OVERSIGHT, ACCOUNTABILITY AND REPORTING

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BC Children and Youth Review

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A. INTRODUCTION

Purpose of Report

The purpose of this report is to provide an overview of the system of oversight, performance management and accountability, including public reporting, for government's child and youth protection programs and services. The report has been prepared as background to the BC Children and Youth Review (the Review) and is intended to provide information on the extent of the system and the type and effectiveness of monitoring, measuring and reporting on performance. This includes consideration of both the internal systems and processes within the Ministry for Children and Families for measuring, assessing and improving its own performance, as well as external agencies and others involved in or concerned with the overall child and youth protection regime in the province.

Separate reports are being prepared on data collection, management and reporting systems within the Ministry and on Child Death Reviews, including the internal process for undertaking Director's Case Reviews and Deputy Director's Reviews of deaths or critical injuries or child and youth in care of the Ministry or known to the Ministry. This report briefly discusses data collection and reporting in the context of performance management, and case reviews as part of the overview of quality assurance, but does not cover these topics in detail. This paper does not address the issue of disputes resolution or complaints as it is understood that a separate paper is being prepared on that topic.

Methodology

The Report was developed on the basis of a review of available written materials and documentation. Information and documentation was made available through the Review Office and was collected from the following individuals:

- Lenora Angel, Assistant Deputy Minister, Aboriginal and Transition Services Division
- Sara Bristow, Acting Manager, Accreditation
- Cory Heavener, Director, Child and Family Development, Divisional Operations
- Kim Henderson, Assistant Deputy Minister, Strategic Planning and Business Intelligence Division
- Arn van Iersel, Associate Deputy Minister, Regionalization and Strategic Projects and EFO
- Donna Knox, Regional Executive Director, Vancouver Coastal Region
- John Mazure, Director, Decision Support and Economic Analysis
- Marilyn Shinto, Manger, Accountability and Performance Improvement

- Mark Sieben, Acting Director, Child and Family Development, Regional Operations

No consultations or interviews were conducted with Ministry officials to confirm the accuracy of the background information contained in the report, or discuss the assessment of the current system, the conclusions or the development of possible options for change contained in the proposals for consideration section. Any errors in detail are the responsibility of the authors; the conclusions and suggestions for improvement represent the views of the authors only.

B. OVERSIGHT, MEASUREMENT & ACCOUNTABILITY

Overview

The oversight, accountability and performance management framework for child protection services and programs in British Columbia contain a number of separate but related components that taken together are designed to provide a comprehensive regime for monitoring, assessing, modifying and reporting on the performance of government services and programs for child and youth protection in the province. The components of the system include independent oversight by an external agency, a mandated performance measurement framework, an internal quality assurance framework and public reporting.

An overview of each of these components of the system, organized according to the pre-Gove Years (1986 to 1995), post-Gove years (1996 to Spring 2002), and post-Core Services Review implementation years (Summer 2002 to present) is provided, followed by a brief assessment of their current status and effectiveness.

Oversight by External Agencies

What is Oversight?

Oversight, defined as "watchful care, superintendence, or general supervision" is often established to ensure that an entity performs its assigned duties and responsibilities and that they are properly and appropriately performed.

The argument for oversight of government child and youth protection services is that it is needed in the public interest and to ensure public confidence in the system. Over the years the extent and level of oversight, or external monitoring of the system, has varied from a system of little or no independent oversight to a system of oversight involving multiple external agencies.

Pre-Gove (1986 to 1995)

Until 1995, and the passage of child youth and advocacy legislation and the introduction of the comprehensive independent oversight regime established in accordance with the recommendations of the 1995 Gove Inquiry into Child

Protection in British Columbia (Gove Inquiry)[1], there was no formal system of independent oversight for child and youth protection in the province. The only formal review processes were internal and directed at child deaths or critical incidents, and, at that time, were unevenly applied (discussed further in the section on Quality Assurance). Some would argue that the independence of the Superintendent's office was specifically intended to provide a check and balance to the regional delivery of child and youth protection services and overall oversight to the performance of child and youth protection services.

As part of a broad review and development of new child protection legislation in the early 1990s[2], the province passed the *Child, Youth and Family Advocacy Act* in 1995. The role of the Child, Youth and Family Advocate was to ensure that the rights and interests of children and youth are protected, ensure that child and youth have access to fair, responsive and appropriate complaint processes, inform and advise government and communities about services to children and youth, and promote and coordinate the establishment of children's and youth's advocacy services. Joyce Preston was appointed the first Child and Youth Advocate in the summer of 1995.

The BC Coroners' Service was responsible for investigating deaths reported to the Coroner (not all deaths are required to be reported to the Coroner, and in 1993, of the 535 children under 19 years of age that died in British Columbia, the Coroner examined 312 of these). The Coroner's Office investigates a death in a manner considered appropriate to the circumstances. In only one percent of these cases did that result in an inquest; the remainder of the investigations resulted in a "judgment of inquiry" – a short report setting out, among other things, cause of death (Report of Gove Inquiry, Volume II, page 136). As well, the Division of Vital Statistics recorded all child deaths in the province according to a classification of diseases.

The Gove Inquiry concluded that both the Coroners' Service and Division of Vital Statistics could be valuable sources of information, but that "another approach is needed for the review of children's deaths and serious injuries" and that "the public needs assurance that every critical incident will be reviewed and, when appropriate, that corrective action will be taken." The report of the Gove Inquiry recommended the establishment of a single province-wide system for receiving reports and investigating child deaths and serious injuries and that the review should be done independently from the organization that delivers, manages and funds child welfare programs. The report recommended the creation of a legislatively mandated body

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[1] The Gove Inquiry undertaken between May 1994 and November 1995, lead by Judge Thomas Gove, into the death of Matthew Vaudreuil, lead to 118 recommendations for change to BC's "child serving system".

[2] In 1996, a new *Child, Family and Community Services Act* was passed replacing the *Family Services Act*.

to be called the Children's Commissioner to take on this function (Gove Inquiry, page 140). The Gove Inquiry recommended that the Children's Commissioner, as an independent authority, also be made responsible for undertaking an automatic review of every continuing care order every 12 months and, if the Children's Commissioner concluded, after consultation with a district office that the continuing care order should be cancelled or varied, the Commissioner would refer the case to the Provincial Court.

The Gove Inquiry also recommended changes to the roles and responsibilities of the recently established Child, Youth and Family Advocate to strengthen the mandate of the Office of the Advocate and provide a stronger oversight role in protecting and promoting the rights and interests of the children and youth. The specific changes recommended by Gove included that the legislation be strengthened by providing that the Advocate only advocate on behalf of families when such advocacy is consistent with and promotes the interests of that family's children; that the Advocate's mandate encompasses all child related services provided or funded by the province; and that the Advocate have explicit authority to appoint legal counsel to represent children and youth, individually or collectively, in appropriate circumstances (Gove Inquiry, page 114).[3]

Post Gove (1996 to Spring 2002)

The Gove Report was adopted by the government, including the recommendation to appoint a Transition Commissioner for Child and Youth Services to oversee the design and implementation of a new system for delivering service to children and youth. This was intended to be a three year transition process but, in September 1996, the Transition Commissioner, Cynthia Morton, issued a report to then Premier Glen Clark recommending immediate and fundamental change including the immediate establishment of the Children's Commissioner; the separation of the "child, youth and family serving responsibilities" from the Ministry of Social Services and the transfer of these duties to a new Ministry for Children, Youth and Families and the termination of the work of the Transition Commission with the new Ministry taking on full responsibility for implementing the remaining recommendations of the Gove Inquiry report. The Premier accepted these recommendations for action and in September 1996, the Ministry for Children and Families[4] was created and the government appointed Cynthia Morton the first Children's Commissioner. In July 1997, the *Children's Commission Act* was proclaimed with the Children's Commissioner reporting to the Attorney General.

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[3] At the time the *Child, Youth and Family Advocacy Act* was repealed in 2002, following the decisions of the Core Services Review (See "Post Core Review Implementation" section), these recommendations were still under consideration.

[4] In 2001, the Ministry was renamed as the Ministry for Child and Family Development, as part of the government reorganization under the new administration.

The Children's Commission was responsible for:

- ♣ Providing oversight and monitoring of the Ministry through review of data arising from complaints, critical injuries and child fatality reviews undertaken by the Ministry and other agencies; conducting further investigations, at the initiative of the Commission, into concerns arising from the data and files; tracking compliance of the Ministry with recommendations made by the Commission; conducting special investigations for the Attorney General or Minister of Children and Families; informing the public about the state of the province's child and family serving system, including public reporting annually or as deemed necessary; and facilitating child focused research;

- ♣ Investigating complaints and conducting panel hearings of complaints about breaches of rights of children in care and provision of services for a child by the Ministry[5]; informally resolving complaints against the Ministry and recommending policy changes; and monitoring adherence to standards set by the Commission for internal complaints resolution;

- ♣ Investigating critical injuries of children and youth in care, investigating unexpected deaths of children and youth in care or who received the services of the Ministry; reviewing the circumstances of deaths of all children in BC; and inquiring into the adequacy of government and medical services provided to children who died.

In addition to the Children's Commission, and the Child, Youth and Family Advocate, several other agencies had within their mandate some degree of oversight role or relationship to the provision of child protection services or programs in British Columbia:

- ♣ The Coroner's Service which continued to have responsibility for investigating deaths reported to the Coroner, including deaths of children in care, or known to the Ministry;

- ♣ Vital Statistics which continued to record all deaths of children according to classification of disease and provide reports to the Ministry and the Children's Commission;

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[5] In 1997, with the passage of the *Children's Commission Act*, the *Child, Family and Community Service Act* was amended to dissolve the Child and Family Review Board, a formal complaints and review board within the Ministry, and transfer responsibility for investigating complaints of alleged breaches of rights of children and youth in care and provision of services by or through the Ministry to the Children's Commission (section 70).

- ♣ The Public Guardian and Trustee which, as guardian of the estate of a child in care, has the power to undertake investigations when informed of the critical injury of a child, to determine whether legal action is warranted;

- ♣ the Ombudsman which continued to have responsibility for handling complaints from children and youth in care and children and youth who receive services from the Ministry and from family members;

- ♣ the Provincial Health Officer, who as the senior medical health officer in the province, has responsibility for, among other matters, reporting to British Columbians on the health of the population and other health issues and recommending actions to improve health and wellness (a May 2001 report issued by the Office was specific to the *Health Status of Children and Youth in Care – What do the Mortality Data Show*?);

- ♣ the Auditor General which is responsible for auditing and making impartial assessments of public sector accountability and performance to the Legislative Assembly (it is understood that the last comprehensive report of the Auditor General on the operations of the Ministry of Children and Family Development, and its predecessors, was a 1992 value for money audit of the Ministry of Social Services involving an assessment of its income assistance programs, management of contracted residential services for children in care and the mentally handicapped and the Ministry human resource management processes for its social workers).

In 1998, the Ombudsman released a report, "Getting There", on the status of the implementation of the Gove Inquiry recommendations. The government used this opportunity to sign off on the completion of the Gove Inquiry implementation ("Timeline of MCFD Quality Assurance Policies and Practices", November 18, 2005, Confidential).

Throughout the period from 1996 to June 2002, the Children's Commission and the Child, Youth and Family Advocate released annual reports and several special reports. The recommendations from the Children's Commission reports, combined with the recommendations from the Chief Coroner, the Ombudsman and the internal Ministry reviews, resulted in 1900 recommendations for action over this period of time.

Post Core Review Implementation (Summer 2002 to present)

The current system of oversight is based on the results of the December 2001, Core Services review, "Report of Core Services Review of the Children's Commission and Overlapping Services Provided by the Child and Youth Advocate, the Ombudsman, and Coroner and the Ministry" (Core Services Review). The Core Services Review considered each of the four core functions undertaken by the Children's Commission and determined that there was overlap and duplication of services as all these functions were undertaken, to some extent, by one or more other agencies. Starting from a clean slate, the Core Service Review report made

specific recommendations on the streamlining and rationalization of the functions of: oversight or monitoring of the Ministry of Children and Family Development; advocating for system change; handling individual complaints about the Ministry; and reviewing child fatalities.

With respect to *oversight or monitoring* of the Ministry of Child and Family Development and *advocating for system change*, the Core Services Review report concluded that "having two specialized children's officers is neither efficient nor effective" and recommended the creation of "one children's officer [to] assist government in effectively carrying out its responsibility to children whose families do not have the capacity, in whole or in part, to look after them without government support or intervention. In general terms, the task of this children's officer will be to provide an informed and independent focus on government's child welfare policy" (Core Services Review, page i). The report concluded that an agency such as a children's officer was required at that time (2002) because the public's need for reassurance about how the child welfare system is functioning was particularly high as a result of the major restructuring of the Ministry in order to devolve authority to regions and communities, and in the face of significant spending cuts within the Ministry. The report recommended, however, the inclusion of a statutory review provision in the legislation as to the continuing need of for a children's officer "because the child welfare system may look very different within a few years" (Core Service Review, page 51). The report envisioned the monitoring function of the children's officer being fulfilled in various ways, including review of the reports generated as part of the Ministry's internal monitoring, reports of the Ombudsman on investigations into complaints against the Ministry, reports of the Public Guardian and Trustee on critical injuries of children in care and Coroner's Service child fatality reports.

With respect to the *complaints function*, the report concluded that the current model of an internal informal complaints process, an internal formal complaints process, an external complaints review process through the Children's Commission and the overriding review authority of the Ombudsman was not the most effective or efficient way to handle complaints about the Ministry. The report recommended the elimination of the current external complaints review process through the Children's Commission and that the Ombudsman process be the only external complaints process. It also recommended enhancements to the internal informal and formal complaints process in the Ministry designed to "improve, rather than undermine, the ongoing relationship between the front line workers and the children and families involved". Further, as concerns advocacy as part of the complaints process, the Core Service Review recommended that the new children's officer would not, for the most part, provide individual advocacy services to children and families, but would have an important role in "removing barriers to children advocating for themselves and family and interested community members advocating on behalf of children. The children's officer's goal will be to ensure that in the child welfare system, the child's perspective is always considered and the child's interests are the focus of the decision-making process" (Core Services Review, page ii).

Finally, with respect to the *review of child fatalities and critical injuries*, the Core Services Review report recommended the discontinuation of child fatality reviews for children in care and children known to the Ministry by a separate agency such as the Children's Commission and the expansion of the role of the Coroner's Service to take on the function of child death review investigations through a Multidisciplinary team including representation from the Coroner's Service, the Ministry of Children and Family Development, the police, and possibly paediatric pathologists and medical experts in child abuse. The work of the Children's Commission in developing a database regarding child fatalities would be continued through a joint effort of the Vital Statistics Agency and Chief Coroner's Office. The investigation of critical incidents regarding children in care or known to the Ministry would be undertaken by the Ministry and, partly, by the Public Guardian and Trustee.

The recommendations of the Core Service Review were adopted. In May 2002 the *Office of the Children and Youth Act* was proclaimed, and the *Child, Youth and Family Advocacy Act* and *Children's Commission Act* were repealed and both agencies dissolved. In September 2002, the Office of Children and Youth became operational and in May 2003, Jane Morley was appointed the first Child and Youth Officer. Under the *Office of the Children and Youth Act*, the Child and Youth Officer's job is to: support - by working collaboratively with children, youth, families, communities, and governments to improve access to relevant government services; observe - by asking questions and gathering information and perspectives on the effectiveness, responsiveness and relevance of services; and advise - by building on what has been learned and by sharing ideas for improvement with communities, governments and the public ("What We Do – Child and Youth Officer's Mandate", www.gov.bc.ca/cyo/).

Legislation was also passed making the Coroner's Service responsible for the tracking of child deaths, including a public reporting component, the establishment and maintenance of a Child Death Review Team and the maintenance of a database for all child deaths ("BC Coroner Service Child Death Review Overview", December 2004). The Child Death Review program, Coroners Service, has released one special public report on child deaths, "Infant Deaths 2003-2004". It is a general report on the deaths of all children under the age of one year between January 1, 2003 and June 30, 2004. The Coroner's Service continues to provide annual statistics on child and youth deaths categorized by age, classification (accident, homicide, natural, non coroner's, suicide or undetermined), gender and month (BC Coroners Service, Child and Youth Deaths, 1997 to 2004).

The roles of the Vital Statistics Agency, the Public Guardian and Trustee, the Ombudsman, the Public Health Officer and the Auditor General were unchanged.

In March 2005, the Ministry provided a copy of all case reviews undertaken since April 1, 2003 and all practice audits undertaken since April 1, 2004, to the Office of the Child and Youth Officer, and the Coroner's Service received a copy of all case reviews. A new process was established to ensure that all case reviews and

practice audits were provided to the Office of the Child and Youth Officer, and all case reviews to the Coroner's Service within one week of completion.

Concluding Thoughts

The system of oversight of government child and youth protection programs moved from what could be characterized as a system of general, unspecified oversight in the pre-Gove Inquiry years to a very comprehensive, defined and rigorous system between the years of 1996 and Spring of 2002. Many would say that the pendulum has swung back. The general public reaction to the Sherry Charlie tragedy and the revelation that 706 child death reviews for the years 2002 through 2004 were not completed by the Coroner's Service was that the existing system was not operating effectively and that there was a need to return to greater oversight and increased public accountability for the Ministry and child and youth protection programs to ensure the safety of children and youth in care of government. Several key stakeholders including past Children's Commissioners and Child, Youth and Family Advocates and the British Columbia Association of Social Workers have made representations to this effect and called for the re-establishment of a stand alone independent oversight body, or even the return of the Children's Commission.

There is a balance to be struck in establishing an appropriate and effective system of oversight and public accountability that must consider issues of cost, timeliness, impact on service provision and public confidence. It is not clear that any of the three systems (pre-Gove, post-Gove or post-Core Review) achieved that balance.

The key to achieving an effective and long-lasting balance is to clearly articulate the objective of independent oversight and then consider how that objective is not, or could not be provided through the current system and what changes or enhancements are needed. There does not appear to be a clear and concise statement of objective for the oversight function relating to any of the three periods.

Performance Measurement

Performance management is a cycle involving:

- ♣ setting out a plan of what an organization intends to achieve and what resources will be required to meet the organization's goals;
- ♣ delivering the services, programs or activities designed to achieve the goals of the organization;
- ♣ knowing what success or achievement of the goals will look like and monitoring performance and collecting information to assess progress; and
- ♣ reporting on the degree of achievement, comparing actual achievement against the initial plan and making appropriate adjustments to the strategies, programs and services based on the information to better meet the goals of the organization.

Performance measurement is a critical component of the performance management cycle. Performance measurement involves determining: what to measure (what success will look like); how to measure it (what information to collect); and how to report it (reporting actual achievement against planned achievement). [Appendix One contains additional information on performance management and accountability.]

In 2000, the new Liberal government established the basis of a performance management and accountability framework for BC government ministries and organizations. The *Budget Transparency and Accountability Act* (BTAA), passed in 2000 and amended in 2001, requires ministries and government organizations to produce on an annual basis, three-year rolling service plans outlining the organization's vision, goals and objectives and intended outcomes. Achievement of the Service Plan outcomes are monitored through tracking of identified performance measures and targets reported publicly on a yearly basis through standardized Annual Service Plan reports. The Minister responsible for the Ministry or organization is required to sign an "Accountability Statement" attesting to the fact that the Minister is accountable for the basis on which the Service Plan was prepared. The Act establishes that Service Plans must be made public with the government's annual budget information in February of each year and that Annual Service Plan reports must be made public in June of each year.

The purpose of the standardized Service Plan and Annual Service Plan report requirements are to inform the public about each Ministry's goals and overall direction – what it intends to accomplish and the strategies and actions for achieving its goals and objectives - and to report publicly on the achievement of these goals and objectives or how well the Ministry is performing in terms of meeting its stated goals. Performance measures "must demonstrate the ministry's effectiveness and level of service delivery with respect to goals, objectives and strategies. Ministries are encouraged to develop outcome or results measures as much as possible. A good performance measure: enables the ministry and the public to form accurate judgments regarding the ministry's success in achieving intended results; is useful in making decisions about future actions; is consistent from one planning period to the next". ("Guidelines for Ministry 2006/07 to 2008/09 Service Plans" – October 2005.)

Performance management can, and should, be applied not just at the broad ministry/public accountability level but also down through the organization. It is understood that there is an expectation that each ministry will develop specific business or operational plans at divisional and branch levels, consistent with the overall ministry service plan, but with specific objectives, strategies and measures to provide information on how efficiently and effectively programs and services

are operating. Ideally, there should even be a link to individual employee performance plans[6].

Pre-Gove (1986 to 1995) and Post-Gove (1996 to Spring 2002)

Prior to 2001 and the introduction of a standardized and formalized performance management framework for government, performance measurement within the Ministry of Children and Family Development (and its predecessors, Ministry of Children and Families and Ministry of Social Services), similar to other ministries, was attempted on an sporadic, non standardized and ad hoc basis. It is understood that predecessors to the Ministry prepared annual reports on their operations. However, these reports were not produced on a timely or regular basis and lacked the rigor of explicit goals and outcomes and ongoing performance measurement.

In 1997, the Ministry released the first edition of a report titled, *Measuring Success: A Report on Family Outcomes in British Columbia*. A second edition of the *Measuring Success* report was published in 1999 and a third in 2002 (with a May 2003 addendum which added early childhood development indicators). The report provides an overview of over 100 indicators of health and well being measures for children, youth and families in British Columbia. The measures include all children, not just those in care or clients of the Ministry. The report is intended to provide an extensive and comprehensive monitoring of outcomes and indicators to allow "the Ministry to assess the extent to which its programs, services and strategic approaches are making a difference at the provincial population level" (*Measuring Success* report). Despite the indication that the report is to be released annually, there has not been a report since the January 2002 edition (with May 2003 addendum). Ministry officials have indicated that it is not possible to release the report annually given that some of the source measures or indicators are only produced every two or even three years. It is understood that a 4th edition is currently being prepared.

Post Core Review Implementation (Summer 2002 to present))

Since the passage of the *Budget Transparency and Accountability Act*, and under the rigor of the performance management regime established by that legislation, the Ministry has prepared and published five Service Plans since 2001/02 and four Annual Service Plan reports (for years 2001/02, 2002/03, 2003/04 and 2004/05).

With respect to the performance measures for child protection services and programs there has been significant change year over year and the measures are output measures of services or activities:

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[6] Employee Professional Development Plans, outlining a public service employee's contribution to meeting the objectives of their work unit and their own professional development needs was mandated in 2004/05. The requirement that each public service employee have an EPDP is no longer strictly complied with.

Year	*Measure*
2001/02	rate of children in care (per 1,000 children under 19 years of age)
	rate of reported at-risk children and youth supported to stay at home
	number of aboriginal communities (designated by Minister) served by Aboriginal agencies with delegated authority
	percentage of children in residential care placed in foster homes instead of other contracted residential resources (excludes Aboriginal children in delegated agencies)
	number of children in care adopted per fiscal year
	proportion of children and youth in continuing custody with a current comprehensive plan of care that is compliant with standards
2002/03	rate of children in care (per 1,000 children under 19 years of age)
	rate of reoccurrence of maltreatment
	percentage of aboriginal agencies serving Aboriginal children in care
	percentage of children in residential care placed in foster homes instead of other contracted residential resources (excludes Aboriginal children in delegated agencies)
	number of children in care adopted per fiscal year
	number of aboriginal children in care served by Aboriginal agencies
2003/04	rate of children in care (per 1,000 children under 19 years of age)
	number of children in care adopted per fiscal year
	number of aboriginal children in care served by Aboriginal agencies
2004/05	number of out-of-care placements
	percentage (number) of child welfare interventions that are resolved through alternative dispute resolution processes (ADR)
	number of aboriginal children in care served by Aboriginal agencies
	percentage of Aboriginal children in care of the ministry who are being cared for by Aboriginal families
2005/06	number of children placed with extended family or in community as an alternative to coming into care [restatement of 2003/05 measure - “number of out-of-care placements”]
	number of families referred to family support services
	number of adoptions of children in care of the ministry
	number of aboriginal children in care served by Aboriginal agencies
	percentage of Aboriginal children in care of the ministry who are being cared for by Aboriginal families

It is understood that the measures were changed in 2004/05 and 2005/06 to reflect changes in service delivery practice (Service Transformation). It is also understood that the measures are to be changed again for the 2006/07 to 2008/09 Service Plan (expected to be published in February 2006).

The Ministry has recently entered into an agreement to participate in a federal/ provincial/territorial Child Welfare Outcomes Initiative that is designed to produce national comparative information on a set of child welfare outcomes including recurrence of child maltreatment, serious injury or death, school performance, child well being and permanence. The initiative is in its early stages. Up to two years of test data will be collected from participating provinces and territories (only Quebec is not a participant) as it becomes available "until such time as the P/T Directors of Child Welfare recommend to their respective Deputy Ministers that it is in usable state, for what purposes and with what limitations" (Update on the Child Welfare Outcomes Initiative, December 2005).

It is understood that the Ministry is also a participant in a provincial inter-ministry initiative involving the Ministries of Children and Family Development, Health and Education to develop a set of integrated performance outcomes and measures for children and youth who are clients of programs of all three ministries.

With respect to operational performance management, it is understood that there is a wide variance in practice with some regions undertaking detailed operational planning at the program level (Vancouver Coastal requires each business unit to have a plan with vision, mission, goals, objectives, strategies and identified outputs, outcomes and measures[7]), to regions that are at the very early stages of introducing planning and performance management concepts to managing their operations. Some regions (notably, the North) produce data and information reports as management tools to focus resources in a manner consistent with strategic service direction. It is understood, however, that management capacity to use the data and generate useful reports is inconsistent and depends to some extent on the analytical capacity in the region.

The Ministry collects a vast quantity of data and produces a number of central reports on children in care and child protection activities. Some of the reports prepared include:

- ♣ Children in Care (CIC) Advance Statistics Report – distribution of CIC by region, aboriginal/non-aboriginal and in delegated agencies for latest month;
- ♣ CIC Caseload Placement Sheets – CID caseload by placement type;

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[7] The Regional Executive Director for Vancouver Coastal indicated that process requires leadership commitment, resources and recognition that the framework will take considerable time to put in place.

- ♣ CIC Trends and Indicators Report – change in protection reports, admissions, discharges, CICs total and funded by region;
- ♣ CFD Regional Budget Forecast - funded caseload and expenditure forecast by region to fiscal year end;
- ♣ CIC Expenditure Report - CIC expenditures and cost per case YTD, gross & net, by placement type, and CFD exceptional/guardianship expenditures;
- ♣ CIC Service Initiative Report (Regional Reporting Summary) - monitors new agreements and placements for CFD (admissions to care - 17/18 year olds), family group conference, mediations, kith and kin, youth agreements, out of care placements, transfers of custody, family development responses to intakes, adoption placements) by region;
- ♣ Service Transformation Monitoring Report - monitors progress towards targets for measures of service transformation outcomes (not produced since March 2005);
- ♣ CIC Initiative Forecast - CIC forecast to fiscal year end (admissions, discharges, aging out).

It is understood that the Ministry is in engaged in a process to review and assess its monitoring, collecting and reporting needs and data requirements with the goal of improving internal operational reports and information.

Concluding Thoughts

With respect to performance management and performance measurement, the Ministry has made strong progress over the past several years in terms of adopting a relatively sophisticated workload monitoring tool[8], making improvements to its data collection and data reporting, and better measuring inputs and outputs. However, there is a gap at the local and provincial level in terms of translating and relating data into effective management information and in providing meaningful reporting of outcomes (as distinct from inputs like budget funding and FTEs and outputs like the number of children in care or child protection investigations).

At the provincial level there has been an inconsistency in performance measures and current measures focus solely on outputs. At the regional level there is uneven application of operational planning and performance management and inconsistent use of data and information to guide management of operations. As well, though the *Measuring Success* report is designed to monitor outcomes and indicators that provide the Ministry with information on the difference its programs are making to the health and well being of children, youth and families, there is no link or congruence between the measures in the *Measuring Success* report and the

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[8] KIDS – Knowing Intentions Determining Services model - for child protection workload assessment and workload management. This model and the issue of child protection workload management is discussed further in a separate paper.

measures in the Service Plan. This calls into question the use and application of the *Measuring Success* report, given that the measures in the Service Plan are those that drive performance in the Ministry and against which the Ministry's performance will be assessed.

It is understood that the Ministry is aware of the need for better, more integrated management information and the need to develop credible and robust outcome measures of its performance and is currently working on both these areas.

Quality Assurance

What is Quality Assurance?

The general purpose of quality assurance is to ensure compliance with established laws, standards and practices; to generate information, measurement and recommendations to make continuous improvements to service delivery; and to provide an internal measure of performance against established program and service delivery standards and principles. Quality assurance activities also form part of the overall performance management and accountability framework, and, if the quality assurance system is used to take corrective action and enhance performance at the system-wide level, there is the secondary benefit of improved performance and enhanced accountability.

The Ministry currently, and over the past two decades, has undertaken quality assurance "to ensure that services are being delivered effectively and according to legislation, standards and ministry goals" ("Timeline of MCFD Quality Assurance Policies and Practices", November 18, 2005, Confidential). Quality assurance mechanisms within the Ministry have taken two basic forms:

- *case reviews* of critical incidents or deaths of a child in care or known to the Ministry; and
- *practice audits*.

Pre Gove Inquiry (1986 to 1995)

Between the years, 1986 and 1992, the Inspections and Standards Unit (ISU), established in 1986 by the Ministry of Social Services, within the Office of the Superintendent of Child Welfare, was responsible for conducting office audits as well as undertaking Superintendent Reviews that were requested by other professionals, foster parents and/or family members. In 1992, ISU became the Audit and Review Division (ARD).

Superintendent's Reviews were primarily associated with case planning issues, however, policy also required that a where a child in care died or was seriously injured under "suspicious or unusual circumstances" a formal ARD review was

mandatory[9]. Though there was a requirement that regional staff report critical incidents and deaths of children in care to the Superintendent, there was no active data collection on child deaths or critical injuries and it is understood that compliance with the requirement for regions to report a critical incident or death to the Superintendent's Office was low. There was no requirement to review the death or critical injury of a child known to the Ministry (Samuels and Ryan, page 25 and 26).

In July 1995, a new policy was established expanding the reporting requirements to include children and youth receiving services that died and/or were critically injured. This new policy, *Reportable Circumstances*, also identified the roles and responsibilities of the Superintendent's Office such as responding to these reports, considering a further review and conducting a further review.

With respect to office audits, it is understood that there was a formal policy to undertake an audit of each district audit every three years on a rotational basis but that these "proactive" audits were rarely done given resource constraints (Samuels and Ryan, 1991 Audit Policy) and from the fall of 1993 no audits were conducted.

The Gove Inquiry into Child Protection in British Columbia (1995) found gaps in the then system of public accountability and reporting for children and youth protection services in the province. "Child welfare service providers must be accountable for their actions, and managers must use quality assurance findings to effect improvements in the child welfare system". The Gove Inquiry made a number of specific recommendations about the practices audits including:

- Each district office's case files should be audited according to a predetermined audit cycle to ensure that provincial standards are being met or surpassed;
- The practice audit process should include assessment of the exercise of judgment;
- The practice audit process should be completely separate from the system that delivers and manages the child welfare program to ensure independence and objectivity;
- Practice audits and reports should be prepared in a manner that will lead to constructive improvements in the delivery of child welfare services; the Ministry should use practice audit findings to improve service delivery and

[9] Under the 1993 Family and Children Services review policy, the Superintendent had three avenues to undertake a "Superintendent's Review": case inquiry by the Deputy Superintendent; case review by ARD; and case inquiry or review by regional staff. (Samuels and Ryan)

provincial practice standards, training and design (Gove Inquiry, Volume 2, page 113).

Post Gove Inquiry (1996 to Spring 2002)

Following the Gove Inquiry and the subsequent establishment of the new Ministry for Children and Families in September 1996, the Quality assurance function was transferred from the Ministry of Social Services along with the other Child Protection Services. The Audit and Review Division (ARD) was a stand-alone division within headquarters with responsibility for Director's Case Reviews and practice audits.

Also, beginning in 1996, the Deputy Director's Office in the Child Protection Division was made responsible for conducting a preliminary analysis following the death of a child in care and children known to the Ministry (following the creation of the Children's Commission, these preliminary reviews became officially known as Deputy Director's Reviews and built into policy and practice). The purpose of a Deputy Director's Review was to review the reports provided by field staff, examine the case management file and other documentation against policy and standards, provide a short analysis and make a recommendation about whether to close the file, or assign the matter to ARD to complete a Director's Case Review. Initially, preliminary reviews were conducted on all child deaths irrespective of the time frame, but at the end of 1996 the policy was amended to the "child known to the Ministry within the last 12 months". During the years 1996, 1997 and 1998, Deputy Director Reviews were conducted on all reported child and youth deaths. For those very high profile deaths and critical injuries, usually a Director's Case Review was assigned immediately. In 1999, Deputy Director's Reviews were discontinued for most of the natural deaths of children or youth in care or known to the Ministry (primarily children who had received services form the Community Living area) unless there were outstanding questions relating to practice ("History of Director's Reviews and Release of Related Information", prepared for Hughes Review – internal - December 2005).

In 1997, as part of further organizational changes in the new Ministry, the ARD was dissolved and the quality assurance function was transferred to the new Quality Assurance Branch of the Child Protection Division in Ministry headquarters. The new Quality Assurance Branch had two units: the Case Review Unit to conduct case reviews and the Audit Unit to conduct audits in accordance with a regularly scheduled audit cycle. As part of the work in addressing and implementing the recommendations of the Gove Inquiry, new standards and methods for auditing case practice were developed and introduced ("History of Director's Reviews and Release of Related Information").

It is understood that the Quality Assurance Branch was provided the budget to manage the case review and practice audit functions through contract with experienced reviewers and auditors. This practice of contracting out the review and audit function continued until 2000/2001 when the function was gradually brought back in-house within the Quality Assurance Branch, Child Protection Division. By

2001, the practice audit function was generally undertaken by in house practice auditors; in-house practice analysts completed most Deputy Director's Reviews whereas Director's Case Reviews were still often completed by contract reviewers. It is further understood that practice audits were conducted on a regular schedule between the spring of 1997 and the end of 2001 and case reviews were completed in accordance with policy as required ("Timeline of MCFD Quality Assurance Policies and Practices").

Post Core Review Implementation (Summer 2002 to present)

At present, and since April 2003, the quality assurance function has been delivered on a regional basis. The transfer of responsibility for quality assurance was part of the move to regionalization and the overall devolution of authority for child protection services.

To support devolution and as a key step to decentralized decision making consistent with the move to regionalization, on July 2, 2002, the Minister designated a Director in each of the five regions under the *Child, Family and Community Service Act*. The Provincial Director in Headquarters maintained his designation. It is understood that the Regional Directors are responsible to the Provincial Director for complying with policies and standards set by the Provincial Director and establishing a quality assurance framework consistent with provincial standards and monitoring regional service delivery and practice.

With the transfer of the quality assurance function, a portion of the FTE complement devoted to the quality assurance was transferred from the Quality Assurance Branch in the Child Protection Division at headquarters to the regions and analysts in the regional offices became responsible for conducting case reviews and practice audits within their regions. The Divisional Operations Branch of the Child Family Division in headquarters was established with responsibility for, among other duties, provincial child protection quality assurance. Four FTEs in the Division support quality assurance activities conducted in the regions in addition to performing developmental work on the establishment of standards, policies, procedures and tools ("Timeline of MCFD Quality Assurance Policies and Practices").

In June 2004, a new *Quality Assurance Standard* was established to direct the conduct of Quality Assurance functions delivered by the regions. The *Quality Assurance Standard* addresses four areas: delegation under the *Child, Family and Community Service Act*, Case Review, Case Practice Audits and Supervisory Consultation and Approval. Of specific interest to this report are the standards around "case review" and "case practice audits". The case review policy outlines the requirements for determining when to conduct a Deputy Director's Review or Director's Case Review and the fundamental review process. The case practice audit policy requires audits to be preformed in accordance with an established regional audit plan that includes regularly scheduled audits and that the audit be conducted using standardized audit tools approved by the Provincial Director. The actual conduct of case reviews is supported by "Case Review Procedures, June

2003" and standard reporting templates. The conduct of practice audits is guided by "Director's Case Practice Audit Methodology and Procedures, June 2004"; "Critical Measures Audit Tool for Child and Family Service Standards, May 2004"; and "Critical Measures Audit Tool for Children in Care Service Standards, May 2004". It is understood that the Ministry is currently working on the development of an audit tool for assessing the Quality Assurance Standard and conduct of case reviews and case practice audits.

Director's Case Reviews are generally undertaken by the regions through use of contractors whereas Deputy Director's Reviews are generally performed by in-house analysts. Between April 1, 2003, and the introduction of the June 2004 *Quality Assurance Standard*, the conduct of case reviews was sporadic. It is understood that "approximately 16 Director's Case Reviews and Deputy Director's Reviews are outstanding between 2002 and 2004" and that this is due to a "lack of resources and lack of individuals [in the regions] with the appropriate skill sets to conduct reviews". It is further understood that regions have been charged with completing these reviews by the end of February 2006 and that longer term action is being taken by the Ministry to address these capacity issues including: adding one FTE per region and four FTEs to headquarters dedicated to quality assurance functions; considering policy changes such as additional clarification in the standard between the difference in a Director's Case Review and a Deputy Director's Review; and regarding the development of recommendations; and file notations respecting a decision not to conduct a review (January 9, 2006, Memorandum from Alison MacPhail to Ted Hughes, titled "Additional Materials").

With respect to office practice audits, no compliance-based practice audits occurred between July 2002 and June 2004. Effective July 2002, all practice audits were suspended and the compliance based audit program discontinued by order of the Executive Committee. During this period, in place of compliance based practice audits, "qualitative audit tools were developed for regions to conduct comprehensive audits on individual cases as these were seen as less intrusive" ("Timeline of MCFD Quality Assurance Policies and Practices"). A new compliance-based practice audit program was reintroduced in April 2004 and, from that point on, audits are now conducted by regional practice analysts on a three or four year cycle. Regions are responsible for establishing their own schedule and it is understood that most regions have adopted a four-year rotational cycle to undertake compliance-based practice audits of all regional offices.

In the summer of 2005, the June 2004, *Quality Assurance Standard* was reviewed and updated with respect to the practice of case review and audits due to concerns regarding "the qualifications and criteria for selecting contractors to conduct case reviews; quality of the reviews and audits, particularly recommendations arising from reviews and audits; implementation of the recommendations arising from the reviews and audits; and tracking of recommendations to ensure implementation" ("Improving Case Reviews and Audits", July 2005). The changes to the Standard include:

- ♣ establishment of qualifications and criteria by the designated directors, Regional Executive Directors and the Provincial Director for the selection of contractors to conduct case reviews and practice audits (currently no established guidelines are in place);

- ♣ a new recommendation development process and sign off policy for case reviews and audits. The new sign off policy will allow the Regional Executive Director and Provincial Director/Assistant Deputy Minister, Child Protection Services to add recommendations to those developed by the writer of the review and the regional designated director.

As well, the need to conduct reviews and audits according to established standards and procedures will be reinforced with MCFD staff.

The Divisional Operations unit, provincial Child and Family Development division, is responsible for the Fatality Incidence Tracking System (FITS), the Incidences Tracking System (ITS)[10] and the Recording Tracking System (RTS) that record and track recommendations from case reviews and practice audits. It is understood that the Ministry is currently developing two new systems that will support integrated practice analysis to replace the existing tracking systems. The Integrated Case Practice Audit Tool (ICPAT) that went into production in July 2004, will allow Ministry case practice auditors to perform case file audits on-line and record the results of these audits directly. The Integrated Practice Analysis Tracking tool (IPAT), which is scheduled to go into production March 31, 2006, will replace the existing tracking systems for recommendations (FITS and ITS) and be fully integrated with the MIS/SWS (social worker management information system).

Regions are responsible for analyzing and implementing recommendations and advising Divisional Operations when the implementation of a recommendation is complete (prior to the devolution of the quality assurance to the regions, the analysis, monitoring and tracking of progress of implementation of recommendations was managed centrally to ensure consistency)[11]. It is understood that there are some concerns respecting the current process, particularly around when a recommendation should be closed off as implemented (i.e., when the recommendation is accepted and an indication given that an action will be taken, or after the action is fully implemented) and that Divisional Operations is currently undertaking a detailed review of the implementation of all recommendations since 2002.

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[10] The FITS and ITS are systems that support the Reportable Circumstances Policy that requires reporting of fatalities and critical injuries of child and youth in care or known to the Ministry.

[11] When the audit function was centrally located, analysis of recommendations, including the determination of required action, and monitoring of implementation was lead centrally.

No information was uncovered to indicate that the Ministry undertakes an analysis of the trends in recommendations or that there is a systematic attempt to roll up, analyze and make recommendations on changes and improvements to provincial standards, policies and practices based on a cumulative analysis of the results of case reviews or practice audits. Additionally, no information was uncovered to indicate that the Ministry undertakes systematic evaluation of the effect and impact of proposed new policies and practices or the formative evaluation of existing programs. It is understood that the new system, IPAT, will provide greater capacity for trend analysis of recommendations. It is further understood that there are resource implications associated with undertaking these functions in a comprehensive, effective way.

It is understood that enhancement of the quality assurance function is a priority of the Ministry. It has recently initiated a review of its quality assurance activities, the "MCFD Quality Assurance Initiative", that is "designed to support the development of a quality assurance framework that will lead to enhanced program and service effectiveness throughout the ministry's business areas. The initiative will assist the ministry to respond, in a proactive way, to the reviews that are currently underway with regard to specific cases, child death reviews and quality assurance. The project will expand in scope as recommendations from reviews received by government are identified for implementation". It is understood that part of this initiative is consideration and movement to a more integrated system for quality assurance. In January 2006, the Ministry announced that it would be increasing staffing resources in both headquarters and the regions to build capacity and support both the provincial and regional quality assurance function. Furthermore, part of the $72 million in increased funding over the next three years, announced in *Budget 2006*, for enhancing "existing programs and supports to care for and protect vulnerable children and youth, including child protection services and children in care" will be expended on "strengthening quality assurance and review functions within the Ministry of Children and Family Development".

The Ministry has also initiated a process to develop and implement a "common review tool" for all reviews undertaken with respect to ministry programs. Presently, there are separate reviews standards, definitions, criteria and processes for reviews under Child and Family Development programs (children in care or receiving services from the Ministry), Child and Youth Mental Health, Youth Justice and Provincial Services for Deaf and Hard of Hearing. There are concerns with the lack of coordination and information sharing resulting in gaps where a review should be undertaken but is not, or where more than one review is undertaken of the same incident. The goal is to establish "a common set of standards for conducting reviews of critical incidents, coordinating service streams where necessary, with reports and recommendations tracked systematically and electronically".

Operational Audits

Over the years, Operational Audits of Ministry operations and the operations of contract service providers have been undertaken by the Internal Audit and

Advisory Services, Office of the Controller General. Audits done of Ministry programs are designed to enhance the performance of these programs. Audits of Ministry programs include a review of the Financial Control Framework for the North Region, a report on Regional Aboriginal Planning Committees and Vancouver Coastal Regional Planning Committee, Family Support Services and Residential Programs for Children in Care. Audits undertaken by IAAS for the Ministry of contracted agencies include financial statement audits, compliance audits, investigative audits and comprehensive audits.

Quality Assurance for Aboriginal Delegated Agencies

Under the *Child, Family and Community Service Act*, the provincial Director may give authority to aboriginal agencies and their employees to undertake administration of all or parts of the Act. The amount of authority delegated is the result of negotiations between the Ministry and the Aboriginal community served by the agency and an assessment of the agencies capacity to deliver services. At present, there are 23 Delegated Aboriginal Agencies in the province and 212 delegated social workers. Seven of those agencies are fully delegated, while the rest provide primarily guardianship and foster support[12].

The Provincial Director retains responsibility for protection and guardianship under the *Child, Family and Community Service Act* to the extent that those powers are delegated to aboriginal agencies including responsibility for overseeing the quality assurance function.

Services provided by Aboriginal delegated agencies are guided by the *Child, Family and Community Service Act* and the Aboriginal Operational Practice Standards and Indicators (AOPSI, 1999, revised in 2004/05). The quality assurance model for delegated Aboriginal agencies includes the following components: adherence to AOPSI; an audit program (practice, operational and financial); delegation, delegation enabling agreements and delegation confirmation agreements; readiness assessments; case reviews (Director's Case Review, Deputy Director's Review, Director's Foster Home Review); staff training and complaints management. A practice analyst in the Ministry is assigned to each Delegated Agency to provide direct support to the Agency for the quality assurance function.

The Ministry meets with each Delegated Aboriginal Agency four times a year to review, policy, practice and operational issues. Beginning in 2003, the Ministry began a comprehensive audit program to fully audit each Delegated Agency every three years to operations and practice standards. The Ministry has recently completed work with the federal government on a common audit tool. The pilot

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[12] Nine percent of children in BC are aboriginal, yet they account for approximately 49 percent of children in care (as of September 2005). Delegated agencies serve about 31 percent of the Aboriginal children in care of the province.

project is complete and the new audit process is being aligned with the provincial practice audit process and audit schedule.

Delegated agencies have the responsibility to provide reports on all critical injuries, fatalities, and serious incidents involving children in care or children who have received services from the Agency within the 12 months prior to the incident to the Director. Delegated Agencies are responsible for conducting case reviews according to established standards consistent with Ministry standards, but depending on the circumstances, the Provincial Director may complete a case review and has the authority to conduct more formal reviews as necessary.

It is understood that the Ministry is currently considering its quality assurance policy and practice as it applies to aboriginal agencies with delegated authority to determine recommendations for strengthening policy and practice (January 9, 2006 Memorandum from Alison MacPhail to Ted Hughes).

Over the longer term, the goal is to transfer authority for aboriginal child and youth services to an Aboriginal Authority. It is understood that this Aboriginal Authority would over time be given full authority and responsibility for child protection services for aboriginal children served by the Authority. The Authority would be held accountable by the Minister for the performance of its duties and responsibilities. In turn, the Authority would have responsibility for quality assurance within its own organization, subject to adherence with provincial standards and policies.

Community Living BC

On October 6, 2004, the legislature passed the *Community Living Authority Act* to be proclaimed when the transfer of responsibility from Community Living Services in the Ministry of Children and Family Development to an independent authority was ready to take place[13]. On July 1, 2005, Community Living BC became a legal entity and designated a Crown Agency under the Provincial Government's Crown Agency Secretariat as a 'Service Delivery Corporation'. As a crown agency, Community Living BC:

- ♣ is accountable to the government through a Responsible Minister;

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[13] Following the Core Services and its recommendations respecting a move to community governance, legislation was passed in October 2002 to enable the creation of interim authorities in preparation for a move to community governance. Subsequently, Interim Authorities were established, including an Interim Authority for Community Living BC. In September 2003, a consultant's report recommended that the Ministry focus on transforming its service delivery system and stabilizing its budget prior to creating governance authorities. The work of the five regional planning committees was discontinued but the interim bodies for Community Living BC and for the creation of aboriginal authorities continued their work.

- ♣ is subject to mandate and policy direction through a "letter of expectation" signed by the responsible minister and the Chair of the agency;
- ♣ has its board appointed by the minister;
- ♣ is subject to best practice corporate governance guidelines; and
- ♣ is subject to audit, financial and performance planning and reporting requirements that apply to all agencies included in the Government Reporting Entity.

The July 1, 2005, Letter of Expectations between the Minister of Children and Family Development and Chair of Community Living BC outlines the roles and responsibilities of the Minister and the agency and the corporate mandate of the agency, including high-level performance expectations, public policy requirements and strategic priorities. The letter of expectations is designed to inform the development of the agency's Service Plans and Annual Service Plan reports. Specific expectations in the letter include that Community Living BC:

- ♣ develop and implement a service plan that will improve existing services, rationalize costs for services so that more families can be served, encourage community participation and result in innovative service delivery systems;
- ♣ ensure consistent levels and quality of service while planning for response to the unmet needs of adults and children with developmental disabilities and their families;
- ♣ ensure that individuals and families are active participants in the individual planning process and that the agency's public documents clearly demonstrate how this is to be achieved.

Under the Act, the Authority must submit its annual service plan and budget plan to the Minister for approval and, if required by the Minister, must submit annual reports and statements to the Minister which may be examined by the Comptroller General and a report made to Treasury Board. As well, the Minister has the authority to prescribe provincial standards for the provision of community living support and administrative services in BC, after consultation with the authority; monitor the authority and establish process to assess the authority's performance of its powers, functions and duties; appoint a minister's representative to enter and inspect authority; and appoint a special advisor and direct the board respecting anything contained in a report of a special advisor. It is understood that the Minister has not at this time prescribed any provincial standards for the authority or made any directions.

In January 2005, the Ministry and the agency agreed to a new service delivery model for Community Living BC to "enhance accountability within the organization to ensure that quality services are delivered", including clearly defining the community's role in planning and evaluating service delivery, that community input is linked to the agency and that the necessary staff supports exist

for community engagement (www.communitylivingbc.ca/pdfs/q&a_jan05_final2.pdf). Community Living BC has passed several policies to support its operations and the implementation of the Community Living BC service delivery model, including a waitlist policy, Individual and Family Support Policy, Health and Safety Standards and a Complaints Policy.

Accreditation

As part of the Ministry's quality assurance framework, third party accreditation is required of all Ministry contractors that provide services to the public and have total annual contracts of at least $500,000 (accreditation is optional for agencies under this limit, subject to approval by Ministry). Where no appropriate accrediting body is available, the service provider organization must comply with Ministry standards and participate in an audit process conducted by the Ministry. Contracts held by service provider organizations that do not earn accreditation by September 30, 2006 may be subject to a re-tendering process. It is understood that other than Alberta, British Columbia is the only Canadian jurisdiction to currently require accreditation of its contracted child and family service providers. To date, 140 contracted agencies, out of a 220, have been accredited.

The two accrediting bodies chosen by the Ministry are the Council of Accreditation for Children and Family Services (COA) and the Commission on Accreditation of Rehabilitation Facilities (CARF). The principle difference between COA and CARF is that COA accredits the entire agency including all of its programs, whereas, CARF accredits specific programs within the agency.

The purpose of accreditation is to improve the quality of services delivered by an organization. "Third party accreditation guides human service organizations in the development and maintenance of interrelated accountability and quality improvement systems. … Accreditation status indicates that the accredited organization has achieved an appropriate level of organizational competence and that it has reliable mechanisms in operation to continually improve the quality of services it delivers" ("Accreditation", www.mcf.gov.bc.ca/accreditation/index.htm). There are two types of standards that an organization is accredited for: generic organizational standards, including governance, leadership, management and controls; and program/service specific standards that apply to the specific services provided by the organization.

At present, four provincial services – The Maples Adolescent Treatment Centre, Provincial Services for the Death and Hard of Hearing, Youth Forensic Psychiatric Services, and Youth Custody Services – are accredited under COA. Four additional provincial services are considering accreditation: Vancouver Coastal Region, Community Living BC (as a "network administrator"), the Accountability and Performance Management unit (headquarters) and the Contract Procurement unit (headquarters). This initiative is at a very early stage and these four units are working with CARF to consider the form of standards appropriate to services delivered by these areas. It is understood that accreditation for child protection services generally has been rejected in the past given the sense that current program

standards, quality assurance and government-wide budget and other controls already cover the components of accreditation.

It is understood that, to date, participation in the accreditation process by contracted aboriginal service delivery organizations has been optional (several aboriginal contractors are voluntarily participating in the contractor's accreditation project).

Concluding Thoughts

The history of quality assurance in the Ministry has been uneven. Following the Gove Inquiry, the Ministry made strong efforts to establish a rigorous and routine quality assurance framework. However, the move to regionalization and devolution of authority for child protection services to the regions appears to have weakened the quality assurance function within the Ministry.

It is understood that the Ministry recognizes that enhancements to the quality assurance framework are required and it appears that enhancements are being lead by the Provincial Director. Nevertheless, there are concerns with the continued delivery of the quality assurance function by the regions with respect to consistency, independence and the ability to identify and introduce systemic service and program improvements.

Public Reporting

Pre Gove Inquiry (1986 to 1995)

Between 1986 and 1995, there was little in the way of formal, standardized reporting by the Ministry. There was no public release of Superintendent's case planning reviews or reviews conducted following a critical injury or death of a child in care, or of practice audits. Annual reports on the operations and programs of the Ministry were sporadic and information was high level and general in nature.

Post Gove (1996 to Spring 2002)

During the years between 1996 and 2001, the Children's Commission and Child, Youth and Family Advocate produced several annual and special reports both general to the "child serving system", and its issues[14], and about child fatalities in the province. Between 1998 and 2002 the Children's Commission held public releases of its child death reviews that often included an update on what actions the Ministry had taken resulting from the recommendations from Directors' reviews.

However, there continued to be very limited reporting by the Ministry about the results of its internal quality assurance activities. Between 1996 and 2001, some

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[14] Reports prepared by the Children's Commission included: regular annual reports on the roles and responsibilities and operations of the Commission; reports analyzing trends; reports on the recommendations and responses to recommendations by the Ministry; and special reports such as its report on "Fetal Alcohol Syndrome – A Call for Action in BC" and "The Youth Report – A Report About Youth by Youth".

press releases were issued by the Ministry following a high profile death and/or injury of a child in care or child known to the Ministry that generally consisted of an acknowledgement of the incident and a commitment to review the matter further. The press release material usually included an indication that the Coroner was also investigating and that the Children's Commission would conduct a further review. Following the Amanda Simpson death in 1999, a public release was done of the Director's Case Review at a press conference in Prince George in the fall of 2000. This release was a special severed summary of the review. This was the first and only time the Ministry publicly reported out on a review until 2003 (History of Director's Reviews and Release of Related Information). With respect to audits, practice audits were posted on the Ministry website for the years 2000 to 2002. IAAS operational audits of Ministry programs and contracted service agencies for years 1997 to 2004 are also posted on the Ministry website[15]

Post Core Review Implementation (Summer 2002 to present)

From Spring 2002 to date, reporting about the "child serving system and issues" is the responsibility of the Child and Youth Officer. The Child and Youth Officer prepares Annual Reports (an overview of the observation and advice to government resulting from the work done by the Child and Youth Officer over the course of the year) and has also prepared special reports on such matters as "Healthy Early Childhood Development in BC", and issue papers on "Child and Youth Mental Health", the "Convention on the Rights of the Child" and "Towards Knowing How Effectively the BC Government is Supporting Children and Youth". The Coroner's Service is responsible for reporting on child death reviews; it has produced one general report on the deaths of children less than one year of age for 2003 to 2004 and provides aggregate longitudinal statistics on deaths of children and youth under the age of 19 years.

As noted earlier, under the *Budget Transparency and Accountability Act* the Ministry publicizes annually its Service Plan and Service Plan Annual Report (see section on Performance Management). The Ministry also publishes via its website, various reports including statistics on the number of fatalities of children in care and those receiving other ministry services and data on outcome results associated with delivery of child welfare services. It also includes a link to the 2001 reports of the Provincial Health Officer respecting the health and mortality of children in care and the general BC child and youth population.

However, there continues to be very limited reporting by the Ministry about quality assurance functions: only two case reviews have been publicly reported (the case reviews of Chassidy Whitford and Sherri Charlie) and there has been no public reporting of audit activities and results (practice audits undertaken between 2000 to 2002 remain on the website, but no new information has been added). It is

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[15] "Accountability and Audits", www.mcf.gov.bc.ca/audit/index.htm and "Operational Audits", www.mcf.gov.bc.ca/audit/corp_audit.htm.

understood that the release of the "two reviews has caused some concern in the Ministry's Privacy and Information Branch. While the Ministry believes in the and supports public accountability and transparency there must be a balance with the confidentiality and privacy rights of children, youth and families served as well as the staff who provide the services" ("History of Directors' Reviews and Release of Related Information").

Concluding Thoughts

Public reporting by the Ministry on its performance and on its quality assurance activities has been uneven and inadequate over the years. It is suggested that this ineffective and insufficient public reporting may have contributed to the public perception about the Ministry's lack of transparency.

Furthermore, information posted on the ministry website is inconsistent. The child fatality statistics do not match other reports and change from year to year and the outcome results posted do not match the measures in the Service Plan.

Summary

	Oversight	*Performance Measurement*	*Quality Assurance*		*Public Reporting*
			Audits	*Reviews*	
Pre-Gove	No independent oversight of child serving system	No formal standardized performance measurement	Superintendent's office – limited and sporadic; no audits from 1993	Some reviews but no formalized policy for reviews or reporting of deaths or critical incidents	No public reporting of audits or reviews
	Coroner's Service – review of certain deaths				
	Ombudsman – external complaint process				
Post Gove	Children's Commission – monitoring and advocating system change, complaints, child death reviews and reporting	*Measuring Success* – report of health and well being outcomes	Audit standards and centralized audit program established and implemented	Case reviews undertaken as determined necessary	Extensive reporting by Children's Commission and Child, Youth and Family Advocate
	Child, Youth and Family Advocate - advocacy				
	Coroner's Service – review of certain deaths				Audits reported 2000-2002
	Ombudsman – external complaint process				Limited reporting of reviews
Post Core Review	Child and Youth Advocate – general monitoring of child serving system	Formalized and standardized Service Plans and Annual Service Plan reports	No practice compliance audits from 2002 to 2004	Case reviews undertaken as necessary	Annual and select reports from CYO; one report from Coroner (03/04)
	Coroner's Service – death reviews and reporting; database	National Child Welfare Outcomes Initiative	April 2004 regional practice audit program reinstituted	New Standard (June '04) and case review procedures (June 2003)	No reporting of audits
	Ombudsman – external complaint process	Inter-Ministry project – indicators for children	New Standard (June 04), tools and methods (May '04)		Limited reporting of reviews

Timeline – Performance Management and Accountability System for Child and Youth Protection in British Columbia

Pre Gove (1986 to 1995)

1986	Former Ministry of Social Services establishes the Inspections and Standards Unit (ISU), as part of the Superintendent's Office, to conduct office audits and Superintendent's reviews of case planning; ad hoc reviews of death or critical injury of a child in care also conducted; there was no formal policy in this area and no public reporting of audits or reviews
1992	ISU becomes the Audit and Review Division (ARD)
1993	Development of a new policy for case reviews and office audits
1993 - 1995	No audits conducted and few Superintendent's reviews undertaken
July 1995	New policy, *Reportable Circumstances*, established setting out roles and responsibilities of the Superintendent in reviewing and reporting on children and youth receiving services that die or are critically injured
Summer 1995	Joyce Preston appointed as Child, Youth and Family Advocate and *Child, Youth and Family Advocacy Act* passed
November 1995	Gove Report submitted; government accepts recommendations and appoints a Transition Commissioner (Cynthia Morton)

Post Gove (1996 to March 31, 2003)

1996	*Child, Family and Community Service Act* passed; Superintendent becomes the Director
1996	Deputy Director's Office, Child Protection Division (HQ), becomes responsible for preliminary reviews following the death of a child in care and children known to the Ministry (as defined by receiving service within last 12 months); purpose of preliminary review is to recommend whether the case should be closed or whether a Director's Case Review should occur
September 1996	Report of Transition Commissioner recommends changes to system, including establishment of a Children's Commission (Cynthia Morton appointed first Children's Commissioner); Ministry for Children and Families created and made responsible for transition
1996 - 1997	ARD now centrally located in HQ and stand-alone; ARD responsible for practice audits and case reviews. No audits conducted; case reviews conducted of high profile deaths and critical injuries

July 1997	*Children's Commission Act* proclaimed; reports to Attorney General
1997	ARD dissolved; new Quality Assurance Branch, Child Protection Division (HQ) established with responsibility for quality assurance function
October 1997	First edition of *Measuring Success: A Report on Child and Family Outcomes in BC* released
1997 – 1999/2000	Practice audits conducted on a regular schedule; case reviews completed as required; no formal public reporting. Case reviews and practice audit functions delivered through contract with experienced reviewers and auditors
1998	Ombudsman Report, *Getting There*, on status of implementation of Gove recommendations released; government uses the report as an opportunity to sign off on Gove recommendations
1999	Deputy Director Reviews discontinued for most natural deaths (primarily children receiving services from Community Living program area)
1999	Second edition of *Measuring Success: A Report on Child and Family Outcomes in BC* released
June 2001	Ministry renamed the Ministry of Children and Family Development
2001	Government introduces performance management for government ministries; requires annual three-year rolling service plans with goals, objectives and performance measures and targets and annual service plan reports
1999/2000 – 2001/02	Quality assurance function gradually brought back in-house to Quality Assurance Branch, Child Protection Division (HQ): practice audits conducted by practice auditors, Deputy Director's reviews conducted by practice analysts; most Director's Case Reviews still completed by contract reviewers; practice audits reported on Ministry website
December 2001	Release of "Report of Core Services Review of the Children's Commission and Overlapping Services Provided by the Child and Youth Advocate, the Ombudsman, Coroner and the Ministry"
2000 - 2002	Results of practice audits posted on Ministry website
May 2002	Flowing from recommendations of Core Services Review, *Office for Children and Youth Act* proclaimed; *Child, Youth and Family Advocacy Act* and *Children's Commission Act* repealed
May 2002	Third edition of *Measuring Success: A Report on Child and Family Outcomes in BC* released (June 2003 addendum added early childhood development indicators)

1996 - 2003	346 Deputy Director Reviews and 55 Director's Case Reviews completed. 987 recommendations from Ministry reviews, and about 1900 recommendations from Ministry reviews combined with recommendations from Children's Commissioner, Chief Coroner and Ombudsman
Post Core Review Implementation (April 2003 to present)	
July 2002	Compliance-based practice audits suspended
April 1, 2003	Audit and case review function becomes responsibility of regions consistent with devolution of authority to regions of Director's roles and responsibilities
April 2003 – Spring 2004	Qualitative, comprehensive case audits conducted by regions; case reviews conducted at discretion of regional designated directors consistent with existing policy and procedure
September 30, 2002	Office of Children and Youth comes into existence
January 2003	BC Coroner's Service Child Death Review Team established
May 2003	Jane Morley appointed as Child and Youth Officer
April 2004	Audits resumed; new compliance based practice audits conducted by regional analysts on three or four-year cycle; none of the audits conducted made public. New Divisional Operations Branch, Child Family Division (HQ) responsible for provincial child welfare quality assurance
June 2004	Quality Assurance Standards implemented for case review, audit, delegation and training
March 2005	All case reviews from April 1, 2003, and all audits from April 1, 2004 sent to Child and Youth Officer; Coroner sent all child death reviews. New process implemented to provide all case reviews and audits to Child and Youth Officer and all child death reviews to the Coroner within one week of completion
June 2005	Quality Assurance Standards amended to add a new step requiring Provincial Director review of all case reviews and audit reports
April 2003 to date	53 Deputy Director Reviews and 7 Director's Case Reviews completed; 16 Director's Case Reviews and Deputy Directors' reviews outstanding between July 2002 and April 2004; a synopsis of two of these reviews have been made public (Chassidy Whitford and Sherri Charlie)

D. PROPOSALS FOR CONSIDERATION

The current external and internal system of oversight, accountability and reporting for child and youth protection services in the province, has many of the elements of an effective overall performance management system and accountability framework.

The question then becomes one of the degree to which these systems are considered to have proven to be adequate and effective. Based on our review of the current system, to the extent possible through a review of documentation and information collected and our understanding of the issues on this basis, it appears that there are some gaps in the framework and areas where enhancements could be made.

Oversight

The key issue around external oversight or monitoring of child and youth protection system in the province is the lack of clarity about the objective of that oversight.

Is the objective of monitoring and oversight to investigate and identify systemic problems in the delivery of child and youth protection services that impact the safety and wellbeing of children and youth, for the purpose of requiring government to address them? Is it to identify, investigate and make recommendations respecting individual and collective errors in child protection decision-making and practice? Is it to provide an independent check and balance to the Ministry to promote public confidence that the system is effective? Is it to provide an evaluation of the child and youth welfare system's capacity including whether the Ministry is adequately funded and staffed, whether the bureaucratic culture is healthy, whether the Ministry is well led and whether there are sufficient community support services, as is proposed by the BC Association of Social Workers in their submission to the Hughes Review? Or is it all or some combination of these.

Once the objectives of external oversight and public accountability are clearly identified and articulated then the question becomes one of the appropriate form and structure, including a consideration as to whether sufficient monitoring and oversight, given the defined objectives, is already provided by the Legislature, the Minister and existing structures, or whether additional mechanisms of independent oversight are required. There is a real question about the extent to which the current structure is part of the problem and whether the current structure could have been implemented and used more effectively. It is suggested that the elements of an effective oversight regime include establishment of clear objectives, a structure with the power and mandate that matches those objectives, a person with the skills, competency and credibility to do the job, and sufficient resources.

There is a range of models for oversight and monitoring:

- ♣ Current model with enhancements to ensure clear and specific direction to the Child and Youth Officer on objectives and expectations for oversight and monitoring of the system and provision of adequate resources to fulfill these responsibilities; sufficient capacity in the Coroner's Service to undertake and report on child death reviews[16], and expanded internal Ministry monitoring and reporting of quality assurance activities;

- ♣ A return to some form of single, independent oversight body that is responsible for monitoring and oversight of the "child serving system", child death reviews, and possibly dispute resolution and complaints, including advocacy. A variant of this model, put forward by the Office of the Auditor General for consideration, is the former Commissioner of Environment and Sustainability. Attached to the Auditor General's Office to ensure the necessary analytical expertise and support to carry out his or her functions, the Commissioner (who was appointed by the Auditor General based on a list put forward by an all party Committee of the Legislature) was responsible for considering strategic plans, goals, specific objectives and performance measures of Ministries and report annually to the Legislature on government, ministry and government organization progress towards sustainability.

- ♣ No external oversight body, but establishment of clear performance outcomes for the child and youth protection in the province and enhanced quality assurance framework designed to monitor compliance with provincial standards, policy and practice and promote continuous improvement, and expanded and regular public reporting on outcomes and quality assurance activities.

Performance Measurement

Measures and targets in the Ministry for Children and Family Development Service Plan, and as reported out in the Annual Service Plan Reports, have changed regularly and significantly year by year. Also, the measures in the Service Plan are limited to output measures of service delivery; there are no measures around outcomes for children receiving child protection services. Given this, and despite reports such as the *Measuring Success* document, it is difficult to assess how the Ministry is performing or meeting key objectives related to the health and well being of children in care or children who are clients of the Ministry or at risk. The output measures contained in the Ministry Service Plan and reported out in the Annual Report are not sufficient to give the public, and stakeholders, an understanding of how well the Ministry is performing in protecting the children and youth.

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[16] It is understood that the separate paper being prepared on the issue of Child Fatality Reviews will specifically address the issue of the appropriate structure for reviewing and reporting on child deaths.

It is suggested the Ministry should apply significant effort to establishing a set of evidence based, credible outcome measures and realistic targets for measuring performance of the child protection system. It is suggested that the work of the National Child Welfare Outcomes Initiative and the provincial inter-Ministry committee on indicators for children could be useful in helping the Ministry to land on a set of outcome measures. Making the Service Plan measures consistent with National Outcomes measures and/or broader provincial measures would ensure consistency and promote efficiency, as only one set of measures would be required to be monitored and reported. Alternatively, or in conjunction, the Human Early Learning Partnership (HELP), at University of British Columbia, funded in part by the Ministry of Children and Family Development, and who have been tracking the development of British Columbia's children for seven years, could be consulted on the indicators and conditions that effect positive childhood development and development of data systems and record linkage of information from multiple dimensions that affect children. It is understood that HELP has partnered with the Child and Youth Officer to examine the effect of taking children into care on their health, educational, criminal justice and income assistance outcomes.

It is also recommended that support be given to the Ministry to continue its efforts to develop meaningful and usable data and management information to support the operations of the Ministry and that there be an explicit link between this operational data, regional performance management information and the identified high-level outcomes of the Ministry for protection of children and youth.

It has also been suggested that the model for performance management and accountability used by some organizations and jurisdictions in the United States be given consideration. The Government Management Accountability and Performance model is an attempt to integrate state level priorities and budget allocations with program level management to provide "continuous feedback on how well the money is being used to achieve results". This is the system in place in Washington State for the Department of Social & Health Services Children's Administration[17].

Quality Assurance

Despite current efforts to strengthen the quality assurance system through establishment of a revised Quality Assurance Standard, tools and methodologies and provision of training and development to promote effectiveness and consistency of the quality assurance function by regions, there are a number of issues with the quality assurance framework in the Ministry that bear consideration. Two are discussed below, and the third, respecting reporting of quality assurance activities, is discussed in the section on Public Reporting.

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[17] "GMAP Washington – Guidelines for Agencies", May 5, 2005; "Vulnerable Children", Department of Social and Health Services Children's Administration – Government Management, Accountability and Performance, January 18, 2006.

Though the Ministry has in place a detailed system for tracking of individual recommendations from reviews and audits, there does not appear to be a comprehensive process for monitoring, considering and analyzing the recommendations to make system-wide corrections and improvements to provincial standards, policy and practice. It is understood that the Ministry is adding one analyst to the Economic Analysis area within the ministry to improve the management information reports and analysis that are provided to executive in the Quality Assurance area (January 9, 2006 Memorandum from Alison MacPhail to Ted Hughes). However, it is suggested that specific effort be directed at establishing the capacity to collate and analyze recommendations from case review and practice audits for the purpose of making systemic recommendations to guide the improvement of child protection services.

Many would suggest that in order to ensure impartiality, quality assurance activities need to be undertaken by a third party; not necessarily an external agency, but a party separate and distinct from the party that is subject to the quality assurance review. This was the position of the Gove Inquiry, which specifically recommended the separation of quality assurance functions from service delivery to ensure objectivity and independence. At present, quality assurance activities are preformed in the regions by regional staff. Prior to 2002 and the devolution of authority to the regions, including responsibility for quality assurance, quality assurance functions were undertaken by a central body within Ministry headquarters. It is understood that there is a concern among staff in the office of the Provincial Director about the rigor of the current quality assurance program. This has resulted in efforts by that office over the past year and a half to strengthen the reliability and efficacy of the quality assurance program, including the development of new standards, audit tools and provision of training to promote consistency and standard application across regions. The question is then, are these efforts sufficient to address concerns about the quality assurance function being preformed in-house by the regions or should regional delivery of quality assurance be reconsidered?

Public Reporting

The report of the Core Service Review hypothesized that there may come a time when what goes on in the Ministry of Children and Family Development is so transparent that there is no longer a need for an external “watchdog” or oversight agency (Core Service Review, page 51). It may be possible to mitigate some of the negative public perception that there is insufficient public accountability for the performance of the child protection system, as well as build public confidence in the system, through improved public reporting, particularly improved public reporting around internal quality assurance activities and results.

It is understood that the Ministry believes that it is significantly constrained in what it may report about its quality assurance activities, particularly with respect to case reviews, because of the protection of privacy legislation by which it is bound. However, there must be some level of information that can be released that goes

some way to meeting public interest and accountability for reporting on critical incidents while not offending privacy legislation. It is suggested that efforts be made by the Ministry to develop a reporting format and standard for case reviews in consultation with interested parties that balances the public and private interests in this area. The Ministry should also review its practice audit reporting format and post the results of practice audits on the Ministry website. Consideration should be given to producing an annual report discussing the aggregate findings of audits and the system-wide changes to standards, policies and practices that have been made, or further action that will be taken, based on these audits to ensure continuous improvement (this is further to the recommendation that the Ministry analyze its audit results in a comprehensive, systemic way).

It is also suggested that consideration be given to encouraging the Ministry to review and assess its entire public reporting framework and consider improvements to make the system more integrated, comprehensive and consistent. The Auditor General has suggested that the Ministry of Children and Families be encouraged to use the Performance Reporting Principles for the British Columbia Public Sector as a way to improve its public reporting. The Reporting Principles have been endorsed by government, the Select Standing Committee on Public Accounts and the Auditor General of British Columbia as best practice in public reporting and are designed to:

- ♣ support open and accountable government – a government that clearly communicates to the public what the government strives to achieve and what it actually achieves;

- ♣ provide a framework for learning organizations – learning organizations clarify reporting requirements and expectation, encourage sound reporting and build on best practice in public reporting;

- ♣ support understanding of the basis on which the performance reports are prepared.

APPENDIX ONE

Performance Management & Accountability

Performance management allows an organization to assess the effectiveness of its performance in meeting its intended goals and objectives and to take corrective action to adjust plans and better align strategies to support improved performance.

Accountability, the obligation of those in authority to explain and report, fully and fairly, on how they carried out their responsibilities, is an integral part of performance management. An accountability framework addresses the questions:

- Who is accountable to whom and for what?
- What information is to be reported?
- How much information needs to be reported?

The obligation to account, and report publicly on the performance of duties and responsibilities is particularly important in the context of government where government provides services and programs to the public. There is an expectation, and even obligation, that the government report publicly on its performance in order to ensure a system of public accountability.

The fundamental components of a performance management and accountability framework for an organization include:

- ***Planning and Budgeting*** – this stage includes the articulation of the purpose and mandate of the agency – what it is designed to achieve – its goal and objectives, and the strategies and activities for achieving those goals and objectives. At this stage the roles and responsibilities of the organization and the components of the organization are defined and measures are established to assess the performance of those responsibilities. A critical part of this stage of the cycle is the development and articulation of measurable goals for meeting assigned responsibilities to determine how effective those charged with authority are in carrying out the performance of their duties.

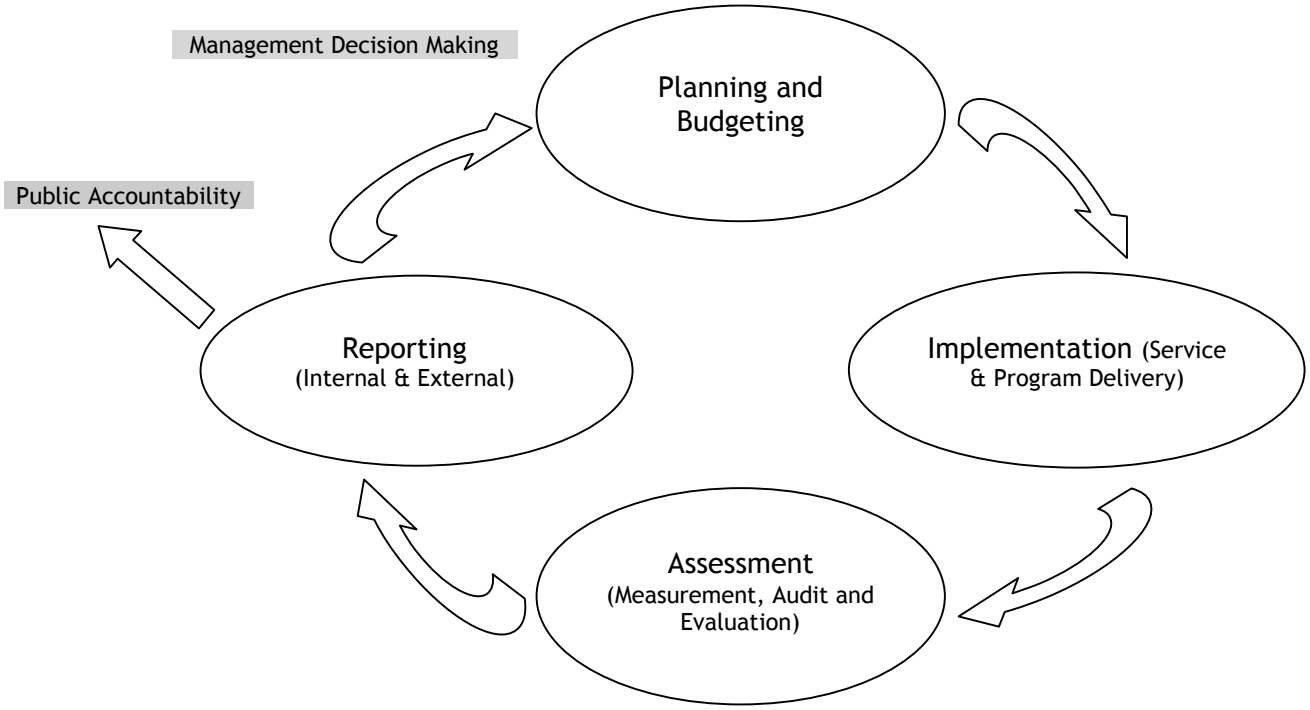
- ***Implementation through Service and Program Delivery*** – the implementation phase includes the design and delivery of services, programs and activities to support the mandate and direction of the organization; this includes

- ***Assessment – Measurement, Audit and Evaluation*** - an integral part of a performance management system is that performance is monitored, measured and reported on against intended outcomes. This includes the ongoing monitoring, audit and assessment of performance of services, programs and activities and reporting out on the performance of those responsibilities. Monitoring and audit of the performance of assigned responsibilities is not only

intended to provide information on the achievement of intended outcomes, but also provides information to support continuous improvement in the performance of duties. Results of monitoring and audit activities are evaluated and, based on those results, action is taken to enhance practices, tools, training and supports or realign strategies.

- ***Reporting*** – the final phase in the performance management and accountability cycle is reporting actual achievement against planned achievement. External reporting meets the objectives of public accountability and internal, operational reporting is designed to inform management decision-making and decisions how better to align strategies, activities and program and service delivery to better meet defined objectives.

The Performance Management and Accountability Cycle



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