



Department  
for Education

# Scaling and deepening the Reclaiming Social Work model

Evaluation report

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# Executive Summary

## Introduction

Scaling and Deepening the Reclaiming Social Work Model aimed to embed 'Reclaiming Social Work' in 5 very different local authorities (Buckinghamshire, Derbyshire, Harrow, Hull and Southwark). Reclaiming Social Work (RSW) is a whole-system reform that aims to deliver systemic practice in children's services. Key elements include in-depth training, small units with shared cases and group systemic case discussions, clinician support, reduced bureaucracy, devolved decision-making and enhanced administrative support. The overall aims include improving risk assessment and decision-making, providing more effective help and risk management for children and families. Keeping families together, where appropriate, is a fundamental aim of RSW. The Innovation Project (IP) was a partnership between a social enterprise, Morning Lane Associates (MLA), and the 5 local authorities. It consisted of the following elements:

- recruitment and development of 50 consultant social workers (CSWs) to lead small multi-disciplinary teams, known as RSW units
- bureaucracy reduction to streamline administrative processes and forms, freeing up social worker time to work with families
- keeping families together by targeting teenagers on the edge of care through specialist RSW units (known as Keeping Families Together (KFT) units)
- coaching the system to support successful implementation of the 3 preceding strands and to support senior managers to embed RSW effectively

## Evaluation design

The study adopted a mixed methods approach and collected data in 3 strands:

- data on the process of change from the perspective of people at every level across the 5 local authorities, including interviews with 213 staff; 29 structured observations of systemic case discussions; and 325 staff surveys
- a comparison of practice, service experiences and outcomes between RSW units and service as usual involving 67 coded observations of direct practice with families; 106 research interviews with parents; 4 research interviews with children; and data from computerised records for 51 families
- case study data on KFT units, including 13 group interviews with staff; 5 observations of direct practice; 10 interviews with family members; and secondary analysis of data on 119 children and young people receiving a KFT service to provide an indication of impact on care entry and potential cost savings



## Overview and context

Delivering the IP proved complex and challenging. This was exacerbated by the ambitious nature of a multi-strand, multi-site project and the tight timescale involved. In this challenging context the important features of the IP programme were successfully delivered. CSWs were recruited and trained, KFT units were set up and efforts were made to reduce bureaucracy and support systemic change.

All 5 local authorities had worked with MLA to develop systemic social work approaches from 2012 to 2013. While specific reasons varied, all reported a similar sense of dissatisfaction with their existing services and a desire to do things differently for families.

RSW unit size, structure and approach varied across the local authorities: units were considerably larger than the original RSW model; some CSWs were case holding, many were not; some had support from clinicians, though many did not; the level of dedicated administrative support varied; and with the exception of KFT units, units did not work cases collectively (a key element of the original RSW model). This is the context within which RSW was to be embedded.

## Findings

### Does RSW provide a better quality of service for families?

There was evidence to suggest that RSW provided a better quality of children's services than normal practice. The quality of direct practice was significantly higher in RSW units, as assessed using a social work skills coding framework. Indeed, the level of direct practice skill observed within the RSW group was the highest identified in any group studied from over 500 recordings across 7 local authorities using this framework.

Families also identified these sessions as more consistently high quality. There was also a higher level of agreement between carers and workers on risk factors in families in the RSW group, suggesting a foundation for more effective risk management. Unfortunately, there were insufficient follow-up interviews to compare outcomes across groups. Children from 2 of the 22 comparison families entered care, while none in the RSW units did. The numbers are too small to draw conclusions, though this finding is consistent with both the aims of RSW and the quality of practice observed with families.

Evidence from the KFT units was also positive. Again, the quality of practice observed – particularly around the positive use of authority – was very high. Of the 119 children referred to the service from multiagency resource panels as at high risk of care, 79% remained at home, with only 25 children (21%) subsequently receiving some form of care. This exceeds KFT's target of keeping 50% of children at home with their families safely.

Qualitative feedback from parents about both the KFT units and RSW practice was overwhelmingly positive. Across both RSW and comparison families, parents appreciated:

- whole-family working, particularly where practice was empathic and strengths-based
- understanding that they were part of the solution to their family's difficulties
- workers that were skilled at respectfully exploring their situation with a view to improving fractured family relationships

These 3 elements dovetail with the aims of RSW. Children also reported positively about their experiences of the service received.

### **What are the factors that make RSW work well?**

There is little existing evidence about the factors that shape the quality of children's services. This study evaluated some of the important components of RSW and the difference they made to the quality of practice in meetings between families and workers. The following 4 factors had a statistically significant impact on quality of practice:

- training in systemic practice was significantly associated with greater worker skill (trained workers 2.99, untrained workers 2.44 ( $t=-3.28$ ,  $p=0.002$ ))
- workers participating in the MLA CSW development programme (selected and trained) demonstrated very high quality practice, 3.50 vs 2.66 ( $t=-3.17$ ,  $p=0.002$ )
- the quality of group systemic case discussion had a very strong relationship with the quality of practice with families (2.35 where discussion was non-systemic, 2.98 where indications of systemic and 3.43 where fully systemic ( $r=0.456$ ,  $p=0.04$ ))
- the presence of clinicians in group case discussions predicted both the quality of the discussion ( $r=0.56$ ;  $p=0.008$ ) and the quality of practice with families (3.64 to 2.52,  $t=-3.69$ ,  $p=0.002$ )

Practitioners were overwhelmingly positive about the elements that differentiated RSW work from practice-as-usual. The following were particularly important:

- a focus on reflexivity and thinking about the purpose and outcomes of social work intervention with children and families
- unit meetings that encourage practitioners to reflect on practice and plan their sessions with the whole family
- input from clinicians that enable them to think in new ways and plan actionable conversations with families about their unique situation

- support from unit coordinators to manage multiple administrative tasks and liaise with families to ensure smooth running of units

Taken together, these create what we term a good practice pyramid. It is these interlocking features - a systemically trained CSW lead, systemic case discussion and clinician input – that, in combination, appear essential to embedding systemic social work practice with families. Dedicated administrative support provides the foundation for the good practice pyramid.

## **What are the challenges facing scaling and deepening RSW?**

Three factors made moving to RSW difficult:

- change, particularly the sort of transformative change required for RSW, is not usually an easy thing to achieve – for individuals or for organisations. This contributed to changes in some elements and sections of the organisations but not others. Perceived tensions between RSW’s therapeutic approach and the wider, more adversarial, child protection system were also identified
- responsibility for creating change was sometimes unclear. The partnership between MLA and 5 local authorities was a core feature of the project but some concerns were raised about who owned the innovation. Such concerns appeared to slow the pace of change. Furthermore, there was substantial change in senior management. For instance, at time of writing, only one of the original organisation leaders who signed up to the IP programme is still in place
- systems change cannot solely rely on excellent leaders. Leaders change, and this underlines the necessity of creating systems that recognise and reward excellence in the delivery of social work practice, rather than relying on exceptional individuals. The wider organisational system judged senior managers by whether they balanced budgets (in the short term) and whether they met Ofsted requirements. Arguably, if these remain the primary benchmarks by which senior managers are judged, the current system of incentives militates against transformation of practice and improved outcomes for children and families

## **Implications and recommendations for policy and practice**

- RSW is a model for excellent social work that has been demonstrated to be deliverable in a variety of different types of local authority. Other authorities should consider it as an option for delivering high quality services that work effectively to keep families together
- delivery of RSW to an acceptable standard is dependent on a good practice pyramid of 3 essential, interconnected elements of practice:

- a consultant social worker who has been trained systemically
- shared thinking and decision-making around cases via group case discussion
- involvement from an appropriately qualified clinician
- staff feedback suggests that enhanced administrative support to aid the smooth running of units and act as family liaison provides the foundation for the good practice pyramid.
- the degree to which RSW is delivered well in any given authority will primarily be decided by the sustained commitment and ownership of the local authority leaders
- a national agreement on the measures and samples necessary to evaluate children's services is needed to allow the comparison of new and interesting ways of delivering services. Key elements of this should include:
  - whether appropriate families are being worked with
  - the quality of service provided – including direct observation and coding of social work practice
  - the views and experiences of children, young people and their parents or carers
  - agreed outcome measures for specific groups of families
- reaching such a national agreement might usefully inform the outcomes of Ofsted's recent consultation on the common inspection framework and provide a platform for a re-imagining of Ofsted's contribution to supporting excellence in the sector

## Overview: Scaling and Deepening the RSW model

Scaling and Deepening the Reclaiming Social Work Model aimed to embed Reclaiming Social Work (RSW) in 5 very different local authorities (Buckinghamshire, Derbyshire, Harrow, Hull and Southwark). RSW is a complex, whole-system reform that aims to deliver systemic practice in children's services through a combination of recruitment; training; small teams with shared cases; group systemic case discussions; reduced bureaucracy, and other elements (see Forrester et al, 2013b; Goodman and Trowler, 2014 for in-depth descriptions). The overall aims are to improve social work risk assessment and decision-making, provide more effective help and risk management for children and families, and support social workers to develop higher levels of professional expertise. Keeping families together, where appropriate, is a fundamental aim of RSW.

The Innovation Project (IP) was a partnership between a social enterprise, Morning Lane Associates (MLA) and the 5 local authorities. It consisted of the following elements:

- recruitment and development of 50 consultant social workers (CSWs) to lead small multi-disciplinary teams, known as RSW units
- bureaucracy reduction to streamline administrative processes and forms, and free up social work time to work with families
- keeping families together by targeting teenagers on the edge of care through specialist RSW units (known as Keeping Families Together (KFT) units)
- coaching the system aimed to support successful implementation of the other 3 foci and to embed RSW more generally by working with senior managers

## What was the project intending to achieve?

The project intended to scale and deepen RSW approaches across the 5 local authorities. Its overall aim was to improve confidence in identifying and managing risk through high quality, skilful practice with families.

Specific stated goals included to:

- increase the overall practice skill of social workers and improve the authorising environment within which they make decisions on their cases
- work systemically with families to effect positive change for children
- recruit and retain talented social workers in frontline practice
- keep families together by reducing the number of teenagers entering care
- reduce the administrative burden to free up time to work with families

- ensure that that the wider organisational conditions help bring about the success of these changes and embed RSW more generally

Specific intended outcomes were identified as:

- impact on practice
  - more reflective, supportive and effective interventions with families to affect positive change
  - release 20% of worker time from administrative tasks to be spent instead working with families
  - increase worker job satisfaction and fulfilment
  - recruit and retain talented workers in frontline practice
- impact on families
  - improve family relationships resulting in fewer re-referrals and a reduction in children subject to a child protection plan, particularly those lasting over 2 years
  - keep families together, specifically reducing the numbers of teenagers entering the care system
- impact on the wider system
  - ensure that organisational conditions help bring about the success of the programme changes and support embedding RSW more generally

## **What was it intending to do to achieve these outcomes?**

There were 4 elements of the RSW project.

1. A CSW recruitment and development programme to ensure an adequate supply of skilled CSWs embedded within partner LAs. Key features included:
  - development of a common CSW person specification
  - a central recruitment campaign administered by MLA to fill up to 10 existing or new CSW posts in each local authority
  - a new, one year, cross local authority CSW development programme, delivered to 50 CSWs, consisting of 9 training days and ongoing coaching by MLA experts
  - opportunities for CSWs to share learning and develop a long-lasting professional network across local authorities

2. Bureaucracy reduction to reduce administrative burden and free up time to work with families. Key features included:
  - a review, redesign and pilot of administrative processes and changes to the authorising environment
  - consultation with DfE, Ofsted and other stakeholders to gain approval and acceptance of streamlined processes and case recording approaches
3. Keeping families together by extending the RSW model to teenagers aged 11 to 18 years on the edge of care. Key features included:
  - setting up a new specialist systemic RSW unit in each local authority
  - a goal based outcome model for both working with families and assessing success
4. Coaching the system to ensure that organisational conditions help bring about the success of the changes that are made under the 3 preceding strands of the project. Key features included:
  - programme leadership from the MLA director and local authority directors
  - KFT unit leadership roles
  - a full time RSW coach in each local authority to coach and support CSWs to embed received training, develop as future RSW coaches and support the process of reducing bureaucracy

## **Have there been any major changes to the project's intended outcomes or activities?**

The progress of the programme across the 5 local authorities was impressive. A total of 41 of 50 CSWs were recruited and trained, although there was some variation in recruitment by local authority (see appendix 1). When and where recruitment of CSWs took place proved problematic, the partnership moved swiftly to recruit candidates internally to maximise the success of the programme. In most local authorities, CSWs joined existing systemic units. However, new units were set up in Harrow and Derbyshire, going live in October and November 2016 respectively. In Derbyshire, CSWs were incorporated into 2 different models across 4 districts: RSW units were set up in 2 districts; and district-wide mentor roles were created in 2 districts (see appendix 1 for further details on varying team structures).

KFT units were introduced in all local authorities; in Derbyshire 2 KFT units were introduced to take account of the size of the county. The units were set up and staffed in line with the original RSW model, with units going live in June 2015 in 3 of the 5 local authorities (Hull, Harrow and Southwark) and September 2015 in the others (Derbyshire

and Buckinghamshire). In Buckinghamshire, an edge of care service aimed at teenagers already existed, hence they decided to target a younger age group (5 to 11 years) who had been subject to long-standing child protection procedures under the category of neglect. In 3 of the 5 local authorities, KFT units were called Preventing Family Breakdown units but KFT is perhaps a more accurate description of service, and in this report they are referred to as KFT units.

Bureaucracy reduction proved the most testing of the project strands in practice. This reflected both the influence of existing activity that the local authorities were undertaking to reduce bureaucracy, and also the wider performance management context within which children's services operate. In particular, concerns that Ofsted would not accept new recording practice hindered progress of this strand. Indeed, one of the local authorities was 'under-improvement' from Ofsted and opted out from the strand due to performance management procedures put in place. Nevertheless, new recording forms were piloted across the KFT units, and more widely in two of the local authorities. However, the forms were introduced towards the end of the evaluation, which precluded assessment of impact on release of social worker time.

Coaching the system was practised at various levels across the innovation, although differences emerged between MLA and local authorities concerning the nature and impact of executive coaching. This aspect of the innovation perhaps speaks most directly to issues of ownership. MLA were originators of the RSW model, but an external agency operating across a diverse group of local authorities that were implementing RSW according to their own vision, needs and local circumstances.

The activities set out in the proposal have therefore overwhelmingly been carried out. However, the degree to which they have embedded RSW is a focus for the evaluation.



## Overview of the evaluation

### What were the evaluation questions?

The complexity and ambitious nature of the proposed innovation meant that a multi-faceted, multi-local authority approach was required. Researchers were embedded on a full-time basis across the 5 local authorities with the aim of building relationships with workers, enriching understandings of practice and encouraging the participation of families. One researcher was embedded in each local authority for up to 12 months and administered all data collection with the oversight of the senior research fellow and principle investigator. The evaluation attempts to capture answers to 3 key questions:

- does RSW provide a better quality of service for families?
- what are the factors that make RSW work well?
- what are the challenges facing scaling and deepening RSW?

### Research design

To answer these questions the study design had 3 strands:

- a comparative study of RSW units (units in which a worker, usually the consultant social worker, had participated in the MLA CSW recruitment and development programme) and service as usual within each local authority. This assessed the quality of practice and parental experience of the service
- evaluation of the KFT units. This was primarily a descriptive study of the quality of the KFT work through observations and interviews with families and professionals. Indications of impact on entry to care and potential cost savings were also explored
- process of change study. Qualitative and quantitative data on the process of change were obtained from over 200 people at every level of the organisation across the 5 local authorities (see appendix 2 for more detail on research design).

### The comparative study

Data collection involved the observation and coding of a meeting between a worker and an allocated family; a research interview with the parent or carer who participated in that meeting, and where possible the child; and a social work questionnaire. An attempt was made to follow up outcomes through a research interview and social worker questionnaire 3 months later but the numbers were too small to allow meaningful analysis of this data. In addition, data on case outcomes was drawn from the Integrated Children's Services (ICS) electronic recording system. Data collected is summarised in Table 1.

**Table 1: Comparative data sources**

	RSW						Service as usual						TOTAL
	L A 1	L A 2	L A 3	L A 4	L A 5	SUB- TOTAL	L A 1	L A 2	L A 3	L A 4	L A 5	SUB- TOTAL	
Observations	6	10	1	5	5	27	12	8	1	11	8	40	67
Parent Interview	11	9	1	4	7	32	19	6	1	4	8	38	70
Child Interview	0	1	0	0	0	1	0	2	0	1	0	3	4
Follow-up Interview	7	8	1	2	6	24	3	3	1	1	4	12	36
Social Worker Questionnaire	8	10	0	4	7	29	18	1 0	0	7	9	44	73
Follow-up Social Worker questionnaire	1	4	0	0	0	5	3	0	0	0	2	5	10
Observation of Supervision	2	2	7	3	4	18	1	0	3	0	7	11	29

Data was collected in the following areas:

- observations of practice - where parents agreed, meetings with workers were observed, recorded and coded for key social work skills using a skills coding framework with established reliability (Whittaker et al, 2016)
- parent/carer interviews - gathered evidence on their experience of the service, engagement, levels of need and risk, using standardised measures for key elements of welfare (see appendix 2 for full information)
- child interview - children or young people were also interviewed and completed ratings of the service received and welfare
- follow-up interview - 3 months later an interview was carried out with parents, exploring their experience of the service, whether agreed goals had been achieved, and changes in standardised instruments and other outcome measures
- social worker questionnaire - social workers completed a questionnaire outlining their rating of concerns and risks for the family at the time the observation took place. At follow-up, workers repeated these ratings. In addition, it provided information on the degree to which goals in work were achieved and the support that workers felt had been provided for their work

## Sample selection

The initial proposal was to recruit a random sample of families allocated to specific teams or units over the data collection period of May 2015 to March 2016. However, recruitment challenges meant that, ultimately, most of the sample was made up of teams and workers who volunteered to ask families whether they would take part.

## Evaluation of the KFT units

The primary focus of the study was not on evaluating the KFT units but rather on understanding the more ambitious attempt at organisational change. Given the difficulties in identifying a valid comparison group, the methodological focus of this strand needed to be adjusted. Specifically, there were 2 elements to the KFT evaluation:

- an in-depth description of the quality of the service provided, and the experiences of different people, including parents, children and those delivering the service, attempted to understand the nature of the KFT service in detail
- the number of children entering care in the time between referral to the service and close of March 2016 was identified through ICS

Table 2 outlines the data collected for the KFT strand of the evaluation.

**Table 2: KFT case study data collection**

	LA1	LA2	LA3	LA4	LA5	TOTAL
Interview with Referring Social Worker	0	1	1	1	1	4
Initial KFT Interview (pre-intervention)	0	2	2	1	1	6
Observation of Case Discussion	0	2	2	1	1	6
Observation of Practice	0	2	1	1	1	5
T1 Interview with Family	1	2	2	0	1	6
Post-Intervention KFT Interview	0	1	2	1	0	4
T2 Interview with Family	0	1	2	0	1	4
Resource Panel Observation	0	0	0	0	1	1
Resource Panel Interview	0	1	1	0	1	3

## Process of change study

The final strand of the study explored the process of organisational change. It attempted to understand how and why change happened, what the barriers were and, where they were overcome, how this was done. Table 3 outlines data collected: 112 individual interviews, 22 group discussions (with 101 people) and 325 staff surveys were completed by people at every level of each local authority. This provided an enormous quantity of qualitative data. Due to space limitations, only key qualitative findings are presented.

**Table 3: Descriptive data sources**

	LA1	LA2	LA3	LA4	LA5	MLA	TOTAL
Key Informant Interviews	8	26	40	17	14	7	112
Group Interviews (n)	7 (37)	3 (19)	5 (20)	0 (0)	6 (23)	1 (2)	22 (101)
Staff Survey	49	87	59	59	71	-	325

## Changes to the methodology

The central focus of the original proposal was to gather data on up to 50 families from each local authority (split between RSW and service as usual comparison groups) providing a total of 250 families split between the 2 groups. This was, with the benefit of hindsight, very over-optimistic. There were 3 main reasons why this was not possible: it was probably unrealistic given the timescales; having individual researchers in each local authority limited engagement and meant that if any researcher had a problem, data collection stopped; and co-operation varied across authorities and even within authorities - research was rarely a high priority for busy organisations. The small sample, and attrition rates, meant the follow-up sample was too small for meaningful comparative analysis.

The other significant change to the evaluation methodology was the approach to KFT. This aspect of the study was also originally designed to be comparative, comparing electronic records of young people allocated to KFT units with young people at risk of entering care but not allocated to the KFT unit. However, difficulties in obtaining a directly comparable group meant that suitable comparison groups were not possible to identify. To address this, the evaluation conducted secondary analysis of data provided by KFT units on proposed plans for the use of care placements for referred children and the actual use of those placements. This provided data on the numbers of children prevented from entering care, but estimates of potential cost savings made were based on estimating that half of the children might have entered care without KFT input.

## Key findings

Key findings are reported in 5 parts:

- the context for innovation - the journey toward RSW
- quality of service for families - findings from RSW and KFT units
- what practitioners, parents, children and young people say about RSW
- the conditions that create RSW and embed practice change
- the challenges facing scaling and deepening RSW

## Part 1: The context for innovation - the journey toward RSW

### What is Reclaiming Social Work?

RSW is an approach developed within the London Borough of Hackney aimed at improving services for children and families. It aims to reclaim social work and re-orientate the child protection system toward practice with children and families that is relational and reflexive, rather than adversarial and punitive. Keeping families together, where appropriate, is a fundamental aim of RSW.

The RSW model involves whole-system change that recognises social work practice as an "especially challenging profession requiring a range of complex skills, a sound grounding in professional knowledge and understanding of its evidence base" (Cross et al: 2010: 3). Previous research has identified RSW as an innovative and effective model to improve outcomes for children and families; one that addresses the quality of direct social work practice but also creates the wider systemic conditions within which such practice can thrive (Cross et al., 2010; Forrester et al. 2013a).

Central to the RSW model is the creation of small multi-disciplinary teams, known as systemic units or RSW units. These are headed by a consultant social worker (CSW) to whom cases are allocated. Under the direction of the CSW the unit then collectively works the case. In the original model, RSW units consisted of the following members: one CSW; one social worker; one child practitioner; one unit coordinator; and clinician who generally worked half time across 2 units. Clinicians have a range of relevant professional backgrounds in systemic family therapy, clinical psychology, child development and child and adolescent mental health (see appendix 3 for more detail).

It should be noted that systemic units were called different things in different partnership local authorities. For the purposes of this report, RSW unit will be used for the sake of simplicity.

## What is systemic social work practice?

RSW units are informed by systemic theory. Systemic social work practice is a relational and strengths-based approach that positions service users as experts in their unique family situation (see appendix 4). A central concept is considering multiple perspectives and multiple possibilities. This aims to enable workers to explore risk to children from multiple perspectives, including those of families and other professionals, and allows for both multiple explanations and therefore solutions for problems. Although it is recognised that in child protection not all resolutions are acceptable, this approach nevertheless seeks to provide opportunities for families to be part of the solution, re-write their stories and demonstrate capacity to safely care for their children (Koglek and Wright, 2013).

## Local authority context

The RSW project sought to embed the systemic social work practice within 5 local authorities in diverse and distinct areas of England:

- Buckinghamshire and Derbyshire are county councils with respective population densities of between 3.0 and 3.2 persons per hectare
- Hull is a city council in the north of England with a population density of approximately 40 persons per hectare
- Harrow and Southwark are 2 London Boroughs, 1 outer and 1 inner, with density levels of 40 and 100 persons per hectare respectively (ONS, 2014)

Similarly, demography and levels of deprivation varied enormously across the 5 local authorities. Hull is one of the most deprived authorities in England; Southwark is also relatively very deprived; Derbyshire has great variety in a large county; Harrow had relatively low levels of deprivation; and finally, Buckinghamshire is a very affluent large county – though with areas of high deprivation (ONS, 2015).

The local authorities also varied with regard to the ethnic profile of their respective populations. Derbyshire and Hull encompassed populations with over 90% white British residents, while Southwark and Harrow are notable for their striking diversity, with less than 40% of residents self-described as White British (ONS, 2012).

Similarly, the levels of service demand and throughput varied between the local authorities, in some cases markedly (see table 4 and figure 1 below). For example, in Hull and Southwark, the rate of children defined as in need by the Children Act 1989 significantly exceeds that of the English average; in Hull by over double. Conversely, child in need (CiN) rates are considerably less than the national average in Buckinghamshire and Harrow. The rate of young people subject to Child Protection Plans (CPP) follows a similar trend (DfE, 2015).

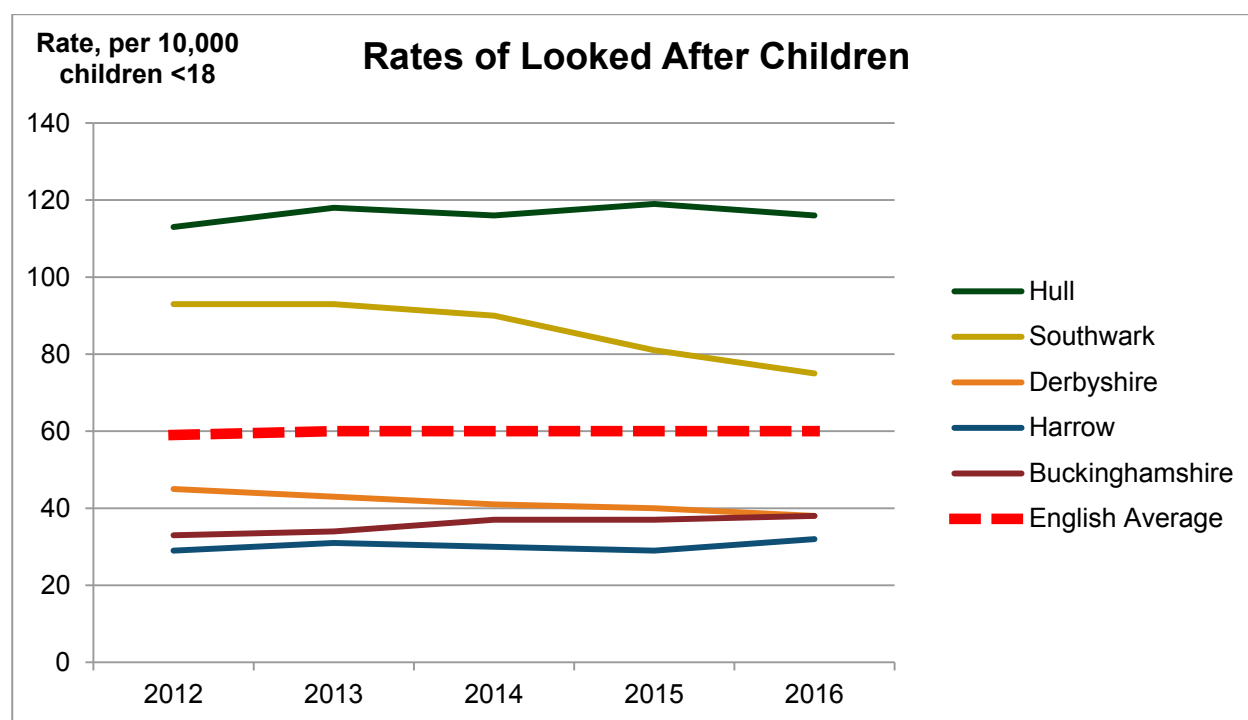
**Table 4: Service demand by local authority**

	Hull	Derbyshire	Buckinghamshire	Harrow	Southwark	England
Rate of Children in Need per 10,000	683	303	227	281	526	337
Rate of Referral to Children's Services per 10,000	837	631	431	334	440	548
Rate of Children subject CPP per 10,000	61	42	28	30	50	43

Source: DfE, 2015

There are also marked variations in the patterns and rates of Looked After Children (LAC), see Figure 1. LAC rates are significantly higher in Hull and Southwark; again, Hull has a rate double that of the national average. Buckinghamshire and Harrow have significantly lower rates (DfE, 2016).

**Figure 1: Rates of looked after children by local authority**



Source: DfE, 2016

## Why Reclaiming Social Work?

All 5 local authorities had worked with MLA or other providers, such as the Tavistock Foundation and the Institute of Family Therapy, to develop systemic social work approaches since 2012 to 2013. While specific reasons varied, all reported a similar sense of dissatisfaction with their existing services and a desire to do things differently for families. The Munro report (2011) was often cited as catalyst for reform, offering opportunities for local authorities to think differently about their services and take action to embed practice change. The Munro report identified RSW as a promising model which led the 5 local authorities to work with MLA, whose director had originally developed the RSW approach in Hackney, to establish and embed system change.

Figure 2 plots activities undertaken by the local authorities prior to, and post, changes made via the IP. The partnership between MLA and the local authorities manifested itself in different ways in different local authorities, underlining the diverse nature of innovation depending on context, priority and user need. Some local authorities rolled out a restructure of the entire Children's Services department, whereas other authorities concentrated on particular service areas. Having received a 'good' Ofsted rating that commented specifically on the quality of existing systemic social work practice, 1 partner local authority could see no added value in restructuring services, citing cost as a prohibitive factor.

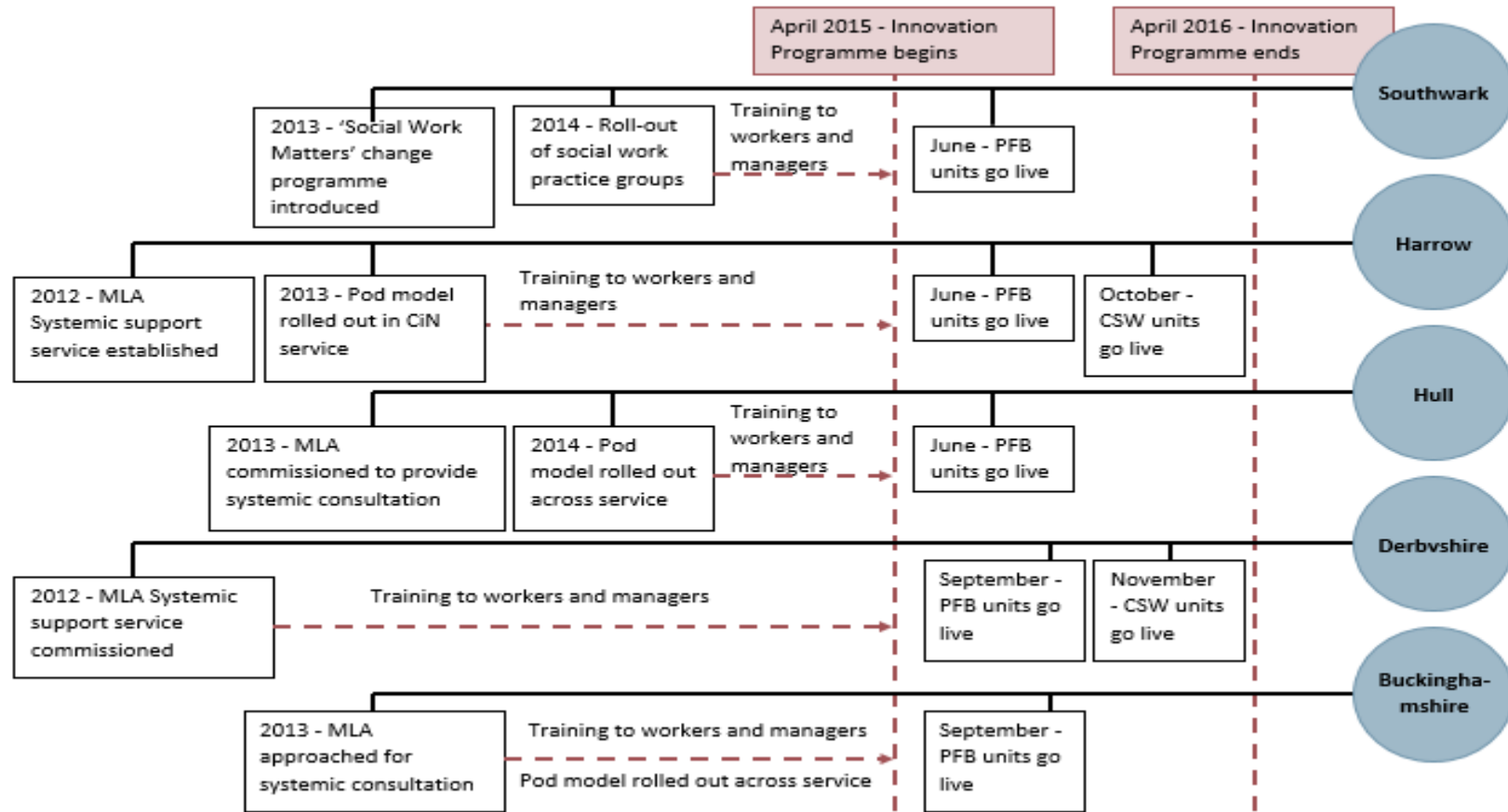
Pre-April 2015, in summary, change activity included:

- Hull, Buckinghamshire and Southwark - service restructure, move to unit model and staff trained systemically. MLA engaged as consultants for the change programme
- Harrow - service restructure, move to unit model within CiN service and staff trained systemically. MLA engaged to set up systemic early Intervention and social work support service
- Derbyshire - staff trained systemically. MLA commissioned to provide training and clinical supervision of complex cases

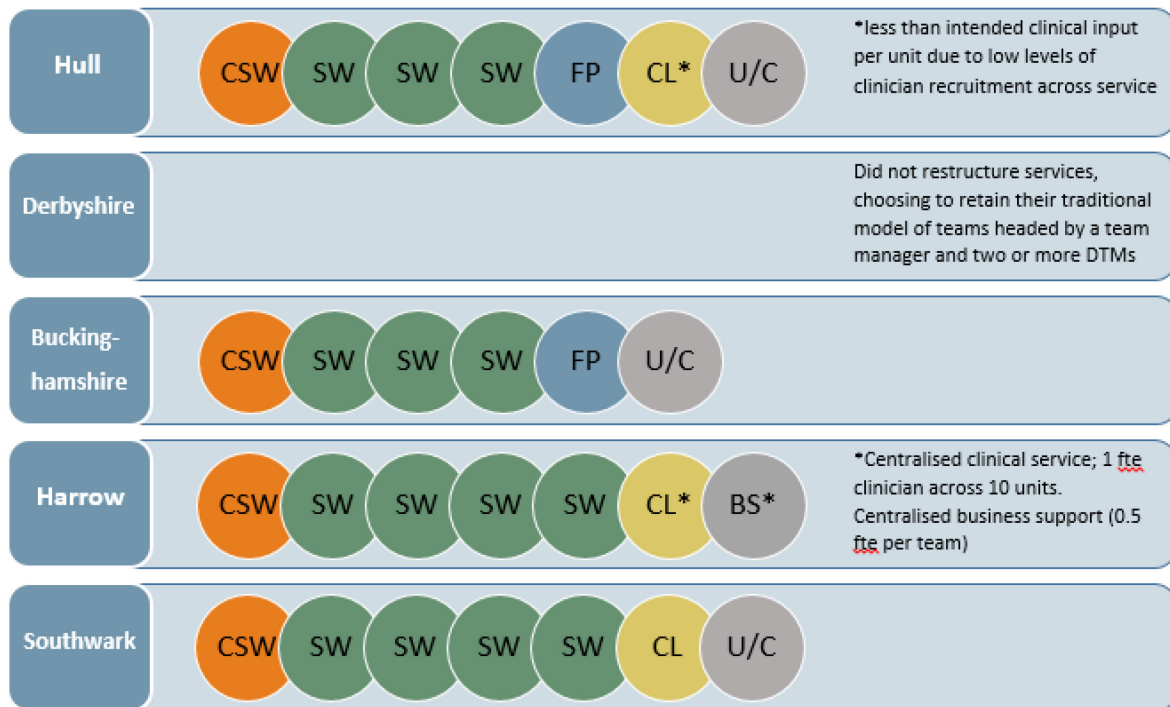
It should be noted that unit size and structure varied across the local authorities: units were considerably larger than the original RSW model; some CSWs were case holding, many were not, depending on local authority or service area within respective local authorities; 2 local authorities had family practitioners, 3 did not; 3 had clinicians, 2 did not, although in practice availability of clinicians varied; 3 had unit coordinators, 2 did not; and RSW units did not collectively work cases, reflecting the larger size of units that resulted in too many cases to be worked together effectively. Figure 3 details differences, where applicable, in unit size and structure prior to the IP (see Appendix 5 for pre- and post-IP unit models). Part 4 discusses the features which are critical to embedding systemic social work practice



Figure 2: Innovation journey by local authority



**Figure 3: Systemic unit models by local authority prior to IP**



## Conclusion

It should be noted that a number of key features of this background situation are pertinent to the evaluation:

- the local authorities had already made significant moves toward the RSW approach prior to the IP
- comparisons of practice are therefore not between RSW and conventional practice, as much as between RSW and other attempts to deliver systemic practice
- it is difficult, using either qualitative or quantitative data, to disentangle the specific impact of the IP from the more general direction of travel

These and other factors are returned to in the final discussion section.

## **Part 2: Does RSW provide a better quality of service for families?**

### **Comparative study**

In total, data was collected from 86 families. Only in a small number of families (n=4) did both the parents and child give consent for the child to be interviewed. As previously noted, numbers were too small for meaningful comparative analysis of outcomes at follow-up interview (T2) 3 months later.

While it is not possible to carry out the planned quasi-experimental study, it is possible to report 2 analyses based on this data. In this section, an analysis of the quality of practice and indicators of service quality compares the RSW units and service as usual. In Part 4 the whole sample is analysed to identify key factors influencing the quality of practice.

The comparative analysis compares practice and experiences in units in which at least one person had been on the CSW development training (the RSW group) and those in conventional teams or units in the local authority (service as usual or the comparison group). The comparison group includes a wide range of different types of training and team setup; with workers varying in level of training, length of experience, the unit or team they worked in, access to clinicians and many other factors. The RSW group includes families where the worker is in the RSW unit of someone trained on the CSW development programme. It is important to note that only 10 of these observations were with someone actually on the programme, largely because CSWs were not case holding. The hypothesis behind the training programme was that selection and training would enable high quality units generally led by someone who had participated on the programme. This element of the study therefore evaluates whether the units created through the CSW programme delivered significantly better practice and outcomes. There were 34 families that took part in a practice observation and/or an interview with a researcher in the RSW group, and 52 in the comparison group.

This section of the report briefly reviews the nature of the sample studied. It then analyses differences between the RSW and comparison samples. The degree of agreement between workers and families on the presence of key issues is then explored, before differences in the quality of practice are analysed. This is followed by a brief section in which outcomes are presented, though for this section no meaningful between-group comparisons are possible.

## The research sample

Eighty-six families participated in the research across the 5 local authorities. Table 5 describes the distribution by local authority. There are considerable variations in numbers between local authorities, and, for this reason, no between-authority analysis is included in this report. For key findings, variations between authorities have been analysed, and, if identified, are noted and discussed.

**Table 5: Family participants by local authority and sample group**

	Hull	Derby-shire	Bucks	Harrow	Southwark	Total
RSW unit family	11	10	1	5	7	<b>34</b>
Service as usual family	24	8	1	11	8	<b>52</b>

## Description of the sample and analysis of RSW and comparison groups

Table 6 provides an overview of key features of data collected from the families through a comparison between the RSW and service as usual groups. Unfortunately, self-identified problems were only collected for about half the sample (39 families) due to a reduced version of the interview schedule being used in Local Authority 1. This was because most observational and interview data was collected in one week, hence time was limited (see appendix 2). Relative to the general population, overall, the families had substantial levels of problems. The General Health Questionnaire (GHQ) scores suggest twice the population level of risk of anxiety or depression, while the SCORE-15 rating - which measures the kinds of changes in family relationships that systemic family therapists see as indications of useful therapeutic change - is similar to that for families using systemic therapy services (see appendix 2 for a fuller description of research measures used).

There was only 1 statistically significant difference (drug and alcohol problems ( $p=0.03$ )) between the two groups, though there was a tendency toward more problems for the RSW unit families. In fact they had twice as many at 0.72 per family compared to 0.36, but the small sample sizes meant that this did not achieve statistical significance. There are therefore no grounds to believe the families in the two samples were very different. One of the most striking findings is that the family life rating suggested families felt there were very serious problems at the point of referral but, for both groups very substantial improvement by the point of study entry. Indeed, by then parents were reporting that family life was going relatively well. This pattern is found consistently across ongoing studies developed jointly at University of

Bedfordshire (UoB) and Cardiff University in children’s services. It has a number of implications for understanding other elements of the data collected. It highlights that, for most families, the period of initial social work involvement is a period of crisis, but that, at least for the families researched, this crisis has often abated significantly by the time of first interview.

**Table 6: Data on family welfare and issues from parent interviews (T1)**

	RSW Unit Family			Service as usual family		
	Mean	SD	N (%)	Mean	SD	N (%)
Life scaling (1-10) at referral	3.12	2.44		2.82	2.81	
Life scaling (1-10) now	7.00	2.02		7.06	2.44	
Score-15	31.96	12.74		31.98	12.53	
GHQ clinically elevated score			14 (44%)			11 (31%)
Parent identified concerns:						
alcohol or drugs			4			0
child’s emotional or behavioural welfare			9 (47%)			7 (35%)
school attendance			5 (29%)			3 (19%)
parental isolation			3 (16%)			4 (20%)
parents’ mental health			8 (50%)			4 (22%)
Average number of concerns identified	0.72	0.67		0.37	0.50	

The evaluation also explored worker perceptions of levels of risk and significant family issues for those families that participated in the study. Table 7 presents the social workers’ rating of concerns, as identified through social worker questionnaires that were collected for each family included in the sample. The average level of concern in relation to types of abuse, was measured on a 4-point scale (1 = no concern; 2 = low concern; 3 = medium concern; or 4 = high concern). Again, this

data was divided into two groups by whether or not workers were based within a RSW unit.

**Table 7: Average social worker rating of concern**

Type of abuse	RSW Unit Family		Service as usual Family		T value	P value
	Mean	SD	Mean	SD		
Perceived risk of abuse, physical	2.00	1.07	2.07	1.31		
Perceived risk of abuse, emotional from domestic abuse	2.21	1.24	2.29	1.29		
Perceived risk of abuse, emotional not domestic abuse	2.69	.97	2.49	1.03		
Perceived risk of abuse, sexual	1.25	.65	1.52	1.02		
Perceived risk of neglect	1.71	.90	2.33	1.32	0.234	0.022
<b>Rating of overall concern</b>	<b>2.82</b>	<b>.72</b>	<b>3.25</b>	<b>.71</b>	<b>0.244</b>	<b>0.017</b>

The average level of concern was only significantly different between the two groups in relation to neglect and overall level of concern, with both being higher in the comparison group. Given that families within RSW units tended to rate their problems more seriously, it is curious that RSW workers tended to rate overall risk as significantly lower than workers within the comparison group. Was there a different understanding or tolerance of risk across the two groups?

To explore this apparent contradiction, further analyses were conducted on the degree to which workers and family members agreed about important family issues. Some level of agreement on the presence of issues is a foundation for working productively with families, so this is an important area to evaluate in its own right. The analysis compared worker identification of the presence of an issue, either suspected or definite, with the parent's identification of the same issue as a concern. It was only possible in 32 families to make a comparison, and within them, there were only 3 points to compare: substance misuse, mental health and social isolation.

Even then, some had fewer points of comparison for some analyses. Table 8 outlines the overall level of agreement for drugs and/or alcohol (19 out of 32 or 59%); for mental health (17 out of 27 or 63%); and for social isolation (14 out of 27 or 52%).

**Table 8: Level of agreement between worker and carer identified issues**

Type of issue	Worker identified issue (suspected or definite)	Carer identified issue	Level of agreement
Drugs and/or alcohol	32	19	59%
Mental health	27	17	63%
Social isolation	27	14	52%

These are rather low levels of agreement as a starting point, with families agreeing with their respective worker's identification of an issue on between 52% and 63% of occasions. However, there were variations in these levels of agreement between the RSW and comparison groups. These are set out in Table 9. While the numbers are small, there was a higher level of agreement about the presence of parental issues (substance misuse and mental illness) for the RSW unit group. This was statistically significant for mental health issues and approaching significance for drug and alcohol issues. Social isolation numbers showed little difference between groups.

**Table 9: Level of agreement between worker and carer identified issues between RSW and comparison group**

	RSW Family		Comparison Family		T-Test Results	P value
	N	Agreement	N	Agreement	T-value	
Drugs and/or alcohol	17	12 (71%)	15	8 (53%)	-1.8	0.08
Mental health	14	9 (64%)	13	5 (38%)	-2.17	0.04
Social isolation	17	8 (47%)	15	9 (60%)	0.585	0.561

There are 2 conclusions that can be drawn from this analysis. First, there was a tendency for RSW workers to have higher levels of agreement with parents about their family's issues. While complete agreement would be impossible, some level of agreement seems to be an indication of good practice in social work. This was combined with families in the RSW group identifying more problems, where workers had lower concern about risk, which suggests that RSW units had lower levels of anxiety about risk.

## How did the quality of practice compare between RSW units and comparison?

Observations of direct practice were coded for key social work skills. These measures were developed in other studies at UoB and Cardiff University and have now been applied across over 500 direct observations of practice. Studies show that skills can be rated reliably and there is a growing evidence base of the links between skills, parental engagement and family outcomes (Whittaker et al, 2016; Forrester et al, forthcoming a and b).

The complete coding system involves coding for empathy, collaboration, autonomy, evocation of intrinsic motivation, purposefulness, clarity about concerns and focus on the child(ren) (please see appendix 2 for a detailed description of the coding framework). For each dimension, observations are coded on a 5 point scale, with 1 being poor practice and 5 being excellent. For the purposes of this evaluation, the skills categories for evocation and autonomy were not included in analyses. 'Evocation' can only be applied when discussions between workers and parents or carers included a specific focus on behaviour change related to that carer.

Since a large proportion of recorded practice sessions did not include this as a topic of conversation, evocation was excluded because it can only be coded for discussions about behaviour change and therefore it would reduce the sample size. 'Autonomy' focuses on individual responsibility and decision-making and it was therefore not a theoretically appropriate dimension of practice for exploring systemic practice. Empirically, the pattern of variation when autonomy was included was similar to when it was excluded. In the analyses below, an overall score for 'social worker skill' was derived by calculating an average of the 5 coded skills categories that were analysed (collaboration, empathy, purposefulness, clarity about concerns and child focus).

Findings are set out in Table 10. For each element of skill, and for the average level, all differences were highly statistically significant. It is also noteworthy that, if anything, differences were higher for the elements associated with 'good authority' (clarity about concerns, purposefulness and child focus), indicating the successful use of systemic principles in child protection conversations, rather than more supportive or therapeutic discussions. To provide context, UoB and Cardiff University have used such measures in various recent studies, and workers commonly score around 2 to 2.5; 3.24 is the highest score thus far seen for any local authority or group of practitioners.



**Table 10: Social work skills in RSW units and comparison group**

	RSW unit		Service as usual		T-test result		
	Mean	SD	Mean	SD	t-value		p-value
Collaboration	3.29	1.20	2.51	.93	2.936	63	.005
Empathy	3.08	1.13	2.24	.86	3.419	65	.001
Purposefulness	3.19	.75	2.59	.77	3.167	65	.002
Clarity of Concerns	3.23	.71	2.54	.81	3.583	65	.001
Child Focus	3.20	.76	2.63	.73	2.994	64	.004
Overall SW Skill	3.24	.77	2.50	.59	4.307	62	<0.001

**Were there differences in parent evaluation of the service?**

Table 11 analyses parental rating of various elements of the social work response. For many indicators of professionalism there was no between group difference. For professional and respectful, there was a tendency to better practice in the RSW group that did not achieve statistical significance ( $p=0.1$ ). In contrast, for the parent’s rating of the observed session, there was a highly significant difference between the groups ( $p=0.004$ ). This reflected the fact that every RSW meeting was rated as good or very good, compared to 76% of the comparison group. While statistically a very significant difference, this does highlight the challenge of demonstrating improved practice over practice that was often perceived to be good or excellent.

**Table 11: Parent ratings of quality of service**

	RSW unit family		Comparison unit Family		Sig. (2-tailed)
	Mean	Standard Deviation	Mean	Standard Deviation	
Experience of social services involvement:					
worker is on time	4.26	1.11	4.34	1.04	.756

	RSW unit family		Comparison unit Family		Sig. (2-tailed)
	Mean	Standard Deviation	Mean	Standard Deviation	
reasons clearly explained	4.45	.86	4.50	.62	.774
included in meetings	4.27	1.10	4.36	.95	.752
I feel understood	4.66	.48	4.60	.76	.736
professional and respectful manner	4.13	1.23	4.53	.76	.116
overall pleased	3.97	1.38	4.00	1.26	.935
Times seen social worker in last 4 weeks	2.68	1.19	2.81	1.18	.758
Rating of how happy with the amount of contact with social worker	3.08	.84	3.03	.47	.758
Rating of how well worker handled observed meeting, 1 (very badly) through 4 (OK) to 7 (very well)	5.97	1.22	6.66	.48	.004

## Outcomes for the families

Comparative analysis is not possible for the follow-up data, which was based on interviews with parents, and questionnaires with social workers, 3 months after the initial (T1) interview. In part, this is because the numbers are small, but also because 90% of the attrition between initial interview and follow-up was in the comparison group, undermining the validity of the comparison. However, it is worth noting that overall there was a move toward positive change across the whole sample. For instance, Life Scaling had increased to 7.6 out of 10 and the proportion identified as having high risk of anxiety or depression (from the GHQ) score had fallen to 18% (the same rate as the general population). In contrast, there had been no shift in the SCORE-15 rating for family functioning.

For the primary outcome measure, Goal Attainment Scaling, a very positive picture emerged: 36% of parents identified their goals for work as having been partially achieved, while 42% felt their goals were fully achieved. For attainment of the social worker's goal (when different from that which the parent identified), the level of goal achievement was even higher: 58% of parents felt the worker's aims had been fully achieved, and 39% thought it had been partially achieved.

It was possible to carry out some comparisons on ICS data for families. Here there were few statistically significant differences because the sample was relatively small. One of the key outcome measures for RSW is whether children enter care. It was noteworthy that, despite the somewhat higher level of apparent risk in the RSW sample, none of the children entered care. In the comparison group 2 families had a child removed. This difference does not achieve statistical significance.

## **Conclusion**

These findings highlight the complexity of evaluating children's services. Timeframes for the project and evaluation meant it was not possible to collect the sample initially hoped for, and this compromises and makes more complex the drawing of conclusions from the data. In this context, 3 conclusions can be drawn from the current study. First, the overall quality of the service received by families varied, but it was often of a comparatively high standard. This makes identifying the specific impact of RSW challenging.

Second, despite this it was clear that practice in the RSW units was of a higher standard than that in normal practice. From the data collected, it cannot be shown that this translates into better outcomes for children and families, though it is difficult to sustain the argument that the quality of practice has no impact on outcomes. It therefore seems sensible to conclude that RSW practice is likely to produce better outcomes for children and families.

Third, there was other evidence that RSW may be delivering a more effective service. There was better agreement between parents and workers on the presence of key issues. RSW workers also seemed to have lower levels of concerns about risks. The numbers were small, but the fact that no children entered care from the RSW units, despite the higher proportion where there were serious parental issues such as drugs, alcohol, and mental illness, is a promising indication of their potential to reduce the use of care. This is particularly so given previous research on RSW.

The next section considers the KFT units as a specific form of the RSW model, before presenting data on what practitioners and families say about RSW. The report then returns to the dataset, outlined above, alongside qualitative data to answer a different question; what conditions are necessary to deliver RSW effectively?

## Do KFT units prevent children entering care?

The primary objective of the KFT services was to reduce entries and re-entries to care, and the time spent in care upon entry. All children referred to KFT were identified by a multi-agency resource panel as being at high risk of entering care. To avoid this, KFT services aimed to work intensely and expertly with families to reduce risk and enable children and young people to stay with their families. KFT intended to support at least 50% of these children to remain safely at home with their families.

### The FAMILY approach

Unlike RSW units in the wider sample, KFT units were structured and staffed in line with the original systemic unit model (see appendix 3 for breakdown by role). They were the only units to work cases collectively, underlining their fidelity to the original RSW model. All unit members participated in 5 days training on KFT's structured intervention, the FAMILY approach. This was followed by 3 further days training throughout the year. Coaching was provided weekly to the whole unit within unit meetings, for the first 2 months. Coaching was then provided fortnightly before moving to monthly telephone sessions. KFT unit meetings were recorded and discussed with the CSW by the coach during these calls. KFT practice was based on a structured, goals-based intervention, known as the FAMILY approach.

FAMILY stands for:

- F – Find out presenting problems, family aims and resources
- A – Agree with family on specific, measurable goals
- M – Map out (with family) the factors contributing to difficulties
- I – Intervene to address specific factors
- L – Look to see if intervention has made a difference (revise if necessary)
- Y – over to You! Help identify how family will sustain changes

The FAMILY approach developed by MLA focuses on the identification and agreement of goals with the family. Generally, each family is asked to identify 3, and a maximum of 4, goals. Once goals are identified, time is spent with the family mapping the reasons why they are currently experiencing difficulties in achieving those goals. It is only after the process of collaboratively mapping what made things problematic for the family that the team engage the family in thinking about how to tackle those difficulties. At this point, a plan is agreed and interventions are put in place. The plan is then monitored by the unit on a weekly basis. The following interview extract describes this process in practice:

We spoke to the family about what they wanted to be different, what they wanted to change about the kids. Initially the children in the family, [said] "No everything's fine." As time's gone on and we've got more involved they've come up with more. So that helped us to then make the goals (social worker).

### **Skilful, purposeful practice**

A small number of direct observations (n=5) were undertaken between KFT practitioners and families. Although a small sample, since there were only 12 potential CSWs and social workers practicing across the KFT units that could have been observed, it represents a high proportion of a small sample frame. Applying the same social work skills coding framework as used in the comparative element of the study revealed that social workers scored exceptionally well for those domains that code the skilful use of worker authority; purposefulness (3.4), clarity of concerns (3.8) and child focus (3.8). This is indicative of practice in KFT units being purposeful, clear for families and focused on concerns for children and young people. Their scores for empathy and collaboration were closer to service as usual.

### **Unit-based interventions to support families to stay together**

Working cases collectively as a unit with families was identified by unit members as a key mechanism to support change. KFT workers welcomed this approach, both providing support for each other but critically for families: for example, "What's helped is that there has been 4 of us going into this house" (social worker). This was underlined by the FAMILY approach, that offered a structured but collaborative and purposeful practice framework for engaging with families:

I think the way of structuring the way we do things... as opposed to getting a bit of paper that says, "these are the issues," and as a social worker I go in and I go, "right, I'll tackle this, this, this and this. I've got a process. I know what I'm working towards. I know how to identify the problem, how to get the parents to identify the problem and then how to intervene" (social worker).

Unit members described weekly unit meetings as allowing for iterative improvement in intervention planning and linking to outcomes: for example, "coming back to the team and saying, 'has it worked, hasn't it worked? What do I do next week?' And having that planned like that lets you know what it is that you're going to go and do" (social worker).

### **Goals achievement and sustainability planning**

Nearing the end of the KFT's work with families, interviews were undertaken with the whole unit to better understand the impact the approach had made. The length of time worked with families often far exceeded the 12-week intervention initially

envisaged. Unit members reflected that the complexity of difficulties faced by families had meant that they had remained involved as a service. They also cited their determination to ensure that changes made were sustainable, so as to prevent future care entry. In some cases, this reflected that understandings of risk to children had developed over time, and further work with the family was required: "We came to realise that it's the oldest child that needs more therapeutic support than anything else. Because he's witnessed a lot of domestic violence, he's become quite anxious and his behaviour can be quite difficult" (social worker).

However, KFT members identified that many of the goals that were initially negotiated between workers and families had been achieved. Goals achieved included making the home a place where young people felt happy and safe: for example, through reduced parental alcohol and drug use; fewer family arguments; improved parental mental health; and young people to be engaged in purposeful activity for example, replacing drug use with safe and healthy alternatives:

One brother is in a much better place now where actually he seems to be sustaining the changes of not using legal highs, he's going into school. When he had been the 1 who hadn't gone into school at all really ... he seems to be in a place where actually both risks are significant lowered (social worker).

When things start to improve for families, the FAMILY approach proposes that the unit work with the family to put together a sustainability plan. This describes what things had helped and how to keep going with them – the 'over to You' element of the approach.

Workers described this as a co-constructed piece of work, written with the family and offered to them as a resource after closure or transfer out of the service; although also, at times, shared with other professionals with the family's agreement:

As part of wind down we've written a transfer summary for them. So all the work that we've done including an example of how we work, our concerns, the strengths, summaries, all of our maps, all of our diaries all in 1 report which all of our families have got. So actually, they can say... "this is what we've done, this is what we focused on" (social worker).

### **Impact on care entry**

At the end of March 2016, a total of 119 children and their families had received a service from KFT units across the 5 local authorities. KFT teams aimed to be able to support at least 50% of these children to remain safely at home with their families, and, in the event, 79% remained at home, with only 25 children (21%) subsequently receiving some form of care provision of at least 1 week, either during the period when they and their family were working with the KFT team or after involvement with

this service ceased (see Table 12). These entries varied in duration, with some as short as 1 week and others continuing for the majority of the year. The average admission length, of those that lasted more than 1 week, was 15 weeks (not including any period after March 2016 during which care provision may have continued).

**Table 12: KFT cases by local authority and where at least 1 week was spent in care**

<b>Local Authority</b>	<b>Number of children at risk of care entry</b>	<b>Cases where at least 1 week spent in care</b>
Local Authority 1	27	11
Local Authority 2	25	4
Local Authority 3	30	0
Local Authority 4	21	5
Local Authority 5	16	5
<b>Total</b>	<b>119</b>	<b>25</b>

### **Impact on service costs**

Table 13 sets out firstly, the actual costs of care for those children who entered care and who received a KFT service; and secondly, the potential costs if all children referred to the respective resources panel had subsequently entered, and remained in the form of care provision being considered by the respective Children’s Services resource panel at the time of referral. This was calculated on 2 assumptions. First, that if the KFT service had not been available, the type of care provision being considered by the resource panel, or already in use, at the time of referral, would have been provided to the young person. Second, that the same care provision would have continued, uninterrupted, until the end of March 2016. Based on these assumptions, the total actual costs (£549,013) was subtracted from potential costs of care to give an estimated total of £3,116,486 in care costs avoided.

However, even though each resource panel was tasked with identifying and referring only those young persons for whom, without the KFT service, they would be considering care provision, in reality it is likely that not every child that was referred to KFT would have definitely gone on to be admitted to local authority care. If only 50% of those children who were referred to the service had been placed in the care provision being considered by the respective local authority, £1,283,736 would have still have been potentially avoided. These calculations offer an indication of the costs each case could have incurred during the course of the running of the units had KFT not existed. In the absence of a comparison group, or historical data on the number of children assessed on the edge of care compared to the number that actually entered care, this presents the next best alternative of assessing potential cost savings.

**Table 13: Potential cost avoidance by local authority**

	<b>Potential cost of care if all children entered and remained in care (£)</b>	<b>Potential cost of care if 50% of children entered and remained in care</b>	<b>Actual cost of care (£)</b>	<b>Potential cost avoidance if all children had entered and remained in care (£)</b>	<b>Potential cost avoidance if 50% of children had entered and remained in care (£)</b>
Local Authority 1	795,570	397,785	102,461	693,110	295,324
Local Authority 2	625,237	312,618.50	40,131	585,106	272,487.50
Local Authority 3	417,582	208,791	0	417,582	208,791
Local Authority 4	1,493,540	746,770	351,810	1,141,730	394,960
Local Authority 5	333,570	166,785	54,612	278,958	112,173
<b>TOTAL</b>	<b>3,665,499</b>	<b>1,832,749.50</b>	<b>549,014</b>	<b>3,116,486</b>	<b>1,283,735.50</b>

### **What do families say about the KFT service?**

Families identified the following important features: collaborative working; user-defined outcomes and solutions; intensity of support; and encouragement to carry on, even when family relationships were challenging:

I feel that if a team like this did not exist then families would not have as much support and interaction. The team has been and continue to be so helpful and supportive, even when I feel helpless they have encouraged me to carry on. We have trusted them and my daughter has felt relaxed and trusting enough to open up to them as they have taken the time to build the relationships (parent).

Families also commented that KFT practice was more supportive than previous experiences of Children's Services. They commented on the strengths-based and service user-led nature of working, that focused on keeping their families together:



You give us so much more time. You let us explain ourselves, you don't come in here and tell us, "You've got to do this or we're going to take your children away" (parent).

It took a while for things to settle in with the KFT team, but they have been 100 times more supportive than our previous experience of working with Children's Services. We've not had any family breakdown since working with the KFT [service]. When we do get to a crisis point there is always a person in the [team] who we can call. I think other teams should work like this (parent).

## **Conclusion**

KFT units appeared to be very successful at preventing children from entering care, given that these were children for whom care was actively being considered as the alternative option. The evidence was encouraging, both from the 5 units working with teenagers on the edge of care and also from local authority 3, which worked with families with younger children subject to long-term neglect: no children receiving a service from KFT entered care from local authority 3. This indicates that the KFT model can be applied successfully beyond teenagers at risk of imminent care entry. As well as providing additional evidence for the effectiveness of the RSW model in general, the KFT model demonstrates the benefits of training whole units in using the FAMILY approach, as well as providing potential significant cost savings for local authorities. The next section outlines the views of workers and families about RSW.

## Part 3: What do practitioners and families say about RSW?

### What do practitioners say about practice improvements for families?

Practitioners identify a series of practice improvements associated with working systemically with families. They described practice that was collaborative, reflexive and purposeful with a view to keeping families together, wherever appropriate and possible. Practice improvements included:

- improved pre-planning of interventions: for example, planning conversations with families in group supervision
- collaborative conversations with families about their unique situations: for example, approaching families with an open mind and exploring their circumstances with curiosity rather than making assumptions about families
- use of reflective questioning to unpick family relationships: for example, using circular questions to explore how different family members think and feel about difficulties to help move them forward as a family
- inviting families to define their own outcomes and solutions to their difficulties
- inviting families to feed back on their experience of social work intervention with a view to adjusting practice accordingly
- undertaking therapeutic work with the whole family: for example, observing family arguments and using scaling questions to understand the severity; followed by discussion of the impact on relationships, particularly children's experiences
- continuity of service to minimise impact of staff leave or turnover on the service experience of families: for example, discussing cases regularly so that all unit members understand the family

For the most part, practitioners thought that families would notice a difference in their approach. Respondents in local authority 3 were more ambivalent in this regard, drawing attention to tension between operating within statutory child protection procedures and timescales, and systemic practice: “sometimes we’re trying to fit a square peg into a round hole when you’ve got statutory guidelines that you follow and you’re trying to be systemic” (social worker).

## What do children and families say about the service they received?

Parents were largely positive about their involvement with children's services. They stressed the importance of listening to families, focusing on strengths and developing respectful and trusting working relationships. Across both the RSW and service as usual group, parents identified the following 3 important features of working systemically with children and families:

- whole-family working, particularly where practice was empathic and strengths-based
- understanding that they were part of the solution to their family's difficulties
- workers that were skilled at respectfully exploring their situation with a view to improving fractured family relationships

Practising non-judgementally was a consistent theme. In the following extract, the parent described the empathic and therapeutic-like relationship with their social worker as 'healing'. For this parent, working systemically with the whole family had enabled a more positive working relationship:

[Current worker] has been much less judgemental than I thought he would be. The process has been about us as a family rather than only looking at the child's side and judging or berating the parent. I feel like he was trying to understand and heal. Very empathic worker. [I] felt like my worker really cared. He has sincere goals for us and that's really important (parent).

However, there was a clear difference when commenting on relationships with previous experiences of children's services, with social workers attached to RSW units consistently praised. Here, parents described feeling understood in their own terms, the importance of having a more equal and trusting relationship with their social workers and, crucially, the invitation to provide solutions that they define rather than feeling that they must fall into line with service-led child protection objectives:

My other social worker's approach was not the best. I wouldn't have felt comfortable talking to her. [Current worker] has a much calmer way and is warmer towards the children. This is how it should work with every family. My previous worker misunderstood me. I felt like I was wasting my time. It was too official and 'to the bone'. The workers need to engage with families first. We don't want to be told ... I really struggled to keep in contact with my previous worker, she didn't seem as open, [she was] sneakier. When we had disagreements, she would give me the full list [of concerns]. There was no room for trust (parent).

## Feedback from children

A small number of interviews (n=4) were completed with children and young people. Low numbers of interviews with children indicates the difficulties of accessibility and consent; social workers often saw children alone at school and hence they were often not present during observations or, where present, parents and children did not consent to take part in an interview. Three out of the 4 interviews were conducted in local authority 2, all 3 of which were within the service as usual group. Overall, feedback was positive. Children and young people described their workers as friendly and supportive and willing to listen to their perspectives. For example, one child commented, "I felt that I was being heard out properly". They described their relationships with their workers as "good because we like each other" and strengths-based, "we talked about a lot of good things and it felt good". Families were important to children, particularly where they had been separated. When asked what was going well right now, one child responded "that I have got my family back". On the whole, children appreciated the support that they received from their social worker: "the support that I got [was] friendly and supportive".

## Part 4: The conditions for creating RSW

One of the contributions the current study can make is to explore the factors that make RSW work. RSW is a complex whole-system change. The current study allows for a natural experiment where the impact of key elements of the RSW model can be tested on the quality of practice. Care needs to be taken in drawing conclusions from such an analysis. First, the numbers involved are small. Second, the study tests only the quality of direct practice with families. There is more to good practice than this: for instance, accuracy of assessments. Nonetheless, while these are important caveats, remarkably little is known about either the factors that influence the fidelity with which RSW is delivered, or more generally the factors that influence the quality of social work practice. For instance, there is currently no international study linking the quality of supervision and practice. The study was fortunate to be able to explore the following factors that are elements of RSW and link them to the quality of practice with families:

- training in systemic practice
- the quality of systemic unit discussions
- the presence or absence of a clinician in unit discussions

### Training in systemic practice and quality of practice

Across the sample as a whole, workers had had varying levels of training in systemic practice. For the observations of practice 4 types of systemic training were identified:

- no training (35 workers)
- training by other provider (15 workers)
- previous MLA training (12)
- worker on CSW development programme (10)

Table 14 sets out the level of skill demonstrated by workers in each of these categories, and for each category a T-test explored whether there were statistically significant differences between those in that group, and all others. The findings were relatively clear: workers with no systemic input demonstrated the lowest level of skill (2.44), there was no substantial difference between the 2 types of training (across the both workers averaged 2.77), while workers on the MLA CSW development programme, who had been selected, and were currently, or recently, receiving significant input, performed best (3.50). In common with several other ongoing studies at UoB and Cardiff University, this indicates that training has a modest impact on practice, but that larger impacts occur when training is supported by ongoing structures that support practice.

**Table 14: Training and quality of social work practice**

	Overall Social Worker Skill			T-test Results	
	Mean	SD	N	T	P
No Systemic Training	2.44	.59	35	-3.28	0.002
Other systemic training	2.65	.70	15	.608	Ns
MLA systemic training	2.91	.67	12	-.682	Ns
Worker on MLA development programme	3.50	.58	10	-3.17	0.002

### Quality of systemic unit discussions

Group case discussions are at the heart of the RSW model; they are the place where case assessment and interventions are planned. For 22 of the workers whose practice had been observed and coded the quality of group case discussions of their unit had also been independently evaluated. This provided the opportunity to analyse the relationship between the quality of unit case discussions, as assessed using a systemic observation framework (which is outlined in appendix 2), and the quality of worker practice with families. These discussions were grouped as being non-systemic (4 or 18%); as showing developing systemic ideas, which we refer to as 'green shoots' (9 or 41%); or demonstrating systemic practice (9 or 41%). In addition, for 10 of the discussions there was a clinician present, while for 12 there was not. This allows each of these variables to be explored in relation to quality of practice.

There was, as might be expected, a strong relationship between these 2 variables. None of the non-systemic discussions had a clinician present, while 3 of the 9 with green shoots and 7 of the 9 that were fully systemic had a clinician present. This suggests that clinicians help create more systemic case discussions. However, given the numbers involved here, analysis of the relationship between each factor and quality of practice is conducted separately.

Table 15 sets out these relationships. There was a strong relationship between the quality of systemic case discussion and the quality of practice ( $r=0.456$ ,  $p=0.04$ ). The relationship was even stronger with the presence of a clinician, with an independent samples T-test finding a strong and highly significant relationship ( $t=-3.69$ ,  $p=0.002$ ).

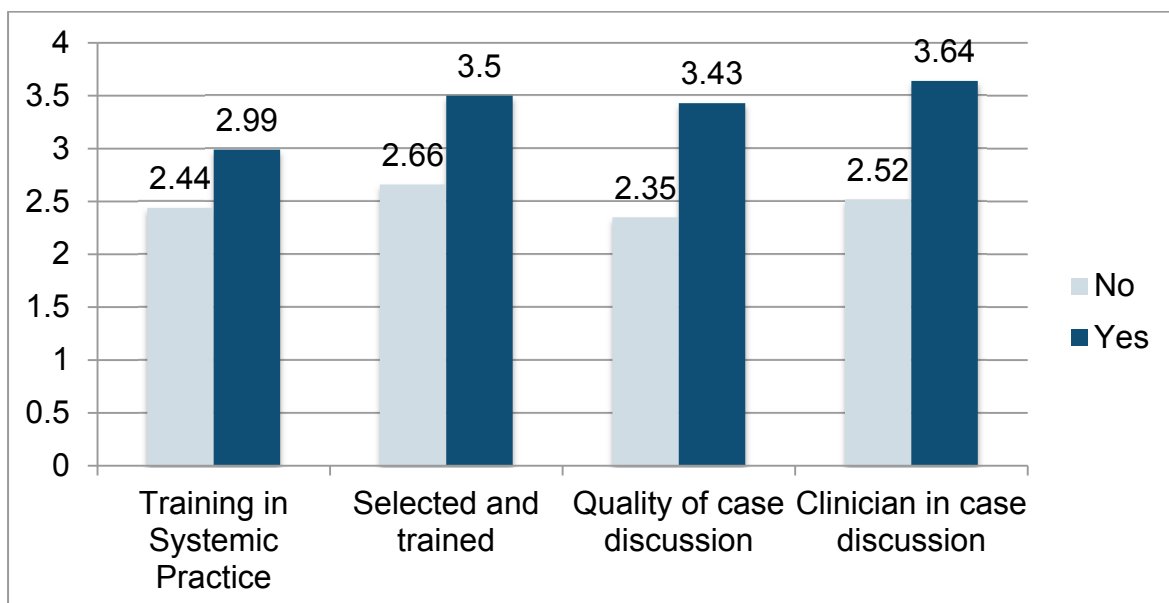
**Table 15: Relationship between quality of practice, case discussions and clinicians**

		SW direct work skill	
		Mean	SD
Coding for quality of supervision	Non-systemic	2.35	.30
	Green shoots	2.98	.95
	Systemic	3.43	.77
Was clinician present at last case discussion?	No	2.52	.75
	Yes	3.64	.61

The findings suggest that training in systemic practice has a small positive impact on the quality of practice, but that the quality of ongoing group case discussions is far more important. This is strongly linked to the presence of clinicians, who have a particularly strong correlation with high quality practice. This is likely to be largely due to their influence on case discussions, but may also be created through other pathways, such as one-to-one consultation with workers. This is referred to as the ‘good practice pyramid’ (see figure 5).

The different factors that contribute to level of practice skills that have been discussed in this section are summarised in Figure 4. Here, the relative contribution of training, participation in the MLA programme, the quality of systemic case discussion and whether there was a clinician present in the discussion, to the quality of practice is presented. It can be seen that, while training made a statistically significant difference, the impact of quality of supervision (including the presence of clinician) was a more potent factor in improving practice.

**Figure 4: What factors influence quality of observed practice?**



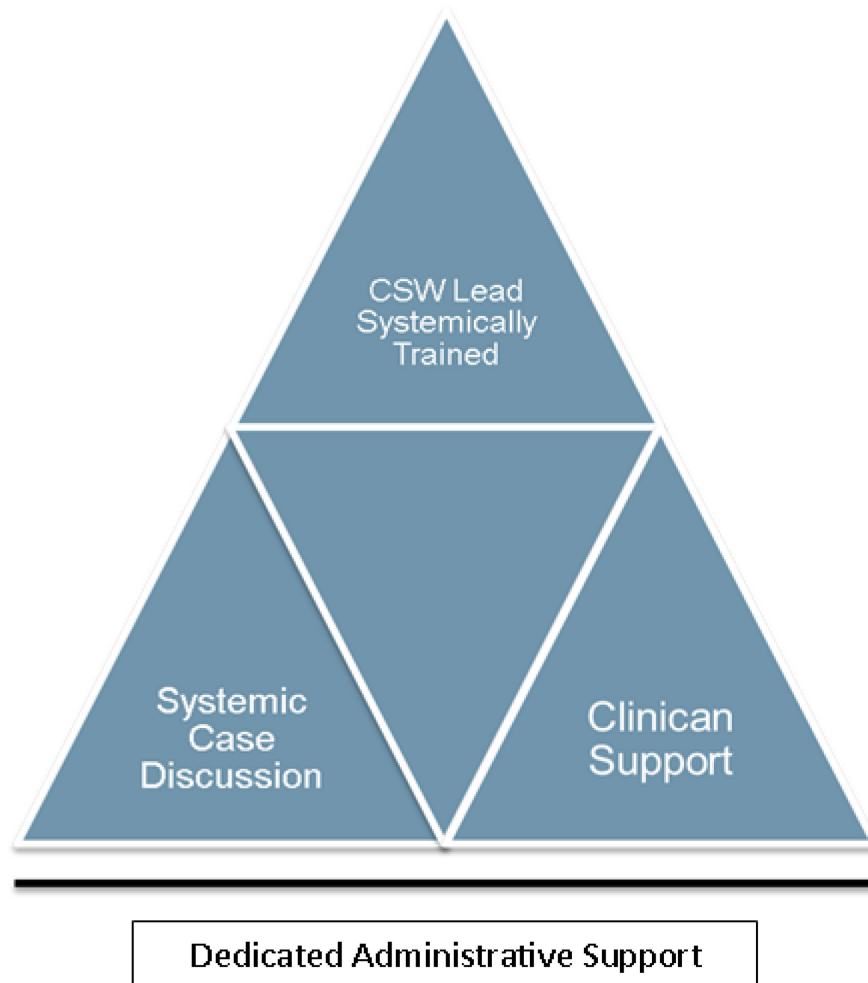
## Understanding the factors that support systemic practice

The rest of this section explores these elements in more detail. It draws on qualitative evidence to explain why these factors are critical to embedding systemic social work practice. It looks at the following aspects in turn:

- CSW who has been trained systemically
- shared thinking and decision-making around cases via group supervision
- involvement from an appropriately qualified clinician

Feedback from managers, practitioners and unit coordinators also points to the importance of enhanced administrative support to coordinate activities and act as first point of contact with families. This is the foundation of the good practice pyramid (see figure 5).

**Figure 5: The good practice pyramid**





## The CSW development programme

### The participants

Many CSW candidates had already undertaken systemic social work training. Some tensions were noted, particularly in local authority 1 where there were concerns that the internal recruitment approach had created an unfortunate and unforeseen division within the wider staff group. However, this approach may have ultimately maximised the potential for programme success by drawing on both a receptive and systemically skilled pool of workers.

### The programme

The CSW recruitment and development programme aimed to embed high standards of professional practice. It was a 9-day programme that was tailored to practising systemically within the child protection social work context (see Appendix 8).

The programme itself was well received: specifically, its focus on practice leadership. In particular, the impact of the programme on reflexivity and thinking about the purpose of social work intervention was repeatedly mentioned in interviews. This included reflecting on their own position as social workers and the impact that this was having with families. Improved critical thinking was enabled via a number of different routes:

- participation at training days: for example, “it just changes the way that you think about things, you can’t kind of un-know, can you?” (CSW)
- individual coaching sessions, such as “you get individual support because I’m still learning. For example, I’ve had an individual coaching session today, looking at the issues that I’m really struggling with and looking at ways of moving forward” (CSW)
- reflective unit discussions: “we spend a lot of time thinking about families and it is quite evidence based. It’s just about having a different conversation and being able to reflect on what you, as a worker, bring to the family, negative and positive. That way you can be mindful and do things differently if things don’t work” (CSW)

### Systemic case supervision

Weekly unit meetings were critical to reflective thinking and widely regarded as a defining feature of effective systemic social work practice. All RSW units had a weekly unit meeting where cases were discussed and decisions made. As part of the CSW programme, a 3-day unit induction was conducted, involving all members of the unit to develop a shared vision and clarity of purpose when working together with

families. Unit inductions were well received and enabled workers to practise differently with families, for example [after the induction] “I’d like to hope that workers go into families without preconceived ideas, with an open mind and just lots of curiosity really and a wish to unpick those family relationships. Really listening to families instead of deciding what needs to happen” (CSW).

## Unit meetings

Researchers observed 29 unit meetings. Unit meetings were held weekly and attended by a small multi-skilled team including, in some sessions but not all, an appropriately qualified clinician. Case discussions lasted between 2 to 4 hours.

An observation framework was developed to record essential elements of systemic supervision. Of the 29 observation schedules that were analysed by researchers, 19 were of RSW units that had 1 worker in the CSW development programme. 10 were service as usual and did not include a participant in the CSW programme.

Observations were analysed blind to minimise bias and assessed as, systemic; green shoots; or un-systemic depending on quality of unit discussions. For a unit meeting to be assessed as systemic, the following 8 features were recorded:

- family relationships were set within the wider social context
- genograms were used to understand patterns of family relationships
- discussion was curious and reflective: for example, open to different ways of thinking about the family
- generation of different hypotheses and/or evidence of challenging established theories about the family
- development of hypotheses into clear and actionable conversations with families
- discussion was collaborative and involved all group members, although it was recognised that the unit coordinator may not always fully contribute
- child and family were present within the conversation
- there was clarity around potential risks to the child or children

Where unit meetings were assessed as green shoots, all the above elements were observed, bar 1 crucial aspect, namely the development of hypotheses into clear and actionable conversations with families. Unit meetings that were assessed as un-systemic were markedly less curious about family relationships; often did not use a genogram; made fewer attempts to generate hypotheses, for example “workers appear closed to new ideas because it may increase their workload” (researcher notes); and actions were largely process-based, such as arranging a visit with the

child at school or making a referral to another agency without a conversation about how this would help or what it might achieve in terms of change for children and families.

### **What happens in unit meetings?**

Systemic unit meetings were remarkably similar across the local authorities, and a wide range of reflective practice was observed. In this example, the unit generated hypotheses about why a teenage mother was struggling to look after her baby:

‘Is the mum’s position as youngest child impacting on her ability ‘to be an adult for 1 day a week’?’ (Consultant social worker)

‘Is she feeling guilty for not being able to parent her baby?’ (Social worker)

On the basis of these hypotheses, the clinician suggested a number of circular questions. These were designed to help the mother think systemically about relationships within her family: for example, “what would your mum say if she was here?’ and ‘what would the baby say?’” (clinician)

One of the most striking features of systemic supervisions was the non-judgemental nature of discussion, even in the most emotionally charged situations; something widely appreciated by families. In the following example, the baby was due to be removed at birth due to concerns about parental mental health and child welfare. The group agreed to share the multitude of procedural tasks in order to spread the emotional responsibility. The discussion was concluded with a reminder by the clinician to avoid becoming enmeshed in a “fixed narrative of hopelessness, [this case] is problem-saturated, so we will need to look for tiny bits of hopefulness”.

### **How do practitioners experience unit meetings?**

Unit meetings were overwhelmingly regarded as a positive forum for embedding reflective practice. Practitioners welcomed the opportunity to discuss cases as a group; appreciated a safe space to discuss anxieties about risk to children, and actively sought out different perspectives to help them move forward with families. In particular, the opportunity to plan interventions proved one of the most welcomed elements of successfully managed unit meetings. One worker offered a description of this process:

We plan questions beforehand. So previously, I would have just gone out and asked questions as I go along. Now we’re thinking about questions. We’re thinking about responses and we’re preparing ourselves for if it’s a ‘yes’ or a ‘no’ and how we respond (CSW).

## The role of the clinician

Clinicians were attached to units to both undertake direct therapeutic work with families, and help facilitate thinking and action planning within systemic unit meetings. Three out of the 5 local authorities had clinicians attached to RSW units. Many clinicians were qualified systemic family therapists; some were clinical psychologists, and others were trained in multi-systemic family therapy. Competencies included skills in supporting others in working systemically; direct work with families and a good knowledge of child development, child and adult mental health and intellectual disabilities.

Clinicians attached to RSW and other units were not funded via the DfE Innovation programme. However, their role was made increasingly apparent via unit observations and in conversations with participants. In particular, the role of the clinician in facilitating conversations with families was welcomed and enabled a different kind of conversation with families: for example:

We had a family, 1 of our more resistant and hostile families and a social worker struggling to get through the door for more than 2 minutes before being ejected. The clinician helped the group generate new ideas and questions. The social worker was a bit sceptical about whether it would work but came back from a visit saying 'I've been there for 1 and a half hours and we had a conversation!' (CSW).

Such conversations were viewed as enabling the safety of children by creating more helpful and in-depth conversations.

## What do clinicians say?

From the perspectives of clinicians, there was high regard for the social workers, recognising the complexity of the work and commending what they considered to be thoughtful and effective practice with families. They saw their role as supporting social workers in their developmental journey toward systemic social work practice. They played a key role in formulation of risks; supported social workers in articulating their concerns and helped them think through their worries. Crucially, they helped social workers plan conversations and intervene more systemically with families.

In this lengthy extract, the clinician describes the importance of critical thinking around risk to children. This clinician identifies their role in supporting social workers to move beyond description to analysis of the situation, to improve decision-making:

I would hope that talking about risk gets far clearer and more concise, so that there is less description and more thinking about explanations for what we are seeing and why that is a worry to us. We do a lot of describing but not a lot of

thinking why that description worries us and what we are going to do about it. It is hard when you are assessing risk and you have a lot of cases and you don't have enough space in your head so you think, 'Mum's a nightmare'. But what do we mean by 'nightmare?' You can slow down those sorts of ways of making decisions that are not always evidenced. They are all statements of truth as if that is the way it is. If we change the way we see it, what would happen then? Does she think that you are pretty frightening? Is there a cultural issue? What is that about? I would hope that we get better at assessing risk, and clearer about why we are making the decision we make, whilst making sure that we keep ourselves in the decision-making.

## **The importance of unit coordinators**

Unit coordinators are a central feature of the RSW model. The role of the unit coordinator is to organise and maintain efficient administrative systems for all cases held by the unit. This includes systems organisation and managing data requirements; recording unit meetings; worker diary management; and acting as first point of contact for families. It is understood that this role is to rationalise, rather than strictly reduce, unavoidable levels of bureaucracy within child protection practice and procedure (Kroll, 2016). Nevertheless, this role is designed to support social workers to spend more time with families by releasing them as much as possible from day-to-day bureaucracy.

## **Experience of unit coordinators**

The use of unit coordinators varied by local authority; local authorities 1, 3 and 5 all incorporated unit coordinators, while local authority 2 and local authority 4 had centralised business support services. Both local authority 2 and local authority 4 introduced new RSW units during the course of the DfE Innovation, with unit coordinators employed in some, but not all, units.

Frontline workers identified the following features of the role as important to families:

- first point of contact for families: for example, "families are reassured by having that point of contact, it's the familiar voice at the end of the phone" (CSW)
- participating in reflective unit meetings: for example, "they are part of the reflective discussion, they know the story of the family" (social worker)
- undertaking visits with families: for example, "our unit coordinator goes out on that first visit, takes all the complaints forms and assessment forms because [unit coordinator] is the person that they talk to on the phone and that means they know who she is". Another worker described the benefit of the unit's coordinator in reducing time spent by workers writing up visits: "minute taking

during meetings with families, for example “I’ve got 1 family that is really, really complex, so having [unit coordinator] there means that she does all the minutes and I can have a meaningful conversation” (CSW).

### **What do unit coordinators say about their role?**

Unit coordinators described their role as demanding and fast-paced. They described covering a range of administrative tasks, from data management to recording meetings; maintaining an overview of the unit’s diary arrangements, as well as taking multiple calls on a daily basis. They recognised that local authority resources were stretched, which made the job more challenging, particularly with regard to high caseloads. Nevertheless, they understood that their role was essential to the smooth running of units, both through management of administrative tasks, and improved communication with families and other professionals. One coordinator commented, “I can’t say that I have made them a better practitioner because that’s them and how they perform, but I’ve been able to improve the running of their practice so that they are able to give better practice” (unit coordinator).

Unit coordinators reported the following aspects of their role as most satisfying:

- first point of contact with families: for example, “if they’re ringing up in a distressed state, I can immediately assure them and they can put a name to a face and they know who I am and very often I can de-escalate things and sometimes I can help them without having to involve the social worker and I case note so that the social workers are aware of what’s happened” (unit coordinator)
- valued sitting with and feeling part of the unit: “it’s good to have such small teams, you get to know the people in your team and you get to really understand the work that they do and you can support them better and I think it benefits the families as well, having a tightknit unit that know each other well and know how to get the best from their families” (unit coordinator)
- contribution to unit meetings, whether hypotheses or adding humanity: “the social workers were going through the case, all these concerns and this girl had so many miscarriages and I said ‘oh my God, that girl must be feeling awful’ and it weren’t that they weren’t thinking about that but they were concerned about the unborn child and so they value the little things we have to add” (unit coordinator)
- improved job satisfaction: “everything is better. I know what is going on with cases and so I feel part of things. In the past, we didn’t have any background to what we were writing but now we do. When someone rings in, you know what it is about, which makes it more interesting” (unit coordinator)

## **Part 5: What are the challenges facing scaling and deepening RSW?**

Both bureaucracy reduction and coaching the system were designed to support agency culture and practice change, to maximise the success of scaling and deepening RSW. As outlined in Part 4, dedicated administrative support is the foundation of the good practice pyramid and had been implemented by many of the local authorities prior to the IP. The IP aimed to build on these positive changes to how bureaucracy was managed and minimise further unnecessary bureaucratic burdens on social workers. Key themes are discussed below.

### **Recruitment difficulties**

Recruiting CSWs proved more problematic than originally envisaged across the local authorities. A total of 41 CSWs were recruited into the programme, although this varied by local authority. The majority (34) were recruited from internal candidates, with only a small number (7) recruited externally. Once it was understood that recruiting CSWs was proving difficult, a more flexible approach was adopted to ensure that respective services would benefit from the workforce development available.

All local authorities reported problems with recruitment to the CSW role. This related to the following themes: mixed enthusiasm for the role; tensions between MLA and local authorities, particularly the difficulties of integrating external recruitment processes with local authority specific HR procedures; differences in what was required from this role, with MLA recruiting candidates with potential to develop as practice leaders and local authorities preferring people with pre-existing management responsibilities; and timing with regard to existing activities, most notably the restructure of Early Help services in local authority 2 and local authority 4.

### **Reducing bureaucracy**

The reducing bureaucracy (RB) strand of the IP aimed to reduce unnecessary administrative processes to free up social worker time to work directly with families. This strand was introduced in 4 out of the 5 local authorities, The fifth local authority was 'under-improvement' from Ofsted and hence considered it inappropriate to participate. Findings from this strand include:

- engagement with reducing bureaucracy was good, but practice patchier
- workshops were conducted with each local authority to identify key priorities for reducing bureaucracy, resulting in 5 common themes

- MLA designed a suite of new recording forms, but local authorities were reluctant to pilot, resulting in a single, new, weekly recording form
- the form piloted across the KFT units and more widely in 2 of the local authorities; this was introduced towards the end of the evaluation so it was not possible to assess the degree to which social worker time was released to work with families
- data collection requirements were also assessed, although they formed the basis for MLA thinking, rather than being shared more widely

### **Barriers to bureaucracy reduction**

This aspect of the IP was to identify and remove barriers to RB, thereby releasing an ambitious 20% of social worker time to work directly with families. The RB strand of the IP was perhaps the most mixed in terms of its impact. All local authorities reported willingness to participate in the RB aspect of the IP, with managers commenting on their own frustration with what was felt to be unnecessary bureaucracy. However, the project quickly began to lose momentum when it came to the details of how best to address the issue.

Perhaps most notable was the impact of existing bureaucracy reduction, particularly the introduction of the new ICS, which both slowed and prevented further change. For example, 3 out of the 4 local authorities were either in the process of commissioning or introducing new ICS, impacting on the willingness of some local authorities to engage with further bureaucracy reduction activity:

One of the things the [MLA] team wanted to do was pilot new forms and actually the last thing we wanted to do was introduce new forms, we were moving from 1 electronic recording system to another one in July so we already had a lot of work on our hands to manage that transition (senior manager).

### **Risky business**

At the same time, a number of the local authorities reported reluctance to take a leap of faith and introduce new recording processes without the explicit permission of key stakeholders, specifically Ofsted. Whether real or perceived, fears that Ofsted would criticise recording methods influenced whether these local authorities were willing to risk changing their recording practices:

What we were hoping for was Ofsted to give us an assurance that if we went to weekly recording, recorded enough to make sure anybody reading it had a sense of risk and the current situation, we would be alright (senior manager).



This led to something of a dilemma; local authorities felt unable to act without permission from these stakeholders, but the respective stakeholders could not give such an explicit go-ahead.

At the same time, concerns were raised about staff willingness to make changes to recording practice. This reluctance was also noted in UoB and Cardiff’s University’s evaluation of social work reform in Hertfordshire (Forrester et al., forthcoming a and b). One senior manager noted that the compliance culture was stifling thinking, creating a climate in which staff needed certainty and concrete permission before they were willing to take the risk to make changes:

I think the other challenge for us is about giving people permission to experiment and that causes quite a bit of difficulty in the beginning because people just wanted an answer, ‘Why are we doing this and why are we doing it this way?’...I wonder what we’ve done to them that they can’t take a risk and they can’t try something new or a different way of doing things. I think that’s a bit scary (senior manager).

## Coaching the system

Coaching the system was not a stand-alone strand on the innovation; rather it was integral to each aspect of the innovation. Each local authority had at least MLA 4 coaches from MLA. A core team of coaches was attached to local authorities in an executive coaching role and also held leadership responsibility for different aspects of the innovation:

- coaches 1, 2 & 3 worked on delivering the CSW leadership programme, supporting CSW-led units and reducing bureaucracy
- coaches 3 & 4 worked part-time on supporting the development of the KFT and supporting the operations of the KFT unit on a weekly basis (Table 16)

**Table 16: MLA coaches by innovation strand and local authority**

Coach	Innovation strand	Coaching by LA
1	Reducing bureaucracy	Local Authority 1
2	CSW development programme	Local Authority 3
3	KFT	Local Authority 4
4	KFT	Local Authority 3 and Local Authority 5

## Coaching for change

As outlined in Part 1, the 5 local authorities had been involved with MLA for several years prior to the IP. Within the context of this longer-term partnership, implementation of coaching the system aspect of the innovation revealed some tensions in the coaching relationship; in how MLA and local authorities understood this role, but also in what conditions were required to support successful system change.

## Shared vision and ownership

While all local authorities were committed to systemic social work practice, differences were evident between MLA and local authorities about how best to further embed change, and who owned the innovation. It is clear that MLA and MLA coaches saw themselves as agents of system change. However, it was not always clear from some local authority senior managers whether there was acceptance of the coaching role, some describing MLA as consultants rather than change agents. Some of the MLA coaches thought fidelity to the RSW model was important to ensure change, but local authorities wanted to be free to modify the approach to their own local needs, context and priorities. The exception to this was local authority 1, where there was an excellent relationship between MLA coach and senior managers, as well as a clear vision for what they hoped to achieve together. Concern was expressed by MLA coaches that large units with large caseloads made it difficult to practise the RSW model in the way that it was intended, because CSWs were expected to have full oversight of all cases within their unit:

This becomes increasingly difficult as numbers of social workers, and therefore numbers of cases, are added to the unit. Working with 4 workers, the CSW will likely struggle to have a sufficient understanding of every child that the unit serves, which may impact on their ability to support workers and make accurate, well informed decisions (MLA coach)

Where coaching the system worked best, the following features were identified:

- shared objectives: for example, an MLA coach was asked to undertake a review of their initial assessment and intervention service and make recommendations about how best to enable this part of the system to fit better with their RSW approach
- role clarity: for example, MLA coaches had a clear and tangible remit via their attendance at Access to Resource Panel meetings. This coaching role enabled decision-making around risk, and ensured that only high-risk families were referred to KFT units

- Flexibility: for example, responding flexibly to challenges, such as difficulties recruiting to the CSW programme
- trouble-shooting implementation challenges: for example, working to reduce the impact of multiple unit inductions on other aspects of the service
- shared governance: for example, the use of regular governance board meetings as a safe, collaborative space to share learning and challenges, and offer feedback to MLA on their approach to coaching and practice change

## The challenge of change

What were the challenges to embedding systemic social work practice? Many related to the wider context within which children's services operate, including austerity, Ofsted, and current child protection processes and procedures. Others related to the degree to which there was commitment within local authorities themselves. While there were many factors identified as making change difficult, almost all could be grouped into the following areas.

### Change is difficult in its own right

Change, particularly the sort of transformative change required for RSW, is not usually an easy thing to achieve, for individuals or for organisations. Learning new ways of thinking, new skills and putting them into practice is hard. Thus, workers identified needing more training and on-going support, more time, better case discussions or supervision. Managers were often leading transformation toward systemic practice without themselves having a strong grounding in the approach. At the same time, the introduction of change in some elements of the organisations, but not others, such as expecting that CSWs maintain line management responsibility, undermined progress toward RSW (see Laird et al, 2017). From the perspective of frontline social workers, implementing a compromised version of RSW proved challenging, including:

- roll out of the model: for example, "I've read the Reclaiming Social Work book, so I've got a really good understanding of how the model works and why it works and it's quite frustrating to come into role and be told, 'you can't do that bit, you can't do this bit'" (social worker)
- conflicting responsibilities between CSW and management role: "I think that when I went through the CSW recruitment process, I wasn't made aware of the management expectations that would be put on the CSWs. I've not been a manager before so that's the part I've found really challenging" (CSW)

- large units with high caseloads: “We have too many cases. In the model the CSW is supposed to hold all the cases in mind and have a working knowledge of all families. That’s really hard when there are so many cases to get through” (CSW)

Other challenges related to the wider context, particularly the tensions between RSW’s therapeutic approach and wider more directive child protection system, for example “I think that [children’s services] think it is safer if a child is on a child protection plan and of course, it doesn’t make children safer, that’s about anxieties in the wider organisation, so I struggle to negotiate that”.

This was echoed in comments by senior managers, who also noted the challenges of managing the anxieties of the wider risk averse context: “50% of the job is dealing with real live risk to children and 50% is professional anxiety that we’re managing in the wider system ... And I’m not talking about families, I’m talking about professionals, agencies, teachers, police, health visitors all worry about children and the response to that is to put it on the social services conveyor belt and that is a challenge that we need to work with” (senior manager).

## **Responsibility for creating change was unclear**

A specific feature of this project was that MLA worked with the local authorities. MLA delivered the elements of the project set out in the proposal, and had a clear sense of responsibility for the achievement of the project. However, perhaps unsurprisingly within large organisations managing multiple and sometimes competing priorities, the degree to which managers felt responsible for delivery of the programme varied. For some local authorities, support from MLA had enabled them to have difficult conversations with both their political leadership and their staff about the need to restructure and focus on what matters to children and families, the quality of practice:

I think that the support from MLA has brought about a shift in practice and management in ways that otherwise I might have thought impossible. I might otherwise have thought, ‘this is as good as it gets’...There is not the remotest possibility of going back (senior manager).

In other local authorities, resistance to the RSW approach was identified within the organisation, particularly from some heads of service, impacting significantly on implementation of the approach: for example, “the then head of the Child in Need service refused to let staff do systemic training, the very engine of our service.”

Among their many other demands and initiatives, moving toward RSW was not near the top of some local authorities’ priorities. In 2 of the 5 local authorities, large service areas were being reorganised, which slowed introduction of the IP. The

starkest illustration of this was in local authority 3 where a poor Ofsted inspection impacted on their ability to participate fully in the project. This change also illustrated another important factor that made creating change difficult: there was very substantial change in senior management. Indeed, at time of writing only 1 of the original organisational leaders who had signed up to the IP remains in post:

We've had a number of senior management changes over a very short period of time...So perhaps during that time the focus and the vision of what MLA had originally been brought in to do has changed or it's gone a different route, which I feel has been overlooked (senior manager).

### **Change cannot rely on excellent leaders alone**

The final learning point is that systemic change cannot solely rely on excellent leaders. Leaders change, and there is therefore a need to create systems that recognise and reward excellence in the delivery of social work practice. One of the findings was that, not only is change inherently difficult, but that the current system of incentives for leaders is profoundly conservative. Two factors are crucial here.

Firstly, senior managers operate in a context of very limited resources. There is constant pressure to save money, and it seems incredibly difficult to protect quality in this context. Thus, at the time of writing, not only have half of the KFT units been cut, but in every instance the RSW model has been adapted – or withdrawn completely - to save money. Senior managers are judged on their ability to deliver services within budget, and often the timescale under consideration is the current year, not longer term potential savings. This was recognised by senior managers who commented on the compromises to the RSW model due to cost implications: “I think there had to be compromises. I think the structure was a compromise. There was some pragmatism in that. I haven't been able to sustain everything” (senior manager).

Secondly, there seemed to be limited means of understanding the quality of the service. In particular, senior executives and elected members had very few ways of knowing what the quality of the service was. In this context, Ofsted inspection has become enormously influential on the nature of children's services across the UK; it is almost the only way in which senior leaders are judged.

While the local authorities have made considerable progress toward reducing unnecessary bureaucratic burdens on social workers through the introduction of unit coordinators, the pervasive fear of an inadequate Ofsted inspection appeared to stall further changes to recording practice. Indeed, in 1 local authority that had experienced an inadequate judgement, a new management role was introduced to ensure timescales and paperwork were completed for Ofsted. The belief that this is what Ofsted seek was so pervasive that it undermined the attempts to reduce

bureaucracy; while everyone subscribed to the goals of this strand, in practice, from senior managers to workers on the frontline, there was significant anxiety that it would lead to poor Ofsted judgements. The general impact of Ofsted on the system was captured by 1 director:

It's the wrong culture. [Ofsted are] running a low warmth high criticism system, so if it isn't good enough to run a family in that way, why should it operate at this level? How can you expect you're going to get a good performance system? We're operating in a constant state of fight or flight!

## Limitations of the evaluation and future evaluation

The study was very successful at collecting the views of professionals at every level of the service on the process of change. It was also successful at gaining an in-depth understanding of the impact that training and service delivery models can have on the practice of workers. It was less successful in obtaining data from families and on outcomes as originally envisaged. In part, perhaps, these aims were themselves unrealistic. There are a number of lessons to be learnt from this study, some of which are of wider significance for children's services.

First, UoB and Cardiff University have successfully used embedded researchers to gather data in a number of other studies. Embedded means that researchers are based within the local authority and therefore work closely with practitioners and managers on a day-to-day basis. This approach was not as successful in this instance because a single worker was embedded in each authority. This is a very challenging role for an individual worker; it allows for no back-up in the event of illness, (1 researcher experienced significant periods of illness during the study), and it assumes a research-ready environment, which is not always the case.

Second, while every authority agreed in principle to the evaluation, the degree of actual co-operation varied, not just between authorities, but also within a given service, between teams and over time: for instance, if a champion for the study left. This meant that a great deal of time was spent negotiating access; research is rarely a priority for busy organisations. In effect, it proved impossible to access families in some locations, or where an individual worker or team were reluctant to participate. The researchers had to work hard to engage professionals in their authority, and it is down to the persistence and support from committed individuals and local authorities that the research team was able to gather the level of data that they did from families about their experiences.

Finally, and most importantly, this study raises important questions about the relationship between quality of service and outcomes. The study has found that the bulk of families saw a substantial improvement in self-reported welfare between referral and allocation, and further improvement thereafter. This may be a welcome finding, but it creates a challenge for evaluating children's services. The challenge arises from the complexity of the role of children's services. Specifically, workers need to identify the families who genuinely require intensive input. For the bulk of families, social workers will have a relatively brief and comparatively limited level of contact. To recognise this, evaluations of children's services need to consider whether the right families are being worked with and then whether the service they are receiving is of a high quality.

## Implications and recommendations for policy and practice

The evaluation provided further evidence that RSW delivers high quality social work services. The quality of practice was high, and there were indications that it helped families to remain together, particularly in the KFT units. Workers felt overwhelmingly positive about RSW as an approach to practice. The study also provided the first evidence about the factors required to deliver RSW to a high standard. Training influenced practice positively, but the most important influences were the quality of the case discussion in units, and the presence of a clinician in those discussions. This is helpful for future attempts to develop systemic practice in children's services. It is likely that it has wider implications, as training alone is unlikely to be as important in shaping practice as the ongoing support for assessment and intervention provided by high quality group supervision.

Yet at the heart of the evaluation was an apparent paradox: despite a leadership committed to delivering the RSW model, and a largely enthusiastic workforce, in general the authorities found it hard to move toward RSW as it was originally envisioned. Some of this difficulty is likely to be present in many of the other innovation projects, because change, for individuals and for organisations, is in general a difficult thing to achieve (see for instance, Munro et al, 2016; Laird et al, 2017). There were, in addition, some specific features of this project that made achieving change a challenge. In particular, the degree to which the local authorities felt responsibility for delivery of the IP varied, and sometimes changed radically, when new leaders came in.

However, the problems with creating change were deeper than this. Ultimately the pressures and incentives that senior managers told us about provided little ongoing reason for continuing to strive toward the excellence represented by RSW. There was no sense of external reward or recognition. Quite the contrary, there were pressures at every turn to cut corners or do things in simpler, more conventional, more bureaucratic ways. Some of this pressure related to short-termism in budgets, with senior managers expected to cut budgets, which compromised longer-term thinking. Yet more than anything, pervasive in its influence, was fear of Ofsted. The need to please Ofsted was powerful, and pleasing Ofsted was largely seen to be more about producing exhaustive record keeping, and less to do with the actual quality of practice. This is well illustrated by the impact of Ofsted inspections on the process of innovation. In 1 local authority, an inadequate inspection resulted in a hiatus from the move to RSW in an effort to focus on basics. In a second local authority a good rating achieved without having moved to RSW meant the authority did not feel it worth investing further in moving to the systemic unit model.



In this context the commitment of leaders and workers to RSW verged on the heroic. There is little benefit or reward for focussing on excellent practice, and at every step there are pressures to cut corners and water down the focus on excellence in RSW. There are vital implications at a national level for how to create better children's services; specifically, a reimagining of the inspection regime to create a more constructive process focussed on excellence in practice and outcomes for children and families. From a systemic perspective, this would further support the success of the various attempts to reform services currently being piloted.

### **Recommendations for policy and practice**

- RSW is a model for excellent social work that has been demonstrated to be deliverable in a variety of different types of local authority; other authorities should consider it as an option for delivering high quality services that work effectively to keep families together
- delivery of RSW to an acceptable standard is dependent on a good practice pyramid of 3 essential interconnected elements of practice:
  - a CSW who has been trained systemically
  - shared thinking and decision-making around cases via group case discussion
  - involvement of an appropriately qualified clinician
  - staff feedback suggests that enhanced administrative support to aid the smooth running of units and act as family liaison provides the foundation for the good practice pyramid.
- the degree to which RSW is delivered well will primarily be decided by the sustained commitment and ownership of the local authority leaders
- a national agreement on the measures and samples necessary to evaluate children's services is needed to allow the comparison of new and interesting ways of delivering services. Key elements of this should include:
  - whether appropriate families are being worked with
  - the quality of service provided; including direct observation and coding of social work practice
  - the experiences of children, young people and their parents or carers
  - agreed outcome measures for specific groups of families
- such a national agreement might usefully inform the outcomes of Ofsted's recent consultation on the common inspection framework and provide a platform for a re-imagining of Ofsted's contribution to supporting excellence in the sector

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## Appendix 1: CSW recruitment and retention by local authority

Table 17: CSW recruitment and retention by local authority

Local Authority	Number of CSWs recruited	Number of CSWs retained
Hull City Council	10	10
Derbyshire County Council	6	5
Buckinghamshire County Council	11	10
London Borough of Harrow	4	3
London Borough of Southwark	10	10

## Appendix 2: Research design

### Research approach

To understand better the nature and impact of social work interventions on outcomes for children and families, researchers were embedded on a full-time basis across the 5 local authorities. The Tilda Goldberg Centre for Social Work and Social Care (TGC) has pioneered this approach in many research projects with a view to building relationships with workers; enriching understandings of practice and encouraging participation of children and families. One researcher was embedded per local authority for up to 12 months, and administered all data collection with the oversight of the Senior Research Fellow and Principle Investigator. This ensured consistency, as far as possible, in data collection and delivery of a complex, multi-local authority, multi-stranded evaluation. It should be noted that long-term sick leave experienced by 1 of the researchers affected data collection. To address gaps, most observations of direct practice in local authority 1 were collected by a team of researchers during 1 week in February 2016.

### Data collection

#### Quasi-experimental data

Initially, the evaluation team planned to randomly identify a sub-sample of families from lists of recent allocations within each local authority: some allocated to RSW units and some to service as usual in order to compare practice and outcomes for families. However, because of the complex and divergent timelines of 5 local authorities (some RSW units did not go live until January 2016), as well as a reluctance of workers to relinquish control of family selection to researchers, random selection was ultimately impractical. Random sampling was replaced by an opportunistic method whereby social work teams consulted with families on their caseloads. The sample profile is discussed below.

Where family consent was given, data was collected in the following areas:

- observation of practice: where parents agreed, meetings with workers were observed, recorded and coded for key social worker skills
- parent and child interview: research interviews with parents and, where appropriate, children gathered evidence on their experience of the service, engagement, levels of need and risk and a range of standardised measures for key elements of welfare. Key outcome measures included:
  - a parent rating of family life (Life Rating Scale)

- identification of goals for work and whether achieved (Goal Attainment Scaling (GAS))
- a parental rating of changes in family relationships (SCORE-15)
- parental rating of child welfare (Outcomes Rating Scale (ORS-40))
- parental stress or anxiety (GHQ-12)
- parental engagement with worker (WAI-12)
- standardised measures, where specific issues were identified, including the child's emotional or behavioural welfare (SDQ), social isolation (SSA), domestic violence (behavioural measures) and alcohol or drug misuse (MAPS)
- open questions related to family experience of social work involvement
- follow-up interview: 3 months later a follow-up interview was carried out with parents, either in person or over the phone. This explored their experience of the service, whether agreed goals had been achieved and changes in standardised instruments and other outcome measures
- child interview: where they agreed, children or young people were also interviewed, and completed ratings of the welfare and service received, including ORS-40 and SDQ
- social worker questionnaire: social workers completed a questionnaire outlining their rating of concerns and risks for the family at T1. At T2 workers repeated these ratings, and, in addition, provided information on the degree to which goals in work were achieved, and the support provided for their work and its contribution: for example, unit members, group supervision and so on

## **Mechanisms that support practice change**

Qualitative data was gathered through one-to-one or group interviews with 213 key informants, including consultant social workers; social workers; clinical practitioners; family practitioners; unit coordinators; middle and senior managers within local authorities. In addition, interviews were undertaken with MLA. Table 18 reports all respondent number by role across the local authorities.

Regarding the KFT study specifically, interviews were undertaken with professionals, including MLA coaches, in relation to both case-specific interventions and on wider experiences of working within this model of service delivery (see Tables 2 and 3). Interviews were also conducted with workers who had originally referred a child to the service and, in 2 cases, with the resource panels who ultimately oversaw the decision to transfer the case to the KFT team. Additionally, an observation of practice between a KFT worker and a family was observed in all but 1 local authority, and families were interviewed to garner their experience of receiving the support

from this service at an earlier and then later stage of involvement, T1 and T2, again in all but 1 of the local authorities.

Twenty-nine structured observations of group supervision, known as unit meetings, were also undertaken across the 5 partner local authorities.

**Table 18: Number of workers by role who participated in research interview**

<b>Role</b>	<b>Number of participants</b>	<b>%</b>
CSW	42	20%
Social Worker	35	16%
Clinical Practitioner	11	5%
Child Practitioner	4	2%
Unit Coordinator	25	12%
Middle Manager	23	11%
Senior Manager (including Principal Social Workers)	38	18%
MLA coaches	9	4%
Other Manager (for example complaints manager)	5	2%
Group interviews with systemic units where roles not specified	20	9%
Total	212	100%

Source: Qualitative interviews with key informants



**Table 19: KFT interviews with workers**

<b>Worker Type</b>	<b>Local Authority 1</b>	<b>Local Authority 2</b>	<b>Local Authority 3</b>	<b>Local Authority 4</b>	<b>Local Authority 5</b>	<b>MLA</b>	<b>Total</b>
CSW	1	2	1	1	1	0	6
Clinician	0	1	0	1	0	0	2
Social Worker	1	2	0	1	1	0	5
Family Practitioner	1	1	0	1	0	0	3
Unit Coordinator	0	1	0	0	0	0	1
MLA Coach	0	0	0	0	0	1	1
<b>Total</b>	<b>3</b>	<b>7</b>	<b>1</b>	<b>4</b>	<b>2</b>	<b>1</b>	<b>18</b>

Source: Qualitative interviews with KFT key informants

**Table 20: KFT case study data collection**

<b>Data collection Type</b>	<b>Local Authority 1</b>	<b>Local Authority 2</b>	<b>Local Authority 3</b>	<b>Local Authority 4</b>	<b>Local Authority 5</b>	<b>Total</b>
Interview with Referring Social Worker	0	1	1	1	1	4
Initial KFT Interview (pre-intervention)	0	2	2	1	1	6
Observation of Case Discussion	0	2	2	1	1	6
Observation of Practice	0	2	1	1	1	5
T1 Interview with Family	1	2	2	0	1	6
Post-Intervention KFT Interview	0	1	2	1	0	4
T2 Interview with Family	0	1	2	0	1	4
Resource Panel Observation	0	0	0	0	1	1
Resource Panel Interview	0	1	1	0	1	3

Source: KFT case study data

## Staff surveys

A survey of all relevant frontline practitioners and managers was carried out in each local authority. A total of 325 surveys were returned: an overall response rate of 39%, but this varied considerably by local authority. Respondents were asked to consider to what extent they agreed with statements related to the following headings:

- work satisfaction
- clarity of role
- time and resources
- peer and management support
- learning and development
- communication and decision making
- organisational support

Responses were given using a 5-point likert scale (Likert, 1932) ranging across disagree strongly, disagree, neither disagree nor agree, agree and agree strongly. Surveys incorporated free text questions for respondents to add additional feedback or explanation that they felt had not been fully conveyed in the body of the survey.

Working across 5 distinct and geographically disparate local authorities required that a flexible approach be taken by researchers in the administration of the respective staff surveys. For example, a number of local authorities had either firm plans or intentions to conduct internal staff surveys during the period of the evaluation. In these cases, compromises were negotiated between researchers and local authority management, both in relation to the content and administration of the survey. Table 21 below outlines that some surveys were targeted at particular service areas, while others used a whole-service sample frame to meet the aims of the respective local authority, who was using it for internal purposes.

While the evaluation team aimed to maintain consistency across all 5 local authorities in relation to the timing, content and administration of the respective staff surveys, various in situ factors led to variation on a number of dimensions. Nonetheless, despite the wide variation in research context across the 5-partner local authorities consistency, or at least comparability, was maintained across the majority of the conducted surveys.

**Table 21: Staff survey design by local authority**

	<b>Timing</b>	<b>Method</b>	<b>Content</b>	<b>Sample</b>
Hull	January 2016	Online; email-link	Negotiated	Whole-service
Derbyshire	August 2015	Paper; researcher-distributed	Researcher-led	Targeted
Buckinghamshire	August 2015	Paper; researcher-distributed	Researcher-led	Targeted
Harrow	July 2015	Online; email-link	Negotiated	Whole-service
Southwark	October 2015	Online; email-link	Researcher-led	Targeted

Source: Survey timings, distribution methods and content management

In total, of the 831 members of Children’s Services staff invited to take part in the evaluation questionnaire, 325 completed questionnaires were returned. Response rates across the 5 local authorities are detailed further in Table 22.

**Table 22: Staff survey response rates by local authority**

	<b>Sample</b>	<b>Response</b>	<b>Response Rate</b>
Hull	332	49	15%
Derbyshire	125	87	70%
Buckinghamshire	121	59	49%
Harrow	121	59	49%
Southwark	132	71	54%
<b>TOTAL</b>	<b>831</b>	<b>325</b>	<b>39%</b>

Source: Response rates, as of 1<sup>st</sup> April 2016

As can be noted, response rates varied significantly between different local authorities for a number of factors. Local authority 2 for example, obtained a 70% return rate, whereas the same survey in local authority 1 had a yield of 15%.

## Comparison groups

For the above datasets we have used the following comparisons.

## Family data

Comparison groups were differentiated by a core element of the IP: the programme of recruitment, training and coaching for CSWs across local authorities. The study compared the quality of practice of social workers based within RSW units that included a participant within the CSW Development Programme, with workers based within the same services that had not received such input, referred to as 'service as usual'. In this way, robust comparisons can be made about the nature and quality of social work, and impact on outcomes for children and families over time and place.

It should be noted that most observations within the intervention group were not of CSWs actively participating in the CSW programme. Rather participants were largely based within RSW units (17 out of 27, 63%) headed by a CSW on the programme (see Table 23). This reflects that many of the CSWs were not case holding and therefore did not undertake direct work with families. Nevertheless, the impact of the programme can be viewed via their practice leadership.

**Table 23: Direct observations by participant type**

<b>Participant type</b>	<b>Number</b>
Participant on the CSW programme	10
Participant within a RSW unit	17
Participant 'service as usual'	40

Source: Social worker sampling data

## Qualitative staff interviews and observations of group supervision

Data collected through interviews with key informants was focused on the factors that support embedding innovation and what mechanisms support practice change. Therefore, in general, comparisons between groups within local authorities were not made. However, given the unique setting and culture of each local authority partner, interviews with individual's party to the process of reform presented invaluable data on the process of change in this local authority, relative to the other 5 partners.

Observations of unit meetings were collected from both RSW and service as usual units. Therefore, a comparative approach was taken to analysing the observational data collected. Analysis assessed the degree to which units were operating systemically and looking specifically for key elements of systemic social work practice across both groups, see below for further details.

## **Staff survey**

These were carried out between July 2015 and January 2016, with each partner local authority varying in the specific timescale of data collection (see Table 5). Given variation in the timing of the IP roll out, and local authority concerns about survey fatigue, one-off surveys were conducted, rather than before and after surveys. This allows for between local authority comparisons, rather than before and after comparisons.

## **Data analysis**

### **Coding of direct practice**

The present evaluation used a social work practice skill coding tool developed by the University of Bedfordshire and the University of Cardiff over the course of a 10 year programme of work exploring approaches to defining and measuring the effectiveness of social work communication skills (Forrester et al., 2008a; Forrester et al., 2008b; Forrester et al., 2014; Forrester et al., forthcoming a and b; Whittaker et al., 2016).

The practice coding tool has been used across a number of research and evaluation projects, both with simulated and live practice sessions – over 500 direct observations of live practice have been observed and analysed using this method. Studies show that skills can be rated reliably, and there is a growing evidence base of the links between skills, parental engagement and family outcomes (Whittaker et al, 2016; Forrester et al, forthcoming a and b). Furthermore, the reliable coding of practice formed a foundation for the present evaluation, from which to explore the relationship between practice skills and outcomes and for research on the individual and organisational factors that influence level of worker skill.

The complete coding system comprises 7 domains of practice skills, as described in Table 24. Each of these skills domains is measured on a scale of 1 (low) to 5 (high).

**Table 24: Social work direct practice skills domains**

Practice domains	Description
Evocation	The extent to which the worker conveys an understanding that motivation for change, and the ability to move toward that change, reside mostly within the service user and therefore focuses on efforts to elicit and expand it
Collaboration	The extent to which the worker behaves as if the session is occurring between two equal partners, both of whom have knowledge that might be useful in the problem under consideration
Autonomy	The extent to which the worker supports, and actively fosters, service user perception of choice, as opposed to attempting to control the family member's behaviour or choices
Empathy	The extent to which the worker understands, or makes an effort to grasp, the family member's perspective and feelings – and communicates this effort
Purposefulness	The extent to which the social worker sets out and maintains a focus for the session whilst demonstrating flexibility in response to the client's agenda.
Clarity about concerns	The extent to which the social worker is clear about the reasons for professional involvement and is able to engage in meaningful dialogue with the service user about issues or concerns.
Child focus	The extent to which the social worker ensures that the child is meaningfully integrated into discussion in order to enhance the family member's understanding of the child's needs.

Four of these skills domains (empathy, collaboration, evocation and autonomy) are drawn from the work of Moyers et al., (2010) who developed a reliable and validated integrity measure of how practitioners demonstrate the core therapeutic skills and values required in motivational interviewing sessions. MI has been of particular significance in understanding key elements of skilled social work communication, not least because the values and principles underpinning MI seem highly compatible with social work values (Hohman, 1998; Wahab, 2005; Watson, 2011) and have yielded a number of real world correlations in UK children's and families' social work settings (Forrester et al., 2008a and b; Forrester et al., forthcoming a and b;). A further 3 skills categories (purposefulness, child focus, and clarity about issues and concerns) have been developed to capture the unique position of social workers in making appropriate use of authority in their work with families. These additional categories, combined with the collaborative categories described above, seek to describe the balance of care and control in social worker interactions with clients.

## Coding process

In the present study, observations of social work sessions with families – most of which were home visits – were conducted by an evaluation researcher who, with the informed consent of the family, audio recorded the interaction. Tapes were then allocated to a team of coders, headed by a researcher trained in both social work and motivational interviewing coding. Members of the team were trained in coding, both with simulated and live tapes, and then allocated audio tapes. Researchers coded tapes blind, in that they did not code tapes from an observation they had been part of, and did not know whether any particular tape pertained to any research variable used in the study. Coding of tapes involved a double-coding process, whereby a sub-sample of tapes were analysed by two researchers to ensure inter-rater reliability (IRR); two researchers listening to the same session would not deviate by more than 1 point on the 5 point scale in their assessment of skill in each of the 7 domains (for a full discussion see Whittaker et al., 2016).

Quality of direct practice was coded using a coding handbook developed at TGC. Two sets of worker skills were measured: those associated with Motivational Interviewing (MI) and more general social worker skills, particularly linked to appropriate use of authority (Ferguson, 2014). Practice skills adapted from the Motivational Interview Treatment Integrity (MITI) were collaboration, autonomy and empathy. Additional practice skills coded for were clarity of concerns, child focus and purposefulness. Each practice skill was coded, and workers were given a score on a 5-point scale ranging from 1, representing low practice skill, to 5, representing high practice skill. Researchers were trained to reliably and consistently code for practice skill (Whittaker et al. 2016).

It should be noted that the coding approach was based on MI rather than systemic social work practice. This is because there is no existing published scale for assessing systemic social work practice. Nevertheless, a systematic analysis was conducted to assess the degree to which the TGC manual captured systemic social work practice. This was based on discussions with systemic practitioners, and a guide to assessing systemic social work practice subsequently developed but yet to be piloted for inter-rater reliability. This found that there was considerable overlap between MI and systemic social work approaches, although there were concerns that the framework may have missed features critical to systemic practice, such as the use of cultural genograms with families (n=7 observed in practice). In practice, this study demonstrates that systemically-trained social workers score well using this coding approach, largely because of the open-ended and reflective questioning techniques that rate highly on this scale.

### **Quantitative data**

All quantitative data was entered onto SPSS: means or distributions are presented, usually comparing the RSW and service as usual groups as defined above. Appropriate statistical testing was done to look for differences (usually independent samples T-tests for scale or ordinal data and Chi-Square for nominal data). For ease of presentation, in this report it is usually just the averages and the statistical significance (p-value) which are presented.

### **Qualitative data**

All interview data has been analysed using the qualitative data analysis software package, Nvivo. Nvivo allows the researcher to index segments of text to particular themes, to link research notes to coding, to carry out complex search and retrieve operations, and to aid the researcher in examining possible relationships between the themes (King and Horrocks, 2010). Initial codes were developed using a concept mapping approach, drawing on questions asked of respondents. Once data was coded using this framework, content analysis was conducted to identify common and divergent themes (Kane and Trochim, 2007).

### **Observations of group supervision**

Observations were analysed blind to minimise bias and assessed as systemic; green shoots; or un-systemic depending on how well unit discussions were enacted. For a unit meeting to be assessed as systemic, the following features were recorded:

- family relationships were set within the wider social context



- discussion was curious and reflective: for example, open to different ways of thinking about the family
- generation of different hypotheses and/or evidence of challenging established theories about the family
- development of hypotheses into clear and actionable conversations with families
- discussion was collaborative and involved all group members, although they recognised that the unit coordinator may not always fully contribute
- child and family were present within the conversation
- there was clarity around potential risks to the child or children

Where unit meetings were assessed as green shoots, all the above elements were observed, bar 1 crucial aspect: the development of hypotheses into clear and actionable conversations with families. Unit meetings that were assessed as non-systemic were markedly less curious about family relationships; often did not use a genogram; made fewer attempts to generate hypotheses; and actions were largely process-based: for example, arranging a visit with the child at school.

## **Profile of the sample**

ICS background data was collected on 51 of the 86 families that took part in the research. This represents every family included in the research in 4 of the 5 local authorities. Due to practical difficulties, ICS data was not collected on the families that took part in the research in local authority 1 (n=35). However, regarding case type - for example CiN or LAC and so on - data for 29 of the total 35 local authority 1 family participants was collected through social worker questionnaires.

While not representing the entire sample, this background data provides information describing the types of case that entered the samples and the point in the services where families were when data collection was undertaken (see Table 8).

Amount of time between initial referral and the point of data collection was calculated to better understand how long each respective family had been in the Children's Services system when they participated in the research. Nearly half (45%) were at what can be called the beginning of Children's Services involvement, between 1 and 9 weeks inclusive. This represents families for whom Children's Services was undertaking an assessment, or for whom an assessment had recently been completed. A further 15 families (29%) had been in receipt of Children's Services for between 10 and 30 weeks. A further quarter (n=13) had been receiving services for longer than this, with 9 families (18%) having received a service for over 52 weeks.

Families had been originally referred into the respective local authorities Children's Services department through a number of referral routes. This referral source was obtainable in 46 of 51 cases. Referrals from other agencies, including Health, Education and Police, made up over three-quarters of sample. Less frequently, referral sources included relatives (n=2), members of the public (n=1) and self-referral (n=1).

Just over half of the participants (n=27) had experienced Children's Services involvement of at least an assessment on at least 1 occasion prior to the present period of involvement. Of those 27 families who had, 14 (52%) had been in receipt of Children's Services involvement on 1 occasion. A further 22% (n=6) had experienced 2 prior periods of Children's Services involvement and 19% (n=5) had 3 prior episodes of involvement. Two families (7%) had experienced an episode of Children's Services involvement on 5 occasions prior to their present involvement.

Information was collected about the level of statutory intervention that was undertaken by the Children's Services department during the respective family's present episode of involvement; between referral and data collection close at 31 March 2016. The data was collected for all family participants in local authorities 2, 3, 4 and 5 (n=51). These data was combined with social worker reported data collected in local authority 1 (n=29 of a possible 35). These data pertained to the present level of statutory involvement at the point of observation or interview rather than the highest level over the course of this episode of social work involvement. In total, data regarding the statutory basis for involvement was collected for 80.

Serious concerns were raised in over half of all cases. Thirty-nine (49%) of families were subject to child protection procedures. 5 (6%) participants had at least 1 child in local authority care, either through a voluntary admission (n=3) or through care proceedings (n=2). Thirteen (25%) families were receiving intervention based on s.17 of the Children Act (1989, Child in Need). A further 10 families (12.5%) received an assessment of at least 1 child's needs with an outcome of no further action. All 10 families were involved with Children's Services in local authority 4; most of the RSW unit participants in this local authority took place specifically within assessment services. Three families were defined within the other category.

Ethnic backgrounds of families were included in all 51 cases. Of those included in the cross local authority sample, just over 50% (n=26) identified as White British. Other prevalent ethnic identities included Black British (n=9), Asian British (n=5) and White European (n=3), with a further 5 families self-describing as Mixed. As might be expected, this overall variation reflects the differing local populations. For example, most families who self-reported as Black British were from local authority 5. Similarly, all the Asian British participants hailed from local authority 4.

Table 25: ICS data collected on comparative sample participants

<b>Length of time between Initial Referral and T1 Observation or Interview</b>	<b>N = 51</b>	<b>Percentage</b>	<b>Valid Percentage</b>
1-9 weeks	23	45.10%	45.10%
10-30 weeks	15	29.41%	29.41%
30-52 weeks	4	7.84%	7.84%
52 weeks	9	17.65%	17.65%
Total	51	100.00%	100.00%
<b>Referral Source</b>	<b>N = 51</b>	<b>Percentage</b>	<b>Valid Percentage</b>
Health	14	27.45%	30.43%
Police	13	25.49%	28.26%
Education	9	17.65%	19.57%
Self	1	1.96%	2.17%
Member of the Public	1	1.96%	2.17%
Relative	2	3.92%	4.35%
Other	6	11.76%	13.04%
Missing	5	9.80%	
Total	51	100.00%	100.00%
<b>Previous Referrals</b>	<b>N = 51</b>	<b>Percentage</b>	<b>Valid Percentage</b>
Yes	27	52.94%	52.94%
No	24	47.06%	47.06%
Total	51	100.00%	100.00%

<b>Number of Previous Referrals</b>	<b>N = 27</b>	<b>Percentage</b>	<b>Valid Percentage</b>
1	14	51.85%	51.85%
2	6	22.22%	22.22%
3	5	18.52%	18.52%
4	0	0.00%	0.00%
5	2	7.41%	7.41%
Total	27	100.00%	100.00%
<b>Highest level of Statutory Involvement</b>	<b>N = 85</b>	<b>Percentage</b>	<b>Valid Percentage</b>
Assessment – NFA	10	12%	12.5%
CiN	23	27%	28.75%
CP	39	46%	48.75%
s.20	3	3.5%	3.75%
Care Proceedings	2	2%	2.5%
Other	3	3.5%	3.75%
Missing	5	6%	
Total	85	100.00%	100.00%
<b>Ethnic Background (of child)</b>	<b>N = 51</b>	<b>Percentage</b>	<b>Valid Percentage</b>
White British	26	50.98%	52.00%
Black British	9	17.65%	18.00%
Asian British	5	9.80%	10.00%
White European	3	5.88%	6.00%
Mixed	5	9.80%	10.00%

Black African	1	1.96%	2.00%
White Other	1	1.96%	2.00%
Refusal	1	1.96%	
Total	51	100%	100%

Source: ICS data

## Appendix 3: What is a systemic social work unit?

A systemic unit is a small multi-disciplinary social work team. In this model, cases are allocated to a consultant social worker. They are responsible for the unit that collectively works the case. In the original model, developed in Hackney, RSW units consisted of the following members:

- a consultant social worker (CSW): leads the unit, has ultimate responsibility for case decision-making and provides expertise and leadership
- a qualified social worker (SW): is a person with a social work degree and works directly with families to enable change
- a child practitioner (CP): may not be social work qualified but also works directly with families
- a unit coordinator (UC): provides enhanced administrative support, rather like a personal assistant and acts as first point of contact for families
- a clinician (C): is a qualified systemic family therapist, providing both therapeutic input for families and clinical supervision to the unit

(Forrester et al. 2013b: 3).

## Appendix 4: What is systemic social work practice?

RSW units are informed by systemic theory. Systemic approaches understand families as systems rather than individuals, with the family system interacting with wider economic and social systems including extended family, local community or professional systems (Forrester et al. 2013b). Systemic social work practitioners focus on the family system rather than the individuals; specifically the difficulties and issues that bring the family to attention of Children's Services. Problems are viewed as arising in relationships, interactions and language that develop between individuals rather than within individuals themselves (Pote et al., nd).

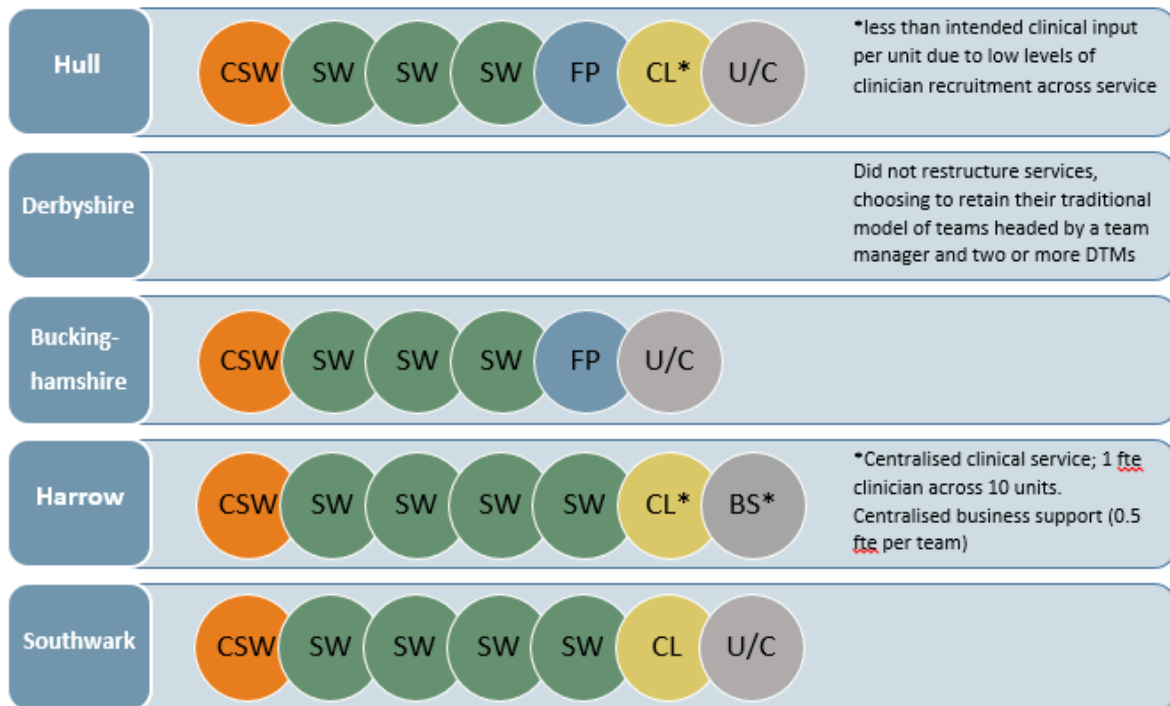
Systemic social work practitioners help families resolve their difficulties by exploring how they operate in relation to others and how their relationship patterns impact on children. Rooted within the Milan School of social constructivist family therapy, understandings about families are constructed through interactions with others by inviting practitioners to actively reflect on how knowledge is constructed about families, with families and within families (Witkin 2011). Reflection, or perhaps more accurately, the concept and practice of reflexivity, enables practitioners to challenge taken-for-granted assumptions about families and work more openly and collaboratively with families to effect change for children.

A key concept in systemic theory is considering multiple perspectives and multiple possibilities. This enables social workers to explore risk to children from multiple perspectives, including families and other professionals, and allows for both multiple explanations and multiple solutions for the problems facing families. However, it is recognised that, in child protection practice, not all solutions are acceptable. Nevertheless, this approach provides opportunities for families to be part of the solution, re-write their stories and demonstrate their capacity to safely care for their children (Koglek and Wright, 2013).

In systemic social work practice, change is facilitated by encouraging reflexivity, or thinking about how beliefs and circular patterns of behaviour within families affect others. Enabling expression of different viewpoints is an important tool for introducing change into a system, creating new possibilities for the future (Koglek and Wright, 2013). Social workers who practice systemically support families to mobilise their own problem-solving resources by encouraging them to think in a reflexive, more relational way about problematic patterns within the family. Thinking reflexively, and acting differently in light of those insights, is at the heart of systemic social work practice and viewed as a key mechanism to support change for children.

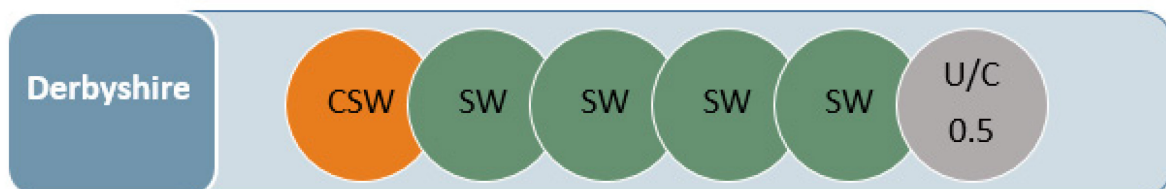
## Appendix 5: Systemic unit model by LA pre and post Innovation

Figure 6: systemic unit models by local authority prior to commencement of Innovation Programme



While 3 of the 5 local authorities chose to retain the unit structure that they had implemented prior to the Innovation Programme, two local authorities - Derbyshire and Harrow - carried out smaller scale pilots of the unit model during the course of the programme. Derbyshire trialled the unit model in one district, splitting a team into two practice units, each headed by consultant social workers and supported by 0.5 fte unit coordinator (see figure 7).

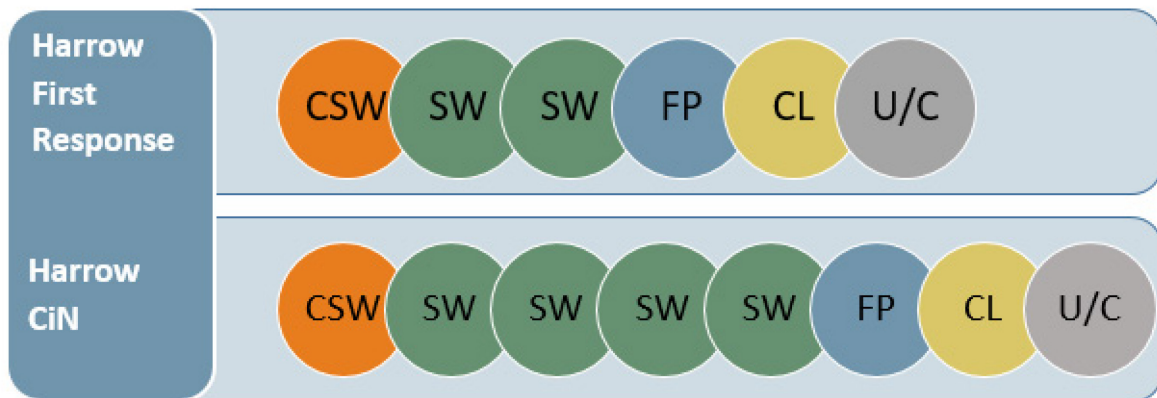
Figure 7: Structure of Derbyshire RSW units





Harrow also trialled a unit model, within the department’s assessment service and to a lesser extent within the child in need service (CiN) (see figure 8). Within the assessment service a unit model closely resembling that of the original Hackney model was trialled, with a CSW, two social workers, a family practitioner a 0.3 fte clinician and a dedicated unit coordinator. Within the CiN service, the units more closely resembled the units structure that had already been rolled out across the service, with a CSW and 4 social workers, but received the additional input of a family practitioner a 0.3 fte clinician and a unit coordinator.

**Figure 8: Structure of Harrow RSW units**



## Appendix 6: CSW development programme modules

There were 4 modules.

### Module 1: RSW values, risk and uncertainty (2 days)

To introduce RSW values and approach to affecting change for families:

- understanding the importance of a relational stance in RSW
- reconnecting with risk as a central aspect of child protection work
- reflexivity as model of change
- share learning across the group

### Module 2: Supervision (3 days)

To manage and develop detailed maps for conversations with families to address blocks in progress:

- enabling reflective practice by generating ideas about what practitioners can do differently in conversations with families
- case progress and review of how actions and inactions impact on risk within the family
- use of hypothesising and dilemmas to address progress that has stalled through curiosity about family logic, scripts and beliefs and our own professional position in the system
- developing hypotheses into clear, actionable conversations to be undertaken with the purpose of influencing the family system and effecting change for children

### Module 3: Unit inductions (3 days)

To support all unit members to develop a shared purpose in how they work together and with families, focussing on:

- clarifying the purpose of unit discussions as focused on the social work task
- the conditions for working together in a safe culture of appreciation, challenge and learning
- context setting, identifying what is getting in the way of progress and generating initial hypotheses
- introducing the Munro tool for calming the system and focusing interventions
- developing hypotheses into questions or intervention for reducing risk in families
- assessing change in families
- understanding unit performance and culture

## **Module 4: Leadership (1 day)**

To examine organisational context as a contributor to effective, social work practice:

- explore the role of leaders in developing a culture that supports good practice
- manage tensions between systemic social work practice and performance culture



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