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Ireland's opportunity to learn from England's difficulties? Auditing uncertainty in child protection

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Abstract

This article draws from the authors' experiences of research in England on aspects of New Labour's reforms in the field of child protection to counsel caution against standardisation processes currently underway in the Republic of Ireland. It is argued that such processes are deeply problematic when dealing with the complexity of child protection work. Alternatives to standardisation are offered drawing from the literature on systems design. Such alternatives are likely to build confidence and trust in services.

Keywords: child protection, standardisation, system design.

Introduction

The title of this paper reworks the old nationalist dictum 'England's difficulty is Ireland's opportunity' to argue that there is an opportunity for Ireland to learn from England's recent difficulties in child protection and to apply these lessons to proposed reforms of children's services. Our particular interest in this paper is the implementation of a standardised business process project to ensure uniform recording and assessment processes (PA Consulting Group, 2009; Health Service Executive, 2009).

We explore the paradox that, at a time where developments such as standardisation are under serious scrutiny in England, they are being embraced in Ireland. We explore the similarities and differences between what is underway in Ireland and developments in England. We argue for, and offer suggestions towards, finding a way through which may help avoid the pitfalls of either a standardisation agenda or unfettered diversity resulting in a post code lottery.

England: new public management, 'deliverology' and child protection

A series of developments in England under New Labour led to a highly centralised 'command and control' approach to regulating the activities of social workers in the area of child protection. Alongside a reformulation of the role of the welfare state, there was also a continuation from the Conservatives of what became known as 'the managerial partnership state' (Featherstone, 2004). Although there were differences from the foregoing neoconservative agenda, New Labour's infatuation with the methods of private business was, if anything, stronger. Enabling, brokerage and regulating were emphasised over providing, and where the state did provide this was both targeted and subject to target setting.

New Labour's approach to public administration provided the perfect medium for so-called new public management (NPM) to flourish (Dillow, 2007). Its ideological contours are that: a central elite know best; strong top-down management is the key to quality and performance; workers are self-interested and inefficient; the standardisation of processes and explicit targets drive quality and these are ensured by rigorous micro-management using performance indicators (Chard and Ayre, 2010). In the context of human services and particularly child protection, NPM has been centrally concerned with managing *institutional* risk (Munro, 2009), creating a climate of 'targets and terror' (Bevan and Hood, 2006).

It is impossible to understand the genesis of the reforms to child welfare in England without understanding the key policy mantras as outlined above. Moreover, they are proving very difficult to destabilise, despite a range of compelling critiques.

Transforming children's services post Climbié

The reform of children's services was accelerated in 2000 with the death of Victoria Climbié (Laming, 2003), but as we shall see from its unmistakable family resemblances, its progenitors are NPM and performance management. Victoria died in London as a result of long-standing cruelty at the hands of her great aunt and her partner. Her death prompted a highly influential inquiry into professional and institutional failure. As a result, government put in place a series of reforms drawing heavily upon concepts of 'business process management', electronically enacted through the Integrated Children's System (ICS) (Shaw *et al.*, 2009; White *et al.*, 2010). The ICS attempts to micro-manage practice through the imposition of a detailed, work-flow model of the case management process and other processes, as figure 1 demonstrates.

Many of Laming's broad diagnostics of the failures contributing to Victoria's death are accurate enough. However, his relative neglect of human, interactional and social factors means that the policy responses, particularly the standardised processes and 'information sharing' initiatives, have been based on a set of erroneous assumptions. The most notable of these is that catastrophic child deaths are substantially the result of professionals failing to *record or share information*. Such failures are not trivial, but in our view rarely are they causal. Rather, they are ubiquitous features of many cases which do not end catastrophically, as Wastell notes:

[T]o be sure that this evidence is decisive, we need to know how often it was present in other cases but did not lead to calamity. ... Unless it can be shown ... that assessments, information gathering and multi-agency collaboration were conspicuously worse in the serious cases, how can it possibly be claimed that these were critical causal features? (Wastell, 2011).

For the causal factors in the death of Victoria, we need to look elsewhere. A re-examination of some of the evidence submitted to the Climbié inquiry will illustrate our point.

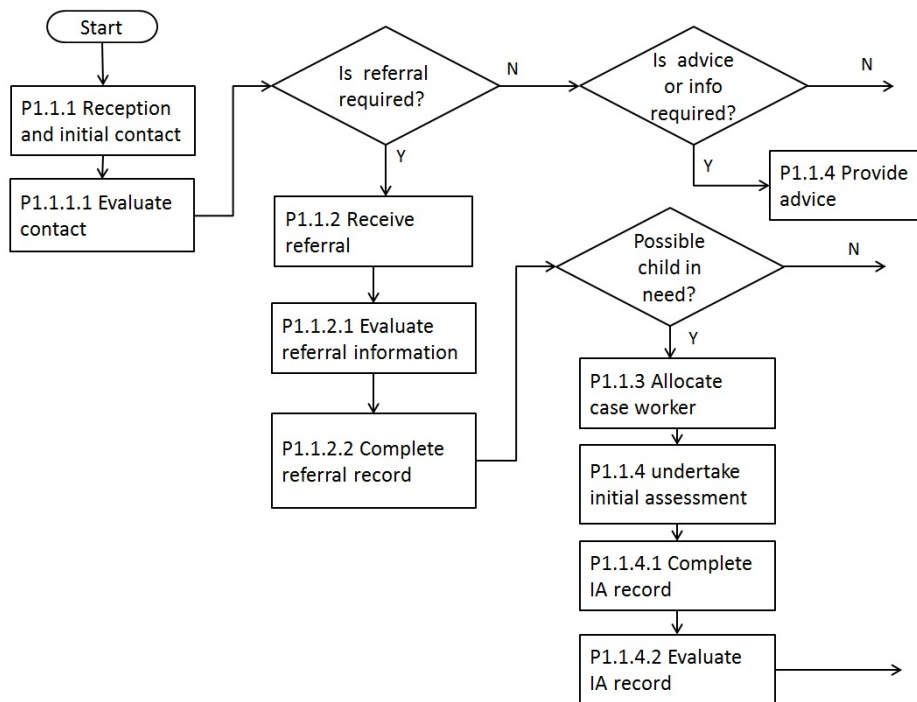


Figure 1: Referral and assessment process as officially charted in the ICS. The diagram is adapted from the Children's Social Care Services Core Information Requirements Process Model (DCSF, August 2008). The diagram covers the first quarter of the process model for "Core case management operations". It is one of 11 such models!

Human factors in child protection: The Laming Inquiry revisited

In July 1999 Dr Schwartz, consultant paediatrician at Central Middlesex hospital, examined lesions on Victoria's body. Her clinical opinion was that the marks were self-inflicted due to intense itching from a scabies infection. This opinion differed from a previously expressed and documented diagnosis by a locum registrar, who produced detailed body maps of Victoria's injuries and was of the view that there was a strong possibility that she had been physically abused. Whilst Dr Schwartz testified to the inquiry that she had made it clear to social services that she could not exclude physical abuse, the production of a medical explanation for some of the injuries proved a highly consequential red herring. The contact with social services to inform them of the 'change' of diagnosis was made by Dr Dempster, a junior doctor unfamiliar with social services and the child protection system.

Dr Dempster followed up several unsatisfactory conversations with social workers with the following letter:

"Thank you for dealing with the social issues of [Victoria]. She was admitted to the ward last night with concerns re: possible NAI [non-accidental injuries]. She has however been assessed by the consultant Dr Schwartz and it has been decided that her scratch marks are all due to scabies. Thus it is no longer a child protection issue.

There are however several issues that need to be sorted out urgently:

- 1) [Victoria] and her mother are homeless. They moved out of their B & B accommodation 3 days ago. 2) [Victoria] does not attend school. [Victoria] and her mother recently arrived from France and do not have social network in this country. Thank you for your help” (cited in Laming 2003, p. 251).

The letter’s communicative intent was to prompt a visit to the hospital by a social worker, but was read by social services as a recategorization of the case, triggering a quite different organizational response. Brent children’s services had two initial assessment teams: referrals were considered first by the duty team, and if the referral appeared to relate to ‘a child in need’, the case would remain with them for initial assessment; if there were child protection concerns, it would be transferred to the child protection team for urgent action. Under the Children Act, 1989 and the associated guidance, the category of child in need was introduced to signal the importance of offering support to families with a range of needs such as housing. This was intended to ensure that local authorities did not just focus narrowly on immediate harms. Thus, within the assumptive world of Brent Social Services, the crucial line of this letter becomes ‘Thus it is no longer a child protection issue’ and not the documented ‘urgent’ social matters. The case thus entered a bottle neck in an over-stretched duty team, dealing with backlog of 200-300 cases a week. Whilst these circumstances are clear, such formal organizational systems escaped Laming’s criticism, indeed he prescribes more of them (White, 2009a).

If we examine the events at Central Middlesex from the point of view of the human actors, it is clear that complexities arise from the need to pass what might be speculative and ambiguous information across service boundaries. Communications within a system are embedded in a range of interpretive dichotomies: signal/non signal; information/noise and pattern/randomness (Serres, 2007). One reader/hearer may find information, where another detects only noise. For the receivers of the referrals, the categories ‘non accidental injury’ or ‘child protection case’ were the signal, the genuine deliberations of the doctors simply noise. There were plenty of instances of information sharing in the Climbié case, but signal and noise were frequently confused.

Research shows that knowledge sharing is influenced by multiple interpersonal, social and organisational factors, including the inhibitory impact of disparate knowledge domains, social hierarchy and low trust (e.g. Cross and Borgatti, 2004). Information throughout child welfare is thus ‘slippery’ (difficult to codify) and ‘sticky’ (difficult to share across boundaries). The problem is not readily responsive to exhortations to ‘share information’ (Swan and Scarbrough, 2001; Reder and Duncan, 2003). Yet, this is exactly what Laming prescribes. The system wasn’t working to support safe practice, yet the prescription was a stronger dose of the same medicine – a rigid workflow, cumbersome forms and centrally imposed timescales.

The death of (Baby) Peter Connolly in 2007, and the media attention it attracted, opened the Laming reforms to renewed scrutiny. Peter was a 17 month infant, subject to a child protection plan, supervised, like the Climbié case, by the London Borough of Haringey.

Both the hospital and the social work staff were too willing to believe the plausible accounts the mother was offering to explain child A's injuries. In the more holistic context of the case the explanations offered by Ms A should have been questioned (Department for Education, 2010).

The quotation above is taken from the Serious Case Review (SCR) into Peter's death. Throughout extensive professional involvement, Peter continued to sustain multiple injuries, as the SCR panel reports above. His death took place years after the implementation of the Laming reforms, which were to ensure that 'this could never happen again'.

So, how *could* it happen again? How can apparently reasonable and motivated staff make repeated errors in the attribution of cause and effect and fail to see what was happening right under their noses? An examination of the literature on human factors in decision-making shows this to be not very surprising at all, the post Laming reforms simply failed to take proper account of these factors. The intrinsic characteristics of information processing by human beings operate as both friend and foe in social work decision-making. At an individual level, we are equipped with an innate apparatus to assess our fellow human beings on an intuitive/emotional level, and alongside this we have particular cognitive biases. The generation of hypotheses is affected by our cognitive capacities in two principal ways: it is limited by what is *available* in memory, and by 'psychological commitment' to the first hypothesis. This is confounded by the related tendency to seek out evidence that confirms a hypothesis, rather than searching for 'disconfirming' evidence (Wolf *et al.*, 1985). Thus, once we have settled on an interpretation of events we tend to deviate little from our initial 'anchor' hypothesis (Kahneman *et al.*, 1982). In Peter's case the fallacious formulation was the result of professionals' belief in his mother's account of his behavioural difficulties, including 'head banging', which was also observed by professionals - 'confirmation bias' in action.

When we add to the equation the social psychological and sociological dimensions, which generate powerfully normative cultural practices, we have a heady cocktail indeed (Haidt, 2001; White 2009b). It is clear that the failures in the case of Peter Connelly were not in *sharing or recording* information, but in having the time, space, argumentative flexibility, analytic ability and trusting relationships to debate and make sense of what was being seen and recorded. If we want safer child protection systems we are going to have to design them for the right species.

In England, the policies implemented under New Labour were to result in a 'perfect storm': timescales, targets and the Integrated Children's System (ICS). It became apparent that a key casualty of these 'reforms' was time spent with families. The audit tail was well and truly wagging the practice dog. Rather than protecting against system failure, these factors exacerbated 'latent conditions for error' (Reason, 2000) because they made the work bureaucratically *complicated* whilst failing to take account of its human *complexity*.

The English system reassessed

The ICS, with its form-based artefacts and rigid processes, was marked out for the urgent attention of a national ‘Social Work Task Force’, set up by the Labour government following the media furore evoked by the Peter Connelly case. Immediate relaxation of its strictures was recommended (Social Work Task Force, 2009).

Further scrutiny of the system followed the general election in 2010 with establishment of the Conservative-Liberal Democrat coalition. Professor Eileen Munro was commissioned to scrutinise and advise on reducing bureaucratic burdens in children’s services. She concluded:

... The demands of bureaucracy have reduced [social workers’] capacity to work directly with children, young people and families. Services have become so standardised that they do not provide the required range of responses to the variety of need that is presented. This review recommends a radical reduction in the amount of central prescription to help professionals move from a compliance culture to a learning culture... (Munro 2011, pp. 6-7).

Munro recommends that services are redesigned using ‘socio-technical’ principles (see below), with due attention to the role of professional judgement. These well-established principles have been used to good effect in healthcare systems exemplified in the patient safety movement (*inter alia* Dekker, 2007; National Patient Safety Agency, 2011).

In the next section, we will change lenses, taking a wider view of the problematics of the attempts to standardise responses in England. We shall see that its failure was far from singular or unpredictable. From the perspective of the research literature on business process management (BPM), its vicissitudes were entirely foreseeable.

Horses for courses and the limits of the BPM paradigm

We have noted above that the failures of the English reforms were quite predictable. BPM is not a magic bullet, indeed as many as 80% of BPM initiatives fail (Trkman, 2010). Moreover, the critical success factors have been well investigated and are ably reviewed by Trkman (2010). The degree to which processes can be validly standardised is one such factor, indeed it is decisive. Technologies for *process management* will only be effective for standard, routine processes and it is vital to distinguish between these and non-routine counterparts (Wastell, 2011); put simply, the message is ‘do not standardise processes that cannot be standardised!’ Lillrank and Liukko (2004) neatly capture this distinction in their “Quality Broom” metaphor (figure 2).

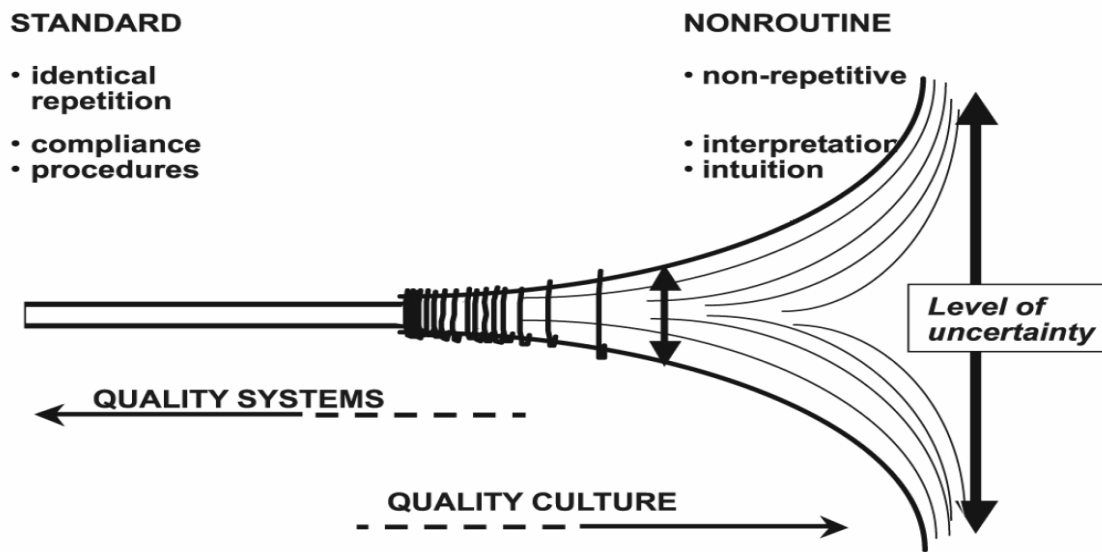


Figure 2: “Quality Broom” metaphor (Lillrank and Liukko, 2004)

Lillrank and Liukko argue that non-routine processes differ from standard routines “in that input is vague and not readily classified into categories. ... Therefore the assessment of an input is an interpretation which must be derived through the search for new information, iterative reasoning, and trial-and-error” (*ibid.* p. 42). Whereas standard processes can be managed directly through procedural or technological means, “non-routine processes are best managed by indirect means, such as competence, professional values, visions and missions” (*ibid.*, p. 44). Through culture, in other words (Mannion *et al.*, 2009). Or as Weick (1987, p. 124) put it:

“Either culture or standard operating procedures can impose order ... but only culture also adds in latitude for interpretation, improvisation, and unique action”

Much of the professional task of social work lies at the “brush” end of the quality broom, which explains ‘in a sweep’ why process standardisation was always the wrong approach.

Another way of characterising these crucial issues is the process/practice dichotomy (Wastell, 2011). ‘Process’ can be defined as a formal set of sequential steps whereby some output is produced, whereas ‘Practice’ refers to the activity of getting the work done, the artful performance of a craft. In social work, the former may be recording a contact with a service, the latter the work with the family and the sense-making involved. Although written in relation to a different professional task, that of software development, one of us argued some time ago that the belief that formalised processes can magically substitute for skilled practice represents a form of fetish (Wastell, 1996). Software engineering went through its standardisation ‘turn’ over a decade ago, and the comparison with social work is instructive. Standard processes were introduced in the form of “structured methodologies” (Wastell, 1999). The effort failed, making way for the development of alternative approaches (agile methods) which gave full space for the virtuosity and creativity of individuals, imposing only a *minimum* of structure. Social

work in the UK is learning now, sadly the hard way, what software engineering learned over a decade ago.

The argument encapsulated in the quality broom metaphor, is thus not for or against standardisation, but for a recognition of the diversity within a system.

Managers need to decide what should be strictly regulated and what should be left to empowered individuals and groups ... A great deal of trouble follows, if processes are interpreted as being different from what on closer examination they really are (Lillrank and Liukko, 2004, p. 45).

Taking these insights, what are we to make of the Irish reform programme? Has it been designed after careful analysis of Irish social work's 'broom'? Does it take account of human factors? Is it based on a thoroughgoing analysis of the causal factors in Ireland's high profile cases, or does it repeat the 'strong but wrong' assumptive base of the English model?

What's happening in Ireland?

Irish social work has seen a steady, incremental process that has broadly followed and adopted the international trends and key themes in the quality programme: raised scrutiny, procedural compliance, accountability (defined in financial terms), practice standardisation, inspection, and, more recently, audit in the form of compliance with agreed agency requirements' (Kemp, 2008, p. 101).

However, Kemp noted that while there were similarities with the UK, the scale and scope of the quality programme at the time he was writing was far less intense and focused. Moreover, he noted the interesting paradox that the more attempts were made to standardise control, the more divergent practice appeared to become. For example, the advent of Children First: National Guidelines for the Protection and Welfare of Children (Department of Health and Children, 1999) was seen as a significant attempt to standardise the way social workers worked, how and who they liaised with, and how they accessed child welfare concerns. However, as soon as the document had been launched, variations were adopted by each Health Board. Indeed, instead of standardising practice, it merely led to greater degrees of divergence and localised arrangements. This finding is important in understanding the latest attempts at standardisation in Ireland (see PA Consulting, 2009).

However, as in the UK the catalyst for much of what has happened has been key inquiry reports including The Report of the Kilkenny Incest Investigation (McGuinness, 1993), The Ferns Report (Murphy *et al.*, 2005), Ryan Report, (2009) and the Roscommon Child Care Case (2010). These raised public awareness, increased demands for better protection and placed child protection social work under increased scrutiny. This created a heightened focus on, and pre-occupation with, procedures which sought standardised responses and individual social worker accountability.

The Irish Social Services Inspectorate and, more recently, the Health Information and Quality Assurance agency (HIQA) have been promoting developments in relation to audit, quality insurance, inspection, effectiveness and efficiency over the last decades. Since 2005, Buckley (2008) notes there have been increasing manifestations of the New

Public Management (NPM) approach. For example, there is increased attention to performance indicators, with Section 8 reports identifying how many child protection conferences were held where parents and children were invited, the numbers where they attended, the number of reports received by category, the number of initial assessments conducted, and the number of cases where initial assessment led to listing on the Child Protection Notification System. However, as Buckley notes, there is no explanation of what these indicators demonstrate. Furthermore, they contrast with the Analysis and Commentary Sections of the Section 8 reports, which give a much fuller and more complex picture of the varying meanings that can be attached to all these indicators.

At the time of writing the HSE is rolling out the National Child Care Information System (NCCIS), which is to be implemented nationally in all Child and Family Social Work departments (Health Service Executive, 2009). While the NCCIS encompasses all areas of Child and Family services, the part of this new system which is of particular concern is the Business Process Standardisation Project. It sets out a national standard framework for recording and for monitoring how Child and Family Social Workers do their work. The standard forms encompass every aspect of the work from referral, initial assessment, further assessment, family support and children in care and must be filled out within specified timescales. We would suggest there are obvious similarities with the ICS work-flow mode.

But what problem is this focus on standardisation addressing in Ireland? If we explore, for example, what happened in the Roscommon case (the most recent case to cause concern) it is not clear at all that a focus on standardising processes is of value. In this case of long-standing sexual abuse and neglect, what emerges is a complex and interrelated constellation of issues involving cognitive 'errors', the conventions of telling and the gendered nature of control issues in families. Categorisation of this case as family support operated to locate interventions at the support end of the continuum and this was exacerbated by the secretive nature of child sexual abuse and gendered practices around control. As has been well documented, children who are being sexually abused are seldom able to open up in any straightforward sense. Wattam (1999) has argued for the importance of attending to the conventions of information exchange in routine and non-routine encounters. Most people, children included, operate with a hierarchy of who should be told what, and in what order. For example, where there is a death in a family, there are usually conventions about who should be told first, and if these are not adhered to, ill-feeling and distress may ensue. Research with children and young people suggests they operate with a strong sense of who they want to tell what to, and sexual abuse by parents can impact profoundly on their sense of what is the right thing to do. For example, if a child is unable to tell their mother about a father's abuse, then it is unlikely that they will easily flout the convention (about who is first in line). To put it bluntly, if those they want to trust with bad news cannot be told, then it is possible they will tell no one at all. Therefore, in such cases standardised protocols that emphasise social workers seeing and talking to the child are unlikely to be of value.

Overall, many of the most high profile scandals in Ireland have involved sexual abuse either in families or in institutions. The Ryan Report (2009) offers a shocking indictment of failures in relation to inspection and audit. However, these can only be

understood within the culture of deference to the Catholic Church, and societal attitudes to those who were poor and/or considered morally depraved.

Conflicts around care and control can characterise many cases where a range of abuses are occurring and these are often gendered in nature. The father in the Roscommon case was noted in the Inquiry Report to control interventions with workers and much practice seemed to take place on his terms and his territory. The knowledge base in relation to working with such men, and the dynamics of the relations they establish with women, are poorly researched and understood and, indeed, we would argue constitute a serious gap currently. It goes without saying that standardised protocols are of little value in such situations as this is highly complex work (Featherstone, 2011). Moreover, there is evidence to suggest that work with men is particularly prone to the kinds of cognitive errors explored above, where they are categorised at an early point as a risk to the child (or resource) with such categorisations becoming fixed and not open to revision.

A small scale consultation carried out by one of us with a team involved in implementing the standardisation project in Ireland suggests that it does support measures to improve audit. For example, it was easier for managers to see at a glance how many referrals had come in and what had happened. Moreover, unlike the infamous ICS system, the forms lent themselves to a narrative approach. However, even at such an early stage of 'roll out' concerns were being expressed about the need to have separate forms per child, and the apparent prescription in relation to the timing of case-conferences. The latter is not just of concern in terms of tempering professional discretion in relation to when the conference might be most valuable, but such conferences can be extremely intimidating events for parents and should arguably only be held when it is clear that they will be of value, rather than to fit with a specific timescale. A separate issue beyond the scope of this paper is that prescription in relation to case-conferences could impact unhelpfully on whether more strengths-based approaches such as Family Group Conferences are held.

Discussion and conclusion: There is an alternative

Social work is not unique as a professional activity, though it does have distinctive aspects, and in looking for different ways of designing social care organisations, it behoves managers and policy-makers to draw on the commodious literature on organisational design. In these evidence-based times, managers must surely practise what they preach for others.

de Sitter *et al.* (1997) identify mounting uncertainty and complexity as key challenges for all organisations, for which two broad options are available. The first is to increase internal complexity, through the creation of more staff functions and processes and, therefore, more sophisticated management control structures. They dub this the strategy of "complex organisations and simple jobs". The second response takes the opposite tack, reducing control and coordination by the creation of self-contained units. Fragmented tasks are to be combined into larger wholes, thinking to be re-united with doing; in other words, a strategy of "simple organisations and complex jobs".

Effectively, the latter response follows a long-established design approach known as sociotechnical systems design (STSD), mentioned above (Wastell, 2011). Several key principles characterise the approach. First, that organisations should be seen as open

systems, comprising (for analytic purposes) two sub-systems, the 'technical' (technology, skills and processes) and the 'social' (motivation, job satisfaction, organisational and group culture). STSD seeks "Joint Optimisation" of these sub-systems, i.e. the search for a mutually-reinforcing balance between what workers need and want, and the technical requirements for effective performance. Other principles include: Minimum Critical Specification (no more should be specified than is absolutely essential) and the Sociotechnical Criterion (responsibility for dealing with contingencies to be given to workers, not supervisors or managers). Put simply, do not over-specify, delegate as much as safety and accountability will allow, liberating people to innovate and adapt to unpredictable situations'.

The success of the "simple organisations, complex jobs" approach is attested in the vignette of Mutual Benefit Life, a US insurance company (Hammer, 1990). Its old process was bureaucratic and labyrinthine: insurance applications could go through 30 discrete steps, spanning five departments, taking up to 25 days. A new approach was needed: departmental boundaries were swept away and a new position created, the case manager:

Case managers have total responsibility for an application from the time it is received to the time a policy is issued. Unlike clerks, who performed a fixed task repeatedly under the watchful gaze of a supervisor, case managers work autonomously. No more handoffs of files and responsibility (*ibid.*, p.106).

This is the epitome of STSD: complex jobs and simple organisation. As a result applications were processed in four hours with case managers handling twice the volume of work. There are examples of such redesign within social work, such as the Borough of Hackney's "Reclaiming Social Work" initiative. Here the "process paradigm" was seen as part of the problem, not the solution: "With greater reliance on a procedural approach ... a workforce often incapable of professional, creative and independent thinking had emerged (Goodman and Trowler, 2011, p. 161). Radical re-organization along sociotechnical principles (small, autonomous work-groups) achieved the virtuous circle of improved outcomes (e.g. reduced children in care) at a lower financial cost (*ibid.*; Munro, 2011).

We have argued that the change programme in Ireland is uniquely placed to take account of what has happened in England. Services must be properly designed with full account of both ends of the quality broom. The developments in England, and the shape of those planned in Ireland, privilege the management of institutional risk over the improvement of practice. Instead, we urge that future developments need to attend to the role of 'trust' in the delivery of human services. Smith (2001) makes an important distinction between trust and confidence. Confidence refers to the general sense of safety and reliability that we invest in systems - having certain expectations in relation to professional roles and the regulatory frameworks governing these systems. Thus, for child care services, confidence would refer to the qualifications of those working in the system, expectations about their role and expectations about the frameworks which regulate and inspect what they do. Clearly, events in Ireland in recent years have led to concern about the reliability of the systems at a number of levels. For example, it is difficult to have confidence when crucial information about children and young people

seems not to have been collected in a systematic way. Confidence is at the ‘hard’, handle end of the quality broom, and can be supported by good systems.

However, this must not be at the expense of trust which serves as a guide to interpersonal relationships where the outcome cannot be guaranteed and, indeed, where the possibilities of disappointment and regret are always present – the ‘soft’ end of the quality broom. If activities such as social work are to bring about positive outcomes in people’s lives, then trust is essential. First, many of those who need services will have experienced situations where their trust was betrayed very profoundly. This might lead to the conclusion that it is better to concentrate on developing systems based upon rights and entitlements. Rights are a vital underpinning for children’s services, but rights are exercised in inter-personal encounters and services (including those based upon rights) mediated by people (Smith, 2001). Research evidence suggests that **how** a service is delivered really matters in terms of whether people continue to access it. For example, young people constantly give feedback on the importance of how they are talked to by workers and whether they feel such workers are genuine. Thus, whilst it is important to measure how many children attend the meetings that are held to discuss their care, it is just as important, if not more so, to devise meaningful measures that assess their level of participation and how they feel about the quality of those meetings.

In order for risk to be assessed and change to happen, service users need to tell the truth (Smith, 2001). Whilst this may not always be possible, it is even more unlikely to happen if social workers are not able to build up relationships that are compassionate and truthful in return. Service users value and respond to those who are honest and can deliver the bad, as well as the good news, in a respectful manner. Integral to the building of relationships is that workers have enough time to assess what is happening, to mull over differing versions of events, to weigh up conflicting sets of evidence and to elicit truthful accounts. This kind of work cannot be done by harried workers running from one case to another without the space to think. Good quality supervision is also necessary as the research on human cognition, explored above, suggests we are all prone to cognitive error, particularly when we are tired and emotionally overwhelmed. Supervision should offer a space to challenge judgements made and to process the emotions that will arise when dealing with painful and distressing situations.

Trust and confidence are related but not the same, and systems that focus only upon confidence building can destroy the possibilities for developing the kind of trusting relationships we have described above (Featherstone, Coogan and Landy, 2010). We would argue that Ireland should grasp the opportunity to embrace principles of system design which aim at building trust and supporting the front-line professional task, guarding against the seductive proxies for quality that timescales and targets produce. These create new arenas for blame and tend to spawn more of themselves in response. There is another way, and in this article we have outlined some of the ideas that are emerging as alternative principles. We hope it contributes to the policy dialogues that are necessary to ensure confidence and trust in the systems developed in both countries.

References

- Bevan, G. & Hood, C. (2006). What's measured is what matters: Targets and gaming in the English public health care system. *Public Administration*, 84(3), 517–38.
- Buckley, H. (2008). Heading for collision? Managerialism, social science, and the Irish child protection system. In K. Burns & D. Lynch, (Eds.), *Child protection and welfare social work* (pp.9-24). Dublin: A&A Farmar.
- Chard, A. & Ayre, P. (2010). Managerialism – at the tipping point. In P. Ayre & M. Preston-Shoot (Eds.), *Children's services at the crossroads* (pp. 95-106). Lyne Regis: Russell House.
- Cross, R. & Borgatti, S. P. (2004). The ties that share: Relational characteristics that facilitate information seeking. In M.H. Huysman & V. Wulf (Eds.), *Social capital and information technology* (pp. 137-159). Cambridge: MIT Press.
- Cross, S., Hubbard, A. and Munro, E. (2010). *Reclaiming social work*. London: Human Reliability and the London School of Economics and Political Science.
- Dekker, S. (2007). *Just culture: Balancing safety and accountability*. Aldershot: Ashgate.
- Department for Children Schools and Families, Process Flow Diagram: P1.1 Core Case Management Operations V4.0,
<http://webarchive.nationalarchives.gov.uk/20090805112952/dcsf.gov.uk/everychildmatters/resources-and-practice/ig00009/> last accessed 3/4/12
- Department of Health and Children. (1999). *Children first: National guidelines for the protection and welfare of children*. Dublin: The Stationery Office.
- Department for Education (2010) Haringey Safeguarding Children Board, Serious Case Review 'Child A'
<http://media.education.gov.uk/assets/files/pdf/s/second%20serious%20case%20overview%20report%20relating%20to%20peter%20connelly%20dated%20march%202009.pdf> last accessed 27/03/2012
- DeSitter, L.U., den Hertog, J. F and Dankbaar, B (1997) From complex organisations with simple jobs to simple organisations with complex jobs, *Human Relations*, 50, 497-534
- Dillow, C. (2007). *The end of politics: New Labour and the folly of managerialism*. Petersfield: Harriman House.
- Dowie, J. & Elstein, A. (Eds.) (1988). *Professional judgement: A reader in clinical decision making*. Cambridge: Cambridge University Press.
- Featherstone, B. (2004). *Family life and family support*. Basingstoke: Palgrave.
- Featherstone, B. (2011, November). *Working with 'fathers' in child protection*. Paper presented at the University of Birmingham, Birmingham.
- Featherstone, B., Coogan, D. & Landy, F. (2010). *Building trust and confidence in children's services*. Retrieved from: <http://www.fairirelandforum.ie>
- Goodman, S. & Trowler, I. (2011). *Social work reclaimed: Innovative frameworks for child and family social work practice*. London: Jessica Kingsley Publishers.
- Haidt, J. (2001). The emotional dog and its rational tail: A social intuitionist approach to moral judgement. *Psychological Review*, 108(4), 814–834.
- Hammer, M. (1990). Reengineering work: Don't automate, obliterate. *Harvard Business Review*, 68(4), 104-112.
- Health Service Executive. (2009). *Report of the NCCIS business process standardisation project, version 0.9 (for implementation)*. Retrieved from:
<http://www.hse.ie/eng/services/Publications/services/Children/nccis.html>
- Kahneman, D., Slovic, P. & Tversky, A. (1982). *Judgement under uncertainty: Heuristics and biases*. New York: Cambridge University Press.
- Kemp, P. (2008). Questioning quality: A critical analysis of the development and implementation of the 'quality agenda' and its impact on child protection social work practice in Ireland. In K. Burns & D. Lynch (Eds.), *Child protection and welfare social work* (pp. 97-110). Dublin: A&A Farmar.
- Laming, Lord (2003). *The Victoria Climbié inquiry: Report of an inquiry by Lord Laming*. Norwich: The Stationery Office.
- Lillrank, P. & Liukko, M. (2004). Standard, routine and non-routine processes in health care. *International Journal of Health Care Quality Assurance*, 17(1), 39-46.
- Mannion, R., Konteh, F. & Davies, H. (2009). Assessing organisational culture for quality and safety improvement: A national survey of tools and tool use. *Quality and Safety in Health Care*, 18, 153-156.
- McGuinness, C. (1993). *The report of the Kilkenny incest investigation*. Dublin: The Stationery Office.

- Munro, E. (2009). Managing societal and institutional risk in child protection. *Risk Analysis*, 29(7), 1015-1023.
- Munro, E. (2011). *The Munro review of child protection: Final report. A child centred system*. London: Department for Education.
- Murphy, F. D, Buckley, H and Larain, J (2005). *The Ferns report: presented to the Minister for Health and Children*. Dublin: The Stationery Office.
- National Patient Safety Agency. (2011). *Patient safety first. The campaign review*. London: National Patient Safety Agency.
- PA Consulting Group. (2009). *Inspiring confidence in children and family services: Putting children first and meaning it – Strategic review of the delivery and management of children and family services*. Dublin: prepared by PA Consulting for the Health Service Executive.
- Reason, J. (2000). Human error: Models and management. *British Medical Journal*, 320, 768-770.
- Reder, P. & Duncan, S. (2003). Understanding communication in child protection networks, *Child Abuse Review*, 12, 82-100.
- Roscommon Child Care Case. (2010). *Report of the inquiry team to the Health Service Executive, 27/05/2010*. Retrieved from: <http://www.hse.ie/eng/services/Publications/services/Children/RoscommonChildCareCase.pdf>
- Ryan, S. (2009). *The report of the Commission to inquire into child abuse – The Ryan report*. Retrieved from: <http://www.childabusecommission.com/rpt/pdfs/>
- Serres, M. (2007). *Parasite*. Minneapolis: University of Minnesota Press.
- Shaw, I., Bell, M., Sinclair, I., Sloper, P., Mitchell, W., Dyson, P., Clayden, J. & Rafferty, J. (2009). An exemplary scheme? An evaluation of the integrated children's system. *British Journal of Social Work*, 39(4), 613-626.
- Smith, C. (2001). Trust and confidence: Possibilities for social work in 'High Modernity'. *British Journal of Social Work*, 31, 287-305.
- Social Work Task Force. (2009). *Building a safe confident future: The final report of the Social Work Task Force*. London: Department of Health and Department of Children, Schools and Families.
- Swan, J. & Scarbrough, H. (2001). Knowledge management: Concepts and controversies. *Journal of Management Studies*, 38(7), 913-921.
- Trkman, P. (2010). The critical success factors of business process management. *International Journal of Information Management*, 30(2), 125-134.
- Wastell, D.G. (1996). The fetish of technique: Methodology as a social defence. *Information Systems Journal*, 6(1), 25-40.
- Wastell, D.G. (1999). The human dimension of the software process. In J.C. Derniame, B. Ali Kaba & D.G. Wastell (Eds.), *Software process: Principles, methodology and technology, Lecture Notes in Computer Science, Volume 1500* (pp. 165-199). Berlin: Springer Verlag.
- Wastell, D.G. (2011). *Managers as designers in the public services: Beyond technomagic*. Devon: Triarchy Press.
- Wattam, C. (1999). Confidentiality and the social organisation of telling. In N. Parton & C. Wattam (Eds.), *Child sexual abuse: Responding to the experiences of children* (pp. 71-90). Chichester: Wiley.
- Weick, K. (1987). Organizational culture as a source of high reliability. *California Management Review*, 29(2), 112-27.
- White, S. (2009a). Arguing the Case in Safeguarding. In K. Broadhurst, C. Grover & J. Jamieson (Eds.), *Critical perspectives on safeguarding children* (pp. 93-110). Oxford: Wiley.
- White, S. (2009b). Fabled uncertainty in social work: A Coda to Spafford *et al.* *Journal of Social Work*, 9(2), 222-235.
- White, S., Wastell, D., Broadhurst, K. & Hall, C. (2010). When policy o'erleaps itself: The 'tragic tale' of the integrated children's system. *Critical Social Policy*, 30(3), 405-429.
- Wolf, F.M., Gruppen, L.D. & Billi, J.E. (1985). Differential diagnosis and competing hypotheses heuristic: A practical approach to judgement under uncertainty and Bayesian probability. *Journal of American Medical Association*, 253(19), 2858-2862.