



Department
for Education

Family Safeguarding Hertfordshire

Evaluation Report

July 2017

Donald Forrester*, **Amy Lynch****, **Lisa Bostock****, **Fiona Newlands****, **Bart Preston**** and **Alex Cary****

***CASCADE: Children's Social Research and Development Centre, University of Cardiff**

****Tilda Goldberg Centre for Social Work and Social Care, University of Bedfordshire**

Contents

List of Figures	5
List of Tables	6
Acknowledgements	8
1 Executive Summary	9
Family Safeguarding Innovation	9
Evaluation Design	9
Key Findings	9
Process of Change	9
Comparison of practice and outcomes before, during and after implementation of FSH	10
Indicators of service outcomes	12
Discussion and Conclusions	12
Recommendations for policy and practice	14
Implications for Hertfordshire	14
National Implications	15
2 Overview of Family Safeguarding Hertfordshire	16
Background, Context and Aims and Outcomes	16
Primary Elements of FSH	16
Hertfordshire Context	17
Children and Young People in Hertfordshire	17
Child protection and children looked after in Hertfordshire	18
Hertfordshire Children’s Services Safeguarding Team	18
Hertfordshire Children’s Services Ofsted Inspection	18
3 Overview of the Evaluation	19
Research Questions	19
Research Design	19
Implementation and Evaluation Timeline	22
4 Evaluation Findings	24
Process of Change Data	24
Qualitative Interviews with Staff	24

Staff Survey Data	27
Comparative study	32
Services and Outcomes Pre- and Post-FSH	32
Understanding FSH: Case studies	44
Understanding FSH: observations of group supervision	48
Key Performance Indicators	50
Introduction	50
Nature of the Dataset	50
Analysis	52
Key findings	53
Estimates of Cost Savings	59
5 Limitations of the Evaluation and Future Evaluation	62
6 Implications and Recommendations for Policy and Practice	65
Recommendations for policy and practice	67
Implications for Hertfordshire	67
National Implications	67
References	69
Appendix 1: Further Detail on Methods and Data Collected	70
Data Analysis	71
Appendix 2: Process of Change – Interviews and Staff Survey	73
Process of Change Data - Qualitative Interviews	73
Staff Survey Data	73
Appendix 3: Mixed methods comparative study: Services and Outcomes Pre- and Post-FSH	76
What services did families receive?	76
What did parents and children think of the service they had received?	77
Appendix 4: Key Performance Indicators	85
NHS data - use of emergency hospital services	85
Police data – number of incidents	88
Appendix 5: Costing Analysis	90
Estimates of cost savings to Children’s Services	90
Estimates of cost savings related to reduction in number of cases	90

Estimates of cost savings related to reduction of number of days in care	91
Estimates of cost savings to other services	92

List of Figures

Figure 1: Timeline for Implementation of Innovation and Evaluation Data	23
Figure 2: Level of Good Authority Plotted Against Time Since FSH Implemented, with Office from which Observation Taken Identified	38
Figure 3: Case Study 1	46
Figure 4: Case Study 2	47
Figure 5: Good Authority and Days Since FSH Started (broken down by office)	83
Figure 6: Care and Engagement Skills and Days Since FSH Started (broken down by office)	84
Figure 7: Adult Emergency Admissions: Monthly Average per Cohort	86
Figure 8: Adult Accident and Emergency Attendances: Monthly Average per Cohort	86
Figure 9: CYP Emergency Admissions: Monthly Average per Cohort	87
Figure 10: CYP Accident and Emergency Attendances: Monthly Average per Cohort	87

List of Tables

Table 1: Evaluation Data by Source	21
Table 2: Direct Practice: Analysis of Skills Pre- and Post-FSH	36
Table 3: Parent and Carer Interviews: Outcomes Pre- and Post-FSH	40
Table 4: ICS Data: Impact of FSH on Use of Care	41
Table 5: Parent's Life Rating by Involvement of Different Adult Workers	42
Table 6: Summary of Case Study Data	45
Table 7: KPI Data – Cohort by Quarter	51
Table 8: KPI Descriptive Data by KPI Area	51
Table 9: Increase or decrease in Average Number of Monthly Emergency Hospital Attendances or Admissions for each Cohort post-FSH Compared with pre-FSH	55
Table 10: Average Monthly Police Incidents Before-and-After FSH	56
Table 11: Educational Absence Data for Cohort 1 and 2: Spring Terms 2015 and 2016	58
Table 12: Case Allocation and Statutory Basis Pre- and Post-FSH	59
Table 13: Estimate of Cost Savings in Relation to Children's Services	60
Table 14: Estimate of Cost Savings in Relation to NHS and Police	60
Table 15: Number of Workers by Role who Participated in Research Discussions	73
Table 16: Number of Workers by Role that Completed each Staff Survey	74
Table 17: Number of Workers by Office that Completed each Staff Survey	75
Table 18: Summary of ICS Data for Families Pre-FSH, Post-FSH and During Transition	76
Table 19: ICS Data on Service Input Pre-FSH, Post-FSH and During Transition	77
Table 20: Parents Views of Services Pre-FSH and Post-FSH	78
Table 21: Data Collection by Office	79
Table 22: Pre- and Post-FSH Scores for Office 1	80
Table 23: Skills by Period Since FSH, by Office	81

Table 24: Independent Samples T-Test Pre- and Post-FSH for Care and Authority	81
Table 25: Correlation Between Days Since FSH and Authority and Engagement Skills	82
Table 26: Increase or Decrease in Average Number of Monthly NHS Hospital Emergency Attendances or Admissions for Each Cohort Post-FSH Compared with Pre-FSH as percentage	85
Table 27: No. Adults in FSH First Year Cohort Involved in a Police Incident	88
Table 28: No. Police Incidents Recorded for First Year Cohort Pre- and Post-FSH	88
Table 29: Estimate of Children's Services Cost Savings Associated with the Reduction in Number of Cases	90
Table 30: Estimate of Children's Services Cost Saving Relating to the Reduction in Number of Days in Care for Newly Allocated Cases	91
Table 31: Estimate of NHS Cost Savings Associated with Reduction in Adult Emergency Admissions	92
Table 32: Estimate of Police and CJS Cost Savings Associated with Reduction in Repeat Police Incidents	94

Acknowledgements

The authors would like to acknowledge the support offered by the Family Safeguarding Partnership for the Evaluation. We would like to thank all the social workers, adult workers, managers, support officers and other staff who participated in the study, as well as those who commented on study design, fed-back on drafts or organised access to workers or to families.

Particular thanks go to staff who provided the KPI data: Jackie Albery, David Butcher, Elaine Dunncliffe, Zara Edwards, Michael MacAllister and Rachel Porter; and their colleagues at Hertfordshire Police, Clinical Commissioning Group, Change Grow Learn, Hertfordshire Partnership University NHS Foundation Trust, and Child and Adolescent Mental Health Services.

We are particularly grateful to staff who arranged for us to accompany them on a visit with families; we feel privileged to have had the opportunity to be so unusually close to social worker practice with children and families.

We are thankful to the parents, carers, children and young people who agreed to allow us to observe a visit with their social worker and take part in in-depth interviews. We really appreciate their time, thoughtful responses to our interviews and questionnaires and the permission to observe meetings which were often about very sensitive issues.

We would also like to extend our thanks to our colleagues at the Tilda Goldberg Centre, who supported data collection, conducted analysis of the practice recordings, and provided support with analysis and administration.

1 Executive Summary

Family Safeguarding Innovation

Family Safeguarding Hertfordshire (FSH) is a whole-system reform of Children's Services which aims to improve the quality of work undertaken with families, and thereby outcomes for children and parents. It brings together a partnership including the police, health (including mental health), probation and substance misuse services. Key elements include specialist workers with domestic abuse, substance misuse and mental health expertise joining teams; training in Motivational Interviewing (MI is 'a client-centered, directive therapeutic style to enhance readiness for change'; Rollnick and Miller, 1995, p325- 334) as a framework for practice for all staff; a move to group case discussions; and structured tools to support direct work. In addition, there is an attempt to provide practice-enabling factors, such as reduced caseloads and assessment workbooks.

Evaluation Design

The evaluation consisted of 3 strands:

- qualitative and quantitative data on the process of change from 185 interviews, 7 focus groups, 8 structured observations and 439 questionnaires from staff at 3 time points
- a comparison of practice, service experiences and outcomes prior to, during and after FSH implementation. This involved 126 observations of practice (104 of which were recorded and coded for skill), 108 research interviews with parents shortly after allocation and 40 at T2 (3 months later), and 11 with children. It also used data from computerised records for 447 families
- analysis of a large dataset that included evidence on service use and outcomes for all children and parents in every family allocated in FSH, for the 12 months from August 2015. Data included police involvement, emergency hospital admissions, school attendance, and substance misuse and mental health service use. The data related to the period prior to allocation (12 months) and the period following allocation (which ranged from 3 to 12 months depending on the date of allocation). It was for 940 families (1,752 children and 1,683 adults)

Key Findings

Process of Change

A huge amount was achieved within a very short space of time, including commissioning

and delivering a large training programme for all staff; recruitment of new specialist adult workers; creating multidisciplinary teams; introducing new ways of working, and reducing caseloads. Effective management oversight and strong interagency working meant that the key planks of FSH were put in place swiftly, challenges were generally overcome and the reforms were delivered in an impressively efficient manner.

Of the 3 core planks of the programme of work, the involvement of adult workers was implemented swiftly and efficiently and there was a substantial reduction in caseloads. The training in MI was delivered, but was of mixed quality. The qualitative feedback for other elements was also mixed, with case discussions being a generally positive element of the changes, while workbooks and the structured work were less well received. In addition, a sense of energy about the project, and commitment to working to keep families together, were evident and likely to be an important, if less tangible, element of the change programme.

Workers were generally very positive about their role and work; about the changes involved in FSH, and a high level of energy and enthusiasm was sustained over the year. Workers' levels of stress, satisfaction and intention to stay in the job were influenced by factors both within and beyond the reform programme, with line managers having a particularly important role. Other crucial factors included access to adult workers, individual workloads and stability at team level.

Comparison of practice and outcomes before, during and after implementation of FSH

FSH was rolled out over the year, and implementation staggered across offices. To address this, the evaluation used various comparisons, including pre- and post-FSH overall, and between individual offices, as well as analyses of changes over time rather than between groups. Overall, families allocated had high levels of presenting problems. A particular feature was the high proportions of families with parental domestic abuse (44%), alcohol (26%) or drug problems (38%) or depression or anxiety (69%). The high prevalence of these issues is the rationale for core elements of FSH, and in particular the specialist workers.

The coding of worker skill for 104 observations of practice rated workers for care and engagement and good authority skills on a 5 point scale (with 5 as high and 3 the anchor point). Level of skill has been found to be linked to outcomes for families in research in other authorities.

Prior to FSH there was a range of practice, but average measures of both care and engagement (2.2) and good authority (2.4) suggested a low level of skill, with workers often telling families what to do and a lack of clarity about concerns. This again supports the rationale for FSH, which aimed to improve the quality of the service provided. When

compared to skills of workers in practice after the implementation of FSH there was a small, though not statistically significant, shift in care and engagement skills (from 2.2 to 2.4). However, the shift in good authority was statistically significant (rising from 2.4 to 2.7, $p=0.02$). This was particularly linked to greater clarity about concerns with families.

It was also possible to explore the relationship between level of skill and time since implementation. Here, positive correlations were found for both care and engagement and good authority, and, for the latter, this was statistically significant ($r=0.20$, $p=0.04$). This demonstrates that the quality of practice improved over the course of the year of the evaluation, and, in particular, that it continued to improve after the initial implementation of the new approach. This is an important finding, as it highlights that simplistic pre-FSH and post-FSH analysis may fail to capture the way in which improvement in practice develops over time.

The limited numbers of follow-up interviews made identifying statistically significant differences pre- and post-FSH in family research interviews very difficult. Nonetheless, there were indications that for important measures there were better outcomes in the post-FSH sample: for instance, 19 of 22 (86%) families had achieved their goals at follow-up interview (compared to 7 of 10; 70%); about one-fifth (2 of 11; 18%) of parents were identified as anxious or depressed compared to almost one-third (4 of 13; 31%), and improvement in Life Scale Rating on a 10 point scale was 3.7 pre-FSH and 4.4 post-FSH.

ICS data was compared for 221 families prior to FSH and 165 post-FSH. Here, there was a small reduction in the proportion of families who had a child enter care at some point, from 12% to 10%. However, the number of days children spent in care over the 5 months post-allocation was calculated for each family (including the majority who had no children enter care). This showed a reduction by more than half, from 20.5 days per family pre-FSH to 9.8 post-FSH. The change was primarily achieved by children being more likely to return from care, and to do so relatively quickly, post-FSH. This is an important positive finding in relation to FSH, with implications for children and families, as well as cost implications.

It is unlikely that these differences in outcomes are due to the modest shifts in skill observed. Evidence suggested that the specialist adult workers were particularly important in this respect. Quantitative analysis found far larger positive changes where adult workers were involved: for instance, for the Life Scale Rating, an average positive change of 6 points on a 10 point scale for families with an adult worker, was almost double that in families without such a worker. This highlighted both that specialist workers were working with families with the largest problems (that is, those who rated their family life lower at referral) and generally achieved larger positive changes for them. This encouraging picture was also reflected in qualitative feedback from families and social workers.

To explore this further, we carried out a small number of in-depth case studies focussed on families where FSH had worked well. The substantial contribution of adult workers, both to direct work with families and to helping workers in conversations about risk and change, was a major feature in these families. It seems clear that the inclusion of adult workers in teams for children and their families was a central success of FSH, providing not just specialist input but also a move towards a more multidisciplinary way of thinking and talking about families, as well as working with them. This is likely to be linked to the positive effects on outcomes, and helps us to understand the particular impact on families with more serious problems, such as the reduced need for children to enter care.

Indicators of service outcomes

The creation of a suite of key performance indicators (KPIs) that provided data for all families allocated in FSH from July 2015 in relation to use of health, policing, education and other services was in itself an enormous achievement, and one of the most innovative elements of the programme. It has the potential to allow interagency oversight and governance by focusing on outcomes that are meaningful for both families and services. For instance, it was possible to examine police involvement or school attendance before-and-after allocation to a worker in FSH. However, the KPIs do not provide a comparison with equivalent data before FSH was implemented as it was not available: the collection of the data being part of the Innovation itself. They therefore currently provide limited evidence to evaluate FSH as a reform.

The KPI data identified that allocated families had very extensive contact with other services. When service use was compared for the months before and the months after allocation, there were substantial reductions in contact with the police (monthly contacts reduced by 66%) and emergency hospital admissions for adults (which reduced by one-half on average). While these do not provide evidence about the impact of FSH compared to allocation prior to FSH, they do provide a strong indication of the positive impact that allocation to a worker made to families on key service use measures.

We have estimated some of the cost savings in the first 12 months of FSH that can be attributed to allocation. It should be noted that these are not a full estimate of cost savings: they are solely for the first 12 months and relate to indicators measured. The estimated cost savings to Children's Services from reduced care and child protection allocations in the first 12 months alone were £2.6 million. For the police and health, too, there were savings related to families being allocated in FSH.

Discussion and Conclusions

The depth and breadth of the organizational changes put in place in Hertfordshire over the course of a year have been exceptional. Our findings support the rationale for

creating these changes; the families allocated to a worker in Children's Services have very high numbers of parental problems and the practice prior to FSH was characterised by little empathy and an approach that often involved telling parents what to do. This is an approach which research suggests is unlikely to create meaningful change, though it is nonetheless common in Children's Services.

There was a small improvement in the quality of important elements of practice post-FSH. The evaluation was able to capture the messy realities of change over time, with gradual improvement being seen over the year, rather than a sudden change. In doing so, it identified that, while the conditions for change can be put in place relatively swiftly, it takes time for workers to begin to practice in new ways.

In this context, this small change in practice skill is unlikely to have created the substantial changes in some important outcomes that were found. For swift, positive impacts, the adult specialist workers seemed crucial. First, where families had serious parental problems, they provided timely and, in general, high quality input that seemed crucial in turning around families' lives. Second, adult specialists helped support a different way of thinking about risk and how to work with families. In this respect their contribution complemented the emphasis in MI on strengths-based approaches.

In light of these positive findings, it is our opinion that the FSH innovation is not just important for what has been achieved within Hertfordshire; but, we feel, there are also national lessons, of which four are particularly important.

First, multidisciplinary teams are a very promising approach for Children's Services. This was about more than simply introducing adult workers; it was about creating the structures within which they could contribute to changed team dynamics. In this respect, group case discussions were a crucial factor that allowed the different perspectives of adult specialists to create more informed assessment of families. Perhaps just as important were the opportunities for informal discussions about families: for instance, before or after a difficult visit. The creation of multidisciplinary teams seems a very promising way of moving to better practice. Indeed, it may lead one to ask why child protection and family support should not be provided by multidisciplinary teams, when the issues dealt with involve complex adult, child and family elements.

Second, creating changes in practice across a service is challenging. FSH has achieved some significant shifts, yet more is required. Training is certainly not enough on its own; on-going input, new ways of thinking about, and discussing, families, and a longer time frame are required to help workers move to more collaborative and effective ways of working. Some of these elements are in place in Hertfordshire, and with the energy and commitment that has been demonstrated to date there are good prospects that further improvements in practice will become obvious over the next year or 2. Some of our recommendations relate to how to support such developments.

Third, achieving change is not just about technical fixes. Crucial for the successes in Hertfordshire was the sense of ownership and passionate belief in the reforms by the leadership team. This was communicated through the organisation as a set of values emphasising that social workers should work with families and seek to create change. This passion is not enough to create change on its own, but it seems unlikely that attempts to replicate promising models will succeed without similar levels of energy. Indeed, we felt this was one of the secret ingredients in Hertfordshire.

The final key national lesson is in relation to the creation of the interagency set of KPIs. We feel this is a potentially revolutionary new innovation for 2 reasons. First, these are genuine and measurable outcomes from the work of Children's Services, for children, adults and the services concerned. The involvement of police, or use of emergency health services, are important outcome measures. At present, we are sorely lacking in such measures in England and internationally, and therefore being able to quantify the impact of allocation on such outcomes provides the opportunity for genuine and meaningful quality assurance and management. Second, the suite of indicators provides an opportunity for strategic oversight of the service by a variety of agencies; and the influence of Children's Services on the need for police involvement, school attendance or hospital admission can be monitored and developed. This provides a platform for co-ordinated and intelligent service provision. While the real benefits of such an approach to data collection will only become apparent if sustained over some years, there can be no doubt that this is both genuinely innovative and of enormous wider importance.

Recommendations for policy and practice

Implications for Hertfordshire

- given the positive nature of the evaluation it is important that the various agencies in the partnership continue their impressive level of cross-agency support and strategic management of FSH
- the KPIs have huge potential, though further work is needed to develop them and address the practical challenges of collecting, collating and analysing findings
- further development of the adult worker role is required. Involving adult workers is a core element in the success of FSH, yet there was variation in the integration of such workers. There could now be an increased focus on developing and harnessing the expertise of adult workers to support multidisciplinary working
- further work is needed in developing the conceptual framework, and in particular in integrating the principles of MI with the way risk assessment is understood and carried out. This is closely linked to the next recommendation
- there is a need to develop the theoretical approach to group case discussion and provide training and supervision for those leading such discussions. Group case

discussions are already making a positive contribution to improving the depth of analysis. However, work is needed to maximise their potential

- further work is needed to support the understanding and application amongst workers of the principles and skills of the practice model being developed by Hertfordshire. This should include a next phase of training, materials and perhaps other initiatives such as coaching or consultancy on cases. Steps are being taken to address this recommendation, and the 3 previous recommendations

National Implications

- all local authorities should consider the potential that multidisciplinary working has for improving practice and outcomes in Children's Services. In Hertfordshire adult specialists have played a central part in creating more family focused assessment and intervention, and this has helped reduce the need for children to enter care, and contributed to other positive outcomes
- multidisciplinary working requires more than simply recruiting adult specialists; processes such as group case discussion and a framework for practice, in this case MI, are necessary to make this a genuinely multidisciplinary experience, and to provide a framework for helpful discussion and new ways of thinking
- the KPIs are a hugely promising approach to measuring outcomes, though setting them up was very resource intensive. We think it important that this innovation continues and is taken up in other local authorities
- this evaluation provides a very positive set of initial indicators of outcomes in such a short period. It provides unequivocal support for continuing the development of FSH. We would therefore encourage other local authorities to consider replicating, or implementing, central elements of FSH. However, for this to work, it needs to be seen as more than a technical fix. To be successful it also requires committed and passionate leadership.

2 Overview of Family Safeguarding Hertfordshire

Background, Context and Aims and Outcomes

The Innovation Project being evaluated is Family Safeguarding Hertfordshire (FSH), which brings together the County Council and Hertfordshire Boards for Health and Wellbeing, Safeguarding and Community Safety in a wide-ranging and complex, multi-agency, whole-system reform aimed at improving the quality of services provided to children and families in Hertfordshire.

The rationale for FSH is that an increase in the quality of assessment and direct work with children and families has the potential to substantially improve outcomes. In particular, the bulk of the families that Children's Services work with have complex issues, with parental alcohol and drug use, domestic abuse and mental health issues being particularly prevalent. FSH attempts to:

- allow workers to spend more time working with families
- increase the skills and knowledge of workers
- provide an inter-professional whole-family response that allows parent and child issues to be addressed effectively

The stated aims for FSH are ambitious. They are to:

- keep more high risk families together safely
- improve health and educational outcomes for children
- reduce physical and emotional harm in families
- increase engagement with families, thereby increasing the help they receive
- strengthen information sharing and shared decision making to better protect children and reduce harm to their parents
- provide high quality services at lower cost

Primary Elements of FSH

There are 4 primary elements of FSH, which are explained below.

Creation of multidisciplinary Family Safeguarding teams:

- increasing the number of teams working on Child Protection and Children in Need cases throughout the county from 19 to 22 between April and November 2015
- Four additional roles recruited to each pair of teams from June 2015, referred to as the specialist adult workers:

- mental health practitioner
- domestic abuse officer, working with perpetrators
- domestic abuse practitioner, working with victims
- substance misuse practitioner
- a clinical psychologist recruited in each office from February 2016
- a model of group supervision introduced to include all allocated workers working with the family

Core skills set to be delivered with Motivational Interviewing (MI) at its heart:

- all team members attended a 3-day MI training course between June and December 2015
- a series of follow-up workshops were held between September 2015 and June 2016
- a structured, direct work programme was designed, incorporating MI, for use with families by all workers, known as the Intervention Programme, which was in use from March 2016

Structured workbook approach to assessing parent's capacity for change:

- this involved the introduction of an electronic workbook as a new method of recording case notes to aid information sharing, streamline processes and reduce the amount of time spent in meetings or on reports
- this was rolled out to all teams in November 2015

Outcomes based performance framework:

- development of a set of indicators across the partnership of agencies involved in delivering FSH, including agreement on information governance protocols and creation of quarterly data collection and analysis processes to monitor impact on wider system
- data was collected from 1 July 2015 to 30 June 2016

Hertfordshire Context

Children and Young People in Hertfordshire

Hertfordshire is a large county, with approximately 260,000 children and young people under the age of 18, 23% of the total population. Around 13% of children are living in poverty. Children and young people from minority ethnic groups account for 17% of all children compared with 22% in the country as a whole, with Asian and mixed-ethnicity

being the most common minority groups. The proportion of children and young people with English as an additional language is 15% in primary schools and 11% in secondary schools, whereas the national averages are 19% and 15% respectively.

Child protection and children looked after in Hertfordshire

At 31 August 2015, 721 children and young people were the subject of a child protection plan, and 16 children lived in a privately arranged fostering placement. This represents a very significant reduction from the 1,140 children subject to a child protection plan at 31 March 2014. Between March 2013 and November 2015, 6 serious incident notifications had been submitted to Ofsted. At 31 August 2015, 1033 children were being looked after by the local authority (a rate of 39.5 per 10,000 children). This was a small increase from 1,005 (38 per 10,000 children) at 31 March 2015 (Ofsted Inspection report, November 2015).

Hertfordshire Children's Services Safeguarding Team

Hertfordshire Children's Services has a stable leadership team; for example, the Director of Children's Services has been in post since 2011. Prior to the introduction of FSH, Children's Services were provided by 140 workers in 5 service groups comprising a total of 19 locality-based safeguarding children's teams, operating from 5 district offices.

Hertfordshire Children's Services Ofsted Inspection

During the period of the Evaluation there was an OFSTED inspection (single inspection of Children's Services), the outcome of which was a judgement of good (report published November 2015). The previous inspection of the arrangements for the protection of children was in March 2013 when there was a judgement of adequate.

3 Overview of the Evaluation

Research Questions

The complexity and ambition of the proposed Innovation meant that a multifaceted approach to evaluation was required in order to capture the process of change, and identify whether there were changes in the quality of the service experienced by families. Evidence of outcomes for children and families and wider indications of the impact on services across Hertfordshire, for instance, in reducing demand for services or re-referrals was also needed. Specifically, the study attempts to answer the following research questions.

Has FSH been implemented as planned?

- what has been implemented well?
- where have there been challenges?
- how have they been addressed?
- what lessons are there for Hertfordshire and more generally from the process?

What is the impact of the new service on the experience of services for children and parents compared to service prior to reform?

- to what degree are the intended changes in the quality and quantity of services delivered?
- what are the experiences of children and families of the service?

To what extent does this appear to have an impact on outcomes for children and parents or carers?

- are outcomes improved for children and for parents?

Are there indications that this is having an impact on service level outcomes, such as level of re-referral, take-up of substance use treatment or police referrals for domestic abuse?

Research Design

To answer these questions the evaluation consisted of data collected in 3 strands:

Firstly, a process of change study:

- qualitative interviews were carried out with staff at every level of the organisation (see Appendix 2 for full details). Interviews were reviewed and key themes emerging were summarised, and are presented here. In addition, a survey of staff was carried out at 3 time points, broadly consistent with pre-, during, and post-implementation of FSH. A total of 439 staff surveys were returned, and key findings are summarised in the main report (see Appendix 2 for further information)

Secondly, a comparative study of quality of practice, service experience and outcomes prior to, during and after FSH implementation. Data was collected on families allocated into FSH between July and October 2015, and then November 2015 to February 2016. This consisted of a whole sample of 447 families. The initial idea of a before-and-after comparison needed to be adapted, as the staggered roll-out made a more complex analysis necessary. Instead, various comparisons, including before-and-after, between offices and over time are provided (see Appendix 3).

The following data was collected for the comparative study:

- observation of practice: meetings between families and workers were observed, recorded and coded for core social work skills, including level of MI skill
- parent and child interview: research interviews with parents, and, where appropriate, children and young people, 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. Full measures are presented in Appendix 1
- parent and child follow-up interview: 3 months later (T2) a follow-up telephone interview was carried out with parents
- social worker questionnaire: social workers completed a questionnaire outlining their rating of concerns and risks for the family at T1 and at T2
- integrated Children's System (ICS) data was gathered for all families (447 families or 860 children) from computerised records

Two further types of analyses were carried out to supplement the comparative element of the study:

- in-depth case studies: families where FSH was working particularly well were identified, and a combination of multiple interviews with parents, children and workers, and observations of practice was used to provide an in-depth picture of FSH in practice
- observation of group case discussions

Table 1: Evaluation Data by Source

Process of Change Data		Pre-FSH	Post-FSH	Total
Research Interviews		101	84	185
Research Group Interviews		3	4	7
Observations of Group Supervision		0	8	8
Staff Surveys		143 (T1) 137 (T2)	159	439
Comparative Study		Pre-FSH	Post-FSH	Total
Observations of Practice		34	92	126
Parent/Carer Interviews		30	78	108
Child/Young Person Interview (T1)		3	8	11
Parent/Carer Interview (T2)		15	25	40
Social Workers Questionnaire (T1)		34	94	128
	Pre- FSH	Transition	Post-FSH	Total
ICS Computerised Records	221	61	165	447
Key Performance Indicators (KPIs)			Total cohort size	
Key Performance Indicator data from Health, Education, Substance Misuse, Mental Health Services, Police and Children's Services.			All families allocated to FSH 2015-16	940 (1,752 children; 1,683 adults)

Finally, a dataset of key performance indicators (KPIs).

- HCC and partner agencies collated data on the use of different services by adults and children in families allocated in FSH. Service use in the 12 months prior to FSH allocation and in each of the quarters post-allocation was used. This allowed for 2 comparisons: service use prior to, and after, allocation to a worker in FSH, and changes in these figures during the 4 quarters of 2015 to 2016. Data was provided in relation to:
 - accident and Emergency use and admission for adults and children
 - victim and offender status in crimes
 - substance misuse services use
 - mental health services
 - school attendance
 - number and length of child protection cases

Data collected is set out in Table 1, broken down by strand. It can be seen that the study involved collecting a very large amount of both quantitative and qualitative data.

Implementation and Evaluation Timeline

In a short period of time the Innovation Project required implementation of a complex and multifaceted project. It also involved a complex and ambitious evaluation of these changes. A particular challenge has therefore been evaluating a service while the service is implementing change.

Figure 1 attempts to capture some of this complexity. Against the timeline on the graph, 3 types of information can be read:

- the dates at which core elements of the FSH Innovation went live

It can be seen that FSH was rolled out in a series of steps. Different offices went live as adult workers were recruited; caseloads were reduced to enable more direct work, and other elements of the Innovation were put in place. Meanwhile the training programme was rolled out across the workforce. Other elements, such as the electronic workbook and the intervention programme, were put in place toward the end of the evaluation period. We have also added the date of the Ofsted inspection to illustrate that, while all this was happening, it was necessary to manage the usual challenges of delivering Children's Services.

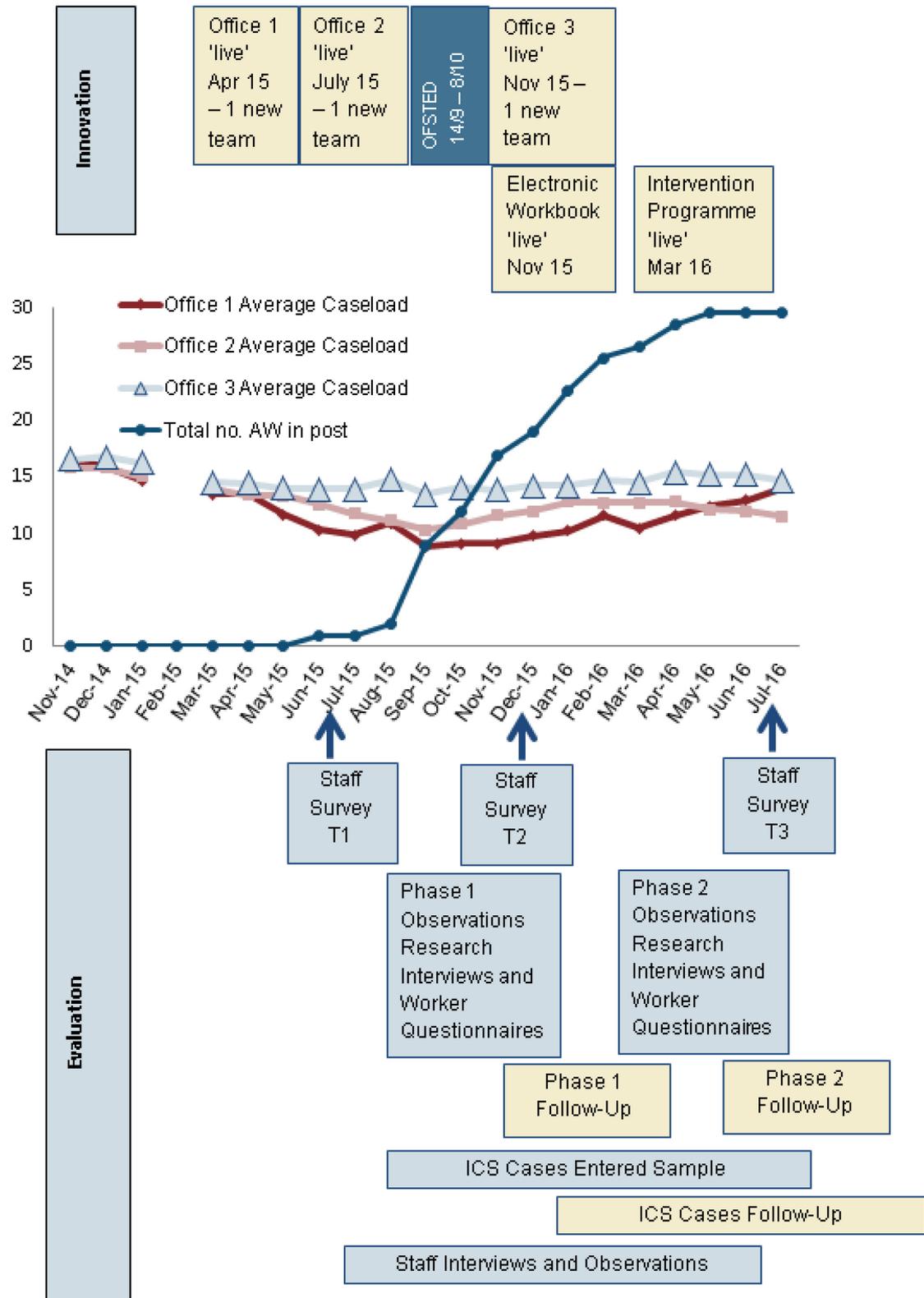
- key indicators of implementation: adult workers in post and caseloads

We mapped recruitment of adult workers and caseload for 2 reasons. It is clear that a large number of adult workers were successfully recruited, which was a major and impressive achievement in itself. Yet, if the date for each office going live is compared to the proportion of adult workers, it is obvious that achieving the full complement of adult workers was achieved some weeks or months after this. This is not a criticism; it is merely an illustration of the complexity of real world change. However, it has implications for understanding the data on quality of service or outcomes, because often, in the early stages of FSH, the service being offered was very different from that of FSH once fully established.

- evaluation data collection timeline

The data collection for the evaluation has been mapped against the process of the implementation to provide a sense of the range of data collected, both by type and across time. A variety of different analyses and comparisons were carried out in an attempt to capture both the best possible evidence about the process and the impact of the FSH reforms.

Figure 1: Timeline for Implementation of Innovation and Evaluation Data



4 Evaluation Findings

Process of Change Data

Qualitative Interviews with Staff

Overview

The overwhelming impression from the interviews was of the pace and scale of change experienced by the teams, with the simultaneous introduction of multidisciplinary team working; a new approach to supervision and case decision-making; the introduction of MI and a new case recording system, the electronic workbook. The process of change was dependent on the degree to which aspects of FSH were experienced by frontline workers as advantageous to practice; in line with their values; the extent to which they were user-friendly, and how soon results could be seen.

The introduction of multidisciplinary teams and group supervision were experienced overwhelmingly positively. The majority of workers were able to offer examples of their perception of positive changes across the different outcomes: for example, service, practice, family experience and family outcomes, including generic, as well as specific, illustrations of where FSH was making a difference. There was a more mixed picture with MI and the electronic workbook.

Experience of the process of change

Elements of FSH: positive experience

The move toward multidisciplinary working through the employment of adult workers and the introduction of group supervision was overwhelmingly well received. Both adult workers and social work practitioners identified benefits to their practice with families, in terms of enhanced inter-agency working, shared responsibility around risk to children, and improved access to support services for vulnerable service users.

Multidisciplinary teams

- the relative advantage of the multidisciplinary working was consistently perceived as superceding the previous approach: why didn't we do this years ago?
- working in partnership with adult workers was viewed as compatible with safeguarding practice and consistent with values of working holistically with families
- specialist adult workers were viewed as improving risk assessment practice and providing immediate support to families; for example: 'the role is going really well,

we are all in one room and can quickly form an action plan, different expertise is shared' (Domestic Abuse Officer)

- benefits described outweighed any risks, and problems were primarily around practical issues such as recruitment and retention, and variations between offices
- positive results were observable immediately to workers, in terms of accessibility and knowledge sharing, task assistance with cases and swift access to support for families
- some respondents felt more clarity needed to be developed about when adult workers should be involved with families

Group supervision

- group supervision was regarded as a positive forum for embedding multidisciplinary practice and improving communication between agencies: 'It takes a lot of effort but it is easier to gather information from multiple sources when we are all in the same place' (Social Worker)
- as with adult workers it was viewed as compatible with social work practice and values, particularly where reflective
- logistical problems of diary management sometimes made it difficult to organise such supervision. High demand for adult workers, high caseloads and the complexity of cases also impacted meant group supervision could be lengthy and ad hoc rather than planned on a weekly basis. It was not always possible to ensure all cases were discussed regularly
- results were observed in terms of improved understandings of risk factors, for example: 'the group look at the situation, what each professional is saying about the children, look at what needs to happen and assess the level of risk. A little bit of expertise from the adult work is really helpful in terms of decision making' (Consultant Social Worker). Discussion and differing perspectives were welcomed, but some concerns were raised that a focus on the child was lost in the face of the overwhelming needs of adults

Elements of FSH: challenges experienced

More ambivalence was expressed in relation to MI and the introduction of the electronic workbook.

Motivational Interviewing (MI)

- while many adult workers had previous experience of MI, and social work practitioners recognised that MI was line with their values, in its strengths-based and solution-focused approach, they reported on the difficulties of introducing MI into child protection practice; for instance, in moving from telling parents what they must do to 'get off the [child protection] plan' to more collaborative working

- for many social workers, it is a new skill that is complex to put into practice and this slowed its adoption, particularly in view of the variation in quality of training and support. Anxieties were expressed about having to use MI when under-confident and uncertain about its compatibility with current child protection practice: for example: 'There is a discrepancy between child protection plans and MI; these dictate what a family must do. There is a focus on get in, get out, work through the plan which doesn't leave much time for MI. MI requires thinking and planning time' (Consultant Social Worker)
- where workers reported having been able to successfully use it in practice, they were more likely to be positive about MIs' capacity to effect change in the lives of children and families: 'I've used it in CiN [Children in Need] cases... I think it's really working because it empowers the family to reflect on what's gone wrong' (Social Worker)

Electronic workbook

- at the time of interviewing, which was as the workbook was being rolled out, the workbook proved the least favoured element of the innovations, in part because of the technical difficulties in recording, but also due to a reluctance to change the content of recording practice
- workers across all roles and in all offices identified technical issues, including system crashing, misassigning roles and information, lack of access for adult workers plus duplication of recording, which slowed the pace of change
- there was ambivalence about the degree to which the electronic workbook offered relative advantage in terms of summarising, rather than recording comprehensively. This reflects an entrenched culture of professional accountability in which it didn't happen if it wasn't recorded. For example: 'I don't like the process, it isn't saving time and is causing anxiety. When in court it won't be good enough, it needs to be more specific' (Child Practitioner). While HCC inform us that courts have said the workbook would be appropriate for presenting evidence, some practitioners were not sure whether this would be true in practice
- practitioners expressed anxiety about the risk of getting it wrong. Positive experiences of using the workbook were limited, reducing opportunities for peer-to-peer learning, even where workbook champions were in place

Worker perception of the impact of FSH

Workers from all 3 offices offered examples of where FSH had made a difference. One-half of the staff interviewed shared a specific example of a positive outcome, more offered generic examples, with comments focused on changes to practice, while some indicated that it was too soon to be able to identify outcomes. A minority said either that they had not identified any change, or gave a mix of negative and positive generic feedback.

Examples related to different outcome levels (as prompted by the researcher), including impact on the service, practice, families' experiences and outcomes for families. The specific themes identified by the staff were impact on:

- the service, including increase in speed of response; decrease in elapsed time on a plan; holding cases at lower risk levels; and changing the course for re-referrals and revolving door cases
- practice, including empowering parents; increased level of purposefulness; and application of MI skills
- families' experience, including increased engagement; access to support; and increased development of trusting relationships
- outcomes for families, including overcoming substance misuse; improved mental health; and reducing risk from domestic abuse

This quote from a Social Worker illustrates common comments:

'Families have got a better chance. Having the adult workers' support when it's needed for the families themselves; it helps us understand families better, it's the informal catch ups over coffee that really make a difference. The way we are working now it makes it easier for the families to engage and increase their chances of staying together.'

Another Social Worker shared how FSH made a positive difference for a particular family they were working with:

'The progress I have made with the family has been due to the drug and alcohol worker...could instantly respond to crisis and go and see mum. This has instilled a level of confidence in the mother that the service can provide her with support. Having somebody who could go to her home and talk to her has been amazing... now I'm getting the domestic abuse officer on board, and I can focus on the children now that other issues are being dealt with... having 3 people working together has also helped with cultural differences. It was an instant response. Families feel that someone is actually doing something.'

Staff Survey Data

Findings from the 3 staff surveys (T1, T2, T3) were consistent with interview findings. Here key findings are reported. Appendix 2 provides fuller details.

Staff experience of FSH and the process of change

Staff were very positive about the FSH innovation, with three-quarters agreeing that they

were excited about FSH at T2 and T3. When defining the aim of FSH, around one-third made reference to each of multi-agency working; the focus on change; the MI approach to working with and empowering families, and 20% made reference to each of the whole-family or holistic approach, and to improving outcomes for families and children. Approximately 10% made reference to the aim of keeping families together.

Staff were generally positive about HCC and its management of change, with around two-thirds of staff in the final survey expressing satisfaction. It was noteworthy that a dip in satisfaction with the management of the process of change was experienced during T2, but that this was addressed, and staff returned to high levels of satisfaction by T3 (see Appendix 2). During the innovation, job satisfaction remained high, with at least three-quarters agreeing that their work gave them a feeling of personal achievement. Overall, staff's intention to stay remained stable over the 3 time points at around 50%.

Staff reported less role conflict over time, with around 60% of workers agreeing that they were asked to fulfil too many roles at T1, compared with around 50% at T3. A similar pattern was evident in the number of workers feeling that there was too much overlap between their role and that of someone else in their team. Approximately 90% of workers agreed that their line manager provided regular supervision and feedback (again there was a dip between T1 and T2; returning to T1 level at T3).

Staff experience of individual elements of FSH

Of the core elements of FSH, staff had the following comments to make.

MI

Two-thirds of respondents expressed agreement that MI was having a positive impact on engagement with, and outcomes for, families. Some workers identified MI as one of the biggest successes of the Innovation, reflecting that the approach was supporting frontline staff to 'empower parents to change, therefore reduce the risk to children', and that it allowed for 'more effective engagement with difficult parents'.

Two-thirds also reported feeling confident using MI with families; however, only one-half reported sufficient support with the development of MI practice skills and that MI was a useful approach for all families. In the response to the open ended question about the biggest challenge workers faced at T3, around 10% identified MI, including challenges in implementing the approach, such as specifically understanding its wider philosophy, and the ability to apply it with resistant families, as well as how to record its use with families.

Adult workers and multidisciplinary working

Workers reported an increased understanding of the role of the adult workers and

identified them as one of the biggest successes, making clear links between their involvement in cases and better outcomes for families:

Working with Domestic Abuse workers ... both man and woman feel they are supported now, not just women. So this helps the whole family.

Social worker

Others reported that 'information can be shared more thoroughly' and 'working collaboratively [helps] identify risks earlier' for children and families.

The biggest challenge identified was accessing adult workers and not having sufficient numbers of adult workers available to start work with families, which 'caused frustration for families and at times made it difficult for the working relationship to develop'.

Group supervision

More than 80% of workers felt that group supervision resulted in greater understanding of risks in families, and 60% that it resulted in a feeling of shared responsibility of a case. 70% felt that group supervision enabled them to be more reflective practitioners. Respondents typically commented that 'the immediate sharing of information between agencies in group supervision' was the biggest success of the innovation, while others felt that group supervision allowed for 'much better joint up working...group supervision more detailed and reflective'.

Despite these positive comments, most respondents (58%) reported that group supervision was not an effective use of their time. This was reflected in open-ended comments, with respondents identifying the time-consuming nature, for example: 'time; time to attend group supervision' as one of the biggest challenges.

Electronic workbook

There was mixed feedback about the electronic workbook, with over 40% reporting that they felt able to use the electronic workbook effectively, and around one-third (30%) reporting that they felt unable to do so. Comments related to both the practical and conceptual challenges of learning how to use the new system, as well as the change in mindset required around the nature of recording case notes.

Training and development

Whilst more than 80% reported that they had the knowledge and skills to work effectively with families (generally), only one-half reported that they had received the training and development they needed to do their job well. More training and development, including on the individual specific elements of FSH, were identified in the responses to the open-

ended questions about whether additional support workers were required.

Staff health and wellbeing

The level of stress and anxiety was measured using the General Health Questionnaire (GHQ-12) at T2 and T3, which can be used to identify overall levels of stress, and also the proportion of respondents who might be considered to be at risk of developing problems relating to stress and anxiety. The proportion of those in the high risk group were fairly consistent between T2 (27%) and T3 (24%). These levels are higher than the general population (18%) but are comparatively low for social work samples, which can be as high as 40%.

In addition, self-reported levels of stress were high throughout the duration of the Innovation with between one-half and three-quarters reporting that they often felt very stressed by the nature of their work over the 3 time points. Self-reported stress levels were at their highest at T3 (73%).

Time and time use

Less than 40% felt they had sufficient time to work effectively with families, falling from around 40% at T2 to around 30% at T3. Half (50%) of workers reported wanting to spend less time recording case notes and writing reports, and over 80% of workers reported wanting to spend more time doing direct work with children and parents. The lack of change between T2 and T3 suggests that issues with time use remains a challenge for staff: they were identified by one in 10 workers in the open-ended responses, the third highest occurring theme.

Caseloads

In response to the open-ended question about the main challenge to the implementation of FSH, continuing high caseloads were identified by approximately 15% of workers. Comments pointed to the additional requirement for increased intensity of working, including the planning that this involves, and being prevented from undertaking this additional direct work with families due to increased or continued high caseloads. It is worth noting if a worker has fewer families, but is expected to do more work with them: their workload can increase even if their caseload is reduced.

Variations at office level

Although the data demonstrates the experience of, and impact of change on, workers in Hertfordshire overall, the average figures mask some important differences at office level. Important areas of difference between offices included variation in GHQ scores over the time period: for example at T2, the proportion of elevated scores ranged from 40% in

Office 2, to 30% in Office 3, to 8% in Office 1. Comparatively, at T3, proportions were down to 8% in Office 2, similar at 28% in Office 3 and significantly increased to 42% in Office 1. There was a similar trend in the percentage of workers' self-report of stress. These variations at office level linked to a converse trend in the reported level of regular supervision and feedback and intention to stay. For instance, those reporting that they were actively looking for a new job in Office 1 rose from 27% to 56%, while in both other offices the figure fell from roughly 50% to approximately 40%.

Aspects of the underlying working context that are likely to have influenced these findings included:

- changes in middle management. For instance, for various reasons mainly unconnected to the Innovation, a stable management team in Office 1 lost several staff. Conversely, newly recruited managers in other offices became more embedded over the time period
- while overall caseloads decreased across Hertfordshire, there was variation between teams at different time points. These variations seemed to influence workers' morale and satisfaction
- finally, there were some factors associated with the roll out of FSH. The feel-good factor associated with FSH arriving in each office was palpable. In the weeks and months after going live, there was an obvious boost in role satisfaction. A reduction in these feelings in the office in which FSH was first introduced appeared to be due to staff changes and workload (as noted above), but the process of change had peaks and troughs which may have interacted with this. In particular, sustaining enthusiasm is a specific and common challenge in innovation

Conclusion

In the first year of FSH, workers have been involved with change on an immense scale, yet overall the picture painted by staff is positive, with high levels of positivity about the different elements. The process of change is not without its challenges, which can also be affected by changes in management, variations in caseload, and different roll-out timetables. Indeed, these findings point to 2 further important factors to consider. The first is that staff's experiences of work are mediated by many factors that are independent of innovation: continuity and quality of support from middle management and individual workload are 2 of the most important. The second is that the changes in FSH have been achieved while the service continues to manage the normal, everyday changes that all Children's Services work with. These include changes in staff including managers, constant high levels of demand and other external factors such as inspections. This whole context, not just FSH, is crucial to understanding the experience at the level of the team and individual worker.

Comparative study

Services and Outcomes Pre- and Post-FSH

This strand of the study compared families allocated in Hertfordshire Children's Services before FSH went live with a sample allocated after FSH. However, this is not a straightforward comparison. For instance, between allocation and follow-up many of the pre-FSH allocations will be in teams that went live. Conversely, some families that were allocated post-FSH may have been in teams where an adult worker had not been allocated, or other elements of FSH were in the process of being put in place.

Furthermore, it became apparent that, due to the timing of roll out of FSH and data collection, all the pre-FSH families were from a single office. Exploring the impact this may have on findings required a number of additional analyses (most of which are presented in Appendix 3). This element of the study is therefore primarily a comparison of services and outcomes in the very early stages of FSH with those once it was more developed (though still developing), with some additional analyses looking at change over time where that was possible.

To save space, most tables are placed in Appendix 3. Here, the most important findings are presented.

What were the needs of families?

Findings here are presented for the whole sample, and include data from social worker questionnaires and from interviews with parents. Key findings were that:

- social workers identified high levels of concern and the presence of multiple risk factors in families. For instance social workers identified medium or high levels of concern in 60% of allocated families
- they also identified very high proportions of families where important risk factors or problems were either suspected or definite:
 - 69% depression or anxiety in parents
 - 23% personality disorder
 - 36% other mental illness
 - 26% alcohol misuse
 - 38% illegal drug use
 - 53% domestic violence
 - 15% parental learning difficulties
 - 46% financial problems
 - 44% housing problems
 - 38% social isolation

- 49% wider family relationship problems

Parents also identified high levels of these core problems, though not to quite the same level as social workers. This may be in part because the families with the most complex problems were less likely to be interviewed, but it is primarily a difference between social worker and parental perceptions of concerns. Parent interviews identified the following:

- 9% identified drug or alcohol problems
- 26% child's behaviour or wellbeing
- 9% child's school attendance
- 19% social isolation
- 18% arguments or fights
- 20% reported a mental health diagnosis
- 41% had elevated levels of stress and anxiety (GHQ-12)

Parents were asked to rate family life on a 10 point Life Rating scale for the time of referral and the time of the research interview, which was shortly after allocation. At referral, the average rating was 3.2, indicating that most parents recognised their family as having serious problems at that point. By interview, the rating was 6.8, suggesting very substantial improvement.

Sadly, it is not possible to attribute this very marked improvement to the work of social workers. Instead, for most families the referral was often prompted by a crisis in the family, and being referred to Children's Services was, in itself, usually a crisis. This was often resolved, either through family actions or by itself, so that by time of interview, families reported far better family functioning. Sometimes Children's Services contributed to this change, though this was only true for a minority of families. This pattern of most families bouncing back after a period of crisis is important for interpreting some subsequent findings, and is returned to in the discussion.

The most important findings from this analysis were that, overall, the families had high levels of difficulties and problems. Also, the key issues social workers identified within families corresponded with the new adult workers' areas of expertise: mental health; domestic abuse; and substance misuse.

How did needs and risks vary in families allocated before or after FSH was implemented?

It is possible that FSH might be focusing on families with fewer or more levels of risk than prior to the Innovation. In fact, there were few statistically significant differences, indicating that the types of issue identified in families remained relatively consistent. The exceptions were that for parental personality disorder, alcohol or drug problems and wider family relationship issues, the proportion with problems was significantly higher in the post-FSH group. This may be a chance finding or may reflect FSH working with, or

identifying, more serious problems.

For parent interviews there were also more similarities than differences. For instance, there were no significant differences in rating of life now, family functioning (SCORE-15) or the proportion experiencing concerning levels of stress or anxiety (GHQ-12). There was also no difference in the proportion identifying social isolation, school attendance or arguments and fights.

Where there were differences identified by parents, they again suggested that the post-FSH sample had more serious levels of problems. The most obvious difference was in the rating of family life at the time of referral. This was 4.0 for pre-FSH families and 2.8 for post-FSH families. The suggestion that referring problems might be more serious for the post-FSH families was supported by higher overall levels of stress or anxiety (total GHQ score) and higher proportions who identified drug or alcohol problems (29% compared to 7%) or behavioural problems in their child (a very substantial 71% post-FSH compared to 36% pre-FSH).

Overall, this suggests that families with similar problems were being worked with, and that therefore comparisons of practice and outcomes are valid; however, there were some issues that were more common in the post-FSH sample and might influence some findings, as discussed below. They consistently tended to identify the post-FSH families as having somewhat more serious problems.

ICS data

ICS data also allows us to compare the pre-FSH and post-FSH samples for a limited number of variables. A similar picture appears. On most measures there were no between group differences, such as number of children, number of adults or ethnicity (see Table 18, Appendix 3). There was a highly significant difference in the number of recorded previous involvements; 0.88 in the pre-FSH sample and 2.47 post-FSH. An explanation for this is that it accords with the picture of somewhat more serious concerns in the post-FSH sample at allocation, though it is also possible that previous involvement is being better recorded on ICS as FSH is rolled out. Crucially, this analysis identifies relatively similar samples of families pre- and post-FSH, with few variables being statistically significantly different between groups.

What service did families receive?

What input did families receive?

Analysis of the datasets enabled exploration of the extent to which FSH was associated with differences in the intensity or quality of service provided for families. Significant differences were identified in the following:

- social workers reported an increase in working directly with families, from 28% of cases pre-FSH to 61% post-FSH
- worker questionnaires also highlighted increased involvement of adult workers, with 23 of 79 (29%) families identifying one of the new roles as being involved. Analysis reflects our findings about the roll out of FSH, with Domestic Abuse and Substance Misuse workers heavily involved in casework, but the problems in recruiting mental health workers is reflected in the lower proportion of families in which they were involved
- parent interviews indicated that, pre-FSH, no additional workers from Children's Services were identified. In the post-FSH sample 23 of 79 families identified an additional worker (29%), and of these around one-half indicated the involvement of more than one additional worker

Important differences identified in the ICS data analysis (see Table 19, Appendix 3) for service inputs were a reduction in the number of allocated social workers for each family (from 1.94 to 1.66) indicating reduced staff turnover, and a reduction in the number of Child in Need meetings (3.01 to 1.94).

ICS analysis found that there was little difference in the pre- and post-FSH sample in number of child protection conferences, strategy meetings and number of s47s started. In particular, families saw their allocated worker a little less often during the transition period and there was no increase post-FSH. This view of little difference in intensity of service was also found in family interviews, where the number of self-reported meetings with the allocated social worker appeared not to have changed pre- and post-FSH. It is possible that this data does not capture input from adult workers or others.

Quality of practice: Was there a move toward higher MI skills?

Meetings between worker and family were observed 126 times, and for 104 of these permission was given to audio record the interaction. The quality of practice was measured initially across 7 dimensions of practice, with each dimension being rated on a 5 point scale; with 5 being the highest score and 3 being the anchor point (see Table 2).

The 7 dimensions measured comprised 3 that are averaged to measure MI skill, such as collaboration, autonomy and evocation, and, in addition, empathy. Description and coding for these were all taken from the Motivational Interviewing Treatment Integrity (MITI) coding scheme (Moyers et al., 2002). In addition, 3 were developed for the application of MI principles into child and family social work specifically. These are purposefulness; focus on the child, and clarity about concerns. For details on the development of this scheme and evidence of its reliability see Whittaker et al (2016).

A complexity of this system is that coding for evocation is only possible when behaviour change is discussed. About one-half of social work interviews do not involve such

discussions. Calculation of MI score, which involves evocation, would therefore only apply to one-half of the sample. A factor analysis of this coding scheme applied to a different sample of 134 observations found the best way of understanding the data was as 2 factors (see Forrester and Killian, forthcoming). Factor 1, which combines collaboration, autonomy and empathy, we call care and engagement skills. Factor 2, which combines purposefulness, clarity about concerns and focus on the child, we call good authority (drawing on the work of Ferguson, 2014).

The relationship between worker skills and outcomes has received very little research attention. In several studies in UK local authorities, we have found a general tendency for family well-being to improve following allocation to a social worker, though this improvement generally appears unrelated to the quality of the service. It tends to be partly a recovery from a point of crisis and partly an indication of the levels of resilience and problem-solving found in families. The lack of influence of social workers on family outcomes is also related to the relatively limited contact they often have with families, with most families receiving minimal input (see Forrester et al, forthcoming). In the minority of families where social workers saw families 8 or more times we have found strong relationships between the skills described here and outcomes (Forrester et al, forthcoming). This suggests that level of worker skill is an important factor to measure to identify not just the inherent quality of the service, but also the likelihood of positive outcomes being achieved with the families with most serious problems.

Table 2 sets out the mean scores pre-FSH and post-FSH. On average, they were between 2 and 3 for each area across both phases. This is within the range we have found across several local authorities (see Forrester et al, forthcoming). Analysis indicated there had not been a move toward the increased application of MI skills, as there was no change in the quality of practice skills being observed in direct practice post-FSH compared with pre-FSH, and no shift in the degree to which MI skills are demonstrated. However, there was a noteworthy, and statistically significant, shift in the use of good authority, increasing from a mean score of 2.37 pre-FSH to 2.69 post-FSH. This was largely related to increased clarity about concerns, as well as more focus on the child.

Table 2: Direct Practice: Analysis of Skills Pre- and Post-FSH

Skill	Pre-FSH	Post-FSH			
	Mean	Mean	t-value	Df (n-1)	P
Evocation	2.20	2.42	.737	43	.46
Collaboration	2.34	2.54	.968	94	.33
Autonomy	2.52	2.53	.070	95	.94
MI Spirit Score	2.23	2.50	.904	42	.37
Empathy	1.87	2.04	.964	101	.34

Skill	Pre-FSH	Post-FSH			
	Mean	Mean	t-value	Df (n-1)	P
Purposefulness	2.61	2.71	.595	101	.55
Clarity of Concerns	2.10	2.64	3.049	102	.003
Child Focus	2.38	2.70	1.770	102	.08
Care and Engagement	2.23	2.38	.916	94	.36
Good Authority	2.37	2.69	2.33	101	.022

Source: Analysis of direct observations of practice

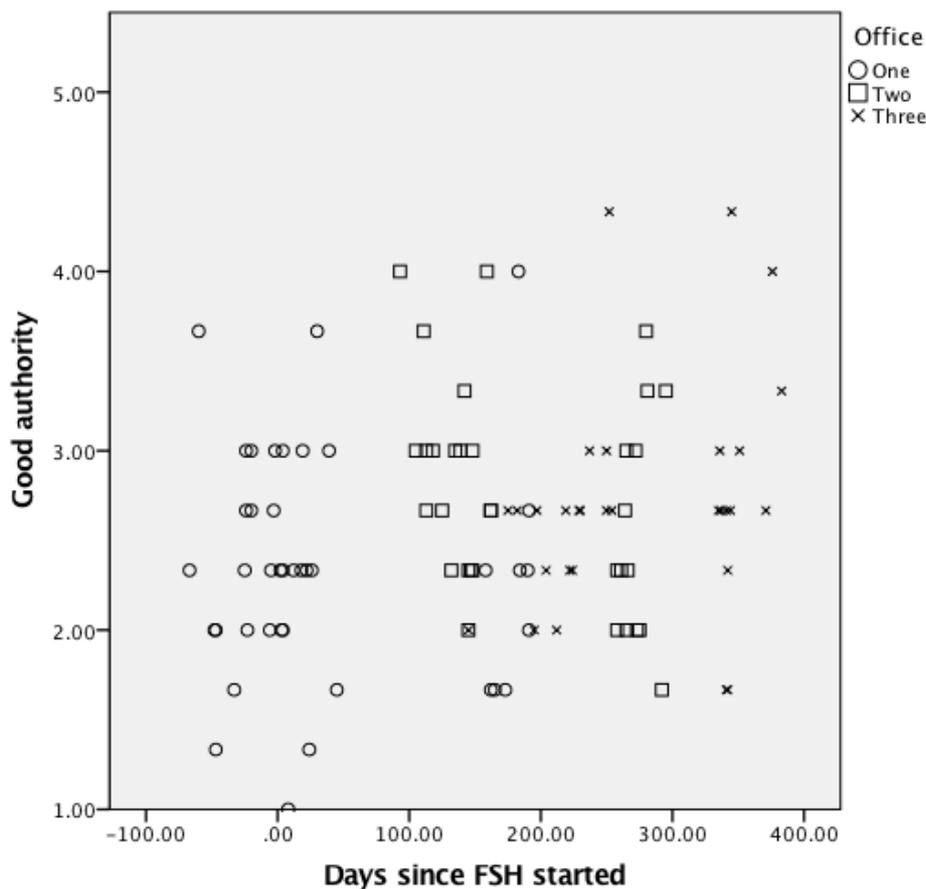
Changes in skills over time

As part of this analysis, we examined changes in skills over time. Specifically, we correlated care and good authority skills with the number of days between the observation and the implementation of FSH. Here we found the following:

- for care and engagement there was a relatively weak positive correlation ($r=0.143$, $p=0.164$)
- for good authority there was a larger positive correlation, and this was statistically significant ($r=0.202$, $p=0.041$)

These results suggest that FSH was creating change in practice over time as it was implemented, though the findings also demonstrate that this was a gradual process. These findings are well illustrated in Figure 2, which plots the level of “good authority” by the days post-FSH, while indicating which office observations took place in.

Figure 2: Level of Good Authority Plotted Against Time Since FSH Implemented, with Office from which Observation Taken Identified



The following features of this graph are worth noting:

- it illustrates the statistically significant shift in the use of good authority over time found in the sample (the scores rise over time)
- some of the complex inter-relationship between office and changes over time can be seen (see Appendix 3 for further analysis)
- more generally, the chart can be seen as a description of the messy realities involved in changing practice. These are measures of practice skill taken over the course of a year of reform and innovation. It can be seen that there was some good practice prior to the innovation, and some poor practice despite all the changes. In short, this is what real world change looks like

What did parents and children think of the service they had received?

Parents' ratings of their relationship with their worker were largely positive before-and-after FSH. The majority of parents agreed that their worker turned up on time; they understand the reasons for social work involvement; and feel included in and understand reasons for meetings. These positive evaluations did not change between pre- and post-FSH (Table 20, Appendix 3).

Overall, feedback collected from the open-ended questions within parent or carer

interviews was mixed. In contrast to the overall ratings of satisfaction, there were more negative than positive comments. Positive feedback tended to be linked to families who had previous involvement with Children's Services, who often contrasted their current experience to a negative experience with a previous worker, or to families who reported having a positive experience of working with the multi-disciplinary teams post-FSH. There was more of a tendency for feedback to be negative in the responses to general feedback. These responses referred to poor communication and to some workers who parents felt demonstrated a judgmental approach.

Feedback from parents and carers throughout the interview highlighted the importance of their relationship with their worker, and the importance of the way they interacted and communicated with them. For parents or carers to have a positive relationship with their worker, it seemed essential to feel as though the worker was empathic and understood their unique situation; for example one parent said: 'present worker understands; feel able to speak to her'. Equally important for parents or carers, was not to feel judged by their worker: for example another parent said: 'didn't get on with other worker, found her judgemental; [current worker] been able to understand family needs'.

As only 11 interviews were completed with children or young people, the data has been analysed as a single dataset, rather than attempting to identify differences between the 2 phases. Overall, feedback was positive. There was a sense that they felt that the service was having a positive influence: for example: 'I liked that everyone is happy and joyful'. When asked what was going well at the moment, one child commented: 'social workers coming'. It was evident from the feedback that they had a good relationship with their worker, enjoyed the time they spent doing direct work: '[I liked doing] the safety plan'; and valued the time their worker took to listen to their perspective and understand their point of view: 'I liked that she asked how I felt' and 'she listens to what we say'.

How did outcomes vary before- and-after FSH?

Table 3 presents outcomes for families, as measured at the follow-up interview. As noted above, the most striking overall finding is the very substantial positive changes that families demonstrate across both pre-FSH and post-FSH samples.

The numbers involved were too small to establish any statistically significant findings. However, there were indications of improved outcomes for families in the post-FSH sample:

- achievement of goals came close to 90%, up from 70%
- few parents were in the at-risk group for stress and anxiety and the average level of stress (GHQ) was lower
- the level of life scaling was similar, though the overall increase in rating of family life between referral and time of interview was substantially greater post-FSH. This was because the rating of life at T1 was lower in the post-FSH sample, suggesting

they had more serious problems

For child outcomes the differences between samples were small and the sample size precluded meaningful statistical analysis.

Table 3: Parent and Carer Interviews: Outcomes Pre- and Post-FSH

Outcome measure		Pre-FSH N=15	Post-FSH N=25
		N (%)	N (%)
Goal Attainment Achievement, extent to which goal achieved	Partially or wholly achieved	7/10 (70%)	19/22 (86%)
General Health Questionnaire	Clinically elevated score, 4 or more	4/13 (31%)	2/11 (18%)
		Mean	Mean
Life Scaling, scaling now		7.73 (n=15)	7.35 (n=23)
Life scaling, change in life scaling since		3.67 (n=15)	4.36 (n=23)
Family functioning (SCORE-15)		29.00 (n=13)	28.70 (n=10)
GHQ Average (stress and anxiety)		2.62 (n=13)	1.82 (n=11)

Source: Parent and carer follow-up interviews

ICS data

ICS outcomes data was focussed primarily on the use of care, and, in this dataset, the sample size was sufficient to draw some firmer conclusions. Table 4 outlines differences in the use of care pre- and post-FSH. It can be seen that there was a:

- reduction of 2 percentage points in the proportion of families in which a child entered care, from 12% to 10%
- very substantial reduction in the number of days children spent in care

Whilst neither difference achieved statistical significance, the reason that reduction in number of days ($t=1.89$; $df=355$; $p=0.06$) does not achieve statistical significance is that while the number of days was reduced very substantially, the number of families involved was relatively small. It is therefore not possible to rule out chance at the $p<0.05$ level; or, put another way, there is a 6% probability that this might be a chance finding, or a 94% probability that it is not due to chance. Given the overall pattern of our findings in this evaluation we think it unlikely that this is a chance finding, as discussed further below.

Table 4: ICS Data: Impact of FSH on Use of Care

	Pre-FSH or Post-FSH		
	Pre-FSH	Transition phase	Post-FSH
	N (%)	N (%)	N (%)
Did any children from family enter care?	26 (12%)	7 (11.5%)	17 (10%)
	Mean	Mean	Mean
How many children entered care per family	.18	.23	.15
How many days spent in care	20.54	16.38	9.81
Foster care (provided by LA)	9.43	12.34	5.33
Foster care (independent agency)	2.97	1.49	.48
Residential	.37	.00	.72
Independent residential	.00	1.51	.00
Secure accommodation	.07	.00	.00
Kinship placement (paid for by LA)	6.29	.70	2.10
Informal or other arrangement	.34	.00	.91

Source: ICS Data

Analysis of the average number of days per child spent in different types of placement shows that the reduction in the use of care was particularly strong amongst independent foster care placements and in kinship placement. The reduction in use of local authority foster care is what might be expected, given the fact that this accounts for the bulk of most care provision for the local authority. The potential cost implications are analysed in the final section of the findings.

What contribution did adult workers with families make?

While there was only a limited shift in worker skills, and, in particular, no indication of greater use of MI skills, was there a difference where an adult worker was involved? To explore this we analysed a variety of outcome measures. The analysis was complicated by the fact that there were differences between different types of adult workers; and bedevilled by relatively small numbers, particularly for most of the standardized instruments. However, it is an important analysis for trying to understand the complex pattern of findings for FSH.

There was, in general, a relatively clear picture of adult workers making a considerable positive difference when they were involved with families. This is outlined in Table 5.

Table 5: Parent's Life Rating by Involvement of Different Adult Workers

			Life rating at referral	Change in life scaling since referral	P value
		N	Mean	Mean	
Is Mental Health Practitioner working with family?	No	69	3.30	+3.40	0.12
	Yes	7	2.70	+7.00	
Is Domestic Abuse Officer (perpetrator) working with family?	No	63	3.34	+3.75	0.92
	Yes	19	2.80	+3.60	
Is Domestic Abuse Practitioner (victim) working with family?	No	60	3.36	+3.32	0.06
	Yes	26	2.45	+5.56	
Is (Substance Misuse) Recovery Worker working with family?	No	68	3.31	+3.32	0.07
	Yes	17	2.66	+6.25	

Source: Parent and carer interviews

Three findings stand out:

- life ratings are generally lower for those families where an adult worker is allocated at the point of referral, indicating that they are working with families with more substantial problems. On average, at referral, their life rating was between 0.5 and 0.8 lower
- there was some variation in impact on life rating between different adult workers. In particular, where one was working with the perpetrator of domestic abuse, the participant, who was usually the victim, did not note any positive effect on family life
- for 3 of the 4 adult worker roles, there were very large positive differences where an adult worker was involved. The positive shift was almost twice as high where an adult worker was involved for mental health, substance misuse or with a victim of domestic abuse

Though these tests did not achieve statistical significance, this is not because of the size of the effect; it is because, with a comparatively small sample, it is difficult to rule out chance explanations.

Concluding comments

The comparative strand of the evaluation presents a complex picture. Five findings stand out.

First, there is strong support for the overall rationale for the FSH initiative. Families had high levels of complex problems, and parental issues were very widespread. The quality of practice gave rise to some concern pre-FSH, with particularly low levels of empathy or collaboration with parents.

Second, there was some shift in the quality of practice. In particular, there was more evidence of good authority; most notably clarity about concerns post-FSH.

Third, evidence from the analysis of skills showed continued improvement over time. For the evaluation, this points to the difficulty of making pre- and post-FSH comparisons. More importantly, for those undertaking complex attempts to embed improved practice, this provides evidence of the ways in which practice changes over time.

Fourth, some stark differences were found in the larger ICS sample. Most obviously, the use of care was significantly reduced. Our findings in this respect are confirmed by ongoing measures from Hertfordshire, indicating a reduction in children in care. There can be no doubt that FSH reduced the use of care for children, though the mechanisms by which this was achieved are less certain.

Finally, one way of understanding this outcome is that the adult workers are contributing to a specific impact on a subset of families. We explored this in the comparative dataset and found that they seemed to be working with families with more serious problems and achieving markedly better outcomes (using life rating). A hypothesis we developed from this data was that the introduction of adult workers was having 2 specific effects:

- adult workers were improving the quality of services and outcomes for families they worked with, often the minority with the most serious problems
- more generally, they were contributing to a move toward a multidisciplinary way of working that was shifting approaches to risk assessment. Specifically, while changing worker skills may be a longer process, changing thinking about risk may be something that could be achieved in a shorter space of time

To explore these 2 ideas we collected some specific sources of information.

First, we carried out a small number of in-depth case studies to explore the influence of adult workers on families with higher levels of risk. For these case studies, we supplemented our approach to data collection from the comparative study (which consisted of observation of practice, social worker questionnaires and research

interviews with parents and children) with, where possible, observations of decision-making. More importantly, we combined qualitative and quantitative data to better understand how the different elements of FSH worked together in this small number of families. These are presented in the next section.

Second, it became obvious that group case discussions are a crucial forum in which the multidisciplinary nature of FSH happens. We therefore observed 8 case discussions and our findings from this analysis are presented after the case studies.

Understanding FSH: Case studies

The case studies combined qualitative and quantitative data to understand how FSH works, with a particular focus on higher risk families where an adult worker was actively involved. Our explicit focus was to identify where FSH seemed to be working well. This is not intended to be a representative sample but rather an in-depth element of the evaluation which explores a rich combination of data sources. The aim is to describe the processes and experiences of FSH so that we can be clearer about what is involved in FSH, and use this knowledge to interpret findings from other sources.

We identified case studies in 2 ways. First, we reviewed our data from the comparative study to identify families for whom we had a full dataset and who met these criteria. Five families were identified and in these families we sought extra information through further interviews with staff or families, and further observations of practice as appropriate. Second, we emailed staff across HCC and asked them to identify families where they felt that FSH was working particularly well. While a number of families were identified by workers through this process a combination of time limitations and low responses from families meant that ultimately only 5 case studies were carried out using this approach.

The analysis of the case studies involved collating data for each family to understand the experiences of different individuals and how FSH might have influenced experiences and outcomes. We then compared across the small sample of case studies to generate key learning points.

A challenge for the current report is presenting rich and complex data such as this in a limited space. The approach we have taken is to present diagrammatically 2 of the case studies, each one page long, which illustrate particularly rich examples of the way in which FSH works. We then outline our main conclusions from the overall case study analysis. For all case studies, names and other details have been anonymised.

Table 6: Summary of Case Study Data

Case Study	Adult Worker Role	Research Data
1. John, Marion, Victoria and Eleanor	Substance Misuse Worker	Observation of Practice (2); Interview with parent (2), Interview with child (1), Worker questionnaire (1); Worker interview (1)
2. Mary and Daisy	Mental Health Practitioner	Observation of Practice (2); Interview with parent (2); Worker questionnaire (2)

Source: Case Studies

Concluding comments

The case studies are often moving testimonies to the transformative impact that effective professional help can have with families where there are serious presenting problems. They illustrate the difference that effective and humane help can make for children and their parents.

An obvious element of the difference experienced in FSH is the help that the adult workers provide. However, it is important to unpack the different elements of this further. The most obvious element is the swift access to effective help for parental issues; here, FSH clearly delivers a qualitatively different experience to that families received before. Adult workers help families directly.

Yet there is more to it than this. A second crucial element is that the adult workers and the child social worker work closely together as a team. This is different from the more normal experience of services provided by different organisations, where the level of coordination can vary considerably.

This is related to a third element of the impact of adult workers: they do not just provide input, they change the nature of the practice toward genuinely multidisciplinary working. FSH is not just about bringing in specialists: it is about moving toward a multidisciplinary way of working. Showing the impact of this is complicated. Our impression is that it changes the way that risk is thought about, and perhaps the ability to tolerate and manage levels of risk; where there is an adult specialist, they are able to explain the types of issue that may be influencing the parent and thus help develop an understanding of resources and strengths, and of the process of change as well as solely a focus on risks. This might go some way to explaining the reduction in children entering care.

Figure 3: Case Study 1

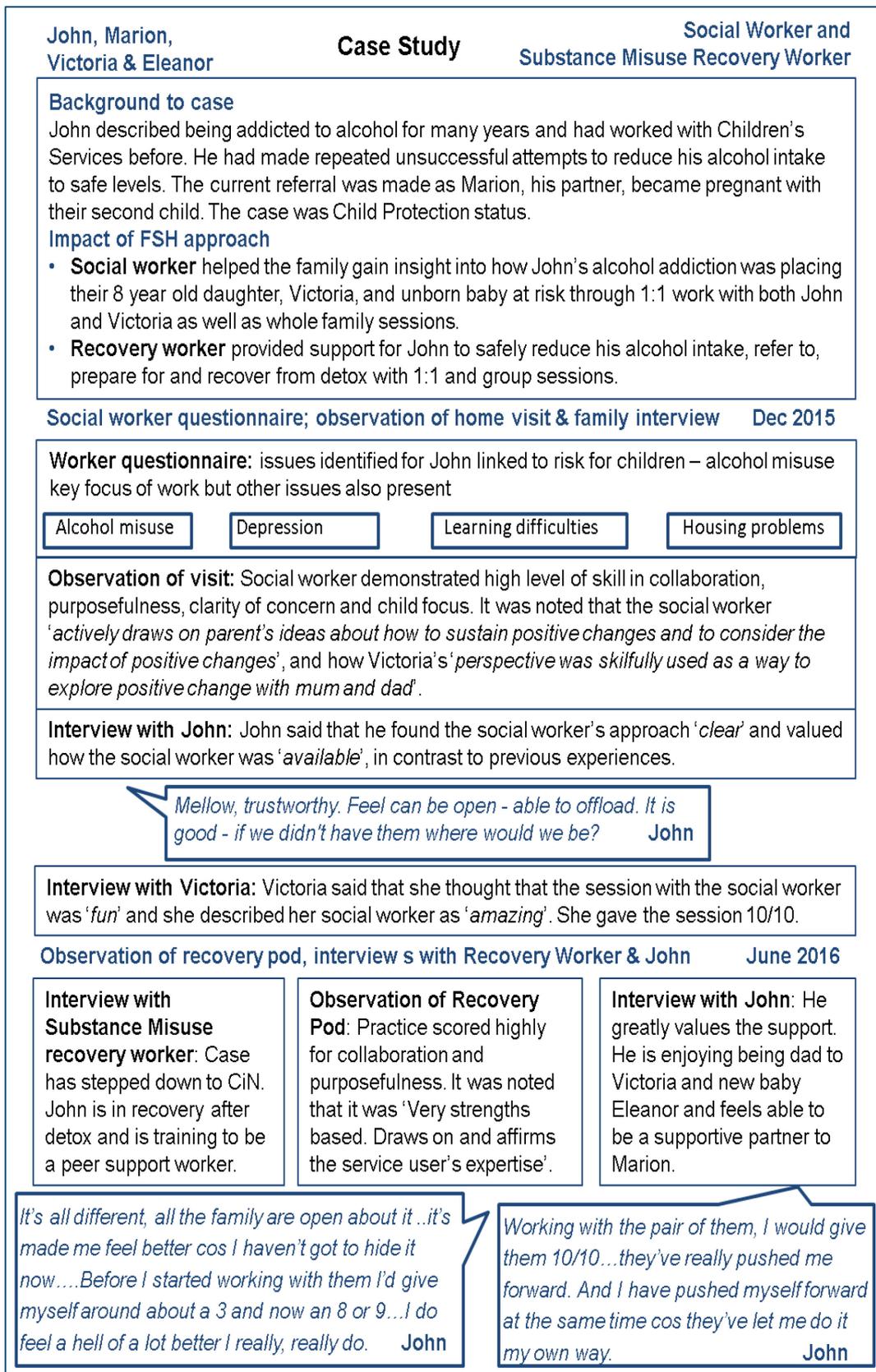
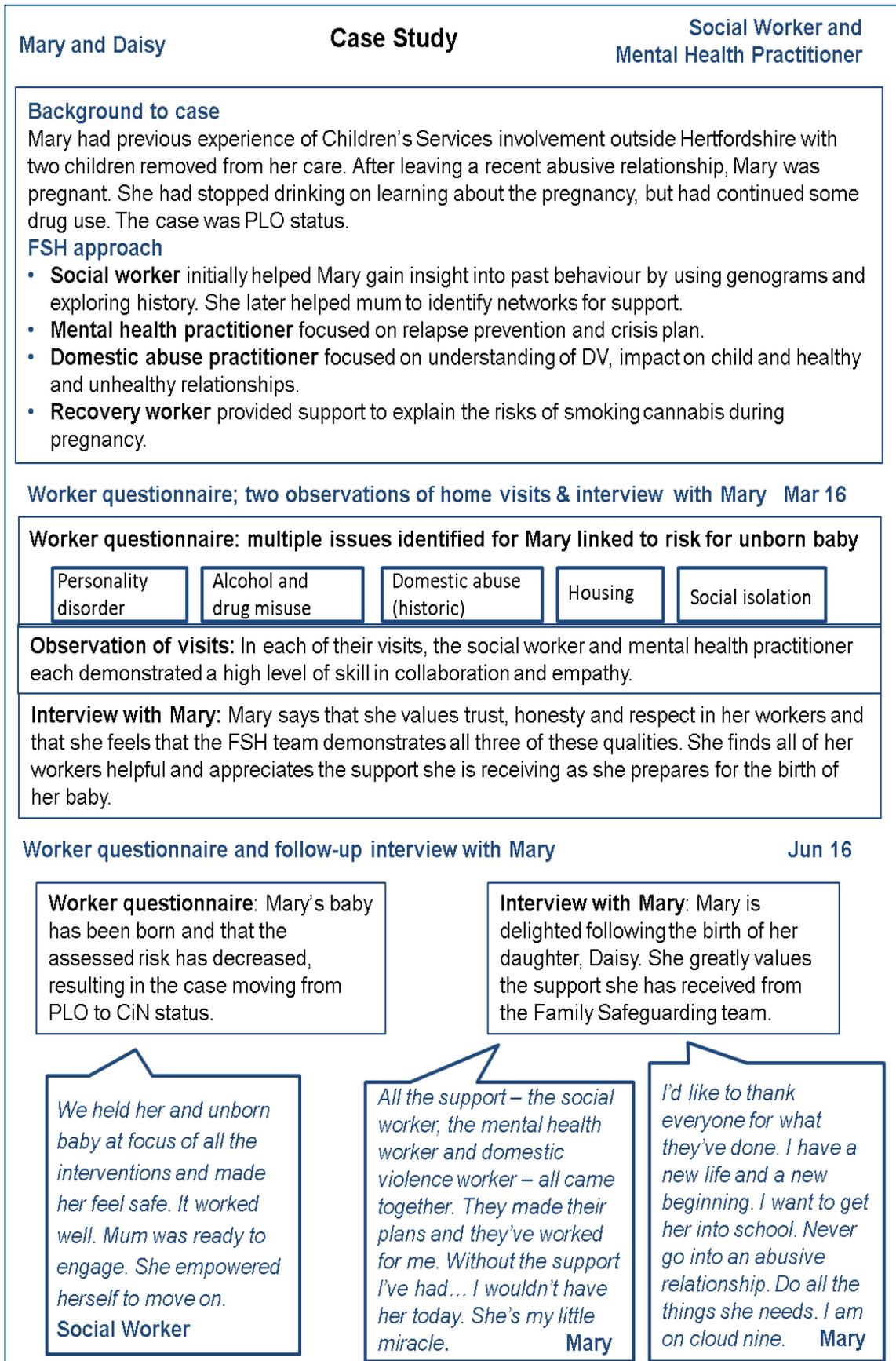


Figure 4: Case Study 2



To explore these issues further, in the next section we turn to consider a crucial forum in which FSH happens, the group case discussions.

Understanding FSH: observations of group supervision

Group supervision was introduced as part of FSH and designed to facilitate case discussion and decision-making from a multidisciplinary perspective. Eight group supervisions were observed to understand this key element of the FSH model.

Observed supervision sessions lasted between 15 minutes and 2 hours and 45 minutes, and the number of families discussed ranged between one and 4. The families discussed had a wide variety of presenting problems and covered all types of statutory basis. Team managers, social workers and support officers were present with a varying mix of adult workers, including a clinical psychologist.

Space limitations mean that only the most important findings can be presented. One finding of importance that emerged was that, in these initial stages of the Innovation, it proved quite hard to arrange group discussions. Adult workers worked across teams and needed to balance work with families and group supervision. Simply getting everyone into one room was a challenge.

Key findings

- there was evidence of collaborative working across the sessions, including improved information sharing and new and wider perspectives on family issues. Adult workers offered considered contributions, and in some cases challenged established hypotheses about risk and family relationships
- in some sessions, concepts linked to MI were apparent, specifically drawing on the cycle of change theory to inform thinking about the family and the degree to which parents were willing or able to engage with change. Few attempts were made to explore parental perspectives, for instance on why they might be resistant to change
- there was evidence of reflective questioning, with some use of open-ended questions to deepen understanding of family dynamics and risk to the child. In other sessions, there was a sense that workers struggled to understand risks within the family. There was a tendency to draw on perspectives of professionals rather than attempt to consider those of parents and children. Fixed hypotheses had a tendency to emerge and could dominate within conversations
- there was a tendency to operate within the what-and-when domain, rather than the how-and-why. There were missed opportunities to follow up open-ended questions and maintain curiosity about cases. Actions tended to focus on procedures such as completing paperwork or a focus on interventions, largely from adult workers. It was not always clear whether parents had been, or would be, consulted about the

accessibility or acceptability of interventions, or whether their ideas about what might support change had been explored

- there was little evidence of discussion about the purpose of interventions or the outcomes in terms of change for children. The interventions discussed were largely aimed at adults; there was limited discussion around direct work with children
- there was no evidence of task assistance to support social workers plan interventions, for example suggesting questions for parents or children to elicit their perspectives on change
- for the most part, supervision appeared to adopt a model focused on professional tasks and activities rather than how to work in partnership with parents
- finally, case discussions tended not to include emotions, either those of the worker or those of children and families. On the face of it, this is surprising: child protection is an extremely emotional business. Yet this is similar to findings about more conventional supervision

Concluding comments

Group case discussions are a core element of the FSH model. They are already showing promise as a forum for generating more complex and nuanced approaches to understanding family problems and contextualising risk. As such, they seem likely to be a core part of the ability of FSH to produce better outcomes for families with more serious problems.

There are still areas for improvement, as might be expected in a newly developed initiative. Clarifying their role and importance is important. The group discussions varied in quality. They did not benefit from a strong theoretical framework and, perhaps as a result of this, there was not always a strong link between the case analysis and the nature of the practice to be carried out with families. More focus on placing the views and feelings of family members at the heart of analysis, and building plans for partnership working, seem important for group case discussions to be developed further.

Key Performance Indicators

Introduction

The KPI data was defined, compiled, collected and collated by Hertfordshire County Council (HCC) in collaboration with partner agencies. The anonymised dataset was then analysed by the evaluation team. We were supported in this by in-house HCC staff; however, this is an independent report on the findings from this data. We focus first on evaluating the nature of the current dataset and then on presenting initial findings.

The KPI dataset is in itself an innovative and important approach to sharing data across agencies that has huge potential for improving strategic management and interagency coordination, not just in Hertfordshire but nationally. Over time it can allow all agencies to monitor the impact of Children's Services on key and meaningful outcomes. It provides a picture of the involvement of multiple agencies with families. It will also be able to generate a sense of relevant cost savings produced by effective Children's Services.

It is hard to over emphasise the potential national importance of this dataset. To date, there are few examples of genuine outcome measures that can be used to evaluate services. Datasets such as this could help replace the current focus on process measures with genuine measures of outcomes, with potentially transformative effects on national inspection and governance.

Although the KPIs are already producing important and helpful data, it is important to recognize that, at present, the ability of the KPI set to produce robust data on the impact of FSH is limited for 2 reasons. Firstly, the KPIs do not provide data on service outcomes for families allocated to HCC Children's Services before FSH. Secondly, we only have findings for the first year of FSH, and therefore very limited follow-up evidence. It will be a year before stronger evidence service use outcomes will be available. At present therefore, we can report only on indications of impact from the KPI dataset.

Nature of the Dataset

Sample

Data was collected on all families allocated in FSH over the 12 months from 1 July 2015. These are divided into 4 quarters, each representing a cohort of families with different post-FSH follow-up periods. The KPIs provide data on service use for the 12 months before allocation and the period after allocation. The 4 cohorts and the

total number of families allocated to FSH in the first year are shown in Table 7.

Table 7: KPI Data – Cohort by Quarter

Quarter referred to FSH	Date range referred to FSH	No. families	No. children (avg per family)	No. adults (avg per family)
Q1 - Cohort 1	1 July – 30 Sept 15	240	445 (1.85)	402(1.68)
Q2 – Cohort 2	1 Oct – 31 Dec 15	192	374(1.95)	396(2.06)
Q3 - Cohort 3	1 Jan – 31 Mar 16	255	481(1.89)	455(1.78)
Q4 – Cohort 4	1 April – 30 June 16	253	452(1.79)	430(1.70)
Q1-4	Year from 1 July 15	940	1,752(1.86)	1,683 (1.79)

Source: Hertfordshire County Council Data

Data collected

Data was collected in relation to NHS, police, education, substance misuse treatment, use of adult and child mental health services. Table 8 provides information on the nature of each indicator and the number of adults or children it related to, broken down by each cohort.

Table 8: KPI Descriptive Data by KPI Area

KPI area	Adult/ CYP	Description	Cohort					% of total FSH Cohort
			Q1	Q2	Q3	Q4	Full Year	
NHS	Adults	Adults accessing A&E services (number of unique attenders - 12 months prior to referral plus period from then to July 16)	115	100	107	109	431	25.6%
NHS	CYP	CYP accessing A&E services (number of unique attenders - 12 months prior to referral plus period from then to July 16)	147	105	136	129	517	29.5%
Police	Adults	Adults involved in police incidents (12 months prior to referral plus period from then to July 16)	38	26	62	74	200	11.9%
Substance Misuse	Adults	Adults working with FSH Substance Misuse Workers (year post referral)	n/a	n/a	n/a	n/a	91	5.4%

KPI area	Adult/ CYP	Description	Cohort					% of total FSH Cohort
			Q1	Q2	Q3	Q4	Full Year	
Substance Misuse	Adults	Adults engaging with Substance Misuse treatment with FSH worker (year post referral)	17	16	21	9	63	3.7%
Mental Health	Adults	Adults known to HPFT (12 months prior to referral plus period from then to July 16)	81	60	66	69	276	16.4%
Mental Health	CYP	CYP known to CAMHS (12 months prior to referral plus period from then to July 16)	72	22	36	45	175	10.0%
Education	CYP	Children attending school in Hertfordshire (12 months prior to referral plus period from then to July 16)	320	288	n/a	n/a	608	34.7%

Source: KPI Data

Analysing this data has involved multiple analyses. Here, key findings are presented. Fuller data can be found in Appendix 5.

Analysis

In theory, this allows for 2 types of analysis:

- comparison of the KPI before-and-after the involvement of FSH (before- and-after analyses). This analysis is strong on the impact of allocation in FSH on families and service use, but does not provide evidence of the difference FSH has made compared to practice before FSH (see below)
- comparison of the KPI post-FSH for different quarters (change over time analyses). This analysis provides more information on change over time - that is, the differential impact on families as FSH is rolled out - but the follow-up period is too limited to draw firm conclusions at this stage

In practice, the time period for data collection means that, for later quarters, there is currently very limited follow-up data. This makes such analysis inappropriate, as the pattern of change in service use often involved a spike of increased use followed by reductions. Short follow-up periods could therefore provide misleading findings. We therefore simply comment on any patterns that indicate changes in outcomes associated with FSH over time.

The focus of this section is, therefore, before-and-after analyses. However, while such analyses provide powerful evidence of the impact of allocation in FSH on outcomes for other services, (we are not aware of any equivalent evidence in the UK); they are limited for evaluating the specific impact of the Innovation Project, because there is a variety of reasons why indicators might change in the time before-and-after allocation in FSH. These include the fact that often allocation is an indication of a crisis of some sort and one might expect a different pattern post-crisis with or without input. For example, the crisis might be the birth of a new baby, or a new partner, or school exclusion; more prosaically, some children in 2015 will become adults during the course of the follow-up. It is thus not possible to be sure it is FSH that is creating a change in levels of an indicator before-and-after allocation. In essence, we do not have access to a counter-factual or what might have happened without the service. In particular we do not have an equivalent dataset for the impact of allocation in Children's Services before FSH.

A related point is that it is important to take into account that this is a description of the impact on measures while reform was being undertaken. A clearer picture of the difference that FSH makes (if any) will be more apparent over time. Furthermore, there is not a full 12 month follow-up set of data. Firstly, this means that comparisons of total numbers pre- and post-FSH are inappropriate and that secondly, comparisons of average monthly service use is for a relatively short follow-up period. The dataset therefore provides an indication of initial impact of allocation; if continued for a longer period the usefulness of the dataset would increase substantially.

Key findings

The use of the KPIs is itself a crucial innovation for national learning. The KPIs indicated the impact of allocation in FSH on the use of other services. If continued over some years it would provide a valuable picture of the contribution that FSH was making to improving outcomes for families with some complex problems that impact disproportionately across services. Key findings were that:

- families allocated in FSH had complex problems that impacted significantly on other services, particularly health and police
- there were strong indications that need for services was reduced by allocation in FSH
- there were indications that the impact of FSH was increasing as it was rolled out; these findings are returned to in the discussion section
- across the KPI set the full worth of the indicators will become apparent if continued for subsequent years

Quality and utility of indicators

Some elements have worked better than others. In broad terms:

- KPIs that involve measurement of discrete, acute incidents tend to provide stronger evidence: for example, use of emergency NHS services or police call-outs
- KPIs that involve engagement in treatment in order to change a more chronic behaviour or condition; for example, progress in, and impact of, engaging in mental health or substance misuse services are more difficult to define, collect and interpret

Use of other services

At present the KPIs identify that children and parents allocated in FSH are responsible for high levels of use of other services. For instance:

- emergency hospital use: 431 (26%) of the parents and 517 (30%) of children and young people accessed accident and emergency in the time period for which data was gathered, an average of 18 months
- mental health services: 276 (16%) of parents and 175 (10%) of children and young people were known to adult or child mental health services in the time period
- police incidents: 200 (12%) of parents were included in a total of 354 recorded police incidents, largely relating to domestic abuse, in the 18 month period

Impact of FSH on Indicators

NHS data: use of emergency hospital services (see also Appendix 4)

This area provided some of the clearest measures of outcomes following FSH, because the measures were clear, time limited and could broadly be understood as negative outcomes. Four indicators were measured, namely: use of accident and emergency and emergency hospital admission for adults and children respectively.

As noted above, there was heavy use of emergency health services by the FSH sample, with more than one-quarter of adults and children using emergency services and more than 2,500 specific incidents of service use. To look at patterns of use, a monthly rate of use was calculated for the 12 months pre-FSH and the 12 months post-FSH. This is likely to underestimate differences because emergency health service use decreases over time post-allocation. Nonetheless, when the average rate for pre-FSH and post-FSH was compared, as set out in Table 9, some clear findings emerge:

- for adults, there is a reduction in emergency admissions post-FSH
- the picture for accident and emergency for adults was more mixed
- for children there was an increase in use of A&E
- the picture for emergency admission for children was more mixed

In addition, when the pattern was compared over time, that is between cohorts:

- all 4 measures showed a reduction in use of emergency services over time; that is, more impact as FSH was rolled out
- this impact was most marked for adults, where there were quite stark reductions in service use post-FSH over time

Interpretation of this pattern is complex. The follow-up period is shorter post-FSH for later cohorts. Our analysis of the data suggests that this is therefore likely to have underestimated the impact, because there is a tendency to increased use during the quarter of allocation. A follow-up at 12 months would allow for more confident analysis. However, there are promising indications of an increased impact as FSH is rolled out of between 25 and 50% above the impact identified in Cohort 1.

Table 9: Increase or decrease in Average Number of Monthly Emergency Hospital Attendances or Admissions for each Cohort post-FSH Compared with pre-FSH

Cohort	1	2	3	4
A&E Attendance – CYP	3.29	1.27	2.42	n/a
Emergency Admission – CYP	(2.46)	(1.67)	2.58	n/a
A&E Attendance – Adult	12.33	1.83	(6.33)	n/a
Emergency Admission – Adult	(1.54)	(2.68)	(3.33)	n/a

Source: NHS KPI Data

Police data: number of incidents (see also Appendix 4, Section 1.2)

The data suggests variation in reporting and or recording over the period particularly for domestic abuse, for example pre-FSH, the average number of incidents per parent per month prior to referral to FSH ranges from 1.0 for Cohort 1 to 9.8 for Cohort 4. This is likely to be attributed in part to Section 76 of the Serious Crime Act 2015 which came into force in December 2015. Given this uncertainty we feel care needs to be taken in drawing conclusions from this data. For instance, if a change in reporting is of relevance then the data is likely to substantially underestimate the impact of FSH, as post-FSH data would be more affected by this increase. Again, data needs to be collected for a further 12 months before conclusions can be confidently drawn.

Nonetheless, there were some strong indications of impact from allocation in FSH. Figures were calculated in relation to average number of incidents in which police were involved. To aid with pre- and post-FSH comparison, a monthly average was calculated. As for health data, the quarter of allocation was excluded. As appropriate for illustrative purposes, the variation in monthly average was projected for a full year.

It can be seen in Table 10 that there was a high level of involvement of police with families allocated in FSH, which was particularly focused on domestic abuse. Two findings stand out. First, there is a substantial reduction in police involvement post-FSH. This is found in each cohort. Second, there are indications that FSH has greater impact as it is rolled out. Interpreting this data is complicated by the change in reporting that affected primarily Cohort 4. For the other cohorts, the impact of FSH, that is, the reduction in involvement with services, increases for the second 2 cohorts. Again, because of the limited follow-up period we believe this is likely to underestimate the impact on families of FSH as a reform..

Table 10: Average Monthly Police Incidents Before-and-After FSH

Cohort	No. Months follow-up	Total no. adults with prior incident	Average no. incidents per month Pre FSH	Average no. incidents per month Post FSH	Reduction in average no. incidents/month
Cohort 1	12	10	1.0	0.4	58%
Cohort 2	7	12	1.4	0.4	70%
Cohort 3	7	37	4.4	1.3	71%
Cohort 4	4	61	9.8	3.5	64%
Total		120			66%

Source: Police KPI Data

Substance Misuse (see also Appendix 4, Section 1.3)

The KPI data includes 91 (5%) parents who were allocated a Substance Misuse Recovery worker (an adult worker within FSH), 63 (4% of total cohort) of whom were involved in treatment phases during the year.

The substance misuse treatment measures provide some of the best indicators of outcomes; indeed, they are unique in this dataset in measuring outcomes directly rather than inferring them from service use. However, they track welfare progress and substance use over time, and, given the short follow-up period, it is premature to draw any conclusions from this dataset. While there are indications of successful

outcomes across the 3 KPI measures, sample sizes to date are small, and longer follow-up is required.

Given these limitations, only key findings are provided here. Of the sample of 63 who were involved in at least one treatment phase, 13 (20.6%) adults completed an exit stage of treatment, and 3 (4.8%) could be identified as successful completers: that is, no representation in the following 6 months. Analysis of levels of alcohol and drug use over treatment phases shows that there was mostly a reduction in use over time: that is, that people who stay in treatment show good outcomes, with generally very substantial reductions. Analysis of levels of wellbeing scores shows that there was generally an increase over subsequent treatment phases for:

- psychological health
- physical health
- quality of life

Mental Health service use (see also Appendix 4, section 1.4)

Analysis of service use data shows that between Q1 and Q2, and Q3 and 4 in the first year of FSH, there was an increase in the number of children and young people open to CAMHS of 28%, and of adults open to HPFT of 56%.

Additional data provided by the FSH mental health team indicated the extensive work of the adult mental health professionals within FSH. For instance:

- in the period 1 November 2015 to 10 August 2016, the 10 mental health practitioners within FSH teams worked with 163 adults for an average of 39 days
- 90 of these adults were discharged in the period, 80 to a GP and 10 to HPFT. Further work is required to develop appropriate KPIs for this group

Education: impact on school attendance

To account for term length and seasonality factors, analysis of the number of sessions absent compared the number of sessions absent in Spring Term 2016 to Spring Term 2015. Due to the availability of data and timings, analysis was conducted for Cohorts 1 and 2, as set out in Table 11 below. Children included in the cohort were all those who were a member of a family with a child referred to FSH who attended school in Hertfordshire. As can be seen in Table 11, the amount of authorized absence remained identical before-and-after. Across the entire sample, the level of unauthorized absence fell from 186 days in total to 109: once variations in term length and cohort size were allowed for, this was a reduction from 0.51% of all possible days to 0.36%.

Table 11: Educational Absence Data for Cohort 1 and 2: Spring Terms 2015 and 2016

Cohort 1 and Cohort 2 Combined	Spring 2015	Spring 2016
No. sessions in term (2 sessions per day)	115	105
No. in cohort	320	288
No. authorised absences	377	308
No. unauthorised absences	186	109
Total no. absences	563	417
No. authorised absences/child	1.18	1.07
No. unauthorised absences/child	0.58	0.38
Total number unauthorised absences	186	109
Total no. absences/child	1.76	1.45
% absence – authorised	1.02%	1.02%
% absence – unauthorised	0.51%	0.36%
% absence – all	1.53%	1.38%

Source: Hertfordshire County Council Data

Children's Services indicators

The initial indicators selected for Children's Services proved unhelpful; they related to service use prior to, and post, allocation, and service use prior to allocation is not comparable with that post allocation. Instead, here, and in the next section, we have worked with HCC to identify some measures that might be useful.

Number of days in care: ICS analysis

Our analysis of ICS data for newly allocated children with a 5 month follow-up period (reported above) provides a helpful basis for examining variations in the use of public care. We use it in calculating cost savings in the next section in combination with prevalence data.

Analysis of number of Child Protection cases: case data analysis

HCC identified a reduction in the number of cases allocated, and a reduction in use of child protection (CP) plans as key service outcomes associated with FSH. Using data provided by HCC we analysed the number of cases open by status, child protection (CP) or Children in Need (CiN), per month during the pre-FSH period (November 2014 to March 2015) compared to the post-FSH period (April 2015 to June 2016). This found that there was an overall reduction in the number of cases of 18.5% and a decrease in the proportion of cases that were CP from 48% to 42%. See Table 12 below.

Table 12: Case Allocation and Statutory Basis Pre- and Post-FSH

Status of case	CiN	CP	Total Cases	% CP
Average no. cases open per month Pre- FSH (Nov 14 - Mar 15)	1,055	969	2,024	48%
Average no. cases open per month Post- FSH (Apr 15 - June 16)	962	687	1,649	42%
Reduction in average no. cases per month post FSH vs. pre FSH	93	282	375	
% reduction	8.8%	29.1%	18.5%	

Source: Hertfordshire County Council Data

Estimates of Cost Savings

From a research perspective it is too early to draw conclusions on the financial savings and other benefits of FSH. This evaluation was carried out during the year in which FSH was implemented, and as a result there are no appropriate before-and-after measures to guide an approach to estimating savings. Great care should therefore be taken in drawing conclusions from this section.

Nonetheless, we are aware that for partners within FSH and those interested in adopting the approach, an indication of the nature and possible scale of cost savings is likely to be important. We have therefore attempted to estimate cost savings by making appropriate projections and applying available cost data to areas where FSH appears to have a positive impact. Given the space limitations it is not possible to present these assumptions in full here (they are set out in Appendix 5). Here we present a summary of our projections of cost savings.

There are many reasons for caution about such projections. At best, analyses of cost savings are an inexact science, and this dataset rarely has strong pre-FSH evidence, is often comparing early FSH with FSH later in the first year, the follow-up periods are, on average, 6 months or less and for all savings we solely attempt to indicate savings in the first 12 months post-allocation. It is important to emphasise that these considerations all serve to make it likely that the estimates are underestimates of the true cost savings. We think it likely they are substantial underestimates. A fuller economic costing model would be possible if the KPIs were collected for a longer period of time.

Cost savings to Children's Services

The best evidence of cost savings was found in relation to Children's Services. Here, there were clear reductions in the numbers of children entering care, the number of child protection plans, and the number of families allocated. Our estimate is that, when evidence from the previous year was compared to the year in which FSH was implemented, the savings identified in Table 13 were found. In sum, we found annual savings already of over £2.5 million per year.

Table 13: Estimate of Cost Savings in Relation to Children's Services

Area of saving	Cost estimates based on	Annual Saving £
Reduction allocated cases	18.5% (CP and CiN) (29.1% reduction in CP)	1,478,016
Reduction in days in care for newly allocated cases	39% reduction in days spent in care for newly allocated cases (child level analysis)	1,193,244
Total		2,671,260

Source: Hertfordshire County Council Data Analysis

The cost savings are calculated by comparing average monthly service use in the 12 months prior to allocation, with the months post-allocation, using the KPIs. Table 14 sets out those areas where a clear pattern suggested savings could be calculated.

Table 14: Estimate of Cost Savings in Relation to NHS and Police

Service	Area of saving	Cost estimates based on	Annual Saving £
NHS	Reduced adult use of A&E	Estimate of 53% annual reduction in emergency admissions	220,002
Police	Reduced police incidents	Estimate of 58% annual reduction in repeat incidents	106,824

Source: KPI Data Analysis

For both NHS indicators and police service use there were indications that the impact, and therefore the savings, increased over time as FSH was rolled out and had increased effectiveness. The follow-up period was too short for confident projection of findings, but our estimate was that the impact on reduction of need for

other services was between 25% and 50% greater when Cohort 1 and Cohort 3 or 4 were compared.

Concluding Comments

- there is strong evidence that FSH produces substantial cost savings within Children's Services even in the first year
- we would expect this to increase as FSH is embedded
- allocation in FSH seems to reduce the use of emergency health services and police involvement when the period prior to allocation is compared with post-allocation
- there are promising indications that even in the first year of implementation, the impact of FSH on reduced use of other services was increasing
- a longer follow-up period is required to evaluate this more adequately

5 Limitations of the Evaluation and Future Evaluation

The primary limitations of the evaluation arise from the timescales in which both the implementation and the evaluation needed to be carried out. As a result, we were evaluating an ever changing picture. While to some extent this can be mitigated by making the process of change itself a focus of study, the fact that FSH was only fully in place as we ended our data collection means that great care needs to be taken in drawing conclusions on outcome data. A specific issue is that, in comparing before-and-after, we are rarely simply comparing these 2, but, more usually, earlier and later, and often, particularly for qualitative data, during. Such a comparison may blunt identification of some of the achievements of FSH.

Second, by and large, where the data we collected is strongest, we have the smallest samples, and conversely, where we have large samples, it is often difficult to interpret the meaning of the data. Thus, our follow-up research interviews provide the best evidence on outcomes for children and families but the numbers involved are small; the KPI data set is very large and has great potential, but there are multiple interpretations possible for the findings, particularly at this early stage when change in measures over time is a central focus of interest.

A particular limitation in this study is that we attempted follow-up family interviews by phone. This was necessary, as we did not have the resources or time for multiple home visits across a large county, but it reduced the proportion of those interviewed at follow-up significantly: by around half of those achieved with face to face follow-up in other studies. This in turn has 2 consequences. First, high levels of attrition mean we cannot know what would happen to families that did not take part in the research, and they are likely to be different to those who did. Second, it is apparent from both the qualitative data and our analysis of the whole dataset that some of the biggest impacts of the FSH reforms may have been on a minority of families worked with: for instance, those with the highest levels of risk. Our evidence on this group is unfortunately limited.

Yet more even than these important technical issues, there are some wider challenges relating to our understanding of what Children's Services are for, and therefore how they should be evaluated, and these extend to any evaluation of reform in such services. Much of the literature on evidence based practice is taken from a medical or psychological background that focuses on the evaluation of particular methods or interventions. There is merit in such an approach, which characterises social workers or other professionals as if they were therapists providing an intervention, and focuses on outcomes. Yet there is more to social work and Children's Services than this. The first task is to identify who actually needs support, or indeed requires, perhaps, an unasked for intervention in their family life. In this respect, social workers are akin to General Practitioners (GP), whose first role is to identify whether there is a problem that requires intervention and who try to ensure help is proportionate. And like a GP, this research

found that, for the bulk of families, issues, even if they appeared quite serious, often resolve themselves relatively quickly. GPs cannot be evaluated solely on their impact on outcomes: they also need to be evaluated on how accurately they have identified illnesses. Similarly, evaluation of Children's Services therefore needs to consider whether or not the right families are being worked with, before evaluating impact on this group.

However, there is a further layer of complexity. Children's Services carry great authority on behalf of the state to intervene with families. In this respect the quality of work is important in its own right, and not just because it may produce certain outcomes. Here, perhaps, a parallel with a judge is more appropriate. The wisdom and proportionality of a judge is important, regardless of whether or not it influences outcomes. Similarly, for Children's Services humane, respectful, authoritative and proportionate involvement in family life is important in its own right: not because it influences outcomes, but because these are the hallmark of the type of society we wish to create. Put simply, process is important as well as outcomes.

If you are uncertain about this, imagine that Children's Services become involved in your family's life. The quality of the social worker might make little difference to how your family functioned. Certainly, their influence would be dwarfed by your personal and social resources. Yet, nonetheless, you would no doubt feel that the way that you were treated was important in its own right, and not solely as a means to the end of improving outcomes. This illustrates the complexity of the role, and the challenges involved in evaluating Children's Services.

Overall, however, there are considerable strengths to the evaluation. The sheer range and quantity of data gathered allows for an exceptionally rich and nuanced picture to be developed. We have tried to do justice to the overall pattern in this comparatively short report, but there are further elements which we will explore in subsequent publications.

We were particularly fortunate to work with an exceptionally well organized and committed group of professionals in Hertfordshire. They provided us with data on KPIs, and a dataset based on ICS data, and worked closely with the team throughout the period of the study to facilitate access to workers, who were themselves supportive in assisting the researchers gain access to families. This is testament to the way that an embedded team can work closely with a local authority to generate a range and quality of evidence that is exceptionally unusual in social work research or the evaluation of innovations in social work.

We want to highlight the potential of the KPI dataset developed by the FSH partnership. There has been considerable and on-going debate about how to measure outcomes in Children's Services, including the recent critical report from the National Audit Office (NAO, 2016). The KPI set assembled by Hertfordshire was able to provide only indications of the impact of the FSH reform at this stage because the follow-

up period was necessarily so limited. However, its genuine worth would be if it could be sustained, so that patterns and changes in use of other services could be mapped with a follow-up period of a year or more. Outcomes such as police involvement and emergency hospital admissions are important indicators of child welfare, as well as having economic cost implications. Gathering and sharing such data has the potential to also provide a basis for interagency collaboration in delivering Children's Services.

A particular strength of the study is that the data gathered allows us to compare and contrast evidence from different sources. This is sometimes referred to as triangulation, though this has connotations of a single, true answer. We felt that we were privileged enough to have evidence from children, parents, workers and senior managers over the course of a year, and we have tried to present a suitably 3 dimensional depiction of the Innovation over time. This is perhaps both the strength of the study, and its weakness; it allows us to explore the complexity of the process of change and its consequences, but our ability to present such complexity makes drawing simple conclusions challenging.

For future evaluations of whole system changes in Children's Services we felt that there were some important implications. First, before considering evaluation of outcomes we need to explore whether the right families are receiving proportionate interventions. This is not a straightforward challenge. While it may be possible to identify false negatives - that is, families where a serious risk to children was missed - it is far more difficult to miss false positives; that is, families being worked with who do not require such involvement. Yet such considerations are important before we think about evaluating outcomes. Second, outcomes are a very complicated area to evaluate. The children that were worked with ranged in age from unborn babies to older teenagers. Furthermore, there are complex debates about who decides what outcomes should be measured. We are preparing a number of papers looking at this issue, but would commend Goal Attainment Scaling as a promising approach. Third, studies have not observed the quality of practice often enough. A strength of the study was our ability to observe and code for a large number of interviews, and this provides some of the strongest indications of the complex realities of changing practice.

6 Implications and Recommendations for Policy and Practice

Our pattern of findings is best explained by 2 crucial lessons that emerge from the study of FSH. The first is that creating meaningful changes in practice in Children's Services is very difficult. Training has limited impact, unless it is backed up by wider cultural changes that are reflected in supervision and the whole approach to understanding what good practice is and how it can be supported. Even if these are in place, they are likely to take time to make a difference. This is, in fact, not surprising. Creating organizational change is difficult, as noted by Cameron et al (2016), 90% of such reforms fail. After all, if a worker has worked in one way for some years, expecting them to change significantly in a few months is probably too much to expect.

It would therefore, perhaps, be unrealistic to expect FSH to have achieved such change. The reform is in its infancy and, while strong and effective management can put in place the conditions for changes in practice swiftly, the actual changes are likely to take considerable time to bear fruit. In this respect, our qualitative evidence suggested that initial enthusiasm had been created through the training in MI, despite reservations about the training itself, and the group discussions showed evidence of producing more reflective and thoughtful consideration of cases. Of particular importance was having adult workers involved in these and in discussion of cases in general, as they provided a different perspective, and therefore prevented overly linear thinking. There were indications of improvements in practice, which suggested that improving practice is possible but that it takes time.

Yet, given the nature of this challenge, in some senses what has been achieved in FSH has crucial learning for Children's Services across the country. For, while deep seated and meaningful change in practice inevitably takes time, FSH managed to create crucially important quick wins that allow the service to continue the focus on improving practice in the longer term.

This is, therefore, the second key lesson arising from the FSH reform. For, while everyday practice did not change hugely, and the process of improving worker skills inevitably takes time, very important reductions were seen in the use of care; the number of child protection cases held, and there were indications of reductions in use of emergency admissions and police involvement. There was also powerful qualitative evidence of transformed practice for some families, and indications in the outcomes for families that those with more serious problems who worked with an adult worker were achieving particularly positive outcomes. So how was this achieved, and what can be learnt from the experience?

The main engine for these changes seemed to be the introduction of adult workers. It

would be simplistic and inaccurate to depict the introduction of adult workers alone to be the magic ingredient; their impact was facilitated by the excitement generated by the innovation process: by training in MI that helped workers to understand different conceptions of working with people; and by putting in place group case discussions that, when done well, created debate and dialogue between different workers. These facilitating elements allowed adult workers to come in and make a significant difference for families. Their input seemed to allow swifter and more effective help for the many families where parental problems were directly affecting the children's welfare. Yet there was more to the involvement of adult workers than simply providing direct input to families. Introducing adult workers moved the nature of practice. It created multidisciplinary teams. This in turn provided an element of challenge and increased the variety of views when families were discussed and thought about. It also created the potential for different professionals to learn from one another.

We therefore feel that FSH has substantial lessons for Children's Services across the country, and that our evaluation has lessons for the FSH Innovation as it develops. The lessons for the country are that creating organisational changes in a complex practice such as social work is difficult, requires sustained whole system change and is therefore unlikely to achieve substantial transformation in short time periods. Yet, crucially, while organisations attempt to create cultural changes to improve practice, there are key changes that can be put in place to support such deeper change. For FSH, most important was the recognition of the high level of complex parental problems in families being worked with, and the insight that introducing adult workers into teams would both enable more effective responses for families, and help support wider improvements in practice by creating a multidisciplinary team. In doing this, the FSH Innovation seems to have been markedly successful. This is a success that we feel other authorities can learn from, particularly if the complexity of achieving transformative changes in professional practice is taken seriously.

For these more deep-seated changes to practice, FSH is still working on creating change. We did not see evidence that attempts to simplify professional practice - for example through assessment workbooks or structured interventions - had succeeded yet. Instead, a longer road focused on improving practice and developing the skills of workers is being embarked upon. However, the introduction of adult workers, creation of group discussions, development of a whole system practice framework related to MI, and on-going focus on supporting workers to undertake meaningful work with families are hugely important first steps in FSHs ambitious attempt to improve practice and transform outcomes for children and families.

Recommendations for policy and practice

Implications for Hertfordshire

- given the positive nature of the evaluation, it is important that the various agencies in the partnership continue their impressive level of cross-agency support and strategic management of FSH
- the KPIs have huge potential, though further work is needed to develop them and address the practical challenges of collecting, collating and analysing findings
- further development of the adult worker role is required. Involving adult workers is a core element in the success of FSH, yet there was variation in the integration of such workers. There could now be an increased focus on developing and harnessing the expertise of adult workers to support multidisciplinary working
- further work is needed in developing the conceptual framework, and, in particular, in integrating the principles of MI into the way risk assessment is understood and carried out. This is closely linked to the next recommendation
- there is a need to develop the theoretical approach to group case discussion and provide training and supervision for those leading such discussions. Group case discussions are already making a positive contribution to improving the depth of analysis. However, work is needed to maximise their potential
- further work is needed to support the understanding and application amongst workers of the principles and skills of the practice model being developed by Hertfordshire. This should include a next phase of training, materials and perhaps other initiatives such as coaching or consultancy on cases. Steps are being taken to address this recommendation, and the 3 previous recommendations

National Implications

- all local authorities should consider the potential that multidisciplinary working has for improving practice and outcomes in Children's Services. In Hertfordshire, adult specialists have played a central part in creating more family focused assessment and intervention, and this has helped reduce the need for children to enter care and contributed to other positive outcomes
- multidisciplinary working requires more than simply recruiting adult specialists; processes such as group case discussion and a framework for practice, in this case MI, are necessary to make this a genuinely multidisciplinary experience, and to provide a framework for helpful discussion and new ways of thinking
- the KPIs are a hugely promising approach to measuring outcomes, though setting them up was very resource intensive. We think it important that this innovation continues and is taken up in other local authorities
- this evaluation provides a very positive set of initial indicators of outcomes in such a short period. As such, it provides unequivocal support for continuing the

development of FSH. We would therefore encourage other local authorities to consider replicating or implementing central elements of FSH. However, for this to work, it needs to be seen as more than a technical fix. To be successful, it also requires committed and passionate leadership

References

Cameron, C., Elliott, H., Iqbal, H., Munro, E. and Owen, C. (2016) *Focus on practice in three London boroughs: an evaluation DfE Children's Social Care Innovation*. London: Department for Education

Curtis, L. and Burns, A. (2015) *Unit Costs of Health and Social Care 2015*, Personal Social Services Research Unit

Ferguson, H. (2014) What social workers do in performing child protection work: evidence from research into face-to-face practice. *Child & Family Social Work* 21: 1365-2206

Forrester, D., Westlake, D., Killian, M., Antonopolou, V., McCann, M., Thomas, R., Waits, C., Whittaker, C. and Hutchison, D. (submitted) Engaging parents and protecting children: Results from a randomized trial of training in Motivational Interviewing for child protection social workers, *British Journal of Social Work*

Forrester, D. Westlake, D., Killian, M., Antonopolou, V., McCann, M., Thomas, R., Waits, C., Whittaker, C. and Hutchison, D. (submitted) What works in engaging parents in child protection work? A study of practice skills, engagement and outcomes for 131 families, *British Journal of Social Work*

Kane, M. and Trochim, W. (2007) *Concept Mapping for Planning and Evaluation*. London: Sage

National Audit Office (2011) *The cost of a cohort of offenders to the criminal justice system*. London: National Audit Office

National Audit Office (2016) *Children in need of help or protection*. London: National Audit Office

New Economy Manchester, Unit Cost Database v1.4 (updated March 2015)

Rollnick, S. and Miller, W.R. (1995) What is motivational interviewing? *Behavioural and Cognitive Psychotherapy* 23.04: 325-334.

Whittaker, C.E., Forrester, D., Killian, M. and Jones, R. (2017). Can we reliably measure social work communication skills? Development of a scale to measure child and family social work direct practice. *International Journal of Child & Family Welfare*, 17(1-2), 47-63

Appendix 1: Further Detail on Methods and Data Collected

This appendix provides additional information on data collection and analysis to complement that in the main report.

The comparative study data collection

Families allocated into FSH were identified in 2 collection periods: families allocated between July and October 2015 and families allocated from November 2015 to February 2016. This consisted of a whole sample of 447 families who were eligible for data collection.

The initial intention was to compare the 2 groups; however, this was not appropriate because the process of rolling out the Innovation across the offices meant that some offices had already moved to FSH in Phase 1. Instead, therefore, families were allocated to the pre- or post-FSH groups based on the point at which their office had moved to FSH. Even this proved problematic, and therefore multiple analyses have been carried out to provide an in-depth analysis of change over time. This is further discussed in the next section, and full analyses explore a variety of comparisons, including both before-and-after, and change over time, in the results section.

Social workers asked parents and carers if they were willing to take part in the research, and, where 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 work skills including level of MI skill
- parent and child post-observation interview: research interviews with parents, and, where appropriate, children and young people, 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 include:
 - parent rating of family life (Life Rating Scale)
 - identification of goals for work and whether achieved (Goal Attainment Scaling (GAS))
 - family functioning (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) and social isolation (SSA)
- parent and child follow-up interview: 3 months later a follow-up telephone interview

was carried out with parents, focusing on their experience of the service; whether agreed goals had been achieved, and any 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 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, adult workers, group supervision
- ICS data was gathered for all these families (447 families or 860 children) from computerised records. This involved: some basic information on family profile; detailed information on services received; outcomes relating primarily to the use of care proceedings which were entered onto SPSS and analysed

Two further types of analysis were carried out to supplement the comparative element of the study:

- families where FSH was working particularly well were identified and a combination of multiple interviews (with parents, children and workers) and observations of practice was used to provide an in-depth picture of FSH in practice: these provide an unusually rich picture of the complexities of practice and the relationship to outcomes
- eight group case discussions were observed

Data Analysis

As noted in the main report, FSH was a rolling programme of reform. The evaluation of before (pre-FSH) and after (post-FSH) outcomes was not therefore straightforward. For the comparative datasets we have used the following comparisons:

- family data (observations and research interviews): accurate date of allocation information was not available for this sample. An estimate was made that, on average, interviews took place 8 weeks after allocation. Thus, for comparative purposes the analysis compares families interviewed prior to, or during, the first 2 months of transition to FSH (pre-FSH), with those interviewed once FSH was in place (post-FSH). However, this proved a problematic comparison. Most importantly all pre-FSH data came from 1 office. A variety of additional analyses were therefore carried out and results are described, including comparisons across offices and analyses of changes over time
- qualitative staff interviews: much of the qualitative data was focused on the process of change and therefore before-and-after comparisons are not generally made
- staff surveys: these were carried out in July 2015, November 2015 and July 2016.

However, as illustrated in Figure 1, the process of change was rolled out across offices at different times. To allow for analysis of this, as well as overall findings where appropriate, the breakdown by office is provided

- ICS data: for comparative purposes, the ICS data is divided into families allocated prior to FSH going live in the relevant office; those allocated during the 2 months of transition after this date, and those referred once FSH was established. Data is presented for each group, but statistical tests simply compare the pre-FSH and post-FSH groups
- KPI data: KPI data is provided for all families referred to FSH by quarter, in the year 1 July 2015 to 30 June 2016. The comparison is between service use prior to, and after, allocation in the service. KPI data therefore does not compare pre-FSH with post-FSH outcomes for the service. It compares use of other services prior to, and after, allocation to a worker in FSH, but not the equivalent data for workers prior to FSH

All qualitative 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, 2004). 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).

Appendix 2: Process of Change – Interviews and Staff Survey

Process of Change Data - Qualitative Interviews

Table 15 shows the number of workers by role that participated in a research discussion with a member of the evaluation team between March and June 2016.

Table 15: Number of Workers by Role who Participated in Research Discussions

Role	Number that participated	%
Team Manager	6	10%
Consultant Social Worker	5	8%
Senior Practitioner	3	5%
Social Worker	16	26%
Child Practitioner	10	16%
Student Social Worker	1	2%
Adult Worker- Domestic Abuse	9	15%
Adult Worker- Substance Misuse	3	5%
Adult Worker- Mental Health	6	10%
Missing	2	3%
Total	61	100%

Source: Qualitative Interviews with workers

Staff Survey Data

Workers who participated in the staff surveys

Table 16 shows the number of workers by role that completed each of the 3 staff surveys; July 2015 (T1), November 2015 (T2) and July 2016 (T3).

Table 16: Number of Workers by Role that Completed each Staff Survey

Staff Survey	T1		T2		T3	
Date of completion	(July 2015)		(Nov 2015)		(July 2016)	
Role	n	%	n	%	n	%
Consultant Social Worker	11	8%	12	9%	14	9%
Senior Practitioner	25	17%	16	12%	12	8%
Social Worker	46	32%	44	32%	50	31%
Child Practitioner	31	22%	28	20%	20	13%
Adult Worker	4	3%	17	12%	19	12%
Team Manager	15	10%	8	6%	17	11%
Support Officer	5	3%	3	2%	13	8%
Role not given	6	3%	9	7%	14	9%
Total	143	100%	137	100%	159	100%

Source: Staff Survey

Table 17 shows the number of workers by office that completed each of the 3 staff surveys; July 2015 (T1), November 2015 (T2) and July 2016 (T3).

Table 17: Number of Workers by Office that Completed each Staff Survey

Staff Survey	T1		T2		T3	
Date of completion	(July 2015)		(Nov 2015)		(July 2016)	
Office	n	%	n	%	n	%
Office 1	38	27%	37	28%	42	26%
Office 2	40	29%	38	29%	52	33%
Office 3	61	44%	57	43%	65	41%
Total	139	100%	132	100%	159	100%

Source: Staff Survey

Appendix 3: Mixed methods comparative study: Services and Outcomes Pre- and Post-FSH

Table 18 summarises family profile data collected from ICS for the 3 samples: Pre-FSH, post-FSH and transition phase.

Table 18: Summary of ICS Data for Families Pre-FSH, Post-FSH and During Transition

ICS Profile Data	Pre-FSH	Transition phase	Post-FSH	Significance p-value
	Mean	Mean	Mean	
Number of Children in Household?	1.92	1.84	2.01	Ns
Number of Adults in household?	1.88	1.44	1.90	Ns
Number of Previous involvements with Children's Services	.88	1.51	2.47	P<0.001
	N %	N %	N %	
Previous involvement with Children's Services	63 (29%)	24 (39%)	87 (53%)	P<0.001
Ethnicity eldest child (% white British)	142 (65%)	42 (69%)	113 (68%)	Ns

Source: ICS data

What services did families receive?

Table 19 summarises service input for families in the research sample during the 5 month period following referral ICS for the 3 samples: Pre-FSH, Post-FSH and transition phase.

Table 19: ICS Data on Service Input Pre-FSH, Post-FSH and During Transition

In the 5 months following referral, how many...	Pre-FSH or Post-FSH			Significance p-value
	Pre-FSH	Transition phase	Post-FSH	
	Mean	Mean	Mean	
Allocated social workers?	1.94	1.80	1.66	<0.001
Times have family members been seen by Social Worker?	12.42	10.25	12.43	ns
Core group meetings	2.96	2.10	2.81	ns
Child in need meetings	3.01	2.41	1.94	<0.001
Child protection conferences	1.21	1.02	1.15	ns
Strategy meetings	.27	.25	.44	ns
s47s started?	.19	.23	.33	ns

Source: ICS data

What did parents and children think of the service they had received?

Table 20 summarises data from the parent interviews for the pre- and post-FSH samples. Data includes the mean scores for parents' views on their experience of Children's Services; the mean number of times parents reported seeing their worker in last 4 weeks; their mean rating for how happy they were with the amount of contact; and the mean rating for how well they felt their worker handled their last meeting. For each area, there is an indication of whether any differences between the 2 samples were statistically significant.

Table 20: Parents Views of Services Pre-FSH and Post-FSH

Experience of children’s services: strongly disagree (1) to strongly agree (5)	Pre-FSH N=30 Mean	Post-FSH N=78 Mean	Significance p-value
on time	4.43	4.29	ns
reasons clearly explained	4.53	4.40	ns
included in meetings	4.07	4.18	ns
feel understood	4.47	4.30	ns
professional and respectful manner	4.23	4.13	ns
overall pleased	3.77	3.82	ns
Times seen social worker in last 4 weeks	2.57	2.77	ns
Rating of how happy with amount of contact with social worker	3.00	2.95	ns
Rating of how well worker handled observed meeting, 1 (very badly), 4 (OK) to 7 (very well)	6.17	5.77	Ns

Source: Parent and carer interviews

Analysis of Direct Observations

As noted in the main report, the analysis of before-and-after measures for observations of practice and family interviews in Hertfordshire was complicated by the fact that firstly, the reform was rolled out sequentially across different offices and secondly, data collection started as this process happened. This was not the case for ICS data, solely for researcher collected data.

As a result, data from before-and-after from observations and interviews is conflated by the office from which it was obtained. In fact, all the pre-FSH data came from one office, and there were significant variations in the timing of data collection in the different offices. These differences are summarised in Table 21, which sets out the breakdown of pre-FSH and post-FSH and the average days post-FSH for each family interview.

Table 21: Data Collection by Office

		Office		
		Office 1	Office 2	Office 3
Number Pre- or Post-FSH	Pre-FSH	34	0	0
	Post-FSH	15	41	38
Mean days since FSH started		52	193	277

This creates complexity for the analysis of observations and interviews, because it is possible that comparisons pre- and post-FSH are conflated with differences between offices. In this section, this possibility is examined further. We focus on coded observations of practice, both because we have a fuller sample for these factors and because the first hypothesis is that FSH will change the ways in which workers practice with families. Changes in outcomes are hypothesised to be, at least in part, linked to these.

We explore the impact of office differences in the following ways:

- we compare Office 1 pre- and post-FSH scores. While a relatively small sample, this is the purest test of FSH, as we have a pre- and post-reform sample
- we describe and compare worker skills in different offices at different stages of the reform process. Thus, for instance, while we do not have any pre-FSH observations in the other offices, we can compare levels of skills in the first and second 100 days post-FSH to explore whether there are office variations or whether offices are relatively similar
- we compare the impact of FSH over time on worker skills in the different offices; here the independent variable is time since FSH, and we see whether there are changes in skills over time

Scores pre- and post-FSH are shown for Office 1. There does not appear to be much difference, though there is a slight increase in care and engagement skills. However, the number post-FSH is far too small to draw any conclusions.

Table 22: Pre- and Post-FSH Scores for Office 1

	Pre or Post-FSH			
	Pre-FSH (n=31)		Post-FSH N=8	
	Mean	Standard Deviation	Mean	Standard Deviation
Care and engagement skills	2.23	.68	2.56	1.03
Good authority	2.37	.63	2.29	.79

Table 23 compared the offices by stages in relation to FSH. The complexities of the table reflect the challenge for the current analysis. It is probably best to ignore the cells with very small samples for some of these analyses, for example, less than 10, as the aim is to identify general trends. This being the case, the column for days 100-200 post-FSH is the only one which allows comparison across offices. Here, there is no meaningful difference between offices. This provides some tentative support for the generalisability of findings from Office 1 to the whole of Hertfordshire.

The table also provides more detail about the shifts in Office 1. Essentially, there was no move in good authority, but there was quite a substantial increase in care and engagement skills. These rose from a very low level, but by a fairly noteworthy amount. This shift is about onestandard deviation, which is certainly an indication of something fairly substantial happening.

However, the picture is more complex in the other offices. The figures for the first 100 days for Office 2 are outliers; 3 very high scores. It is probably more accurate to say there was little difference in practice skills in the second and third hundred days post-FSH. For Office 3 the picture was also complicated. Again it is probably best to compare the post-300 days figures with the previous figures combined. These suggest a limited increase in both care and engagement and good authority.

Table 23: Skills by Period Since FSH, by Office

	Time since FSH									
	Pre-FSH		First 100 days		Second 100		Third 100		300+	
	Mean	n	Mean	n	Mean	n	Mean	n	Mean	n
OfficeCare 1	2.04	16	2.46	19	2.62	15	.	0	.	0
Authority	2.42	16	2.31	19	2.30	15	.	0	.	0
OfficeCare 2	.	0	2.83	3	2.24	20	2.33	17	.	1
Authority	.	0	4.00	3	2.83	20	2.55	17	.	1
OfficeCare 3	.	0	.	0	2.47	6	2.36	14	2.52	17
Authority	.	0	.	0	2.40	6	2.72	14	2.82	17

If practice in Office 1 is broadly similar to practice in the other offices, then it is valid to compare pre-FSH and post-FSH levels of skills. This analysis is set out in Table 24.

Table 24: Independent Samples T-Test Pre- and Post-FSH for Care and Authority

	Pre or Post-FSH	N	Mean	Std. Deviation	T	P
Care and engagement	Pre-FSH	29	2.2299	.68489	-.916	.362
	Post-FSH	67	2.3781	.74512		
Good authority	Pre-FSH	31	2.3656	.62867	-2.330	.022
	Post-FSH	72	2.6852	.64249		

There was a small positive shift in care and engagement skills, though it was not statistically significant. However, there was a statistically significant positive shift in skills related to good use of authority.

To further explore these relationships, and avoid the relatively small numbers in some cells in the table above, we explored whether there was a correlation between time post-FSH and each type of skill overall. We then explored these relationships within offices.

Again, overall there were indications of positive changes. As can be seen in Table 25 the relationship was statistically significant for good authority. The shift was smaller, though still positive, for care and engagement.

Table 25: Correlation Between Days Since FSH and Authority and Engagement Skills

		Days since FSH started
Good authority	Pearson Correlation	.202*
	Sig. (2-tailed)	.041
	N	103
Care and engagement skills	Pearson Correlation	.143
	Sig. (2-tailed)	.164
	N	96

However, this relationship varied considerably across offices. Office 1 saw little shift in authority, though a fairly large relationship between care skills and time post-FSH ($r=0.246$). Office 3 had a large positive shift in good authority ($r=0.297$) and little change in care. There was an inverse relationship between time since roll-out of FSH and level of skill in good authority in Office 2 which was quite noteworthy ($r=-.314$) that is, skills appeared to get worse over time, and a small positive shift in care skills ($r=0.126$). Puzzling out the fact that Office 2 seemed to shift negatively while the overall shift was positive (and statistically significant) took some time. It is most easily explained through consideration of Figure 5.

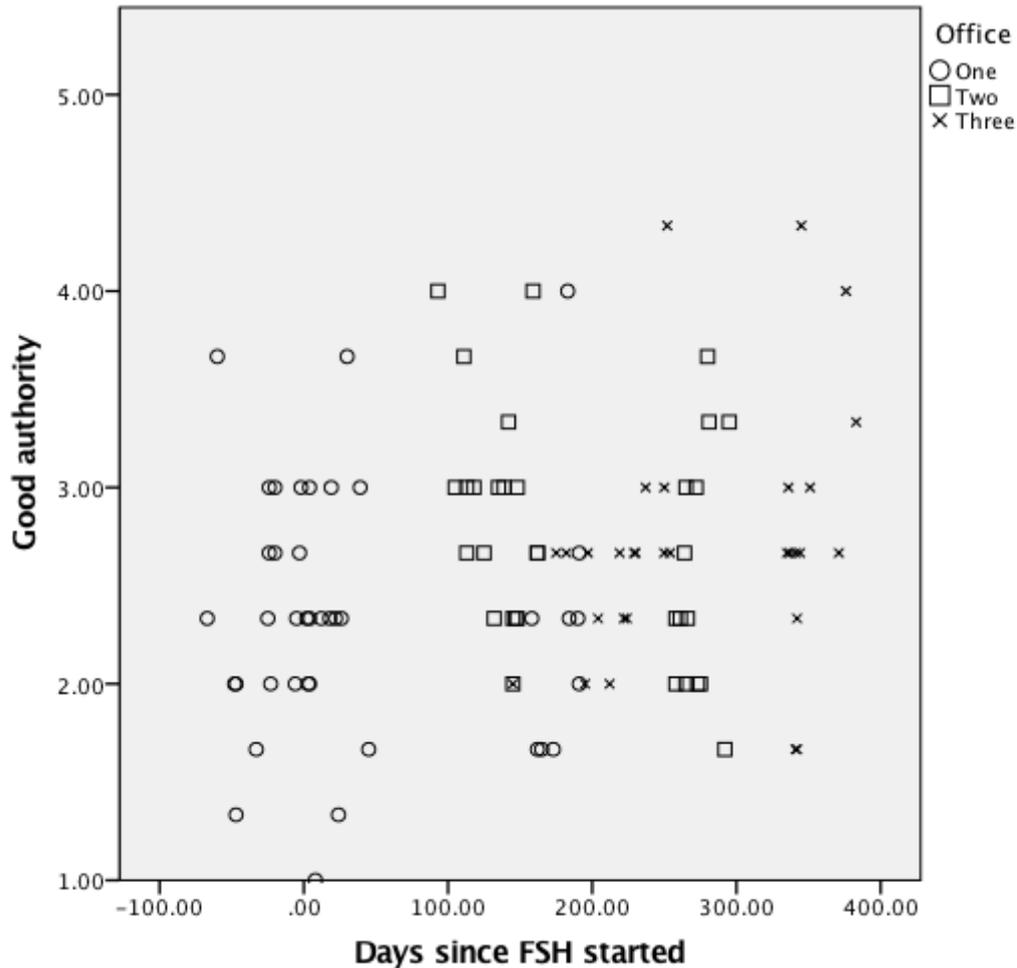
In Figure 5 the scores for good authority are plotted against the number of days pre- or post-FSH by office. A number of features of this graph are worth noting:

- it illustrates the statistically significant shift in the use of good authority over time found in the sample; the scores rise over time
- the negative shift within Office 2 is fully contextualised. The reason this had minimal impact on the overall relationship between time post-FSH and use of authority is that Office 2 had a relatively narrow window for data collection, and was

therefore skewed by a small number of relatively good interviews toward the beginning of this period

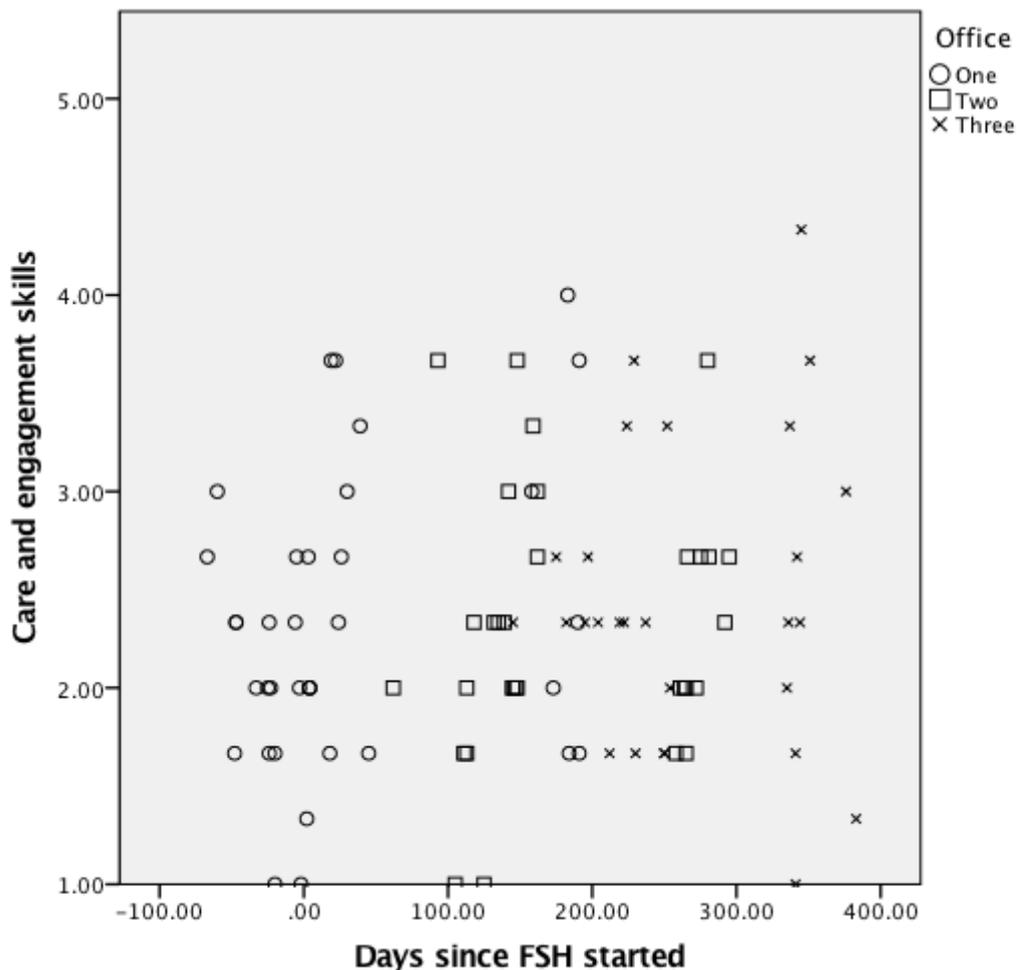
- more generally, the chart can be seen as a description of the messy realities involved in changing practice. These are measures of practice skill taken over the course of a year of reform and innovation. It can be seen that there was some good practice prior to the Innovation, and some poor practice despite all the changes. This is what real world change looks like

Figure 5: Good Authority and Days Since FSH Started (broken down by office)



For completeness, the graph showing shifts in care and engagement skills is also provided, Figure 6. The shift here is not statistically significant: it could be due to chance (there is a 1 in 8 chance), or other factors, such as office differences. Nonetheless, it does seem that there is a reduction in the poorest practice, and perhaps more good practice post-FSH.

Figure 6: Care and Engagement Skills and Days Since FSH Started (broken down by office)



Conclusions

This analysis has focused on unpacking the complexity of analysing changes in practice skills in a large authority over time. Our conclusion from these analyses is that:

- there are indications of a statistically significant shift in skills related to the use of good authority
- the positive shifts in engagement and care skills did not achieve statistical significance
- these shifts were not simply pre- and post-FSH but increased over time

Appendix 4: Key Performance Indicators

NHS data - use of emergency hospital services

Table 26 summarises the percentage difference in the average number of monthly NHS hospital emergency attendances or admissions for the period following referral to FSH compared with the period prior to FSH. Data is included for each Cohort 1 to 3. There was no follow-up data available for Cohort 4 at the time of analysis.

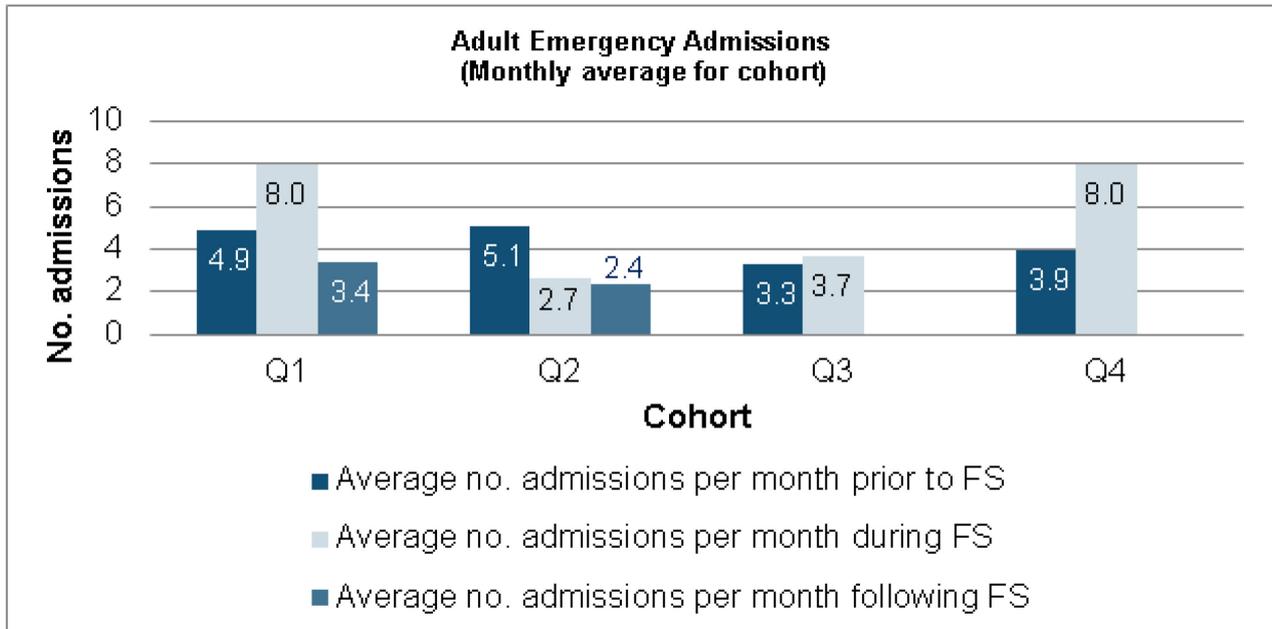
Table 26: Increase or Decrease in Average Number of Monthly NHS Hospital Emergency Attendances or Admissions for Each Cohort Post-FSH Compared with Pre-FSH as percentage

Cohort	Cohort 1	Cohort 2	Cohort 3	Cohort 4
A&E Attendance – CYP	15.2%	7.0%	10.4%	n/a
Emergency Admission - CYP	(50.9%)	(45.5%)	88.6%	n/a
A&E Attendance – Adult	55.2%	11.5%	(35.8%)	n/a
Emergency Admission - Adult	(31.4%)	(52.8%)	(100.0%)	n/a

Source: NHS KPI data

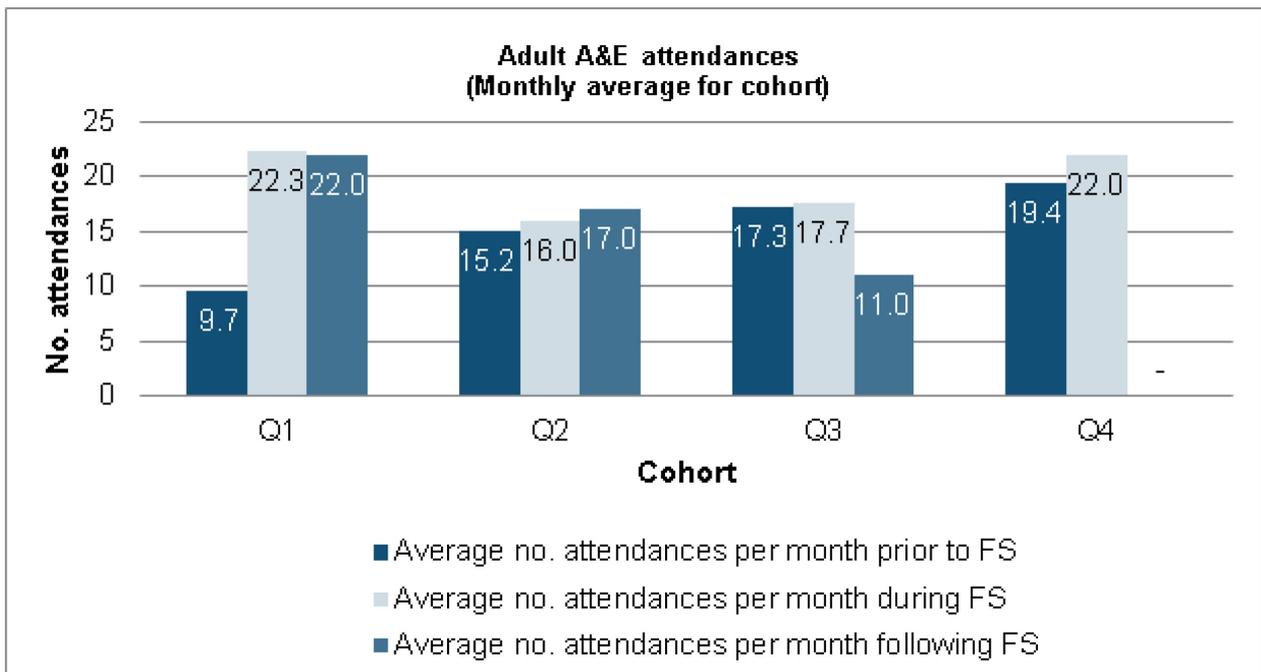
Figures 4 to 7 summarise the average number of monthly NHS hospital emergency attendances or admissions in the period prior to, the month of, and the period post-referral to FSH. There was no follow-up data available for Cohort 4 at the time of analysis.

Figure 7: Adult Emergency Admissions: Monthly Average per Cohort



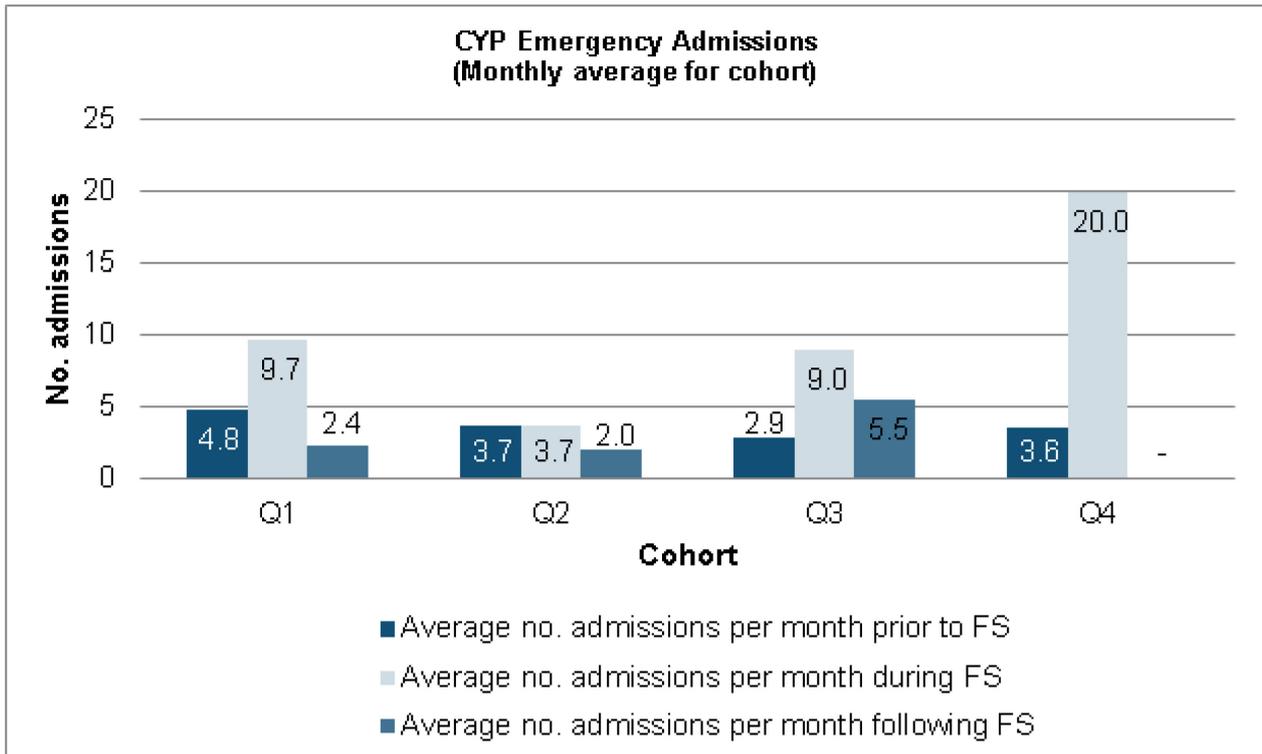
Source: NHS KPI data

Figure 8: Adult Accident and Emergency Attendances: Monthly Average per Cohort



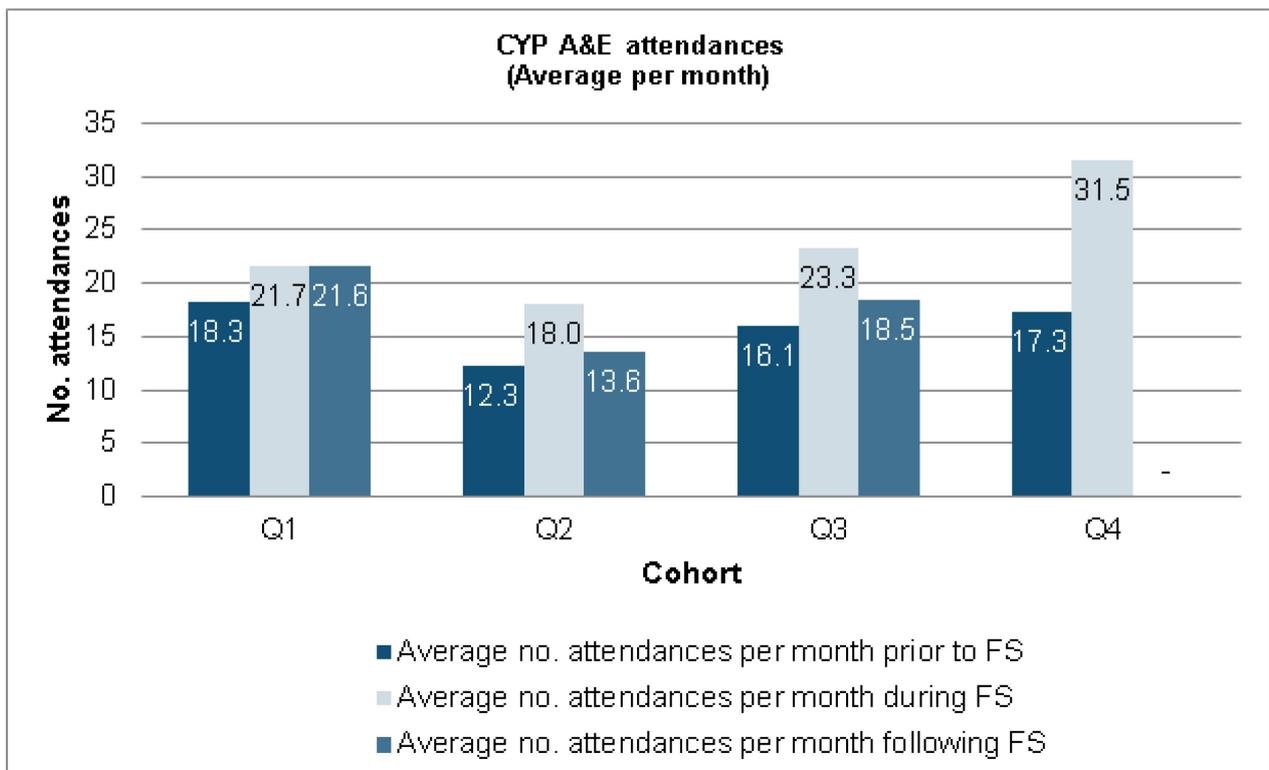
Source: NHS KPI data

Figure 9: CYP Emergency Admissions: Monthly Average per Cohort



Source: NHS KPI data

Figure 10: CYP Accident and Emergency Attendances: Monthly Average per Cohort



Source: NHS KPI data

Police data – number of incidents

Table 27 summarises the police data regarding the number of adults from the first year FSH cohort who were identified as involved in a police incident; detailed analysis by HCC suggested all incidents could be assumed to be related to domestic abuse. The table summarises the number of adults from each cohort who were involved with a police incident prior to FSH, and those for whom there was no prior incident: that is the first incident was from the time of referral to FSH.

Table 27: No. Adults in FSH First Year Cohort Involved in a Police Incident

No. adults in cohort	Cohort 1	Cohort 2	Cohort 3	Cohort 4	Full Year
Adults with prior incident	10	12	37	61	120
Adults with no prior incident	28	14	25	13	80
Total adults in FSH first year cohort with recorded Police Incident	38	26	62	74	200

Source: Police KPI data

Table 28 summarises the police data regarding the number of incidents recorded in which an adult from the first year FSH cohort was involved. The table summarises the number of incidents in each cohort that were linked to an adult who had been involved with a police incident prior to FSH, and those that were linked to adults for whom there was no prior incident: that is, the first incident was from the time of referral to FSH.

Table 28: No. Police Incidents Recorded for First Year Cohort Pre- and Post-FSH

Total no. incidents	Cohort 1	Cohort 2	Cohort 3	Cohort 4	Total
No. incidents pre FSH					
Adults with incidents prior 12 months	12	17	53	118	200
Adults with no incident in prior 12 months	0	0	0	0	0
Total no. incidents prior 12 months	12	17	53	118	200

Total no. incidents	Cohort 1	Cohort 2	Cohort 3	Cohort 4	Total
No. incidents post FSH					
Adults with incidents prior 12 months	5	3	9	14	31
Adults with no incident in prior 12 months	50	17	36	20	123
Total no. incidents post-FSH	55	20	45	34	154

Source: Police KPI data

Appendix 5: Costing Analysis

Estimates of cost savings to Children's Services

Estimates of cost savings related to reduction in number of cases

Table 29 sets out the estimated annual cost saving calculation relating to the overall reduction in the number of Children in Need (CiN) and Child Protection (CP) cases post-FSH (April 2015 to June 2016) when compared with pre-FSH (November 2014 to March 2015).

Table 29: Estimate of Children's Services Cost Savings Associated with the Reduction in Number of Cases

Status of case	CiN	CP	Total Cases	Total Cost (£ pa)
Average no. cases open per month Pre- FSH (Nov 14 - Mar 15)/ related annual cost	1,055	969	2,024	6,490,752
Average no. cases open per month Post-FSH (Apr 15 - June 16)/related annual cost	962	687	1649	5,012,736
Reduction in average no. cases/related annual cost saving	93	282	375	1,478,016
% reduction	8.8%	29.1%	18.5%	22.8%
Cost of case pa (£) – see note on unit costs below	1,920	4,608		

Source: Hertfordshire County Council Data

Note on unit costs

The annual costs of a CiN and a CP case were provided by HCC. The costs were calculated using a top down approach to include costs for social worker, manager and administrative support time, based on average caseloads. Costs associated with CP and family group conferences were also included. The model assumed 35% of CP cases were Public Law Outline. Overheads were included at a rate of 2% for service overheads and an additional 27% for corporate overheads.

Estimates of cost savings related to reduction of number of days in care

Table 30 sets out the estimated annual cost saving calculation relating to the overall reduction in the number of days in care post-FSH when compared with pre-FSH for newly allocated cases. The reduction in the number of days in care was identified in ICS analysis (see Section 4.2).

Table 30: Estimate of Children's Services Cost Saving Relating to the Reduction in Number of Days in Care for Newly Allocated Cases

	Full year cohort
No. children entering care	166
No. days in care pre-FSH	120.12
No. days in care post-FSH	73.45
Cost of care pre-FSH	£3,071,490
Cost of care post-FSH	£1,878,246
Estimated annual cost saving	£1,193,244

Source: Hertfordshire County Council Data

Assumptions in Cost Model summarised in Table 30

- number of children entering care: ICS analysis conducted by HCC demonstrated that 78 children referred to FSH in the period June 2015 to January 2016 entered care. During the same time period, 443 families were referred to FSH. Applying a factor of 2.12, to reflect the total number of families in the full year cohort of 940, results in an estimated number of children entering care of 166 in the year
- number of days in care: the number of days in care is the actual number of days for the post-FSH and pre-FSH sample, extracted from ICS. This represents a reduction of 39%
- unit costs: the average cost per day of care of £154 applied in the model was provided by HCC. The cost was calculated using a top down approach to include

costs for social worker, manager and administrative support time, based on average caseloads, legal costs and average placement costs (CiPFA Benchmarking 2016). Overheads were included at a rate of 2% for service overheads and an additional 27% for corporate overheads

Estimates of cost savings to other services

Estimate of NHS cost savings associated with reduction in adult emergency admissions

There is an estimated annual cost saving of £220,002 as set out in Section 4.3.2 and Table 31 below.

Table 31: Estimate of NHS Cost Savings Associated with Reduction in Adult Emergency Admissions

Cohort	Total admissions prior 12 months	Total admissions in follow-up period	No. months in follow-up period	Annualised no. admissions based on Average Monthly Reduction to-date	Estimate of reduction (no. admissions / cost)	Estimate of reduction (%)
1	59	27	8	41	19	31%
2	61	12	5	29	32	53%
3	40	0	2	0	40	100%
4	47	n/a	0	27	20	42%
Total	207			97	110	53%
Unit cost	1,982			1,982	1,982	
Estimated total cost	410,274			192,254	220,002	53%

Source: Hertfordshire NHS KPI and Unit cost data

Key assumptions in Adult Emergency Admissions cost model

- reduction in number of admissions: monthly reduction in number of admissions for each cohort is based on the monthly reduction in the follow-up period to date and extended for a 12 month period. As there was no follow-up data available for Cohort 4, the average of Cohort 1 and 2, (reduction of 42%) was applied. The resulting reduction in number of admissions is 53%
- unit cost: the cost of a single emergency admission ranges from £73 to £22,157, and a mean cost has been calculated at £1,982, to take into account a provider-specific multiplier of between 1.14 and 1.20 (Herts 2014 to 2015). This compares to an estimated non-local cost of £1,863 (New Economy Manchester Unit Cost Database v1.4)

Estimate of Police and Criminal Justice System cost savings associated with reduction in repeat police incidents

There is an estimated annual cost saving of £106,824 as set out Section 4.3.2 and Table 39 below. This has been calculated by:

- multiplying the number of incidents for the full year cohort prior to referral to FSH by the unit cost per incident
- estimating the total number of police incidents for this cohort in the 12 months post-FSH
- applying the unit cost to the estimated number in the above, and comparing the 2 costs

Table 32: Estimate of Police and CJS Cost Savings Associated with Reduction in Repeat Police Incidents

Incident Type	Pre-FSH		Post-FSH		Decrease	
	Annual no. incidents	Estimated cost	Estimated annual no. incidents	Estimated cost	Estimated annual no. incidents	Estimated annual cost
Victim	186	170,004	78	71,292	108	98,712
Offender	14	14,196	6	6,084	8	8,112
Total	200	184,200	84	77,376	116	106,824

Source: Hertfordshire Police KPI and Unit Cost data

Estimate of costs: pre-FSH

A total of 200 police incidents were recorded for the FSH first annual cohort for the 12 month period prior to referral to FSH, which equates to an estimated annual cost of £184,200.

Unit costs

The average cost to the police of a single domestic abuse incident is estimated at £914 (data provided by Hertfordshire Constabulary). Additional costs to the Criminal Justice system are estimated at £667 (New Economy Manchester Unit Cost Database v1.4). The model assumes that 100% of all incidents incur the police unit cost and that 15% of all offender incidents and 0% of all victim incidents incur the CJS unit cost. As a result, the unit cost per incident included in this model is £914 for victim incidents and £1,014 for offender incidents.

Estimated reduction in repeat incidents: post-FSH

The cost model assumes the reduction of 58% achieved for Cohort 1 in the 12 months post-FSH is applied to the full year cohort, resulting in an estimated number of incidents post-FSH of 84.

Estimate of costs: post-FSH

Application of the same unit cost results in an estimated annual cost of £77,376 post-FSH, which, compared to the estimated annual cost pre-FSH, results in an estimated annual saving of £106,284.



Department
for Education

© Department for Education

Reference: DFE-RR574

ISBN: 978-1-78105-635-6

The views expressed in this report are the authors' and do not necessarily reflect those of the Department for Education.

Any enquiries regarding this publication should be sent to us at:

richard.white@education.gov.uk or www.education.gov.uk/contactus

This document is available for download at www.gov.uk/government/publications