Safer and Effective Staffing Research and Policy Development Older People's and Children's Social Work in Northern Ireland

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Safer and Effective Staffing Research and Policy Development

Older People's and Children's Social Work in Northern Ireland

Report 1- The Starting Point: Baseline Analysis

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Safe Staffing Research and Policy Development in Older People's and Children's Social Work in Northern Ireland: Report 1- The Starting Point: Baseline Analysis

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Foreword – Aine Morrison

Safer and effective social work staffing, across the social work workforce in Northern Ireland (NI) is a priority for the Office of Social Services (OSS) within the Department of Health. OSS recognises the significant challenges social work services NI face currently and the pressures this puts on staff. There is a complex interplay of factors affecting current staffing levels including population factors causing increased demand for services, the aftermath of the COVID-19 pandemic, funding shortfalls and the resultant impact on staff wellbeing. While defining what safe staffing means is complex and brings many challenges, I believe that it is essential that we set some standards for what we believe to be reasonable workloads. Such standards will support staff wellbeing and assist service and workforce planning.

OSS initiated this evidence-based research project in January 2023, led by Professor Paula McFadden and Linda Johnston, NISCC Associate for older people's services and Emerita Professor Mary McColgan and Paul McConville, OSS Professional Officer for children's services.

Separate projects for mental health services are co-chaired by Professor Gavin Davidson and Darren Strawbridge and Fiona Rowan, OSS Professional Officers and for children's homes Professor Karen Winter and Patricia Owens, OSS Professional Officer. These projects will report separately.

This phase of the project is concentrating on HSCT services, but it is hoped that the work will then inform social work services in other settings.

Steering Groups were established for the work in older people and children's services involving a wide range of stakeholders. This collaborative model drew on the knowledge and expertise of key personnel with relevant operational practice and knowledge on key issues and challenges. The engagement of key stakeholders has been a core strength of the initiative in co-producing and sense checking the methodology, research design and data submitted.

The project involved data collection from 270 social work teams on workloads, waiting lists and staffing; and focus groups with teams and steering groups, plus interviews with front line

social workers. Diary analysis also informed the insights into ‘a week in the life of a social worker’.

This phase one report has recommended a definition for safer and effective staffing in social work, ten principles to underpin safer staffing and a conceptual framework.

Phase two will make recommendations for caseload sizes and models and tools for calculating these.

These two reports and the work of the other steering groups will then inform Department of Health safe staffing guidance for social work in these programmes of care.

I would like to acknowledge and thank the Co-Chairs and the steering groups for their commitment, time and enthusiasm for this work and thank the research team for their diligence with data collection and analysis. Thanks are also due to Dr Justin MacLochlainn and Dr Hannah Davies, Research Assistants on these projects.

Most of all, I would like to thank all of the social workers and managers who participated in gathering the team level data and participating in focus groups and interviews.

Contents

List of Abbreviations

ABE	Achieving Best Evidence
ASW	Approved Social Worker
AYE	Assessed Year Employment
BASW NI	British Association of Social Workers Northern Ireland
BCP	Balanced Caseload Process
BHSCT	Belfast Health and Social Care Trust
CAF	Children and Families
CCS	Children's Court Servies
CHPD	Care hours per patient day
CS	Children's Services
CUP	Collaborative Unallocated Process
CWA	Caseload Weighting Approaches
CWIP	Child Welfare Inequalities Project
DAPO	Designated Adult Protection Officer
DoH NI	Department of Health Northern Ireland
DoLS	Deprivation of Liberty Safeguards
EY	Early Years
FC	Family Centre
FE	Funded Establishment
FIT	Family Intervention Team
FMI	Functional Mental Illness
GW	Gateway
HSC	Health and Social Care
ICT	Integrated Care Team
IO	Investigating Officer
LAC	Looked After Children
MASN	Maximum Allowance of Student Numbers
MCA	Mental Capacity Act
MHO	Mental Health Order
NHSCT	Northern Health and Social Care Trust
NI	Northern Ireland
NIPSA	Northern Ireland Public Service Alliance

NI SCC	Northern Ireland Social Care Council
NISRA	Northern Ireland Statistics and Research Agency
NHS	National Health Service
NQSW	Newly Qualified Social Worker
ONS	Office of National Statistics
OP	Older People
OPSW	Older People Social Work
OSS	Office of Social Services
PIA	Pre-Interview Assessment
PSW	Principal Social Worker
QUB	Queens University Belfast
RAG	Red-Amber-Green
RCN	Royal College of Nursing
RCT	Residential Child Teams
SEHSCT	South Eastern Health and Social Care Trust
SHSCT	Southern Health and Social Care Trust
SPPG	Strategic Planning and Performance Group
SSW	Senior Social Worker
SUD	Service User Database
SWA	Social Work Assistant
UU	Ulster University
WHO	World Health Organisation
WHSCT	Western Health and Social Care Trust
WTE	Whole Time Equivalent

Caveat on data reported, ethics, governance, and quality assurance.

The quantitative data presented in this report was submitted by HSC Trust representatives as of either **28th February or 31st March**, and quality assured by Local Collaborators for Children's and Older Peoples Services across Northern Ireland. All the quantitative data presented in this Report was based on submissions by either HSC Trust representatives or Local Collaborators. Some gaps and data entry errors were identified following quality assurance, therefore 'sense checking' processes were engaged in with local collaborators and senior managers from HSC Trusts. These were corrected accordingly by the research Team. The data presented reflects each HSC Trust's *reported* position at the time of final data entry. Similarly, the qualitative analysis from interviews and focus groups was presented to Steering Groups and the Office of Social Services, Department of Health (DoH) Co-Chair group to ensure transparent reporting of the data.

Ethical and governance approvals were provided by Ulster University (reference FCASPS-23-007) and the five HSC Trusts in Northern Ireland (IRAS reference 325970).

Please Note: Professor Gavin Davidson, Queens University Belfast, is reporting separately on safer and effective staffing in Mental Health social work in Northern Ireland.

Please Note: At the point of data collection, between **28th February and 31st March**, agency staff were being phased out across all HSC Trusts, and being replaced by temporary or permanent contracts. References in the analysis about agency staff, therefore, must be read in this context. Agency social work staffing was permanently ended on 30th June 2023; therefore this aspect is no longer relevant.

Introduction

The issue of safe staffing in the Health and Social Care (HSC) sector has come to the fore because of recruitment and retention challenges, staff burnout, the impact of the COVID-19 pandemic, and exacerbated by the cost-of-living crisis, whereby those from areas of higher deprivation are at increased risk of statutory social work intervention (Bywaters et al., 2020; Limb, 2022; McFadden et al., 2015; McFadden et al., 2024a; McFadden et al., 2024b; Moriarty et al., 2018; Ravalier et al., 2022; The Guardian, Dec 2022; Vassilaki et al., 2022). The World Health Organisation (WHO) emphasises that safe staffing is not simply about the number of staff but also about having staff with required competencies equitably distributed and with support from the broader health system (WHO, 2016). Safe staffing should also mitigate burnout, workforce turnover and improve retention issues arising from workloads in excess of human capacity and highly stressed working environments (CIPD, 2022).

In the UK, various operational tools and policy guidance govern staffing in different HSC sectors. Adult social care, regulated by the Care Quality Commission, defines safe staffing through specific guidelines (Care Quality Commission, 2024). Nurses adhere to policy guidance and tools such as the care hours per patient day (CHPD) to determine safe staffing levels (Carter, 2016; Gianassi and Rudman, 2018), the Shelford Safer Nursing Care Tool (2013), RCN Toolkit for Older People's Wards (2012), Rhys Hearn (1970), the National Services Scotland Care Home Staffing Model (2009; as cited in Mitchell et al., 2017), and the Delivering Care Framework (2015) is similarly utilised in Northern Ireland. The Nursing and Midwifery Council underscores that safe staffing is not only about numbers but also skills-mix and considers other staff and settings (Nursing & Midwifery Council, 2016).

There are less developed operational tools and frameworks established on safe staffing in social work. In the Department of Health, Northern Ireland, Social Work Workforce Review (2022, Recommendation 2b), safe staffing is a priority area, with regional consistency in social work practitioner numbers a current focus of attention (Davidson et al., 2022). In Scotland, regulations for safe staffing are outlined in the Integrated Health and Social Care Workforce Plan (2019) and legislation is due to be enacted in Scotland in 2024 (The Health and Care Staffing; Scotland Act 2019). Intensive research in Scotland on social worker caseloads is available in the 'Setting the Bar' Report (Millar & Barrie, 2022) published by Social Work Scotland. The report estimates indicative workloads for Childrens' Services of no more than 15 cases (children) and for adults 20-25 cases per staff member. Experiences in the U.S. and

Finland suggest that numbers alone may not guarantee a safe service (Child Welfare Information Gateway; Yliruka et al., 2022) however, numbers provide a baseline of what is realistic before social workers experience burnout and reduction in wellbeing. For example, a children's services social worker, from the HSC Workforce Study during December to January 2022-2023 explains:

> *"Huge unmanageable caseloads and work demands that are impossible to meet within working times. Often don't have time to take breaks… it's an intense environment that has a significant impact on workers' physical and mental health"* (McFadden et al., 2023*b*, *p*.42).

In Northern Ireland, statutory functions, to a certain extent, define roles in Children's Services, Older People's Services, and Older People's Mental Health. Within Older People Social Work programmes of care, the workforce is facing increasing pressures with specific roles designated for safeguarding procedures on top of the introduction of the Mental Capacity Act (MCA). This adds further demands to social workers in the Older People's social work sector, specifically due to most MCA assessments being required for older people in relation to Deprivation of Liberty Safeguards (DoLS) which is the area of the MCA currently enacted (HSC Workforce Planning Strategy, 2016; Lynch et al., 2016; ONS, 2017). Safe staffing therefore extends beyond numbers, requiring equitable deployment, competencies, and systems support, with social work legislation and evidence-based practices needing further development. It is important to note that the pressures in social work are not isolated and are mirrored across the health and social care sector (NHS Workforce Plan, June 2023).

The UK NHS Workforce Plan (2023) sets out a 15-year strategy outlining a systemic, strategic direction to address workforce deficits, including plans to 'train, retain and reform' the NHS. This Workforce Plan involves growth in education and 'training' to provide additional staff by increasing accessible education pathways including apprenticeships. 'Retain' relates to improving the work culture and leadership in NHS organisations to retain current staff and bring workforce stability. 'Reform' addresses a drive to improve skills and productivity in the workforce with a strong emphasis on core deployable skills needed in an agile system.

An example of the ambition presented in the NHS Workforce Plan (2023) is the goal of increasing nursing training places by 40% over the next five years and to create an additional

170k nurses by 2036/7. The Plan has been criticised due to the lack of detail about 'how' the government will fund the growth as well as address infrastructure challenges. At the same time, the Workforce Plan has been welcomed because it recognises the need for workforce analysis providing detailed evidence on projected numbers. However, it has also been pointed out that projected numbers require independent review. Despite the criticisms and fiscal and infrastructure limitations, the NHS Workforce Plan goes some way to address criticism about a lack of workforce supply and demand analysis as noted in the House of Commons Report (House of Commons, 2021).

Social work is noticeable by its absence from the NHS Workforce Plan likely due to health and social care being less integrated in the UK than in NI. Notwithstanding, social work workforce planning can model its strategy on the 'train, retain and reform' logic. All these areas are covered by the conceptual framework in this report using a systemic conceptual model relating to workforce 'capacity (train and retain), communication (retain and reform) and connection (retain and reform). Retention strategies are critical for social work workforce stability, acknowledging the significance of recruitment not being the solution to a retention problem (McFadden, et al., 2024b)

The Northern Ireland Social Care Council (2022) argues that effective workforce planning is necessary for ensuring continued high quality and safe service delivery within the required regulatory Standards of Conduct and Practice in social work. The pressure on registered social workers does not lessen in periods of high pressure, and accountability to continue to deliver services to the highest standards remains at individual and organisational levels. Moral injury and moral distress are reported when social workers struggle to meet the demands of the service and is evidenced as a contributing factor to burnout (McFadden et al., 2015).

Williams and Vieyra (2018) stress the importance of professions undertaking regular workforce studies to inform the future directions, needs, and capacity of the profession. They argue that having comprehensive knowledge about the social work workforce can strengthen the position of the social work profession as core to the '*national, social, psychological, and health services development and delivery agenda*' (Williams & Vieyra, 2018, *p*. 4).

Aims

This Report is part of a wider study aiming to make evidence-based and empirically rigorous recommendations for safer staffing levels in social work and caseload management, to inform the development of Department of Health (DoH) guidance and policy on safer staffing for Social Work in Older People (OP) and Children's Services (CS).

Research Question: How can safe staffing levels be established for Children's and Older People's services in social work in Northern Ireland?

Methodology

Objectives

To address the research question above, the study has the following objectives:

1. To gather information on the scope of current social work and social work assistant posts in Older People's and Children's Services across Northern Ireland (NI).
2. To document overall average and range of caseload numbers at Team and Programme of Care level, funded establishment, social work activity, vacancies, and absence.
3. To examine governance structures in single disciplinary and multi-disciplinary Teams in Older People and Children's services.
4. To explore caseload weighting or measurement tools in use across NI in Older People and Children's Services.
5. To make recommendations (Report 2) on safer staffing levels needed in Older People's and Children's services in Northern Ireland to inform DoH guidance on safe staffing policy.

The study employed mixed methods:

a) Quantitative data collection on social work staffing levels at the Team and Trust level on workload distribution and social work activity in Children's and Older People's Social Work across all five health Trusts in Northern Ireland. The data was collected using the Qualtrics survey tool (Objectives 1, 2, 3, and 4).

b) Interviews with a purposive sample of front-line social workers in Children's and Older People's Social Work (Objectives 4 and 5).

c) Focus groups with front-line social workers and managers from Older People's and Children's services (Objective 3, 4 and 5).

The research design was iterative, and the methodology was developed as part of a co-production process with Local Collaborators and Steering Groups who contributed to and tested the survey questions, as well as providing input into the qualitative data collection.

Data Collection

Data for this report were collected using three different methods: an online survey completed at the Team level across the Trusts; one-to-one interviews with front-line social workers from Older People (n=10) and Children's Services (n=11) and twelve focus groups (n=2 x Steering Groups and n=10 front-line Teams from Children's and Older People's services).

Survey

The Qualtrics online survey tool was used to collect Team level information from managers. The data collected provided a top-level overview at a point in time (**either 28th February or 31st March 2023**) of staffing levels, vacancies, absence, workload, capacity, differences in workloads in relation to specialist roles, uni-disciplinary or multi-disciplinary governance structures, Assessed Year in Employment staff (AYE – those qualified less than a year), waiting lists and governance. The online Qualtrics survey was sent to the Local Collaborator (LC) at each HSC Trust for data to be inputted by Team managers and was submitted via Qualtrics on a pre-defined date for overall analysis by the research Team. The survey included opportunities to elaborate on specific questions such as:

- Does the total number of social workers (across all bands) and social work assistants PLUS vacancies in the Team correspond with the number of funded positions*?
- Have Teams in this programme of care developed caseload weighting approaches to manage workload demands and referrals?
- Do Teams in this programme of care use waiting lists?

***Note**: In the results section we acknowledge the variation in understanding about funded establishment, how this is financed, calculated, and operationalised.

Sample Profile

A total of 270 Teams responded to the survey. The majority of responses came from Children's Services (n = 190) followed by Older People's Social Work (n = 80; see Table 1). The five Trusts were anonymised using the letters A, B, C, D, and E.

Table 1: Team Level Survey Responses Across Trusts

Trust	Older People's Social Work	Children's Services	Total
A	15	49	64
B	18	38	56
C	17	39	56
D	17	33	50
E	13	31	44
Total	80	190	270

A further breakdown by Team types across services were as follows (see Table 2).

Please Note: Within this report, we did not present results for single Team types, or Teams with Team type data missing, or Teams who indicated that their Team Type was not captured by the survey question. Overall, there were 174 Teams analysed in Children's, and 75 Teams in Older People's Social Work

Table 2: Team Types Across Services

In which programme of care does your Team provide services?				
		Older People	Children's Services	Total
Which service area does this social work Team belong to?	Missing Data	1	3	4
	Older People Community Services	56	0	56
	Older People Hospital Services	5	0	5
	Older People Mental Health Services	10	0	10
	Adult Safeguarding Gateway Team	4	0	4
	Gateway or Single Point of Entry	0	20	20
	Family Intervention Teams	0	58	58
	Looked After Children	0	23	23
	14 Plus/16 Plus/18 Plus Teams	0	10	10
	Leaving Care/After Care	0	1	1
	Residential Child Teams	0	21	21
	Children with Disabilities	0	13	13
	Fostering	0	14	14
	Adoption	0	2	2
	Early Years	0	8	8
	Children's Court Services	0	2	2
	Family Centres	0	3	3
	Team not captured by these options	4	12	16
Total		80	190	270

Note: Within this report, we did not present results for the single Team types. Overall, there were 174 Teams analysed in Children's, and 75 Teams in Older People's Social Work.

Interviews

A total of twenty-one (21) individual interviews were conducted with a sample of front-line workers, (10 x Older People's Social Work and 11 x Children's Services) to gain an in-depth understanding on workload, activity analysis, time prioritisation and risk management. The interviews asked about working models currently used in HSC Trusts. Questions also focused on safe staffing related topics and workload.

Focus Groups

A total of 12 focus groups were conducted using a semi-structured framework to gain deeper insights into how staff in different services and with different levels of responsibility and experience conceptualised safe staffing, workload, and governance within their Team/Trust/Region. Focus group interviews included managers and Assistant Directors from OP and CS (1 x Older People and 1 x Children's Services). A further 10 x Team Level Focus groups (2 from each HSC Trust) with front-line social workers from (5 x OP and 5 x CS). Questions focused on safer staffing related topics and workload issues. Participants were recruited by their respective Local Collaborators. On the day of interview, all participants were informed that they would be referred to by pseudonyms in all accounts of analysis to protect their anonymity. Similarly, participants were informed that their respective Trust would also be anonymised.

Data Analysis

Quantitative survey data were analysed using SPSS 28. The analysis compiled in this report used exclusively descriptive statistics, specifically frequencies, and percentages. Some individual Team data pertaining to caseload numbers were missing and discrepancies were quality assured and corrected by Local Collaborators.

The data derived from Focus groups and interviews were analysed using a reflective thematic analysis approach based on Braun and Clarke's six phase framework (Braun & Clarke, 2012), because of its flexible methodology and potential to provide developed and detailed accounts of the data. After initial transcription by the interviewer, the data was subsequently analysed following an inductive approach outlined by Hayes (2021). The data underwent multiple readings for underlying meanings and patterns before the coding process was initiated. The interviewer began making notes and annotating ideas for coding. The subsequent phase of analysis involved coding, where the data was systematically organized into coherent groups,

resulting in an overall conceptualization of data patterns. The following steps involved categorising the existing codes into potential themes, with the assistance of mind-maps to create a thematic map containing candidate themes.

Following this stage, the themes were reviewed by the full research Team in relation to coded extracts to ensure that they accurately represented the data. Furthermore, the validity of individual themes was assessed concerning the entire dataset and whether the themes adequately captured the evident meanings in the complete dataset. During this phase, themes were further refined and redefined. Both the interview investigator along with their respective investigating Team (n=6 per programme of care) analysed the transcripts, coded extracts, and potential themes, resolving any disagreements in interpretation through consensus. The construction of themes primarily operated at a semantic level, acknowledging concepts directly conveyed by participants while also considering the possibility of latent concepts. The themes were organised into systems level data, beginning at individual levels, then Teams, organisation, and policy level overarching themes (Bronfenbrenner, 2000).

Results

Quantitative Data

Table 3 shows an overview of the social work Teams that submitted data about staffing and workloads and related questions, across all five HSC Trusts in 2023 (the five Trusts were anonymised using the letters A, B, C, D, and E). A total of 80 regional Older People Social Work Teams, mainly Community Teams, as well as some Hospital and Older People's Mental Health Teams, submitted data. A total of 190 regional Children's Services Teams also submitted data. The data came from Family Intervention, Gateway, Leaving and After Care (LAC), 14+ (including 16+) Teams, Adoption, Fostering, Children's Court Services, and Residential Children's Teams completed the survey. Not all Trusts submitted Residential Children's data or Adoption Team data. We present the data that was submitted.

Table 3: Team Level Survey Responses Across all 5 HSC Trusts Northern Ireland

Trust	Older People	Children's Services	Total
A	15	49	64
B	18	38	56
C	17	39	57
D	17	33	50
E	13	31	44
Total	80	190	270

Note: The five Trusts were anonymised using the letters A, B, C, D, and E.

Note: If Team type data was missing Team level analysis was not possible. After filtering these Teams out, the analysis presented in this report was based on 249 social work Teams - 174 Children's Teams and 75 Older People's Teams.

Qualitative Data

A total of twenty-one interviews with individual social workers were conducted related to safe staffing with a sample of front-line workers, (10 x OPSW and 11 x Children's Services). The interviews were used to gain an in-depth understanding on workload, activity analysis, time prioritisation and risk management. The interviews also included questions about existing workload/caseload modelling in Northern Ireland and explored working models currently used in HSC Trusts.

A total of twelve focus group interviews were conducted using a semi-structured framework to gain deeper insights into how staff in different services and with different levels of responsibility and experience conceptualised safe staffing, skill-mix, workload, and governance within their Team/Trust/Region. Focus group interviews included Steering Groups made up with managers and Assistant Directors from Older People's Social Work (OPSW) and Children's Services, Department of Health Northern Ireland (DoH NI), Unions, Northern Ireland Social Care Council (NI SCC), Strategic Planning and Performance Group (SPPG), and the British Association of Social Work Northern Ireland (BASW NI). Questions focused on safer staffing related topics and workload issues.

Please Note Basic Assumptions: In the Team level analysis on workload or caseloads, Steering Groups agreed that one case equals one child or older person rather than families or carers.

Demographic and Socio-economic Context

Central to any understanding of safe and effective social work is the demography of the population social workers serve (see Table 4). Based on the 2021 census, the total population of Northern Ireland is 1,895,510, a five per cent increase from 2011 (NISRA, 2022). In terms of age, there are 395,816 children under 16 – 20% of the total population, and 319,949 people 65 years or over (17%). Furthermore, since 2011, the largest increase in population has been in people over 65 with 62,800 more older people than in 2011 - a 24% increase (NISRA, 2022). There was also a small increase (3%) in the number of children under 16. However, within this group there was a decrease of 9% among the youngest age (0-4). Based on long term demographic analysis, NISRA predict that as the post-war generation ages, within the next ten years, there will be more people aged 65 and over, than children aged 0 to 14 years (NISRA, 2022).

The largest proportion of children under 16 (25%) and older people (27%) are in the Northern HSC Trust which serves the largest population. The Western Trust has the smallest population and the lowest proportion of children (17%) and older people (16%) (NISRA, 2023).

Table 4: Population of Children and Older People in NI by Trust

	Western	Northern	Southern	South Eastern	Belfast	NI totals
Children aged 0-15 years	65,477	97,761	89,719	73,105	69,754	395,816
Adults 65 years and older.	49,709	86,014	58,703	69,683	55,840	319,949
Total population	303,207	480,194	388,688	364,191	359,230	1,895,510

Northern Ireland has lower income inequality than the rest of the UK, this is largely because the highest incomes in the UK are higher than the highest incomes in Northern Ireland (House of Commons, 2023; Joseph Rowntree Foundation, 2022). According to the 2021 census the percentage of individuals living in relative poverty in NI was 17%. The percentage is higher for children at 22%. However, there are variations across HSC Trusts. The highest percentage of children (33%) and individuals (22%) living in relative poverty is in the Western Trust. This compares with the Belfast Trust where 14% of individuals and 21% of children are living in relative poverty (NISRA, 2023). From a health and social care perspective, these figures are worryingly high and demand for social work interventions are all the more critical. It is worth noting that poverty rates across the whole of a Trust area do not provide a recognition of the fact that those in areas of higher deprivation, within Trusts, may be experiencing very acute poverty which will mean that teams within Trusts will be serving very different populations. Additionally, and according to the Child Welfare Inequalities Project (CWIP; Bywaters et al., 2020), the rate of child welfare interventions was directly correlated to the socioeconomic status of people which could have a bearing on safe staffing in these areas.

Life expectancy also varies across HSC Trusts. While the regional life expectancy for men is 78.8 years and 82.6 for women, in the Belfast Trust the life expectancy is lower – 76.6 years for men and 81.2 for women (NISRA, 2023). The survey for this study recorded a total of 53,085 cases (see Table 5) across both Children's Services (CS) and Older People's Social work (OPSW), 34,426 in OPSW and 18,659 in Children's Services. The highest number of cases overall were reported in the Belfast Trust (BHSCT) and the lowest in the Northern Trust (NHSCT). For CS the lowest number was recorded in the Northern Trust and the highest in the South Eastern Trust (SEHSCT). For OPSW, the highest number of cases was recorded in the BHSCT and the lowest in the SHSCT. Caseload numbers reported in this survey therefore do not map onto Trust population – which is highest in the NHSCT, nor does it match indicators of deprivation which are highest in the WHSCT.

Table 5: Breakdown of Cases Reported in this Study by Trust

Reported Caseloads	Western Trust	Northern Trust	Southern Trust	South Eastern Trust	Belfast Trust	Total
Children's Services	3639	2833	4519	3861	3807	**18659**
Older People	6795	6481	6679	6459	8012	**34426**
Total	10434	9314	11198	10320	11819	**53085**

Also, of interest in the context of safe and effective social work staffing, is the demographic of the existing workforce. As of 28 November 2023, there were 6,583 social workers registered to practise in Northern Ireland across all programmes of care and in non-statutory settings (NISCC, 2023; see Table 6). The majority – 3,737 (57%) - of registered social workers are employed in HSC Trusts. The largest number of social workers is in the BHSCT (846) and the smallest in the SEHSCT (679). The NHSCT, with the highest population of children and people over 65, employs 779 social workers (see breakdown by Trust below). The number of social workers in each Trust therefore does not correspond with the population size, nor the number of cases reported in this study.

Table 6: Number of Registered Social Workers by Trust (NISCC)

HSCT Trust	Number of registered Social Workers
Belfast Health and Social Care Trust	846
Northern Health and Social Care Trust	779
Western Health and Social Care Trust	744
Southern Health and Social Care Trust	689
South Eastern Health and Social Care Trust	679

The social work workforce is overwhelmingly female: 84% of all NISCC registrants were female according to the 2022 Department of Health study of the future workforce (DoH, 2022). In terms of issues related to safe staffing around well-being, care, and burnout, it is the gendered nature of the social work workforce that is notable given the "double or triple burden" many working women carry (Hochschild, 2002; Griffin, 2017).

Key Concepts of Safer and Effective Social Work

Three concepts of Capacity, Communication and Connection emerged from the analysis of the qualitative data as well as ten governing principles (see Figure 1 below). The concepts and governing principles and definition of safer and effective staffing in social work, inform a conceptual framework which will be the basis of recommendations in Report 2. The qualitative findings from Focus groups and interviews are across systems level and provide in-depth analysis from the social worker and Teams perspective.

Three inter-related and overarching concepts underline the need to promote a safer and more effective work environment for social workers. The concepts have been developed to ensure services are both safer and more effective for service users, carers, and their families, while promoting workforce retention through workforce wellbeing and support. The three concepts are identified as three 'Cs', namely Capacity, Communication, and Connection.

Capacity: This means time to complete all aspects of the job within the parameters of working time available.

The concept of capacity centres firstly on having sufficient staffing resources, through competent workforce planning with an agreed funded establishment to meet the needs of the service. Capacity therefore refers to individuals and Teams, having realistic time available within the working day to meet the demands and responsibilities associated with the social work role and tasks. 'Time available' includes individual social worker time and Team capacity, skill mix, administrative support, and peer and supervisory support. Capacity also requires workloads (all aspects of time needed for the role) and caseloads (service user specific aspects of the role) to be distributed across Team members based on transparency, equity, fairness, skills, knowledge, and experience.

Capacity might mean the Team needs to use waiting lists, so they are not overwhelmed with new referrals. Waiting lists (unallocated cases) are typically only used as a last resort if the workload and caseload volume are beyond Team capacity. Waiting lists require clear management arrangements, overseen by senior managers using a good governance approach and review process to minimise risk to service users, carers, and families. Acknowledgment is also needed about the wellbeing impact on social work staff in the longer term, if the situation

deteriorates for those on waiting lists, requiring crises intervention through Duty Intake workers. We have seen that waiting lists often mask the overall pressure on Teams and therefore it is not recommended as a longer-term solution.

In Northern Ireland, a useful model for good governance and management of waiting lists and unallocated cases are the Service User Data Based (SUD) from Older People Social Work in BHSCT. This SUD approach captures service user identifiers, for example, PARIS ID, name and address, review type, date of review, due date of next review, case risk rating, funding type, hours contracting, date and due date of monitoring visit and staff alignment. The Service User Database (SUD) is a record of overall service users on the database that are Red, Amber, Green (RAG) rated, according to priority. The Collaborative Unallocated Process (CUP), developed in the SEHSCT, enables managers to screen new and unallocated caseloads in Children's Services. The BHSCT piloted a combined SUD and CUP model in Older People's Social Work which promotes a standardised approach, identification of risk within allocated and unallocated caseloads, and enables a planned approach to completion of care reviews and monitoring visits, captures levels of vacant caseloads, and provides governance and management oversight using the monthly dashboard report. See brief overview of SUD model in Appendix 7a.

In SHSCT Older People's services, a model 'Safer and Transparent (SaT) Caseloads' model was integrated within PARIS (with potential to move to Encompass) and uses a RAG rating approach (red, amber, green) and focuses solely on the number of 'active' cases at any given time within the entire caseload. Intervention is determined not only on complexity, but consideration of priority, level of urgency, statutory obligations, and assessed risk levels. There are two broad categories, including active and review cases. The model gives managers oversight of the pressures in 'real time' and an ability to escalate this information to senior managers. Having a digital solution in PARIS, enables this approach to avoid a slow bureaucratic process, allowing time in supervision for other important areas of case management to be discussed. See brief overview of SaT in the Appendix 7b and contact details in Appendix 5 Safe Staffing Event Presentations.

Communication: This refers to open and transparent communication with social workers about workload allocation, ensuring that principles of equity, fairness, and trust underpin the workplace culture.

Good communication should be a policy objective at Team and organisational levels, as this fosters trust, not just in colleagues at Team level, but also in senior managers and the wider organisation. Communication should be seen as a multiple directional commitment from social workers with peers in Teams, with supervisors and senior managers - so that there is bottom up, top down and lateral flow. Teams whose culture is supportive and nurturing of all colleagues, including early career social workers (our future workforce), report feelings of 'safety' and having a sense of 'shared risk' (with colleagues, managers, and the wider organisation) rather than individual risk, which tends to cause burnout and result in 'intentions to leave' (McFadden, 2018). Relationships, therefore, are critical to safer and more stable Teams. Research shows that both organisational and professional commitment were strong retention factors for social workers and so should be nurtured (McFadden, et al., 2015).

Effective communication about workload and caseloads enables staff to be realistic about time needed for all aspects of work and to meet the demands of the job. This links back to the concept of 'capacity' at both individual and Team level, including having the right levels of skills and experience within Teams. To foster trust, openness, transparency, equity, and fairness, one possible mechanism to use could be a 'caseload whiteboard'. The whiteboard would record an overview of Team names (not service user names) and fluid caseload demands (acknowledging that these can change rapidly) and provide a visible method of both developing an agile Team level response in real time whilst developing collegiality by showing if a Team member is 'visibly' over-burdened with higher than manageable levels of higher risk work. The whiteboard approach could be used with a digital solution such as Encompass or a manual whiteboard approach whilst waiting for a digital solution.

This method may be referred to as collective allocation management or 'Teaming', whereby a Team examines overall priority and capacity, informing the allocation process with the correct skill and experience needed to respond (Cuomo, 2010; McFadden et al., 2024a). While Teaming suggests a whole Team approach to caseloads, this does not mean that individual workers will not have their own cases. Teaming can be used when there are highly complex cases, needing Team level discussion, support, prioritisation, and intervention. This aims to both support the key worker usually assigned to the case and the service recipient, so that they can get effective interventions in a timely manner, with the highest standards of care.

Connection: This conceptualises the need for positive connection through relationships with individuals and Teams so that workers feel connected to each other, management, and the wider organisation.

The concept of connection underpins the need for positive functional relationships with co-workers, supervisors, managers, and the wider organisation. Positive relationships within a confident organisational culture and climate is one of the main buffers to counter burnout risk and maintaining retention at work (McFadden, 2018). As discussed previously in relation to communication, connection requires open and honest communication, teamwork, camaraderie, collective and compassionate leadership. The 'Social Work Leadership Framework' (DoH, 2022) outlines the need to recognise that leadership behaviours and attitudes influence all levels of social work practice from front-line workers to Team leaders and into senior management. The Framework also outlines how leadership responsibilities nurture a compassionate culture in the planning and delivery of services for social work recipients.

> *"Compassionate leadership involves a focus on relationships through careful listening to, understanding, empathising with and supporting other people, enabling those we lead to feel valued, respected and cared for, so they can reach their potential and do their best work. There is clear evidence that compassionate leadership results in more engaged and motivated staff with high levels of wellbeing, which in turn results in high-quality care."* (West, 2021).

Our qualitative analysis provides evidence that a culture and climate of care supports staff wellbeing while ensuring the highest standards of care for service users, carers, and families. A positive example of Team efforts to promote a caring climate involves 'daily huddles', or 'Teaming', so that Team members can connect in an agile and responsive way to support colleagues in times of unforeseen emergency or set of emergencies in the work of the wider Team. These 'huddles' are a daily 'checking in' mechanism between team members, so that workers feel that they are not alone with risk, and instead a 'shared risk' which is authentic, value based, and the *modus operandi*. Peer, supervisor, and management support develops a feeling of camaraderie and was associated with retention and wellbeing at work (McFadden et al, 2023b). These elements of organisational culture - placing staff wellbeing at the centre of dynamics and engendering collective responsibility throughout the organisation - are crucial components of safer staffing.

The ‘Three C’s’ headings are compatible with the logic (recruit, retain and reform) of the wider NHS Workforce Plan (2023). Capacity is the foremost conceptual driver in the findings together with Communication and Connection, all of which are inter-connected and are essential components of safer and effective staffing in social work.

Note: Report 2 will provide further analysis on these key concepts and how they apply to metrics for safe staffing workloads.

Defining Safer and Effective Social Work

A definition of safer and effective social work has not existed prior to this research study anywhere in the available literature scoped as part of the project (McFadden et al 2024a). The definition below has evolved from the analysis of interviews with front-line social workers and focus groups with social work Teams and Steering Groups from Children’s and Older People’s Social Work (consisting of senior HSC Trust managers, SPPG, Department of Health, NI SCC, British Association of Social Workers, and Trade Unions). This is therefore a definition based on the voice of the workforce and relevant stakeholder perspectives (McFadden et al., 2023). See page 20, Figure 2, for Safer and Effective Staffing in Social Work Poster.

> Safer and Effective Staffing in social work requires having enough staff with the right knowledge, experience and skills, workload capacity, and flexibility, to respond to service user needs in an efficient, effective, and timely manner. Safer staffing requires regular supportive, reflective supervision and sufficient time to deliver the highest standards of care. This includes having effective and compassionate line management and a supportive Team with adequate skill mix and knowledge to support the wellbeing of all Team members, in particular, early career social workers.

Ten Principles of Safer Staffing in Social Work

These principles were developed from the analysis of interviews with front-line social workers and focus groups with Children's and Older People's Social Work, as well as with the Steering Groups mentioned above.

Figure 1: Ten Principles of Safer and Effective Social Work

The underpinning principles noted in this definition of safe staffing in social work includes the following:

1. Funding adequate workforce capacity
2. Team and individual social worker workload within capacity ensuring trust, integrity, transparency, fairness, and equity in workload allocation
3. Skill-mix, knowledge, and experience
4. Compassionate and effective leadership
5. Staff wellbeing and psychological safety
6. Team camaraderie and support

7. Good governance, including corporate governance, supervision and waiting list management
8. Efficient and effective social work interventions which meet NI SCC Standards of Conduct and Practice
9. Regular review of workload during supervision
10. Closure of cases in a timely manner

Please Note Basic Workload Assumptions: It is important to distinguish workload and caseload. Workload includes all areas of the social work role, including Duty Intake, mandatory training, professional meetings, and anything outside of specific casework. Caseload is all work related to service users and families, including all parts of the social work process from assessment, planning, intervention, review, and evaluation (see Appendix 6 Whole Time Equivalent (WTE) annual non-case-related workload hours overview).

Safer and Effective Staffing in social work

Safer and Effective Staffing in social work requires having enough staff with the right knowledge, experience and skills, workload capacity and flexibility, to respond to service user needs in an efficient, effective and timely manner. Safer staffing requires regular supportive, reflective supervision and sufficient time to deliver the highest standards of care. This includes having effective and compassionate line management and a supportive team with adequate skill mix and knowledge to support the wellbeing of all team members, in particular, early career social workers. *(McFadden et al 2024)*

Principles

Principle 1
Workforce Capacity
Funding adequate workforce capacity

Principle 2
Workload within Capacity
Team and individual social worker workload within capacity ensuring trust, integrity, transparency, fairness and equity

Principle 3
Skill-mix
Skill-mix, knowledge and experience

Principle 4
Compassionate Leadership
Compassionate and effective leadership

Principle 5
Wellbeing
Staff wellbeing and psychological safety

Principle 6
Camaraderie
Team camaraderie and support

Principal 7
Governance
Good governance including corporate governance, supervision and waiting list management

Principle 8
Interventions
Timely flexible efficient and effective social work interventions in line with professional Codes of Conduct as set by Northern Ireland Social Care Council

Principle 9
Regular Review
Regular review of workloads during supervision

Principle 10
Closure
Closure of cases in a timely manner

Key Concept 1
Capacity
Principles 1, 2, 3, 7, 8, 9, 10

This means time to complete all aspects of the job within the parameters of working time available and having enough staff to meet the demands of service user needs in line with professional Codes of Conduct as set by Northern Ireland Social Care Council.

Key Concept 2
Communication
Principles 2, 4, 5, 6, 7, 8, 9, 10 (multi-directional from front line social workers to managers and the wider organisation)

This refers to open and transparent multi-directional communication between social workers and managers about workload allocation, ensuring that principles of equity, fairness and trust underpin the workplace culture.

Key Concept 3
Connection
Principles 3, 4, 5, 6, 7, 8, 9

This conceptualises the need for positive connection through relationships with individuals and teams so that workers feel connected to each other, management, the wider organisation and the social work profession.

Ulster University · Queen's University Belfast · Department of Health · HSC Belfast Health and Social Care Trust · HSC Northern Health and Social Care Trust · HSC Southern Health and Social Care Trust · HSC South Eastern Health and Social Care Trust · HSC Western Health and Social Care Trust

Specialist Roles and Caseloads

The analysis of the data collected through the team level survey (individual Teams are units of assessment), gives a top-level overview of differences in workloads in relation to staff with specialist roles. It should be noted that not all staff with specialist roles require workload easement, for example, Investigating Officers, Pre-Interview Assessment or Achieving Best Evidence Interviewers. Specifically, the survey asked whether social workers providing specialist roles had lower caseloads than those without specialist roles (such as Approved Social Worker; Designated Adult Protection Officer; Investigating Officer; Senior Social Work Practitioners; Senior Social Workers (SSWs) (Steering groups advised, if there were two SSWs in the same team one had a caseload and one did not); Pre-Interview Assessment (PIA) or Achieving Best Evidence (ABE) interviewers; specialist assessment or others). The results conclusively demonstrate that there is no easement of caseloads for social workers with specialist roles. For example, over 75% of the OPSW Community Social Work Teams reported that specialist social workers did not have lower caseloads. In Children's Services, Family Intervention Teams, only one Team indicated that those with specialist roles had caseload easement. Similarly, less than 10% of LAC Teams reported lower caseloads for staff with specialist roles. Children with Disabilities Teams report no workload easement for specialist roles regionally. For more detailed data on specialist roles at the service level see Quantitative Findings within Children's and Older People Services.

Caseload ratios

The issue of caseload ratio is central to any consideration of safe and effective social work. As indicated above, policies and guidelines to support safe staffing usually start from a baseline of what is considered a reasonable number of cases, depending on the type of social work and service user needs. Therefore, central to the data analysis for this study is establishing an empirically informed figure on what current caseload ratios are. The components which will inform conclusions and recommendations in Report 2, include qualitative interviews, and focus groups with front line workers and Teams and Steering Groups, as well as evidence from literature. Metrics to establish safe workloads will also include analysis based on the role and tasks for social workers in a range of Teams from OPSW and Children's Services.

Based on the data from the survey, an overall staff to caseload ratio for each Team type across Trusts has been calculated and presented regionally. In most Trusts, workload pressures in both Children's Services and OPSW were reflected in the use of waiting lists to keep caseload

numbers down. However, qualitative data reveals that work arising using waiting lists, eventually returns to the social workers through Duty Intake. Duty intake is a feature across all social work teams. Models of how that is operationalised may vary but the system provides an available social worker to deal with issues as they arise through the intake system. The data from the focus groups and interviews indicates that by the time a case comes to the attention of Duty Intake, service user circumstances and situations are likely to have changed and become more complex. Therefore, the use of waiting lists may act as a 'holding' mechanism to stem the flow of referrals and act as a protection to not overwhelm social workers with the true volume of work in the short term but may increase the volume and intensity of work over the longer term as cases increase in complexity. Use of waiting lists might also mask the true service user demand required in the provision of Children's Services and OPSW (see Appendix 1a and 1b).

In this way, in the calculations of caseload ratios presented, the analysis combines 'allocated' and 'unallocated' cases to show a true level of direct and indirect work for Teams. The analysis also takes account of the current practice of waiting lists, which includes the scenario of ratios that consist of current unallocated cases. Whilst this analysis represents a point in time (28th February and 31st March 2023), a full picture of cases is essential to estimate future safe staffing workload and workforce requirements considering roles and tasks for social workers across programs of care as well as demographic changes and population estimates (NISRA, 2022).

Administrative support

Given the pressures on the social work workforce and the increasing demands, the role of administrators is crucial to support social workers to managing workload. In his report, Ray Jones notes the increased administrative burden on social work and recommends enhancing the skills-mix in Teams by increasing the number of administrative posts (Jones, 2023). Within this context, the small number of administrative staff reported across both CS and OPSW is notable, with some Trusts reporting no administrative Band 2 in CS Teams (see Table 7).

Table 7: Children's Services Administration Support Regionally

Teams	*N*	Band 2 Support	Band 3 Support
Family Intervention	58	2.5	33.8
Children with Disabilities	13	0.5	15.5
Gateway Teams	20	6.5	14.5
Looked After Children	23	5	24.5
Fostering	14	1	10
Early Years	8	7.2	10
Residential Child	21	21	43
Family Centres	3	0	4
Children's Court Services	2	0	2
Adoption	2	0	2
14+	10	1	10

Reported data as of 28th February and 31st March 2023

Administrative support was also inconsistently reported in Older People's Social Work, with some Trusts reporting no administrative Band 2 posts in their Community Teams (see Table 8 below).

Table 8: Older People's Social Work Administration Support Regionally

Teams	*N*	Band 2 Support	Band 3 Support
Community	56	12.5	63
Mental Health	10	0	8
Hospital	6	8	4

Reported data as of 28th February and 31st March 2023; Other Team types not included due to small numbers of return

Supervision

Children's Services

Munro (2010) describes supervision as a 'core mechanism for helping social workers reflect on the understanding they are forming of the family, their emotional response, and whether this is adversely affecting their reasoning, and for making decisions' (Munro, 2010 *p*. 53). The significance of reflective supervision in social work practice is widely acknowledged within the profession and in policy (Department of Health, Social Work (NI) Supervision Policy, 2024; Ravalier et al., 2023). Various stakeholders, including policymakers, managers, practitioners, and academics, recognise that effective supervision is a crucial component for ensuring the high quality of social work practice (Bashirinia, 2013; Beddoe et al., 2015). Positive formal and informal supervision also emerged in the qualitative data as a key element of safe staffing and overall Team wellbeing. In this regard, the data reported was relatively positive, indicating that monthly supervision is the norm and with many Teams – particularly in Children's Services – also reporting regular peer group supervision.

Detailed below (see Table 9) is a breakdown of reported Team participation in supervision and group supervision on a regional basis within Children's Services. Most Teams had supervision monthly. Just over half of Teams regionally received group supervision, of which peer supervision was the most reported. There were variations in the frequency of group supervision reported with the most common being monthly. For a further breakdown of supervision by Team type please see Quantitative Findings within Children's Services of this report.

Table 9: Children's Services Supervision Support Regionally

Supervision Frequency	***n =174***	**%**
- Monthly	172	98.9%
- 6 Weekly	2	1.1%
- Twice Monthly	-	-
Group Supervision	n=96	55.2%
- Peer level	71	74.0%
- Specialist	6	6.3%
- Both (Peer & Specialist	13	13.5%
- Other	6	6.3%
Group Supervision Frequency		
- Monthly	38	39.6%
- Every 2 Months	8	8.3%
- 4 Times a Year	24	25.0%
- Other	12	12.5%
- Not Reported	14	14.6%

Reported data as of 28th February and 31st March 2023

Older People's Social Work

As noted above, the importance of supervision in the field of social work is widely recognized by professionals across the spectrum. Detailed below (see Table 10) is a breakdown of reported Team participation in supervision and group supervision on a regional basis within OPSW. Most Teams had supervision once a month. Just over a third of Teams regionally received group supervision, of which supervision at peer level was the most common. There were some variations reported in the frequency of group supervision, with the most common being "other". For a further breakdown of supervision by Team type please see Quantitative Findings within Children's Services of this report.

Table 10: Older People's Social Work Supervision Support Regionally

Supervision Frequency	***n =75***	**%**
- Monthly	52	65%
- 6 Weekly	12	15%
- Twice Monthly	6	8%
- Less than these options	10	12%
Group Supervision	n=30	38%
- Peer level	26	87%
- Specialist	0	0%
- Both (Peer & Specialist)	3	10%
- Other	1	3%
Group Supervision Frequency		
- Monthly	9	30%
- Every 2 Months	6	20%
- 4 Times a Year	4	13%
- Other	11	37%
- Not Reported	14	14.6%

Reported data as of 28th February and 31st March 2023

Funded Establishment

Children's Services

The size of the workforce is measured in Whole Time Equivalent (WTE) staff in post and the WTE of funded vacancies. When asked if the total number of social workers (across all Bands) and social work assistants plus vacancies in the Teams correspond with the number of Funded Establishment (FE) positions, responses were variable (see Table 11): Regionally, 32 Teams (18.4%) indicated that the numbers of staff did not add up to the Funded Establishment (FE); Eighty-two (82; 47.1%) Teams indicated that the numbers were equivalent to their Funded Establishment, and 60 (34.5%) Teams did not answer this question (see FE quotes in Appendix 4). In general, comments indicate that 32 Teams were operating below Funded Establishment. Qualitative data across the region indicate that a review of Funded Establishment has not taken place for at least 10 years.

It is important to note that there wasn't regional consistency in the understanding about how Funded Establishment is calculated, therefore responses need to be interpreted with caution. It is, however, important to note that responses indicate a lack of workforce planning calculations in at least a decade or longer.

Table 11: Funded Establishment Regionally (Children's Services)

Teams	*Do the total number of social workers (across all Bands) and social work assistants plus vacancies in the Teams correspond with the number of Funded Establishment?*		
	Yes (*n*)	**No (*n*)**	**Did not answer (*n*)**
Family Intervention (*n*=58)	26	10	22
Children with Disabilities (*n*=13)	10	1	2
Gateway (*n*=20)	6	5	9
Looked After Children (*n*=23)	10	5	8
Fostering (*n*=14)	8	2	4
Early Years (*n*=8)	5	1	2
Residential Child (*n*=21)	10	6	5
Family Centres (*n*=3)	1	1	1
Children's Court Services (*n*=2)	-	1	1
Adoption (*n*=2)	1	-	1
14+ / 16+ (*n*=10)	5	-	5
Total (*n*=174)	**82**	**32**	**60**

Reported data as of 28th February and 31st March 2023

Older People's Social Work

When asked if the total number of social workers (across all Bands) and social work assistants plus vacancies in the Teams correspond with the number of Funded Establishment positions, responses were variable (see Table 12): Regionally, 12 Teams (16.7%) indicated that the numbers of staff did not add up to the Funded Establishment (FE); 51 (70.8%) Teams indicated that the numbers were equivalent to their Funded Establishment, and nine (12.5%) Teams did not answer this question (see FE quotes in Appendix 4). In general, comments indicate that two-thirds of Teams were operating in line with their Funded Establishment. Qualitative data across the region indicate that a review of Funded Establishment has not taken place in at least ten years or longer.

Table 12: Funded Establishment Regionally (Older People's Social Work)

Teams	*Do the total number of social workers (across all Bands) and social work assistants plus vacancies in the Teams correspond with the number of Funded Establishment?*		
	Yes (*n*)	**No (*n*)**	**Did not answer (*n*)**
Community (*n*=56)	41	8	7
Mental Health (*n*=10)	5	3	2
Hospital (*n*=6)	5	1	-
Adult safeguarding/Gateway	2	1	1
Total (*n*=72)	**53**	**13**	**10**

Reported data as of 28th February and 31st March 2023

Waiting Lists and Governance

Children's Services

A total number of 109 (62.6%) Teams indicated using waiting lists within Children's Services regionally (see Table 13). A range of methods for managing risk and governance of waiting list were shared in qualitative responses. Management oversight and Duty Intake were the primary means of managing waiting lists. One example of a management structure to manage waiting lists is the Collaborative Unallocated Process (CUP; SEHSCT), whereby a panel of managers oversee and allocate cases on the waiting list according to priority and capacity (see Appendix 7a/7b for other governance and management examples). It is important to note that the interview and focus group data suggests that waiting lists only serve as a delay mechanism to protect social workers from being overwhelmed with true levels of service demand. Duty Intake social workers often deal with escalated risk in cases presenting for support which might have been avoided if earlier intervention and prevention social work had been available at the point of referral.

Table 13: Waiting lists and Governance Regionally (Children's Services)

Teams	*Do Teams in this program of care use waiting lists?*	*How is risk and governance around waiting lists managed?*
	Yes (%)	
Family Intervention (*n*=58)	49 (84.5%)	*Managed and governed by Team Leaders, Senior Managers, and Senior Social Workers & Collaborative Unallocated Processes (CUP)*
Children with Disabilities (*n*=13)	12 (92.3%)	*Team Leaders, Senior Managers, and Senior Social Workers through the duty system at weekly or monthly meetings. Within Trust 'E', a Team indicated rag-rating (Red Amber Green) unallocated cases based on level of need. This was defined either a priority level 1, 2, or 3.*
Gateway (*n*=20)	19 (95.0%)	*Line Managers, Team Leaders, Senior Managers, and Senior Social Workers through the duty system daily.*
Looked After Children (*n*=23)	2 (8.7%)	*Team Leaders, and Senior Management, through the duty system at weekly or monthly meetings. Within Trust 'E', some Teams indicated utilising a transfer list for moving from family support services to LAC services to manage waiting lists.*
Fostering (*n*=14)	7 (50.0%)	*Line Managers, and Senior Social Workers, at weekly or monthly meetings. Within Trust 'B', some Teams indicated that waiting lists are for individuals or couples to undertake fostering or adoption assessments.*
Early Years (*n*=8)	5 (62.5%)	*Regional procedures, at weekly or monthly meetings.*
Residential Child (*n*=21)	7 (33.3%)	*Trust Resource Panel and at Head of Service level*
Family Centres (*n*=3)	1 (33.3%)	*Regular meetings/discussions to prioritise families on waiting lists.*
Children's Court Services (*n*=2)	2 (100%)	*Monthly meetings/discussions to prioritise those on waiting lists.*
Adoption (*n*=2)	2 (100%)	*Team Leaders who export unallocated cases monthly to Senior Managers or Head of Service*
14+ / 16+ (*n*=10)	3 (30.0%)	*Not described*
Total (*n*=174)	**109 (62.6%)**	

Older People's Social Work

A total number of 46 (61.3%) Teams indicated using waiting lists within OPSW regionally (see Table 14). A range of methods for managing risk and governance of waiting lists was shared (see quotes below) in qualitative responses. An example of an approach used in BHSCT is the Service User Database (SUD) which was influenced by the CUP Model used in SEHSCT for Children's Services waiting list management. This shows that management oversight and Duty Intake were the primary means of managing waiting lists. The interview and focus group data suggests that waiting lists often serve as a delay mechanism to protect social workers from being overwhelmed with true levels of service demand. Duty Intake social workers regularly

deal with escalated risk in cases presenting for support which might have been avoided if earlier intervention and prevention social work had been available at the point of referral.

Table 14: Waiting lists and Governance Regionally (Older People's Social Work)

Teams	*Do Teams in this program of care use waiting lists?*	*How is risk and governance around waiting lists managed?*
	Yes (%)	
Community (*n*=56)	38 (67.9%)	*Governance and management of waiting lists included review by senior managers, forms of RAG rating, standard operating procedures for referral, and weekly and bi-weekly senior social worker review*
Mental Health (*n*=10)	6 (60.0%)	*Managed through a variety of governance measures including weekly management review, urgent referrals and medical review*
Hospital (*n*=6)	1 (16.7%)	*Not described*
Adult Safeguarding (*n*=3)	1 (33.3%)	*Not described*
Total (*n*=75)	**46 (61.3%)**	

Caseload Weighting Approaches

Children's Services

When asked '*Have Teams in this program of care developed caseload weighting approaches to manage workload demands and referrals?'* 74 Teams regionally (42.5%) responded 'yes', they have used caseload weighting approaches (see Table 15). However, only one Team provided a description of what this approach may have looked like, whereas some Teams suggested that there was a caseload weighting approach in place, but not in use:

> *'Caseload weighing has been previously implemented however this has taken a standstill due to staffing issues and resources and Teams having to take a generic approach in priorities i.e. child protection and looked after children's cases'* (Trust C).

> *'Across the service there is a caseload weighting model however it is not being used fully given current demands, pressures and the implementation of the BCP (Balanced Caseload Process)'* (Trust D).

Varied comments were provided in qualitative data about caseload weighting but often cited as difficult to implement in the face of ongoing service pressures and reductionist approaches to numerical point systems that were considered unhelpful by staff (see Appendix 3 for further quotes).

Table 15: Caseload Weighting Approaches Regionally (Children's Services)

Teams	*Have Teams developed caseload weighting approaches?*	*Description of Caseload Weighting Approach*
	Yes (%)	
Family Intervention (*n*=58)	33 (56.9%)	*Not described*
Children with Disabilities (*n*=13)	8 (61.5%)	*Not described*
Gateway (*n*=20)	2 (20.0%	*Not described.*
Looked After Children (*n*=23)	10 (43.5%)	*Not described*
Fostering (*n*=14)	5 (35.7%)	*Not described*
Early Years (*n*=8)	5 (62.5%)	*Not described*
Residential Child (*n*=21)	6 (17.9%)	*Not described*
Family Centres (*n*=3)	0 (0%)	-
Children's Court Services (*n*=2)	0 (0%)	-
Adoption (*n*=2)	2 (100%)	*Two hours was equal to one point regardless of complexity*
14+ / 16+ (*n*=10)	3 (30.0%)	*Not described*
Total (*n=1*74)	**74 (42.5%)**	

Older People's Social Work

When asked '*Have Teams in this program of care developed caseload weighting approaches to manage workload demands and referrals?'* 30 Teams regionally (48.2%) responded 'yes', they have used caseload weighting approaches. Only a few Teams provided a description of what these approaches looked like. The data provides insight into the operation of weighting processes including criticism of limitations which can be time consuming and not uniformly helpful. Other comments indicate the use of RAG-rating (red, amber, green) as a means of prioritising workload. There are a range of examples across Trusts, which have similarities in relation to categories of priority such as 1, 2, 3 or Red, Amber, Green. Each Trust is independently using a common approach to caseload weighting and gaining an overview of cases at Team level and worker caseload levels. Comments also show that methods used to measure workload pressures inform escalation of workload pressures to the Strategic Performance and Planning Group (SPPG) (see comments in Table 16 below and Appendix 3).

Notably, Trust structures for OPSW vary regionally. For example, one Trust (Trust E) has a Mental Capacity Act (MCA) Team, which alleviates the MCA work from Older People

Community Teams. Also, some Trusts have permanency Teams, which oversee Older People in residential or nursing care. Some Trusts also have a Duty Social Worker as a permanent post, supported by a social care worker (or social work assistant). These initiatives are worthy of consideration across Trusts and would usefully be evaluated in another Phase of the Safe Staffing Project. Another observation is that social care workers (or social work assistants) are available through permanent contracts, bank staff, and agencies, which provides some support to Teams under pressure.

Table 16: Caseload Weighting Approaches Regionally (Older People's Social Work)

Teams	Have Teams developed caseload weighting approaches?	Description of Caseload Weighting Approach
	Yes (%)	
Community (*n*=56)	27 (48.2%)	*Standard Operating Procedures - Referral Management Process:* *• An emergency referral (P1) for assessment will start on the same day as receipt of referral.* *• An urgent referral (P2) - assessment will commence within three days.* *• A routine referral (P3) - assessment will start within four weeks.* *Grading model for complexity reviewed monthly, RAG, and referral procedures.* *There is a developed Case Load weighting tool for PCOP based on a 1,2,3 grading system of complexity. This exercise is carried out monthly. This model assists the SW Manager in the allocation role and in ensuring governance around staff caseload numbers. this also assist with the regular cleansing of caseloads.* *It is also a transparent tool that all staff can see and is used to ensure fairness and equity across the Team surrounding the allocation of daily work.* *Caseload weighting tool utilized. Focuses solely on number of active cases at any given time within an entire caseload. Intervention is determined not only on complexity but consideration of priority, level of urgency, statutory obligations and assess risk levels.* *Yes - but it needs updated to reflect the ongoing changes re: case complexity etc. because of new statutory requirements resulting from work such as MCA etc.* *Monthly reporting to SPPG re: unallocated and vacant caseloads.*
Mental Health (*n*=10)	3 (30.0%)	*Based on point allocation for complexity/risk /frequency of contact with client and family/carer.*
Hospital (*n*=6)	0 (0%	*This is a challenge as the work is fast paced. (Hospital) (Trust A)*
Adult Safeguarding (*n*=3)	0 (0%)	-
Total (*n=75*)	**30 (40.0%)**	

Vacancies and Implications

Children's Services

Within Children's Services regionally HSC Trusts reported to the research team (174 Teams), there were 146 empty posts, the majority of which were within FIT Teams (see Table 17). There were also 22 vacancies related to maternity leave across this service regionally. There were 37 vacancies related to sick leave regionally, and 16 vacancies were related to either 'other' or 'missing data'. Overall, there were 220 vacancies reported within the 174 Teams analysed for this report regionally.

Please Note: We are aware that the Social Workforce Implementation Board is developing data capability across social work services in response to recognising issues about data quality.

Implications

When there are vacant posts, Teams need to manage risk across uncovered caseloads and prioritise the risk levels across caseloads. Affected Teams utilise manager level overview of uncovered caseloads to prioritise risk and have a Duty Intake worker assigned to prioritise key tasks. In some examples, a social care worker (or social work assistant) supports Duty Intake, and this system manages incoming priority social work tasks. Continuation of vacancies in the longer term, can create ongoing problems and a vicious cycle of risk management and crises intervention with a reduction in the ability to have processes for early intervention and prevention. In other sections of this report we acknowledge the development of systems for management and governance of waiting lists and workload pressures across HSC Trusts (CUP; SUD; and SaT, see *p*.14).

Table 17: Unfilled Posts Regionally (Children's Services)

Team (*n*)	Empty posts	Maternity leave	Sickness	Other	Missing	Total (% Unfilled)
FIT (58)	55.5	4	6.5	2	5.6	73.6 (22.4%)
CwD (13)	12	2.5	2	0	0	16.5 (14.8%)
GW (20)	17	6.5	7	0	0	30.5 (18.7%)
LAC (23)	26	2	4	0	0	32 (22.2%)
Fost (14)	7.8	1	2	2.4	0	13.2 (12.9%)
EY (8)	2.6	0.5	2	1	0	6.1 (13.1%)
RCT (21)	14.5	4	7	5	0	30.5 (14.2%)
FC (3)	2	0	1	0	0	3 (14.3%)
CCS (2)	0	0	0	0	0	0
Adop (2)	4	0	1	0	0	5 (31.3%)
+14 (10)	5	1	4	0	0	10 (21.1%)
Total (174)	**146.4**	**21.5**	**36.5**	**10.4**	**5.6**	**220.4**

Note: Reported data as of 28th February and 31st March 2023; *FIT=Family Intervention Teams; CwD=Children with Disabilities Teams; GW=Gateway Teams; LAC=Looked After Children Teams; Fost=Fostering Teams; EY=Early Year Teams; RCT= Residential Child Teams; FC=Family Centres Teams; CCS= Children's Court Services; Adop=Adoption Teams. % Unfilled worked out by number of vacancies divided by the total number of SWs with caseloads + vacancies x 100*

Older People's Social Work Vacancies

Within OPSW Community, Mental Health, and Hospital Teams (75 Teams), there were 41 vacancies related to empty posts the majority of which were within Community Teams (see Table 18). There were also 21 vacancies related to maternity leave across this service regionally. There were 25 vacancies related to sick leave regionally, and 13.5 vacancies were related to either 'other' or 'missing data'. Overall, there were 100.5 vacancies reported within the 75 Teams analysed for this report regionally.

Implications

When vacant posts arise Teams need to manage risk across uncovered caseloads and prioritise the risk levels across caseloads. Affected Teams therefore utilise manager level overview of uncovered caseloads to prioritise risk and have a Duty Intake worker assigned to prioritise key tasks. In some examples a social care worker (or social work assistant) supports Duty Intake, and this system manages incoming priority social work tasks. Continuation of vacancies in the longer term, can create ongoing problems and a vicious cycle of risk management and crises intervention with a reduction in the ability to have processes for early intervention and prevention.

Please Note: HSC Trusts also in some circumstances are using waiting lists to manage staffing pressures.

Table 18: Unfilled Posts Regionally (Older People's Social Work)

Team (*n*)	Empty posts	Maternity leave	Sickness	Other	Missing	Total (% Unfilled)
Comm (56)	34.5	18	24	1	0	77.5 (12.6%)
MH (10)	5	1	1	0	7	14 (21.3%)
Hospital (6)	1.5	2	0	0	2.5	6 (9.2%)
AS (3)	0	0	0	0	3	3 (18.8%)
Total (75)	**41**	**21**	**25**	**1**	**12.5**	**100.5**

Note: Reported data as of 28th February and 31st March 2023; Comm= Community; MH= Mental Health; AS=Adult Safeguarding

Regional Summary

The findings presented in Report 1, are providing an overview of a snapshot of the social work terrain reported on the 28th February or the 31st March, 2023. These findings together with the literature review and metrics on roles and tasks will lead to recommendations around the establishment of safer and effective workloads in advance of policy and legislation in this area being introduced in Northern Ireland. Achieving optimal caseload sizes is an ambitious goal in the short term, medium and longer term. Considering broader societal changes such as demographic shifts, increasing poverty and the out workings of an ongoing cost-of-living crisis, this wider context also needs to be considered in workforce planning.

While the UK NHS Long Term Workforce Plan (2023) does not explicitly mention social work, its emphasis on 'recruit, retain, and reform' are compatible with the conceptual framework established in this study, related to 'capacity (recruit and retain),' 'communication (retain and reform),' and 'connection (retain and reform).' While establishing optimal workforce capacity may be fiscally challenging, the concepts of communication and connection require limited financial investment and offer potential for significant improvements in collective workforce support. Report 1 represents an evidence-informed approach to workforce planning based on demand and capacity analysis rather than the 'funding envelope', as suggested by the House of Commons, Health and Social Care Committee (2021, *p*.58).

The analysis identifies systemic problems that demand systemic solutions. Frontline social workers and managers, dealing with overwhelming workloads and waiting lists, often feel the burden of individual and Team capacity challenges. Concerns about the impact on service users, workload pressures, professional accountability, and individual registration contribute to burnout and intentions to leave (MacLochlainn et al., 2023; McFadden et al., 2023). The report

emphasises the need for shared responsibility across all levels of the system, with open acknowledgment of systemic issues. Addressing workforce challenges is crucial to tackling retention issues in the sector, and education and training numbers will need to be projected to align with identified future workforce needs as this is essential to meet changing societal and population needs and support the future workforce.

The following sections provide summaries of the quantitative and qualitative findings. The quantitative findings compiled below were analysed by service area (Children's or Older People's Social Work) and by Team type, both within and across Trusts. Similarly, the qualitative findings were analysed by service area across Trusts.

Children’s Services

Role and Task of Social Workers in Statutory Child Care Services – A Summary

The overarching backdrop for social workers involved in childcare is defined by the legislation, policy and regulations governing their role and responsibilities.

The five Health and Social Care Trusts in Northern Ireland are responsible for exercising statutory functions under the Health and Social Care Act (Northern Ireland) 2022. Since 2022 with the closure of the Regional Health and Social Care Board, Trusts have assumed direct responsibility for the delivery of social care and children's functions to the Department of Health. These functions include but are not limited to:

1. Children's (NI) Order 1995
2. Adoption Order 1987
3. Children's Services Co-operation (NI) Act 2015
4. Carers and Direct Payments (NI) Act (NI) 2002
5. Adoption and Children Act (NI) 2022
6. Section 21 of the Human Trafficking and Exploitation (Criminal Justice and Support for Victims Act (Northern Ireland) 2015 (appointment of Independent Guardian), (Roulston, 2023).

Thus, social workers employed in Health and Social Care Trusts exercise their duties in relation to this legislative framework. In Children's Services the role of social worker to afford protection from abuse and harm to children and young people is defined by statutory functions such as, Article 66 of the Children [Northern Ireland] Order, 1995, which outlines the requirement to undertake a child protection investigation and a duty to intervene if children are at risk of 'significant harm'. Social workers are also duty bound to act in the 'best interests' of children and safeguard them from harm, abuse, or neglect.

There is a concomitant legal duty to provide outlined in Article 18 of the Children (Northern Ireland) Order 1995 "*to provide personal social services for children in need*, *their families and others*". The definition of a 'child in need' is clearly articulated in Article 17 of the Order and includes: -

(a) he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him of services by an authority under this Part.

(b) his health or development is likely to be significantly impaired, or further impaired, without the provision for him of such services; or

(c) he is disabled, and "family", in relation to such a child, includes any person who has parental responsibility for the child and any other person with whom he has been living.

Article 17A was added to the original Children Order ("as made") to reflect the DUTY to provide assessments and services for children who are carers. Therefore, the statutory functions of Children's Services extend further than child protection and a duty to intervene if children are at risk of 'significant harm'. They also include the duty to actively promote a reasonable standard of health or development of children and young people through the provision of a range of services by HSCTs to prevent impairment of health or development and the provision of services to assist children with disabilities and their families. The statutory basis for provision of such services is further articulated in Part IV of the Children (Northern Ireland) Order 1995 and Schedule 2 to that Order.

Day to Day Work for Children's Services Social Workers

Although social workers in Northen Ireland work across a range of settings, Gateway Teams, Family Intervention Teams, Child Protection Teams, Looked After Children Teams, Leaving and Aftercare Teams, Residential Child Care, Children with Disabilities Teams; there is a similarity to the tasks they carry out. They intervene at moments of crisis and need within families. Their professional knowledge and skills are applied to assessing need, managing risk, protecting children, providing support, and building effective working relationships to make positive change happen. Drawing on a social work framework, they undertake assessments of children and young people's needs, they provide detailed analysis of these needs to inform the provision of support, interventions, and decisions about how children and young people's health, wellbeing and safety can be promoted and protected. Their work requires working in partnership with families, extended networks and other organisations and professionals to ensure collaborative arrangements support and protect children and young people. Social workers play a crucial role in upholding the rights of children and young people according to

the United Nations Convention on the Rights of the Child and ensuring their needs are met in a way which promotes their participation in decisions that affect their lives.

UNOCINI (Understanding the Needs of Children in Northern Ireland) is the current framework for undertaking an assessment of children and young people's needs; its purpose is to guide social workers through a comprehensive process for establishing the extent to which children and young people's needs are being met, the supports required to support and maintain their health and wellbeing and put in place plans to ensure their development. How this is achieved involves focusing on actions to safeguard and protect children and young people, to ensure they are getting optimal care in whatever setting they are living, working in partnership with service users and families to advocate for them, to help them fulfil the best outcomes for their children and young people. Thus, the task requires social workers to be able to build rapport with children and young people, engaging their families and their wider network, developing relationships founded on respect and trust to explore difficult issues in the face of resistance and fears about statutory intervention. Undertaking assessments requires time to plan the work, drawing on other professional perspectives, writing a report with evidence-based analysis, articulating sound professional judgments, and outlining plans for intervention.

For example, on a day-to-day basis, the priority areas for FIT Teams can be defined as: (1) children who are living at home under child protection plans, (2) high risk children receiving family support where the emphasis is on ensuring they are seen regularly and monitoring their care, (3) prioritising statutory visits and responsibilities, and (4) work that is court mandated such as court directed parental contact. In such circumstances, the social work role involves a high level of monitoring, alongside a high level of coordination with other professionals, regular maintenance of records, attendance at case conferences, preparation of reports for court, LAC reviews, case conferences, care planning and core group working.

Supervision of parental contact may involve regular meetings with a requirement to observe, monitor and record the contact, liaise with foster carers, and direct work with children and young people. Often the role of supervising contact is conducted by social work assistants to alleviate the pressure from social workers' time. Social work assistants also support social worker workloads by conducting pieces of work directly with families such as court-directed parental skill support interventions.

The complexity of the social work role in children's services is compounded by several factors:

(1) The impact COVID has had on the social/emotional lives of service users and children and young people.

(2) The limited time for undertaking early intervention due to high waiting lists which delays the offer of support.

(3) Increased numbers of children and young people who are identified as 'being at risk' and require Looked After Services.

(4) The incidents of domestic violence, increased levels of mental distress combined with alcohol/ drug use.

(5) Greater awareness of the impact of trauma on the lives and life chances of children and young people.

In addition to formal workloads, social workers are engaged in the training and support of AYE social workers, social work Intake Duty rota, unallocated cases, and the liaising with other disciplines, agencies, and professionals on case specific planning. Completion of tasks also included monthly reporting requirements to the Strategic Planning and Performance Group and caseload management systems within Trusts.

All social workers in Children's Services participate in formal, regular supervision, informal and group supervision to discuss cases, decisions and workloads with senior staff or line managers. This process contributes to shared risk but also enables social workers to appraise senior colleagues of issues faced in the managing their caseload.

Quantitative Findings within Children's Services

This section provides a summary of the information collected in the survey: type and frequency of supervision; how many of the social work Team (including administrative staff) were in each Agenda for Change pay Bands; overall caseloads - both allocated and unallocated – in each sector of Children's Social Work regionally; how many Social Workers (SWs) are carrying cases overall; the regional ratio of staff-to-caseload; numbers of practice teachers; staff vacancies; funded establishment (FE); numbers of agency staff across Trusts; as well as how many Teams reported using caseload weighting approaches (CWA) and how many of the Teams were using waiting lists; and whether social workers with specialist roles had lower caseloads.

Family Intervention Teams (Regionally)

The following description of Family Intervention Teams (FIT) regionally was derived from an overview of fifty-eight (58) FIT Teams from the five HSC Trusts. The majority of Teams were uni- disciplinary. All (58; 100%) Teams had an operational manager (team leader/senior social worker). Most Teams received social work supervision monthly (n=56; 96.6%). Thirty-Four (34; 58.6%) of the Teams indicated that they received group supervision. Twenty-seven (27) Teams reported group supervision at peer level; two (2) reported specialist supervision; five (5) reported both types of group supervision (peer & specialist). Thirteen (13) Teams had supervision frequency of once a month and thirteen (13) Teams reported group supervision at a frequency of four times a year, three (3) Teams reported a frequency of once every two months, while five (5) Teams selected 'other'.

Staffing Descriptives – Family Intervention Teams

The Family Intervention Teams regionally (see Table 19) employed 77.5 social work assistants (Band 4); 55 Assessed Year in Employment (AYE) social workers (Band 5); 134.9 social workers (Band 6); and 126.4 Band 7 social workers covering a range of roles including Designated Team Leaders (48); Senior Social Work Practitioners (94); Senior Social Workers (43); and Joint Protocol Trained (105). Of the 55 Band 5 (AYE) social workers, nine were agency staff. There were 134.9 Band 6 social workers recorded however it is not clear how many of these were temporary or permanent as this information were not consistently reported. Ten (10) of the Band 6 staff in the Teams were agency.

Table 19: Description of Family Intervention Teams (FIT) at Regional Level

Trust	Trust A	Trust B	Trust C	Trust D**	Trust E	Total
Teams (*n*)	17	5*	9	19	8*	58
Unfilled Band 6 Vacancies	19	6.6	16.5	21.5	10	73.6
Band 2	2.5	0	0	0	0	2.5
Band 3	19.3	5	6	0	3.5	33.8
Band 4	34.4	9.6	22	0	11.5	77.5
Band 5	21	2	3	21	8	55
Band 6	47.5	17.4	18.5	33.5	18	134.9
Band 7	36.9	11	26	38.5	14	126.4
Agency AYE	7	0	0	2	0	9
Agency Band 6	3	0	4	0	3	10
Practice Teachers	12	1	3	5	2	23
Overall caseload *	1128	405	1069	1707	799	5108
Allocated Cases	1074	338	972	1453	744	4581
Unallocated Cases	54	67	97	254	55	527
Total number of SWs w/caseloads	88.4	25.4	38.5	71	32	255.3
Ratio of SW to allocated caseload	1:12	1:13	1:25	1:20	1:23	1:18
Ratio of SW to total caseload (allocated + unallocated)	1:13	1:16	1:28	1:24	1:25	1:20
If vacancies were filled Total number of social workers/caseloads	107.4	32	55	92.5	42	328.9
Ratio of SW to allocated caseloads if vacancy filled	1:10	1:11	1:18	1:16	1:18	1:14
Ratio of SW to allocated and unallocated if vacancy filled	1:11	1:13	1:19	1:18	1:19	1:16
How many Teams developed caseload weighting approaches?	6	4	8	9	6	33
How many Teams use waiting lists?	14	5	7	17	6	49

Note: Steering Groups agreed that cases were per child, and not per family; * To explain low overall FIT caseloads of Trust B + E, Trust B consisted of 5 teams whereas Trust E had 8. If we take Trust E as an example, each team has approx. overall caseload of 100 (8 teams divided by the overall caseload of 799). If we use this number (100 = overall caseload per team) as an average and extrapolate roughly to the regional outlook we can see that the overall caseload per Team in Trust E is higher than in the overall regional picture (overall caseload = 5108 divided by 58 teams = an average overall caseload per Team of 88 across the region; ** Trust D had merged FIT and LAC Teams and therefore the Team number for their FIT data is larger than other Trusts; Reported data as of 28th February and 31st March 2023.

Caseload Ratio Analysis: When considering the caseload ratio analysis of SW to total FIT caseload (allocated + unallocated), there was some variation within Trusts, for example, Trust A reported an individual Team overall caseload ranging from 1:11 – 1:15; Trust B reported an individual Team range from 1:11 – 1:22; Trust C reported an individual Team range from 1:19 – 1:48; Trust D reported an individual Team range from 1:16 – 1:28 with one outlier at either end of the range i.e., 1:7 on the lower end and 1:61 on the upper end; and Trust E reported an individual Team range from 1:11 – 1:45 with one outlier on the upper end of 1:75 (see Table 20 below).

Table 20: FIT: Regional Frequency of Caseload Ratio (allocated + unallocated)

Trust	0-15	16-25	26-35	36-45	46+	Total
A	17	-	-	-	-	17
B	2	3	-	-	-	5
C	0	6	2	-	1	9
D	1	15	2	-	1	19
E	2	3	-	2	1	8
Total	22 (38%)	27 (47%)	4 (7%)	2 (3%)	3 (5%)	58

Calculation of Social Workers with Caseloads – Basic Assumptions

To calculate the number of social workers carrying caseloads, we added the AYE Band 5 social workers (55), Band 6 social workers (131.9; 3 Band 6 were assumed Team Leader in the absence of Band 7s in their respective teams – see Appendix 1b), and Band 7 social workers who were not assumed to be Designated Team Leaders (68.4), this total is as follows (55 + 131.9 + 68.4 = 255.3).

Please Note our Assumptions: We calculated the Band 7 staff with caseloads using the following subtraction from the overall Band 7 social workers recorded: We subtracted an assumed Designated Team Leader (58: most Teams were assumed to have a Band 7 who provided the role of Team Leader and therefore would not carry a caseload) from the total number of Band 7 social workers (126.4) to arrive at sixty-eight-point-four (68.4) Band 7 staff with caseloads. When no Band 7 was reported in the Team, data on specialist roles (such as Approved Social Worker) or Designated Team Leaders, or Senior Social Worker or Senior Practitioner were used to assume that one person was Team manager and did not carry a caseload. We also assume (based on qualitative feedback from focus groups and interviews with front-line workers) that Designated Team Leaders do not carry caseloads. This left 255.3 social workers who were assumed to carry caseloads. We also deducted that social work assistants do not carry caseloads in FIT Teams due to qualitative data reporting in surveys, interviews and focus groups. Instead, social work assistants in FIT Teams were reported to take aspects of work from social workers, for example, supervised contact and low-level family support such as parenting support.

Family Intervention Unfilled Posts

The FIT Teams regionally, had 73.6 unfilled Band 6 social work vacancies (average vacancy per Team was 1.3 across 58 Teams; see Table 21). Six-and-a-half (6.5) were related to sick leave (4 weeks or more); four (4) were related to maternity leave; fifty-five and a half (55.5)

were empty posts; the remainder unfilled Band 6 vacancies were unaccounted for in the data (7.6).

Table 21: Family Intervention Teams Unfilled Posts Regionally

Trust	Empty posts	Maternity leave	Sickness	Other	Missing	Total
ACS	15	-	-	-	4	19
BCS	3	2	1	-	0.6	6.6
CCS	14.5	-	2	-	-	16.5
DCS	16	1	2.5	2	-	21.5
ECS	7	1	1	-	1	10
Total	55.5	4	6.5	2	5.6	73.6

Note: Reported data as of 28th February and 31st March 2023; The percentage (%) of vacancies to overall SWs/caseloads if vacancies were filled (vacancies divided into SWs with caseloads if vacancies were filled multiplied by 100), per Trust, for FIT teams were as follows; A=17.7%; B=20.6%; C=30.0%; D=23.2%; and E=23.8%

Family Intervention Funded Positions

When asked if the total number of social workers (across all Bands) and social work assistants plus vacancies in the Teams correspond with the number of Funded Establishment positions, responses were variable: Teams indicated that the numbers of staff did not add up to the Funded Establishment (10 Teams); twenty-six (26) Teams indicated that the numbers were equivalent to their Funded Establishment, and twenty-two (22) Teams did not answer this question (see Funded Establishment quotes in Appendix 4). In general, comments indicate that ten (10) of the Teams were operating below Funded Establishment. Qualitative data across the region indicate that a review of Funded Establishment has not taken place for at least 10 years.

Family Intervention Practice Teachers

The FIT Teams regionally reported to having twenty-three (23) practice teachers across the 58 Teams. When asked if practice teachers have smaller caseloads than non-practice teachers only one (1) Team reported, 'yes' and five (5) Teams reported 'no'. Other Teams did not answer this question.

Family Intervention Training

Responses indicated 126 social work staff were Joint Protocol trained and able to conduct PIA (Pre-Interview Assessment) and/or ABE (Achieving Best Evidence) interviews. A total number 198 social workers within these Teams were trained as Leads for Signs of Safety assessments,

with 202 social workers trained to do specialist assessments, for example, pre-birth assessments, and a further 23 staff trained in Family Group Conferencing.

Family Intervention Administrative Support

Teams were supported by two-and a-half (2.5) Band 2 and thirty-three point-eight (33.8) Band 3 administrators. Administrative support was inconsistently reported, with some Trusts reporting no administrative Band 2 posts.

Family Intervention Caseloads

The combined overall caseload for the 58 Teams was 5108. A breakdown of the overall caseload revealed that 4581 were allocated cases, with 527 cases unallocated (10.3%). When we divide the number of allocated cases (4581) by the number of staff with caseloads (255.3), the ratio is 1:18, indicating an average caseload across FIT Teams regionally of eighteen (18). When we divide the total number of allocated and unallocated cases (5108), across the number of staff with caseloads, the ratio becomes 1:20, which is an average caseload size of twenty (20) across Bands 5, 6 and Band 7 social workers that carried caseloads. If the vacancies were filled, the caseload ratio would become 1:14 for allocated cases. If unallocated cases are added to allocated, the caseload ratio becomes 1:16 per social worker.

Family Intervention Specialist Role Caseloads

When asked if social workers with a specialist role (such as ASW, DAPO, Senior Social Work Practitioners, or other) have lower caseloads than those without specialist roles, thirty-three (33) (56.9%) Teams said ‘no’, eighteen (18) Teams said, ‘it varies’, six (6) Teams selected ‘unknown’, and only one (1) Team said, ‘yes’. Twenty-three (23) Teams reported those with specialist roles have caseloads of between 10 and 15; twenty-three (23) Teams reported those with specialist roles have caseloads of between 16 and 25; nine (9) Teams indicated caseloads between 26 and 35, whereas three (3) Teams did not respond. This indicates close similarity to other caseloads for those without specialist roles, which suggests that there was no easement of caseload for those with specialist roles.

Family Intervention Social Work Assistant Caseloads

In relation to FIT Teams social work assistant caseload sizes, most Teams reported that SWAs undertake some aspects of work in social work cases but do not have their own caseloads.

Therefore, we assume that social work assistants (SWA's) in Children's Services do not carry their own caseloads but do assist social workers with their caseloads.

Family Intervention Caseload Weighting Approaches

Thirty-three (33; 56.9%) Teams indicated they had developed caseload weighting approaches to manage their workload demands, whereas thirteen (13) Teams indicated not developing caseload weighting approaches. Twelve (12; 20.7%) Teams did not respond to this question.

Family Intervention Waiting Lists

Forty-nine (49; 84.5%) Teams indicated using waiting lists and provided further information on risk and governance processes and practice in this area (see Appendix 2).

Brief Analysis – Family Intervention Teams (Regionally)

The 58 Family Intervention Teams regionally were managing caseloads between 31-191. Overall, the Teams were managing an allocated caseload ratio of 1:18, and an overall (unallocated plus allocated cases) caseload ratio of 1:20 among 255.3 members of staff that carry caseloads within these Teams, and we have ranked these ratios previously in the analysis (see Table 20). There were 73.6 unfilled Band 6 vacancies reported across the Teams. Six-and-a-half (6.5) were related to sick leave (4 weeks or more); four (4) were related to maternity leave; fifty-five and a half (55.5) were empty posts; and the remaining unfilled Band 6 vacancies were unaccounted for in the data. When we add the vacancies reported, the caseload ratio for allocated cases becomes 1:14, whereas for overall caseloads the ratio becomes 1:16.

The majority of Teams were uni-disciplinary. All Teams had a Band 7 operational manager (team leader/senior social worker). Most Teams received social work supervision monthly. Thirty-four (34) Teams indicated that they received group supervision. Twenty-seven (27) Teams reported group supervision at peer level; two (2) reported specialist supervision; and five (5) Teams reported both types of group supervision (peer & specialist). Thirteen (13) Teams had supervision once a month; thirteen (13) Teams reported group supervision four times a year; three (3) Teams reported group supervision once every two months; and five (5) Teams selected 'other'.

There were fifty-five (55) Band 5 social workers reported although it is unclear how many of these were temporary or permanent as this information was not reported. Regionally, nine (9)

Band 5 staff were reported as agency staff across Teams. There were 134.9 Band 6 social workers reported. It was also unclear how many of these were temporary or permanent as this information was not reported, although ten (10) Band 6 were reported as agency staff. There were 126.4 Band 7 social workers recorded covering a range of roles including Designated Team Leaders; Senior Social Work Practitioners; Senior Social Workers; and Joint Protocol Trained.

Thirty-three (33) Teams used caseload weighting approaches although none of them described what these looked like. Waiting lists were used by forty-nine (49) Teams and were managed and governed by Team Leaders, Senior Managers, and Senior Social Workers. Service users were directed to the duty system if issues required immediate intervention. Within Trust 'D', some Teams indicated using Collaborative Unallocated Processes (CUP) to manage waiting lists. Teams were supported by two-and-a-half (2.5) Band 2 and thirty-three point-eight (33.8) Band 3 administrative staff. Most of the training reported included, Signs of Safety, and specialist training such as pre-birth risk assessment, Joint Protocol training, and Family Group Conferencing. Ten (10) Teams indicated that the numbers of staff did not add up to the Funded Establishment; twenty-six (26) Teams indicated that the numbers were equivalent to their Funded Establishment; and twenty-two (22) Teams did not answer this question. Out of the 58 Teams, only twenty-three (23) reported to having practice teacher(s) in their Team.

Children with Disabilities (CwD) Teams (Regionally)

The following description of Children with Disabilities Teams regionally was derived from an overview of thirteen (13) CwD Teams across Children Services from the five Health and Social Care Trusts. Teams were uni-disciplinary (6) and multi-disciplinary (7). All thirteen (13; 100%) Teams had an operational manager who was a social worker. All Teams received social work supervision monthly. Ten (10; 76.9%) of the Teams indicated that they received group supervision. All Teams reported group supervision at peer level. Seven (7) Teams had group supervision once a month and two (2) Teams reported group supervision four times a year, while one (1) Team selected 'other'.

Staffing Descriptives – Children with Disability Teams

The CwD Teams regionally (see Table 22) employed twenty-two (22) social work assistants (Band 4); six (6) Assessed Year in Employment (AYE) social workers (Band 5); 76.3 social workers (Band 6); and twenty-six (26) Band 7 social workers covering a range of roles

including Designated Team Leaders (9); Senior Social Work Practitioners (10); Senior Social Workers (10); and Joint Protocol Trained (11).

Table 22: Description of Children with Disabilities Teams at Regional Level

Trust	Trust A	Trust B	Trust C	Trust D	Trust E	Total
Teams (*n*)	3	2	4	3	1	13
Unfilled Band 6 Vacancies	1.5	0	7	3	5	16.5
Band 2	0	0	0	0	0.5	0.5
Band 3	4	2	5	2	2.5	15.5
Band 4	0	3	6	9	4	22
Band 5	0	0	1	0	5	6
Band 6	16.8	6	35	12.5	6	76.3
Band 7	4	2	10	4	6	26
Agency AYE	0	0	0	0	0	0
Agency Band 6	0	0	0	5	0	5
Practice Teachers	3	1	2	2	0	8
Overall caseload	623	286	1126	896	309	3240
Allocated Cases	463	266	1026	527	154	2436
Unallocated Cases	160	20	100	369	155	804
Total number of SWs w/caseloads	17.8	6	42	13.5	16	95.3
Ratio of SW to allocated caseload	1:26	1:44	1:24	1:39	1:10	1:26
Ratio of SW to total caseload (allocated + unallocated)	1:35	1:48	1:27	1:66	1:19	1:34
If vacancies were filled Total number of social workers/caseloads	19.3	6	49	16.5	21	111.8
Ratio of SW to allocated caseloads if vacancy filled	1:24	1:44	1:21	1:32	1:7	1:22
Ratio of SW to allocated and unallocated if vacancy filled	1:32	1:48	1:23	1:54	1:15	1:29
How many Teams developed caseload weighting approaches?	1	2	2	2	1	8
How many Teams use waiting lists?	3	1	4	3	1	12

Note: Reported data as of 28th February and 31st March 2023; CwD Teams may carry caseloads larger than 15

Of the six (6) Band 5 (AYE) social workers, none were agency staff. There were 76.3 Band 6 social workers recorded although it is unclear how many of these were temporary or permanent as this information was not consistently reported. Five (5) of the Band 6 staff in the Teams were agency.

Caseload Ratio Analysis: When considering the caseload ratio of SW to total CwD caseload (allocated + unallocated) there was some variation within Trusts, for example, Trust A reported an individual Team overall caseload ranging from 1:28 – 1:39; Trust B reported an individual Team range from 1:42 – 1:54; Trust C reported an individual Team range from 1:22 – 1:34;

Trust D reported an individual Team range from 1:53 – 1:54 with one outlier on the upper end of 1:104; and Trust E only reported one Team (see Table 23 below).

Table 23: CwD: Regional Frequency of Caseload Ratio (allocated + unallocated)

Trust	0-15	16-25	26-35	36-45	46+	Total
A	-	1	2	-	-	3
B	-	-	-	1	1	2
C	-	2	2	-		4
D	-	-	-	-	3	3
E	-	1	-	-	-	1
Total	-	4 (31%)	4 (31%)	1 (7%)	4 (31%)	13

Calculation of CwD Social Workers all Bands with Caseloads

To calculate the number of social workers carrying caseloads, we added the AYE Band 5 social workers (6), Band 6 social workers (76.3), and Band 7 social workers who were not assumed to be Designated Team Leaders (13). The total is as follows (6+76.3+13 =95.3).

Please Note: We calculated the Band 7 staff with caseloads using the following subtraction from the overall Band 7 social workers recorded: an assumed Designated Team Leader was subtracted (13: each Team were assumed to have a Band 7 who provided the role of Team Leader) from the total number of Band 7 social workers (26) to arrive at thirteen (13) Band 7 staff with caseloads. We assume (based on qualitative feedback from focus groups and interviews with front-line workers) that Designated Team Leaders do not carry caseloads. This left 95.3 social workers who were assumed to carry caseloads. Due to qualitative information from the survey and focus groups and interviews, we also deducted that social work assistants do not carry caseloads in CwD Teams.

CwD Unfilled Posts

CwD Teams regionally, had sixteen-point-five (16.5) unfilled Band 6 social work vacancies (average vacancy per Team was 1.3 across 13 Teams; see Table 24). Two (2) were related to sick leave (4 weeks or more); two-and-a-half (2.5) were related to maternity leave; and twelve (12) were empty posts.

Table 24: Children with Disabilities Teams Unfilled Posts Regionally

Trust	Empty posts	Maternity leave	Sickness	Other	Missing	Total
ACS	1	0.5	-	-	-	1.5
BCS	-	-	-	-	-	0
CCS	3	2	2	-	-	7
DCS	3	-	-	-	-	3
ECS	5	-	-	-	-	5
Total	12	2.5	2	0	0	16.5

Note: Reported data as of 28th February and 31st March 2023; The percentage (%) of vacancies to overall SWs/caseloads if vacancies were filled (vacancies divided in to SWs with caseloads if vacancies were filled multiplied by 100), per Trust, for CwD teams were as follows; A=7.8%; B=0%; C=14.3%; D=18.2%; and E=23.8%

CwD Funded Positions

When asked if the total number of social workers (across all Bands) and social work assistants plus vacancies in the Teams correspond with the number of FE positions, one (1) Team indicated that the numbers of staff did not add up to the FE; ten (10) Teams indicated that the numbers were equivalent to their FE, and two (2) Teams didn't answer this question (see FE Quotes in Appendix 4). In general, comments indicate that only one of the Teams were operating below Funded Establishment.

CwD Practice Teachers

The CwD Teams regionally reported having eight (8) Teams with practice teachers across the 13 Teams. When asked if practice teachers have smaller caseloads than non-practice teachers only one (1) Team reported, 'yes' and five (5) Teams reported 'no'. Other Teams failed to report on this question.

CwD Training

A total number of sixty-two (62) social workers were reported as being trained to perform assessments under the Mental Capacity Act (MCA). Sixteen (16) indicated that they were Joint Protocol trained and able to conduct PIA and/or ABE interviews. A total number of eighteen (18) social workers within these Teams were trained as Leads for Signs of Safety assessments, with five (5) social workers trained to do specialist assessments, for example, pre-birth assessments, and a further seven (7) staff trained in Family Group Conferencing.

CwD Administrative Support

Teams were supported by one-half (0.5) Band 2 and fifteen and one-half (15.5) Band 3 administrators. It is clear that not all CwD administrative staff were reported across all HSC Trusts.

CwD Caseloads

The combined overall caseload of the 13 Teams was 3240. A breakdown of the overall caseload revealed that 2436 were allocated cases, with 804 cases unallocated (24.8%). When we divide the number of allocated cases (2436) by the number of staff with caseloads (95.3), the ratio is 1:26, indicating an average caseload across CwD Teams regionally of twenty-six (26). When we divide the total number of allocated and unallocated cases (3240), across the number of staff with caseloads, the ratio becomes 1:34, which is an average caseload size of thirty-four (34) across Bands 5, 6 and Band 7 social workers that carried caseloads. If the vacancies were filled, the caseload ratio would become 1:22 allocated cases. If unallocated cases are added to allocated, the caseload ratio becomes 1:29 per social worker.

CwD Specialist Role Caseloads

When asked if social workers with a specialist role (such as ASW, DAPO, Senior Social Work Practitioners, or other) have lower caseloads than those without specialist roles, four (4; 30.7%) Teams said 'no', seven (7) Teams said, 'it varies', and two (2) Teams selected 'unknown'. Three (3) Teams reported those with specialist roles having caseloads between 10 and 15; four (4) Teams reported those with specialist roles have caseloads between 16 and 25; two (2) Teams indicated caseloads between 26 and 35, whereas three (3) Teams indicated average caseloads higher than these categories. One (1) Team did not respond. These caseload numbers are similar to those of social workers without specialist roles, which suggests that there was no easement of caseload for those with specialist roles.

CwD Social Work Assistant Caseloads

In relation to social work assistant caseload sizes, most Teams reported that SWAs undertake some aspects of work in social work cases but do not have their own caseloads. Therefore, we assume that SWAs do not carry their own caseloads but do assist social workers with their caseloads.

CwD Caseload Weighting Approaches

Eight (8; 61.5%) Teams indicated they had developed caseload weighting approaches to manage their workload demands, whereas three Teams indicated they had not. See Appendix 3 for individual Team quotes on caseload weighting approaches.

CwD Waiting Lists

All thirteen (13) Teams indicated using waiting lists and provided further information on risk and governance and processes and practice in this area (see Appendix 2) for individual Team quotes).

Brief Analysis – Children with Disabilities (Regionally)

The thirteen (13) CwD Teams regionally were managing variable caseloads between 135-264. Overall, the Teams were managing an allocated caseload ratio of 1:26, and an overall caseload ratio of 1:34 among 95.3 members of staff that carry caseloads within these Teams, and we have ranked these ratios previously in the analysis (see Table 23). There were sixteen and one-half (16.5) unfilled Band 6 vacancies across the Teams. Two (2) were related to sick leave (4 weeks or more); two-and-a-half (2.5) were related to maternity leave; and twelve (12) were empty posts. When we add the vacancies reported, the caseload for allocated caseloads ratio becomes 1:22, whereas the overall caseloads ratio becomes 1:29.

Six (6) of the Teams were uni-disciplinary, and seven (7) Teams were multi-disciplinary. Teams were assumed to be managed by Designated Team Leaders. All Teams received social work supervision monthly. Ten (10) of the Teams indicated that they received group supervision. All Teams reported group supervision at peer level. Seven (7) Teams had a group supervision once a month and two (2) Teams reported group supervision four times a year, while one (1) Team selected ‘other’. There were six (6) Band 5 social workers. It is unclear how many of the Band 5 staff were temporary or permanent as this information was not reported. There were 76.3 Band 6 social workers, it also remains unclear as to how many of these were temporary or permanent as this information was not consistently reported. Five (5) Band 6 were reported as agency staff. There were twenty-six (26) Band 7 social workers covering a range of roles including Designated Team Leader; Senior Social Work Practitioner; Senior Social Worker; and Joint Protocol Trained.

Eight (8) Teams used caseload weighting approaches, none described what these looked like. Waiting lists were used by all thirteen (13) Teams and were managed and governed by Team Leaders, Senior Managers, and Senior Social Workers through the duty system at weekly or monthly meetings. Within Trust 'E', a Team indicated RAG-rating unallocated cases based on level of need. This was defined either a priority level 1, 2, or 3. Teams were supported by one-half (0.5) Band 2 and fifteen and a- half (15.5) Band 3 administrative staff. The majority of training staff reported having received included assessments under the Mental Capacity Act (MCA); Signs of Safety, and specialist training such as pre-birth risk assessment, Joint Protocol training, and Family Group Conferencing. Only one (1) Team indicated that the numbers of staff did not add up to the FE. Ten (10) Teams indicated that the numbers were equivalent to their FE and two (2) Teams did not answer this question. Out of the thirteen (13) Teams, only eight (8) reported to having practice teachers.

Gateway (including Single Point of Contact) Teams Regionally

The following description of Gateway Teams regionally was derived from an overview of twenty (20) Gateway Teams (GT) across Children Services from the five HSC Trusts. All Teams were uni-disciplinary and had an operational manager who was a social worker. All Teams received social work supervision monthly. Ten (10; 50.0%) of the Teams indicated that they received group supervision. Six (6) Teams reported group supervision at peer level; and four (4) reported both types of group supervision (peer & specialist). Eight (8) Teams had supervision once a month; one (1) Team reported group supervision four times a year, and one (1) Team selected 'other'.

Staffing Descriptives – Gateway Teams

The GT regionally (see Table 25) employed eight (8) social work assistants (Band 4); eighteen (18) AYE social workers (Band 5); 83.4 Band 6 social workers and 51.5 Band 7 social workers covering a range of roles including Designated Team Leaders (3); Senior Social Work Practitioners (34.5); Senior Social Workers (17); and Joint Protocol Trained (43). Of the eighteen (18) Band 5 (AYE) social workers, none were reported as agency staff. There were 83.4 Band 6 social workers recorded although it is unclear how many of these were temporary or permanent as this information were not consistently reported. Five (5) of the Band 6 staff in the Teams were reported as agency.

Table 25: Description of Gateway Teams at Regional Level

Trust	Trust A	Trust B	Trust C	Trust D	Trust E	Total
Teams (*n*)	6	4	2	4	4	20
Unfilled Band 6 Vacancies	12	4	4	7.5	3	30.5
Band 2	5	0	0	0	1.5	6.5
Band 3	2	9	2	0	1.5	14.5
Band 4	7	0	1	0	0	8
Band 5	6	2	4	3	3	18
Band 6	24	11	11	17	20.4	83.4
Band 7	8	17.5	5	10	11	51.5
Agency AYE	0	0	0	0	0	0
Agency Band 6	0	0	1	0	4	5
Practice Teachers	6	1	1	4	2	14
Overall caseload	351	354	377	703	1213	2998
Allocated Cases	283	309	132	471	585	1780
Unallocated Cases	68	45	245	232	628	1218
Total number of SWs w/caseloads	32	26.5	18	26	30.4	132.9
Ratio of SW to allocated caseload	1:9	1:12	1:7	1:18	1:19	1:13
Ratio of SW to total caseload (allocated + unallocated)	1:11	1:13	1:21	1:27	1:40	1:23
If vacancies were filled Total number of social workers/caseloads	44	30.5	22	33.5	33.4	163.4
Ratio of SW to allocated caseloads if vacancy filled	1:6	1:10	1:6	1:14	1:18	1:11
Ratio of SW to allocated and unallocated if vacancy filled	1:8	1:12	1:17	1:21	1:36	1:18
How many Teams developed caseload weighting approaches?	0	0	1	1	0	2
How many Teams use waiting lists?	6	4	2	3	4	19

Note: Reported data as of 28th February and 31st March 2023.

Caseload Ratio Analysis: When considering the caseload ratio of SW to total caseload (allocated + unallocated) there was some variation within Trusts, for example, Trust A reported an individual Team overall caseload ranging from 1:5 – 1:14; Trust B reported an individual Team range from 1:7 – 1:20; Trust C reported an individual Team range from 1:19 – 1:48; Trust D reported a range from 1:14 – 1:40; and Trust E reported an individual Team range from 1:30 – 1:50 (see Table 26 below).

Table 26: Gateway: Frequency of Caseload Ratio (allocated + unallocated)

Trust	0-15	16-25	26-35	36-45	46+	Total
A	6	-	-	-	-	6
B	2	2	-	-	-	4
C	-	1	-	-	1	2
D	1	-	1	2	-	4
E	-	-	1	1	2	4
Total	9 (45%	3 (15%)	2 (10%)	3 (15%)	3 (15%)	20

Gateway Calculation of Social Workers all Bands with Caseloads

To calculate the number of social workers carrying caseloads, we added the AYE Band 5 social workers (18), Band 6 social workers (83.4), and Band 7 social workers who were not assumed to be Designated Team Leaders (31.5), this total is as follows (18 + 83.4 + 31.5 = 132.9).

Please Note: We calculated the Band 7 staff with caseloads using the following subtraction from the overall Band 7 social workers recorded: We subtracted an assumed Designated Team Leader (20: Teams were assumed to have a Band 7 who provided the role of Team Leader and therefore would not carry a caseload) from the total number of Band 7 social workers (51.5) to arrive at 31.5 Band 7 staff with caseloads. We assume (based on qualitative feedback from focus groups and interviews with front-line workers) that Designated Team Leaders do not carry caseloads. This left 132.9 social workers who were assumed to carry caseloads. We also deducted that SWAs do not carry caseloads in GT based on qualitative findings from interviews and focus groups.

Gateway Unfilled Posts

GT regionally had thirty and a-half (30.5) unfilled Band 6 social work vacancies (average vacancy per Team was 1.5 across 20 Teams; see Table 27). Seven (7) were related to sick leave (4 weeks or more); six-and-a-half (6.5) were related to maternity leave; seventeen (17) were empty posts.

Table 27: Gateway Teams Unfilled Posts Regionally

Trust	Empty posts	Maternity leave	Sickness	Other	Missing	Total
ACS	9	3	-	-	-	12
BCS	-	2	2	-	-	4
CCS	2	-	2	-	-	4
DCS	5	1.5	1	-	-	7.5
ECS	1	-	2	-	-	3
Total	17	6.5	7	0	0	30.5

Note: Reported data as of 28th February and 31st March 2023; The percentage (%) of vacancies to overall SWs/caseloads if vacancies were filled (vacancies divided in to SWs with caseloads if vacancies were filled multiplied by 100), per Trust, for Gateway teams were as follows; A=27.3%; B=13.1%; C=18.2%; D=22.4%; and E=9.0%

Gateway Funded Positions

When asked if the total number of social workers (across all Bands) and social work assistants plus vacancies in the Teams correspond with the number of Funded Establishment (FE) positions, five (5) Teams indicated that the numbers of staff did not add up to the FE ; six (6) Teams indicated that the numbers were equivalent to their FE, and nine (9) Teams did not answer this question (see FE quotes in Appendix 4). In general, comments indicate that five (5) Teams were operating below Funded Establishment.

Gateway Practice Teachers

The GT regionally reported fourteen (14) Teams with practice teachers across the twenty (20) Teams. When asked if practice teachers have smaller caseloads than non-practice teachers, five (5) Teams reported, 'yes' and five (5) Teams reported 'no'. Other Teams failed to respond to this question.

Gateway Training

Eighty-three-and-a-half (83.5) social workers indicated that they were Joint Protocol trained and able to conduct PIA and/or ABE interviews. A total number of forty-six (46) social workers within these Teams were trained as Leads for Signs of Safety assessments, with thirty-three (33) social workers trained to do specialist assessments, for example, pre-birth assessments, a further four (4) staff were trained in Family Group Conferencing; and three (3) social workers were trained to perform assessments under the MCA.

Gateway Administrative Support

Teams were supported by six-and-a-half (6.5) Band 2 and fourteen-and-a-half (14.5) Band 3 administrators.

Gateway Caseloads

Of the twenty (20) Teams, their combined overall caseload was 2998. A breakdown of the overall caseload revealed that 1780 were allocated cases, with 1218 cases unallocated (40.6%). When we divide the number of allocated cases (1780) by the number of staff with caseloads (132.9), the caseload ratio is 1:13, indicating an average caseload across Gateway Teams regionally of thirteen (13). When we divide the total number of allocated and unallocated cases (2998), across the number of staff with caseloads, the ratio becomes 1:23, which is an average caseload size of twenty-three (23) across Bands 5, 6 and Band 7 social workers that carried caseloads. If the vacancies were filled, the caseload size would become 1:11 for allocated cases and 1:18 for all cases (unallocated + allocated).

Gateway Specialist Role Caseloads

When asked if social workers with a specialist role (such as ASW, DAPO, Senior Social Work Practitioners, or other) have lower caseloads than those without specialist roles, thirteen (13; 65%) Teams said ‘no’, three (3) Teams said, ‘it varies’, three (3) Teams selected ‘unknown’, and only one (1) Team said, ‘yes’. Five (5) Teams reported those with specialist roles have caseloads of between 10 to 15; ten (10) Teams reported those with specialist roles have caseloads of between 16 and 25, whereas five (5) Teams failed to respond to this survey question. This indicates that those with specialist roles have similar caseloads to social workers without specialist roles, suggesting no easement of caseload for those with specialist roles.

Gateway Social Work Assistant (SWA) Caseloads

In relation to SWA caseload sizes, most Teams reported that SWAs undertake some aspects of work in social work cases but do not have their own caseloads. Therefore, we assume that social work assistants (SWA’s) do not carry their own caseloads but do assist social workers with their caseloads.

Gateway Caseload Weighting Approaches

Only two (2; 10%) Teams indicated developing caseload weighting approaches to manage their workload demands, whereas fifteen (15) Teams indicated they had not. Three (3) Teams failed to respond to this question (see Appendix 3).

Gateway Waiting Lists

Nineteen (19; 95%) Teams indicated using waiting lists and provided further information on risk and governance and processes and practice in this area (see Appendix 2).

Brief Analysis – Gateway (Regionally)

The twenty (20) Gateway Teams regionally were managing caseloads between 30-366. Overall, the Teams were managing an allocated caseload ratio of 1:13, and an overall caseload ratio of 1:23 among the 132.9 members of staff that carry caseloads within these Teams. There were 30.5 unfilled Band 6 vacancies across the Teams, and we have ranked these ratios previously in the analysis (see Table 26). Seven (7) were related to sick leave (4 weeks or more); six-and-a-half (6.5) were related to maternity leave; and seventeen (17) were empty posts. When we add the vacancies reported, the ratio for allocated caseloads ratio becomes 1:11, whereas the overall caseload ratio becomes 1:18.

All Teams were uni-disciplinary and had an operational manager who was a social worker. All Teams received social work supervision monthly. Ten (10) of the Teams indicated that they received group supervision. Six (6) Teams reported group supervision at peer level; and four (4) reported both types of group supervision (peer & specialist). Eight (8) Teams had supervision once a month; one (1) Team reported group supervision four times a year, and one (1) Team selected ‘other’.

There were eighteen (18) Band 5 social workers, it remains unclear how many of these were temporary or permanent as this were not reported, however there were no Band 5 agency staff reported across Teams regionally. There were 83.4 Band 6 social workers reported however it remains unclear how many of these were temporary or permanent as this was also not reported. Five (5) Band 6 were reported as agency staff. There were 51.5 Band 7 social workers covering a range of roles including Designated Team Leaders; Senior Social Work Practitioners; Senior Social Workers; and Joint Protocol Trained.

Only two (2) Teams used caseload weighting approaches, none described what these were. Waiting lists were used by nineteen (19) Teams and were managed and governed by Line Managers, Team Leaders, Senior Managers, and Senior Social Workers through the duty system daily. Teams were supported by six-and-a-half (6.5) Band 2 and fourteen-and-a-half (14.5) Band 3 administrative staff. The majority of training reported included Joint Protocol training; Signs of Safety; specialist training such as pre-birth risk assessment; Family Group Conferencing; and MCA Assessments. Five (5) Teams indicated that the numbers of staff did not add up to the FE; six (6) Teams indicated that the numbers were equivalent to their FE; and nine (9) Teams did not answer this question. Out of the twenty (20) Teams, only fourteen (14) reported having practice teacher(s).

Looked After Children Teams (LAC) (Regionally)

The following description of LAC Teams regionally was derived from an overview of twenty-three (23) LAC Teams across Children Services from the five HSC Trusts. All Teams were uni-disciplinary, and all had an operational manager who was a social worker. The twenty-three (23) Teams received social work supervision monthly (100.0%). Seventeen (17; 73.9%) of the Teams indicated that they received group supervision. Twelve (12) Teams reported group supervision at peer level; Three (3) Teams reported specialist supervision such as Signs of Safety; and two (2) reported both types of group supervision (peer & specialist). Four (4) Teams had a supervision once a month; four (4) Teams had a supervision once every two months; four (4) Teams reported group supervision four times a year; and five (5) Teams selected 'other'.

Staffing Descriptives – LAC Teams

The LAC Teams regionally (see Table 28) employed thirty-five (35) social work assistants (Band 4); twenty-five (25) AYE social workers (Band 5); 63.1 social workers (Band 6); and 46.8 Band 7 social workers covering a range of roles including Designated Team Leaders (6); Senior Social Work Practitioners (31); Senior Social Workers (18); and Joint Protocol Trained (28). Of the twenty-five (25) Band 5 (AYE) social workers, one (1) was reported as agency staff. There were 63.1 Band 6 social workers, it remains unclear how many of these were temporary or permanent as this were not consistently reported. Two (2) of the Band 6 staff in the Teams were reported as agency staff.

Table 28: Description of Looked After Children Teams at Regional Level

Trust	Trust A	Trust B	Trust C	Trust D*	Trust E	Total
Teams (*n*)	5	6	5	0	7	23
Unfilled Band 6 Vacancies	7	8	2	-	15	32
Band 2	1	0	0	-	4	5
Band 3	5.5	6	7	-	6	24.5
Band 4	7	11	10	-	7	35
Band 5	10	6	5	-	4	25
Band 6	10	15.6	19	-	18.5	63.1
Band 7	7	11.8	9	-	19	46.8
Agency AYE	0	1	0	-	0	1
Agency Band 6	0	1	0	-	1	2
Practice Teachers	1	2	1	-	2	6
Overall caseload	267	479	364	-	581	1691
Allocated Cases	264	408	364	-	574	1610
Unallocated Cases	3	71	0	-	7	81
Total number of SWs w/caseloads	22	27.4	28	-	34.5	111.9
Ratio of SW to allocated caseload	1:12	1:15	1:13	-	1:17	1:14
Ratio of SW to total caseload (allocated + unallocated)	1:12	1:17	1:13	-	1:17	1:15
If vacancies were filled Total number of social workers/caseloads	27	35.4	30	-	49.5	143.9
Ratio of SW to allocated caseloads if vacancy filled	1:10	1:12	1:13	-	1:12	1:11
Ratio of SW to allocated and unallocated if vacancy filled	1:10	1:14	1:13	-	1:12	1:12
How many Teams developed caseload weighting approaches?	2	2	3	-	3	10
How many Teams use waiting lists?	1	0	0	-	1	2

Note: Reported data as of 28th February and 31st March 2023; * Trust D had merged FIT and LAC Teams (see FIT analysis above) and therefore did not return any LAC Teams.

Caseload Ratio Analysis: When considering the ratio of SW to total LAC caseload (allocated + unallocated) there was some variation within Trusts, for example, Trust A reported an individual Team overall caseload ranging from 1:9 – 1:15; Trust B reported an individual Team range from 1:11 – 1:27; Trust C reported an individual Team range from 1:9 – 1:20; Trust D had merged FIT and LAC Teams (see FIT analysis above); and Trust E reported an individual Team range from 1:10 – 1:28 with one outlier on the upper end of 1:69 (see Table 29 below).

Table 29: LAC: Regional Frequency of Caseload Ratio (allocated + unallocated)

Trust	0-15	16-25	26-35	36-45	46+	Total
A	5	-	-	-	-	5
B	3	2	1	-	-	6
C	4	1	-	-	-	5
D	-	-	-	-	-	-
E	2	3	1	-	1	7
Total	14 (61%)	6 (26%)	2 (9%)	0 (0%)	1 (4%)	23

LAC Calculation of Social Workers all Bands with Caseloads

In terms of social workers carrying caseloads, we added the AYE Band 5 social workers (25), Band 6 social workers (63.1), and Band 7 social workers who were not assumed to be Designated Team Leaders (23.8), this total is as follows (25 + 63.1 + 23.8 = 111.9).

Please Note: We calculated the Band 7 staff with caseloads using the following subtraction from the overall Band 7 social workers recorded: We subtracted an assumed Designated Team Leader (23: Teams were assumed to have a Band 7 who provided the role of Team Leader and therefore would not carry a caseload) from the total number of Band 7 social workers (46.8) to arrive at 23.8 Band 7 staff with caseloads. We assume (based on qualitative feedback from focus groups and interviews with front-line workers) that Designated Team Leaders do not carry caseloads. This left 111.9 social workers who were assumed to carry caseloads. We also deducted that social work assistants do not carry caseloads in LAC Teams based on qualitative data from surveys, interviews and focus groups.

LAC Unfilled Posts

The LAC Teams regionally had thirty-two (32) unfilled Band 6 social work vacancies (average vacancy per Team was 1.4 across 23 Teams; see Table 30). Four (4) were related to sick leave (4 weeks or more); two (2) were related to maternity leave; and twenty-six (26) were empty posts.

Table 30: LAC Teams Unfilled Posts Regionally

Trust	Empty posts	Maternity leave	Sickness	Other	Missing	Total
ACS	5	1	1	-	-	7
BCS	6	1	1	-	-	8
CCS	2	-	-	-	-	2
DCS	-	-	-	-	-	0
ECS	13	-	2	-	-	15
Total	26	2	4	0	0	32

Note: Reported data as of 28th February and 31st March 2023; The percentage (%) of vacancies to overall SWs/caseloads if vacancies were filled (vacancies divided in to SWs with caseloads if vacancies were filled multiplied by 100), per Trust, for LAC teams were as follows; A=25.9%; B=22.6%; C=6.7%; D=0%; and E=30.3%

LAC Funded Positions

When asked if the total number of social workers (across all Bands) and social work assistants plus vacancies in the Teams correspond with the number of FE positions, responses were variable: Five (5) Teams indicated that the numbers of staff did not add up to the FE; ten (10) Teams indicated that the numbers were equivalent to their FE, and eight (8) Teams did not answer this question (see FE quotes in Appendix 4). In general, comments indicate that five (5) of twenty-three (23) Teams were operating below FE.

LAC Practice Teachers

The LAC Teams regionally reported to having six (6) Teams with practice teachers. When asked if practice teachers have smaller caseloads than non-practice teachers only one (1) Team reported, 'yes' and five (5) Teams reported 'no'.

LAC Training

The survey recorded thirty-three (33) staff in LAC Teams that were Joint Protocol trained and able to conduct PIA and/or ABE interviews. A total number of thirty-eight (38) social workers within these Teams were trained as Leads for Signs of Safety assessments, with seventy-nine (79) social workers trained to do specialist assessments, for example, pre-birth assessments, and a further four (4) staff trained in Family Group Conferencing.

LAC Administrative Support

Teams were supported by five (5) Band 2 and twenty-four-and-a-half (24.5) Band 3 administrators.

LAC Caseloads

The combined overall caseload of the twenty-three (23) Teams was 1691. A breakdown of the overall caseload revealed 1610 were allocated cases, with 81 cases unallocated (this is skewed by data from Trust B reporting 71 unallocated cases). This indicates a total of 4.8% of overall cases were unallocated within the twenty-three (23) Teams. When we divide the number of allocated cases (1610) by the number of staff with caseloads (111.9), the ratio is 1:14, this indicates an average caseload of fourteen (14). When we divide the total number of allocated and unallocated cases (1691), across the number of staff with caseloads, the ratio becomes 1:15, which is an average caseload size of fifteen (15) across Bands 5, 6 and Band 7 social workers that carried caseloads. If the vacancies were filled, the caseload ratio would become 1:11 allocated cases. If unallocated cases are added to allocated, the caseload ratio becomes 1:12 per social worker.

LAC Specialist Role Caseloads

When asked if social workers with a specialist role (such as ASW, DAPO, Senior Social Work Practitioners, or other) have lower caseloads than those without specialist roles, eighteen (18; 78.3%) Teams said 'no', three (3) Teams said, 'it varies', and only two (2) Teams said, 'yes'. Ten (10) Teams reported those with specialist roles have caseloads of between 10 and 15; and thirteen (13) Teams reported those with specialist roles have caseloads of between 16 and 25. These caseload numbers are similar to those of social workers without specialist roles, suggesting no easement of caseload for those with specialist roles.

LAC Social Work Assistant Caseloads

In relation to SWA caseload sizes, most Teams reported that SWAs undertake some aspects of work in social work cases but do not have their own caseloads. Therefore, we deduce from qualitative survey data, that social work assistants (SWA's) do not carry their own caseloads but do assist social workers with their cases.

LAC Caseload Weighting Approaches

Ten (10; 43.5%) Teams indicated they had developed caseload weighting approaches to manage their workload demands, whereas thirteen (13) Teams had not (see Appendix 3).

LAC Waiting Lists

Only two (2; 8.7%) Teams indicated using waiting lists and provided further information on risk and governance and processes and practice in this area (see Appendix 2).

Brief Analysis – Looked After Children (Regionally)

The twenty-three (23) LAC Teams regionally were managing caseloads between 12-126. Overall, the Teams were managing an allocated caseloads ratio of 1:14, and an overall caseload ratio of 1:15 between 111.9 members of staff that carry caseloads within these Teams. There were three (3) unfilled Band 6 vacancies across the Teams, and we have ranked these ratios previously in the analysis (see Table 29). Four (4) were related to sick leave (4 weeks or more); Two (2) were related to maternity leave; and twenty-six (26) were empty posts. When we add the vacancies reported, the ratio for allocated cases becomes 1:11, whereas the overall ratio becomes 1:12.

All Teams were uni-disciplinary and had an operational manager who was a social worker. The twenty-three (23) Teams received social work supervision monthly. Seventeen (17) of the Teams indicated that they received group supervision. Twelve (12) Teams reported group supervision at peer level; three (3) Teams reported specialist supervision such as Signs of Safety; and two (2) reported both types of group supervision (peer & specialist). Four (4) Teams had supervision once a month; four (4) Teams had supervision every two months; four (4) Teams reported group supervision four times a year; and five (5) Teams selected 'other'.

There were twenty-five (25) Band 5 social workers, it remains unclear how many of these were temporary or permanent as this was not reported, however one (1) Band 5 agency staff was reported across Teams regionally. There were 63.1 Band 6 social workers, however it remains unclear as to how many of these were temporary or permanent as this were not reported. However, two (2) Band 6 staff were reported as agency staff. There were 46.8 Band 7 social workers covering a range of roles including Designated Team Leaders; Senior Social Work Practitioners; Senior Social Workers; and Joint Protocol Trained.

Ten (10) Teams used caseload weighting approaches, none described what they involved. Waiting lists were used by only two (2) Teams and were managed and governed by Team Leaders, and Senior Management, through the duty system at weekly or monthly meetings. Within Trust 'E', some Teams indicated using a transfer list for moving from family support

services to LAC services to manage waiting lists. Teams were supported by five (5) Band 2 and twenty-four-and-a-half (24.5) Band 3 administrative staff. Most of the training staff received included, Signs of Safety, and specialist training such as pre-birth risk assessment, Joint Protocol training, and Family Group Conferencing. Five (5) Teams indicated that the numbers of staff did not add up to the FE; ten (10) Teams indicated that their numbers were equivalent to FE; and eight (8) Teams did not answer this question. Out of the twenty-three (23) Teams, only six (6) reported to having practice teacher(s) in their Team.

Fostering Teams (Regionally)

The following description of Fostering Teams regionally is derived from fourteen (14) Fostering Teams that reported across Children Services from the five HSC Trusts. All Teams were uni-disciplinary and had an operational manager who was a social worker. The fourteen (14) Teams received social work supervision monthly (n=14; 100.0%). Only two (2) Teams reported that they received group supervision, both reported group supervision at peer level supervision once a month.

Staffing Descriptives – Fostering Teams

The Fostering Teams regionally (see Table 31) employed eleven (11) social work assistants (Band 4); no Assessed Year in Employment (AYE) social workers (Band 5); 76.7 social workers (Band 6); and 26.1 Band 7 social workers covering a range of roles including Designated Team Leaders (5); Senior Social Work Practitioners (12.5); and Senior Social Workers (9). There were 76.7 Band 6 social workers reported however it remains unclear how many of these were temporary or permanent as this information was not consistently reported. Three (3) of the Band 6 staff in the Teams were reported as agency staff.

Table 31: Description of Fostering Teams at Regional Level

Trust	Trust A	Trust B	Trust C	Trust D	Trust E	Total
Teams (*n*)	1	4	2	3	4	14
Unfilled Band 6 Vacancies	0	3.9	4	0	5.3	13.2
Band 2	1	0	0	0	0	1
Band 3	0	4	2	0	4	10
Band 4	0	5	4	2	0	11
Band 5	0	0	0	0	0	0
Band 6	7	13	19	18	19.7	76.7
Band 7	1	7.5	5	4	8.6	26.1
Agency AYE	0	0	0	0	0	0
Agency Band 6	0	0	0	0	3	3
Practice Teachers	0	1	1	0	1	3
Overall caseload	148	344	581	288	494	1855
Allocated Cases	141	336	555	288	418	1738
Unallocated Cases	7	8	26	0	76	117
Total number of SWs w/caseloads	7	16.5	22	19	24.3	88.8
Ratio of SW to allocated caseload	1:20	1:20	1:25	1:15	1:17	1:20
Ratio of SW to total caseload (allocated + unallocated)	1:21	1:21	1:26	1:15	1:20	1:21
If vacancies were filled Total number of social workers/caseloads	7	20.4	26	19	29.6	102
Ratio of SW to allocated caseloads if vacancy filled	-	1:16	1:21	1:15	1:14	1:17
Ratio of SW to allocated and unallocated if vacancy filled	-	1:17	1:22	1:15	1:16	1:18
How many Teams developed caseload weighting approaches?	1	2	0	-	2	5
How many Teams use waiting lists?	0	4	1	-	2	7

Note: Reported data as of 28th February and 31st March 2023.

Caseload Ratio Analysis: When considering the ratio of SW to total caseload (allocated + unallocated) there was some variation within Trusts (see Table 32), for example, Trust A reported an individual Team overall caseload from 1:21; Trust B reported an individual Team range from 1:15 – 1:26; Trust C reported an individual Team range from 1:20 – 1:35; Trust D amalgamated three Teams into one thus disaggregation is not possible; and Trust E reported an individual Team range from 1:8 – 1:19 with one outlier on the upper end of 1:35.

Table 32: Fostering: Regional Frequency of Caseload Ratio (allocated + unallocated)

Trust	0-15	16-25	26-35	36-45	46+	Total
A	-	1	-	-	-	1
B	1	2	1	-	-	4
C	-	1	1	-	-	2
D	1*	-	-	-	-	3*
E	1	2	1	-	-	4
Total	5 (36%)	6 (43%)	3 (21%)	0 (0%)	0 (0%)	14

*Trust D amalgamated three Teams into one therefore disaggregation is not possible

Fostering Calculation of Social Workers all Bands with Caseloads

To calculate the number of social workers carrying caseloads, we added the AYE Band 5 social workers (0), Band 6 social workers (76.7), and Band 7 social workers who were not assumed to be Designated Team Leaders (14.1), this total is as follows (0 + 76.7 + 12.1 = 88.8).

Please Note: We calculated the Band 7 staff with caseloads using the following subtraction from the overall Band 7 social workers recorded: we subtracted an assumed Designated Team Leader (14: Teams were assumed to have a Band 7 who provided the role of Team Leader and therefore would not carry cases) from the total number of Band 7 social workers (26.1) to arrive at 11.1 Band 7 staff with caseloads. We assume (based on qualitative feedback from focus groups and interviews with front-line workers) that Designated Team Leaders do not carry caseloads. This left 88.8 social workers who were assumed to carry caseloads. Based on qualitative data from interviews and social workers we deduced that social SWAs do not carry caseloads in Fostering Teams.

Fostering Unfilled Posts

The Fostering Teams regionally, had thirteen-point-two (13.2) unfilled Band 6 social work vacancies (average vacancy per Team was 0.9 across 14 Teams; see Table 33). Two (2) were related to sick leave (4 weeks or more); one (1) was related to maternity leave; seven-point-eight (7.8) were empty posts; and two-point-four (2.4) were related to ‘other’.

Table 33: Fostering Teams Unfilled Posts Regionally

Trust	Empty posts	Maternity leave	Sickness	Other	Missing	Total
ACS	-	-	-	-	-	0
BCS	1.5	-	-	2.4	-	3.9
CCS	1	1	2	-	-	4
DCS	-	-	-	-	-	0
ECS	5.3	-	-	-	-	5.3
Total	7.8	1	2	2.4	0	13.2

Note: Reported data as of 28th February and 31st March 2023; The percentage (%) of vacancies to overall SWs/caseloads if vacancies were filled (vacancies divided in to SWs with caseloads if vacancies were filled multiplied by 100), per Trust, for fostering teams were as follows; A=0.0%; B=19.1%; C=15.4%; D=0.0%; and E=17.9%

Fostering Funded Positions

When asked if the total number of social workers (across all Bands) and social work assistants plus vacancies in the Teams correspond with the number of FE, responses were variable: two (2) Teams indicated that the numbers of staff did not add up to their FE; eight (8) Teams indicated that the numbers were equivalent to their FE, and four (4) Teams did not answer this question (see FE quotes in Appendix 4). In general, comments indicate that only two (2) of the Teams were operating below Funded Establishment.

Fostering Practice Teachers

The Fostering Teams regionally reported to having four (4) Teams with practice teachers. When asked if practice teachers have smaller caseloads than non-practice teachers none (0) of the Teams reported, 'yes', and three (3) Teams reported 'no'. One (1) Team did not respond to this survey question.

Fostering Training

The survey recorded one social worker as Joint Protocol trained and able to conduct PIA and/or ABE interviews. A total number of five (5) social workers within these Teams were trained as Leads for Signs of Safety assessments, with twelve (12) social workers trained to do specialist assessments, for example, pre-birth assessments, and a further one (1) staff trained in Family Group Conferencing.

Fostering Administrative Support

Teams were supported by one (1) Band 2 and ten (10) Band 3 administrators. This suggests that not all Teams had either Band 2 or Band 3 administrative support.

Fostering Caseloads

The combined overall caseload of the fourteen (14) Teams was 1855. A breakdown of the overall caseload revealed that 1738 were allocated cases, with 117 cases unallocated. This indicates that a total of 6.3% of cases unallocated. When we divide the number of allocated cases (1738) by the number of staff with caseloads (88.8), the ratio is 1:20, indicating an average caseload of twenty (20). When we divide the total number of allocated and unallocated cases (1855), across the number of staff with caseloads, the ratio becomes 1:21, which is an average caseload size of twenty-one (21) across Bands 5, 6 and Band 7 social workers that carried caseloads. If the vacancies were filled, the caseload ratio would become 1:17 for allocated cases and 1:18 for all cases.

Fostering Specialist Role Caseloads

When asked if social workers with a specialist role (such as ASW, DAPO, Senior Social Work Practitioners, or other) have lower caseloads than those without specialist roles, five (5; 35.7%) Teams said 'no', two (2) Teams said, 'it varies', and three (3) Teams said, 'yes'. Five (5) Teams reported those with specialist roles have caseloads of between 10 and 15; eight (8) Teams reported those with specialist roles have caseloads of between 16 and 25; and one (1) Team reported caseloads of between 26 and 35. This indicates that social workers with specialist roles have similar caseload sizes to those without specialist roles.

Fostering Social Work Assistant Caseloads

In relation to SWA caseload sizes, most Teams reported that SWAs undertake some aspects of work in social work cases but do not have their own caseloads. Therefore, we deduced that social work assistants (SWA's) do not carry their own caseloads but do assist social workers with their caseloads.

Fostering Caseload Weighting Approaches

Five (5; 5.7%) Teams indicated developing caseload weighting approaches to manage their workload. Eight (8) Teams did not indicate that they had developed caseload weighting approaches. One (1) Team did not report on this question (see Appendix 3).

Fostering Waiting Lists

Eight (8; 57.1%) Teams indicated using waiting lists and provided further information on risk and governance and processes and practice in this area (see Appendix 2).

Brief Analysis – Fostering (Regionally)

The fourteen (14) Fostering Teams regionally were managing caseloads of between 44-315. Overall, the Teams were managing an allocated caseload ratio of 1:20, and an overall caseload ratio of 1:21 among the 88.8 members of staff that carry caseloads within these Teams, and we have ranked these ratios previously in the analysis (see Table 32). There were thirteen-point-two (13.2) unfilled Band 6 vacancies across the Teams. Two (2) were related to sick leave (4 weeks or more); One (1) was related to maternity leave; seven-point-eight (7.8) were empty posts; and two-point-four (2.4) were related to 'other'. When we add the vacancies reported, the ratio for allocated caseloads becomes 1:17, whereas the overall caseload ratio becomes 1:18.

All Teams were uni-disciplinary and had an operational manager who was a social worker. The fourteen (14) Teams received social work supervision monthly. Only two (2) Teams reported that they received group supervision, both reported group supervision at peer level once a month.

There were 76.7 Band 6 social workers reported although it remains unclear as to how many of these were temporary or permanent as this information was not reported. However, three (3) Band 6 staff were reported as agency staff. There were twenty-six-point-one (26.1) Band 7 social workers covering a range of roles including Designated Team Leaders; Senior Social Work Practitioners; and Senior Social Workers.

Five (5) Teams used caseload weighting approaches, although none described what they were. Waiting lists were used by eight (8) Teams and were managed and governed by Line Managers, and Senior Social Workers, at weekly or monthly meetings. Within Trust 'B', some Teams indicated that waiting lists are for individuals or couples to undertake fostering or adoption assessments. Teams were supported by one (1) Band 2 and ten (10) Band 3 administrative staff. The majority of training staff had undergone included, Signs of Safety, and specialist training such as pre-birth risk assessment, Joint Protocol training, and Family Group Conferencing. Two (2) Teams indicated that the numbers of staff did not add up to the FE; eight (8) Teams

indicated that the numbers were equivalent to their FE; and four (4) Teams did not answer this question. Out of the fourteen (14) Teams, only four (4) reported to having practice teacher(s) in their Team.

Early Years Teams (Regionally)

The following description of Early Years Teams regionally was derived from an overview of eight (8) Early Years Teams across Children Services from four out of the five HSC Trusts (Trust E did not return any Early Years Teams). All Teams were uni-disciplinary and had an operational manager who was a social worker. All Teams received social work supervision monthly (n=8; 100.0%). Only one (1) Team reported that they received group supervision, this was reported at peer level once a month.

Staffing Descriptives – Early Years Teams

The Early Years Teams regionally (see Table 34) employed four (4) social work assistants (Band 4); no Assessed Year in Employment (AYE) social workers (Band 5); 43.4 social workers (Band 6); and five (5) Band 7 social workers covering a range of roles including Designated Team Leaders and Senior Social Workers. There were 43.4 Band 6 social workers, it remains unclear how many of these were temporary or permanent as this information was not consistently reported. None of the Band 6 staff in the Teams were reported as agency staff.

Table 34: Description of Early Years Teams at Regional Level

Trust	Trust A	Trust B	Trust C	Trust D	Trust E	Total
Teams (*n*)	2	2	2	2	0	8
Unfilled Band 6 Vacancies	1	3	1.5	0.6	-	6.1
Band 2	1	3	0	3.2	-	7.2
Band 3	4	2	2	2	-	10
Band 4	0	1	1	2	-	4
Band 5	0	0	0	0	-	0
Band 6	10	11	12	10.4	-	43.4
Band 7	1	2	0	2	-	5
Agency AYE	0	0	0	0	-	0
Agency Band 6	0	0	0	0	-	0
Practice Teachers	2	0	2	1	-	5
Overall caseload	643	440	655	201	-	1939
Allocated Cases	615	440	569	179	-	1803
Unallocated Cases	28	0	86	22	-	136
Total number of SWs w/caseloads	9	11	10	10.4	-	40.4
Ratio of SW to allocated caseload	1:68	1:40	1:57	1:17	-	1:45
Ratio of SW to total caseload (allocated + unallocated)	1:71	1:40	1:66	1:19	-	1:48
If vacancies were filled Total number of social workers/caseloads	10	14	11.5	11	-	46.5
Ratio of SW to allocated caseloads if vacancy filled	1:62	1:31	1:49	1:16	-	1:39
Ratio of SW to allocated and unallocated if vacancy filled	1:64	1:31	1:57	1:18	-	1:42
How many Teams developed caseload weighting approaches?	1	2	0	2	-	5
How many Teams use waiting lists?	1	1	1	2	-	5

Note: Reported data as of 28th February and 31st March 2023.

Caseload Ratio Analysis: When considering the caseload ratio of SW to total caseload (allocated + unallocated) there was some variation within Trusts (see Table 35), for example, Trust A reported an individual Team overall caseload ranging from 1:68 – 1:79; Trust B reported an individual Team range from 1:37 – 1:44; Trust C reported an individual Team range from 1:58 – 1:73; Trust D reported an individual Team range from 1:19 – 1:20; and Trust E did not report any Early Year Teams.

Table 35: Regional Early Years: Frequency of Caseload Ratio (allocated + unallocated)

Trust	0-15	16-25	26-35	36-45	46+	Total
A	-	-	-	-	2	2
B	-	-	-	2	-	2
C	-	-	-	-	2	2
D	-	2	-	-	-	2
E	-	-	-	-	-	-
Total	0 (0%)	2 (25%)	0	2 (25%)	4 (50%)	8

Early Years Calculation of Social Workers all Bands with Caseloads

To calculate the number of social workers carrying caseloads, we added the AYE Band 5 social workers (0), Band 6 social workers (43.4), and Band 6 and Band 7 social workers who were not assumed to be Designated Team Leaders, this total is as follows (0 + 40.4 + 0 = 40.4).

Early Years Unfilled Posts

The Early Years Teams regionally, had six-point-one (6.1) unfilled Band 6 social work vacancies (average vacancy per Team was .8 across 8 Teams; see Table 36). Two (2) were related to sick leave (4 weeks or more); one-half (.5) was related to maternity leave; two-point-six (2.6) were empty posts; and one (1) was related to 'other'.

Table 36: Early Years Teams Unfilled Posts Regionally

Trust	Empty posts	Maternity leave	Sickness	Other	Missing	Total
ACS	-	-	-	1	-	1
BCS	1	-	2	-	-	3
CCS	1	0.5	-	-	-	1.5
DCS	0.6	-	-	-	-	0.6
ECS	-	-	-	-	-	0
Total	2.6	0.5	2	1	0	6.1

Note: Reported data as of 28th February and 31st March 2023; The percentage (%) of vacancies to overall SWs/caseloads if vacancies were filled (vacancies divided in to SWs with caseloads if vacancies were filled multiplied by 100), per Trust, for early years teams were as follows; A=10.0%; B=21.4%; C=13.0%; D=5.5%; and E=0.0%

Early Years Funded Positions

When asked if the total number of social workers (across all Bands) and social work assistants plus vacancies in the Teams correspond with the number of FE positions, responses were variable. One (1) Team indicated that the numbers of staff did not add up to the FE. Five (5) Teams indicated that the numbers were equivalent to their FE, and two (2) Teams did not answer this question (see FE quotes in Appendix 4). In general, comments indicate that only one (1) of the Teams was operating below FE.

Early Years Practice Teachers

The Early Years Teams regionally reported to having five (5) Teams with practice teachers from eight (8) Teams. When asked if practice teachers have smaller caseloads than non-practice teachers two (2) Teams reported, 'yes' and three (3) Teams reported 'no'.

Early Years Training

Three (3) social work staff were reported as being Joint Protocol trained and able to conduct PIA and/or ABE interviews. Only one (1) social worker within these Teams was trained as Lead for Signs of Safety assessments, with five (5) social workers trained to do specialist assessments, for example, pre-birth assessments, and a further one (1) staff trained in Family Group Conferencing.

Early Years Administrative Support

Teams were supported by seven-point-two (7.2) Band 2 and ten (10) Band 3 administrators.

Early Years Caseloads

The combined overall caseload for the eight Teams was 1939. A breakdown of the overall caseload revealed that 1803 were allocated cases, and 126 unallocated (7%). When we divide the number of allocated cases (1803) by the number of staff with caseloads (40.4), the caseload ratio is 1:45, indicating an average caseload across Early Years Teams regionally of forty-five (45). When we divide the total number of allocated and unallocated cases (1939), across the number of staff with caseloads, the ratio becomes 1:48, which is an average caseload size of forty-eight (48) across Bands 5, 6 and Band 7 social workers that carried caseloads. If the vacancies were filled, the caseload ratio would become 1:39 for allocated cases and 1:42 for all cases (allocated plus unallocated).

Early Years Specialist Role Caseloads

When asked if social workers with a specialist role (such as ASW, DAPO, Senior Social Work Practitioners, or other) have lower caseloads than those without specialist roles, three (3; 37.5%) Teams answered ‘no’, and five (5) Teams responded ‘unknown’. Four (4) Teams reported social workers with specialist roles having caseloads of between 10 and 15; one (1) Team reported those with specialist roles having caseloads of between 46 and 55; two (2) Teams reported specialist caseloads of between 56 and 65; and one (1) Team reported specialist caseloads of more than 96. This indicates that there was no easement of caseload for those with specialist roles.

Early Years Social Work Assistant Caseloads

In relation to SWA caseload sizes, most Teams reported that SWAs undertake some aspects of work in social work cases but do not have their own caseloads. Therefore, we deduced that social work assistants (SWA's) do not carry their own caseloads but do assist social workers with their caseloads.

Early Years Caseload Weighting Approaches

Five (5; 62.5%) Teams indicated they had developed caseload weighting approaches to manage their workload demands, whereas two (2) Teams reported they had not. One (1) Team did not respond to this question (see Appendix 3).

Early Years Waiting Lists

Five (5; 62.5%) Teams indicated using waiting lists and provided further information on risk and governance and processes and practice in this area (see Appendix 2).

Brief Analysis – Early Years (Regionally)

The eight (8) Early Years Teams regionally were managing caseloads between 96-406. Overall, the Teams were managing an allocated caseload ratio of 1:45, and an overall caseload ratio of 1:48 among the 44.9 staff that carry caseloads within these Teams. There were six-point-one (6.1) unfilled Band 6 vacancies across the Teams, and we have ranked these ratios previously in the analysis (see Table 35). Two (2) were related to sick leave (4 weeks or more); One-half (.5) was related to maternity leave; two-point-six (2.6) were empty posts; and one (1) was related to 'other'. When we add the vacancies reported, the ratio for allocated caseloads becomes 1:39, whereas the ratio for the overall caseload becomes 1:42.

All Teams were uni-disciplinary and had an operational manager who was a social worker. All Teams received social work supervision monthly. Only one (1) Team reported that they received group supervision at peer level once a month. There were 43.4 Band 6 social workers reported although it is unclear how many of these were temporary or permanent as this information was not reported. No Band 6 staff were reported as agency. There were five (5) Band 7 social workers covering a range of roles including Designated Team Leaders and Senior Social Workers.

Five (5) Teams used caseload weighting approaches, none described what they were. Waiting lists were used by five (5) Teams and were managed and governed by regional procedures, at weekly or monthly meetings. Teams were supported by seven-point-two (7.2) Band 2 and ten (10) Band 3 administrative staff. Most of the training reported included, Signs of Safety, and specialist training such as pre-birth risk assessment, Joint Protocol training, and Family Group Conferencing. One (1) Team indicated that the numbers of staff did not add up to their FE. Five (5) Teams indicated that the numbers were equivalent to their FE; and two (2) Teams did not answer this question. Out of the eight (8) Teams, only five (5) reported to having practice teacher(s) in their Team.

Residential Child Teams (Regionally)

The following description of Residential Child Teams (RCT) reported regionally was derived from an overview of twenty-one (21) Residential Child Teams across Children Services from the five HSC Trusts (this reported data is not representative of the total number of RCTs regionally). Ten (10; 47.6%) Teams were uni disciplinary. All Teams had an operational manager who was a social worker. and received social work supervision. Seventeen (17) Teams received supervision monthly (81.0%); two (2) Teams received supervision six-weekly; one (1) Team received supervision twice-monthly; and one (1) Team reported supervision 'less than these options. Seventeen (17) Teams received group supervision. Seven (7) Teams reported that they received group supervision at peer level; two (2) Teams reported both peer group and specialist led supervision; Three (3) Teams reported 'something else' and went on to describe both Team Development and Reflective Practice related supervision; two (2) Teams indicated 'specialist' supervision; and three (3) Teams did not respond to this question in the survey.

Staffing Descriptives – RCT

The Residential Child Teams reported regionally (see Table 37) employed seventy-two (72) SWA (Band 4); forty-five (45) AYE social workers (Band 5); one hundred and eighteen (118) social workers (Band 6); and forty-three (43) Band 7 social workers covering a range of roles including Senior Social Work Practitioners (5), Approved Social Worker (1), Designated Adult Protection Officers (4), Designated Team Leaders (20), Deputy Team Leaders (24), Protocol Trained Staff (1), Senior Social Workers (7), and other disciplines (3).

Of the one hundred and eighteen (118) Band 6 social workers reported it is unclear how many of these were temporary or permanent as this information was not consistently reported. Five (5) of the Band 6 staff were reported as agency staff, as were four (4) Band 5 social workers.

Table 37: Description of Residential Child Teams at Regional Level

Trust	Trust A	Trust B	Trust C	Trust D	Trust E	Total
Teams (*n*)	4	5	7	1	4	21
Unfilled Band 6 Vacancies	6	12	8	0	4.5	30.5
Band 2	4	9	7	1	0	21
Band 3	18	7	10	8	0	43
Band 4	1	14	50	0	7	72
Band 5 AYE	3	17	12	4	9	45
Band 6	22	35	33	3	25	118
Band 7	8	14	12	0	9	43
Agency Band 5 AYE	0	0	1	0	3	4
Agency Band 6	0	0	1	0	4	5
Practice Teachers	0	2	3	1	3	9
Overall caseload	60	20	52	42	14	188
Allocated Cases	60	20	41	42	12	175
Unallocated Cases	0	0	11	0	2	13
Total number of SWs w/caseloads	29	61	50	6	39	185
Ratio of SW to allocated caseload	1:2	1:0.3	1:0.8	1:7	1:0.3	1:0.9
Ratio of SW to total caseload (allocated + unallocated)	1:2	1:0.3	1:1	1:7	1:0.4	1:1
If vacancies were filled Total number of social workers/caseloads	35	73	58	6	43.5	215.5
Ratio of SW to allocated caseloads if vacancy filled	1:2	1:0.3	1:0.7	-	1:0.3	1:0.8
Ratio of SW to allocated and unallocated if vacancy filled	1:2	1:0.3	1:0.9	-	1:0.3	1:0.9
How many Teams developed caseload weighting approaches?	0	1	3	0	2	6
How many Teams use waiting lists?	3	1	2	1	0	7

Note: Reported data as of 28th February and 31st March 2023.

RCT Calculation of Social Workers all Bands with Caseloads

To calculate the number of social workers carrying caseloads, we added the AYE Band 5 social workers (45), Band 6 social workers (118), and Band 7 social workers who were not assumed to be Designated Team Leaders (22), as follows (45 + 118 + 22 = 185).

RCT Unfilled Posts

The Residential Child Teams regionally, had thirty-and-a-half (30.5) unfilled Band 6 social work vacancies (average vacancy per Team was 1.5 across 21 Teams; see Table 38). Seven (7) were related to sick leave (4 weeks or more); four (4) were related to maternity leave; fourteen and a-half (14.5) were empty posts; and five (5) were related to 'other'.

Table 38: Residential Child Teams Unfilled Posts Regionally

Trust	Empty posts	Maternity leave	Sickness	Other	Missing	Total
ACS	3	2	-	1	-	6
BCS	6	1	2	3	-	12
CCS	3	-	5	-	-	8
DCS	-	-	-	-	-	0
ECS	2.5	1	-	1	-	4.5
Total	14.5	4	7	5	0	30.5

Note: Reported data as of 28th February and 31st March 2023; The percentage (%) of vacancies to overall SWs/caseloads if vacancies were filled (vacancies divided in to SWs with caseloads if vacancies were filled multiplied by 100), per Trust, for residential child teams were reported as follows; A=17.1%; B=16.4%; C=13.8%; D=0.0%; and E=10.3%

RCT Funded Positions

When asked if the total number of social workers (across all Bands) and SWAs, plus vacancies in the Teams correspond with the FE positions, responses were variable: six (6) Teams indicated that the numbers of staff did not add up to the Funded Establishment; ten (10) Teams reported that the numbers were equivalent to their FE, and five (5) Teams did not answer this question (see Funded Establishment Quotes in Appendix 4). In general, comments indicate that six (6) of the Teams were operating below Funded Establishment.

RCT Practice Teachers

The Residential Child Teams regionally reported to having nine (9) Teams with practice teachers across the twenty-one (21) Teams. When asked if practice teachers have smaller caseloads than non-practice teachers no (0) Teams reported, 'yes' and five (5) Teams reported 'no'. Four (4) Teams selected 'n/a.'

RCT Training

Two (2) social work staff within these Teams were reported to have been trained to perform assessments under the Mental Capacity Act (MCA). One (1) social worker was practicing ASW

(Approved Social Worker) under the Mental Health Order (MHO). One (1) social worker participated in the HSCNI Trust Rota. Four (4) social work staff indicated that they were Joint Protocol trained and able to conduct PIA (Pre-Interview Assessment) and/or ABE (Achieving Best Evidence) interviews. Seventeen (17) social workers within these Teams were trained as Leads for Signs of Safety assessments, with thirteen (13) social workers trained to do specialist assessments, for example, pre-birth assessments, and a further two (2) staff trained in Family Group Conferencing.

RCT Administrative Support

Teams were supported by twenty-one (21) Band 2 and forty-three (43) Band 3 administrators.

RCT Caseloads

The combined overall caseload for the twenty-one (21) Teams was 188. A breakdown of the overall caseload revealed that 175 were allocated cases, with 13 cases unallocated (6.9%). When we divide the number of allocated cases (175) by the number of staff with caseloads (185), the ratio is 1:0.9, indicating an average caseload across Early Years Teams regionally of less than one. When we divide the total number of allocated and unallocated cases (188), across the number of staff with caseloads, the ratio becomes 1:1, which is an average caseload size of one across Bands 5, 6 and Band 7 social workers carrying cases. If the vacancies were filled, the caseload ratio would become 1:0.8 allocated cases. If unallocated cases are added to allocated, the caseload ratio becomes 1:0.9 per social worker.

RCT Specialist Role Caseloads

When asked if social workers with a specialist role (such as ASW, DAPO, Senior Social Work Practitioners, or other) have lower caseloads than those without specialist roles, ten (10) Teams reported ‘no’; two (2) Teams said, ‘it varies’; one (1) Team reported ‘yes’; and eight (8) Teams said, ‘unknown’. All Teams reported those with specialist roles having caseloads below ten (10).

RCT Social Work Assistant Caseloads

In relation to SWA caseload sizes, most Teams reported that SWAs undertake some aspects of work in social work cases but do not have their own caseloads as indicated by qualitative data

from the survey. Therefore, we deduced that social work assistants (SWA's) do not carry their own caseloads but do assist social workers with their caseloads.

RCT Caseload Weighting Approaches

Six (6; 28.6%) Teams reported that they had developed caseload weighting approaches to manage their workload demands, compared to fourteen (14) Teams who indicated that they had not. One (1) Team did not respond to this question (see Appendix 3).

RCT Waiting Lists

Seven (7; 33.3%) Teams indicated using waiting lists and provided further information on risk and governance and processes and practice in this area (see Appendix 2).

Brief Analysis – Residential Child Teams (Regionally)

The twenty-one (21) Residential Child Teams regionally were managing caseloads of between 1 and 52. Overall, the Teams were managing an allocated caseload ratio of 1:0.9, and an overall caseload ratio of 1:1 among 185 members of staff that carry caseloads within these Teams. There were thirty-and-a-half (30.5) unfilled Band 6 vacancies across the Teams. Seven (7) were related to sick leave (4 weeks or more); Four (4) were related to maternity leave; fourteen-and-a-half (14.5) were empty posts; and five (5) were related to 'other'. When we add the vacancies reported, the ratio for allocated cases becomes 1:0.8, whereas the ratio for the overall caseload is 1:0.9.

Ten (10) of the twenty-one (21) Teams were uni disciplinary. All Teams had an operational manager who was a social worker and received social work supervision. Seventeen (17) Teams received supervision monthly; two (2) Teams received supervision six-weekly; one (1) Team received supervision twice-monthly; and one (1) Team reported supervision frequency 'less than these options'. Seventeen (17) Teams received group supervision. Seven (7) Teams reported that they received group supervision at peer level; two (2) Teams reported both peer group and specialist led supervision; three (3) Teams reported 'something else' and went on to describe both Team Development and Reflective Practice related supervision; two (2) Teams indicated 'specialist' supervision; and three (3) Teams did not respond to this question in the survey.

There were forty-five (45) Band 5 social workers and one hundred-and-eighteen (118) Band 6 social workers. It is unclear how many of these were temporary or permanent as this information was not reported. However, four (4) Band 5 staff and five (5) Band 6 staff were reported as agency staff. There were forty-three (43) Band 7 social workers reported covering a range of roles including Senior Social Work Practitioners; Approved Social worker; Designated Adult Protection Officers; Designated Team Leaders; Deputy Team Leaders; Protocol Trained Staff; and Senior Social Workers.

Six (6) Teams used caseload weighting approaches however none provided any detail. One (1) Team noted that these approaches 'are not applicable to residential'. Waiting lists were used by seven (7) Teams and were managed and governed through a Trust Resource Panel and at Head of Service level. Teams were supported by twenty-one (21) Band 2 and forty-three (43) Band 3 administrative staff. The majority of training reported included, Signs of Safety, and specialist training such as pre-birth risk assessment and MCA assessment, Joint Protocol training, and Family Group Conferencing. Six (6) Teams indicated that the numbers of staff did not add up to the Funded Establishment; Ten (10) Teams indicated that the numbers were equivalent to their Funded Establishment; and five (5) Teams did not answer this question. Out of the twenty-one (21) Teams, only nine (9) reported to having practice teacher(s) in their Team.

Family Centres Teams (Regionally)

The following description of Family Centres Teams regionally was derived from an overview of three (3) Family Centres Teams across Children Services from three out of the five HSC Trusts. All three (3) Teams were uni-disciplinary and had an operational manager who was a social worker. All Teams received social work supervision monthly. Two (2) of the Teams indicated that they received group supervision. Both Teams reported group supervision at peer level. One (1) Team had supervision once a month and one (1) Team reported group supervision four times a year.

Staffing Descriptives – Family Centres Teams

The Family Centres Teams regionally (see Table 39) employed two (2) SWAs (Band 4); no AYE social workers (Band 5); seventeen (17) social workers (Band 6); and four (4) Band 7 social workers covering a range of roles including Designated Team Leaders (3); Senior Social Work Practitioners (1); Senior Social Workers (2); and Joint Protocol Trained (2). There were seventeen (17) Band 6 social workers reported although it is unclear how many of these were

temporary or permanent as this information was not consistently reported. None of the Band 6 staff in the Teams were agency.

Table 39: Description of Family Centres Teams at Regional Level

Trust	Trust A	Trust B	Trust C	Trust D	Trust E	Total
Teams (*n*)	1	1	0	1	0	3
Unfilled Band 6 Vacancies	-	2	-	1	-	3
Band 2	0	0	-	0	-	0
Band 3	1	3	-	0	-	4
Band 4	1	0	-	1	-	2
Band 5	0	0	-	0	-	0
Band 6	4	6	-	7	-	17
Band 7	1	1	-	2	-	4
Agency AYE	-	-	-	-	-	0
Agency Band 6	-	-	-	-	-	0
Practice Teachers	1	-	-	1	-	2
Overall caseload	38	46	-	30	-	114
Allocated Cases	31	35	-	26	-	92
Unallocated Cases	7	11	-	4	-	22
Total number of SWs w/caseloads	4	6	-	8	-	18
Ratio of SW to allocated caseload	1:8	1:6	-	1:3	-	1:5
Ratio of SW to total caseload (allocated + unallocated)	1:10	1:8	-	1:4	-	1:6
If vacancies were filled Total number of social workers/caseloads	4	8	-	9	-	21
Ratio of SW to allocated caseloads if vacancy filled	1:8	1:4	-	1:3	-	1:4
Ratio of SW to allocated and unallocated if vacancy filled	1:10	1:6	-	1:3	-	1:5
How many Teams developed caseload weighting approaches?	-	-	-	-	-	0
How many Teams use waiting lists?	1	-	-	-	-	1

Note: Reported data as of 28th February and 31st March 2023

Family Centres Calculation of Social Workers all Bands with Caseloads

To calculate the number of social workers with caseloads, we added the AYE Band 5 social workers (0), Band 6 social workers (17), and Band 7 social workers who were not assumed to be Designated Team Leaders (1), this total is as follows (0 + 17 + 1 = 18).

Please Note: We calculated the Band 7 staff with caseloads using the following subtraction from the overall Band 7 social workers recorded: We subtracted an assumed Designated Team Leader (3: most Teams were assumed to have a Band 7 who provided the role of Team Leader and therefore would not carry a caseload) from the total number of Band 7 social workers (4) to arrive at one (1) Band 7 staff with caseloads. We assume (based on qualitative feedback from

focus groups and interviews with front-line workers) that Designated Team Leaders do not carry caseloads. This left eighteen (18) social workers who were assumed to carry caseloads. Based on qualitative findings from interviews and focus group we also deducted that SWAs do not carry caseloads.

Family Centres Unfilled Posts

The Family Centres Teams regionally, had three (3) unfilled Band 6 social work vacancies (average vacancy per Team was 1 across 3 Teams; see Table 40). One (1) was related to sick leave (4 weeks or more); none (0) were related to maternity leave; and two (2) were empty posts.

Table 40: Family Centres Teams Unfilled Posts Regionally

Trust	Empty posts	Maternity leave	Sickness	Other	Missing	Total
ACS	-	-	-	-	-	0
BCS	1	-	1	-	-	2
CCS	-	-	-	-	-	0
DCS	1	-	-	-	-	1
ECS	-	-	-	-	-	0
Total	2	0	1	0	0	3

Note: Reported data as of 28th February and 31st March 2023; The percentage (%) of vacancies to overall SWs/caseloads if vacancies were filled (vacancies divided in to SWs with caseloads if vacancies were filled multiplied by 100), per Trust, for family centres teams were as follows; A=0.0%; B=25.0%; C=0.0%; D=11.1%; and E=0.0%

Family Centres Funded Positions

When asked if the total number of social workers (across all Bands) and social work assistants plus vacancies in the Teams correspond with the number of FE positions. One (1) Team indicated that the numbers of staff did not add up to the Funded Establishment; one (1) Team reported that the numbers were equivalent to their Funded Establishment, and the other Team did not answer this question (see FE quotes in Appendix 4). Qualitative data across the region indicate that a review of Funded Establishment has not taken place for at least 10 years.

Family Centres Practice Teachers

The Family Centres Teams regionally reported to having two (2) practice teachers across the three Teams. When asked if practice teachers have smaller caseloads than non-practice teachers one (1) Team reported, 'yes' and one (1) Team reported 'no'.

Family Centres Training

Two (2) social work staff were reported as being Joint Protocol trained and able to conduct PIA and/or ABE interviews. A total number of four (4) social workers within these Teams were trained as Leads for Signs of Safety assessments, with fourteen (14) social workers trained to do specialist assessments, for example, pre-birth assessments.

Family Centres Administrative Support

Teams had no (0) Band 2 and four (4) Band 3 administrators. Administrative support was inconsistently reported, with some Trusts reporting no administrative Band 2 or 3 posts.

Family Centres Caseloads

The combined overall caseload was 114. A breakdown of the overall caseload revealed that 92 were allocated cases, with 22 cases unallocated (19.3%). When we divide the number of allocated cases (92) by the number of staff with caseloads (18), the ratio is 1:5, indicating an average caseload across Family Centres Teams regionally of five (5). When we divide the total number of allocated and unallocated cases (114), across the number of staff with caseloads, the ratio becomes 1:6, which is an average caseload size of six (6) across Bands 5, 6 and Band 7 social workers that carried caseloads. If the vacancies were filled, the caseload ratio would become 1:4 for allocated cases and 1:5 if unallocated cases are added to allocated.

Family Centres Specialist Role Caseloads

When asked if social workers with a specialist role (such as ASW, DAPO, Senior Social Work Practitioners, or other) have lower caseloads than those without specialist roles, two (2) Teams said, ‘it varies’, and one (1) Team said, ‘yes’. All three (3) Teams reported those with specialist roles have caseloads of between 10 and 15. This indicates similar caseload numbers to those staff without specialist roles, which suggests no easement of caseload for those with specialist roles.

Family Centres Social Work Assistant Caseloads

In relation to Family Centres Teams social work assistant caseload sizes, most Teams reported that SWAs undertake some aspects of work in social work cases but do not have their own caseloads. Therefore, we assume SWAs do not carry their own caseloads.

Family Centres Caseload Weighting Approaches

None of the Teams indicated developing caseload weighting approaches to manage their workload demands (see Appendix 3).

Family Centres Waiting Lists

One (1) Team indicated using waiting lists and provided further information on risk and governance and processes and practice in this area (see Appendix 2).

Brief Analysis – Family Centres (Regionally)

The three (3) Family Centres Teams regionally were managing caseloads between 30-46. Overall, the Teams were managing an allocated caseload ratio of 1:5, and an overall (unallocated plus allocated cases) caseload ratio of 1:6 among the eighteen (18) members of staff that carry caseloads. There were three (3) unfilled Band 6 vacancies across the Teams. One (1) was related to sick leave (4 weeks or more); none (0) were related to maternity leave; and two (2) were empty posts. When we add the vacancies reported, the ratio for allocated caseloads ratio becomes 1:4 and for overall caseloads the ratio becomes 1:5.

All Teams were uni-disciplinary and had an operational manager who was a social worker. All Teams received social work supervision monthly. Two (2) of the Teams indicated that they received group supervision. Both Teams reported group supervision at peer level. One (1) Team had supervision once a month and one (1) Team reported group supervision four times a year.

There were seventeen (17) Band 6 social workers reported but it is unclear how many of these were temporary or permanent as this information was not reported. None of the Band 6 social workers were reported as agency staff. There were four (4) Band 7 social workers covering a range of roles including Designated Team Leaders; Senior Social Work Practitioners; Senior Social Workers; and Joint Protocol Trained.

None of the Teams used caseload weighting approaches. Waiting lists were used by one (1) Team and were managed and governed with regular meetings/discussions to prioritise families on waiting lists. Teams had no (0) Band 2 and four (4) Band 3 administrative staff. The majority of training reported included, Signs of Safety, and specialist training such as pre-birth risk assessment, and Joint Protocol training. One (1) Team indicated that the numbers of staff did not add up to the FE; one (1) Team indicated that the numbers were equivalent to their FE and

one (1) Team did not answer this question. Out of the three (3) Teams, only two (2) reported to having practice teacher(s) in their Team.

Children's Court Services Teams (Regionally)

The following description of Children's Court Services (CCS) Teams regionally was derived from an overview of two (2) Court Services Teams across Children Services from two out of the five HSC Trusts who reported these Team types. Both Teams were uni-disciplinary and had an operational manager who was a social worker. Both Teams received social work supervision monthly. One (1) of the Teams indicated that they received group supervision at both peer group and specialist led four times a year.

Staffing Descriptives – Children's Court Services Teams

The Children's Court Services Teams regionally (see Table 41) only reported ten (10) Band 7 social workers covering a range of roles including Senior Social Work Practitioners (8), and Senior Social Workers (2).

Table 41: Description of Children's Court Services (CCS) Teams at Regional Level

Trust	Trust A	Trust B	Trust C	Trust D	Trust E	Total
Teams (*n*)	0	1	0	0	1	2
Unfilled Band 6 Vacancies	-	-	-	-	-	0
Band 2	-	-	-	-	-	0
Band 3	-	1	-	-	1	2
Band 4	-	-	-	-	-	0
Band 5	-	-	-	-	-	0
Band 6	-	-	-	-	-	0
Band 7	-	4	-	-	6	10
Agency AYE	-	-	-	-	-	0
Agency Band 6	-	-	-	-	-	0
Practice Teachers	-	1	-	-	-	1
Overall caseload	-	124	-	-	397	521
Allocated Cases	-	98	-	-	397	495
Unallocated Cases	-	26	-	-	0	26
Total number of SWs w/caseloads	-	3	-	-	5	8
Ratio of SW to allocated caseload	-	1:33	-	-	1:79	1:62
Ratio of SW to total caseload (allocated + unallocated)	-	1:41	-	-	1:79	1:65
If vacancies were filled Total number of social workers/caseloads	-	-	-	-	-	-
Ratio of SW to allocated caseloads if vacancy filled	-	-	-	-	-	-
Ratio of SW to allocated and unallocated if vacancy filled	-	-	-	-	-	-
How many Teams developed caseload weighting approaches?	-	-	-	-	-	0
How many Teams use waiting lists?	-	-	-	-	-	2

Note: Reported data as of 28th February and 31st March 2023

CCS Calculation of Social Workers all Bands with Caseloads

Since there were only Band 7 social workers reported in the two (2) Teams, in order to calculate the number of social workers carrying caseloads we subtracted an assumed Designated Team Leader (2: most Teams were assumed to have a Band 7 who provided the role of Team Leader and therefore would not carry a caseload) from the total number of Band 7 social workers (10) to arrive at eight (8) Band 7 staff with caseloads. We assume (based on qualitative feedback from focus groups and interviews with front-line workers) that Designated Team Leaders do not carry caseloads.

CCS Funded Positions

When asked if the total number of social workers (across all Bands) correspond with the number of FE positions, one (1) Team indicated that the numbers of staff did not add up to the FE and the other Team did not answer this question.

CCS Practice Teachers

The Children's Court Services Teams regionally reported to having one (1) practice teacher across the two Teams. When asked if practice teachers have smaller caseloads than non-practice teachers this Team reported, 'no'.

CCS Training

Six (6) social work staff were reported as Joint Protocol trained and able to conduct PIA and/or ABE interviews, however, this was not used in their current role. A total number of one (1) social worker within these Teams was trained as Leads for Signs of Safety assessments, with four (4) social workers trained to do specialist assessments, for example, pre-birth assessments. Only one (1) social worker was trained in Family Group Conferencing.

CCS Administrative Support

Teams were supported by two (2) Band 3 administrators.

CCS Caseloads

The combined overall caseload for the two (2) Teams was 521. A breakdown of the overall caseload revealed that 495 were allocated cases, with 26 cases unallocated (5%). When we divide the number of allocated cases (495) by the number of staff with caseloads (8), the caseload ratio is 1:62, indicating an average caseload across Children's Court Services Teams regionally of sixty-two (62). When we divide the total number of allocated and unallocated cases (521), across the number of staff with caseloads, the ratio becomes 1:65, which is an average caseload size of sixty-five (65) across Band 7 social workers that carried caseloads. There were no (0) unfilled vacancies reported in the survey.

CCS Specialist Role Caseloads

When asked if social workers with a specialist role (such as ASW, DAPO, Senior Social Work Practitioners, or other) have lower caseloads than those without specialist roles, one (1) Team

said, ‘it varies’, and one (1) Team said, ‘unknown’. One (1) Team reported those with specialist roles have caseloads of between 22 and 36, whereas the remaining Team did not respond to this survey question. The Children’s Court Services social workers are specialist Band 7s therefore all staff had specialist roles within this service.

CCS Caseload Weighting Approaches

None (0) of the Teams indicated developing caseload weighting approaches to manage their workload demands.

CCS Waiting Lists

Both Teams indicated using waiting lists and provided further information on risk and governance and processes and practice in this area (see Appendix 2).

Brief Analysis – Children’s Court Services Teams regionally

The two (2) Children’s Court Services Teams regionally were managing caseloads between 127-397. Overall, the Teams were managing a caseload ratio of 1:62 for allocated cases, and an overall (unallocated plus allocated cases) ratio of 1:65 among the eight (8) members of staff that carry caseloads. There were no (0) unfilled Band 6 vacancies across the Teams because there were no Band 6 staff. Both Teams were uni-disciplinary and had an operational manager who was a social worker. Both Teams received social work supervision monthly. One (1) of the Teams indicated that they received group supervision at both peer group and specialist led four times a year. There were ten (10) Band 7 social workers covering a range of roles including Senior Social Work Practitioners; and Senior Social Workers.

None (0) of the Teams used caseload weighting approaches. Waiting lists were used by both Teams and were managed and governed with monthly meetings/discussions to prioritise cases on waiting lists. Any issues that arise in the case whilst sitting on the waiting list are usually dealt with by Gateway. Teams were supported by two (2) Band 3 administrative staff. The majority of training reported included Signs of Safety, Family Group Conferencing, and specialist training such as pre-birth risk assessment. One (1) Team indicated that the numbers of staff were equivalent to their FE, and one (1) Team did not answer this question. Out of the two (2) Teams, only one (1) reported to having practice teacher(s) in their Team.

Adoption Teams (Trust B)

The following description of Adoption Teams was derived from an overview of two (2) Adoption Teams across Children Services was reported from only one of the five HSC Trusts. Both Teams were uni-disciplinary and had an operational manager who was a social worker. Both Teams received social work supervision monthly and group supervision. One (1) Team reported group supervision at peer level and the other Team reported both peer group and specialist supervision. One (1) Team had supervision once a month and the other Team reported group supervision every two months.

Staffing Descriptives – Adoption Teams (Trust B)

The Adoption Teams within Trust B (see Table 42; other Trusts did not report on Adoption Teams) employed five (5) SWAs (Band 4); seven (7) social workers (Band 6); and four (4) Band 7 social workers covering a range of roles including Designated Team Leaders (2) and Senior Social Work Practitioners (2). There were seven (7) Band 6 social workers reported but it is unclear how many of these were temporary or permanent as this information was not reported. None (0) of the Band 6 staff in the Teams were agency.

Table 42: Description of Adoption Teams

Trust	Trust A	Trust B	Trust C	Trust D	Trust E	Total
Teams (*n*)	0	2	0	0	0	2
Unfilled Band 6 Vacancies	-	5	-	-	-	5
Band 2	-	0	-	-	-	0
Band 3	-	2	-	-	-	1
Band 4	-	5	-	-	-	5
Band 5	-	0	-	-	-	0
Band 6	-	7	-	-	-	7
Band 7	-	4	-	-	-	4
Agency AYE	-	0	-	-	-	0
Agency Band 6	-	0	-	-	-	0
Practice Teachers	-	1	-	-	-	1
Overall caseload	-	327	-	-	-	327
Allocated Cases	-	138	-	-	-	138
Unallocated Cases	-	189	-	-	-	189
Total number of SWs w/caseloads	-	9	-	-	-	9
Ratio of SW to allocated caseload	-	1:15	-	-	-	1:15
Ratio of SW to total caseload (allocated + unallocated)	-	1:36	-	-	-	1:36
If vacancies were filled Total number of social workers/caseloads	-	14	-	-	-	14
Ratio of SW to allocated caseloads if-vacancy filled		1:10	-	-	-	1:10
Ratio of SW to allocated and unallocated-if vacancy filled		1:23	-	-	-	1:23
How many Teams developed caseload weighting approaches?	-	2	-	-	-	2
How many Teams use waiting lists?	-	2	-	-	-	2

Note: Only Trust B entered Adoption Teams within the survey; Reported data as of 28th February and 31st March 2023

Adoption Calculation of Social Workers all Bands with Caseloads

In terms of social workers carrying caseloads, we added the AYE Band 5 social workers (0), Band 6 social workers (7), and Band 7 social workers who were not assumed to be Designated Team Leaders (2), this total is as follows (0 + 7 + 2 = 9).

Please Note: We calculated the Band 7 staff with caseloads by subtraction from the overall Band 7 social workers recorded – a designated Team Leader (2: most Teams were assumed to have a Band 7 who provided the role of Team Leader and therefore would not carry a caseload) from the total number of Band 7 social workers (4) to arrive at two Band 7 staff with caseloads. We assume (based on qualitative feedback from focus groups and interviews with front-line workers) that Designated Team Leaders do not carry caseloads. This left nine social workers who were assumed to carry caseloads. We also deducted that social work assistants do not carry

caseloads in Adoption Teams based on findings from the qualitative data. Instead, social work assistants were reported to take aspects of work from social workers for example supervised contact.

Adoption Unfilled Posts

The Adoption Teams in Trust B reported five (5) unfilled Band 6 social work vacancies (average vacancy per Team; see Table 43). One (1) was related to sick leave (4 weeks or more) and four (4) were empty posts.

Table 43: Adoption Teams Unfilled Posts

Trust	Empty posts	Maternity leave	Sickness	Other	Missing	Total
ACS	-	-	-	-	-	0
BCS	4	-	1	-	-	5
CCS	-	-	-	-	-	0
DCS	-	-	-	-	-	0
ECS	-	-	-	-	-	0
Total	4	0	1	0	0	5

Note: Reported data as of 28th February and 31st March 2023; The percentage (%) of vacancies to overall SWs/caseloads if vacancies were filled (vacancies divided into SWs with caseloads if vacancies were filled multiplied by 100), per Trust, for adoption teams were as follows; B=35.7%

Adoption Funded Positions

When asked if the total number of social workers (across all Bands) and social work assistants plus vacancies in the Teams correspond with the number of FE positions, one (1) Team indicated that their numbers were equivalent to their FE and the other Team did not answer this question (see Funded Establishment Quotes in Appendix 4).

Adoption Practice Teachers

The Adoption Teams reported to having one (1) practice teacher in one (1) Team When asked if practice teachers have smaller caseloads than non-practice teachers this Team reported, 'no'.

Adoption Training

One (1) social worker within these Teams was reported as having been trained as Leads for Signs of Safety assessments, with five (5) social workers trained to do specialist assessments, for example, pre-birth assessments.

Adoption Administrative Support

Teams were supported by two (2) Band 3 administrators.

Adoption Caseloads

The combined overall caseload of the two (2) Teams was 327. A breakdown of the overall caseload revealed that 138 were allocated cases, with 189 cases unallocated (57.8%). When we divide the number of allocated cases (138) by the number of staff with caseloads (9), the caseload ratio is 1:15, indicating an average caseload across Adoption Teams of fifteen (15). When we divide the total number of allocated and unallocated cases (327), across the number of staff with caseloads, the ratio becomes 1:36, which is an average caseload size of thirty-six (36) across Bands 5, 6 and Band 7 social workers carrying caseloads. If the vacancies were filled, the caseload ratio would become 1:10 for allocated cases and 1:23 for all cases (unallocated + allocated).

Adoption Specialist Role Caseloads

When asked if social workers with a specialist role (such as ASW, DAPO, Senior Social Work Practitioners, Specialist Assessment or other) have lower caseloads than those without specialist roles, one (1) Team said 'no' and one (1) Team said, 'it varies'. One (1) Team reported those with specialist roles have caseloads of between 10 and 15 while the other Team indicated those with specialist roles have caseloads of between 46 and 55. This suggests that social workers with specialist roles have similar caseloads to those without specialist roles.

Adoption Social Work Assistant Caseloads

In relation to Adoption Teams SWA caseloads, the Teams reported that SWAs undertake some aspects of work in social work cases but do not have their own caseloads.

Adoption Caseload Weighting Approaches

Both Teams indicated they had developed caseload weighting approaches to manage their workload demands (see Appendix 3).

Adoption Waiting Lists

Both Teams indicated using waiting lists and provided further information on risk and governance and processes and practice in this area (see Appendix 2).

Brief Analysis – Adoption Teams (Trust B)

The two (2) Adoption Teams within the survey were managing caseloads between 120-207. Overall, the Teams had a caseload ratio of 1:15 for allocated cases, and for all cases (unallocated + allocated) the ratio was 1:36 among nine (9) members of staff that carry caseloads within these Teams. There were five (5) unfilled Band 6 vacancies across the Teams. One (1) related to sick leave (4 weeks or more), and four (4) empty posts. When we add the vacancies reported, the ratio for allocated caseloads ratio becomes 1:10 and for all cases 1:23.

Both Teams were uni-disciplinary and had an operational manager who was a social worker. The two (2) Teams received social work supervision monthly. Both Teams indicated that they received group supervision. One (1) Team reported group supervision at peer level and the other Team reported both peer group and specialist supervision. One (1) Team had supervision once a month and one (1) Team reported group supervision every two months.

There were seven (7) Band 6 social workers reported although it is not clear how many of these were temporary or permanent as this information was inconsistently reported. There were no (0) Band 6 social work reported as agency staff. There were four (4) Band 7 social workers covering a range of roles including Designated Team Leaders and Senior Social Work Practitioners.

Both Teams used caseload weighting approaches, one described a weighting system where by two hours was equal to one point regardless of complexity. Waiting lists were used by both Teams and were managed and governed by Team Leaders who export unallocated cases monthly to Senior Managers or Head of Service. Teams were supported by two (2) Band 3 administrative staff. The majority of training that was reported were, Signs of Safety, and specialist training such as pre-birth risk assessment. One (1) Team indicated that the numbers of staff were equivalent to their FE. Out of the two (2) Teams, only one (1) reported to having practice teacher(s) in their Team.

14+ Teams (Regionally)

The following description of 14+ Teams regionally was derived from an overview of ten (10) 14+ Teams across Children Services from three of the five HSC Trusts. The majority of Teams were uni disciplinary. All ten (10) Teams had an operational manager who was a social worker and received social work supervision monthly. Three (3) of the Teams indicated that they

received group supervision at peer level. One (1) Team had supervision once a month and two (2) Teams reported group supervision four times a year.

Staffing Descriptives – 14+ Teams

The 14+ Teams regionally (see Table 44) employed twenty-nine (29) SWAs (Band 4); five (5) AYE social workers (Band 5); twenty-nine-and-a-half (29.5) social workers (Band 6); and thirteen (13) Band 7 social workers covering a range of roles including Designated Team Leaders (8); Senior Social Work Practitioners (8); Senior Social Workers (3); and Joint Protocol Trained (10). Of the five (5) Band 5 (AYE) social workers, none (0) were agency staff. There were 29.5 Band 6 social workers reported. It is unclear how many of these were temporary or permanent as they this information was not consistently reported. None (0) of the Band 6 staff in the Teams were agency.

Table 44: Description of 14+ Teams at Regional Level

Trust	Trust A	Trust B	Trust C	Trust D	Trust E	Total
Teams (*n*)	6 *	1	3	0	0	10
Unfilled Band 6 Vacancies	5	1	4	-	-	10
Band 2	1	0	0	-	-	1
Band 3	3	0	7	-	-	10
Band 4	14	1	14	-	-	29
Band 5	2	0	3	-	-	5
Band 6	12.5	1	16	-	-	29.5
Band 7	5	1	7	-	-	13
Agency AYE	0	0	0	-	-	0
Agency Band 6	0	0	0	-	-	0
Practice Teachers	4	1	2	-	-	7
Overall caseload	381	8	295	-	-	684
Allocated Cases	310	6	295	-	-	611
Unallocated Cases	71	2	0	-	-	73
Total number of SWs w/caseloads	13.5	1	23	-	-	37.5
Ratio of SW to allocated caseload	1:23	1:6	1:13	-	-	1:16
Ratio of SW to total caseload (allocated + unallocated)	1:28	1:8	1:13	-	-	1:18
If vacancies were filled Total number of social workers/caseloads	18.5	2	27	-	-	47.5
Ratio of SW to allocated caseloads if vacancy filled	1:17	1:3	1:11	-	-	1:13
Ratio of SW to allocated and unallocated if vacancy filled	1:21	1:4	1:11	-	-	1:14
How many Teams developed caseload weighting approaches?	2	0	1	-	-	3
How many Teams use waiting lists?	2	0	1	-	-	3

Note: Reported data as of 28th February and 31st March 2023: *Trust A reported caseloads for only 5 Teams therefore the omitted Team's SW/caseloads (*n*=1) were not counted in the above analysis

Caseload Ratio Analysis: When considering the caseload ratio of SW to total caseload (allocated + unallocated) there was some variation within Trusts (see Table 45 below), for example, Trust A reported an individual Team overall caseload ranging from 1:23 – 1:30 with one outlier on the upper end of 1:73; Trust C reported an individual Team range from 1:8 – 1:14. Trust D and E did not report individual 14+ Teams.

Table 45: 14+: Regional Frequency of Caseload Ratio (allocated + unallocated)

Trust	0-15	16-25	26-35	36-45	46+	Total
A	-	3	1	-	1	5
B	1	-	-	-	-	1
C	3	-	-	-	-	3
D	-	-	-	-	-	-
E	-	-	-	-	-	-
Total	4 (44%)	3 (33%)	1 (11%)	0 (0%)	1 (11%)	9

14+ Calculation of Social Workers all Bands with Caseloads

To calculate the number of social workers carrying caseloads we added the AYE Band 5 social workers (5), Band 6 social workers (29.5), and Band 7 social workers who were not assumed to be Designated Team Leaders (3), this total is as follows (5 + 29.5 + 3 = 37.5).

Please Note: We calculated the Band 7 staff with caseloads using the following subtraction from the overall Band 7 social workers recorded: We subtracted an assumed Designated Team Leader (10: most Teams were assumed to have a Band 7 who provided the role of Team Leader and therefore would not carry a caseload) from the total number of Band 7 social workers (13) to arrive at three (3) Band 7 staff with caseloads. We assume (based on qualitative feedback from focus groups and interviews with front-line workers) that Designated Team Leaders do not carry caseloads. This left 37.5 social workers who were assumed to carry caseloads. Based on the qualitative data we also deducted that SWAs do not carry caseloads in 14+ Teams.

14+ Unfilled Posts

The 14+ Teams regionally, had ten (10) unfilled Band 6 social work vacancies (average vacancy per Team was 1 across 10 Teams; see Table 46). Four (4) were related to sick leave (4 weeks or more); one (1) was related to maternity leave; and five (5) were empty posts.

Table 46: 14+ Teams Unfilled Posts Regionally

Trust	Empty posts	Maternity leave	Sickness	Other	Missing	Total
ACS	4	-	1	-	-	5
BCS	1	-	-	-	-	1
CCS	-	1	3	-	-	4
DCS	-	-	-	-	-	0
ECS	-	-	-	-	-	0
Total	5	1	4	0	0	10

Note: Reported data as of 28th February and 31st March 2023; The percentage (%) of vacancies to overall SWs/caseloads if vacancies were filled (vacancies divided in to SWs with caseloads if vacancies were filled multiplied by 100), per Trust, for 14+ teams were as follows; A=27.0%; B=50.0%; C=14.8%

14+ Funded Positions

When asked if the total number of social workers (across all Bands) and social work assistants plus vacancies in the Teams correspond with the number of FE positions, five (5) Teams indicated that the numbers were equivalent to their FE and five (5) Teams did not answer this question (see Funded Establishment Quotes in Appendix 4). In general, comments indicate that Teams were operating in line with their FE. Qualitative data across the region indicate that a review of Funded Establishment has not taken place for at least 10 years.

14+ Practice Teachers

The 14+ Teams regionally reported to having seven (7) practice teachers across the ten (10) Teams. When asked if practice teachers have smaller caseloads than non-practice teachers only two (2) Teams reported, 'yes' and five (5) Teams reported 'no'.

14+ Training

Responses to the survey indicate that fourteen (14) staff across the Teams had been Joint Protocol trained and able to conduct PIA and/or ABE interviews. A total number of five (5) social workers within these Teams were trained as Leads for Signs of Safety assessments, with fifteen (15) social workers trained to do specialist assessments, for example, pre-birth assessments.

14+ Administrative Support

Teams were supported by one (1) Band 2 and ten (10) Band 3 administrators.

14+ Caseloads

The combined overall caseload of the ten (10) Teams was 684. A breakdown of the overall caseload revealed that 611 were allocated cases, and 73 unallocated (10.7%). When we divide the number of allocated cases (611) by the number of staff with caseloads (37.5), the ratio is 1:16, indicating an average caseload across 14+ Teams regionally of sixteen (16). When we divide the total number of allocated and unallocated cases (684), across the number of staff with caseloads, the ratio becomes 1:18, which is an average caseload size of eighteen (18) across Bands 5, 6 and Band 7 social workers that carried caseloads. If the vacancies were filled, the caseload ratio would become 1:13 allocated cases. If unallocated cases are added to allocated, the caseload ratio becomes 1:14.

14+ Specialist Role Caseloads

When asked if social workers with a specialist role (such as ASW, DAPO, Senior Social Work Practitioners, or other) have lower caseloads than those without specialist roles, five (5) Teams said 'no', three (3) Teams said, 'it varies', and only two (2) Teams said, 'yes'. All ten (10) Teams reported those with specialist roles have caseloads of between 10 and 15. This suggests that there was no easement of caseload for those with specialist roles.

14+ Social Work Assistant Caseloads

In relation to 14+ Teams SWA caseload sizes, most Teams reported they undertake some aspects of work in social work cases but do not have their own caseloads. For example, one Team reported the following: "SWA does not hold a specific caseload however works with the major of young people known to the 14 Plus Team. SWA manages contact arrangements for 45+ hours of contact per week. SWA completes spot checks and assists with support plans for young people". Therefore, we assume that social work assistants (SWA's) do not carry their own caseloads but do assist social workers with their caseloads.

14+ Caseload Weighting Approaches

Three (3) Teams indicated they had developed caseload weighting approaches to manage their workload demands, whereas eight (8) Teams had not (see Appendix 3).

14+ Waiting Lists

Only two (2) Teams indicated using waiting lists and provided further information on risk and governance and processes and practice in this area (see Appendix 2).

Brief Analysis – 14+ (Regionally)

The ten (10) 14+ Teams regionally were managing caseloads between 8-110. Overall, the Teams were managing an allocated caseload ratio of 1:16, and an overall (unallocated plus allocated cases) caseload ratio of 1:18 among 37.5 staff that carry caseloads within these Teams. There were ten (10) unfilled Band 6 vacancies across the Teams and we have ranked these ratios previously in the analysis (see Table 45). Four (4) were related to sick leave (4 weeks or more); one (1) was related to maternity leave; and five (5) were empty posts. When

we add the vacancies reported, the ratio for allocated caseloads ratio becomes 1:13, whereas the overall caseloads ratio becomes 1:14.

The majority of Teams were uni disciplinary. All Teams had an operational manager who was a social worker. Most Teams received social work supervision monthly. Three (3) of the Teams indicated that they received group supervision at peer level. One (1) Team had supervision once a month and two (2) Teams reported group supervision four times a year. There were five (5) Band 5 social workers it is not clear how many of these were temporary or permanent as this information was not reported. No (0) Band 5s were agency staff. There were twenty-nine-and-a-half (29.5) Band 6 social workers reported. It is also unclear how many of these were temporary or permanent as this information was not reported. No (0) Band 6 were reported as agency staff. There were thirteen (13) Band 7 social workers covering a range of roles including Designated Team Leaders; Senior Social Work Practitioners; Senior Social Workers; and Joint Protocol Trained.

Three (3) Teams used caseload weighting approaches although these were not described. Waiting lists were used by two (2) Teams, none described how these were managed. Teams were supported by one (1) Band 2 and ten (10) Band 3 administrative staff. The majority of training reported included, Signs of Safety, and specialist training such as pre-birth risk assessment, and Joint Protocol training. Five (5) Teams indicated that the numbers were equivalent to their Funded Establishment; and five (5) Teams did not answer this question. Out of the ten (10) Teams, only seven (7) reported to having practice teacher(s) in their Team.

Qualitative Findings within Children's Services

All five (5) HSC Trusts in Northern Ireland are represented in this summary. Interviews were conducted with eleven (11) front-line Children's Services social workers across practice settings until data saturation was reached (Guest, 2016). Additionally, six (6) focus groups (see Figure 3) were conducted with whole Teams across Trusts and with the Safe Staffing in Social Work Steering Group for Children's Services, comprising Assistant Directors or Heads of Service across all HSC Trusts, BASW NI, NI Social Care Council, and the SPPG. In total, fifty-four (54) people participated in these Focus groups and interviews.

Figure 3: Breakdown of Focus group Participation across Trusts (CS)

Focus groups *n*=6

- **Trust A** = A childcare Team situated in a rural area, combining family support, child protection and LAC
- **Trust B** = Composed of two different LAC Teams
- **Trust C** = Composed of disability services manager, Gateway, Family Intervention, and 14+ Team
- **Trust D** = Composed of members of different Teams across Children's Services, including Leaving and aftercare, residential care, Children and Families (CAF), Children with disabilities, fostering and Adoption and Permanence services
- **Trust E** = Composed of members of different Teams across Children's Services, including residential care, family support, Gateway, Children with disabilities, fostering and Looked After Children's services
- **Children's Services: Steering Committee** composed of Assistant Director or Service Managers across all five HSC Trusts, Strategic Planning and Performance Group, Union representative, NI Social Care Council and BASW Northern Ireland

Introduction

The data from the interviews and focus groups with social workers in Children's Services suggest that safer staffing is conceptualised across five themes connected to:

1. The service users that social workers work with and support.
2. The social workers themselves.
3. The organisation in which the social worker is employed.
4. The Team within which social workers work; and
5. The line manager that social workers report to.

Service Users

Most interview and focus group participants were primarily concerned about their service users. The focus group consisting of Steering Group members (made up of all NI NHS Trust representatives including Assistant Directors or Heads of Service; BASW NI; NI Social Care Council; SPPG) associated with Children's Services defined the primary role of the service as follows:

> *"…to safeguard and protect children and young people, to ensure they are getting good enough care in different settings, to be advocates for them, to develop good relationships with services users and their families so they can achieve the best outcomes possible for children and young people"* (Focus Group, Steering Group Children's Services).

This view of the role of children's social work was shared by all social workers participating in the study. Discussions about safe staffing therefore initially focused on how perceptions of unsafe working conditions affected service users. There was broad agreement that current caseloads and staffing were unsafe for service users. As one social worker explained:

> *"Our waiting lists for assessment, we have…so many families on our list who have been assessed at the viability stage and who actually have been on our list with no support whatsoever for maybe the guts of 12 months or 14 months and there's nothing we can do about that because we're short staffed."* (AYE Social Worker, Kinship and Foster Team).

In general, safe staffing in relation to service users was conceptualised around the number of complex and/or urgent cases a social worker had to manage. Additionally, case predictability and number of stakeholders (e.g., family members, other professionals) involved in each case were considerations in terms of work involved. While the number of stakeholders increased the volume of interactions, social workers depended on stakeholders and family networks for placement and safety planning. The greater the complexity, urgency, and unpredictability, the more concerns there were for service users' safety:

> *"At the minute for us we're with the waiting list… we're not getting to do much early intervention because we're so bottlenecked with those high risk cases a lot of*

child protection, a lot of edge of care, a lot of high risk crisis situations and we just don't have the services or the resources to be able to move them along …Our residential or our disability residential unit is at capacity and it is going to be at capacity for the next couple of years because of the age of the children, you know there's no other placement opportunity for them… it's just where they are. So what does that mean for all the other children with a disability that need placement? It's not going to happen." (Mixed Focus Group).

Most respondents reported that complexity and urgency of cases had increased:

"The issues they're now working with families - with children, like trauma and emotional issues, you know, more complexities… a lot more work than what they were a good few years ago (AYE Social Worker, Kinship and Foster Team).

This was also noted by an individual participant in Trust *anonymised*:

"We've noticed within this Team that there's such a high number of young people that are now facing school-based anxiety and school refusal. So, we've had a significantly higher number of referrals going to colleagues in the Education Welfare Services, where we have had to draw on that support. […]because lock down has had such a significant impact on young people's ability to manage within a school setting and with a high number of group work settings with other young people a lot of anxiety has been built up over lock down where they haven't been exposed to that for a while and we're expecting young people to go back to where they have left off and it hasn't been easy." (Band 7 Senior Social Worker, 14+ Team).

The size and complexity, urgency as well as predictability of a social worker's cases affected whether they felt they could meet all statutory and non-statutory obligations and offer all required support to children and their families. Reflecting on the time spent on services being delivered, one social worker explained:

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"…And so we don't, we genuinely don't have enough staff. You know, even though I'm saying my Team is pretty much fully staffed and that's not to say that's what it is

in the whole of [Trust name] and there is definitely a lot more LAC children than there would have been [5 years ago] … And even in terms of like filling in all statutory visits …there's like I have literally got made up a table that says when I last saw the child and if they're {this is awful to say}, but whether they are amber, red or green. And I will go and I will look to see how many weeks it is, and I'll be like when is the due date by which I have to see them and I will make sure that I will always check on this to make sure that I am keeping on top of it" (Band 6 Social Worker, LAC Team).

The social worker themselves

Safe staffing was a very important concept to all interview participants, and most felt that safe staffing was currently not possible. While most interviewees elaborated on safe staffing in relation to their service users, many also spoke about how work affected their own sense of physical and mental wellbeing and feeling of physical safety.

Physical safety

There was an underlying, often subtle, discussion about physical safety, which emerged specific to children's services. This included actual or perceived levels of (potential) aggression or threats from parents or guardians, whose children were in the system:

"[W]hen you go into the home and the parents aren't happy to see you, you know. We [have] a lot of tension that way, and a lot of - not aggression per se. But just difficulty, you know…. I haven't had anything personally, but, I mean, I have colleagues that have been threatened." (Band 6 Social Worker, Child and Family Team).

Further examples were given of service users' (families) arriving at social workers' private addresses. There was also mention of actual violence against social workers, which affected their behaviour, including how they parked their cars or how they entered premises. This was especially relevant as social workers often work alone. A respondent in the Focus group of Trust *anonymised* defined safe staffing as including the element of physical safety:

"It's about the Team and Team members being physically safe in their jobs and as lone workers" (Focus Group).

Psychological safety

Psychological safety was also an important element of safe staffing. Psychological safety includes mental health, avoidance of burnout, ability to regulate emotions and to deal with ethical guilt. Psychological coping skills were seen as an essential element of social work training. As one social worker highlighted:

> *"[it is important] that they [social work students] learn their own coping strategies and their own coping techniques to make sure that yes, that they can go outside, take a walk, that that they can take 5 minutes and don't feel guilty about taking 5 minutes for a cup coffee."* (Band 6 Social Worker, LAC Team).

However, perceptions of unsafe staffing affected social workers emotionally and psychologically, especially if they felt they were unable to protect, help and support service users, as evidenced in the below case about a social worker's inability to find placements for children at risk. For this social worker, the urgency and complexity of their caseload required them to work beyond their capacity to try and cope with lack of placements for children deemed to be at risk. The social worker also described having no time to take breaks due to job pressures, administration, and report writing:

> *"…For all the children that we have, we review them on a daily basis because some are in unsafe homes and unsafe placements and that has a big impact emotionally on our Team because we're constantly hearing the ongoing harm that that child is experiencing because we haven't been able to find a placement for them." … "And I know when I should stop [to take a break] and but there is that need to respond to people, follow things up, have reports completed and if I don't do the reports, no one else will.* (Band 6 Social Worker, Foster Team).

Organisation level

Many of the safe staffing concerns expressed by participants were based on organisation level variables, such as working conditions, workload, work processes, recruitment, and retention of staff, and, in some cases, geographical distance between place of work and service users.

Working conditions

Discussions of working conditions included working hours and ability to complete tasks within set working hours - whether these were full-time or part-time - and if these working hours were realistic. Realistic working hours depend on the ability to manage work-life balance, administrative demands and to self-manage. Self-management capabilities varied across social work staff which led to workloads being adapted depending on abilities. Furthermore, it was indicated that social workers on part-time contracts did not immediately have a reduced workload but were expected to manage the same work until they were able to transfer cases to colleagues.

Workload

References to workload included narratives about time pressures and ability to meet and prioritise work-related obligations. Some social workers reported developing their own systems to help prioritise tasks. Strategies ranged from keeping a notebook, to postponing statutory visits until the last opportunity, to deprioritizing reports and documentation to have more time available for service users. All respondents agreed that this was problematic because it affected the consistency and reliability of processes. In addition to formal workloads, respondents spoke about the impact of additional work, including the training and support of AYE social workers, social work duty rota, unallocated cases, and the liaising with other agencies and professionals on workload planning. These unpredictable tasks were added to normal workloads and were seen to compete for time with other tasks:

> *"I spent a considerable amount of time last week chasing up the GPs to speak to them about medicals that were done a year ago because of our unallocated waiting list."* (AYE Social Worker, Kinship and Foster Team).

Pay was not discussed in detail but there was an indication that pay was used as a recruitment tool to attract social workers to other services or other Trusts. Lastly, working conditions included discussions about shared workspaces and hotdesking. While hot-desking added stress and unpredictability, shared workspaces were regarded as both difficult and beneficial, because this affected privacy but also afforded the opportunity to discuss cases.

Discussions around work processes included reporting requirements and caseload management systems. It was agreed that administrative duties - including reporting and documentation

requirements - had increased. This was due to the requirement to document cases, including service users' financial management, but also to document staffing that informed workload management. Lack of staff increased documentation and in turn required additional staff, while reducing their capacity to fulfil statutory requirements:

> *" Just to say with all the issues that we've talked about, all of that has generated reports, yes additional reports COVID taught us well. I didn't as a manager before knowing about RAG status before, but everything's linked to RAG status. You've a spreadsheet you've always something you know what could have been a phone call before, a couple of emails or a smaller discussion and agreement has become multi-disciplinary or large so that in terms of governance it's good there's learning in terms of actually we're holding each other to account were sharing learning there's minutes of those meetings. It's positive, but actually it generates more work and it's ridiculous.'* (Mixed Focus Group).

> *" And there's monthly reporting functions as well that go up about all the unallocated lists, unallocated assessments. You know, unallocated cases, you know, they're all reported up in terms of what do you have in terms of staffing complements as well."* (Mixed Focus Group).

Furthermore, while many respondents were aware of case load weighting approaches in social work, most interviewees within Children's Services did not use case load weighting to manage and assign caseloads:

> *"not in usage and not regarded as beneficial by staff"* (Mixed Focus Group).

> *"Well, we don't do … I know I don't do caseload weighting. When I was a social worker, our Team leader would do caseload weighting and it was like two points for every hour. Or something. It was the most ridiculous. Honestly, it was ridiculous. It didn't make any sense and it was you… you were making it up"* (Focus Group, Looked After Children' Teams).

This was often because caseload weighting did not take into account different levels of complexity, urgency, and unpredictability. There was also discussion about the level of

objectivity that guided case assessment. As discussed below, this often depended on the relationship between social workers and their line managers.

Recruiting to support staffing levels

In the interviews and focus groups there was a common narrative about staffing levels and how these affected safe staffing. The ability to recruit and fill positions was seen as a prerequisite for safe staffing and Trust *anonymised* elaborated on measures taken to facilitate recruitment and retention:

> *"Accommodating flexible working. If you want job share or reduced hours or flexible hours, anything that the Trust can do to retain staff"* (Focus Group).

A factor that affected staff retention at the individual level was Team support and the functioning of a Team:

> *"No, I'm not leaving because I know that I have a really solid Team. We're all very supportive of, like we genuinely are."* (AYE Social Worker, LAC Team).

However, at least for Trust *anonymised*, staffing problems persisted:

> *"We are just finding it really difficult, and people aren't expressing the interest to come into the social work world at the minute. Neither of these posts have been filled for a long time".* (Band 6 Social Worker).

Furthermore, there was an indication that staff turnover affected Team leadership. This was the case, for example, in Trust *anonymised*, where respondents reported that a social work Team's leadership had changed three times in one year. This affected consistency as well as trust and relationships within the Team:

> *"...But I mean it actually frightens me in CAF [Child and Family Team] and wherever else, residential that somebody with such little experience in fieldwork can manage a Team because it's a whole different kettle of fish. What then happens and it's glaringly obvious the Teams fall apart"* (Mixed Focus Group).

A sense checking exercise was conducted with managers and those in the Steering Groups about staffing numbers. One manager, who had conducted previous analysis on safe workloads in FIT and other children's services commented as follows:

> *"These are the numbers we found to be optimal in 2015; FIT – 15; Gateway – 10; LAC and 14+ and 16+ were 12."*

Geographical distance

Lastly, geographical distance or proximity was seen to affect safe staffing. This was mostly the case in Trusts covering rural areas which required daily travel between the office and service users' locations:

> *"So you know, [child's name] might be in [anonymized] one time and then she has to make her way to [anonymized] and then she'll have a contact at [anonymized]. We try not to have the child travel. So, we travel rather than the child having to travel."* (Focus Group, Looked After Children' Teams).

Geographical distance also involved travel between Northern Ireland and England or the Republic of Ireland if placements were not available in Northern Ireland and this affected workers' schedules, availability, and ability to manage workloads as evidenced in the account of an AYE in Trust *anonymised*:

> *"[I] suppose myself as the social worker, my boss and the independent social work in England all shared weekly visits from June until October"…"it puts pressure certainly on you for a week or two to bounce back from that as well because you try and take calls as best you can but you know when you're driving or you're in England and stuff you, you're not really much use to people"* (AYE Social Worker, Kinship and Foster Team).

In summary, most social workers (except one interviewee who worked in residential care) felt that they were unable to safely manage their workload and caseload within their allocated working time.

The steering group discussion with Children's Services managers acknowledged this:

> *"People are really concerned about caseloads, which are far in excess of what we know people can safely manage and cope with; people are working in unsafe ways and that's not a criticism of managers who are allocating work to them; they know that the work has to go somewhere, cases need to be seen."* (Focus Group, Steering Group).

Team

This section refers to the importance of the social work Team in providing the context for safe staffing. There was very broad agreement that the Team was essential in this regard. Subthemes associated with the Team included Team support and relationships, Team composition, and shared risk through informal and formal governance structures.

Team support and relationships

Teams were important in providing support, providing space for open and honest communication between staff, and building trust and relationships. The relationships and trust between Team members and managers also helped to manage expectations about availability and flexible working, and helped to prioritise time and tasks, as colleagues were able to support and cover for one another:

> *"[T]ends to be some people prefer assessments - some people prefer support and placements, so it's really weighing that up as to what you prefer - certainly as well what you can manage. I've always found as well if you take it on and can't manage it - it's a good enough Team - you can always go to your manager and say look, there's too much can you take something off me?"* (AYE Social Worker, Kinship and Foster Team).

However, it was acknowledged that Team cohesion and Team support varied. The focus group in Trust *anonymised*, a rural Childcare Team, felt that their Team was more collaborative than other Teams in the same Trust:

> *"[we are] more collaborative, supporting each other' and having a 'shared responsibility' for work"* (Focus Group, Childcare Team).

This was evidenced by good practices where permanency work led to upskilling and cascade learning where staff have 'buddied up' to increase their skills. In a crisis, the Team reported that they rally around to respond and help each other due to the relationships between staff and the culture supported by the manager. The Team was described as 'close', and this was evidenced by Team members being sensitive to each other and being aware when colleagues were under pressure:

> *"When a crisis happens in one of our cases, there's a natural response among everyone in the Team to go 'what do we need to do to help'. I had a placement breakdown on a Friday afternoon and literally [anonymized] jumped in and 'I'll do this referral' to be just around to make phone calls for me so I can then do other bits and pieces. So it's sort of like when it's a crisis, everyone just jumps in and helps as we resolve the crisis."* (Focus Group, Childcare Team).

Skills Mix in Teams

Furthermore, there was agreement that a Team needed a range of skills and a mix of staff across Bands to work well. Social work assistants in Children's Services carry out aspects of work that are not a statutory function, such as supervision of contact, or doing court directed interventions to support parents, and alleviate qualified social workers from these time-consuming tasks. However, there was agreement that staff shortages affected the functioning of a Team, which might affect safe staffing as outlined in the quote below:

> *"[In] own Team, we are super fortunate. We have a really established Team and there's an awful lot of experience within that and you know, not necessarily include myself, but you know there's a depth and breadth of knowledge there. But when I look across to some of our LAC colleagues or, you know, FIT colleagues, and think oh my word, the Teams are decimated, and you know that in turn I guess indirectly impacts on us because there aren't social workers who are picking up other pieces of their work."* (Band 6 Social Worker, Family Placement Team).

> *"There's a level below that Team leads would talk about, we'd look at incidents and they would talk about a bad shift. And I said, well, what we do about that bad shift that keeps on, consistently there are incidents that are happening? But we need to*

re look at the rotas. So there's mixing the rotas and mixing the skill set and the strengths and so on." (Band 6 Social Worker, Residential Childcare).

Skills mix remained an important aspect of safe staffing for Children's Service's social workers and teams. This included the ability for social work assistants to rapidly escalate any concerns to social workers; and social workers ability to get social work assistants to intervene in aspects of work which supports their overall role and tasks. There were also limitations to skills mix as discussed below.

Shared risk

Trust, relationships, and mutual support through a mix of skills enabled sharing of risk within Teams and across the organisation. Risk was also shared among colleagues based on the sharing of information and feedback. While there were advantages to sharing risk there were also pitfalls:

"What I've noticed about that case ...you were writing a lot about contact, and you were asking everyone in the room because everyone had done contact with that [service user] you know, this is when the Team does come together and work together and then you go "right stop you said…". And she's like, "Quick let me write it down." And then she's writing it down. But you know one person can't remember every single thing as much as you want." (Focus Group, Looked After Children' Teams).

"The permanency Team has an oversight of all the children who have a permanent care plan and whose case remains before the court. So they would give written feedback, guidance and agree next steps and that's attended by both the social worker and the social work manager. All of the decisions are recorded". (Focus Group, Permanency Childcare Team).

From a formal process and governance perspective, the responsibility for risk was not individualized rather it was situated at the organisation and Team level. The focus group consisting of steering group members elaborated on processes at Trust, programme of care and Team level to share risks:

"We have all of those processes to support staff so that they're not standing alone in terms of decision making" (Focus Group, Steering Group).

Leadership/Line Management

The final theme identified in the qualitative interview and focus group data was in relation to leadership and line management. The theme of leadership and line management often interacted with that of the Team, discussed above.

Relationship between staff and line managers

Interviewees and focus groups talked about the importance of trust and communication between line managers (e.g., Team Leaders) and front-line social workers. Staff felt supported if their line managers had an open-door policy and were available, if needed. This also included line managers having a good overview of workloads, including their cases and intention to work overtime:

"My boss is very good at keeping us protected in terms of …she likes to make sure that that we have like that we don't have unallocated cases…and my boss has looked at everybody's caseloads" (AYE Social Worker, LAC Team).

"Having that open door policy, making sure that the staff are actually getting their leave. And Breaks." (Mixed Focus Group).

"Gosh I guess when you feel flat out with your time and time has accrued and we have a manager who's, you know, quite keen not to let that happen and likes to know if we're planning to work over and things like that." (Band 6 Social Worker, Family Placement Team).

The role of supervision

On a more formal level, most social workers commented on the importance and usefulness of (regular) formal, informal and group supervision to discuss cases, decisions and workloads with senior staff or line managers. This was part of shared risk but also enabled social workers to refer issues up to their line management if workloads were not manageable:

"[E]ven that informal supervision, even this morning - I had had that meeting with those carers on Thursday. I was off Friday. I was able to come in and say to him, what do you think? And. Just run it past and. It was matter of a couple of minutes, but I came away going {relieved}... And that is definitely having those couple of minutes here, there or whatever…" (Mixed Focus Group).

"I think making sure that we have good supervision levels as well. I think that's important to make sure that you have that protected time to make sure that you can go, and you can discuss all your concerns, all your risks, everything that's going on in each of your cases and being able to have that protected time. I'm very lucky in my Team because we do have that time." (AYE Social Worker, LAC Team).

Leadership style and attributes

Relationships with line managers were often more successful if leaders adhered to compassionate and supportive leadership styles in line with the HSC collective leadership strategy on compassionate and shared leadership. Teams worked better if line managers had a good knowledge of cases and of the system but also of their staff and a "sixth sense" when individual Team members needed to take a break or required support. Compassionate leadership included covering for staff members as evidenced by a line manager in Trust *anonymised*, who acknowledged that they took on much of the work themselves, either doing the work themselves or getting some else to help. This position was reinforced by their sense of responsibility and being immersed in the Team's work:

"I would always try to sit out in the floor and become involved with the daily runs of some of the cases. I think it's about my own style of management and wanting to make sure that everything is running smoothly". (Band 7 Senior Social Worker, LAC Team).

"Just, just, just kindness and compassion [that our line manager has]. That that's what our line manager always says. You know, just we had a Team meeting this morning and it was ended with, you know, she has an open-door policy if you ever need anything, whether it be professionally or personally, you can go in and you can have a chat". (AYE, Family Intervention Team).

This relational and compassionate leadership style and associated leadership attributes were critical to achieve Team cohesion in difficult situations. This also facilitated staff retention and job satisfaction amongst staff:

> *"Our Team was really bad, for staff for like 2 years was over COVID period for 2020. And like I had thirty children on my caseload, though, and I wasn't supposed to have any but higher management were really good. ... Ourselves, our Team leader, our service manager and then the head of service (name redacted). And that was really beneficial and the committee chairman though, and you got that opportunity to talk about those cases that are really high risk and higher priority."* (Focus Group, LAC Team).

It was acknowledged, however, that line managers were sometimes buffering their staff from unrealistic caseloads and work expectations without sufficient support and resources themselves. It is unclear from our data whether line managers themselves coped with these demands:

> *" A person running the shift as well and I'm in charge and trying to delegate tasks and trying to do the safeguarding and the paperwork and I have bank staff coming in that don't know the home, don't know the kids don't know what they're doing. Having a body isn't really good enough for me in a situation that the police are called and sometimes they're sitting there not knowing what to do with themselves and I'm like instead of me barking orders people, it's better to do it myself. And then I'm burnt out."* (Focus Group, Residential Social Worker).

This summary captures the voices of 54 social workers, from AYE level to Band 6 and Band 7 staff. Overall, the views reflect risks and concerns about service user and social worker wellbeing, working conditions, burnout, and vacancies. There also examples of Teams that function well, with positive peer level relationships and leadership which is supportive and fair to Team members. Teams that express better working conditions, demonstrate camaraderie and support and a 'tuned in' social work manager with a 'shared risk' and 'all hands-on deck' approach. Regular informal and formal supervision, and a supportive culture with positive relationships are at the heart of these positive Team experiences. Key principles include trust,

openness, equity, and fairness. These concepts should be included in safer staffing policies and procedures, to promote staff wellbeing, retention, and commitment to the profession.

Older People's Social Work (OPSW)

Role and Task of Social Workers in Older People's Services: A Summary

Older people social work sits within an integrated health and social care structure across all five Health and Social Care Trusts in Northern Ireland. The program of care for older people is Program of Care (for Department of Health, Strategic Planning and Performance Group) statutory function reporting for Primary Care and Older People) and is named variably in Trusts with slightly different iterations, for example, some Trusts using 'Primary Care and Older People' and others 'Community and Older People's Services'. In some Trusts, teams were restructured from having a multi-disciplinary management structure, which includes nursing and social work, with some Trusts now having a social work management structure following systems reviews and a split away from Integrated Services (ISD)Teams. Older people social work teams' interface with district nursing, occupational therapy, integrated care teams, acute hospital sector, older people mental health and dementia teams.

Older people are classified as those over 65 years old. Legislation and policy which underpins social work practice with older people spans a range of areas as follows:

1. **Health and Personal Social Services Order (NI) 1972 and 1992** – Provides the 'duty to assess need'. The 'duty to assess need' is, however, ambiguous, and potentially dependent on available resources with Trusts having Panels in cases above an 'enhanced' rate of assessed need, to make decisions according to levels of assessed risk. Trust managers use 'Fair Access to Care Criteria' to make decisions about resource allocations based on agreed thresholds of risk and need assessment.

2. **Chronically Sick and Disabled Act (1978)** – Planned provision of community services fall under Section 1 and 2 of this Act.

3. **Mental Health (NI) Order 1986** – This legislation covers a range of powers and duties to intervene and safeguard those at risk (to self or others) due to mental disorder (Article 111 [b]). In older people social work, one of the main applications of this Order is with people who have dementia.

4. Social work in Older People services also have a significant role to play in the use of Mental Health (NI) Order, 1986, functions to manage financial affairs for those who lack capacity.

5. **Mental Capacity Act (2016) Northern Ireland** - The Act provides the legal framework for making decisions on behalf of people who are over the age of 16 and lack the mental capacity to make decisions themselves. The Deprivation of Liberty Safeguards (DoLS) is a major part of the Act which has been implemented, and social workers have been primarily tasked with Mental Capacity Assessments (MCA's) under the DoLS aspect of the Act, with the majority of DoLS assessments being with older people in care homes and in hospital settings.

6. **Disabled Persons Act 1989** - Section 4 of the DPA (1989) entitles the service user to an assessment and services which are not means tested, therefore these are 'rights-based services.'

7. **Human Rights Act (1998)** - Key Articles of the European Court of Human Rights contextualise the backcloth to planned social care provision: Article 6 – the right to a fair trial, in this instance implies the 'right to be heard/to be involved' Article 8 – the right to private and family' life is protected by the provision of community care services base in their own home or a homelike environment.

8. **Carers and Direct Payments Act (2002)** – Self -Directed Support is a personalised budget for use to provide flexible approaches to service recipients and their carers to access services. This legislation also covers Carers Assessments as a statutory requirement, to ensure those providing care for others have their own needs assessed.

9. **Adult Safeguarding: Protection and Prevention in Partnership (2015)** - This policy is for all organisations working with, or providing services to, adults across the statutory, voluntary, community, independent and faith sectors. It sets clear and proportionate safeguarding expectations across the range of organisations. Social workers frequently work in roles of Investigating Officer and DAPOs in cases which are single social services led investigations or joint protocol, involving the Police Service Northern Ireland if a crime is suspected.

10. **Adult Safeguarding Operational Procedures: Adults in Need of Harm and Adults in Need of Protection (2016) -** These procedures set out the broad principles of good

practice when responding to situations where adults are at risk or in need of protection. They place the adult at the centre of the safeguarding process and provide some practical guidance on how specific roles such as the Adult Safeguarding Champion should be implemented (2016 p. 7).

Day to Day Work for Older People's Social Workers

A major part of the daily roles and tasks of social workers are to manage their caseloads to ensure that cases in need of prioritisation due to assessed risk, get urgent attention. The role includes the requirement to assess the needs of new referrals, doing home visits and meeting with service users and families and carers, and offering carers assessments. When a full assessment of need is completed, the social work is tasked with planning care packages with approval from line managers. An online standardised assessment tool is used (E-NISAT) so that assessed need is recorded in a system available to managers and other relevant disciplines. Often assessment requires input from disciplines including nursing, occupational therapy, physiotherapy, General Practitioners, so a full holistic multi-disciplinary assessment can be completed. If safeguarding concerns are identified, policy and procedures (9) relating to safeguarding adults are implemented and case discussions involving relevant disciplines, and if necessary, the PSNI is initiated. A social worker is likely to be the appointed Investigating Officer who conducts the investigation which will be either led by social services, joint protocol with the PSNI (if crime is suspected) or led by the PSNI in certain circumstances.

Planning and implementing care plans often involve resource implications and approvals at line manager and at funding panels (these are typically only for enhanced care packages). Factors which slow down the implementation timeline for delivery of care packages can be the unavailability of care packages available. This is often true in relation to 'delayed discharges' from the acute hospital sector, with people in hospital medically fit for home discharge but community-based care packages may not be available or funding for nursing home admissions may not be approved in a timely manner. Care planning for personal care is conducted through Domiciliary Care, Reablement Teams and Brokerage departments, which adds further to the processes of getting a care plan in place. Other types of service-based interventions can include applications for day care and respite care, which may form a part of an overall care package, which aims to meet assessed need of service users and their carers and families. Alongside these pressures, social workers now are tasked with completing Mental Capacity Act assessments relevant to Deprivation of Liberty. This requires in-depth assessments, assisted

decision making and time-consuming information gathering from relevant professionals including General Practitioners. Even though the task in protecting people's rights and liberties is at the forefront of the social work role, social workers have noted that the Deprivation of Liberty assessments to be a particular strain on their time and is verified by the Older People Steering Group members.

Duty Intake is in general, approximately 2-3 days per month (is variable across Trusts). As there are large numbers of unallocated cases, duty often involves crises response. Without capacity for early intervention services provision are often delayed and the persons situation changes or deteriorates. Those on waiting lists are advised to contact Duty Intake if they require urgent services.

Social workers have a duty to monitor and review open cases with a requirement for frequency of visits. This is dependent on whether a case is in the community or in institutional settings. Frequency of visits is determined by levels of risk and the Department of Health requirements. In addition to case related job roles, Appendix 6 sets out non case related requirements including supervision, mandatory training, and professional meetings (team meetings).
Those with specialist roles, such as Senior Practitioners, Practice Teachers, Designated Adult Protection Officer and Approved Social Workers, report not having caseload easement.

Skills mix in older people social work teams includes Band 4 social care workers (or social work assistants), and it is variable between Trusts, whether or not, these workers carry caseloads. In some Trusts social work assistants support parts of casework for social workers such as monitoring and reviewing cases, responding to low-risk tasks for service users and carers, liaising with hospital and domiciliary care departments on case related work. Social care workers also are part of the Duty Intake rota. Administrative staff provide minutes of meetings and report on domiciliary care and adult safeguarding data amongst many other administrative tasks. The current project was not tasked to analyse the role of administrative staff, but we have provided data on the numbers of admin staff reported form Trusts.

Quantitative Findings within Older People's Social Work (OPSW)

A total of eighty (80) Teams from Older People's Social Work (OPSW) completed the survey across the five Trusts. The majority (56) from Older People's Community Social Work (see Table 47 below).

Table 47: Team Type Across Trusts

Team Type	CSW	MH	HSW	GW	AS	MCA	Other	Total
Trust								
A	10	3	1	0	0	0	1	15
B	16	0	2	0	0	0	0	18
C	9	3	2	1	1	0	1	17
D	12	3	1	0	1	0	0	17
E	9	1	0	0	2	1	0	13
Total	56	10	6	1	4	1	2	80

Note: CSW= Community Social Work Teams; MH= Mental Health Teams; HSW= Hospital Social Work Teams; GW=Gateway Single Point of Entry Team; AS=Adult Safeguarding Teams; MCA=Mental Capacity Act Team; Reported data as of 28th February and 31st March 2023

Older People Community Social work

Community social work Teams include permanent placement and integrated care Teams and comprised just under 70% of all Older People's Social work Teams in the Survey and 90% of the regional OPSW caseload. Just over half (31, 56%) of the Community Social Work Teams were multi-disciplinary.

Staffing Descriptives – Community Social Work Teams (Regionally)

The following description of Community Social Work Teams was derived from an overview of fifty-six (56) Community Teams from the five HSC Trusts (see Table 48). Twenty-five (25) of the community social work Teams reporting were uni-disciplinary and thirty (30) were multi-disciplinary. One Team answered, "this does not apply to this Team". Fifty (50) Teams reported that their operational manager was a social worker. Monthly supervision was reported by forty-one (41) Teams with a further eight (8) Teams reporting supervision every six weeks, four (4) Teams every two months, and two (2) less frequently than that.

Table 48: Description of Community Social Work Teams at Regional Level

Trust	Trust A	Trust B	Trust C	Trust D	Trust E	Total
Teams (*n*)	10	16	9	12	9	56
Unfilled Band 6 Vacancies	8.5	29	9	13	18	77.5
Band 2	1.5	2	0	4	5	12.5
Band 3	11	35	0	2	15	63
Band 4	15.5	20	30	1	34	100.5
Band 5	13	11	2	26	6	58
Band 6	61	86	61	89	69	366
Band 7	12	23	7	12	21	75
Agency AYE	6	0	0	0	0	6
Agency Band 6	4.5	1	1	0	0	6.5
Practice Teachers	3	5	2	2	2	14
Overall caseload	5386	6378	4966	5727	7620	30077
Allocated Cases	4890	6061	2821	5667	6675	26114
Unallocated Cases	496	298	2145	135	945	4019
Total number of SWs w/caseloads	88.5	129	84	120	121	542.5
Ratio of SW to allocated caseload	1:55	1:47	1:34	1:47	1:55	1:48
Ratio of SW to total caseload (allocated + unallocated)	1:61	1:49	1:59	1:48	1:63	1:55
If vacancies were filled Total number of social workers/caseloads	97	158	93	142	139	619
Ratio of SW to allocated caseloads if vacancy filled	1:50	1:38	1:30	1:40	1:48	1:42
Ratio of SW to allocated and unallocated if vacancy filled	1:56	1:40	1:53	1:40	1:55	1:49
How many Teams developed caseload weighting approaches?	7	0	7	4	9	27
How many Teams use waiting lists?	6	15	7	1	9	38

Note: Reported data as of 28th February and 31st March 2023

Caseload Ratio Analysis: When considering the caseload ratio of SW to total caseload (allocated + unallocated) there was some variation within Trusts (see Table 49), for example, Trust A reported an individual Team overall caseload ranging from 1:53 – 1:70 with one outlier on the upper end of 1:92; Trust B reported an individual Team range from 1:33 – 1:77 (half of Teams had overall caseloads in the forties); Trust C reported an individual Team range from 1:61 – 1:72 with two outliers (1:16 & 1:21) at the lower end; Trust D reported an individual Team range from 1:59 – 1:86 (one quarter of Teams had overall caseloads in the eighties with two outliers at the lower range i.e., 1:21; and Trust E reported an individual Team range from 1:49 – 1:69 with two outliers on the upper end i.e., 1:78 and 1:88.

Table 49: Community: Regional Frequency of Caseload Ratio (allocated + unallocated)

Trust	0-15	16-35	36-55	56-75	76-95	96+	Total
A	-	-	4	5	1	-	10
B	-	2	10	2	2	-	16
C	-	2	-	7			9
D	-	2	-	6	4	-	12
E	-	-	3	4	2	-	9
Total	0 (0%)	6 (11%)	17 (30%)	24 (43%)	9 (16%)	0 (0%)	56

OPSW Community Social Work Calculation of Social Workers Carrying Caseloads

In terms of social workers carrying caseloads (see Table 48), we added the AYE Band 5 social workers (58), Band 6 social workers (366), those Band 4 SWAs who were reported as carrying cases (99.5) and Band 7 social workers who were not assumed to be Designated Team Leaders (19), this total is as follows (58 + 366 + 99.5+19= 542.5).

OPSW Community Social Work Unfilled posts

Across the five Trusts there were seventy-seven-and-a-half (77.5) unfilled Band 6 vacancies. The largest number of vacancies were empty posts (34.5; see Table 50).

Table 50:OPSW Community Unfilled Posts Regionally

Trust	Empty posts	Maternity leave	Sickness	Other	Missing	Total
AOP	2	3	2.5	-	-	7.5
BOP	10	8	10	-	-	28
COP	9.5	2	7	1	-	19.5
DOP	9	3	2.5	-	-	14.5
EOP	4	2	2	-	-	8
Total	34.5	18	24	1	0	77.5

Note: Reported data as of 28th February and 31st March 2023; The percentage (%) of vacancies to overall SWs/caseloads if vacancies were filled (vacancies divided into SWs with caseloads if vacancies were filled multiplied by 100), per Trust, for community teams were as follows; A=8.8%; B=18.4%; C=9.7%; D=9.2%; and E=12.9%

OPSW Community Social Work Funded Establishment

When asked if the total number of social workers (across all bands) and SWAs plus vacancies corresponded with the number of funded positions, forty-one (41) Teams responded yes. Although several of these added caveats, including that even with funded positions they were still overworked and or using temporary and agency staff. Four (4) Teams answered ‘no’ and a

further four (4) reported more social workers than they were funded for. The remaining Teams did not respond (see Appendix 4).

OPSW Community Social Work Practice Teachers

There were only eighteen (18) Practice Teachers (in 17 Teams) reported across the fifty-six (56) Teams, two (2) of which were also the Designated Team Leader. Only one (1) Team indicated that the Practice Teacher had a lower caseload. The very low number of Practice Teachers has implications for social work education and the future workforce.

OPSW Community Social Work Training

A total of three hundred and one (301) staff across all Trusts indicated that they were able perform assessments under the MCA (Mental Capacity Act), which represents over half of all social workers in Community Teams carrying cases. Four (4) were reported as practicing ASW (Approved Social Worker) under the Mental Health Order. Fifty-eight (58) social workers were reported as practicing Designated Adult Protection Officer (DAPO) under Adult Safeguarding: Prevention and Protection in Partnership Policy and two hundred and ninety-one (291) were reported as practicing Investigating Officers under Adult Safeguarding Policy (Adult Safeguarding: Prevention and Protection in Partnership). Additionally, four (4) staff participate in the HSCNI Trust Rota, six (6) are Joint Protocol trained and able to conduct PIA and/or ABE interviews, four (4) are trained as Leads for Signs of Safety assessments (suggesting that they might have previously worked in Children's Social Work), three (3) are trained in family Group Conferencing and twenty-six (26) are trained to do specialist assessments.

OPSW Community Social Work Administrative Support

The Older People Community Social Work Teams were supported by twelve-and-a-half (12.5) Band 2 and sixty-three (63) Band 3 administrative staff across the fifty-six (56) Teams, which represents an average of only 1.3 administrative staff per Team.

OPSW Community Social Work Caseloads

The combined overall caseload of the fifty-six (56) Teams was 30,061. A breakdown of the overall caseload revealed that there were 25,726 allocated cases and 4668 unallocated cases (16%).

OPSW Community Social Work Specialist role caseloads

In response to the question of whether social workers with a specialist role had a lower caseload, forty-three 943) out of the fifty-six (56) Teams responded 'No'. Three (3) Teams responded 'it varies' and two (2) Teams responded yes. One (1) Team indicated that this was unknown. Only one (1) Team reported 'Yes' and a further six (6) said that it varies from time to time. The remaining Teams did not respond.

OPSW Community Social Work Social Work Assistant Caseloads

Seven (7) Teams indicated that SWAs do not carry cases. Of those Teams with SWAs carrying cases, eighteen (18) Teams reported average caseloads of higher than sixty-six (66). Only eight (8) Teams reported average social work assistant cases lower than 35.

OPSW Community Social Work Waiting Lists

Thirty-eight (38) Teams indicated that they use waiting lists. Governance and management of waiting lists included review by senior managers, forms of RAG rating, standard operating procedures for referral, and weekly and bi-weekly Senior Social Worker review (see Appendix 2).

OPSW Community Social Work Caseload weighting approaches

Twenty-seven (27) Teams from three Trusts (Trusts A, C and E) reported using some kind of caseload weighting approach. Examples provided included a grading model for complexity reviewed monthly, RAG, and referral procedures (see Appendix 3).

Brief Analysis – OPSW Community Social Work (Regionally)

The fifty-six (56) Community Teams regionally were managing caseloads between 95 and 1149. Overall, the Teams were managing an allocated caseload ratio of 1:48, and an overall (unallocated plus allocated cases) caseload ratio of 1:55 among the 542.5 members of staff that carry caseloads within these Teams, and we have ranked these ratios previously in the analysis (see Table 49). There were seventy-seven-and-a-half (77.5) unfilled Band 6 vacancies across the Teams. Twenty-four (24) were related to sick leave (4 weeks or more); eighteen (18) were related to maternity leave; thirty-four-and-a-half (34.5) were empty posts and one (1) was reported as "other". When we add the vacancies reported, the ratio for allocated caseloads ratio becomes 1:42, whereas the overall caseloads ratio becomes 1:49.

Twenty-five (25) of the community social work Teams reporting were uni-disciplinary and thirty (30) were multi-disciplinary. One (1) Team answered, “this does not apply to this Team”. Fifty (50) Teams reported that their operational manager was a social worker. Monthly supervision was reported by forty-one (41) of the Teams with a further eight (8) Teams reporting supervision every six weeks, four (4) Teams every two months, and two (2) less frequently than that.

There were fifty-eight (58) Band 5 social workers recorded, it remains unclear how many of these were temporary or permanent as this information was not reported. Nine (9) Band 5 agency staff were reported across Teams regionally. There were three hundred and sixty-six (366) Band 6 social workers, it also remains unclear as to how many of these were temporary or permanent as this information was not reported consistently. Sixteen-point five (16.5) Band 6 staff were reported as agency staff. There were seventy-five (75) Band 7 social workers covering a range of roles including Designated Team Leaders; Senior Social Work Practitioners; Senior Social Workers; and Designated Adult Protection Officers.

Twenty-seven (27) Teams used caseload weighting approaches including traffic light systems and tools focusing on number of active cases, risk and complexity (see Appendix 2). Waiting lists were used by thirty-eight (38) Teams and were managed and governed by Team Leaders, Senior Managers, and Senior Social Workers including regular contact and updates with service users. Trust E reported a standard operating procedure (SOP), distinguishing between emergency, urgent and routine referrals and monthly upward reporting to management on caseloads.

Teams were supported by twelve-and-a-half (12.5) Band 2 and sixty-three (63) Band 3 administrative staff. The majority of training reported included, MCA and Investigating Officer and Adult Safety. Six (6) Teams indicated that the numbers of staff did not add up to the FE, two (2) of which reported that they were over their funded establishment; forty-one (41) Teams indicated that the numbers were equivalent to their FE and six (6) Teams did not answer this question. Out of the fifty-six (56) Teams, seventeen (17) reported to having practice teacher(s) in their Team.

Older People Mental Health Social Work (FMI and dementia)

While Community Social Work represented most of the OPSW Teams reporting in the survey, there were also ten (10) Older People's Mental Health Teams across four Trusts (including functional mental illness and dementia). Eight (8) of the Mental Health Teams were multi-disciplinary including Psychiatric Nurses, occupational therapists, and psychologists. Trust B did not report any Mental Health social work Teams (see Table 51).

Table 51: Description of Older People Mental Health Teams at Regional Level

Trust	Trust A	Trust C	Trust D	Trust E	Total
Teams (*n*)	3	3	3	1	10
Unfilled Band 6 Vacancies	7	2.8	3	1	13.8
Band 2	0	0	0	0	0
Band 3	3	5	0	0	8
Band 4	2	5	0	4	11
Band 5	6	1	1	0	8
Band 6	19	14	6	6	45
Band 7	5	5	3	3	16
Agency AYE	0	0	0	0	0
Agency Band 6	1	0	0	0	1
Practice Teachers	1	0	1	0	2
Overall caseload	1321	1496	262	116	3195
Allocated Cases	1276	1180	262	108	2826
Unallocated Cases	45	316	0	8	369
Total number of SWs w/caseloads	29	22	7	12	70
Ratio of SW to allocated caseload	1:44	1:54	1:37	1:9	1:40
Ratio of SW to total caseload (allocated + unallocated)	1:46	1:68	1:37	1:10	1:46
If vacancies were filled Total number of social workers/caseloads	36	24.8	10	9	83.8
Ratio of SW to allocated caseloads if vacancy filled	1:35	1:48	1:26	1:12	1:34
Ratio of SW to allocated and unallocated if vacancy filled	1:37	1:60	1:26	1:13	1:38
How many Teams developed caseload weighting approaches?	1	1	0	1	3
How many Teams use waiting lists?	2	3	0	1	6

Note: Reported data as of 28th February and 31st March 2023

OPSW Mental Health Calculation of social workers carrying caseloads

In terms of social workers carrying caseloads in Mental Health social work we added the Band 4 Social Work Assistants (11), the eight AYE Band 5 social workers (8), Band 6 social workers (45), and Band 7 social workers who were not assumed to be Designated Team Leaders (6), this total is as follows (11+8+45+6 = 70).

OPSW Mental Health Unfilled posts

Across the four Trusts reporting Mental Health Teams there were thirteen-point-eight (13.8) unfilled Band 6 posts. One (1) was related to maternity leave and five (5) due to empty posts. A 0.8 vacancy was related to sick leave of more than four weeks. Data was missing about the remaining unfilled Band 6 posts. The percentage (%) of vacancies to overall SWs/caseloads if vacancies were filled (vacancies divided in to SWs with caseloads if vacancies were filled multiplied by 100), per Trust, for mental health teams were as follows; A=19.4%; B=n/a; C=11.3%; D=30.0%; and E=11.1%.

OPSW Mental Health Funded Establishment

When asked if the total number of social workers (across all Bands) and social work assistants plus vacancies in the Teams correspond with the number of FE positions, five (5) Teams responded 'yes'. One (1) Team reported being under the funded establishment by two social workers, two (2) Teams reported being over the funded establishment and two (2) Teams gave no response (see Appendix 4).

OPSW Mental Health Practice Teachers

There were two (2) practice teachers reported across the four Trusts.

OPSW Mental Health Training

Thirty-seven (37) staff indicated that they were able perform assessments under the MCA (Mental Capacity Act) and three (3) were practicing ASW (Approved Social Worker) under the Mental Health Order. Nine (9) social workers were reported as DAPO under Adult Safeguarding: Prevention and Protection in Partnership Policy and thirty (30) were reported as practicing Investigating Officers under Adult Safeguarding Policy (Adult Safeguarding: Prevention and Protection in Partnership).

OPSW Mental Health Administrative Support

Teams reported eight (8) Band 3 administrators which works out at less than one administrative staff member per Team.

OPSW Mental Health Caseloads

The combined overall caseload of the ten (10) Teams was 2197. A breakdown of the overall caseload reported 2067 allocated cases and 130 unallocated.

OPSW Mental Health Specialist role caseloads

In response to the question of whether social workers with a specialist role had a lower caseload, four (4) Teams answered that it varies from time to time. Three (3) Teams responded no, and two (2) Teams responded yes. One (1) Team indicated that this was unknown.

OPSW Mental Health Social Work Assistant Caseloads

Only two (2) from the ten (10) Mental Health Teams indicated that SWAs carry cases. Both Teams reported an average caseload for Social Work Assistants of 16-25 however one of these Teams did not report any Band 4 staff.

OPSW Mental Health Caseload Weighting Approaches

Five (5) Teams did not respond to the question regarding the development of caseload weighting approaches. Three (3) Teams reported either researching possible approaches or that they were awaiting roll out of tools. One (1) Team reported using a Caseload weighting tool "based on point allocation for complexity/risk /frequency of contact with client and family/carer."

OPSW Mental Health Waiting Lists

Six (6) out of the ten (10) Teams reported using waiting lists. These lists were managed through a variety of governance measures including weekly management review, urgent referrals and medical review (see Appendix 2).

Brief Analysis – OPSW Mental Health (Regionally)

The ten (10) Mental Health Teams regionally were managing caseloads between 36 and 458. Overall, the Teams were managing an allocated caseloads ratio of 1:40, and an overall (unallocated plus allocated cases) caseload ratio of 1:46 among seventy (70) members of staff that carry caseloads within these Teams. There were thirteen-point-eight (13.8) unfilled Band 6 vacancies across the Teams. Three point eight (3.8) were related to sick leave (4 weeks or more); one (1) was related to maternity leave; five (5) were empty posts and four (4) were

reported as “other”. When we add the vacancies reported, the ratio for allocated caseloads becomes 1:40, whereas the overall caseload ratio becomes 1:46.

Seven (7) of the mental health social work Teams reporting were multi-disciplinary and three (3) were uni disciplinary. Five (5) Teams reported being managed by a social worker. Two (2) of these Teams reported monthly supervision. The other three (3) indicated supervision every four to six weeks depending on availability. Half of the mental health Teams reporting (5) were not operationally managed by a social worker. Three (3) of these Teams received supervision every six weeks and the other two monthly.

There were eight (8) Band 5 social workers reported. There were forty-five (45) Band 6 social workers, one (1) of which was reported as agency staff. There were sixteen (16) Band 7 social workers covering a range of roles including Designated Team Leaders; Senior Social Work Practitioners; Senior Social Workers; and Designated Adult Protection Officers. Three (3) Teams reported either researching possible caseload weighting approaches or that they were awaiting roll out of tools. One (1) Team reported using a Caseload weighting tool “based on point allocation for complexity/risk /frequency of contact with client and family/carer.” Another Team explained *“This Team is a specialised service that supports clients with complex mental health needs. Where the risks are significant and requires specialised input from mental health services.”*
Waiting lists were used by six (6) Teams and were managed through a variety of governance measures including weekly management review, urgent referrals and medical review were managed.

Teams were supported eight (eight) Band 3 administrators which works out at less than one administrative staff per Team. The majority of training reported included, MCA and Investigating Officer and Adult Safety. Three (3) Teams indicated that the numbers of staff did not add up to the FE, one (1) of which reported that they were over their funded establishment. Five (5) Teams indicated that the numbers were equivalent to their FE; and two (2) Teams did not answer this question. Out of the ten (10) Teams, two (2) reported to having practice teacher(s) in their Team. As the data indicates, the caseload ratio across older people Mental Health Teams ranges considerably among Trusts with one having a ratio of 1:10 and another with a ratio of 1:68. While the regional average of 1:46 is within the upper levels of what is

considered manageable from the qualitative data, the considerable variation across Teams and Trusts is notable.

Older People Hospital Services

In addition to community and mental health Teams, there were five (5) older people hospital services Teams that reported data across four of the Trusts (see Table 52 below).

Table 52: Description of Hospital Services Teams at Regional Level

Trust	Trust A	Trust B	Trust C	Trust D	Total
Teams (*n*)	1	2	1	1	5
Unfilled Band 6 Vacancies	3	2	1	0	6
Band 2	0	6	0	2	8
Band 3	1	1	1	1	4
Band 4	0	0	1	0	1
Band 5	0	7	1.5	1	9.5
Band 6	4	28	4.6	5	41.6
Band 7	1	11	1	1	14
Agency AYE	0	0	0.5	1	1.5
Agency Band 6	2	0	0	0	2
Practice Teachers	1	0	3	0	4
Overall caseload	88	103	217	409	817
Allocated Cases	73	103	217	274	667
Unallocated Cases	15	0	0	135	150
Total number of SWs w/caseloads	4	44	7.1	6	61.1
Ratio of SW to allocated caseload	1:18	1:2	1:31	1:46	1:11
Ratio of SW to total caseload (allocated + unallocated)	1:22	1:2	1:31	1:68	1:13
If vacancies were filled total number of social workers/caseloads	7	46	8.1	6	67.1
Ratio of SW to allocated caseloads if vacancy filled	1:10	1:2	1:27	1:46	1:10
Ratio of SW to allocated and unallocated if vacancy filled	1:13	1:2	1:27	1:68	1:12
How many Teams developed caseload weighting approaches?	0	0	0	0	0
How many Teams use waiting lists?	0	0	0	0	1

Note: Reported data as of 28th February and 31st March 2023

Again, there is a great deal of variation across Teams and Trusts with one (1) Team reporting caseloads of over 400 while a Team in another Trust reported caseloads of less than 100. Across the four Trusts reporting, the ratio for all cases in hospital social work is 1:13.

OPSW Hospital Services Calculation of Social Workers Carrying Caseloads

It should be noted that the nature of hospital social work is very fluid and therefore social workers do not carry cases in the same way as, for example, community social work. This is reflected in the significant variation in the data reported on caseloads which likely reflects different Team level processes for what counts as a "case". In terms of social workers assumed to be carrying caseloads in Hospital Services, we added the one (1) Band 4 Social Work Assistant, the AYE Band 5 social workers (9.5), Band 6 social workers (41.6), and Band 7 social workers who were not assumed to be Designated Team Leaders (9), this total is as follows (1+9.5 + 41.6 + 9 = 61.1).

OPSW Hospital Services Unfilled Posts

Across the four Trusts reporting Hospital Services Teams there were six (6) unfilled Band 6 posts. Two (2) were related to maternity leave and one point five (1.5) due to empty posts. Data was missing about the remaining unfilled Band 6 posts. The percentage (%) of vacancies to overall SWs/caseloads if vacancies were filled (vacancies divided in to SWs with caseloads if vacancies were filled multiplied by 100), per Trust, for hospital teams were as follows; A=42.9%; B=4.3%; C=12.3%; D=0.0%.

OPSW Hospital Services Funded Positions

When asked if the total number of social workers (across all Bands) and social work assistants plus vacancies in the Teams correspond with the number of FE positions, five (5) Teams responded 'yes'. The Team in Trust *anonymised* answered that they were waiting for new social work positions that had been created to be funded (see Appendix 4).

OPSW Hospital Services Practice Teachers

There were four practice teachers reported across the four Trusts: three in Trust C and one in Trust A.

OPSW Hospital Services Training

Fifty-two (52) staff indicated that they were able perform assessments under the MCA (Mental Capacity Act) and four (4) were practicing ASW (Approved Social Worker) under the Mental Health Order. Twelve (12) social workers were reported as practicing DAPO under Adult Safeguarding: Prevention and Protection in Partnership Policy and forty-four (44) were

reported as practicing Investigating Officers under Adult Safeguarding Policy (Adult Safeguarding: Prevention and Protection in Partnership). Three (3) social work staff indicated that they were Joint Protocol trained and able to conduct PIA and/or ABE interviews and five (5) social workers were reported as trained to do specialist assessments, for example, pre-birth assessments, and a further one (1) staff trained in Family Group Conferencing.

OPSW Hospital Services Administrative Support

Teams were supported by eight (8) Band 2 and four (4) Band 3 administrators.

OPSW Hospital Services Caseloads

The combined overall caseload of the six (6) Teams was 817. A breakdown of the overall caseload recorded 667 allocated cases and 150 unallocated. There is considerable discrepancy in the reporting between overall cases and those reported allocated or unallocated. This could be because of the different ways in which Hospital Teams calculate caseloads and what counts as a case.

OPSW Hospital Services Specialist Role Caseloads

Four out of the five Teams reported that specialist roles do not have lower caseloads and two reported that it varies from time to time.

OPSW Hospital Services Social Work Assistant Caseloads

The average caseload reported for social work assistants ranged from 16 to 95. Notably only one Trust reported a Band 4 Social Work Assistant in their staffing complement.

OPSW Hospital Services Caseload Weighting Approaches

Only one (1) Team responded to the question about caseload weighting, reporting: *"I closely monitor 2-3 times a week case and review an excel spreadsheet of caseloads. This changes on a daily basis and review cases due to complexities. This is a challenge as the work is fast paced"* (see Appendix 3).

OPSW Hospital Services Waiting Lists

One (1) Team reported using waiting lists. All other Teams responded 'no' (see Appendix 2).

Brief Analysis – OPSW Hospital Services (Regionally)

The five (5) Older People Hospital Teams regionally were managing caseloads between 88 and 409. Overall, the Teams were managing an allocated caseloads ratio of 1:11, and an overall (unallocated plus allocated cases) caseload ratio of 1:13 among 61.1 members of staff that carry caseloads within these Teams. There were six (6) unfilled Band 6 vacancies across the Teams. One (1) was related to sick leave (4 weeks or more); three (3) were related to maternity leave; two (2) were empty posts. When we add the vacancies reported, the caseload for allocated caseload ratio becomes 1:6 whereas the overall caseload ratio becomes 1:18.
All Teams reporting were uni disciplinary. All five (5) indicated their operational manager was a social worker. Four (4) of the Teams received supervision monthly and the other two (2) every six weeks.

There were nine and one-half (9.5) Band 5 social workers reported, one point five (1.5) was agency staff. Three (3) were Band 5 staff reported as permanent and two point five (2.5) as temporary. There was no information provided about the contractual status of the remaining Band 5 staff members. There were 41.6 Band 6 social workers, two (2) of which was reported as agency staff. There is a discrepancy between the number of Band 6 social workers reported when asked about their contractual status and when asked about numbers in each band. There were fourteen (14) Band 7 social workers covering a range of roles including Designated Team Leaders; Senior Social Work Practitioners; Senior Social Workers; and Designated Adult Protection Officers. None (0) of the Teams reported using caseload weighting approaches and one (1) Team indicated they use waiting lists, monitored by the Senior Social Worker two to three times a week on an excel spreadsheet.

Teams were supported by eight (8) Band 2 and four (4) Band 3 administrators. The majority of training reported included, MCA and Investigating Officer and Adult Safety. One (1) Team indicated that the numbers of staff did not add up to the FE, reporting that they were awaiting new posts to be funded. The other five (5) Teams indicated that the numbers were equivalent to their FE. Out of the five Teams, three (3) reported to having practice teacher(s).

Older People Gateway and Adult Safeguarding

Three Trusts also reported Adult Safeguarding and Gateway Teams (see Table 53 below). Of the four (4) Teams, two were uni-disciplinary and two were multi-disciplinary. Two (2) Teams reported that their operational manager was a social worker. The Teams received supervision monthly, six-weekly and every two months. One (1) Team reported group supervision that was both peer and specialist at a rate of four times a year.

Note: Cases were only related to social work cases, as screened by managers during initial referral processes. When asking about caseloads in the survey, we specifically asked about 'across the social work team' to ensure we were focusing on social work caseloads. We note this in our assumptions recorded in Appendix 1a and 1b.

Table 53: Description of Adult Safeguarding/Gateway Teams at Regional Level

Trust	Trust C	Trust D	Trust E	Total
Teams (*n*)	1	1	2	4
Unfilled Band 6 Vacancies	0	0	3	3
Band 2	0	0	0	0
Band 3	0	1	4	5
Band 4	0	0	2	2
Band 5	0	1	0	1
Band 6	1	3	10	14
Band 7	1	6	6	13
Agency AYE	0	0	0	0
Agency Band 6	0	0	0	0
Practice Teachers	0	2	0	2
Overall caseload	0	61	276	337
Allocated Cases	0	61	276	337
Unallocated Cases	0	0	0	0
Total number of SWs w/caseloads	0	9	16	25
Ratio of SW to allocated caseload	n/a	1:7	1:17	1:13
Ratio of SW to total caseload (allocated + unallocated)	n/a	1:7	1:17	1:13
If vacancies were filled Total number of social workers/caseloads	n/a	9	19	28
Ratio of SW to allocated caseloads if vacancy filled	n/a	1:7	1:15	1:12
Ratio of SW to allocated and unallocated if vacancy filled	n/a	1:17	1:15	1:12
How many Teams developed caseload weighting approaches?	0	0	0	0
How many Teams use waiting lists?	1	0	0	1

Note: Reported data as of 28th February and 31st March 2023; Trust A and B did not report on this Team type

Brief Analysis – Adult Safeguarding (Regionally)

The following is a brief analysis of Older People Gateway and Adult Safeguarding Teams. The four Gateway and Adult Safeguarding Teams regionally were managing caseloads between 0-276. Overall, the Teams were managing an allocated caseload ratio of 1:13, and an overall (unallocated plus allocated cases) caseload ratio of 1:13 among twenty-five (25) members of staff that carry caseloads within these Teams. There were three (3) unfilled Band 6 vacancies across the Teams, all three (3) related to empty posts; When we add the vacancies reported, the caseload for allocated caseloads ratio becomes 1:12, whereas the overall caseloads ratio becomes 1:12.

There was one (1) Band 5 social worker who was a permanent staff member. There were fourteen (14) Band 6 social workers all of whom were permanent. There were thirteen (13) Band 7 social workers covering a range of roles including Designated Team Leaders; Senior Social Work Practitioners; Senior Social Workers; and Designated Adult Protection Officer. Two (2) were reported as uni-disciplinary and two multi-disciplinary. Two (2) of the Teams were managed by a social worker and one (1) Team reported supervision monthly, another six weekly and the third two monthly (see Table 53 for a breakdown of the Adult Safeguarding Gateway/Gateway Teams).

None of the Teams reported using caseload weighting approaches. One (1) of the Teams used waiting lists but only for carers assessment referrals. Teams were supported by two (2) Band 3 administrative staff. All social workers reported being trained in Designated Adult Protection Officer (DAPO) under Adult Safeguarding: Prevention and Protection in Partnership. One (1) Team indicated that the numbers of staff did not add up to the FE and the other Teams reported that the numbers were equivalent to their FE. One (1) Team reported having two practice teachers.

Qualitative Findings within Older People's Social Work

All five Health and Social Care Trusts in Northern Ireland are represented in this summary. Interviews were conducted with ten (10) front-line Older People's Social Work social workers across community and acute practice settings. Additionally, six (6) focus groups (see Figure 4) were conducted with whole Teams across Trusts and with the Safe Staffing in Social Work Steering Group for Older People Services, comprising of representation from Assistant Directors or Heads of Service level across all HSC Trusts, Union, BASW NI, NI Social Care Council, and the Strategic Planning and Performance Group. In total, fifty-three (53) people participated in these Focus Groups and interviews.

Figure 4: Breakdown of Focus group Participation across Trusts (OPSW)

Focus groups *n*=6 (participants *n*= 43)

- **Trust A** = This is a multi-disciplinary Team consisting of Social Workers, Community Psychiatric Nurses, an Occupational Therapist, a social work deputy Team manager and a nursing Team manager working in Dementia and FMI (n=6).
- **Trust B** = Uni-disciplinary community care Team (n=7).
- **Trust C** = Social Workers, including Team leaders and practitioners at lower bands, practising in multi-disciplinary Integrated Care Teams (n=8).
- **Trust D** = Mixed focus group involving Social Workers, Team leaders and managers from various service (n=10).
- **Trust E** = multi-disciplinary Community Care Team including Social Care Workers, Social Workers and a Senior Practitioner (n=7)
- **Older People: Steering Committee** composed of Assistant Director or Service Managers across all 5 HSC Trusts, Strategic Planning and Performance Group, Union representative, NI Social Care Council and BASW Northern Ireland (n=5).

Similar to Children's Services, the evidence collected as part of the interviews and focus groups with social workers in Older People's Social Work in Northern Ireland suggest that safe staffing is conceptualised across themes connected to:

1. The service users that social workers work with and support.
2. The social workers themselves.
3. The Team within which social workers work; and

4. The line manager or superior that social workers report to.
5. The organisation in which the social worker is employed.

These themes will be discussed in turn. We will shed light on how each of these themes is important in making sense of and enabling and/or disabling perceptions of safe staffing.

Service Users

The experience of service users and the effective delivery of services were often viewed as being pivotal to the concept of safe staffing. Analysis of the qualitative data identified several factors underpinning the overall workload of social workers as having a significant impact on the delivery of services and how well the needs of service users are met. These factors include caseload volume and case complexity, alongside the increasing variation and complexity of roles and responsibilities currently associated with Older People's Social Work (OPSW). Given the workload pressures, many of the participants expressed 'guilt' and 'frustration' at not having the appropriate time and resources to best serve the interests of their service users:

> *"I really do think time, so precious. And that's what our service users want. They want to feel listened to, carers want to feel listened to. They don't want somebody sitting, checking their watch and feeling rushed and feeling that calls aren't being replied to, things aren't being responded to".* (Social Worker, Community Team).

Some social workers also expressed frustrations that workload pressures inhibited preventative work or timely intervention with service users, creating the need for more and more crises work. While one social worker from Trust *anonymised* expressed concerns for the "*lower level cases that are going a bit under the radar … because there's nobody looking at them"* (Social Worker, Community), another explained how staff shortages created delays in dealing with urgent needs of service users. Participants from Trust *anonymised* focus group referred to a "*vicious cycle"* of outcomes for service users and social work Teams:

> *"So we have an office duty system every day and really especially in those times where the staffing is low […] you really notice the challenges it poses and a lot of what we're getting is the same families ringing through speaking to somebody different every day with the same issue […] But while that's ongoing, the crisis is building and building. And then it whenever it reaches a peak then somebody's*

dispatched out in an emergency. And the family are, you know, there's no preventative work, nothing preventative has been done. Families have really bad feelings about social services and the social worker because they've been palmed off for maybe 2 or 3 weeks […]. So you're starting on the back foot, so you're already going out with that." (Social Worker, Community).

Caseload: Volume and Complexity

Caseload and workload are separate concepts. Caseloads are the numbers of cases held by social workers and in OPSW sometimes also held by social work assistants (some Trusts give social work assistants their own cases and other Trusts give them parts of work on a case held by a social worker). Workload is the overall work related to the job, which includes caseload, duty intake, record keeping and paperwork, supervision, training, meetings, and contact with other departments and professionals.

The interviews and focus groups, in most cases, revealed that social workers perceived their caseloads to be high and, in many cases, unmanageable. There are a variety of services represented in the data from both acute hospital and community settings. While a single number representing a reasonable caseload was identified in community settings there was no such figure identified in acute hospital settings. Acute caseloads are more fluid with discharges from hospital. Workload is therefore complex in different ways. In general, participants suggested the 'ideal' caseload number for community based OPSW social workers in terms of capacity, was 35 cases. One social worker in a very busy community Team identified 30 as a baseline figure since there was always a constant stream of intake and assessment that pushed up numbers:

"I think I would be much more confident with … 30 or there or there abouts…sometimes we'll get to certain level and then it creeps up very, very quickly because you take on more places like new allocations and there's some cases can't go to social care, you hold them for as long as you have them" (Social Worker, Community, Focus Group).

There was also an issue for some regarding the relationship between social care and older people's social work in terms of the volume of cases that social care workers were dealing with.

In this context, cases could be rotating in and out of social care with caseloads never reducing. As a social care worker in one of the focus groups explained:

> *"But we also have to sort of take in the consideration of the cases that are rotated in and out and in between, so the hundreds that (we) have at the start of the year may not be the same hundred (we) have at the end of the year because they're taking backwards and forwards to social work and social care, depending on the level of complexity or whether they needed an annual review"* (Social Care Worker, Community, Focus group).

There was wide agreement that a 'safe' and 'fair' volume of cases for each social worker should consider time, travel and case complexity, acknowledging that complexity can fluctuate over time, alongside the level of liaison with other professionals and services required for each case. An interviewee noted concern that management's view of a social worker caseload being 50, is not based on any analysis of the time involved in current roles and tasks:

> *"Optimally, I don't think caseloads currently, taking into account the full range of roles and responsibilities of social workers have to take on and not least taking into account the impact of the MCA limitation, I don't think a caseload should be any higher than 35"* (Social Worker, Community).

Another social worker compared the volume and complexity of cases in OPSW to their time working in Children's Services. Although they explained they didn't have the same *"level of worry"*, working in OPSW brought different challenges in terms of caseload volume when working with multiple professionals and services:

> *"It's your everyday, you know, when you think of one case has a number of people involved in terms of the care provider, district nurses, mental health Team, GP, you're dealing with a lot of communication with other professionals about one case and you might have 50 something of those cases going on. So it's the high volume that is the stressful part in older people's"* (Social Worker, Community).

The fluctuation of case complexity was also acknowledged as a challenge even for those who suggested they had a 'manageable' case load. A social worker based in a hospital setting explained that:

> *"…it just depends on the level of complexity because you could have four packages of care and 4-6 cases is probably quite realistic, but if you had four placements that would be a bit more difficult, a lot more paperwork, a lot more liaising with different people/agencies. So yes, I personally I feel that my workload daily is very manageable"* (Social Worker, Hospital).

The unpredictable nature of cases further adds to the complexity of workload planning and impacts on service delivery. One social worker explained that "*you could have your whole week planned and it could change five times"* (Social Worker, Mixed Focus group).

Complexity of cases also arose from lack of capacity elsewhere in the system, in particular social care, where unmet demand in social care could escalate so that by the time cases came to social workers, they were more complex than they might have been had issues been addressed earlier:

> *"… there is a high level of need for social work services and social care services and the caseloads by the time they get to us are much more complex than they would have traditionally been. So in terms of like say for example supported housing, … there would have been a conduit towards supported housing, but almost by the time we get people to our doors, now they're beyond the point at which they could avail of that service. So I think not only has the volume changed, I think the stage which people are being referred …So by the time they get to our door, they're much further down the pathway and more complex, which takes more time than they would have been traditionally"* (Social Worker, Community, Focus Group).

On top of caseloads, many social workers discussed their responsibilities on 'duty intake' and the impact this can have for overall workload volume and complexity. Some social workers raised concerns about the redirection of unallocated cases via duty intake work. Unallocated waiting list cases in need of immediate support are directed through the duty system, but this means that intake-based work can be more complex and challenging, sometimes with people

in crises. Many social workers across different trusts and Teams described the duty work as intensive, commenting that pressures have been moved to another part of the social work system rather than an alternative to support staff. A finding that was apparent in the analysis of one HSC Trust, was a lack of record keeping around Duty Intake. A social worker reflected concerns about the record keeping of duty calls records which were not systematically kept.

> *"To me it's absolutely astounding that in this Team there's no record kept of that"* (Social Worker, Community).

Fundamentally, a more manageable caseload was intrinsically linked to providing clients with the kind of services they need:

> *"And I'll be very honest about that. I think also for our service users ...if they're sitting under a social worker who has 25, they're going to be seeing(them) a lot more often and getting a better service than sitting under a Social Worker who is completely overwhelmed"* (Social Worker, Community Focus group).

Caseload: Roles and Responsibilities

The role of social workers typically involves a range of social work processes, from assessment, to planning, intervention, monitoring and reviewing cases. However, in recent years, legislative changes such as the move towards personalised budgets for care, in the form of Self-Directed Support, carers assessments, and importantly, the introduction of the Deprivation of Liberty Safeguarding, Mental Capacity Act (MCA), all place new roles and tasks on social workers which are both time-intense in terms of paperwork and administration. Additionally, adult safeguarding, and care management processes are an integral aspect of work in this sector which also require timely attention and need for accuracy.

Given the volume and variation of what are deemed critical tasks, many participants found it challenging to prioritise tasks and responsibilities within their heavy workloads. Several social workers acknowledged that many statutory reviews are "*quite often out of date"* while a focus group participant bemoaned the *"multitude of tasks"* and that *"everything is a priority"* (Social Worker, Mixed Focus group).

One participant was concerned that management's view of a social worker caseload of 50 is not based on any analysis of the time involved in current roles and tasks, "*not least taking into account the impact of the Mental Capacity Act*" (Social Worker, Community). OPSWs discussed the skilled nature of the work involved in the implementation of the MCA to date and the need to have enough time to do it well in the best interests of service users. Participants suggested that 90% of Deprivation of Liberty applications were for older people.

> *"....or no adjustment was made in advance of the implementation of MCA, even though those, even though that state in my view would have been anticipated"* (Social Worker, Community).

Notwithstanding, one Trust stated that they had a dedicated team that took responsibility for conducting MCA assessments thus, easing the workload demand of the regular team.

> *"...at this time, I suppose we have a team that's doing the MCA assessments you know, so there is a team that are doing that and actually whenever that came in about a year and a half, maybe two years ago, things were very, very difficult and we were trying to do them ourselves as a team and the paperwork was taking quite a significant amount of time. Since that's been introduced, I suppose, they've introduced the referral paperwork, is quite streamlined, quite easy to do, and that that team and that paperwork has taken quite a bit of pressure off us as social workers"* (Social Worker, Community).

The increased pressures associated with formal social work processes is also attributed to the perceived encroachment of paperwork. For example, Self-Directed Support was deemed time intensive with paperwork and administration. Although it is recognised that there is ongoing work to improve the efficiency of recording and reporting information, many social workers from across all Trusts called for a better streamlining of processes to avoid the duplication of work and effort, some calling the systems and processes "*not fit for purpose*" (Social Worker, Mixed Focus Group).

Many social workers also acknowledged that a lot of work is 'unseen' or 'unrecognised' within workload records, particularly the informal support offered to families and caregivers. One social worker explained that this support is "*continual throughout the entire journey that you're*

with that family, you're providing either formal or informal support to carers, and that's a massive part of our job" (Social Worker, Integrated Care Teams Focus Group). It was also acknowledged that this informal support was even more critical when there were delays in service provision. Many stressed that a lot of the informal work being undertaken with families and caregivers, is not being adequately recorded or recognised.

Social Workers

While social workers described safe staffing as contingent on their working conditions, abilities, and opportunities to keep service users well and safe and address service-related risks, they also emphasised that safe staffing should consider the health, safety, and wellbeing of social workers themselves. Many participants discussed the pleasure they had when working with older people, with a clear desire to do "*the best by the patient and their families"* (Social Worker, Mixed Focus Group). One social worker compared her time in OPSW to Children's services:

> *"....by and large, you know the vast majority of the clients that I'm working with now are pleased to see you, which is really nice when you're coming from children's and they don't want you through their door, whereas in older people's, most people want to see you and are welcoming you and are very pleasant people to work with"* (Social Worker, Community).

Impact on Wellbeing

Despite enjoying OPSW, we found that the health and wellbeing of many social workers was increasingly impacted by workload pressures, often precipitated by a "*feeling that you would love to be able to do more for people*". Anxieties about not meeting service-user needs was reported widely often expressing disappointment that they were unable to do their jobs in the manner to which they aspired:

> *"[The anxiety] never goes away and I think my colleagues and the Team would agree we are working and feeling that we, we don't have the time to give people, the service they deserve. To me, I feel we scratch the surface. We, what we do isn't preventative, we react, and that shouldn't be the way that we work"* (Social Worker, Community).

Participants often described increased stress and *'fear'* they felt when trying to manage heavy and complex caseloads, where there are evident risks to the wellbeing of service users. Like many participants, one social worker described how they prioritise their workload based on risk. They suggest that fear associated with managing complex mental health related cases, where the risks may be higher, leads to additional stress and encroachment of work life boundaries. They also explain feeling they must work additional hours in evenings and weekends to manage the workload which will help reduce anxiety around high-risk cases:

> *"So you find yourself maybe sticking the laptop on when you shouldn't"* (Senior Social Worker, Community).

The constant demand on social workers, alongside their sense of duty to service-users leads to some social workers working long hours, changing annual leave plans, or cancelling training. Participants described working until 7 pm in the evening "*to stay on top of things'* (Social Worker, Mixed Focus Group)" "*logging in at home…..knowing that there is stuff you want to get sorted and done"* (Social Worker, Community) or leaving work later than others because their *"stress levels would go through the roof"* (Social Worker, Mixed Focus Group) if tasks were not actioned. Others shared how difficult it is to switch off explaining how *"during those busy spells, it affects you when you're off at the weekend and in the evening, it's on your mind more*" (Social Worker, Community). Another social worker described how their caseload did not go down even when they changed to a 4-day week, meaning often logging on during days off (Social Worker, Community).

This sense of duty ultimately affects work-life boundaries and is further compounded by the daily rituals of "*listening to other people's lives, other people's problems, other people's families*". A social worker explained how they felt *"drained"* from absorbing their service user's problems, trying to process what they're telling them and thinking of ways to support them (Social Worker, Community). However, a key difference with Children's Services was the impact on personal and physical safety. This issue did not arise in the data collection with Older People's Social Work, but a participant reported that they felt safer as a lone worker in comparison to when they worked in Children's services.

The overall affect that caseload and working conditions had on staff wellbeing was acknowledged by line managers involved in the interviews and focus groups. One line manager during a focus group described the efforts they go to redress wellbeing concerns:

> *"But I can see the pressure that has been put on the Team and, you know, I feel that as a manager on a day-to-day basis, and constantly trying to keep staff in post, trying to reassure, trying to reduce stress, trying to put stress toolkits in, trying to take cases off and swap cases round, you know and you know it, it's only adds to the crisis. The feeling that the Team… there's no stability, there's no quiet time, there's no… They feel guilty having the Team meeting, they feel guilty going out for lunch because they're just constantly under so much pressure"* (Social Worker, Integrated Care Teams Focus Group).

It was acknowledged that while some line managers are supportive, social workers were also relying sometimes too much on Team leaders for support:

> *"We just offload to them and it's not always fair because there's only so much their shoulders can take"* (Social Worker, Integrated Care Teams Focus Group).

Team leaders often escalated the problems to more senior management, although it was appreciated there was little senior managers could do to alleviate the pressures. Rather than escalating the issues, one social worker emphasised the need for staff to take individual responsibility for managing and responding to their individual wellbeing needs but acknowledged that staff need to be supported and encouraged to do this. They suggested:

> *"I think it's about ensuring that people have the confidence to say when they are at their capacity because in hospital you just get case after case after case. And I think you need to be able to say you have to be able to say no. I can't take anything else, just at the minute to protect themselves, you know?"* (Social Worker, Mixed Focus Group).

Individual action to protect wellbeing was described by another social worker who self-referred to occupational health because of concerns that workload pressures were impacting on their wellbeing and their ability to cope with caseloads. They did not want to be pathologised for

issues that were - in their view - about inadequate management planning, unrealistic workloads and a lack of care for staff. The interviewee had a positive Occupational Health experience and felt validated by this process.

When discussing individual wellbeing of social workers, some participants also acknowledge the organisational wellbeing supports offered by their Trusts to buffer the stresses and demands of the job. However, these were met with scepticism and ridicule by many. One participant commented that:

> *"…these endless live well emails that come around … I just deleted these as soon as I come in, because the more stressed you are, the more they begin to annoy and the more you see them"* (Social Worker, Mixed Focus Group).

Ultimately the impact on social workers' wellbeing was further compounded by lack of recognition. Social workers involved in a mixed Focus group, discussed being made to feel like a *"donkey"* when longer hours are expected but not rewarded with overtime. Others commented on the low morale and high turnover in social work. One social worker summarised:

> *"I feel like a bit more recognition from the Trust in general that social work is a difficult job that we're trying our best and difficult circumstances. And a bit of acknowledgement might help boost morale a little bit and help"* (Social Worker, Mixed Focus group).

Impact on one's own profession

Further effects of workload pressures were related to hollowing out of aspects of what social work ought to be. Many social workers bemoaned the fact they were unable to engage in sufficient reflective practice and therapeutic work which are deemed fundamental to social work practice. One social worker (Integrated Care Teams focus group) queried when the last time social workers reflected on their cases, suggesting *"We don't have the time, do we?"* Whilst another suggested that safe staffing would only be achievable when there is a "*very clear and defined social work role"* with *"all the things we went to university to train for", including "[reasonable] caseload numbers….".* Another participant also emphasised therapeutic social work as *"really and truly a big part… of my role",* but due to the limitations

of the Team, the amount of work and the caseloads, the Team could not deliver the therapeutic interventions that are ideally needed.

Interestingly, one social worker inferred a lack of agency in deciding what was safe and unsafe in their role, commenting that: *"It's really difficult to know whether it's safe or not, like even what we're working on now. We don't really know if it's safe or not. We're just working it because …we don't have an alternative."* (Social Worker, Community). Such revelations are concerning when social workers have statutory and professional responsibilities for advocating for service-user interests.

Teams

Perceptions of safe staffing were not only reflected through an individual lens. How Team members worked together to share and manage risks, enabling the effective and safe delivery of services was also important. The shared approach was contingent on several factors including whether Teams were sufficiently staffed, the stability of Teams, the quality of relationships between Team members and managers, trust, fairness, equity of workloads and collective Team capacities. Integrated Team-working across professional boundaries also had a major impact on perceptions of Team effectiveness.

Sharing Risk across the Team

Many social workers discussed the importance of a sharing risk within Teams so that staff do not feel isolated in assessing and responding to the risk associated with their cases. Open communication, honesty and trust among colleagues were critical factors in facilitating this shared risk approach. Sharing risk could be both informal and formal, through ongoing Team interactions and 'open door policies', or through more established routines, such as Team daily huddles. One manager described their Team's use of the 'morning huddle' that facilitated open communication about the challenges they faced with service users and the decisions affecting practice:

> *"Because we've been under so much pressure, the morning huddle is a good forum for anybody to say, look, I'm a bit overwhelmed today, I have so much. I mean, so it gives that forum for everybody to help out. And our mantra always says, "we don't carry risk, we share risk."* (Multi-disciplinary Focus Group).

However, it was also recognised that consulting other Team members about the level of different risk factors can lead to ambiguity. An AYE social worker revealed they were conscious that different Team members – based on experience, skills, and personality, had different approaches to risk. They recounted an example of when they and their manager had different interpretations of risk which made them feel unsure and uncomfortable (AYE, Multi-disciplinary Team).

Sufficiently Staffed Teams

Maintaining safe staffing at Team level is influenced by having the optimal numbers of staff, related to Funded Establishment. However, although Teams should be allocated the appropriate number of posts, it is evident that many Teams are understaffed for several reasons. For example, budgetary challenges inhibit the recruitment of staff, there are frequent transfers of staff between Teams, staff are off on sick/maternity or other long-term leave, staff have decided to reduce working hours, or simply that staff leave their employment altogether:

> *"…our funded establishment isn't worth as much to me now, so you know, I should have funding at the minute to go out for three more Band 6. I don't because the way the budget is. It's based on three years ago and I don't have enough money to go out for three full-time posts at the minute. Right, because the budget hasn't increased"* (Multi-disciplinary Focus Group).

Many participants were working within understaffed Teams, and this has led to higher caseloads, greater pressure on staff and increasing feelings of resentment. A social worker revealed that the situation of understaffing has been noted in the risk register but feels that this has no real meaning, as 'nothing changes', and if something goes wrong, there is a 'blame culture', where adverse incident reviews usually attribute blame to a social worker or nurse. Yet despite pressures, social workers continue to take the burden of understaffing for the sake of service-user interests:

> *"We do it because, you know the service users have a need and we can't neglect that"* (Social Worker, Mixed Focus Group).

In contrast, where participants were working in 'fully staffed' Teams, experiences seemed much more positive. A social worker from Trust *anonymised* described:

"At the moment, we have our full complement of staff. We have very few instances of long-term staff sickness and we have a really, really well staffed Team and I have only positive experiences within this setting." (Social Worker, Hospital).

Staff Retention and Team Stability

The challenges of increasing and unpredictable caseloads were often attributed to understaffed Teams and poor Team stability. While many social workers enjoyed their job, the impossibility of doing it all in a 37-hour week was highlighted, as one Social Worker put it *"there's just too much of it"* (Social Worker, Community Focus Group).

One social worker (Community) suggested that high caseloads explained why some social workers chose to leave Teams, in the hope that "*the grass is greener on another Team",* but that "*It's just such a vicious cycle, because if we have a full Team of staff, people would not be so under pressure"* but until they get a full complement of staff, *"people will keep leaving"*. Many participants reported staff retention within Teams as a critical issue and suggested ways in which it could be more effectively addressed. For example, hybrid working, and flexible working were discussed to incentivise members to remain with Teams. Also, rather than social workers seeking promotion on different Teams, a re-banding or internal Team promotion was suggested as an incentive and reward for social workers to remain with Teams. Others acknowledged that Team activities to promote cohesion are important, but also needs to be balanced with demands for greater flexibility and remote working. For example, one social worker queried why Team meetings on Zoom and working from home were not possible even when it makes sense logistically.

Furthermore, some social workers reported a dependency on agency staff to cover sickness and absence in their Team and although having additional staff members helps to cover gaps, the continued use of agency workers affects Team stability and overall capacities. The use of agency staff to cover gaps is a wider concern in social work (Jones, 2023). At the of data collection plans were underway to limit the use of agency work in the whole of social work. However, an agency social worker voiced concerns about agency workers feeling *"forced out*" or "*into Trust contracts*", making many consider leaving the profession altogether (Multi-disciplinary Focus group).

Skills Mix and Collective Team Capacity

In describing what contributes to effective and safely staffed Teams, many social workers acknowledged the benefits and drawbacks of heterogenous Teams involving a range of experience, expertise, and professional roles. It was acknowledged that different Team members might have different capacities to deal with case volumes and complexities, which also depends on tenure within the role, banding of positions, and management experience.

Firstly, the role of social care coordinators, or social support workers, typically a Band 4, were lauded as being integral and "*so valuable*" (Senior Social Worker, Community) to caseload management within Teams. Some Teams had social care workers who undertake the support work that can creep onto the workload of social workers. Other Teams had social care coordinators with dedicated roles to manage settled cases, and/ or the duty system and this seemed to alleviate the pressure on social workers. It is worth noting that one Team from Trust *anonymised* had changed the process for how social care coordinators supported caseload management:

> *"Up until recently, cases were typically co-allocated to social care coordinators and social workers, allowing for a smoother transition of responsibilities between more and less complex tasks. However, because the social workers case allocation was deemed too high or 'non-compliant' social care coordinators now receive their own less-complex cases, but this means that when cases fluctuate with complexity, caseloads need to transfer back and forth between different social care coordinators and social workers, adding additional governance and Team management challenges. This is also leading to poorer service user experience as the professionals providing support changes frequently, depending on who is available at that moment"* (Senior Social Worker, Community).

The service manager of the Team also explains that this change was difficult for the social care coordinators as they did not have the integral support from an allocated social worker to manage their cases, causing increased nervousness when supporting service users.

Secondly, the role of an assistant care manager is a further example of a position that was introduced with the intention of relieving case load pressure on care managers. Assistant care managers are responsible for many of the annual reviews and/ or 'settled cases. However, from

the perspective of the care managers, this resulted in perverse outcomes where care managers maintained the volume of cases, but now had to take care of all complex cases, which resulted in their workload feeling that it increased 'tenfold' (Social Worker, Mixed Focus Group).

Retaining experienced staff was also identified as key to effective Teams. Participants suggested that the Trust could look at retaining their experienced staff, such as Senior Practitioners, within Teams, rather than being promoted outside of their existing Teams. This would keep a concentration of knowledge and experience within each Team, assist those new to the role and ultimately, help with overall staff retention.

Having a range of experience on Teams was also deemed important for the development of AYE staff. It was acknowledged that AYEs, alongside a frequent churn of other new staff, require the existing Team members to provide additional guidance and support to settle new staff into their positions. While participants acknowledged the importance of providing this guidance, there was also frustration when they felt their input was a substitute for appropriate line management:

> *"Certainly, in the absence as well of the line managers, there's a lot of times where naturally your day is then taken up you know working on something else or you know getting involved in in a discussion about another person's case"* (Social Worker, Community).

Skills Mix - Multi- Disciplinary Teams

Many of the participants worked in multi-disciplinary Teams involving a range of professionals including Occupational Therapists (OTs), Physiotherapists, Nurses, Psychiatry Consultants, Speech Language therapists and Mental Health Practitioners. Considering safe staffing and the experience of service users, social workers reported both benefits and challenges when working in these Teams. Benefits include the value of learning among professions, the ability to work flexibly to mitigate staff shortages, and the potential value of joint working for a holistic approach to service needs. When multi-disciplinary Teams are scheduled to meet regularly to discuss cases, one social worker explained they can complete risk assessments in a timelier manner, rather than waiting for input from other professionals (Social Worker, Mixed Focus Group). Where social workers were informally co-located with other professionals, benefits for decision making were also identified:

"So it is something that's really helpful because you can just step in and speak to somebody rather than maybe if you're chasing somebody .... can maybe take a bit longer to sort of get response back" (Social Worker, Mixed Focus Group).

However, social workers also cautioned that the dynamic in multi-disciplinary Teams could have an impact on the social work profession. For example, some social workers perceived their input '*isn't necessarily valued'*, and report feeling '*intimidate*d' or '*overwhelmed'* when attending consultant-led meetings (Multi-disciplinary Focus group). One social worker described *'working in the shadows'* of nurses and physios, while their role gets diluted, inhibiting them highlighting the value of their role. Another social worker explained:

"We are very much social workers working within a medical model, so our division is medicine and emergency medicine so that you know, we are very much slotted into a division that doesn't really recognize social work values. They try to recognise these values, but we have to face the fact that we're trying to facilitate hospital discharge...." (Social Worker, Hospital).

While some participants raised concerns about the dominance of a medical model of care, others noted that their role as social workers often becomes blurred with other roles. A participant explained how they had acquired the title of Mental Health Practitioner, while another explained the overlap of their role with Psychiatric Nurses. This social worker further suggests that due to the staffing crisis, working in overlapping roles has become the norm and that more clarity is required around the roles of social workers and nurses for safe staffing in social work. There has been a tendency to view the role of the social worker as dealing with finances and the role of the nurse to deal with medication, while everything else has become blurred leading to perceptions that social work within Integrated Care Teams was likened to a "*dumping ground*" (Social Worker, Integrated Care Teams focus group). Similarly, a social worker (Multi-disciplinary Focus Group) commented on anxiety when drawn into medication-related tasks in the job, particularly related to discussions with patients about 'side effects', and medication related observations that are outside the social worker's comfort zone.

Line Manager and Leadership

Line management and appropriate supervision were identified as integral to the delivery of safe staffing. Recognizing the significance of supervision to the management of caseload risk, participants discussed numerous approaches, both formal and informal, that they perceived to be effective. Overall, two-way communication was identified as a critical factor for effective management of Teams and their workload.

Perceptions of Supervision

Most social workers considered formal supervision as instrumental in managing their responsibilities. Participants often reported feeling 'supported' when having the 'time and space' to discuss individual cases and concerns with senior social workers. One social worker reported how upcoming supervision meetings forced them to reflect on and consider their caseload, work completed and tasks outstanding (Mixed Focus group). However, given ongoing pressures, supervision also involved explaining an increasing list of things that have not been completed.

Relatedly, others reported that supervision could be more of a monitoring exercise, not addressing the concerns of social workers have around service-user risk, rather to identify "*things which haven't been done"* (Social Worker, Mixed Focus Group). Underpinning this cynicism were different perceptions of tasks that were deemed a priority, as one participant explained:

> *"…it's a lot of the less important things which don't take priority, you know, like, … the multiple different systems that we have to use and update, and things like carers assessments, you know which we are really, really hammered with … they're really like clamping down on us"* (Social Worker, Mixed Focus Group).

Frequency and timeliness were key criteria used by participants to judge the effectiveness of supervision. Some social workers seemed frustrated at the infrequency of supervision, resulting in lost opportunities to discuss difficult cases, that they then navigate without formal guidance. A social worker explained, *"you can't leave it for six weeks, two months. […] by the time the six weeks is up, you could have gone through difficulties in many a case."* (Integrated Care Teams Focus group). Vacancies in Team lead positions also contributed to the infrequency of supervision for some Teams. However, alongside the opportunities for formal supervisions,

participants recognised that guidance and support about caseloads was accessible in more informal, and often more timely ways through open door policies with senior staff. Regular "*daily safety huddles"* were used to raise issues that could be referred upwards to a "*collective leadership huddle"* (Social Worker Community Focus Group).

These policies were commonly reported across all trusts, but how well they were taken up in practice by social workers often depended on the "*busyness of the Team"* (Integrated Care Teams Focus group). It was also recognised that co-location with managers was instrumental in accessing this more informal and timely guidance. Therefore, community social workers who often work remotely and" who *may not see their Team from one day to the next",* may not be able to avail of such informal mechanisms as readily (Social Worker, Mixed Focus Group).

Effective Management of realistic workloads

When discussing management's role in managing caseloads, many participants clearly recognized the difficulties of managing case allocation and services fairly and equitably in reactive and under-resourced services, responding to shifting and unpredictable crises and demands. However, participants did appreciate the efforts of managers who attempted to consider nuances of caseloads and their associated tasks and commitments. For example, one participant acknowledged their manager's consideration of travel distances and the frequency of visits required, ensuring working hours would not exceed the norm. Another Senior Social Worker explained how supervision meetings are integral not only for judging capacity for caseloads, but also to consider overall circumstances that might impact on their working lives:

> *"People are in work working, but you have to take on into consideration how many hours people are in work, what's going on outside of work and balance all that as well"* (Social Worker, Community, Focus Group*).*

In more dynamic settings, such as hospitals, social workers explained the importance of continual update and feedback on progress with cases. It is this constant communication that enabled managers to take decisions on where further support is needed across the Team:

> *"So, we're checking in with her at least three times a day to make sure that we're progressing or if we are having any difficulties and if we do, she looks to see if*

somebody else can support us. It's a very, very supportive environment" (Social Worker, Hospital).

Participants also reported reactive approaches to the management of their Team's workload when under significant pressures. For example, actions on case distribution were taken in a 'firefighting' mode. Rather than prioritise work relating to their individual allocation of cases, they worked as a Team to determine how best to logistically manage the overall demand on the service (Integrated Care Teams focus group). Positive Team dynamics also played a crucial role in supporting individual social workers self-care:

"I mean one thing with the Team is a really good buzz on the office, there's a really good bond. And I think the thing that really makes a difference having that person beside you that you can have a laugh with, they can talk you off the ledge…If there's a crisis that they're down to and everybody will walk in together and I think that makes a massive difference in terms of managing and self-care (Social Worker, Community, Focus Group).

Organisation

Finally, this section of the findings from OPSW interviews and focus groups outlines key themes controlled or influenced by wider organisational factors. Caseload weighting systems are the primary organisational mechanism through which risks and workloads are managed, but participants' experience of caseload weighting systems was varied. Organisational interventions to support Teams, such as wellbeing or Team building support, were also identified as influencing factors. Lastly, participants also commented on wider, systemic issues that frustrate their abilities to deliver services safely and effectively.

Caseload weighting

Experiences of caseload weighting systems as a management and planning tool were mixed. Some were unaware of the mechanism, some referred it to a "*pointless exercise*" (Integrated Care Teams focus group), while others use it positively to plan and manage their workloads. In comparison to their experience in Children's Services, one interviewee from Trust *anonymised* commented on the lack of awareness of caseload weighting systems in Older People's Social Work. They explained that it was not used at all in their current Team,

commenting that *"most of my colleagues don't know what that means"* (Social Worker, Community).

Where participants were familiar with such systems, they referred to the use of various RAG approaches that were supposed to account for the level of risk and complexity associated with each case. However, they were often described as being redundant, or irrelevant when caseload numbers were unmanageable and when "*social workers just simply cannot get through the amount, the volume of work that they've been allocated on a week-to-week basis*" (Integrated Care Teams focus group). There were also frustrations that many of the caseload weighting systems were designed without considering the MCA assessments and Deprivation of Liberty Safeguarding work, which adds significant pressures when managing caseloads.

Another social worker explained the difficulties of using caseload weighting when the complexity of cases is often unknown at the outset, highlighting the importance of supervision to discuss ongoing difficulties associated with cases and the need for caseload weighting records to be updated (Social Worker, Community). One social worker talked positively about how the systems help track their caseload development and is a useful tool to inform supervision sessions with their manager (Social Worker, Community). However, the need to continually update the rating of cases was seen as another task on top of increasing demands:

> *"When things change quite quickly, the onus is then you. It's another thing to do at the end of the day or the end of the week ...., but if two or three crisis have come in and you haven't updated it, you don't necessarily get the credit for it"* (Social Worker, Mixed Focus Group).

Organisational Supports for Wellbeing

Interviewees and focus groups referred to various organisational supports that helped alleviate the impact of workload pressures on Teams and boost morale. Whilst the organisational wellbeing supports targeted at individuals were met with a degree of cynicism, the support for Team building was very much welcomed. For example, some participants in Trust *anonymised* focus group each shared positive stories about recent Team building initiatives but acknowledged that managers had 'to fight' to receive funding for these. The Team also had to accept the compromises to workloads even though Teams were still under pressure.

> *"Obviously money was got from somewhere and we were able to facilitate a day out and they got their lunch and they got to go[anonymised] and they had an absolutely brilliant day and think everyone was really motivated by it. But that's the first sort of [thing for] morale. I don't know if any other Team would have been able to do something like that, because it's just notoriously difficult"* (Social Worker, Mixed Focus group).

Another social worker mentioned their self-referral for an Occupational Health assessment as a result of lack of sleep and impact on their mental health due to workload stress. They took this step to protect themselves from being stretched beyond capacity and to avoid sick leave, which would happen had they not taken this step. However, this social worker was concerned that managers would unfairly pathologise them in terms of 'capability' when the issues they were experiencing were systemic not individual. The Occupational Health doctor recommended they were not given additional cases:

> *".... quite a lot of work stress, OK, not sleeping at night. Umm. A lot of, frankly, anger and resentment in relation to lack of support from managers in relation to the Mental Capacity Act .... And hearing the same from other members of staff.... I personally, through all that, managed not to go off work sick, umm, whereas other people did. It's not fair. It's not right. It's not Safe.* (Social Worker, Community).

This interviewee reporting having a caseload size of 43, and a usual caseload of between 40 and 45 although others in the Team would have much more than this. Acting to have their health protected by Occupational Health recommendations was described as a 'big step' for this social worker to protect their health and wellbeing.

Service interfaces and tensions

Many participants highlighted the ongoing difficulties interacting with other services or departments in the wider social work and health care system. They acknowledged the entire system is under strain and identified many examples of 'blockages' or 'hold ups' that were preventing their own service from being delivered effectively and efficiently. For example, with reference to a small specialist service with a 'step up and step down' transfer approach between core and specialist services, a social worker explained how the specialist service will

retain more cases than appropriate when external services are overwhelmed and unable to take cases back (Multi-disciplinary Focus Group).

Another social worker from Trust *anonymised* explained the perverse outcomes for caseload management demonstrating awareness of the systemic issues causing cases to be stuck in inappropriate services because they simply cannot be transferred:

> *"There's a really major issue with the movement of cases between services. So, like so [X} and I work in the same office. And I know that [X} holds a lot of complex cases that potentially could come to me, and I also hold cases where the complexity has reduced significantly, but I can't move the case back to {X's} Team. I have nearly more placement cases than I have community cases and I can't get them moved on to the Permanent Placement Team because that's channel is closed. So, there's a big hold off in all of the systems and which, which means the cases not being worked by the right service. I think it's around staffing a lot of the time"* (Social Worker, Mixed Focus Group).

Participants also acknowledged that these systemic issues impact on their workloads, but also on service-user and carer experiences. One social worker explained the consequences not being able to access timely domiciliary care packages:

> *"... I really notice it now, particularly with the dom {domiciliary} care providers. There's always been an issue ... the demand outweighs supply for care packages, but it really seems to have hit. [It's...] probably the worst it's ever been within the last couple of years and that then is impacting on the whole system and the impact it has on us. If we can't get the package and the support isn't available at home, we are looking to get people then into placement to ensure they're safe and their needs can be met. You're then, that's maybe escalating your DoLS. It's escalating care stress"* (Social Worker, Community).

Another participant explains the consequences further in relation to the process from hospital discharge onwards:

"The hospital then are in the same position they're trying to get their beds cleared…. More and more, the package isn't there to support them to go home. So, they go into the placement for rehab and we then have to follow up within a two-week period, but there may still be no package at the end of that two-week period. So, we've people in nursing homes who don't, who shouldn't, be there. Their needs could be met at home but the support isn't there to provide it. Whereas if we got that person home, we don't have the same level of review to do with them in the home. But the processes our Trust have in place are that we need to be reviewing that two weekly because our Trust funded it and we need to ensure that options are being explored. So that has increased a lot and the number of placements we all have in the Team has increased a lot." (Social Worker, Community).

An Example of a Practice Innovation: Older People (Dementia and FMI)

An Example of a Practice Innovation: Older People (Dementia and FMI)

Case Study Background and Context

This example of good practice, encapsulates the best aspects of multi-disciplinary team working, engaging collaboratively across disciplines, and promoting wellbeing of colleagues and team camaraderie. Positive accounts of multidisciplinary team support, with good managerial relationships, in the context of challenges and pressures, provide a template for how teams might proactively support each other whilst working with risk and challenging casework and services pressures.

This is a multi-disciplinary Team consisting of Social Workers, Community Psychiatric Nurses, an Occupational Therapist, a social work deputy Team manager and a nursing Team manager. A Consultant Psychiatrist is also attached to the Team and a consultant led Team meeting is held weekly to make clinical decisions related to service users. Despite Operational Guidance and agreed guidance on optimal numbers of staff, the Team falls below recommended numbers. Several factors contribute to staffing gaps including difficulty recruiting in the location and general challenges in the process of recruitment through BSO (Business Services Organisation). Alongside these challenges there are issues with recruitment more widely, affecting the recruitment of nurses more than social workers to this Team.

The Team interface with Intermediate Care Services, Community Services, and the community and voluntary sector. Their statutory functions include Direct Payments, Carers Assessment, Care Management, Mental Capacity Assessments. The Team acknowledges a blurring of roles between social and medical tasks, but social work functions are distinct, especially related to secure protection, social care reports and adult safeguarding. Social work is relationship based and holistic in the context of consultant led practice, using a biopsychosocial model. The Team has a crises response function Monday- Friday and have an Office Duty, turn taking model to support this. The Team also has the support of Out of Hours mental health crises support, as well as the general Out of Hours support for cases at risk of crises in the evenings and weekends.

Analysis

The focus group participants discussed many aspects of the work, in response to 'safe staffing' questions. The main themes emerging include 'Team governance structures and "shared" risk', 'firm boundaries and interface tensions' and 'challenges in maintaining safe staffing levels. A Safe Staffing definition evolved from the discussion.

Team Governance Structures and Shared Risk

Supervision and professional update meetings occur at least monthly and an open-door policy with the Team manager also supports the Team on a day-to-day basis. The Team has an open communication style, speak with each other regularly about service user and decisions affecting practice. There is **trust** among colleagues and a daily 'huddle' where Team members get together each day and discuss any concerns about cases and support each other. A 'shared' risk approach is adopted so staff do not feel alone with risk. An agency worker commented:

> *"But even when you were saying about shared risk, I think this is the only role that I've been in where I genuinely feel risk is shared because of our daily huddles." And what I, sorry I keep referring back to children's but it's the only role I've ever experienced burnout, no support, high caseloads, It was very risky working and things like that, in that role, it was the only role I was ever led to feel and believe that it was my responsibility for that caseload and that child and that family, not the Trusts."* (Agency Band 6 Social Worker).

In terms of clinical support, **peer and manager support** and regular clinical meetings with the consultant were deemed to be extremely valuable. Working in pairs, open **communication** and keeping the Corporate Risk Register up to date, were noted as priorities for supporting staff.

> *"Because we've been under so much pressure, the **morning huddle** is a good forum for anybody to say, look, I'm a bit overwhelmed today, I have so much. I mean, so it gives that forum for everybody to help out. And our mantra always says, "**we don't carry risk, we share risk**."* (Nursing Manager).

Firm Boundaries and Interface Tensions

As the Team interfaces with other structures, there were tensions, particularly in maintaining firm boundaries around acceptable referrals. The AYE social worker felt these tensions were more stressful than working with risk and service user complexities.

> *"Sometimes that's the biggest challenge I've had, especially as a new professional. Some of the challenging conversations we do have to have with families, I'd nearly feel more confident in that role. But sometimes standing up to another professional is a bit… intimidating. That's the biggest change."* (AYE Band 5 Social Worker).

Challenges in Maintaining Safe Staffing Levels

The manager has an overview of all cases but requires **communication** on risk to be a two-way process, so that any changes are managed in a timely manner. Keeping workloads optimal was a challenge when holding cases thought of as inappropriate. The volume of case referrals was high and having these allocated fairly was important, taking account of staff members' existing caseload and travel and complexity.

> *"Caseloads usually fluctuate like I say, they fluctuate up and down. If I could keep caseloads below 30 that would be fabulous. And unfortunately, sometimes they creep up to 40-45-47"* (Nursing Manager).

Comments that support the methods of allocation of referrals, reflect **trust** in the managers judgement and a feeling of support and **fairness:**

> *"I think {manager's name} has a really good overview as well through meetings like we're such a big geographical area as well that you might have someone who's, you know it might take you most of an hour to get there. To your visit, and some people even need daily visits sometimes or you know, so you might have five people on a case load, or another person might have two people, but that might take a lot more time. Even the travel and the admin of that. {Manager's name} is very good at making sure, you know, even the allocations each week, you know are very realistic."*

Maintaining safe staffing at Team level was influenced by having the optimal numbers of staff, related to funded establishment. It was evident that the number of posts funded are not available and the reasons for this, relate to budgetary challenges and a vagueness about how calculations are arrived at and reviewed:

> *"...our funded establishment isn't worth as much to me now, so you know, I should have funding at the minute to go out for three more band sixes. I don't because the way the budget is. It's based on three years ago and I don't have enough money to go out for three full-time posts at the minute. Right, because the budget hasn't increased".* (Nursing Manager).

A dependency on agency staff evolved from sickness and absence in the Team and is part of a wider concern in social work, due to workforce instability concerns. The Ray Jones Review of children's service in Northern Ireland, has implications across the whole of social work, and an agency social worker voiced concerns about agency workers feeling 'forced out' or 'into Trust contracts', making many consider leaving the profession altogether:

> *".... if agency does come to an end in June, you know, based on the* ***stress and the workload and the wages****, I could very easily just give it a break. A lot of people that I've spoken to that are agency we want to get, get a break and this is their chance or opportunity they feel pushed out"* (Agency Band 6 Social Worker).

The focus group discussion enabled the main areas which challenge 'safe staffing in social work' to be discussed in an open forum which included other disciplines and a range of levels of experience. From the discussion, the following definition emerged.

> *"Safe Staffing isn't just about numbers {although numbers remain pivotal}, it is about managing and sharing complex risk and having collective Team capacity to respond to crises. It is also about good governance, skill mix, staff retention and Team stability. Finally, it is about maintaining the core principles of trust, fairness, equity, open and transparent communication and peer and manager support."*

A week in the life of Older People and Children's Social "Workers: Insights from the Time Diary Data Collection Tool

Introduction

As part of the safe staffing study, interview respondents were asked to complete an online time diary data collection tool over a "typical" five day working week prior to their scheduled interview or over the same or following week.

Time diaries as a research tool

Time diaries or activity logs have become a familiar and valuable research tool, offering insights into social workers' and carers' lives amongst others, in an era when time is of key significance (Robinson 1999; Holmes & McDermid, 2013; Lillis, Leedham & Twiner 2020; Eggli et al., 2022). However, the use of an online data collection method is a relatively new approach which helps speed data collection and reduce the need for resource-intensive use of paper forms, their distribution and collection, and subsequent data input work. Drawbacks of online time data collection include the problem of self-report measurement bias, for example related to the social desirability criterion, variations in time perception or as triggered by directive questions in remote data collection tools, individual variations and contextual factors including work pressures (Brenner & DeLamater, 2016; Carrasco & Domínguez, 2015; Lillis, Leedham & Twiner, 2020). Problems with designing the tools themselves, especially in terms of how to measure time, are also highlighted in the literature, indicating there is probably no "ideal" solution and that this issue remains a persistent challenge in time diary-based research (Kan & Pudney 2008; Sullivan et al., 2020).

Data collection

Before their interviews respondents were asked to complete an online survey tool regarding their job title, their service area (whether in Children Services or Older People's Social Work) and whether their employment was full-time or part-time. To preserve anonymity, no further baseline data were collected. Respondents were then asked to access the system daily for the five-day period. Areas to be completed within the daily time diary included recording the approximate time spent on key social work tasks. The tasks were pre-categorised, so that the respondent was prompted to fill out durations of time spent on key tasks as appropriate to the service in which they worked. Their general task areas were assessment, planning, intervention,

review, evaluation and "other". For example, those working in Older People's Social Work were asked to fill out time spent on the following tasks within "assessment": General assessment; paperwork and administration in relation to assessment including file recordings and IT input; arranging initial assessment meetings; risk assessment including multi-disciplinary assessment / meetings; Deprivation of Liberty, Mental Capacity Assessments; safeguarding assessments, investigations, interviews and arranging meetings; attending assessment related meetings – case related (discharge planning meetings, case conferences, case discussions, best interests / signs of safety meetings / safeguarding meetings / care planning work with Domiciliary Care, Brokerage and Reablement Departments); Approved Social Worker assessment activities and follow up; and Carer Assessments and follow up (e.g. applying for carer support funding). The research participants could also give and explain the amount of time spent on an "other" category within assessment. This allowed for participants to include a task which the expert research Team had not envisaged, and this was possible within each of the general task areas.

Limitations of this section of the study

Not all days of work were completed, fully and accurately by the respondents. Therefore, the dataset was smaller than envisaged. The lack of completeness was likely a result of the respondent's time constraints, which is supported by research analysing the effect of work pressure on activity log completion (Lillis, Leedham & Twiner, 2020). As the research in this report demonstrates, social workers are likely to be time poor in terms of managing work beyond "core" tasks. In future, an online format which can be completed more quickly might better facilitate time diary data collection.

Respondents were asked to complete the diary analysis during a typical week, when they were not absent because of annual leave or training to allow a picture of a 'usual' working day. The responses from the Older People's Social Work are skewed because they included training days not typical of a usual week. The time allocated for training was more than for assessment which does not align with what was reported in interviews and focus groups.

As the completed returns were low, a descriptive approach was used for analysis. Comparisons were possible based on the question on 'time spent beyond contracted hours' as this was collected in the form of numbers of hours and minutes. The times provided in response to this question produced scale variables that permitted a wider range of descriptive analysis.

However, given the small numbers of respondents providing full, accurate responses, the analysis below is largely descriptive in qualitative terms. It nevertheless gives a picture of "a week in the life of" a social worker in both Children's Services and Older People Social Work.

Responses

In all, there were 21 interviews undertaken across the five Trusts. Of these, 13 interviewees chose to fill out a time diary, giving a response rate of 62%. Anecdotally, the main reasons given for unwillingness to participate in this area of the research related to the inability of interviewees to devote time to the diary during the working week. Only six diaries were fully completed by full-time social workers, with another completed by a part-time social worker and one further diary partially completed by a full-time social worker. The description below is therefore based on the full responses of three full-time social workers from children's services and three full-time social workers from Older People's Social Work.

Baseline data

Q2 What is your role/job title?

"Social worker" was the main role reported (by 8 respondents) whilst three gave their titles as "senior social worker", one as "residential social worker". Two of the respondents did not give this information.

Of the six full-time social workers who fully completed the tool for the week, all have their title as "social worker".

Q3 Do you work full-time or part-time?

Almost all respondents worked full-time (12), with only one respondent working part-time. As noted, data included here is that given by six full-time social workers.

Q5 Which service area do you work in?

Five respondents worked in children's services and eight in Older People's Social Work. However, time diaries were completed fully by three full-time respondents from children's services and three full-time social workers from Older People's Social Work.

Findings

Working beyond scheduled hours

The time diary data show that for each weekday, extra time was worked by at least one respondent working in Older People's Social Work (see Table 54). The average extra time worked by these respondents over the week was 75 minutes. One respondent did not work extra time over the course of the week they completed the log.

Table 54: Extra time worked beyond scheduled hours in Older People's Social Work

Day	Number of respondents working over designated hours (n=3)	Extra time worked (in minutes)
Monday	1	30
Tuesday	2	105
Wednesday	1	30
Thursday	1	30
Friday	1	30
Total		225
Average		75

No respondents from Older People's Social Work reported having to work on leave days and no respondent reported working extra time at the weekend.

All the Children's Services' respondents worked some extra time during the week of the diary. The time diary data show, that for each weekday, extra time was worked by at least one respondent working in children's services (see Table 55). The average extra time worked by these respondents over the week was 378 minutes.

Table 55: Extra time worked beyond scheduled hours in Children's Services

Day	Number of respondents working over designated hours(n=3)	Extra time worked (in minutes)
Monday	3[1]	145
Tuesday	2[2]	120
Wednesday	2	210
Thursday	2	540
Friday	2	120
Total		1135
Average		378

No full-time respondents from Children's Services reported having to work on leave days and none reported working extra time at the weekend.

Social workers in Older People's Social Work spent the largest proportion of their time on general assessment, Mental Capacity Assessment, risk assessment and multidisciplinary assessment. They also report significant time on training and record-keeping. Paperwork and administration in relation to assessment including file recordings and IT input, care, and support planning care (including self-directed support planning). Review meetings including arranging and attending/chairing/minuting reviews. Supervision and contact with service users and contact with carers, families, and significant others. Case-related contact with other staff (such as case conferences), monitoring care plans, review visits to residential, nursing, or domiciliary care; and office duty (Duty Intake).

Workplan for OPSW

An ideal workplan in OPSW would require all the components listed in the diary analysis and will take further work to assess time allocation required for each aspect of an OPSW job plan which will be estimated in Report 2.

Children's Services' social workers spent the largest proportion of their time undertaking assessments, contact with families, carers or significant others and travel, followed by Initial assessment of family, closing cases, training, attending non case related meetings. Direct work with parents/carers/family networks, direct work with children and young people. Statutory home visits to family support cases, supervisory visits to foster/adoptive carers, contact with service users, and contact with other staff (case-related). A significant amount of time was also spent on Duty Intake.

Workplan for Children's Services

An ideal workplan in Children's Services would require all the components listed in the diary analysis and will take further work to assess time allocation required for each aspect of a child protection social workers proposed job plan, which will be estimated in Report 2.

Diary Analysis

Extra time spent working

Workload pressures were associated with qualitative findings from interviews that social workers work beyond designated hours to manage their caseloads (see Tables 54/55 above). Respondents were typically working over their contracted hours during the week they reported on. In OPSW this was an average of 75 minutes (one hour and fifteen minutes) per week. In Children's Services this was an average of 378 minutes (six hours and eighteen minute) per week which is more or less equivalent to an extra day per week).

Working beyond contracted hours, in a "typical" working week, suggest that levels of staffing are "unsafe", particularly in relation to Children's Services. The associations between working beyond capacity, poor staff health, burnout and staff turnover and their implications for service users is well reported (McFadden, Campbell, & Taylor, 2015; Beer, Phillips & Quinn, 2021; Jiang, Jiang, & Chen, 2022).

Wide range of complex tasks

The week in the life of a social worker analysis reveals that respondents are engaged in a complex array of work related to assessment, planning, intervention, review, and evaluation, contact with service users, carers and significant others and colleagues and various "other" work tasks. Social workers in OPSW spent the largest proportions of their time undertaking Mental Capacity Assessment, other assessments including risk and multi-disciplinary assessments, care planning, liaising with service users, families and carers, domiciliary care departments and other disciplines. Training and record-keeping also take up substantial time with paperwork and increased administration, an ongoing burden for older people social workers.

The considerable time spent by one of the respondents in training in the reported week (2 days) is probably atypical, from our own experience, and may skew the results somewhat. The level of record-keeping work and the challenges of managing Mental Capacity Assessments on top of other elements of the diverse workload, are two important themes emerging from interview data. Impediments to practice related to "paperwork" and associated elements of the bureaucratisation of, and managerialism in, social work, which have long been discussed in the literature and continue to be an area of research as the problem persists (Finch, 1976; Munro, 2010; Pascoe, Waterhouse-Bradley, & McGinn, 2022). Boyle and colleagues (Boyle,

Montgomery, & Davidson, 2022) document increased workloads and stress experienced as a result of adult social workers' Mental Capacity Act work. The picture of complexity and overload derived from examples of a working week in older people's social work services speaks to challenges for achieving safe staffing in this area of practice.

Children's Services social workers who participated in the diary entries, spent the largest proportions of their time undertaking: fostering and adoption assessments; contact with families, carers or significant others, travel, and Duty Intake. There are links with the literature which considers stress and burnout reflecting the over-demanding nature of roles which can expect too many complex tasks to be undertaken in too short a timeframe (e.g., McFadden, Campbell, & Taylor, 2015). Again, based on our snapshot of a typical working week for Children's Services' social workers, overload, and over-complexity in workloads present challenges for the achievement of safe staffing.

Diary Analysis Conclusion

The time diary data illustrates both the complexity of the work undertaken, the dominant tasks according to the type of service the social workers worked in and the degree to which overtime seems to be a common feature of the working weeks of social workers in both OPSW and Children's Services. There are strong links with the findings emerging from the interviews themselves, with implications for social work safe staffing derived from overload, and over-complexity in workloads and the diary analysis supports the evidence of working excess hours to manage the roles and tasks. This is particularly problematic in Children's Services, with diary entries showing the social workers working a six-day week.

Discussion

This study aimed to provide an empirically rigorous evidence base for safer staffing levels in social work. The analysis will inform the development of Department of Health (DoH-NI) policy guidance on 'Safer and Effective Staffing for Social Work' in Older People's Social Work, Children's Services, and Mental Health (reported separately by Professor Gavin Davidson). The study aimed to address the primary research question through several objectives. The first objective was to gather information on the current landscape of social work positions in Older People's Social Work and Children's Services across Northern Ireland. The second objective was to document various aspects of staffing, such as the average and range of caseload numbers at Team and Programme of Care levels, funded establishment, social work activity, vacancies, and absences. A further objective was to explore governance structures within Teams in Children's and Older People's Social Work.

The study also aimed to examine caseload weighting tools or methods used to measure caseloads in these services across Northern Ireland. Ultimately, the findings in this report are intended to inform recommendations on appropriate staffing levels for Children's and Older People's Social Work in Northern Ireland, aiming to support the Department of Health guidelines on Safer and Effective Staffing policy. The Department of Health Social Work Workforce Review, Northern Ireland (2022, Recommendation 2b) recommended a renewed focus on Safe Staffing in Social Work, and an analysis of current workforce supply and demand capacity, to ensure an evidence base underpinning workforce planning in a meaningful and impactful way. This report has been commissioned by the Department of Health in response to this recommendation.

Children's and Older People's Social Work

The study adopted a mixed methods approach. Firstly, quantitative data was collected across all five HSC Trusts from a total of 190 regional Children's Services Teams and 80 OPSW Teams. The Teams reporting included a range of social work Team types across the sector.
Secondly, qualitative data was collected through a series of individual interviews with front-line social workers along with focus group interviews with staff from several Teams and management levels. The interviews and focus groups discussed issues around safe staffing and workload as well as exploring existing caseload weighting approaches currently in operation within the region.

In his Independent Review of Children's Social Care (Jones, 2023) Professor Ray Jones highlights the long-standing challenge staff shortages in social work. He reports combined vacancy and absence between 26% and 40.9% in Family Intervention Teams. Such staffing shortages, which have a significant impact on the delivery of statutory functions across HSC Trusts. Social workers are already among the most stressed professionals in the UK (Ravalier, 2019). Further difficulties due to global recruitment and retention challenges and the instability and inexperience of social workers can also adversely affect services across these programmes of care (Healy & Meagher, 2007; McFadden et al., 2015). The situation for social work staffing deteriorated during the COVID-19 pandemic with a demonstrable reduction in staff well-being and increased evidence of burnout and intention to leave the profession, across the U.K. social work workforce (McFadden et al., 2023; MacLochlainn et al., 2023).

In Northern Ireland, there are also several demographic challenges. The existing social work workforce does not easily map onto the numbers of children and older people and service demands. As of 28 November 2023, there were 6,583 social workers registered to practise in Northern Ireland across all programmes of care and in non-statutory settings (NISCC, 2023). The largest number of social workers is in the BHSCT (846). However, the NHSCT with the highest population of children and people over 65, only employs 779 social workers. The number of social workers in each Trust therefore does not correspond with the population size, nor the number of cases reported in this study. Further analysis of the links between demography and social work supply would be a useful avenue to support workforce planning.

Owing to Northern Ireland having the highest rates of deprivation, and the lowest rates of social work intervention in the UK (Bywaters et al., 2020), there is evidence of increasing numbers of children in need, as well as children on the Child Protection Register and a continuing trend in increasing numbers of children going into state care (NISRA, 2024). Increasing numbers of unaccompanied asylum-seeking children are presenting within Children's Services and there is a rising demand for child and adolescent mental health services, along with rising incidences of domestic violence and poverty across the region (Jones, 2023). The increased numbers of service users in both Children's and Older People's Social Work have intensified the demand for foster placements and care leaver services among many in children's services.

Moreover, within OPSW services regional level statistics suggest challenges ahead due to the aging population. The population aged 85+ has increased by 28.1 per cent in the decade since

mid-2010, a rate almost six times higher than the population (NISRA, 2021). The increase in older people is predicted to increase further with people aged 65 and eventually outnumbering children by 2031 (NISRA, 2022). The quantitative data in this study reveals a workforce grappling with these challenges. OPSW Teams are confronted with staffing vacancies, caseload complexities, and increased administrative burdens. While two-thirds of Teams reported operating in line within their funded establishment (FE), financial constraints impeded understaffed Teams from recruiting. The caseload analysis indicates high workloads and complexities which are exacerbated with the use of waiting lists, reported by 61 per cent of Teams. The role of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) has significantly increased OPSW workload, and paperwork, including that related to Self-directed Support, further burdening social workers with caseloads beyond manageable levels, within working hours capacity.

Similarly, the quantitative data from Children's Services reveals stark high vacancies in staffing numbers. The workforce can be assessed through whole-time equivalent (WTE) staff currently in positions and the WTE of funded vacancies. When questioned about the alignment of the number of social workers (across all Bands) and social work assistants, along with vacancies in the Teams, with the number of funded establishment (FE) positions, responses were variable. Regionally, 18.4 per cent of Teams indicated that the staff numbers did not match the FE. Just under half indicated alignment with their FE, while over one-third did not provide an answer to this question. Qualitative analysis from across all HSC Trusts indicates that a systematic review of FE has not occurred in the last decade or even longer. Despite the staffing challenges, there were positive findings regarding the high level of oversight of unallocated work and a well-established approach to monthly one-to-one supervision in both OPSW and Children's Services.

Assessed Year in Employment

Following training, the critical next step in the learning journey of a social worker is the compulsory Assessed Year in Employment (AYE) which acknowledges the additional support and supervision needs of newly qualified social workers (NQSW) (Croisdale-Appleby, 2014; Moorhead, 2019). The findings on AYE social workers in this report contributes to the literature exploring the correlation between the support needs of early career social workers as they transition from social work education into the workplace and workforce stability (Tham & Lynch, 2019). Managers charged with the support and supervision of AYE staff should be

afforded the time and space for those tasks and AYE caseloads should be protected in terms of volume and complexity (Carpenter et al., 2015; NISCC, 2019b). This will allow the space for reflection which is critical for professional learning, development, and resilience (Kearns & McArdle, 2012: Ravalier et al., 2023; Department of Health Supervision Policy, 2024). Supporting AYE social workers is critical due to evidence of poor retention of early career social workers and their intention to leave the profession, at a rate of seven to one, compared to more experienced workers (MacLochlainn et al., 2023). Moreover, it emphasises the critical importance of reflection time for professional learning and development at all stages of a social work career.

The findings in Report 1 align with the conclusions of the Social Services Workforce in Europe Report (Turlan, 2019), which highlighted systemic challenges faced by social work workforces across Europe. The qualitative findings from this study in both Children's Services and OPSW highlight key issues around waiting lists, unallocated cases, and a growing orientation to "crisis working" requiring staff to work beyond contracted hours.

The qualitative findings demonstrate several examples of compassionate leadership, line manager support and collegiality across Teams. Compassionate leadership approaches support staff wellbeing and evidence an authentic approach to implementation of effective arrangements for organisational oversight and accountability of risk.

Strengths and Limitations

It is critical that social work continues to meet changing social, economic, psychological, health, and environmental needs to contribute to improved health and social wellbeing for the population of Northern Ireland. This study is therefore timely in its links to the strategic context of Health and Wellbeing 2026: Delivering Together, (DoH, 2016) and to the Department of Health, HSC Workforce Strategy 2026, which already identifies social work workforce shortages and fiscal requirements to address these (DoH, 2017). The study findings can contribute positively to optimum workforce modelling decisions for social work in the envisioned newly configured health and social care system (DoH, 2016).

The study constitutes a strong empirical evidence-base predicated on sound principles of research governance and ethical integrity. The findings take account of a wide range of professional views and experiences and culminate in the first regionally agreed definition of

safe staffing, underpinned by a set of key principles and a conceptual framework (three ‘C’s’). These findings can support evidence-based decisions about workforce modelling into the future by providing empirical data on the social work workforce which has hitherto been limited (Williams & Vieyra, 2018; House of Commons 2021). The lack of empirical evidence has previously thwarted comprehensive workforce planning for social work.

The analysis will undoubtedly present challenges. It is hoped that this evidenced-based research study on the safer and effective staffing in social work can enable the evidence-informed decision making required to render the profession fit for the future in Northern Ireland.

Report 1 Conclusion

The findings presented in this Report (1) presents an overview of the baseline data during 2023 across Children and Older People Services, in relation to staffing supply and service demands and lays the groundwork for evidence-based strategic planning to inform the development and implementation of Safer and Effective Social Work policy and legislation over the coming years (2024-2027). The report also urges comprehensive consideration of broader societal changes such as demographic shifts, increasing poverty and the out workings of an ongoing cost-of-living crisis in social work workforce planning.

The findings of this study align with retention and turnover trends in the broader NHS workforce and the objectives of the NHS Workforce Plan (2023) to address deficits in various healthcare professions. While the NHS Workforce Plan does not explicitly mention social work, its emphasis on 'recruit, retain, and reform' corresponds with the conceptual framework in this study related to 'capacity (recruit and retain),' 'communication (retain and reform),' and 'connection (retain and reform).'

The analysis identified systemic problems that demand systemic solutions. Frontline social workers and managers, dealing with overwhelming workloads and waiting lists, often experience the burden of individual and Team capacity challenges as existential crises. Concerns about the impact on service users, workload pressures, professional accountability related to individual registration, contribute to burnout and intentions to leave the profession. The report emphasises the need for shared responsibility across all levels of the system, with open acknowledgment of systemic issues within. Open communication about pressures and

challenges aims to connect all parts of the collective system, fostering a positive workplace culture to retain and support the workforce, especially early career social workers.

Addressing workforce capacity issues is crucial to tackling retention in the sector, and future education and training numbers should align with identified and projected workforce needs. The analysis presents current workforce pressures, but continuous review is essential to meet changing societal and population needs and support the future workforce.

In consideration of the workforce, risk must be shared across all levels of the system - with the issues being openly acknowledged as systemic. Open communication about pressures and challenges, aims to connect all parts of the collective system and promote a positive workplace culture to hold and retain the workforce, nurture early career social workers, and value all staff. This aligns with the values and ethics of social work which can be applied to how all parts of the system are supported, particularly 'the people' who are the human infrastructure, without which the whole system collapses.

Finally, the findings of this study augment our knowledge of the increasing job demands on social workers and the consequent adverse impact on services (Dima et al., 2021; Holmes et al., 2021; Wu & Chen, 2022). The study also demonstrates the continued negative impact of COVID-19 on Children's and Older People's Social workers reported by McFadden et al (2023) and MacLochlainn et al (2023). Work pressures lead to deteriorating mental well-being and increase rates of burnout which has a negative impact on service user experiences and outcomes (McFadden et al., 2018). It is our collective responsibility to ensure social work is a sustainable profession into the future.

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Appendices

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Appendix 1a: Overview of Staffing data from survey – Older People's

The appendices in this section (1a) provide detailed description of the results of the Team level survey for Older People's Social Work, providing data on Team type, numbers and types of staff, caseloads and other descriptives pertaining to safe staffing including unfilled Band 6 posts and caseloads.

The following points apply to all the data from the OP Teams across the Trust.

- There were variations in reporting numbers of staff in Teams. The most consistent and reliable reporting was in relation to Banding questions (Question 15, how many of each of the following Agenda for Change pay bands). We therefore used the Banding data in all calculations and analysis.
- In some Teams and in some Trusts social work assistants did carry caseloads. Therefore, unless reported otherwise Band 4 Social Work Assistants were included in the caseload calculations.
- As AYE social workers carry caseloads, albeit theoretically smaller than Band 6 social workers, they were included as WTEs in the caseload analysis.
- Designated Team Leaders Band 7 were assumed not to carry a caseload.
- When no Band 7 was reported in the Team, data on specialist roles (such as Approved Social Worker) or Designated Team Leaders, or Senior Social Worker or Senior Practitioner were used to make an assumption that one person was Team manager and did not carry a caseload. When more than one Band 7 was reported in the Team, those not designated as Team leaders were included in caseload calculations.
- When reporting Band 6 vacancies, reason for vacancy (sick leave of more than four weeks; maternity leave; empty post) was not always reported or did not add up to the stated number of Band 6 vacancies.
- When asking about caseloads in the survey we specifically asked about 'across the social work team', to ensure we were focusing on SW caseloads.

Based on the data from the survey, an overall staff to caseload ratio for each Trust has been calculated and presented. When caseload data was missing, we used statistical methods and available data from each Team to estimate overall allocated caseloads across the Trust.

Trust AOP overview analysis

Table AOP1: Frequency of Team Type Responses within Trust A

Team Type	Frequency	% of Teams Reporting
Older People Community Social Work	10	66%
Older People Mental Health Services	3	20%
Older People Hospital Services	1	6%
Team is not captured in these options	1	6%
Total	**15**	100%

Table AOP 2: Older People Social Work Teams in Trust A

Staff									Caseloads					
Team	Service	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Total	Total cases	Allocated	Unallocated	% Unallocated	Ratio of staff to cases (overall**)	Ratio of staff to cases (allocated)
AOP01	Community	0	1	2	0	5	1	9	390	386	4	1.0%	1: 56	1: 55
AOP02	Mental Health	-99*	-99	-99	1	9	3	13	360	360	0	NA	1:30	1:30
AOP03	Community	0	1	2	0	4	1	8	435	422	13		1: 73	1: 70
AOP04	Community	0	1	0	1	5	1	8	406	296	110		1: 68	1: 49.
AOP05	Community	-99	-99	1	-99	-99	1	2	80	80	0		1:80	1:80
AOP06	Community	-99	2	2	2	11	2	19	866	740	126		1:54	1:46
AOP07	Mental Health	0	1	0	4	6	1	12	558	525	33		1:56	1:53
AOP08	Community	1.5	0	2	3	3	2	11.5	575	544	31		1:64	1:60
AOP09	Community	0	1	2	0	5	1	9	383	383	0		1:55	1:55
AOP10	Community	-99	1	0.5	1	5	0	7.5	457	380	77		1:70	1:58
AOP11	Hospital	-99	1	-99	-99	4	1	6	88	73	15		1:22	1:18
AOP12	Mental Health	0	1	2	1	4	1	9	403	391	12		1:58	1:56
AOP13	Community	-99	-99	-99	-99	4	2	6	458	390	68		1:92	1:78
AOP14	Community	0	1	3	1	6	1	12	532	476	56		1:53	1:48
AOP15	Community	-99	2	2	-99	12	2	18	804	793	11		1:54	1:53
TOTAL		1.5	13	18.5	14	83	20	150	6795	6239	556		1:56	1:51

*-99 means missing data i.e. data was not reported by the Trust.. ** Overall means allocated and unallocated cases added together.

Please Note: Outlier Team information with lower caseloads (e.g., 1:18 as above) skews the social worker caseload total ratio. In Trust AOP, there was 121.5 social workers who were reported to be carrying caseloads

Table AOP 3: Description at Trust Level – All Team Types

Trust AOP	*n*	%	Type
Teams	15		10 Community, 3 mental health, 1 gateway, 1 other
Programme of Care			Older People
Uni-disciplinary	10	75%	
Multi-disciplinary	5	25%	
Unfilled Band 6 Vacancies	18		
Band 2	1.5		
Band 3	13		
Band 4	18.5		Social work assistants
Band 5	14		AYE social workers
Band 6	83		Social workers
Band 7	20		Social workers
Permanent AYE	4		
Temporary AYE	10		
Permanent Band 6	49.5		
Temporary Band 6	27		
Agency AYE	6		
Agency Band 6	8.5		
Practice Teachers	6		
Overall caseload	6795		
Allocated Cases	6239		
Unallocated Cases	556		
Total number of SWs	121.5		
Ratio of SW to allocated caseload	1:51		
Ratio of SW to total caseload	1:56		
If vacancies were filled Total number of social workers/caseloads	139.5		
Ratio of SW to allocated caseloads if vacancy filled	1:45		
Ratio of SW to allocated and unallocated	1:49		
Highest average caseload size for SW with specialist roles*	53		
Lowest Caseload size for SW with specialist roles**	46		
Highest Caseload size for SW with no specialist roles***	57		
Lowest Caseload size for SW with no specialist roles****	47		
Highest Caseload size for SWA	67		
Lowest Caseload size for SWA	50		
Number of Teams who developed caseload weighting approaches	9		
Do Teams use waiting lists?			
Yes	9		
No	5		
Missing	1		

Trust BOP overview analysis

Table 1BOP		
Team Type	Frequency	% of Teams Reporting
Older People Community Social Work	16	88%
Older People Hospital Services	2	12%
Total	**18**	100%

Table 2 BOP: Older People Social Work Teams in Trust BOP

Staff									**Caseloads**					
Team	**Service**	**Band 2**	**Band 3**	**Band 4**	**Band 5**	**Band 6**	**Band 7**	**Total Staff**	**Allocated**	**Unallocated**	**Total**	**% unallocated**	**Ratio of staff to caseload (overall**)**	**Ratio of staff to caseload (allocated)**
BOP01	Community	0	2	0	1	3	1	7	176	-99	176	0%	1:44	1:44
BOP02	Community	1	1	0	0	4	3	9	196	0	196	0%	1:33	1:33
BOP03	Community	0	4	2	1	5	1	13	610	49	659	8%	1:82	1:76
BOP04	Community	-99*	4	2	-99	6	1	13	527	34	561	6%	1:70	1:66
BOP05	Community	-99	3	1	1	6	1	12	429	6	435	1%	1:54	1:54
BOP06	Community	-99	2	1	-99	5	1	9	448	16	464	4%	1:77	1:75
BOP07	Community	-99	2	1	6	5	1	15	396	0	396	5%	1:33	1:33

BOP08	Community	-99	2	3	-99	7	1	13	411	38	449	9%	1:45	1:41
BOP09	Community	-99	1	1	-99	6	1	9	309	20	329	6%	1:47	1:44
BOP10	Community	-99	1	1	-99	5	1	8	331	33	364	10%	1:61	1:55
BOP11	Community	1	1	2	-99	8	2	14	394	41	435	10%	1:40	1:36
BOP12	Community	-99	1	2	1	8	2	14	510	11	521	2%	1:43	1:43
BOP13	Community	-99	3	1	1	6	2	13	401	11	412	3%	1:46	1:45
BOP14	Community	-99	3	1	-99	6	1	11	325	7	332	2%	1:47	1:46
BOP15	Community	-99	3	1	-99	6	2	12	336	5	341	1%	1:43	1:42
BOP16	Hospital	4	1	-99	5	19	7	36	74	0	74	0%	1:2	1:2
BOP17	Community	-99	2	1	-99	5	2	10	281	27	308	10%	1:44	1:40
BOP18	Hospital	2	-99	-99	2	9	4	17	29	-99	29	0%	1:2	1:2
Total		8	36	20	18	114	34	230	6183	298	6481	4%	1:49***	1:47***
		*-99 means missing data. ** Overall means allocated and unallocated cases added together ***The Trust wide ratios are only for the Community based social workers and do not include the two hospital Teams.												

Table 3 BOP: Description at Trust Level all Team types

Trust BOP	*n*	%	Type
Teams	18		16 Community, 2 Hospital
Programme of Care			Older People
Uni-disciplinary	2	11.1%	
Multi-disciplinary	16	88.9%	
Unfilled Band 6 Vacancies	31		
Band 2	8		
Band 3	36		
Band 4	20		Social work assistants
Band 5 (AYE)	18		AYE social workers
Band 6	114		Social workers
Band 7	34		Social workers
Permanent AYE	5		
Temporary AYE	2		
Permanent Band 6	112.95		
Temporary Band 6	4		
Agency AYE	0		
Agency Band 6	1		
Practice Teachers	6		
Total Overall Cases	6481		
Total Overall Allocated Cases	6183		
Total Overall Unallocated Cases	298		
Overall Hospital Older People Cases	103		
Allocated Community OPSW Cases	6080		
Unallocated Community OPSW Cases	298		
Allocated and Unallocated Community Cases	6378		
Total number of SWs w caseloads (Community)	129		
Ratio of SW to allocated caseload (Community)	1:47		
Ratio of SW to total caseload (Community)	1:49		
Highest average caseload size for SW with specialist roles	Not reported		
Lowest Caseload size for SW with specialist roles	Not reported		
Highest Caseload size for SW with no specialist roles	97		
Lowest Caseload size for SW with no specialist roles	8		
Highest Caseload size for SWA	69		
Lowest Caseload size for SWA	6		
Number of Teams who developed caseload weighting approaches	0		
Do Teams use waiting lists?			
Yes	15		
No	3		
Missing	0		

Note 2: As Hospital Social Work caseloads are fluid due to the nature of this area of practice, we have averaged caseload sizes separately for community based social workers.

Trust COP overview analysis

Table COP1: Frequency of Team Type Responses within Trust COP

Team Type	Frequency	% of Teams Reporting
Older People Community Social Work/Integrated Care Teams	7	41%
Older People Community Social Work/Community Stroke	1	5%
Older People Community Social Work/Non-acute hospital	1	5%
Older People Hospital Services	2	11%
Older People Mental Health Services/Dementia Only	3	18%
Gateway or Single Point Of Entry	1	5%
Team is not captured in these options	1	5%
Missing data	1	5%
Total	17	100%

Table 2: Older People Social Work Teams in Trust COP

Staff									**Caseloads**					
Team	**Service**	**Band 2**	**Band 3**	**Band 4**	**Band 5**	**Band 6**	**Band 7**	**TOTAL**	**Total cases**	**Allocated**	**Unallocated**	**% unallocated**	**Ratio of staff to caseload (overall**)**	**Ratio of staff to caseload (allocated)**
COP01	Community	0	0	0	0	7	0	7	95	95	0	0%	1:16	1:16
COP02	Community	0	0	0	0	5	0	5	124	85	39	0%	1:31	1:21
COP03	Community	0	0	3	0	5	1	9	573	270	303	53%	1:72	1:34
COP04	Mental Health	0	0	5	1	8	1	15	886	570	316	36%	1:63	1:41

COP05	Community	0	0	5	0	8	1	14	810	558	252	31%	1:62	1:43
COP06	Community	0	0	5	0	8	1	14	797	330	467	59%	1:61	1:25
COP07	Community	0	0	4	0	7	1	12	736	434	302	41%	1:67	1:39
COP08	Community	0	0	4	0	6	1	11	687	417	270	39%	1:69	1:42
COP09	Community	0	0	4	1	7	1	13	741	229	512	69%	1:62	1:19
COP10	Hospital	0	0	0	1	0	0	1	0	0	0	0%	0	0
COP11	Hospital	-99	1	1	1.5	4.6	1	9.1	217	217	0	0%	1:27	1:27
COP12	Gateway	-99	-99	-99	-99	1	1	2	0	0	0	0%	0	0
COP13	Non response	-99	-99	-99	-99	1	1	2	0	0	0	0%	0	0
COP14	Intermediate care service	0	1	0	0	2	0	3	0	0	0	0%	0	0
COP15	Community	0	2	1	1	2	2	8	403	403	0	0%	1:58	1:58
COP16	Mental Health	0	2	0	0	4	2	8	321	321	0	0%	1:64	1:64
COP17	Mental Health	0	1	0	0	2	2	5	289	289	0	0%	1:72	1:72
TOTAL		0	7	32	5.5	77.6	16	138.1	6679	4218	2461		1:57***	1:36***

*-99 means missing data. ** Overall means allocated and unallocated cases added together *** the Trust wide ratios exclude staff from the Teams with no cases

Table 3 COP Description at Trust Level all Team types

Trust COP	N	%	Type
Teams	17		9 community, 2 hospital, 3 mental health, 1, gateway, 2 other
Programme of Care			Older People
Uni-disciplinary	5	33%	
Multi-disciplinary	12	67%	
Unfilled Band 6 Vacancies	17.3		
Band 2	0		
Band 3	11		
Band 4	32		Social work assistants
Band 5	5.5		AYE social workers
Band 6	77.6		Social workers
Band 7	16		Social workers
Permanent AYE	5		
Temporary AYE	-		
Permanent Band 6	72		
Temporary Band 6	6.8		
Agency AYE	-		
Agency Band 6	1		
Practice Teachers	7		
Overall caseload	6679		
Allocated Cases	4218		
Unallocated Cases	2461		
Total number of SWs*	117		
Ratio of SW to allocated caseload**	1:36		
Ratio of SW to total caseload	1:57		
If vacancies were filled Total number of social workers carrying caseloads	134.3		
Ratio of SW to allocated caseloads if vacancy filled	1:31		
Ratio of SW to allocated and unallocated (if vacancies filled)	1:50		
Highest average caseload size for SW with specialist roles*	60		.
Lowest Caseload size for SW with specialist roles	44		
Highest Caseload size for SW with no specialist roles	57		
Lowest Caseload size for SW with no specialist roles	44		
Highest Caseload size for SWA***	95		
Lowest Caseload size for SWA	0		
Number of Teams who developed caseload weighting approaches	10		
Do Teams use waiting lists?			
Yes	13		
No	4		
Missing	0		

Note: *= discarded Teams that do not carry cases ** discarded Band 4 social work assistants that don't carry cases *** only one of the 17 Teams reported SWAs carrying cases

Trust DOP Overview Analysis

Table 1 DOP : Frequency of Team Type Responses within Trust DOP

Team Type	Frequency	% of Teams Reporting
Older People Community Social Work	12	71%
Older People Mental Health Services	3	17%
Older People Hospital Services	1	6%
Adult Safeguarding	1	6%
Total	**17**	100%

Table 2 DOP: Older People Social Work Teams in Trust DOP

Staff									**Caseloads**					
Team	**Service**	**Band 2**	**Band 3**	**Band 4**	**Band 5**	**Band 6**	**Band 7**	**TOTAL**	**Allocated**	**Unallocated**	**Total**	**% unallocated**	**Ratio of staff to caseload (overall**)**	**Ratio of staff to caseload (allocated)**
DOP01	Mental Health	0	0	0	1	1	1	3	93	0	93	0	1:47	1: 47
DOP02	Mental Health	-99*	-99	-99	-99	3	1	4	133	0	133	0	1:44	1:44.
DOP03	Mental Health	0	0	0	0	2	1	3	36	0	36	0	1:18	1:18
DOP04	Community	-99	-99	-99	1	5	1	7	449	0	449	0	1:75	1:75

DOP05	Community	-99	-99	-99	2	21	4	27	479	0	479	0	1:18	1:18
DOP06	Community	-99	-99	-99	5	25	1	31	619	0	619	0	1:21	1:21
DOP07	Community	-99	-99	-99	2	5	-99	7	567	0	567	0	1:81	1:81
DOP08	Community	-99	-99	-99	3	3	1	7	380	0	380	0	1:63	1:63
DOP09	Community	-99	-99	-99	1	4	-99	5	432	0	432	0	1:86	1:86
DOP10	Community	0	0	0	3	3	1	7	397	0	397	0	1:66	1:66
DOP11	Safeguarding gateway	0	1	0	1	3	6	11	61	0	61	0	1:7	1:7
DOP12	Community	0	0	0	2	3	1	6	390	0	390	0	1:78	1:78
DOP13	Community	0	0	0	4	6	0	10.00	691	0	691	0	1:69	1:69
DOP14	Community	-99	-99	-99	3	3	1	7	478	0	478	0	1:80	1:80
DOP15	Hospital	2	1	-99	1	5	1	10	274	135	409		1:68	1:46
DOP16	Community	1	1	-99	2	3	1	8	310	60	370		1:74	1:62
DOP17	Community	3	1	1	-99	8	1	14	475	0	475	0	1:59	1:59
Total		**6**	**4**	**1**	31	103	22	180	6264	195	6459		1:45	1:44
	Note: We assumed every Team had a social worker who provided the role of Team Leader therefore did not carry caseloads. *-99 means missing data. ** Overall means allocated and unallocated cases added together													

Table 3 DOP: Description at Trust Level all Team types

Trust DOP	N	%	Type
Teams	17		12 Community, 3 Mental Health, 1 hospital, 1 safeguarding
Programme of Care			Older People
Uni-disciplinary	11	65%	
Multi-disciplinary	6	35%	
Unfilled Band 6 Vacancies	16		
Band 2	6		
Band 3	4		
Band 4	1		Social work assistants
Band 5	31		AYE social workers
Band 6	103		Social workers
Band 7	22		Social workers
Permanent AYE	18		
Temporary AYE	3		
Permanent Band 6	83.3		
Temporary Band 6	3.6		
Agency AYE	4		
Agency Band 6	5		
Practice Teachers	9		
Overall caseload	6459		
Allocated Cases	6264		
Unallocated Cases	145		
Total number of SWs w caseloads	142		
Ratio of SW to allocated caseload	1:44		
Ratio of SW to total caseload	1:45		
If vacancies were filled Total number of social workers/caseloads	158		
Ratio of SW to allocated caseloads if vacancy filled	1:40		
Ratio of SW to allocated and unallocated	1:41		
Highest average caseload size for SW with specialist roles	57*		
Lowest Caseload size for SW with specialist roles	52*		
Highest Caseload size for SW with no specialist roles*	61		
Lowest Caseload size for SW with no specialist roles*	42		
Highest Caseload size for SWA	120		
Lowest Caseload size for SWA	70		
Number of Teams who developed caseload weighting approaches	5		
Do Teams use waiting lists?			
Yes	1		
No	16		
Missing	0		

Note: * discarding counts of 0

Trust EOP Overview Analysis

Table 1 EOP: Frequency of Team Type Responses within Trust EOP

Team Type	Frequency	% of overall response
Older People Community Social Work	9	69%
Older People Mental Health Services	1	8%
MCA Service	1	8%
Adult Safeguarding Gateway	2	15%
Total	13	100%

Table 2 EOP: Older People Social Work Teams in Trust EOP														
Staff									**Caseloads**					
Team	**Service**	**Band 2**	**Band 3**	**Band 4**	**Band 5**	**Band 6**	**Band 7**	**Total Staff**	**Allocated**	**Unallocated**	**Total**	**Ratio unallocated**	**Ratio of staff to caseload (overall**)**	**Ratio of staff to caseload (allocated)**
EOP01	Community	2	2	4	1	7	2	18	961	53	1014	5%	1:78	1:74
EOP02	Community	-99*	5	4	1	8	2	20	866	52	918	6%	1:66	1:62
EOP03	Community	-99	1	4	1	6	1	13	671	89	760	12%	1:69	1:61
EOP04	Community	-99	1	5	-99	9	1	16	764	65	829	8%	1:59	1:55
EOP05	Community	1	1	4	2	6	2	16	1022	127	1149	11%	1:88	1:79
EOP06	Community	1	2	6	0	6	2	17	580	55	635	9%	1:49	1:45
EOP07	Community	1	2	4	0	5	2	14	530	82	612	13%	1:61	1:53
EOP08	Community	-99	1	3	1	3	2	10	383	55	438	13%	1:55	1:48
EOP09	Safeguarding	0	2	1	0	4	3	10	176	0	176	0%	1:25	1:25
EOP10	Mental Health	-99	-99	4	-99	6	3	13	108	8	116	7%	1:10	1:9
EOP11	MCA Service	0	3	2	1	5	6	17	0	0	0	0%	0	0
EOP12	Safeguarding	0	2	1	0	6	3	12	100	0	100	0%	1:11	1:11
EOP13	Community	0	0	0	0	19	7	26	898	367	1265	29.0%	1:51	1:36
TOTAL		5	22	42	7	90	36	202	7059	953	8012	11.9%	1:49	1:44
. *-99 means missing data. ** Overall means allocated and unallocated cases added together														

Table 3 EOP: Description at Trust Level all Team types

Trust EOP	N	%	Type
Teams	13		9 Community, 1 mental Health, 2 Safeguarding, 1 MCA
Programme of Care			Older People
Uni-disciplinary	8	62%	
Multi-disciplinary	5	38%	
Unfilled Band 6 Vacancies	15		
Band 2	5		
Band 3	22		
Band 4	42		Social work assistants
Band 5	7		AYE social workers
Band 6	90		Social workers
Band 7	36		Social workers
Permanent AYE	2		
Temporary AYE	1		
Permanent Band 6	61.6		
Temporary Band 6	6.6		
Agency AYE	-		
Agency Band 6	5		
Practice Teachers	3		
Overall caseload	8012		
Allocated Cases	7059	88%	
Unallocated Cases	953	12%	
Total number of SWs	162		
Ratio of SW to allocated caseload	1: 44		
Ratio of SW to total caseload	1:49		
If vacancies were filled Total number of social workers/caseloads	177		
Ratio of SW to allocated caseloads if vacancy filled	1:40		
Ratio of SW to allocated and unallocated	1:45		
Highest average caseload size for SW with specialist roles	28*		
Lowest Caseload size for SW with specialist roles	10*		
Highest Caseload size for SW with no specialist roles*	28		
Lowest Caseload size for SW with no specialist roles*	17.5		
Highest Caseload size for SWA	76		
Lowest Caseload size for SWA	16		
Number of Teams who developed caseload weighting approaches	10		
Do Teams use waiting lists?			
Yes	10		
No	2		
Missing	0		

Appendix 1b: Overview of staffing data from survey – Children's Services

The appendices in this section (1b) provide detailed description of the results of the Team level survey for Children's Services Social Work, providing data on Team type, numbers and types of staff, caseloads and other descriptives pertaining to safe staffing including unfilled Band 6 posts and caseloads.

The following **assumptions** apply to all the data from the CS Teams across Trusts.

- There were variations in reporting numbers of staff in Teams. The most consistent and reliable reporting was in relation to Banding questions (Question 15, how many of each of the following Agenda for Change pay bands). We therefore used the Banding data in all calculations and analysis.
- In most Teams and in all Trusts social work assistants did not carry caseloads. Therefore, unless reported otherwise Band 4 Social Work Assistants were not included in the caseload calculations.
- As AYE social workers carry caseloads, albeit theoretically smaller than Band 6 social workers, they were included as WTEs in the caseload analysis.
- Designated Team Leaders Band 7 were assumed not to carry a caseload.
- When no Band 7 was reported in the Team, data on specialist roles (such as Approved Social Worker) or Designated Team Leaders, or Senior Social Worker or Senior Practitioner were used to make an assumption that one person was Team manager and did not carry a caseload. When more than one Band 7 was reported in the Team, those not designated as Team leaders were included in caseload calculations.
- When reporting Band 6 vacancies, reason for vacancy (sick leave of more than four weeks; maternity leave; empty post) was not always reported or did not add up to the stated number of Band 6 vacancies.
- When asking about caseloads in the survey we specifically asked about '(across the social work team)' to ensure we were focusing on SW caseloads.

Trust A: Description of Gateway Teams at Trust Level – A_CS_GW

Teams A_CS_GW	*n*	%	Type
Teams	6		Gateway
Programme of Care			Children's Services
Uni-disciplinary	6	100%	
Multi-disciplinary	0	0%	
Unfilled Band 6 Vacancies	12		
Band 2	5		Admin
Band 3	2		Admin
Band 4	7		SWA
Band 5	6		AYE social workers
Band 6	24		Social workers
Band 7	8*		Social workers
Permanent AYE	0		
Temporary AYE	0		
Permanent Band 6	Missing		
Temporary Band 6	0		
Agency AYE	0		
Agency Band 6	0		
Practice Teachers			
Yes	6		
No	0		
Overall caseload	351		
Allocated Cases	283	80.6%	
Unallocated Cases	68	19.4%	
Total number of SWs w/caseloads	32**		
Ratio of SW to allocated caseload	1:9		
Ratio of SW to total caseload (allocated + unallocated)	1:11		
If vacancies were filled Total number of social workers/caseloads	42		
Ratio of SW to allocated caseloads if vacancy filled	1:7		
Ratio of SW to allocated + unallocated	1:8		
Highest caseload size for SW with specialist roles	24		
Lowest Caseload size for SW with specialist roles	12		
Highest Caseload size for SW with no specialist roles	24		
Lowest Caseload size for SW with no specialist roles	10		
Have this Team developed caseload weighting approaches?			
Yes	0		
No	6		
Does this Team use waiting lists?			
Yes	6		
No	0		

Note: *= Team Leaders did not carry caseloads: **= 6 Band 5s + 24 Band 6s + 2 Band 7s (6+24+2=32).

Trust A: Description of Children with Disabilities Teams at Trust Level – A_CS_CwD

Teams A_CS_CwD	*n*	%	Type
Teams	3		Children with Disabilities
Programme of Care			Children's Services
Uni-disciplinary	2	50%	
Multi-disciplinary	1	50%	
Unfilled Band 6 Vacancies	1.5		
Band 2	0		Admin
Band 3	4		Admin
Band 4	0		Social work assistants
Band 5	0		AYE social workers
Band 6	16.8		Social workers
Band 7	4*		Social workers
Permanent AYE	0		
Temporary AYE	0		
Permanent Band 6	8		
Temporary Band 6	0		
Agency AYE	0		
Agency Band 6	0		
Practice Teachers			
Yes	3		
No	0		
Overall caseload	623		
Allocated Cases	463	74.3%	
Unallocated Cases	160	25.7%	
Total number of SWs w/caseloads	17.8**		
Ratio of SW to allocated caseload	1:26		
Ratio of SW to total caseload (allocated + unallocated)	1:35		
If vacancies were filled Total number of social workers/caseloads	19.3		
Ratio of SW to allocated caseloads if vacancy filled	1:24		
Ratio of SW to allocated and unallocated	1:32		
Highest caseload size for SW with specialist roles	25		
Lowest Caseload size for SW with specialist roles	5		
Highest Caseload size for SW with no specialist roles	33		
Lowest Caseload size for SW with no specialist roles	20		
Have this Team developed caseload weighting approaches?			
Yes	1		
No	2		
Missing	-		
Does this Team use waiting lists?			
Yes	3		
No	0		
Missing	-		

Note: *= Designated Team Leaders did not carry caseloads: **= 0 Band 5s + 16.8 Band 6s + 1 Band 7s (0+16.8+1=17.8).

Trust A: Description of Family Intervention Teams at Trust Level – A_CS_FIT

Teams A_CS_FIT	*n*	%	Type
Teams	17		FIT
Programme of Care			Children's Services
Uni-disciplinary	17	100%	
Multi-disciplinary	0	0%	
Unfilled Band 6 Vacancies	19		
Band 2	2.5		Admin
Band 3	19.3		Admin
Band 4	34.4		Social work assistants
Band 5	21		AYE social workers
Band 6	47.5		Social workers
Band 7	36.9		Social workers
Permanent AYE			
Temporary AYE			
Permanent Band 6			
Temporary Band 6			
Agency AYE	7		
Agency Band 6	3		
Practice Teachers			
Yes	12		
No	5		
Overall caseload	1128		
Allocated Cases	1074	95.2%	
Unallocated Cases	54	4.8%	
Total number of SWs w/caseloads	88.4		
Ratio of SW to allocated caseload	1:12		
Ratio of SW to total caseload (allocated + unallocated)	1:13		
If vacancies were filled Total number of social workers/caseloads	107.4		
Ratio of SW to allocated caseloads if vacancy filled	1:10		
Ratio of SW to allocated and unallocated	1:11		
Highest caseload size for SW with specialist roles	45		
Lowest Caseload size for SW with specialist roles	9		
Highest Caseload size for SW with no specialist roles	45		
Lowest Caseload size for SW with no specialist roles	6		
Have this Team developed caseload weighting approaches?			
Yes	6		
No	6		
Missing	5		
Does this Team use waiting lists?			
Yes	14		
No	3		

Trust A: Description of 16+ Teams at Trust Level - A_CS

Staff								Caseloads					
Team	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Total Staff	Allocated	Unallocated	Total	% unallocated	Ratio of staff to caseload (overall****)	Ratio of staff to caseload (allocated)
A38	1	0	4	0	3	1	9	70	0	70	0%	1:23	1:23
A39	0	1	3	0	4	1	9	78	13	91	14.3%	1:23	1:20
A40	0	2	2	1	2	1	8	61	12	73	16.4%	1:24	1:20
A41	0	0	2	1	0	1	4	40	33	73	45.2%	1:73	1:40
A42	0	0	2	0	2.5	1	5.5	61	13	74	17.6%	1:30	1:24
A43	0	0	1	0	1	0	2	0	0	0	0%	n/a	n/a
Total	**1**	**3**	14	**2**	12.5	**5**	37.5	310	71	381	18.6%	1:28	1:23
**** Overall = allocated and unallocated cases added together.													

Trust A: Description of Early Years Teams at Trust Level – A_CS_EY

Teams A_CS_EY	*n*	%	Type
Teams	2		Early Years
Programme of Care			Children's Services
Uni-disciplinary	2	100%	
Multi-disciplinary	0	0%	
Unfilled Band 6 Vacancies	1		
Band 2	1		Admin
Band 3	4		Admin
Band 4	0		Social work assistants
Band 5	0		AYE social workers
Band 6	10		Social workers
Band 7	1*		Social workers
Permanent AYE	4		
Temporary AYE	0		
Permanent Band 6	missing		
Temporary Band 6	0		
Agency AYE	0		
Agency Band 6	0		
Practice Teachers			
Yes	2		
No	0		
Overall caseload	643		
Allocated Cases	615	95.6%	
Unallocated Cases	28	4.4%	
Total number of SWs w/caseloads	9**		
Ratio of SW to allocated caseload	1:68		
Ratio of SW to total caseload (allocated + unallocated)	1:71		
If vacancies were filled Total number of social workers/caseloads	10		
Ratio of SW to allocated caseloads if vacancy filled	1:62		
Ratio of SW to allocated + unallocated	1:64		
Highest caseload size for SW with specialist roles	65		
Lowest Caseload size for SW with specialist roles	60		
Highest Caseload size for SW with no specialist roles	63		
Lowest Caseload size for SW with no specialist roles	50		
Have this Team developed caseload weighting approaches?			
Yes	1		
No	1		
Missing	-		
Does this Team use waiting lists?			
Yes	1		
No	1		
Missing	-		

Note: *= Team Leaders did not carry caseloads: **= 0 Band 5s + 9 Band 6s + 0 Band 7s (0+9+0=9).

Trust A: Description of Looked After Children Teams at Trust Level - A_CS

Staff								Caseloads					
Team	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Total Staff	Allocated	Unallocated	Total	% unallocated	Ratio of staff to caseload (overall****)	Ratio of staff to caseload (allocated)
BT79 0AP	1	2.5	0	6	2	2	13.5	78	0	78	0%	1:9	1:9
BT48 6SB	0	1	6	2	2	1	12	60	0	60	0%	1:15	1:15
BT48 6SB	0	1	0	1	3	1	6	57	3	60	5.0%	1:15	1:14
BT48 6SB	0	1	1	1	2	2	7	57	0	57	0%	1:14	1:14
BT48 6SB	0	0	0	0	1	1	2	12	0	12	0%	1:12	1:12
Total	**1**	5.5	**7**	10	10	**7**	40.5	264	**3**	267	1.1%	1:12	1:12
**** Overall = allocated and unallocated cases added together.													

Trust A: Description at Team Level – A13_CS _Family Centres

Team A13_CS_Family Centres	*n*	%	Type
Teams	1		Family Centres
Programme of Care			Children's Services (FC)
Uni-disciplinary	1	100%	
Multi-disciplinary	0	0%	
Unfilled Band 6 Vacancies	0		
Band 2	0		Admin
Band 3	1		Admin
Band 4	1		SWA
Band 5	0		AYE social workers
Band 6	4		Social workers
Band 7	1		Social workers
Permanent AYE	0		
Temporary AYE	0		
Permanent Band 6 (2 part-time)	4		
Temporary Band 6	0		
Agency AYE	0		
Agency Band 6	0		
Practice Teachers	1		
Overall caseload	38		
Allocated Cases	31	81.6%	
Unallocated Cases	7	19.4%	
Total number of SWs w/caseloads	3*		
Ratio of SW to allocated caseload	1:10		
Ratio of SW to total caseload (allocated + unallocated)	1:12		
Highest caseload size for SW with specialist roles	12		
Lowest Caseload size for SW with specialist roles	8		
Highest Caseload size for SW with no specialist roles	12		
Lowest Caseload size for SW with no specialist roles	8		
Highest Caseload size for SWA	8**		
Lowest Caseload size for SWA	5**		
Have this Team developed caseload weighting approaches?	No		
Does this Team use waiting lists?	Yes		

Note: * = We assume part-time (3 – support worker) workers equalled 1 of the Team number. **= This number does not correspond to the statement from the Team that suggests that SWA do not carry caseloads.

Trust A: Description at Team Level – A08_CS _Fostering

Team A08_CS_Fostering	*n*	%	Type
Teams	1		Fostering
Programme of Care			Children's Services (Fos)
Uni-disciplinary	1	100%	
Multi-disciplinary	0	0%	
Unfilled Band 6 Vacancies	0		
Band 2	1		Admin
Band 3	0		Admin
Band 4	0		Social work assistants
Band 5	0		AYE social workers
Band 6	7		Social workers
Band 7 (not reported except in relation to funded posts)	1		Social workers
Permanent AYE	0		
Temporary AYE	0		
Permanent Band 6	4		
Temporary Band 6	3		
Agency AYE	0		
Agency Band 6	0		
Practice Teachers	0		
Overall caseload	148		
Allocated Cases	141	95.3%	
Unallocated Cases	7	4.7%	
Total number of SWs w/caseloads	7*		
Ratio of SW to allocated caseload	1:20		
Ratio of SW to total caseload (allocated + unallocated)	1:21		
Highest caseload size for SW with specialist roles	N/A		
Lowest Caseload size for SW with specialist roles	N/A		
Highest Caseload size for SW with no specialist roles	23		
Lowest Caseload size for SW with no specialist roles	19		
Highest Caseload size for SWA	-		
Lowest Caseload size for SWA	-		
Have this Team developed caseload weighting approaches?	No		
Does this Team use waiting lists?	No		

Note: * = Band 7 DTL do not carry caseloads.

Trust A: Description at Team Level – A23_CS _GM

Team A23_CS_GM	*n*	%	Type
Teams	1		Generic Model
Programme of Care			Children's Services
Uni-disciplinary	1	100%	
Multi-disciplinary	0	0%	
Unfilled Band 6 Vacancies	4		
Band 2	1		Admin
Band 3	3		Admin
Band 4	3		Social work assistants
Band 5	1		AYE social workers
Band 6	11.5		Social workers
Band 7	5.5		Social workers
Permanent AYE	1		
Temporary AYE	0		
Permanent Band 6	11.5		
Temporary Band 6	0		
Agency AYE	0		
Agency Band 6	0		
Practice Teachers	0		
Overall caseload	0		
Allocated Cases	14		
Unallocated Cases	0		
Total number of SWs w/caseloads	15****		
Ratio of SW to allocated caseload	N/A		
Ratio of SW to total caseload (allocated + unallocated)	N/A		
If vacancies were filled Total number of social workers/caseloads	19		
Ratio of SW to allocated caseloads if vacancy filled	1:10		
Ratio of SW to allocated and unallocated	1:10		
Highest caseload size for SW with specialist roles	16		
Lowest Caseload size for SW with specialist roles	9		
Highest Caseload size for SW with no specialist roles	15		
Lowest Caseload size for SW with no specialist roles	9		
Have this Team developed caseload weighting approaches?	No		
Does this Team use waiting lists?	Yes		

Note: ****= Three Band 7 DPTs and SWAs do not carry caseloads.

Trust A: Description at Team Level – A04_CS _GP

Team A04_CS_GP	*n*	%	Type
Teams	1		GP Practice
Programme of Care			Children's Services
Uni-disciplinary	0	0%	
Multi-disciplinary	1	100%	
Unfilled Band 6 Vacancies	1		
Band 2	0		Admin
Band 3	0		Admin
Band 4	1		Social work assistants
Band 5	0		AYE social workers
Band 6	0		Social workers
Band 7	1		Social workers
Permanent AYE	0		
Temporary AYE	0		
Permanent Band 6	0		
Temporary Band 6	0		
Agency AYE	0		
Agency Band 6	0		
Practice Teachers	0		
Overall caseload	0		
Allocated Cases	0		
Unallocated Cases	0		
Total number of SWs w/caseloads	0		
Ratio of SW to allocated caseload	N/A		
Ratio of SW to total caseload (allocated + unallocated)	N/A		
Highest caseload size for SW with specialist roles	N/A		
Lowest Caseload size for SW with specialist roles	N/A		
Highest Caseload size for SW with no specialist roles	N/A		
Lowest Caseload size for SW with no specialist roles	N/A		
Highest Caseload size for SWA	N/A		
Lowest Caseload size for SWA	N/A		
Have this Team developed caseload weighting approaches?	No		
Does this Team use waiting lists?	Yes		

Trust B: Description of Gateway Teams at Trust Level – B_CS_GW

Teams B_CS_GW	*n*	%	Type
Teams	4		Gateway
Programme of Care			Children's Services
Uni-disciplinary	4	100%	
Multi-disciplinary	0	0%	
Unfilled Band 6 Vacancies	4		
Band 2	0		Admin
Band 3	9		Admin
Band 4	0		Social work assistants
Band 5	2		AYE social workers
Band 6	11		Social workers
Band 7	17.5*		Social workers
Permanent AYE	0		
Temporary AYE	2		
Permanent Band 6	7 reported		
Temporary Band 6	0		
Agency AYE	0		
Agency Band 6	0		
Practice Teachers			
Yes	1		
No	missing		
Overall caseload	354		
Allocated Cases	309	87.3%	
Unallocated Cases	45	12.7%	
Total number of SWs w/caseloads	26.5**		
Ratio of SW to allocated caseload	1:12		
Ratio of SW to total caseload (allocated + unallocated)	1:13		
If vacancies were filled Total number of social workers/caseloads	30.5		
Ratio of SW to allocated caseloads if vacancy filled	1:10		
Ratio of SW to allocated + unallocated	1:12		
Highest caseload size for SW with specialist roles	20		
Lowest Caseload size for SW with specialist roles	5		
Highest Caseload size for SW with no specialist roles	25		
Lowest Caseload size for SW with no specialist roles	5		
Have this Team developed caseload weighting approaches?			
Yes	0		
No	2		
Missing	2		
Does this Team use waiting lists?			
Yes	4		
No	0		
Missing	-		

Note: *= Designated Team Leaders did not carry caseloads: **= 2 Band 5s + 11 Band 6s + 13.5 Band 7s (2+11+13.5=26.5).

Trust B: Description of Family Intervention Teams at Trust Level – B_CS_FIT

Teams B_CS_FIT	*n*	%	Type
Teams	5		FIT
Programme of Care			Children's Services
Uni-disciplinary	5	100%	
Multi-disciplinary	0	0%	
Unfilled Band 6 Vacancies	6.6		
Band 2	0		Admin
Band 3	1		Admin
Band 4	9.6		Social work assistants
Band 5	2		AYE social workers
Band 6	17.4		Social workers
Band 7	11*		Social workers
Permanent AYE	6		
Temporary AYE	0		
Permanent Band 6	12	100%	
Temporary Band 6	0	0%	
Agency AYE	0		
Agency Band 6	0		
Practice Teachers			
Yes	1		
No	4		
Overall caseload	405		
Allocated Cases	338	83.5%	
Unallocated Cases	67	16.5%	
Total number of SWs w/caseloads	25.4		
Ratio of SW to allocated caseload	1:13		
Ratio of SW to total caseload (allocated + unallocated)	1:16		
If vacancies were filled Total number of social workers/caseloads	32		
Ratio of SW to allocated caseloads if vacancy filled	1:11		
Ratio of SW to allocated and unallocated	1:13		
Highest caseload size for SW with specialist roles	30		
Lowest Caseload size for SW with specialist roles	12		
Highest Caseload size for SW with no specialist roles	29		
Lowest Caseload size for SW with no specialist roles	10		
Have this Team developed caseload weighting approaches?			
Yes	4		
No	-		
Missing	1		
Does this Team use waiting lists?			
Yes	5		
Missing	-		

Note: *= 5 from 11 Band 7 SWs were *Designated Team Leaders* and did not carry caseloads;

Trust B: Description of Fostering Teams at Trust Level – B_CS_Fos

Teams B_CS_Fos	*n*	%	Type
Teams	4		Fostering
Programme of Care			Children's Services
Uni-disciplinary	4	100%	
Multi-disciplinary	0	0%	
Unfilled Band 6 Vacancies	3.9		
Band 2	0		Admin
Band 3	0		Admin
Band 4	5		Social work assistants
Band 5	0		AYE social workers
Band 6	13		Social workers
Band 7	7.5*		Social workers
Permanent AYE	0		
Temporary AYE	1		
Permanent Band 6	7.6		
Temporary Band 6	1		
Agency AYE	0		
Agency Band 6	0		
Practice Teachers			
Yes	1		
No	3		
Overall caseload	344		
Allocated Cases	336	97.7%	
Unallocated Cases	8	2.3%	
Total number of SWs w/caseloads	16.5**		
Ratio of SW to allocated caseload	1:20		
Ratio of SW to total caseload (allocated + unallocated)	1:21		
If vacancies were filled Total number of social workers/caseloads	20.4		
Ratio of SW to allocated caseloads if vacancies filled	1:16		
Ratio of SW to allocated plus unallocated if vacancies filled	1:17		
Highest caseload size for SW with specialist roles	25		
Lowest Caseload size for SW with specialist roles	10		
Highest Caseload size for SW with no specialist roles	28		
Lowest Caseload size for SW with no specialist roles	9		
Have this Team developed caseload weighting approaches?			
Yes	2		
No	1		
Missing	1		
Does this Team use waiting lists?			
Yes	4		
No	0		
Missing	0		

Note: *= Designated Team Leaders did not carry caseloads: **= 0 Band 5s + 13 Band 6s + 3.5 Band 7s (0+13+3.5=16.5).

Trust B: Description of Looked After Children Teams at Trust Level – B_CS_LAC

Teams E_CS_LAC	*n*	%	Type
Teams	6		LAC
Programme of Care			Children's Services
Uni-disciplinary	6	100%	
Multi-disciplinary	0	0%	
Unfilled Band 6 Vacancies	8		
Band 2	0		Admin
Band 3	0		Admin
Band 4	11		Social work assistants
Band 5	6		AYE social workers
Band 6	15.6		Social workers
Band 7	11.8*		Social workers
Permanent AYE	5		
Temporary AYE	1		
Permanent Band 6	3		
Temporary Band 6	2		
Agency AYE	1		
Agency Band 6	1		
Practice Teachers			
Yes	2		
No	4		
Overall caseload	479		
Allocated Cases	408	85.2%	
Unallocated Cases	71	14.8%	
Total number of SWs w/caseloads	27.4**		
Ratio of SW to allocated caseload	1:15		
Ratio of SW to total caseload (allocated + unallocated)	1:17		
If vacancies were filled Total number of social workers/caseloads	35.4		
Ratio of SW to allocated caseloads if vacancy filled	1:12		
Ratio of SW to allocated and unallocated	1:14		
Highest caseload size for SW with specialist roles	25		
Lowest Caseload size for SW with specialist roles	11		
Highest Caseload size for SW with no specialist roles	29		
Lowest Caseload size for SW with no specialist roles	11		
Have this Team developed caseload weighting approaches?			
Yes	2		
No	4		
Missing	-		
Does this Team use waiting lists?			
Yes	0		
No	6		
Missing	-		

Note: *= Designated Team Leaders did not carry caseloads: **= 6 Band 5s + 15.6 Band 6s + 5.8 Band 7s (6+15.6+5.8=27.4).

Trust B: Description of Adoption Teams at Trust Level – B_CS_Adoption

Teams B_CS_Adoption	*n*	%	Type
Teams	2		Adoption
Programme of Care			Children's Services
Uni-disciplinary	2	100%	
Multi-disciplinary	0	0%	
Unfilled Band 6 Vacancies	5		
Band 2	0		Admin
Band 3	1		Admin
Band 4	5		Social work assistants
Band 5	0		AYE social workers
Band 6	7		Social workers
Band 7	4*		Social workers
Permanent AYE	0		
Temporary AYE	0		
Permanent Band 6	7		
Temporary Band 6	0		
Agency AYE	0		
Agency Band 6	0		
Practice Teachers			
Yes	1		
No	1		
Overall caseload	327		
Allocated Cases	138	42.2%	
Unallocated Cases	189	57.8%	
Total number of SWs w/caseloads	9**		
Ratio of SW to allocated caseload	1:15		
Ratio of SW to total caseload (allocated + unallocated)	1:36		
If vacancies were filled Total number of social workers/caseloads	14		
Ratio of SW to allocated caseloads if vacancy filled	1:10		
Ratio of SW to allocated and unallocated	1:23		
Highest caseload size for SW with specialist roles	48		
Lowest Caseload size for SW with specialist roles	0		
Highest Caseload size for SW with no specialist roles	52		
Lowest Caseload size for SW with no specialist roles	14		
Have this Team developed caseload weighting approaches?			
Yes	2		
No	0		
Missing	-		
Does this Team use waiting lists?			
Yes	2		
No	0		
Missing	-		

Note: *= Designated Team Leaders did not carry caseloads: **= 7 Band 6s + 2 Band 7s (7+2=9).

Trust B: Description at Team Level – B28_CS _14+

Team B28_CS_14+	*n*	%	Type
Teams	1		14+
Programme of Care			Children's Services
Uni-disciplinary	1	100%	
Multi-disciplinary	0	0%	
Unfilled Band 6 Vacancies	0		
Band 2	0		Admin
Band 3	0		Admin
Band 4	0		Social work assistants
Band 5	0		AYE social workers
Band 6	4.5		Social workers
Band 7	2		Social workers
Permanent AYE	2*		
Temporary AYE	0		
Permanent Band 6	4.5		
Temporary Band 6	0		
Agency AYE	0		
Agency Band 6	0		
Practice Teachers	0		
Overall caseload (estimate)	138*		
Allocated Cases	138	100%	
Unallocated Cases	0	0%	
Total number of SWs w/caseloads (estimate***)	5.5**		
Ratio of SW to allocated caseload (estimate)	1:25		
Ratio of SW to total caseload (estimate)	1:25		
Highest caseload size for SW with specialist roles	25		
Lowest Caseload size for SW with specialist roles	25		
Highest Caseload size for SW with no specialist roles	25		
Lowest Caseload size for SW with no specialist roles	25		
Have this Team developed caseload weighting approaches?	No		
Does this Team use waiting lists?	No		

Note: *= We assumed that the overall caseload as well as allocated and unallocated are underestimated. Therefore, estimating from the median of both specialist and no specialist caseloads (i.e., 25) and multiplying by total number of SWs carrying caseloads (25 x 5.5) we estimate the allocated cases to be 138: ** = Band 7 SW was Designated Team Leaders and did not carry caseloads

Trust B: Description at Team Level – B35_CS _14+

Team B35_CS_14+	*n*	%	Type
Teams	1		Family Intervention
Programme of Care			Children's Services
Uni-disciplinary	1	100%	
Multi-disciplinary	0	0%	
Unfilled Band 6 Vacancies	1		
Band 2	0		Admin
Band 3	0		Admin
Band 4	0		Social work assistants
Band 5			AYE social workers
Band 6	1		Social workers
Band 7	1		Social workers
Permanent AYE	0		
Temporary AYE	0		
Permanent Band 6	1		
Temporary Band 6	0		
Agency AYE	0		
Agency Band 6	0		
Practice Teachers	1		
Overall caseload	8		
Allocated Cases	2*	93.7%	
Unallocated Cases	2*	6.3%	
Total number of SWs w/caseloads	1**		
Ratio of SW to allocated caseload	1:2		
Ratio of SW to total caseload	1:8		
If vacancies were filled Total number of social workers/caseloads	2		
Ratio of SW to allocated caseloads if vacancy filled	1:1		
Ratio of SW to allocated and unallocated	1:4		
Highest caseload size for SW with specialist roles	12		
Lowest Caseload size for SW with specialist roles	6		
Highest Caseload size for SW with no specialist roles	12		
Lowest Caseload size for SW with no specialist roles	6		
Have this Team developed caseload weighting approaches?	No		
Does this Team use waiting lists?	Yes		

Note: *= These numbers do not align with the highest caseload size for SWs with specialist and no specialist roles or the overall caseload number, therefore were assumed an error: ** = Band 7 SW was Designated Team Leaders and did not carry caseloads.

Trust B: Description at Team Level – B04_CS _CCS

Team B04_CS_CCS	*n*	%	Type
Teams	1		Court Services
Programme of Care			Children's Services
Uni-disciplinary	1	100%	
Multi-disciplinary	0	0%	
Unfilled Band 6 Vacancies	0		
Band 2	0		Admin
Band 3	0		Admin
Band 4	0		Social work assistants
Band 5	0		AYE social workers
Band 6	0		Social workers
Band 7	4		Social workers
Permanent AYE	0		
Temporary AYE	0		
Permanent Band 6	0		
Temporary Band 6	0		
Agency AYE	0		
Agency Band 6	0		
Practice Teachers	1		
Overall caseload	124		
Allocated Cases	98	79.0%	
Unallocated Cases	26	21.0%	
Total number of SWs w/caseloads	3*		
Ratio of SW to allocated caseload	1:33		
Ratio of SW to total caseload (allocated + unallocated)	1:41		
Highest caseload size for SW with specialist roles	36		
Lowest Caseload size for SW with specialist roles	22		
Highest Caseload size for SW with no specialist roles	n/a		
Lowest Caseload size for SW with no specialist roles	n/a		
Have this Team developed caseload weighting approaches?	No		
Does this Team use waiting lists?	Yes		

Note: * = Band 7 DTL does not carry a caseload

Trust B: Description at Team Level – B06_CS_CwD

Team B06_CS	*n*	%	Type
Teams	1		Children w/Disabilities
Programme of Care			Children's Services
Uni-disciplinary	0		
Multi-disciplinary	1	100%	
Unfilled Band 6 Vacancies	0		
Band 2	0		Admin
Band 3	0		Admin
Band 4	1		Social work assistants
Band 5	0		AYE social workers
Band 6	3		Social workers
Band 7	1		Social workers
Permanent AYE	1		
Temporary AYE	0		
Permanent Band 6	Missing		
Temporary Band 6	0		
Agency AYE	0		
Agency Band 6	0		
Practice Teachers	1		
Overall caseload	125		
Allocated Cases	105	61.1%	
Unallocated Cases	20	38.9%	
Total number of SWs w/caseloads	3*		
Ratio of SW to allocated caseload	1:35		
Ratio of SW to total caseload	1:42		
Highest caseload size for SW with specialist roles	36		
Lowest Caseload size for SW with specialist roles	24		
Highest Caseload size for SW with no specialist roles	36		
Lowest Caseload size for SW with no specialist roles	30		
Have this Team developed caseload weighting approaches?	Yes		
Does this Team use waiting lists?	Yes		

Note =*Senior Social Worker and SWA do not carry caseloads. Although this Team reported 1 AYE it also reported no Band 5s, we assume the latter.

Trust B: Description at Team Level – B24_CS_CwD

Team B24_CS	*n*	%	Type
Teams	1		Children w/Disabilities
Programme of Care			Children's Services
Uni-disciplinary	0		
Multi-disciplinary	1	100%	
Unfilled Band 6 Vacancies	0		
Band 2	0		Admin
Band 3	0		Admin
Band 4	2		Social work assistants
Band 5	0		AYE social workers
Band 6	3		Social workers
Band 7	1		Social workers
Permanent AYE	0		
Temporary AYE	0		
Permanent Band 6	3		
Temporary Band 6	0		
Agency AYE	0		
Agency Band 6	0		
Practice Teachers	0		
Overall caseload	161		
Allocated Cases	161	100%	
Unallocated Cases	0	0%	
Total number of SWs w/caseloads	3*		
Ratio of SW to allocated caseload	1:54		
Ratio of SW to total caseload	1:54		
Highest caseload size for SW with specialist roles	46		
Lowest Caseload size for SW with specialist roles	30		
Highest Caseload size for SW with no specialist roles	46		
Lowest Caseload size for SW with no specialist roles	30		
Have this Team developed caseload weighting approaches?	Yes		
Does this Team use waiting lists?	No		

Note =*Senior Social Worker and SWAs do not carry caseloads.

Trust B: Description at Team Level – B19_CS_EY

Team B19_CS_EY	*n*	%	Type
Teams	1		Early Years
Programme of Care			Children's Services
Uni-disciplinary	1	100%	
Multi-disciplinary	0		
Unfilled Band 6 Vacancies	2		
Band 2	2		Admin
Band 3	0		Admin
Band 4	0		Social work assistants
Band 5	0		AYE social workers
Band 6	6		Social workers
Band 7	1*		Social workers
Permanent AYE	0		
Temporary AYE	0		
Permanent Band 6	Missing		
Temporary Band 6	0		
Agency AYE	0		
Agency Band 6	0		
Practice Teachers	0		
Overall caseload	220		
Allocated Cases	220	100%	
Unallocated Cases	0	0%	
Total number of SWs w/caseloads	6**		
Ratio of SW to allocated caseload	1:37		
Ratio of SW to total caseload (allocated + unallocated)	1:37		
If vacancies were filled Total number of social workers/caseloads	8		
Ratio of SW to allocated caseloads if vacancy filled	1:28		
Ratio of SW to allocated and unallocated	1:28		
Highest caseload size for SW with specialist roles	-		
Lowest Caseload size for SW with specialist roles	-		
Highest Caseload size for SW with no specialist roles	-		
Lowest Caseload size for SW with no specialist roles	-		
Have this Team developed caseload weighting approaches?	Yes		
Does this Team use waiting lists?	Yes		

Note: *= Band 7 SWs were *Designated Team Leaders* and did not carry caseloads. **= + Six Band 6s

Trust B: Description at Team Level – B20_CS_EY

Team B20_CS_EY	*n*	%	Type
Teams	1		Early Years
Programme of Care			Children's Services
Uni-disciplinary	1	100%	
Multi-disciplinary	0		
Unfilled Band 6 Vacancies	1		
Band 2	1		Admin
Band 3	0		Admin
Band 4	1		Social work assistants
Band 5	0		AYE social workers
Band 6	5		Social workers
Band 7	1*		Social workers
Permanent AYE	0		
Temporary AYE	0		
Permanent Band 6	Missing		
Temporary Band 6	0		
Agency AYE	0		
Agency Band 6	0		
Practice Teachers	0		
Overall caseload	220		
Allocated Cases	220	100%	
Unallocated Cases	0	0%	
Total number of SWs w/caseloads	5**		
Ratio of SW to allocated caseload	1:44		
Ratio of SW to total caseload (allocated + unallocated)	1:44		
If vacancies were filled Total number of social workers/caseloads	6		
Ratio of SW to allocated caseloads if vacancy filled	1:37		
Ratio of SW to allocated and unallocated	1:37		
Highest caseload size for SW with specialist roles	-		
Lowest Caseload size for SW with specialist roles	-		
Highest Caseload size for SW with no specialist roles	-		
Lowest Caseload size for SW with no specialist roles	-		
Have this Team developed caseload weighting approaches?	Yes		
Does this Team use waiting lists?	No		

Note: *= Band 7 SWs were *Designated Team Leaders* and did not carry caseloads. **= Five Band 6s

Trust B: Description at Team Level – B03_CS _FC

Team B03_CS_FC	*n*	%	Type
Teams	1		Family Centres
Programme of Care			Children's Services
Uni-disciplinary	1	100%	
Multi-disciplinary	0	0%	
Unfilled Band 6 Vacancies	2		
Band 2	0		Admin
Band 3	3		Admin
Band 4	0		Social work assistants
Band 5	0		AYE social workers
Band 6	6		Social workers
Band 7	1		Social workers
Permanent AYE	8*		
Temporary AYE	0		
Permanent Band 6	Missing		
Temporary Band 6	0		
Agency AYE	0		
Agency Band 6	0		
Practice Teachers	0		
Overall caseload	46		
Allocated Cases	35	76.1%	
Unallocated Cases	11	23.9%	
Total number of SWs w/caseloads	6**		
Ratio of SW to allocated caseload	1:6		
Ratio of SW to total caseload (allocated + unallocated)	1:8		
If vacancies were filled: Total number of social workers/caseloads	8		
Ratio of SW to allocated caseloads if vacancies filled	1:4		
Ratio of SW to allocated and unallocated	1:6		
Highest caseload size for SW with specialist roles	8		
Lowest Caseload size for SW with specialist roles	4		
Highest Caseload size for SW with no specialist roles	8		
Lowest Caseload size for SW with no specialist roles	4		
Have this Team developed caseload weighting approaches?	No		
Does this Team use waiting lists?	No		

Note: * = We assume this as an error as this number was not evident in the Banding questions: ** = Band 7 DTL does not carry a caseload

Trust B: Description at Team Level – B27_CS _RCT

Team B27_CS_RCT	*n*	%	Type
Teams	1		Residential Child Team
Programme of Care			Children's Services
Uni-disciplinary	1	100%	
Multi-disciplinary	0	0%	
Unfilled Band 6 Vacancies	4		
Band 2	3		Admin
Band 3	2		Admin
Band 4	1		Social work assistants
Band 5	5*		AYE social workers
Band 6	6		Social workers
Band 7	3		Social workers
Permanent AYE	0		
Temporary AYE	0		
Permanent Band 6	6		
Temporary Band 6	0		
Agency AYE	0		
Agency Band 6	0		
Practice Teachers	0		
Overall caseload	3		
Allocated Cases	3		
Unallocated Cases	0		
Total number of SWs w/caseloads	8		
Ratio of SW to allocated caseload	?		
Ratio of SW to total caseload	?		
Highest caseload size for SW with specialist roles	N/A		
Lowest Caseload size for SW with specialist roles	N/A		
Highest Caseload size for SW with no specialist roles	N/A		
Lowest Caseload size for SW with no specialist roles	N/A		
Have this Team developed caseload weighting approaches?	Missing		
Does this Team use waiting lists?	Yes		

Note: *= This Team is a bespoke Children's Residential for a maximum of Six (6) young people, we assume that these Band 5s are an input error therefore we do not include them in SWs carrying caseloads:

Trust B: Description at Team Level – B29_CS _RCT

Team B29_CS_RCT	*n*	%	Type
Teams	1		Residential Child Team
Programme of Care			Children's Services
Uni-disciplinary	1	100%	
Multi-disciplinary	0	0%	
Unfilled Band 6 Vacancies	9*		
Band 2	3		Admin
Band 3	1		Admin
Band 4	4		Social work assistants
Band 5	5		AYE social workers
Band 6	9		Social workers
Band 7	3		Social workers
Permanent AYE	1		
Temporary AYE	3		
Permanent Band 6	8		
Temporary Band 6	1		
Agency AYE	0		
Agency Band 6	0		
Practice Teachers	0		
Overall caseload	7		
Allocated Cases	7		
Unallocated Cases	0		
Total number of SWs w/caseloads	Unknown		
Ratio of SW to allocated caseload	?		
Ratio of SW to total caseload	?		
Highest caseload size for SW with specialist roles	N/A		
Lowest Caseload size for SW with specialist roles	N/A		
Highest Caseload size for SW with no specialist roles	N/A		
Lowest Caseload size for SW with no specialist roles	N/A		
Have this Team developed caseload weighting approaches?	No		
Does this Team use waiting lists?	No		

Note: *= This number is assumed to be an input error as only 3 unfilled posts were explained in the data:

Trust C: Description of 14 Plus Teams at Trust Level – C_CS_14+

Teams C_CS_14+	*n*	%	Type
Teams	3		14 +
Programme of Care			Children's Services
Uni-disciplinary	2	66.6%	
Multi-disciplinary	1	33.3%	
Unfilled Band 6 Vacancies	5		
Band 2	0		Admin
Band 3	7		Admin
Band 4	14		Social work assistants
Band 5	3		AYE social workers
Band 6	16		Social workers
Band 7	7*		Social workers
Permanent AYE	3		
Temporary AYE	0		
Permanent Band 6	16		
Temporary Band 6	0		
Agency AYE	0		
Agency Band 6	0		
Practice Teachers			
Yes	2		
No	1		
Overall caseload	295		
Allocated Cases	295	100%	
Unallocated Cases	0		
Total number of SWs w/caseloads	23**		
Ratio of SW to allocated caseload	1:13		
Ratio of SW to total caseload (allocated + unallocated)	1:13		
If vacancies were filled Total number of social workers/caseloads	28		
Ratio of SW to allocated caseloads if vacancies filled	1:11		
Ratio of SW to allocated plus unallocated if vacancies filled	1:11		
Highest caseload size for SW with specialist roles	15		
Lowest Caseload size for SW with specialist roles	1		
Highest Caseload size for SW with no specialist roles	20		
Lowest Caseload size for SW with no specialist roles	8		
Have this Team developed caseload weighting approaches?			
Yes	1		
No	2		
Missing	-		
Does this Team use waiting lists?			
Yes	0		
No	3		
Missing	-		

Note: *= Designated Team Leaders did not carry caseloads: **= 3 Band 5s + 16 Band 6s + 4 Band 7s (3+1+4=23).

Trust C: Description of Early Years Teams at Trust Level – C_CS_EY

Teams C_CS_EY	*n*	%	Type
Teams	2		Gateway
Programme of Care			Children's Services
Uni-disciplinary	2	100%	
Multi-disciplinary	0	0%	
Unfilled Band 6 Vacancies	1.5		
Band 2	0		Admin
Band 3	2		Admin
Band 4	1		Social work assistants
Band 5	0		AYE social workers
Band 6	12		Social workers
Band 7	0*		Social workers
Permanent AYE	0		
Temporary AYE	0		
Permanent Band 6	12		
Temporary Band 6	0		
Agency AYE	0		
Agency Band 6	0		
Practice Teachers			
Yes	2		
No	0		
Overall caseload	655		
Allocated Cases	569	86.9%	
Unallocated Cases	86	13.1%	
Total number of SWs w/caseloads	12**		
Ratio of SW to allocated caseload	1:47		
Ratio of SW to total caseload (allocated + unallocated)	1:55		
If vacancies were filled Total number of social workers/caseloads	13.5		
Ratio of SW to allocated caseloads if vacancy filled	1:42		
Ratio of SW to allocated + unallocated	1:49		
Highest caseload size for SW with specialist roles	missing		
Lowest Caseload size for SW with specialist roles	missing		
Highest Caseload size for SW with no specialist roles	49		
Lowest Caseload size for SW with no specialist roles	49		
Have this Team developed caseload weighting approaches?			
Yes	-		
No	-		
Missing	2		
Does this Team use waiting lists?			
Yes	1		
No	1		
Missing	-		

Note: *= No Band 7s reported: **= 0 Band 5s + 12 Band 6s + 0 Band 7s (0+12+0=12).

Trust C: Description of Looked After Children Teams at Trust Level – C_CS_CwD

Teams C_CS_CwD	*n*	%	Type
Teams	4		Children with Disabilities
Programme of Care			Children's Services
Uni-disciplinary	4	100%	
Multi-disciplinary	0	0%	
Unfilled Band 6 Vacancies	7		
Band 2	0		Admin
Band 3	5		Admin
Band 4	6		Social work assistants
Band 5	1		AYE social workers
Band 6	35		Social workers
Band 7	10*		Social workers
Permanent AYE	0		
Temporary AYE	0		
Permanent Band 6	29		
Temporary Band 6	1		
Agency AYE	0		
Agency Band 6	0		
Practice Teachers			
Yes	2		
No	2		
Overall caseload	1126		
Allocated Cases	1026	91.1%	
Unallocated Cases	100	8.9%	
Total number of SWs w/caseloads	42**		
Ratio of SW to allocated caseload	1:24		
Ratio of SW to total caseload (allocated + unallocated)	1:27		
If vacancies were filled Total number of social workers/caseloads	49		
Ratio of SW to allocated caseloads if vacancy filled	1:21		
Ratio of SW to allocated and unallocated	1:23		
Highest caseload size for SW with specialist roles	19		
Lowest Caseload size for SW with specialist roles	4		
Highest Caseload size for SW with no specialist roles	100		
Lowest Caseload size for SW with no specialist roles	17		
Have this Team developed caseload weighting approaches?			
Yes	2		
No	2		
Missing	-		
Does this Team use waiting lists?			
Yes	4		
No	0		
Missing	-		

Note: *= Designated Team Leaders did not carry caseloads: **= 1 Band 5s + 35 Band 6s + 6 Band 7s (1+35+6=42).

Trust C: Description of Family Intervention Teams at Trust Level – C_CS_FIT

Teams C_CS_FIT	*n*	%	Type
Teams	9		FIT
Programme of Care			Children's Services
Uni-disciplinary	9	100%	
Multi-disciplinary	0	0%	
Unfilled Band 6 Vacancies	16.5		
Band 2	0		Admin
Band 3	6		Admin
Band 4	22		Social work assistants
Band 5	3		AYE social workers
Band 6	18.5		Social workers
Band 7	26*		Social workers
Permanent AYE	2		
Temporary AYE	2		
Permanent Band 6	12.5		
Temporary Band 6	1		
Agency AYE	0		
Agency Band 6	4		
Practice Teachers			
Yes	3		
No	6		
Overall caseload	1069		
Allocated Cases	972	90%	
Unallocated Cases	97	10%	
Total number of SWs w/caseloads	38.5**		
Ratio of SW to allocated caseload	1:25		
Ratio of SW to total caseload (allocated + unallocated)	1:28		
If vacancies were filled Total number of social workers/caseloads	55		
Ratio of SW to allocated caseloads if vacancy filled	1:18		
Ratio of SW to allocated and unallocated	1:19		
Highest caseload size for SW with specialist roles	26		
Lowest Caseload size for SW with specialist roles	9		
Highest Caseload size for SW with no specialist roles	29		
Lowest Caseload size for SW with no specialist roles	7		
Have this Team developed caseload weighting approaches?			
Yes	8		
No	1		
Missing	0		
Does this Team use waiting lists?			
Yes	7		
No	2		
Missing	-		

Note: *= 9 from 26 Band 7 SWs were *Designated Team Leaders* and did not carry caseloads; **= 3 Band 5s + 18.5 Band 6s + 17 Band 7s carrying caseloads = 38.5

Trust C: Description of Fostering Teams at Trust Level – C_CS_Fos

Teams C_CS_Fos	*n*	%	Type
Teams	2		Fostering
Programme of Care			Children's Services
Uni-disciplinary	2	100%	
Multi-disciplinary	0	0%	
Unfilled Band 6 Vacancies	4		
Band 2	0		Admin
Band 3	2		Admin
Band 4	4		Social work assistants
Band 5	0		AYE social workers
Band 6	19		Social workers
Band 7	5*		Social workers
Permanent AYE	0		
Temporary AYE	0		
Permanent Band 6	14.5		
Temporary Band 6	0		
Agency AYE	0		
Agency Band 6	0		
Practice Teachers			
Yes	1		
No	1		
Overall caseload	581		
Allocated Cases	555	95.5%	
Unallocated Cases	26	4.5%	
Total number of SWs w/caseloads	22**		
Ratio of SW to allocated caseload	1:25		
Ratio of SW to total caseload (allocated + unallocated)	1:26		
If vacancies were filled Total number of social workers/caseloads	26		
Ratio of SW to allocated caseloads if vacancies filled	1:21		
Ratio of SW to allocated plus unallocated if vacancies filled	1:22		
Highest caseload size for SW with specialist roles	40		
Lowest Caseload size for SW with specialist roles	16		
Highest Caseload size for SW with no specialist roles	40		
Lowest Caseload size for SW with no specialist roles	20		
Have this Team developed caseload weighting approaches?			
Yes	0		
No	2		
Missing	-		
Does this Team use waiting lists?			
Yes	1		
No	1		
Missing	-		

Note: *= Designated Team Leaders did not carry caseloads: **= 0 Band 5s + 19 Band 6s + 3 Band 7s (0+19+3=22).

Trust C: Description of Gateway Teams at Trust Level – C_CS_GW

Teams C_CS_GW	*n*	%	Type
Teams	2		Gateway
Programme of Care			Children's Services
Uni-disciplinary	2	100%	
Multi-disciplinary	0	0%	
Unfilled Band 6 Vacancies	4		
Band 2	0		Admin
Band 3	2		Admin
Band 4	1		Social work assistants
Band 5	4		AYE social workers
Band 6	11		Social workers
Band 7	5*		Social workers
Permanent AYE	4		
Temporary AYE	0		
Permanent Band 6	11		
Temporary Band 6	0		
Agency AYE	0		
Agency Band 6	1		
Practice Teachers			
Yes	1		
No	1		
Overall caseload	377		
Allocated Cases	132	35%	
Unallocated Cases	245	65%	
Total number of SWs w/caseloads	18**		
Ratio of SW to allocated caseload	1:7		
Ratio of SW to total caseload (allocated + unallocated)	1:21		
If vacancies were filled Total number of social workers/caseloads	22		
Ratio of SW to allocated caseloads if vacancy filled	1:6		
Ratio of SW to allocated + unallocated	1:17		
Highest caseload size for SW with specialist roles	8		
Lowest Caseload size for SW with specialist roles	5		
Highest Caseload size for SW with no specialist roles	8		
Lowest Caseload size for SW with no specialist roles	5		
Have this Team developed caseload weighting approaches?			
Yes	1		
No	1		
Missing	-		
Does this Team use waiting lists?			
Yes	2		
No	0		
Missing	-		

Note: *= Designated Team Leaders did not carry caseloads: **= 4 Band 5s + 11 Band 6s + 3 Band 7s (4+11+3=18).

Trust C: Description of Looked After Children Teams at Trust Level – C_CS_LAC

Teams C_CS_LAC	*n*	%	Type
Teams	5		LAC
Programme of Care			Children's Services
Uni-disciplinary	5	100%	
Multi-disciplinary	0	0%	
Unfilled Band 6 Vacancies	2		
Band 2	0		Admin
Band 3	7		Admin
Band 4	10		Social work assistants
Band 5	5		AYE social workers
Band 6	19		Social workers
Band 7	9*		Social workers
Permanent AYE	4		
Temporary AYE	0		
Permanent Band 6	10		
Temporary Band 6	Missing		
Agency AYE	0		
Agency Band 6	0		
Practice Teachers			
Yes	1		
No	4		
Overall caseload	364		
Allocated Cases	364	100%	
Unallocated Cases	0		
Total number of SWs w/caseloads	28**		
Ratio of SW to allocated caseload	1:13		
Ratio of SW to total caseload (allocated + unallocated)	1:13		
If vacancies were filled Total number of social workers/caseloads	30		
Ratio of SW to allocated caseloads if vacancy filled	1:12		
Ratio of SW to allocated and unallocated	1:12		
Highest caseload size for SW with specialist roles	23		
Lowest Caseload size for SW with specialist roles	6		
Highest Caseload size for SW with no specialist roles	23		
Lowest Caseload size for SW with no specialist roles	7		
Have this Team developed caseload weighting approaches?			
Yes	3		
No	2		
Missing	-		
Does this Team use waiting lists?			
Yes	0		
No	5		
Missing	-		

Note: *= Designated Team Leaders did not carry caseloads: **= 5 Band 5s + 14 Band 6s + 2 Band 7s (5+19+4=28).

Trust C: Description at Team Level – C22_CS _LC

Team C22_CS_LC	*n*	%	Type
Teams	1		Leaving Care
Programme of Care			Children's Services
Uni-disciplinary	1	100%	
Multi-disciplinary	0	0%	
Unfilled Band 6 Vacancies	1		
Band 2	0		Admin
Band 3	2		Admin
Band 4	5		Social work assistants
Band 5	0		AYE social workers
Band 6	6		Social workers
Band 7	2		Social workers
Permanent AYE	0		
Temporary AYE	0		
Permanent Band 6	6		
Temporary Band 6	0		
Agency AYE	0		
Agency Band 6	0		
Practice Teachers	0		
Overall caseload	108		
Allocated Cases	108	100%	
Unallocated Cases	0	0%	
Total number of SWs w/caseloads	7*		
Ratio of SW to allocated caseload	1:15		
Ratio of SW to total caseload (allocated + unallocated)	1:15		
If vacancies were filled: Total number of social workers/caseloads	8		
Ratio of SW to allocated caseloads if vacancies filled	14		
Ratio of SW to allocated and unallocated	14		
Highest caseload size for SW with specialist roles	14		
Lowest Caseload size for SW with specialist roles	14		
Highest Caseload size for SW with no specialist roles	18		
Lowest Caseload size for SW with no specialist roles	16		
Have this Team developed caseload weighting approaches?	Yes		
Does this Team use waiting lists?	Yes		

Note: * = 0 Band 5s + 6 Band 6s + 1 Band 7s (0+6+1=7).

Trust C: Description at Team Level – C38_CS _PP

Team C38_CS_PP	*n*	%	Type
Teams	1		Public Protection Team
			All Directorates
Programme of Care			Children's Services
Uni-disciplinary	1	100%	
Multi-disciplinary	0	0%	
Unfilled Band 6 Vacancies	0		
Band 2	0		Admin
Band 3	0.5		Admin
Band 4	0		Social work assistants
Band 5	0		AYE social workers
Band 6	0		Social workers
Band 7	1		Social workers
Permanent AYE	0		
Temporary AYE	0		
Permanent Band 6	0		
Temporary Band 6	0		
Agency AYE	0		
Agency Band 6	0		
Practice Teachers	0		
Overall caseload	420		
Allocated Cases	420	100%	
Unallocated Cases	0	0%	
Total number of SWs w/caseloads	1*		
Ratio of SW to allocated caseload	1:420		
Ratio of SW to total caseload (allocated + unallocated)	1:420		
If vacancies were filled: Total number of social workers/caseloads	-		
Ratio of SW to allocated caseloads if vacancies filled	-		
Ratio of SW to allocated and unallocated	-		
Highest caseload size for SW with specialist roles	420		
Lowest Caseload size for SW with specialist roles	420		
Highest Caseload size for SW with no specialist roles	0		
Lowest Caseload size for SW with no specialist roles	0		
Have this Team developed caseload weighting approaches?	No		
Does this Team use waiting lists?	No		

Note: * = Only 1 Band 7 in this Team so they are assumed to carry caseloads

Trust C: Description at Team Level – C39_CS _ACS

Team C39_CS_ACS	*n*	%	Type
Teams	1		Acute Children's Services
Programme of Care			Children's Services
Uni-disciplinary	1	100%	
Multi-disciplinary	0	0%	
Unfilled Band 6 Vacancies	0		
Band 2	0		Admin
Band 3	0		Admin
Band 4	0		Social work assistants
Band 5	0		AYE social workers
Band 6	0		Social workers
Band 7	1		Social workers
Permanent AYE	0		
Temporary AYE	0		
Permanent Band 6	0		
Temporary Band 6	0		
Agency AYE	0		
Agency Band 6	0		
Practice Teachers	0		
Overall caseload	60		
Allocated Cases	60	100%	
Unallocated Cases	0	0%	
Total number of SWs w/caseloads	1*		
Ratio of SW to allocated caseload	1:60		
Ratio of SW to total caseload (allocated + unallocated)	1:60		
If vacancies were filled: Total number of social workers/caseloads	-		
Ratio of SW to allocated caseloads if vacancies filled	-		
Ratio of SW to allocated and unallocated	-		
Highest caseload size for SW with specialist roles	15		
Lowest Caseload size for SW with specialist roles	8		
Highest Caseload size for SW with no specialist roles	0		
Lowest Caseload size for SW with no specialist roles	0		
Have this Team developed caseload weighting approaches?	No		
Does this Team use waiting lists?	No		

Note: * = Only 1 Band in this Team carrying caseloads

Trust D: Description of Family Intervention Teams at Trust Level – D_CS_FIT

Teams D_CS_FIT	*n*	%	Type
Teams	19		FIT
Programme of Care			Children's Services
Uni-disciplinary	19	100%	
Multi-disciplinary	0	0%	
Unfilled Band 6 Vacancies	21.5		
Band 2	0		Admin
Band 3	0		Admin
Band 4	0		Social work assistants
Band 5	21		AYE social workers
Band 6	33.5		Social workers
Band 7	38.5*		Social workers
Permanent AYE	-		
Temporary AYE	-		
Permanent Band 6	-		
Temporary Band 6	-		
Agency AYE	-		
Agency Band 6	-		
Practice Teachers			
Yes	5		
No	14		
Overall caseload	1707		
Allocated Cases	1453	85.1%	
Unallocated Cases	254	14.9%	
Total number of SWs w/caseloads	71**		
Ratio of SW to allocated caseload	1:20		
Ratio of SW to total caseload (allocated + unallocated)	1:24		
If vacancies were filled Total number of social workers/caseloads	92.5		
Ratio of SW to allocated caseloads if vacancy filled	1:16		
Ratio of SW to allocated and unallocated	1:18		
Highest caseload size for SW with specialist roles	35		
Lowest Caseload size for SW with specialist roles	7		
Highest Caseload size for SW with no specialist roles	62		
Lowest Caseload size for SW with no specialist roles	7		
Have this Team developed caseload weighting approaches?			
Yes	9		
No	4		
Missing	6		
Does this Team use waiting lists?			
Yes	17		
No	2		
Missing	-		

Note: *= Designated Team Leaders did not carry caseloads: **= 21 Band 5s + 33.5 Band 6s + 16.5 Band 7s (21+33.5+16.5=71).

Trust D: Description of Looked After Children Teams at Trust Level – D_CS_CwD

Teams D_CS_CwD	*n*	%	Type
Teams	3		Children with Disabilities
Programme of Care			Children's Services
Uni-disciplinary	0	0%	
Multi-disciplinary	3	100%	
Unfilled Band 6 Vacancies	3		
Band 2	0		Admin
Band 3	2		Admin
Band 4	9		Social work assistants
Band 5	0		AYE social workers
Band 6	12.5		Social workers
Band 7	4		Social workers
Permanent AYE	-		
Temporary AYE	-		
Permanent Band 6	-		
Temporary Band 6	-		
Agency AYE	0		
Agency Band 6	5		
Practice Teachers			
Yes	2		
No	1		
Overall caseload	896		
Allocated Cases	527	58.8%	
Unallocated Cases	369	41.2%	
Total number of SWs w/caseloads	13.5**		
Ratio of SW to allocated caseload	1:39		
Ratio of SW to total caseload (allocated + unallocated)	1:66		
If vacancies were filled Total number of social workers/caseloads	16.5		
Ratio of SW to allocated caseloads if vacancy filled	1:32		
Ratio of SW to allocated and unallocated	1:54		
Highest caseload size for SW with specialist roles	60		
Lowest Caseload size for SW with specialist roles	35		
Highest Caseload size for SW with no specialist roles	60		
Lowest Caseload size for SW with no specialist roles	35		
Have this Team developed caseload weighting approaches?			
Yes	2		
No	1		
Missing	-		
Does this Team use waiting lists?			
Yes	3		
No	0		
Missing	-		

Note: *= Designated Team Leaders did not carry caseloads: **= 0 Band 5s + 12.5 Band 6s + 1 Band 7s (0+12.5+1=13.5).

Trust D: Description of Gateway Teams at Trust Level – D_CS_GW

Teams D_CS_GW	*n*	%	Type
Teams	4		Gateway
Programme of Care			Children's Services
Uni-disciplinary	4	100%	
Multi-disciplinary	0	0%	
Unfilled Band 6 Vacancies	7.5		
Band 2	0		Admin
Band 3	0		Admin
Band 4	0		Social work assistants
Band 5	3		AYE social workers
Band 6	17		Social workers
Band 7	10*		Social workers
Permanent AYE	-		
Temporary AYE	-		
Permanent Band 6	-		
Temporary Band 6	0		
Agency AYE	0		
Agency Band 6	0		
Practice Teachers			
Yes	4		
No	0		
Overall caseload	703		
Allocated Cases	471	67.0%	
Unallocated Cases	323	33.0%	
Total number of SWs w/caseloads	26**		
Ratio of SW to allocated caseload	1:18		
Ratio of SW to total caseload (allocated + unallocated)	1:27		
If vacancies were filled Total number of social workers/caseloads	33.5		
Ratio of SW to allocated caseloads if vacancy filled	1:14		
Ratio of SW to allocated + unallocated	1:21		
Highest caseload size for SW with specialist roles	28		
Lowest Caseload size for SW with specialist roles	6		
Highest Caseload size for SW with no specialist roles	28		
Lowest Caseload size for SW with no specialist roles	6		
Have this Team developed caseload weighting approaches?			
Yes	1		
No	2		
Missing	1		
Does this Team use waiting lists?			
Yes	3		
No	0		
Missing	1		

Note: *= Designated Team Leaders did not carry caseloads: **= 3 Band 5s + 17 Band 6s + 6 Band 7s (3+17+6=26).

Trust D: Description of Early Years Teams at Trust Level – D_CS_EY

Teams D_CS_EY	*n*	%	Type
Teams	2		Gateway
Programme of Care			Children's Services
Uni-disciplinary	2	100%	
Multi-disciplinary	0	0%	
Unfilled Band 6 Vacancies	0.6		
Band 2	3.2		Admin
Band 3	2		Admin
Band 4	2		Social work assistants
Band 5	0		AYE social workers
Band 6	10.4		Social workers
Band 7	2*		Social workers
Permanent AYE	0		
Temporary AYE	0		
Permanent Band 6	7.9		
Temporary Band 6	1.9		
Agency AYE	0		
Agency Band 6	0		
Practice Teachers			
Yes	1		
No	1		
Overall caseload	201		
Allocated Cases	179	89.1%	
Unallocated Cases	22	10.9%	
Total number of SWs w/caseloads	10.4**		
Ratio of SW to allocated caseload	1:17		
Ratio of SW to total caseload (allocated + unallocated)	1:19		
If vacancies were filled Total number of social workers/caseloads	11		
Ratio of SW to allocated caseloads if vacancy filled	1:16		
Ratio of SW to allocated + unallocated	1:18		
Highest caseload size for SW with specialist roles	0		
Lowest Caseload size for SW with specialist roles	0		
Highest Caseload size for SW with no specialist roles	78.5		
Lowest Caseload size for SW with no specialist roles	53.8		
Have this Team developed caseload weighting approaches?			
Yes	2		
No	-		
Missing	-		
Does this Team use waiting lists?			
Yes	2		
No	-		
Missing	-		

Note: *= Band 7s were assumed to be DTL and do not carry caseloads: **= 0 Band 5s + 10.4 Band 6s + 0 Band 7s (0+10.4+0=10.4).

Trust D: Description at Team Level – D27_CS _FC

Team D27_CS_FC	*n*	%	Type
Teams	1		Family Centres
Programme of Care			Children's Services (CCS)
Uni-disciplinary	1	100%	
Multi-disciplinary	0	0%	
Unfilled Band 6 Vacancies	1		
Band 2	0		Admin
Band 3	0		Admin
Band 4	1		Social work assistants
Band 5	0		AYE social workers
Band 6	7		Social workers
Band 7	2		Social workers
Permanent AYE	0		
Temporary AYE	0		
Permanent Band 6	3		
Temporary Band 6	0		
Agency AYE	0		
Agency Band 6	0		
Practice Teachers	1		
Overall caseload	30		
Allocated Cases	26	86.7%	
Unallocated Cases	4	13.3%	
Total number of SWs w/caseloads	8*		
Ratio of SW to allocated caseload	1:3		
Ratio of SW to total caseload (allocated + unallocated)	1:4		
If vacancies were filled: Total number of social workers/caseloads	9		
Ratio of SW to allocated caseloads if vacancies filled	1:3		
Ratio of SW to allocated and unallocated	1:3		
Highest caseload size for SW with specialist roles	n/a		
Lowest Caseload size for SW with specialist roles	n/a		
Highest Caseload size for SW with no specialist roles	n/a		
Lowest Caseload size for SW with no specialist roles	n/a		
Highest Caseload size for SWA	-		
Lowest Caseload size for SWA	-		
Have this Team developed caseload weighting approaches?	No		
Does this Team use waiting lists?	No		

Note: * = Band 7 DTL does not carry a caseload: ** = 0 Band 5s + 7 Band 6s + 1 Band 7s (0+7+1=8).

Trust E: Description of Family Intervention Teams at Trust Level – E_CS_FIT

Teams E_CS_FIT	*n*	%	Type
Teams	8		FIT
Programme of Care			Children's Services
Uni-disciplinary	8	100%	
Multi-disciplinary	0	0%	
Unfilled Band 6 Vacancies	10		
Band 2	0		Admin
Band 3	3.5		Admin
Band 4	11.5		Social work assistants
Band 5	8		AYE social workers
Band 6	18		Social workers
Band 7	14*		Social workers
Permanent AYE	8		
Temporary AYE	0		
Permanent Band 6	Missing		
Temporary Band 6	Missing	0%	
Agency AYE	0		
Agency Band 6	3		
Practice Teachers			
Yes	2		
No	6		
Overall caseload	799		
Allocated Cases	744	93.1%	
Unallocated Cases	55	6.9%	
Total number of SWs w/caseloads	32**		
Ratio of SW to allocated caseload	1:23		
Ratio of SW to total caseload (allocated + unallocated)	1:25		
If vacancies were filled Total number of social workers/caseloads	42		
Ratio of SW to allocated caseloads if vacancy filled	1:18		
Ratio of SW to allocated and unallocated	1:19		
Highest caseload size for SW with specialist roles	36		
Lowest Caseload size for SW with specialist roles	10		
Highest Caseload size for SW with no specialist roles	31		
Lowest Caseload size for SW with no specialist roles	9		
Have this Team developed caseload weighting approaches?			
Yes	6		
No	2		
Missing	-		
Does this Team use waiting lists?			
Yes	6		
No	2		
Missing	-		

Note: *= Designated Team Leaders did not carry caseloads: **= 8 Band 5s + 18 Band 6s + 6 Band 7s (8+18+6=32).

Trust E: Description of Fostering Teams at Trust Level – E_CS_Fos

Teams E_CS_Fos	*n*	%	Type
Teams	4		Fostering
Programme of Care			Children's Services
Uni-disciplinary	4	100%	
Multi-disciplinary	0	0%	
Unfilled Band 6 Vacancies	5.3		
Band 2	0		Admin
Band 3	4		Admin
Band 4	0		Social work assistants
Band 5	0		AYE social workers
Band 6	19.7		Social workers
Band 7	8.6*		Social workers
Permanent AYE	0		
Temporary AYE	0		
Permanent Band 6	Missing data		
Temporary Band 6	1		
Agency AYE	1		
Agency Band 6	3		
Practice Teachers			
Yes	1		
No	3		
Overall caseload	494		
Allocated Cases	418	84.6%	
Unallocated Cases	76	15.4%	
Total number of SWs w/caseloads	25.3**		
Ratio of SW to allocated caseload	1:17		
Ratio of SW to total caseload (allocated + unallocated)	1:20		
If vacancies were filled Total number of social workers/caseloads	30.6		
Ratio of SW to allocated caseloads if vacancies filled	1:14		
Ratio of SW to allocated plus unallocated if vacancies filled	1:16		
Highest caseload size for SW with specialist roles	25		
Lowest Caseload size for SW with specialist roles	2		
Highest Caseload size for SW with no specialist roles	25		
Lowest Caseload size for SW with no specialist roles	14		
Have this Team developed caseload weighting approaches?			
Yes	2		
No	2		
Does this Team use waiting lists?			
Yes	2		
No	2		
Missing	-		

Note: *= Designated Team Leaders did not carry caseloads: **= 1 Band 5s + 19.7 Band 6s + 4.6 Band 7s (1+19.7+4.6=25.3).

Trust E: Description of Gateway Teams at Trust Level – E_CS_GW

Teams E_CS_GW	*n*	%	Type
Teams	4		Gateway
Programme of Care			Children's Services
Uni-disciplinary	4	100%	
Multi-disciplinary	0	0%	
Unfilled Band 6 Vacancies	3		
Band 2	1.5		Admin
Band 3	1.5		Admin
Band 4	0		Social work assistants
Band 5	3		AYE social workers
Band 6	20.4		Social workers
Band 7	11*		Social workers
Permanent AYE	3		
Temporary AYE	0		
Permanent Band 6	Missing		
Temporary Band 6	0		
Agency AYE	0		
Agency Band 6	4		
Practice Teachers			
Yes	2		
No	2		
Overall caseload	1213		
Allocated Cases	585	48.2%	
Unallocated Cases	628	51.8%	
Total number of SWs w/caseloads	30.4**		
Ratio of SW to allocated caseload	1:19		
Ratio of SW to total caseload (allocated + unallocated)	1:40		
If vacancies were filled Total number of social workers/caseloads	33.4		
Ratio of SW to allocated caseloads if vacancy filled	1:18		
Ratio of SW to allocated + unallocated	1:36		
Highest caseload size for SW with specialist roles	26		
Lowest Caseload size for SW with specialist roles	16		
Highest Caseload size for SW with no specialist roles	36		
Lowest Caseload size for SW with no specialist roles	8		
Have this Team developed caseload weighting approaches?			
Yes	0		
No	4		
Missing	-		
Does this Team use waiting lists?			
Yes	4		
No	0		
Missing	-		

Note: *= Designated Team Leaders did not carry caseloads: **= 3 Band 5s + 20.4 Band 6s + 7 Band 7s (3+20.4+7=30.4).

Trust E: Description of Looked After Children Teams at Trust Level – E_CS_LAC

Teams E_CS_LAC	*n*	%	Type
Teams	7		LAC
Programme of Care			Children's Services
Uni-disciplinary	7	100%	
Multi-disciplinary	0	0%	
Unfilled Band 6 Vacancies	15		
Band 2	4		Admin
Band 3	6		Admin
Band 4	7		Social work assistants
Band 5	4		AYE social workers
Band 6	18.5		Social workers
Band 7	19*		Social workers
Permanent AYE	3.5		
Temporary AYE	0		
Permanent Band 6	Missing		
Temporary Band 6	Missing		
Agency AYE	0		
Agency Band 6	1		
Practice Teachers			
Yes	1		
No	6		
Overall caseload	581		
Allocated Cases	574	98.8%	
Unallocated Cases	7	1.2%	
Total number of SWs w/caseloads	34.5**		
Ratio of SW to allocated caseload	1:17		
Ratio of SW to total caseload (allocated + unallocated)	1:17		
If vacancies were filled Total number of social workers/caseloads	49.5		
Ratio of SW to allocated caseloads if vacancy filled	1:12		
Ratio of SW to allocated and unallocated	1:12		
Highest caseload size for SW with specialist roles	24		
Lowest Caseload size for SW with specialist roles	14		
Highest Caseload size for SW with no specialist roles	24		
Lowest Caseload size for SW with no specialist roles	9		
Have this Team developed caseload weighting approaches?			
Yes	3		
No	4		
Missing	-		
Does this Team use waiting lists?			
Yes	1		
No	6		
Missing	-		

Note: *= Designated Team Leaders did not carry caseloads: **= 4 Band 5s + 18.5 Band 6s + 12 Band 7s (4+18+12=34.5).

Trust E: Description of Fostering Teams at Trust Level – E_CS_RCT

Teams E_CS_Fos	*n*	%	Type
Teams	4		Residential Child
Programme of Care			Children's Services
Uni-disciplinary	4	100%	
Multi-disciplinary	0	0%	
Unfilled Band 6 Vacancies	4.5		
Band 2	0		Admin
Band 3	0		Admin
Band 4	7		Social work assistants
Band 5	9		AYE social workers
Band 6	25		Social workers
Band 7	9*		Social workers
Permanent AYE	2		
Temporary AYE	0		
Permanent Band 6	0		
Temporary Band 6	1		
Agency AYE	3		
Agency Band 6	4		
Practice Teachers			
Yes	3		
No	1		
Overall caseload	14		
Allocated Cases	12	85.7%	
Unallocated Cases	2	14.3%	
Total number of SWs w/caseloads	39**		
Ratio of SW to allocated caseload	1:0.3		
Ratio of SW to total caseload (allocated + unallocated)	1:0.4		
If vacancies were filled Total number of social workers/caseloads	43.5		
Ratio of SW to allocated caseloads if vacancy filled	1:0.3		
Ratio of SW to allocated and unallocated	1:0.3		
Highest caseload size for SW with specialist roles	2		
Lowest Caseload size for SW with specialist roles	0		
Highest Caseload size for SW with no specialist roles	5		
Lowest Caseload size for SW with no specialist roles	0		
Have this Team developed caseload weighting approaches?			
Yes	2		
No	2		
Missing	-		
Does this Team use waiting lists?			
Yes	0		
No	4		
Missing	-		

Note: *= Designated Team Leaders did not carry caseloads: **= 9 Band 5s + 25 Band 6s + 5 Band 7s (9+25+5=39).

Trust E: Description at Team Level – E16_CS _FT

Team E19_CS_CCS	*n*	%	Type
Teams	1		Family Trauma
Programme of Care			Children's Services
Uni-disciplinary	1	100%	
Multi-disciplinary	0	0%	
Unfilled Band 6 Vacancies	1		
Band 2	n/a		Admin
Band 3	n/a		Admin
Band 4	n/a		Social work assistants
Band 5	n/a		AYE social workers
Band 6	n/a		Social workers
Band 7	n/a		Social workers
Permanent AYE	0		
Temporary AYE	0		
Permanent Band 6	0		
Temporary Band 6	0		
Agency AYE	0		
Agency Band 6	1		
Practice Teachers	0		
Overall caseload	49		
Allocated Cases	49	100%	
Unallocated Cases	0	0%	
Total number of SWs w/caseloads	4*		
Ratio of SW to allocated caseload	1:12		
Ratio of SW to total caseload (allocated + unallocated)	1:12		
If vacancies were filled: Total number of social workers/caseloads	5		
Ratio of SW to allocated caseloads if vacancies filled	1:10		
Ratio of SW to allocated and unallocated	1:10		
Highest caseload size for SW with specialist roles	14		
Lowest Caseload size for SW with specialist roles	10		
Highest Caseload size for SW with no specialist roles	14		
Lowest Caseload size for SW with no specialist roles	10		
Have this Team developed caseload weighting approaches?	Yes		
Does this Team use waiting lists?	Yes		

Note: * = One of the Band 7s provided the role of DTL and does not carry a caseload

Trust E: Description at Team Level – E19_CS _CCS

Team E19_CS_CCS	*n*	%	Type
Teams	1		Children's Court Services
Programme of Care			Children's Services
Uni-disciplinary	1	100%	
Multi-disciplinary	0	0%	
Unfilled Band 6 Vacancies	0		
Band 2	0		Admin
Band 3	0		Admin
Band 4	0		Social work assistants
Band 5	0		AYE social workers
Band 6	0		Social workers
Band 7	6		Social workers
Permanent AYE	0		
Temporary AYE	0		
Permanent Band 6	0		
Temporary Band 6	0		
Agency AYE	0		
Agency Band 6	0		
Practice Teachers	0		
Overall caseload	397		
Allocated Cases	397	100%	
Unallocated Cases	0	0%	
Total number of SWs w/caseloads	5*		
Ratio of SW to allocated caseload	1:79		
Ratio of SW to total caseload (allocated + unallocated)	1:79		
If vacancies were filled: Total number of social workers/caseloads	n/a		
Ratio of SW to allocated caseloads if vacancies filled	n/a		
Ratio of SW to allocated and unallocated	n/a		
Highest caseload size for SW with specialist roles	nil		
Lowest Caseload size for SW with specialist roles	nil		
Highest Caseload size for SW with no specialist roles	nil		
Lowest Caseload size for SW with no specialist roles	nil		
Have this Team developed caseload weighting approaches?	No		
Does this Team use waiting lists?	Yes		

Note: * = Band 7 DTL does not carry a caseload

Trust E: Social Work Staff Description at Team Level – E28_CwD

Team E28_CS	*n*	%	Type
Teams	1		Children w/Disabilities (CWD)
Programme of Care			Children's Services
Uni-disciplinary	1	100%	
Multi-disciplinary	0		
Unfilled Band 6 Vacancies	5		
Band 2	0.5		Admin
Band 3	2.5		Admin
Band 4	4		SWA
Band 5	5		AYE social workers
Band 6	6		Social workers
Band 7	6		Social workers
Permanent AYE	0		
Temporary AYE	0		
Permanent Band 6	0		
Temporary Band 6	0		
Agency AYE	0		
Agency Band 6	0		
Practice Teachers	0		
Overall caseload	309		
Allocated Cases	154	49.8%	
Unallocated Cases	155	50.2%	
Total number of SWs w/caseloads	16*		
Ratio of SW to allocated caseload	1:10		
Ratio of SW to total caseload	1:19		
If vacancies were filled Total number of social workers/caseloads	21		
Ratio of SW to allocated caseloads if vacancy filled	1:7		
Ratio of SW to allocated and unallocated	1:15		
Highest caseload size for SW with specialist roles	28		
Lowest Caseload size for SW with specialist roles	21		
Highest Caseload size for SW with no specialist roles	34		
Lowest Caseload size for SW with no specialist roles	19		
Have this Team developed caseload weighting approaches?	Yes		
Does this Team use waiting lists?	Yes		

Note =*One Senior Social Worker who provided the role of DPL and SWAs do not carry caseloads.

Appendix 2: Risk and governance around waiting lists

Appendix 2-1: Children's Services

How is risk and governance around waiting list protocols managed?	
Trust A (CS)	Staff have been allocated to manage waiting list and cases are responded to by duty system.
	One Band 7 and 1 Band 4 SWA manages and responds to waiting list
	Crisis meetings are held monthly to discuss assessed needs of children. Social Work Managers in the community highlight cases which are deemed in crisis and at risk of placement breakdown.
	Team Health Check monitors this monthly
	Regional Procedure with regard to application forms being received and allocated for SW staff to assess. Timescales are held regionally with regard to completing registrations.
	Regular meetings/discussions take place to prioritise families on waiting list.
	Policy for unallocated caseloads
Trust B (CS)	Waiting lists are reviewed by SSW with templates to manage same that are sent to SWSM to review
	SSW reviews waiting list daily
	There is guidance around unallocated within the Gateway Service
	Monthly unallocated meetings, duty system in place
	waiting list is used to manage the unallocated cases. There is an unallocated policy, cases managed by duty social worker and then reviewed on a weekly basis by the Team leader. Any of those cases above 20 days
	Oversight by Senior Management
	regular supervision, concerns escalated to senior management, unallocated policy utilized
	placement planning meetings are held regarding all referrals into residential. this may look at group dynamic risk assessments across the homes
	They are managed by our senior managers.
	Senior Social Worker regularly monitors any waiting list
	Reported to line manager on a monthly basis. Private assessments undertaken to reduce waiting lists.
	unallocated work captured and escalated to management and subject of constant review. Team placed on at risk register and weekly meetings- referring Team advised and other agencies involved

	Waiting lists are for individuals or couples wishing to undertake fostering or adoption assessments to become foster carers or adopters only so no risks in terms of governance
	Reported fortnightly to HOS. Discussed and prioritised in supervision with SWSM
	Team Leader reports unallocated cases monthly to senior managers.
	Centralised system in place for Fit Person assessments. Allocated by band 6 admin to each Team leader who allocates to sw and filtered into the monthly caseload
	Waiting list reviewed by SSW regularly in consultation with the referring Team.
	regular kinship pressures meeting with HOS to appraise of waiting list demands and cases that may need prioritised
Trust C (CS)	Multi-disciplinary checks completed on waiting cases
	All immediate safeguarding concerns are addressed and safety plans agreed to manage potential risk, cases then go on a waiting list to be allocated to a Social Worker for an Initial Assessment. Unallocated cases are reviewed weekly by Team Lead and Line Manager.
	Unallocated cases are reviewed by Senior Social Worker and senior Management
	regular review and overseed by Head of Service. parents are informed re waiting list. md checks are updated throughout period of being on waiting list.
	Team leader follows guidance on the management and monitoring of unallocated cases Senior Management audit the unallocated monthly
	We have a Family Support Project in which 2 SSWP's monitor the unallocated cases and allocate MD checks to SWA's on a weekly basis. This is discussed with service Manager.
	Reviewed via Team manager and social work assistants on a monthly basis. MD checks and home visits completed. Harm Matrix signs of safety tool used as well
	occasionally senior managers review it, but mostly its just reviewed by the Senior social worker, the waiting lists are all family support (not CP or LAC) and can wait for a long period of time before they are looked at.
	If any cases require to wait on a waiting list this is frequently reviewed by Senior Management
	only waiting list for PAs managed by HOS
	HOS quality assures any new referrals for service. Each Young Person has their own Risk Assessment and Care Plan which assesses their risk level and behaviours of concern etc. As some of our Young People's level of risk is higher than others, some Young People are on the Head of Service level of Risk Assessment.
	Children/young people are presented by their social worker to an overnight forum once per month and are scored using a scoring tool. The child/young person with the

	highest score is first on the waiting list. Should their needs change they are presented again for review.
	Through a Trust Resource Panel and at Head of Service level
	weekly meetings to review unallocated with 8a duty system to deal with response to families unallocated return to management
	Team manager prioritises in consultation with manager
	decisions are made about what work should be suspended and usually involves not completing registrations as this is lower risk
	Unallocated & de-allocated cases are on a waiting list and managed via the regional protocol. In addition we review the waiting list weekly (Service Manager, 2 TM's and 2 SSWP) and consider any updated information that we have received to help triage for allocation when we have availability. We use a RAG rating to help triage cases. We have a tracking document that we update after each meeting.
Trust D (CS)	through bed and resource panel
	Waiting lists only used for new applicants, therefore there is no risk. Where possible the Senior tries to ensure allocation within agreed timescales. This is kept under review by the PSW on a monthly basis in supervision.
	Waiting lists are only ever used for new childcare applicants, hence there is no risk involved as they are not yet registered. The service tries to work to regionally agreed timescales for application timescales, and the waiting list is reviewed on a monthly basis or more frequently if capacity is in the Team. This is monitored by the PSW in supervision of the SSW on a monthly basis.
	Senior Social Worker manages waiting list. Liaison with CAFT SW/Referring agents to get updates. The cases are managed by CAFT/referring agent ongoing prior to and during the family centres intervention therefore managing risk issues.
Trust E (CS)	The waiting list is a transfer list for cases moving from family support services to looked after children's services. There is a triage system in place at present to 'colour' the family in terms of their complexities. Transfer protocol in place / operation
	R.A.G rated CP & LAC prioritised
	Regular review of waiting list, continuous thresholding when new information received, review of level risk completed by SSW.
	- SSW reviews waiting list frequently in line with Practice Guidance - SSW identifies tasks on w/lists for staff to complete - Staff check in on cases they worked on duty and update SSW if tasks need/ or have been completed
	-Management of unallocated cases internal protocol in place -On receipt of referral SSW screens for allocation waiting list or further screening required.

	-Duty SW completes checks to see if other staff involved and informs them of referral -Duty SW completes review of history of involvement and flags areas of concern on WL cases Any subsequent new information received leads to review of threshold of case and prioritization for allocation -SSW and SP's review waiting lists on regular basis and identify tasks to be completed on duty when staff have capacity -SP in Team updates and maintains list of waiting list cases and tasks to be completed -SSW to review unallocated cases on regular basis and reflects this on recording system
	Waiting lists are regularly reviewed and new information analysed in terms of risk and prioritized for assessment when required - reviewed as per practice guidance relating to unallocated cases. Multi-disciplinary checks are ongoing whilst cases remain on the waiting list System checks completed at time of referral of histories reflected Professional knowledge / Learning from Case Management reviews alongside theory forms decision making around the management of risk. Safety Plan / Network meetings can take place to increase safety whilst cases are unallocated
	Weekly SW visiting Supervision with PSW/SSW Kinship Assurance Committee
	Needs led basis = safeguarding & risk
	Case is on the waiting list until it can be allocated - allocations occur on a monthly basis - any issues that arise in the case whilst sitting on the waiting list are usually dealt with by Gateway.
	Priority given to CP / LAC transfers from Gateway - FS case RAG rated. Reviewed regularly by SSW and updated checks information used to prioritise for allocation.
	Regularly reviewed by the SW and in line with the Team caseload and closure or transfer of cases
	If a case is added to the waiting list. The family are notified and advised to contact the Team number for support should they require it before allocation.
	The number of unallocated cases is rag rated based on level of need. These are defined as either a priority level 1, 2 or 3. These parents/ carers will receive regular contact via telephone based on their triaged priority. The outcome of this contact is forwarded to SSW to ascertain level of risk and if family need to be allocated as a result. The children with disability waiting list is also rag rated based on level of need at point of referral. All parents/Carers of the children on that waiting list are aware of the duty phone number should they require SW support. Ongoing phone calls and updates are also sought from those on the waiting list.
	letter to parents, admin staff aware, SSW has oversight and can respond if required, traffic light system to manage risk
	We are 6 bedded home, managed by Residential Panel on monthly basis.

Appendix 2.2. Older People's

How is risk and governance around waiting list protocols managed?	
Trust A (OP)	Manager screens referrals and makes contact with Service user/family The Social Work Manager then categorizes the referral using a red, amber and green traffic light system based on the level of risk and initial assessment of need. These cases are then subsequently allocated accordingly. These unallocated cases are reviewed regularly using the above traffic light system.
	new referrals to the Team are screening by service manager and 2 Team Managers weekly. In between times urgent cases (i.e. palliative) are screened as they come in that day. All cases on the unallocated list (waiting list) are contacted routinely to check if there are any changes in care needs or issues with care etc. and any necessary actions taken to ensure there any risk is mitigated. These cases are also made aware of the waiting list once they are screened, care is sourced if applicable and MHRA applied for. These clients also are advised of the duty social worker/telephone number to enable them to contact the Team in between times if an emergency/need arises. unallocated cases are also rag rated red, amber and green to ensure risky/complex cases are prioritized for allocation and reprioritization takes place every week to update same.
	No SOP in place for the management of unallocated – prioritise those in greatest need and allocate when there's capacity (based on risk). Manager screens referrals, makes contact with service user, and provides duty SW details to enable contact in an emergency situation.
	There is an established rag rating system for all unallocated referrals. The SW Manager screens and triages the referrals on a weekly basis and uses a red, amber and green traffic light system to assess risk and complexity. The manager will contact the referrer or family and carry out an initial assessment to assist with allocation. There is an established SharePoint site with all the relevant information.
	The SWM Band 7 screen and triages all referrals prior to allocation.

	The Community Services Manager screens the referrals The Community Services Manager maintains contact with the referred individuals/Family. Those at greatest risk are allocated for urgent SW response via the Team duty system
	Those with lesser needs are screened into the waiting list Considerations such as family support and capacity around decision making are part of the screening
	referrals are triaged based on priority of need
	waitlists are for medical review only not SW assessment of needs etc (Mental Health)
	Screened out at initial referral. Discussed with MDT on a weekly basis. Urgent referrals seen by duty officer, this operates 9am-5pm Monday to Friday. Care Management is every 3 months or sooner if required. (Mental Health)
	Manager screens referrals at least weekly and Huddles take place weekly to review unallocated cases. (Hospital)
Trust B (OP)	All cases are registered on a shared database for transfer, while they are on this list they remain the responsibility of the referring Named Worker in the Community Team
	SSW reviews allocations weekly/fortnightly to determine critical need. Teams currently on risk register due to rising vacant posts/staffing.
	A letter is sent out to inform service user/carer that they are on a waiting list. Any queries are picked up and dealt with via duty.
Trust C (OP)	Social Work Professional Lead to review cases awaiting allocation. Social Work Professional Lead to escalate the numbers Awaiting Allocation to their ICT Manager when the following occurs: • Urgent/Emergency cases being managed on the waiting list (immediate escalation to the ICT Line Manager and Head of Service as necessary • Number of weeks that Service User is waiting in excess of 5 weeks accessed via Paris report • Number of Cases on a waiting list that exceeds 10% of the Team's overall cases open.

	ICT Social Work Managers will sample 10% of unallocated cases at cyclical professional supervision and record that they have done so
	Reviewed weekly and Locality Manager has overview as does Head of Service (Hospital)
Trust D (OP)	very small waiting lists at times - triaged by senior social worker and rag rated, reviewed daily and allocated in regards to urgency
	community are unable to create waiting lists and must allocate all referrals onto caseloads, no matter the size of caseloads
	Issues with regards safe caseloads have been raised with snr management via the governance report been but no input at this time from snr management re same.
Trust E (OP)	Managed on a weekly basis and monthly governance meeting
	Risk screening to determine P1 - same day response P2- urgent - within 3 working days P3 - routine referral
	Rag rating and referral management criteria applied Risk stratification of cases on a weekly basis by SP's Monthly dashboard Monthly reporting to SPPG

Appendix 3. Have Teams developed caseload weighting models?

Appendix 3.1. Children's Services

Have Teams in this programme of care developed caseload weighting models to manage workload demands and referrals?	
Trust A (CS)	specific to Early Years
Trust B (CS)	Work is on-going for PA led young people for over 18 year olds.
	There is a caseload weighting tool that is to be used during staff supervision however it is not designed to quantify the real quantity of work undertaken by staff.
	There is a case load weighting policy and is completed in individual supervision as per policy
Trust C (CS)	Consideration given to case complexity , i.e. if a looked after child case or court involvement Geographical distance also considered
	caseload weighing has been previously implemented however this has taken a standstill due to staffing issues and resources and Teams having to take a generic approach in priorities i.e. cp and lac cases.
	No case load weighting is not being used in supervision
	The Team engaged in a 6 month trial for a caseload weighting model last year but nothing further has come of this
	Currently a pilot scheme has been introduced in a couple of Teams. Previous caseload weighting models have been used
	A new model is being developed but not yet in practice
	there was one system in place but it was difficult to use and not always appropriate. Another format was being piloted by a Team but I am unsure what the outcome was
	Discussed during supervision to establish if SW have capacity to accept more cases
	if staffing levels permit, case load weighting is implemented
	cw exists within the Programme of care
	SSW does caseload weighting with SW's at supervision and this informs case allocation.
	Yes - dependent on complexity /travel and no of children per family
	A basic tool that looks at approximating how many hours each case required per week (taking account of travel, direct work, recording and meetings) and a calculation to ensure that the total number of hours required does not exceed the total number of hours available. We are working on rolling it out to the Team.
Trust D (CS)	Yes a regional model for Early Years work was developed.
Trust E (CS)	Across the service there is a caseload weighting model however it is not being used fully given current demands, pressures and the implementation of the BCP
	There has been a caseload weighting model developed, however this has been stood down at this time

Appendix 3.2. Older People's

Have Teams in this programme of care developed caseload weighting models to manage workload demands and referrals?	
Trust A (OP)	PCOP caseload weighting model 123
	yes - but it needs updated to reflect the ongoing changes re: case complexity etc. as a result of new statutory requirements resulting from work such as MCA etc.
	Caseload weighting model used within social work Team however this is largely a manual exercise therefore not 'live' to provide an accurate caseload weighting on a daily basis. It's too time consuming to work caseload weighting manually however hopeful that encompass will resolve this element/challenge.
	There is a developed Case Load weighting tool for PCOP based on a 1,2,3 grading system of complexity. This exercise is carried out on a monthly basis. This model assists the SW Manager in the allocation role and in ensuring governance around staff caseload numbers. this also assist with the regular cleansing of caseloads. It is also a transparent tool that all staff can see and is used to ensure fairness and equity across the Team surrounding the allocation of daily work.
	This is a 1,2,3 PCOP caseload weighting model which is used monthly alongside supervision to assist with the allocation and management of risk within the Team.
	Use of the traffic light system to determine level of need/risk/intervention
	yes-caseload weighing tool used at supervision
	This Team is a specialised service that supports clients with complex mental health needs. Where the risks are significant and requires specialised input from mental health services. (Mental Health)
	I closely monitor 2-3 times a week case and review an excel spreadsheet of caseloads. This changes on a daily basis and review cases due to complexities. This is a challenge as the work is fast paced. (Hospital)
	No but researching tools currently (Mental Health)
Trust B (OP)	Caseload weighting tool utilized. Focuses solely on number of active cases at any given time within an entire caseload. Intervention is determined not only on complexity but consideration of priority, level of urgency, statutory obligations and assess risk levels.
	Active cases are categorised under High/Medium/Low. Consensus that 15-21 active cases is a manageable workload with a combination of High/Medium/Low. Cases don't remain active and categorisation changes regularly depending on activity.
Trust C (OP)	Caseload weighting tool based on point allocation for complexity/risk /frequency of contact with client and family/carer. However this hasn't been rolled out to this Team yet.
	It is only being rolled out within the next 4 weeks as part of review of memory services
Trust D (OP)	Cases are categorized according to level of risk and demand on social workers time. Caseload weighting tool is in situ for each staff member and used in supervision to weight caseload effectively and by managers regarding referrals into the Team. Alongside this an annual review register is in situ.

	This is worked by 2 WTE staffing these are assistant care managers. The cases on the register require minimal intervention and service users avail of two monitoring calls per year and one annual review. There is criteria in situ if the case demands further intervention the case will move back to the core Team for same.
	Annual review only caseload established and moved to separate locality wide caseload. Caseloads measured using 1, 2, 3 score in remaining caseload.
	Case Load weighting model and Annual review register in situ within the ___ Community Social care Team is being spread to the ___Community Social Care Teams
	there is a case load weighting model in place, for monitoring case priorities and risks
	other Teams in ____ and ____ have what they call as a caseload weighting but this has not been applied within my Team as it is not a useful tool and does not support managing the workload demand/referrals, does not promote a person centred approach & does not promote good SW practice
Trust E (OP)	Standard Operating Procedures - Referral Management Process: • An emergency referral (P1) for assessment will start on the same day as receipt of referral. • An urgent referral (P2) - assessment will commence within three days. • A routine referral (P3) - assessment will start within four weeks. RAG rating - Red Amber Green - risk stratification tool in place Review of waiting list weekly Monthly reporting to SPPG re: unallocated and vacant caseloads Case audit as part of supervision and regular review of RAG rating on individual caseloads
	Standard Operating Procedures - Referral Management Process: • An emergency referral (P1) for assessment will start on the same day as receipt of referral. • An urgent referral (P2) - assessment will commence within three days. • A routine referral (P3) - assessment will start within four weeks. RAG rating - Red Amber Green - risk stratification tool in place Review of waiting list weekly Monthly reporting to SPPG re: unallocated and vacant caseloads Case audit as part of supervision and regular review of RAG rating on individual caseloads

Appendix 4: Funded Establishment Quotes

Appendix 4.1. Children's Services

Does the total number of social workers (across all bands) and social work assistants PLUS vacancies in the Team correspond with the number of funded positions?	
Trust A (CS)	No the Team are funded for 4 Band 6, 1 Band 4 and 1 Band 7
	Funded for one band 7 social work manager. Funded for two band 6 shift lead social work posts. Currently have one band 7 assistant manager temporarily.
	No funding is not sufficient for the current qualification as previous funding still sitting for band 5 posts however these are no longer available in this role
	Service was set up unfunded.
Trust B (CS)	No there are 3 band 5 AYE Social Workers within the Team
	No, I have 2 AYE Band 5 SW and 2 SWA posts all of which are filled. I have 4 SW posts in total, 3 are filled and 1 is vacant. This is a temporary vacancy.
	No - Unfilled 3 posts
	yes - 2 x going through employment checks
	NO -one Agency worker to help with pressures in the Team
Trust C (CS)	No - Team functions with 3 senior practitioners and 2.5 sw's, x2 social work assistants. funded posts + 7 sw staff plus Team leader
	We are also funded a 3rd SWA however they are not in post - out for recruitment
	No additional social staff to meet children's needs
	no extra sw to cover temporary position
	There is one social worker on career break and attempts were made to recruit to the post but someone turned it down which delayed filling the post
Trust D (CS)	No, one staff member reduced working times due to health, other part of the post not filled due to processes being followed.
Trust E (CS)	Yes -not counting Senior Social Worker -please note that the Team leader / senior social work is counted in overall staff count as this person doesn't carry a caseload... - I is off on long term sickness though and 1 SP is covering her role as role as carrying some cases.

Appendix 4.2. Older People's

Does the total number of social workers (across all bands) and social work assistants PLUS vacancies in the Team correspond with the number of funded positions?	
Trust A (OP)	Our funded establishment in _____PCOP IS 3.5 Social Workers and there was 4 Band 6 Social Workers in the Team. There was still a 0.5 WTE Social Work post vacant in February 2023.
	Yes - swa funding converted to social work resource (included in the above figures)
	NO Three of the band 6 social work posts are unfunded posts.
	3.5 WTE over funded establishment
	Our funded establishment in ____ is 5.5 Social Workers and 2 Social Work Assistants. Currently in post there are 7 social workers and 2 Social Work Assistants
	No - overfunded 1 Band 6 and 0.4 of a SWA
	1 unfunded post within this, filled by agency SW
	Funded for 4 social workers and 2 senior social workers.
	Currently have - 2 band 6 social workers, 1 band 7 SSW, 1 band 7 Acting SSW (due to maternity leave) (Mental Health)
	Awaiting new Social Work posts created to be funded (Hospital)
Trust C (OP)	Total number is slightly above the number of funded positions by 0.16 WTE
	No - review of memory services being rolled out to the Team and funded positions being reviewed - currently total number is above funded positions
Trust D (OP)	No, we currently have a band 6 nurse/ keyworker also in the Team.
	Yes - however still not enough to cover the current workload and pressures

Appendix 5: Safe Staffing Event Presentations

Social Work Safe Staffing Event, with International Experts (FLYER)

Friday 26th May, The Great Hall, Magee Campus, Ulster University,
Derry-Londonderry, 9.30 am – 4.00 pm

Who is this for?

Older People, Children's Services and Mental Health Safe Staffing in Social Work steering group members and their nominated team representatives to showcase innovative models of managing referral and service demands, whilst keeping staff and service users safe.

Who is running the event?

This is a partnership event between The Department of Health, Office of Social Services, HSC Trusts, Ulster University and Queens University Belfast. The event is funded by Ulster University.

Keynote Speakers

Professor Timo Harrikari (Finnish Institute for Health and Welfare THL)

Professor Timo Harrikari is a social scientist and currently employed as a full research professor of social work at the Finnish Institute for Health and Welfare THL, Finland. In recent years, he has worked in equivalent positions at the Universities of Helsinki, Tampere and Lapland. Harrikari holds Reader positions not only in social work (University of Helsinki and Lapland) but also social policy (University of Jyväskylä) and childhood and youth studies (Tampere University) as well as sociology of law and criminology (University of Turku).
For 25 years, Harrikari's research has focused on social work, especially the questions of child welfare, juvenile crime, and probation. He has recently focused the scope of research more on social work as a societal phenomenon and at the very latest phase, disaster social work.
Harrikari's latest international contributions are *Social Work and Social Change* (ed., Routledge 2014), *Towards Glocal Social Work in the Era of Compressed Modernity* (with Pirkko-Liisa Rauhala, Routledge 2019) and Social Work during COVID-19: *Glocal Perspectives and Implications for the Future of Social Work* (ed., Routledge 2023). In addition, Harrikari has published numerous peer reviewed articles in high-standard scientific journals and edited volumes.

Dr Austin Griffiths, Assistant Professor in the Department of Social Work, University of Western Kentucky

 Dr Austin Griffiths has 16 years of combined professional practice experience in both child and adult protective services and in facilitating applied research. He is the Director of Western Kentucky University's Life Skills Centre for Child Welfare Education and Research and is an Assistant Professor in the Department of Social Work. Dr Griffiths actively serves as a consultant with the Centre for States and Collaborative Analytics & Solutions, LLC. He is currently the Principal Investigator on a Medicaid funded project entitled the Kentucky Child Welfare Workforce Wellness Initiative and the co-author of the textbook *Child Welfare and Child Protection: An Introduction.* Dr. Griffiths is passionate about improving the lives of families and children. Most of his research is focused on improving the lives of the professionals who work with vulnerable populations by enhancing their health, wellness, and work life balance.

Presentations at Social Work Safe Staffing Event, with International Experts, Friday 26th May 2023, Magee Campus, Ulster University

Title	Presenters	Organisation	Contact
The Finnish Experience of Safe Staffing in Social Work	Professor Timo Harrikari	University of Helsinki	Timo.Harrikari@ulapland.fi
State Specific Models of Safe Staffing in Social Work	Dr Austin Griffiths	University of Western Kentucky	austin.griffiths@wku.edu
Tusla's Experience of applying their National Policy and Toolkit for Social Work Caseload Management	Sinead Murtagh	Tusla	Sinead.murtagh@tusla.ie
Caseload Management Model: Foyle Trust Caseload Weighting 2003 Is it working? Is it still relevant?	Stephen McLaughlin	Western Health and Social Care Trust	Stephen.McLaughlin@westernrntrust.hscni.net
Belfast HSCT approaches to manage demand and capacity in frontline social work Teams via business continuity and skill mix	Lisa Hine	Belfast Health and Social Care Trust	Lisa.hine@belfasttrust.hscni.net
Caseload Weighting and Referral Management for Older People's Social Work in the Western HSCT	Vanessa Hegarty and Joanne McBride	Western Health and Social Care Trust	Vanessa.hegarty@westerntrust.hscni.net Joanne.mcbride@westerntrust.hscni.net
Model of case load weighting in mental health services in the SE Trust	Yvonne Russell-Coyles and Tracey McVeigh	South Eastern Health and Social Care Trust	Yvonne.Russell-Coyles@setrust.hscni.net

			Tracey.mcveigh@setrust.hscni.net
Quality investment for quality services - workforce planning and safe staffing in mental health social work	Kerry Cuskelly -	Mental Health Social Work, HSE Dublin	Kerry.cuskelly@gmail.com
Effective management of information/unallocated work using RAG rating and **Collaborative Unallocated Process (CUP) - pilot in the Belfast HSCT.** The Service User Database (SUD) is a record of overall service users on the database that are RAG rated – the CUP is for those new and on unallocated caseloads.	Pam Borland Current contacts about the model are below; Grace Reihill Janine Gordon	Belfast Health and Social Care Trust	Pam.borland@belfasttrust.hscni.net grace.reihill@belfasttrust.hscni.net janine.gordon@belfasttrust.hscni.
Managing cases in older people's social work – the experience in Donegal	Seamus McGarvey	HSE Donegal	Seamus.McGarvey@hse.ie
Northern HSCT approaches to manage demand and capacity in frontline social work Teams: an unallocated caseload assurance framework and reducing bureaucracy initiatives	Johnny Dillon and Sharon Campbell	Northern Health and Social Care Trust	Jonathan.dillon@norhterntrust.hscni.net Sharon.campbell@northerntrust.hscni.net
Safer and Transparent (SaT) Caseloads in the SHSCT	Charlene McGuigan & Alana Carr	Southern Health and Social Care Trust	Charlene.McGuigan@southerntrust.hscni.net Alana.carr@southerntrust.hscni.net

The management of unallocated cases: timely access to safer care in SHSCT	Paul Murtagh	Southern Health and Social Care Trust	Paul.murtagh@southerntrust.hscni.net

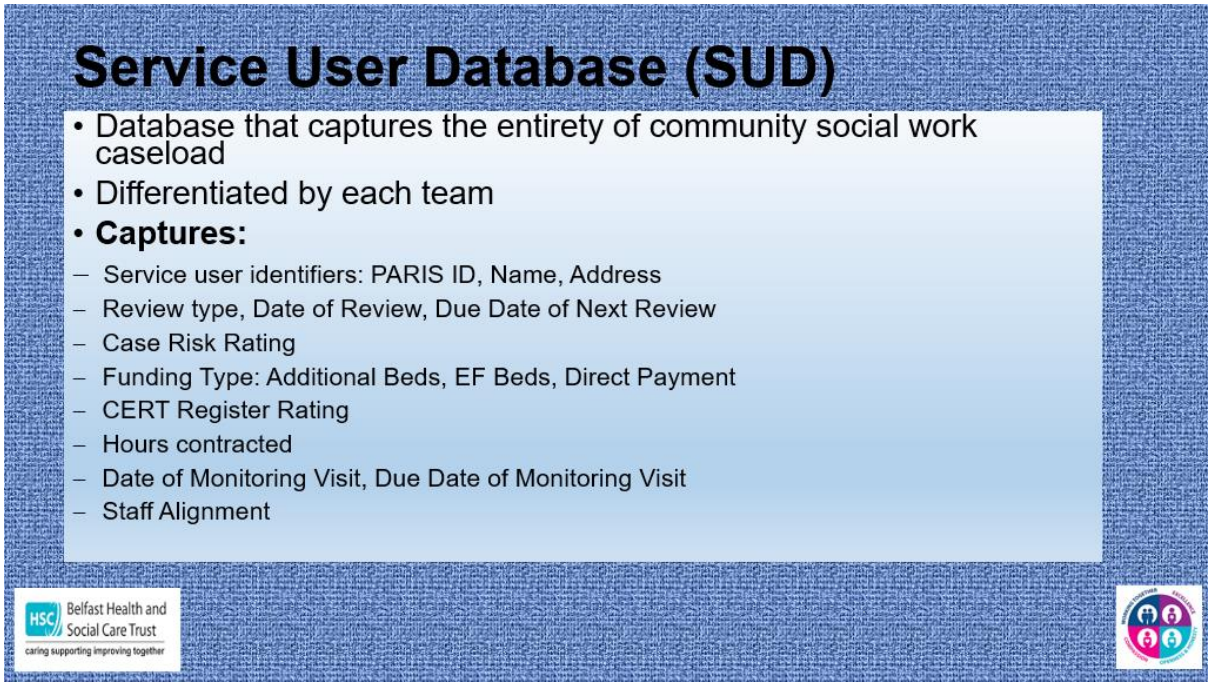
Appendix 6: Calculating Annual Hours Using Workload Capacity Framework

CALCULATING ANNUAL HOURS USING WORKLOAD CAPACITY FRAMEWORK (McFadden et al 2023)

An analysis of hours a Whole Time Equivalent (WTE) has in a working year was calculated. The hours are calculated according to 37.5 hours WTE per working week.	
Hours Available	Total Hours Remaining for Casework
37.5 hours x 52 weeks	1950 hours
Minus Annual Leave average 30 days or 225 hours)	1725 hours
Minus 10 Statutory Days 75 hours	1715 hours
Minus Office Duty – estimated at 30 days per year or 225 hours	1490 hours
Minus Mandatory NI SCC Training Days x 5 days or 37.5 hours	1452.5 hours
Minus Professional Meetings* – Averaged at 6 hours monthly over 10 months – 60 hours	1392.5 hours
Minus Supervision – 1.5 hours per month for 10 months or 15 hours	1377.5 hours
Total number of annual hours available for casework	**1377.5 hours or 193 annual days**

**Professional meetings such as Team meetings or other non-casework related meetings.*

Appendix 7a Service User Database (SUD)



Safer and Transparent Caseloads in the SHSCT

(Older People's Services)

Ruth McKee, Alana Carr and Charlene McGuigan
Integrated Care Teams
2023

Southern Health and Social Care Trust
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