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Children's Social Care Innovation Programme

Final evaluation report

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Rees Centre for Research in Fostering and Education



Social Science in Government

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Executive Summary

Background

In 2011, the [Munro review](#) of child protection concluded that the regulatory framework and local structures focused too much on risk avoidance and compliance for there to be effective practice. Munro proposed that there should be more of a focus on national and international evidence to drive practice improvements. In response to McKinsey's work on features of promising practice systems, the Department for Education's (DfE) Children's Social Care Innovation Programme was set up in 2014 to kick start new approaches to deliver significant and sustained improvement. Wave 1 of the programme, saw £110 million invested in 57 projects¹. This report provides the overview of the evaluation of the Programme which was undertaken by the Evaluation Coordination Team from the Rees Centre, University of Oxford.

Methodology

The Evaluation Coordination team allocated evaluation teams to projects, reviewed and provided feedback on evaluation plans and draft evaluation reports and supported and challenged the evaluation teams to produce as robust evaluations as possible.

A data checklist was constructed from the measures being used by each project across the programme and was used in the analysis that informs this report. This allowed us to identify opportunities for comparison across projects, to describe and evaluate the initiative as a whole, and to promote the pooling of expertise from across the evaluation teams. The data checklist included 14 hard outcomes, that is, numerical data collected through the local authority or other organisation for administrative purposes and usually measured in a consistent way. It also included 9 soft outcomes which were those on which there is less consistency in use of measures, and which tend to be collected more specifically for the project evaluation, that involved completion (often self-completion) of checklists, questionnaires, interviews or rating scales.

Aims

The aims of Wave 1 of the Innovation Programme were stated as:

- the quality of services increase, so that children who need help from the social care system have better life chances

¹ Elsewhere, Wave 1 of the Innovation Programme is referred to as 53 projects because the 5 National Implementation Service projects are treated as one. As they are separate interventions individually evaluated, we treat them as 5 projects.

- local authorities achieve better value for money across children’s social care; and
- there are stronger incentives and mechanisms for innovation, experimentation and replication of successful new approaches

These provide a benchmark against which to consider how far they started to be met, as evidenced by the evaluation of Wave 1 projects.

Key Findings

Quality of services

45 project evaluations reported outcomes in the short timeframe of Wave 1 (10-18 months). Service users, social workers and others interviewed provided their perspectives that services had improved. The quality of services increased in 42 of the 45 projects that reported outcomes in Wave 1, in so far as these outcomes reflected the aims, or service users and social workers’ reported improvements. These outcomes included:

- 24 of the 45 project evaluations reported reductions in children in care, children identified as CIN, children in residential care, increased reunifications with birth families or de-escalation from CIN and/or CP. 6 of the 45 reported negative findings (for example, increases in numbers entering care), five reported mixed findings and 10 did not report on these outcomes
- 14 out of 23 projects that aimed to do so, reported reductions in numbers of children entering care, numbers in care or days spent in care
- 9 out of 31 projects that intended to do so, reported positive improvements in staff knowledge, attitudes and self-efficacy, 6 of the 31 reported increased social worker job satisfaction reflected in reductions in absence rates and/or use of agency staff
- only 4 projects of the 12 that aimed to do so, provided strong evidence of improvements in social worker turnover but all 5 projects that intended to reduce caseloads did so

Evidence from the evaluations suggested that these improvements could be attributed to:

- systemic practice as a theoretical underpinning informing conceptual practice frameworks that translate into engagement in high quality case discussion, that is family-focused, and strengths-based, to build families and/or young people’s capacity to address their own problems more effectively

- social work practices that maximise direct contact with families and young people and are flexible and reflective
- social work supervision by clinicians or consultant social workers
- specialist adult workers (for example mental health, domestic abuse, child sexual exploitation (CSE), substance abuse) who provided expert and timely input for families with the most severe problems, and contributed to the multi-professional teams providing a different perspective on managing the risks within the families and shared case reviews
- multi-professional teams, co-located and undertaking assessment and reviews of individual cases to achieve better safety planning
- consistent support to parents and foster carers through one main link person and for young people, key worker support which is young person-centred and high intensity
- in addressing domestic abuse, working with all family members, having one key worker, small caseloads and working with perpetrators all seem to have contributed to better outcomes
- co-design approaches to service development that genuinely enable young people to take responsibility for the services they receive for example, the *House Project*

The role of multi-professional teams and specialist adult workers appeared to contribute to better outcomes even where the quality of social work practice with families was yet to be judged as better.

Evidence was promising but not yet secure in the timeframe of Wave 1, on the contribution made by specific approaches and interventions such as:

- Family Group Conferencing
- Restorative Practice
- Signs of Safety
- National Implementation Service Programmes

Value for money

The aim of the Programme for local authorities to achieve better value for money was reported on by 25 (nearly half) of the projects. The other 32 projects did not report on value for money, either because their samples were too small, or because they were unable to get sufficiently robust data on costs (and comparisons) in the time.

- 21 projects reported cost savings/benefit, some very considerable indeed, for example, £2.6m savings in Hertfordshire (though this figure was projected)

- 6 of these used a fiscal return on investment methodology and reported significant savings, in NE Lincolnshire for every £1 invested, there was a £3.80 saving. In 3 of the mental health projects, Norfolk and Suffolk's *Compass*, Surrey's *Extended Hope* and Wigan's *SHARE*, for every £1 spent directly supporting young people in the project, over £3 was saved
- 2 projects reported no savings as yet and a further 2 made an initial loss, due to the high costs of the specialised service in one case, and under-occupancy of residential facilities in the other

Stronger incentives and mechanisms for innovation, experimentation and replication

The extent of interest in securing projects in Wave 2 suggests that the experience of Wave 1 did incentivise further innovation, experimentation and replication. Of the next Wave of projects, 10 are continuations, in most cases scale and spread of the Wave 1 projects. The mechanisms needed (such as legal and cross-service agreements) in order to enable this innovation and experimentation to progress, have become clearer through Wave 1, and the longer run-in times for Wave 2 will facilitate these.

Most importantly, organisations are more likely to innovate when they see others benefitting from attempts to do so. Improving social work practice, keeping families together, increasing placement stability, reducing offending and saving money were all outcomes from Wave 1 that incentivised others to consider their capacity to innovate. In Wigan and Rochdale's *Achieving Change Together (ACT)* for example, the ways of working in the innovation project influenced wider practice both within and beyond these two local authorities.

Acknowledgement by Ofsted is another way in which local authorities are incentivised to replicate positive findings. The Ofsted inspection of Triborough in 2016, found that *Focus on Practice* was making an effective contribution to practice. All three residential homes involved in the *RESuLT* training received "Good" or "Outstanding" ratings in their Ofsted inspections. In 2015, Ofsted's inspection report on Leeds commented on the contribution that Family Group Conferencing and Restorative Practice was making to early support.

In 2016, Lincolnshire, one of the 10 pilot areas in the *Signs of Safety (SoS)* project, received an Ofsted inspection report that said social workers in Lincolnshire "are better able to understand the range of risks that children face and the impact that domestic abuse is having on them" by using the initiative.

Recommendations

Recommendations for policy

- **Deregulation:** Continue and reinforce the current policy to support deregulation in order to allow a wider range of innovations. Projects engaging in deregulation need longer to be tested in order to be given a 'fair trial'
- **Support for systemic social work:** National policy needs to reflect the evidence on the efficacy of systemic social work in the professional standards, training frameworks and inspection criteria

Recommendations for practice

Children's services providers should take note of the features of promising practice in improving outcomes that emerged from Wave 1 including:

- **using a systemic, family-focused, strengths-based approach** that supports families and young people to take more responsibility for their own lives
- **multi-professional working** that involves a wide range of services including specialist workers in substance abuse, domestic violence, mental health, CSE, female genital mutilation (FGM) and offending to make a distinctive but synthesised contribution to case reviews and decision-making
- **providing consistent support** to parents, young people and foster carers through one consistent 'key worker'
- **maximising direct contact** with families and young people that is flexible and reflective
- **provide high quality social work supervision** by clinicians or consultant social workers
- **maximising education, employment and training (EET):** Providing support and training opportunities for those transitioning from care, so that they can find and maintain EET. Make this a condition of their participation in the project
- **use short-stay residential provision** but resist financial drivers to fill beds

Recommendations for evaluation of Wave 2

- **Samples:** Target much larger samples, especially of young people whose voice was in general, poorly represented in Wave 1
- **Robust designs including comparison groups:** Wave 2 projects which are mostly funded for 3-4 years, should seek to adopt the most robust designs possible including

randomised control trials (RCTs), and where these are not possible, well-matched comparators. This requires adequate funding

- **Common measures:** More consistency on outcomes and measures in Wave 2 should be achieved through the thematic structure. The Innovation Programme should seek to establish common measures for reporting trends in children's social care, building on the current [Barnard et al](#) work
- **Standardise cost benefit:** Wave 2 of the Innovation Programme should seek to standardise approaches to cost benefit analysis so that comparisons can be made across projects – this needs to include measures taken, time period assessed, costs assessed, sample sizes and methodology adopted
- **Use of practice observation and/or scenarios:** The relationship between outcomes for children and families, and changes in social work and/or professional practice should be explored further through more robust methods in order to test out the specific approaches that lead to the most improvement in outcomes
- **Sustainability and Transferability:** Build in plans for sustaining innovation from the start of projects. Evaluate both sustainability and where appropriate, transferability of effects in projects aiming to scale and spread Wave 1 innovations
- **Data collection and use:** Consider using embedded researchers as a potential way to address the research-practice gap, but acknowledge that they require adequate resources

Policy Response

The findings from this Wave 1 evaluation has led the DfE has to tailor its Wave 2 and 3 evaluations against the most promising practice measures and outcomes emerging from the first 57 projects. They have identified the following 7 practice measures and 7 outcomes that they want to examine further. These are:

Practice measures

- Strengths-based practice frameworks
- Systemic theoretical models
- Multi-disciplinary skills sets
- High intensity/consistency of practitioner
- Family focus
- Skilled direct work
- Group case discussion

Outcomes

- Create greater stability for children
- Reduce risk for children
- Increase wellbeing and resilience for children and families
- Reduce days spent in state care
- Increase staff wellbeing
- Reduce staff turnover and agency rates
- Generate better value for money

The practice measures and outcomes are viewed by the DfE as the most influential in transforming social work practice and outcomes for children and families. The DfE is keen to build the evidence base in these areas and are exploring these in the Wave 2 evaluations.

Background

Aims of the Innovation Programme

This report provides an overview of the evaluation of Wave 1 of the Department for Education’s (DfE) Children’s Social Care Innovation Programme which took place 2014-2016 in England. The Innovation Programme was set up to address the concerns raised by the Munro review, Association of Directors of Children’s Services [report](#) and Local Government Association ([LGA](#)) [report](#). These sources suggested that the regulatory framework and local structures focused too much on risk avoidance and compliance and insufficiently on national and international evidence of effective practice, and new approaches to achieve significant and sustainable improvement.

The Innovation Programme drew on McKinsey’s work on understanding the barriers to innovation and use of evidence which was adapted by DfE for the Programme, as shown in Figure 1:

Figure1: McKinsey’s 10 main barriers to innovation in children’s services

C There are 10 main barriers to radical improvement and innovation in children’s services in England (1/3)

External context	Structure	Conduct	Performance
<ul style="list-style-type: none"> ▪ Significant growth in demand e.g. looked-after children 1.8% pa ▪ Confusion on State’s role in sector ▪ Intense public and media response to public scandal puts spotlight on industry ▪ LA facing significant budget pressure –will increasingly be looking to children’s services for efficiencies 	<ul style="list-style-type: none"> C1 LAs can lack the critical mass and organisational competence to commission for radical improvement and innovation in services C2 Service provider organisations aren’t always incentivised to radically improve and innovate their services 	<ul style="list-style-type: none"> C3 Frontline social care staff don’t always have the time, skills or confidence to radically improve and innovate services C4 LA leadership can lack capability and incentives to radically improve and innovate services C5 There are some legal barriers, and many perceived barriers, to radically improving and innovating services C6 New innovations often fail to ‘spark’, and proven innovations often fail to spread effectively across LAs C7 Poor data quality and availability makes it hard for social workers, LAs, regulators, and central government to drive radical improvement and innovation C8 Current performance management system tends to promote compliance rather than radical improvement or innovation C9 Challenges in collaboration at the interface of different agencies limits innovation, particularly for child protection C10 Culture of resistance to change and risk aversion 	<ul style="list-style-type: none"> ▪ High variability across LAs in child outcomes: <ul style="list-style-type: none"> – Highest GCSE attainment gap ~2.6x size of the lowest) – Care quality (% of children experiencing <3 placements) highest is 1.4x lowest) – Value for money (up to 7.5x more costly) ▪ Limited correlation between spend and outcomes ▪ There is a significant gap in outcomes between cared-for children and other children e.g. 44% attainment gap at GCSE

Department for Education 0

The McKinsey analysis sets out the features of promising practice systems and the barriers to improving children’s social care which then formed the rationale for the

Innovation Programme. The Programme is described² as ‘seeking to support local efforts to transform services for the most vulnerable children by providing tailored funding and professional support to innovative projects’. It is intended to be an ambitious programme in order to inspire whole system change ‘so that in five years’ time [from 2014]:

- the quality of services has increased, so that children who need help from the social care system have better life chances
- local authorities (LAs) achieve better value for money across children’s social care; and
- there are stronger incentives and mechanisms for innovation, experimentation and replication of successful new approaches’

Two main ways of working were set out for the Programme:

- individual pilots and change programmes which test or spread more effective ways of supporting vulnerable children
- changing conditions in the system so that it is better able to innovate in future and drive sustained improvements in outcomes for vulnerable children

Initially, the 2 main focus areas were:

- rethinking children’s social work
- rethinking support for adolescents in, or on the edge of care

Other social care priorities that did not fit within these two areas were also considered such as fostering and adoption, specialist interventions (for example Multi-Systemic Therapy [MST]), multiple removals of children into care, domestic violence and substance abuse (specifically, the Family Drug and Alcohol Courts [FDAC]).

The first wave of the programme in which £110 million was invested was commissioned in Spring 2014. This involved 57 projects³ working across a wide range of children’s social care. The Spring Consortium’s Interim Learning Report in 2016 noted that the Programme covered all 9 regions of England and involved 59% of all local authorities either as a lead organisation or as a partner. Local authorities led just over half of the projects in Wave 1, the others being led by a mixture of voluntary, community private and other public sector organisations. Each project was assigned a coach from the Spring Consortium who were was responsible for supporting the Programme delivery. More details about each project with a summary of their early implementation and outcomes

² DfE (2014). Overview report: Department for Education Children’s Social Care Innovation Programme

³ Elsewhere, Wave 1 of the Innovation Programme is referred to as 53 projects because the 5 National Implementation Service projects are treated as one. As they are separate interventions individually evaluated, we treat them as 5 projects.

can be found in the [Spring Consortium Directory](#). A further £200 million was invested in April 2016 in Wave 2 which continued to prioritise social work and adolescent services but in addition, invited projects:

- building on the recommendations of the Narey report on residential care, particularly piloting 'Staying Close' and regional commissioning of residential care
- testing the use of social investment to improve support for care leavers
- testing alternative delivery models for children's social care
- testing and developing understanding of targeted support to prevent children entering child protection systems

This report addresses the evaluation of Wave 1 drawing on the 56 (one project was not completed) individual project evaluation reports published on the [Spring website](#). [Two-page summaries](#) of these reports designed to engage the interest of a wider community can be found on the Spring website. Most projects were funded in late 2014 so implementation started in early 2015 with projects having different end dates - evaluations in Wave 1 therefore ran for 10-18 months. In some cases (for example *Safe Families*, *Match Foster Care*) the delays to implementation and small group sizes limited the validity of any quantitative evaluation of impact, providing some early information on outcomes, but rather more on the process of implementation. Some projects (for example, North Yorkshire County Council's *No Wrong Door*) commissioned evaluations that extended beyond this window, but the extended evaluations sit outside the scope of this report.

There are also 5 thematic reports that complement this report, each with a particular focus. These can be found on the [Rees Centre](#) and [Spring Consortium websites](#):

1. What have we learned about social work systems and practice?
2. Adolescent service change and the edge of care
3. Child sexual exploitation and mental health
4. Systemic conditions for innovation in children's social care
5. Informing better decisions in children's social care

Aims of the evaluation

Evaluation was stated to be a core component of the [Innovation Programme](#). It was acknowledged that evidence was needed both of the outcomes of individual projects and of the outcomes across projects and of the wider Programme, in the prioritised focus areas. This evidence was needed to persuade those practitioners, service managers and providers both in and beyond the Programme, to continue innovating or revise their approach in order to improve their service. Evaluation was also needed to maximise the value for money of the significant investment that had been made in the Programme. The

DfE wanted to know what works, for whom, and under what circumstances, and to contribute to a stronger and more extensive evidence base in children's social care for the future.

The specific aims of the evaluation were to:

- identify evidence that indicates how much progress funded projects made towards achieving the Innovation Programme objectives
- where this evidence was only likely to be available in the longer term, that is beyond [Wave 1] Sept 2016), identify proxy indicators or 'green shoots' that suggest progress towards longer term outcomes
- support the Spring Consortium to identify the structural and systemic conditions that best facilitated consistently effective practice in children's social care
- enable high quality individual project evaluations to identify what works, for whom and in what circumstances
- develop a culture of evidence-informed children's social care practice

The role as Evaluation Coordinator was to:

- set strategic direction, expectations and high standards for evaluation including the need to minimise burdens on service providers
- assist the DfE in establishing a framework of evaluation organisations ready to work with funded LAs and organisations
- quality-assure, advise, oversee and develop individual project evaluation plans and where needed, challenge their leaders and the evaluators to provide more robust evidence and implementation plans
- propose, agree and bring together common data from across the projects to assess progress across the whole programme and provide an overall assessment of the evidence of systemic change
- assess how individual projects contribute to sustained evaluation activity and building a culture of evidence-informed children's social care practice
- provide ongoing feedback and quality assurance to the evaluation teams and individual projects on the findings
- analyse how projects are making use of existing data
- support the Spring Consortium to identify the structural and systemic conditions that best support use of evidence and development and embedding of these
- identify themes from across the programme and broker meetings of individual project clusters that share interests to develop greater coherence

- ensure that evaluations include plans for maximising user engagement including young people, in order to increase subsequent use of evidence
- support the development of a high-quality evidence base in children’s social care and the culture of using evidence to inform practice
- influence on-going communication of evidence and outputs to maximise impact

The ways in which these objectives were addressed are described in the methodology section below.

What is innovation?

A commonly used definition of innovation is the development and dissemination of a new product, service or process that produces economic, social or cultural change⁴. Within the Innovation Programme, the definition of innovation provided by the [Spring Consortium](#)⁵ was that it:

“describes a new practice, model or service that transforms mainstream ways of doing things. While improvement focuses on achieving better outcomes through more efficient use of the same resources, innovation looks to achieve better, *different* outcomes using new resources (or using existing resources in new ways).”

Innovation can be distinguished from ‘invention’ which is defined as: ‘the first occurrence of an idea for a new product or process’, while innovation is the first attempt to carry it out in practice. The literature on innovation in general, suggests that ideas, which initially may be regarded as unusual or marginal by people other than those proposing them, are often subsequently brought into the mainstream⁶. A successful service innovation requires the initial idea to have become widely available.

Innovation as a driver for change

Innovation and change are overlapping but not equivalent concepts⁷. Change implies growth or development in this context, of a public service or element of the service. Innovation is a specific form of change implying discontinuity from existing policies or practice. It might involve changes to organisation, staffing, priorities, skills or resources.

⁴ Nesta, cited in Sebba et al., (2009) *Youth-led innovation*. London: Nesta

⁵Spring Consortium Innovation Insights Board 1: The value of innovation in children’s social care

⁶ Bessant, J. and Tidd, J. (2007) *Innovation and Entrepreneurship*. London: Wiley.

⁷ Brown, K., and Osborne, S. P. (2012). *Managing change and innovation in public service organizations*. London: Routledge.

Glisson⁸ noted that effective innovations are as much about creating appropriate organisational contexts as they are about the ideas themselves. He went on to clarify the important distinction between organisational climate, as the psychological impact of the work environment on employees' wellbeing, motivation and performance, and organisational culture as the shared norms, values and expectations within the organisation. This distinction is relevant to our experience in the first wave of the Innovation Programme, for example, Munro, Turnell and Murphy's *Signs of Safety Action Research Report* notes that organisational culture requires the embedding of 3 principles if it is to effectively support good practice – working relationships, shared reflective practice and being grounded in everyday experience – and the project accessed information about these through regular staff surveys.

What is known about innovation in children's services?

Existing research on innovation confirms that innovation is not always the best way to achieve progress⁹ but that the evidence base is lacking for helping to identify which services or situations in children's social care are most likely to benefit from innovation. In a children's services context, Glisson and colleagues developed the Availability, Responsiveness and Continuity (ARC) model of organisational effectiveness¹⁰ and demonstrated its use to support innovation that led to increased job satisfaction, reduced staff turnover and improved service outcomes. This approach is a 'team-based, participatory, phased intervention designed to improve organizational culture and climate in mental health and social service organizations, support innovation, and remove barriers to effective services'¹¹. It involves five principles illustrated here with examples from Wave 1 of the Innovation Programme:

- **mission-driven** as in Wigan and Rochdale's CSE project which developed a shared mission through co-design work over a 4-month period
- **results-orientated** as in Leeds' *Family Valued* and North East Lincolnshire's *Creating Stronger Communities* use of the Outcomes-Based Accountability framework
- **improvement-directed** as in Coram's *Permanence Improvement Project* in which successful reduction in time taken to place a child was associated with single-minded activation and intensification of family-finding practice

⁸ Glisson, D. (2015) The Role of Organizational Culture and Climate in Innovation and Effectiveness, *Human Service Organizations: Management, Leadership & Governance*, 39:4, 245-250.

⁹ Fincher, C. (1980). AIR Between Forums: The Failures of Innovation. *Research in Higher Education*, 12(4), 373-376. Retrieved from <http://www.jstor.org/stable/40195340>

¹⁰ Glisson, C., and Williams, N.J., (2015). Assessing and changing organizational social contexts for effective mental health services. *Annual Review of Public Health*, 36:5. doi:10.1146/annurev-publhealth-031914-122435.

¹¹ Glisson, C. (2015). *opp. cit.*, p.247

- **relationship-centred** as in Pause’s project with women who experience repeat removals of children from their care. The establishment of trusting relationships was crucial in supporting women to make sustainable changes
- **participation-based** as in Stoke’s *House Project* in which the young people co-designed their housing through a co-operative run for and by them

The ARC model involves evidence-based improvement strategies such as feedback, teamwork and participatory decision-making. These strategies are reflected in the coaching model which the Spring Consortium adopted and in many of the projects in Wave 1 that made good progress. Within the Innovation Programme, ‘innovative’ has been taken to apply to the initial idea, to any part of the implementation process, or to both. The Programme was stated at the outset as being to:

‘support local authorities and other organisations to try new approaches and learn from best practice, including internationally. We want to stimulate and support innovation in the delivery and structures of children’s social care and help spread proven innovations more rapidly.’¹²

Policymakers commitment to develop drivers of innovation can be seen in the current policies and plans for children’s services¹³ and workforce development¹⁴. Service users increasingly play an active part in the development of new or improved services by generating ideas, identifying needs and designing and building their own solutions¹⁵. In the Innovation Programme, there is interest and investment in how people who receive services can help to design and deliver services and products – and the innovative processes used to do so. Many of the projects in the Innovation Programme include co-design and co-production with users, the strongest examples perhaps being Stoke on Trent’s *House Project* in which young people transitioning from care have helped set up and run an innovative housing cooperative and University of Kent’s 4 waves of co-design workshops with young people, their carers and social workers, to scope out a new digital service for vulnerable young people.

¹² DfE (2014, p.4). *Overview report: Department for Education Children’s Social Care Innovation Programme*

¹³ DfE (2016a). *Children’s social care reform: A vision for change*

¹⁴ DfE (2016b). *Putting children First: Delivering our vision for excellent children’s social care*

¹⁵ Flowers, S., Mateos-Garcia, J., Sapsed, J., Nightingale, P., Grantham, A., and Voss, G. (2008). *The New Inventors: How users are changing the rules of innovation*. London: NESTA

Methodology

Selecting the evaluation team for each project

The Evaluation Coordinator team reviewed each project's final bid to the Programme and provided feedback on the proposed evaluation to the Investment Board, who made recommendations on funding allocations. In Wave 1 of the Innovation Programme, the Evaluation Coordinator compiled a catalogue of the 22 evaluation teams that had been selected on to the evaluation framework by a DfE tendering process. The catalogue listed the evaluation teams' specialist skills and experience in children's social care evaluation. It included research and evaluation expertise including any cost benefit analysis, experience in children's social care, research management experience and costs. It was designed to help projects, with advice from the Evaluation Coordinator Team and their Spring coach, to choose the evaluation team from a shortlist of 3, judged to have the capacity to evaluate each project, taking into account focus and size.

Project leads were then encouraged to discuss their requirements further with one or more of the recommended evaluation teams and to explore how the evaluation team would approach the evaluation plan, methodology and costs. Based on these conversations and advice from the Rees team, they selected the evaluation team. Thirteen of the 57 projects did not choose one of the 3 evaluation teams initially recommended to them and in several of these cases, problems between the evaluation team and project occurred during the course of the evaluation, although it is possible that these difficulties could have arisen had they selected a recommended team.

Developing evaluation approaches and plans

The evaluation teams worked with the projects to develop the detailed evaluation plan and agree the deliverables, outputs and costs. A basic [Evaluation Guide](#) approaches was provided by the Evaluation Coordinator to support this. The evaluation plans were sent to the Evaluation Coordinator team and DfE to review. They were reviewed against the Early Intervention Foundation (EIF) [Evidence Standards](#)¹⁶ in an effort to predict what each evaluation might contribute to the relevant body of evidence. Where possible, the evaluation plans built on the identification of a comparable control group from within the same locality, or from a statistical neighbour, or with a plan to compare intervention outcomes with those of a robustly constructed baseline cohort subject to 'business as usual'. If all else was not possible, historical data from that local authority (EIF levels 2/3) was used. Of the 57 project evaluations, 24 provided at least some comparative data

¹⁶The EIF assessment process was developed specifically to inform judgments about the extent to which a programme has been found effective in at least one rigorously conducted evaluation study.

from one of these sources. While some evaluation plans were rated higher, none of the completed evaluations delivered evidence that was above EIF level 4, since this requires multiple interventions with randomised control trials (RCTs). Appendix 1 shows the number of evaluation plans falling into each EIF rating. These ratings do not necessarily reflect the standard of the final evaluations.

Robust evaluations (RCTs, mixed methods including gathering perceptions of families and young people) can be disruptive to practitioners' and managers' daily work and the timescales in Wave 1 of the IP exacerbated this greatly. This is one of the main reasons why there were only 3 RCTs in the 57 evaluations – Catch 22's *Project Crewe* that randomly allocated 88 families to the intervention (44 to business as usual), the National Implementation Service's *Multi-systemic Therapy – Problem Sexual Behaviour* (MST-PSB) that allocated 21 families to the intervention (and 19 to business as usual) and *Safe Families* that allocated only 13 families to the intervention (13 to the control group) and thereby made no claims from the findings of the RCT part of the evaluation. The longer time frame in Wave 2 provides an excellent opportunity to raise the bar on evaluation which should enable projects to achieve more robust findings on impact, and some projects undertaking scale and spread activities which can test the model's transferability.

Formative and summative evaluation

Evaluation in Wave 1 of the Innovation Programme as designed to provide both formative feedback (encouraging projects to tweak their approach in response to findings) and summative feedback (assessing overall effectiveness) at the level of individual projects and the overall programme. For example, in September 2014 many evaluation teams in the IP reported that from interviews with front-line staff, a key barrier emerging to improving practice was the need for better communication about the project aims and the precise staff roles within them. The evaluation team for Newcastle's *Family Insights Programme* for example, provided this feedback to project leaders who then addressed it. In *Family Safeguarding Hertfordshire*, the communications were strong from the outset but became less so halfway through the project, at which point the evaluation team fed back the concerns of participants and these were effectively addressed.

Similarly, the formative evaluation of the overall programme, for example, indicated the need to push evaluation teams harder on the criteria that projects were using to define 'edge of care' populations so that outcomes wouldn't look better than they were due to recruiting young people at risk but not at the edge of care. (The Evaluation Coordinator asked a number of evaluation teams for example, in the case of evaluations of the adolescent projects to look at this.) Feedback was also provided on the need for more robust evaluation of cost benefits of projects which led to 25 projects providing appropriate data to enable these analyses to be undertaken. The decision was also taken

to extend reporting timescales in order to achieve better data on outcomes within the limited timescale.

Service managers and practitioners (understandably) have priorities other than evaluation, limited resources and often lack the relevant skills for robust evaluation. Hence, evaluation teams were expected to build capacity for future evaluation in the local authorities and other organisations that were leading projects. The extent to which they achieved this is reported below.

Support to evaluation teams

The Evaluation Coordination team were tasked with supporting and challenging the evaluation teams to produce as robust evaluations as possible.

Interest group meetings

In order to maximise the value-added of being part of an Innovation Programme rather than 57 individually operating projects, those evaluation teams perceived as having interests in common were brought together at the start, during and at the end of the Wave 1 period. Interest groups were constructed by grouping projects under the broad foci of social work, adolescence, mental health and/or CSE, fostering and adoption, new forms of commissioning and delivery, and embedded researchers. In general, these last two categories overlapped with the others and so these groups of projects only met once. The adoption and fostering projects spanned a very wide range of interests so again only met once. The adolescent and social work interest groups met 3 times each.

Data collection and analysis

The evaluation plans enabled a list of hard (for example, reducing the number of children looked after) and soft (for example, improving job satisfaction of the workforce) outcomes to be constructed for all 57 evaluations. 'Hard' and 'soft' refer to the outcomes rather than to individual measures of those outcomes. So, a reduction of numbers coming into care is a hard outcome, but an improvement in mental health is a soft outcome because there is less consensus about how this is defined or measured.

The data checklist provided an important overview of measures across the programme and has been used in the analysis that informs this report. It included 14 hard measures and 9 soft measures. These are shown in Tables 1, 2 and 3 below which present the number of projects whose evaluations reported findings for each outcome.

Key Findings

Reporting of outcomes

Table 1 presents the numbers of projects reporting positive, negative or mixed findings on the 13 hard outcomes. The fourteenth hard outcome was 'reducing social worker caseloads' which is reported in Table 3 with the other workforce outcomes.

The outcomes for children, young people and families are ultimately the best indication of the efficacy of the Innovation Programme. However, Wave 1 evaluations were very short, making it likely that we would learn more about implementation than outcomes. Forty-five projects reported on outcomes for children, young people and families and/or outcomes relating to the workforce, within the timeframe. These outcomes are discussed with reference to the extensive findings in these evaluations from surveys, interviews, documentary analysis and case reviews. The main areas of practice and provision that emerged are then discussed with reference to projects across the Programme and short case studies are used to illustrate these.

The 12 evaluations that did not report on outcomes included those that were developing new models of commissioning, delegation or delivery that meant the main activity was about negotiating and setting up a new system, prior to implementing the change that might lead to improved outcomes. One example was the North London Children's Efficiency Programme's (NLCEP) *Residential Innovation Project* involving a collaboration between five north London boroughs to develop a residential model of care and intervention that allowed young people entering care to remain in the local area or return to it. The facility was not set up by the end of the evaluation of Wave 1 so no outcomes could be recorded. Similarly, in Achieving for Children's *Better by Design*, which involved moving children from residential care to foster care via a short-term residential facility, only a small number moved within the timeframe. NSPCC's *New Orleans Intervention Model* (NIM) is an approach that provides intensive assessment of, and treatment for, children up to the age of 5 in foster care due to abuse or neglect. It is delivered by a multidisciplinary infant mental health team with the intention of improving judicial decisions about the child's permanent placement by putting the quality of a child's relationships at the heart of decision making. This project began in January 2016, much later than the other projects, and hence by January 2017 the service had just been set up and the first 17 children referred.

Other examples of projects concerned with developing models that therefore did not produce outcomes in the Wave 1 evaluation included:

- Council for Disabled Children's (CDC), *Innovation in Social Care Assessments for Disabled Children programme*, which involved 5 local authorities in co-producing

new assessment approaches for assessing the needs of disabled children and their families

- West Sussex's led *South East Together* (SET) project that explored the viability of establishing a Regional Dynamic Purchasing System¹⁷ (DPS) to support the commissioning and procurement of specialist placements
- Cambridgeshire's *Multi Systemic Therapy service* (CMST) involved moving from local authority control to a staff-led mutual which was not yet fully set up by the end of the evaluation
- University of Kent's project on *How Technology can Support Young People in Care* ran co-design workshops in which young people in care, their carers and social workers, scoped out a new digital service. By the end of the project, several concepts or early prototypes were produced for potential further development

Two projects aimed to set up knowledge hubs and so did not intend to generate outcomes within the timeframe. Tavistock's *Family Drug and Alcohol Court* (FDAC) set up a 'national unit' to collect and disseminate evidence on their model that provides an alternative way of working with parents involved in care proceedings who are experiencing substance misuse. The Wave 1 project was limited to setting up the unit. Similarly, NSPCC's *Learning into Practice* project aimed to improve what is learned from Serious Case Reviews (SCRs) by collating and disseminating information on practice issues and causes from SCRs. Two projects (Barnardo's and MOPAC) addressed FGM and reported on engagement, providing data on changes in attitudes and knowledge from surveys and interviews but no outcome data as such. One project failed to start its intervention before an Ofsted inspection deemed them 'inadequate'.

¹⁷The Dynamic Purchasing System is a procurement tool which has some similarities to an electronic framework agreement, but where new suppliers can join at any time (Crown Commercial Service 2015, *The Public Contracts Regulations 2015 – Dynamic Purchasing System.*)

Table 1: Hard Outcomes for children, young people and families

Outcome	Total projects measuring outcome*	Generally, positive findings	Generally, negative findings	No change or specifies change is non-significant	Mixed or unclear findings**
Reducing the number of children looked after	23	14	4	1	4
Reducing number/type of CIN	16	8	0	1	7
Reducing re-referrals	11	4	2	3	1
Increasing the number of children looked after who return home safely, in a timely manner	9	4	0	0	0
Reducing the number of children in residential care	6	5	0	0	0
Increasing placement stability	14	6	0	1	3
Education, employment and training (EET)	18	10	0	1	3
Reducing number missing	7	2	2	0	2
Reducing youth crime	6	2	0	0	4
Reducing crisis presentations	7	3	0	0	2
CSE - improved systems, reporting, convictions (not solely reduction)	8	3	0	1	3

Outcome	Total projects measuring outcome*	Generally, positive findings	Generally, negative findings	No change or specifies change is non-significant	Mixed or unclear findings**
Reducing homelessness	4	0	0	0	2
Reducing gang affiliation	2	2	0	0	0

*Total projects measuring outcome includes those using only qualitative measures, hence the subsequent 4 columns may not add up to this total.

**Some evaluations did not measure group differences or change over time/link to intervention

Outcomes for children, young people and families: number of children in care and number entering care

Summary on numbers in care and/or entering care

There are encouraging reductions in the numbers in care and/or entering care in 14 of the 23 projects in which sample sizes and outcomes enabled meaningful comparisons and which had aimed to reduce these numbers. This is in the context of numbers increasing nationally¹⁸.

Better engagement with families, assessment and identification of needs, seem to contribute to reducing the numbers in care through more effective services, but might simultaneously increase numbers in some projects, through increased identification.

A mixed picture emerged in a few projects, with possible contributing factors providing partial explanations, such as significant increases in the number of unaccompanied asylum seekers needing care, which were recorded differently across local authorities.

The longer-term impact for those not entering care is as yet unknown – what enhanced support will be needed to sustain these children out of care safely? How many will enter care later, re-enter care or experience negative outcomes from not being in care?

Meanwhile, more families are being kept together and costs significantly reduced.

Fourteen evaluations of the 23 that aimed to reduce numbers in care (including 6 of the 9 social work projects that reported on this outcome), noted a reduction in the number in care and/or entering care, 4 (3 social work, 1 adolescent), noted an increase in these numbers and a further 4 had mixed or unclear findings. Some reductions were very substantial, for example, in Leeds' *Family Valued*, those in care reduced from 1253 in April 2015, to 1226 in August 2016. Newcastle's *Family Insights* evaluation stated that 50% of the 87 children in care were returned to their families, compared to 25% under the preceding model. In Morning Lane's *Reclaiming Social Work*, 79% of the 119 children in families that received the Keeping Families Together (KFT) service, remained at home, with only 25 children (21%) subsequently receiving some form of care provision for at least one week.

In *Family Safeguarding Hertfordshire* (FSH), there was a small reduction in the proportion of families who had a child enter care at some point, from 12% to 10%, but the number of days children spent in care showed a reduction by more than half, from 20.5 days per family pre-FSH, to 9.8 post-FSH. Islington's *Doing what counts: Measuring what matters* evaluation, noted that the number of children in care had levelled out at 300 (excluding Unaccompanied Asylum Seeking Children [UASC]), following a rise in the previous year.

¹⁸ Nationally, the numbers of children entering care has continued to increase, in 2016-17 by 2% compared to the previous year (DfE, 2017, SFR 50/2017)

A further estimated fall to 277 (a 7.7% reduction) was predicted, but the evaluation notes that whether this reduction resulted from improved child safety and permanence planning was uncertain.

Three adolescent system change projects reported a significant reduction in children entering care and numbers in care, compared to national increases. Enfield's *Family and Adolescent Support Service (FASH)* aimed to support children and adolescents (11-18 years) and their families through the inclusion of other services (psychology, mediation, learning mentors and youth work), rather than referring out to other agencies; increase face-to-face working and establish effective relationships and support. An estimated decrease of 20% of young people who were in care in 2016-17 when compared to 2014-15 and 2015-16 figures was reported in the evaluation. In North Yorkshire's *No Wrong Door*, 191 (86%) of the 223 referrals (of the total 290 referred to the project), were judged to be edging towards or on the edge of care and were successfully supported to remain at home. 45% of young people who started off in care, ceased to be looked after; in a matched comparison group, it was 20%. The number of days spent in care also reduced. This was attributed partly to the impact of the multi-professional hubs.

Action for Children's Step Change aimed to improve outcomes for young people (aged 11-17 years) on the edge of care or custody by introducing evidence based programmes including Functional Family Therapy (FFT) and Multi-Systemic Therapy (MST). The majority of young people (45, 80%) using Step Change did not go into care during the evaluation. A substantial majority (34, 61%) remained with the same caregiver, but 11 (20%) of young people continued to be, or went into care during the follow-up.

Six projects addressing areas other than social work or adolescent services, also reported reductions in young people entering or in care. For example, the evaluation of Norfolk and Suffolk's *Compass* noted that while involved with the intervention, only 3 of the 152 children who had contact with the Outreach Service entered care. Of the 16 young people who were living in foster care at referral, 5 were successfully returned to their homes, significantly higher than the reunification rate prior to the project.

Daybreak's *Family Group Conferencing*¹⁹ (FGC) evaluation analysed 213 cases in which a FGC was held, and noted that just over three-quarters (76%) of children were living with a parent or relative compared to less than two-thirds (61%) of those for whom no FGC was held (76% FGC, 61% no-FGC). During the evaluation timeframe, court

¹⁹ [FGC] enables wider family members to contribute to decision making where there are child protection or welfare concerns, including where a child cannot remain safely with birth parents...[It] is an important part of pre-proceedings planning. [It provides] a means of involving the family early so that they can provide support to enable the child to remain at home or look at alternative permanence options for the child (p.16, Department for Education 2014, *Court Orders and Pre-proceedings*. London: DfE).

proceedings were initiated in 29% of FGC cases compared to 50% of cases where no FGC was convened. Reductions in court proceedings in response to FGC was also noted in NE Lincolnshire's *Creating Strong Communities* and Leeds *Family Valued*. The evaluation of *Pause* estimated that had the 125 women (who had experienced repeat removals of children into care) not been engaged in the project, an estimated 21-36 pregnancies would have led to those numbers of children entering care.

Increasing numbers coming into care

The projects noting an increase in those in care and/or entering care include Durham's *Families First* (focusing on reflective and holistic practice), in which the number of children in care increased from 61.6 per 10,000 to 67.8 per 10,000 and the rate of children entering care increased from 26.1 per 10,000 to 29.9 per 10,000. This increase was attributed by the evaluators to improvements needed in consistency of information sharing and cooperation between teams as well as longer implementation of the changes, before rates would be reduced. However, their rate of new Child Protection Plans (CPP) per 10,000 children reduced from 50.3 to 46.5 (some of which might reflect those moving from CPP into care). NE Lincolnshire's *Creating Stronger Communities* evaluation reported that, despite reducing court proceedings through the use of FGC, children in care rates were increased from 77 in 2013/14 to 86 in 2015/16 and that the project needed to run for longer to see a reduction in these.

In Hampshire and Isle of Wight's *Social Care Innovations*, an 80% increase in the number of children becoming looked after was noted, significantly higher in the project than for Hampshire as a whole (53%) during the same period. The number of Isle of Wight children becoming looked after also increased, but less significantly. Managers interviewed identified two factors that might have contributed: increased worker awareness and knowledge leading to more children identified as at risk and the numbers of unaccompanied minors during the same period of time having more than doubled.

Children in Need (CIN), Child Protection Plans (CPP), re-referrals and reunifications

Summary on CIN, CPP, re-referrals and reunification with families

Significant reductions in children identified as CIN or de-escalation from CIN was achieved in 8 of the 16 projects measuring this outcome, in response to the use of systemic social work practices. For example, in SoS, the rate of children becoming subject of a CPP reduced significantly, by 22% from 2014–2016.

Better safety planning and engagement of families were reported to contribute to reductions in CIN and/or CPP and increasing reunifications with birth families

Reductions in CIN and/or CPP and re-referrals were also attributed to effective multi-professional work and in the use of specialist workers in mental health, domestic abuse or substance abuse.

Working with all family members and having one key worker per family were also important in bringing about change.

Working with perpetrators of domestic violence seems to be a contributing factor in reducing its incidence.

Speeding up the family finding process in adoption did not compromise the likelihood that an appropriate match had been made.

Reduction in the number of CIN and CPP

The overall picture is more encouraging (in that none reported increasing CIN or CPP) on reducing numbers of CIN and CPP than that on reducing numbers in care, given that all these measures increased nationally over the same period²⁰. However, while 8 projects reported these reductions, including 6 that focused on social work system change, 7 others, including 2 social work system change ones, noted data that were unclear or mixed, and one reported no change. In the 10 pilot LAs undertaking MTM's *Signs of Safety*, the rate per 10,000 of children becoming the subject of a CPP reduced significantly, by 22% in pilots between 2013/14 and 2015/16 from an average of 38 to 29 per 10,000; over the same period the average for their statistical neighbour authorities (comparators) went up by 2%. The difference between pilots and their comparators was statistically significant in 2015/16 (but had not been in the previous 2 years prior to the project).

Family Valued in Leeds showed a significant reduction in the number in CIN, from 2318 in August 2015, to 2022 in a year later. The average reduction of CIN cases for the 6 clusters in the project was 6.5%, compared to a 1.2% reduction across all 25 city clusters. There was a significant reduction (13%) in the number of CPPs, from 666 in April 2015 to 581 in August 2016.

Durham's *Families First* evaluation noted a reduction in new CPPs per 10,000 children from 50.3 to 46.5. The number of new CPPs for neglect specifically, fell from 348 to 301. In Enfield, of the 49 young people who were on a CIN plan on entry to the new service, 12 (25%) remained on a CIN plan; 2 were stepped up to CPP and 4 entered care. Of the 60 young people who had no previous concerns, 2 were stepped up to a CIN plan and 1 entered care. The clear majority (92, 76%) of the 121 who were referred to the service of

²⁰ The number of children in need increased by 0.9% in 2015-16 and the number who were subject of a child protection plan increased by 1.2%

young people, left the project with no concerns recorded, an improvement on the rates prior to the project.

In Hertfordshire, CIN cases reduced from 1055 to 962 (8.8%), CPP from 969 to 687 (29.1%). The evaluation attributes this to the key role played by adult specialist workers who they suggested provided two functions. For families with the most serious problems, their expert and timely input dissipated the immediate crisis and provided the basis for turning things around. Secondly, their input into the multi-professional teams provided a different perspective on managing the risks within the families.

Newcastle's *Family Insights* evaluation reported that 12% of cases were de-escalated, 75% moving from a CPP plan to a CIN plan. This compared to 21% of cases under the preceding model of social care. The majority of cases which had closed had most recently been on a CIN plan, and the most common status of closures was 'no further action'. However, there was some evidence of worse outcomes in the 'segmented' social work teams in the Newcastle project. NE Lincolnshire's *Creating Stronger Communities* evaluation reported that CIN open referrals fell from 371 to 358; CPPs fell from 77 to 59 in same period. Some of the smaller projects reported positive findings, but with very small numbers involved, for example, 9 young people who were admitted with a legal status were discharged without one in Norfolk and Suffolk's *Compass*.

Fluctuations and small sample sizes also made changes difficult to attribute to the project. Royal Borough of Windsor and Maidenhead (RBWM), offered targeted family support, culturally-matched as far as possible, via community based 'hubs' to approximately 90 Army and Asian families that were showing signs of struggling with the overall aim of safely reducing the need for statutory (social worker-led) interventions. The number of children with a CPP declined from 8 in September 2015 to 1 at September 2016, but fluctuated in between these 2 time points. The evaluators concluded that the small sample and historical fluctuating trends make it difficult to attribute the outcomes to the project. However, given the significant overall rise in CIN (777 to 992) and CPP (74 to 109) across the Borough during this period, it is encouraging that the number of Pakistani children with a statutory plan has remained relatively low.

Reducing re-referrals and/or re-entries into care

Ten projects reported numbers of children and young people re-referred to services or re-entering care, 6 of these reporting generally positive outcomes, 2 negative and the other 2 no change or mixed. In North Yorkshire, only 15% (25 out of 164) re-entered care during the 18-month time period from April 2015. Of those, only 7 experienced more than 1 return to care. In NE Lincolnshire, re-referrals fell by 11% over 12 months which the evaluators partly attribute to the integrated working across services. *Family Insights* in Newcastle reduced the re-referral rate from 4% to 2% but the evaluators were cautious in assuming that this could be attributed to the project innovations, or was sustainable.

Doncaster's *Growing Futures* reported a decrease of 16% repeat referrals per Multi-Agency Risk Assessment Conferences (MARAC) during the year 2016/17 compared to the average for the previous two years. Working with all family members, having one key worker, the Domestic Abuse Navigator (DAN), small caseloads and working with perpetrators all seem to have contributed to these better outcomes. In Leeds, the rate of repeat referrals for domestic violence reduced, with a clear downward trend. Similarly to Doncaster, their model involved working with all family members and perpetrators. In MTM's SoS, just over half of the 270 families in the study (142, 53%) were not re-referred to children's services including 86 of the 97 closed or stepped down to early help cases. The evaluators attribute this partly to the better use of safety planning and greater engagement of families, in particular involving children more effectively.

Number of children looked after who return home safely and/or spent less days in care

Only 4 out of 9 projects reported positive quantitative outcomes on the numbers of children who returned home safely, though a further 2 reported on reductions of number of days in care through less waiting time in the adoption process, and are therefore included in this section. In Newcastle, 50% of the 87 children in care in the project were returned to their families, compared to 25% under the preceding model. The evaluators suggested that this might reflect better social work practice combined with reduced caseloads (though not consistently across the service). In North Yorkshire's *No Wrong Door*, 40% of the 67 young people who were referred from care, ceased to be looked after during their engagement with the project, returning home or moving to independent living. This was more than double the number of those ceasing to be looked after in the comparison group. In Stockport, the numbers ceasing to be looked after are not reported but the numbers of children for whom the court allocated a care order at home doubled during the project, from 23 in 2014 to 47 in 2016. This was attributed to the use and embedding of [restorative practices](#) within social work and in both Stockport and Newcastle, a strong learning culture.

Both Cornerstone's *Adoption Support Programme* and Coram's *Permanence Improvement Project* reduced the waiting time in care for children for whom an adoption order had been agreed. Cornerstone's evaluation noted that 45% of parents had a child placed within six months compared to only 36% of those recruited in 2014-2015. Nationally in March 2016, 30% of children had been waiting 18 months or more. Two aspects of the service seem to have contributed in particular, to these better outcomes: the 3-day training course using Dyadic Developmental Psychotherapy (DDP)²¹ reported on very favourably by the adoptive parents, and Cornerstone's independence from the statutory services, which they stated was important to them.

²¹ Dyadic Developmental Psychotherapy involves the child and parents working together with the therapist to develop healthy patterns of relating and communicating where a child has experienced trauma.

In the evaluation of the Coram project, children with a placement order made in the project year waited an average of 113 days for an adoptive family to be found and approved, compared to an average of 246 days in the previous year. An enhanced intervention for children defined as likely to be 'harder to place', led to even better outcomes. Furthermore, waiting times in the comparator authority increased. The interviews with managers and practitioners confirmed that the Coram Consultancy, and its data-led and practice-based methodologies, had enabled purpose and pace to be established more reliably in family-finding and decision-making. There was no evidence in either of these adoption projects that speeding up the family finding process had compromised the likelihood that an appropriate 'match' had been made.

Residential care, placement stability and education, employment and training

Summary on residential care, placement stability and education employment and training

Placement instability and unnecessary escalation can be avoided by providing key worker support which is young person-centred and high intensity.

For those transitioning from care, providing support and training opportunities to find and maintain EET as a condition of participation in the project, is worth testing more widely.

Consistent support to parents and foster carers with one main link person seems to contribute to greater placement stability/likelihood of staying out of care.

A co-design approach to service development that genuinely enables young people to take responsibility for the services they receive, increases stability.

Specific interventions such as MST and KEEP providing therapeutic input and specific training to parents and/or carers, can have a positive effect on educational outcomes, though there were too few participants in these interventions in Wave 1 to provide secure evidence.

Reducing the number of children in residential care

Five projects reported reducing numbers in residential care. The SoS pilots had lower mean residential care ratios in 2015-16 than either their statistical neighbours or the national data for all local authorities. North Yorkshire County Council was operating at 97% capacity in their residential children's homes during the 2014/15 financial year, with a total of 15 residential beds. The use of residential placements was reduced to 45%, of a total of 12 residential beds, during the second year of *No Wrong Door*. In Stockport, the 9.2% of children in care who had been in residential care at baseline was reduced to

5.5% (forecast to achieve a reduction of just over £1.2 million in the cost of LAC in 2016-2017 compared to previous actual spend).

In *SYEP*, the 14 young people at risk of CSE, for whom the alternative was an out-of-area placement or who had previously been placed out-of-area or in secure residential homes, have remained safely in their own communities in specialist foster placements. This has been possible through trained and experienced foster carers with direct access to clinical expertise, combined with key worker support for young people. Similarly, in Wigan and Rochdale's *ACT*, intensive early support was provided to 25 young people, escalation was avoided and no secure placements have been used. The pilot is therefore providing good early evidence that placement instability and unnecessary escalation for CSE-affected young people can be avoided by providing key worker support which is young person-centred and high intensity.

Increasing placement stability

Six projects provided hard outcomes on improved placement stability, none reported worse stability and 4 no change or mixed findings. In North Yorkshire, there was a reduction in the number and proportion of young people experiencing 3 or more placement moves (from 13 to 10 children). Of the 60 young people interviewed at baseline, 19 reported experiencing stability following referral and a further 13 young people from the 32 at follow up interviews reported increased placement stability. In *ACT*, none of the young people judged to be edge of care came into care, and no young people in care moved out-of-area, or to high cost or secure placements. While no comparator data were available, *ACT*'s referral criteria included young people at risk of, or experiencing CSE who were also at risk of placement escalation into high cost and/or secure placements.

In total, 6 of the 116 children placed in Fostering Network's *Mockingbird Family Model* experienced placement disruptions, one of which was described as being a planned placement change. In 2 cases, the child moved into another home in the same group of families. This suggests a rate of 4% unplanned placement change compared to the 8% national rate. In Coram's *Permanence Improvement Project*, no early family disruption was reported for the 54 children with Permanency Orders made in the project year. There were 3 disruptions in the comparison site during that year of the project on a significantly larger cohort. Consistent support to families and foster carers and a co-design and production approach to service development (for example, Wigan and Rochdale, North Yorkshire and Calderdale) are characteristics of the innovations that seemed to increase stability.

Education, employment or training (EET)

Ten projects reported some positive findings for outcomes on education, employment and training one no change and 3 mixed findings. The majority of young people that were

EET on entering North Yorkshire's *No Wrong Door* remained so throughout (69 out of 91, 76%). There was also evidence of a quarter (13 out of 51) of the young people who were NEET on referral, becoming EET, a higher rate than previously noted for this population.

In Stoke's *House Project*, by the end of the evaluation, of the 9 young people still participating in the project (one had dropped out), all were in some form of EET, 5 in further education, 2 had traineeships, 1 had full time work and another was working part time and claiming benefits. Participation levels, therefore, appeared to have remained good throughout which reflected the support and training opportunities to find and maintain EET, as a condition of membership of the project. For the 15 young people in Calderdale's *Right Home* on whom data were available at both the start and the end of the evaluation, EET increased.

Other projects reported on a range of relevant outcomes to education and employment. In Enfield's *FASH*, poor attendance and bad behaviour both reduced by over 50% from entry to exit. Strong relationships between the 25 young people interviewed and their learning mentors, including the mentors accompanying young people to college and job interviews, helped to secure training or employment. In *Family Safeguarding Hertfordshire*, authorised absence remained unchanged but unauthorised absence fell from 186 days to 109; once variations in term length and cohort size were allowed for, this was a reduction from 0.51% of all possible days to 0.36%.

Evidence from surveys, interviews and other sources provided further evidence on EET. In Hampshire, 101 (92%) of the young people involved suggested that their engagement in education, employment or training had improved. In Durham's *Aycliffe*, the 11 young women reported that their attitudes towards learning and their own capacity to do so, improved during the project.

The *Tri-borough Alternative Provision (TBAP) Multi Academy Trust* provided education for young people who have been excluded from mainstream schools in a residential educational setting outside London (the Residence). This was intended to support young people who attended one of its academies and who are in, or on the edge of care, and/or involved in the youth justice system. On average, net achievement was consistently higher for the 15, 12-16 year olds that attended the Residence at least once during the year, (except for in the first half of term one); in later terms, achievement was 5 times higher for learners who attended compared with those who did not. Younger attendees secured significantly higher achievements than older ones who appeared to gain little benefit.

The *Multisystemic Therapy – Family Integrated Transitions (MST-FIT)* intervention, has 2 stages: first, the young person enters a 12-week therapeutic programme within a specialist *MST-FIT* residential home. Then the young person returns to the family home, where the *MST-FIT* therapist continues to work with both the young person and the

parent for a further 4 months. Of the 19 young people at enrolment on the *MST-FIT* project, 7 were in full-time education, 8 were receiving alternative education provision, and 4 were not in education. At completion or near-completion, 14 were in full-time education, 4 were receiving alternative provision, and one was not in education.

One of the projects reporting mixed findings was Hackney's *Family Learning Intervention Programme (FLIP)*. It aimed to improve outcomes for adolescents on the edge of care, to remain with their families or within a stable foster placement using tailored, intensive, 1-6 week residential interventions involving evidence-based therapeutic interventions for families, aspiration-raising experiences, and specialist support. Due to significant barriers in moving towards its full implementation, *FLIP* was operating as an interim model throughout the evaluation period, based in temporary residential settings. Of the 7 young people for whom these data were available, 2 showed a positive change in educational outcomes, 2 showed a negative change and 3 no change. However, of the 6 comparator adolescents, none showed a positive change and 4 showed a negative change on these measures. This suggests that participation in *FLIP* may prevent a deterioration in educational outcomes though the numbers are too small to be confident of this.

Missing episodes, youth crime and crisis presentations

Missing episodes

On missing episodes, 2 projects reported positive outcomes, 2 negative and 2 mixed. In *MST-FIT*, missing incidents reduced from 13 in 2014, to 11 in 2015, to 0 in 2016. In *No Wrong Door*, the year prior to the project, there were a total of 503 missing incidents recorded for the young people that were subsequently referred; this reduced by 54% to 253 following referral and engagement in the project. For a matched cohort of young people not accessing the project, there was also a reduction in missing from home incidents, although the decrease was much smaller (from 1318 to 1231, or 9%).

Stockport and Hampshire's social work project evaluations both reported increased numbers missing, in Hampshire's CSE strand, an increase of 7% during the early period of the pilot programme was reported. However, the evaluators suggested that this might reflect an improvement in the recording of these incidents. In Stockport, the number that went missing from home increased by 86% over the project period, and a 160% increase in numbers missing from care was recorded over the same period. Again, it seems possible that some of this huge increase reflects better detection.

Ealing's *Brighter Futures*, involved the creation of two new multi-professional edge of care teams (MAST East and MAST West) and a new in-care team (CONNECT). Caseloads within MAST and CONNECT were lower than in traditional social work teams (6-8 instead of 18-25), to allow more time to work intensively with young people and their

parents or carers. In 8 of the 21 cases for which data was available, missing episodes reduced (4 CONNECT and 4 MAST young people), although in 2 further MAST young people, they increased. National data for that period suggest that the percentage of young people reported as having 3 or more missing episodes increased from 6.3% in the year ending 31 March 2015 to 15.6% the following year, which needs to be taken into account in drawing conclusions from the mixed outcomes from projects.

Youth crime

Two project evaluations reported positive outcomes and 4, all with small samples, mixed outcomes. Arrests for those in *No Wrong Door* fell from 63 to 39 (a decrease of 29%) while for all young people in North Yorkshire across the same period, there was a small increase (under 1%) from 687 to 693 arrests. This was attributed to the multi-professional work, in particular close working with the police liaison officer and accessibility of support to the young people.

Crisis presentations

Five projects provided data on crisis presentations, 3 reporting positive outcomes and 2 mixed outcomes. In Surrey's *Extended HOPE*, there were reductions in hospitalisation rates for mental health issues: 23% (126) of telephone support contacts and 27% (34) of the face-to-face contacts were attributed to preventing Tier 4 admissions; and 17% (92) of telephone contacts and 26% (33) of face-to-face contacts as having prevented Accidents & Emergency presentations. Similarly, stakeholder interviews in Priory's *Belhaven* project revealed a number of instances where admissions to hospitals and Tier 4 services had been avoided. Both these evaluations attribute the improvements to more effective multi-professional working across services.

In the year prior to *No Wrong Door*, there were 21 presentations to Accident and Emergency departments, whereas in the first year, there were 9 presentations. In the following 6 months, there was just one attendance.

Pause is a voluntary programme for women who have experienced, or are at risk of, repeat removals of children from their care. It offers women an 18-month, individually-tailored, intensive package of support, delivered by a dedicated practitioner. A condition of engagement in the programme, is the agreement to use an effective form of reversible contraceptive for the 18-month duration of the programme, to allow women the opportunity to reflect and focus on their own needs. It was extremely effective in reducing the number of pregnancies experienced by women, while 2 women became pregnant during their time with *Pause*, it is estimated that between 21 and 36 pregnancies would have occurred, had the cohort of 125 women not been engaged in the programme. Given the women's histories, these pregnancies would have been likely to have resulted in removals.

Other hard outcomes

The other outcomes in Table 1 were not reported by more than 3 projects and therefore cannot provide cross programme evidence to any meaningful extent. However, it is worth noting that evaluations of 2 of the CSE projects, Wigan and Rochdale and Sheffield's *SYEP* reported substantial reductions in CSE risk, though in relatively small samples. In Wigan and Rochdale, reductions in risks were recorded for all 9 young people who reached a second review, in 3 of these cases there was improvement in relation to all 10 risk factors. Improvements were most common in relation to young people's awareness of rights and risks; sexual health; going missing; relationships with parents or carers; school attendance and internet or mobile phone safety. The risks least susceptible to improvement were mental health, alcohol or drug use and association with risky peers or adults. Enfield's *FASH* evaluation also reported a significant reduction in CSE risk.

Soft outcomes for children, young people and families

Summary on soft outcomes for children, young people and families

Where young people's mental and emotional health improved, this was in response to improved integrated, multi-professional working, better engagement of the young person and family and a strong focus on strengthening relationships and resilience.

Focused training for parents, carers or residential staff (*KEEP*, *AdOpt*, *RESuLT* and *Step Change*) that increases their understanding, confidence and management of complex problems, improves the emotional wellbeing of young people as reflected in their decreasing SDQ scores, though sample sizes were small.

Ensuring that young people are not only listened to, but their views acted upon, improves their engagement in services and helps them to address their problems.

Youth workers, mentors and others that provide support for young people to 'open up' about their difficulties, help them to improve communication with their families and provide practical help with education and employment, are seen by young people and families to have contributed to improvements.

Evaluations focused more on the resilience of parents/carers than on young people, but evidence suggests that providing support designed to enhance the parent and/or carer and/or young person's control of the situation is reported by them to improve wellbeing.

As shown in Table 2, many more evaluations reported on soft outcomes than on hard ones, reflecting the difficulties accessing data in the timescale in Wave 1. Four outcomes were reported on by 5 or more projects; mental and emotional health, quality of

relationships between young people and adults, young people's and families' resilience and the quality of relationships between young people and their peers.

Young people's mental and emotional health

Fourteen project evaluations reported positive improvements in mental and physical health, none reported a decline and 10 noted mixed findings or no change. With the exception of MTM's SoS (whose outcomes in this area showed no significant change but did confirm the likelihood that the young people met the criteria for the project), Enfield, Ealing and North Yorkshire's *No Wrong Door*, the numbers involved in these projects were small and there was little consistency in measurements used.

Table 2: Soft outcomes relating to children, young people and families

Outcome	Total projects measuring outcome	Generally, positive findings	Generally, negative findings	No change or specifies change is non-significant	Mixed or unclear findings**
Improving young people's mental and emotional health	26	14	0	2	8
Improving the quality of relationships between young people and parents/ carers/ social workers	34	13	0	0	5
Improving the quality of relationships between young people and their peers	10	3	0	0	2
Improving young people's and families' resilience	28	7	0	0	4
Improving young people's physical health	9	1	0	1	1
Providing adolescents with complex needs with a secure stable base	6	0	0	0	2

*Total projects measuring outcome includes those using only qualitative measures, hence the subsequent 4 columns may not add up to this total.

**Some evaluations did not measure group differences or change over time/link to intervention

Over the course of the evaluation the SDQ scores for young people under *No Wrong Door* reduced (a positive finding), from 19.5 to 16.8, whereas for a comparison cohort of young people SDQ scores remained static, 11.7 and 11.5. SDQ scores were collected by 18 projects in total, but some were completed by carers, some social workers and some self-completed by the young people.

All the mental health and CSE projects collected data on young people's mental and emotional health. Small samples and short timescales contributed to a lack of quantitative evidence of improvement, even where interview data suggested such improvements had occurred. Parents, carers and other professionals reported improvements in young people's emotional and behavioural wellbeing and mental health across the projects, for example, in the *Compass* project, most of the parents reported improvements in young people's behavioural and emotional functioning, including reductions in violent behaviour. Yet there was a mixed picture from the quantitative measures which showed no change in young people's internalising and externalising problems and self-esteem, but positive changes in 'total difficulties' on the SDQ. Standardised quantitative measures of mental health and emotional wellbeing were reported as mixed for young people in the *Aycliffe*, *SYEP*, *St Christopher's Safe Steps* and *Surrey's Extended HOPE*.

Young people's self-reports in Priory's *Belhaven* and Wigan's *Specialist Health and Resilient Environment (SHARE)*, however, showed improvements in factors including emotional health and wellbeing, understanding of emotions, increased confidence, feeling able to ask for help, more positive future thinking, and ability to work through difficulties, attributed to more effective multi-professional working and better engagement of the young people

Four of the 5 National Implementation Service (NIS) project evaluations (*AdOpt*, *KEEP*, *RESuLT* and *MST-PSB*) reported on SDQ outcomes. *AdOpt* is a group-based parenting programme specifically designed to help promote parenting techniques aimed at helping adoptive parents understand and respond to complex needs, whereas *KEEP* is aimed at foster and kinship carers. Similar improvements in child functioning as measured by the SDQ were reported by both these evaluations. The *AdOpt* evaluation reported significant reductions in the SDQ total difficulties score and in conduct problems but these differences were not evident for the remaining SDQ scores (emotional, hyperactivity and/or inattention and peer problems, prosocial behaviours). The *KEEP* evaluation reported that there were no differences between the *KEEP* and control groups on overall SDQ scores but the *KEEP* group scores decreased (indicating improvement) for both the emotional distress and prosocial sub-scales, with the follow-up scores of the intervention group decreasing while those of the control group increased significantly.

In the *RESuLT* evaluation, staff SDQ ratings for the young people suggested that conduct problems for the young people in the Intervention Homes stayed the same or deteriorated less than for the young people in the control group, but small numbers make these findings unreliable. The *MST-PSB* evaluation noted a greater decrease in

emotional symptoms in the *MST* group (from 2.36 to 1.14) than the control group (from 2.33 to 1.87), but little change in either group on conduct problems.

Overall, outcomes from these interventions suggest promising rather than secure impact on mental health with *AdOpt* looking strongest from the Wave 1 data so far.

Improving the relationships between young people and adults (parents, carers, social workers)

Thirteen projects reported positive findings on improved relationships between young people and their families, carers or social workers, though the samples of young people reporting feedback were small, even in the larger evaluations.

The evaluation of Daybreak's *Family Group Conferencing* noted that 12 of 13 young people reported that their views were represented at the conference and 9 out of 13 felt that their views were listened to. In both NE Lincolnshire and Leeds, families thought the FGC had worked well, that families' views were heard and they recounted positive features of FGCs which implied young people's views were taken into account:

“You get your views heard and everyone gets their chance to put their point across and everyone gets listened to. It was really, really, positive for us all.”

(Mother, Case Study Two, Leeds *Family Valued* Evaluation Report p.44)

The 12 young people in Calderdale's Right Home completed the [Good Childhood Index](#) and their average 'satisfaction with family' score increased (from 5.50 to 6.75) at follow-up, suggesting an upward trend in wellbeing at 3 months after referral. The 5 young people in the Gloucestershire adolescent pilot consistently rated engagement with the practitioners positively, reporting that they explained the services to them, listened to their views and developed a trusting relationship to them, some helping them to pursue a particular education or employment goal.

While 6-10 year old children in the *Signs of Safety* evaluation reported positively on happiness, their responses on their relationships with social workers were more nuanced. Over 80% of the 111 children believed their social worker regarded them as important, but only 60% thought they could talk to their social worker about their worries, though this increased to 65% later in the project.

Evaluations of 2 of the mental health projects (*Belhaven* and *Compass*) and two of the CSE projects (*ACT* and *SYEP*) revealed improvements in family functioning and relationships. In Priory's *Belhaven*, families were reported to have been given a better insight into their child's needs by allowing frequent contact, compared to more traditional intensive services. Improvements in family relationships through involvement with the *Compass* service were reported by 8 of the 22 young people, which given their complex needs, represents significant progress. Three of the young people reported that their

family was arguing less, and had improved their ability to communicate. However, 9 out of 21 young people reported uncertainties about changes in themselves or their families.

In Wigan and Rochdale's *ACT*, young people said that the workers had enabled them to communicate more openly with their families, and many parents expressed their gratitude that the *ACT* worker had enabled their son or daughter to open up. In Sheffield's *SYEP* young people have engaged with the support provided, 9 out of 14 of them showed a reduction in risk and were extremely positive about the support they had received. Nearly two-thirds (61%) of the young people felt listened to and treated with respect by their social worker and felt safe to talk about private matters with them.

Improving the quality of relationships between young people and their peers

Only 3 projects reported positive outcomes on relationships between young people and their peers and a further 2 related mixed findings, all with small samples.

Improving young people's and families' resilience²²

Seven projects reported positive findings on resilience, mostly of parents rather than of the young people, and a further 4 recounted mixed findings. In the SoS evaluation, parents' scores improved significantly between Time 1 and 2 on the [Pearlin Mastery Scale](#), suggesting that parents' sense of being in control of their lives had improved. Islington's evaluation report noted reduced levels of stress in family life for the 281 parents interviewed between referral, second interview (101 parents) and third interview (23 parents). The *Safe Families* evaluation noted that depression decreased for the primary carer in both intervention and control groups, more significantly for the *Safe Families* participants, but parental anxiety reduced more for those in the control group.

The *AdOpt*, evaluation reported a significant improvement in overall parental satisfaction and efficacy based on a sample of 80-91 parents (not all of them completed every question). Interviews and focus groups with 36 parents evidenced that the *AdOpt* programme had positive effects on child outcomes and parenting practices as well as parenting satisfaction. Adoptive parents also reported that they felt more connected to others and less isolated. Similarly, the evaluation of *KEEP* provided evidence of increased resilience in parents, the intervention group showing improvements compared with the control group on the parenting and wellbeing scales.

Only one report provided data on more than 3 young people's resilience. Action for Children's *Step Change*, measured 39 (58%) young people and 54 (81%) primary caregivers at baseline, of whom 15 (26%) young people and 18 (32%) primary caregivers

²² Variations in the definitions of resilience were explored at the interest group meetings in an attempt to establish greater commonality in measures used across the evaluations.

also provided follow-up data using [SCORE-15](#), a self-report outcome measure of changes in family relationships which covers resilience. Family functioning at follow-up was significantly more positive than baseline, both for young people and caregivers.

Other evaluations described mixed findings. The *Pause* evaluation for example, noted that, 21 women (47%) had reported an increase in feelings of resilience, 8 (18%) had experienced no change, and 16 women (35%) had experienced a reduction in resilience. However, their outcomes on indicators that might be expected to reflect resilience, such as domestic violence, were much improved. Almost half (46.4%) of the women involved with *Pause* who disclosed that they had experienced an incident of domestic violence during their intervention, reported that no further incidents had taken place during the final months of the evaluation.

Hard and soft outcomes relating to the workforce

Summary on outcomes relating to the workforce

Group supervision increased knowledge and understanding of family-focused and reflective practice

Effective use of systemic social work led to reductions in sickness rates in Focus on Practice and MLA. In Hampshire, reductions were achieved through use of social worker PAs and in MST-FIT through training.

Reduction in the use of agency staff, was reported in the evaluations of Focus on Practice and Hampshire's PA strand, reducing costs significantly

Five project evaluations reported reduced caseloads as an outcome (though it was part of the intervention in others), on average to around 8 per social worker which compared very favourably to the 'usual' teams. This increased direct contact time, but staff perceptions still regarded caseloads as problematic in some of these projects

Table 3 shows the number of projects that reported on hard and soft outcomes relating to the workforce. In general, those that reported on these outcomes were positive, though a higher proportion was mixed than for outcomes for children and families. This perhaps reflects the challenges in changing the entrenched culture and problems that the Programme was set up to address. Only one project (St Christopher's *Safe Steps*), reported a negative outcome on one outcome (recruitment and retention), though very positive on some others. Strategies that look promising are further discussed below.

Improving staff knowledge, attitudes and self-efficacy

Nine projects reported positive improvements in staff knowledge, attitudes and self-efficacy and a further 3, described mixed findings.

In *Family Safeguarding Hertfordshire*, 104 observations of practice revealed that workers often told families what to do and displayed a lack of clarity about concerns at the outset, but by the end had shifted significantly in 'good authority' (clarity about concerns, purposefulness and child focus), though there was only a small shift in care and engagement skills. This was corroborated by staff reporting better understanding of concerns with families following group supervision which also enabled them to be more reflective practitioners though over half did not think supervision was a good use of time. Within the specialist Keeping Families Together (KFT) teams, social workers scored exceptionally well on worker authority, purposefulness, clarity of concerns and child focus, reflecting the strong focus in these teams on the concerns of young people.

The evaluation of *Reclaiming Social Work* noted that social workers in the pilots scored significantly higher on all dimensions (collaboration, empathy, purposefulness, clarity of concerns, child focus, and overall social work skill) than did the comparison social workers. Differences were higher for the elements associated with good authority, indicating the successful use of systemic principles in child protection conversations, rather than more supportive or therapeutic discussion. Islington's evaluation reported improvements in Motivational Social Work (MSW) practice skills and parental engagement, though the evaluators suggested it was too early for these to be reflected in child outcomes. The level of skill demonstrated suggested that MSW might be an effective approach to enhancing practice impact for children.

The *Creating Strong Communities* evaluation in NE Lincolnshire reported that 98% of the 59 staff in the survey had a clear understanding of Restorative Practice principles at follow-up, and 88% of them indicated they were actively using it to implement change. Nearly 90% of the 1339 staff trained in *Signs of Safety* noted the SoS framework to be extremely or moderately useful in their decision-making regarding the safety and wellbeing of children. In the *Stockport Family* project, 65% of the just over 100 staff completing the surveys agreed that they had access to the right tools and resources to work effectively with families, an increase of 7% compared to the previous year (although 20% somewhat, or strongly, disagreed).

Table 3: Hard and soft outcomes relating to the workforce

Outcome	Total projects measuring outcome*	Generally, positive findings	Generally, negative findings	No change or specifies change is non-significant	Mixed or unclear findings**
Improving staff knowledge, attitudes and self-efficacy	31	9	0	0	3
Improving job satisfaction of the workforce	31	6	0	0	6
Improving recruitment/retention of the workforce	12	4	1	1	3
Reducing social work caseloads	5	5	0	0	0

*Total projects measuring outcome includes those using only qualitative measures, hence the subsequent 4 columns may not add up to this total.

**Some evaluations did not measure group differences or change over time/link to intervention

Improving job satisfaction of the workforce

Twelve projects reported on job satisfaction in the workforce, 6 giving positive outcomes and 6 mixed.

Triborough's *Focus on Practice* trained over 500 social workers and other related practitioners, 160 supervising practitioners, and senior managers in systemic practice. Social worker absence rates through sickness showed a reduction of over 40% in 2 boroughs (LBHF, from 2.7 to 1.6 and RBKC from 2.6 to 1.5) and 20% in the third (WCC from 2.4 to 1.9). There was a corresponding reduction in the use of agency staff in 2 boroughs, (LBHF, 29 to 18 FTE) and (WCC, 16 to 0 FTE) though not in the third (RBKC), one year into the project. For those participating in *MST-FIT*, findings from one residential home suggest a 58% decrease in staff sickness and 90% decrease in number of assaults after *MST-FIT* was introduced. In Hampshire's project strand on PAs to support social work teams to release their time for more direct work with families, social worker sickness rates were reduced by 83%, compared with a 165% increase in sickness rates amongst other teams. This contrasts with Newcastle in which staff sickness levels increased since June 2015, reaching 3% in August 2016 though it was 6% for the same period in the remainder of children's social care.

Project Crewe's evaluation reported that social workers in the project had lower stress scores on average than those not in the project (mean of 3.3 compared to 5.6). All but one social worker (8 of 9) attributed this to workload, whilst comparatively fewer project staff cited workload as the main factor in stress (6 out of 19). They instead reported that complex cases, and the challenge of collaborating with non-project staff, caused stress. Staff in residential care facilities who undertook *RESuLT* training were generally positive about work at the start of the training, and improved further after the training, in particular for 'Motivation', 'Communication' and 'Quality of Work'.

Improving recruitment/ retention of the workforce

Four projects reported positive outcomes, one negative, one no change and 4 mixed findings on recruitment and retention of the workforce. No significant changes between pilot authorities and their comparators were reported in the evaluation of *Signs of Safety*, in social worker vacancy, turnover or agency worker rate.

Family Safeguarding Hertfordshire's evaluation noted from the staff survey that intention to stay remained stable over the 3 time points at around 50%. Administrative data analysis show a reduction in the number of allocated social workers for each family (from 1.94 to 1.66) indicating reduced staff turnover. Since the completion of the *Frontline* programme, 4 leaders who had been planning to leave their posts had decided to stay.

In Hampshire's *Social Care Innovations*, the evaluation noted positive findings for recruitment and retention on one strand and negative on the other strand which did not

recruit sufficient staff for the planned project work. Social worker vacancies and the use of agency workers reduced in teams piloting PAs but in the second strand, setting up Family Intervention Teams (FIT) including specialist domestic abuse, substance misuse and mental health practitioners, only one team was fully staffed during the project.

The Mockingbird evaluation reported on retention of foster carers noting that during Wave 1, full retention of foster carers was achieved compared to a national estimate of around 6% of foster carers ceasing to foster in the year 2014/2015 [reported by Ofsted](#).

In the Match project, the supervising social worker (SSW) from Match took on the role of the LA child social worker (CSW) for the young people, including statutory visits, looked after child (LAC) reviews, personal education plan (PEP) reviews and contact and work with the birth family. Each young person was also allocated an independent advocate. The evaluation report noted that all 8 young people in the project had the same Match social worker throughout the project compared to 1.8 social workers (some had 3 or 4) for those not in the project. Match carers and young people liked this joint approach but LA managers had some concerns about retaining corporate parenting responsibility without direct LA involvement with the child.

Projects with mixed findings included NE Lincolnshire, in which average vacancies rose from 5.4% to 15.7%; turnover fell from 11.9% to 7.4%. Social worker indicators were considered by the evaluators to be influenced by internal promotions and a need to back fill posts.

In the evaluation of St Christopher's *Safe Steps*, 23 out of 38 staff left during the year of the evaluation. One reason suggested by the evaluators was that the project initially attracted people who were idealistic but lacked residential experience. Interviewees also identified management difficulties, the emotionally demanding nature of the work, unpredictable shifts, long hours, commuting, pay and having no time for non-working life. This highlighted many of the issues that emerged in the [Narey review](#) of residential care and that the Innovation Programme is trying to address in Wave 2, by identifying residential care as one of several priority areas.

Reducing social work caseloads

Capacity is a significant concern in the social care field, the [Munro Review](#) advised that heavy caseloads were an obstacle to good practice. According to [ADCS in 2016](#), social workers working with children in need, child protection and children in care cases, had caseloads varying from 8 to 24. Five project evaluations provided positive outcomes on caseloads, one no change and one reported negative outcomes.

The evaluation of *Signs of Safety* reported a significant fall in the number of children in need per child's social worker. However, the evaluators note that the workforce survey

from which this data is extracted is in the early stages of development and that this reduction might reflect improved data collection.

In Ealing's *Brighter Futures* evaluation, caseloads of 6-8 per worker in the project are compared favourably to around 20-25 in traditional social work teams in that borough. Similarly, Enfield's FASH evaluation noted that low caseloads (6-8) compared to the usual ones in Enfield of 25 to 40 cases, enabled more intensive social work support to young people. Match project caseloads generally averaged 8-10 families per worker, considerably smaller than those held by the LA supervising social workers, where caseloads of 15-20 foster families would be more typical.

Caseloads in Stockport were lower at the end of the Wave 1 project than the mean for the authority over the last 5 to 6 years, yet the staff survey showed a decline in staff views about workloads and capacity. For example, 73% of staff surveyed agreed that they often worked over their contracted hours to cope with their workload in 2016, compared with 64% in 2015.

Project Crewe created space for social workers to focus on more complex child protection cases. It did not reduce overall social worker caseload as the CIN cases diverted to the project were typically replaced by additional referrals. Several Family Practitioners worried that taking on more cases would impact on the sustainability of the *Project Crewe* model. Despite the caseload being capped at 12, and the evaluation evidence suggesting that this has not increased during the first 12 months of the Wave 1 evaluation, they worried about documenting visits, completing CIN plans and conducting frequent enough visits.

Similarly to *Project Crewe*, *Family Safeguarding Hertfordshire* reduced caseloads as part of the innovation in order to increase intensity of work with families and while not achieved consistently across all teams, there was an overall reduction in caseloads. The evaluation noted that continuing high caseloads were identified by approximately 15% of workers and feedback through surveys and interviews suggest that some workers felt that they were being prevented from undertaking this additional direct work with families due to increased or continued high caseloads. The evaluators point out that if a worker has fewer families, but is expected to do more work with them, their workload can increase even if their caseload is reduced.

Aycliffe staff felt that they could not spend the required time with young people – nearly two-thirds (60%) of staff felt that their caseloads did not give them sufficient time to work effectively with young people even though caseloads were small. So, staff perception of time use seems to be important to job satisfaction and is explored further below. The contribution of caseloads to stress emerges in many of the staff surveys in projects that did not specifically report on caseload.

Value for money of the Programme

Table 4 shows the value for money data reported by 25 projects, slightly less than half (44%) of the projects in the Programme. Of these, 21 report evidence of cost savings though 4 of these (Gloucestershire, Cambridgeshire, Sheffield's *SYEP*, Hackney's *FLIP*), are projected or estimated future savings rather than actual, to date. As the measures taken, time period over which evaluation was conducted, costs assessed, sample sizes and methodology all varied, it is difficult to compare these outcomes across projects. Nine additional evaluation reports included only the cost of the project, and did not provide information on the costs of the benefits, alternatives or on potential costs avoided (for example, Action for Children, Fostering Network, RBWM) so have not been included in this table.

Seventeen evaluations listed in Table 4 compared the cost of the intervention with the cost of the alternative and/or 'business as usual', or showed the difference between actual costs and costs avoided. Of these, 13 showed savings, 2 showed no difference and 2 showed increased costs of the intervention. Six other projects used a fiscal return on investment methodology. Two provided information on savings made without comparisons between costs incurred and avoided. A further 2 reports provided information on costs incurred and some potential costs avoided, but did not make clear whether the intervention incurred an overall saving or loss. Finally, one project (Triborough's *Focus on Practice*) reported that placement costs were reduced over 2 years since baseline, but staff salary costs increased. The reduced use of agency staff and reduced rate of staff sickness provided better value for money.

Overall, 21 projects demonstrated savings, some very considerable. Moving forward, establishing a common approach to assessing value for money would enable evidence from different projects to be compared and value of the overall Programme to be judged.

Table 4: Value for money reported for each of 24 projects

Project	Positive value for money	No difference in costs	Negative value for money
Evaluations providing costs with comparators (business as usual)			
Morning Lane	£3,116,486 potentially avoided in care costs. If only 50% of children referred to the service had been placed in care, £1,283,736 would have been potentially avoided.		
Leeds	Cost estimates associated with BAU are around £1943 per family, compared with £1663 per family participating in FGC – an overall saving of £280 per family		
Hampshire and Isle of Wight	Cost of having a PA estimated at £4,408 and a conservative estimate of the savings is £9,000 per social worker. Volunteers delivered average of 3 'substantive' interventions resulting in a unit cost of approx. £396 per intervention		
Catch 22	Savings of £78 per case		
Daybreak	Savings of £65.86 per child per week on average weekly cost of care		
Council for Disabled Children	Savings of £98 per case, though data provided on cost and staff time was selected by the local authority, some data was estimated and may have been subject to bias.		
Gloucestershire	Potential cost savings of between £393-1147 per child per month		
North Yorkshire County Council	Costs avoided to the police – c.£200,000 - during first year Savings reductions in CAMHS referrals c.£160,000 per annum Savings associated with speech, language and communication support c.£300,000 per annum Savings associated with not placing young person outside the area c. £440,000 per person/ per annum, compared to BAU Savings through increased placement stability c. £20,000		

Project	Positive value for money	No difference in costs	Negative value for money
MST-FIT	Cost savings of £15,000-32,000 per year less than a mainstream residential home		
Pause	Cost savings of £1.2 - 2.1 million per year after the 18-month intervention period. Potential cost savings from reductions in levels of domestic violence, harmful alcohol use, and Class A drug use of £628-732,000		
TBAP	Savings of £45,200 per young person per year compared to standard residential home but some costs estimated		
Wigan and Rochdale's ACT	Assuming 30 clients per year on £305k running costs, annual benefits of over £1.6m through reduced and avoided costs of secure and high-cost accommodation		
Hackney's FLIP	Average net saving of £12,327 per intervention (if observed outcomes maintained over 12 months)		
Achieving for Children			£368,819 - higher cost due at least in part to the under-occupancy of the facility during the period of evaluation
Priory			Placements mean of 33 weeks, costs mean of £196,119. Compared to an average length of stay in a CAMHS Tier 4 service of 112 days and costing £72,016, average loss of £124,103 per placement.
MTM's Signs of Safety		No savings	

Project	Positive value for money	No difference in costs	Negative value for money
Match		No savings	
Evaluations providing fiscal return on investment (FROI), which shows the benefit/cost ratio on a project.			
Cambridgeshire	For every £1 spent directly supporting young people the estimated saving is £3 (estimated on current service as not yet running as a Mutual)		
Enfield	For every £1 spent directly supporting young people in the project, £1.84 is saved		
NE Lincolnshire	For every £1 spent directly supporting young people in the project, £3.80 is saved		
Norfolk and Suffolk Compass	For every £1 spent directly supporting young people in the project, £3.39 is saved		
Surrey	For every £1 spent in the project, £3.0 is saved, or £1.50 under the most pessimistic scenario (50% outcome sustainability)		
Wigan SHARE	For every £1 spent directly supporting young people, £3.30 is saved, or £1.70 under the most pessimistic scenario (50% outcome sustainability)		
Evaluations providing information on savings made without comparisons between costs incurred and avoided			
Hertfordshire	Savings from reduced care and child protection allocations in the first 12 months were £2.6 million		
Sheffield's SYEP	Based on 22 young people being supported, estimated avoidance or cost savings were £1,166,854 across the year. The average saving per young person was therefore £53,039		

What does the evaluation of the Innovation Programme suggest contributed to good outcomes?

The relationship between quality of social work practice and outcomes

[Thematic Report 1](#) *What have we learned about social work systems and practice?*

provides a synthesis of the implementation of some of the main interventions used by the projects such as Outcomes-Based Accountability, Signs of Safety, Restorative Practice, Motivational Interviewing and Family Group Conferencing. The evaluation reports provide rich information on the implementation of these approaches, for example the large number of people trained in Signs of Safety (MTM, Leeds and NE Lincolnshire), and the number of family group conferences held (Leeds, Daybreak, NE Lincolnshire). Less information is available on the outcomes achieved from these interventions, partly reflecting the short timescales in Wave 1, though reductions in children entering care, number of children in need or with a child protection plan were evident which might be attributable to the intervention (for example, in the 3 projects involving FGC, more children whose families were engaged in a FGC stayed with their families afterwards). In some projects, it was clear that the quality of social work practice had contributed to these outcomes (for example, Leeds), in others there was no evidence of improvements in practice.

In Leeds, where nearly 6000 people were trained in restorative practices, there were direct observations of practice and outcomes for children improved significantly in terms of reductions in numbers entering care, numbers in need and numbers with child protection plans. There was observational evidence as well as interview and survey responses indicating that social workers were working differently, using restorative social work practices in ways that often involved long-term commitments to families. The observations revealed a challenge for social workers in ending these relationships effectively when there was not always sufficient time to ensure that families were able to move on safely without them. It also identified a gap in the confidence and skills in working with men, in particular in the context of domestic violence. Overall, some of the improvements in outcomes could be attributed to enhanced social work practice.

However, quality of practice did not always improve even when better outcomes were achieved. An important dilemma emerging from the Wave 1 evaluation of Hertfordshire, using Motivational Interviewing (MI), was that outcomes improved but quality of social work practice did not improve significantly. Very few projects (Hertfordshire, MLA, Islington, Leeds), included multiple direct observations of social work practice. For example, the Hertfordshire's evaluation included 126 direct observations of meetings between families and workers, which were recorded and coded for core social work skills, including level of MI skill.

But in other projects including Leeds and MLA, social work practice is reported as having improved as well as outcomes and this evidence is drawn from direct observations. The evaluation of *Reclaiming Social Work* noted that the quality of direct practice was significantly higher in the RSW units than in all previous assessments of practice using the same coding framework. Families interviewed confirmed the higher quality of sessions and outcomes improved in that more children stayed out of care. The evaluators conclude that training in systemic practice, quality of group systemic case discussion and the presence of clinicians in these discussions all contributed to higher quality of practice.

Evaluations that did not include direct observation, assessed changes in social work practice through self-completed questionnaires from social workers, or interviews with social workers and families, sometimes using practice scenarios as part of the interview. For example, in NE Lincolnshire over 90% of staff trained in SoS indicated that the application of it was generating clear benefits in the way they worked with families, and there was evidence of outside agencies responding to SoS by adapting their referral procedures. In Triborough's *Focus on Practice* evaluation, responses to practice scenarios suggested that practitioners were less oriented towards the *Focus on Practice* methods and concepts (which included MI) than the interview responses indicated. It is possible that the evaluations involving observations were providing more rigorous evidence in relation to actual changes in practice in contrast to 'intentions' to change.

Hertfordshire's evaluators suggest a different or additional explanation – the possibility that it was the introduction of specialists (for example, in mental health or domestic abuse) who worked with adults in the family and influenced decisions in the social work teams, that led to the changes in outcomes for children and families, rather than increased skills in social work practice. Their report concludes that specialist adult workers were working with the families with the most severe problems and achieving substantial changes for many of them. They confirmed this from several sources of data and concluded that it was not just the specialist input that they provided that was important (though it was reported to be crucial), but that this led to a more multi-professional way of discussing the families as well as working with them. While only one project, Hertfordshire was one of the largest projects making a significant contribution to the findings on social work practice.

In contrast to this, a common finding across the mental health and child sexual exploitation projects noted in [Thematic Report 3](#), was that interviewees (particularly parents and/or carers and other professionals) reported improvements in young people's emotional and behavioural wellbeing and mental health, but that the findings from standardized quantitative measures of wellbeing were more equivocal. This was illustrated in the *Compass* project evaluation, in which most of the parents reported improvements in young people's behavioural and emotional functioning, yet there was a mixed picture from the quantitative measures completed by young people, parents and

teachers, that showed no change in some of the young people's problems and self-esteem. In general, the quantitative findings across the projects are likely to have been influenced by the small sample sizes, lack of longer-term follow-ups and short timescale.

Specialist adult workers in multi-professional teams using group case discussion

Specialist adult workers were a common feature across projects that in many, seem to have made a substantial contribution to improved outcomes. In some projects (for example, *No Wrong Door*, *Enfield* and *Reclaiming Social Work*), a range of specialist workers joined the multi-professional teams and in addition to providing specialised input to families, they seem to have changed the team dynamics enabling development of more genuinely multi-professional work. Ealing's *Brighter Futures* approach included the widest explicit breadth of expertise, including clinical psychologists, family support, youth justice and education workers, as well as a Connexions specialist, and social workers. Sefton and North Yorkshire included a police officer, while Enfield and all the CSE projects included CSE workers. Teams in Leeds and Hampshire included specialist domestic abuse workers as did Doncaster where the Domestic Abuse Navigators (DANs) were central to the intervention.

The contribution of multi-professional teamwork is discussed in more detail in [Thematic Report 2, *Adolescent service change and the edge of care*](#) in which it is noted that co-located teams develop and adopt a shared vocabulary that provided families with more accessible and consistent language. Individual professional expertise is shared, but enhanced through the sharing of case knowledge in regular team meetings in which any team member was equipped to take on the role of lead professional, referring to other team members as necessary. This investment in case management ensured that the process was not delayed because one key worker was not available. Group case discussion within a clear framework for practice (for example MI, SoS) seems to have contributed to better outcomes even where the quality of social work practice with families is yet to be judged as better.

The role of non-social work staff and volunteers

A range of people were involved in projects who were not qualified in social work but provided support, directly or indirectly to social workers in order to free up their time to undertake more direct work with families. Some projects that had good outcomes seem to make flexible use of non-social work qualified staff including highly skilled administrators and family support workers. Some had also developed their use of volunteers.

In Hampshire and the Isle of Wight, highly skilled administrators or 'PAs' were employed in a ratio of 1:3 PAs to social workers to support social work teams to release their time

for more direct work with families. They undertook pro-active diary management, telephone and email enquiries, pre-populating key reports with basic information, monitoring and chasing social worker compliance relating to KPIs (for example, statutory visits on time) and agency checks. This has decreased social worker time spent on administrative tasks (from 36% to 14%) and increased the time they are spending with families (from 34% to 58%), although only 30% of social workers piloting PAs thought they had more time to spend with families citing caseloads as the reason.

Project Crewe offered a personalised and intensive model of support managed and delivered by non-social work qualified staff, known as ‘family practitioners’. Their role was to develop and deliver the CIN plan; working with families to help them build resilience and maintain long term positive change, using [Solutions-Focused Brief Therapy](#) as well as other feedback tools. Each qualified social work consultant managed 4 family practitioners. The evaluation suggested that they contributed to closing CIN cases, through freeing up social work time, enabling families to be visited more frequently.

In *Pause*, highly skilled practitioners worked with small caseloads of 6-8 women, to promote and sustain change. In addition to emotional and psychological support, practitioners offered women significant help to resolve more practical issues. The evaluation report noted that practitioners held difficult conversations with their clients, offering challenging support to enable them to see things from a new perspective. A key issue for many women was the locus of responsibility for the removal of their children. A significant minority of women reported that talking with their practitioner had enabled them to understand why their children had been removed, and to accept their share of responsibility for that outcome. As one woman commented:

“At the beginning, I was really low. And then *Pause* came along, and I saw a bigger and brighter future, where I can maybe get a job, have a better life. I've seen that there's going to be a future, whereas in the beginning there wasn't a future for me. [...] and that's thanks to [my Practitioner]” (Client 23, p.57, *Pause* Evaluation Report).

Some initial positive outcomes have emerged from two projects in using volunteers. *Safe Families* recruited volunteers to support vulnerable families across 20 local authorities over short periods of time, while maintaining strong attention to child protection and child wellbeing. The evaluation suggested that *Safe Families* has stimulated a steady flow of people (3063 volunteers across 20 LAs) from the community willing to give their time, and satisfaction levels among volunteers remains strong. The evaluation found that *Safe Families* had the potential to safely support about 15% of children on the edge of care (subject to child protection services) who otherwise would be accommodated by local authorities with foster carers or in residential homes under Section 20 (in care), although the evaluators concluded that many of those identified are not those who would have gone into care but rather those needing ‘Early Help’. The report concludes that families are helped, volunteers benefit from the sense of giving something back to society and

local authorities reduce their costs, though the evidence of this remains limited at this time.

In Hampshire and the Isle of Wight, a network of volunteers including family support workers, youth mentors and others were recruited to provide significant added value to statutory work with children and families. 107 (56%) were trained as volunteer mentors, 63 (33%) as volunteer family support workers, 16 (8%) to provide advice and advocacy for permanently excluded pupils, and 94 (49%) to undertake return interviews with children who had gone missing. The evaluation report suggested that having volunteer mentors recruited and trained specifically for this role can provide highly effective support to young people on the edge of care, many of whom have been helped back into education, employment, training and/or positive activities. Furthermore, having volunteers available to do return from missing interviews has enabled Hampshire to undertake almost double the number of interviews compared with the pre-pilot period.

Creating more time for direct contact with families

Explicit in the aims of many of the projects, in particular those working on transformational change of social work, was reducing burdens and demands on social workers and providing them with more support to free up time for direct contact with families. Where this happened, there was usually evidence of improved outcomes.

In Ealing's *Brighter Futures*, reduced caseloads and increased administrative support created time to dedicate to young people. Teams feel safer and supported, with an increased level of confidence in developing relationships. The regular group supervision enables discussion of issues or cases improving the quality of decisions and ability for professionals such as youth workers to take action. In addition, because every member of the team is involved in discussions around every child, each is able to respond to urgent issues or questions from children, families and foster carers. This has already resulted in families saying they feel better supported and more confident in their ability to access help.

Project Crewe reported increases in direct contact time with families, mainly with the Family Practitioners rather than with social workers. In *Reclaiming Social Work*, reducing bureaucracy in order to create more direct contact time with families was a key aim of the project, but the streamlining of recording had only just been introduced at the end of Wave 1. In Hertfordshire, 40% of social workers felt they had sufficient time to work effectively with families, but this fell to around 30%, 80% of workers reported wanting to spend more time doing direct work with children and parents.

This suggests issues around time use remains a challenge for staff. As we suggested in Thematic Report 1, social worker time is not created only by reducing caseloads. The optimum number of cases per worker is difficult to determine, given the varying

complexity of cases and the differing levels of worker experience. Increasing contact time with families, therefore, is not simply a matter of reducing caseloads, but balancing the range of work so that practitioners have caseloads which are manageable and managed.

Working ‘with’ not ‘on’ families

Central to systemic social work, restorative practices and SoS, is the principle that social workers and family support teams work ‘with’ rather than ‘on’ families, supporting them to become more resilient in addressing their own problems rather than telling them what to do. For example:

“Signs of Safety aims to achieve respectful engagement with families, that harnesses their strengths and resources as a hopeful foundation to rigorously explore highly personal and anxiety-producing problems, and then together to find solutions.” (p.12, [Munro, Turnell and Murphy 2016](#))

Similarly, in *Focus on Practice*, the central thrust is that social work should be encouraging families to seek solutions for themselves, through the support of practitioners. This was raised as a major contributor to improved practice in most of the social work evaluation reports and some of the evaluations of other projects (for example, *Pause*).

In *Family Valued*, the social workers conceptualised restorative practice as deploying resources and services which would help the families resolve their own issues, involving wider kin and friendship networks that the family identified as important to them, as part of that process. Restorative practice meant working collaboratively with families to try to support them to identify and resolve their problems (with the necessary supports from social care and elsewhere), largely on the basis of their own plans:

“The old model was social workers taking control within families, dictating what needs to change, a more dictatorial model. Some workers still adopt that approach, so the family becomes very dependent on the worker and other support services, and families go through the motions rather than think for themselves. They will do what they are told to get the social worker off their back, and then can’t sustain it, so it’s not a good method.” (Social Worker, *Family Valued* Evaluation Report, p.58)

In *Family Safeguarding Hertfordshire*, there was a tendency for social workers’ practice at the start of the project to involve telling families what to do. This shifted towards the end of Wave 1, to a greater focus on the concerns of young people and families and enabling them to address these more effectively. Similarly, in the *Reclaiming Social Work* evaluation, families commented that the practice was more supportive than in their previous experiences of children’s services. They commented on the strengths-based and service user-led nature of working that focused on keeping their families together:

“You give us so much more time. You let us explain ourselves, you don’t come in here and tell us, ‘You’ve got to do this or we’re going to take your children away’” (Parent, *Reclaiming Social Work* Evaluation Report, pp.40-41).

Overall, the outcomes for young people and families were better in projects that worked on the basis of this underlying principle of building resilience to facilitate them to make progress themselves.

The role of supervision and consultant social workers and clinicians

Many different roles were created in the Innovation Programme projects, often to support, supervise and challenge social workers. These roles were in general considered to have made a substantial contribution to positive outcomes achieved. According to [Skills for Care in 2007](#) (p.3), high quality social work supervision:

“...is [also] vital in the support and motivation of workers undertaking demanding jobs and should therefore be a key component of retention strategies. Supervision should contribute to meeting performance standards and the expectations of people who use services, and of carers and families, in a changing environment.”

Strengthening supervision was part of many of the more successful projects. Frontline’s *Firstline* project provided a programme of training, coaching and action learning sets to 38 *Firstline* managers from 8 local authorities, targeting those who were already assessed as ‘good’ in order to develop a cohort of outstanding leaders of frontline practice. *Firstline* leaders reported that the programme had helped them to consider other people’s perspectives, to be more reflective, more mindful and self-aware. They described utilising improved professional practice for supervision, leadership of team meetings and to influence change in local authorities’ policies and systems. Social workers from *Firstline* teams identified improvements in 6 of the 8 leadership capabilities that were identified in the *Firstline* capability framework.

In *Focus on Practice*, 20 clinicians and 3 heads of clinical practice (family therapists or clinical psychologists) were appointed for two years in each of the boroughs and embedded in the social work teams. They were seen as authentic experts, an extra resource to help resolve ‘stuck’ cases and provide social workers with systemic ways of addressing problems. They bridged theory and practice, so supporting continued learning about systemic practice. Clinicians accompanied social workers on family visits and reports of this were positive. Part of the value of the role was its flexibility and presence ‘on the floor’ in social work teams, making them responsive to social work needs. The evaluation concluded that they were making a significant contribution to outcomes and the posts are being made permanent.

Of 24 assessment social workers in *Focus on Practice*, 10 reported there had been change in practice towards systemic supervision; the remaining 14 thought there had

been no change, or very little. Barriers to systemic supervision that they identified were the volume of cases to be discussed, the (in)frequency of supervision, and the challenges of translating training into practice.

Approximately 90% of workers in *Family Safeguarding Hertfordshire* agreed that their line manager provided regular supervision and feedback, more than 80% of workers felt that group supervision resulted in greater understanding of risks in families and 60% that it resulted in a feeling of shared responsibility of a case. 70% felt that group supervision enabled them to be more reflective practitioners. Despite these positive comments most respondents (58%) reported that group supervision was not an effective use of their time, suggesting that the case for the impact of supervision on outcomes, still needs to be made with practitioners.

Just over three-quarters (76%) of those who responded to the survey in the SoS evaluation, received SoS case supervision. Over two-thirds (68%) of respondents were able to access group supervision, with just over half of social workers in authorities in the new grouping doing so, and around 75% in the groupings with more SoS experience.

Overall, the evaluations offer some evidence of the contribution of supervision to better practice, the increased priority given to supervision, the additional time and resources invested in it, but further need to convince practitioners of its value.

Use of short-term residential care and respite care

As discussed in Thematic Report 2, projects took differing approaches to interrupting the journey of adolescents towards care. The use of short-term residential facilities to do this was a feature of the mental health, CSE, some of the adolescent projects and Calderdale's *Right Home*. These included short term residential provision for young people, and sometimes families. The multi-professional hub was based in a residential provision in *No Wrong Door*, to provide more intensive and impactful interventions.

Mockingbird and *TBAP* provided respite care and the promising outcomes in *Mockingbird* were partly attributed by those involved, to the availability of both planned and emergency respite. While *TBAP* looked promising, it was too early to draw any firm conclusions. There was evidence that some parents welcomed the experience of supported respite that provided a range of positive activities with more focused and intensive work to develop family relationships and resilience.

Crucially, a 'no heads on beds' principle was at the centre of the *No Wrong Door* approach and this was effective in freeing managers to resist filling beds from outside the target cohort. Where this was not the case, such as in Sefton's *Community Adolescent Service* and Durham's *Aycliffe*, the pilot provision was abandoned. The evaluations acknowledged the pressure to fill beds irrespective of need, as unit costs are much

higher when the provision is not at capacity. Projects in the Programme have shown that short-term residential care can be beneficial but that the costs of empty beds must be taken into account.

Case Study – North Yorkshire County Council's *No Wrong Door*

North Yorkshire County Council's *No Wrong Door* (NWD) demonstrated the art of the possible. It provided an integrated service for young people, aged 12 to 25, who either were in care, edging to, or on the edge of care, or had recently moved to supported or independent accommodation. Two residential hubs operated in Scarborough and Harrogate, each with a team of a manager, 2 deputy managers, NWD hub workers, communications support worker, life coach and a police liaison officer. Some young people were placed in the hubs, others were supported by outreach either in foster care, or with their families.

It achieved wide-ranging positive outcomes in Wave 1 and is continuing to progress.

Outcomes included:

- 191 (86%) of the 223 referrals classed as edging towards or on the edge of care (290 referrals in total, remaining 67 were not judged to be edge of care) were supported to remain at home
- 45% of young people who started off in care ceased to be looked after - in a matched comparison group, it was 20%
- 76% of young people that were EET on entering the project remained so (69 out of 91). A quarter (13 out of 51) of those who were NEET on referral became EET
- use of residential placements were reduced from 97% of 15 beds to 45%, of a total of 12 beds
- 9 presentations to Accident and Emergency departments compared to 21 in the previous year
- arrests fell from 63 to 39 (decrease of 29%) while for all young people in North Yorkshire, there was a small increase (under 1%) from 687 to 693 arrests
- missing incidents reduced by 54% from 503 to 253 following referral and engagement - decrease in matched cohort of 9% (from 1318 to 1231).
- SDQ scores for young people in the project reduced from 19.5 to 16.8 – in the comparison cohort of young people, SDQ scores remained static

Value for money

Costs avoided included the police at around £200,000, reductions in CAMHS referrals around £160,000 per annum, speech, language and communication support around £300,000, not placing young person outside the area around £440,000 per person per annum

What contributed to these outcomes?

- strong, consistent leadership
- multi-professional hub was based in a residential provision, to provide more intensive and impactful interventions
- a range of specialist workers joined the multi-professional teams in addition to providing specialised input to families

- accessibility of support to young people
- liaison with the police was exceptional
- a data technician from within the police service positioned alongside children's services to collect data across agencies.

City of Bradford's Wave 2 project is implementing *No Wrong Door* and other projects are adopting elements of the model. North Yorkshire County Council is continuing to develop the model and rolling it out within the County.

Facilitators and barriers to innovation in children's social care

[Thematic Report 4](#) addresses the systemic conditions for innovation in children's social care drawing on the evidence from across the 57 projects. In this section, a few of the facilitators and barriers, further discussed in [Thematic Reports 4 and 5](#) are considered. Almost all of the evaluation reports commented on quality, consistency and sustainability of leadership – as summarised in the *Right Home* evaluation report, it was clear that crucial to progress had been strong leadership, clear communication channels, a shared vision and common goals with buy-in within and across partner agencies. Some projects demonstrated these, others didn't but evaluation teams highlighted evidence of the effect of this on achieving outcomes. Other factors are briefly described here.

Use of data

Local authorities (LAs) and other organisations welcomed the [literature and evidence reviews](#) (for example, on CSE provided by the evaluation team for Hampshire and the Isle of Wight) produced by several of the evaluation teams to inform the early development of their projects. They also found it helpful to meet others undertaking similar innovations through the Spring Learning Days and Rees interest group meetings. The ADCS regional structure provides opportunities for learning but meetings are often taken up trying to address more immediate day-to-day challenges such as budget cuts, changes in legislation and accountability frameworks.

LAs are highly variable in their effective use of data some having more data expertise and others making insufficient use of data. There was evidence that the evaluations in the IP increased capacity to evaluate and in particular, to use data. Many reports noted that they have worked closely with projects to help them make better use of their routinely collected data and anticipate that this guidance will allow the LAs to continue to make use of evaluation to shape their services.

For example, the University of York set up local systems in Stoke and Calderdale for recording referral routes and basic characteristics to monitor whether services are working with the intended client group. This has included co-designing a system from

scratch in one service, emphasising the importance of using a monitoring framework that can help the service to identify who their service users are, what is happening to them during and post intervention (including drop outs) and how to use soft as well as hard measures to demonstrate impact. Working with one project on ways of demonstrating evidence, has contributed to the LA's decision to gather their own case study examples of families' experiences to take to sustainability meetings to demonstrate impact.

Data sharing

Despite recognising the importance of multi-agency data-sharing in principle, this was not realised in practice in many projects with any degree of success, due to the complexity of different organisational targets, systems and priorities. It undermined the ability of the evaluation to articulate the impact of the service. In Ealing and North Yorkshire, the sharing of data was a particular strength and added a rich multi-agency context to the evaluation of those projects. Some other projects had real difficulty providing baseline and initial data on impact as the challenges of developing an integrated multi-agency data collection system were greater than anticipated. In some of these cases, the projects worked hard with the evaluation team to provide retrospective data to support the judgements in the evaluation reports.

The role of embedded researchers

Eight projects had 'embedded' or 'practitioner researchers'; 5 of these were social work systems change innovations – Durham, Stockport, Islington, Newcastle and Morning Lane; 2 were adolescent service change projects – NYCC and Enfield. The other one was Norfolk and Suffolk's *Compass*, a mental health project.

These roles were of 2 kinds. The first were research-experienced practitioners, referred to as 'practitioner researchers', usually seconded from within the social work service (for example, Newcastle, Durham), though in Norfolk and Suffolk's *Compass*, the researcher was appointed by the Trust. Part of their role was allocated to collecting data within the service and regularly feeding back findings in order to better inform decisions. The second type of embedded researcher was seconded into the service from a university or the evaluation team itself (for example, NYCC, Enfield, Islington, MLA), in order to undertake a similar role. Stockport had both.

In Enfield and NYCC, the researchers were sourced from the evaluation team not the local authority, and were not experienced practitioners – they were located in the local authority team, developed familiarity with the contextual working of the authority, collected data on behalf of the evaluation team and fed this back to the project team. Under the supervision of the evaluation team, the embedded researcher in *Compass* prepared the documents for the ethics application, conducted interviews with young

people and parents, arranged the focus groups with *Compass* staff and arranged collection of outcome measures.

Their effectiveness was reported to vary significantly with strong claims made in some of the evaluation reports about their contribution (for example, Stockport, Islington, NYCC and Norfolk and Suffolk). In Islington, they captured social work practice improvement and advised the local authority how best to mainstream aspects of their data collection. In several projects, but particularly Stockport, they provided more immediate access to young people, families, schools and social workers as they were trusted and could establish a climate of openness. Their role provided immediate and ongoing feedback which led to a 'design by doing' process in the service.

Where they were less effective, this was due to lack of research expertise or status of some of the practitioner researchers, being pulled back into their practice teams due to caseload pressures or university researchers having insufficient understanding of the detailed practice needs. In some projects, there was a single researcher embedded in each authority which proved too challenging as it allowed no back-up in the event of illness and assumed a research-ready environment, which was not always the case. In Newcastle, they have been made permanent appointments. The contribution to outcomes of embedded and practitioner researchers are also discussed in Thematic Reports 4 and 5.

Resistance to change in organisations

A majority of the evaluations noted the slow speed at which the system-level change required took place. The least impactful element of *Firstline* seemed to be the influence of leaders on their organisations more widely, demonstrating the huge challenge in changing organisational culture. Some services were seen to be particularly problematic in this respect - mental health, housing (and particularly local authority housing), probation and others. The evaluation of *Pause* noted that there are limits to what advocacy at the operational level could achieve, particularly where established protocols de-prioritise clients within services. The report exemplifies this by noting that a common systemic barrier to access is the requirement within several services that professionals close cases if clients miss multiple appointments, a behaviour common to *Pause* clients.

The *House Project* evaluation report also quoted evidence from interviews of self-acknowledged resistance in local authorities and differences in pace between officers in the services and council politicians:

'One of the things we're coming up against....it's just a traditional thing within local authorities...we are very slow to change policies and procedures so when you're trying to be innovative and very quick in reacting to the needs of our young people on the project, it's just two clashes of pace. It's a major obstacle, we want to move things rapidly, the council moves in a more sluggish kind of way, they are not

saying “no we can’t do that”, quite rightly they’re exploring how we go about changing council policies that are long written in stone.’

(*House Project Evaluation*, pp. 62-3)

While one aim of the Innovation Programme might usefully be to increase the speed of improvement, the pace needs to enable all those with a vested interest to remain on board and capacity for organisational change to become embedded.

Projects use of evidence from the Innovation Programme evaluations

During the evaluations, evaluation teams ensured that they provided projects with formative feedback in easily accessible forms. For example, the evaluation team for *RESuLT* provided a summary of findings in response to a request from the participating local authorities, to inform their decisions about future involvement in the programme. A report was produced collaboratively between the evaluation team and project on *No Wrong Door* for the North Yorkshire constabulary outlining improvements in offending behaviour and young people missing from care to inform their ongoing policy development.

In Ealing’s *Brighter Futures*, the evaluation team completed Social Network Analysis to explore, map and compare the working relationships and links between professionals, the young person and family and/or carers in a small number of *Brighter Futures* cases (innovation model) and compared these with locality team cases (traditional model). The LA used the findings to help inform decisions about team configurations and to identify the essential ingredients of the model moving forward.

In *Pause* the evaluation team, at the project’s request, provided feedback to the project about their style of communication with partners and helped them to improve this and established learning logs for front line workers, analysed their responses and provided workshops to reflect and improve their practice.

These examples, and there were many more, illustrate the importance of the evaluation team achieving a strong balance between maintaining independence and providing timely and practical feedback drawing on the evidence before the evaluation is completed.

Sustainability, scale and spread

Potential for sustainability, scale and spread were key initial criteria applied in awarding Innovation Programme projects. As we noted in Thematic Report 1, sustainability was a major issue that emerged across the projects. While some projects received transition funding and others had funding commitment from their local councils for extended periods, Wave 1 projects were mainly funded for 12-18 months. Some had sustainability

plans built in so that local authorities started with a commitment to continue beyond the funding period. Others were more dependent on the Innovation Programme funding with no clear exit plan. In some cases, this meant that the project was already losing momentum before the evaluation was complete (for example, staff moving to new posts).

Early positive evidence of implementation was common but some evaluation reports noted a tendency to revert back to old habits when under pressure and operating within a high-risk environment. Many projects started to flounder once key leaders moved on. Hence, building the capacity for change gradually into the organisation without investing too much in one or 2 people alone, seems to be a key message.

Forty-six of the 57 projects have continued. Some of these, such as *MTM*, *Pause*, *The House Project*, *Mockingbird*, *Barnardo's*, *Frontline*, *Coram* and *Hertfordshire* have received further grants through the next wave of the Innovation Programme. Others such as *Focus on Practice*, *Creating Strong Communities* and *No Wrong Door* are continuing because there was an initial commitment from the local authority to extended funding. Some of the same local authorities and/or organisations have Wave 2 projects focusing on different innovations to that which they undertook in Wave 1 (for example, Calderdale, Hackney, MOPAC, Catch 22, Newcastle).

Those that did not continue, had 3 main reasons for not doing so:

- they were developing a prototype, system, intervention or model that was completed in the project timeframe (for example, NSPCC's *Learning into Practice*, NLCEP's *Residential Innovation Programme*, West Sussex's *South East Together*)
- they were not cost effective (for example, Priory, Achieving for Children) or had insufficient funds to continue (for example, Enfield despite the cost savings, decided to redirect the funds to another part of the service)
- the outcomes were not effective or not effective enough to justify further development of that innovation (for example, *Aycliffe*, RBWM)

There is also a need to ensure that longer-term plans are communicated to and understood by, those receiving the service. The evaluation of *Pause* reported one woman's concerns:

'if it wasn't for them helping me in a lot of ways... *Pause* is finished with me next week, and where does that leave me?' (Client 18, *Pause Evaluation Report*, p.53).

Limitations of the evaluation

The short timescale of Wave 1 projects limited the evaluation designs – 3 randomised controlled trials only and 2 of these struggled with sample sizes because of the timescale. Projects underestimated set up times needed, delays in recruiting both project

staff and participants and local authority senior management turnover, all of which led to much smaller samples in most projects which contributed to a lack of quantitative evidence of improvement, even where the interview and other data suggested such improvements had occurred. Changes to the model of intervention or to the target cohort, also provided a challenge to some evaluation teams. For example, the *TBAP Residence* model went through a termly evolution making comparison of the experiences of the first and last cohort problematic.

Many of the limitations raised earlier by the Evaluation Coordinator have been addressed through the commissioning of evaluations in Wave 2. This includes simplifying the allocation of evaluation teams to projects, engaging evaluation teams much earlier before the project begins, clarifying that independent evaluation is a requirement for all projects awarded grants through the Innovation Programme, clarifying the role of the Spring Consortium coaches, strengthening the feedback on the evaluation plans and centralising the ethics approval. Crucially, the Wave 2 projects are longer, mostly 3-4 years providing the opportunity for more robust evaluations focusing on outcomes and cost benefits. In addition, the grouping of evaluations within themes that include both Wave 1 projects that are continuing, Wave 2 projects and [Partners in Practice](#) that support development in local authorities, is a major improvement to increase shared learning.

A key limitation to interpreting data across the Programme was the fact that despite agreement between some evaluation teams to try and collect common indicators across projects, there was insufficient commonality on either what data to collect or how to define the indicator (for example, numbers of children in care, numbers of care episodes or numbers of days spent in care). Given the variations in the innovations being evaluated, this is unsurprising. However, as the evaluation team for Hertfordshire and MLA recommended, national agreement on the measures and samples needed to evaluate children's services would be helpful.

Taking this a step further, this evaluation team went on to suggest the creation of an inter-agency set of Key Performance Indicators (KPI) which would enable the impact of changes on key outcomes such as hospital admissions and police contact to be monitored and developed. Work on this is currently underway by Barnard, Holmes and colleagues funded by [The Nuffield Foundation](#) designed to produce a comprehensive outcomes framework for monitoring to children's social care services, which is intended to encourage greater use of data to inform policy and practice relating to vulnerable children and thereby improve outcomes for children.

The availability of data was an issue for a number of evaluations, particularly where initial plans were premised on bringing together data from children's services, health, and/or the police, for example. *No Wrong Door* was rare in securing a data technician from within the police service to sit alongside children's services, so data could be collected

across agencies. In other cases, the difficulty of obtaining data sharing agreements was under-estimated and many evaluation teams could not, in practice, access the data they had expected.

Finally, measuring changes in social work practice emerged as a key challenge. A minority of projects utilised observation coding systems. Discrepancies between the outcomes from observations and perceptions of those interviewed challenges clear conclusions being drawn but justifies the adoption of mixed-methods evaluation. It also suggests further work is needed to unpick the process of change in social work practice.

Value for money of the evaluations in the Innovation Programme

One area of continuing debate focuses on the value for money of the evaluations – what did they tell us that we didn’t already know? Why do they cost so much? Table 5 shows the percentage of the Programme budget spent on each of the evaluations in Wave 1. This shows that nearly 80% of the projects were evaluated for less than 8% of the programme costs.

Table 5: Evaluation Budget as % of Programme Costs

%	Number of Projects
2-4	13
5-8	28
9-10	6
>10	5

Note: In these calculations, the 5 National Implementation Service evaluations were treated as one project due to the budget allocation arrangements

Comparing Wave 1 evaluation costs to other major government-funded programmes of evaluation suggests that the allocation may be rather low to achieve robust evaluations. Since its launch, the Education Endowment Foundation (EEF) has commissioned 93 evaluations and committed £52 million of funding to innovative and scalable projects. Most of the EEF projects though not all, are RCTs and they allocate budgets to the evaluation that are on average 15% of the project costs. Similarly, the National Institute for Health Research (NIHR) website has many examples of improvements to healthcare and cost savings achieved through its evaluations. For example, one evaluation by the NIHR demonstrated that the NHS could save a further £40m each year by not purchasing mechanical chest compression devices. The costs it publishes suggests that the evaluations are in the range of 15-20% of programme costs.

The Treasury guidance²³ states that the question that should be addressed in allocating resources to evaluation is ‘can one afford not to do a proper evaluation?’ It notes that skimping on the evaluation can have serious consequences and that it is more cost-effective to conduct a robust evaluation, than to repeat or add additional evaluation. It notes on p.34 that:

“In those cases where the innovative initiatives might offer “low cost solutions” evaluation resources might be “disproportionately” high but are still needed to demonstrate the scale of the returns on the policy investment.”

In the light of this guidance and examples from other sectors, it seems to us that the Wave 1 evaluations provided reasonable, and in some cases, very good value for money (for example, in the Hampshire evaluation, the 6 rapid reviews produced to underpin the project would alone usually have cost more than the evaluation budget).

²³ HM Treasury (2011) *The Magenta Book: A guide to Evaluation*. London: HMT.

Conclusions

The aims of Wave 1 of the Innovation Programme provide a benchmark against which to consider how far they have started to be met, as evidenced by the evaluation of Wave 1 projects. These aims were stated as:

- the quality of services increase, so that children who need help from the social care system have better life chances
- local authorities achieve better value for money across children's social care; and
- there are stronger incentives and mechanisms for innovation, experimentation and replication of successful new approaches

Quality of services

45 project evaluations reported outcomes in the short timeframe of Wave 1 (10-18 months). Service users and others interviewed provided their perspectives that services had improved. The quality of services increased in 42 of the 45 projects that reported outcomes in Wave 1, in so far as these outcomes reflected the aims, or service users reported improvements. These outcomes included:

- 24 project evaluations reported reductions in children in care, children identified as CIN, children in residential care, increased reunifications with birth families or de-escalation from CIN or CP
- 14 out of 23 projects that aimed to do so, reported reductions in numbers of children entering care, numbers in care or days spent in care
- 9 out of 31 projects that intended to do so, reported positive improvements in staff knowledge, attitudes and self-efficacy, 6 of the 31 reported increased social worker job satisfaction reflected in reductions in absence rates and/or use of agency staff
- only 4 projects of the 12 that aimed to do so, provided strong evidence of improvements in social worker turnover but all 5 of the projects that intended to reduce caseloads did so

Evidence from the evaluations suggested that these improvements could be attributed to:

- systemic practice as a theoretical underpinning informing conceptual practice frameworks that translate into engagement in high quality case discussion, that is family-focused, and strengths-based, to build families/young people's capacity to address their own problems more effectively
- social work practices that maximise direct contact with families and young people and are flexible and reflective

- social work supervision by clinicians or consultant social workers
- specialist adult workers (for example, mental health, domestic abuse, CSE, substance abuse) who provided expert and timely input for families with the most severe problems, and contributed to the multi-professional teams providing a different perspective on managing the risks within the families and shared case reviews
- multi-professional teams, co-located and undertaking assessment and reviews of individual cases to achieve better safety planning
- consistent support to parents and foster carers through one main link person and for young people, key worker support which is young person-centred and high intensity
- in addressing domestic abuse, working with all family members, having one key worker, small caseloads and working with perpetrators all seem to have contributed to better outcomes
- co-design approaches to service development that genuinely enable young people to take responsibility for the services they receive e.g. the *House Project*

The role of multi-professional teams and specialist adult workers appeared to contribute to better outcomes even where the quality of social work practice with families was yet to be judged as better.

Evidence was promising but not yet secure in the timeframe of Wave 1, on the contribution made by specific approaches and interventions such as:

- Family Group Conferencing
- Restorative Practice
- Signs of Safety
- National Implementation Service Programmes

Value for money

The aim of the Programme for local authorities to achieve better value for money was reported on by 25 (nearly half) of the projects. The other 32 projects did not report on value for money, either because their samples were too small, or because they were unable to get sufficiently robust data on costs (and comparisons) in the time.

- 21 projects reported cost savings/benefit, some very considerable indeed, for example, £2.6m savings in Hertfordshire (though this figure was projected)
- 6 of these used a fiscal return on investment methodology and reported significant savings, in NE Lincolnshire for every £1 invested, there was a £3.80 saving. In 3

of the mental health projects, Norfolk and Suffolk's *Compass*, Surrey's *Extended Hope* and Wigan's *SHARE*, for every £1 spent directly supporting young people in the project, over £3 was saved

- 2 projects reported no savings as yet and a further 2 made an initial loss, due to the high costs of the specialised service in one case, and under-occupancy of residential facilities in the other

Stronger incentives and mechanisms for innovation, experimentation and replication

The extent of interest in securing projects in Wave 2 suggests that the experience of Wave 1 did incentivise further innovation, experimentation and replication. Of the next Wave of projects, 10 are continuations, in most cases scale and spread of the Wave 1 projects. The mechanisms needed (such as legal and cross-service agreements) in order to enable this innovation and experimentation to progress, have become clearer through Wave 1, and the longer run-in times for Wave 2 will facilitate these.

Most importantly, organisations are more likely to innovate when they see others benefitting from attempts to do so. Improving social work practice, keeping families together, increasing placement stability, reducing offending and saving money were all outcomes from Wave 1 that incentivised others to consider their capacity to innovate. In Wigan and Rochdale's *Achieving Change Together (ACT)* for example, the ways of working in the innovation project influenced wider practice both within and beyond these two local authorities.

Acknowledgement by Ofsted is another way in which local authorities are incentivised to replicate positive findings. The Ofsted inspection of Triborough in 2016, found that *Focus on Practice* was making an effective contribution to practice. All 3 residential homes involved in the *RESuLT* training received "Good" or "Outstanding" ratings in their Ofsted inspections. In 2015, Ofsted's inspection report on Leeds stated that:

"Adopting a restorative approach, extensive and effective use is made of family group conferencing (FGC), multi-systemic therapy (MST) and family intervention services (FIS) to achieve early support, early change and early improvement. These services are well-established and delivered by confident, knowledgeable, well-trained and supported practitioners. Parents who spoke to inspectors feel that this help is effective and has made a difference to their lives."

In 2016, Lincolnshire, one of the 10 pilot areas in the SoS project, received an Ofsted inspection report that said social workers in Lincolnshire "are better able to understand the range of risks that children face and the impact that domestic abuse is having on them" by using the initiative.

Recommendations

Recommendations for policy

- **Deregulation:** Continue and reinforce the current policy to support deregulation in order to allow a wider range of innovations. Projects engaging in deregulation need longer to be tested in order to be given a 'fair trial'
- **Support for systemic social work:** National policy needs to reflect the evidence on the efficacy of systemic social work in the professional standards, training frameworks and inspection criteria
- **Support for the development of common measures and data-sharing:** The Innovation Programme should seek to establish common measures across local authorities and organisations and increase data-sharing for reporting trends in children's social care

Recommendations for practice

Children's services providers should take note of the features of promising practice in improving outcomes that emerged from Wave 1 including:

- **using a systemic, family-focused, strengths-based approach** that supports families and young people to take more responsibility for their own lives
- **multi-professional working** that involves a wide range of services including specialist workers in substance abuse, domestic violence, mental health, CSE, FGM and offending to make a distinctive but synthesised contribution to case reviews and decision-making
- **providing consistent support** to parents, young people and foster carers through one consistent 'key worker'
- **maximising direct contact** with families and young people that is flexible and reflective
- **provide high quality social work supervision** by clinicians or consultant social workers
- **maximising education, employment and training (EET):** Providing support and training opportunities for those transitioning from care, so that they can find and maintain EET. Make this a condition of their participation in the project
- **use short-stay residential provision** but resist financial drivers to fill beds

Recommendations for evaluation of Wave 2

- **Samples:** Target much larger samples, especially of young people whose voice was in general, poorly represented in Wave 1
- **Robust designs including comparison groups:** Wave 2 projects which are mostly funded for 3-4 years, should seek to adopt the most robust designs possible including RCTs, and where these are not possible, well-matched comparators. This requires adequate funding
- **Common measures:** More consistency on outcomes and measures in Wave 2 should be achieved through the thematic structure. The Innovation Programme should seek to establish common measures for reporting trends in children's social care, building on the current [Barnard et al](#) work
- **Standardise cost benefit:** Wave 2 of the Innovation Programme should seek to standardise approaches to cost benefit analysis so that comparisons can be made across projects – this needs to include measures taken, time period assessed, costs assessed, sample sizes and methodology adopted
- **Use of practice observation/scenarios:** The relationship between outcomes for children and families, and changes in social work/professional practice should be explored further through more robust methods in order to test out the specific approaches that lead to the most improvement in outcomes
- **Sustainability and Transferability:** Build in plans for sustaining innovation from the start of projects. Evaluate both sustainability and where appropriate, transferability of effects in projects aiming to scale and spread Wave 1 innovations
- **Data collection and use:** Consider using embedded researchers as a potential way to address the research-practice gap, but acknowledge that they require adequate resources

Postscript: Policy Response

The findings from this Wave 1 evaluation has led the DfE has to tailor its Wave 2 and 3 evaluations against the most promising practice measures and outcomes emerging from the first 57 projects. They have identified the following 7 practice measures and 7 outcomes that they want to examine further. These are:

Practice measures

- Strengths-based practice frameworks
- Systemic theoretical models
- Multi-disciplinary skills sets
- High intensity/consistency of practitioner
- Family focus
- Skilled direct work
- Group case discussion

Outcomes

- Create greater stability for children
- Reduce risk for children
- Increase wellbeing and resilience for children and families
- Reduce days spent in state care
- Increase staff wellbeing
- Reduce staff turnover and agency rates
- Generate better value for money

The practice measures and outcomes are viewed by the DfE as the most influential in transforming social work practice and outcomes for children and families. The DfE is keen to build the evidence base in these areas and are exploring these in the Wave 2 evaluations.

Appendix 1: Early Intervention Foundation ratings for initial project evaluation plans

Table 6: Breakdown of evaluation plans (56*) against Early Intervention Foundation (EIF) categories

Evidence or Rationale for the project	Evidence strength rating	No. of Evaluation Plans
Multiple high-quality evaluation (RCT/QED [#]) with consistently positive impact across populations and environments	5	Not applicable [†]
Single high-quality evaluation (RCT/QED [#]) with positive impact	4	1
Lower-quality evaluation (not RCT or QED) showing better outcomes for programme participants	3	6
Logic model and testable features, but no current evidence of outcomes or impact	2	23
No testable features or current evidence of outcomes or impact	1	26

*One plan was not rated as its design was not applicable

† No single evaluation could reach 5 on the evidence strength scale, as none of them could constitute 'multiple high-quality evaluations'; which would require scale and/or spread in Wave 2.



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