referrals for assessment, and children going into to care since 2017, as well as slight reduction in the disparity between Māori and non-Māori children. Similarly, measures to support the workforce have resulted in a stabilisation of staff retainment (though this has been impacted by the COVID-19 pandemic), and there has been an increase to the commissioning of services to Māori and iwi partners and corresponding attention to appropriate funding (Oranga Tamariki, 2022).

Aroturuki Tamariki, The Independent Children's Monitor, also finds that whilst there has been significant progress in the reform of Oranga Tamariki relating to children in care, there is still a need for development. There is a need for extended support for caregivers and social workers, including support to develop cultural competencies, for social workers to spend time with children, whānau, caregivers and communities, and for caregivers of children with disabilities to be adequately supported. There is also a need to improve how children and young people are supported to express their opinions, be involved in decision-making and to know their rights. The prevalence of disability among tamariki in care is not well understood. Despite successive efforts to integrate agencies

since 2014, collaborative inter-agency working between Oranga Tamariki, health and education is often inadequate and does not translate to positive outcomes or experiences for children and young people, particularly for mental health provision (The Independent Children's Monitor, 2022).

Progress and impacts of health reforms

A review of local integration in health care found that evaluations tended to provide limited evidence in terms of the outcomes achieved and whether changes were successfully embedded over the medium- to long-term (Cumming et al., 2021), though these are able to show both what gets in the way of successful integration and what factors facilitate efforts. In terms of barriers, these included the lack of a shared electronic information system; a lack of trust between organisations; uncertainty over who takes responsibility for the socio-economic determinants of health; and a lack of leadership. To overcome these, there is a need for leadership, including staff engagement, commitment, and teamwork, as well as the need for adequate resourcing, including the freeing up of staff time and training (Cumming et al., 2021).

A key strength of the health system is the early adoption and extended use of information technology, particularly in primary care. All residents have a unique health index number, and all GPs use electronic medical records. Considerable investment has been directed towards standardising the collection and reporting of data, especially ethnicity data, and this information is increasingly being shared across health and administrative datasets. The government is now undertaking a Digital Health Work Programme to accelerate the implementation of an electronic health record for all New Zealanders which can be shared across service providers and across regions. The Integrated Data Infrastructure (IDI), links national datasets including health, education, housing, social services and justice. It is another tool that can contribute to answering complex research, policy, and evaluation questions, aiming to improve lives (Goodyear-Smith and Ashton, 2019). Other strengths of the health system include nationally-led health workforce planning, high-quality training of health professionals with robust regulation and reaccreditation systems, and a focus on quality and safety surveillance (Goodyear-Smith and Ashton, 2019).

Potential learning for Scotland

Despite significant cultural and historic differences, there are several key similarities between the policy agendas for children's services in Scotland and New Zealand. For example, the need for early and preventative help for families to avoid children going into care; engagement with communities; and support for the workforce. All have prominence in *The Promise*, the conclusions of Scotland's Independent Care Review (2020). New Zealand has seen several stages of reform, with the drivers, barriers and impacts of these reforms (both intended and unintended) tracked across these stages. With the similarities in the policy agendas of both countries, learning from New Zealand will have particular relevance to Scotland.

Structural change did not have the desired impact

The 2015 review by the Expert Panel on Modernising Child Youth and Family made several key recommendations on the structural integration of ministries, and many of these recommendations were delivered through subsequent reform. The review stated that the complex needs of children and families required a co-ordinated response but that the system at the time was disjointed and fragmented, and that the agency with responsibility for children's services did not have a mandate to direct services the wider sector. However, the structural changes made in the subsequent reform did not elicit the change hoped for. Another stage of reform between 2019 and 2021 was required to address significant omissions in this reform, integrating measures to address a range of other factors such as culture change, support for the workforce and attention to the drivers of inequality. Keddel commented that "both the structural reorientation and the associated name change have been more aspirational than operationally significant" (Hyslop & Keddel 2019, p113). There is significant learning for Scotland about the efficacy of structural change alone, and the importance of considering all other changes that are required in a given circumstance, and what will be required to sustain that change.

Scheduling of reform measures

In New Zealand there has been focus on particular agendas in latter reforms and, above all, addressing inequalities experienced by Māori children and whānau (families). Many of these changes will have a positive impact on all children, such as improvements to provision of early and preventative family support. However, it has been necessary to address this overarching issue of Māori equality before other changes can be implemented, because without it, no reform measure is likely to be successful for *all* children. It is likely that there will be a need for additional attention to ensure that these changes have resulted in improvements to the experiences of children. For example, where reform has resulted in practice changes to promote children being cared for by foster carers of the same ethnicity.

Whilst this context in New Zealand is not comparable to Scotland, there is valuable learning about the importance of comprehensive planning of reform measures and in certain circumstances, the scheduled implementation of the most urgent issues that must be addressed before other changes can begin.

Lags in implementation of reforms

At every distinct stage of reform, research and reviews have commented on a lag between the ambitions of the reform and both the retention of prior policy agendas (which may or may not be consistent with the ethos of the reform), as well as the resurfacing of cultural assumptions that a reform aimed to remove. The Office of the Children's Commissioner has pointed out the prevalence of the 'child rescue model' in policy, despite ambitions to move away from this model since the 2019-2021 reviews. This has meant that at different stages of reform, there have been occasions where the overall focus of policy remains similar to what was in place before that reform. In a similar vein, gaps in the implementation of legislation have remained for significant periods of time, only for reforms to 'catch up' with these provisions. Namely the provisions in the Oranga Tamariki Act 1989 Act that support the rights of children to stay with their whānau, hapū and iwi.

Funding

New Zealand operates a centralised model for children's services, commissioning third sector services to deliver on policies set by Oranga Tamariki. There is a unique context in New Zealand for commissioning services via Whānau Ora, as this supports the devolution of power and resources to Māori (Hyslop, 2022). Nonetheless, the sustainability of funding of the organisations delivering services has arisen in the material we considered for this case study, across several different stages of the reform as a significant barrier to the implementation of the reform agenda. This includes the matching of funding of services to meet cost of living increases for the workforce. This will have significant relevance to Scotland in the context of current budgetary pressures and the cost of living crisis.

Changes to reform agendas

The successive reforms to children's services in New Zealand raise questions about the need to balance a need to sustain change over the time it takes to implement that change (often requiring longer time periods than anticipated for complex and transformational change), and the need to make necessary revisions to reform agendas to correct errors or omissions. In New Zealand, the changes appear wholly justified, as is evident in the series of six reviews carried out from 2019-2021, and the ensuing Ministerial Advisory Board Review and Further Direction Action Plan. The fast progression of these reforms complicates the collection of any evidence about the efficacy of any singular reform agenda, instead only a cumulative impact of the reforms on the lives of children, young people and their families can be measured.

The answer to what extent the commitment to 'stick with' a change programme over the time required to implement this programme has primacy over the need to revise that programme when necessary, will be specific to a particular setting. It is however a dilemma that must be considered and anticipated at the start of any significant initiative, as careful and considered planning will be required to manage the disruption of any subsequent changes.

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Health and social care integration in Northern Ireland

Introduction

Northern Ireland has a smaller population than Scotland (1.9 million population compared to Scotland's 5.5 million population) but offers an example of a country that has a longer history of adult and children's health, social care and social work integration. The Northern Ireland Executive, which is the devolved government in Northern Ireland equivalent to the Scottish Government, views an integrated, all-age health and social care system as central to achieving many of the National Outcomes that it aspires to, most notably the National Outcomes of 'Our children and young people have the best start in life', 'We have a caring society that supports people throughout their lives' and 'We all enjoy long, healthy active lives' (Northern Ireland Executive, 2021).

In referring to 'an integrated health and social care system', the implication is that there is a single, national all-age system operating in Northern Ireland. However, as this case study finds, a more accurate description is that there is a unifying governance and delivery structure in which national, regional and local bodies are organised. Within this structure, there is then flexibility for local planning and delivery to meet local needs but, at the national level, national leadership has been impacted by the lack of a functioning Northern Ireland Executive since February 2022.

There are, however, questions over whether the needs of Northern Ireland's children and young people are of sufficient strategic priority in the context of an ageing population and other health and social care system pressures. It is in this context that the Independent Review of Children's Social Care Services in Northern Ireland was established to carry out a fundamental examination of Northern Ireland's children's services and the extent to which they are supporting children, young people, families, carers and staff. The review reported on 21 June 2023 and this case study looks at the emerging findings and recommendations.

Authors' note

The term 'national' has been used when referring to Northern Ireland-wide policies, structures and facilities but these are widely referred to as 'regional' in Northern Ireland publications.

Setting the context

Northern Ireland has a long history of health, social care and social work being planned collectively. In 1974, the Department of Health and Social Services was established, with public safety functions of the Department of the Environment transferred to it in 1999.

In 2016, the department was renamed the Department of Health and it continues to hold responsibility for Northern Ireland's children and adult health, social care and social work services (Department of Health, 2022a).

Beyond government departmental changes, in 2002, the Northern Ireland Executive initiated the Review of Public Administration that led to a streamlined health and social care system. From 18 Health and Social Services Trusts, the reforms led to one national Health and Social Care Board acting on behalf of the Department of Health and five regional Health and Social Care Trusts (HSCT). The five Health and Social Care Trusts are still in place and are the key structure in the funding and delivery of adult and children's health, social care and social work services. However, with the aim of streamlining governance and accountability at the national level, the Health and Social Care Board was disbanded in 2020 and its responsibilities transferred to the Department of Health, the Strategic Planning and Performance Group and the Health and Social Care Trusts (Department of Health, 2022a). Northern Ireland's 11 local authorities do not hold responsibilities for adult or children's health, social care and social work.

National

- The Department of Health is one of nine government departments and is responsible for health, social care and social services in Northern Ireland. In relation to children in need and their families, its responsibilities include:
 - Establishing and reviewing the legislative and policy context for the planning and delivery of health, social care and social work (including child protection and children in care) services for children and their families
 - Providing regulations, guidance and standards for services to help ensure the quality and effectiveness of social care and social work services, and
 - Discharging, monitoring and accountability functions through collation and analysis of regional information and bilateral meetings with HSCTs on their delivery of their social care and children's functions.
- Within the Department of Health is:
 - The Strategic Planning and Performance Group, which plans, commissions and oversees the delivery of health, social care and social work services for the population of Northern Ireland. Its membership is headed by the Director of Strategic Performance, Safety and Service Improvement; Director of Hospital and Community Care; Director of Finance and Corporate Governance; Director of Primary Care; and the Programme Director Integrated Care System (NI).
 - The Office of Social Services, which provides professional advice on government policy, oversight for social work training, and is the sponsorship body for the NI Social Care Council.
 - The Social Care and Children's Directorate, which is part of the Strategic Planning and Performance Group, and is responsible for professional oversight, governance, performance management and accountability as well

as strategic oversight of HSCTs in relation to the exercise of social care and social work functions.

- The Children & Young People Strategic Partnership, which is led by the Social Care and Children's Directorate and is a multi-agency strategic partnership consisting of the leadership of all key agencies across statutory, voluntary and community sectors who have responsibility for improving outcomes for all children and young people in Northern Ireland. It is supported by sub-groups focusing on cross-cutting issues.
- The Safeguarding Board for Northern Ireland was established in 2012 following the publication of the Safeguarding Board Act (2011) and replaced the Regional Child Protection Committee with an extended role to include the wider area of safeguarding as well as statutory child protection. The Board has five local area safeguarding panels coterminous with the five trust boundaries, and a case management review panel.
- The Children's Court Guardian Agency for Northern Ireland (formerly the Northern Ireland Agency for Guardian Ad Litem Agency) provides support so that the voices of children who are involved with public law and adoption proceedings are heard.
- The Regulation and Quality Improvement Authority is the independent body responsible for monitoring and inspecting the availability and quality of health, social care and social work services in Northern Ireland and encouraging improvement in the quality of those services.
- The NI Social Care Council was established by the Department of Health to support high quality standards of social work and social care and is responsible for: maintaining a register of social workers and social care workers in Northern Ireland; setting workforce standards for their conduct, training and practice; and setting standards for and regulating social work education and training.
- And there are specialist national facilities, such as Donard Glenmona (a regional residential children's home), Woodlands Juvenile Justice Centre, Lakewood Secure Care Centre, and Beechcroft Inpatient Hospital for Children and Young People.

Regional

- Five Health and Social Care Trusts (HSCTs) (Belfast; Northern; South Eastern; Southern; and Western) provide overall responsibility for strategic area planning and local delivery to meet their population's needs, guided by a national strategic outcomes framework. They manage and administer hospitals, health centres, residential homes, day centres and other health and social care services. In relation to children's social work, and on behalf of the Department of Health, HSCTs are responsible for the care and protection of all children in need in their area, and act as the 'corporate parent' for children and young people 'looked after' by the HSCT. Within HSCTs:

- Services are organised along a continuum ranging from front-door 'Gateway Teams', to 'Family Intervention Teams' to 'Looked After Children Teams' to '14/16+ Teams' (after care services).
- Each has a multi-disciplinary 'Children's Disability Team' and this operates alongside but separate to care and protection teams.
- Each manages the CAMHS (Children and Adolescent Mental Health) service in their area.
- Five Outcomes Groups are partnerships of senior leaders across all sectors within each of the five HSCT areas. Chaired by the Director of Children Services in each Trust, these focus on early intervention, building preventative places and improving outcomes for children and young people. Each Outcomes Group reports to the Children & Young People Strategic Partnership and receives regular reports from Locality Planning Groups and Family Support Hubs.

Local

At the local level, there are 17 'Area' Integrated Care Partnerships, each of which is overseen by an Area Integrated Partnership Boards that has responsibility for overseeing the work of the partnership and the governance of all affiliated structures. Each Board sets the local direction and priorities for its area, based on local need and in line with the strategic outcomes set by the Northern Ireland Executive's Department of Health. The Integrated Care Partnership model is designed to increase local autonomy, and as the model and partnerships mature, it will see Boards take control over the planning and (previous national) funding for services delivered within their localities. The development of the new funding model is, however, a complex undertaking and will take significant time and resources to achieve.

The key children's social care and social work structures that the Area Integrated Partnership Boards have direction over are:

- 25 Locality Planning Groups, which focus on identifying and understanding need at local community level, and then engaging communities in discussion about how organisations can work together to more effectively address need at a local level.
- 29 Family Support Hubs (Box 2), which offer the co-ordination of and signposting to early intervention services; and link with Outcome Groups and Locality Planning Groups to report on local priorities and contribute to the identification of needs of families that are not being met.

Source: Children and Young People's Strategic Partnership (2021); Department of Health (2018); Department of Health (2021a; 2022b; 2022c); Regulation and Quality Improvement Authority (2018)

There is a unifying governance and delivery structure in place in Northern Ireland in which national, regional and local bodies are organised. In this context, the priority over

recent years has been on achieving stronger integration between and across different levels, services and professionals within the health and social care system to ensure people access the right, high quality services at the right time.

Beginning with the 'Systems, Not Structures - Changing Health and Social Care: Expert Panel Report' (Bengoa et al., 2016), which was commissioned by the Minister for Health to consider the best configuration of health, social care and social work services in Northern Ireland. Overall, the Panel advanced the need for care in Northern Ireland to move away from a paternalistic approach based on ill health to one that works with patients towards a model of "personalised, preventative, participative and predictive" care (Bengoa et al., 2016 pp42). Under this vision, the key developments proposed by the Panel included the need to:

- Enhance cross-service and cross-profession working at the national, regional and local level to address Northern Ireland's societal and health challenges. The review found examples of this among providers but they were doing so "in the absence of strategic intent, and is operating under traditional contract models and output targets that do not support the system transformation which is required to address the challenges" (Bengoa et al., 2016 pp42).
- Break down professional boundaries between staff and create new generic roles to provide an integrated, sustainable model of care for the population. This would require a relaxing of professional regulatory barriers that delineate one professional role from another.
- Promote local decision making, local innovation and scaling up of best practices among local systems of care to best meet local needs.
- Empower and engage with the workforce in designing new models of care.
- Encourage, sustain and scale up front line improvements and innovation at the provider level where they can demonstrate improved outcomes.
- Establish an outcomes-based approach through adopting an 'Accountable Care System' and accompanying commissioning model that financially incentivises improved working between health and social care partners and that can demonstrate improved health and wellbeing outcomes. This aligns with the Northern Ireland Executive's (2020) 'New Decade, New Approach' deal to restore the power-sharing Executive in Northern Ireland and set out its commitment to the development of an outcomes-focused programme for government.

The Panel concluded that "Transforming the health social care system is an enormous and complex task that will need to be progressed steadily over at least the next ten years and which will require a combination of change strategies" (Bengoa et al., 2016 p54). As a first step in the implementation process, they recommended that the Minister for Health "should create, communicate and lead a clear, powerful, long-term vision for the Health and Social Care system" (Bengoa et al., 2016 p53).

Health and Wellbeing 2026: Delivering Together (Department of Health, 2016) sets out the Department of Health's response to the Bengoa Review. It endorsed the Panel's findings and outlined the Northern Ireland Executive's ambition to:

- Embed a new model of person-centred care focussed on prevention, early intervention, supporting independence and wellbeing. This entails empowering local providers and communities to work in partnership, doing so through Health and Social Care Trusts and multidisciplinary primary care teams consisting of GPs, pharmacists, district nurses, health visitors, allied health professionals, social workers and the third sector. In relation to children and families, the success of the Early Intervention Transformation Programme was to be built on by increasing capacity within the Early Intervention Support Service (Box 1) and Family Support Hub model (Box 2).
- Make the health and social care system an employer of choice, which includes creating opportunities for the workforce to develop their skills and find suitable career paths at all levels. Pay, terms and conditions are set within the Department of Health's national framework termed the 'Agenda for Change'.
- Adopt a new outcomes-based approach that puts an onus on all to work together, across traditional silos and boundaries to deliver the best outcomes.
- Reduce bureaucracy and achieve a much more consolidated and common record for patients and others using services with fewer separate IT systems.

Box 1: Early Intervention Support Service

The Early Intervention Support Service was established in Northern Ireland in 2016 with the aim of offering early intervention, family support to families with additional needs but who not meet social work thresholds (that is, Tier 2 of the Thresholds of Need (Hardiker) Model – Department of Health, 2010). By offering early support, the service has sought to reduce the number of children and families formally defined as 'in need' by social services, thus avoiding families pushed into and through the child protection and care system. The service has aimed to reduce pressures on the statutory social care system.

In terms of its operation, the Early Intervention Support Service provides families with a key worker who conducts home visits and keeps in telephone contact for approximately 12 weeks. The key workers:

- Are trained in delivering a number of evidence-based therapeutic approaches and interventions of support, including Solution Focused Brief Therapy, Motivational Interviewing, Solihull approach, Autism Keyhole Training, and Cognitive Behavioural Therapy.
- Provide practical support and advice for the family, to help engage with other service provision and resources available in local communities, such as food banks, housing, after school clubs and the Citizens Advice Bureau.
- Carry out a whole family strengths-based, needs-led assessments using the Outcomes Star™ Assessment Tool (www.outcomesstar.org.uk) and develop an action plan with families based on this assessment.

The key workers are part of the service's Family Support Team, which includes a service manager, 2.5 therapeutic workers, 1 practical support worker, and

administrative support. There is one Early Intervention Support Service in each of the five Health and Social Care Trusts, with these five services linked to five Family Support Hubs.

An evaluation of the service found that it was well received by families on account of it being welcoming, non-judgemental, relationship-based and flexible to their needs. These features contributed to a low drop-out rate among families and, using the Outcomes Star, evidence of improved family wellbeing and increased confidence in parenting.

However, challenges identified by the evaluation were increasing numbers of referrals, including more complex circumstances, and a lack of alternative services to refer families to where they required more specialist supports. This was particularly the case in more rural areas.

Source: Lynn and Corbijn van Willenswaard (2018); Winter et al. (2018; 2021).

Box 2: Family Support Hubs

As of April 2021, there were 29 Family Support Hubs providing coverage across Northern Ireland. In terms of their core activities, the Hubs:

- Act as a collaborative interface across the statutory, voluntary and community sectors to enable families to access a wide range of early intervention services. The Family Support Hubs do not have a service development or provider role. Instead, they are a single, local but virtual point of contact that signposts and refers families to early intervention support; and
- Support children and families with additional needs who do not meet social work thresholds (that is Tier 2 of the Thresholds of Need (Hardiker) Model – Department of Health, 2010). Indeed, a key driver behind the development of Hubs was to reduce the number of inappropriate referrals to Gateway Social Work Services by providing family and early intervention support.

In terms of their composition, national standards have brought some consistency and commonalities, but the model is not uniform and the makeup of each Hub reflects local contexts and needs of the people they support. In terms of their key features, each Hub has:

- An appointed lead agency which takes responsibility for the co-ordination and operations of the Hubs. Typically, the lead agency is a third sector organisation (for example, Action for Children)
- A co-ordinator – a Hub member of staff – who reviews the referrals made to the Hub, assesses the needs, and matches these to the most appropriate service offer of members
- A unique set of member organisations that is determined by the availability of service providers in local areas. Provision can span parenting programmes and

support, early years services (nurseries, pre-school, day care, and crèches), youth work, youth clubs and afterschool provision, counselling, behaviour management, adult education, food banks, debt management, therapeutic services, and specialist provision in response to issues such as drug and alcohol misuse and mental health, and

- A designated social worker from the Gateway social work team, who provides a key link between family support and statutory child protection intervention. In some Trusts the Social Work Gateway Manager chairs the Hub meetings, while in others a Gateway social worker attends the Hub meetings. The relationship with social work means that Hub members report good awareness of thresholds and protocols for escalating cases to statutory intervention.

In terms of governance:

- Overall responsibility for the Hubs is held by the five Outcomes Groups, doing so on behalf of the Children and Young People's Strategic Partnership.
- A Regional Family Support Hub Co-ordinator supports the development of the Hub network across Northern Ireland. The role provides expert advice and disseminates learning and best practice to all Hubs and Outcomes Groups in order to improve standards in Hub provision.

In terms of outcomes and impact:

- In 2021/2022, 8,461 families were referred to the service, with this figure representing a year-on-year increase since these were established in 2014/15.
- Referrals come from a wide range of sources, with the main sources in 2021/2022 being self-referrals (21% of referrals), GPs (12%), schools (10%), health visitors (9%) and community organisations (8%).
- Outcomes Star™ is the assessment tool used to establish an initial baseline and to measure progress by families during and at the end of the support of the service.
- 93% of families showed improvement in at least one of the outcome areas including: improved parenting skills/capacity; improved family relationships; increased participation/involvement in education/training/employment or improved emotional wellbeing.
- More widely, the Hubs have improved collaborations with services such as social work, CAMHS, health visiting, speech and language therapy, autism service, education welfare, and the voluntary and community sector. Other benefits for practitioners include having access to accurate and up-to-date information about the community and local services, better integration between services, and having the access to families who are reluctant to engage with support facilitated.
- For families, the Hubs offer accessible and timely support that are community-based, trauma-responsive and non-stigmatising. Furthermore, the growing awareness of Hubs has encouraged families to seek help when issues emerge,

secure in knowing services are only delivered via the Hubs where there is informed consent and families can engage voluntarily. This has helped to increase the proportion of self-referrals to the Hub from 12% of referrals in 2015/16 to 21% in 2021/22. However, there is still recognition that families often first look to alternative (non-family/non-state) support when they are seeking help, particularly if they have a large extended family.

- At the strategic level, Hubs have helped to provide information and influence strategic developments at the local, regional and national level.

Sources: Department of Health (2021b); Children and Young People's Strategic Partnership (2022); Health and Social Care Board / Social Care Institute for Excellence (2016); Mason et al. (2021); Regulation and Quality Improvement Authority (2018); Social Care Institute for Excellence (2021)

Children's social care and social work services are part of Northern Ireland's health and social care system for all ages that is governed by the Department of Health. However, and notwithstanding approaches such as the Early Intervention Support Service and Family Support Hubs, there was an observation that strategic attention at the national and regional level is focused on adult care needs and services. For example, both the Bengoa Review and Health and Wellbeing 2026: Delivering Together made only limited reference to children and young people's needs and services; while a children's services director in a Health and Social Care Trust commented on the "(low) profile and priority of children's services within an integrated care system when weighted against acute services – acute wins every time!" (CSCSNI, 2023 p4).

In light of this, the Independent Review of Children's Social Care Services, chaired by Professor Ray Jones, was tasked with a fundamental examination of Northern Ireland's children's services to ensure they are adequately supporting children, young people, families, carers and staff. Launched in February 2022, it reported in June 2023 and consisted of three key strands: the experience and outcomes of children, young people and their families who use Children's Services; service structural arrangements; and social work practice (Department of Health, 2022c).

The need for structural change was a core recommendation from the report: "It is the clear and firm conclusion of this Independent Review that the children's social care crisis in Northern Ireland is systemic and endemic. It spans all of Northern Ireland and all areas. It is not of recent creation but is long standing. It is not caused by individual failings but by the current children's social care structures, systems and processes across the region. It needs to be addressed by changes in governance, organisational arrangements, and a re-set of the focus to deliver on the requirements of the Children Order (Northern Ireland) 1995." (Jones, 2023 p114).

In the context of "well founded and long-standing concerns that children's social care is marginal within organisations and arrangements understandably and necessarily focussed on the significant difficulties within health services" (Jones, 2023 p233), the

report recommends that a national children and families social care arm's length body be established. Specifically, "a single region-wide organisation be created for statutory children and families social care services [...] It would have a lead responsibility to promote the multi-professional and multi-agency integration of services for children and families [...and...] with its dedicated and single remit and focus on children and families it will be well placed to take on this strategic role" (Jones, 2023 p215).

Northern Ireland's five Health and Social Care Trusts would retain its children's health and social care remit but work with the proposed new national body to best meet the needs of children, young people and families. One of the country experts we consulted suggested that the proposed national body can bring stronger leadership and status to the children's social care and social work sector.

The Bengoa and Jones' reviews are the highest profile and systematic reviews of Northern Ireland's health, social care and social work system but other, more subject specific reviews have also been completed in recent years. These include: into trauma-informed care (2019); integrated therapeutic care for care experienced children and young people (2022); family focused practice (2018); residential care (2014); national facilities for children and young people (2018); the national CAMHS Inpatient Unit and acute CAMHS care pathways (2014); best practice in cross-departmental working practices (2015); and the social work workforce (2022). The number of reviews has brought a sense of 'review fatigue', with Bengoa et al. (2016 p9) stating that "the Health and Social Care system has repeatedly spent significant time and resources analysing the challenges it faces, identifying the weaknesses in the current model, making recommendations for change, but subsequently failing to enact the necessary transformation to make these happen". Similarly, a children's services director of a Health and Social Care Trust highlighted that "it is vital that the final report from this (Jones) Review must not follow the stalemate of previous reviews" (CSCSNI, 2023 p5). This finding implies that there is an implementation gap impacting on Northern Ireland's health, social care and social work system.

Structural developments

Professor Ray Jones' Independent Review of Children's Social Care Services (2023) has led to recommendations for structural changes into how children's social care and social work services are governed and organised but, currently, the emphasis of health and social care integration in Northern Ireland is on closer collaboration between and across structural levels, multi-agency services and professionals to better respond to the needs of individuals. This ambition is outlined in the Integrated Care System NI Draft Framework: Future Planning Model (Department of Health, 2021a), in which Northern Ireland's integrated care system is defined as:

"A collaborative partnership between organisations and individuals with a responsibility for planning, managing, and delivering sustainable care, services and interventions to meet the health and wellbeing needs of the local population. Through taking collective

action, partnerships will deliver improved outcomes for individuals and communities, and reduce inequalities” (Department of Health, 2021a pp10).

Within this definition, key features are a health, social care and social work system focused on improving outcomes and characterised by local planning and collaborative working between services.

The drive to improve outcomes is not specific to health, social care and social work. New Decade, New Approach (Northern Ireland Executive, 2020) encourages partners across Northern Ireland’s public sector services to think and work outside of their boundaries to solve Northern Ireland’s social, health and economic issues. The outcomes-based approach is, for example, evident in the Children and Young People’s Strategy 2020-2030 (Department of Education, 2021). Led by the Department of Education but requiring the contribution of all nine of Northern Ireland’s government departments, the strategy seeks to deliver on the key outcome contained in Northern Ireland’s draft Outcomes Framework that “we give our children and young people the best start in life, ensuring that they grow up in a society which provides the support they need to achieve their potential”. A future development is to translate this outcome into agreed data indicators that can measure progress towards the outcome. Indeed, the Children and Young People’s Strategic Partnership has stated within its Children & Young People’s Plan 2021-2024 that it will:

- Identify measurable population and performance indicators to inform multi-agency integrated planning
- Maintain child rights indicators and UNCRC monitoring, and
- Provide support in the production of outcome-based accountability monitoring tools and report cards, for Outcome Groups, Locality Performance Groups and Family Support Hubs.

In relation to local planning, the Integrated Care System NI Draft Framework: Future Planning Model states that:

“The model is based on the principle of local level decision making which is underpinned by a population health approach with a focus on improving outcomes. The model ensures that local providers and local communities are empowered and enabled to come together to plan care and services for their area” (Department of Health, 2021a pp10).

Local planning to meet local needs, combined with each HSCT having different mindsets, organisational cultures and practices, means Northern Ireland’s health, social care and social work provision varies across its regions and localities (Fargas-Malet and McSherry, 2020). Examples of this include different therapeutic care models being used across the five Health and Social Care Trusts (Department of Health, 2018) and different service availability within Family Support Hubs.

Local planning to meet local needs is central to Northern Ireland’s children’s health and social care system but there is also an acknowledgement that national harmonisation is valuable in some areas too. For example, standardisation in guidance, policies and procedures (including for transitions to adult services), a single therapeutic care model

for 'looked after' children, the nationally co-ordinated recruitment of foster carers, a national chair post to manage access to secure care, a national IT system that supports information sharing, national consistency and collation of health and social work workforce data, workforce planning, and a standardisation of job titles (Department of Health, 2021b; Department of Health and Department of Education, 2021; Department of Health, 2022c; 2022d; Leavey et al., 2019; McCartan et al., 2022; Teggart et al., 2022).

There are existing examples of harmonisation, including the use of the 'four-tier' Thresholds of Need (Hardiker) Model to assess levels of need in families; the 'Understanding the Needs of Children in Northern Ireland' inter-agency assessment framework; and the 'Administrative Systems Recording Policy, Standards and Criteria for Northern Ireland' policy (Department of Health, 2010; RQIA, 2018). These are designed to enable multi-agency practitioners and services to share and record their concerns about children using a common format, language and understanding of their levels of risk and need. However, there are found to be variations in the local use and implementation of these national resources, which have impeded joined-up working (McCartan et al., 2022; RQIA, 2018).

A key feature of Northern Ireland's health and social care system that supports collaborative working at the local level is the 'co-ordinator' or 'interface officer' role. Each Family Support Hub has a co-ordinator and each Early Intervention Support Service has a key worker, while other similar roles are interface officers in 'looked after children', CAMHS, and disability services (Department of Health, 2021b; Department of Health and Department of Education, 2021) and Think Family Champions who seek to connect adult and children's mental health services together and embed whole family practice across services (Grant et al., 2018; McCartan et al., 2022). While the remits of each specific co-ordinator or interface role differs, collectively they aim to provide understanding of the different services available in their local area; match services to people needing support; support seamless transitions between services; and identify and address service barriers and constraints in their local area (Department of Health, 2021b).

Other features of the Northern Ireland health and social care system that support collaborative, inter-agency working are:

- The Think Family Northern Ireland approach, which aims to increase working between children's, adult and mental health practitioners so that the mental health needs and impacts on families are holistically assessed and met. Developments include a joint protocol to provide clear guidance on service response and promote inter-agency collaboration, the revision of adult mental health screening and assessment tools, specialised training, and the introduction of Think Family Champions to promote joint working across services (McCartan et al., 2022).
- A national focus on trauma-informed practice that stemmed from the Safeguarding Board Northern Ireland commissioning a rapid evidence assessment to facilitate and support the adoption of trauma-informed practice across health, social care, justice, education, and community and voluntary systems in Northern

Ireland (Bunting et al., 2019). The Northern Ireland Framework for Integrated Therapeutic Care for Care Experienced Children and Young People is an example of where trauma-informed practice is an underpinning skill (Teggart et al., 2022).

- The co-location of workers from different services, with examples from schools where social workers are based in schools to support children, young people and school staff with trauma and attachment difficulties (Department of Health, 2022d) and, in some areas, 16+ teams having social work, mental health and disability practitioners working together (Kelly et al., 2016).

Progress and impacts

The drive towards greater integration in Northern Ireland's health and social care system is viewed as a 10-year process, as demonstrated by the 2016 publication of the Health and Wellbeing 2026: Delivering Together document. Given this timeframe and the impact of the COVID-19 pandemic, assessing the impact of the drive towards greater integration is difficult at this stage.

Prior to the pandemic and despite higher proportions of children living in deprived neighbourhoods and higher referral rates to children's services, Bywaters et al. (2020) and McCartan et al. (2018) found that child welfare intervention rates were lower in Northern Ireland compared to the rest of the UK. Contributory factors were considered to be the positive impact of Northern Ireland's integrated health, social care and social work services, its strong community and voluntary sector (which has partly been born out of The Troubles), and the role of Family Support Hubs (McCartan et al., 2018). The role of Family Support Hubs is also evident in the Social Care Institute for Excellence (2016; 2021) reports in terms of more collaborative working between services, enabling the right support at the right time for children and families, and in providing intelligence to influence national, regional and local planning.

However, since McCartan et al.'s study, the number of children and young people supported under statutory measures has increased. Data published by the Department of Health (2022e) report:

- 10% increase in the number of children on the Child Protection Register between 2017 and 2022, and
- a 21% increase in the number of children 'looked after' between 2017 and 2022.

Multiple factors are thought to have contributed to this situation. In relation to people needing the support of services, the lives of children, young people and families are becoming more complex, presenting services with an increasing intensity of need (Department of Health, 2018; 2022d; RQIA, 2018). Families are also experiencing increasing levels of poverty and inequality (Teggart et al., 2022), while McCartan et al., (2021) find that Northern Ireland has the highest prevalence of parent mental health issues in the UK, with similarly high levels among Northern Ireland's children and young people.

Among the workforce, practitioners have an enhanced awareness of child protection issues and so have greater urgency to take action to protect children who are potentially at risk (Teggart et al., 2022). However, the increasing complexity of the work, high caseloads and the associated travelling to visits, meetings and court appearances are increasing workforce stress and demands (RQIA, 2018). Relatedly, there are also major workforce gaps across adult and children's social care and social work services, resulting in significant investment in agency staff (Bengoa et al., 2016; Department of Health, 2021b; 2022c; 2022d). This situation has been exacerbated by experienced staff moving to newly created 'transformation' posts, at times leaving core teams with high numbers of inexperienced staff (Department of Health, 2022d). There is also some frustration at the national recruitment process of health and social care staff, which is seen to have led to delays in recruitment (RQIA, 2018). The effect of this is that social workers are having to focus on process and the transactional work (that is doing the assessment, filling in the right form, getting the care package in place, holding the review and so on) rather than the relational work which can feel mechanistic and deeply dissatisfying for social workers and the people they are working to support (McCartan et al., 2018).

More widely, professionals from different teams and services are often found to not be working together cohesively. Examples of this are:

- Children's relationships with professionals disrupted by the way social work teams are organised in HSCTs – for example, from the 'Gateway Team', to the 'Family Intervention Team', to the 'Looked After Children Team', to the '14/16+ Team' – leading to children and families being passed to different teams and also within these teams, often experiencing multiple changes to their social worker due to workforce turnover and vacancy levels (Department of Health, 2022c).
- Variation in how children's disability teams within HSCTs work with CAMHS and autism services (Department of Health, 2022c).
- Fractured transitions from children's to adult services (Kelly et al., 2016; Kelly et al., 2022). Leavey et al. (2019 p961), for example, "found major gaps in the quality of the transition process, whereby none of the cases transferred from CAMHS to Adult Mental Health Services met all four criteria of an optimum transition. Few people had a transition-planning meeting or a period of parallel care. Moreover, we noted that the transfer of information between services was uncommon."
- Different IT systems in different services and HSCTs hindering communication and information between services and practitioners (McCartan et al., 2022).
- Partial use of national tools and resources designed to support inter-agency working. For example, McCartan et al. (2022) found that half of Think Family Northern Ireland case files used the 'Understanding the Needs of Children in Northern Ireland' inter-agency assessment framework. In relation to mandatory reporting, Northern Ireland is unique in the UK that it is the only jurisdiction that has any form of mandatory reporting legislation. Section 5(1) of the Criminal Law (Northern Ireland) Act (1967) provides for a criminal offence of failing to disclose

an arrestable offence to the police which would include most offences against children. However, this legislation exists as a technicality for all offences, rather than a concerted effort to target the problem of child maltreatment. As a consequence, the actual practice of reporting relies on a voluntary system strengthened by the development of information-sharing policies and protocols (Bunting et al., 2010).

- Children and young people having to retell their stories to different professionals (Fargas-Malet and McSherry, 2018).
- Legal and medical professionals exerting greater power, status and voice than social work professionals (Fargas-Malet and McSherry, 2018; 2020).

There is also a sentiment that health and social care financial resources are too often (and inflexibly) committed to the building and maintenance of hospitals rather than outcomes for patients (Department of Health, 2016). The view of one of the country experts we consulted was that social care and social work was the secondary partner in relation to Northern Ireland's health and social care system. Reported gaps or shortages in services include preventative and early intervention services; therapeutic services for children under the age of 11; capacity of the CAMHS service to meet assessed need; services for young people with autism; and a secure mental health facility and assessment centre for children at high risk and severe mental health issues (Department of Health and Department of Education, 2021; Fargas-Malet and McSherry, 2018). Other reported challenges are carers describing a lack of information provided on the services available and families having difficulties accessing or travelling to specialist services from more rural locations (Fargas-Malet and McSherry, 2018).

These challenges provide context to Independent Review of Children's Social Care Services conclusion of the crisis in Northern Ireland's children's social care services being systemic and endemic. Responding to these challenges is then made more difficult by political instability in the Northern Ireland Executive and Assembly, budgetary constraints, the impact and recovery from the impact of the COVID-19 pandemic, and the increasing demands placed on health and social care services by an ageing population (CSCSNI, 2023; Department of Health, 2021b).

These are significant challenges and ones that Professor Jones' 2023 review aims to help address. However, before the review concluded, we could point to the learning from previous reviews into Northern Ireland's health and social care system (or parts of it), not least the importance of: effective leadership, shared vision and shared ownership, cross-professional working, investing in staff training, development of guidance to accompany legislation, clear and effective communication structures, and clarity on the data and information required to allow effective monitoring of outcomes (Byrne et al., 2015; Department of Health, 2018).

Potential learning for Scotland

Northern Ireland has been working towards a unifying, integrated governance and delivery structure in which national, regional and local bodies are organised. This is not a 'national care service'. The main structures within its integrated structure are the (national) Department of Health, the five (regional) Health and Social Care Trusts, and the 29 (local) Family Support Hubs. Northern Ireland's 11 local authorities do not hold responsibilities for adult or children's health, social care and social work.

The priorities for Northern Ireland's health and social care system closely mirror those of Scotland. For example, rebalancing the system towards preventative and early intervention support; breaking down professional boundaries to facilitate multi-disciplinary working; having social care and social work be seen as an employer of choice; scaling up and sustaining improvements and innovative practice; and embedding an outcomes focused approach to service planning and delivery.

There is variance in health, social care and social work provision in order to meet local needs and this is seen as an important feature of the Northern Ireland system. However, there are calls for a more co-ordinated, national approach to some aspects, including in practice guidance, models of practice, specialist services, IT systems, recruitment activity, and workforce data and planning.

'Co-ordinators' or 'interface officers' are key roles within Northern Ireland's health and social care system as they connect different services for children, young people and families. Their skills and knowledge help to make the health and social care system feel 'integrated' to people needing the support of services.

Children's social care and social work in Northern Ireland is facing a number of challenges, including a rising demand for services, more complex needs of children, young people and families, and workforce shortages. Furthermore, there are concerns that these needs do not have the same visibility and priority among health and social care system leaders compared to those of the growing demands in adult health and social care. It is in this context that the Northern Ireland Review of Children's Social Care Services is recommending the need for a dedicated, arms-length national children and families social care body in Northern Ireland that would work with existing regional and local structures to prioritise and advance the needs of children, young people and families.

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The reform of policing in Scotland and the creation of Police Scotland

Introduction

The Police and Fire Reform (Scotland) Act was passed in summer 2012 bringing a major programme of reform to both Scotland's police and fire and rescue services. This case study focuses on the transformation of the police service and the creation of Police Scotland, which involved the merger of eight regional police services and the national-level Scottish Crime and Drug Enforcement Agency and Scottish Police Services Authority into a single, national force.

While this case study is not focused on adult or children's health and social care services, the creation of Police Scotland offers valuable learning that can inform the design and implementation of transformational change in other service areas, such as adult and children's health and social care. In particular, the case study highlights important issues for consideration relating to the speed of the reform legislation, the governance arrangements between national and local partners, the importance of transformational leadership, and the impact of a national police force on local policing and the Police Scotland workforce.

Setting the context

Scotland is one of a number of northern European countries (including Denmark, the Netherlands, Norway, Sweden and Finland) to have moved towards a greater centralisation of their police forces in recent times (Moggré et al., 2018). Influenced by the New Public Management values of economy, effectiveness and efficiency (Hood, 1991), centralisation has been portrayed as simplifying and standardising practices and processes, leading to higher effectiveness and efficiency (Moggré et al., 2018; Terpstra et al., 2019). In a Scotland context, many of the drivers for reform related to opportunities for gains in efficiency and effectiveness, and financial savings. These drivers included:

- The impact of the 2008 financial crash and the resulting cuts to public sector budgets in the period of financial austerity (Fyfe, 2019; Henry et al., 2019; Loveday, 2018; Moggré et al., 2018; Terpstra and Fyfe, 2015; Terpstra et al., 2019). The Scottish Government stated that "economies of scale and reduced duplication associated with the creation of a single police force would save 10% of the police budget per year without any reduction in the numbers of police officers" (Terpstra and Fyfe, 2019 p103).
- Increasing levels of transnational and transregional crimes (such as organised crime, cybercrime and terrorism) requiring specialist policing teams (Fyfe, 2019; Terpstra et al., 2019).

- National and international events hosted in Scotland, as well as the response to transnational and transregional crimes, requiring better co-ordination of policing across Scotland (Henry et al., 2019; Terpstra and Fyfe, 2019). Better co-ordination of policy also extended to having integrated IT systems.
- A movement towards more central co-ordination and strategic direction of policing via regimes of inspection, auditing and target-setting (Henry et al., 2019) and the establishment of national policing bodies such as the Association of Chief Police Officers in Scotland in 2006², the Scottish Police Services Authority in 2007 and the Scottish Policing Board in 2010 (Terpstra and Fyfe, 2015).
- Some national police bodies already in operation with responsibility for areas such as training (the Scottish Police College), drug-related crime and forensic services (Fyfe, 2019).

A further influential driver was the publication of the Commission on the Future Delivery of Public Services (the Christie Commission) in 2011. It advanced the need for enhanced working at the local and community level, an increased focus on prevention, and greater partnership working across the public sector in order to reduce demand for services and reduce inequalities. The Christie Commission's findings are interwoven within the aims of Scottish policing reforms. The three aims of Scottish policing reform, which pointed towards a more progressive approach to policing in Scotland than that of police forces in England and Wales, were to:

- Protect and improve local services despite financial cuts, by stopping duplication of support services eight times over and not cutting frontline services. Create more equal access to specialist support and national capacity – such as murder investigation teams and firearms teams – where and when they are needed.
- Strengthen the connection between services and communities, by creating a new formal relationship with each of the 32 local authorities, involving many more local councillors and better integrating with community planning partnerships.

In the context of these drivers and a consensus that change was needed, the political momentum towards policing reform began with the Scottish Government establishing the Sustainable Policing Project in September 2010 to consider and review options for reform. The Sustainable Policing Project team consisted of civil servants and police officers, and they worked together at the Scottish Police College rather than at Scottish Government offices. "Symbolically and substantively this was important in allowing the police to have a strong voice in exploring the options for reform. It suggested a cultural shift in the centre of gravity of the reform process: rather than reform being 'done' to the police by government, reform was now being done 'with' the police" (Fyfe, 2019 p7).

The Sustainable Policing Project team explored three options (Audit Scotland, 2013; Fyfe, 2019; Scottish Government, 2011):

- To maintain the eight regional forces but with increased collaboration

² The Association of Chief Police Officers in Scotland was abolished in April 2013

- Further regionalization to, for example, three or four forces, and
- A single national service.

It appraised these three options across: the scale of benefits that could be achieved under each structural model; the challenge in managing the transition to each new model; and the complexity of delivering services in the different models once the transition is complete (Scottish Government, 2011). In considering these three dimensions, the resulting report was clear in its support for a national police force, concluding that "The single force model represents the most significant change ...but it also... provides the greatest opportunity to manage change, drive efficiency and in delivering operations when the change is complete. The eight force model represents the opposite" (Scottish Government, 2011, p5). The key benefits of a national police force were reported to be more equal access to specialist teams and functions, more streamlined command and leadership arrangements, and long-term financial sustainability (Scottish Government, 2011).

However, wider support for a national police force was moderate at best. A public consultation carried out by the Scottish Government between February and May 2011 revealed that less than 10% of respondents were in favour of a national force, with a majority preference for a regional structure because of anxieties that a national force would mean an end to local responsiveness and that resources would gravitate to the big cities (Scottish Government, 2011; Fyfe, 2014). Within the police, opinion was also divided (Loveday, 2018; Moggré et al., 2018) and "even as late as 2011 a move towards a single service was not inevitable, despite relative political consensus that some reform was necessary" (Henry et al, 2019).

In the face of divided opinion, the decision to establish a single national force – Police Scotland – has been described as "an entirely political decision" (Moggré et al., 2018 pp11). Furthermore, "deadlines were considered as crucial, leading to a lack of serious consideration of alternatives" (Moggré et al., 2018 p14). From the decision to explore options for reform, 18 months later legislation was passed to create a national force (Terpstra and Fyfe, 2015). As Murray and Malik (2019 p179) report, the legislation for the reforms "proceeded exceptionally quickly through the Scottish Parliament and completed all three parliamentary stages in just four months...(and)...the pace of the Bill saw substantive issues dismissed and amendments rejected with minimal debate, mostly along party lines". In particular, requests from other political parties for greater detail on the Scottish Government's outline business case for reform and projected cash savings were not responded to (Murray and Malik, 2019).

Structural developments

Following the passing of The Police and Fire Reform (Scotland) Act 2012, the three main organisations responsible for policing in Scotland are Police Scotland, the Scottish Police Authority and the Scottish Government. Their activities are then scrutinised at a national level by HM Inspectorate of Constabulary in Scotland and at a local level via Local

Scrutiny Panels.

National

Police Scotland is led by the Chief Constable and supported by a command team of three Deputy Chief Constables (who individually hold responsibility for the North, East and West areas of Scotland), a Deputy Chief Officer, Assistant Chief Constables and Directors.

Police Scotland's joint vision with the Scottish Police Authority is outlined in 'Policing 2026: Our 10 year strategy for policing in Scotland' (Police Scotland/Scottish Police Authority, 2017). Its five key areas of focus demonstrate a continuation of the three aims of the reform, including the more progressive approach to policing stemming from the Christie Commission. The key areas of focus are:

- Protection: based on threat, risk and harm.
- Prevention: tackling crime, inequality and enduring problems facing communities.
- Communities: focus on localism, diversity and the virtual world.
- Knowledge: informing the development of better services.
- Innovation: dynamic, adaptable and sustainable.

Linked to these five areas of focus are Police Scotland and Scottish Police Authority's six strategic objectives:

- Improving public contact, engagement and service.
- Strengthen effective partnerships.
- Empower, enable and develop our people.
- Invest in our use of information and technology.
- Enhance cyber and forensic capabilities.
- Transform corporate support services.

In terms of structures, the key Police Scotland structures at a national level are:

- Two national specialist divisions that support local policing by ensuring every community in Scotland has access to specialist policing services where and when required:
 - The Specialist Crime Division which provides investigative and intelligence functions such as Major Crime investigation (noting that Major Investigation Teams are based regionally covering North, East and West areas of Scotland), Public Protection, Organised Crime, Counter Terrorism, Intelligence and Safer Communities; and
 - The Operational Support Division which provides specialist support functions such as Road Policing, Firearms, Public Order, Air Support, Marine Policing, Dogs and Mounted Branch, as well as Emergency and Events Planning.
- Other key structures are:

- The Contact, Command and Control Division, with area control rooms at four locations across the country which deploy resources.
- Corporate functions spanning people and development, finance and corporate communications.
- Scottish Police College, which delivers all police training from two locations (Tulliallan, Clackmannanshire and Jackton, South Lanarkshire).

The Scottish Police Authority was established under the Police and Fire Reform (Scotland) Act 2012 as an arms-length body between the Scottish Government and Police Scotland which provides strategic direction and oversight of Police Scotland. Its main functions are to:

- Maintain the Police service
- Promote the policing principles
- Promote and support continuous improvement in the policing of Scotland
- Keep under review the policing of Scotland
- Hold the Chief Constable to account for the policing of Scotland.

The Scottish Government sets the strategic policing priorities for Scotland but is not expected to direct specific areas of operational policing activity.

The Scottish Government's Strategic Police Priorities for Scotland, which align with those outlined in 'Policing 2026: Our 10 year strategy for policing in Scotland' (Police Scotland/Scottish Police Authority, 2017), are:

- Crime and Security – prioritises prevention, detection, investigation, equality and human rights to support positive criminal justice outcomes; responds to threats, and maintains public order, both locally and nationally
- Confidence – continues to inspire public trust by being ethical, open and transparent; maintains relationships and engages with local communities, to build a positive reputation at a local, national and international level
- Partnerships – works collaboratively to keep communities safe, sharing a collective responsibility to deliver preventative services that improve outcomes for individuals, increase resilience and address vulnerability
- Sustainability – adapts resources and plans for both current and future social, economic and financial circumstances, considering the environmental impact of policing and its operations
- People – values, supports, engages and empowers a diverse workforce to lead and deliver high quality services, with a focus on workforce development and overall wellbeing; and
- Evidence – uses evidence to innovate and develop services which address the current and emerging needs of individuals and local communities, and ensure that resources, capacity and skills are in the right place to deliver outcomes.

In addition to (or within) these priorities, the Scottish Government has also placed other priorities on Police Scotland, such as maintaining a workforce level of at least 17,234 police officers in Scotland.

His Majesty's Inspectorate of Constabulary in Scotland (HMICS) is the independent scrutiny body. In existence for over 100 years, its role was reaffirmed by the Police and Fire Reform (Scotland) Act 2012, which gave it wide ranging powers to look into the 'state, effectiveness and efficiency' of Police Scotland and the Scottish Police Authority.

Regional

Police Scotland has 13 policing divisions, each headed by a Chief Superintendent who ensures that local policing in each area is responsive, accountable and tailored to meet local needs. Each division encompasses response officers, community officers, local crime investigation, public protection and local intelligence.

Local

The Police and Fire Reform (Scotland) Act 2012 made local policing a statutory requirement and local Area and Divisional Commanders were required to prepare Local Policing Plans for each of Scotland's 32 local authorities.

Local authorities and other local partner organisations are responsible for approving Local Policing Plans, doing so as part of Local Scrutiny Panels that form within local community planning partnership structures.

The three main national organisations – Police Scotland, the Scottish Police Authority and Scottish Government – are intended to work together in a tripartite relationship. However, this has been described as a complex tripartite relationship (Murray and Malik, 2019). Relations between senior leaders in Police Scotland and the Scottish Government "became much closer than previously, raising questions about the risks of politicisation of the police" (Terpstra and Fyfe, 2019 p103). The Scottish Police Authority was, at least in the early days of the reform, the lesser partner and struggled to fulfil its core statutory roles and functions (HMICS, 2019; Murray and Malik, 2019). Partly this was because the Scottish Police Authority was a new organisation and, indeed, signalled a key change in police governance, ending the accountability of regional police forces to locally elected councillors and instead placing governance in a new national organisation of non-elected but multi-skilled (spanning policing, legal, financial, and human rights backgrounds) officials (Fyfe et al., 2021; Terpstra and Fyfe, 2019). As a new organisation, the Scottish Police Authority took time to develop, while in contrast Police Scotland and the Scottish Government were largely existing organisations. Even once established, the Scottish Police Authority is an organisation with limited resources. "With its organisational capacity currently capped at 50 staff, it is tasked with oversight of two organisations totalling an overall staff capacity of 23,869 as of March 2017" (Scottish

Police Authority 2017, p62). Its limited resources, combined with it being an arms-length body that does not have direct access to the data held by Police Scotland, has impacted on the Scottish Police Authority's ability to scrutinise and hold national policing to account (HMICS, 2019; Murray and Malik, 2019). However, as the Scottish Police Authority has developed as an organisation, there is now understood to be a more balanced relationship between Police Scotland, the Scottish Police Authority and the Scottish Government.

A second tripartite relationship also exists between the 32 Local Scrutiny Panels, the Scottish Police Authority and Police Scotland. It too is described as a 'complex tripartite relationship' because of tensions between national policy and governance and local policing priorities (Henry et al., 2019; Murray and Malik, 2019). Illustrative examples of such tensions and the emergence of a 'one size fits all' approach have included the increased use of stop and search; the closing of local police offices and curtailment of police-run traffic warden schemes; and the routine arming of rural patrol officers in the former Northern Constabulary (Fyfe, 2019; Henry et al., 2019). Across these examples, Loveday (2018) found that central direction overrode previously agreed local commitments and described local accountability as symbolic rather than real. Henry et al. (2019 p574) consequently argued that "appeals to localism in the early years of Police Scotland were not reactionary sentiment against change. Rather they articulated failures of the new system of policing to provide recognition of, and responsiveness to, public interests or to provide a meaningful check and balance against policing discourse being (and/or being perceived to be) monopolized by the powerful voices of the police and central government".

A related issue is that of the form and function of Local Scrutiny Panels. Henry et al. (2019) and Terpstra and Fyfe (2015) found Local Scrutiny Panels varied across Scotland, largely due to a lack of detail concerning their operation in the 2012 Act. The variance led to questions of how well Local Scrutiny Panels represented their communities and understood how communities felt about their local policing, noting that public trust and confidence are key measures of policy effectiveness (Henry et al., 2019). Where local concerns were then identified by Local Scrutiny Panels, there were then questions as to whether local Area Commanders had the rank and authority to challenge national policing priorities or affect local change where local authorities do not have the same boundaries as Police Scotland's 13 police divisions (Fyfe et al., 2021; Henry et al., 2019).

Progress and impacts

Almost 10 years on since the formation of Police Scotland and the Scottish Police Authority, there are conflicting views on the progress of integration and its impact. A positive picture is presented by the Scottish Police Authority (2022b) in reporting that a number of benefits have been realised, including:

- Efficiency savings leading to £200 million per year saved from the policing budget.

- Police officer numbers in Scotland maintained, and at a higher ratio of police officers per citizen (33 officers per 10,000 citizens) than in England and Wales (22 officers per 10,000 citizens).
- The number of recorded crimes and offences decreasing, and clear-up rates for crimes increasing.
- Local policing remains focused on local need.
- Public trust in policing remains high.

However, the wider narrative from stakeholders and observers is that reform has been a challenging experience. "The implementation of police reform has proved to be much more difficult and complex than originally anticipated by the government and has been associated with significant political and leadership problems" (Terpstra and Fyfe, 2019 p104). The main source of evidence has been the four-year independent evaluation of police reform commissioned by the Scottish Government and carried out by a consortium of the Scottish Institute for Policing Research (SIPR), ScotCen Social Research and What Works Scotland. Beginning in February 2015, the evaluation was tasked with assessing progress towards achieving the three main aims of reform, namely reduced duplication of back-office services, improved access to national capacity and specialist expertise, and strengthened connections with communities (Fyfe, 2019).

Four evaluation reports and a number of academic articles have since been published but, as a caveat, there is acknowledgment from the evaluation team that formulating a research methodology that could capture all stakeholders' views was difficult. For example, they noted that "the documentary evidence is largely process rather than outcome focused; is oriented to 'producer' rather than 'consumer' perspectives (so reform is seen largely from the position of those holding senior positions...rather than from the position of those using the services); focuses on strategic rather than operational matters; and offers national rather than local perspectives so fails to capture the diversity of experience of reform for different people and places across Scotland" (SIPR, 2017 p9). It has also been difficult to find the appropriate timescales for assessing the outcomes of reform (Fyfe, 2019). Notwithstanding these methodological caveats, the evaluation reports and associated academic articles provide a deep understanding of Police Scotland's formation and offers important learning that can inform the integration of other services.

In aiming for more equal access to national capacity and specialist expertise (for example, via the Specialist Crime Division), this is the area where there is the strongest evidence of progress being made (SIPR, 2019). However, there is also a sentiment that there is a 'distance' between local policing and national, specialist teams. For example, some local officers have limited knowledge of specialist, national teams, while there are concerns around the extent to which specialist, national teams understand local communities. Terpstra et al. (2019 p340) conceptualise this as 'abstract policing' that is characterised by policing that is "more at a distance, more impersonal and formal, less direct, and more decontextualised". The following question is then posed: "is this the

kind of police that we want, at a distance from the public and partners, fragmented, and largely dependent on system knowledge and IT systems?" (Terpstra et al., 2019 p355).

Following on from Terpstra et al.'s (2019) question, and in aiming to reduce duplication, local officers highlighted the importance of both IT provision and access to vehicles for efficient and effective local service delivery (SIPR, 2017). However, the consolidation and integration of Police Scotland's ICT infrastructure has proved challenging with Murray and Malik (2019) describing it as 'disjointed'. The Year 1 report found that the process of merging different systems and the implementation of a new ICT system had been challenging (SIPR, 2016). Foley (2017) offers greater detail here by pointing to the failure of the 'ambitious' i6 ICT integration project in 2016, a failure to integrate other back-office functions, and the Scottish Police Authority's acknowledgement in 2017 that 125 legacy systems remained in place, including '17 or 18' payroll systems. Over time, the evaluation reports did find that progress was being made, as illustrated by their finding that "Officers spoke positively about improved access to IT support services since reform and their ability to access computers remotely. The move to a centralised system for the Vulnerable Person Database was also mentioned as a positive example of improved IT-enabled information sharing across Scotland" (SIPR, 2017 p19).

The third aim was strengthened connections with communities, and, of the three aims, this is the aim that has attracted most interest in the evaluation and academic studies. Some positive examples were found, such as instances of co-location of police and council staff that had led to improved joint-working on community safety issues, joint activities between the police, mountain rescue and the coast guard in rural areas, and valued relationships between community wardens, council workers and the police contributing to prevention-focused initiatives (SIPR, 2017). However, the consensus is that strengthening connections with communities has been challenging. At a structural level, there is the 'complex tripartite relationship' between the 32 Local Scrutiny Panels, the Scottish Police Authority and Police Scotland. At the local officer level, the experience has been of local resources being stretched due to the redeployment of local officers to specialist, national teams and reductions in the number of civilian Police Scotland staff. The impact of this has been local officers reporting that they have less capacity for community engagement activities, which in turn impacts on the gathering of local intelligence and public perceptions of local policing presence (Fyfe et al., 2021). A related factor is Police Scotland's approach to performance measurement which has focused on short term, enforcement outputs rather than longer term, preventative outcomes (SIPR, 2016).

Beyond the three main aims of Police Scotland reform, the evaluation and academic studies find important themes relating to Police Scotland's workforce. Developing a new organisational culture has taken time and, at the outset of integration, there was a feeling that the emergent culture was that of the former Strathclyde Police Force. It had a culture of performance management and enforcement, so running counter to the more progressive aims of policing reform (Fyfe, 2019; SIPR, 2016), and its dominance also brought a sense of cultural loss among those from other legacy forces (SIPR, 2016).

Another issue in relation to establishing a new organisational culture has been a reported 'us and them' culture developing between local officers and specialist teams operating at a national level (SIPR, 2017).

A second workforce issue has been the impact of integration on the support for the workforce, with the new, national structure leading local officers to report a number of issues (Fyfe et al., 2021; Terpstra et al., 2019). These issues include:

- Reduced access to and interaction with senior officers.
- Reduced supervision as the new structure means sergeants have more officers under their management. Rural officers are also more likely to be based in a different location from their sergeant, for example.
- Supervision changing in nature from "direct, personal and context-dependent forms of supervision" to "increasingly abstract quantitative targets" (Terpstra et al., 2019 p346).
- Reduced training opportunities for local officers, as training was now largely 'role-based' and orientated to those in specialist functions. Local officers saw this as limiting the range of work that they can be involved in and restricting their career opportunities to move to specialist teams (SIPR, 2017).
- Reduced career development and promotion opportunities as there were fewer supervisory (for example sergeant) positions within Police Scotland and taking up an opportunity in a specialist, national team may require relocating. However, an opposite view was also held by some that being part of a national police force increased the range of opportunities available.
- Greater reliance on email to communicate announcements across the organisation, and local officers feeling 'bombarded' with emails and information.

Overall, Fyfe et al. (2021 p18) find that "frustrations around career development when combined with concerns about the impact of having reduced resources, or being asked to do more with the same resources; the increase in paperwork and the subsequent impact on officers' workloads; the lack of paid overtime and limited flexibility in working patterns; the reduction in pension benefits; and a lack of positive feedback from senior officers contributed to a perception of low morale within the organisation".

The final workforce issue within the studies we looked at relates to the Scottish Government's pledge to maintain police officer numbers at not less than 17,234 police officers (Loveday, 2018). HMICS (2019; 2022) asserts that there is a need to move beyond this and, in its place, advance:

- Effective workforce planning that can reshape the workforce to meet changing demand and threats in Scotland; and
- More responsive recruitment processes, with HMICS (2022) reporting serious issues in resource deployment connected to levels of retirement, abstraction (that is, temporary redeployment of officers to respond to specific and/or national operations), secondment, delays in filling vacancies, vetting and recruiting probationers.

Outside of the workforce issues, two other prominent issues are the leadership of Police Scotland's reform and governance arrangements. On leadership, observations of the Police Scotland reform process are that:

- Leaders did not communicate the rationales and benefits of reforms (Scottish Police Authority, 2022b). Too much of their communication was centred on the 'what' and 'how' of reform, rather than communicating 'why' changes are needed and the 'big picture' of what the new organisation wants to achieve (Fyfe et al., 2021). Furthermore, much of the communication was internally-focused, meaning wider partner organisations had less understanding of the implications and impact of reforms.
- Leaders did not have the range of skills and expertise to deliver and implement complex, transformational change. To overcome this, greater consideration of bringing in specialist skills sets from experienced, external professionals was proposed (SIPR, 2016).
- Leaders did not have a clearly articulated theory of change which would articulate the impact of policing reform, both at the national level but also at the local level (Fyfe, 2019).

Governance arrangements run through our earlier discussions of the 'national' and 'local' tripartite relationships. The tensions identified form part of a longstanding theme of governance across HM Inspectorate of Constabulary in Scotland annual reports and thematic inspections (HMICS, 2019). These include:

- The need for absolute clarity and understanding of relative roles, responsibilities and accountability and in particular where boundaries lie between Police Scotland, the Scottish Police Authority and Scottish Government
- Local and national demand needing to be properly balanced, resourced and prioritised
- Governing bodies having appropriate capacity, capability and competence to exercise their functions
- Exercise of effective support and scrutiny, and
- Balanced democratic representation and input.

While governance arrangements are important to clarify and embed, there is appreciation across the literature that the reform was not (and was never going to be) a single event that took place on a single date, 1 April 2013 (Fyfe, 2019; Henry et al., 2019). Instead, it has proven to be an ongoing and sometimes contested process of negotiation and incremental change in which legislation is adapted and made to work in practice (Henry et al., 2019). Indeed, Henry et al. (2019) put forward that the considerable scope within the enabling legislation for discretion regarding implementation was probably a necessity given the complexity of amalgamating eight regional police services and two national agencies into a single organisation.

Fyfe (2019) highlights the need for expectations management to mitigate against the often-held views of political leaders that reform is an event rather than a process, and

that reform can quickly deliver improvements in efficiency and effectiveness. In building understanding of the process of reform, Fyfe (2019) goes on to state that some aspects of reform do happen quickly, such as the appointment of new leadership teams and establishing new structures, but more fundamental changes around culture and strategy are often the focus of complex processes of negotiation and implementation and take longer to achieve.

Potential learning for Scotland

This case study provides a recent example of major national transformational reform in Scotland. While not focused on adult or children's health and social care services, the creation of Police Scotland nonetheless offers valuable learning that can inform the design and implementation of transformational change in other service areas.

The decision to move to a national police force was a political one with efficiencies, effectiveness, cost savings and the findings from the Christie Commission to the fore. The decision did not receive universal support and there were further concerns around both the fast pace of the legislative process and the limited detail within the Police and Fire Reform (Scotland) Act 2012. However, the scope and discretion within the legislation has since been seen as helpful and necessary, noting that heavily prescriptive legislation cannot co-exist with the understanding that transformational reform of this scale is a long-term process of negotiation and incremental change. Another reflection is that Scottish Government officials working alongside police colleagues within the Sustainable Policing Project enabled a degree of co-production in the formulation of the reforms.

The reform of policing in Scotland has been a long-term process and, 10 years on since the Police and Fire Reform (Scotland) Act 2012, the integration process still continues. For politicians and policy makers, there is a need to understand that such transformational change is not a single event and takes many years. This then also has implications for how and when the impacts and outcomes of reforms are sought, whether through performance measurement or evaluation.

An independent evaluation team (the consortium of the Scottish Institute for Policing Research, ScotCen Social Research and What Works Scotland) was commissioned to capture and share the learning from the early years of the reform process. This was seen to be a productive arrangement with regular dialogue with senior Police Scotland, Scottish Police Authority and Scottish Government staff.

Leadership experience in bringing about transformational change among senior police officers was limited. To complement their operational skills, there would have been benefit from specialist change and implementation skills and expertise being brought in. Key areas would have been around establishing a theory of change, communicating the change internally and externally (with more emphasis on communicating 'why' the reforms are needed), building a new, collective Police Scotland organisational culture, and consolidating Police Scotland's ICT infrastructure.

In terms of the structures established following the Police and Fire Reform (Scotland) Act 2012, the roles, responsibilities and accountabilities of Police Scotland, the Scottish Police Authority, the Scottish Government and the Local Scrutiny Panels were not fully defined, and this led to 'complicated tripartite relationships' between them at the national and local level. Nationally, the Scottish Police Authority was a completely new organisation and this meant that it took time to develop as an organisation and grow

in its governance role. Appreciation of the time it takes for new organisations to develop is therefore needed, particularly when they have such a key role to play in the future structural landscape.

The national-to-local relationship has been found to be particularly complex with national priorities not always aligning with local policing needs, with the former taking precedence. This sense of local policing feeling peripheral has also been reported in relation to the weakened supervisory supports and career opportunities for local officers following the reforms.

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The creation of a national child and family agency – Tusla – in the Republic of Ireland

Introduction

The Republic of Ireland provides a strong comparator country for Scotland on a number of fronts. Their populations are similar: population size (5.1 million in Ireland and 5.5 million in Scotland) and population density (73 people per km sq in Ireland and 70 per km sq in Scotland). However, Ireland performs better on economic and child wellbeing measures. Economically, Ireland has experienced a period of strong economic growth to have a US\$100,200 GDP per capita, exceeding the UK's US\$47,300, although it only spends a marginally higher proportion of its total income on children and family social protection services than the UK does (1.3% of GDP compared to 1.2% in the UK). On child wellbeing, the UNICEF Innocenti Report Card 16 finds that Ireland ranks highly on child wellbeing (12th of 41 countries) and on conditions (policies and context) for child wellbeing (8th of 41 countries), with the UK ranking 27th on both of these respective measures.

The formation of Tusla: Ireland's national child and family agency provides a further point of interest for Scotland. Established in 2014, Tusla brought together child and family support and social work services, which were previously part of the national health structure, and educational welfare services. The learning from Tusla, including its approach to national and integrated ways of working, is the focus of this case study. However, the case study also recognises that other national, regional and local structures and agencies are involved in the delivery of children's services in Ireland, and these are considered in the context of Tusla.

Setting the context

From the 1970s onwards, there has been an 'ongoing quest for change and improvement' in Ireland's children's services (Burns and McGregor, 2019). As enshrined in different pieces of legislation (for example, the Health Act 1970 and Child Care Act 1991), the desired changes or shifts revolved around moves to (Burns and McGregor, 2019; Power and Power, 2022):

- Children and family services that are characterised by early intervention, preventative and community-based approaches rather than risk and crisis management.
- Family-based models of alternative care rather than care mainly delivered in large institutional settings.
- Care and support being delivered by statutory agencies and with greater national consistency, as opposed to variable service delivery across different voluntary, community, religious and philanthropic organisations.

- Professionalise the social work workforce, including professional registration and enhanced inspection and scrutiny of services.
- Incorporate children's rights into Irish law, policy and practice, with the UNCRC ratified in Ireland in 1991.

In addition to these desired changes, three other key factors were:

- Long-held criticisms that children's services in Ireland were marginalised within a larger health system. As a small part of the health and social services that were governed by the Health Service Executive (HSE), it was felt that the primary focus was on the hospital sector (Burns and McGregor, 2019). Family support played an important but relatively minor part in terms of resources and staffing and was largely delivered by the voluntary and community sector (McGregor and Devaney, 2020).
- There were national reports published (for example, Commission to Inquire into Child Abuse Report and the Roscommon child abuse inquiry) that exposed the abuse of children in Ireland and pointed to the need for a more child- and family-based approach to care and protection services. One country expert we consulted noted that these reports encouraged the breaking up of the monolithic Health Service Executive into independent government agencies (such as Tusla) with clearer lines of accountability. Another country expert noted that the children's services had suffered within the Health Service Executive as its focus was dominated by medical and hospital needs and priorities.
- The 2008 global economic recession had a significant impact on the Irish economy and led to a sustained period of budgetary austerity. Opportunities for financial efficiencies and savings were consequently sought, whether through breaking up of parts of the Health Service Executive or, as one country expert commented: "statutory services were depleted in many instances and this created a vacuum that was filled by an embracing of market mechanisms and privatisation. For example, some two thirds of children's residential services are now private providers. Tusla's 2023 strategic plan has ambitions to rebalance this situation and, indeed, to even reverse it with a stated goal of 40:60 private: public in the coming years".

Change and improvement was, however, found to be a protracted process (Burns and McGregor, 2019). To overcome this lack of progress, the Report of the Task Force on the Child and Family Support Agency (Department of Children and Youth Affairs, 2012) was commissioned and this set the blueprint for the establishment of a new national child and family agency as a separate independent state authority responsible for child protection and family support services. The Child and Family Agency Act 2013 followed the publication of the report, thus legislating for the new agency but also stating that partnership and co-operation was central to the delivery of seamless services for children and families.

Combined, the Task Force report and the legislation provided the opportunity for stakeholders to think creatively around the most effective way of delivering services so

that they are responsive to the needs of children and families' and integrated in providing seamless services. Notwithstanding the country experts we consulted noting that there was some scepticism among stakeholders around the difference that a restructure of services into a single organisation would have, the creation of a new child and family agency was viewed as a means of providing the fresh start and sense of purpose called for by the sector.

Structural developments

The formation of Tusla – the Child and Family Agency has been viewed as the most comprehensive reform of child protection, early intervention and family support services in Ireland. Established in January 2014, Tusla became the new, dedicated state agency responsible for improving children's welfare and outcomes. It aims to do this by ensuring that families and communities are supported to keep children safe from harm so that all children are provided with an equal right to grow and develop with the care and the support they need, now and into the future. Its four goals are to:

- Ensure children and families receive a consistent, quality and integrated response from all its services, with National Standards for, for example, Foster Care and Residential Care supporting this
- Deliver an independent regulatory service focused on the safety and wellbeing of children and young people through continuous improvement and partnership with stakeholders
- Ensure that staff and leaders are supported and empowered to continuously learn and improve, and to
- Ensure local teams and services are facilitated and supported by national systems and resources that promote integration and accountability.

In terms of services, Tusla brought together early years, educational welfare, family and community supports, child protection and welfare, alternative care, and domestic, sexual and gender-based violence services. Specifically, Tusla is charged with:

- Supporting and promoting the development, welfare and protection of children, and the effective functioning of families
- Offering care and protection for children where their parents have not been able to, or are unlikely to, provide the care that a child needs
- Providing educational welfare services to support every child to attend school or otherwise to receive an education
- Ensuring that the best interests of the child guide all decisions affecting their lives
- Consulting children and families so that they help to shape the agency's policies and services
- Strengthening interagency co-operation to ensure seamless services responsive to needs, and
- Commissioning children and family services.

Since its establishment in 2014, Tusla's services and governance arrangements have evolved. Two key decisions were made at the outset: one relating to health, the other to education. With regards to health, there had been consideration of whether Tusla should hold other children's health and social care services, such as public health visiting (community nursing), child and adolescent mental health services (CAMHS) and psychological services. However, these have remained with the HSE on account of a concern about the resourcing and pace of change when establishing a new agency and the belief that these services 'best fit' with other HSE services (Burns and McGregor, 2019). In terms of education, Tusla took on the 'School Attendance Service' that existed at the regional counties level but the opportunities from connecting health, social care and education have not been maximised. One country expert we consulted felt that this was largely down to the traditional, educational focus of the Department of Education which has not embraced a more holistic approach to children's wellbeing.

More recently and looking ahead, there are further examples of Tusla's evolution:

- It was decided in 2020 that the governance of two of Tusla's educational welfare services – Tusla Education Support Service (TESS) and Alternative Education Regulation Service (AERS) – should move from Tusla's parent government Department of Children, Equality, Disability, Integration and Youth to the Department of Education.
- Tusla's domestic, sexual and gender-based violence services will move to a new national Domestic, Sexual and Gender-Based Violence Service. This service will start in January 2024 and provide national co-ordination, funding and support to almost sixty specialist services supporting women, men and children who are victims and survivors. The governance of this will transfer to the Department of Justice.
- There are also proposals for Tusla's inspection and regulation of private and voluntary residential care settings to transfer to the Health Information and Quality Authority (HIQA, 2022).

Beyond its service composition and governance arrangements, there is also recognition that Tusla was a new organisation and that it has taken time to develop its corporate infrastructure, particularly given that it is a large organisation of almost 5,000 staff. Via a Memorandum of Understanding with the Health Service Executive, its central infrastructure for IT, financial, procurement, human resources and estates services have been heavily dependent on the Health Service Executive (Tusla, 2023).

Tusla is the key children's services agency in Ireland, but it is one part of a large children, young people, and families service ecosystem with key functions delivered at the national, regional and local level (Table 1).

National

The Department of Children, Equality, Disability, Integration and Youth is the lead ministry in relation to children's social work and holds ultimate responsibility for the implementation of Children First: National Guidance for the Protection and Welfare of Children. The Department has five divisions, of which three (Child Policy and Tusla Governance; Youth Justice, Adoption, Youth and Participation; and Early Learning and Care and School-Age Childcare) have oversight of children's services policy and provision. The Department is the main source of Tusla's annual funding and it receives monthly reports from Tusla on the agency's spending to date. Other national government departments with a children's services remit are:

- The Department of Education, with responsibility for schools.
- The Department of Health, with responsibility for adult and children's health services and governs the Health Service Executive. As outlined in Box 1, Ireland is currently engaged in a ten-year reform Sláintecare programme of health and social care services.
- The Department of Social Protection, with responsibility for welfare and employability services.

In delivering government policy and direction, the key national children's service agencies are:

- Tusla – the Child and Family Agency – is the state agency responsible for improving children's lives and wellbeing.
 - Tusla services include child protection and welfare, family support, early years services, and domestic violence. Its children and family services are designed to work on a continuum from Prevention, Partnership and Family Support services through to Tusla's Child Protection and Welfare services.
 - Services are either delivered 'in house' or commissioned from external organisations as agreed through national and local commissioning plans. A Commissioning Toolkit was developed to ensure a nationally coherent and consistent approach to commissioning within Tusla. The Toolkit is primarily aimed at those making commissioning decisions within Tusla but also to bring transparency for external partners. To support this activity, the Institute of Public Care (IPC) of Oxford Brookes University was brought in to provide technical support and masterclasses on Area and National Commissioning Plans/Frameworks.
 - In terms of scale, December 2020 data (Tusla, 2021) find that the agency had 4,796 Whole-Time Equivalent staff (inclusive of 198 agency staff). The largest staff groups were social work (36% of staff), social care (27% of staff) and administration (21%). The remainder were employed across education and welfare, family support, nursing and other health, psychology and counselling, and management.

- The Adoption Authority of Ireland is an independent body established in November 2010 under the Adoption Act 2010. Its purpose is to improve standards in both domestic and intercountry adoption.
- The Ombudsman for Children's Office is an independent statutory body established in 2004 to promote the rights and welfare of children, and independently examine and investigate complaints made by or for children about the administrative actions of public bodies, schools and hospitals.
- CORU – the Health and Social Care Professionals Council - is Ireland's regulatory agency for health and social care professionals, such as social workers, medical scientists, occupational therapists, and speech and language therapists, with each profession having a registration board within CORU.
- The Health Information and Quality Authority (HIQA) is the regulatory agency for health and social services and providers, including children's services (child protection, residential care, special care, detention and foster care). It develops standards, registers providers, and carries out inspection and monitoring visits. However, within children's residential services, HIQA inspects Tusla services but Tusla inspects private and voluntary providers.

In relation to health, the Health Service Executive (HSE) is the agency responsible for the delivery of public health and social care services in Ireland and reports to the Department of Health. The HSE is Ireland's largest single employer, with over 100,000 staff, and is organised into a number of medical divisions (for example, acute hospitals, mental health and primary care) and geographical divisions, which are outlined in the rows below. Its services include:

- Disability Services and the Children's Disability Network Teams that operate across the country
- Mental Health Services that include Child and Adolescent Mental Health Services (CAMHS).

Regional

Tusla is regionally divided up into 17 Integrated Service Areas to manage the delivery of services. Each has its own management structure and Child Protection and Welfare department(s). Each is required to develop its own Area Commissioning Plan.

Within the Health Service Executive, there are six (new) Regional Health Areas that are responsible for the planning and delivery of integrated health and social care services in their regions. These six regions were established following the recommendations of the Oireachtas Committee on the Future of Healthcare Sláintecare Report (2017) and saw a restructure from the nine Community Health Organisations (that is, nine health regions) that previously operated.

Local

In the management and delivery of children’s services, the two main local structures are:

- 26 Children and Young People’s Services Committees – one for each of Ireland’s 26 counties – which bring together all relevant stakeholders in the statutory and community and voluntary sector at a managerial level to jointly plan and co-ordinate services for children, young people and their families. Their age remit spans all children and young people aged from 0 to 24 years and their purpose is to ensure effective interagency co-ordination and collaboration to achieve the best outcomes for all children and young people in their area.

Tusla’s Family and Community Services Resource Centre Programme which supports 109 local communities through a network of 121 Family Resource Centres nationwide and two outreach Centres (see Box 2). The Centres deliver a range of universal and targeted services to families in disadvantaged areas across the country based on a life-cycle approach. Within health, there are 32 Local Health Offices which are the entry point to community health and personal social services. Services provided through Local Health Offices and from Health Centres include general practitioner services, public health nursing, child health services, community welfare, speech therapy, and social work. Local authorities in Ireland do not have a direct role in children’s services. The 31 councils in Ireland (26 county councils, 3 city councils and 2 city and county councils) are responsible for the provision of public services and facilities such as housing, planning, roads, environmental protection, fire services, and maintaining the electoral register. They also play a significant part in supporting local economic development and enterprise. Below the county level, there are 95 municipal districts.

Sources: Brady et al. (2019); Burns and McGregor (2019); O’Leary and Lyons (2023); Power and Power (2022); Rodriguez et al. (2018); Tusla (2019; 2021; 2023); Irish Government, HQIA, HSE and Tusla websites.

Box 1: Sláintecare reform of health and social care services

Sláintecare is a 10-year programme to transform the Republic of Ireland’s health and social care services, with the vision of one universal health service for all, providing the right care, in the right place, at the right time. The programme follows the Oireachtas Committee on the Future of Healthcare, which was established to devise cross-party agreement on a single, long-term vision for health and social care and the direction of health policy in Ireland.

The programme aims to transform the delivery of healthcare in Ireland, building towards equal access to services for every citizen based on patient need and not their ability to pay. By putting people at the centre of the health system and developing primary and community health services, the Department of Health and HSE are working together to provide new models of care that allow people to stay healthy in

their homes and communities for as long as possible. Health and social care integration is at the heart of this, and integrated care is defined as 'where services, funding, and governance are co-ordinated around the needs of the patient, encompassing both acute and community care'.

To implement the programme, the Sláintecare Programme Board was established at the programme's outset in 2021 and comprises of senior members of the Department of Health and HSE. Within the HSE, a Sláintecare Programme Office has been set up to develop a strategic and programmatic approach to the implementation and sequencing of reforms and develop detailed action plans, deliverables, costs and timelines for each area of reform.

In terms of reforms that have been made to date (2023), the six (new) Regional Health Areas are a result of the recommendations made in the Oireachtas Committee on the Future of Healthcare Sláintecare Report. The Regional Health Areas replace the former nine Community Health Organisations with the aim of ensuring geographic alignment and better service integration with the six regional Hospital Groups in Ireland. The Regional Health Areas also aim to empower local decision-making and support population-based service planning, including moving healthcare closer to people's homes and improving patient experience.

Source: Health Service Executive website

One of Tusla's goals is to 'ensure local teams and services are facilitated and supported by national systems and resources that promote integration and accountability'. Key developments that support this service integration are:

- The development and implementation of national standards (for example, in foster care, residential care and special care) and national practice models that facilitate consistency of practice across Ireland's multi-agency services. The two key models are:
 - Meitheal – this is closely comparable to the Getting It Right For Every Child approach in Scotland and focuses on identifying, understanding, and responding to the needs and strengths of children, young people and families in a timely, preventative manner. In doing so, Meitheal aims to reduce pressures on the child protection system and provide support for those leaving care or protection (Malone and Canavan, 2022). At its heart are the use of Meitheal Review Meetings (akin to 'Team Around the Child'/Child's Planning meetings in Scotland) which bring together parents and relevant multi-agency partners to develop collaborative action plans (Burns and McGregor, 2019; Rodriguez et al., 2018). Importantly and notably, Meitheal is a voluntary process for children and families and, indeed, is led by children and families.
 - Signs of Safety – this is the national approach to child protection practice in the Republic of Ireland and was incorporated into the Tusla Child Protection and Welfare Strategy 2017–2022. To support implementation, all child protection

social workers in Ireland received national training in the model (Burns and McGregor, 2019).

- Joint Protocol for Interagency Collaboration between the Health Service Executive and Tusla (Tusla and HSE, 2017) which is a shared resource for Tusla and HSE staff that sets out the referral pathways between services, information sharing arrangements, funding requirements, and guidance on how to resolve any issues should these arise.
 - At the individual child level, the protocol provides guidance on inter-agency Meitheal Review Meetings to collectively plan how to meet the child's needs.
 - At a local area level, the protocol sets out the roles and responsibilities of multi-agency Area Joint Working Groups which meet on a monthly basis to review referral levels and discuss unresolved actions required and needs of children and families.
- The 26 Children and Young People's Services Committees as they enable co-ordinated, multi-agency service planning and are characterised by shared responsibility and shared knowledge of services at a local level (Rodriguez et al., 2018). The inter-agency work of the Committees was found to improve communication, understanding, and connection between services, facilitating the emergence of multidisciplinary, creative, timely, and integrated responses to complex needs among family members (Rodriguez et al., 2018).
- The 17 Integrated Service Areas acting as multi-agency networks that collectively manage the 121 Family Resource Centres (Box 2). The aim for the Family Resource Centres is that they each deliver to a population of 30,000 to 50,000 people (Rodriguez et al., 2018).
- The development of the National Child Care Information System as a single integrated management information system to manage child protection cases. The system is then to be enhanced through the development of a new Tusla 'Case Management System' to support management of all Tusla services that will improve sharing of information between relevant professionals (HIQA, 2022).

Box 2: Family Resource Centres

Tusla's Family and Community Services Resource Centre Programme aims to overcome disadvantage and improve the functioning of the family unit. It operates through a network of 121 Family Resource Centres to provide services and supports to local communities.

Funded by Tusla, each Family Resource Centre operates autonomously, working inclusively with its local families, communities, statutory and non-statutory agencies, thus enabling service flexibility and alignment to local needs. Arrangements include having local residents on the voluntary management committees of Family Resource Centres.

Family Resource Centres provide a range of universal and targeted services and development opportunities that address the needs of families. These can include:

- Providing information, advice and support to families, including on local service availability and referral routes
- Providing counselling and support to individuals and groups
- Delivering education courses and training opportunities
- Establishing and supporting new community groups to meet local needs and deliver local services (for example, childcare facilities and after-school clubs).

Source: Family Resource Centre National Forum website

A further development with regard to national standards and practice was contained in the Children First Act 2015. A legal obligation was placed on 'mandated persons' to report the harm of abuse to Tusla and to co-operate with Tusla in the assessment of concerns. Mandated persons include social workers, doctors, nurses, allied health professionals, teachers and early years workers. The reporting of abuse can relate to the harm experienced by children now or the historical abuse of children (Health Service Executive, 2023). Its introduction in 2017 received near-unanimous political support, and had the support of various children's rights organisations, but there were concerns that the number of reports would overwhelm the system and lead to reports being unallocated and slow responses (Hanly, 2020). The number of reports to Tusla did increase by 20% in its first year (Hanly, 2020) and there have been some reports of delayed responses and different approaches being taken in different parts of the country (Pellegrini et al., 2022). However, there is no evidence that mandatory reporting has overwhelmed the system. Instead, the available research finds that teachers would welcome more support and training around child protection and reporting concerns (Nohilly and Treacy, 2022), while psychologists found that the immediate reporting of the (historical) abuse experienced by their clients may not be the most appropriate step in helping the individual to process the abuse they experienced (Pellegrini et al., 2022).

A theme that comes through the Ireland policy and service landscape is the attention to implementation. The nationwide Signs of Safety training to practitioners is being implemented, but the implementation activity can also be seen in relation to the Meitheal national practice model. For example, local co-ordinators were in place to support the (ongoing) development of Family Resource Centres and ensure linkages with the Tusla-led child protection system (Malone and Canavan, 2022); and a Meitheal 'Fidelity Checklist' was developed and used to assess whether the practice model was being delivered locally as intended (Rodriguez et al., 2018). While fidelity and consistency of practice is important, Rodriguez et al. (2018) found that these alone are not enough and effective implementation of the Meitheal model requires a climate of 'flexibility' and 'encouragement' among staff, alongside increased staffing, supports, resourcing and time to engage in training. One of the country experts we consulted reflected that Tusla had produced a number of strategies and guidelines but these can be quite remote from practice and have not brought about the change to practice aspired to. However, where progress has been made (such as in relation to a shared culture), the country expert felt more people-oriented leadership of the agency had played a critical role. In particular,

one Tusla chief executive officer actively decided to visit the different Tusla offices around the country to meet and listen to the issues staff were having, and then worked hard to improve the quality of communications across the agency.

Progress and impacts

The last 10 years have seen significant changes in Ireland's children's services – not least the creation of Tusla and the implementation of two national practice models (Meitheal and Signs of Safety). It will take time for the impacts of these developments to be understood and, indeed, the level of impact will be affected by wider factors, including the COVID-19 pandemic. As one country expert commented, Tusla is still emerging and evolving and to date there has not been much research that has reviewed Tusla's services and practice. We have considered the areas of progress made, and the challenges or future areas of development for children's services in Ireland.

Areas of progress

The first area of progress is in relation to enhanced multi-agency, integrated working between agencies. This can particularly be seen at the local level via the Family Resource Centres where local service networks have formed, collaboration between different sectors and services have increased, and there has been an embedding of the 'No Wrong Door' principle into practice, which helps to ensure children and families are referred to the most appropriate services for them, irrespective of how they first engage with services (Rodriguez et al., 2018). However, the Ombudsman for Children (2022) did also identify weaknesses in inter-agency working, with children with complex needs most affected.

The second area of progress is the increase in children and families' participation, although the evidence base is weaker here. Brady et al.'s (2019) analysis of HIQA inspection reports on Tusla's compliance with the national participation standards for children in care found that there was much good participatory practice being conducted by social care professionals. There is evidence of children and young people being supported in a variety of ways to express their views in a safe and inclusive space, and of staff being responsive to the diverse needs of children and young people. In relation to the Meitheal practice model, feedback from parents was that they found Meitheal empowering and as a catalyst for changes in their relationships with professionals, including being listened to more and having a central role in decisions about the provision of help and support (Rodriguez et al., 2018). However, Rodriguez et al. (2018) and McGregor et al. (2020) also found that parental help-seeking of Meitheal and family supports was affected by limited levels of public awareness of Meitheal and the family support services available to them. Indeed, both studies found that family support continues to be closely associated with child protection services, and that families will at first go to their own informal networks or to universal services, such as their GP or a child's teacher.

Rodriguez et al. (2018) also found that the process of engaging children and young people by services is at times questionable and tokenistic, in terms of ensuring informed consent, children's involvement in decision-making, and the priority placed by practitioners in children's participation. Similarly, the UN Committee on the Rights of the Child (2023) has urged the Irish government and partners to ensure the meaningful participation of children in the design and implementation of policies and programmes, to develop systematic child-rights impact assessment procedures for national and subnational legislation and policies relevant to children, and to deliver systematic training on children's rights to the children's services workforce. The final area of progress is some evidence of outcomes improving over time, with this seen in different service areas:

- Using measurement tools such as the General Health Questionnaire, Strengths and Difficulties Questionnaire and Outcomes Star, Rodriguez et al. (2018) found that the Meitheal practice model has contributed to improving family outcomes
- Tulsa Performance and Activity Reporting data reports comparing January 2015 to January 2023 data:
 - The number of children's social work open cases has decreased from 27,300 to 22,400 cases; and
 - The number of children in care has decreased from 6,357 children to 5,597 children.
- More widely, and a reflection of wider income support measures introduced by the Irish government, the rate of consistent child poverty decreased from 7% in 2020 to 5% in 2021 (Ombudsman for Children, 2022).

However, Tulsa (2023) reports that demand for services for children and young adults who have a diagnosis of moderate to severe disability continues to grow, while there remains a very high demand for specialist residential care for children with very complex needs. This level of need is also reflected by the Ombudsman for Children (2022) who is concerned that the impact of the COVID-19 pandemic exacerbated existing inequalities experienced by particular groups of children, including children with disabilities, children living in alternative care, Traveller and Roma children, children with mental health difficulties, and children experiencing homelessness.

Areas for development

While there is some evidence of practice, services and outcomes improving, the material we looked at does highlight a number of service and practice areas that require further attention and/or resourcing. A number of these relate to how joined up the different services are and, therefore, the extent to which children and families can seamlessly access the services they need.

The first is on thresholds between services. Tusla's child and family services are intended to work on a continuum from Prevention, Partnership and Family Support services (that is, Meitheal and the Family Resource Centres) and Tusla's Child Protection and Welfare services, with the Hardiker tiered model helping to delineate thresholds. However, within

this continuum, the Meitheal model operates outside of the child protection system in that, for instance, families cannot be involved with Meitheal and Child Protection and Welfare at the same time. If a child protection concern arises during the Meitheal process, a referral is made to Child Protection and Welfare and the Meitheal process closed. This can limit the continuity of support, while Meitheal practitioners also found that some families referred to Meitheal had very high levels of need that would be more appropriately met through Tusla's Child Protection and Welfare Service (Rodriguez et al., 2018).

Accessing specialist services is reported to be a key challenge for children who have physical and intellectual disabilities, autism spectrum disorder, mental health difficulties, or who require speech and language therapy and trauma-informed therapeutic support, or adolescents at high risk and require additional supports (Ombudsman for Children, 2022; Rodriguez et al., 2018). In relation to disabled children, the UN Committee on the Rights of the Child (2023 p.9) highlight the need to "strengthen support for the social integration and individual development of disabled children, including by ensuring their access to early detection and early intervention programmes, providing capacity-building to child protection professionals on the rights and specific needs of children with disabilities, ensuring their personal assistance, rehabilitation and assistive devices".

Across specialist services, the issue primarily relates to capacity in and resourcing of specialist services, as this leads to lengthy waiting lists (Rodriguez et al., 2018; UNCRC, 2023). It should also be noted that these services are not governed and managed by Tusla, but instead by the Health Service Executive, and are highly dependent on private and third sector commissioned providers. As one country expert commented, "pursuing a privatisation agenda can create more problems than it solves. Certainly, volatility is highest in the private sector, with more centre openings and closures than either the public or voluntary sector. Children in care particularly value building trusting relationships and stability, and staff continuity is therefore particularly important".

Relatedly, there are particular concerns around the provision of mental health services for children, which are governed and delivered by the Health Service Executive. The Ombudsman for Children (2022) noting a continuing trend of complaints about services, including long waiting lists for treatment. The Mental Health Commission (2023) Interim Report arising from an Independent Review of the Provision of Child and Adolescent Mental Health Services (CAMHS) in the State affirmed these concerns. The report's highly critical findings included:

- A lack of governance in many areas that is contributing to some inefficient and unsafe CAMHS services. Governance issues included failures to manage risk, to fund and recruit key staff, to look at alternative models of providing services when recruitment becomes difficult, and to provide a standardised service across the country
- Uncoordinated waiting lists across different services such as CAMHS, Community Disability Network Teams or primary care services, and

- Poor relationships and limited joint working between primary care services, Community Disability Network Teams and CAMHS.

Another area for further attention is aftercare services for young people leaving care. The Ombudsman for Children (2022) highlights concerns about the discretionary nature of Tusla's obligation to provide aftercare services to young people leaving care. Aftercare arrangements were found to be *ad hoc* in nature, reliant on staff goodwill and prefaced on the engagement of the young person (Palmer et al., 2022). Where aftercare planning has occurred, the Ombudsman for Children (2022) refers to the complaints it has received in relation to:

- Delays in, and inadequate levels of, aftercare planning.
- Failures to allocate aftercare workers.
- Inappropriate onward placements.
- Considerable variation in aftercare service provision nationally.
- Deficits in interagency cooperation in the provision of aftercare supports for children with disabilities.

To enhance aftercare supports, Palmer et al. (2022) advocate the need to address the 'care cliff' whereby many professional supports are withdrawn almost overnight when care leavers reach 18 years of age (or 23 if they remain in full time education), and replace this with a more gradual withdrawal of supports tailored to meet the specific needs of each care leaver. The Ombudsman for Children (2022) and Gilligan et al. (2022) propose a review of eligibility criteria for aftercare services and changing the two exclusionary criteria that do not act in young people's best interests:

- Children who have not been in the care of the State for a period of 12 months are ineligible for aftercare.
- Children who have experienced homelessness and received services, but have not been formally placed in care, are excluded from receiving aftercare supports and services.

In delivering the high-quality services aspired to, significant cross-cutting challenges are resources and, linked to this, recruitment and retention of staff. Beginning with resourcing, there is found to be an absence of dedicated budgets for CAMHS (with it having to compete for funding against other Health Service Executive mental health services) and for services that meet the needs of disabled children (Mental Health Commission, 2023; Ombudsman for Children, 2022). Lack of resources was also found to impact on the implementation of the Meitheal practice model. Feedback from professionals found that consistent and standardised implementation of Meitheal would require additional staff, funding (including in non-pay budgets), resources, managerial support, leadership, and staff training (Rodriguez et al., 2018).

Concerning recruitment and retention, Ireland has had a lower number of social workers per head of population compared to other countries (O'Meara and Kelleher, 2022) but retention rates in children's social work have historically been relatively high, leading to a stable workforce with high levels of experience and expertise (Burns and McGregor,

2019). However, in recent years, the demand for services has increased, while recruitment and retention issues have worsened. To illustrate this, Clarke and McMahon (2020) report that between 2015 and 2019 Tusla experienced a 30% increase in referrals, but only a 1% increase in the social care workforce, with agency workers being increasingly used to bolster service provision. The services received by children and families have consequently been impacted, including children not having an allocated social worker or experiencing multiple changes in social workers over a short period of time (Burns and McGregor, 2019; HIQA, 2022). Malone et al. (2022) found that failures to reach the necessary staff complement and high levels of staff turnover were leading to geographical differences in Meitheal service provision.

The recruitment and retention of social workers has been the subject of a number of HIQA reports, parliamentary questions, Ministerial statements, and national and local media reports but O'Meara and Kelleher (2022) find that there is no national workforce strategy or planning for the training, recruitment and retention of the social workers. O'Meara and Kelleher also report that there is a data deficit about social workers on which to develop an informed workforce plan. One source of information is Social Care Ireland's Recruitment, retention and professionalisation in residential childcare in Ireland survey. This found that the greatest challenges reported by staff being pay and conditions (27% of staff), hours (17%), respect (13%), violence (12%), stress (12%), support (10%), and progression (5%) (Power, 2022). The feeling of dissatisfaction among the health and social care workforce led to prolonged periods of stoppages and strikes in the 12-18 months leading up to the COVID-19 pandemic (Power and Burke, 2021).

While there may not be a national social work workforce strategy, Tusla recognises the recruitment and retention challenges facing the sector and are taking forward a number of actions, including (HIQA, 2022; Tusla, 2021; 2023):

- In conjunction with the Department of Children, Equality, Disability, Integration and Youth, working with and seeking to influence universities to increase the supply of Social Work and Social Care professional graduates.
- Supporting graduate placements in Tusla.
- Championing Tusla's services and communicating the agency as an employer of choice.
- Employing other professional groups and using social care staff to complete tasks traditionally completed by social workers.
- Implementing retention initiatives to retain existing staff, including:
 - A new induction policy for new staff.
 - A buddy programme for staff in their first year.
 - Working with senior managers to develop Local Retention Plans.
 - Seeking feedback from staff on their experiences of starting work at Tusla, and using this feedback to make future improvements.

In terms of training and development needs, a finding of the UN Committee on the Rights of the Child (2023) was that there be systematic training put in place for all

practitioners working with children on children's rights, the UNCRC and on what a child rights-based approach to actions and decisions entails.

While this discussion on recruitment and retention has focused on social work roles, challenges exist across children's services. For example, the Ombudsman for Children (2022) highlights the recruitment and retention of mental health services staff, social workers, secondary school teachers, and staff in children's disability services. Two reports focus on the predicaments facing the social care and mental health workforce:

- Power and Dashdondog (2022) highlight the challenges in the social care sector (that is, children's residential and specialist care), finding that practitioners are facing too many risks to manage in their practice, were paid less as they were mainly working for private and third sector providers rather than Tusla or another public sector employer, and were confronted with limited development and progression opportunities. In November 2023, a register for social care workers is expected to be opened by CORU and this has been long awaited as it is hoped that registration will help see the social care field achieve the professional status of other health and social professions. A further, and unprecedented, response has been for the Health Service Executive to offer a full-time contract (subject to successful interview) for all health and social care graduates of 2023 from all professional education programmes.
- The Mental Health Commission (2023) found CAMHS teams were significantly below the recommended staffing levels, while staff in post felt burnt out and frustrated by not being able to provide what they saw as a safe and effective service.

There has been significant investment made by Tusla in the agency's data and IT infrastructure, with the catalyst being an external hacking of its data systems in 2021 where personal data of 20,000 people were compromised. However, and despite developments such as Tusla's Performance and Activity Reporting website (<https://www.tusla.ie/data-figures/>) which presents monthly and quarterly data across a range of child welfare, protection and care indicators and its new Integrated Financial Management System which will offer a joint finance and procurement system for both Tusla and the Health Services Executive, the final area for future attention and development is the need for better data collection and data sharing among agencies (O'Leary and Lyons, 2023). Across children's services, the Ombudsman for Children (2022) and UN Committee on the Rights of the Child (2023) have identified deficits in the systematic collection of comprehensive disaggregated data with regard to children, including children with disabilities, homeless children, children in care (including informal kinship care arrangements), Roma children, and children with a migrant background. In addition, concerning CAMHS services, the Mental Health Commission (2023) found real deficiencies in CAMHS' IT and management information systems, stating that most services do not have an IT system that manages appointments, schedules rotas, maintains clinical files and provides reports on activity.

Potential learning for Scotland

To drive forward and implement long-established desires for more preventative, family- and community-based provision, and ensure that children's services were not marginalised within the health system, the decision was taken to establish a dedicated national child and family agency – Tusla. Soon approaching a decade since it was established, Tusla continues to evolve but the understanding is that it has helped bring national consistency in practice and enhanced inter-agency working across Ireland. At the same time, a reflection from a country expert we consulted is to question whether having a national agency has stymied (local) innovation. People-based leadership and an attention to implementation has helped establish an organisational culture and national ways of working among Tusla staff. However, there is also recognition that more is needed to ensure implementation, including additional staff, funding, resources, managerial support and attention to the practice level when developing national strategy documents.

While Tusla appears to have facilitated national improvements to family support, child protection and care provision, children's health services are under the remit of the Health Service Executive and Ireland's health service is undergoing its own transformational Slaintecare reforms. Children's mental health and disability services are widely reported to be in crisis and it is unclear what influence Tusla has over these services.

The disconnect with health can also be seen in the regional and local planning and delivery structures that exist in children's services compared to health services, as the boundaries do not align and this would seemingly impact on the opportunities for joint planning across children's and health services.

Beyond access to specialist, health services, other key areas for further development in Ireland were found to be aftercare services for young people leaving care, and addressing recruitment and retention challenges across social work and other children's services workforces.

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