Department for Education

Suspected Inflicted Head Injury Service (SIHIS)

Evaluation of pilots to reduce unnecessary family court delays

Technical Annex

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Government Social Research

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Annex A: KEQs and sub-questions

This annex sets out the Key Evaluation Questions (KEQs) and sub-questions for each of the evaluation components.

Process evaluation

1. How was the Suspected Inflicted Head Injury Service (SIHIS) set up and implemented by the NHS Trusts?
    a. Was the SIHIS pilot implemented as set out in Application Guidance provided by the Department for Education (DfE)?
    b. To what extent did implementation vary across the NHS Trusts, and why?
2. What were the barriers and facilitators to implementation of the SIHIS?
    a. What difficulties/barriers did the Trusts face, were they overcome, and if so, how?
    b. What factors facilitated implementation, and how (includes seconded clinicians' support activities)?
3. Is the SIHIS pilot acceptable to key stakeholders (Trusts, families, other organisations affected by the pilot)?
    a. Is it perceived to be relevant to the problems being addressed?
    b. Is it coherent with existing services and provision?
    c. Is there sufficient resourcing for implementation (staffing, budget, guidance etc.)?
    d. Is there broad buy-in to the SIHIS across stakeholders? Are there any objections to continuing implementation of the SIHIS after the pilot ends and without pilot funding?
    e. For families: Based on information from those working closely with families, was the SIHIS acceptable to families, did they have any objections to its continuation beyond the pilot phase?

Impact evaluation

4. What do key stakeholders (e.g. leaders, practitioners, and families) perceive as outcomes of the pilot? How do they believe the outcomes came about?
    a. To what degree do stakeholders believe that the intermediate outcomes on the theory of change (ToC) were achieved? Were any intermediate outcomes not realised, if so, why? How did the pilot generate the changes needed to reach the intended outcomes (mechanisms)?
    b. To what degree do stakeholders perceive that the pilot outcomes on the ToC were achieved? Were any not realised, and if so, why?
    c. Do stakeholders perceive that the pilot is likely to contribute to the long-term impacts on the ToC, or other long-term impacts?
    d. Were there other unexpected outcomes?

    e. Under what conditions did the pilot lead to the intended, or other unexpected, outcomes (contextual enablers)?

5. What does the refined pilot ToC look like?
6. What, if any, were the unintended consequences (positive and negative)?
    a. Who did the negative or positive unintended consequences affect?

Economic evaluation

7. To what extent does the pilot represent value for money?
    a. What are the social and economic costs of the pilot? What might the costs look like if the SIHIS is rolled out?
    b. What are the social and economic benefits of the pilot?
    c. What is the estimated benefit-cost ratio for the pilot?
8. How do cost reductions caused by the pilot vary by group, e.g. between court costs and costs faced by local authorities and households?

Summative KEQ

9. What have we learned across pilot NHS Trust sites that can help to guide rollout of the SIHIS to other NHS Trusts/for other types of injuries?

Annex B: Evaluation matrix

The evaluation matrix below identifies the data sources (primary and secondary) used to answer each KEQ.

KEQs	Interviews round 1	Interviews round 2	Pilot monitoring data	Document review	Wider literature review
Process evaluation					
How was the SIHIS set up and implemented by the NHS Trusts?	X		X	X	
What were the barriers and facilitators to implementation of the SIHIS?	X		X	X	
Is the SIHIS pilot acceptable to key stakeholders (Trusts, families, other organisations affected by the pilot)?	X			X	
Impact evaluation					
What do key stakeholders (e.g. leaders, practitioners, and families) perceive as outcomes of the pilot? How do they believe the outcomes came about?	X	X			
What does the refined pilot ToC look like?	X	X			

KEQs	Interviews round 1	Interviews round 2	Pilot monitoring data	Document review	Wider literature review
What, if any, were the unintended consequences (positive and negative)?		X			
Economic evaluation					
To what extent does the pilot represent value for money?				X	X
How do cost reductions caused by the pilot vary by group, e.g. between court costs and costs faced by local authorities and households?				X	X
Summative KEQ					
What have we learned across pilot NHS Trust sites that can help to guide rollout of the SIHIS to other NHS Trusts/for other types of injuries?		X			

Annex C: Documents reviewed for this report

Documents were reviewed to provide insight into pilot design and delivery, and to underpin the development of the cost-benefit model.

Programme documentation

- His Majesty's Treasury (HMT) Shared Outcomes Fund Round Three: Family Justice Bid

Bid documents

- Application to pilot a new multidisciplinary team: the Suspected Inflicted Head Injury Service (SIHIS) for NHS Trusts: Manchester University NHS Foundation Trust – Royal Manchester Children's Hospital
- Application to pilot a new multidisciplinary team: the Suspected Inflicted Head Injury Service (SIHIS) for NHS Trusts: Birmingham Children's Hospital
- Application to pilot a new multidisciplinary team: the Suspected Inflicted Head Injury Service (SIHIS) for NHS Trusts: Sheffield Children's NHS Foundation Trust

Documents issued by DfE

- DfE (2024a). NHS Suspected Inflicted Head Injury Service (SIHIS) for children: introducing a new multidisciplinary team 2024-2025: Application guide for NHS Trusts February 2024.
- DfE (2024b). Suspected Inflicted Head Injury Service: Questions Answered. August 2024.
- SIHIS pro forma template (V1 – 3)
- Pilot 3 logic model (DfE draft)

Wider literature

- Alma Economics (2021). The social cost of adverse outcomes of children who need a social worker. Technical report.
- Beckett, C., Dickens, J. and Bailey, S. (2014). Concluding Care Proceedings within 26 Weeks: Report of the Evaluation of the Tri-borough Care Proceedings Pilot, Updated Version. Centre for Research on Children and Families, UEA, Norwich.

- Brown. R., and Ward, H., (2013). Decision-making within a child's timeframe. An overview of current research evidence for family justice professionals concerning child development and the impact of maltreatment. Childhood Wellbeing Research Centre.
- Cassidy, D., and Davey, S., (2011). Family Justice Children's Proceedings – Review of Public and Private Law Case Files in England & Wales. Ministry of Justice,
- Giovannini, E., (2011). Outcomes of Family Justice Children's Proceedings – a Review of the Evidence. Research Summary 6/11. Ministry of Justice.
- Law Society (2018), Cost of a day in court – New analysis by the Law Society.
- Mutual Ventures, Delivery Report (unpublished internal document, Department for Education).
- Mutual Ventures (2022). Impact of court delays on children's services. Financial impact modelling support.
- National Audit Office, (2025). Improving family court services for children. 21 May 2025. Report Summary.
- Office for National Statistics (ONS) – Employment and labour market – People in work – Employment data covering employment rates, hours of work and earnings.

Annex D: Monitoring data

Monitoring data was provided by NHS Trust Administrators. The Annex contains tables showing the following data:

- Monitoring data related to SIHIS cases during the pilot, by Trust
- SIHIS support meetings, number of clinicians attending, and number of SIHIS cases discussed, by Trust

Table 1: Monitoring data related to SIHIS cases during the pilot, by Trust

	Birmingham	Manchester	Sheffield
Total number of SIHIS cases during the pilot	14	11	7
Number of local authorities which sent one or more cases to the SIHIS	7	8	3
Number of final SIHIS reports sent to court	7*	3**	5
Number of multidisciplinary team meetings per SIHIS case – mean per case	2	2	3
Number of multidisciplinary team meetings per SIHIS case – range across all cases	1-3	1-3	1-4
Number of SIHIS cases which required a multi-agency Strategy Meeting	13	10	7
Number of SIHIS cases diverted from court	2	6	2
Percentage of SIHIS cases diverted from court	15%	55%	29%

	Birmingham	Manchester	Sheffield
Number of weeks from admission to hospital to production of final report to the court – mean per case	9.5	10	21***
Number of weeks from admission to hospital to production of final report to the court – range across all cases	4-14	3-19	11-34
Number of clinicians who contributed to final SIHIS report – mean per case	5	7	6
Number of clinicians who contributed to final SIHIS report – range across all cases	3-7	3-11	5-7
Number of different clinical disciplines required for completion of each SIHIS report - mean per case	5.5	5	5.5
Number of different clinical disciplines required for completion of each SIHIS report – range across all cases	4-8	3-7	5-6
Total number of clinical disciplines required across all cases during the pilot	10	7	6
Number of clinicians who received formal wellbeing support in the Trust during the pilot	4	0	0

Source: data provided by NHS Trust Administrators.

Notes to table: *5 cases were ongoing at the end of the pilot, with SIHIS reports still to be submitted; **2 cases were ongoing at the end of the pilot, with SIHIS reports still to be submitted. *** The significantly higher number in Sheffield is in part due to an outlier of 34 weeks for one

case. Without this outlier, the mean number of weeks falls to 18 weeks. Note that we are aware that in some instances, a case was diverted from court after a SIHIS report was submitted to the courts (e.g. by Social Services)

Table 2: Number of clinicians attending SIHIS support meetings, by Trust

Month	Type of meeting	Number of SIHIS clinicians from Birmingham Trust	Number of SIHIS clinicians from Manchester Trust	Number of SIHIS clinicians from Sheffield Trust
Apr-24	DfE / SIHIS Introductory Meeting	4	5	6
May-24	Inception meeting	5	5	8
Jun-24	Northern Heads meeting	5	6	6
Jul-24	DfE site visit to Sheffield	n/a	n/a	30+
Sep-24	FJC Symposium SIHIS planning meeting	1	1	1
Nov-24	SIHIS Pilot Evaluation Matrix (Admin)	0	0	2
Nov-24	Northern Heads meeting	6	6	5
Nov-24	DfE/Sheffield Clinicians meeting (virtual)	n/a	n/a	3
Dec-24	DfE site visit to Birmingham	8	n/a	n/a
Dec-24	SIHIS pilot peer review session (virtual)	4	7	4
Dec-24	DfE site visit to Manchester	n/a	11	n/a
Feb-25	SIHIS mid-pilot meeting	4	5	4
Mar-25	Northern Heads meeting	6	6	6

Source: Data provided by DfE

Table 3: Number of SIHIS cases discussed at SIHIS support meetings, by Trust

Month	Type of meeting	Number of SIHIS cases discussed from Birmingham Trust	Number of SIHIS cases discussed from Manchester Trust	Number of SIHIS cases discussed from Sheffield Trust
Apr-24	DfE / SIHIS Introductory Meeting	0	0	0
May-24	Inception meeting	0	0	0
Jun-24	Northern Heads meeting	2	2	2
Jul-24	DfE site visit to Sheffield	n/a	n/a	3
Sep-24	FJC Symposium SIHIS planning meeting	0	0	0
Nov-24	SIHIS Pilot Evaluation Matrix (Admin)	0	0	0
Nov-24	Northern Heads meeting	2	2	2
Nov-24	DfE/Sheffield Clinicians meeting (virtual)	n/a	n/a	0
Dec-24	DfE site visit to Birmingham	2	n/a	n/a
Dec-24	SIHIS pilot peer review session (virtual)	1	1	1
Dec-24	DfE site visit to Manchester	n/a	2	n/a
Feb-25	SIHIS mid-pilot meeting	0	0	1
Mar-25	Northern Heads meeting	2	2	2

Source: Data provided by DfE

Annex E: Technical detail on primary data collection for the process and impact evaluations

This Annex sets out the sampling of locations for in-depth interviews and the identification and recruitment of interviewees.

Sampling of locations for in-depth data collection

In this section we describe the sampling process, and the final sample, for the SIHIS evaluation. The sample was selected in November-December 2024 in collaboration with DfE. Sampling was purposive, in line with a set of guiding criteria. The number of locations selected for in-depth interviewing was agreed with DfE based on available resources and ensuring proportionality across the three pilots to reduce unnecessary delays in the family courts. The aim was to identify locations that would provide the most valuable insights and learning, ensuring variation across characteristics of interest (pilot and demographic characteristics), and relevance to the evaluation.

All three NHS Trusts were included in our data collection. The sampling frame from which we could select local authorities was set up using information provided by each Trust on the number of SIHIS cases (i.e. cases which had been discussed by the multidisciplinary team (MDT) and deemed to involve possible abuse) by mid-November 2024. At that time, Birmingham had seven cases (with families residing in four different local authorities), Manchester had nine cases (families residing in seven different local authorities), and Sheffield had seven cases (families residing in three different local authorities).

We selected purposively from within the sampling frames as follows:

- local authorities with some cases progressing to court and others not progressing to court, where possible (the latter was of interest in order to understand the processes underlying diversions from court). As there was only one SIHIS case in some local authorities, those with more cases progressing to court were given preference.
- Inclusion of the city local authority within which the Trust hospital sits, if possible. This was possible for two of the three Trusts: as there were no cases from Manchester city, Salford was included instead.

Following these criteria gave us the desired sample of six local authorities. We then checked the selection against key variables of interest:

- Average case duration in the selected local authorities was, on the whole, above the cohort[1] average of 38 weeks (2023/24 data), though with some exceptions, notably in Manchester where most of the local authorities had a below average case duration.
- One local authority that falls outside the geographical remit of the three NHS Trusts (Dudley).
- Some variation in demographic characteristics, particularly size of population.

The characteristics of the selected areas are shown in Table 4.

In round two, we reduced the sample to three local authorities (one per Trust) of the six included in the initial sample. For each Trust, we selected the local authority which had sent the highest number of cases to the SIHIS:

- Birmingham: Birmingham City (sent 8 cases)
- Manchester: Tameside (sent 2 cases)
- Sheffield: Sheffield City (sent 4 cases)

[1] 'The cohort' refers to all local authorities in the sampling frame.

Table 4: Characteristics of sampled areas

Trusts	Local authorities	Av case duration, Q1 2023/24 (weeks)	GDHI per head of population (ONS, 2018)	Size of population (ONS, 2022)	Rural including hub towns (%) (GOV.UK, 2011)	White: English, Welsh, Scottish, NI or British (%), (ONS, 2021)	Born outside the UK (%), (ONS, 2021)
Birmingham							
	Birmingham City	55	16,183	1,157,603	0.1	42.9	26.7
	Dudley	50	*17,644*	*324,931*	*0.1*	*82.4*	*5.3*
Manchester							
	Salford	36	16,445	278,064	0.1	74	19
	Tameside	29	21,818	232,753	0.3	82.4	10.3
Sheffield							
	Sheffield City	44	17,459	566,242	4.1	74.5	15
	Doncaster	36	19,777	311,027	19.7	86.6	10.4

Identification and recruitment of interviewees

Respondent categories were identified through a review of programme documentation, ToC workshops, discussions with DfE, the inception meeting with the Expert Panel, and other stakeholder engagements. We aimed to ensure representation across a range of relevant roles, including NHS staff, staff in local authorities, Cafcass staff, family court staff, and professionals in direct contact with families.

The table below shows the number of interviewees engaged and the categories they represent. We interviewed a total of 26 individual respondents (with five NHS respondents interviewed twice).

Table 5: Interviewee categories and numbers

NHS Trust	NHS	Cafcass	Local authority legal team	Judges	TOTAL
Birmingham	4	1			**5**
Manchester	9			1	**10**
Sheffield	7		1		**8**
Not linked to a specific geographic area				1	**1**
Sub-totals	20	1	1	2	
Secondees					**2**
TOTAL					**26**

We had low numbers of interviewees in some of the stakeholder groups outlined in our inception report. In particular, we had a low number of interviewees from Cafcass and local authorities in which SIHIS patients resided, and none from the family courts. We also interviewed three professionals (NHS clinicians and a Cafcass guardian) who had had direct contact with families whose cases had gone through the courts during pilot implementation.

We interviewed a Designated Family Judge (DFJ) covering one of the Trust areas, and a High Court judge in the Family Division. The former reported feedback from

two fellow DFJs who had presided over SIHIS cases in their area. The latter reported feedback from several DFJs who had presided over SIHIS cases. This was in addition to email evidence from a DFJ who had presided over ‘a few’ SIHIS cases.

We were unable to secure any interviews in four of the six local authorities in which SIHIS patients resided (all except Birmingham and Sheffield, for which we had one interview each). This means we have very limited insight into how the SIHIS affected processes in local authorities in which SIHIS patients reside, or the views of professionals working in those local authorities.

Annex F: Technical detail on cost-benefit analysis

This annex provides technical detail on the economic evaluation, in particular the methodology for arriving at programme costs and benefits, and the assumptions underpinning our estimates.

Programme costs

Overview

Cost data related to the funding for pilot implementation was made available centrally from DfE as part of monitoring funding allocations.

Programme benefits

Overview

Programme benefits can be categorised into two broad strands:

- Financial benefits due to operational savings
- Wider societal benefits

Financial benefits due to operational savings

The financial benefits due to operational savings are caused by the reduction in the significant costs of running courts and the staff involved in cases. A reduction in case length (and especially a reduction in the number of hearings associated with case lengths) leads to savings for both the public sector and families.

These reduced costs can be broadly divided into those incurred on a per-case-per-week basis and those arising per hearing:

- Weekly costs include increased placement costs during proceedings – typically higher than those incurred once proceedings have concluded – and the legal staffing costs borne by local authorities for the duration of a case.
- Per-hearing costs include the time commitment of social workers, barristers' fees, additional local authority legal staffing requirements, lost earnings for families attending court, and the operational costs of running court hearings.

Taken together, these represent a substantial financial burden, which can be eased through reductions in both the length of cases and the number of hearings required.

Our estimates of the costs per case per week are derived from previous research commissioned by DfE (Mutual Ventures unpublished Delivery Report) and shared with Alma Economics. Specifically, we assume the costs per case per week to be £697, with 55% of that being due to increased placements costs during proceedings and 45% due to legal staffing costs for local authorities. Using the same source, we assume cost savings for local authorities per hearing to be £3,581, which is a mix of costs related to social workers, barristers and additional legal staffing costs for local authorities.

Drawing on the Law Society's Cost of a Day in Court (2018) – which includes His Majesty's Courts and Tribunals Service (HMCTS) staff expenditure, costs of salaried and fee-paid judges, and estate-related expenses such as utilities and property leasing – we applied an inflation adjustment to arrive at a current estimate of £1,760 per hearing.

In addition to the costs borne by local authorities and the court system, families also face financial burdens when attending court hearings – primarily in the form of foregone labour income. To estimate this opportunity cost, we used a conservative approach based on national averages and minimum wage data. We estimate that families lose approximately £28 in foregone earnings per hearing.

Wider societal benefits

The reduction in negative impacts on child wellbeing from fewer court delays is a significant benefit. Unnecessary delays in court proceedings can leave children spending excess time "inadequately protected from all forms of maltreatment (emotional abuse and neglect, as well as physical and sexual abuse)" (Brown and Ward, 2013).

We grouped the social costs attributable to the prolonged exposure of children to maltreatment into two broad categories:

- Impact on wellbeing: This refers to the impact of adverse outcomes on the wellbeing of children who are exposed to more maltreatment. For example, increased prevalence of anxiety and depression results in a loss in productivity and an increase in costs to healthcare services, but also in a decline in quality of life and overall wellbeing. To quantify the health impact in monetary terms, we use Quality Adjusted Life Years (QALYs). This approach accounts for both the quantity and quality of life, weighting life years gained or lost by the quality of health during those years. One QALY represents one year of life in perfect health and is valued at £70,000, as stated in the HMT Green Book.

- Cost to public services: Some adverse outcomes experienced by children who have a prolonged exposure to maltreatment due to lengthy court cases, such as worse mental health and increased substance use, result in increased use of public services. These include, among others, higher use of the NHS and the criminal justice system. We calculated the extra social cost incurred due to the increased use of these services driven by the increased incidence of adverse outcomes.

To estimate the benefits related to reduced exposure to maltreatment when case duration is decreased, we built on Alma Economics (2021), in which the Alma Economics team carried out a cost-benefit analysis for the recommended reforms analysed as part of the Independent Review of Children's Social Care. The team calculated the annual costs to services and wellbeing costs for children who are victims of abuse and neglect based on a review of the academic and grey literature. We use these figures (inflation-adjusted) to estimate how a reduction in case duration could lead to decreased exposure to maltreatment, thereby resulting in cost savings.

Additional benefits

In addition to the benefits quantified and monetised in the cost-benefit analysis (CBA) model, there are other benefits that have been excluded due to a lack of robust evidence, including:

- Reduced stress and anxiety for families: The stress and disruption associated with court proceedings and attendance at case management hearings (CMHs) could result in increased stress and anxiety for children and families. Therefore, an increased number of diverted cases could result in improvements to wellbeing. While 10 of the 32 cases in the pilot were diverted after the production of a SIHIS report, in the absence of a counterfactual, we cannot assess the extent to which these diversions were attributable to pilot activities. Therefore, we do not monetise these benefits.

Assumptions

Hearings

We could not locate data on the average length of hearings during public law cases and assumed them to last 0.5 days on average. This assumption was affirmed through discussions with Mutual Ventures.

As no quantitative data on outcomes was available and some costs only occur per hearing, we need to make an assumption as to how a reduction in case length

translates into a reduction of hearings. The Beckett et al. (2014) evaluation of the Tri-borough care proceedings pilot found that a reduction of median case length of 22 weeks was associated with a reduction in hearings of 1.2 days (from 5.2 days to 4 days). Hence, we currently assume that a week's reduction in court length is associated with a reduction in 0.055 hearings. As hearings are discrete events, this figure will be rounded to the nearest whole number for the purposes of cost estimation. Hence, only a reduction in case length of about 9.1 weeks and more is expected to lead to a reduction in the number of hearings.

Average age of children

While we don't have exact data on the average age of children involved in the cases, we estimated this number to be 4. This estimate is based on the data presented in Table 2 of Cassidy and Davey (2011).

Foregone labour income

The estimate for foregone labour income per hearing is based on the following conservative assumptions: one parent attends each hearing, has the same probability of being employed as the national employment rate (75%), earns the minimum wage, and works an average number of hours per week. Using the 2024 minimum wage of £11.44 per hour and the UK average of 32.1 hours worked per week, this equates to a weekly income of £367.22. Assuming that one half-day (i.e., 4 hours) of work is lost per hearing, the gross loss per hearing is £36.72. Adjusting for the 75% employment rate, the estimated average foregone income per hearing is £27.52. All data used in the calculations is sourced from ONS.[2]

Wider societal benefits

The CBA uses a time horizon of 20 years. As the estimate for the average age of a child involved in the process is four years, we include the wider societal benefits for children for fourteen years and six years for impacts on adults.

To estimate the benefits related to reduced exposure to maltreatment when case duration is decreased, we built on Alma Economics (2021), in which the Alma Economics team carried out a CBA for the recommended reforms analysed as part of the Independent Review of Children's Social Care. The team calculated the annual costs to services and wellbeing costs for children who are victims of abuse and neglect based on a review of the academic and grey literature. The work

[2] ONS – Employment and labour market – People in work – Employment data covering employment rates, hours of work and earnings.

identified the following channels on how exposure to mistreatment affected the costs to services and wellbeing costs:

Costs to services - Maltreatment increases the demand on public services through the following channels:

- For children (0-18 years):
    - Anxiety and depression → healthcare costs
    - Conduct disorders → healthcare and social care costs
    - Offending → youth criminal justice system costs
    - Social care needs → increased spending on children's social care and education
- For adults (19-81 years):
    - Anxiety and depression → ongoing healthcare costs
        - Alcohol and drug misuse → healthcare and criminal justice system costs
        - Anti-social behaviour → criminal justice system costs
        - Homelessness → costs to homelessness services, the NHS, and the criminal justice system

Wellbeing costs - Maltreatment also leads to reductions in quality of life, measured as QALY (quality-adjusted life year) losses:

- For children (0-18 years):
    - Anxiety and depression → QALY losses
- For adults (19-81 years):
    - Anxiety and depression → QALY losses
        - Alcohol and drug misuse → QALY losses
    - Homelessness → QALY losses
    - Mortality → QALY losses

Since the CBA for the Independent Review of Children's Social Care was carried out in 2021, the UK's societal valuation of a QALY has been increased from £60,000 to £70,000, reflecting general price changes. Hence, we updated the numbers to reflect that and arrived at the following estimated annual costs.

Table 6: Annual wellbeing and service costs due to adverse outcomes (2024/25 prices)

Type of cost	Cost
Annual cost to services per child due to adverse outcomes	£428
Annual cost to services per adult due to adverse outcomes	£7,521
Annual wellbeing costs per child due to adverse outcomes	£1,410
Annual wellbeing cost per adult due to adverse outcomes	£4,948

Source: Alma Economics analysis, 2025

We could not identify any existing literature directly linking the length of court proceedings to the incidence of (further) maltreatment for children. Therefore, our findings are built on conservative estimates. According to the data collected by Mutual Ventures, around 35% of children are not removed from their carer during proceedings. In some cases – especially when children are eventually removed at the end of proceedings – this may suggest a misjudgement that left them at risk of ongoing maltreatment. Longer case durations can extend exposure to such risks. In the absence of direct evidence, we make a conservative assumption that 10% of these children experience further maltreatment during the court proceedings. These are the number of cases where a reduction in case length could lead to a reduction in negative outcomes for the involved children.

In the absence of robust evidence directly linking case duration to maltreatment rates, we apply a conservative, staggered framework to estimate potential benefits from reduced proceedings length. We assume the relationship between delay and outcomes is non-linear, with benefits increasing progressively as delays are further reduced. While quantitative evidence linking case duration to maltreatment is limited, findings from Giovannini (2011) support our assumption. Specifically, they found evidence that longer waiting times to finalise placement were associated with a range of negative outcomes including further parental maltreatment, and increased psychological harm due to anxiety and distress. The assumed impact on wellbeing and service-related outcomes is shown in the table below. It shows that the estimated reduced incidence of (further) maltreatment due to reduction in case length ranges from 0% for a 1-4 week reduction in case length, to 5% for a 21+ week reduction in case length.

Table 7: Estimated reduced incidence of (further) maltreatment due to reduction in case length

Weeks Reduction	Estimated Impact
1 to 4 weeks	0%
5 to 8 weeks	1%
9 to 12 weeks	2%
13 to 16 weeks	3%
17 to 20 weeks	4%
21+ weeks	5%

Overarching assumptions

Inflation

All benefits and costs in our analysis have been presented in real terms – with the effects of general Consumer Price Index (CPI) inflation removed as per HMT Green Book guidance.

Discounting of benefits and costs

In line with HMT Green Book guidance, future benefits and costs attributed to the pilot have been discounted and presented as present values. This discounting adjusts future benefits and costs to reflect social time preference, capturing the higher value society attaches to consumption now compared with in the future. Our analysis used two different discount rates as per the Green Book. For any benefits monetised in QALY, we applied the health rate of 1.5% and for any other benefits, we applied the standard social discount rate of 3.5% in real terms.

Time horizon

Given the expected lag between the implementation costs of the pilot and the realisation of its benefits, the model assumes that costs are incurred in Year 0, with benefits commencing in Year 1. While the pilot ran for only one year, a 20-year time horizon is used in the model to capture the full extent of longer-term impacts, such as improvements in wellbeing, and reduced public service use. Many of these benefits – particularly those arising from better developmental outcomes and reduced exposure to harm – emerge gradually over time, making a longer horizon essential for a meaningful cost-benefit analysis.

Numbers of cases and children affected by the pilot

There were 32 SIHIS cases in the pilot across the three NHS trusts. Although data on the number of children per case is not available, it is likely that each case involved a single child, as cases are triggered when a child is brought to the hospital with a head injury and requires separate clinical investigations.

Annex G: Expert panel composition

The following outlines expert panel members who supported the evaluation.

Martha Cover

- Barrister at Coram Chambers.
- Specialises in care proceedings and kinship and adoption law.
- Has represented children through their court-appointed guardians, and older legally competent children directly.
- Since 2004, Martha has been a member of government working parties and professional advisory groups developing new initiatives in the family justice system and/or producing original research.

Maud Davis

- Senior Advocate – Child and Family, Bindmans LLP.
- Maud has over 20 years' experience in family law, representing children in complex care cases as well as dealing with adoption, cases brought under the inherent jurisdiction, and deprivation of liberty and secure accommodation cases.
- She is an experienced advocate who deals with hearings at all levels, including the Court of Appeal, representing parents as well as children.

Susannah Bowyer

- Assistant Director, Research in Practice.
- Susannah leads the Research in Practice ‘children and families’ team, as well as a range of commissioned research and evaluation projects, including work with The Association of Directors of Children’s Services (ADCS) and Government bodies.

Bianca Karpf

- Registered child and family social worker with experience working in an inner London Child Protection team, including experience of the family court system from public law outline (PLO) through to final hearing.
- Has worked in a Leaving Care service and with survivors of torture at the Helen Bamber Foundation.
- Bianca brings social care expertise and a perspective from the children’s charity sector.

Kenny Gibson

- Deputy Director - NHS Safeguarding.
- Oversees several portfolios including tackling abuse, exploitation, radicalisation and violence nationally.
- Leads on Contextual Safeguarding; Trauma Informed Care; Prevent in the NHS and Child Protection Information System.
- Kenny will share this post with Deborah Perriment and bring in other NHS England (NHSE) colleagues for specific subject matter when appropriate.

Annex H: Decision not to interview families for this evaluation

After extensive discussions with staff from DfE and the Delivery Partners involved in other DfE-sponsored pilots to reduce unnecessary delays in the family courts – including former social workers and child protection professionals with significant experience of working with families going through the family courts system – we decided, in collaboration with DfE, not to interview families for this evaluation. The reasons were as follows:

- An overarching ethical concern, shared by all parties to the evaluation, about the possible re-traumatisation of individuals just as they were exiting a traumatic experience in the courts.
- The need to wait until families were at a late stage of their court case (likely to be after the final hearing), which could lead to recall problems.
- The need to wait until after the final hearing made it likely that we would have very small samples for each pilot, making it difficult to ensure anonymity.
- The changes in process introduced by the SIHIS were likely to be largely invisible to families.
  We were advised that securing ethical approval from the NHS to speak with patients was likely to be particularly burdensome.

We instead sought to interview stakeholders in close contact with families whose cases were going through the courts during the pilot timeframe, such as local authority social workers and Cafcass Guardians. Given the limitations of our final sample, very few interviewees had had direct contact with families with a child referred to the SIHIS.

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