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# Evaluation of the Integrated Family Support Service First Interim report

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**Evaluation of the Integrated Family Support Service  
First interim Report  
May 2012**

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Views expressed in this report are those of the researcher and not necessarily those of the Welsh Government

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## Executive Summary

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1. SQW with Ipsos MORI and Professor Geoff Lindsey of the Centre for Educational Development, Appraisal and Research (CEDAR) at the University of Warwick were appointed to undertake the evaluation of the Integrated Family Support Service (IFSS) model in August 2010. This report covers findings about the setting up and early stages of the IFSS model, **covering the period up to September 2011.**

### **IFSS: The model**

2. The IFSS programme is focused on supporting families with complex needs, where a child/children can be at risk as a result of parental substance misuse problems. The Integrated Family Support Team (IFST) is a multiagency team which is intended to both deliver interventions to some of the most vulnerable and high risk families and support the development of a highly skilled workforce. In each local area the service is being delivered by a newly recruited team. The team is employed by the local authority and reports to a board which comprises a range of partners including police and health services. The work with families is structured around two phases.
  - Phase 1 Intensive Intervention – is expected to last four to six weeks
  - Phase 2 Maintaining the Family Plan – During Phase 2 the family, IFS Spearhead worker and case coordinators for adults and children work together to provide the professional interventions that are deemed necessary for the family to remain in a positive process of change to meet the objectives of the Family Plan.

### **The IFSS Pioneer areas**

3. There are three IFSS Pioneer areas in Wales – Newport, Rhondda Cynon Taff / Merthyr Tydfil (as consortia), and Wrexham. All are covered by the evaluation, although in the report we have sought to anonymise the areas by referring, in no particular order, to Sites 1-3. The data suggest the scale of need varies considerably between the three Pioneer Areas, although the IFSTs are of a similar size. However, in the short term as a new service it could be anticipated that there would be sufficient latent need/demand for support amongst the population to generate sufficient referrals to utilise the existing capacity.

## Implementing IFSS

4. All three Pioneer Areas feel that they generally have the right skill mix in place now (the teams have a majority of staff with a background in social work). Two important learning points were highlighted:
  - A potential need was highlighted for the inclusion within the teams of an adult learning difficulties specialist
  - The need for a social worker from adult services in the team in order to fully meet the needs of families.
5. There was also some uncertainty about the balance of tasks set out for the Consultant Social Worker (CSW, a new post created through IFSS). It may be that the balance between roles will change, perhaps becoming more operational.
6. The Pioneers experience with regards to the **recruitment of staff** has varied. Site 1 Pioneer began their recruitment process in May 2010 with interviews held in June and July 2010. A rigorous recruitment process was adopted, incorporating an assessment centre comprising interviews and various skill and psychometric tests, which staff noted was challenging and to some extent daunting but on reflection gave them confidence that they had the right skills to do the job.
7. A more standard, but perhaps less holistic approach to recruitment was adopted in the other sites. They subsequently faced challenges both in attracting suitable candidates, and later in retaining staff.
8. Pioneer Areas have a duty to establish an Integrated Family Support Board (IFSB or the Board). All three Pioneer Areas have established IFSBs, which are now meeting regularly. In all three areas the Boards are supported by an Implementation/Operational/Steering Group.
9. All three Pioneers report that their **Implementation Groups are proving effective mechanisms for resolving issues** and so far there has not been need for escalation of operational issues to Board level. They also report goodwill at Board level. This good level of partnership working was seen to reflect: the relations between the individuals involved; and a general desire to support IFSS. If this good level of operation can be maintained, and it is early days, then it may be that the need for a Section 58 agreement (a type of service level of agreement between the IFST and those providing 'family support services' under IFSS), which was a requirement of the areas, is much less than expected. However, it may be too soon to draw any conclusion and this may need further evaluation.

10. The Welsh Government has provided training for the IFSTs and all the Core Team members attended a four day training course. In general, the IFST members gave positive feedback about the training, finding that it enthused them for the job ahead. Staff generally felt that the **training prepared them sufficiently to get started with delivery but that they have had to draw significantly upon their previous experience**. It was emphasised that the current approach to training had been appropriate, given the need for experienced staff post qualification to fill the core team roles.
11. The IFSTs have worked hard over the last 12 months to **address the wider awareness and understanding of the service**, particularly within the referring partners of Children's social care teams. A number of lessons are apparent from this experience, especially that location and relationships matter, as it takes time and effort to build profile and trust.

### **Delivering IFSS**

12. From the 150 assessments carried out, 130 cases were accepted onto the IFSS programme in the first year. This accounts for 43% of the anticipated 300 cases across all three pioneer areas. Despite the lower than anticipated numbers a few cases were still rejected due to a lack of team capacity at that specific point in time. Even allowing for a settling in period during year one, **the indications to date would be that the initial figure of 100 cases per area (per year) would not be attainable with lower demand sitting alongside reported constraints in supply**.
13. As the programme has developed the teams noted that they have increasingly come to the **view that the 'crisis' (the time for them to intervene) should be defined in terms of the family experience**. This point of definition raises several interesting issues around timing, especially in light of any capacity issues, alongside the application for professional judgement about who will / will not be helped.
14. The Pioneers are also coming to question how long the Phase 1 intensive intervention should be. For some this was seen as questioning the specificity of the model, but more widely the Pioneers have the opportunity to generate evidence on the relationship between the length of this stage and subsequent outcomes.
15. It is too early to judge the outcomes from IFSS to date. The intervention is designed as a 12 month programme of support and although the end of the first 12 month delivery period has been reached, no families have completed the full 12 months of intervention. However, **data and qualitative feedback**

**from the areas suggest positive trajectories were being followed by families supported.**

16. In general IFSS staff report that their experiences of Phase 2 so far have generally been positive. The IFSS spearhead workers schedule regular meetings with the family, the case holding children's social worker, adult social workers and other relevant services to review progress. However, it has been noted that the high turnover of staff in mainstream social work teams has resulted in inconsistent engagement with families especially over the extended period of IFSS Phase 2 delivery.

### **Staff experiences of delivering IFSS**

17. The **staff reported a number of very positive experiences**, which reflect the ethos of IFSS:
- Staff had a strong **feeling of being involved in a team**, to which their skills were vital and felt their role carried a high level of responsibility
  - Embracing the **focus on the family** as a whole rather than just children or just adults
  - Valuing the opportunity to **work intensively with a family** and dedicated time to working through issues with them
  - Working with a family to **solve problems** (one consultee described this as 'positivity not negativity').

### **Issues for consideration**

18. This report has considered the implementation and delivery of the IFSS in the first 12 months of operation. Feedback from all three areas has been positive. They remain positive that IFSS will lead to improved outcomes for families.
19. However, there remain a number of areas where further consideration is required. The key points for the Pioneers to consider in moving forward are:
- The throughput of cases and implications for capacity as they enter a period of 'steady state'
  - Developing a clearer, professional judgement on the types of families and at what 'crisis' point they think IFSS can work.
20. The initiation phase has also highlighted a number of points for future IFSS areas as they seek to implement an IFSS model:

- A key lesson for new areas is the value in investing in the recruitment and initial set-up of the IFST.
- The importance of getting these relationships right, and the time required to do this must be built in to the initiation phase and then re-enforced over the early weeks and months.

### **Issues and uncertainties about the delivery model**

21. The issues highlighted in this section refer to the nature of the model and policy framework surrounding it. In several instances the evidence does not point as yet to strong conclusions, but rather to pointers that the Welsh Government may wish to consider as the rollout proceeds. The main points arising were that:

- If the Boards continue to operate well in their absence then the need for an S58 Agreement should perhaps be re-assessed
- There will be a need to consider the scale of throughput which can be achieved and to consider the implications of this in terms of the overall level of demand in each area
- The skills mix and job roles of the IFST will probably require to be refined
- As the Pioneers more tightly specify their target groups for IFSS there is a question of understanding whether some of those being excluded in some areas are in fact gaining positive outcomes in others; and what support is being offered to those who fall outside this range, but who need support.



### **Issues for the evaluation**

22. Evidence on a range of the points set out above will be gathered through the evaluation, which in particular will be considering:
- The evolving models across the three areas
  - The views of families.

## 1: Introduction

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- 1.1 SQW with Ipsos MORI and Professor Geoff Lindsey of the Centre for Educational Development, Appraisal and Research (CEDAR) at the University of Warwick were appointed to undertake the evaluation of the Integrated Family Support Service (IFSS) model in August 2010 following a competitive tendering process. This report covers contains findings about the setting up and early stages of the IFSS model, **covering the period up to September 2011**.
- 1.2 IFSS is being implemented across Wales using a phased approach. Three Phase 1 Pioneer Areas were designated in April 2010 and have been operational since September 2010. The Pioneer areas are Newport, Wrexham and a consortium of Rhondda Cynon Taff / Merthyr Tydfil. These areas were selected by the Welsh Government following an invitation to all authorities to express interest. These three areas will be the focus of the evaluation.
- 1.3 The focus of the evaluation is on the three Pioneer areas (referred to as Sites 1-3 throughout), and in this report mainly the set up and early stages of their delivery. Originally the expectation was that the evaluation findings and specifically an assessment of outcomes and cost-effectiveness would inform the roll-out decision. However, on 14 July 2011, the Deputy Minister for Children and Social Services announced an intention that IFSS would become “widely available” across Wales and two new IFSS Areas would be implemented in 2011/12:
  - A regional consortium of Hywel Dda University Health Board, Powys Teaching Health Board, and their respective local authorities Carmarthenshire, Ceredigion, Pembrokeshire and Powys.
  - A consortium of Cardiff and Vale University Health Board and its respective local authorities Cardiff and the Vale of Glamorgan.
- 1.4 Upon the announcement of this decision the emphasis of the evaluation shifted to understanding process and delivery elements, to *inform the shape of the future roll out* of IFSS across Wales.
- 1.5 The remaining chapters in this document describe:
  - The nature of the Integrated Family Support Service
  - The evaluation approach

- The Pioneer Areas
- The implementation of the IFS Teams and Boards
- The delivery of the IFS service to date
- The lessons and issues arising from our findings.

## 2: The Integrated Family Support Service

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- 2.1 This chapter sets out the background and legislative framework of the IFSS, provides a summary of the intended model and details the phased roll-out of the programme. The chapter draws upon the IFSS Practice Manual<sup>1</sup>.

### Introduction

- 2.2 In February 2010, the Children and Families (Wales) Measure<sup>2</sup> gained Royal Assent. The Measure provides the legislative framework through which the Welsh Government will take forward their commitment to tackle child poverty. The Measure focuses upon helping families most at need within Wales and one part specifically focuses upon the development of the Integrated Family Support Service (IFSS).
- 2.3 The IFSS model was designed to reform and invigorate health and social services delivery for vulnerable children and their families in Wales. The model was to focus on helping high need families where there was evidence of parental substance misuse combined with an increased risk to the child. The longer term aim was to roll out this service to include families where there was domestic abuse, mental illness and /or learning disabilities.

### Background to the model

- 2.4 The IFSS model drew heavily on the experiences of Option 2, a service funded by the (then) Welsh Assembly Government that works with families in which parents have drug or alcohol problems and there are children at risk of harm. It is a short (4 to 6 weeks) intensive intervention (with workers who are available 24 hours a day). Workers use a combination of Motivational Interviewing and Solution-Focused counseling styles as well as a range of other therapeutic and practical interventions.
- 2.5 The impact of the model in Wales has been evaluated.<sup>3</sup> These findings are summarised in Table 2-1 below.

Table 2-1: Key findings from Option 2 in Wales – extracts from the evaluation report

Positive confirmed findings	Areas for further investigation
Option 2 did <i>not</i> reduce the proportion of children who	We do not know the impact of Option 2 on child welfare.

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<sup>1</sup> Emlyn-Jones, R, Bremble, A, 'Integrated Family Support Services Practice Manual: Supporting the Pioneer Areas in Wales', IFSS Central Resource on behalf of the Welsh Assembly Government, August 2010.

<sup>2</sup> <http://wales.gov.uk/topics/childrenyoungpeople/poverty/childrenandfamilies/?lang=en>

<sup>3</sup> Final Report on the Evaluation of "Option 2", Prepared for the Welsh Assembly Government, Dr. Donald Forrester et al, 2007

Positive confirmed findings	Areas for further investigation
entered care	This is important because even an excellent service may inadvertently harm children if it prevents children who would benefit from care entering care
Option 2 significantly reduced the time children spent in care	Option 2 often appears to produce change for a period of time but some families return to previous levels of difficulties
The only group in which Option 2 increased the likelihood of care entry were children referred as “at risk” of going on the child protection register	... and so would longer periods or top-up interventions be helpful for some families?
	The contrast between service users’ perception of Option 2 and their views of “normal” social work was striking and suggests important lessons about skilful ways of working need to be learnt for diffusion into general practice

*Source: SQW summarised from the evaluation report*

2.6 The Option 2 approach has been considered more widely in a literature review by Forrester<sup>4</sup>, which reports that:

- Achieving changes with families with complex problems is difficult. Even skilled and professional interventions do not work for all families. However excellent the service, the intervention should not therefore be thought of as a “silver bullet” that will resolve the issues in all families
- The variations in the outcomes of different Integrated Family Preservation Services (IFPS) approaches highlighted the importance of the quality of the service being delivered.

2.7 The initial evaluation of Option 2 focussed for pragmatic purposes on the potential impact on children entering care. However, the limited number of interviews with families who had received the service in the last year suggested that the benefits of involvement with Option 2 applied to a variety of issues beyond care entry. In particular, families identified significant reductions in alcohol or drug related problems and a far more positive family atmosphere.

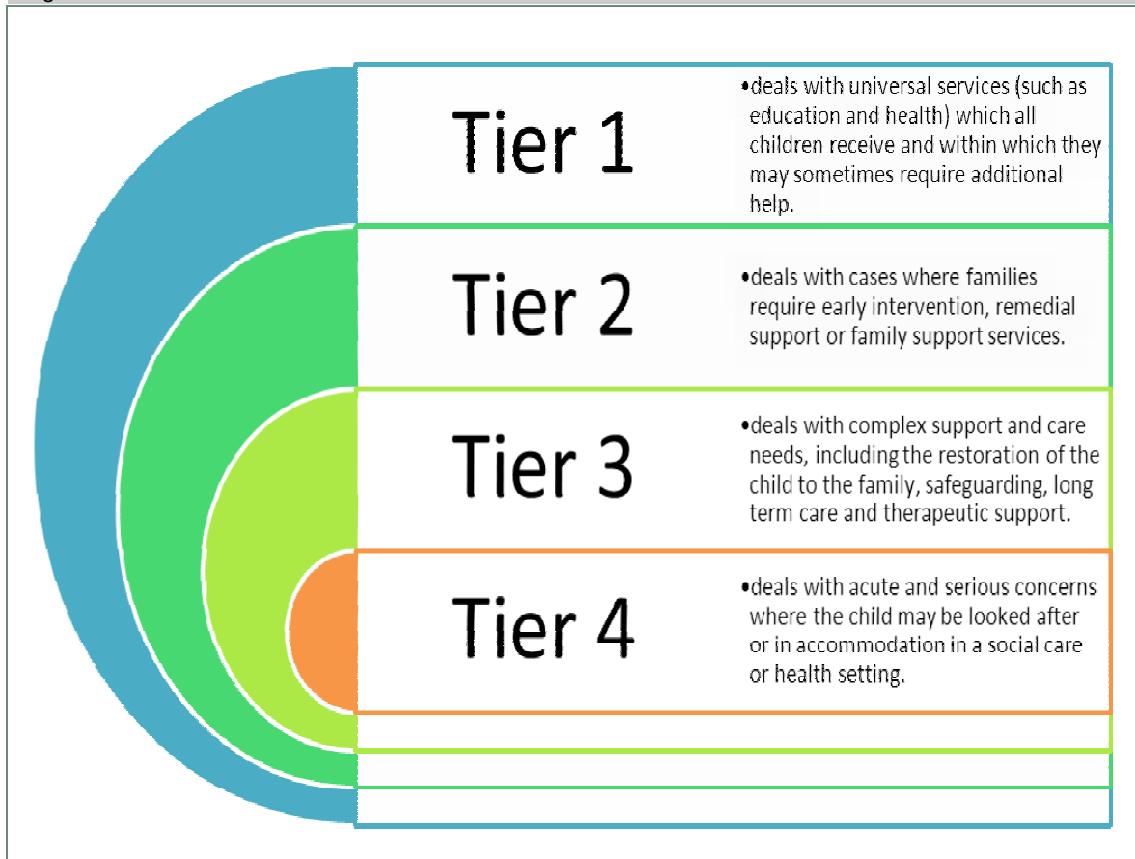
### ***IFSS: The model***

2.8 The IFSS Guidance specifies that the Service will deliver family focused services to enable parents to achieve the necessary behavioural changes to improve their parenting capacity, and will engage with the extended family in the process of that change. It is also seeking to address the social, cultural and organisational factors which have an impact on the safe care of the child or young person and their parents.

<sup>4</sup> What is the impact of care on children’s welfare? A focused review of the literature, Prepared for the Welsh Assembly Government, Dr. Donald Forrester et al, 200?; and The “Option 2” Model and Homebuilders: A Guide to support the IFS Teams Prepared for the Welsh Assembly Government, Forrester and Williams, 2010.

2.9 The IFSS programme is focused on supporting families with complex needs, where a child/children can be at risk as a result of parental substance misuse problems. The Welsh Government defined four 'tiers of need' in its ten year strategy for social services in Wales<sup>5</sup>. Figure 2-1 presents the four 'tiers of need'. As stated in the Measure (2010) IFSS is targeted at supporting families at Tiers three and four of need.

Figure 2-1: Welsh Government 'Tiers of Need'

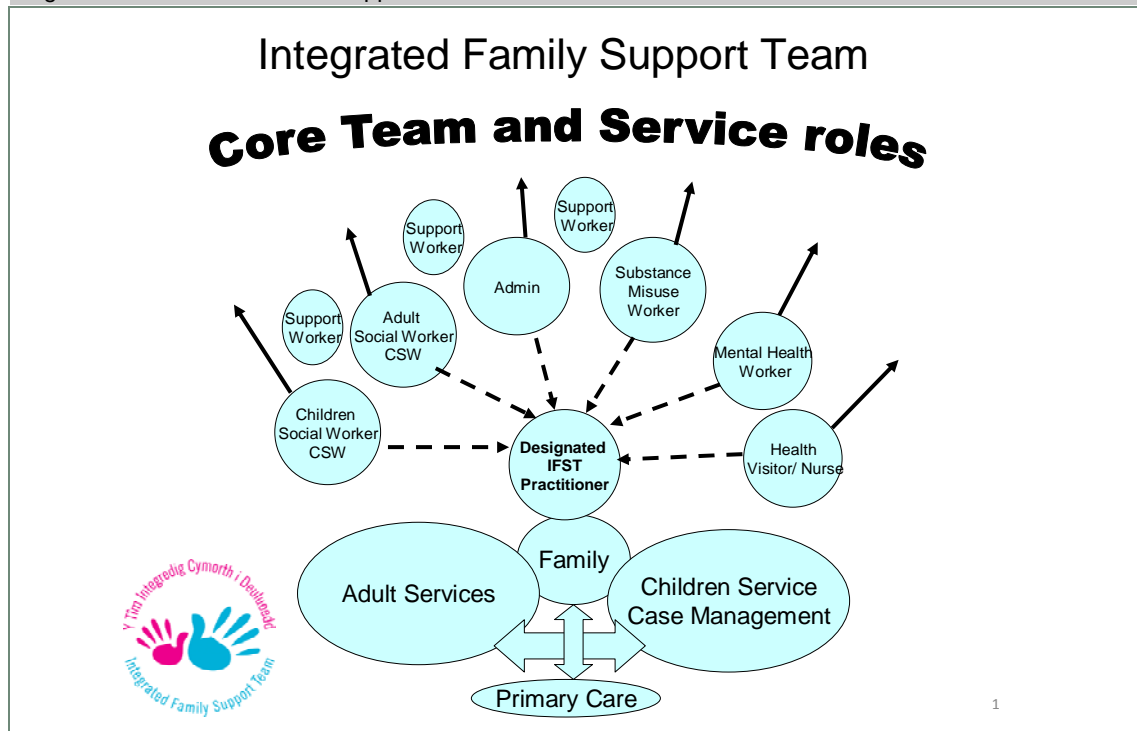


Source: Adapted by SQW from 'A Strategy for Social Services in Wales over the Next Decade: Fulfilled Lives, Supportive Communities', February 2007, Welsh Assembly Government

2.10 The Measure supports a key aspect of IFSS by placing statutory duties on both local government and their respective health board partners to take collective responsibility to ensure the integration and provision of seamless services to families with complex needs, where a child/children can be at risk (Tiers 3/4 of need) through IFSS. Figure 2-2 represents the IFST at the heart of the process brokering between the family and the children and adults social services.

<sup>5</sup> 'A Strategy for Social Services in Wales over the Next Decade: Fulfilled Lives, Supportive Communities', February 2007, Welsh Assembly Government

Figure 2-2: IFST as broker of support



Source: Welsh Government

2.11 The model is underpinned by a set of principles which require the IFSS to:

- Strengthen the safeguarding and welfare of children through restorative action to better support parents/carers
- Improve the quality of service experience by parents and children when they engage with professionals
- Be family focused and family centred
- Facilitate service change
- Be a resource to existing services
- Build trustful relationships
- Deliver holistic and intensive Evidence Based Interventions (EBIs)
- Provide a training resource to child and adult services on Evidence Based Interventions to engage complex families.

### ***The Integrated Family Support Team***

2.12 The Integrated Family Support Team (IFST) is a multiagency team which is intended to both deliver interventions to some of the most vulnerable and high risk families and support the development of a highly skilled workforce. In

each local area the service is being delivered by a newly recruited team. The team is employed by the local authority and reports to a board which comprises a range of partners including police and health services.

2.13 The Integrated Family Support Team (IFST), according to the guidance, is expected to offer five principle functions:

- Provide advice and consultancy to practitioners and agencies on engaging complex families with parental substance misuse
- Undertake direct work with families through the application of time limited family focused interventions
- Jointly with the case managers co-ordinate agencies, practitioners and others to access the services which the family needs (Family Support Functions)
- Spot purchase services not otherwise available
- Provide training on evidence-based interventions (EBIs) to the wider workforce.

### ***Target group***

2.14 For the purpose of the Pioneer phase of IFSS the target group for receipt of the service is defined in the Guidance as:

- Parent/s or carer/s of children in need where one or both parents/carers have a dependence upon alcohol or drugs
- AND
- Children in need, children in need of protection and children in care where the child's plan is to return home
- OR
- Expectant parents where one or both parent has a substance misuse problem that is likely to give rise to the child being in need of protection.<sup>6</sup>

2.15 In addition the guidance specifies the need for families to be identified as likely to derive benefit from such an intervention. The assessment of a family's appropriateness for referral should be made using the Assessment

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<sup>6</sup> The AND and OR have been added to the definition for clarity



Framework<sup>7</sup>. The Assessment Framework *'provides a systematic way of analysing, understanding and recording what is happening to children and young people within their families and the wider context of the community in which they live'*. Should the assessment indicate the family needs referral to IFSS it will also need to indicate the willingness and commitment of families to engage with IFSS teams.

- 2.16 The Guidance stipulates that referrals can only be made by the local authorities children services. To ensure that children in families where support is provided by adult services are not missed, local authorities need to ensure that they have arrangements in place to identify children who may be in need, or in need of protection, as a result of their parent/carer's substance misuse. Assessments will be made using tools and assessments which have been revised in accordance with the Measure including the Unified Assessment Process (UAP), Wales In-Depth Integrated Substance Misuse Assessment Toolkit (WIISMAT) and/or Care Programme Approach (CPA) for mental health. Should the assessment and initial contact reveal that a child is in need, or is in need of protection, as a result of the adult's needs then a referral should be made to children social services for an assessment.
- 2.17 Referrals to IFSS are screened for appropriateness, with regard to both the target group and also that a family focused intervention is appropriate and timely. Where agreement is reached between the IFST and the case-holding social worker to provide intervention for the family, a member of the team will be identified on the basis of the appropriateness of their core skills and availability.
- 2.18 Throughout the IFS intervention the case-holding adult and children's services will maintain responsibility for management of the adult's and/or child's case. The IFS Practitioner and the case manager/s are expected to work in very close collaboration for the duration of the IFS engagement.

### ***Direct work with families***

- 2.19 The direct work with families is structured around two phases.
- **Phase 1 Intensive Intervention** – Phase 1 is expected to last four to six weeks. However, the Teams in Pioneer Areas were tasked to test whether this length of engagement was sufficient. At the beginning of Phase 1 the IFS lead practitioner (Spearhead worker) works through a range of tools resulting in the identification of a set of Family Goals which is translated into a weekly plan of action for the remainder of

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<sup>7</sup> Department of Health, *'The Assessment Framework for Children in Need and their families'*, 2001, The Stationery Office.

Phase 1. At the end of Phase 1 the family, the IFS spearhead worker, and case coordinators for adults and children review progress against the goals identified for Phase 1 and agree a Family Plan which identifies the overall needs of the family. The plan also specifies how the authority proposes to respond to the full range of child and family needs, and the expectations of the other services and practitioners in accessing 'family support functions' to enable the family to make sustained change towards meeting the short and long-term family goals.

- **Phase 2 Maintaining the Family Plan** –During Phase 2 the family, IFS Spearhead worker and case coordinators for adults and children work together to provide the professional interventions that are deemed necessary for the family to remain in a positive process of change to meet the objectives of the Family Plan. Ongoing support provided in Phase 2 might include: counselling from alcohol and drug services; school mentoring for children; parenting self-help group; IFSS support work or wider workforce support; and/or support from wider family and friends. Whether or not the Family Plan includes direct IFS services the IFS spearhead worker should remain involved over the next 12 months to carry out a number of functions including: call and attend follow-up case reviews to record implementation of and progress against the Family Plan; make contact with the family at 1, 3, 6 and 12 months after the end of the intensive intervention (re-scaling family goals and recording progress and providing a written report to the referrer); and booster sessions when required. At the end of the 12 months of Phase 2 the family's involvement with IFSS will be marked with the completion of the final review forms.

### 3: The evaluation

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- 3.1 This section summarises the agreed research approach. This was the subject of considerable discussion between SQW, the Welsh Government and the IFSS Pioneer (Phase 1) areas, which reflected the complexity of the task and the changing policy landscape. The research approach was approved by the Research Ethics Committee for Wales in May 2011.

#### Research objectives

- 3.2 The research specification issued by the Welsh Government was clear that the purpose of this study was to develop an in-depth understanding of the impact IFSS had on:

- Practice and multi-disciplinary agency working
- The provision and outcomes of integrated family care for families where there is parental substance misuse alongside an increased risk to the child;
- The wider service system.

- 3.3 The specific objectives of the research as specified in the Invitation to Tender (ITT) were:

- Identifying whether the right people and the right numbers are being engaged through the Service – both client level and partners
- Understanding the nature of the wider system change and where further improvements are required
- Identifying the impact of the service on child, adult and family welfare
- Identifying the impact of the service on the welfare of children, parents and families compared to other options
- Analysing if the services make a difference to the services subsequently used by individuals
- Establishing the effectiveness of the pioneer area IFSS Boards in assessing and analysing local need and auditing provision; and comparing different approaches by the pioneer areas.

- 3.4 Following the issuing of the ITT, the Welsh Government amended its policy position. It was announced in March 2011 that IFSS would be rolled out

across Wales in the next few years. As such, the need for a comparative element to assess the effectiveness of IFSS (the fourth bullet point above) was withdrawn from the specification. The other objectives remained relevant, but the focus of the evaluation was more heavily on learning lessons to inform the intended rollout.

#### Evaluation approach

3.5 Given the need to evaluate both the approaches taken to develop IFSS and its impact, a two-pronged evaluation framework is being used. The two areas of enquiry are:

- *Process and implementation* – the process of setting-up and executing the programme and the subsequent cultural change that occurs as a result
- *Service delivery and outcomes* – the resultant service user engagement and subsequent outcomes that are experienced as a result of participating in the programme.

#### ***Study design: process and implementation***

3.6 This element was designed to capture the development process through which each of the areas progresses. In particular, it is gathering data on: the composition and organisation of each local team; and the approaches adopted to referral, intensive and on-going use of support. It also provides an opportunity to reflect on lessons learned through staff perceptions of key enablers and barriers. This includes analysis of the workings of the IFST, and its fit with wider structures as facilitated through each local authority and stakeholder partners. This information will provide a basis to guide future approaches in other areas.

3.7 Given the relatively limited number of areas it was important that the development in each area was understood fully to ensure that the full breadth of activity and experience was captured effectively. Therefore, an approach based around individual qualitative interviews and discussion groups, augmented by quantitative survey of staff time use and practice, was applied in all IFSS Pioneer Areas.

3.8 It is evidence gathered through this strand which forms the basis of the findings in this interim report. Details of the number of responses to the various routes of enquiry are contained in Table 3-1. The fieldwork was conducted between September and November 2011. The main focus was on the members of the immediate IFST, to focus on their motivations for joining and gather early feedback on how the model was operating. In addition,

interviews were conducted with a number of IFSS Board members which included Directors of Social Services, heads of Service (including Child Protection), the Police and a representative of the Voluntary and Community Sector.

Table 3-1: Numbers of consultees

Site	Total interviews conducted	No. of individual interviews with IFST	No. of people attending staff focus group	No. of interviews with IFSS Board members	No. of responses to staff online survey
Site 1	11	7	7	4	9 (100%)
Site 2	10	6	5	4	9 (82%)
Site 3	10	7	5	3	9 (90%)

Source: SQW

### ***Study design: service delivery and outcomes***

- 3.9 This strand of the project aims to evaluate the impact of IFSS on families via two methods, by:
- Quantitatively assessing the impact of IFSS on 'hard' outcome measures, as described below
  - Exploring qualitatively the way in which the IFSS interacts with families and how this interaction impacts on the achievement of positive outcomes for families.
- 3.10 Following in-depth discussions with the three IFSS pioneer areas and other key stakeholders, it was agreed to base the quantitative element of the study on routinely-collected administrative data augmented by commonly used validated tools for those families eligible for IFSS. Routine data is captured by family social workers, as well as associated data from schools, police records and hospital admissions.
- 3.11 The routine data is being augmented by asking all families eligible for IFSS to complete the Warwick Edinburgh Well-Being Scale and Strengths and Difficulties questionnaire. The three areas began using these tools in November 2011, and so no data are yet available for this report.
- 3.12 The qualitative work will involve a small number of case study families working in each site. The benefit of a qualitative, case study approach is that it helps us to understand in depth the outcomes that the IFSS has on the whole family, e.g. how an intervention leads to change and how the family dynamic alters over time. It will also gather perceptions of the service provision in their area, thus helping to answer elements of the process evaluation.
- 3.13 Case studies data will be collected from around 15 families in each site (c.40-45 in total) through:
- Face-to-face visits to each family on two occasions – once 4-5 months after commencing the IFS intervention (i.e. shortly after the intensive phase of IFS has completed), and at 14-15 months after commencement (shortly after families' one year follow-up interview with the IFS team)
  - Interim telephone discussions with the same families. These interim telephone discussions would take place 7-8 months after families commenced the IFS intervention.

## 4: The Pioneer areas

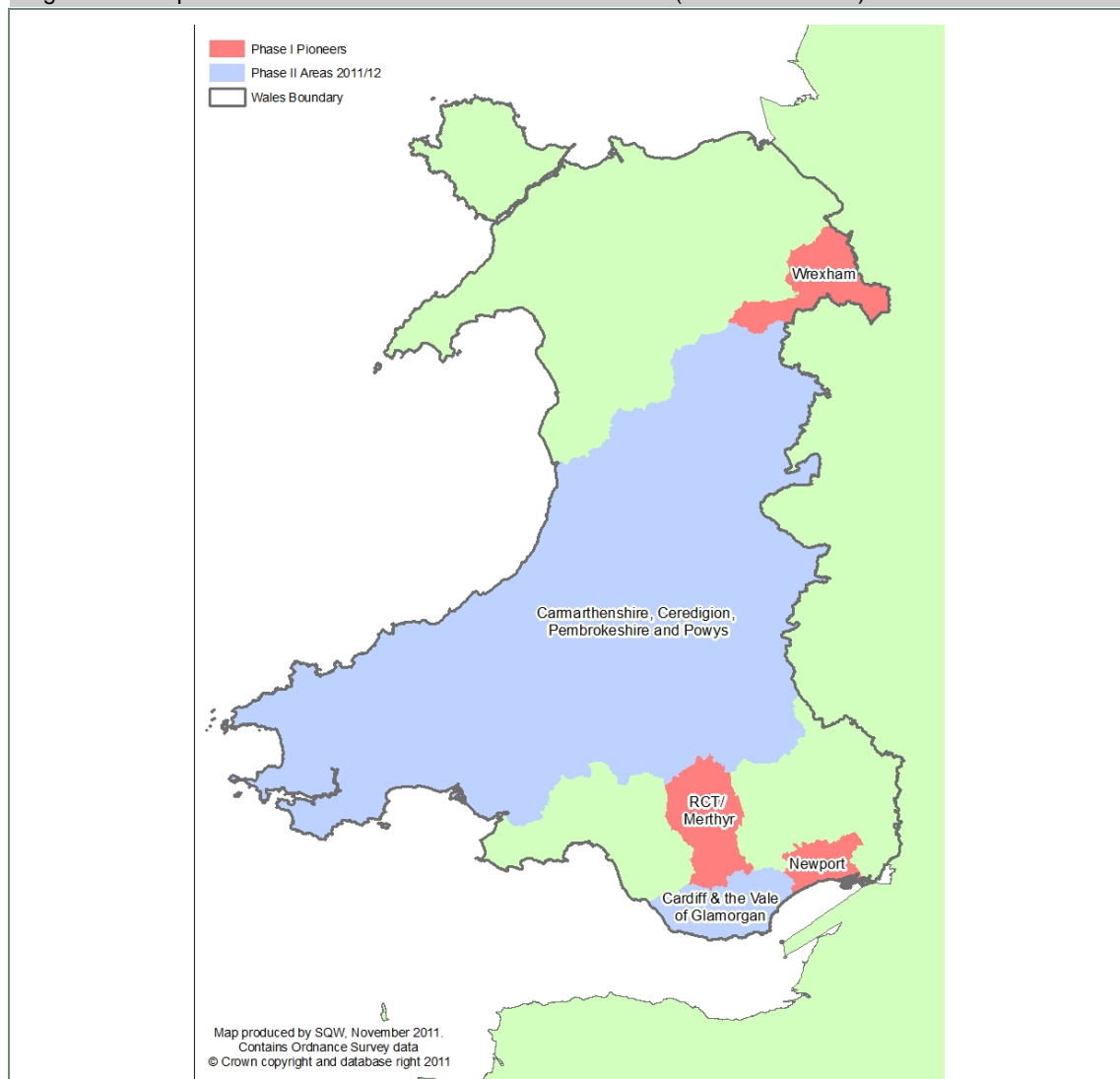
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- 4.1 The Chapter briefly details the context of the three Pioneer areas considering the scale of need in the areas and the rationale the given by each area for seeking to become a Pioneer.

### The IFSS Pioneer areas

- 4.2 There are three Pioneer areas in Wales – Newport, Rhondda Cynon Taff / Merthyr Tydfil (as consortia), and Wrexham. All are covered by the evaluation. These areas were selected by the Welsh Government following an invitation to all authorities to express interest.

Figure 4-1: Map of Phase I Pioneer Areas and Phase II Areas (announced 2011)



Source: SQW

- 4.3 It was anticipated that each IFST would support 100 families a year with families receiving 4-6 weeks of intensive intervention and then continued support as required for a period of a year. The extent to which the services can deliver this level of support will be dependent on the level of local need or demand for the service, the capacity of the team and also how flows of demand fit alongside capacity (in particular the team is unlikely to have capacity to deal with a sudden rise, yet conversely if it cannot deal with cases early then the time for the intervention to be appropriate may pass fairly quickly). Understanding the scale and nature of demand, and the ways in which the teams can cope with this will be a key element of the evaluation.

### ***Local need***

- 4.4 The target groups for the IFSS intervention are families with children in need, children in need of protection and children in care where the child's plan is to return home where the parent/carers of the children have a dependence on alcohol or drugs, and expectant parents where substance misuse is likely to give rise to the child being in need of protection. Whilst nationally available data do not identify the presence of substance misuse it is possible to identify the scale of 'demand' for the service in terms of the numbers of children in need. It should be noted that only snapshot data is available i.e. the total number of CIN on the 31<sup>st</sup> March in a given year. The scale of need may vary throughout the year so this data should be interpreted with caution.
- 4.5 We would also anticipate a high level of correlation between children in need and parental substance misuse. Estimates included in the published Substance Misuse Strategy for Wales (2008-2018)<sup>8</sup> included figures from the Hidden Harm report, which estimated that there could be as many as 17,500 children and young people in Wales living in families affected by parental drug misuse. The report estimated that 'Sixty four per cent of problematic drug using mothers and 37 per cent of fathers live with their children'. In addition it was estimated that some 64,000 Welsh children might be adversely affected by parental alcohol problems.
- 4.6 Table 4.1 provides a snapshot of the scale of CIN on 31<sup>st</sup> March 2011. The data reveal considerable variation in the scale of need in both real terms and as a proportion of the areas total age matched population. The extent to which parental substance abuse is a factor appears to vary even more.
- 4.7 Even with cautious interpretation the data suggest the scale of need varies considerably between the three Pioneer Areas. In the medium to long term

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<sup>8</sup> Welsh Assembly Government (2008) *Working Together to Reduce Harm; The Substance Misuse Strategy for Wales 2008-2018*. Cardiff: WAG



this variation may warrant review of the assignation of equal delivery targets across the three Pioneer areas, with numbers varied set in relation to the level of relative demand. However, in the short term as a new service it could be anticipated that there would be sufficient latent need/demand for support amongst the population to generate sufficient referrals. As the three Pioneers have broadly matched delivery capacity within their teams (detailed in Chapter 5) the flat delivery target across the areas makes sense for the time being.

Table 4-1: Children in Need, March 2011

	Total Children in Need	Rate per 10,000 population aged 0-17	Parental substance/ alcohol misuse present	% of cases with substance abuse as a factor
Merthyr Tydfil	530	435	15	3%
Newport	1035	320	400	39%
Rhondda Cynon Taf	1690	335	170	10%
Wrexham	960	340	285	30%
Wales	19710	315	3,975	20%

Source: SQW Analysis of Statistical Directorate, Welsh Assembly Government Data

### ***Pioneers rationale for engagement***

- 4.8 Many local authorities applied to become IFSS Pioneers. From the three which were successful, and so are the focus of the evaluation, the decision to bid was driven by concern about the growing demand from families facing complex challenges, in particular those facing substance misuse issues. Furthermore, all areas reported increasing levels of referrals to social services and children designated as children in need, children in need of protection and looked after children. Therefore, their local circumstances mirrored the wider national context, and so they too had identified a need to develop more effective early intervention to support families to avoid the need for high cost interventions at a later time.

## 5: Implementing IFSS

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- 5.1 This chapter details the arrangements that the three Pioneer areas have put in place to deliver IFSS. It sets out the nature of the Integrated Family Support Team (IFST) and Board in each area, as well as how the IFST has been recruited and trained.

### The IFST in the Pioneer Areas

#### ***Team composition***

- 5.2 The IFSS Guidance specifies that the IFST must have a core team of five multi-disciplinary professionals who are from one of the following professions: social work, nursing and health visiting. One of the team should be designated a Consultant Social Worker (CSW).
- 5.3 All three Pioneer Areas have a CSW in post: in Site 3 there are three in post, in Site 1 there are two and in Site 2 there is one in post. The CSWs in post are all highly experienced ranging from seven years to 19 years of experience and an average of 13 years of experience.
- 5.4 The different number of CSWs in each Pioneer will be an area of interest as this high level post is likely to give areas access to high level skills. However, the CSW is also expected to undertake a wider range of duties (such as practice development and research) but spend more than half of their time on direct case work. As such there may be a tradeoff between the higher level and more expensive CSW against the greater direct client support undertaken by other IFST practitioners.

Table 5-1: Pioneer Site IFST composition

	Site 1	Site 2	Site 3
IFST Manager	1	0.7	1
Consultant Social Worker	2	1	3
IFST multi-disciplinary professional	6	6	7
IFS Support Workers	0	1	0
Independent Reviewing Officer (IRO)	1*		0.5
Admin Support/ Performance Management	1	2.5	2
Total	10	11.2	13.5

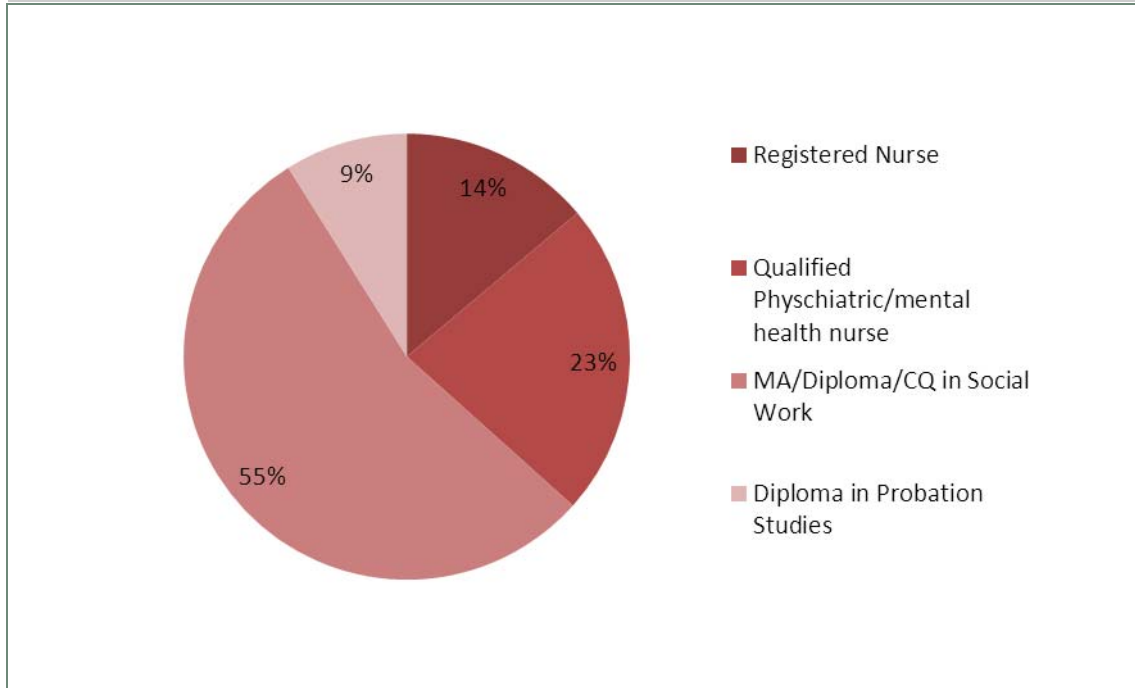
The Site 1 team have access to an Independent Reviewing Officer (IRO) who is based in the Reviewing Team in the Local Authority

- 5.5 The teams are dominated by those with a background in social work. Over half (55%) of the IFSS staff members responding to our online survey in October 2011 were qualified social workers. Qualified psychiatric/ mental health nurse made up a quarter of the staff, 14 % were registered nurses and nine per cent held a Diploma in Probation Studies.
- 5.6 All three Pioneer areas have team members with social work and psychiatric/mental health backgrounds and qualifications. However, there is variation within the teams regarding representation of staff from particular disciplines. In Site 2 they do not currently have a health visitor in post as their seconded health visitor opted to return to their health visiting post. Site 3 has recently appointed to the health visitor position which had been vacant for six months. Although it is not a requirement of the teams in Site 1 there is no representation from probation within the team, whereas in both Sites 2 and 3 secondees from the Probation service have been appointed.
- 5.7 All three Pioneer Areas feel that they generally have the right skill mix in place now, with the exception of Site 2 which is seeking to appoint to the vacant health visitor post.<sup>9</sup>
- 5.8 The team highlighted important learning points, which reflected issues that they had come across. Similar issues may arise in other areas depending on local context. The key issues highlighted were:
- A potential need was highlighted for the **inclusion within the teams of an adult learning difficulties specialist**. This need reflected that many of their clients had learning difficulties and the team thought that a greater understanding of this condition would have helped when working through the IFSS materials.
  - Site 2 also noted the need for a **social worker from adult services in the team** in order to fully meet the needs of families.

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<sup>9</sup> Since drafting the report, this post has been filled.

Figure 5-1: Breakdown of professional qualifications of IFST members



Source: SQW Survey of IFSS Staff 2011 n= 22

5.9 The guidance specifies five key components of the CSW role within the IFST. These are to provide:

- Expert Practice - at least 50% of the CSW role should be spent on direct work with the children and families referred to the Integrated Family Support Service (IFSS)
- Leadership and Consultancy - to complement the operational management of the IFST with an emphasis on practice development by example and through mentorship of practitioners
- Practice and Service Development –ensuring practice is evidence based and contributing to the service in operation
- Education Training and Development – include responsibility for education and training in respect of the evidenced based interventions (EBIs) recommended by IFSS within the IFSS and to those mainstream services in health and social care with which the IFST interfaces
- Research and Development - ensuring that the IFST is aware of the most recent research evidence, and developments that can be effectively applied within the functions of IFST and shared with practitioners/service manager who have a direct interface in supporting IFST to fulfil its functions.

5.10 In interpreting how to support the CSW to ensure that practice is evidence based and that the IFST is aware of the most recent research evidence, the

Pioneers have adopted different approaches. In Site 1 and Site 3 this requirement has been addressed by enrolling the CSWs on MSc courses in Advanced Social Work Research and Practice. In Site 2 links have been established with the local University and a joint article for a professional publication will be submitted by the end of March 2012. From April 2012 onwards the CSW in Site 2 will continue to produce research of practical benefit to the IFST.

- 5.11 Responses to the survey of IFST staff suggested that the balance of the CSWs activity may not be in-line with the guidance across the board. The proportion of CSW time spent in the last week in direct work with children and families ranged from five per cent to 55 per cent, averaging 33 per cent. Overall the majority (53%) of CSW time in the week preceding the completion of the survey was spent on agency tasks (admin, team meetings, training etc.).
- 5.12 However, there was a general sense of **uncertainty about how the CSW role should evolve**, especially as the model evolves and becomes mature and widespread. It may be that the balance between roles will change, perhaps becoming more operational. This should be reviewed through the coming years of the evaluation.
- 5.13 Almost two thirds (64%) of IFST staff (excluding administrative staff) have amassed 11 years or more experience post qualification. A further 18 per cent have six to ten years of experience and 18 per cent have three to five years of experience.
- 5.14 Overall, the Pioneer Areas appear to have recruited teams which are appropriately qualified and highly experienced. Although the teams are broadly happy with the mix of skills available to meet the needs that they are encountering, one or two additional specialist needs are beginning to emerge, especially in relation to working with parents who exhibit learning disabilities.

### ***Recruitment of staff***

- 5.15 The Pioneers experience with regards to the recruitment of staff has varied, with two broad approaches being taken. Originally both Sites 2 and 3 anticipated recruiting some staff on short-term secondments of around six months with the expectation that they would be trained and develop practice and then return to their original service taking with them the skills and approaches learnt and developed within the IFST. Sites 2 and 3 began their recruitment process in the summer of 2010. Both Sites 2 and 3 have experienced similar challenges with regards to recruitment: needing to advertise some posts repeatedly and receiving less than enthusiastic

responses to advertised posts. Sites 2 and 3 have experienced relatively high levels of turnover in the first 12 months of operation with both areas experiencing the departure of the IFST Manager, causing understandable disruption to the wider team as well as the departure of one or two team members and some long-term sickness.

- 5.16 In contrast the Site 1 Pioneer began their recruitment process in May 2010 with interviews held in June and July 2010. A rigorous recruitment process was adopted, incorporating an assessment centre comprising interviews and various skill and psychometric tests, which staff noted was challenging and to some extent daunting but on reflection gave them confidence that they had the right skills to do the job.
- 5.17 Sites 2 and 3 both experienced issues recruiting to the CSW posts. In Site 2 none of the staff recruited (excluding the secondees) were working within Site 2 prior to joining the team. This has brought some benefits and some challenges; it means the team is fresh and not overly tied to their 'home' agencies' but it has also meant that the team has had to work hard to establish relationships with wider services. In contrast to the experience in Site 2, in Site 1 all but one member of the team was working in the localities prior to joining the IFST which is viewed by the team as beneficial as they know the area, have local networks and know the people in the agencies they are working with.
- 5.18 Across the three areas the reasons staff were attracted to the role were remarkably similar. They identified the opportunity to:
- Work more intensively with families, focused on solutions
  - Try a new approach and work within a multi-disciplinary team
  - Join a new team and work out the new approach together as a team.
- 5.19 Perhaps reflecting the high levels of experience across the teams, a strong desire to be freed from working within 'silos' and an opportunity to have 'time and space' to work with a family to address the breadth of the challenges they face, was voiced by staff. The knowledge some had of Option 2 also positively influenced some staff to apply.
- 5.20 These experiences present **a number of issues which should be borne in mind when recruiting more widely for the service roll-out.** Two of the three areas have experienced issues recruiting staff, which has had implications for delivery. However, whilst it is not the only factor Site 1's investment in the recruitment process appears to have supported the establishment of a stable team. When setting up a new team and establishing

a new service recruitment delays and staff turnover can be very disruptive. As such, investment in the recruitment stage would be well placed.

5.21 Looking forward, two other, inter-related points emerged which should influence future recruitment:

- The **difficulties in attracting suitable applicants**, especially local may be overcome in future if the Pioneers are perceived to be successful. Harnessing stories of positive work and staff could help in this regard (and some emerging messages are highlighted through the evaluation at the end of Chapter 6)
- At the time of the initial recruitment it was reported to be **difficult to develop full job descriptions** due to uncertainty about exactly what would be involved. This should be less of an issue in future and could be an area where collaboration between the Pioneers would be helpful to those who follow.

#### The IFSS Board

5.22 Section 61 of the Measure 2010 places a duty on the Pioneer Areas to establish an Integrated Family Support Board (IFSB or the Board). The statutory objectives of the Board are to:

- Ensure the IFSTs deliver an effective service
- Promote good practice by the local authorities and Local Health Boards (LHB) participating in the teams in respect of the functions assigned to the Teams
- Ensure that IFSTs have sufficient resources to carry out their functions
- Ensure that the local authorities and LHBs participating in IFSS co-operate with the IFSTs in discharging the Teams' statutory functions.

5.23 The Board membership must include:

- the Director of Social Services
- the lead Director for Children & Young People's Services (where the Director of Social Services is not the lead Director for C&YP Service)
- the lead Officer for Children and Young People's Services from the LHB.

5.24 It was also expected that Board membership should include:

- Senior representatives from Education and/or Inclusion

- Senior representatives from Housing
- Director of Primary, Community and Mental Health Services
- Senior representation from Youth Offending Team and/or Probation Services or Police.

5.25 All three Pioneer Areas have established IFSBs, which are now meeting regularly. In Site 2, the IFSS functions of the Board have been combined with governance requirements for Families First.<sup>10</sup> In Site 3, the remit of the Board also covers four other integrated teams: the Family Support Team (FST); the Family Assessment and Support Service (FASS); the Substance Misuse Team (SMT) and the Early Intervention and Prevention Service (EIPS).

5.26 The Board composition and scale varies considerably between the Areas. Site 1 Board comprises representation from both local authorities but is relatively tightly focused with ten members. In contrast and reflecting its wider remit, membership of the IFSB is very broad in Site 3 comprising 25 members. Site 2's combined IFSB and Families First Board comprises 17 members including representation across Site 2 and neighbouring authorities.

5.27 The breadth of membership in Site 2, and especially Site 3, is in-line with IFSS guidance which gives the option to Areas to widen the sources of expertise on the Board beyond those specified and indeed both incorporate representation from neighbouring local authorities who are able to operate as *critical friends*. However, the functioning of the Boards at this scale should be monitored to ensure attendance is consistent and the scale does not hinder decision making in the future. The apparently more focussed membership in Site 1 provides a useful contrast going forward.

5.28 In all three areas the Boards are supported by an Implementation/Operational/Steering Group. The Implementation/Operational/Steering Groups are focused on managing and supporting the operational delivery of the IFSS including issues relating to staffing, throughput and performance, partner engagement and support.

5.29 The IFSS Pioneers were tasked to put in place a Section 58 agreement, which sets out the services that will be included within the 'Family Support Functions' available to the IFST in each area. The Section 58 agreement is a record of the services being provided by partners, the level of resources and objectives for the IFST. To date none of the Pioneer Areas have agreed their Section 58 agreement. The delay in finalising the agreements appears to

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<sup>10</sup> Families First is a Welsh Government initiative which is a major contributor to the Child Poverty strategy and Site 2 leads the north Wales Families First Pioneer site in partnership with Flintshire and Denbighshire.



have arisen as a result of uncertainty relating to the understanding and interpretation of the Section 58 requirements. It appears that the Areas were expecting further guidance from the Welsh Government, that the Government was not expecting to supply.

- 5.30 That said, all three Pioneers report that their Implementation Groups are proving effective mechanisms for resolving issues to date and so far there has not been need for escalation of operational issues to Board level. They also report goodwill at Board level. This good level of partnership working was seen to reflect: the relations between the individuals involved; and a general desire to support IFSS. **If this good level of operation can be maintained then it may be that the need for a Section 58 agreement is much less than expected.** That said, as time goes on it is possible that unforeseen challenges will arise and so the continued functioning of and liaison between Boards, Implementation Groups and IFSS and wider services will be a key feature in future years of the evaluation.
- 5.31 A number of the services are subject to external inspection. It was commented that **the increased use of multi-professional inspection might re-enforce and enhance cross agency working**, without the need for further formal agreements.

#### Training

- 5.32 The IFSS model is based around the use of motivational interviewing techniques and other evidence based tools including Brief Solution Focused Therapy (BSFT) and Cognitive Behaviour Therapy. The guidance highlights the need for 'implementation fidelity' (delivering the intervention in the way it was intended) in order to deliver these approaches and use the tools effectively. To this end, all IFST members are required to attend training in the use of MI and BSFT within complex families.
- 5.33 The Welsh Government has provided training for the IFSTs and all the Core Team members attended a four day training course.
- 5.34 In order to fulfil their remit to spread learning and understanding of IFSS the Pioneer Areas are required to train sufficient members of the IFST as accredited trainers in motivation interviewing and other techniques. Staff in each team have been trained as trainers and have already begun delivering training to wider staff in the areas.

#### ***Staff feedback on the training***

- 5.35 The training undertaken by the members of the IFST in the early stages of IFSS was considerable. It incorporated an initial four days training about the

IFSS approach (including motivational interviewing), plus a range of additional modules, and written submissions to secure accreditation.

5.36 In general, the **IFST members gave positive feedback about the training**, finding that it enthused them for the job ahead. However, whilst staff welcomed the approach, the training did raise some concerns:

- Some staff reported that the training was daunting because although they were experienced practitioners in their field they were all novices in this approach. This was not necessarily a negative, rather just a reflection of the change and challenge that they had taken on, but perhaps needs to be explained and handled sensitively with future participants
- Some concern was raised about the scale of training required with staff noting that the accreditation requirements are quite onerous, and that they had not anticipated needing to do quite so much
- Some concern was also raised about the extent to which all members of the IFST should be required to complete the full four day training. There was a difference across two sites, reflecting different expectations. In one site the view was that administrative staff had benefited from attending as it helped them understand the wider work of the team. Yet in another site it was thought that administrative staff should not attend. This latter site thought that administrative staff were in effect being trained to become IFSS practitioners, which we understand was not the case and so probably reflects a communication issue.

5.37 It was also noted that **completing the training was one thing but putting it into practice is another**. It was felt that the learning continues beyond the training room. Staff generally felt that the training did prepare them sufficiently to get started but that they have had to draw significantly upon their previous experience. It was emphasised that the current approach to training had been appropriate, but only because staff had this wider grounding. This would reinforce the requirement in the guidance for all IFSS practitioners to have at least three years post qualifying experience. In future, and especially as the IFSS workforce has to grow to cover the whole of the country, **there will be a need to consider if a longer course will need to be developed to support less experienced practitioners become ready to adopt the IFSS approach**.

### Informing wider services

- 5.38 The IFSTs were established as new, well-funded teams who would be delivering a new approach to working with the most complex families. The teams have been afforded considerable time to invest in training and team development, and will have time and resource to work intensively with families over a sustained period without case-holding responsibilities
- 5.39 However, the teams also experienced initial scepticism and resentment from mainstream services largely arising from mis-understanding how the IFSTs would support mainstream and other services to support their families. The tension was increased by some apparent jealousy about the resources available to IFST members, e.g. having ipad, etc. These issues simply emphasise the importance of the teams taking time to explain fully their responsibilities and how they can provide an additional resource but not replace existing services, and to build personal relations with wider services.
- 5.40 The IFSTs have worked hard over the last 12 months to address the awareness and understanding of the service, particularly within the referring partners of Children's social care teams. A number of lessons are apparent from this experience:
- **Location matters** – the Sites 1 and 3 IFSTs are based on a business park away from other children's services teams, as were the Site 2 team initially. This meant that the teams were less likely to make ad hoc contact with the wider referring and support services which limited familiarity and awareness. The Site 2 Team have since moved to offices in the main Council building alongside other Children's Services teams, and as such, are able to make more frequent contact with other services, service colleagues can pop in and ask questions of the team and team members report increases in referrals since the move and think this is linked to familiarity and accessibility.
  - **Relationships matter** – The IFST have invested considerable time introducing themselves to referral and support teams. They have attended team meetings, presented on the role and remit of the service and fed information through Head of Service. The Management Steering/ Implementation Groups have proved important in this role but the importance of informal contact is also highlighted by the IFSS staff. They note that being available to discuss potential cases with referring social workers and providing advice and guidance on approaches which could be used is invaluable in building relationships and trust which results in referrals.

5.41 The **feedback from the IFS teams suggested some particular points of emphasis that could help to build these relationships**. Building on their experiences it would seem that it is important to show how IFSS can be an additional resource and add value over and above standard services, which they suggested was through:

- **The amount of time that they could spend on each case** compared to standard social work practice
- The IFSS approach **focussing on working with the family to achieve agreed goals**, rather than a deficit approach which focussed fixing on 'what was wrong'.

## 6: Delivering IFSS

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- 6.1 This chapter explores the delivery profile and experiences of the IFSS Pioneer areas in the first year of operation. We consider the IFSS delivery in each of its component stages: referrals and acceptances; Phase 1 Intensive Support; and Phase 2 Maintenance. Finally, this chapter considers how IFSS is working with wider provision and the experiences of staff.

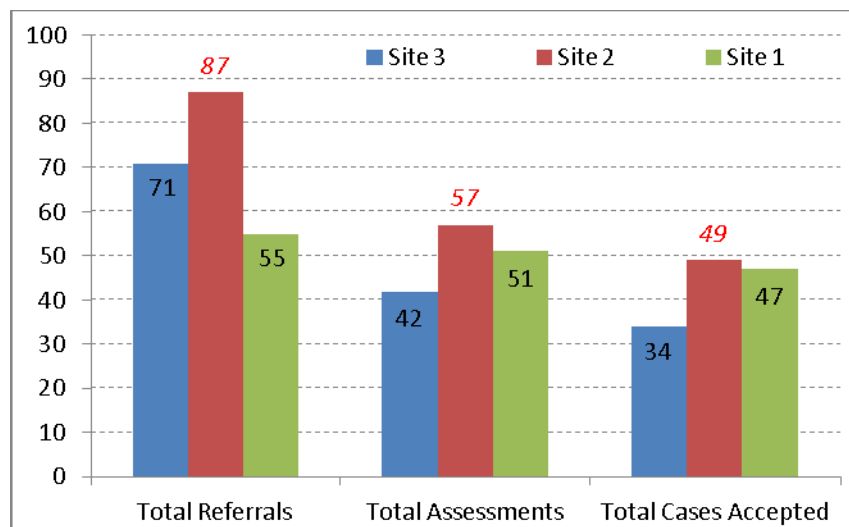
### Referrals and acceptances

- 6.2 Based on modelling work by WAG there was an expectation that the Pioneer Areas would work with 100 families per year. From the outset this expectation was met with some wariness by the Pioneers. They recognised that although latent need /demand for the service may have been high; the capacity of the team; and the time needed to recruit, train and build awareness and understanding of the service amongst referral teams would limit the delivery potential. Together these factors would mean that, at least in the first year, the programme would see a high level of demand (assuming referral mechanisms worked well) but constrained supply of IFSS practitioners.

### *Throughput to date*

- 6.3 In the first year of the programme, to end of August 2011, a total of 213 referrals were made to the service across the three Pioneer Areas. The highest proportion (41%) of these was in Site 2 with 87 referrals made. A total of 150 referrals (70%) progressed to the initial IFSS assessment, meaning that the referrals were deemed in line with the criteria and appropriate for assessment. Site 3 experienced the lowest proportion of referrals suitable for assessment. They reported receiving a large number of enquiries and referrals in the early stages of the programme when the service was less widely understood. From the 150 assessments, 130 cases were accepted onto the IFSS programme in the first year. This accounts for 43% of the anticipated 300 cases across all three pioneer areas.

Figure 6-1: Referrals, assessments and cases accepted to August 2011



Source: SQW analysis of pioneer site data

- 6.4 Table 6-1 details the throughput of the IFSS within the Pioneer areas in the first 12 months of delivery. Referrals to IFSS are made by caseholding social workers in children's services. IFSTs report that initial referrals were frequently inappropriate but that over the course of the year as understanding and awareness of the service has improved the appropriateness of the referrals have improved. To achieve this improvement **the IFST staff have spent considerable time attending social work meetings to build wider relationships and understanding of the programme.** This highlights the point made in the previous chapter about the importance of the IFST building relationships and understanding with existing services.
- 6.5 Although the data suggest that the referrals in Site 1 are almost always appropriate there is need for some caution in the interpretation of the data as areas have highlighted that the three Pioneers are in many cases using different definitions. For example in Site 1 inappropriate referrals are filtered out before being counted as a formal referral to the IFSS. The Pioneers have raised concerns about the variation in the definitions used around data reporting and are working together to identify consistent definitions.

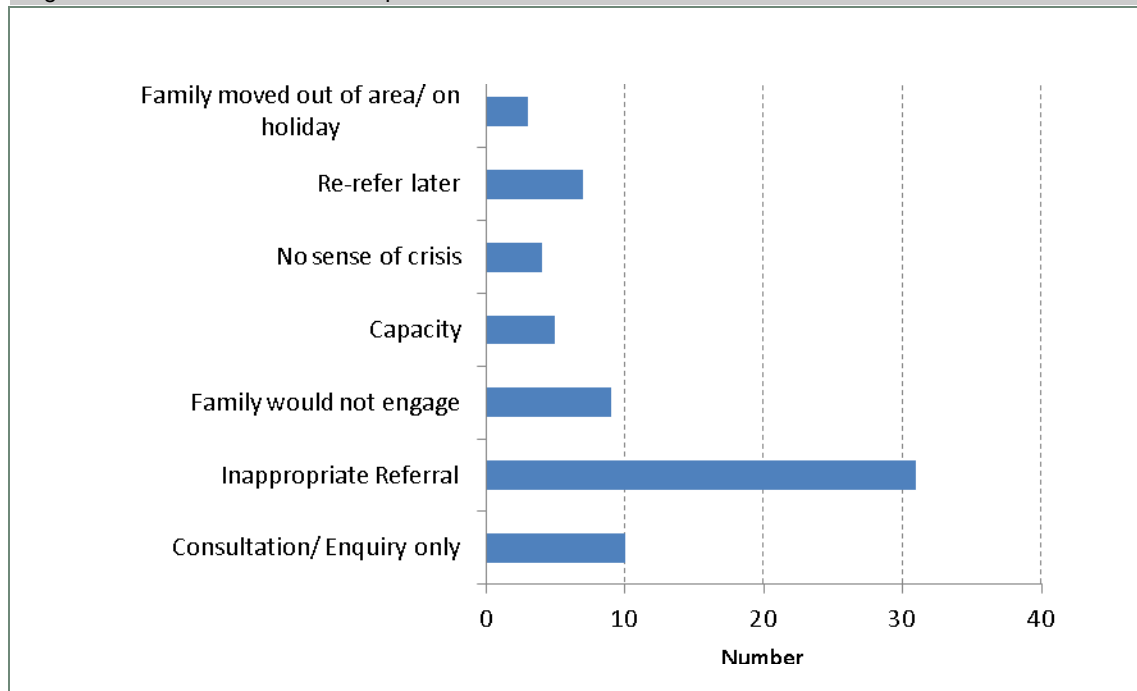
Table 6-1: IFSS Throughput to date

	Site 1	Site 2	Site 3
No of Referrals	55	86	69
No of referrals deemed inappropriate	4	20	22
No referrals unable to progress due to capacity issues			5
No of referrals progressing to 72 hr assessment	51	66	42
No of cases accepted to Phase 1	49		34
No of families completing Phase 1	43	26	20
No of families completing Phase 2	0	0	0

Source: SQW analysis of pioneer site data

- 6.6 The available data shows (Table 6-2) that the most common of reasons for non-acceptance was inappropriate referrals where the family did not meet the IFSS criteria, both as defined in the measure and then interpreted locally. This included an issue around timing and the definition of crisis, that we return to below, but also cases where for example the substance misuse issue was with the young person not the parent.
- 6.7 Despite the lower than anticipated numbers a few cases were still rejected due to a lack of team capacity at that specific point in time. It will be important to track if capacity issues grow as the service becomes more established which could lead to social workers being more likely to refer to it. This will also help to inform any future judgement about the possible capacity of a team. Even allowing for a settling in period during year one, **the indications to date would be that, the initial figure of 100 would not be attainable.**

Figure 6-2: Reasons for Non-acceptance



Source: SQW analysis of pioneer site data

Note this data is not reflective of all cases as a reason was not always recorded.

6.8 Understanding why referrals were inappropriate requires consideration of the criteria and how readily these can be communicated to social work teams who are expected to refer in to IFSS. For the pioneer phase, the Guidance specifies that the regulations are limited to the following areas:

- Children in need, children in need of protection and children in care where the child's plan is to return home

AND

- Parent/s or carer/s of children in need where one or both parents/carers have a dependence upon alcohol or drugs

OR

- Expectant parents where one or both parent has a substance misuse problem that is likely to give rise to the child being in need of protection.

6.9 In addition to the criteria specified above the IFSS Practice Manual notes that an additional high level risk category is: "where a family is at a point of crisis and where the children in that family are likely to become looked after by the local authority (including unborns)."

6.10 This framework for target families leaves considerable scope for local areas to determine their own ways of working depending on local needs. Defining 'crisis' has proved problematic for the IFSS Pioneers who have reflected on



whose definition of a crisis should be used: that of the social worker; social work thresholds; or the families. **As the programme has developed the teams noted that they have increasingly come to the view that the 'crisis' should be defined in terms of the family experience rather than that of the social care services as determined by social care thresholds. Staff report that this is when families are most receptive to working with the IFST**, and by providing support at an earlier stage the intervention is able to 'get families back on the right path' before the challenges become insurmountable.

6.11 This point of definition raises several interesting issues:

- **Timing matters.** One area explained that they had stopped operating a waiting list as this built expectations amongst social workers and families. Rather, when capacity became available they would support the 'most appropriate' case, as some families may have moved beyond a point of being helped, or more urgent issues may have arisen
- **Judgement matters.** IFSS is not for all and it may be that the practitioners could develop a guide based on their experience to help future workers identify appropriate cases. This could form part of the initial training
- **By implication some families are 'too difficult / too far gone' for IFSS.** This may be true, but if so it raises the question of what else can be offered to this group.

6.12 IFSTs and wider service teams reflect that definition of crisis may result in the need for children's services to take on higher numbers of Children in Need (CIN) as this status means that a case holding social worker is allocated from Children's Services. Previously the family may have been supported through Adult Services, however at present only a child's case holding social worker can refer to IFSS. Before that it was commented that it was important as part of establishing IFSS to engage Adult Services and ensure that they took a wider view of the family unit than they often did. This required significant time, and has to recognise the extent of cultural change required by adult social workers. It will be important in later stages of the evaluation to understand how far these changes in the workings of Adult Services have been required and delivered, and this in turn may influence future guidance about referral routes in to IFSS.

- 6.13 The guidance supports the inclusion of CIN as well as children on the Child Protection Register (CPR) and Looked After Children (LAC)<sup>11</sup>. Table 6-2 summarises the legal status on referral of families supported by IFSS Pioneer Areas in the first 12 months of delivery.

Table 6-2: Legal Status of Families supported

	Site 1		Site 2		Site3	
	No.	%	No.	%	No.	%
LAC	10	17	11	22	6	14
CPR	30	50	14	29	22	52
CIN	20	33	24	49	17	40
Total	60	100	49**	101%	42*	106%

\*3 families were both CPR and LAC

\*\* 8 further families were a combination of two of the three categories

- 6.14 Around 40% of the families supported have been CPR and a similar number CIN. Anecdotal reports from IFST staff and representatives from wider services suggest a sense of increased success with families with CIN status rather than CPR or LAC. Staff report that they feel they are interacting with the family at an earlier stage of concern and are able to work with the family to prevent issues escalating. However, Site 3 has chosen to focus on avoiding children becoming LAC and so has sought to focus on preventing this from occurring. If maintained this should be more apparent in the figures in the next period, and will provide a contrast to the others areas which are adopting a different definition of crisis.

### ***Phase 1 – Intensive Support***

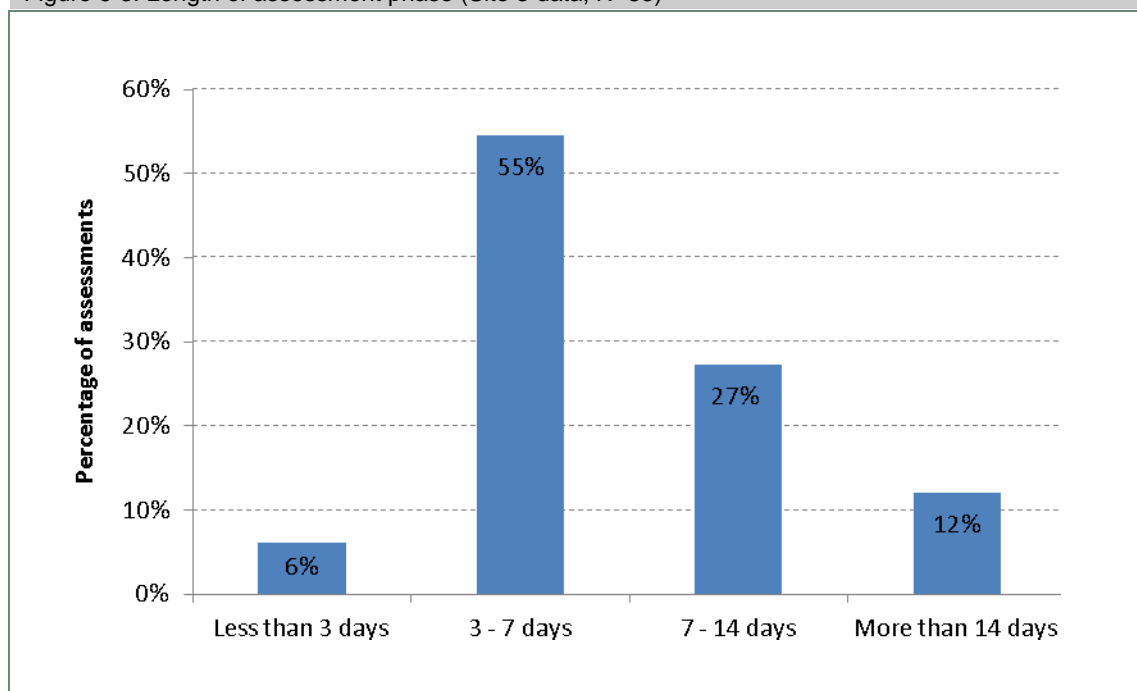
- 6.15 This section provides an indication of the IFSS delivery, reviewing whether each stage of the delivery follows the recommended patterns and the lessons that emerge from this. Data is not available in a consistent form across the areas, and so we have presented the data that is available, and added qualitative comments on the other areas to supplement this.
- 6.16 IFSS is designed as a responsive and timely intervention. The Guidelines indicate that within 72 hours of the referral being made, an assessment will be written up by the IFSS spearhead worker to ascertain whether the family is able to work with the IFSS. There is cause to believe that there is some

<sup>11</sup> Integrated Family Support Services: Statutory Guidance and Regulations, Welsh Assembly Government August 2010

fluctuation in the time taken by IFSTs to complete the 72 hour assessment. Figure 6-3 shows that in Site 3 only 6% of cases are assessed within the first 72 hours, with just under two thirds (61%) being assessed within the first week and 88% assessed within the first two weeks. That so many cases take more than one week is potentially concerning given the situation of some of these families, and this becomes much more concerning for the 12% of cases that took longer than two weeks to assess.

- 6.17 On the other hand, in some cases the delay relates to the readiness of the family, which is not thought ready to go at 'full pace' to start with, even although they are seen for the first time within the recommended 24 hour period. While understandable, it does question the overall suitability of the family for IFSS and is an issue that should be explored further in the coming years.
- 6.18 **It is important that referral routes are as efficient as possible to ensure that capacity is maximised and families are supported quickly.** The original referral process in Site 1 passed a referral from a case holding social worker to their social work team manager and then onto the head of service before being passed to the IFSS Manager. However, this process resulted in delays in referrals being accepted and passed to the 72 hour assessment in sufficient time. Subsequently the head of service has been removed from the review chain and referrals pass directly from the social work team managers to the IFSS Manager.

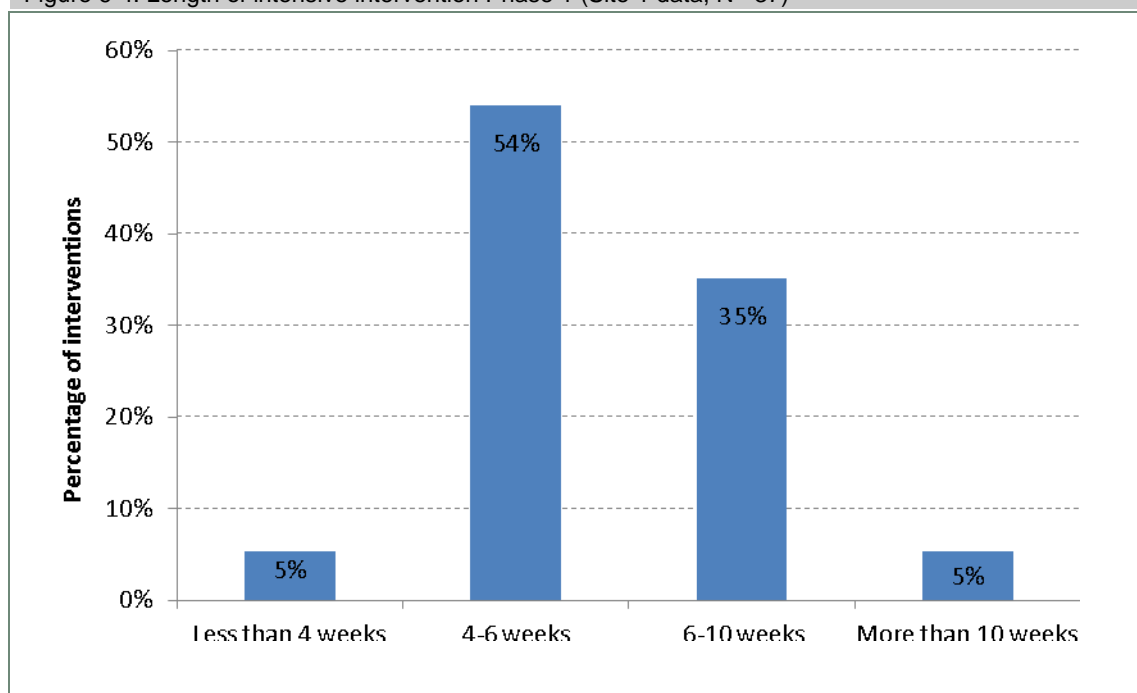
Figure 6-3: Length of assessment phase (Site 3 data, N=33)



Source: SQW analysis of pioneer site data

- 6.19 The IFSS guidance suggests that the Phase 1 intensive intervention should be delivered over a period of four to six weeks. Reports from the Pioneers suggests that there is considerable variation in the duration of the Phase 1 intervention. Figure 6-4 shows that in RCT /Merthyr over half (54%) of cases were completed within the 4 to 6 week period with 35% completing in 6-10 weeks and a small minority (5%) completing in less than 4 weeks or more than 10 weeks. Site 2 staff reported raising the variation in duration of Phase 1 with the IFSS trainers who informed them that it was possible and even of merit to complete the Phase 1 intervention quickly. This response raised concern amongst the team as it called in to question the 4-6 week guideline, and gave a sense that ‘the quicker the better’ rather than placing a focus on the content and outcomes of the activities undertaken.
- 6.20 The consensus was that the initial training could have been clearer on what was expected / appropriate practice around the length of this stage. It is to be hoped that the work of the **Pioneers will generate evidence on the relationship between the length of this stage and subsequent outcomes.** Alternatively, it may show no relationship because professionals are applying suitable judgement, in which case this could be document to help share learning with those who follow.

Figure 6-4: Length of intensive intervention Phase 1 (Site 1 data, N= 37)



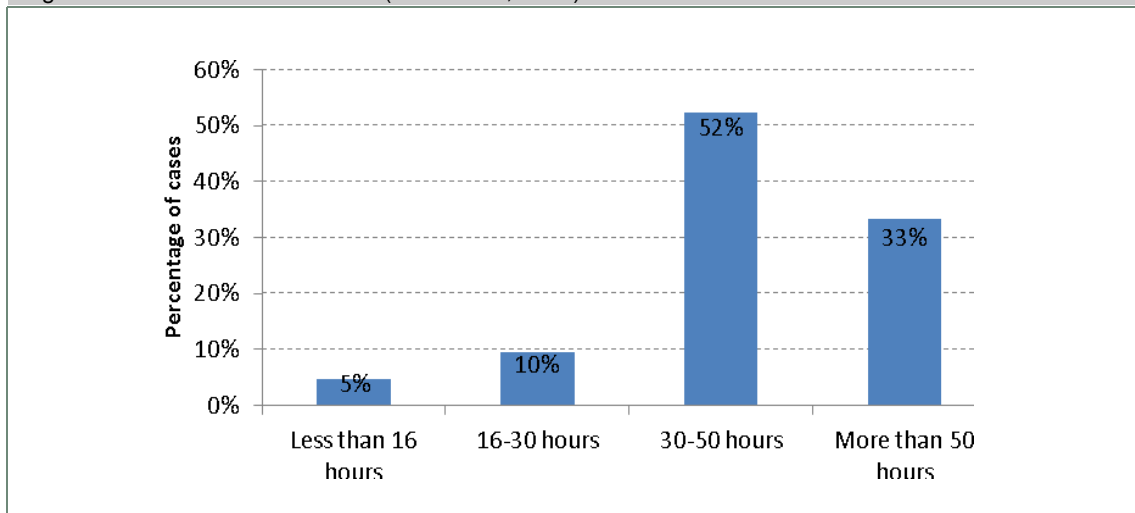
Source: SQW analysis of pioneer site data

Note these figures do not include all cases, only those where the intensive intervention was complete at the time of data collection.

- 6.21 Guidelines recommend a family receives between 16 and 20 hours a week in the 4-6 week intervention phase, this equates to anywhere between 64 and 120 hours. Figure 6-5 suggests that families are not receiving/do not need

such an intense amount of contact time, with half of families in Site 3 receiving between 30 and 50 hours in Phase 1. Site 2 also reported significant variation in the intensity of contact with families in Phase 1 (ranging from 30 – 70 hours). Once this variation became apparent the Site 2 Pioneer decided that if an IFSS spearhead worker thinks it is unlikely that they will deliver 50 hours with a family they are required to discuss the case and approach with their manager.

Figure 6-5: Total Phase 1 contact (Site 3 data, n=21)



Source: SQW analysis of pioneer site data

Note these figures do not include all cases, only those where phase 1 was complete at the time of data collection.

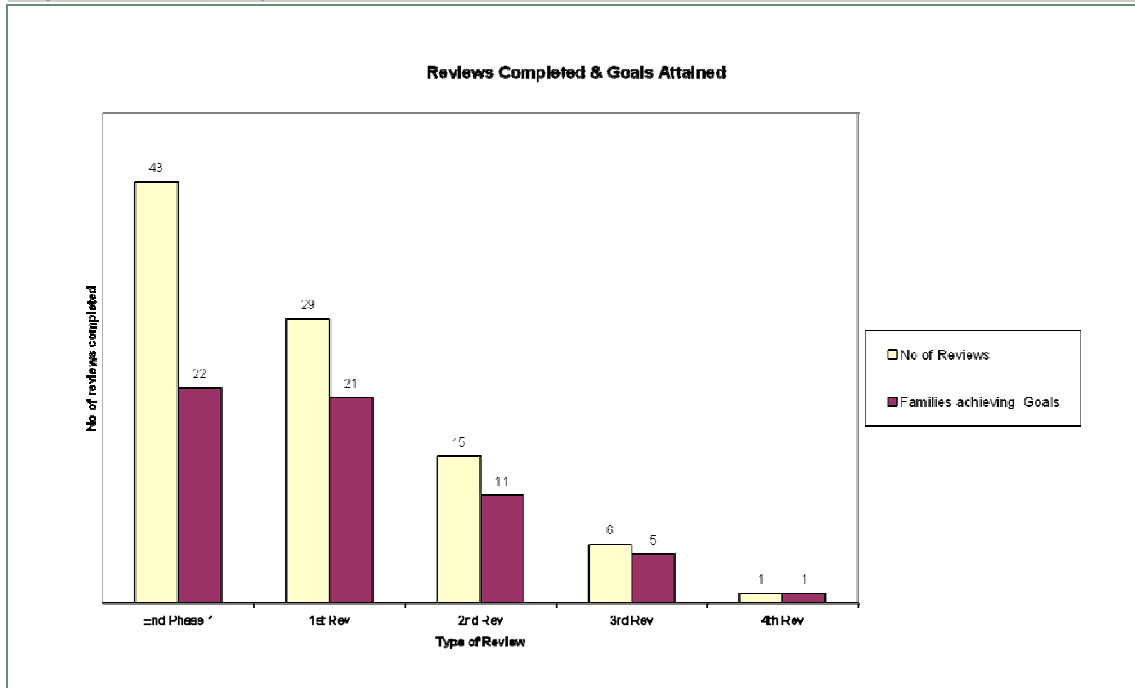
- 6.22 Although the data suggests that the families supported by IFSS Pioneers in the first 12 months received less than the recommended level of direct support the guidance does clearly state that the Pioneers are tasked to test the required intensity and duration of the intensive phase. As such the approach taken so far, where the duration and intensity varies depending upon the families' capacity to engage and need seems appropriate and outcomes should be monitored accordingly.

### ***Progress in Phase 1***

- 6.23 It is too early to judge the outcomes from IFSS to date. The intervention is designed as a 12 month programme of support and although the end of the first 12 month delivery period has been reached, no families have completed the full 12 months of intervention. However, the teams have put in place their own measures of family progress, based on case reviews. **The data from the areas suggest positive trajectories were being followed by families supported.**
- 6.24 Figure 6-6, Figure 6-7 and Figure 6-8 show the varying presentations of the progress of families over the course of the intervention. Although the

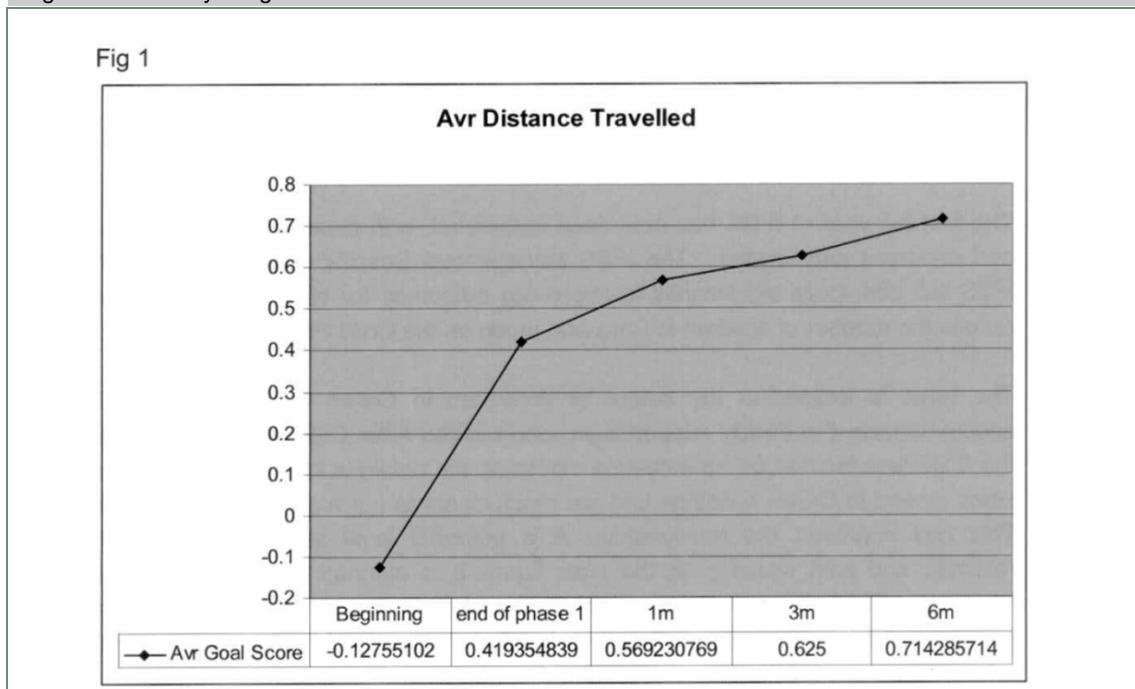
Pioneers have all used different approaches to assessing this, the direction of travel in all three areas is broadly positive.

Figure 6-6: Family progress in Site 1



Source: IFSS Pioneer Site Annual Reports 2011

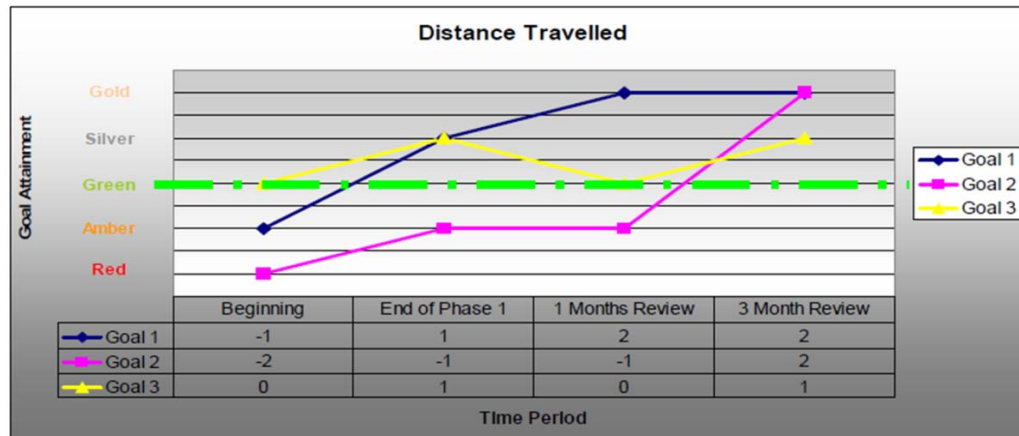
Figure 6-7: Family Progress in Site 2



Source: IFSS Pioneer Site Annual Reports 2011

Figure 6-8: Family progress in Site 3

Figure 13



Source: IFSS Pioneer Site Annual Reports 2011

6.25 This view of a positive experience was supported through consultations with IFST staff and staff from wider service teams. One wider service manager reported that IFSS is being seen as the 'best chance to get families back on track'. Even in cases where through the IFSS intervention it becomes evident that the child cannot remain with the family IFSS is being recognised as supporting the discussion relating to care proceedings with the child and family and is welcomed by the family courts where it is seen as providing evidence of the efforts made by both the authority and the family. In such cases IFSS was credited as helping to speed up the decisions and help prevent 'decision drift' which is ultimately better for the child and family. Wider work force motivation will be covered in the future evaluation going forward.

6.26 Some examples of the reported benefits for families are contained in Figure 6-9.

Figure 6-9: Examples of emerging outcomes

It is a seamless service from start to finish. The families are saying what they need as opposed to being told what they need.

Families know their short term goals individually, but also where things will go for them if those goals are met.

... give the family confidence and help family relationships we can go and see family relationships and understand them rather than just getting a snapshot.

They gain trust in services as it can be a positive experience for families.

The family communication is a big one. That they can talk about the strengths and their positives. We use the tools to facilitate those discussions, strengths cards can help parents see that they do have strengths and are good parents.

Source: SQW consultations with IFSTs

## Phase 2 – maintaining the Family Plan

- 6.27 IFSS is a 12 month intervention of which only four to six weeks incorporates the intensive support from the IFST spearhead worker. Phase 1 is focused on identifying the barriers that families face and the strengths they can utilise to move forward. Progressing along that pathway is the focus of Phase 2 and arguably is where the integrated aspect of the services lies as a range of services and support (including the families own networks) can be drawn upon in seeking to meet the families goals.
- 6.28 Throughout the initial 12 month delivery period 89 families have progressed into Phase 2 across all Pioneer Areas. As detailed in Chapter 2, Phase 2 focuses on maintaining the Family Plan and should be led by the case-holding social worker with inputs from the range of 'family support functions' identified as necessary to assist the family to progress to meeting its goals.
- 6.29 In general IFSS staff report that their experiences of Phase 2 so far have generally been positive. The IFSS spearhead workers schedule regular meetings with the family, the case holding children's social worker, adult social workers and other relevant services to review progress. However, it has been noted that the high turnover of staff in mainstream social work teams has resulted in inconsistent engagement with families especially over the extended period of IFSS Phase 2 delivery. When new staff take over a case they are unfamiliar with the progress a family has made which can mean the strengths based approach is undermined. This highlights the importance of new social workers in the wider services having an understanding of IFSS, perhaps built in as part of their induction programme. Moreover, where a case working social worker leaves, a handover process needs to ensure continuity of the IFSS plan.
- 6.30 Data from the survey of IFSS staff reveals that over four in five (84%) staff were confident that they are able to access support from wider services to enable them to do their job. There is some variation in the services they are drawing upon and also less confidence amongst staff that they are able to access support from wider services to support the families with which they worked, with 72% reporting confidence with this aspect of support. Almost all (96%) are working with health services regularly; however there appears to be lower levels of engagement with education and criminal justice services (72%).

### ***IFSS special commissions***

- 6.31 In delivering continuing support through Phase 2 the IFSS Board has the capacity to commission special services to support family progress. The



Pioneers have taken different approaches to this. In Site 2 the IFSB have commissioned Action for Children and Barnardo's to provide additional support to families when a need is identified:

- Action for Children - provide solution focused counselling for families in Phase 1 and Phase 2. A Service Level Agreement is in place for provision of the service to 60 families annually (10-15 at any one time). In the first year of delivery they did not utilise this resource due to insufficient demand as a result of reduced throughput. At present they are delivering to capacity reflecting the upturn in referrals and cases proceeding the phase 1;
- Barnardo's – is commissioned to provide Family Group Meetings (FGMs) to families with children on CPR – IFSS purchased 20 FGMs for period April 2011 – March 2012, IFSS families can be prioritised.

6.32 In addition to block commissioning of services the IFSS has the capacity to make one off support purchases to meet the needs of individual families. Sites 1 and 2 have used this function, including purchasing childcare to support a lone parent to engage in the intensive phase and a six week bespoke programme of family counselling.

6.33 Site 3 has also contracted with Barnardos. This will involve the recruitment and training of the FASS (a more general family support service, which is being introduced and modelled along similar lines to IFSS); the recruitment and training of a young person's substance misuse service – team members of which will be integrated into the developing early intervention and prevention service, as well as closely aligned to IFST/FASS. Both of these new teams will come under the overall governance of the Site 3 IFSS board.

#### Staff experiences of delivering IFSS

6.34 As detailed in Chapter 5 the IFSTs comprise newly recruited staff from a range of health, social care, substance misuse and probation backgrounds. The staff in the Pioneer teams are highly experienced professionals but in joining multi-agency teams and delivering a new approach most admit to being out of their comfort zone. They have had to get used to working in different ways with different colleagues.

6.35 The **staff reported a number of very positive experiences, which reflect the ethos of IFSS:**

- **Value in working alongside other professions**, recognising the usefulness in having different perspectives to deal with issues as they

arose and recognising that different professionals has complementary skills, but previously these had not been well joined up

- **Embracing the focus on the family** as a whole rather than just children or just adults
- Valuing the **opportunity to work intensively with a family** and dedicated time to working through issues with them
- Working with a family to solve problems that the family wanted to solve, not focussing on what the professional thought needed to be fixed (one consultee described this as '**positivity not negativity**').

6.36 However, they also recognised that they had faced some issues. Both the Site 2 and Site 3 Pioneers reflect that the shift to multi-agency working has proved more challenging for those team members from a health background. This was seen to reflect that health professionals was more likely to come with a view of being able to identify a problem and tell people the solution, rather than working with people to identify appropriate, person-centred solutions.

6.37 Concern was also raised that the staff in the IFST can risk losing their sense of professional identity. In Site 2 the seconded health visitor opted to return to the health visiting team prior to the completion of her secondment as she felt she was losing touch with her professional practice. In response the team has introduced a strategy to keep multi-agency workers at the forefront of their own professional practice. The strategy incorporates provision for staff to access training from their parent profession, undertake an optional piece of research which considers how IFSS practice can be integrated into their home organisation and spend time in their own organisation on a regular basis.

6.38 To address issues of professional identify and team working, it was explained that a constant reminder of the core purpose and aims of IFSS helped to re-focus minds; away from what was difficult and on to what was to be achieved.

6.39 As part of the evaluation, SQW established an e-survey based around IFSS staff experience and work satisfaction. This found that in general staff reported high levels of satisfaction with their jobs, reporting a sense of being able to 'really work with and support families'. Key findings from the survey include:

- **Staff felt their jobs required them to be creative and learn new skills.**

A large proportion (96%) of respondents felt they were able to be creative in their job, with all staff agreeing that their job required them

to learn new things. However, over a quarter (28%) of staff felt that their job involved a lot of repetitive work; this was particularly the case with those in business or administrative roles.

- **Staff felt that although they worked hard, they were not asked to do excessive amounts of work and there was enough time to get tasks done.**

Staff usually considered that they were not asked to do an excessive amount of work, with 80% agreeing. This is also reflected in that the majority (92%) felt they had enough time to get their jobs done. That said, over a third of the staff reported that their job required working very hard, and this was particularly the case for those from health and social work backgrounds.

- **Staff had a strong feeling of being involved in a team, to which their skills were vital and felt their role carried a high level of responsibility.**

A high proportion (92%) of respondents felt a sense of inclusion within a team, with 96% of respondents agreeing that their skills were vital to that team; this was particularly the case with those in business or administrative roles.

- **Some staff felt they were not free from conflicting demands and half found their jobs stressful.**

Less than half (40%) of respondents considered themselves free from conflicting demands, with all those in business or administrative roles disagreeing with this statement. Just over half of staff (56%) agreed that their job was stressful, and this was particularly the case for those in health work roles.

## 7: Issues for consideration

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- 7.1 This report has considered the implementation and delivery of the IFSS in the first 12 months of operation. It is the first report of the three year contract and as such we are not presenting conclusions about the effectiveness of IFSS. Rather it has focussed on the process of introducing and delivering IFSS and so in this final chapter we have highlighted implementation focussed issues for consideration by the Welsh Government, the Pioneer areas and the areas to which IFSS is rolling out. We also highlight areas for further investigation as the evaluation progresses.

### *Summary of findings*

- 7.2 In focussing on the process of introducing and delivering IFSS it is important to record that the qualitative **feedback from all three areas has been positive. They remain positive that IFSS will lead to improved outcomes for families.**
- 7.3 In the first 12 months of delivery the IFSS Pioneers have:
- Recruited and trained highly experienced and enthusiastic teams from a range of professional backgrounds
  - Established multi-agency governance and management arrangements
  - Supported wider service teams to understand the service offer and begun to provide training and support to teams
  - Established and refined referral systems
  - Provided support to over 150 families
  - Indicated some progression of families through the service, albeit these families were still at an early stage
  - Established the programme in line with the IFSS Guidance.
- 7.4 These achievements should not be underestimated and demonstrate the commitment at strategic and delivery levels within the Pioneer areas to IFSS, and in particular are testament to the commitment of the Teams.

### Issues for consideration

- 7.5 However, there remain a number of areas where further consideration is required. In the sections below we group these considerations as follows:

- Learning about implementing IFSS
- Issues and uncertainties about the model
- Issues for the evaluation.

### ***Learning about implementing IFSS***

7.6 Across the three Pioneers the report has identified differences emerging in practice. This was most apparent in terms of:

- The size of the team and the way that is recruited
- The structure of the team, including the number of CSWs
- How team accept new referrals and then allocate these to team member
- Differences in the way that each team described their key objectives and target group.

7.7 In addition, there are a series **key points for each of the Pioneers** to consider in moving forward are:

- The throughput of cases and implications for capacity as they enter a period of 'steady state'. Much work has been done to create robust referral mechanisms and to ensure that the cases referred are broadly correct, so now is the time to understand how many cases can be supported when combining new families, existing families (beyond the intensive period) and allowing for families leaving at the end of the programme
- Developing a clearer, professional judgement on the types of families and at what 'crisis' point they think IFSS can work for. This should also be informed by evaluation evidence. The learning of what works and who for can then be fed in to the training delivered for future areas
- Identify and define in a way that can be communicated more widely the criteria / definitions used at key transition point, for example around cases that are/are not accepted and at what point the intensive intervention phase is deemed to be complete
- The special commissions have to date not had the opportunity to operate as required. It will be important that these are tested further in future

- Similarly, while wider services have been engaged and worked alongside, it will be important that the teams begin to influence wider service practice. This change should also help in ensuring continuity of approach where new social workers take over cases when an existing social worker who has been informed about IFSS leaves.

7.8 The initiation phase has also highlighted a number of **points for future IFSS areas** as they seek to implement an IFSS model:

- In two of the three areas there have been recruitment and retention difficulties which disrupted delivery. A key lesson for new areas is the value in investing in the recruitment and initial set-up of the IFST. The experience in the Pioneers suggests that it is important to be very clear at the recruitment stage about the nature of the role and team and the expectations of the role. Allowing time to attract sufficient quality recruits will be important
- Multi-agency working is overall identified as positive but there is concern about the need to develop a new professional identities and to consider how staff can be supported to maintain contact with their original service and recognise the value that they are getting from moving in to a new and developing field
- The location of the IFSTs and the time that they spent building profile and describing their potential added value to other services has also played a significant role in their ability to build relationships with wider services and referral agencies. The importance of getting these relationships right, and the time required to do this must be built in to the initiation phase and then re-enforced over the early weeks and months.

7.9 The key learning points detailed above are summarised in .

Table 7-1: Summary of key points

**... for the Pioneers**

- Test demand and capacity limits
- Develop clear definitions about when families are accepted / move on at key points in the process
- Develop fuller relationships with other services
- Influence wider service delivery

**.. for future IFSS areas**

- The importance and challenge of getting the recruitment process right
- The need recognise that moving in to IFSS is for many staff a daunting professional experience and that they will need to be supported
- The need to spend time building relationships and clarifying roles with other services

Source: SQW

### ***Issues and uncertainties about the delivery model***

7.10 The issues highlighted in this section refer to the nature of the model and policy framework surrounding it. In several instances the evidence does not point as yet to strong conclusions, but rather to **pointers that the Welsh Government may wish to consider as the rollout proceeds**. The main points arising were that:

- Although the IFS Boards are operational and are reported to be working well, as yet no Section 58 Agreements are in place. The Pioneers were making progress on these, but if the Boards continue to operate well in their absence then the need for an Agreement should perhaps be re-assessed
- There will be a need to consider the scale of throughput which can be achieved and to consider the implications of this in terms of the overall level of demand in each area. It may be that in time some proxies of demand and supply can be developed to help local areas better assess the appropriate scale of their IFSS team
- The skills mix and job roles of the IFST will probably require to be refined. In particular there was uncertainty about the suggested balance of time allocation to the Consultant Social Worker and there may be a need for access to adult learning disability skills. There may also be a need to consider different levels of training depending on the background of recruits, or to more tightly define who can become a team member given the reported need for previous experience to fully utilise the training offered
- There are differences emerging locally in how the IFSS Guidance has been interpreted. However, as yet this does not appear problematic. Rather, it is likely to provide more rich learning about effectiveness, and how the model can be adapted to local circumstance. In time, the Guidance should be revisited to build on the lessons that emerge from the Pioneers (which in turn will most likely be around the points in the implementation section above)
- As practice develops there are some resources being developed (e.g. job descriptions) or that could be developed (e.g. on the definition of crisis) which could be helpful to offer to future areas
- As the Pioneers more tightly specify their target groups for IFSS there is a question of understanding whether some of those being excluded in some areas are in fact gaining positive outcomes in others; and what support is being offered to those who fall outside this range, but who

need support. In time this may lead to tighter guidance being developed, but as yet the evidence base would not suggest how this should be done.

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### ***Issues for the evaluation***

7.11 Evidence on a range of the points set out above will be gathered through the evaluation, which in particular will be considering:

- Data consistency. Without consistent data the ability to assess throughput and programme achievements is limited, which in turn will restrict the learning that can be gleaned. It is anticipated that the monitoring specification now being completed by all areas will help to address this issue
- Similarities and differences between areas. The approaches in each area have different nuances (for example around the nature of families targeted, team structure and the distribution of cases across the team). It will be important to understand: how far these operational differences remain and why; and the extent to which they influence outcomes
- The views of families. In this overall encouraging picture the voice of the recipient families has only been heard by proxy. In the next stages of the evaluation we will gather both consistent outcome data and qualitative family feedback to understand in more detail why the families believe IFSS has/has not helped them
- The influence of the wider governance structures and fit of IFSS to existing services. These are crucial part so the model. As IFSS becomes more mature and the number of cases grows, its influence on wider services, and in turn their ability to respond will be more fully tested.