

Social Work – Working for Families
A Service Transformation by Cambridgeshire County Council
Children's Services

An Evaluation by
Cambridgeshire and Peterborough NHS Trust
In Partnership with
University of Cambridge
Anglia Ruskin University

Dr Paul Wilkinson^{1,2}, Dr Esther Mugweni¹, Ms Amy Broadbent¹, Ms Rebecca Bishop^{1,2}, Dr Jane Akister³, Dr Dickon Bevington¹

1. Cambridgeshire and Peterborough NHS Trust

2. University of Cambridge

3. Anglia Ruskin University

Additional contributions from with SWWFF implementation team: Elaine Petch (Principal Social Worker), Sally Wood (Professional Clinical Lead) and Rachel Watson (Lead for Systemic Practice)

Acknowledgements

We would like to thank the families, staff, managers and managers of partner agencies for sharing their time in taking part in this study. We would like to thank the social work professionals who took time to recruit families. We would like to thank Professor Ian Goodyer for help in the planning of the study. We would like to thank Cambridgeshire County Council for funding this evaluation and helping us to develop and improve our methodology, in particular Elaine Petch, Sally Wood and Rachel Watson.

Correspondence

Please address all correspondence with regards to this evaluation to:

Dr Paul Wilkinson
University Lecturer and Honorary Consultant in Child and Adolescent Psychiatry
University of Cambridge Section of Developmental Psychiatry
Douglas House
18b Trumpington Road
Cambridge. CB2 8AH
pow12@cam.ac.uk
01223 746077

Report Structure

This report begins with an executive summary, followed by key findings from our four groups of research participants. Contents for the full report start on page 17.

Headlines from the Evaluation

- ✚ The overall opinions of all participant groups were that the SWWFF transformation has benefitted client families and staff
- ✚ Questionnaire data from staff suggested that they overwhelmingly prefer the new model. In particular, the unit structure helps staff feel more supported and may lead to better practice as more ideas are available to help develop the intervention with each family
- ✚ The systemic training has led to improved quality of social work practice
- ✚ Communication with service users and other agencies is improved

Report Structure

This report begins with an executive summary, followed by key findings from our four groups of research participants. We have integrated comments on how SWWFF has improved and evolved between the interviews and the time of the report throughout. Contents for the full report start on page 17.

Executive Summary

Introduction

In 2012, Cambridgeshire Children's Social Services began a major service transformation to adopt the Social Work – Working for Families model (SW:WFF). Based on reports of the successful Hackney Reclaiming Social Work model, there was a restructuring to small social care teams, normally of 4.5 whole time equivalents, including a clinician. While there was some evidence to suggest that the changes to practice and managerial reorganisation involved in SW:WFF were effective in the densely populated inner city setting of Hackney, there was no evidence for how such a service transformation might translate into a mixed urban, suburban and rural setting. Introducing this model into Cambridgeshire involved relocating staff across the county as well as developing new ways of working. An ambitious programme of systemic training for the workforce was undertaken. The systemic approach was designed to underpin 3 domains: practice with service users; leadership and management of the social work task and interagency working. The SW:WFF evaluation includes data collected from client families, staff, managers who implemented SW:WFF and partner agencies. Quantitative data was obtained from families (on their opinions of the service and the family's presenting problems) and staff (on their experiences of and attitudes towards the SW:WFF transformation). Detailed interviews were carried out with four participants groups on their experiences of and attitudes towards SW:WFF: client families, unit professionals, social care managers and managers of partner organisations. Analysis of the interviews allowed us to draw out themes relating to the advantages of the new model; the challenges faced and to propose recommendations for the future development of the SW:WFF model (see Full report sections 2, 3 and 4).¹

The Executive Summary is extracted from the comprehensive, 288 page, full report of the evaluation which details the methodology, full analysis of the questionnaires and interviews together with discussion of these findings in relation to other transformations of services with recommendations for future consideration. The detailed report will inform the SWWFF

¹ All references are to sections in the Full Report.

implementation team moving forward, and also any other authorities considering a similar restructuring of service provision. The SW:WFF report supports and adds to the findings from the evaluation of the Hackney Reclaiming Social Work model which was primarily a detailed description of practice in the different local authorities designed to try to understand what factors shape effective social work practice. In the Hackney report, workers in units rated the quality of the work and the environment as much better than those in traditional teams, with all the independent or semi-independent reports from court and other agencies reporting a very encouraging picture of practice, and families seeming generally positive (see 1.2.3). However, the authors highlighted that the samples were small, but overall though, the range of evidence suggested that the systemic unit model was appreciated more by workers than the more traditional approach that preceded it. The evaluators conclude that *key to the success of the approach is joint allocation in small teams*. Shared allocation also ensures that the unit is a genuine team with a shared purpose, rather than a group of workers each with their own cases. The confirmatory findings from the SW:WFF report are therefore important in adding validity to the Hackney findings and adding detail relating to management of the transition and the interagency findings.

The research was completed in June 2014 . During the time that the research was taking place, before completion of this report, there were significant changes made within Cambridgeshire Children's Social Care. Many areas for development were apparent and acted upon during the course of the ongoing evolution of this new service, independent of the results shown in the research. Responses from the SW:WFF implementation team are included in the body of the report to reflect this and are clearly marked as such (as '**Comment from SW:WFF leadership team**').) Also included in the appendices are brief reflections from the research team and the SW:WFF implementation team on the experience of commissioning and conducting the research and the research process.

Cambridgeshire

Cambridgeshire is a mixed urban-suburban-rural county in East Anglia, with 53% of district council wards classified as urban city/town in 2011. At the 2011 census, population was 621,210, a growth of 12%

in the previous 10 years, which was the largest growth in any county council authority in England. 29% of households contained dependent children.

The local economy and deprivation vary greatly throughout the county. Deprivation levels are significantly higher than the national average in Fenland, in the north. Deprivation levels are considerably lower than the national average in South Cambridgeshire (see 1.1.2).

Key Findings

Key Findings from Families

(Cambridgeshire, 29 individuals, from 13 families; Hackney, 11 families)

Themes from our data indicate three factors that were perceived as affecting attainment of positive change in family functioning and wellbeing. These factors also impacted on the likelihood of having a positive relationship with a Unit.

- **The first set of factors** pertained to the skills of the social work professionals. This included their communication skills and their ability to determine the specific challenges that the family was facing and providing appropriate timely intervention for the family to be to make the necessary changes.
- **The second set of factors** pertained to the family's engagement with the social work professionals and their willingness to take up the services being offered. Thus making the changes expected of them.
- **The final category of factors** had to do with the quality of interagency work and the ability of different partner agencies to work together in supporting the family to make the necessary changes.

The experiences of the families with the unit model, results from the interplay between these factors: the social workers skills, the organisation and management of services and the collaborations with partner agencies (see Figure 1 below and Full Report 4.3.1).

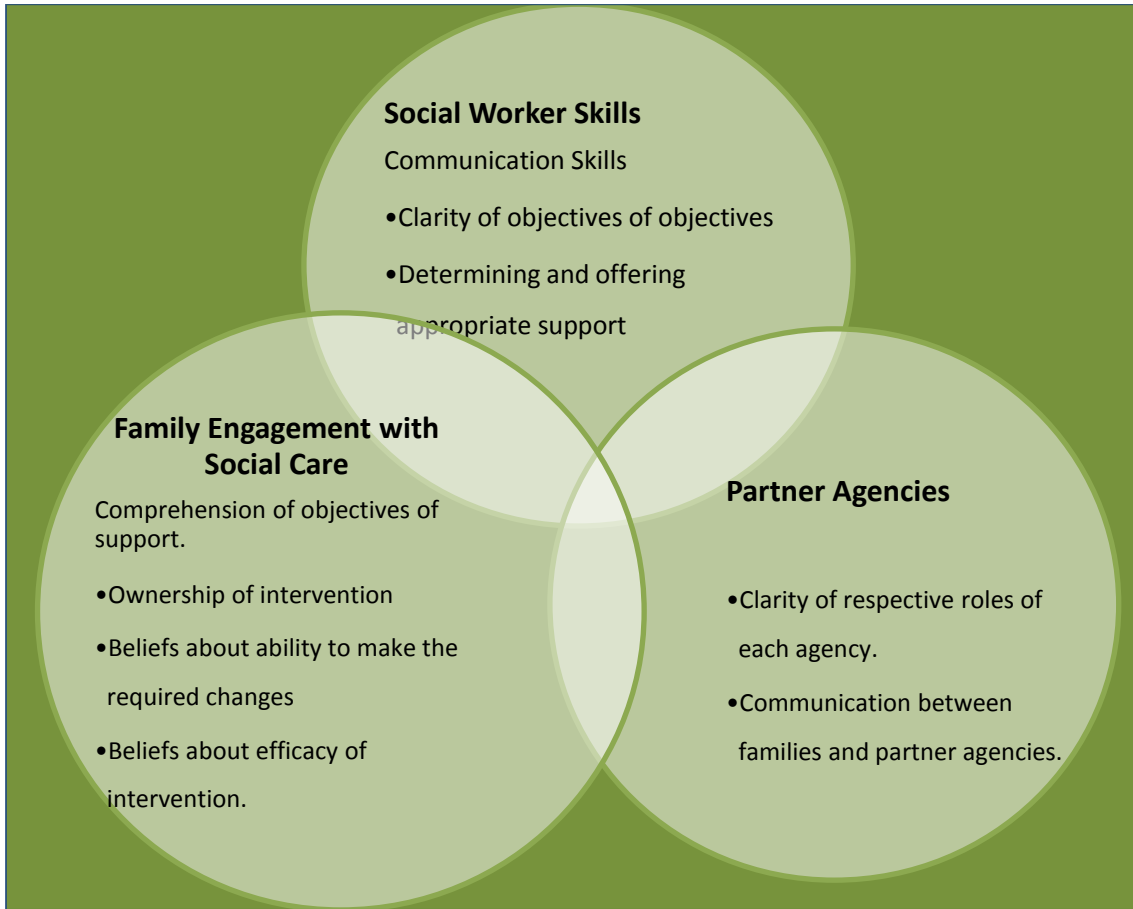
Findings

1. 72% of families felt listened to; 71% found social care helpful (see 3.1.2)
2. Families praised communication skills of social care staff (see 3.1.1)
3. Families praised good communication between social care and partner agencies (see 3.1.1).
4. Sometimes staff raised expectations of families and then did not deliver what the families thought they would receive (see 3.1.1)

Recommendations

1. Continue to develop clearer interagency working (see 3.1)
2. Facilitate staff to set realistic expectations for families (see 3.1)

Figure 1: Factors affecting relationship between Unit and Family and attainment of expected change



Key Findings from Staff

(Cambridgeshire, n=175; Hackney, n=65)

'... we are way more reflective, we are able to share risk, share difficult decisions, check things out with each other, we just feel so much more nurtured and protected ... and supported.' (Social Worker)

Staff identified numerous benefits of the model that they felt had improved the working experience for staff as well as the quality of the service provided to children and their families. The common factor underpinning these benefits was the improved teamwork and reflective practice that staff felt had been introduced as part of the SW:WFF model. This identified the systemic approach, which emphasizes the importance of using the perspectives of other unit members in reflecting on both progress and risks, as a key factor behind staff satisfaction with the model.

The improvements to the service that staff members associated with the SW:WFF model during the interviews centered around three main themes:

- Safer practice through shared responsibility and reflective discussion
- An improved team structure
- Improved relationships with families.

Findings

1. 93% of staff stated they prefer the SW:WFF model. 87% of staff thought the SW:WFF model has led to decreased risk for children and families, and 76% thought it has led to decreased risk for staff. In addition, 92% felt well-supported and 99% felt it provides a helpful service for the families (see 3.2.2).
2. Staff found the reflective approach of the new model beneficial to themselves and families (see 3.2.1).
3. The diversity of the new units, with clinicians and unit co-ordinators, is beneficial (see 3.2.1).
4. High staff movement leads to increased workloads, is difficult for families and makes reflective discussions harder (see 3.2.1).²

Recommendations

1. Consider the optimal unit size (there are advantages and disadvantages of the current unit size of 4.5 wte, see 3.2.1)
2. Consider ways to reduce staff movement between/from units (see 3.2.1)

² It is important to emphasise here that a lot of staff movement is due to promotions and moving between teams rather than poor recruitment and retention in Cambridgeshire. Difficulties in recruitment/retention of social workers is a national problem, and in fact vacancy rates are considerably lower in Cambridgeshire than in neighbouring counties.

Key Findings from Managers who Implemented SWWFF in Cambridgeshire

(n=10)

'The positive surprises are in the sense of.... It's an excellent way of working. I think, what we hoped for has come to pass. When it works well, it works really well.' (Manager 2)

'Well like I said, you just wouldn't go back, you know, you wouldn't.' (Manager 6)

Findings

1. Social Work Practice was more transparent (see 3.3.2)
2. Social Work Practice was enhanced by an improved theoretical and knowledge base (see 3.3.3)
3. Staff were better supported and were carrying out more direct work (see 3.3.3).
4. It was difficult to recruit consultant social workers and manage high staff movement between units; this could result in the use of agency staff without systemic training (see 3.3.4).
5. One significant challenge was high caseloads and small units together with lack of clarity about when to transfer/close cases (see 3.3.4).
6. Another significant challenge was developing an understanding of the role of the clinicians and using them appropriately (see 3.3.4).

Recommendations

1. Develop strategies to manage demand –including improved links with locality teams and being clearer about when to close cases (3.3.6).
2. Further consider the optimal unit size (see 3.3.6).
3. Further clarification of the role of the clinician and group managers (3.3.6).³

³ Definition of role is clearly ongoing with such a relatively new model of practice.

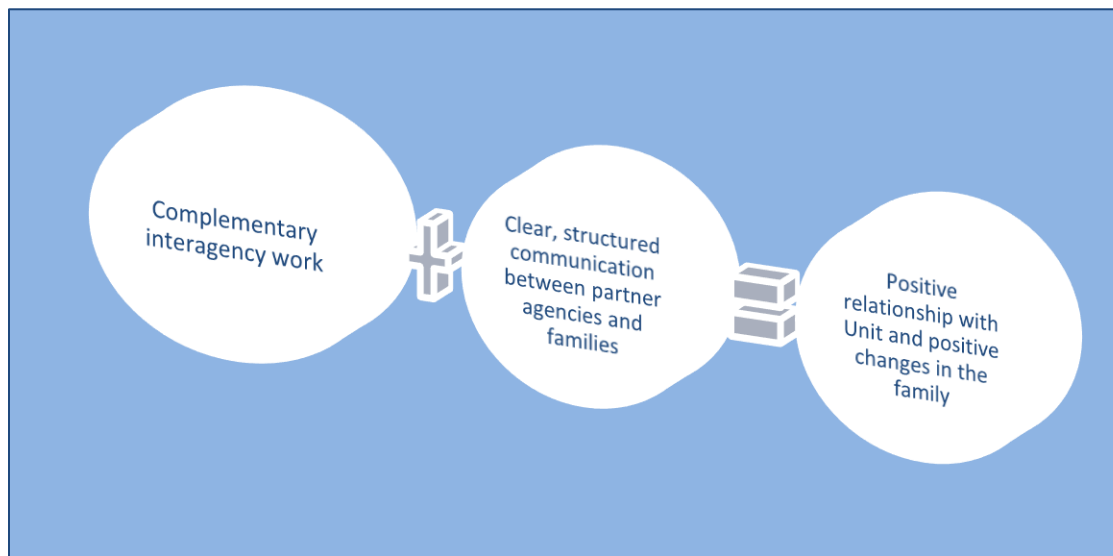
Key Findings from Partner Agencies

(Cambridgeshire, n=11; Hackney, n=3)

'I, personally I think it's, this is, this is a good way of working. I think if, if people are still working in older ways, they should look at this as the way forward.....I would say from my experience, this has worked well for us.' (Partner Agency 10)

A combination of structured complementary interagency work and clear communication between agencies contributed to positive relationships between families and Units as well as positive changes in the family as indicated in the figure 2 below. Other agencies are clearly perceiving social workers as more professional and accessible.

Figure 2: Positive Change and Interagency working



Findings

Partner Agencies experienced social care units as:

1. More positive and better informed (3.4.3).
2. Easier to access (3.4.3).
3. Using theoretical perspectives to identify the strengths and difficulties within families (3.4.3).
4. Providing valuable input to pre-legal proceedings (3.4.3).

Recommendations *(from partner agencies)*

1. Ensuring that the Units have manageable caseloads (3.4.5)
2. Setting realistic expectations (3.4.5)
3. Increasing continuity of care for families (3.4)

Strengths and Limitations

The main strength of this evaluation lies in the in-depth interviews and subsequent detailed qualitative analysis from four key participant groups working in, and being affected by, the transformation of Cambridgeshire children's social care: families themselves (n=13), social care professionals working in units (n=175), social care managers (n=10), and managers of partner organizations (n=11).

A limitation is that this is not a longitudinal study and therefore does not evaluate whether input from the SW:WFF unit model improved outcomes for families (See Full report 4.2). As in the Hackney evaluation, numbers are small but taken together the 2 evaluations provide validity for the benefits of the unit model.

As noted in the introduction the detailed findings are discussed in the full report of the evaluation.

Contents

1.	Introduction	20
1.1.	Social Work – Working for Families	21
1.1.1.	Key Features of the SW:WFF model[1]	22
1.1.2.	Cambridgeshire	25
1.2.	Evaluations of Previous Service Transformations in Children’s Social Care Services	26
1.2.1.	Social Work - Working for Families	26
1.2.2.	Adolescent Mentalization-Based Integrative Therapy.....	26
1.2.3.	Three Recent Evaluations of Service Transformations	28
1.2.4.	Other Evaluations – References	45
1.3	Purpose of this Evaluation	46
2.	Methodology.....	47
2.1.	Methodology Introduction.....	48
2.2.	Qualitative Data Collection and Analysis	49
2.2.1.	Introduction	49
2.2.2.	Qualitative Evaluation Approach	50
2.2.3.	Qualitative Interview Research Participants.....	51
2.2.4.	Qualitative Data Analysis	54
2.2.5.	Validity of Qualitative Findings	56
2.2.6.	Qualitative Methodology – Summary and Conclusions.....	57
2.2.7.	Qualitative Methodology – References	57
2.3.	Quantitative Methodology.....	59
2.3.1.	Participants	59
2.3.2.	Questionnaires and Scales	60
2.3.3.	Procedure for Data Collection.....	62
2.3.4.	Data Analysis	63
2.3.5.	Quantitative Methodology – References.....	64
2.	Results.....	65
3.1.	Acceptability of SW:WFF to Families	66
3.1.1.	Acceptability of SW:WFF to Families – Qualitative Data	66
3.1.1.1.	Introduction	66

3.1.1.2. Description of Families.....	66
3.1.1.3. Process of Involvement with Children’s Social Care Services	67
3.1.1.4. Support and Services Offered to Families.....	67
3.1.1.5. Beliefs about efficacy of interventions	68
3.1.1.5.1. Positive change and positive relationship with family.....	70
3.1.1.5.2. Lack of change and negative relationships between families and Units	79
3.1.1.6. Recommendations from Families	87
3.1.1.7. Summary and Conclusions	90
3.1.2. Quantitative Family Data	91
3.2. Acceptability of SW:WFF to Staff.....	98
3.2.1. Acceptability of SWWFF to Staff – Qualitative Data	98
3.2.1.1. Introduction	98
3.2.1.2. Description of staff members	98
3.2.1.3. Improvements in the service	99
3.2.1.4. Challenges during and after the transformation	111
3.2.1.5. Recommendations	125
3.2.1.6. Summary and conclusions	129
3.2.2. Quantitative Analysis of Staff Data	131
3.3. Lessons from Managers who Implemented the SWWFF Model	151
3.3.1. Description of Managers.....	151
3.3.2. Intended Outcomes of the Service Redesign.....	152
3.3.3. Improvements in the Service	153
3.3.4. Challenges	158
3.3.5. Achievement of Significant Outcomes.....	177
3.3.6. Recommendations	178
3.3.7. Summary and Conclusions	184
3.4. The Perceptions of Partner Agencies about the SW:WFF Model	185
3.4.1. Introduction	185
3.4.2. Description of Partner Agencies	186
3.4.3. Perceived Improvements in the Service	186
3.4.4. Perceived Challenges	194
3.4.5. Recommendations	207
3.4.6. Summary and Conclusions	210

4. Discussion and Implications of Findings.....	211
4.1. Introduction to Discussion	212
4.2. Strengths and Limitations	213
4.3. Key Findings	217
4.3.1. Key Findings from Families.....	217
4.3.2. Key Findings from Staff	218
4.3.3. Key Findings from Managers who Implemented SW:WFF	219
4.3.4. Key Findings from Partner Agencies	220
4.4. Discussion of Results	221
4.4.1. Improvements in the Service	221
4.4.2. Challenges During and Since the SW:WFF Transformation	224
4.4.3. Recommendations	229
4.4.3. Summary	233
APPENDICES	234
APPENDIX 1a: Initial Study Protocol 25 January 2013	235
APPENDIX 1a: Amended Study Protocol 2 July 2013	250
APPENDIX 2: Value for Money in Social Welfare Services?	266
APPENDIX 3: The Changing context of the Evaluation – Lessons Learnt	280
APPENDIX 4. Bespoke Questionnaires Used	293

1. Introduction

This introduction will start by giving the background of the SW:WFF model, and the demographics of the county of Cambridgeshire. It will then summarise the published evaluations of similar service transformations. It will finish by describing the purposes of this evaluation. Comments from the SW:WFF implementation team have been added to the end of sections where changes have been made since the end of the interviews (completed Spring 2014) and the finalization of this report (Summer 2015).

1.1. Social Work – Working for Families

Cambridgeshire County Council have recently completed a major reorganisation of the social care system for children and families, to the 'Social Work Working for Families' (SW:WFF) model. SW:WFF represents a significant shift in the way that Social services for children and families are organised, and work. It was drawn from a "systemic" model of care first deployed in Hackney, NE London, that has been positively reviewed and evaluated (see chapter 1.2). The first SW:WFF units went live in January 2012; the final units went live in October/November 2013.

While there was some evidence to suggest that the changes to practice and managerial reorganisation involved in SW:WFF were effective in the densely populated inner city setting of Hackney, there was no such evidence for how such a reorganisation might translate into a mixed urban, suburban and rural setting such as Cambridgeshire. Nor was the evaluation of the first iteration of this method in Hackney definitive - in terms of its sampling methodology, and the kinds of outcome measures applied. As is always the case, the model deployed in Hackney has continued to develop, and needed to be adapted to fit the different demands of the Cambridgeshire setting. Given, also, the fact that many other Social Services departments across the UK (and beyond) are subject to major reorganisations that are costly and disruptive (though with the intent to improve outcomes for complex and vulnerable families), an evaluation of this process and this model of care appeared very necessary.

1.1.1. Key Features of the SW:WFF model[1]

1.1.1.1. Organisation of social workers into small teams ("Units"), mostly of 4.5 whole time equivalents.

Units comprise:

- a. A consultant social worker (CSW). As well as having a managerial/leadership role for the rest of the unit, the CSW differs from the traditional social work manager role in that they have a greater link to practice as they also offer direct work with families
- b. Two social workers
- c. A half-time clinician (with professional clinical training, in many cases in family therapy or clinical psychology) who is able to address mental health and relationship problems as an early intervention. As well as providing direct intervention, clinicians facilitate improved systemic work from their social worker colleagues through discussion of cases at unit meetings and provide ongoing clinical consultation to their colleagues
- d. A unit co-ordinator, who takes on a lot of the administrative tasks previously carried out by social workers, freeing social workers to spend more time in face-face contact.

1.1.1.2. An emphasis on systemic practice as an underlying theory underlying social care practice. Since the publication of the Framework for the Assessment of Children in need and their Families (DOH, 2000) the influence of systemic or relational practice has been increasingly evident in statutory social care practice. SW:WFF's emphasis on systemic practice is rooted in the discipline of systemic psychotherapy or family therapy. Systemic practice refers to a shift in emphasis towards a relational frame and systemic practice is supported by evidence (Carr, 2000) that it is effective in making change with a variety of presenting difficulties typical of those represented within children's social care. Difficulties are thought about as having circular causality and are seen as being mutually influenced by the range of relationships which create the context in which families in difficulties present. Systemic practice values thoughtful, respectful and reflective discussions with colleagues and families. In order to support the embedding of systemic social work, all consultant social workers were offered the Year 1 Certificate Course in Systemic Practice. This was delivered at the time of the research by the Institute of Family Therapy and Morning Lane Associates. Social workers were also offered Year 1 training and a number of the consultant social workers also completed Year 2 in systemic training. The embedding of systemic social work practice was supported by the presence of systemically trained or experienced clinicians in units; and regular learning circles to support the integration of systemic practice into statutory social work interventions.

Comments from SW:WWF team:

During the time of the research taking place, the systemic training offer has further developed. Staff are now offered either the Year 1 Certificate Course in Systemic Practice jointly offered by the clinical team and IFT; or an 'In-house' systemic practice course offered by the clinical team. Unit Coordinators and Agency staff are also now being trained systemically. These changes have been made to ensure that there is a robust link between systemic theory and improving social work practice in Cambridgeshire .

1.1.1.3. As well as staff being trained in systemic practice with families, units themselves work in a systemic way. The traditional model of social care is that one social worker works with a family, with supervision from a senior social worker/manager. While this can be seen as time efficient, individual workers can feel isolated, and if supervision is infrequent/of poor quality, there is a risk of poor practice. In the SW:WWF model, all cases are discussed in the weekly unit meeting. The aim is for in-depth reflective discussion of cases, with the aims being that a wider range of opinions can contribute to case management; individual workers feel more supported; responsibility is shared more widely. In addition, the hope is that all unit members know about all cases, and multiple unit members may work with the same case. This leads to a wider set of skills coming to bear on each case and greatly improves continuity when the main professional is on leave or leaves the unit. Also for families contacting the unit the plan is that all members of the unit have some understanding of their current concerns and the plans that are in place to support change.

1.1.1.4. Social workers have less paperwork, and so more time to spend with families. This is partly due to a deliberate rationalisation of organisational bureaucratic demands, and partly due to the presence of the unit co-ordinator.

1.1.1.5. Consultation with professionals outside the unit (for example in other agencies) is encouraged.

1.1.1.6. Each unit has a role and covers a particular geographical locality. In many cases, there are several units of the same type in the same locality.

1.1.1.6.1. Access Units

Referrals are considered by the Integrated Access Team (IAT) and all referrals judged to meet the threshold needed to receive a social work intervention are passed to an access team. The access teams carry out initial assessment and intervention, and in lots of cases close cases quickly. If longer-term social care input is thought to be necessary after this initial intervention, cases are passed to an appropriate unit.

1.1.1.6.2. Child in Need (CIN) Units

The CIN units are responsible for Children in Need Units are responsible for:

- Children in need
- Children subject to a child protection plan
- All court work – children in proceedings
- Children looked after where the plan is to return home

1.1.1.6.3. Looked After Children (LAC) Units

The LAC Units are responsible for supporting those children where there is a long term plan for them to stay in care. For young people leaving care, they continue to be supported by the 18-25 service if needed. There are 2 permanence Units where children under 2 are ‘fast tracked’ to their permanent future placement, either rehabilitation home, kinships care or adoption. The Adoption service is provided by a collaboration between Cambridgeshire County Council and Coram.

1.1.1.6.4. Children’s Disability Services

The Countywide Social Care Service for Disabled Children contains Social Work Units, Self Directed Support Teams, Community Support Services, and Short Break Residential Units within the parameters of a strong inclusive commissioning framework.

1.1.2. Cambridgeshire

Cambridgeshire is a mixed urban-suburban-rural county in East Anglia, with 53% of district council wards classified as urban city/town in 2011 [2]. It no longer includes the city of Peterborough, which became a unitary authority in 1998. At the 2011 census [3], population was 621,210, a growth of 12% in the previous 10 years, which was the largest growth in any county council authority in England. 23% of the population was aged 19 or under, similar to the average of England and Wales. 85% of the population were white British, greater than the national average. Notable ethnic minorities include Asian/Asian British (4%), travellers (Romany and Irish), and Eastern Europeans (many of whom are recent immigrants, working in Fenland arable farms). 29% of households contained dependent children. Unemployment was lower than the national average, at 3% of those aged 16-74.

The local economy and deprivation vary greatly throughout the county. Deprivation levels are significantly higher than the national average in Fenland, in the north. Deprivation levels are considerably lower than the national average in South Cambridgeshire [4][5].

References

1. Wood, S. and R. Watson, *Cambridge Safer Families: The experience so far*. Context, 2014(131): p. 17-20.
2. <http://atlas.cambridgeshire.gov.uk/urbanrural/2011/atlas.html>
3. <http://www.cambridgeshireinsight.org.uk/census-2011/county-overviews>
4. http://www.rural-evidence.org.uk/pages/wp-content/uploads/2011/09/DeprivedRuralAreas_12_Cambridgeshire.pdf
5. <http://atlas.cambridgeshire.gov.uk/IMD/AllDeprivation/atlas.html>

1.2. Evaluations of Previous Service Transformations in Children’s Social Care Services

Before describing three services transformations, we are giving details of the SW:WFF model and AMBIT, as these models are present in the evaluations.

1.2.1. Social Work - Working for Families

As discussed in section 1.1, SW:WFF is drawn from a "systemic" model of care first deployed in Hackney, NE London, where preliminary evaluations were positive [1]. This model is now commonly referred to as ‘The Hackney Model’ or ‘Reclaiming Social Work’ with its emphasis on direct, relational work with families. Key changes from "Care as Usual" include the organisation of social workers into small teams ("Units"), that include a clinically-trained practitioner (in many, but not all, cases a family therapist) so that they are able to address mental health and relationship problems as an early intervention. With administrative support, the emphasis is on supporting social workers in a practitioner role, rather than a more "hands off" managerial/care coordinating role.

1.2.2. Adolescent Mentalization-Based Integrative Therapy

AMBIT [2] is an approach that encourages the use of simple and previously evidence-based practices (such as basic Cognitive Behavioural Therapy, basic Family work, or basic physical and sexual health promotion) in a coherent psychologically-oriented framework that includes three further elements: (a) a strong emphasis on developing and sustaining active peer-to-peer support and improved communication between team members, (b) proactive work to address relationships across the wider multi-agency network, particularly to reduce the instances of poorly-integrated care and (c) creation of “learning organisations” that encourages local teams to adopt systematic ways of making active use of their outcomes data and local experience in

continuously developing, recording and broadcasting their current best practice; evidence-based practice is always a judicious balance between emerging evidence from scientific research and knowledge about the demands of local culture and services.

The theoretical "glue" that holds this approach together is the concept of "Mentalization" - which is defined as the imaginative activity of "making sense of one another's actions on the basis of what might be going on in the mind of the actor (their intentions, beliefs, hopes, fears, etc)". This is an approach that has been developed over the past decade, and applied in evidence-based (NICE-approved) therapy for adults with personality disorder ("Mentalization-Based Treatment" or MBT) [3]. Because of the strong developmental themes in this way of making sense of emerging patterns of behaviour, there has recently been a lot of research and development activity in applications of this same concept with children and families. Crucially, mentalization-based approaches have a very good "fit" with many other theoretical approaches (for instance "Systemic" approaches, or "Cognitive-behavioural" ones), so that integrating AMBIT with the systemic training that the SW:WFF units have received is relatively simple.

AMBIT offers a manualized framework to support and guide practice with complex cases particularly where there may be "co-occurring" social, physical and psychological problems and disorders (e.g. clear protocols that are recorded so that these can guide and shape the management of a case, as well setting the ethos within which the team operates. See <http://ambit.tiddlyspace.com> for the online manual.) In this respect it represents a different approach from "Care as Usual" by a Social work team - hence the need to examine whether it offers any additional value.

Part of the AMBIT method, however, is also designed to support and encourage local teams to develop their own locally-"attuned" adaptations of practice; AMBIT is not a rigid "one-size-fits-all" approach. Local teams are encouraged to edit and author their own local versions of AMBIT's 'open-source' web-based manual - so that these come to represent more accurately the nature of *local* practices and expertise and ideally come to be identified by teams as a place where they "define themselves and their approach to the work, and their ongoing learning about improving outcomes".

In this way, AMBIT seeks to offer a structured framework which supports local services to marry elements of externally-validated evidence-based practices with their own locally-derived "practice-based evidence".

As a non-commercial "open source" approach to therapy (hosted by the charity the Anna Freud Centre, and supported by a grant from Comic Relief) that aims explicitly to share knowledge about best practice via freely available web-based treatment manuals and training materials (such as streaming video role-plays and lectures that are built into the web-based manuals), AMBIT has the opportunity to offer evidence-based support very widely to services that often struggle to find the budget for more expensive training packages. The proposed study offered the opportunity to evaluate evidence of its effectiveness in terms of the outcomes for families and for workers who are transferring to the SW:WFF approach. Cambridgeshire SW:WFF did not in the end implement AMBIT, for a number of reasons (discussed in Appendix 3.3); but clinicians received some introductory training in skills drawn from MBT-F, which has contributed to the range of interventions which they can offer.

1.2.3. Three Recent Evaluations of Service Transformations⁴

This section summarises, in some detail, three recent evaluations of service transformations all aimed at improving outcomes for children and families through a family oriented approach to service provision. These transformations were concerned with how social work teams and the wider group of professionals engaged with these families can operate most effectively. The 'Reclaiming Social Work' report which evaluates the model on which SW:WFF is based. We also look at an interim report on service transformation in Camden where they are using AMBIT, an approach which can be used to transform existing structures and therefore requires less radical restructuring, and at EssexFamily where a flexible contract with an outside agency (in this case Barnados) was used to transform their services. These three reports offer a view into different

⁴ Much of the text in the summaries is taken directly from the reports to maintain accuracy. This is not referenced each time.

approaches to restructuring service delivery, while all focusing on complex, troubled families. The three reports also demonstrate that there is limited evidence of improved outcomes for children and families.

1.2.3.1. Reclaiming Social Work? An Evaluation of Systemic Units as an Approach to Delivering Children's Services [4]

'It is hard to over-state the difficulty involved in carrying out child and family social work.'

This evaluation of systemic units is an in-depth comparative description of practice and the factors shaping it in three local authorities. One of the authorities used the systemic unit model; the other two authorities differed but both had a more conventional model for the structure of services. The study evaluated whether the systemic unit model led to improvements for service users, what the effects were from the staff perspective, and how the managers and partner agencies experienced this service transformation

The primary focus of the report is a detailed description of practice in the different local authorities which attempts to understand what factors shape good or poor practice. As such, the authors propose it provides extensive evidence on the likely effectiveness of the systemic unit approach. Perhaps it is important to note here that there is no 'before' and 'after' data to support the likely improved outcomes for children and families.

The previous evaluation commissioned by the London Borough of Hackney was carried out toward the end of the process of moving from traditional style teams to the new units [1]. This allowed comparisons between workers in the units (66 returned questionnaires, a response rate of 57%) and a smaller number in traditional teams (16, response of 13%). It also allowed comparisons of experiences of services before and after Reclaiming Social Work and views on the current quality of the service. As well as current workers, questionnaires were returned from courts (13 responses), a local voluntary agency (who reviewed 44 referrals to them) and an advocacy service for looked after children. Eleven families were interviewed about their experience of services. These sources of data were supplemented by a comparison of Hackney's

key performance indicators (KPIs) and a piece of qualitative research that combined an unspecified number of interviews with staff, 3 focus groups and 4 days of observational study.

The overwhelming tone of the findings in the previous evaluation was positive. Workers in units rated the quality of the work and the environment as much better than those in traditional teams. All the independent or semi-independent reports from court and other agencies reported a very encouraging picture of practice, and families seemed generally positive.

Reclaiming Social Work was associated with reducing the number of children in care and the spend on Children's Services. The reported improvements in practice, together with a reduction in costs, provides an argument in support of the Systemic unit model

However, the authors highlight that the samples are small, the response rates are poor (which often means only those with a particular passion are responding) and the comparisons are predominantly between practice before and after systemic units were put in place. Overall, the range of evidence suggests that the systemic unit model is appreciated more by workers than the more traditional approach that preceded it. Caution needs to be exercised since the systemic unit model was a new innovation, with the consequent excitement that accompanied it. At a prosaic level, one of the most important elements of the move to systemic units is not mentioned in the report: all staff in Hackney had to reapply for their positions and a high proportion were not re-employed in the new model. Hackney recruited new, enthusiastic and (perhaps) highly skilled staff. It is at least possible that this affected the responses of staff, and it is likely to be a key element of the overall changes produced.

However, taken as a whole, the findings from the initial evaluation of systemic units in Hackney were promising.

The study reported on in Reclaiming Social Work used a theory-orientated approach using multiple methods to build up a theory of what the systemic unit model is, how it influences the service received by families and what types of outcomes it is associated with. The study therefore addressed the following research questions:

1. What do social workers do?
2. What factors influence what they do?
3. What are the key characteristics of the systemic unit model? In particular, how does it differ from normal practice?
4. What are the observable differences in the nature of practice? For instance:
 - How often are clients seen,
 - How long are families allocated,
 - What types of service do they receive, and
 - Are there differences in the nature of direct practice with families?
5. What influence does this have on clients?
 - Parental engagement with services?
 - Parental satisfaction with social services?
 - Parental well-being?
 - Child well-being?
6. What impact does this have on social workers?
 - Less stressed?
 - More positive about the organisation?

The study had two main limitations. The first is that only a limited amount of data was collected on the views of parents or children, and none directly looked at outcomes. The second is that in comparing the systemic unit model with practice in two other authorities the findings are heavily dependent on the nature of the authorities being studied. Both authorities experienced significant issues during the period of data collection that influenced almost every aspect of the study. It is therefore open to question how much the differences were due to the systemic unit model and the degree to which they were due to other factors.

The model used to understand the systemic units started with a detailed description of practice, first in general and then in systemic units compared to conventional teams. Children's Services were dealing with very high levels of demand, with many families with serious problems and often in situations that other professionals had found impossible to work with. The study, in comparing the different authorities, found that practice differed between the systemic units. Nonetheless the study found that the unit approach evidenced:

- More time spent with families and children
- High quality assessments
- Consistently high levels of skill in direct work with families
- An ability to be able to provide more intensive help for families – particularly at times of crisis or for families with complex problems

Social workers rated their work as involving better relationships with families, they demonstrated higher levels of skill in interviews with simulated clients and there was a higher level of agreement between workers and clients on the presenting issues in families. Overall, *the report concluded that practice within the systemic units model during the period of the study was notably and consistently of a very high standard.*

Based on observational data the authors suggest 6 main differences between the systemic units and more conventional teams. These are:

- Shared allocation
- Case discussions
- Unit Coordinator
- Systemic model
- Skills Development
- Other roles (Consultant and Clinician particularly)

It is interesting to note that some elements of the systemic unit model were found in other authorities. For instance, the Assessment team in one authority was split into 3 smaller groups and these felt far more like the systemic units approach than any other conventional team.

There was also considerable variation between teams within more conventional authorities: there were some outstanding Team Managers or Deputy Team Managers and they created comparatively safe and supportive environments for social workers to practice. These produced the best practice in conventional contexts, though even here the organisation and delivery of practice felt qualitatively different to the systemic unit model. For instance, there was less in-depth discussion of cases, generally less time spent with families and less capacity to respond to complex families or acute crises.

The evaluation proposes that the most important innovation is shared allocation of cases in a **small team**. This necessitates group discussion and decision-making, and thereby creates a very different way of thinking about and delivering practice. The additional administrative support and use of a systemic approach then fit very well with this necessity for a shared approach to practice. The basing of Clinicians in the units also seemed important. Their clinical expertise provided an important source of different views, support for skills development and institutionalised debate and discussion within units in a way that seemed important.

Ultimately, perhaps the most important issue is the impact of the systemic way of working on practice and outcomes. This evaluation found:

- Workers were somewhat less stressed and anxious
- Workers found their work more rewarding and enjoyable
- Social workers reported less violence and fewer threats from parents; they had greater confidence in their assessments
- Workers spent more time with families each week and families spent 2 to 3 times more time with social workers
- Consultants had far more client contact time than Deputy Managers
- Workers had higher levels of communication skills
- There was greater agreement about what key issues in families were for workers and parents
- Families were more positive about their workers and the service they received

Overall this provides a convincing picture of high quality practice, reduced administrative burden, stronger assessments and a more positive service experience for families. Unfortunately, there is no direct evidence from the evaluation to show that this approach to social work practice produces better outcomes for children and families.

One of the considerations arising from (and shaping) the study was just how difficult it is to evaluate Children's Services. The complexity of differences between authorities – shaped as they are by local need, policies and procedures, the skills and practice of managers and workers and myriad other factors – make describing and evaluating differences difficult. The findings also point to the great challenges involved in thinking about measuring outcomes.

The randomized controlled trial (RCT) is often used to evaluate different interventions. It is clear from the findings reported in Reclaiming Social Work that the systemic unit model is not easily amenable to such an approach. The systemic unit model is not simply the unit structure, but also requires a number of macro differences throughout the organisation. In other words the intervention being studied is not straightforward and includes systems, values, structures that interact to produce practice. Furthermore, it is not just the complexity of the reforms being studied that poses a challenge for evaluation, but also the range of outcomes that would be problematic.

While an RCT was not considered a realistic approach for this study it would have been possible to have used standardised measures to gain 'before' and 'after' data on wellbeing and mental health of child and family members together with family functioning data to lend weight to the findings.

The reclaiming social work study looked at three local authorities and identified seven key factors that support good social work practice across all the study sites. These were:

- *Wider practical organisational support for Children's Services:* for example, providing adequate space, good IT systems and other practical supports for practice.

- *Strong administrative support:* social workers require good administrative support, and administrative support that is closer to a PA than a bureaucratic filer of forms is most appropriate to the social work role.
- *Small teams:* one of the key insights of the systemic unit model was that smaller teams work better. We found this across more conventional teams too.
- *High ratio of supervisors to staff:* with the complexity of the families that workers deal with, supervisors can only effectively manage a limited number of social workers. Adequate ratios of supervisors to staff were crucial for the organisation to work.
- *Recruitment of high quality staff:* it is beyond the scope of this study to evaluate this element of LA1, however the fact that workers in LA1 obtained higher scores in simulated interviews is likely in part to be due to recruitment of staff and may influence many other findings.
- *Limited workload:* social workers can only work effectively with a relatively small number of families. Allocating more than they can manage means that workers and managers formally or informally decide to prioritise some and give limited attention to others. Controlling caseloads – even if that involves making difficult decisions about only working with high priority families – is necessary to allow effective service delivery.
- *Articulating clear values:* one of the most impressive features of LA3 was that while the levels of stress and workload of the staff were exceptionally high at the time of the study, staff in general seemed highly motivated and committed to the welfare of the families they worked with. This was also true for some teams in LA2. Key to this seemed to be managerial articulation of clear values that put children's welfare first.

Where these seven factors are present Children's Services would usually be delivering work of a high standard. All seven were present in the Unit Model so did they alone explain the positive practice identified in the Unit Model? The evaluation team do not believe that this was the case, though it is not possible to be certain about this unless an authority with these factors present was compared to one with these factors plus systemic units. They felt that overall systemic units added considerable value beyond these basic features of good Children's Services. The Reclaiming Social Work evaluation concluded that workers organised in the Unit Model spent more time with children and families, that their work was more consistently of a high standard and that their assessments tended to be more in-depth and consistently thorough. These are then linked to some outcomes they have evidence for (namely that families' appreciated the service more, that there was greater agreement between worker and family on family needs and that there was less violence and aggression and better engagement of families and young people) and others that are hypotheses based on qualitative comments from workers or managers.

The systemic approach seemed very well suited to shared allocation, as it provided a framework for both assessments and interventions with families. The move to training and skills development that focused on one particular approach has been criticised in theory, but in practice it seemed to provide a very helpful way of focusing shared working. The roles within the unit all made important contributions, but the Consultant, Clinician and Unit Coordinator were particularly distinctive, and it is probably these roles that add particular value to the unit way of working. They help transform the unit from a small team of social workers to a more varied group able to provide a range of different types of help.

The evaluators conclude that *key to the success of the approach is joint allocation in small teams*. Shared allocation also ensures that the unit is a genuine team with a shared purpose, rather than a group of workers each with their own cases.

In contrast, the conventional hierarchical model operates in a linear way, like a chain of command from senior management to worker. This can work when each link is strong and well supported, for instance where the seven key requirements for effective Children's Services

identified above are present. Such a system may appear easier to manage, but it is particularly vulnerable to failure and it is not clearly shown whether it is appropriate for the very high levels of need and risk found in almost all families with complex needs.

We have included extensive summary of this report as it identifies key features for effective practice and describes components of the Unit Model. The major limitation, and unanswered question is whether or not its introduction (involving an expensive restructuring of service delivery) changes the outcomes for children and families.

1.2.3.2. Camden Transformation Team Evaluation: Interim Report [5]

This is an interim report for the University College London (UCL) evaluation of the Camden Transformation Team's (TT) work as part of the Troubled Families programme. The report is provided at the request of Camden TT and outlines progress to date, evaluation method, initial findings, recommendations and next steps. The report covers the first evaluation period which is essentially the same point as the interim report for reclaiming social work.

The Camden approach to 'troubled families' adopts a model of working which can be applied to its existing structure for service delivery. In this sense it is a radical restructuring of approach but does not necessitate of teams or 'on the ground organisation'.

Listening to Troubled Families, a research report undertaken by the Department for Local Communities and Government (DCLG)'s Troubled Families Team, demonstrated the intergenerational nature of these families' problems and that despite long-term involvement with services, engagement with the family unit as a whole is often lacking, leading to little improvement. The intergenerational aspect to the problems has been cited as a consequence of a lack of co-ordination between agencies working and a failure to consider the wider family context. In December 2012, a guide to working with troubled families was compiled by the DCLG recommending an expansion of family intervention services, unified assessment

processes and interventions focused on a single 'whole-family' approach with a dedicated family worker and importantly improved co-ordination to support families across services.

The Troubled Families national team provided a set of recommendations in *Working with troubled families: a guide to evidence and good practice* to act as an aid to the development of new ways of working with the identified families. From this work Camden established the Complex Families Project with the Integrated Family Framework (IFF) used by the Camden Transformation Team. The Transformation Team was established to test the new ways of working and includes practitioners from a range of agencies and services.

The intention of this evaluation is to inform the development of Camden's IFF as it moves towards full implementation across Camden, from both staff and family perspectives. The evaluation of practice and its impact is a key operating principle of the Complex Families Project and the intention of this evaluation, in addition to the DCLG criteria, is to contribute to that process. The evaluation takes a broad perspective including staff perspectives, both of the current Transformation Team and the wider network of agencies and services, and family members' experiences which will be combined with quantitative data. A key objective is to increase learning about potential facilitators and barriers to the implementation of the new model.

The project found that at identification, these families had an average of eight agencies/services working with different members of a family, with poor information sharing between these services and a failure to consider the underlying factors contributing to the families' problems. It can be seen that the concerns that prompted this service transformation are almost identical to those of the other evaluations summarised here, and that the attempts to improve services are underpinned by very different philosophies.

Central to the operating principles of the Transformation Team has been the provision of **AMBIT training**.

AMBIT provides a model for working with the 'hard to reach' youth with complex social vulnerabilities and mental health problems, often working with services who cannot adequately provide for their needs. The approach is organised around a mentalization-based framework for integrating practices from evidence-based interventions. The key principles of AMBIT centre on using simple (easily trainable) mentalization based practices in four main areas of practice: in face to face work with children and families, in team work practice (providing core supervisory structures that provide a 'team around the worker' approach to complement the team around the child), in working with complex interagency networks (using techniques to address network dis-integration), and in supporting a "Learning Organisation" approach (through the use of innovative 'wiki-based manualization').

These principles are reflected in the work of the Transformation Team with both the families and the wider network of agencies working with the family. From our work to date, it appears that the AMBIT model has been used primarily to facilitate reflective practice and co-ordinated team and systems working around the family, and to promote engagement with this complex population.

At this early stage of the evaluation it is not yet possible to draw any robust conclusions from the data so far collected. However, a high percentage of families are considered as 'turned around', in line with the Government's DCLG success definitions. These high numbers of families reaching success who have engaged with the TT offers the possibility of real and sustained change emerging from the IFF approach. For families with high numbers of service involvement the TT, along with the provision of a key worker/(s), and better coordination across these services was also beneficial.

It has been apparent that families have noted a distinct difference in the TT service when compared to previous care they have been in receipt of and the coordinated and dedicated approach of the TT is likely to have contributed to the high proportion of these complex families being turned around. Whilst the data on service involvement is only available on a small amount of families who completed the ECO, it does demonstrate a reduction in the

amount of services. This is in line with the operating principles of the complex families project and indicates a reduction in the overcrowding of professionals around a family.

The TT have provided a sound conceptual framework (IFF) for working as a team incorporating many of the AMBIT principles. The team should start to develop a similar framework to conceptualise and operationalise the 17 interventions provided for families and a robust method for characterizing and collecting good quality data on the number of contacts with a family. Specifically the services should consider developing improved methods for data collection including data on:

- the specific nature of interventions provided directly to families,
- the nature and frequency of family contact with services
- the nature and frequency of TT support to the services in the wider network in relation to specific families.

The evaluation, at this stage, identifies better co-ordination of effort and clearer models of practice as leading to improvements in the function of these families and less use of services. They do not report on the thorny question of ‘value for money’ but this could be addressed in the next stage of the evaluation.

1.2.3.3. ‘EssexFamilies’ Tendring Evaluation [6]

‘EssexFamily’ was one of 16 national Community Budget pilots established to develop more flexible ways of delivering services to families with complex needs as part of the Troubled Family Initiatives. The common goal across the pilot areas was to work towards:

“...families thriving in independence from government intervention, in good health and wellbeing, with a safe and nurturing environment for their children, economically active and engaged positively in the community.”

Recognising the importance of early intervention and the role of communities and partners from the public and voluntary sectors, five localities (Harlow, Castlepoint and Rochford,

Basildon, Colchester, Tendring) agreed to lead the delivery of the initial prototypes for families with complex needs, building partnerships with a combination of professional services, families and communities. These local partnerships were responsible for deciding what the priorities for each prototype should be, the resources they needed and where they should be implemented. The EssexFamily Tendring (EFT) response to this challenge aimed to:

- Secure better outcomes for families with complex needs, promoting independence, health and well-being.
- Realise cost savings through these better outcomes and through efficiencies in the mainstream system.
- Ensure sustainability of the prototype through system change and effective community support.

Families involved in the pilot were nominated by a range of partners and a strategic multi-agency steering group of Chief Executives and organisational leaders ensured there was commitment from all key partners. The project was focused on delivering real impact whilst not being risk averse. Family consent to share information between and across the partners was obtained at the outset and the two FSWs were allocated through a flexible contract with Barnardos. This is an interesting option for restructuring services since it is simple to dismantle if it is not proven effective or can be taken into the mainstream approach if it is effective. Restructuring costs are therefore minimal until there is evidence of effectiveness.

A joint, family-centred action plan was agreed and a dedicated 'Team Around the Family' (TAF) established. The team included statutory and voluntary sector partners working cohesively and promptly to address those issues contributing to family crisis. Traditionally plans have focussed on one member of the family; this prototype focussed on the whole family unit. This family-centred action plan was reviewed regularly with barriers identified and successes celebrated. A robust exit plan was developed with each family to empower them to integrate into local support systems and ensure that as they make positive progress they can move from intensive support provided by statutory and third sector to community based support. This was intended

to enable families to maintain and build on the progress they had achieved and reduce the possibility of needing to access further intensive support.

For this study the disadvantages characterising families with complex needs were:

Poverty

Poverty, including debt, Accommodation issues, Long-term unemployment

Child protection

Welfare, neglect and / or protection issues

Health

Difficult family relationships, substance misuse, mental health issues, poor physical health

Schooling

Developmental delay and/or special educational needs, poor school attendance and exclusion issues

Offending

Offending and antisocial behaviour, domestic abuse

The methodological approach used in this research project was both qualitative and quantitative. Face-to-face interviews were carried out with family members, while family functioning was measured using the Family Assessment Device (FAD). Use of services was tracked before and after the intervention together with an evaluation of whether the service was 'value for money', using the cost calculator from Loughborough University.

The intention of EFT was to provide early intervention for 'families with complex needs' with the focus not only on the child but on all family members. In order to determine value for money we asked EFT to provide us with information about the family in terms of what level of

concern they presented with on referral to the project with reference to the Child Protection Plan.⁵ These levels are from 1-4 as follows:

Level 1: Universal – Children with no additional needs

Level 2: Vulnerable – Children with additional needs

Level 3: Complex - Children with complex needs

Level 4: Acute - Children whose needs are prolonged, specialist and critical

In comparison with the threshold of need, EFT intended to work with families presenting at high end level 2: that is those troubled families who could benefit from an early intervention before potential escalation to child protection services. In reality the families referred were all 'level 3' or higher.

It would appear that EFT has contributed to improving the lives of the families although this cannot entirely attribute the changes to EFT because other agencies have been involved. Key findings show:

- The families considered their family support worker (FSW) as **somebody they could call on** who would listen to them and provide support when they needed it. (A named person).
- Families reported the relief they felt when they were **signposted** to specific agencies or were made aware of where they could access support and someone helped them to get there.
- The fluidity of the **practical support** tailored for each family appealed to the families. This support has provided the families with help to overcome financial and other stresses;
- **Information sharing among professionals.** The Team Around the Family (TAF) meetings were considered a success of the EFT project. Families reported on the benefits of

⁵ In Essex the *Essex County Council: Guidance for Threshold of Need and Intervention Criteria for Children's Services* is used to assess this need.

having all professionals involved with their family at one meeting point. Service use decreased.

- **Family functioning** improved during the intervention. This is evidenced by the changes in their family functioning scores after the intervention and by their interview responses;
- **Value for Money.** The EFT project was commissioned from an agency external to the local authority. The original agreement was to work intensively with 20 families per annum offering practical and emotional support. Using the Loughborough Cost Calculator we found that this was not an adequate number to make the project cost effective. The cost per unit depends on the level of need. Ensuring cost effectiveness is important as otherwise the service transformation is not an improvement on business as usual. The evaluation was able to indicate how many families, with what level of need, would offer value for money (e.g. If working with families at Level 2 (vulnerable), the project needs to have a throughput of at least 27 families per annum to offer value for money).

The EFT evaluation suggests that the team-around-the-family, family-focused, co-ordinated approach leads to improved outcomes for children and families but needs a higher throughput of families to be cost effective. As with the Camden TT better team working and co-ordination of services led to decreased service use (particularly expensive, emergency services).

1.2.3.4. Conclusions

Overall the three evaluations summarised here show different approaches to transforming services to be more family-focused, all of which promise better integration of service with smaller teams and clear practice guidelines. The families in all the evaluations report experiencing more responsive services, working better together. However, it is important to take into account the fact that the Essex and Camden transformations were for services working with 'Troubled Families', a less complex group, at a lower level of need, than the families receiving help from the social care service that is the subject of this report.

1.2.4. Other Evaluations – References

1. Cross, S., A. Hubbard, and E. Munro, *Reclaiming Social Work. London Borough of Hackney Children and Young People's Services*. 2010, Human Reliability: Dalton, Lancashire.
2. Bevington, D., et al., *Innovations in Practice: Adolescent Mentalization-Based Integrative Therapy (AMBIT) – a new integrated approach to working with the most hard to reach adolescents with severe complex mental health needs*. Child and Adolescent Mental Health, 2012. **18**(1): p. 46-51.
3. Bateman, A. and P. Fonagy, *Randomized controlled trial of outpatient mentalization-based treatment versus structured clinical management for borderline personality disorder*. Am J Psychiatry, 2009. **166**(12): p. 1355-64.
4. Forrester, D., et al. *Reclaiming Social Work? An Evaluation of Systemic Units as an Approach to Delivering Children's Services. Final report of a comparative study of practice and the factors shaping it in three local authorities*. 2013 22 Sep 2014]; Available from: http://www.beds.ac.uk/data/assets/pdf_file/0011/258491/Final-Report-RSWv3-19072013.pdf.
5. Pilling, S., et al., *Camden Transformation Team Evaluation: Interim Report* 2014.
6. O'Brien, N., J. Akister, and T. Moules, *'EssexFamilies' Tending Evaluation*. 2013, Anglia Ruskin University Repository.

1.3 Purpose of this Evaluation

We initially planned a detailed three year mixed methods analysis of the SW:WFF transformation, with baseline and longitudinal qualitative and quantitative data collection from a range of relevant stakeholders, including client families, unit staff, social care managers and partner agencies; and examination of changes in hard data such as child deaths. The initial project protocol and aims are appendix A.

The SW:WFF evaluation research project was ambitious in its aim to carry out a rigorous evaluation of the introduction of the unit model in Cambridgeshire. The main justification for the duration of the study was to be able to follow-up large numbers of client families for a year after intervention was started, collecting effectiveness and cost-effectiveness data. We had great difficulties in recruiting families to the project (described in detail in appendix 3). The decision was therefore taken to terminate the study early (after 16 of the planned 36 months). However, we were still able to complete a good quantity and quality of baseline in depth interviews of all participant groups; and collect questionnaires from the majority of social care staff.

Our revised aims were to investigate:

- How acceptable the SW:WFF model of social care is to client families and professionals working within SW:WFF.
- The experiences of service transformation managers about the process of change itself, what worked well and where problems occurred.
- The opinion of partner agencies, within and outside the local authority, about whether the change to SW:WFF has changed the service social care provides for families, and whether it has influenced working relationships between their teams and children's social care.
- To make recommendations from our data as to ways the Cambridgeshire SW:WFF model could be improved; and on what other organisations undergoing a similar transformation could consider to improve their transformation

2. Methodology

2.1. Methodology Introduction

Cambridgeshire County Council commissioned Cambridgeshire and Peterborough NHS Trust (in partnership with the University of Cambridge and Anglia Ruskin University) to evaluate the SW:WFF transformation.

There were two components to the SW:WFF evaluation: quantitative evaluation, where larger numbers of participants were given questionnaires to complete; and qualitative evaluation, where smaller numbers of participants were interviewed in depth about their experiences and opinions.

Both methodologies have advantages and disadvantages. The main advantage of quantitative research is that the large numbers mean that samples are often representative of the population being studied, hence results can be generalized to the whole sample. The use of large numbers means that statistical testing can be used to investigate whether different measures are associated with each other, and whether this association is more than would be expected by chance. The main advantage of qualitative research is that participants can give detailed information, and can be questioned for further details. This can lead to very rich data, which tells us of things that may not have been previously thought of. In particular, it can explain why things happen and why people feel the way they do.

The combination of quantitative and qualitative methods in the same study ('mixed methods analysis') means that both advantages are present. An example in this study is that the quantitative questionnaires tell us what proportion of staff prefer the new SW:WFF model. The qualitative interviews tell us why they prefer it (or do not prefer it).

Data collection started in 2013 and was completed in Spring 2014.

2.2. Qualitative Data Collection and Analysis

2.2.1. Introduction

The aims of the qualitative component of the evaluation were:

- To describe and explain how acceptable the SW:WFF model is to client families and professionals working within SW:WFF.
- To describe and explain the process of change itself, what worked well and where problems occurred from the perspective of the managers who effected the change.
- To describe and explain the perceptions of internal and external partner agencies of the SW:WFF model.

This chapter provides details of the qualitative component of the evaluation. It is divided into five main sections. 1.2 discusses the qualitative evaluation approach 1.3 describes the participants and procedures for in the semi-structured interviews. 1.4 details the data analysis process. 1.5 discusses the validity of our qualitative findings.

2.2.2. Qualitative Evaluation Approach

The qualitative component of the evaluation aimed to understand the perceptions and experiences of families, staff, managers and partner agencies rather than to quantify them. Qualitative methods provided us with the opportunity to obtain in depth information on issues not fully explored in the quantitative data [1].

There are several methodological theories used in qualitative research design such as Phenomenology, Ethnography and Grounded Theory [2]. This study adopted a pragmatic approach not bound by one theory and its associated methodology. For instance, the aim of this evaluation was not to develop new theory, so grounded theory was deemed inappropriate; nor did the evaluation seek to investigate the culture in Units as this research question has already been answered [3, 4] thus ethnography was not appropriate for this evaluation; finally, the evaluation did not seek to define the meanings of the experiences of families, partner agencies or staff, and as such phenomenology was also inappropriate. Following these qualitative methodological theories rigidly would have limited our ability to collect data required to answer all the research questions fully [5, 6].

We used semi-structured interviews for all the different research participants. These are useful for obtaining detailed information of the participants' perspective on the research topic [7]. We developed an *interview guide* to ensure that we asked participants questions systematically that addressed the evaluation questions and objectives. We also made use of *probes* in the form of neutral questions, phrases and sounds or gestures to encourage participants to elaborate on their answers [7]. We used both face-to-face and telephone interviews.

2.2.3. Qualitative Interview Research Participants

2.2.3.1 Sampling and Recruitment

Qualitative research can involve purposive sampling [1, 5, 8]. Purposive sampling allows selection of participants whose features allow detailed exploration of central research themes [5].

2.2.3.1.1. Families

Purposive sampling was used to recruit families for the qualitative evaluation. All families that consented to the evaluation were given the option to opt in or out of a qualitative interview. Due to the challenges in recruitment of families we did not follow strict latent classification (as initially planned) to invite a range of families for a qualitative interview. Instead we asked all families who gave us quantitative data. This included families who had either reported positive experiences with their Unit during quantitative baseline data collection or families that had reported negative experiences with the Unit during quantitative baseline data collection. This allowed us to obtain varied experiences.

A single interview was conducted at a time and location convenient to that family. Interviews enquired about users' perceptions of services, expectations of and beliefs about efficacy of interventions, comprehension of aims and objectives of service. All interviews were audio recorded and transcribed verbatim into the computer by the researchers and CPFT NHS Trust employees.

2.2.3.1.2. Staff Members

During the quantitative baseline data collection, all staff members were given the option to opt into a qualitative interview. Purposive sampling was then used to select staff for qualitative interviews. 35 people were interested in the qualitative interviews. 19 staff members were from Access Units; 11 from CiN Units and 5 from LAC Units. There were no qualitative interviews with Disability Units as we did not have any expressions of interest from these Units. The 35 staff members represented Consultant Social Workers, Social Workers, Unit Coordinators and Clinicians. We purposely selected 13 participants to be balanced by staff role, Unit location and staff opinion of SW:WFF.

We conducted single semi-structured interviews that characterised in depth staff perception and anticipation of their roles, their predictions for service success and where risks and threats to implementation and good outcomes were. Interviews also examined their opinions on the service and

whether their experience had met expectations. We evaluated how the process of change had felt for social workers. All interviews were audio recorded and transcribed by CPFT staff and the researchers before analysis.

2.2.3.1.3. Children's Social Care Services Managers

Purposive sampling was used to recruit managers into the study. Managers who have effected this service transformation were identified by the Head of Social Work and asked if they wanted to participate in this evaluation. Each consenting manager had one semi-structured interview with the researchers to discuss the ongoing service transformation, including what has worked well, what has not worked well, and key learning points for future similar service transformations. All interviews were audio recorded and transcribed by CPFT staff and the research team before analysis.

2.2.3.1.4. Partner Agencies

Purposive sampling was used to recruit Children's Social Care's internal and external partner agencies into the study. Partner agencies were identified by the research team and Children's Social Care. Interview invitation emails were sent to relevant managers in the partner organisations. All managers who consented to take part in the study were requested to obtain feedback from their teams about their experiences and perceptions of SW:WFF prior to the interview.

We interviewed managers individually, asking for their opinions on whether the change to SWWFF had changed the service social care provides for families, and whether it had influenced working relationships between their teams and Children's Social Care. They were asked in detail about what works well and does not work well, and for suggestions as to how children's social care could work even better. We aimed to understand experiences and opinions of how SW:WFF was improving (or not improving) the care given to families; and how this service transformation had impacted other agencies. With the exception of one interview where the participant declined to have the interview recorded all other interviews were audio recorded and transcribed by CPFT staff and the researchers before analysis. In addition, one of the interviews was destroyed as per instruction from the CPFT Research and Development department. This was because the manager had three team members present during the interview but we did not have ethical approval to conduct interviews with team members from partner agencies. The manager of this organisation was unable to do a second interview.

2.2.3.2 Profile of research participants

2.2.3.2.1. Families

Six families agreed to take part in the qualitative interviews. This included mothers, fathers and children.

The families that took part in the study were diverse and had multifaceted challenges including:

- One or both parents suffering from severe mental health problems such as schizophrenia, bipolar disorder or severe unipolar depression which affected their ability to parent and meet the needs of their children.
- One or both parents having severe physical health problems that affected their ability to meet the needs of the children.
- Families that had generational challenges in parenting such as generational neglect and thus long term involvement of Social Care in their families.
- One or both parents having severe alcohol and substance abuse problems.
- Domestic violence
- Families with children that had severe emotional and behavioural difficulties and parents requiring support to deal with the challenging behaviour.
- Parents' involvement in various criminal activities.
- Families with severe financial challenges and debt.

Families were recruited from CiN, LAC, and Access Units. There were no families recruited into the study by the Disability Units.

2.2.3.2.2. Staff Members

13 staff members participated in the qualitative interviews to represent the different opinions on SWWFF and the different locations for the Units. 3 Consultant Social Workers; 3 Clinicians, 4 Social Workers and 3 Unit Coordinators participated in the interviews. To garner varied experiences and perspectives, participants were recruited from most of the different services provided by Children's Social Care services, namely Access, CiN and LAC, and included both permanent and agency workers. We included staff with a full range of opinions on SW:WFF.

2.2.3.2.3. Managers

Ten managers in the form of Heads of Services and Group Managers participated in the interviews. All the managers had practised as a social worker for at least fifteen years. There were four male and six female respondents. Participants were recruited from all the different services provided by Children's Social Care services namely Access, CiN, LAC and Disability allowing for varied experiences to be presented.

2.2.3.2.4. Partner Agencies

Eleven managers took part in the study, representing some of Social Care's internal and external partners. They were recruited from court and justice systems, health services, advocacy services and voluntary services. Agencies varied in that some only worked with families referred to them by Children's Social care. Other partners were able to make referrals to Social Care and vice versa. Collaborative work varied from occasional to very regular. Partner agencies worked with various types of Units including Access, CiN, LAC and Disability which allowed for narratives of varied experiences of working with the Units.

2.2.4. Qualitative Data Analysis

We used Framework analysis to analyse the data from families, partner agencies and managers [9]. For the staff interviews, thematic analysis was carried out [10]. These are compatible and similar methods of analysis for identifying and exploring themes and meaning within verbal data. Different analytic methods were used as these interviews were analysed by two different researchers. For both analysis methods, preliminary analysis of the interviews was done during transcription, when we identified a few key themes from the data. We used NVivo 10 for data management because it has features that facilitate iterative movement between original data and subject related orders [11, 12]. NVivo 10 allowed within and between case searches thorough systematic and comprehensive coverage of the data [11, 12].

For the family, partner agencies and manager interview data, the framework analysis began with familiarisation with the data, from which a coding system was developed and applied to the different sets of interviews. Data was then coded using this system. For each interview set, we sorted data so that material with similar content was located together [13, 14]. Finally we used anonymised quotations to illustrate descriptive and explanatory findings [13, 14].

For the staff interview data, the thematic analysis was also begun by becoming familiar with the data by reading and re-reading the transcripts, and noting key concepts and themes [10]. Half of interviews were fully coded. This coding was driven by the information in the raw data itself, but also by pre-held knowledge and questions. The codes were merged, expanded, and grouped into themes to create a coding system that was then applied to the remainder of the interviews [10]. As this is an iterative process, ongoing refinements were made to the coding system [10]. With all the data coded, the codes and themes were used to explore meaning and connections within the interviews. Verbatim, anonymised quotations were used in the presentation of the findings [12-13].

2.2.5. Validity of Qualitative Findings

In this section we describe some of the key methodological considerations for this study to ensure validity of findings. Validity has to do with the extent to which an account accurately represents the social phenomena to which it refers [15-17]. In the table below we detail the various techniques suggested by Whittmore (2001) which we used to ensure validity:

Table 1: Techniques to demonstrate validity in this research

Type of Techniques	Technique	How this was applied to this research
Design consideration	Sampling	Purposive sampling was used to recruit participants.
	Employing triangulation	There was triangulation of data sources. We collected data from families, partner agencies and Children's Social Care Managers.
Data generating	Articulating data collection decisions	We recorded different decisions we made during data collection and discussed them as a research team.
	Providing verbatim transcriptions	Verbatim transcriptions were made after data collection.
	Performing a literature review	This was done before the study and to inform the discussion chapters.
	Using computer programs	N-Vivo 10 was used for data analysis.
	Expert checking	Findings were presented to various members of the team who are experts in their field, including: a Reader in Social Work, a university lecturer in child and adolescent psychiatry and a consultant child and adolescent psychiatrist.
Presentation	Providing thick descriptions	This was done during the write up in which we aimed to provide detailed accounts of experiences described or explained by participants.
	Providing evidence that supports interpretations	Evidence in the form of anonymised quotations was provided for interpretations made.

2.2.6. Qualitative Methodology – Summary and Conclusions

This chapter has documented the qualitative evaluation process. We have described the evaluation approach and design including description of the semi structured interviews. We summarised the data analysis procedures and we conclude by discussing how we ensured validity of our findings.

2.2.7. Qualitative Methodology – References

1. Denzin, N., & Lincoln, Y., ed. *Collecting and Interpreting qualitative materials* 2003, Sage Publications: London.
2. Holloway, I. and L. Todres, *The status of method: flexibility, consistency and coherence*, in *Qualitative research in Health Care*, I. Holloway, Editor. 2005, Open University Press: Maidenhead.
3. Forrester, D., David, Westlake., Michelle, McCann., Angela, Thurnham., Guy, Shefer., Georgia, Glynn., and Mike Killian, *Reclaiming Social Work? An Evaluation of Systemic Units as an Approach to Delivering Children's Services: Final report of a comparative study of practice and the factors shaping it in three local authorities*. 2013, University of Bedfordshire Tilda Goldberg Centre for Social Work and Social Care: Bedford.
4. Munro, E., Cross, Steve., & Alison, Hubbard, *Reclaiming Social Work London Borough of Hackney Children and Young People's Services*. 2010, London School of Economic London.
5. Patton, *Qualitative Evaluation and Research Methods* 2nd ed. 1990, London: Sage.
6. Snape and Spencer, *The foundations of qualitative research*, in *Qualitative Research Practice: A guide for social science students and researchers*, Ritchie and Spencer, Editors. 2003, Sage: London.
7. Legard, R., Keegan, J., Ward, K., *In depth interviews* in *Qualitative Research practice: A guide for social science students and researchers*, J. Ritchie and J. Lewis, Editors. 2003, Sage Publications London
8. Hansen, E., *Successful qualitative Health research : A practical introduction*. 2006, Berkshire: Open University Press.
9. Ritchie, S., and O'Connor, , *Carrying out qualitative analysis*, in *Qualitative research practice: a guide for social science students and researchers*, , in *Qualitative research practice: a guide for*

- social science students and researchers*, Ritchie and Lewis, Editor. 2003, Sage Publications: London.
10. Braun, V. and V. Clarke, *Using thematic analysis in psychology*. *Qualitative Research in Psychology*, 2006. **3**(2): p. 77-101.
 11. Ritchie, Spencer, and O'Connor, *Carrying out qualitative analysis*, in *Qualitative research practice: a guide for social science students and researchers*, Ritchie and Lewis, Editors. 2003, Sage Publications: London.
 12. Bazeley, *Qualitative Data Analysis with NVivo*. 2007, London: Sage Publications.
 13. Miles, M. and M. Huberman, *Qualitative Data Analysis: An expanded source book*. 2nd ed. 1994, London: Sage
 14. Ritchie, Spencer, and O'Connor, *Carrying out qualitative analysis*, in *Qualitative research practice: a guide for social science students and researchers*, Ritchie and Lewis, Editors. 2003, Sage Publications: London. p. pp 220-263.
 15. Whittmore, S. Chase, and C. Mandle, *Pearls, Pith and Provocation : Validity in Qualitative Research* *Qualitative Health Research*, 2001. **11**(4): p. 522 - 537.
 16. Lewis and Ritchie, *Generalising from Qualitative research*, in *Qualitative research practice : A guide for social science students and researchers*, J. Ritchie and J. Lewis, Editors. 2003, SAGE Publications: London.
 17. Sparkes, A., *Myth94: Qualitative Health Researches will agree about validity*. *Qualitative Health Research*, 2001. **11**(4): p. 538-552.

2.3. Quantitative Methodology

2.3.1. Participants

This study evaluated two levels of research participants:

2.3.1.1. SWWFF Client Families

SW:WFF has 47 social work units. SW:WFF aimed to recruit 10 families per unit due to each unit's likelihood of holding a current caseload of 12-45 cases at any one time. Unfortunately, recruitment was very difficult and quite unsuccessful for several reasons which will be discussed later on in the report. 29 individuals from 13 families completed questionnaires (adult head of house-holds, adult non-head of household and children). Families used self-ratings (parents and children) and parent ratings (of children).

There were two purposes of data collection:

- a. To gather baseline data on family/individual wellbeing and function
- b. To gather data on acceptability of the SW:WFF intervention

2.3.1.2. SW:WFF Staff

The staff aspect of the study involved researchers approaching 303 social work professionals who worked in the SW:WFF unit model: consultant social workers, social workers (experienced and newly qualified ASYE (Assessed and Supported Year in Employment)), clinicians and unit coordinators. 175 consenting participants completed the questionnaires. Throughout the research high staff movement reduced maximum possible recruitment into the study. Some staff actively said they would not take part because they were too busy or in the process of leaving. Some staff left at the beginning of implementation because they found that the model did not suit them. More recently some moves have been internal as a result of promotion or a change of function.

There were two purposes of data collection:

- a. To gather data on acceptability of the SW:WFF model for staff
- b. To examine staff attitudes and test if these were associated with acceptability of the SW:WFF model

2.3.2. Questionnaires and Scales

[For bespoke questionnaires created for this study, please see appendix 3.]

2.3.2.1. SW:WFF Client Families

2.3.2.1.1. Rating of Child/Adolescent Mental Health: Strengths and Difficulties Questionnaire

The Strengths and Difficulties (SDQ) is a brief measure of psychological well-being in 4-16 year olds and comprises 25 items on symptoms related to mental health and behavior [1]. This questionnaire was completed by the parent/head of household who had the most contact with the child. One SDQ was completed for each child in the family aged between 4 and 16 years. Participants were asked to base their answers on the child's behavior over the previous six months.

2.3.2.1.2. Parental Mental Health and Wellbeing: Adult Wellbeing Scale

The Adult Wellbeing scale is designed to assess parents'/caregivers' mental health and how they have been feeling in the past few days. The scale is the Irritability, Depression, Anxiety (IDA) Scale [2], which covers four aspects of wellbeing: depression, anxiety and inwardly and outwardly directed irritability.

2.3.2.1.3. Family Function: SCORE 15

The Score-15 is a self-report measure which comprises 15 Likert scale items. It is designed to measure aspects of their interactions and family processes and family function [3]. This was completed by all family members who were old enough to complete it (i.e. 10 years or older)

2.3.2.1.4. Family Experience: SW:WFF Family Experience Questionnaire

The SW:WFF Family Experience Questionnaire assesses how families have found being helped by their social services team. It is a short questionnaire comprising 7 questions: 3 questions using Likert scales, 3 qualitative free text questions and one yes/no question.

2.3.2.1.5. Demographics and Environment Questionnaire

This questionnaire had full details on family structure, service use and social stressors, for use in the planned economic evaluation.

2.3.2.2. SW:WFF Staff

The staff aspect of the study utilised two questionnaire scales: The SW:WFF Staff Attitude questionnaire and the SW:WFF Staff Experiences of SW:WFF Questionnaire (5 multiple choice items; see Appendix 4).

The SW:WFF Staff Attitudes questionnaire was used to assess staff beliefs, feelings and experience in social care. Initial questions asked about level of training and experience. Responses to items on attitudes were on a four point Likert scale. The attitude questionnaire was developed by using the original questions from the Co-Morbidity and Co-Morbid Clients' Problems Perceptions Questionnaire, produced by the Scottish Effective Interventions Unit [4]. Some of these questions were then adapted to create the Practice, Relationships, Education, Attitudes and Coherence in Helping Youth (PREACHY) questionnaire, which probes and assesses the experiences and beliefs of workers with complex youth [5]. The research group reduced this to 9 questions.

We developed the Experiences questionnaire to ask staff about their experiences of working in the SW:WFF model. There were five questions with responses to items on a four point Likert scale.

2.3.3. Procedure for Data Collection

2.3.3.1. SW:WFF Client Families

Families referred to social care were informed about the SW:WFF Evaluation and were given information sheets at the second or third Access unit visit. While the aim of the research team and management was for all families to be invited, in reality only some social workers recruited families. Families were also recruited through CiN and LAC units, as families were eligible to enter the study for up to two months after the initial Access, CiN or LAC appointment. At the subsequent meeting, they were asked if they would be happy to take part. Social workers collected signed forms and contact details from families, so that researchers could contact them and arrange data collection within the home or over the telephone. The researchers helped the family if needed. All family members aged over 16 years or over were asked for separate informed consent, which included parents and children not living at the index household but who are actively involved in the casework. Children under the age of 16 who were judged to be old enough to understand the study and complete questionnaires were given age-appropriate information sheets and asked for assent. If the family didn't want to take part at that second meeting, they were asked if they would be happy to be asked at future meetings, or would rather not be asked again. This was always respected. The set of parent and child/adolescent questionnaires were administered at the initial assessment by social care. Family data was collected and managed using REDCap electronic data capture tools hosted at the University of Cambridge. REDCap (Research Electronic Data Capture) is a secure, web-based application designed to support data capture for research studies, providing 1) an intuitive interface for validated data entry; 2) audit trails for tracking data manipulation and export procedures; 3) automated export procedures for seamless data downloads to common statistical packages; and 4) procedures for importing data from external sources (Stratton et al., 2010).

2.3.3.2. SW:WFF Staff

The staff aspect of the study involved researchers recruiting participants face to face by contacting unit coordinators and arranging to attend all 46 unit meetings. Researchers gave a short 5-10 presentation about the SW:WFF Evaluation/research and gave participants an

opportunity to ask any questions they had. Participants then read an information sheet, signed a consent form and completed the two questionnaires during the unit meeting. This took approximately 10-15 minutes to complete. Managers explained the importance of this to staff face to face. Researcher's details were provided on information sheets so staff could answer any questions after meeting them at the unit meeting. For consenting staff, completed questionnaires were posted and emailed to researchers, not managers. If participants were absent from unit meetings, researchers left spare questionnaires with the unit coordinators and/or emailed participants to provide them with information about the study. Managers explained the importance of this to staff face to face. Participants were recruited from June 2013-March 2014. This was due to variation in each of the units going 'live' and working within the unit model which depended on when each unit received a compulsory week's induction and systemic training for all unit members. Participants were reminded of their right to not answer any questions that they did not wish to, that their responses would be kept confidential from their manager and other employees of Cambridgeshire County Council and that they had the right to withdraw from the study at any time. Team members were explicitly told that management wouldn't know if they participated and wouldn't think or act unfavorably towards them if they don't participate. Participants were thanked for their participation. The department's ethics committee approved the study before data collection commenced. SPSS software was used to analyse the data.

2.3.4. Data Analysis

The most important data in most cases was the descriptive data.

In some cases with staff data, we tested whether correlations between scores on certain scales were more than would be expected by chance. In those cases, we used the Spearman's rank correlation test, given this was ordinal rather than interval data. In some cases, where sample sizes in individual cells were low, we combined groups and used chi-squared test (for 2 x 2 tables) or the chi-squared likelihood ratio test (for n x n tables; takes into account ordering among rows/columns).

The small sample size of family data meant it was not appropriate to test for significance of differences/correlations.

2.3.5. Quantitative Methodology – References

1. Goodman, R., *The Strengths and Difficulties Questionnaire: a research note*. J Child Psychol Psychiatry, 1997. **38**(5): p. 581-6.
2. Snaith, R.P., et al., *A clinical scale for the self-assessment of irritability*. British Journal of Psychiatry, 1978. **132**: p. 163-71.
3. Stratton, P., et al., *Developing an indicator of family function and a practicable outcome measure for systemic family and couple therapy: the SCORE*. Journal of Family Therapy, 2010. **32**: p. 232-58.
4. Watson, H., et al., *Co-Morbidity and Co-Morbid Clients' Problems Perceptions Questionnaire*. 2005, Scottish Effective Interventions Unit.
5. Bevington, R. and P. Fuggle. 22 Sep 2014]; Available from: <http://ambit.tiddlyspace.com/#PREACHY>.

2. Results

3.1. Acceptability of SW:WFF to Families

3.1.1. Acceptability of SW:WFF to Families – Qualitative Data

3.1.1.1. Introduction

This chapter aims to build a detailed picture of how acceptable social care work delivered in the SW:WFF model is to families. We detail the perceptions of services held by families. We also present their expectations of and beliefs about the efficacy of interventions. This section addresses one of the research objectives which is to evaluate how effective social work delivered in the SW:WFF model is at improving the mental health, wellbeing and family function of its client families. Our intention is to highlight the complexity of the processes through which participants experienced social care services delivered in the SW:WFF model. Analysis aimed to identify diversity, complexity and contradictions in the subjective evaluations of the acceptability of services to families. Families were able to point out positive aspects as well as negative aspects of their engagement with Social Care.

It is important to point out that the term “Unit” was frequently used synonymously with “social worker” by the families. They identified the Unit predominantly as a social worker and unit coordinator and sometimes clinician and consultant social worker depending on severity, levels and length of involvement as well as the specific interventions the Unit offered the family. Even in instances where families had met various members of a Unit, they identified a key social worker that was involved with them on behalf of the Unit. Where the engagement had been brief, families only knew the social worker who had completed the assessments and brief work with them and identified this person as the Unit.

3.1.1.2. Description of Families

The families that took part in the study were diverse and had multifaceted challenges including:

- One or both parents suffering from severe mental health problems such as Schizophrenia, Bipolar or severe Depression which affected their ability to parent and meet the needs of their children.
- One or both parents having severe physical health problems that affected their ability to meet the needs of the children.
- Families that had generational challenges in parenting such as generational neglect and thus long term involvement of Social Care in their families.
- One or both parents having severe alcohol and substance abuse problems.

- Domestic violence
- Families with children that had severe emotional and behavioural difficulties and parents requiring support to deal with the challenging behaviour.
- Parents' involvement in various criminal activities.
- Families with severe financial challenges and debt.

3.1.1.3. Process of Involvement with Children's Social Care Services

Families were referred to Social Care Services in different ways including referral by other professionals such as mental health workers, GPs, school teachers or probation officers. Other families were referred to Social Care Services by concerned members of the extended family. In some occasions, families self-referred to Children's Social Care Services to get some help in overcoming challenges they were facing.

3.1.1.4. Support and Services Offered to Families

The Units systematically worked out the historical and current risk to the safety of the children in the family. They also looked at the protective and safety factors within the family's system. The Units also considered the children's experiences of what was happening in the family and complicating factors in the family circumstances. Based on the discussion of these factors as a Unit, Social Workers decided on the actions to be carried out to make the families safer. Participants highlighted various ways that Social Workers tried to make the families safe including: crisis intervention, support and guidance in improving family wellbeing; direct work with the family to reduce risk and improve family functioning to support the change, as explained by Parent 5:

Interviewer: Ok, so social workers try to make families safe in different ways. Can you list any of the different ways that they tried to work with you, or tried to support you?

Parent 5: Erm, just, really, trying to make us talk, because we can't talk to each other...Erm, I seen once or twice which was the manager I think. And then, I also seen another lady that came to the house and worked with us, one time. ...Erm, and she just done a little bit of role-play with us.

Sometimes disadvantaged families got the support they required to make applications for housing, short breaks or other resources that would improve their wellbeing and family functioning. The Units also worked with other professionals that could support the families to make the necessary changes including schools, mental health worker, and probation officers as highlighted by Parent 2 and Parent 6 in different interviews:

Interviewer: And er what has been most useful to you about the involvement of social services with your family, if anything?

Parent 2: The only thing is just once again getting that whole school network together.

Interviewer: What kind of support have they been giving XXX? What sort of services have they offered him?

Parent 6: Um...well they've tried to get him into college, they've tried to get him into work....you know...they've tried ...all sorts of stuff....you know...When he's due to go to court he will meet with the Youth Offending worker they're trying to take him to all these places so they are doing everything they can.

In other instances, the Units made referrals to specialist services such as Child and Adolescent Mental Health Services (CAMHS), Specialist Family Support Services (SFSS), Freedom Project, Family Intervention Project (FIP), or Multisystemic Therapy (MST) as discussed by Parent 1:

There was a lady who was a child therapist that XXX and I met very briefly.... And I think the net conclusion that they both came to which was CAMHS and Social Care, that is the social worker and the therapist was that MST should be the operative service. I think it was good that there was a meeting of minds.

The list of services discussed above is not exhaustive but represents some of the key elements of the services and support that families were receiving from children's social care services. The interviews sought to elucidate families' perceptions of the efficacy of the services being offered and some of the perceived benefits and limitations of services delivered in the Unit model. We also sought information on the quality of interprofessional collaboration where families were involved with more than one agency.

3.1.1.5. Beliefs about efficacy of interventions

In the interviews, families were asked about their relationship with the Social Care Unit and more specifically, the staff members they had been involved with. We also solicited information about the different ways that the social work Unit had worked with families to make them safer as well as the various services and recommendations they had been given. To understand the efficacy of

interventions, participants were asked about the changes in their family wellbeing and functioning following the involvement of Children's Social Care Services.

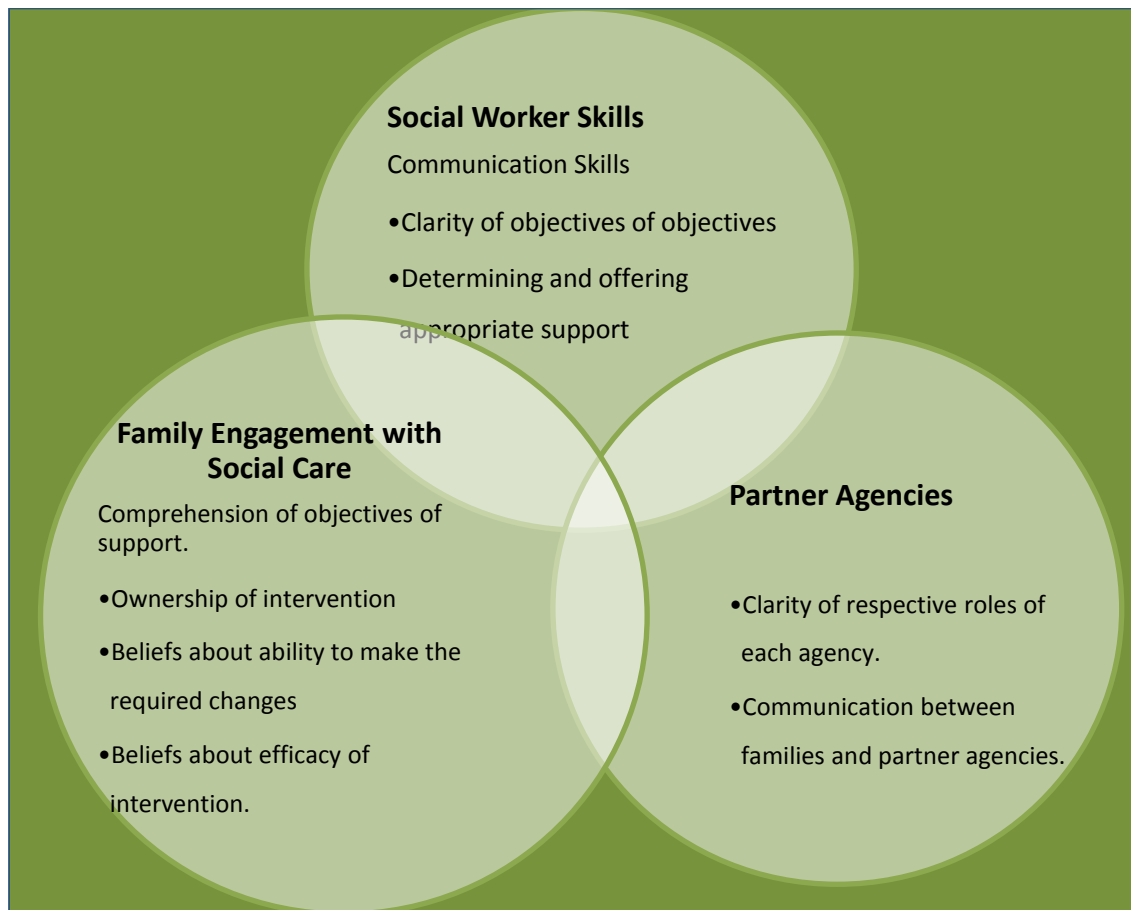
We categorised responses into positive identifiable changes and lack of identifiable changes. We then looked at the factors that were perceived as contributing to identifiable changes or lack of change. We sought to establish whether or not families had clarity and comprehension of the aims and objectives of the services they were being offered. We also sought to understand how the relationship between the Unit and the family affected the families' views of the efficacy of interventions.

Themes from our data indicate that there were three factors that were perceived as affecting attainment of positive change in the family functioning and wellbeing. These factors also impacted on the likelihood of having a positive relationship with a Unit.

- **The first set of factors** pertained to the actual skills of the social work professionals. This included their communication skills and their ability to determine the specific challenges that the family was facing and providing appropriate timely support for the family to be to make the necessary change.
- **The second set of factors** pertained to the actual family's engagement with the social work professionals and their willingness to take up the services being offered. Thus making the change expected of them.
- **The final category of factors** had to do with the quality of interagency work and the ability of different partner agencies to work together in supporting the family to make the necessary changes.

While we talk about these as separate categories it is important to point out that there these are all very interrelated as indicated in Figure 1 below:

Figure 1: Factors affecting relationship between Unit and Family and attainment of expected change



We shall now discuss each of these different factors as they relate to the positive changes or lack of change in the family.

3.1.1.5.1. Positive change and positive relationship with family

Our analysis of the themes in the data suggests that the appropriate mix of social worker skills, family willingness to engage with the Unit and good interagency working supported families to make changes to keep their families safe. Families that thought they had achieved such changes reported a positive relationship with the Unit.

3.1.2.5.1.1. Social Worker Skills

Participants were asked about the useful and practical skills that the Social work staff from the Units they had worked with had displayed. They were also asked about the skills that they generally thought were important in supporting families to make positive changes. One of the key qualities, universally mentioned in the dataset, was effective communication skills.

Different families indicated how effective communication made the difference between engaging with the social work staff and not engaging with social work staff. Participants highlighted the importance of clear, respectful, effective, consistent, communication. Such communication was perceived as clarifying the exact concerns that necessitated involvement with Social Care and what the involvement entailed. The communication specified what engagement was meant to achieve, how long it would last and expectations from both the social work Unit and the family during the engagement. In particular parents appreciated being valued and not being seen as “excess requirement to the needs of the child”. In other words, they wanted to be involved in the decision making and planning about their children despite the difficult circumstance that they were in. Some social workers were reported as having these **good communication skills** as discussed by Parent 6 below:

Parent 6: Erm...Well XXX has very recently in the last month had a new Social Worker. And she's great. She is the best. She agrees in communication. I was like yeah...finally, somebody who sees the importance of keeping us in the loop! It's just communication that's all. ...that's all. That's the big thing....I know I can just phone the social worker, you know, like XXX was meant to come and visit us the other week and XXX never showed up. I spoke to her after that weekend we had a chat. She spoke to XXX and she got straight back to me...brilliant...that's all I want ...brilliant.

Clearly to Parent 6, being kept informed, having someone call her back about her concerns and unmet expectations was very important in maintaining a good working relationship with the Unit and in the Unit gaining credibility with the family.

Parent 6 went on to explain that another key aspect of good communication was social workers **being empathetic** and acknowledging just how difficult being involved with Social Care was for the family:

Erm ...I...I feel that as a whole Social Care have not acknowledged how hard this has been on us. The new Social Worker has and she is the first one out of all the social workers that XXX has had who has said this must be really hard for you. She is the only one that acknowledged that actually we still care about him and we want to know...we want to be kept in the loop...we don't have to know all the details but

important things like being moved...when he gets issued with final warnings...and things like that ...behaviour...we just want to be kept in the loop you know...that's all.

Closely related to empathy was the **ability to discuss safeguarding concerns** with a family without making the family “afraid, patronised or intimidated”. Families indicated that they appreciated it when social work staff reassured them that they were there to support them to make the family safe rather than to just take away their children as discussed by Parent 3 and Parent 4. Parent 3 was so happy with the support she received she recommended uptake of Social Care services to other families:

Interviewer: Ok, do you have any other comments or issues that you would like us to know about your experience with the social care unit?

Parent 3: Umm...I think other families should take the opportunity, if they get offered the help. Cos I think it does help....I just think it's very helpful.....Although it's quite scary when you hear social services. Cos all you think is they're coming to take your children away because I've done this wrong or (laughs).... It's like, quite frightening....Once you get, I think once you get over that, and you realise they're there to help you, not to, come and take your children away from ya (laughs)

Interviewer: What would you say has been most useful to you, about the involvement of social services with your family?

Parent 4: Erm, I think with me, because I, like obviously, I was quite angry when they told me social services were coming out to....Cos I didn't think I had an issue with my daughter. I thought I dealt with things quite well..... And I suppose it was nice, to, have their opinion, to see if I was as well. I mean, I knew I had shouting...but, erm, yeah, once they came, I was ok with that. But I think it's just that initial, if I was to say social services are coming, you'd just think the worst (laughs)

In addition, families pointed out that some of the social workers had been very **respectful** in their communication with them. The social workers were reported as **not being judgemental** to families and approaching them with pre-existing views based on how families were referred to Social Care. In contrast they actually took time to get to know the family and establish exact challenges they were facing. Such a positive approach was seen as being very helpful in supporting the families to make the necessary changes in family functioning.

Parent 4 particularly appreciated that although the probation officer had referred them to Social Services, the social worker did not approach the parent with preconceived ideas based on the referral. Parent 4 appreciated that different members of the Unit were able to make visits to the family home

and actually made an informed judgment about the safety of the children. One of these visits included the social worker and the probation officer which helped put the challenges being faced by the parent into perspective. Even though this was a very difficult visit, parent 5 appreciated that social worker maintained a positive attitude towards her and worked with them to improve communication and thus make their family safer.

Families also had good working relationships with Units that made appropriate timely referrals to specialist services such as SFSS or MST or FIP. Such social workers were described as knowledgeable, structured and organised. Families perceived this support as changing family circumstances as discussed by Parent 1 and 3:

Parent 1: I think the best support to date being with the specialist services from XXX and also with MST.

Parent 3: ..XXX my erm FIP worker, she's really really nice as well. I get on...I get on really well with herI feel like if I've got a problem, I can tell her.

Interviewer: Is she your point of call or?

Parent 3: She is, yeah. If I'm worried about something. I'll ask her, I'll go to her and seek her advice.

Some of the families also indicated that they had a positive relationship with the Unit if they could see that the social worker was genuinely interested in their wellbeing and improving their circumstances and was able to deliver on any promises made to the families:

Interviewer: What about the Unit before that what was the relationship like?

Parent 6: I give my credit to YYY. She tried and she was she got XXX into a hostel. She tried to help him and really tried to get alongside him. She really did try. I take my hat off to her but he was not being very compliant at the time so it was hard. Yeah and she had to close the case on himand that was really hard for her but she did come round and see us but you could see it was that it was the hardest thing she had to do.

For some families, good communication skills also meant the social worker having awareness that they were unable to understand some of the technical information in the statutory assessments. Families thus expected social work staff to be able to go through the reports with them rather than just drop these off to them. Parent 5 compared the two social workers that had worked with their family in handling the similar situations:

Parent 4: Yeah, I don't feel like I got all my views across...Or that, you know that, I mean, I....there wasn't anybody, here, to go through the report with me...You know. I didn't have so much ... (pause) support from my old social worker. She should have been here to go through the report with me. She didn't. She...she got somebody to drop it off on a Friday night. When I had the whole weekend to I guess stew.....

Interviewer: I guess worry about it?

Parent 4: Yeah, stew on it you know. Erm, I didn't like that....Erm, but this one is different. You know, she takes the time to go through it. Even if its briefly yeah...She's she goes through it with me, yeah so erm, no I think they're really good at their job and that's about it...I'm happy now.

Parent 4 made the point that there was a marked difference between the communication skills of the two social workers that she had been involved with. Even though her children were on child protection plans, parent 4 had a very good relationship with her second social worker. She esteemed the new social worker highly and was appreciative of her support to understand what was in the report they had written and what was expected of her. She went on to explain how the social worker's skills had made a significant difference to her:

Interviewer: Are there other skills or qualities that you think social care services staff should possess?

Parent 4: She pretty much has all the qualities she needs already.

Interviewer: Yeah?

Parent 4: I think that's why they're good at their job, yeah.... Erm to, I'm not sure if I can err how I would have coped without them

In the instances where the family felt there was a change in their functioning, they was reported satisfaction with the level of face to face contact with the family. This was viewed as important for the Unit getting to know the family as well as ensuring that the family followed the recommendations and interventions that have been agreed on.

This section highlights that the single most important skill that families valued in their social workers was good communication skills. Closely related to this was the social worker's ability to help them clearly define and understand the risks to the children and to come up with a specific plan to address the concerns raised. Furthermore, the social worker had to prioritise the family and be able to make sufficient face to face contact with the family to support them to make the change. However, making the family safe did not all depend on the social workers' skills, the family's engagement with the Unit and experiences of relevant interagency collaboration were equally important. Below we discuss family engagement with the Unit and how this helped to change family circumstances.

3.1.1.5.1.2. Families who engage

Over and above the skills of the social workers, it was apparent from the data that perceived efficacy of interventions and having a positive relationship with the Unit was also dependent on the family engagement with the Unit. The family had to be willing to accept and apply the interventions recommended by the Unit and consistently follow through the advice that they had received in order to obtain the change. For example, Family 2 and Family 3 reported a very positive relationship with their respective Units because their social workers had effectively communicated their concerns to the family using the various skills discussed in the previous section.

The families which appear to have made positive use of interventions from Units had also managed to express their views and come to an agreed consensus about possible solutions. These families accepted that there were some genuine issues to be concerned about with regards to their family wellbeing and so had an awareness and willingness to improve family functioning. Such families took ownership of the interventions offered. With this ownership came the belief that they could change, and thus they were able to make the change. These families were very grateful that the Units/ social workers had helped them to make this improvement in the family functioning and helped them in a time of crises:

Parent 4: You know, they....erm sort of went beyond the milestone if you get what I mean.....

Interviewer: And what's been the most useful thing to you about the involvement of social services with your family? Would it be err them picking you up at that crucial point that you thought oh?

Parent 4: Yeah, I believe so, yeah....I think helping me, when I was at my lowest really

Closely related to acknowledgment of the concerns raised was that the family had to be convinced that the intervention was appropriate for them and that it would work for their family. For example parent 2 and parent 4 mentioned that they were receptive of the services and interventions that were offered to them because they thought these interventions were effective and would change their family circumstances. However, when the families and Unit had different agendas or different views on the efficacy of the intervention, then the intervention was dismissed by the family as highlighted by Parent 1 and Parent 5:

Parent 1: What was the least helpful engagement? I think they weren't very structured. I really didn't know what was gonna be achieved. I had my agenda which is I wanted to get therapeutic support particularly for XXX. But they I think had a different agenda which is how can we quickly get out of this family how can we quickly escape and not spend any money I think that was at the back of my mind that

there was a plan to say your problem you deal with it **and it was like getting blood out of a stone sometimes to try and get what I wanted from Social care quite honestly.**

Interviewer: Are there any skills or qualities which you thought were good?

Parent 5: (Silence)....No because they've got my back against the wall and they don't.....I think they would be brilliant if they worked with parents possibly who weren't being parents...I've already....I keep doing the family groups and courses and know how to talk to children and go on their level and reward and consequences.

Parent 1 and Parent 5 both had a different understanding of the challenges they were facing from that which they thought the Unit was offering, and thus wanted and expected different interventions from what Social Care offered them. It is possible that because of this mismatch in understanding of family needs and appropriate solutions to the challenges, the families were not receptive of those particular interventions.

Further discussion with parent 1 indicated that their social worker had very good communication skills and despite their initial protests, the social worker had convinced them of the efficacy of the interventions. Parent 1 then agreed to try out the interventions. Due to the complexity of the circumstances that got them involved with social care, change was eventually achieved but this was gradual and meant trying out different interventions until there was an intervention that finally worked. Family 1 had to come to terms with the fact that change was a "journey or a long term process". The positive change was a gradual change; the Unit members persisted with the family and eventually managed to obtain the change required of the family.

3.1.1.5.1.3. Partner Agencies

Yeah...in the brief erm engagement with CAMHS and Social Care I thought they seemed to work pretty seamlessly together.....it seemed as if there was a good communication stream between the social worker and the therapist so I had no concerns about that.

As exemplified by this quote from parent 3, our analysis indicates that some of the families that reported a positive relationship with the Unit and positive changes in their families had received timely referrals to specialist services. These families felt that the agencies worked very well together during their engagement with them. In addition, social workers had created a safety network for children by working very closely with schools. Partner agencies worked with families in various ways including:

- Addressing very challenging behavioural problems in children.

- Intensive support for various members of the family to reduce risk and work towards sustainable change in the family.
- Improving school attendance.
- Reducing anti-social behaviour
- Offering suitable courses for families that could improve their parenting skills.
- Coping with significant life events such as reunion with birth parents for Looked after Children.

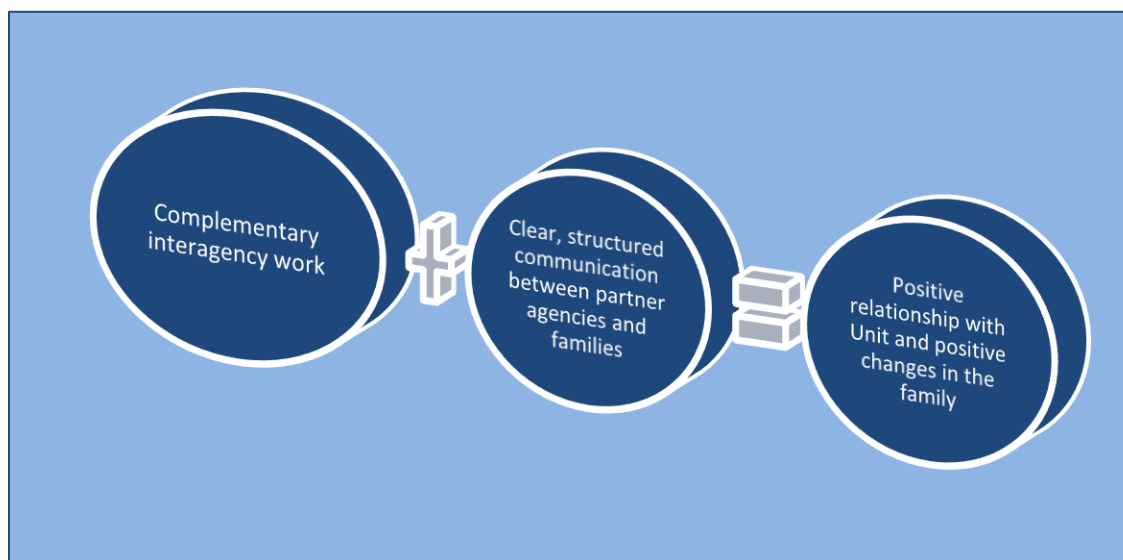
It is important to point out that schools were highly acclaimed by most of the families. Participants indicated that schools were generally very supportive of vulnerable families:

Parent 2: I called the school and thank God have been there and have been huge support Erm..I believe the school have done things well like they are paying for him to have play therapy which again is supposed to be CAMHS but that never got sort of offered at CAMHS umm...

Parent 3: Well xxxxxxx (eldest child) and xxxxx (second eldest child) school support them hugely, absolutely massively.

Our analysis of the themes indicates that a combination of structured complementary interagency work and clear communication between agencies contributed to positive relationship between families and Units as well as positive changes in the family as indicated in the figure 2 below:

Figure 2: Positive Change and Interagency working



Narratives from families indicated that well structured complementary work between agencies helped families to achieve the expected changes. For example, for family 1, the social worker and the SFSS had very different but complementary approaches to supporting the family and this was very much appreciated by the family:

Parent 1: The social worker was an exceptionally good individual. They listened more than they spoke and I think XXX really appreciated it. I think the social worker did a really nice job of listening to XXX and I think she really wanted that sensitivity she didn't want to be told you do this you do that.....I think the social worker did the right thing in terms of appointing a specialist familyI can't remember what it's called...

Interviewer: Specialist family support services?

Parent 1: There you go. OK. Umm...because she was a very no nonsense individual. And she essentially laid down parameters of....XXX this is what you will do... no further discussion. I think actually XXX quite liked that because providing her with a box or boundaries of what you should and should not do, what's acceptable actually helped to give her some structure....So two very very different approaches. Both of which had their pluses and minuses but I thought those were good elements of what Social Care had done.

Families also reported positive relationship with the Unit and efficacy of interagency work when it was actually clear what role each of the different agencies was supposed to play. This included knowing what work the social worker would do with the family and what the other partner agencies would achieve. Most importantly, each agency had to deliver on their commitment. This was also perceived as ensuring that there was no duplication of efforts by agencies.

Interagency work was also viewed as positive and efficacious when there was consistent good communication between the social workers and partner agencies to understand how each agency was progressing in the direct work that they were doing with the families. Families also appreciated being kept abreast of this interagency communication with the family:

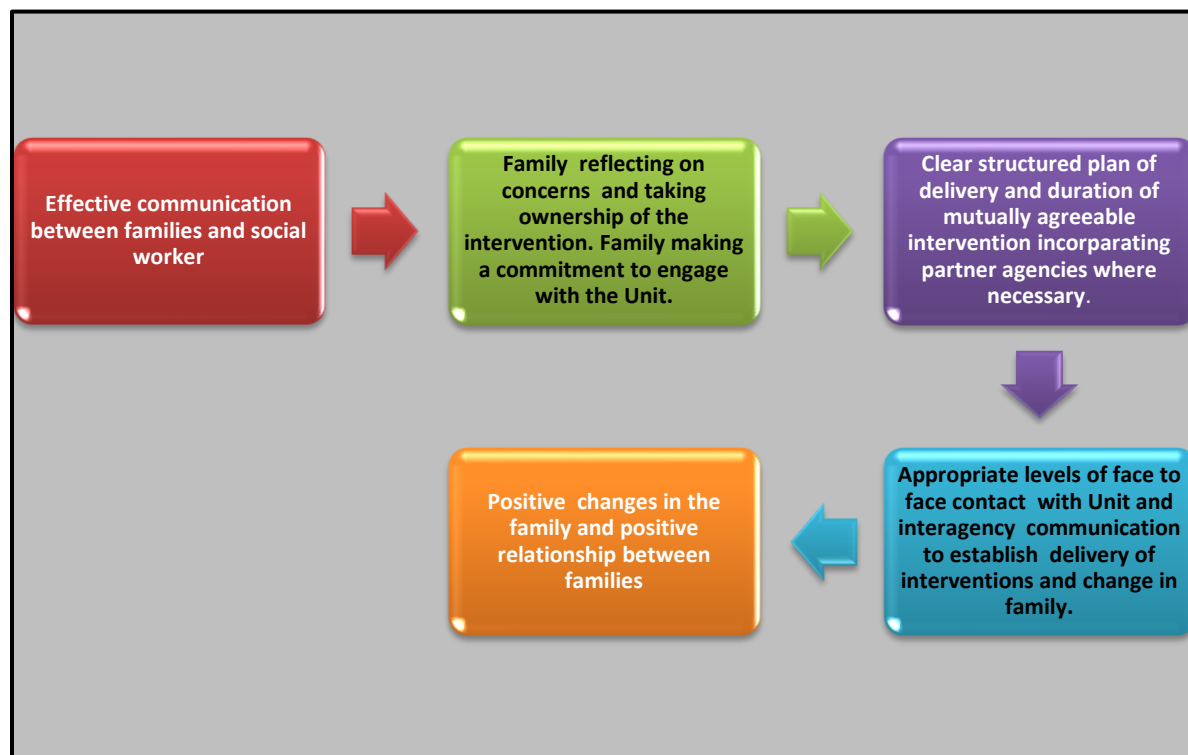
Interviewer: What clues did you get that made you think any of these agencies were working well together?

Parent 6: Communication. It's as simple as that. I really do believe...you know...The Youth Offending Service person was the focal person. He would talk to me and talk to the social worker and talk to XXX and other agencies and he'd get back to me. He would get in touch with various people you know...he was just brilliant

Status review meetings or child in need meetings were also reported as presenting a transparent opportunity for each agency to discuss what they were doing with the family and changes that were or were not occurring in the family.

This section has discussed some the factors that families reported as being key in achieving positive change and maintaining a positive relationship between the Unit and the families as summarized in figure 3 below:

Figure 3: Positive relationship between Unit and Family and Occurrence of positive changes



The themes presented in this section highlight some key learning points on how various social workers effectively engaged families and supported them in making their families safer. The following section describes and explains instances where families were unable to make changes required of them and where the families had negative relationship between families and Units.

3.1.1.5.2. Lack of change and negative relationships between families and Units

Although the majority of families were able to point out the strengths of the Units they had worked with, there were some families that felt that there were some aspects of their engagement with

Children's Social Care services that could have been done differently. These families had either not been able to notice any change in their family functioning or the change had taken longer than the family had anticipated.

Two of the families interviewed had either a completely negative relationship with the Unit or were able to detail a few positive aspects that were overshadowed by negative aspects of the engagement. One such family had worked with several different social workers and detailed the various strengths and weaknesses of the different Units they had had. Similar to the factors that contributed to positive relationship between the Unit and families, the social worker's skills, the family's lack of engagement with the Unit, and quality of the interagency work also contributed to the negative relationship between the Units and families. These same themes emerged in the narratives on why the families had not changed during the engagement with Social Care.

3.1.1.5.2.1. Social Worker Skills

In all the cases where there was a negative relationship between the family and the Unit, or where families felt that involvement with Children's Social Care services had not changed their family functioning, communication was identified as the main underlying problem:

Interviewer: Ok how would you describe your relationship with the current social Care Unit?

Parent 2: It's rubbish!

Interviewer: Can you tell me a little bit more why you think it's rubbish?

Parent 2: Er...its rubbish because communication isn't there...it's not on a regular basis. That's your social care people. Um...I can't speak that of XXX.....XXX has done everything they said they would do.

Parent 2, like other families who had not seen any changes in their family functioning, felt that communication with the Unit was not very good. To begin with, these families reported not being very clear what Social Care services were trying to actually achieve with their families:

Child 1 Yeah exactly, waste, time wasting

Parent 2: Yeah

Child 1: I just don't understand what they're trying to do

Interviewer: Uhum

Given that family members were not sure what the Unit were supposed to be doing it was not surprising that they were unable to make the changes expected of them by that Unit.

Furthermore families who had a negative relationship with the Unit reported how the visits from the Unit had not been very well organised as evidenced by last minute cancellations of meetings or Unit members not turning up when they have promised the family that they would do a visit. As such, these particular families were not happy with the level of face to face contact. In their opinion some of the Unit members did not know the families enough to be able to provide the appropriate support that could change the families' circumstances as discussed by parent 6:

Interviewer: Were there any specific things which they did which you thought were helpful?

Parent 6: Erm...not really because the SOCIAL WORKER hardly saw XXX at all... (laughs) So erm... It's sad that I've got to be this negative. The social worker was really nice and they felt that they knew XXX but in four months they saw XXX for two hours. So how can they say they know XXX? They said XXX was a great chap, polite and lovely lad but in this meeting when they spoke to the school...the school listed all the struggles they had been having with XXX so it was like two different people they were talking about.

Parent 6 was clearly not happy about the level of face to face contact which in her opinion was not sufficient enough to allow the Unit to make a meaningful judgement of their family situation or their child. Given the discrepancies in assessments by the school who spent more time with the child and the social worker who had not had a chance to spend as much time with the child, the family was unable to trust the judgment of their social worker.

Another aspect of communication mentioned by families with a negative relationship with their Units was that they felt that they were not listened to. For example, some of the Units would ask families what they could do to help them. Families reported that they elaborated their problems to the Unit and suggested interventions that they thought would work. However, the Units were sometimes unable to give the families the exact support that they asked for either because they did not meet the threshold for that level of support or it was beyond the remit of the Children's social care services. However this approach in communication raised the expectation levels of the families and left them disappointed when they were told that their suggested interventions were inappropriate. It was interpreted as not listening to what the family felt was the right intervention for them.

Due to this mismatch in the approach to be taken by the Unit and family, these cases were open for a long time without any noticeable change in family functioning from the perspective of the family. This made such families frustrated with the Units that they were working with due to lack of change:

Parent 1: Initially Cambridgeshire Social Care said that they were not going to be involved however I wanted some support and help so had to enquire further and push for additional support and resources to become availablePerhaps they don't listen as well. Because it's not for me trying all fronts to try and get help and me getting so frustrated I had to go to a private therapist in order for her to write a recommendation to say help needs to be provided. I think that was time...precious time that was lost.

Parent 5: I suppose it's just frustrating when they keep asking you how is it we can help and you tell them and they keep saying well we can't do that we can't do that well...stop asking me what I want and then tell me what you can actually do?

The experiences of parent 1 and 5 were very different from parent 2 who felt that the Unit "went the extra mile". Parent 1 felt that their experience was like "getting blood out of a stone". The varied experiences of these three families indicates to us that just as there is variability in the problems for each family, so there may be variability of practice between the Units. It is likely to be helpful for families if there is consistency of practice in the services and help that can be given to families. It is also possible that families that were resistant to change did not take any ownership and responsibility for the challenges they were having and felt the need to place blame on external parties.

Negative experiences with a Unit were also a product of disappointment with the limited access to the Unit clinician. This stemmed from the introduction letter that made families aware that there was a clinician who worked within the Units. However, if the role of the clinician was not clearly defined to the family, families appear to have assumed that the clinician was inevitably available to do direct therapeutic work with them. If this did not happen, families were disappointed especially if they thought this was the intervention that would change their family circumstances as parent 1 explained further:

Interviewer: And what things could they have improve on?

Parent 1: I think they should have listened sooner to the notion of we need more erm..... We need more support earlier therapeutic support should have been offered a lot sooner than it had been. In fact there was one individual which was the therapist in the social care Unit who XXX met very brief who is called xxx.bI can't remember her last name..that really should have been done sooner....

Another aspect of communication raised by families who had a negative relationship with Units was how communication sometimes came across in a way that made the parents feel that they were not important by not giving them information on what was happening with the child:

Parent 6: The social worker said there's no need to for this meeting, it was an interim meeting and they said there's no need and that just really hurt my feelings really.....

Interviewer: Can you tell me a little bit more about that meeting? What was the meeting for and why did he decide that it was not necessary?

Parent 6: It was just an interim meeting that was going to happen between the last child review meeting and the one that was going to happen because they met with XXX for an hour said that they had the child's wishes and they didn't feel there was a need for an interim meeting.And...to me...it was just like OK fine but at least meet with me and fill me in. **It was just like we were surplus to requirements and we didn't need to be told anything.**

In some instances, families thought that the transfer between Units could have been done with better communication. Participants expressed the importance of clear communication on what the transfer meetings were supposed to achieve and who should attend. In addition, some families felt that there was insufficient communication within the Unit and between Units when transfer occurred as they had to keep repeating their stories and updates to different members of the Unit or when they were transferred to a new Unit:

Parent 2: The way it was described when we had the visit you know... they said we're all in units and everybody's aware of what everybody else is doing and you know

Child 1: They all know all the time and all the stuff

Parent 2: But then XXX came along, and you know they were the next social worker and they had absolutely no idea. I mean what what

Child 1: They didn't know who we were like; they didn't know what our case was about like...

This family reported feeling exhausted from having to retell their story to different members of the Unit and to new Unit members when they got transferred. They reported that they had several different social workers during their engagement with children's social care services and found this frustrating.

This section has highlighted the importance of clear well directed communication between the families and Units, that considers the perspectives of family members, supports families to make the changes required of them, and improves the working relationship between families and Units.

3.1.1.5.2.2. Families who do not engage

The perception that interventions were not efficacious was also a product of families' lack of engagement with Social Care. In all cases we interviewed, families were aware that there were some

challenges in the family functioning and that they needed help. While some families felt they knew the exact intervention which would change their family functioning, some families were less sure of what would actually bring the change in the family. Furthermore although there was an awareness of challenges in family functioning, some families were unable to couple this awareness with appropriate corresponding action to address the challenges in the absence of ongoing persistent oversight from the Unit. The need to change was only urgent when the Unit was present and able to provide them with the support to carry out the interventions. If this was absent the families reported being unable to follow through with the intervention and thus not making any sustainable changes in their family wellbeing:

Parent 2: At first it was ... (pause).... this is....what were going to do and then obviously when they didn't follow through with that we were pretty laid back in that too.

Child 1: Like we'd let them come in and like say what they're gonna do and stuff but then they just like didn't follow through that kind of thing...And it's just whatever

Parent 2: You know cos they come in and frighten the absolute pants off you sometimes....This is what I'm going to do, blah blah blah and you know so...

This family made the point that if the Unit did not follow through with the recommendations they gave the family then the family felt that they did not need to also follow through with the advice. However, discussion with the family revealed that the family was still getting support from the Unit. The Unit members were aware of the lack of change. So while it appeared as though the Unit was not following through with what they said when the case was open, their transfer of the case to along term Unit and intensive support in the form of FIP suggests that they were monitoring the family enough to know that there was no change. It is possible that the Unit were aware that the current strategy was not working and hence were trying a different approach through working with a partner agency.

Sometimes the lack of change was because of the family circumstances were really very volatile and would take time to mend and get back to normal family relationships. Families had to be aware and accept that change was going to take time and that they were going to need support to make that change. All family members had to be willing to take up the interventions and support given to them. If any member of the family was unwilling to engage with Social Care Services then this delayed the occurrence of positive change in the family. Some of the families were able to reflect on this aspect and also reflected on how the Units they had worked had taken a holistic approach and trying various interventions to get all family members on board with the hope that once everyone was on board there would be positive family functioning.

3.1.1.5.2.3. Partner Agencies

While there were several reports of positive interagency collaboration, there were other reports of interagency collaboration that could be improved. For example, parent 5 reported how CAMHS and Social Care Services had not had clear communication with her to explain their respective roles. As a result when she asked for help from one agency, she was told to ask for that help from the other agency which made the involvement very frustrating:

For instance I would speak to Social Care and Social Care would well say CAMHS need to be doing more so I would speak to CAMHS and they would say that's family support lady's job you know...and I just feel like I'm just sort going round the houses and I'm neither here or there.

Parent 5 made the point that even though different agencies were involved with her family, she was unsure who to turn to for specific support as each agency asked her to go to the other agencies for support. Ultimately this meant that things were left undone because no agency actually took the issue up as they assumed that someone else was doing them. Parent 5 reported that the Unit had become aware of this problem in the interagency work and were organising a professionals meeting to clarify roles and remits of the different agencies.

In other reports, the agencies were all aware of what each agency was supposed to be doing but some of the agencies did not follow through with the work that they were supposed to be doing with the family. This meant that one agency had to take up the work that should have been done by another agency. For example, some families pointed out that schools sometimes did the work that should have been done by Social Care or by CAMHS. It is possible that communication between schools and Social Care had taken place and some work designated to the school. However if this was not clearly communicated to the family, families assumed that Social Care were not meeting their obligation and that schools were actually picking up the work that has been left undone by the Unit.

Closely related to this issue was the need for sensitivity about information sharing and requests that were made to the schools. While most schools were indeed said to be very supportive, their involvement also made things more complicated for families as reported by parent 1:

Interviewer: Is there anything the Unit could have done differently?

Parent 1: In the child in need meeting the social worker suggested to the school that they appoint an individual teacher in the school for XXX to be able to speak to and talk about any frustrations or concerns..... now XXX feels very nervous that somehow it's been a sort of bull in a China shop....approach maybe that's been taken by the school that, "XXX, we know you have problems and you should be able to get counselling in school" and XXX doesn't want to do that. XXX is a private child and if XXX has problems they don't want discussed in the school environment. I think the approach that was taken by social worker urging the school effectively to talk to somebody has created new problems regrettably.

Parent 1 made the point that both the Unit and the partner agency in this case had to be sensitive in how they handled information that was shared with them. Parent 1 was aware for the importance of school involvement but thought their involvement in their family may have been unnecessary given that the social worker was already aware that the child was in receipt of professional counselling and therapeutic services.

The themes presented in this section highlight some key learning points on what can result in a negative relationship between the Unit and the family as well as factors that may hinder engagement with families and make attainment of the expected change challenging. In the following section we discuss some of the recommendations from families on how to improve services.

3.1.1.6. Recommendations from Families

There were several recommendations that families suggested to Social Care Services which largely emanated from their direct experiences with the Units described in previous sections. We summarise the key recommendations from families below:

3.1.1.6.1. Communication

All the families emphasised the importance of good communication between the Unit and the family. As indicated in the section on positive experiences, they want this communication to be clear, honest, respectful, well directed, and empathetic – demonstrating that their own experiences have been taken seriously, their predicaments understood, even if the Unit does not share the same beliefs about them. The clarity of this ideal communication would enable the family to gain understanding of social care concerns and how to address them as discussed by Parent 6 below:

I think being honest and speaking just speaking it as it really is...you know... don't use any jargon tell it in plain English so you can really understand what is going on.....but then say we can really appreciate that is really hard for you and we're really sorry it's this way but this is the way it is. It's just about being honest but being respectful of all parties as well as.

It is important to point out that several of the social workers from the Units that families we interviewed were with were said to have these good communication skills.

3.1.1.6.2. Listening

Another important aspect of the communication mentioned by families was that they wanted to be listened to. They wanted to feel that their views about the safeguarding concerns were heard and that there was sufficient face to face contact with the Unit to develop a structured intervention that would actually change their personal circumstances as described by parent 1:

Interviewer: Ok, so what specific qualities or skills do you think social care staff should display which may be really helpful to families.

Parent 1: Um...so I do think the approach of being good listeners...erm...not being erm...too pushy ...Erm..in terms of saying ...this we know is the solution to all your problems without first trying seeking to understand and then be understood.

Some Units were reported as doing very well in this. Other Units could also copy this good practice.

3.1.1.6.3. Prevention

Although families were aware that some services could not be offered to them because they did not meet threshold levels or because the Unit felt that the interventions were inappropriate, families felt that Social Care as a whole would benefit from doing some preventative work:

Parent 5: I think what Social Care need to do er..really try is to do prevention rather than cure. I feel that is where it's really lacking. I feel people keep asking for help and asking for help and ask for help. And they don't get it until they are literally at the point of where it is too late.

Furthermore some participants indicated that when prevention work was not done and problems escalated, this ended up costing Social Care Services more money:

Parent 1: Too often I was communicated to about finances and money and that social care will only be involved if you reach a certain criteria or threshold of some kind of ...we don't have moneys in order to support that. Well, I believe it was pounds wasted calling out all these additional services. It ended up costing I think our local economy more money than trying to provide the support at an early basis. And the fact that our child was the loser in this one because they were just emotionally so troubled and unable to attend school. So I think there's a big disservice from Social Care Cambridgeshire not to involved with a higher level of support up front. If I give a drug to a cancer patient I don't start with softly softly drug feed intravenous infusion you have what's called a loading dose of that medicine and then you taper it down to adjust appropriately. I think a similar approach needs to be taken as well.

Parent 1 like parent 5 and another family made the point that it was important for Social Care to do more work to prevent escalation and or a repetition of the problems that made the families open to Social Care Services. Parent 1 particularly makes a point of a loading dose or loading intervention for families that have specific problems.

3.1.1.6.4. Make transition to long term Units faster

One of the key issues that families that had been transferred to long term Units shared with us was they felt that it was important to make the transition to long term Units faster. This was important so that the family did not establish relationships with Social Workers only to then have to move to other Units and then having to try and make new relationships with the new social worker. It also meant that there

were no delays for families waiting to be moved to long term Units. Families also suggested that swift transfer meant that the gains made in the family function are not lost while waiting for transfer meetings to be scheduled in.

3.1.1.6.5. Clear interagency working

Our analysis indicates that a combination of structured complementary interagency collaboration and clear communication between agencies was very helpful for families who had referrals made. To begin with families indicated the importance of making referrals promptly where this was necessary so that their families did not deteriorate while trying interventions that were not working:

Parent 2 : It's just ever so ever so wishy washy. And in particular it was very very apparent months ago that the intervention we were having wasn't really working. They said they were going to pass it onto, you know, the other social worker or whatever...

Interviewer: Uhum

Parent 2: I mean, you know we could have been referred to FIP ages ago, and by now we perhaps would be engaging you know.....but we've waited three months now.

Once referrals were made, families indicated the importance of interagency or professionals meetings where the roles and remits of each of the agencies were clearly explained to the family. Furthermore, families indicated the importance of being informed of communication between the agencies as a way of reassurance that the relevant agencies were fulfilling the agreed work. It is important to point out that some Units were reported as working very well with partner agencies and other units can also copy this good practice.

3.1.1.6.6. Realistic expectations

It was important to several families that they be given very realistic expectations of what Children's Social Care was going to help them with. This included clarifying what the roles of the different members of the Unit were and the extent to which the different members would be able to carry out any relevant one to one work with family. This was really important so that families would not feel that they are being denied a service which Social Care services are able to provide.

Furthermore families indicated the importance of being involved in decision making about interventions. However rather than asking what the Unit can do to help family, the Units can suggest

and give several options of what they can actually do to help. The Unit can then give the family the choice to choose from what they have said they are actually able to do. This would mean that the family still feel that they are involved in the decision making process but also that the Unit is actually able to do what the family have said would be helpful for them which would create a win-win situation and increase engagement with the family.

3.1.1.7. Summary and Conclusions

In this chapter, we described how acceptable social care work delivered in the SWWFF model is to families. We have detailed how the interaction between social worker skills, family engagement and partner agencies contributed to expectations of and beliefs about efficacy of intervention. Most families were able to detail positive aspects of their engagement with children's social care services. They discussed the complexity of the processes through which social workers successfully delivered services to their families. We have also managed to highlight some ways to improve the delivery of social care services based on good practices mentioned by participants as well as learning from their negative experiences. These include:

- Clear, honest, effective communication between the Unit and the family.
- Structured and timely delivery of appropriate interventions.
- Setting realistic expectations.
- Listening to families and increased face to face contact with families.
- Making timely referrals.
- Transparent and organised interagency collaboration and communication.

Families reported several positive experiences. It is possible that these positive experiences reported by families are because practice has improved due to working in a Unit and social workers were able to learn from each other different ways of effectively engaging the family. However a randomised controlled trial would be required to provide substantive evidence comparing outcomes and experiences of families receiving services in a Unit model and those receiving services delivered in the usual or standard way.

3.1.2. Quantitative Family Data

3.1.2.1. SW:WFF Family Experience Questionnaire

The first question asked families to rate how well they thought that they were being listened to by those in their social care unit. 72.4% of families thought chose the score 4 or 5 (upper two categories, table 1).

Table 1. Responses to Question on Being Listened To

	1 (Not at all)	2	3	4	5 (As much as you want them to listen)
Frequency	3	0	5	10	11
Percentage	10.3%	0	17.2%	34.4%	37.9%

The next question asked participants to indicate how easy it has been for them and their family to talk to members of their social care unit. Again, the majority were positive, with 66% rating 4 or 5 (table 2).

Table 2. Responses to Question on Finding Staff Easy to Talk to

	(1 Not at all)	2	3	4	(5 Very easy to talk to)
Frequency	5	1	4	7	12
Percentage	17.2%	3.4%	13.8	24.1	41.4%

The third question asked families about their experiences of how helpful the social care unit has been to them and their family. 71.4% answered a 4 or 5 (table 3)

Table 3. Responses to Questionnaire on Helpfulness

	1 (Not at all)	2	3	4	5 (Very Helpful)
Frequency	3	2	3	6	14
Percentage	10.7%	7.1%	10.7%	21.4%	50%

The next question was qualitative in nature, and examined what families have found helpful about the way that their social care unit has been working with them. There were several positive comments from some of the families, including from this adult who is also head of the household, who found the following aspects helpful: “Level of support during difficulties with xxx (child), good at doing their job, listened to, honest, firm but fair, working with not judging you, want to improve life, make children happy”. It is evident that specific and tailored interventions for families are helpful and appreciated: “Help me with my anger issues and to get over the death of my father and help with money” and “Clinician - worked with family; situations, relationships, explored each person's point of view”. One parent indicated that the social care unit is always available when they require it: “Emergency duty care helpful in explaining what is acceptable and what is not” and “Telephone calls have been helpful”. Another parent found the “Direct work with the children outside of the family i.e. cafes, food outlets” to be helpful.

The next qualitative question asked families if anything has been unhelpful about the way that the social care unit worked with them. One parent identified that “A few comments out of the report were incorrect.” Another unhelpful way of working that was identified by a child and a parent of two different families was that of change. Comments included “Different social workers i.e. 13 social workers in 3 years on and off” and “They always change” (members of staff from the social care units). The problem of “communication” was stated by several of the families. Other issues reported include: Unable to get hold of unit, not being able to access the clinician despite being offered and unsure of respites. Another family member commented: “Feeling like as parents don't matter; very little decision making, our opinions don't matter” and felt quite negative about their experience.

Additionally, the SW:WFF Family Experience questionnaire asked participants with a simple yes or no response whether they were clear about what their social care unit was trying to help them work on. The majority of family members agreed that they understood what their social care unit was helping them to work on (72.4%), with only 20.7% not agreeing with this statement. Two individuals (both children) either missed answering this question or found this question to be not applicable in their case (table 4).

Table 4. Responses to Question on Whether They Know What Their Social Care Unit Was Trying to Help Them Work On

Do families understand what their social care unit was trying to help them work on?	Yes	No	Unsure/Missing/N/A
Frequency	21	6	2
Percentage	72.4%	20.7	6.9%

The final question of the SW:WFF Family experience questionnaire asked individuals whether there was anything else that they would like the researcher to pass onto the social care unit that might help them provide a better service in the future. This again was a free text answer. Some positive comments included “They are doing a good job”. However, one adult answered “Bit confused – who was the social worker (different one each visit).” Another family member wasn’t aware about the service transformation: “Didn’t know the structure was changing (to SW:WFF until it was explained by social worker)”. Suggested improvements include providing “continuous support”, “not waiting until a crisis – prevent” and “revise the threshold levels”. A couple of families were pleading for help through their comments “We want help - more frequent involvement.” And “Help”.

3.1.2.2. Family Function: SCORE 15

On the Score 15, which measures family functioning, a lower score indicates high family functioning, whilst a high score identifies lower family functioning. The range of possible scores is 15-75.

Before results were analysed, participants were sorted and split by family member type i.e. into Parent head of household (13), parent non-head of household (7), and child (8), to assess whether differences in perception of how their family is functioning exist, as measured by their total score on the Score 15. One adult non-head of household chose not to complete this questionnaire. Table 5 summarizes the results of participants' responses to the Score 15. There are, as yet, no clinical norms to help interpret these scores.

Table 5. Results on Score 15 Scale of Family Functioning, Split by Respondent Category

Report			
Score			
Type of Family Member	N	Mean	Std. Deviation
Child	8	31.5	6.9
Head of Household	13	29.4	12
Non-Head of Household	7	30.3	12
Total	28	30.2	10

3.1.2.3. Adult Wellbeing Scale

The Adult Wellbeing scale is designed to assess adults' mental health and wellbeing in the last few days. There are four different dimensions: depression, anxiety, inwardly directed irritability and outwardly directed irritability. 21 adults (14 head of household and 7 non-head of household) completed this questionnaire. Designated heads of household were more likely to be mothers, and non-heads of households were more likely to be fathers, which may confound comparisons between groups (ie being female (a well-recognised risk factor for depression) rather than being head of household, may cause higher scores). Table 6 shows proportions of participants in the normal/abnormal ranges for the dimensions.

Table 6. Scores on Adult Wellbeing Scale

	Head of Household			Non-Head of Household		
	Normal	Borderline	High			
Depression	3 (21%)	9 (64%)	2 (14%)	3 (43%)	3 (43%)	1 (14%)
Anxiety	8 (57%)	5 (62%)	1 (7%)	5 (71%)	1 (14%)	1 (14%)
Outward-irritability	11 (79%)	3 (21%)	0	6 (86%)	0	1 (14%)
Inward-irritability	14 (100%)	0	0	5 (71%)	1 (14%)	1 (14%)

The small numbers make it hard to draw conclusions, but do suggest that adults in families with social services involvement are likely to have a relatively high probability of high depressive symptoms.

3.1.2.4. Strengths and Difficulties Questionnaire

Adult head of households completed the parent-rated Strength and Difficulties Questionnaire (SDQ) for each of their children aged between 4 and 16 years. Participants were asked to base their answers on their child's behavior over the last six months. The SDQ contains five sub-scales: Emotional symptoms, conduct problems, hyperactivity, peer problems and pro-social. Parents completed SDQs for 22 children (11 males, 11 females). Across the general population, 10% of children/young people score in the abnormal range, and 10% in the borderline range. Results are shown in table 7.

Table 7. Parent-Completed SDQ Scores for Their Children

	Normal	Borderline	Abnormal
Total Difficulties Score	16 72%	0	6 27%
Emotional Symptoms Scale Score	17 77%	1 5%	4 18%
Conduct Problems Scale Score	12 55%	3 14%	7 32%
Hyperactivity Scale Score	15 68%	2 9%	5 23%
Peer Problems Scale Score	13 59%	3 14%	6 27%
Pro-social Scale Score	20 91%	0	2 9%
Impact Scale Score	13 59%	2 9%	7 32%

As can be seen, while a greater-than-expected number of children/young people fell into the abnormal range than would be expected in the population, the majority scored in the normal range.

The impact scale score was calculated by summing items on the overall distress and social impairment questions. Questions assessed how much the difficulties upset the child, and how much they interfered with the child's home life, friendships, classroom learning and leisure activities. The impact scale had a higher-than-expected frequency of children scoring within the abnormal range (32%), however again the majority were in the normal range. This may indicate that while families under social care identify that they have problems, only a minority think that their children's individual problems lead to distress/impairment.

These results do suggest that the majority of families themselves identify that it is family problems that lead to them needing help from social care, rather than individual mental health difficulties in the child.

Comment from SW:WFF leadership team:

This seems like positive systemic understanding of presenting issues.

3.2. Acceptability of SW:WFF to Staff

3.2.1. Acceptability of SWWFF to Staff – Qualitative Data

3.2.1.1. Introduction

This chapter aims to build a detailed picture of the staff experiences and opinions of the SW:WFF service transformation in Cambridgeshire Children's Care Services. Staff on the ground are an integral component of the outcome of a service transformation such as this, and their views and experiences therefore constitute an important perspective in our enquiry about the implementation of the SW:WFF model. During the interviews, staffs were asked about their perceptions and experiences of the unit model, their predictions for service success, and where the risks and threats to implementation and good outcomes were. In particular, the interviews were designed to capture their anticipations and actual experiences of the unit model. We also evaluated how the process of change had felt for the social work professionals involved.

Analysis aimed to identify diversity, complexity and contradictions in the subjective evaluations of the new model of working. In particular, we wanted to identify what the staff members considered to have worked well and not so well, and how these factors have affected their working environments and engagement with families. We attempt to draw recommendations from this to help both Cambridgeshire Social Care and other services considering implementing the SW:WFF model.

This chapter is divided into four sections. We begin in 3.2.1.2 with a brief description of the staff members who took part in the interviews. In 3.2.1.3 the improvements in the service and positive outcomes of the transformation from the staffs' perspective are explored. The challenges that they highlighted are discussed in 3.2.1.4. This chapter finishes in 3.2.1.5 with recommendations from the staff members for improving future SW:WFF services and transformations.

3.2.1.2. Description of staff members

In total, 13 staff members participated in interviews. Purposive sampling was used to select participants with a full range of roles, unit types and opinions of SW:WFF. In terms of job role, 3 participants were consultant social workers (CSW), 4 were social workers (SW 2 of whom were agency), 3 were unit coordinators (UC) and 3 were clinicians. Families were recruited from CiN, LAC, and Access Units. There were no families recruited into the study by the Disability Units. There was a full range of opinions of

the SW:WFF transformation, as asked about in Question 5 of the Staff Experiences Questionnaire: 'Overall, I prefer working in the SW:WF model compared to previous models of social work practice'. Frequency of responses were: slightly disagree: 4; slightly agree: 3; strongly agree: 5; not applicable (ie not previously working in social care): 1. There was considerable variation in the length of time that staff members had been in post, ranging from just two months, up to when the Units began to go live eighteen months before. The extent of individuals' work experience and length of time as a qualified practitioner was also varied, and ranged from five months to twenty years.

3.2.1.3. Improvements in the service

J (CSW): I think it's brilliant. I've been working in erm, traditional social work models...

Interviewer: Ok

J (CSW): Erm, for... however long. For a number of years, and erm... where you get your manager overseeing say, ten social workers...

Interviewer: Yep

J (CSW): ...who's managing thirty cases and you just get on with it, and you're task-focused, and you get on with it and you get to know your child or adolescent you are working with, and that's that and you just roll. Now, we do that, but we are *way* more reflective, we are able to share risk, share diff- difficult decisions, check things out with each other, erm, we just feel so much more nurtured and protected is what it is really, and supported.

The quote above demonstrates the support for the unit model and for systemic practice that many staff members expressed during the interviews. They identified numerous benefits of the model that they felt had improved the working experience for staff as well as the quality of the service provided to children and their families. As will be discussed, the common factor underpinning these benefits was the improved teamwork and reflective practice that staff felt had been introduced as part of the SW:WFF model. This revealed the systemic approach, which emphasizes the importance of using the perspectives of other unit members in reflecting on clinical progress and risks, as a key factor behind staff satisfaction with the model.

The improvements to the service that staff members associated with the SW:WFF model during the interviews centered around three main themes, which will each be explored in detail within this section:

- Safer practice through shared responsibility and reflective discussion
- An improved team structure

- Improved relationships with families.

3.2.1.3.1. Safer practice through shared responsibility and reflective discussion

Safety considerations were prominent in the staff members' discourses, and were a common topic in their evaluations of the SW:WFF model. All of the staff interviewed, whether supportive of the unit model or not, reported finding the shared responsibility and reflective discussion associated with the unit structure to be helpful, and to make practice safer.

Through shared responsibility of cases and by making decisions together in a way that "...kind of strips back some of the power in the role..." (Participant D (SW)), the SW:WFF approach was felt by many staff members to provide a safer way of working than traditional social work practice. Shared discussion was reported to take place most commonly during the unit meetings, when staff members had the opportunity to reflect, to question, and to learn from each other.

I think safe social work is done with, erm, in... in a kind of a group way. I don't think safe social work practice is kind of the linear structure in which it used to be set up in Cambridge. You know, repor- me holding all my... you know, my twenty odd cases and sharing that. I was very lucky to have good supervision about every six weeks with my line manager. It just doesn't make se- looking back it just doesn't make sense.

(Participant G (CSW))

You know, there's always a reason and not just because... it's very thought out, and that what makes our unit feel very safe. Because any decision making is always well thought out. And even on that day it might be the right decision, it might be the wrong decision the next day, you know at that time it was thought out. There was a discussion around it and it wasn't just a blasé... thing. So that's what I think makes us feel safe on our unit.

(Participant C (UC))

As these quotes demonstrate, reflective discussion and shared caseloads were felt to enhance safety in practical ways because staff members are able to explore different perspectives that they may not have thought of alone, and to consider alternative ways forward in their work with families. As Participant C (UC) highlights, by making decisions together and discussing the information available to them at a given point, unit members are afforded a sense of security through collective agreement and there is documented assurance that action is taken on logical, thought-out grounds. Further to this, several interviewees explained that even when unit members were unable to come to a common decision, the

discussions were still valuable for exploring the viewpoints of the family members and the clash in opinions was recorded for future reference in case circumstances changed.

So I think, you can't always... you know... it's- it would be *completely*, you know... you're not able to say: "Oh we always agree, we always come to consensus". Most of the time we do, but when we don't, we actually record differences in thoughts.

(Participant B (clinician))

As the above quotes from participants C (UC) and G (CSW) also show, safety was additionally impacted by the enhanced emotional wellbeing of unit staff that regular support between unit members can nurture. For some, the unit meetings were felt to be akin to group supervision, and experienced as supportive. They were reported to provide staff with an opportunity to offload the difficult emotions that supporting vulnerable children and families can provoke.

J (CSW): If you... if you miss out on unit meetings, you just feel like... "I'm getting too out there", like, "what's going on?" and "I haven't caught up with anybody".

Interviewer: Yeah

J (CSW): And you come back and it becomes really tight and you close the doors... and when we close the doors, we can... we know that it is a context where you can let go. You know, I mean... when you... when you've had a rotten time, when you've felt really repulsed by some sexual abuse and you've been, er... having to then liaise with the abusers and things, and it... it instils emotions in us. And you go out there and we're very professional, and you close the door and can say "that angered me so much, and I felt so tearful", or whatever it was, and we can all just... accept and reflect. And then... go out.

E (clinician): You just try to help each other out, rather than being all sort of, you know "I'm fine. I'm always under... everything's under control."

Interviewer: Exactly, uhum, lovely.

E (clinician): And some... some... and some clients will get to you and you just er... (sigh) you get stuck, you get annoyed and...

Interviewer: It's important to voice it though, isn't it?

E (clinician): Yeah.

Interviewer: Rather than hold it but then... that was the original idea, wasn't it you held the cases yourself? But...

E (clinician): Yeah.

Interviewer: You've got to struggle.

E (clinician): Oh, I mean I- you know, it's nice in the unit meetings. It's camaraderie, so...

In this way, staff felt that individual judgement was less likely to be biased or clouded by strong emotions, and there was again a sense of the workload and burden being shared. In these ways, staff felt that the SW:WFF model helped them to think and to make decisions more safely. It is of note here, therefore, that the safety benefits of the unit model were not simply attributed by staff to the outcomes for children and families; rather, it was hugely important for staff to feel safe themselves, and they were conscious that their own wellbeing can positively affect the individuals they support.

Because it's about your emotional wellbeing and if you can build up your own resilience through this model, erm... then you're gonna function that much better. But you can't do that when there's hardly anyone there.

(Participant J (CSW))

You know, there is always a layer of kind of change within the organisation going on, and it makes us vulnerable, so it makes families vulnerable because we feel vulnerable.

(Participant G (CSW))

Several staff felt that having a culture of reflective and team work had also improved their practice and enhanced the safety of children and families by positively influencing other aspects of work for the better, not just team working. Firstly, one important example of this related to shared caseloads and staff absence or leave. With SW:WFF, differently to before the transformation, staff reported that cases were "not just left drifting, or just sitting there not having anyone doing anything on it" (Participant F (UC)) when primary workers were away. This was because all unit members were responsible for all cases and had knowledge of the families. This helped maximise the safety of children, who were not forgotten about or left waiting. It also enhanced units' relationships with families, who received a more knowing and understanding service from other unit members when their primary worker was away. A second example of how the SWWFF model had impacted safety was through the effect of the reflective unit culture upon individual supervision, as the following quote shows:

Erm, it is, it is... and our supervisions now take on quite a different, er, they are quite different. Because in our unit meetings we talk about the cases, but for us we talk about the cases but we talk about *our* relationships with the cases, so: 'how are *you* finding working with so and so' 'how are *you* finding that difficult meeting the other day' 'what did you think about what was happening' or 'how would you function if we went down

this road, down that road'. And 'what's the Unit's relationship with this child, or with this baby whatever it is' – which is again, it's very systemic, because it's about how do we relate in these concepts? And that's what... that's what's very sort of different about supervision which I found in the past was so much like, "what are you doing now? Where is he living now? And what are you doing now?"...

(Participant J (CSW))

This transition to a more reflective style of supervision was often attributed by staff to the change to the SW:WFF model. By addressing 'how' and 'why' questions in supervision, rather than just 'what' questions, staff members' emotional needs were being met in addition to their professional development and learning needs. By talking about these two needs together, Participant J (CSW) demonstrates that both are fundamental for improving the quality and safety of social work practice. As is also clear in the quote, many of the interviewees explicitly named systemic concepts and processes during the interviews. The presence of such terminology and labeling demonstrated a good knowledge of systemic practice among the majority of the unit staff (excepting some of the unit coordinators, as will be discussed later in this chapter), and an understanding of why and how the systemic approach could be used to make social care practice safer. Staff therefore revealed not only that they had sufficient training and knowledge to work systemically in both individual practice and team situations, but that they found it a more appropriate and holistic approach than the traditional model of social work.

A particular systemic concept that the staff members talked about and related to improved levels of safety in their practice was that of 'safe uncertainty'⁶. There was wide recognition that traditional models leave social workers to make safeguarding decisions alone. This can provoke anxiety, the desire to strive for certainty, and lower receptiveness to feedback from others. While different interviewees displayed varying levels of comfort with receiving feedback from others in their unit, they agreed that a stance such as SW:WFF is more creative and flexible because it encourages alternative perspective-taking and accepts that different truths can simultaneously exist. This was generally felt to be a safer way of working and to promote better outcomes. Staff members reported feeling more curious, more able to question and challenge their own prejudices and judgments, and more aware of what different family members' perspectives might be. By understanding cases from these multiple perspectives, unit members were better equipped to come up with a practical plan to help move the family forward and improve the situation for the children.

⁶Mason, B. 1993. Towards Positions of Safe Uncertainty. *Human Systems: The Journal of Systemic Consultation & Management*. Vol. 4, pp189-200

I think it helps a great deal more that we are in the Unit Model and we can... like I say, we bounce ideas around the table and you can kind of take devil's advocate and say "Well you're not wrong. You're not wrong. How can we make this so that everybody understands the different viewpoints?" That, erm, is quite interesting, how that's kind of worked, you know.

(Participant J (CSW))

K (clinician): It's the most containing framework for organisations to work in. It's very, very focused on the relationships between the parts, whether it's a family or an organisation, or a group... it doesn't matter. That's where the focus is, is on how do you, er... mesh different perspectives, different police, different practitioners, different backgrounds. How do you make them come together for the benefit of those people within that organisation? And those people that they serve, if it's an organisation that's serving people.

Interviewer: Hmm, hmm.

K (clinician): If it's a family, it's for, how do you help them live together and meet their needs?

By comparing the interviews, it was clear that the extent to which each individual derived a sense of safety from shared responsibility and reflective discussion was linked to their commitment to the systemic approach, and to their within-unit relationships. Closer examination revealed that those individuals who reported good communication and a sense of team spirit within their unit also said they found it easier to engage in reflective practice and admit to uncertainty than those who had not gelled as well with their colleagues. While the connotations of poor within-unit relationships will be discussed later on alongside other challenges that staff experienced with the SW:WFF model, the positive outcomes of the unit model team structure will now be considered more closely.

3.2.1.3.2. Improved team structure

The second strong theme in the staff interview data was the positive effects of the Unit structure. As many staff had been employed in Cambridgeshire Children's Social Care before the transformation they were able to provide candid comparisons of their 'before' and 'after' experiences, and to highlight the improvements and problems that had arisen in this regard. Others were able to compare to their experiences of working for other social care providers. In the discourses of the staff members who were positive about the unit model structure, there were two prevalent sub-themes: the first was an

appreciation of the mixture of skills, experiences and specialities in the unit; the second was a strong sense of team spirit and containment.

Turning to the first of these sub-themes, many staff enjoyed working in units comprised of diverse roles and valued the alternative perspectives and skills that different individuals could bring to the work they undertook together.

So I think... subconsciously I'm always taking it in and, I suppose, because I do get to hear the clinician and how she is on the phone with families, and do find I sort of pick up her approaches. And I think because my background is in mental health... so, erm... with XXXX [mental health patients] so you are always looking at different ways... to sort of engage people in conversation, particularly if people are anxious, if they are angry and all those sorts of things. So I've sort of built on that from the clinician and her approach, and I can just see very much that the social workers do pick up on her approach.

(Participant C (UC))

I think the... the unit coordinator is a fantastic... post. I think it's truly superb. Our unit coordinator is excellent, erm... and we had a... a... an administrator in a very similar kind of vein when I worked in (another council). I think to have somebody more central like that who has a very good grasp of the social worker's cases, better than I have. Erm... that's... that's one of the biggest strengths.

(Participant M (agency SW))

K (clinician): Erm, and I think actually there's... there's a kind of magic... potential magic, in working so closely with social workers because the flip side of what I just said is that you can get... systemically, you can get as systemic practitioner, you can get a bit wedded to the idea that all... all realities are possible.

Interviewer: Hmm, hmm.

K (clinician): And actually what social workers bring to the field very well is "we're in the domain of action" – we're, you know... "we've got to be doing something." At times, "we have to be doing something".

Interviewer: Hmm, hmm.

K (clinician): And I think those different dialogues can be, probably, for... you know, the... the safest dialogues that you can have.

Overall, clinicians and unit coordinators engaged in this type of dialogue more than social workers, although there was appreciation *for* all roles *from* all roles during the course of the interviews. It is

possible that as the clinician and unit coordinator roles were newer and less defined than the social worker role, individuals in these posts had greater cause for reflection and comparison with their colleagues. As the above quotes demonstrate, recognizing their colleagues' strengths allowed staff to understand their own areas of weakness, and to appreciate the benefits of team working. Furthermore, this contributed to an environment of learning and questioning with regards to how systemic work was undertaken within the unit and how staff understood the roles and responsibilities of all unit members. By stating that "...I do get to hear the clinician and how she is on the phone with families, and do find I sort of pick up her approaches", Participant C (UC) describes how the unit environment can be a stimulus for self-improvement and learning new through observation of colleagues. For Participant K (clinician), there is "...potential magic, in working so closely with social workers..." because they approach the work with different approaches, and comparison through teamwork allows a more balanced and holistic view to emerge. Importantly, as these examples show, whether the outcome of unit working was that the staff members became more similar in their skill-set or were able to value their differences, they related the benefits directly back to the work done with families, and recognised better outcomes.

In particular, staff linked the role of unit coordinator to service improvements. Many unit coordinators had considerable prior experience within Children's Social Care Services and had undertaken direct work with families, meaning that they were able to contribute meaningful insights during case discussion and had excellent communication skills for dealing with families. Unit coordinators relished the occasional opportunity to go on visits and meet the families and "have a name and a face, as opposed to just a name" (Participant H (UC)), and often reported that they would like to do this more. As unit coordinators were often the first point of contact for families on the telephone or by email, many staff felt strongly that having experienced and closely involved unit coordinators enhanced the quality of service that families experienced. It also motivated the belief that unit coordinators should receive the same training in systemic practice as other unit staff; as will be seen later, this was not always the case, and was a cause of dissatisfaction among some participants.

The role of clinician was also highly valued by other unit members. Clinicians were particularly valued for their ability to bring a new slant to case discussion, and for the short-term therapeutic work they could do with families that helped to initiate change. As will be discussed later, the role of clinician was revealed as needing further clarification, and some individuals felt it should be a peripheral role at the Access stage so that therapeutic work did not begin with families and risk being cut short. Overall,

however, clinical input was felt to be beneficial and appropriate in the social work setting, and an improvement on the traditional style of practice.

Looking to the second of the two sub-themes regarding unit structure, another positive outcome for staff was the team spirit and a sense of containment that it nurtured. Sometimes this was stated directly as gratitude and praise for colleagues; at other times it was indirect, and present in descriptions of collaborative working and Unit successes. In either case, it was associated with better staff wellbeing and favourable working relationships between unit members, which resulted in stable, mindful care for children and families.

Erm... that we genuinely- I described it with my unit that when I am out and I am faced with something that I'm not quite sure if I've said the right thing, or could it... could it have gone another way, I feel like I've got my crew behind me. ... That is you need- and we work very remotely, we hardly ever... are all here, erm... but we speak to each other every day, and it's like we've always got this net with you, to help you go. And you never had that before.

(Participant J (CSW))

Umm...and I find you know, the quality of some of the staff absolutely amazing. I'm really, you know... some of the social workers are absolutely amazing. So...umm...no, I feel that I... I... from my experience I... I am enjoying it, and I feel that's quite... now the... because I think there is tough changes, but the... the resentment about the implementation of the model... has mainly gone, I feel, because the staff that were really not supportive...umm... have left.

(Participant B (clinician))

The impact of the service transition upon the staff group in Cambridgeshire was considerable, with some individuals having left due to dissatisfaction with the new model and some not being appointed to the new model. By the time of the staff interviews, however, there was a sense that the majority of the staff who wanted to leave had done so, and that the situation was beginning to settle. This is captured in the above quote from Participant B (clinician). There was a strong relationship within the data between good within-unit bonds, and staff supporting the model and remaining in post. Whilst it is not possible within our research design to establish a cause-and-effect directionality between these factors (i.e. it may be that staff who were supportive of the model made more effort to bond with their unit

colleagues, or alternatively that good within-unit relationships improved staff perception of the model), it is certainly relevant that the importance of staff containment during the transition and the containing effects of good unit relationships were frequent themes throughout the interviews. As staff instability and loss are likely to impact negatively upon families, the importance of within-unit staff relationships is significant. Our findings demonstrate that units were a primary source of stability and containment for staff during and after the transition. Therefore, it may be beneficial for localities undertaking a move to the SWWFF model to closely consider the composition of units and ways to promote good staff relationships from the outset.

3.2.1.3.3. Improved relationships with families

The third main service improvement that was highlighted during the staff interviews as a result of the transition to the SW:WFF model was better relationships between units and families. This is not to say that there were not any challenges in this regard, but that in certain areas staff had noticed changes for the better; specifically, these changes related to communication. The SW:WFF model transformed how staff talked and thought about families, as has already been discussed in relation to reflective discussion and the implementation of systemic practice. Resultantly, unit members felt better able to understand the perspectives of parents and children, to develop trust with them, and to use these relationships to work alongside them and promote change.

I think the... the... the main thing is being able to talk with, and have conversations with, families and children. Rather than... I mean, the language has changed in Cambridgeshire. We don't talk about 'discussions', erm, we talk about 'conversations'. We don't talk 'about' people, we talk 'with' them. Erm... and I think the language has got much more respectful.

(Participant I (CSW))

I've had experiences of, you know, families feeling so stigmatised and so, erm... erm... not valued by social workers, and just giving up. Either giving up or being very angry. And then of course, you know, you're not gonna do any constructive work with the family who hates your guts, because you've just come in, wag your finger and tell them what they do wrong. You just need to do a... you know, if you want to deliver some good, you really need to get the family on board.

(Participant E (clinician))

Many of the staff talked about feeling that the treatment and behaviour towards families in Cambridgeshire had become more respectful since the transition to SW:WFF. This included the language used to talk to and about families, and the greater level of consideration given to understanding their situations and reasons for becoming involved with social care services from multiple perspectives. Interestingly, several staff also commented on the common-sense nature of the new approach and that they had found it less radical than they expected. For many, although it represented a linguistic shift in the way that things were named and discussed, it felt natural: “its how I work as a person, it fits in very well with my personality and how I would practice” (Participant D (SW)). Participant J (CSW) expressed feeling daunted initially, but later realising that it: “...is just simply having respect for families and treating them as a way... as a way you would wish to be treated”. These differences between what staff expected and what they later discovered demonstrates the difficulty of preparing a staff group for such a major transition, and the varied responses that may occur. It highlights the importance of preparing as much as possible for the transition to help set realistic expectations about what it will be like, and providing excellent guidance that is flexible for individuals with different types of work and training experience. This may represent an area of improvement for future SW:WFF transitions; well-informed staff members are more likely to be committed and stable if they are able to keep longer-term organisational aims in mind during periods of change, and therefore more able to maintain strong supportive relationships with children and families during these times.

Whether staff found the SW:WFF approach to be very different to their previous working experiences or not, there was a change from talking “about” families to talking “with” them. It was stated this this went alongside greater respect between unit staff and families within the new model (Participant I (CSW)). It represented a challenge to the power often associated with the traditional social work role by putting families and staff on a more even footing. By helping families to feel more in control, this was felt to reinforce relationships with them and ultimately to improve engagement.

L (agency SW): But when I’m looking at a systemic approach, I’m actually helping them change from inside. And they are making the decisions, and I am not.

Interviewer: Ok.

L (agency SW): Number one. So I find it very quality work. Second, I can go in with the approach, saying that “I’m here to help you”.

Interviewer: Uhum

L (agency SW): Not to identify right away the problems in your parenting. So, it has given me for... erm, a chance to form a positive working relationship with the parents.

When parents felt less threatened by involvement with social care services, they were more receptive to interventions and education. Good working relationships meant that unit members were better positioned to support families to effect change, but also made work more rewarding for staff themselves. These findings are cohesive with the outcomes of the family interviews, in which parents reported non-threatening staff who listened to their needs to be easier to work with. Within our findings, the most important and enjoyable aspect of work for all staff was to engage with families and children. The better these relationships were for them, the more satisfied they were in their role.

The improved communication and relationships as a result of the systemic approach extended to children as well as parents. Staff had noticed in particular that the reflective work they undertook with their unit colleagues helped to bring the child's perspective more to the fore, as the quote below from Participant D (SW) illustrates. This made it easier to empathise and understand their mindset in context, and to develop good relationships when working with them. The unit meetings were reported to be critical in helping with this; indeed, the staff were almost unanimous in finding the unit meetings a necessary and central part of their practice. The meetings afforded staff a chance to explore the perspectives of all members of the family, especially children, and to maintain a curious and open approach in addition to developing action points to guide their work. This demonstrates the systemic approach in action in Cambridgeshire: good within-unit communication and collaboration was helpful for promoting deeper understanding in staff, which effected better relationships with families and children, and ultimately influenced the outcomes of social care engagement in a positive way.

Erm, and I think it's allows for much more work with children as well. It's much more positive in respects of the... child's voice and the child's journey through the work and you know, I feel like that's more clearly set out than I've been used to.

(Participant D (SW))

E (clinician): Er, thoughts are shared, responsibility is shared.

Interviewer: Of course.

E (clinician): And... erm... they've sort of helped to, er... understand, maybe, give a little bit more about w- why things might have got to that level for the families.

Interviewer: Yeah.

E (clinician): And usually, when you understand the 'why', it's much, much easier to empathise. It's much, much easier to... to work in a constructive way.

To summarise so far, it is evident that the unit staff in Cambridgeshire experienced numerous positive changes and outcomes as a result of the transition to the SW:WFF model. They felt that practice was largely safer, the diversity of roles within the units was beneficial, and relationships and communication with families had improved as a result of the model. Reflective discussion and shared caseloads were revealed as significant driving factors underlying these changes. Overall, the model was received positively and systemic practice was felt to be an appropriate and helpful way of carrying out social work and effecting good outcomes for children and families. It must be held in mind when evaluating these findings that there had been significant staff loss prior to these interviews taking place, meaning that the staff in our sample were perhaps likely to be more accepting of the model than others who had already left. Furthermore, there was consensus amongst the interviewees that it had taken time to settle into the model, and for staff and families to adjust to the new way of functioning. Indeed, despite these positive outcomes and improvements, there were a number of areas that staff members were less satisfied with. It is these challenges that we now turn to.

3.2.1.4. Challenges during and after the transformation

Our analysis of the staff interview data revealed a number of challenges that unit members had experienced as a result of the transition to the SW:WFF model. These challenges will be explored in this section. They grouped into four overarching themes:

- Compatibility of the systemic approach with social work practice
- High staff movement
- Role confusion
- Inadequate training

3.2.1.4.1 Compatibility of the systemic approach with social work practice

So I feel the whole idea of systemic practice is... is... is excellent. I just, erm... my only... my only reservation is that it needs to be tailored more to the social work task.
(Participant I (CSW))

The sentiment expressed by Participant I (CSW) in the quote above was stated by numerous staff members during the interviews. Although not opposed to the idea of a systemic approach to social work, many felt it needed further development to improve its suitability for this domain. They highlighted three particular sub-themes: first, it concerned staff that the wider organization had not adjusted its procedures to fit better with systemic practice and to help the units manage their workloads

and commit to it properly; second, there was concern that it was less efficient than the traditional social work model, resulting in children being left in negative situations for longer, and therefore being less safe; third, it was seen by some to hinder the flexibility of the theoretical 'toolkit' used by social workers. The first of these issues is demonstrated in the quote below:

I feel the model in itself is a very, you know, very good base in terms of how you work it. I think we are still a bit caught with some of the procedures. With actually, if we have some...um...thinking in one way, ahh... that would make sense within the model...the organisation itself doesn't function like that, and therefore counteracts sometimes some of the...of the... good thinking, or good, you know, things that could be happening.

(Participant B (clinician))

Although the units had changed to a new way of functioning, some staff members felt that the organisation had not adjusted enough to accommodate this. As a result, they had so many paperwork and recording duties to fulfil that it was not possible to spend the amount of time with families that had originally been intended. One staff member commented that this lack of time for family-focused work was a reason that a number of other social workers had left. Furthermore, upon going live, members of several units felt their caseloads had been much too high; rather than building up a caseload gradually, they reported suddenly having fifty families to become acquainted with, often with several children. This made unit meetings unmanageably long, and all of the staff interviewed said that their unit were unable to discuss every case each week. Instead, most units managed to discuss each case fortnightly, excepting where there were specific concerns that made a case a higher priority. A negative outcome of this extensive workload was that cases were left open too long, causing unnecessary stress to families, and damaging the unit's statistics. While staff members were primarily interested in helping families, they recognised that poor unit data would ultimately lead to the introduction of strategies intended to help, which would actually increase their workload. The target-setting that resulted from the OFSTED inspection was given as an example of this. Furthermore, the stress of this workload and the feeling that they were letting families down were both significant personal worries for staff members. In these ways, the implementation of the SWWFF model was felt to hinder high quality work and to be a cause of stress for unit staff:

C (UC): I know we've got the five units but I think the difficulty is... that unit who are on duty for that week, you get clobbered. And people are saying "Yeah but you've got five weeks to clear it all up", but with the initial assessment timescales which is within ten days you could end up having 10 assessments due on one day and...

Interviewer: Wow

C (UC): ...so you're sort of pressurised for the week of duty and the week after, and I just think sometimes it's *really* hard to be able to... like for the clinicians to spend meaningful time with the families because there is just so much on our caseload. So I think that's... where it's difficult.

Staff members reported that one outcome of these multiple pressures was a reduction in systemic practice within the units. When the workload was too high and time was constrained, they reverted to factual discussion in unit meetings and reflective practice fell by the wayside. At times like these staff also said they did not see families enough, and because of the shared caseload approach, when somebody did visit it was often a unit member who knew them less well. As relationships are central in systemic practice, this certainly reveals a challenge to its genuine implementation. Protecting staff time and ensuring caseloads are manageable appear to be key factors in supporting units to work systemically.

Interestingly, in cases where units did stick rigorously to reflective work, it was seen by some as a waste of time:

I... feel that if I've- if I've got a difficulty with one of my cases I would rather go to my consultant social worker and discuss it one-to-one, because I feel that in the... in the unit meetings there's this tendency for... bizarre possibilities to come up, and for... for the... the- the... the discussion doesn't stay focused on the central issues. It goes off on far too many tangents, and those tangents are explored at length, but the central issue's not.
(Participant M (agency SW))

Some interviews stated opinions that agency staff were more resistant to unit working and systemic practice; especially when caseloads were high it was not seen as a priority. They reported more personality clashes with staff that pushed to work systemically. Such clashes were also reported between permanent employees, although in our sample it appeared to be less common than among agency workers. These disagreements were usually associated with the agency worker feeling questioned and challenged, leading to a sense of professional distrust and rejection by their unit. Of course, such challenging may be appropriate, and/or a non-systemically trained agency social worker may not be used to the open discussion/challenging that is an integral part of SW:WFF.

L (agency SW): But what happens is that, because we work collectively...

Interviewer: Yep

L (agency SW): So I have... I think I have kind of spent or overspent a lot of time to convince... that I have really done the work. And I think positive about this family... so when I'm... positive, and I want to close the case, I'm being questioned a lot.

Interviewer: Uhum

L (agency SW): And I feel that the professional experience is being questioned, in that sense, quite a lot.

Interviewer: So in this structure, er... do you feel that your skills and your abilities and your opinions are respected, or, er... like you were saying, some people make decisions on your behalf. Tell me about that.

M (agency SW): Yeah, I do. I feel that my, er... professional activities is being challenged for no obvious reason other than that somebody thinks something different might be happening.

In addition to this, several of the permanent staff were aware of the difficulties that some agency staff had with the SW:WFF model, and that there was resistance to it:

A (SW): And they... that social worker then left and then we kind of had...couldn't find any permanent staff to replace her so it was agency, that... I don't think agencies were really...I don't know if this is bad to say, but they don't seem to really enjoy the unit model.

Interviewer: Okay... We've had a lot of feedback about that.

A (SW): Yeah... They kind of want their independence and do it their way.

C (UC): And I think we have had... quite a lot of agency staff in. Some fantastic agency workers, but they haven't been on the unit training, they maybe don't... really like working, because it is quite... you are very exposed on the unit.

Interviewer: I've heard that a few times

C (UC): And I think some do find that a struggle, and I think some people think "Oh why do I need to explain why I've done this and this... just get on with it".

Ultimately, these difficulties in finding the right balance between support and challenge, occasionally made it harder for staff to feel supported in their work with families, and damaged within-unit relationships. Consequently, agency workers often did not feel part of a unit and did much of their work independently, rather than as a team. These findings indicate the breakdown of systemic work when

there was breakdown of relationships, and indicate the difficulties of having a staff group that are divided between the new and old models of practice.

Comment from SW:WFF leadership team:

It is important to think about the balance between support and challenge in child protection work and how to recruit agency staff able to work collaboratively with colleagues and to support them in joining units. We have since addressed this by offering some systemic induction to agency staff.

This downside of the model and its potential negative impact on families interconnects with the second sub-theme highlighted by the staff in relation to the fittingness of the systemic model of social work practice: lack of efficiency and the potential to leave children for too long. As already discussed, the new model introduced the concept of ‘safe uncertainty’ and challenged the power and certainty associated with the traditional social work role. While reduced certainty was seen as having considerable benefits for approaching cases in a more thoughtful and holistic way, it also provoked concern in some staff children would be left in unsafe situations for longer.

L (agency SW): I would have rather liked to... you know, err... the timescales and the decision making to not be delayed because that hampers the... the child’s safety.

Interviewer: Of course.

L (agency SW): A lot of times, I have been able to pick up signs of risk to the child, but the case has yet not gone into a conference stage.

This was sometimes associated with the problems of using a strengths based model, whereby staff were so busy focusing on the positives that they were less efficient at meeting safeguarding needs, meaning that: “a child might get lost in... in the efforts” (Participant I (CSW)). Notably, the staff members who raised this concern were all social workers, and all had been practicing for more than five years. Further long-term assessment of children’s safety may be necessary to explore whether the concerns of these experienced staff come to fruition. Alternatively, they may be indicative that a transition such as this is harder for those with lengthy experience and trust in another way of working.

Comment from SW:WFF leadership team:

This has been a helpful challenge, which we have been addressing over the last year.

The final sub-theme that staff raised regarding the appropriateness of the SWWFF model for social work practice was its compatibility with the social workers' 'toolkit' of theories and interference with the ability of practitioners to use these flexibly. Some staff members felt that systemic practice had been thrust upon them as the primary approach they should use, despite believing that it was not always the most suitable approach for every case and having been trained to use multiple theories in their work. As already mentioned, conflicting opinions on this topic were a source of tension and compromised unit functioning. Many staff expressed the sentiment of Participant G (CSW) below, that systemic practice was useful but should not be the only approach in social work:

G (CSW): it feels a little bit like... a brainwashing process.

Interviewer: Does it feel like you have to push the others as well?

G (CSW): It's like a doctrine, its like "oh systemic, systemic...", where actually I think "no, I quite like psychodynamic perspectives to thinking".

Interviewer: You've got lots of skills in that as well.

G (CSW): And I was, you know... So I, I think it's *part* of our tool kit.

It should be acknowledged that there were many contrasting views on this subject from interviewees, and that most participants could see more than one perspective. Furthermore, all staff members we spoke to said they did not feel their professional autonomy was negatively affected by the SW:WFF model, and that they were mostly free to practice in way they saw as most appropriate for each case. These somewhat conflicting findings are indicative of a lack of guidance regarding the implementation and ethos of systemic practice at the outset of the implementation of the model that will be useful for local authorities considering implementing this model to consider..

Comment from the SW:WF leadership team:

Within SW:WFF Cambridgeshire County Council have already completed an evaluation of the 2014 systemic training, having embedded the model during the time of the research. There has been a movement towards a more complex understanding of how systemic approaches can contribute to the social work task in Cambridgeshire. Rather than a simplistic description of 'strengths-based' for example, there is greater incorporation of these ideas into managing risk in a timely and relevant way for children and families. Evidence that systemic practice can aid this task rather than slow it down in competition with safeguarding has been evidence in feedback from court and in unit working (Howlett, 2015). This is seen as a natural development of joint

working and embedding new practice over time. In addition, agency staff are now offered some systemic induction.

3.2.1.4.2 High staff movement

High rates of staff loss and absence were raised by several of the groups of professionals we interviewed. This difficulty had a direct and substantial impact upon the unit staff. Their feedback was primarily focused on the outcomes of this staff loss, which affected units' workloads and ability to function. It was striking that the impact upon unit staff was not only practical, but emotional too.

In many interviews, the effects of staff movement on relationships within the units and their ability to practice systemically were evident:

B (clinician): Ah...I, for me, the biggest difficulty of the model is the...umm...staff change. It's the staff changing. It's the fact that, actually, that model does require that you *do* know the people that you work with quite well. That you do get to trust them, that they get to trust you. That you can...um...engage in reflective practice about what has been working, not working, and before you come to that level of...umm...trust and... and be comfortable enough to do that, umm...you have to have had certain stability.

Interviewer: Hmm.

B (clinician): And I feel that's not happening. There's no, you know, there's very little...there's very little stability...in... in the model. Workers come and go, they haven't...they have...they don't know much about the model sometimes and it's just like starting *all* over again.

K (clinician): I know that the best functioning teams that I have worked in are ones that are... you know, have a core of stability to them. Erm, you can't expect every team member to hang around, you know. But they have a core of stability and you create a way of working as a team.

Interviewer: Of course, yeah.

K (clinician): And I think, because there is only six of you or five of you, that's a tiny team, so, you know, you only need a two people to shift in some way and actually that's kind of blown apart, so...

Interviewer: Of course.

K (clinician): So... so I think that is a bit of problem with it. I think probably the units should be bigger.

These findings are indicative of the extent to which staff members had come to value their colleagues within the systemic approach, but also of the fragility of the units themselves. As the quotes above show, the trust and shared knowledge that develops between unit members is crucial for working collaboratively and producing good outcomes for families. Resultantly, the exodus of staff after the introduction of the model had been damaging, and the movement of staff to cover loss in other units was very destabilizing each time for the other staff and the children and families they supported. If social workers moved and took their cases with them, the new unit had a higher caseload to deal with and the families had to get to know a new team. The promotion of social workers to consultant positions was a further source of instability, as even if these staff members were staying in the same place, it resulted in inexperienced unit leaders trying to run units whilst learning the ropes of a more advanced role.

It was generally reported that being one member of staff down was manageable for units temporarily, but more than that was problematic. This was the case even when staff had not resigned; poor management of annual leave resulted in several staff from the same unit being off at the same time, and there was little contingency for staff sickness. Like Participant K (clinician) above, a number of individuals felt that bigger units would help to address this problem. For unit coordinators the effects of absence could be radical, as they were expected to cover each others' units at these times. However, the requirement for unit coordinators to minute unit meetings and upload the notes electronically despite all unit meetings happening on the same day of the week meant that this was often an unmanageable task.

C (UC): It's so frustrating because you've got that twenty-four hour deadline, and... and I think where its fallen down is we have a lot of people on leave.

Interviewer: Hmm, Hmm

C (UC): And... so there was... at one point, there was only two unit coordinators for five units.

Interviewer: Wow

C (UC): So you're trying to get your own minutes on, and then people ask you to do theirs. It's just not feasible.

This had been addressed by the initial model design, as units were 'buddied' together to help them manage workload during staff absences. It was clear from staff feedback that the buddy system had

potential, but would benefit from attention and improvement by managers. Particular problems were the lack of coordination of leave and lack of communication between the units.

Regarding contributing factors to the high rates of staff loss, the interviews indicated that lower salaries in Cambridgeshire and lack of promotion opportunities were relevant issues for unit staff in addition to the emotional strain that has already been discussed. Several unit coordinators expressed that there was a lack of career path and no higher role to be promoted to. Some had come from, or had wished to go into, Child and Family Worker roles, and as such had aspirations and experience that they did not feel were valued within the SW:WFF model. As a result, to earn more and to progress, many knew that they would eventually leave. Available roles were also highlighted by the social workers, who felt the loss of the senior social worker position in the transition. For those who did not wish to become consultant social workers, there were felt to be few opportunities to learn and be promoted at a comfortable speed. Again, this was seen as an understandable reason and motivation to leave.

I am actively leaving, and things like that. And a lot of that comes from things like career progression... for process coordinators. There isn't a clear path. ... And it just feels like there's not... there's no interest, I suppose, in us being able to do anything further.

(Participant H (UC))

G (CSW): And we need to think seriously, you know, if this is high-end child protection work and court work, it's skilled work, and we need to find a way of keeping Social Workers within our Units.

Interviewer: Of course.

G (CSW): Erm, and, and... and I don't know what the answer to that is. Erm... because not everyone wants to be a Consultant.

While the issue of high staff movement was perceived by many interviewees as a problem, it is important to state that a lot of the movement was not due to staff leaving the service, but due to movement between teams, promotions and maternity leave. It is also important to put this in the context of the national picture of difficulties in staff recruitment and retention in social care, and to state that vacancy rates of 10% in Cambridgeshire are lower than neighbouring counties and the 25% national vacancy rates (figures correct October 2014).

Comments from SW:WFF leadership team:

Cambridgeshire County Council are aware of these issues via their own staff forums

and senior managers are actively engaged in addressing the issues about recruitment and retention.

At a national level, Isabel Trowler has recently presented on changes in frontline CP staffing. She supported a view that due to the challenges of frontline CP work, staff movement is to be expected to maintain staff in social work practice. While this does impact, we need to think about how to manage this as a national challenge.

3.2.1.4.3 Role confusion

It has already been discussed that at the time of the staff interviews, staff revealed confusion around the way the systemic approach should be implemented and the extent to which staff were free to utilise other theoretical approaches in their work. Another related challenge that was highlighted was role confusion. As will be discussed, this was primarily a problem for the role of the clinician, but individuals in every unit role stated that they would have liked more clarification and guidance on their responsibilities and role scope from the start of the transition.

The data indicated that staff that had been present throughout the transition had experienced a flexible and open approach at the start, which had gradually become more restricted and prescribed over time. This was in part linked to measures taken after the poor outcome of the OFSTED inspection, and in part to the managerial response to settling into the model and an accompanying push for consistency in practice between units. While these were both reasons that staff could understand, the pressure to continually change and adjust to new routines was an exhausting experience, and a cause of role confusion.

I (CSW): I worry about the confusion in role identity between Social Worker and particularly the Consultant Social Worker if they have completed systemic practice, and the role of the clinician. And I still think that you are social worker in the first instance, but you are working systemically, so your safeguarding mantra has to be the one that drives your care plans.

Interviewer: Yeah

I (CSW): Erm, and the only other thing I wanna say is about, erm... how the organisation... had a fantastic value base and ideology of... erm, unit-isational of social work but they have... contaminated it and confused it with the amount of new procedures and quality assurance frameworks. And having two parallel systems...

Interviewer: Hmm, Hmm

I (CSW): Running parallel to each other has just, erm... that's just caused chaos.

For this individual, the sense of role confusion is also linked to confusion about the organisation's theoretical and practical approach to social care: by not understanding the epistemology, it is difficult to define working roles. This is related to the challenges discussed earlier regarding the implementation of systemic practice in a social work setting. This confusion may be important for unpicking the inconsistency between units and provide a clear way forward for future transitions. Clarification of these issues through training, guidelines and discussion may be containing for units, helping them to understand their roles and be more settled when having to move between units.

Role confusion was a particular issue for clinicians, and for those working alongside them. Many staff felt that the scope of the clinician's role had been poorly defined, and this led to anxiety for families, difficulties with inter-agency relations, and poorer within-unit relationships, as the expectations of what the clinicians were able to undertake were inaccurate.

B (clinician): I feel almost initially... I think we're meeting a much better balance now. I feel it- initially there was a lot of more prescriptive like: "Ooh yeah, clinician's gonna do that; clinician's gonna do this..."

Interviewer: Hm hm.

B (clinician): Umm and ultimately that was you know, a bit scary.

Interviewer: Yes.

B (clinician): In terms of, "I don't think that's something I can do", or, "Sorry but I'm not the best person to do that". Erm, and I think with trust - and that's where the unit thing is coming as well - with trust, I have been able to say, erm... "No", you know, "That's *definitely* not my expertise", I might ask one of other clinician but actually, you know, I... this... I would fail the family if I was pretending that I can do that. So I think that's... now, it's much more...I think the teams are much more aware of what, umm...er, I can do and how helpful I can be in some ways or in specific situations.

As in the quote above, some clinicians found that their unit colleagues expected more of them than they could provide. In other cases, the same was found with partner agencies, who incorrectly believed that the introduction of the clinician role meant that longer-term therapeutic interventions would be provided by the units. As a result, some agencies initially refused referrals for children, not realising that it was beyond the units' scope to keep cases open and provide interventions. The children affected were reported to have experienced a considerable delay in care. Furthermore, it was mentioned in many

interviews that there was great need for guidelines regarding the type and duration of therapeutic intervention that clinicians should undertake with children and families. Social workers and clinicians alike were concerned that while some therapeutic input was helpful for some families, for others it was “like opening a can of worms” (Participant L (agency SW)), as there was not enough time for the piece of work to be finished before the case needed to be closed or transferred to long-term services. Some felt this to the extent that they believed the clinical role in Children’s Care Services should lie outside the immediate unit structure, and represent a service that unit staff could refer children to.

These varied views demonstrate that at the time of the interviews, while the majority of the staff appreciated the clinicians and felt they were invaluable front-line unit members, the negative impact that unfinished clinical work could have for clients understood to be considerable, and not a feature of good quality social care. Considering the evidence examined here, then, there is a clear need to clarify from the start the details of the clinical role to unit members, partner agencies, families, and to clinicians themselves.

Comment from SW:WFF leadership team:

Through the development of the model and the clinicians becoming more established over time, their roles in the units (to promote and enhance systemic social work) have become more clear across the service. However embedding clinicians in social work units has also been challenging for families and partner agencies who do have hopes that long term work can be offered. Cambridgeshire Social Care were clear that their clinicians cannot replace other services e.g CAMHS services, but as their resources have become more stretched, there has been more pressure for clinicians to fill gaps in service provision which they are unable to provide.

3.2.1.4.4 Inconsistency in training

We turn now to the final theme that arose from the staff interviews, which highlighted a need for more consistent training of unit staff. This was a particular issue for unit coordinators and agency staff, many of whom felt they were underprepared for the tasks they were expected to complete, and had poor understanding of the SW:WFF principles and systemic approach. While staff in the two roles discussed the issue differently, both expressed feeling demoralised and undervalued as a result.

The responsibilities of unit coordinators were described as heavily involved with the cases and the work of their unit colleagues, yet they repeatedly reported having little or no systemic training. All UCs were supposed to receive a day's systemic orientation in the unit induction week. Some said they had been taken out of the systemic training during the induction week to do business administration training, and others had been unable to book onto a course.

F (UC): (laughs) I do think they could do more with the unit coordinators about it. And I do kind of feel like... when we started, I remember my first day and I was thinking "oh my god what have I got myself into?" (Laughs)

Interviewer: (laughs)

F (UC): And they kind of just... dumped me phoning, erm... calling up a lady who was like saying she doesn't want her kid, and I was thinking "I don't know what to say to her."

Interviewer: Yeah.

F (UC): Well I think I handled it pretty well, but I was pretty upset after.

Interviewer: Yeah of course.

F (UC): And then I was like "I don't know if I want to do this role. They're just gonna make you...", cos to me that felt like it was a social worker.

As the excerpt above illustrates, this lack of training was a considerable barrier for unit coordinators, who were expected to be the first point of contact for families on the telephone and via email, to attend and minute the unit meetings, and to support the other members of their unit in achieving goals for families. Indeed, two individuals candidly stated that they were unable to provide a definition of systemic practice. Without a full understanding of the aims and nature of the approach, unit coordinators described feeling left to "stab in the dark" (Participant H (UC)). For the organisation, this represented an area of false economy, as it caused unit coordinators to feel undervalued and disconnected, which ultimately reduced their productivity, damaged unit relationships, and therefore affected the ability of units to support families and children effectively. Furthermore, it compromised the quality of the unit meeting minutes due to lack of knowledge on the unit coordinator's part. With such focus from the organisation on the importance of the unit meeting and minutes, this was a surprising deficiency. Given the centrality of unit coordinators in organising the administration and activities of their units, this certainly represents an area for improvement.

H (UC): If you've got a member of the unit that doesn't feel valued or doesn't feel supported, it impacts the service as a unit...

Interviewer: Yeah of course.

H (UC): ...that you give.

Interviewer: Uhum

H (UC): Erm, and you disengage I think, from the unit a little bit as well. If I'm honest, I'd say I'd probably I'd disengaged from my unit, because I don't feel valued, I suppose.

As can be seen here, the unit coordinators discussed this issue in very direct terms and were aware of the deficiencies in their training. The challenge presented differently, however, amongst agency staff. The agency staff in our sample had joined the units they worked in after the transition, and as such, had not received the same induction as permanent staff. Although one individual acknowledged their lack of induction, the mismatch in theoretical approaches between agency and permanent staff was more noticeable as agency staff rejecting the systemic approach despite having hardly tried it, and feeling they were not accepted within their units. After commenting that they had not been provided a proper induction, agency staff often reported feeling questioned, doubted and mistrusted by their colleagues, especially due to the level of information sharing requested during unit meetings. This finding implies a lack of understanding about the approach, and failure on the part of the organisation to prepare these staff for the extensive level of reflection and sharing at all staff were expected to engage in:

I feel that my, er... professional activities is being challenged for no obvious reason other than that somebody thinks something different might be happening. Erm... if it's... if it's a possibility that it had never entered my head, when they suggest it I think, "Oh my god, yeah, I missed that" - then I would really welcome that. But when it's something fairly obvious and I've considered it, I've discarded it, er... then I'm being asked to go and investigate further to find out whether it's the case, I... I just... I- I- I do get quite frustrated.

(Participant M (agency SW))

Interviewer: So, for example, if you've identified something that's wrong, are you able to say "Look guys I've made this mistake"? Does it feel easy and ok to talk about it?

L (agency SW): No.

Interviewer: No? Ok

L (agency SW): Cos there, there's been constant criticism, and you know... kind of questioning throughout already.

Rather than experiencing such questioning as reflective discussion, there was a tendency of agency staff to feel criticized. As this last quote shows, the effects of this for family work may be considerable, as there is the potential for agency staff not to discuss mistakes or uncertainties with the rest of the unit

for fear of being challenged. This had implications here for the personal wellbeing of staff due to the stress that it caused. As systemic practice was felt by many to be an improved and safer way of practicing social work, it also has implications for the safety and welfare of children. Given that permanent staff and those who had received adequate training did not find the systemic approach to be a challenge to their professional ability and autonomy, it seems likely that more extensive knowledge of this approach would be beneficial for agency staff and those they work with. Better inductions and training are therefore indicated.

Comment from SW:WFF leadership team:

These issues were recognised over the time of the research and are being addressed by SW:WFF: A programme of UC training that runs throughout the year is in place for 2015. Cambridgeshire Social Care will be assessing the impact that this has for unit coordinators.

Having presented the improvements and challenges in the services following the adoption of the SW;WFF model, we present our recommendations, based on interviews with staff members, about how to improve the services provided to families.

3.2.1.5. Recommendations

Based on the information and lessons shared by the staff during the interviews, and as explored in the above sections, the following are some key recommendations based on the interviews with the staff members.

3.2.1.5.1 Better staff containment and supervision

G (CSW): Despite what- the kind of things they tried to do to make us feel like we were informed. We felt uncontained and there was unrest.

Interviewer: Hmm, hmm.

G (CSW): And I think that any authority who might be considering taking on this model needs to look very carefully about how that's managed because I think it places families at risk.

Managing staff expectations and encouraging teambuilding before effecting major changes may be critical for managing future transitions as smoothly as possible to help staff, and therefore families, to

feel contained. It was seen as important to continue with these efforts after the immediate transition period, as staff and families both continue to feel vulnerable. The following strategies were suggested:

- Ensure that unit members receive consistent supervision. A system to monitor supervision and commitment from both managers and staff members may be useful.
- Improving the accessibility of training and promotion opportunities, so that staff members feel that the organisation understands their needs and priorities.
- Improving pathways for unit members to access support from higher management. This was particularly important when a unit's consultant social worker or group manager was unsupportive of the SW;WFF model.

3.2.1.5.2 Better training and promotion opportunities for unit coordinators

The unit coordinators were viewed as essential team members, and they undertook possibly the widest variety of tasks and positions than any other role in the units. As they are integral in unit functioning, it was seen as essential that all unit coordinators receive training in systemic practice, from the outset of local authorities implementing the model, ideally alongside the other members of their unit. In addition, as this role was seen to have no career progression opportunities, this is an important area of development and may be a key contributor to staff retention.

3.2.1.5.3 Better training and integration of agency staff

Many agency staff members have been employed during the transition period and after in Cambridgeshire, partly due the problems of staff retention. As they are important members of small units, it is necessary to provide them with a full unit induction and training in systemic practice. This is crucial for good relationships between unit members and therefore to support best practice with families and children. An approach that emphasises the potential for regular small "bitesize" locally- (rather than expensive externally-) delivered training events has gone some way towards this, and a regular programme of training over the year is in place for 2015.

Comment from SW:WFF leadership team:

An approach that emphasises the potential for regular small "bitesize" locally- (rather than expensive externally-) delivered training events has gone some way towards this, and a regular programme of training over the year is in place for 2015. Agency staff also now receive some training in systemic techniques as part of their induction

3.2.1.5.4 Clarifying the roles of clinicians

There was consensus amongst the staff at the time of the research that there was a place for clinicians within Children's Social Care Services, but that the type and extent of work that they are expected to undertake needed clarification. There is learning here for local authorities considering implementing SWWFF models, in order to avoid disappointment for children and families and to reduce the possibility of disengagement from services in the future, it may be beneficial to set clearer guidelines regarding the therapeutic interventions that clinicians are able to provide as unit members from the outset. This includes making sure that families are informed from the start of the role of the clinician, and that staff within other areas of Social Care Services and in partner agencies understand the remit of unit clinicians. Cambridgeshire's progress on this is seen in point 3.2.1.4.3

3.2.1.5.5 Further development of systemic practice for social work

One of the key recommendations in this area was to prepare staff better for the differences between the SW:WFF model of practice and the traditional model they were used to. A particularly important difference perceived by some participants was that children may be left with their families for longer than would previously have happened, and how and why this is considered safe practice when using a strengths-based model.

Comment from SW:WFF leadership team:

The model is not predicated on leaving children in families when it is not safe to do so; it is predicated on intervening to address risk to enable children to remain in their families WHEN it is safe to do so, part of which is developing family strengths as well as identifying risks

3.2.1.5.6 Consider optimum unit size

Managing workloads and staff absence was an important issue for participants, and they recommended alterations to the units as a helpful strategy. There was a preference for slightly bigger units with around 8 or 9 individuals. This did not necessarily mean increasing the number of social workers, but analysing where the needs lie for support with the workload and employing suitable individuals. It was suggested that Child and Family workers could be beneficial unit members. While some staff did suggest bigger units, it is important to contextualize this in reference to study findings that staff found the unit model in its current format helpful; increasing unit size may reduce some of these advantages, including shared caseloads and adequate time for reflective discussion of all cases.

Comment from SW:WFF leadership team:

We have now tried experimenting with larger units – this does lose the key SW:WFF advantage of shared caseloads

3.2.1.5.7 Start with low caseloads

Starting out with high caseloads before the units had adjusted to the new way of working and the duty week system was especially challenging. It was suggested that units are helped to manage their caseloads and not feel overwhelmed from the start. Setting expectations in advance is an essential aspect of this.

3.2.1.5.8 More streamlined recruitment, better staff retention and reduced staff movement

Staff respected that the organisation had continued to keep recruitment standards high, but the delays in new staff starting was an area for improvement. Suggestions for recruitment were to give more effort to helping existing social workers who were interested in applying for a promotion, and to raise salaries in Cambridgeshire, which were lower than other areas of the country. For staff retention, ensuring existing employees feel valued and supported was seen as essential. Better preparation for the nature and intensity of systemic work was also considered a key area for improvement. While staff perception of problems with recruitment/retention were high, and while this can be improved in any service, it is important to also state that this is a national problem, and is less of a problem in Cambridgeshire than elsewhere. The main cause of staff leaving units is in fact internal transfers, such as promotions; it is therefore important to try to minimise and reduce the impact of these.

3.2.1.5.9 Closer relationships between group managers and unit staff

Group managers were often seen as hands-off and disinterested until there was a difficulty with a case, when they would suddenly turn up and sometimes override unit decisions.

H (UC): We then had managers making the decisions, but us a a unit having to deliver those messages and still work with the family.

Interviewer: Yeah

H (UC): And not necessarily agreeing with what was being said.

It was recommended that group managers be more present within the units and build better relationships with the unit staff. In particular, it was suggested that they attend more unit meetings. Furthermore, it was considered vital that group managers be advocates for the SW:WFF model and systemic practice, to instil a positive culture within an organisation.

Comments by SW:WF leadership team:

Managers are now given systemic training from the clinical team to provide congruence across the hierarchy regarding model and its place within social work practice.

3.2.1.6. Summary and conclusions

In this chapter, we have described the perspectives of the unit staff members and explored the positive aspects and challenges that they associated with the transformation to the SW:WFF model in Cambridgeshire.

Staff recognised a number of positive outcomes of the new model, and felt that it had improved social work practice in various ways. Despite a number of challenges still to overcome, there was a resounding support and preference for the SW:WFF model and systemic practice. In particular, staff valued the reflective discussion, their unit meetings, and preferred sharing responsibility for cases. It was largely reported to be safer for children and to improve relationships with the families they supported.

At the time they also identified some challenges, which pointed to areas for improvement. These were: compatibility of the systemic approach with social work practice; high staff loss and movement; role confusion, particularly regarding the role of clinician; and inadequate training, an issue that primarily affected unit coordinators and agency staff.

From these challenges, and from the suggestions of the unit staff, we make the following recommendations for service improvement and to help other local authorities wishing to make a similar transition:

- Improving staff containment and supervision before and after transition
- Improving the training and promotion opportunities for unit coordinators
- Improving the training and integration of agency staff
- Clarifying the roles of clinicians
- Further developing the use of systemic practice for the social work context
- Re-examining the construction of units, and possibly making them bigger
- Starting with low caseloads when units go live
- Streamlining recruitment procedures and improving staff retention
- Developing closer relationships between group managers and unit staff

Comments from SW:WFF leadership team:

Cambridgeshire Social Care report that they have recognised all these issues independently of the research over the last two years, and have changed over time as part of a more embedded service. As is reflected in this report there are changes in practice, organisation, and training addressing each of these areas.

3.2.2. Quantitative Analysis of Staff Data

Out of 303 staff members approached, 175 (58%) returned questionnaires. Some of the non-response was due to staff movement, some was due to staff choosing not to be in the study. As we do not know the opinions of staff who did not return questionnaires, we cannot state whether these results would apply to all social care professionals.

3.2.2.1. Staff Background

The first question on the SW:WFF Staff Attitudes Questionnaire examined the type of role within the organisation each social work unit member worked as. The majority of professionals completing the questionnaires were social workers. Within most units there was usually one qualified experienced social worker and one ASYE (Assessed and Supported Year in Employment) which is a newly qualified social worker that has qualified within the last year. Some units also had an additional agency social worker member, particularly if two newly qualified social workers were in a unit. Distinctions between these were not made between these on this question, but they were on the following question. Clinicians often worked within two units, which explains the lower number of clinicians. Each unit also had a consultant social worker and unit coordinator. Demographics for this question are illustrated in table 1 and indicate a representative cross section of professional roles within the units.

Table 1. Staff Roles.

Role	Primarily face to face work with families (social worker in most cases)	Primarily a supervisory role with some face to face contact (clinician in most cases)	Primarily a management or administrative role, with some supervisory and or face to face contact (consultant social worker or unit coordinator in most cases)	No answer
Number / %	108 62%	17 10%	47 27%	3 2%

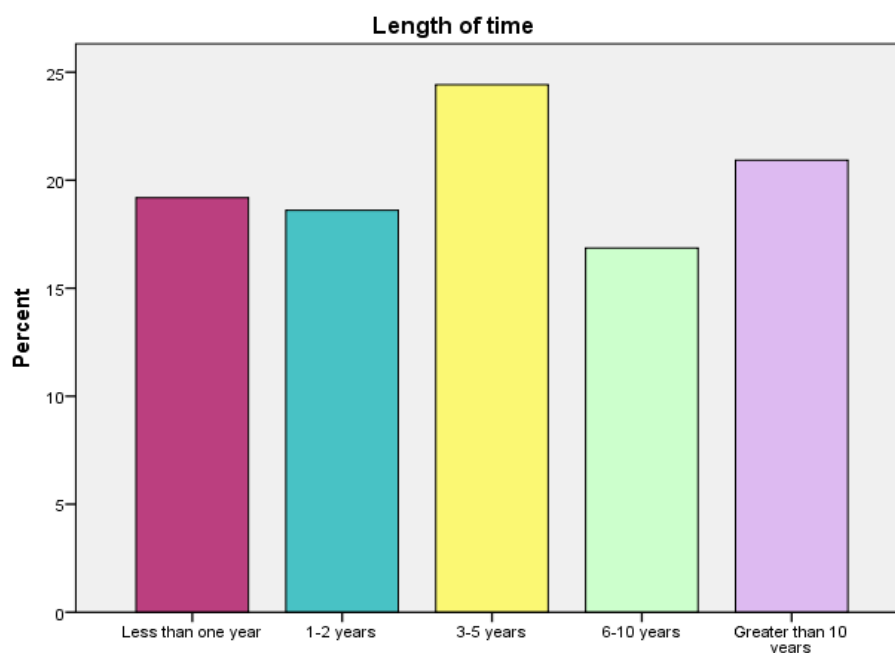
Participants were asked about what training and experience they had (table 2). The most common answer from participants was having a degree in social work, unsurprisingly as the majority of the work force are social workers.

Table 2. Staff training and experience

Training and Experience	Number / %
Administration training	25 14%
Formal training/education but not in social care	14 8%
Degree in social work	89 51%
Currently in training for a professional clinical qualification	3 2%
Qualified as a health professional	25 14%
Professional social work qualification AND additional specialist therapeutic training	16 9%

Participants were also asked to indicate how long they had been working within, and having direct client contact in, a statutory setting (i.e. not just Cambridgeshire County Council Childrens' Social Care). Results are in figure 1. The most frequent length of time working in social care was 3-5 years (24%), followed closely by greater than 10 years (21%). This variety in experience may be beneficial: more experienced workers to share their knowledge and experiences with the newer qualified staff and vice versa as newly qualified staff would have a more recent memory of theoretical teaching from their social work training.

Figure 1. Participants' length of time working in social care

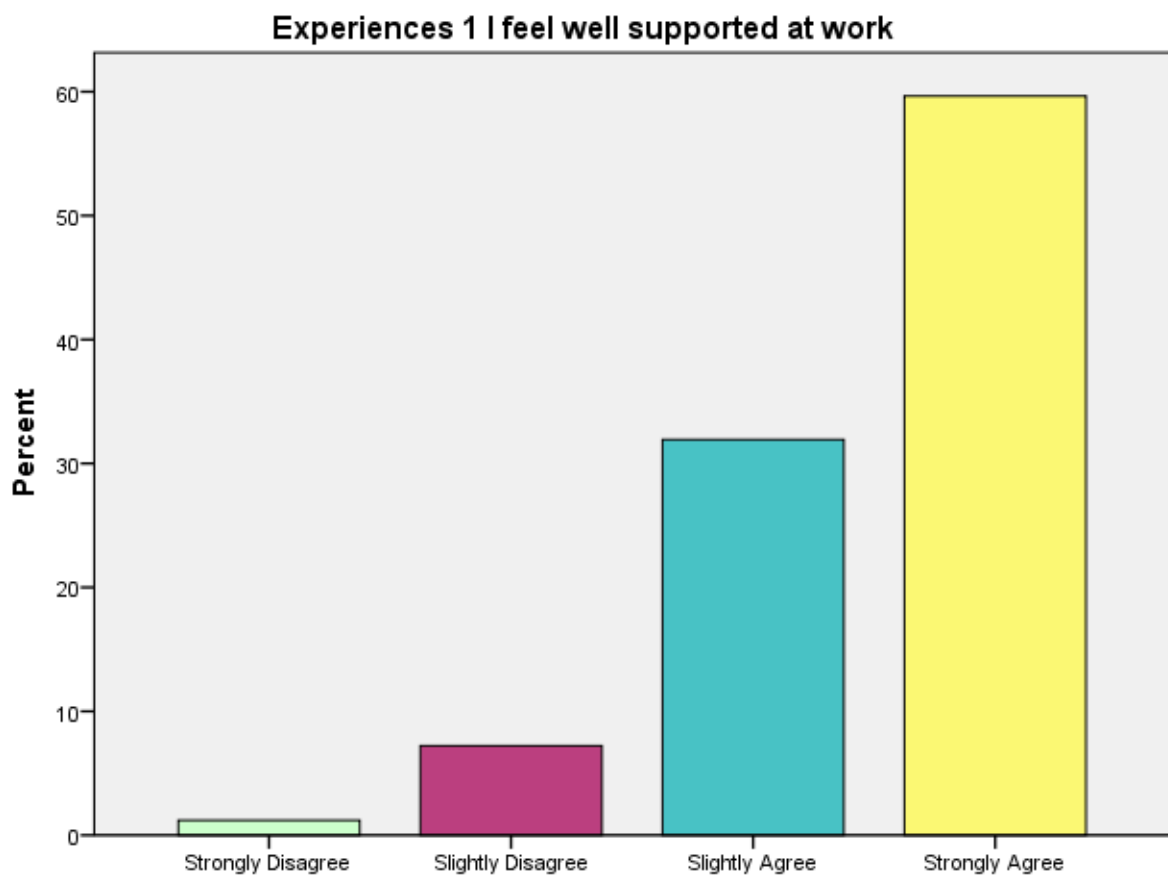


3.2.2.2. Staff Experiences of SW:WFF Questionnaire

1. *'I feel well supported at work'*

Staff appear to feel considerably supported at work within the units as shown in figure 2, with 59% of individuals answering strongly agree to this question, followed by 32% who slightly agree. Thus the majority feel supported.

Figure 2. Responses to question 'I feel well supported at work'

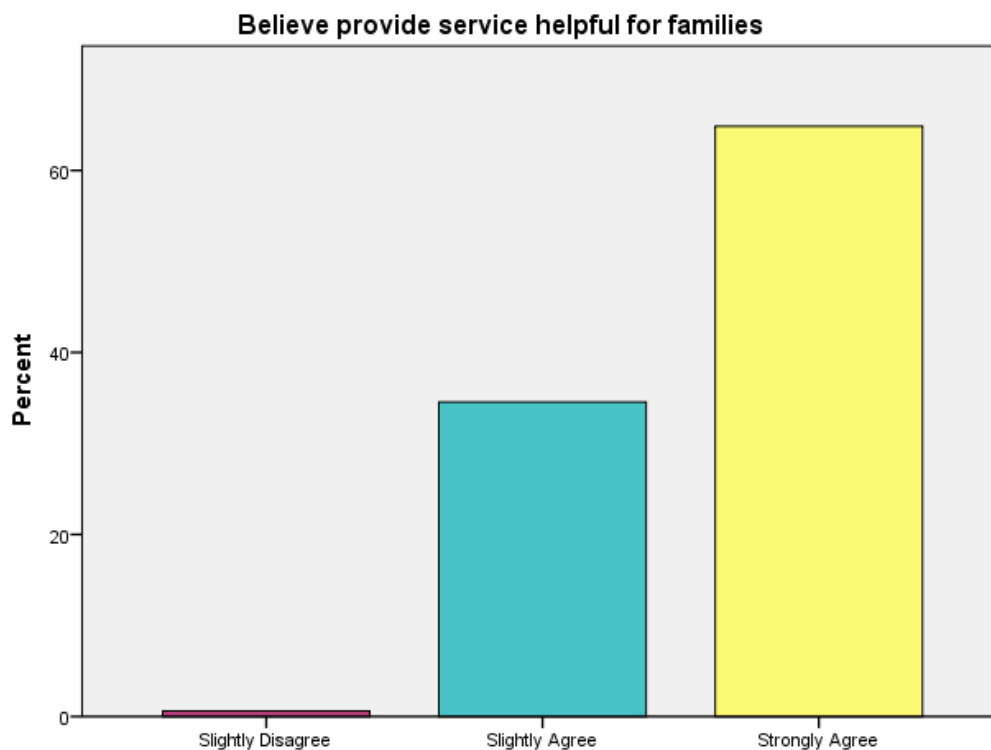


2. 'I believe we provide a service that is helpful for the families we see'

As well as feeling supported within work, the majority of the workforce believe that they provide a service that is helpful for the families they see (figure 3), with 64% agreeing strongly and 34% agreeing slightly. Only one participant (0.6%) slightly disagreed with this statement. Nobody selected the option strongly disagree.

There was a significant correlation between feeling well-supported and believing that the service provided was helpful to families seen (r_s (n=165) = .43, $p < .00005$).

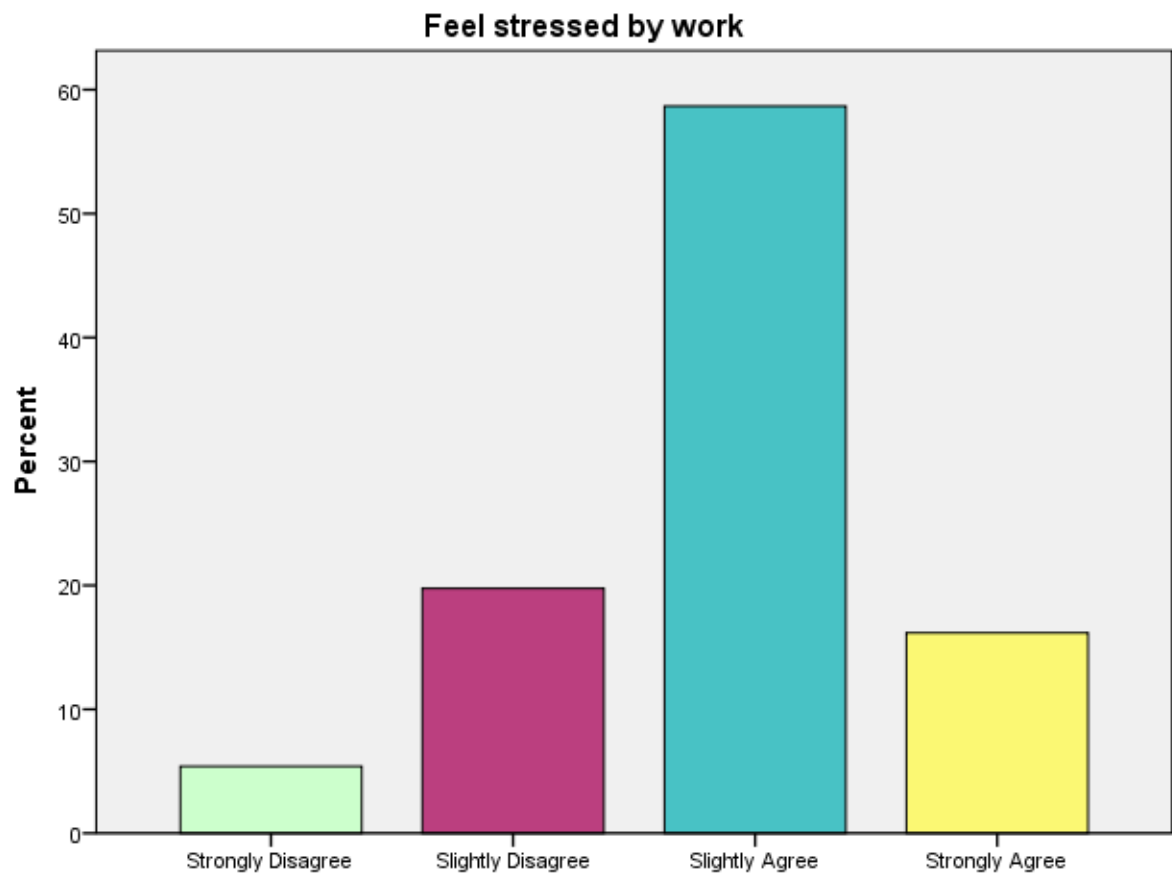
Figure 3. Responses to question 'I believe we provide a service that is helpful for the families we see'



3. *'I feel stressed by my work'*

Despite the positive outlook that participants have on the SWWFF model and the support that they have in the units, there is still some reported stress by unit members with 71% of staff either slightly agreeing or strongly agreeing that they feel stressed by work as indicated in figure 4 below.

Figure 4. Responses to question 'I feel stressed by my work'

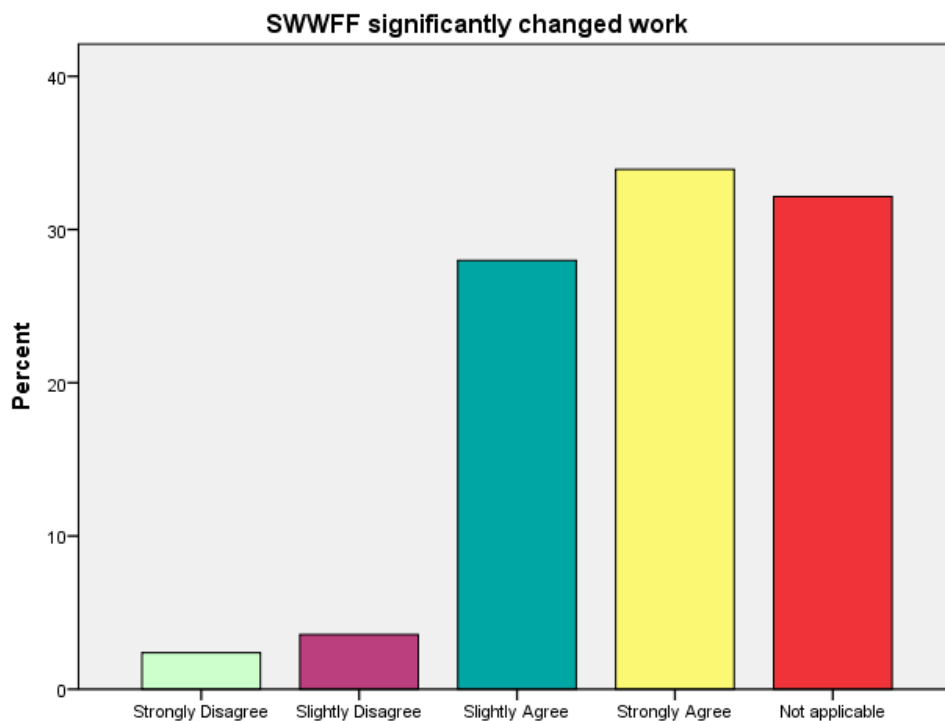


4. *'SWWFF has significantly changed the way I work compared to previous models of social work practice'*

Most of the workers felt that the SW:WFF unit model has changed the way they work compared to previous models of social care practice (figure 5). 34% strongly agreed and 28% slightly agreed. However, this question was not applicable to a lot of respondents, namely newly qualified social workers, unit coordinators and clinicians, who hadn't worked in a different model to SWWFF before; thus 32% of the sample selected 'not applicable'. Thus 91% of participants with prior social care experience agreed that they had changed the way they work.

There was a small negative correlation between length of time working in this setting and answers on whether SW:WFF had changed the way participants' worked ($r_s(n=114) = -0.24, p = 0.009$). Thus staff with more experience reported feeling less like SW:WFF had significantly changed the way they worked. It is therefore possible that more experienced staff are less likely to change how they work when services are transformed.

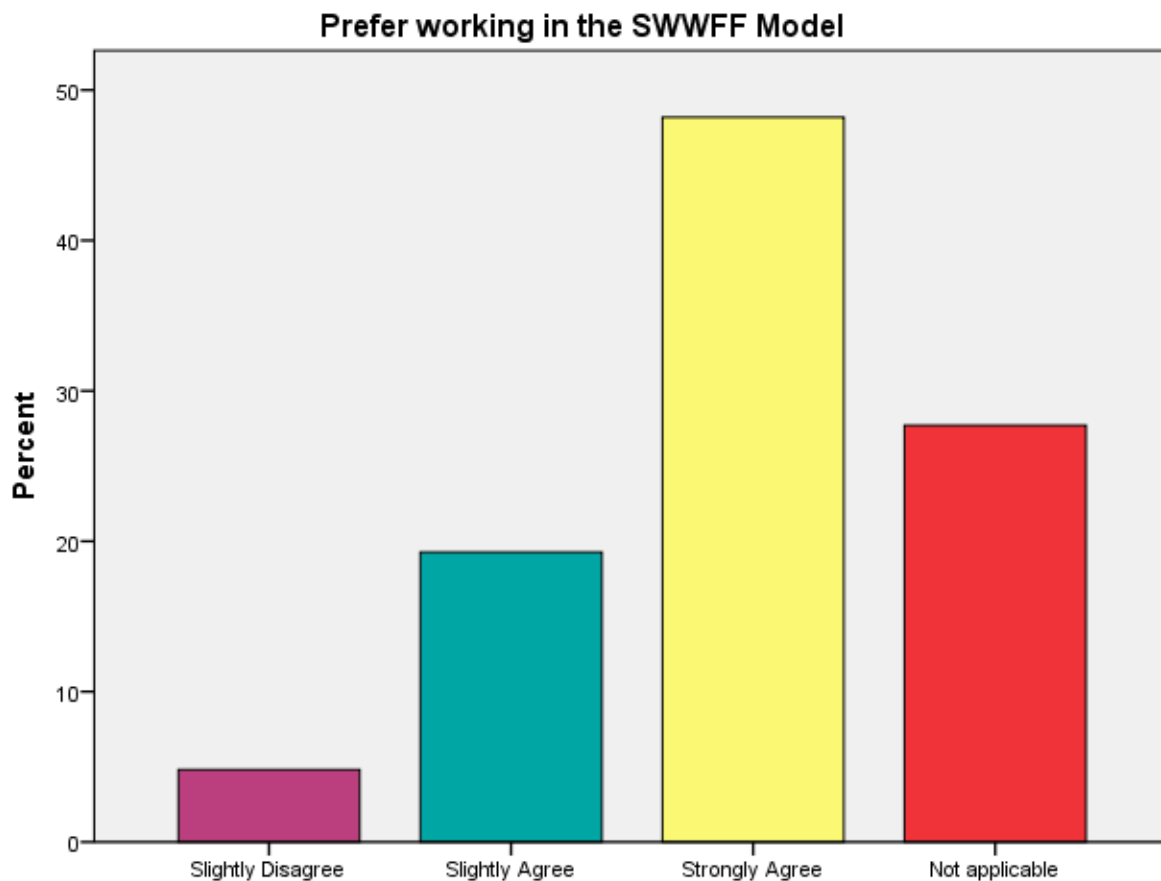
Figure 5. Responses to question 'SWWFF has significantly changed the way I work compared to previous models of social work practice'



5. *'Overall, I prefer working in the SWWFF model compared to previous models of social work practice'*

A large percentage of the workforce agreed that they preferred working in the new SWWFF unit model (figure 6). 48% strongly agreed and 19% slightly agreed. Again, this question was not applicable to staff new to SW:WFF. 93% of applicable responses were therefore positive about SWWFF.

Figure 6. Responses to question 'Overall, I prefer working n the SWWFF model compared to previous models of social work practice'



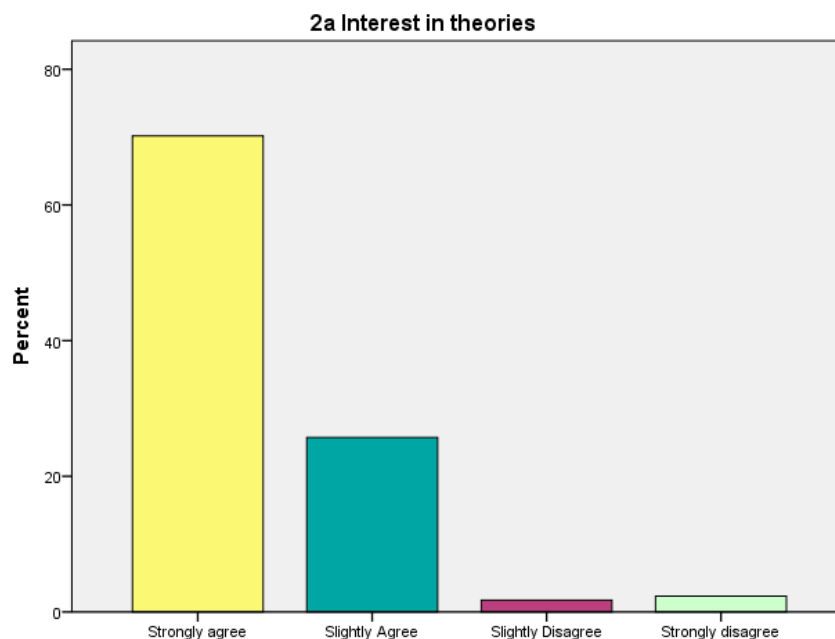
3.2.2.3. SWWFF Staff Attitudes Questionnaire

In section 2 of the SWWFF Staff Attitudes questionnaire, participants were asked about themselves, in terms of their experience of the work and their beliefs about their work, and were asked to answer “as it is” rather than “as it should be”. Below is a summary of participants’ responses to each of these questions

2(a) ‘I am interested in theories about the nature of the problems faced by complex families, and the different ways workers can respond to them’

It is clearly evident that a number of participants are interested in and curious about the nature of the problems faced by complex families and the different ways workers can respond to them. 69% strongly agreed and 25% slightly agreed with this statement and question (figure 7).

Figure 7. Responses to the statement: ‘I am interested in theories about the nature of the problems faced by complex families, and the different ways workers can respond to them’

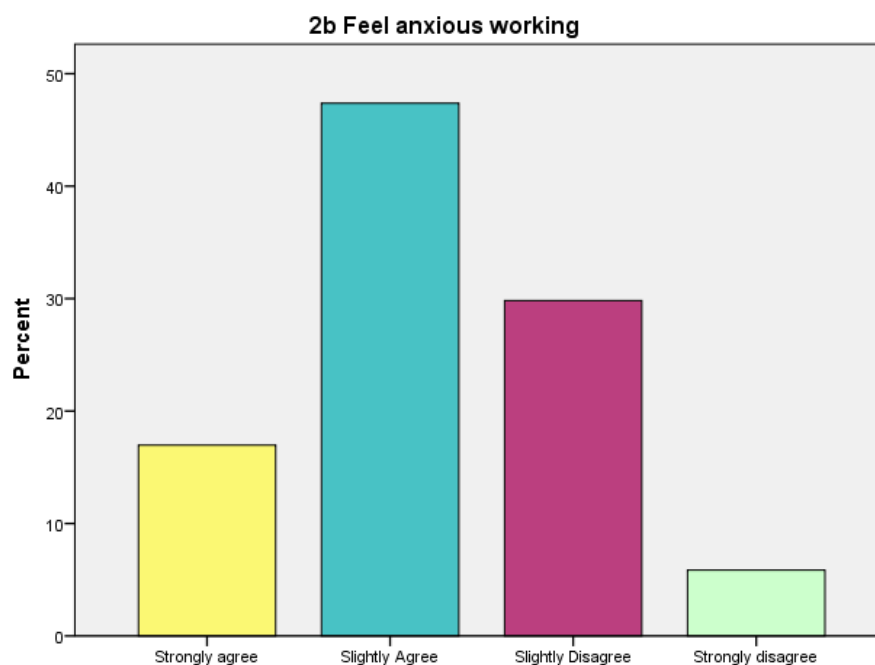


2(b) 'At times I feel anxious working with complex families in distress'

The majority of workers at times felt anxious when working with complex families in distress (figure 8). The most frequent answer was slightly agree, with 46% of workers giving this response, followed by 29% saying they slightly disagreed with this statement.

We found a significant correlation between this question on feeling anxious at times and feeling stressed at work (SW:WFF staff experiences questionnaire question 3, r_s (n=166) = -.41, $p < .00005$). Thus those staff who said that they are sometimes anxious felt more stressed overall by their work.

Figure 8. Responses to the statement/question 'At times I feel anxious working with complex families in distress'



We cross-tabulated length of time working in social care with anxiety (table 3). Strongly and slightly agree were collapsed into one category; and strongly and slightly disagree were collapsed into one category. We found that increasing experience was associated with lower anxiety (LR $\chi^2 = 14$ (df4), $p = 0.008$).

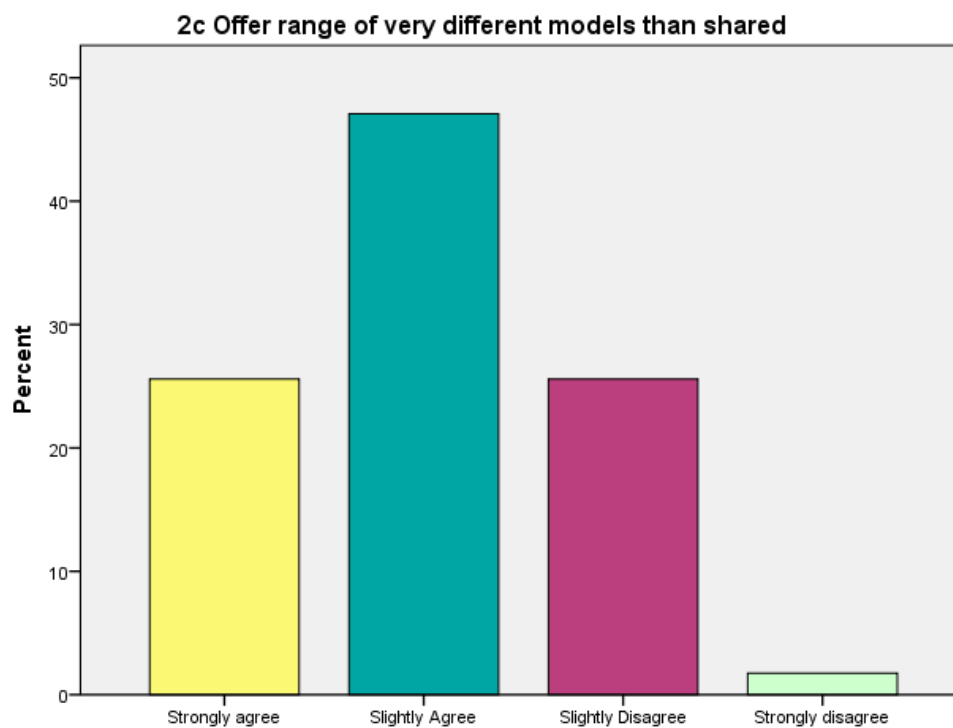
Table 3. Cross tabulation of length of time and feeling anxious at times when working with complex and vulnerable families

		Strongly agree	Slightly Agree	Slightly Disagree	Strongly disagree
Length of time	Less than one year	7	18	7	0
	1-2 years	8	14	9	1
	3-5 years	6	26	9	1
	6-10 years	6	9	10	4
	Greater than 10 years	2	14	16	4

2(c) *'In a unit/team doing this work, it's more important to have people who can offer a range of very different methods of understanding and working than it is to have a shared model'*

The most common response, 46%, was 'slightly agree' (figure 9). A not insignificant 27% disagreed with this statement.

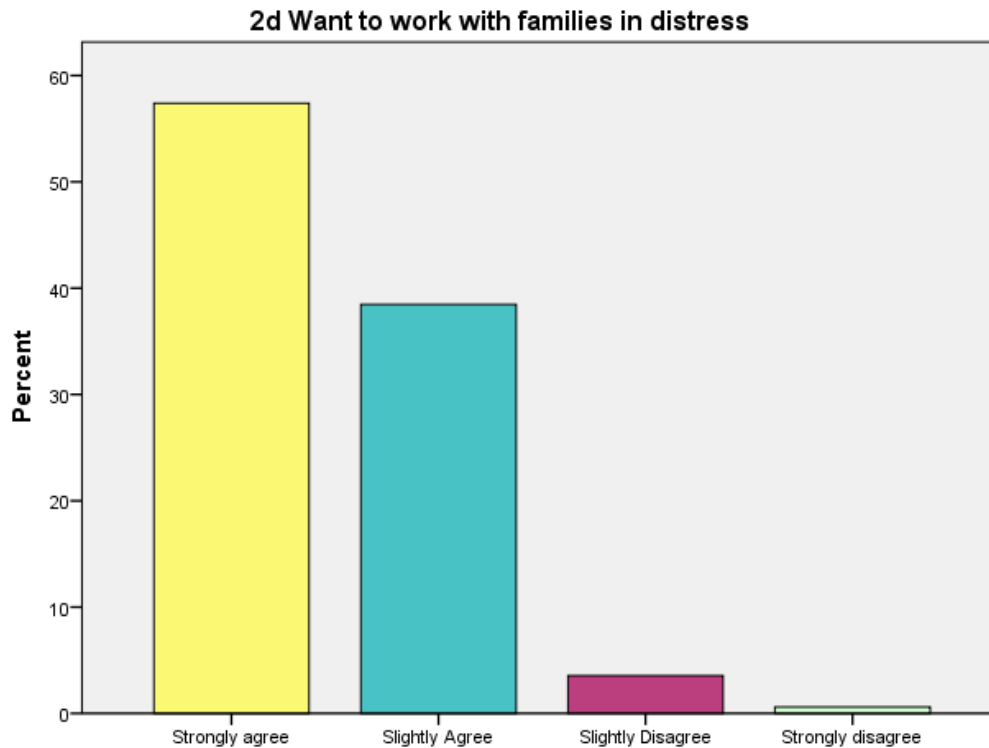
Figure 9. Responses to the statement/question: 'In a unit/team doing this work, it's more important to have people who can offer a range of very different methods of understanding and working than it is to have a shared model'



2(d) 'I want to work with vulnerable families in distress'

Nearly all respondents strongly agreed (55%) or slightly agreed (38%) with the statement that they want to work with families in distress (figure 10). These workers work with very vulnerable and complex families with high levels of risk and unpredictability in challenging environments and situations. To work within this field, workers must really want to do this.

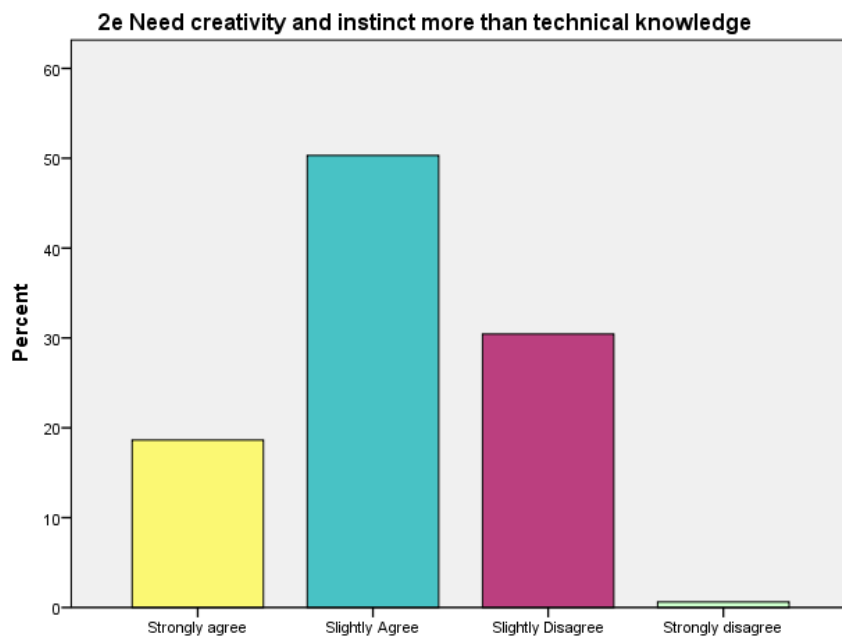
Figure 10. Responses to the statement/question: 'I want to work with vulnerable families in distress'



2(e) 'In general you need creativity and instinct in this work, more than technical knowledge from books'

A large percentage of workers felt that to work within this field, you need creativity and instinct more than technical knowledge from books, with 63% of participants agreeing with this statement (figure 11).

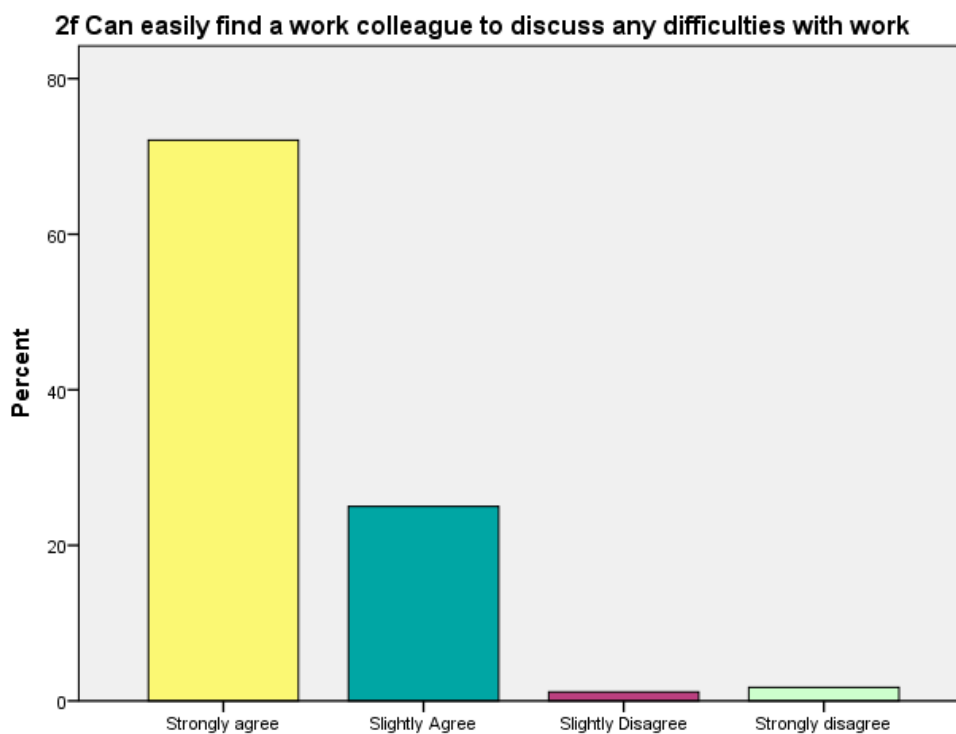
Figure 11. Responses to the statement/question: 'In general you need creativity and instinct in this work, more than technical knowledge from books'



2(f) *'If I felt the need when working with my clients I could easily find a work colleague with whom I could discuss any difficulties with the work that I might encounter'*

A significant proportion of workers strongly agreed that they could easily find a work colleague with whom they could discuss any difficulties with the work that they may encounter (71%), followed by 25% of the sample slightly agreeing with this question.

Figure 12. Responses to the statement/question: 'If I felt the need when working with my clients I could easily find a work colleague with whom I could discuss any difficulties with the work that I might encounter'



2(g) 'I am confident I have the skills to do effective work with complex vulnerable families'

82% of the sample agreed that they confident that they have the skills to do effective work with complex vulnerable families (figure 13).

Figure 13. Responses to the statement/question: 'I am confident I have the skills to do effective work with complex vulnerable families'



Training levels were cross-tabulated with confidence levels (table 5). Strongly and slightly agree were collapsed to one category; strongly and slightly disagree were collapsed to one category. All types of social/clinical training were collapsed to one category; admin training/non-social care training were collapsed to one category (this would represent unit co-ordinators). 89% of those with clinical/social work training agreed they were confident they had the necessary skills, as opposed to 74% of those with non-clinical/SW training. This difference was statistically significant ($\chi^2 = 5.2$ (df1), $p = 0.023$).

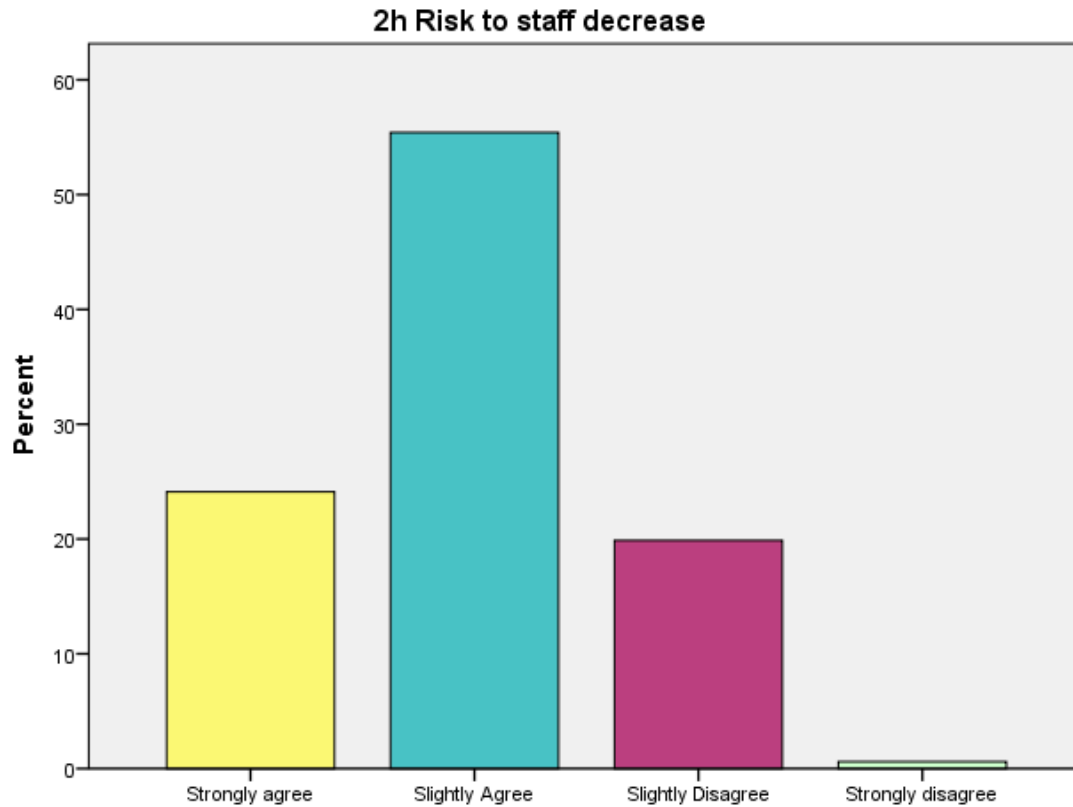
Table 5. - Cross tabulation of training and confidence of having the skills to do effective work

		Strongly agree	Slightly Agree	Slightly Disagree	Strongly disagree
Training and Experience	Administration training	4	12	7	1
	Formal training/education but not in social care	1	11	2	0
	Degree in social work	26	49	12	0
	Currently in training for a professional clinical qualification	1	1	1	0
	Qualified as a Health Professional	14	9	2	0
	Professional Social Work qualification AND additional specialist therapeutic training	8	8	0	0
Total		54	90	24	1

2(h) 'As a result of the change in working practices I believe the risk to staff will decrease'

76% of staff agreed believe that as a result of the service transformation, the risk to staff will decrease (figure 14). There was no significant effect of staff training on this belief.

Figure 14. - Responses to the statement/question: 'As a result of the change in working practices I believe the risk to staff will decrease'

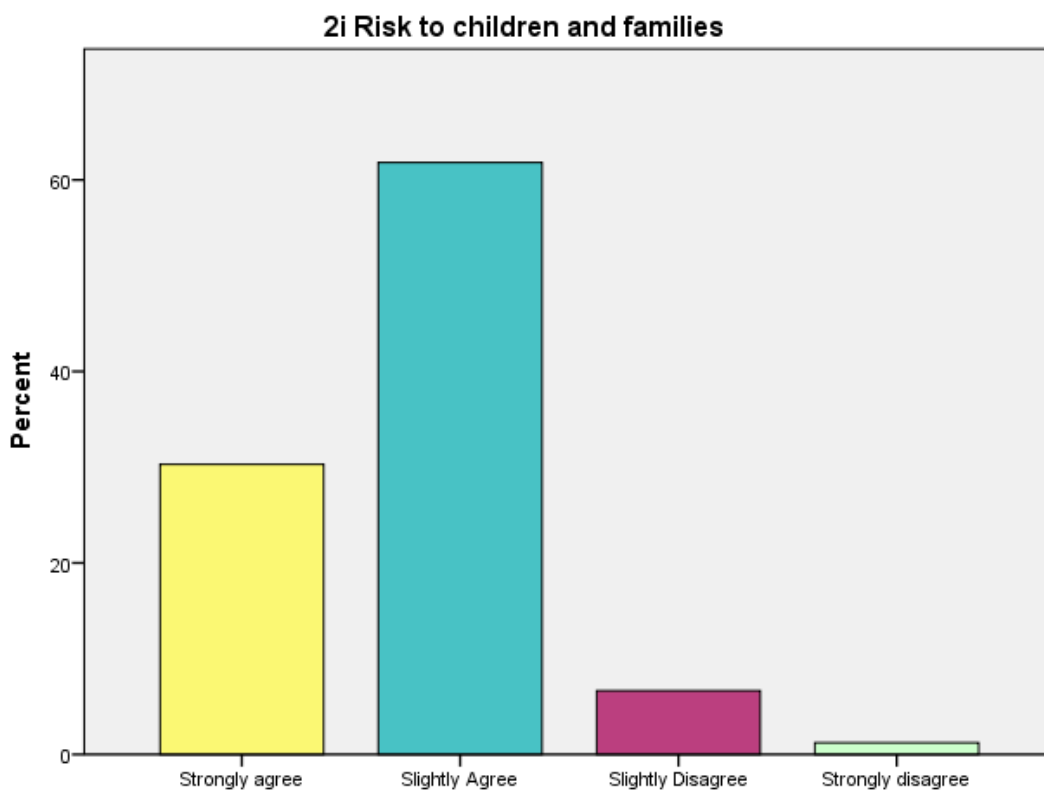


2 (i) 'As a result of the change in working practices I believe the risk to children and families will decrease'

A similar pattern of results to the question regarding decreased risk to staff is seen below in figure 15 for the question about risk to children and families: 87% believe risk decreased.

There was a strong correlation between beliefs about risk decreasing for staff and risk decreasing for families/children (r_s (n=162) = .58, $p < .00005$).

Figure 15. Responses to the statement/question: 'As a result of the change in working practices I believe the risk to children and families will decrease'



3.2.2.4. Conclusions

The staff questionnaire data has demonstrated that staff are very supportive of the transformation to the SW:WFF model: 93% of staff stated they prefer the SW:WFF model. 87% of staff thought the SW:WFF model has led to decreased risk for children and families, and 76% thought it has led to decreased risk for staff. In addition, 92% felt well-supported and 99% felt it provides a helpful service for the families.

Staff who felt more supported at work were more likely to believe that the service was likely to be helpful to families. In addition staff who believed that risk has reduced to families were more likely to think that risk has also reduced to staff. This suggests that staff believe that improvements in their own support has led to improvements in the quality and safety of the service they provide to families.

3.3. Lessons from Managers who Implemented the SWWFF Model

This chapter aims to continue to build a detailed picture of the complex array of factors that shaped the successes and challenges of the implementation of the SWWFF model by Cambridgeshire County Council in its first 18 months. We follow on from the findings presented in previous chapters that identified the strengths and limitations of the SW:WFF model in its early days from the view point of partner agencies as well as families. This chapter aims to provide an understanding of the service transformation from the perspectives of managers who effected the service transformation.

We provide candid narratives from the managers who implemented the SW:WFF model about their experiences and opinions of the change process. Interviews were conducted to understand what worked well and didn't work well overall; particularly difficult points in the change process and how these were overcome (or not). Interviews also solicited important lessons managers would advise managers of other social care organisations planning a similar transformation.

This chapter is divided into six sections. 3.3.1 describes the managers who participated in this study. 3.3.2 details the intended outcomes of the service redesign. 3.3.3 describes the improvements in the service following the service transformation. 3.3.4 describes some the challenges experienced during the implementation of SW:WFF. 3.3.5 is on the progress in achievement of significant outcomes. 3.3.6 details the recommendations.

3.3.1. Description of Managers

Ten managers in the form of Heads of Services and Group Managers participated in the interviews. All the managers had practised as a social worker for at least fifteen years. There were four male and six female respondents. Participants were recruited from all the different services provided by Children's Social Care services including Access, CiN, LAC and Disability, allowing for varied experiences to be presented.

3.3.2. Intended Outcomes of the Service Redesign

In order to get an understanding of the service transformation, we asked managers about the significant outcomes that they were aiming for when they decided to adopt SW:WFF. We sought to get views on the specific needs of Cambridgeshire that managers thought would be addressed by the SW:WFF model. The data indicates that the service transformation was driven by the desire to provide better services for families rather than any flaws in the services being provided:

Manager 3: Erm, more transparent work with families, more about keeping families together, where safe to do so, and removing children more quickly, where it's not safe to do so..... Erm, but looking back on the cases, I think it's the way they spoke to families. I think the way they spoke to families...was, absolutely atrocious to be quite honest. Erm, so its that's (breathes in) so this model ... (pause) makes that a lot more transparent, you know, you can't hide, anymore and, individual draconian punitive practices with families, its go to come to the fore, so I think, I think that's what, its addressed.

Manager 4: Well I think the idea was around us being able to offer better services to families. Umm...being more transparent in our work to where we were giving families the intervention and having time on our hands to go out and do social work and take away the bureaucracy and us being office based. It was about turning it around. So old world social work before transformation we would have probably been 70% office based and 30% in the field and the idea of the model was turning that around so we would be 30% in the office and 70% in the field. So it was about improving our practice and working very differently with the families and bringing the methodology around systemic practice and social learning theory. So doing it in a much more holistic way than we would have done before transformation.

As highlighted in the excerpts, various managers indicated that the service transformation was about trying to actually find ways to do more than just “stick a plaster” on families. By adopting the SW:WFF model, it was anticipated that social workers would be empowered to deliver high quality interventions to families which would create sustainable change. The interventions delivered would emanate from a wider knowledge base grounded in systemic and social learning theoretical underpinnings and the work would be done transparently. The interventions would also be supported by focused and meaningful case-based discussions from Unit meetings and ongoing support from experienced clinicians working as part of the Unit. It was anticipated that the presence of the Unit coordinators would free up social workers to actually be able to do direct work with families and be less involved with paperwork.

To effect this change and meet the above outcomes, the service transformation built on the successes and lessons learnt from the service redesign that was done in Hackney. Senior managers worked very closely with relevant colleagues from Hackney and the consulting firm Morning Lane. They also made

some radical changes to the model to meet the specific needs of Cambridgeshire. This included the removal of the Senior Child Family worker /"unqualified staff" post from the Unit. Unqualified staff either left Cambridgeshire or were reabsorbed in the Units as Unit coordinators rather than practitioners. This change was reportedly driven by the desire to improve the quality of services provided to families:

And it doesn't mean to say that erm alternatively qualified people can't offer a service to families but I think that the assessment, and erm, planning should be conducted by qualified staff. It's what the families deserve I think, supported by the alternatively qualified people in other roles but not responsible for the assessment and planning. (Manager 7)

Other posts that were lost during the service transformation included the service manager, operational manager and the senior social worker posts. New posts were created for the model namely consultant social workers; group managers and heads of services. Staff were required to apply for the posts in order to be appointed. The new posts were crucial for effective delivery of the objectives of the SW:WFF model. Below we detail some of the service improvements following the service redesign.

3.3.3. Improvements in the Service

The positive surprises are in the sense of, it's err its, its, its, an excellent way of working. I think, what we hoped for, erm, has, come to pass. When it works well, it works really well (Manager 2)

Well like I said, you just wouldn't go back, you know, you wouldn't, (Manager 6)

Our data indicates there were several aspects of the model that were working extremely well. The areas that were specifically identified as having improved included improved social work practice which was entrenched in a wider knowledge base grounded in Systemic and Social Learning Theories as well as the input from the clinicians. Managers also highlighted the benefits of shared caseloads for Unit members and families. These aspects are discussed in detail in the following sections.

3.3.3.1. Improved practice

All the managers interviewed were able to cite some examples of marked improvement in the social work practice as a result of the wider knowledge base from which the Units operated. The social workers were reported as conducting more detailed and focused assessments of the families. The

systemic approach and the input from the clinicians supported the development of different plausible scripts about families rather than reliance on a dominant script from the worker that was involved with the family. The structured Unit meetings were reported as empowering the social workers by looking at alternative hypotheses on factors impacting family functioning and discussion of various interventions that could be delivered to support the family to change. The excerpts below highlight this change in practice:

I think a good unit meeting, is, is, is really stimulating. And I think it, generates ... (pause) kind of respectful challenge, amongst professionals and their opinions. So when that works, that is really good, and you think God, you know this is, this is excellent. (Manager 6)

The clinicians bring into units, erm, a different style of, analysing practice. And, and what it's done, is helped people, to think much more widely about the cases they're involved with..... And, to think about and to hypothesize why things may be happen in particular ways, and then how you might intervene with that piece of work (Manager 5)

Erm, I see a more multi-faceted assessment. We are using the systemic training and those clinicians and, in a different way, I think we're getting a much better understanding than we did before; it's still not perfect but never will be because that's the nature of the work. Erm, I think that the degree of professional challenge entirely has risen between each other and I think that's healthy. I think we have had times where that strength based focus has gone too far, in the sense that we have got over-optimistic with Care Plans or assessments. (Manager 1)

The discourses above indicate the improvement in practice that stemmed from the professionals challenging each other about assumptions and evidence for their decisions. This also provided a safety net for over optimism. Manager 1 highlights a critical aspect of the social work which is delivered systemically which is the strength based approach which was raised by both partner agencies and families as useful in engagement of families. This approach enabled the workers to help families identify and realise their potential to make the changes to make children safer.

Overall, the systemic approach was perceived as enabling social workers to do more meaningful safeguarding work with families than would have been possible in the traditional model as indicated in the example cited below:

Case Study 1: Systemic practice at work

In the old world we would have closed the case...there is no question dad is in prison, it's a DV (Domestic Violence) case, mum is a victim ...two small children at home and dad's in prison. So in the old world there is no risk as dad is not there lets close the case.... But actually working it systemically from a very different view is dad's coming out one day and we need to get this family thinking and doing something different because if not...when he comes out she's gonna have him back and we are gonna be back in this crisis.

One of the children....was about eight years old... and we did a lot of work with him on safety... We have done a genogram...and he loved it. The feedback from the teacher...was that she had never seen him with such a smile on his face. So when you hear that it makes our job or the social worker doing this job so much worthwhile. **We worked with other agencies and mum** and I don't even know how the Unit did it but they got alarms on the property, they got extra lighting put up outside. They got security cameras by housing and they put ...they made this house so secure ummm ...we wouldn't have done that in the old world. We would have closed it because there was no risk. Looking at it ...we are doing change at a much deeper level to stop it ever having to come back to us or **stopping the kids from being at risk.**

The professional discussions in unit meetings allowed staff to reflect on their practice and have conversations to discuss when the strength based approach was not going to achieve the desired outcomes quickly enough and when other actions such as removal of children was more appropriate. Furthermore, the Unit meetings were also seen as valuable for picking up and managing poor practice because the work which was done by each worker was more transparent:

It is so much more transparent. So if someone is managing poorly, it is noticed and evidenced very quickly. So as a manager, we are having to manage poor practice on a different scale but it's much quicker that is

managed and can be rectified quickly and this is safer for the Unit, safer for the families and safer for Cambridgeshire. (Manager 4)

I think, the practice has changed dramatically. I think where there is poor practice ,it's now held aloft for all to see, when in the past it wasn't, erm, I think erm, you know, staff feel better supported generally, I think, I think the outcomes for families is better (Manager 3)

Hence it was believed that the SWWFF model made social work practice safer for families and Cambridgeshire. There was a safety net for social workers as they shared the pressures and reasonability of management of cases.

The adoption of SW:WFF was also viewed as a positive move away from the traditional incessant assessments with little or no resulting input or direct work to address the results of the assessments. The difference with the SW:WFF model was assessments were actually used as a basis for deciding on the work to be done with families by the Units:

And I think that's because erm, we've trained people to intervene in families, they can do, so they now want to do it. So what we used to offer people was pretty superficial sometimes in the past , you know, series of initial assessments...What's the point in doing five initial assessments you know if you don't do anything after that anyway so now people can, help families to change, and, they want to. (Manager 7)

The clinicians were seen as playing a key role in helping the social workers put the systemic training into practice and ensuring that practice did not go back into the old routines of assessments which were not accompanied by interventions that resulted in change in the families:

I think they [Clinicians] are an irreplaceable and invaluable and in an essential part, of the offer..... Erm, I I think it's really easy to send people off on training. So we sent all our staff on a year's systemic training, and they could still come back and practice exactly how they used to, before they went on training andThe clinicians are critical as in helping translate what they'd learnt on training into changed, behaviours at workErm they are there to, help the units with their thinking, in that unit meeting....They don't, they can't replace what CAMHS do but they can do a short term intervention which might be sufficient. So I think they're invaluable. (Manager 7)

Similar opinions about the value that clinicians brought to the Units were expressed by partner agencies as has been presented in previous chapters.

3.3.3.2. Benefits of shared caseloads

It was the opinion of some of the managers that the adoption of SW:WFF had improved services for families when their allocated social worker was off sick, on annual leave or if they left Cambridgeshire. The concept of sharing the caseload inherent in the SW:WFF model meant there was continuity of work during both planned and unplanned staff absences:

So if someone is off sick and it is particularly their case load someone in that Unit the consultant, other social worker or unit coordinator will know enough to keep that case ticking until they come back so it's completely different. I would expect that if you interviewed any social worker they are two of the biggest changes is they...in the old world you would spend a week preparing for your leave and then come back and spend a week catching up. Cause you would come back to emails, cases kicking off... all things that were not managed while you were off so it's quite ummm... yeah...its quite reassuring that you can take time off and you know someone in that Unit is looking after your cases. (Manager 4)

Although the subject of staff movement or movement in the model was very controversial as will be discussed in the challenges section, it was the opinion of some of the managers that sharing the caseload reduced the impact of staff movement as there were people from the Unit who knew about the case unlike in traditional social work practice:

And, so, does it de, de-stabilise when somebody moves?! Course it does. But the, but the positive of the unit, is that it wouldn't stay, de-stabilise it as half as much as the traditional model..... And the unit, now have got three other people there, that know the cases, two other people. So yeah of course they de-stabilisethe reason the unit model was set up was to reduce that, and it does reduce that. (Manager 3)

There were different opinions about staff movement within a Unit and how this affected staff members and families as will be discussed in the challenges section.

While the above summarises some of the achievements and improvements in the services post the service transformation, we wanted to find out about some of the challenges managers had had in implementing the SW:WFF model and how they had managed to overcome the challenges or not overcome them. We detail these below.

3.3.4. Challenges

There were various challenges that managers had experienced in the implementation of the SW:WFF model. Their experiences and opinions have been shared as part of the learning that occurred during the transformation so that this can be used as a basis for improvement of the SWWFF model which as detailed above is running well but has great potential to become even better. It is the opinion of the researchers that experiences that are detailed in the following sections should be shared to provide useful learning points for Cambridgeshire and for other local authorities. We formed this opinion based on the fact that the issues raised by some of the managers have already been brought up by both internal and external partner agencies as well as the families that we interviewed. This triangulation of data sources adds validity and trustworthiness to what was shared by the managers.

The challenges that managers had experienced included:

- Fluidity of the Units
- High caseloads
- The impact of the OFSTED inspection
- Lack of clarity about the role of clinicians
- Challenges in embedding systemic practice

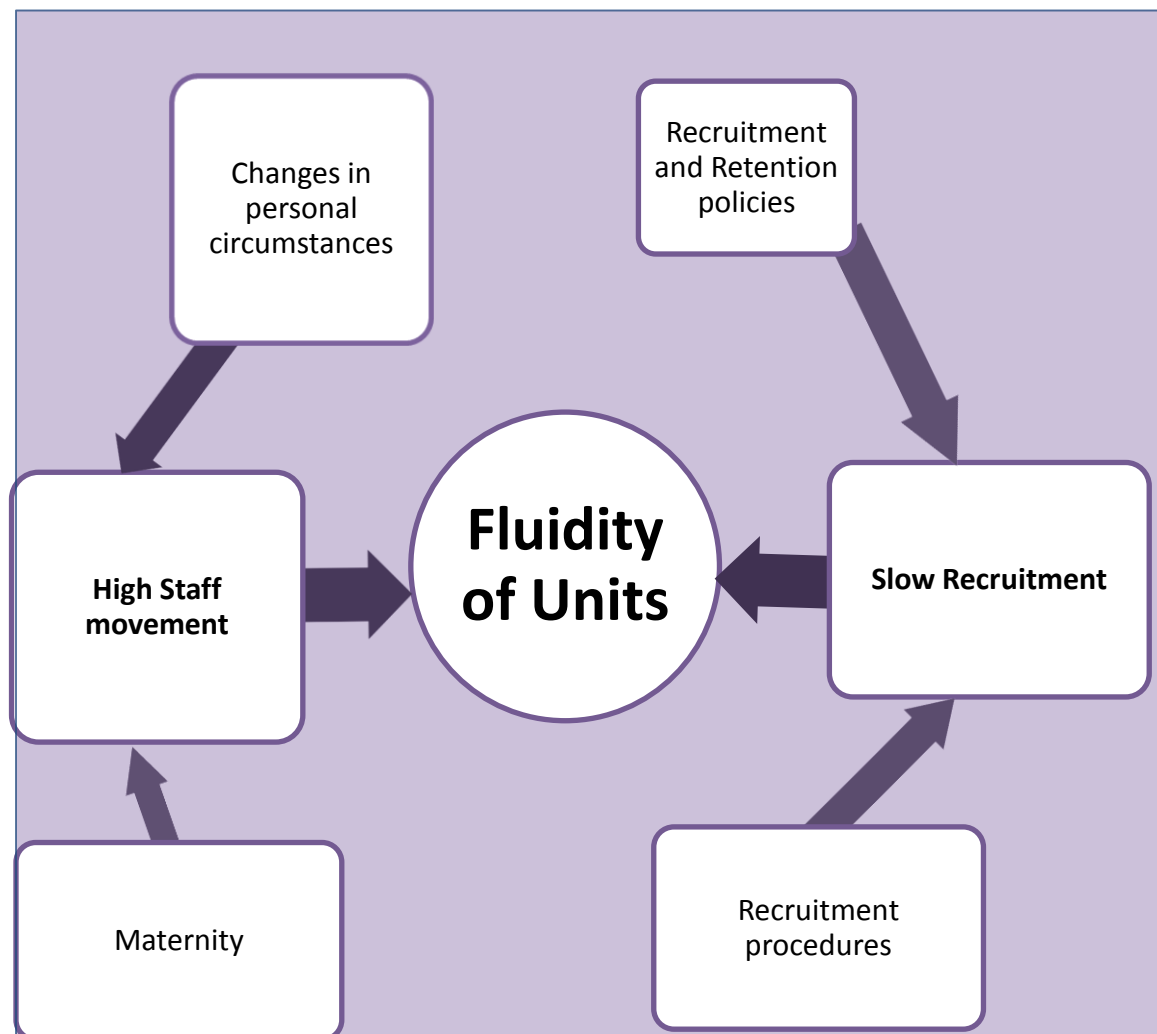
3.3.4.1. Fluidity of the Units

One of the key themes in the data from managers was the fluidity of the Units. Our working definition of the term fluidity of Unit is the constant changes in the Unit composition:

I think one of the things that we need to be very conscious of is that the unit membership is, is really a shifting picture, that I I think we had an idea, or at least I know I had an idea, erm, we would gradually roll out the units and....you know, and they would pretty much stay the same, with a certain amount of change, but not a lot. The reality is that a lot of the units have changed quite...dramatically. People have been promoted, people have gone on maternity leave, all sorts of things and, and I think what we've got to keep a very close eye on, is that, that first, those first units.... first units had that weeks induction those ...if you went and looked a, a, number of them won't have had the induction training together and erm some of the people that have had the systemic won't be in the same place either. (Manager 2)

Fluidity of the Units resulted in changes in leadership styles, Unit working relationships and skills and experiences mix as indicated in the excerpt. Fluidity of Units also meant a change in the skills mix in the Unit and more variable practice to the families being supported by the Unit. There were various factors that contributed to staff being moved around in the Units. These were high staff movement; slow recruitment of the consultant social workers as highlighted in figure 1 below:

Figure 1: Fluidity of the Units



A. Slow recruitment of the consultant social workers

One of the biggest challenges highlighted in the data was the length of time it had taken to recruit consultant social workers and as a consequence the length of time it had taken to roll out the model in Cambridgeshire:

And we launched the units in January 2012, and, erm, we knew that what was going to be a challenge, managing erm, two systems; units and the traditional, but we imagined that we would be finished by the autumn 2012. Haa (laughs). What we didn't realise was erm, the recruitment challenges that there would be. (Manager 7)

Although recruitment of social workers in general had been a challenge, recruitment of the consultant social workers was reported as being particularly difficult. One of the reasons cited for this was the lack of understanding of what the role entailed by people outside of Cambridgeshire:

Manager 2: We didn't recruit easily the consultant social workers

Interviewer: Ok and why is that?

Manager 2: I think it's a diff... it's an odd job. I think it's a fantastic, job. But a lot of people either want to be practitioners or they want to be managers. And to have a job that does both, it takes a certain sort of person. The people who we've got who are permanent are very good at it, but a lot of people, don't, from the outside, not working in this way, don't actually see that as something that makes a lot of sense and everything. So, it's a struggle

Another reason for the delays in the recruitment of consultant social workers was the fact that Cambridgeshire had set "a very high bar" for the post. This emanated from the belief that the role would either make or break the Unit and hence the need to get the right people into post. Cambridgeshire had therefore set a rigorous recruitment process which included various assessments and an interview before being offered the job. Due to these extra requirements, Human Resources had been unable to cope with the recruitment demands and Childrens Social Services had their own administration staff help with the recruitment process. However this did not remove the delays in the recruitment of the consultant social workers.

The slow recruitment of consultant social workers meant that sometimes staff had to be moved around across the Units to meet the operational demands:

Erm it has been quite a challenge recruiting to the consultant social worker role. We've erm, offered secondment offered opportunities and fast tracked erm some social workers and we've always had to move staff about in a way that we didn't really want to have to do....Erm but its, you're balancing all the time, err trying to, allow a healthy unit you know to grow and develop together and having to cover, the operational requirements so....(Manager 7)

Initially, erm and filling the s consultant social work posts, in a timely way to get the units up and running, was, was another challenge. So erm, there had been a little bit of feeling like we were robbing Peter to pay Paul and moving people about erm, which was a challenge to manage, and to keep staff, optimistic, and fully engaged in, in the model though (Manager 8)

As described above the Units who had more experienced permanent staff were sometimes moved into consultant social worker positions which destabilised the Units. In other reports, the movement of staff meant left less experienced staff left in a Unit:

So we've tended to have, the experienced workers as the consultants, which is good, but then we've got, err a lot of ASYEs in the, in the social work posts.... the reason that's problematic is that they can't, they have protected a protected caseload, you have to be more (sighs) concerned aboutThe complexity of the cases obviously. Erm, although they are co-working a lot of the cases, but that then leaves the consultant social worker, to pick up all the, high-endChild protection investigations and such. So that, that has been, more problematic to manage, not impossible, you can have an agency backing up those units that do have newly qualified in (Manager 8)

So our staff makeup was, very inexperienced, so you know,we're still quite limited on the amount of people that we can give complex work to, care proceedings and things.....So, there's an awful lot of pressure on the consultant social worker to, you know manage the child protection stuff.... (Manager 6)

Having less experienced staff meant that the consultant social workers had the additional pressure of having to do more practitioner work than management. In other cases the weakened Unit had to rely on the support of experienced agency workers which was also problematic in that agency workers had not received the Unit induction and some were not fully aware of the systemic practice:

I mean there is lots of, you know, we have employed lots of agency workers who are, very, a wide range of abilities. Erm, and then, you know, not the answer really, but erm ... (pause) so yeah, so that's been difficult. (Manager 6)

I have never, had us use so many agency staff...We've had to have a lot of agency staff. And, quite a few of them have had issues about their practice which has been a problem. And for me, that's been the weakness.... but when you're taking agency staff on, they're not people who've got this background in systemic work. They aren't committed necessarily to staying, and I do think that they some of them struggle not all of them, but some of them definitely do struggle (Manager 2)

The result of agency workers was reported as introducing variability of practice particularly if they did not have any systemic training.

Moving staff across Units also introduced pressure on the Unit as the change altered their case load:

It's complicated when staff move, because the cases that they're working tend to have to move with them, and then that alters the caseloads, and, it means that the unit then have to get to grips with, a whole new set of cases, that that other practitioner brings. Cause you can't just, move somebody out of a unit and leave all their cases (Manager 8)

The quote above highlights some of the pressures that Units were under as a result of staff movement during the time that Cambridgeshire encountered challenges with recruitment. At the time the report was written, Cambridgeshire had completed recruitment of consultant social workers and all the Units had gone live. It is possible that this theme would have been less relevant if data collection had been done at a later stage as had been the original evaluation plan. However the insights in this section are useful for other local authorities who may wish to do a similar service transformation.

B. High staff movement

The other thing is, let's be honest, people come, they try the .. The unit, it might not be for them, some people leave. Erm, you have, you know, erm, some people , err there's a positive... have gone off, in terms of, you know pregnancy. So you're always sometimes recruiting, sometimes standstill a little bit, and I think, you tend to, tend to underestimate the impact of that a little bit (Manager 10)

Closely related to the movement of staff due to challenges in the recruitment was the reported high staff movement for various personal reasons. Some of the reasons cited for the staff movement by partner agencies were the low salaries and work related stress. Managers seemed to think that their staff were less stressed in the Unit model than in the traditional model:

I don't hear anybody complaining at all, about this way of working. I think people it's a way of sharing the stress, because it's difficult, this work.....Erm, at times, it can be quite scary, for some of our inexperienced staff, the responsibility...Erm, so I think it's, err, err, as, as a way of working, in a very stressful environment, where, were under the microscope all the time...And I think this is much better for people. (Manager 2)

Therefore stress was not reported by managers as a factor contributing to the high staff movement. However, one of the themes from the data echoed the opinions of managers that the salaries in Cambridgeshire were lower than other local authorities and this contributed to slow recruitment and high staff movement in Cambridgeshire.

While there was some staff movement because some people did not like working in a Unit, there was marked staff movement due to maternity. Cambridgeshire like other local authorities had a young female workforce and as a result there were sometimes gaps in the workforce due to people going off on maternity leave:

The other thing that erm we didn't identify, was that because of the nature of the workforce, its largely female and largely young female, erm, we've had erm, a lot of, erm maternity cover to cover. I think in the traditional model, if people left on maternity leave, managers didn't always backfill those people. They would leave it until maybe, they'd got a couple or something or that and another vacancy. And then they would try and backfill. Whereas in the unit model, a unit isn't a unit unless it's got four point five, people in it, so it is a more expensive way to do social work. (Manager 7)

When people left Cambridgeshire or went on maternity leave this also resulted in either new staff being recruited or staff being moved around the Units in order to meet operational needs. As highlighted in the previous section, this process brought on the additional challenges of variable practice, loss of appropriate skills and experiences mix and an overreliance on agency workers. Movement also affected the working relationships with partner agencies. Effective collaboration with partner agencies was perceived by families as a necessary aspect of family engagement and addressing the complex needs and challenges of families open to Social Care.

Of particular importance is the perception from some managers that movement of staff although inevitable in some cases impacted on the continuity of services for families and their engagement with Social Services:

Interviewer: And how do you think err, the shifting picture of the units' impacts on the work, which is being delivered, by the units?

Manager 2: Its, nowhere near as good as being able to offer continuity for families. So one of the things that, we said to families was, you will have a group around you, if somebody leaves or somebody's on sick leave or annual leave, there will be continuity because the rest of the group will, remain the same. That hasn't always been able to be the case. Sometimes, erm, we've had to move workers from one unit to another, and sometimes they've taken cases with them, sometimes they've left them behind. I don't quite

know, how, we have to aim to have a, a steady err and consistent group of staff as we possibly can around a family, because it creates setbacks every time you change a staff group. Then, you're taking a couple of steps back to get to know what's going on and people get cross with this. They may have engaged with one group of people, but by the time they're on their second or their third, they can be fed up.

The above concerns were also raised by families and partner agencies and are worth taking into consideration by other local authorities who may wish to adopt the model. As indicated earlier it is possible that if more qualitative data had been collected after all Units were fully functional this would have been less of a concern to managers. However it offers useful learning points for future service transformation.

3.3.4.2. High caseloads

And the biggie is their caseloads, we still...their capacity is still very very high and that's a barrier to what we want to do with this model. It does mean we have some other challenges to face..... We are still over capacity for what we should be in the Unit model. (Manager 4)

One of the main issues raised by several managers was how high caseloads impacted on the Units delivering social work systemically. In order for the Units to meet the expected outcomes of the service transformation and do more high quality direct work with families, they had to have a manageable caseload which allowed effective case discussion, collaborative practice and meaningful direct work with families:

I think, you know the unit model and maybe this is one of the flaws in the unit model is that, well I don't see it as a flaw, but it, you could see it as one, its, that the staff are actually, they tend to be working with less cases on average, than they were before ...less children on their caseload...but they're working more intensively, and in different ways, so, erm the unit numbers have to be lower. (Manager 8)

The issue with the unit model is that it is slower, you'd, if you wanna use that terminology, down a single practitioner, of course it is, cos you've got four people, five people sometimes, sat round a table discussing a case, rather than one. So it is slower. (Manager 3)

As part of the planning prior to the adoption of SW:WFF, there had been some estimation of the appropriate caseloads for the different types of Units. There was a general consensus in the data, that the Units were holding more cases than had been anticipated prior to the unitisation and this impacted on the ability of the Units to do the direct work that they were set up to do:

Well, I think, certainly, if you, if you look back to the original ... consultation documents, I think...thirty five children in a child in need unit...about forty children in an access unit....And pretty quickly, we realized that capacity, is a real issue, access units with a hundred children, were not, unusual....So I think we kind of underestimated the capacity. (Manager 6)

Figure 2: High caseloads



There were four factors mentioned in relation to the high caseloads: underestimation of demand, small Unit size; lack of clarity of the social work task and unclear transfer policies as indicated in figure 2 above.

It was not very clear from the interviews conducted why demand for services was very high but there were some comments to suggest that there had been an underestimation of the demand for services. As a result of this underestimation, there were fewer Units created than what would actually meet the demand:

I think one of the difficulties has been is that the numbers were wrong. People got their numbers wrong. They started with too few units, the figures coming through the front door weren't correct. And I think, erm, even now, I think were still playing catch-up from those mistakes. (Manager 3)

The existing Units were therefore taking more cases than they could successfully deliver systemic social work to. The matter was further complicated by the average Unit size of four and a half people. This made the Units very vulnerable and unable to cope in the event that any of the Unit members were away for genuine reasons:

This week one person [is] off sick, one person, not in for the next two days and the unit coordinator on leave. There is no capacity in that unit. (Manager 5)

So units are quite small..... you need someone to leave, someone to go off sick. Someone on a course and someone on holiday and there's no one there. (Manager 6)

To address the capacity issue, managers sometimes added an additional agency worker to the Unit. As discussed earlier the use of agency workers had several challenges. In other narratives, a Unit Buddy system was in place to enable Units to cover each other. However this was also problematic in that each Unit was already under tremendous pressure and in most instances did not have capacity to be able to cover another Unit.

We must point out that the subject of Unit size was controversial with various opinions on whether Units could effectively meet demand and deliver systemic social work practice with only four and a half people in the Unit:

Ok I, I'm not the only one to think that the units could probably do with being one person more. So, in an ideal world, I would like the units to have six staff in, rather than five so an extra social worker. So a CSW, three social workers, a clinician and a unit coordinator, I think would be better....I think it would, help, when, you have somebody go off sick, or leaves or, whatever that happens. The chances of the units being able to carry on regardless, I think, err, are, are stronger. You've only got to have somebody off sick and somebody else on holiday and, and the units struggle (Manager 2)

The main concern for managers who raised this issue was how the small Unit size made the Units vulnerable which posed a challenge in providing consistent practice to families. Whilst some managers were of the impression that having more staff in the Unit would help with addressing the high caseloads

the alternative view was to actually create more Units to meet the demand rather than to make the Units much bigger:

So, but then when you have an extra agency worker attached to that unit, that makes the unit bigger, which means the caseloads bigger, which means that the unit meetings are long and there's more children to discuss. So, it is actually better to keep the units smaller and to have more units...(Manager 8)

I think if you have more than [five people], I think it tips into a team..... I have tried it. Erm, I had an additional worker, err, in a unit. Erm, but what happens then, is the consultant social workers' role changes from one of a practitioner to a team manager, and you kind of working against, you start to work against the model. The model is about keeping experience, good staff, working front-line. If you make it bigger then it turns it into a team. I think, with my experience. So it's better to have more units, than a bigger unit. (Manager 3)

It was the perception of some of the managers that making the Units bigger would affect the role of the consultant social worker as well as affect the ability to know about the different cases as the Unit meetings would be much longer due to having a bigger caseload.

In addition, it was the perception of some of the managers that the Unit size did not have as much of an impact on the caseloads as lack of clarity of the specific challenges faced by families and how to address their needs and support them in a timely manner:

I think we need to be clearer about the tasks. So as managers ...we wonder why, why is this case open to us? And I think we need to be much clearer, about, what are we trying to do, and you know how were gonna do it and how long is it gonna take us? And then close it, and I think we need to be, sort of be smarter and quicker about that (Manager 6)

Managers had overcome this challenge by supporting the Units identify the underlying issues that Units were trying to address in a family and helping Units about setting realistic timescale of when the social work task would be completed. It was thus vital that Group Managers attend Unit meetings and support the Units from time to time.

In other narratives, the high caseloads were not so much about the Unit size but an indication of the need for more work being done around the transfer policies. It was the perception of some of the managers that Units were "clogged" because of unclear transfer policies. This emanated from managers

taking different view points on when cases should be transferred in a genuine attempt to protect their Units from having more work allocated to them. As such transfers were only accepted depending on the safe guarding needs, with low level needs though being able to benefit from long term involvement being rejected and expected to be handled by Access Units who themselves were working over their capacity. Several attempts had already been made to address the transfer policy but this was still largely problematic:

But we started off by having quite a prescriptive transfer policy, it will go over at these points, and everyone said we don't need that, we should just do it on principles. The principle of what's right for the family. So, we undid all the prescription and did that, and it was chaos.... (Laughs) so then, we had to go back to a bit of prescription....people are under pressure, they, they just go by, you know, they protect themselves with the rules don't they, so we, it's up to us to think about how we're going to make that process, more family friendly than it is at the moment. (Manager 7)

Finally it was the perception of some of the managers that the high caseloads was an indication of the need to do more work to strengthen the Integrated Access Team (IAT) as was also discussed by partner agencies. One of the managers suggested that some of the work being done by the Units did not actually require Children's Social Care input and could have been resolved by Locality. This misdirection of cases was presumably a result of poor links with Locality (which has since improved) as such inappropriate cases were passed onto the Units:

Because I think they (Locality) should be taking up a lot more of the work than what they do, I think their links need to be better.... so there's a danger that we'll inundate staff with, work and, you know, one of the weaknesses of a model, is that, you know, I call it slow. But if you give a case, to a unit, they will delve into the problem, to solve it... And sometimes, they don't necessarily need to cos it's not really our level of work. But because nobody else will deal with it, we will deal with it, and that, kind, the danger is that it clogs us up (Manager 3)

The above suggestion is important given that it was also raised by partner agencies and addressing it may also help address the caseloads for the Units.

Comment from SW:WFF leadership team:

Since the time of the research, Cambridgeshire Social Care have done a lot of work on making transfer policies clearer.

3.3.4.3. The impact of the OFSTED inspections

During the service transformation, Cambridgeshire received an “inadequate” rating from OFSTED which was a huge turning point in the implementation of the SW:WFF model:

Well I suppose that initially ...I mean it was devastating...I mean it knocked people quite a lot. I think they didn't, they don't feel inadequate at all and they are not inadequate at all. They turn up here every day and do really really good job of social work so I think the word is the worst one using inadequatebut I don't think anyone could deny what was found....(Manager 4)

And, and, basically the way I translated it....was, they said that our architecture, is, right, and looks good, but actually some of our basic housekeeping isn't right and, so we've got toget back down to thinking, and what's the day to day housekeeping that we need to do, to make sure, our house is in order (Manager 7)

And I think OFSTED, what OFSTED did, was, it highlighted a number of key areas. One was around timescales; one was round recording. (Manager 5)

One of the key issues that the service transformation was meant to achieve was address the “over-bureaucratisation and over processing” of social work practice by allowing people to do more innovative work with families. It was the opinion of some of the managers that before the OFSTED inspection there were insufficient frameworks and guidance for accurate record keeping or seeing children in the expected timescales as staff were very focused on innovative practice.

The OFSTED inspection resulted in changes in the delivery of social work to ensure that the fundamental and basic principles of social work practice were adhered to. Although it was a very difficult outcome, managers had worked hard to address the concerns raised by OFSTED. This included the development of the Unit Meeting template to ensure that the discussions about the families were being accurately recorded. There was also the introduction of dashboards to support staff in knowing whether or not they were completing the expected social work tasks such as seeing the children within the stipulated timescales. New performance standards were introduced including checks and balances that scrutinised the work being done by staff:

Let me think how I'm gonna phrase this. There wasn't as much empathy, for the work that was being produced.....So people were held to account, for the standard of work the produced....Erm and people were performance managed, and, you know that (sighs) they moved on or else they decided they weren't suited

to this model, or suited to the, we way of working, I should say..... We err, you know, we've got numerous checks and balances, so transfers, case closures, IPCPs. If the work wasn't good enough, it was rejected, where in the past, it wasn't. (Manager 3)

While the report from OFSTED improved the quality of the work being done by the Unit however, it became a challenge to practice social work systemically and also be able to do all the paperwork and "tick box exercises" required within the expected timescales:

And that's the kind of challenge really, how to retain the creative, systemic social work model, alongside, something that is good or outstanding, according to OFSTED. And that's hopefully where we'll be at but it's a pretty uncomfortable journey (Manager 6)

What's happenedand I think its linked to OFSTED, is, erm the introduction of, the, the, timescales and the dashboard, and all of the things which show that we're doing the job that we' re meant to be doing. And, and all of that I understand and agree with, but actually, its swung the other way, so I hardly ever hear anybody talking about systemic anymore but I hear is, people saying have you done it, in time scale? So it's a difference between, erm, having a focus around, a methodology for intervention which is based on, theoretical practice, and a method of intervention, which is based on time scales. If I'm honest that's how it feels to me (Manager 5)

It was the opinion of some of the managers that Units were under a lot of additional pressure as a result of the OFSTED inspection and this sometimes interfered with doing creative work with families. The inspection left higher expectations of Units with regards to timescales and record keeping. It was the opinion of some of the managers that staff felt guilty about not being able to do the systemic practice:

You're now gonna be doing systemic practice which is slower, at the same time, we still expect you to do, what is it, six pieces of paperwork to get a child accommodated. So, that's been the difficult. The pressure on the, the staff is that they, they start to feel guilty, they feel guilty that they can't do the systemic practice that, that they want to do, because we still make it too hard for them to do that because of all the bureaucracy and the procedures. (Manager 3)

Comment from SW:WFF leadership team:

In the subsequent re-inspection (March 2015) Cambridgeshire moved from 'inadequate' to 'good'. The inspection commended the integration of standards and procedures for completing basic social work tasks with creative systemic practice that provided a quality service for families. It is

understood locally that learning has been achieved about balancing basic practice standards and integrating new ideas.

3.3.4.4. Lack of clarity about the role of the clinicians

Oh I think the [clinicians] are very, erm, helpful indeed. Erm, I, I think that there's probably room for more discussion, erm, and understanding, amongst the whole staff group, about what our expectations, should be. So sometimes there is a plan, that there will be long term clinician work with a family. We haven't got the capacity to do long term clinician work, with a family. The clinicians will do a, short series of, of sessions, with some families and they do that incredibly well, and sometimes they do it very intensively..... But it's a very precious resource. And, and, erm, I think that there is erm, still some scope for further discussion about what we can realistically expect (Manager 2)

The clinicians were viewed as a critical and valuable part of the Units. However, it was unclear the amount of work that clinicians were able to realistically do with the families. This issue was also of significance to internal and external partner agencies as well as families.

It was the opinion of some of the managers that the clinicians needed to be available to the Unit members for consultation on how to deliver social work systemically to families. In addition, they were to support staff during the Unit meetings by supporting the systemic and social learning practice as well as support practice by providing teaching sessions and also doing direct work with the families. Some managers suggested the need to balance between social care involvement and therapeutic involvement by clinicians. This was linked to instances when cases would be open because of the clinical input for the family rather than any safe guarding concerns:

And clinicians get in such into families, and actually, we were had cases being open, where there was no social work role. It was more like a therapeutic clinician role. And I didn't think that was clearly complimentary practice. Erm, and having to say to clinicians, you know it's, it's lovely for somebody, that you're seeing them every week for three hours or whatever, you know, sorry, exaggerating...but actually, I need you over here doing this (Manager 5)

Given how families found the experience of social care involvement difficult, there may be need to consider the above comments so that families are not unnecessarily open to Social Care.

Finally, some comments were raised about the future role of the clinicians in the Units as more social workers got systemic training. It was anticipated by some that the role of the clinician would become more of a specialist referral for Units rather than actually being part of the Unit:

So if we were training all the CSWs up in systemic thinking, approach, you don't necessarily need the clinician with you all the time. But however, for example, if I got a case inand thought that mum had a learning disability then I could, look at my, clinical base, and, and and get that clinician to do that. Or, for example, if I have a DV case at the moment, I'd have to refer that to an external agency. We've got this massive group of clinicians internally, and if they can create their own program, then I'd, refer to them. So ...if we were training the Consultant Social Workers, you still have that systemic voice anyway. Then [clinicians] can still attend unit meetings (Manager 3)

Clearly these varying opinions on role of the clinicians in the Units suggests a need for further discussion to clarify the needs of the Units and how the varied skills and experiences of the clinicians could be maximised in supporting best practice and this is ongoing. Furthermore, it is important to point out that the families, partner agencies and most of the managers felt that the clinicians were a very critical aspect of the success of the SW:WFF model. [SW:WFF team comments about the Increased clarity of the clinician role since the time of these interviews is described in section 3.2.1.4.3.]

Comment from SW:WFF leadership team:

The role of clinicians has now been reviewed. As a result of this, they are seen as integral to the unit model.

3.3.4.5. Challenges in embedding systemic practice

The adoption of the SW:WFF model meant staff went through a cultural shift in how they delivered social work practice. Although each Unit received induction prior to starting their work there were some challenges at both management and front line level in embedding the systemic theory into practice. The cultural shift to adopting the theoretical frameworks was iterative as front line staff and managers tried to understand balancing systemic theory and social work practice as well as balancing the knowledge gap between those who had systemic training and those who did not:

Manager 3: So I think some people, and I've done it myself, will use the terminology of systemic practice as a weapon to prove a point, or to win a debate.....They would simply say, but that's not systemic, and this is systemic. And that's just a real lack of knowledge of what systemic practice is. And it's real (sighs). So people

who don't understand systemic, will, get scared of it, and step away from it, and try to undermine systemic practice. But the other flipside to that is people who've got, you know, the land of the blind, one-eyed man's king. People have got some vague understanding of systemic, and will just use it as a shotgun to, to win all arguments. People, because they get scared of systemic, and whatever that means....They'll, they'll start to undermine systemic and say it's dangerous. It's too strength focused. It leads to over optimistic practice (sighs).

Several managers spoke about the risk and anxiety inherent in social work. As such traditional practice was a reactive practice which did not have a strength based focus. It involved making assessments and making decisions rather than reflective practice inherent with delivering social work systemically. This was a tremendous cultural shift. As not everyone in the Units or management had systemic training there were times when the term "systemic" was used incorrectly. Furthermore to be able to focus on the strengths of a family was a real paradigm shift as was working alongside clinicians to deliver social work practice systemically. The attendance of Group Managers and sometimes Heads of Services at the Unit meetings brought balance during the transition albeit some of the managers had no systemic training.

Combining the social workers and clinicians in delivering the service also meant that there was some professional terminology for example that was used by clinicians that social workers or their managers were unfamiliar with. It was also a process appreciating that the clinicians had diverse backgrounds, skills and experiences and thinking of how best to make use of this diversity in delivering social work systemically:

So you've got one clinician who is an educational psychologist background, someone else in a family therapist background. They're different. And they, you know, they do different things, and they, you know, use different knowledge bases, and I think that, I don't, I don't, I don't think we realise that. But the, but the difference was good, I mean, you kind of think oh, you know, we've got a pool of a very wide range of skills and knowledge there, which is probably a, probably a benefit.(Manager 6)

Furthermore, for some of the social workers, it was actually a process to accept their identity as social workers rather than thinking of themselves as systemic therapists. Managers overcome this challenge by continuously reminding social workers that they were not systemic therapists but that they were following a systemic approach to social work. Over time staff were reported to have come to terms with this initial identity crisis and realising that they were not stopping their social work practice but were doing it differently.

Another challenge reported in embedding systemic practice was the over-reliance on clinicians that some of the social workers developed in the first year of the implementation:

And, but what happens then, is that the units, erm, defer responsibility to clinicians (giggles), instead of saying ok, I understand that, I'll try some of that. What they really want to do is give it all to a clinician, to go away and make it better. And that's not what ever what was expected or attended or is or is professional, practice from a social work point of view (Manager 5)

The data suggest that the managers supported the Units to understand the role of the clinician in helping them to deliver social work systemically rather than taking over their social work practice.

Another challenge people had to come to terms with was that systemic intervention was not able to address every case and was not necessarily relevant for every case. This was mentioned for Domestic Violence cases as well as cases that were in court. Managers therefore acknowledged the strength and wider knowledge base provided by the systemic theory but also accepted its limitations. This is a valuable lesson for other local authorities considering the Unit model.

Comment from SW:WFF leadership team:

Clinicians offer systemic intervention but also contribute to assessment of risk and assessment of significant harm on children's development in these types of cases.

3.3.4.6. Lack of clarity about the role of Group Managers⁷

The interviews conducted suggest that the role of the group managers had evolved over time and there was lack of clarity on what their role was at the start of the service transformation:

I think the very obvious competing claims on my time. No, it's alright I'm just trying to think, how I do explain that? One of the things that becomes quite apparent in the last couple of months and have been involved in a number of conversations with, err, people like XXXXX and HR officers and other Group

⁷For confidentiality and anonymity the quotes in this section are not accompanied by any of the manager identifiers from previous sections.

Managers and XXXXXX . There is a lack of clarity about the Group Manager role Ok. It does feel that because that lack of clarity, we're all things to all people as well as jack of all trades. (Participant A)

My job is to fill the gaps, but there's only one of me ...and I can't fill every gap that there is, and I can't keep every time scale, that there is. So I think, much as I, want to value, the, possibility and potential for reflective practice and, systemic thinking. Actually what I'm doing it hanging on by my finger nails most of the time, just to keep the time scales in order. (Participant B)

It appeared that the role of the Group Managers was very multi-faceted and demanding. It involved supporting the Units when the Consultant Social Worker was absent, thus stepping down to cover their role. On occasion it involved going to court when there was no one available from the Unit to perform this task. The role also involved doing quality assurance by ensuring that accurate record keeping was done by the Units as well as keeping the expected timescales. Group Managers were also expected to attend some of the Unit meetings, support the consultant social workers in their roles and also conduct audits as a quality control measure. Thus their role had evolved over the service transformation and had not been very clearly defined when the transformation commenced.

Despite giving the Units direct support, the Group Managers had not received any systemic training and the issue was controversial among the managers with some managers thinking Group Managers did not need systemic training and others feeling it was essential:

Erm, however, I have had to ask Consultant Social Workers 'what's this word mean?' 'What's this concept about?' – You're describing something that I'm not familiar with. But, and, I'm happy to do that. I think if, if you weren't you could really struggle cos we're producing another layer of jargon. To be honest..... With regards to the Group.... We need a better understanding of the, evidenced based theories, that we're bringing into our practice. (Participant C)

So that's [systemic training for Group Managers] being addressed, now, thankfully. Erm, I think the original argument you could suggest, was to have ...people who had feet in child protection, who didn't get, as, as I said before, carried away with the systemic fairies. But you did have people who were grounded in ermpure social work, theory. To an extent, erm, so maybe that was the argument for that, and I can kinda see that. (Participant D)

At the time the interviews were conducted, some systemic training was being organised for Group Managers and is now in place. It was unclear what had led to this development. It is possible that as the role had been unclear when the transformation began and providing training for the group Managers

had not been a priority at the start. However lessons had been learnt during the transformation which indicated some benefit that would arise from managers having some kind of systemic training to support them in their role and to support best practice.

3.3.5. Achievement of Significant Outcomes

Having interviewed managers about the improvements in the services and the challenges of implementing the SW:WFF model, we asked managers about whether or not they thought they had achieved the significant outcomes they were aiming for in the service transformation. Our data indicates that there were varying opinions about whether or not the outcomes had been attained. Some managers were of the opinion that significant outcomes had been achieved and evidenced this achievement by the higher calibre of work being done by the Units with various cases to illustrate the changes in the services as exemplified in case study 2 below:

Case Study 2: Keeping families together when it is safe to do so

There was a young boy, who was living with grandparents, and, he was turning up for school with mouldy sandwiches. And they were basically saying look, you've got five weeks or else were gonna take this kid out, and put him somewhere else. And my first question was do they love this kid? Yeah, does he love them? Yes. Why do you think they're not doing it? And jokingly I said, you know, can they read? It turned out that Grandma had Alzheimer's. Grandmother was, had, very bad eyesight. So what they were doing was beating this family with big wooden sticks, saying you can't achieve, what we want you to achieve, and when you can't achieve what we know you can't achieve, were gonna take this kid and, and what I simply said was, well maybe we need to look at this differently. Maybe instead of putting the, the support worker at the school, to see if he's bringing mouldy butties how about putting the support worker in the house, to make sure he's not being given mouldy butties. And let's clean up their house, and stuff like that. And that happened.And like, in a very short period, it had turned round, and the grandmother was giving hugs out to the workers and thanking them, stuff like that. So that's an example, ofwhat this model will bring.

The case study above represents one of the many examples managers shared with the research team to highlight the achievement of the outcomes that were being aimed for by the service transformation. Other indicators of the achievement included the decrease in re-referral rate. This was also seen as an indication that the systemic approach was working and the level of work with families was resulting in sustainable change:

Interviewer: And what were the significant outcomes that you were aiming for in retraining and do you think that you have achieved these significant outcomes?

Manager 4: I think we are achieving them...I think so I can only talk from where we at now. So four five months re-referral rate was quite high ...I think it was 25-26% right now it is at 16% so that's a significant drop..... ..so before we would have gone in and we would have supported families made the change got out...that change would have gone back down and they would have gone back down. Now are doing the extra deep dive and supporting them that's with the systemic and social learning and we are supporting them very differently and with that that means that when we close them they are not coming back. We are always gonna have some re-referrals but for me that is how we evidence that we are making a difference right now and that will be our own evidence...

Having said this, it is needful to point out that some of the managers felt that while there were some positive changes in the services delivered to families, achievement of the goals of the service transformation was a process as some Units had been running longer than others:

Manager 7: Erm, I think we're on the journey to doing it [achieving significant outcomes] . Erm, you know I've just said already that we, last week was the, the final unit was erm inducted. So we've got, some units who've been, running for nearly two years and, some people who this is their first week...So we can't possibly expect to have, consistency of, delivery....I think we've got a way to go before I'd say we were fully consolidated and fully confident, you know, that we were erm, that we were in the sort of robust place that we wanted to be.

3.3.6. Recommendations

Based on the lessons shared by managers in this chapter, the following key recommendations have been put forward by the managers:

3.3.6.1. Managing demand

One of the critical issues raised by managers was how the high caseloads impacted on the delivery of social work systemically. There were seven recommendations to address the high case loads:

3.3.6.1.1. Strengthening IAT

Get your numbers right, build a strong, very strong front door... (Manager 3)

One of the key recommendations in addressing the challenge of high caseloads was to strengthen the Integrated Access Team (IAT) by ensuring that stringent thresholds were in place which only allowed cases that really required Social Care involvement to be passed on to the Access Units. It was also suggested that stronger links to Locality be made at IAT so that cases that required low level input were directed to Locality teams rather than being directed to the Access Units.

Another suggestion to strengthen IAT was to streamline services by removing the Access function and only having a very large IAT team which would pass cases on to CiN Units:

They [IAT] have social workers who will go out and, and have a kind of look see, go and see families. It kind of begs the question, if you've got that, why do you need then an access function and then a child in need function. Because your, so a family, in theory, could, could have contact from a social at the IAT, then a social worker in access for twelve weeks and then child in need. So it kind of raised the issue of, why don't we just have a... a big IAT, and then just everything's child in need (Manager 6)

Comment from SW:WFF leadership team:

Links with Locality teams have been strengthened since the time of the interviews.

3.3.6.1.2 Building stronger transfer policies

Earlier sections highlighted that the transfer policies contributed to high caseloads for Units. As such there were several recommendations that future transformations learn from the experiences in Cambridgeshire and put in policies in place to make transfer of cases much easier and in the best interests of the family. Given this background, one of the suggestions from managers was to have Units perform both the CiN and Access function in order to reduce the contentions around transferring cases and to provide continuity for families:

We can blame them [families] for being fed up, when actually we've done that to them. So, I know there's been some talk about whether or not it would be possible, and I don't know if it would, but I can see the attraction, in, having cases that come to a unit and just stay there, and don't go, from access to CiN. (Manager 2)

Interviewer: Ok, and what are the key lessons you would give other managers of other local authorities if they wanted to do this thing?

Manager 3:I wouldn't have...a separate service for access and CiN, I would have one service ...

This recommendation was also in line with suggestions that were made by families to increase family engagement. These issues have been addressed by management since the time of these interviews.

Comment from SW:WFF leadership team:

The issues around different teams providing Access and CIN functions has been addressed since the interviews.

3.3.6.2. Increasing the Unit Size

One of the suggestions to manage demand was to increase the size of the Units from 4.5 to 6 people. The challenges and merit of this approach have already been discussed in earlier sections. In particular, the advantages of increased unit size may be outweighed by the fact that the full unit model is less likely to work as well if there are more staff (and hence families) (see p.124).

3.3.6.3. Increasing the number of Units

Closely related to strengthening IAT was an accurate understanding of demand for services and development of enough Units to meet the demand. Currently, there were some concerns that there were not enough Units to address demand in Cambridgeshire.

3.3.6.4. Addressing bureaucracy

After the initial OFSTED inspection, there was added additional pressure on the Units due to the amount of paperwork and processes they had to engage in order to deliver services to families. There were some comments to streamline the services, the number of assessments and remove bureaucracy that hindered doing social work systemically.

Comment from SW:WFF leadership team:

These issues have been addressed by management since the time of these interviews. There is now a single assessment process and there have been many structural changes.

3.3.6.5. Removing court cases from Units

There were narratives to indicate the challenges of trying to do systemic social work with court cases. There was an argument that if it was known that court cases would not really benefit from the systemic social work then there was potential to create a separate court team so that Units were not under pressure from the tasks that go with court cases.

Comment from SW:WFF leadership team:

Howlett's (2015) article suggests learning in this area, about how cases in court can benefit from effective systemic social work interventions which is not inconsistent with safeguarding children in a timely way. Robust systemic social work is likely to provide the evidence needed to go to court. Time limited interventions which assess capacity for change are central to robust assessments for court. Care Proceedings can only be effective and timely following effective social work practice. We think it is a misunderstanding that you would not offer a systemic intervention when risks are too high and capacity for change too limited.

3.3.6.6. Ensuring that Units are clear about what they want to achieve with families

In order to avoid the Units working over capacity, different managers suggested the importance of Units being fully clear of what the challenges being faced by each family they had were as well as being clear on how best to address the needs of the family in a timely fashion. Initially, lack of clarity on the social work task was thought to contribute to cases being opened for longer than necessary and thus increasing the caseload for the Units.

Comment from SW:WFF leadership team:

More recent development has shown managers to experience their units creating joint plans with families that are SMART, and identify systemic training as critical to this. Now fewer cases are open longer than needed (part of children's social care improvement plan).

3.3.6.7. Recruitment and retention strategy

Get the right staff. Pay more, if you need to do that (chuckles) even in the short term. Recognise that it's going to cost you a lot of money to begin with but recognise that there's savings to be made, further down the line. (Manager 3)

There was a general consensus that future service transformations would need to pay particular attention to staff recruitment and retention policies as indicated in the excerpt above. Challenges in recruitment had a knock on effect such as the need to rely on agency workers to cover staff shortage which was very expensive.

So we, so I think you, if you looked at the figures, our agency staff, erm, the finance, budget, has probably gone through the roof covering some of the gaps (Manager 8)

As suggested by manager 3 earlier, it is imperative to consider increasing the salaries in Cambridgeshire bearing in mind that staff shortages had far reaching consequences such as lack of continuity for families which impacted engagement with families as well as with partner organisations. It was thus nearly a universal recommendation from managers to improve recruitment and retention policies in particular addressing the salary scales to match other local authorities. As stated in chapter 3.2, while high staff movement was identified by many groups as a problem, this is a national problem in social care, and may be less of a problem in Cambridgeshire than elsewhere (see p 117).

Comment from SW:WFF leadership team:

The Improvement Board have focused on recruitment and retention. Salaries in Cambridgeshire have been/are being reviewed.

3.3.6.8. Sustained engagement with partner agencies

While there had been consultation of stakeholders prior to the service transformation, there was some discussion around the need to sustain engagement of stakeholders as the implementation had a bearing on their work for example building stronger links with Locality and other internal functions such as Human Resources.

3.3.6.9. Clarifying the roles of Clinicians at the point of transformation

The clinicians played a vital role in the Units. However all the data including data from manager interviews suggested a need at the point of transformation to further clarify the role and remit of the

clinicians as well as setting realistic expectations on what the clinicians could achieve given the pressures of the work in the Units.

Comment from SW:WFF leadership team:

The experience locally is that this has now happened. Pressures continue given the difficulty in accessing other services that our families may require either from our partners in Adult MH or CAMHS, voluntary sector organisations, given the considerable pressure all services are experiencing in terms of increasing demands and reducing resources.

3.3.6.10. Clarifying the role of Group Managers

The role of the Group Managers had evolved over time to meet the ongoing demands of the service transformation. Future service transformations may benefit from an awareness of the demands of this role and thus providing the appropriate support and training to ensure that Group Managers are able to do their role effectively.

3.3.6.11. Flexibility with the model

Cambridgeshire had mirrored the structure for Hackney Social Work Unit. Are there other varieties of a Unit out there? (Manager 1)

Don't wed yourself to, the model, so it can't be changed (Manager 3)

While the SW:WFF model was very much appreciated by the managers, they recommended that future service transformations have a level of flexibility with the model and be able to tailor the model to address the needs of their particular local authority but still being able to deliver systemic social work. It may be useful for local authorities considering the model to build this in as an expectation.

3.3.6.12. Addressing the management training needs of Consultant Social Workers

Finally, we asked managers about training that could support best practice in the Units and there was a general consensus to have a training program in place to support Consultant social workers to fulfil their management role. This was largely because some of the social workers who were recruited to the post were excellent and experienced practitioners but with minimum experience of staff management:

The consultantsas I said earlier some of them have never been managers before so teaching them what supervision looks like and how do we know if it is poor practice and how do we challenge that so real supporting, teaching, modelling, reflecting...the whole lot. (Manager 4)

Yeah, I would erm go for management training, of, the CSWs, to give them more, management style training. So they've got the systemic training, I think the, the gap is, actually managing people, managing, time, managing, a unit, managing staff. (Manager 3)

Although Consultant Social Workers were already undergoing formal systemic training, it was suggested that having this additional management training would help support best practice in the Units.

3.3.7. Summary and Conclusions

In this chapter, we have described and explained the complex array of factors that shaped the successes and challenges of the initial implementation of the SW:WFF model by Cambridgeshire County Council. Managers were able to identify clearly the improvements in the services post the service transformation and gave illustrative case studies to show the improved work being done by Units as a result of the wider knowledge base from which they operated. There was an appreciation of how the social work delivered in the SWWFF model was safer for families and for workers. Managers reported staff being happier about the benefits of shared caseloads as work on the families they were involved in continued even in their absence.

There were some challenges that were identified by the managers. These were: fluidity of the Units; high caseloads ; the impact of the OFSTED inspections; lack of clarity about the role of clinicians and group managers ; challenges in embedding systemic practice . We have also managed to highlight some recommendations for other local authorities wishing to do a similar service transformation. These include:

- Managing demands
- Developing a robust staff recruitment and retention policy
- Sustained engagement of partner agencies
- Having clarity about the roles and remits of clinicians
- Having clarity about the roles of the Group Managers
- Providing support and training for Consultant Social Workers
- Being flexible with the model and tailoring it to meet local needs.

3.4. The Perceptions of Partner Agencies about the SW:WFF Model

3.4.1. Introduction

Some insights on the importance of collaborative working in addressing the complex needs of vulnerable children and families open to Social Care have been explored in chapter 1. These insights are strengthened by an analysis of the experiences of internal and external partner agencies of working with the Units. We build on the key themes described by families by providing a detailed description of the impact the service transformation has had on the collaborative relationships between Children's Social Care and its key internal and external partner agencies.

Interviews were conducted with managers of partner agencies. In addition to providing their personal opinions on SW:WFF, managers were asked to speak to their teams in advance of the interviews to gather team members' experiences of working with the Units. While most managers were able to ask their team members for feedback before the interview, a minority were unable to get feedback and presented their views on SW:WFF. The collective experiences of team members in the partner agencies have been used to write this chapter.

We collected data to understand whether the transformation to the SW:WFF model has influenced working relationships between partner agencies team members and children's social care. Data were collected to understand if adoption of the SW:WFF model changed the service social care provided to families. Particular attention was paid to narratives of what works well and does not work well in the SW:WFF model. Furthermore, partner agencies pointed out important lessons for managers of other social care organisations planning a similar transformation.

This chapter is divided into four sections. We begin by giving a brief description of the internal and external partners that participated in this interview. The second section is on aspects of the service that have improved since the service transformation. The third section is on perceived challenges and the last section is on recommendations that can improve services.

3.4.2. Description of Partner Agencies

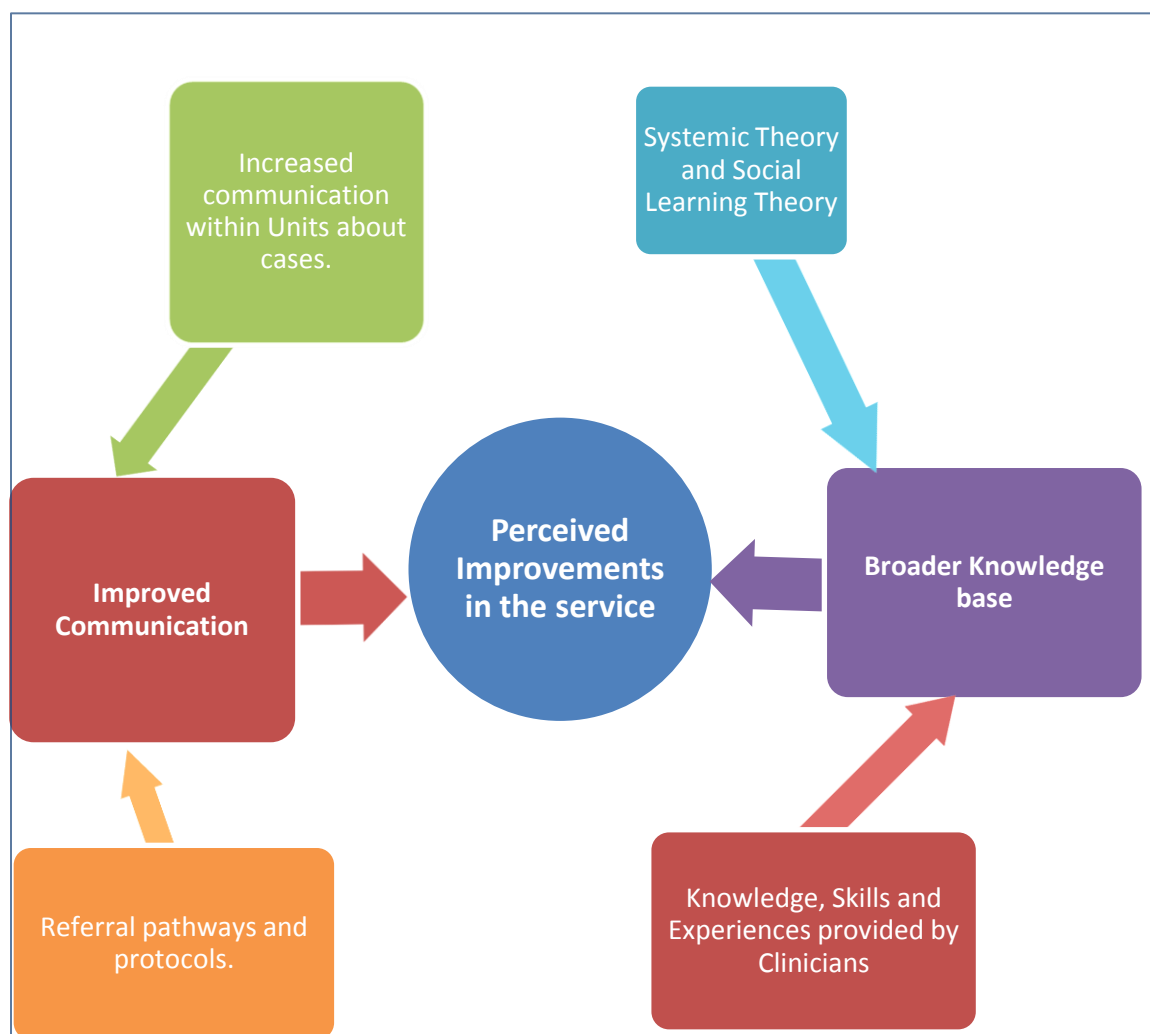
Eleven managers took part in the study, representing some of Social Care's internal and external partners. They were recruited from court and justice systems, health services, advocacy services and voluntary services. Agencies varied in that some only worked with families referred to them by Children's Social care. Other partners were able to make referrals to Social Care and vice versa. Collaborative work varied from occasional to very regular. Partner agencies worked with various types of Units including Access, CiN, LAC and Disability which allowed for narratives of varied experiences of working with the Units.

3.4.3. Perceived Improvements in the Service

I, personally I think it's, this is, this is a good way of working. I think if, if people are still working in older ways, they should look at this as the way forward.....I would say from my experience, this has worked well for us. (Partner Agency 10)

The excerpt above emphasises the perceptions from various interviews in which partner agencies identified definite improvements in the services provided to families and children after the service transformation. This was linked to improved communication within the Unit and with key partners as well as the broader knowledge base that the Units were operating from as indicated in figure 1 below:

Figure 1: Perceived Improvements in the Service



3.4.3.1. Improved Communication

Partner agencies indicated that there has been significant improvement in communication between their teams and Units. Team members valued the key role played by the Unit coordinators in ensuring that meaningful communication and relevant information sharing occurred. This improved communication allowed partner agencies to provide the appropriate services to families within the expected timescales as described by Partner Agency 4 and 2:

The development of the unit coordinators has been very helpful, and generally, having a coordinator there as a single point of contact, within that unit facilities, timely, interventions and information sharing. (Partner Agency 4)

What does work well is having the unit coordinators. So you know if you can't get hold of the consultant or the social worker, having the...the unit coordinator, who skill is being aware of the cases and able to update them on things, that's a real benefit. (Partner Agency 2)

Partner agencies valued the idea and experience of being able to get reasonable updates on a case from any of the members of the Unit. Furthermore partner agencies valued the Unit meetings which presented an opportunity for regular communication about the different cases. This meant different members of the Unit knew enough about the case to update partner agencies when necessary. Other partner agencies also noted that the Unit members were livelier because people talked to each other about cases and shared responsibilities even outside of the Unit meeting. In addition, this increased communication within Units meant that "families are more held" in the event of the case worker allocated the family leaving and there were no noticeable gaps to some partner agencies as other members of the Unit were able to keep track of progress on the case and update the partner agencies as required:

It's really good to phone a unit and know that at almost all times there is someone there who we can speak to who knows what is going on with a particular family. (Partner Agency 1)

Participants described some challenges in communication that were addressed by the adoption of SW:WFF. Prior to the transformation there had been specific challenges such as being unable to get updates on cases, being unable to get hold of relevant social workers or leave important messages reliably. It was the perception of most participants that these challenges had been addressed by the transformation:

This person was very keen to emphasise she feels the communication is hugely improved and that messages can be left reliably (Partner Agency 1)

I have spent... in the past hours and hours and hours and hours ...trying to get hold of a social worker or someone who knows the case or someone to speak to someone and just going to a voicemail or something. But that has not happened because there is someone that we can speak to so that seems to be a very big improvement. (Partner Agency 5)

A few participants also attributed improvements in communication to the presence of clinicians in the Units. This was of importance when Units made referrals for further intensive clinical or therapeutic interventions or when Units received referrals for social care input. One participant indicated how being

able to talk to clinicians in the Unit had removed the “historical mutual suspicion” between their agencies. Other participants did not necessarily attribute this to the presence of clinicians but thought that on the whole their teams and Units were less critical of each other and more willing to listen and understand the differences in opinions and professional practices:

I feel that erm, we’re working more closely with allocated social workers. There are still points of friction and still occasions where things go wrong and, and that there’s erm different organisation perspectives as well, that that contribute to that sometimes. But on the whole, I, I feel we’re working more effectively with, the social care teams in the unit model, than we were previously. (Partner agency 8)

While we are now recognising the benefits that both approaches a one size fits all and I don’t care whether it’s a multi-systemic approach or XXX approach, is not going to work (Partner Agency 4)

As indicated in the discourses above, it seemed that differences in opinion still occurred but there was an increased appreciation of the role of the different professional perspectives as well as the strengths and limitations of the theoretical perspectives that formed the ethos of the work done by different organisations. In addition participants reported being able to confidently raise concerns arising from these differences at management level:

I just think there is a probably more open attitude to hearing about concerns so for instance I raised a concern today with XXX. I haven’t actually read my emails but I read the first line and it started off positively. Whereas at one time I wouldn’t have got a response or it might have been quite defensive and I think I wouldn’t have done it by email because it would have been too delicate. I would have needed to have a face to face conversation. But I feel as if confidently people will receive what I’m saying in a positive, in a kind of open way whereas previously I didn’t think they would. So you know it’s moved on quite phenomenally in that sense. (Partner Agency 7)

While the above participant acknowledged the changes in communication post the transformation, they were not convinced that the changes were necessarily a product of the transformation but perhaps because the transformation had brought in new people, new managers and thus new personalities who were more open to receive and act on feedback from partner agencies:

Interviewer: Ok, thank you for that. And how much do you about the service transformation in children’s social care and have you noticed any differences?

Partner Agency 7: Erm...how much do I ...I know a lot about it. I know all about the plan of what it was aiming to do and have I noticed any differences? Well I think the differences aren’t necessarily because of

the transformation in terms of Units but the differences I have noticed a desire and leadership from social care [management] to ensure staff work together positivelyErm I think personalities are really really important and I know they shouldn't be so important but they are (laughs)....And I think more recently there's been a change in management in social care that has have just made it easier to work together.

There was general consensus that Children's Social Care managers had made great efforts to engage their various partners before the service transformation. As a result, all participants were aware of the service transformation. In some instances this initial engagement had been sustained over time and improved communication with partner agencies through the joint development of clear referral protocols. It was reported that in some instances, managers had engaged external and internal partners in the development of the protocols and referral pathways. This gave clarity to partner agencies on when and how to make or accept a referral.

But Social care erm...over the recent months and years the relationship has been much clearer through a number of protocols being put into place but also by greater expectation of communication and joint working between our teams and social care. (Partner Agency 7)

Moreover the service transformation was understood to have clarified the thresholds for social care involvement. These had previously been a source of contention as some partners were not really clear why some of their referrals were declined and had the impression that the thresholds were not fixed which made making referral to social care difficult:

They were rewriting the thresholds and so at a point in that process that document, in the draft format, that document was made available to us for comment. Erm, and, and, and I think that clarified things a bit and made us less concerned that, that thresholds might sort of move about we had a perception that, erm, er that they kind of moved, moved up and down. (Partner Agency 1)

Post the consultations, it had become clearer what these thresholds were and made communication and referral between partner agency teams and Units much easier. However, there were other agencies that reported that referral pathways between them and Social Care were still vague and there had not been a platform to explore how to make referrals or discuss the type of referrals that were appropriate. Referrals were made by Units who were aware of their services rather than on a clearly laid out protocol. While there was an acknowledgement of leaders in social care making an effort to improve working relationships with partner agencies, there were some reports of significant deterioration in

collaborative relationships after the transformation as described by Partner Agency 2:

I tried to make links with the XXX (senior managers) and to talk to them about referral pathways but well... since the Unit model they don't see us anymore. They also don't see what we are doing. We are still doing as much referrals or maybe even more but it's not acknowledged. So in a sense what was positive before the model is that we were much more visible within Social Care but not anymore (Partner Agency 2).

The above participant shared their view that perhaps there had been a presumption within Social Care that the SW:WFF model was able to address all the needs of the family through the presence of the clinicians in the Unit thus requiring less reliance on other partner agencies. However, they argued, after SWWFF was adopted, it had become apparent that specialist services were still required but no action had been taken by senior management to make clear referral pathways. In the opinion of this participant, while clinicians and Units on the ground had this understanding of the need for collaborative work to meet the needs of the family, this need seemed to be less clear to management.

3.4.3.2. Broader knowledge base

One of the changes highly acclaimed by the partner agencies was the evident broader knowledge base within the Units. This was perceived as emanating from the systemic and social learning theory as well as the input provided by the clinicians. The combination was seen as improving services for families by allowing social workers to explore issues with the families in different ways:

So yeah yeah it's hugely beneficial to have another discipline within the Unit erm which would take a slightly different view on what is happening in the family or have a different hypothesis as to what's happening and all that. I think it's really it's a positive...I think it's a real benefit to the family and Unit but also the department. You don't have so much tunnel visionOh we know this family, we've worked with this family for yearswe know what they are like and this is why they are doing it. (Partner Agency 3)

Different participants acknowledged that the clinicians improved practice by helping the social workers to explore alternative reasons to explain vulnerability and risk in families. They also reported their opinion that the transformation challenged social workers to explore alternative areas to focus their efforts on in order to support the families to create the required change. Some of the participants were

able to cite examples of social workers' creativity when working and supporting families as well as social workers tackling specific family challenges as opposed to just making assessments:

Erm, there was a great example that one of the workers mentioned about, with this, this particularly vulnerable young person and partner and baby. They felt that the systemic approach actually was very evident. Then the, then the number of people from the Unit who are all very au fait with the case, and the very creative whole family approach which was very noticeable. (Partner Agency 6)

Furthermore partner agencies had noticed a shift post the transformation in that the social workers used the theoretical perspectives to identify the strengths and positives within the families:

My colleague has noticed a sort of change in focus, or a change in emphasis, in meetings. Er, these might be professionals meetings about a child, or they might be child in need meetingson the part of social care, which she calls a 'strength focused' way of speaking by which I think she means, she notices that, that social workers are more likely to accentuate the positives about families and the resilience factors about families, which she says is very helpful. (Partner Agency 1)

As discussed in the previous chapter, the above approach was very much appreciated by families as it translated into a respectful positive working relationship with them, which was very important for their engagement. This approach was also evident even in very difficult circumstances such as child protection:

Their work was excellent from the Unit, because we could, could speak to, make contact with the unit, and the unit coordinator was very informed.....There were some difficult decisions taken as part of it, beingerm, being subject to a, a child, a protection plan isn't a happy decision for anybody but within that, I think the family felt respected and, and their views listened to and taken into account at least, even if they weren't agreed with. (Partner Agency 6)

Some partner agencies noticed the level of detail and knowledge displayed in professional meetings that emanated not just from adoption of the systemic or social learning theory but the collective thinking from Unit meetings. It was the opinion of some of the partner agencies that the SWWFF model reduced reliance on individual skills as several workers were able to contribute to management of cases:

Previously it (social work practice) seemed to be more, reliant on, an individual worker, having capacity and having the specific skills, knowledge and experience to deal with the case. So if you, if you had a, a

particular child protection issue or a erm, some particular concerns if you had a very skilled social worker with time available then you'd get very, very good response. And they'd be very proactively engaged. The benefit with the Unit model is that its less, less based on an individual worker Erm, and, if a worker is less, confident, I dunno then usually there's other, other workers as well that they have, they have broader discussions within the teams so, rather than being based on one person's skills or lack of skills, erm there's a broader range of those available (Partner Agency 3)

Several other participants also commented on the positive differences in the social work that was being delivered by some Units as a result of being able to draw on the skills and experiences of various members. This was particularly important for newly qualified social workers as the Unit model offered them the opportunity to learn from other experienced social workers thus providing better services to families. It was the opinion of some of the partner agencies that this wider knowledge base gave social workers confidence to take action on matters which they did not do prior to the service transformation:

We used to find with individual social workers, erm, they tend to be very, erm, averse to taking action perhaps on, on an urgent job. And we've, obviously opinion of that's reduce and that actually that's not the case anymore. (Partner Agency 10).

In addition, the clinicians were valued for their input pre legal proceedings as there was evidence of more work being done in preparation for these. Moreover, clinicians were seen as offering a cheaper and quicker alternative to independently recognised experts, albeit the experience and expertise of the clinicians was variable. Overall, social workers seemed more confident about the input they required from other partner agencies in proceedings as they appeared more certain in their opinion and able to respond appropriately when their opinions were challenged by partner agencies.

Finally, clinicians were also valued for their wider knowledge of other services. As such, they were able to signpost and make referrals for families to relevant specialist services. Some agencies reported receiving referrals from the Units via the clinicians who knew about their expertise on supporting families in different ways. Such agencies valued being invited to the Unit meetings to be able to provide regular input on the management of cases.

This section has been on some of the perceived improvements in the services that were discussed by the partner agencies. Below we discuss the challenges that were identified by partner agencies.

3.4.4. Perceived Challenges

I'm not not-positive about the Units. I just think they were probably there were expectations raised about how they were gonna function and I don't think they are functioning as they were intended to when they first started and I don't think that's been communicated and so there's a sense of maybe disappointment.

(Partner Agency 7)

Although there were some positive changes emanating from the service transformation, participants identified some challenges post service transformation. There were narratives to the effect that some aspects of the Units were not actually functioning as had originally been discussed during the consultations. The challenges identified by participants were:

- levels of direct work with families
- Variability of practice
- Family transitions between Units
- High staff movement
- Differences in professional practices and levels of partner agency engagement post the transformation

These are indicated in figure 2 overleaf:

Figure 2: Perceived Challenges



3.4.4.1. Levels of direct work with families

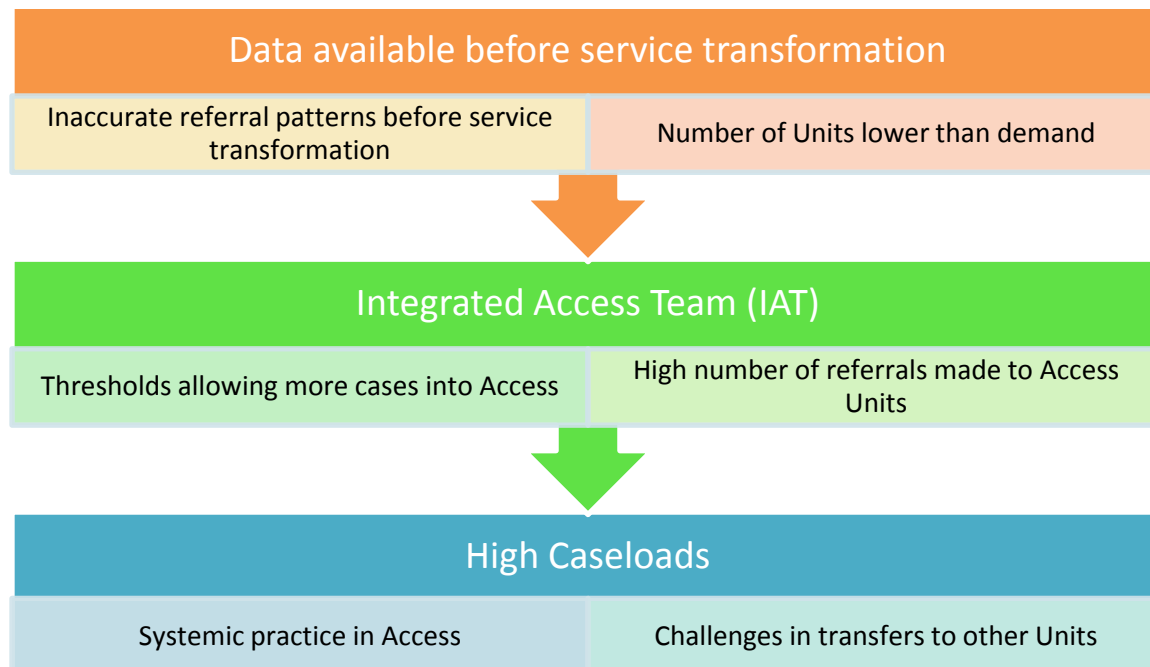
It's almost like they have gone from having these big teams that were really really busy who didn't have enough time to do direct work to having smaller Units who are really really busy, who don't all some do, but some don't have enough capacity to go and do the work they were supposed to do and that's the whole point of the Unit and..... I think that's really sad. (Partner agency 3)

I think there is probably a bit of disappointment around Units if I'm gonna be really honest. In that I think they were certainly promoted as being an entity that would do sort of complex work and also practical work and roll up their sleeves and get stuck in. I think there is a sense that they are not able to do that because of demand I think the demand has been greater than anticipated. I think there is sense maybe that it's not working as well as it could be. (Partner Agency 7)

While some Units were able to do some direct work with families, there was some disappointment expressed by some partner agencies around the low levels of direct work with families from some Units. This was not discussed as a criticism on the part of the Units but an acknowledgement that although the Units and the whole ethos of the model was increased direct work with families, the Units were under

immense pressure due to high caseloads and did not have the capacity to function in the way they had been promoted. It was the perception of some of the agencies that the Units were carrying higher caseloads than appropriate for the Unit model and which made systemic practice harder and direct work with families impractical. Participants had a variety of opinions on reasons for the high case loads; they felt they were a product of challenges within the system which all had a knock on effect on the Units as indicated in figure 3 below:

Figure 3: High caseloads



It was also the impression of some of the partner agencies that the number of Units in Children’s Social Care did not meet the demand for services. While it was acknowledged by various participants that a lot of planning had gone into deciding the number of Units, there were some questions from participants on whether or not there had been accurate data available at the time of the transformation to make accurate predictions of the number of Units that would be able to sufficient meet the demand:

I’m not sure how much how accurate the data was at the time of the transformation. I think they felt there were enough Units to meet the demands and of course demand does go up and down particularly around child deaths. I don’t know how much contingency was factored in around that known fact really, so I think there’s some learning about that. (Partner Agency 7)

As discussed in the quote above, there were some comments from the partner agencies to the effect that more attention could have been paid to the referral patterns and an increased understanding of the local needs in determining the number of Units required. The current number of Units was lower than the demand commonly perceived by participants, which meant that the Units had more cases than they could handle. There were comments on the lack of contingency plans for difficult times, such as child deaths. This sometimes resulted in the use of agency workers and there was a reported over-reliance on this group of workers, as indicated in the dialogue below:

Interviewer: What specific things do you think could be improved?

Partner Agency 4: Well, from again from this, is from the frontline workers is the, their perception is there's an overreliance on agency workers

The use of agency workers was seen as leading to problems. It was associated with a lack of continuity for families and possibly variability of practice as will be explored later in this chapter.

Although an accurate description of thresholds in IAT (Integrated Access Team) was provided to the researchers, several other different participants thought the high case loads were an indication of further work that needed to be done with the IAT to review the thresholds for Social Care and possibly reduce the referrals made to Access Units:

There's a lot coming into Access that needs to come out, and actually the CIN Units don't have enough capacity to take on. So there are some issues about front door potentially. So IAT, so the amount that actually goes into Access. Access having too much and then there's a block about where it goes next. You need to strengthen the assessment in the IAT. (Partner Agency 7)

I think some of the referrals that are coming in whether they are actually appropriate social care referrals or whether they should have been picked up earlier maybe they should have been picked up earlier. Perhaps there shouldn't be so many referrals that come through in the first place. (Partner Agency 3)

It was thus the impression of several partners that the high caseload was an indication of the need to fix the "front door" of social care in such a way that fewer referrals actually went into the Access Units and that cases were referred to other relevant partner agencies.

Other participants were unsure about the appropriateness of the systemic practice at the Access level:

Yeah, I question, this is my own personal thought, whether they should even be doing the whole err, systemic part at Access? Erm, because, they're going in, and doing the assessments basically to figure out what support's needed. I think the systemic practice is probably better done at, the CiN level..... (Partner Agency 9)

The participant above thought systemic practice potentially made the Access Units hold the cases longer resulting in a higher case load when the Units were on duty as they would still have cases open. Perhaps this perception was because the partner agencies were not sure if Access Units were meant to do more work than carry out assessments with the family.

The reduced ability to do direct work with families was thought to also be a product of the amount of paperwork that Units had to do:

Erm, workers previously spending eighty percent of the time doing the paperwork and twenty percent with families, and that being completely the other way around, there's no, sense from us that, that's the case. It doesn't feel like the paperwork's been reduced and doesn't feel like the unit coordinators been able to erm, soak up that majority of work. So it, it feels like some of the, promises that were, were given about that, just haven't, been reality at all.... (Partner Agency 6)

The paperwork that workers had to do was linked to the Ofsted benchmarking review and report, a process that had increased pressure on the workers for paperwork. As such, this was experienced as having impacted upon the amount of time that the Units had to do direct work with the families.

Finally, reduced levels of direct work were thought to emanate from social workers being very busy doing the work that had previously been done by unqualified staff. Service transformation was seen as having removed the role of the unqualified social work staff, and there were some questions as to whether or not this move had actually been appropriate. Given the high demand on the Units and the amount of work the social workers were expected to do, it was the perception of some of the partner agencies that unqualified staff could have been integrated into the Units to assist with some of the less skilled tasks that kept the social workers busy and thus unable to do direct work with families:

There's sort of more routine sort of tasks that the old alternatively qualified staff used to do in the bigger teams that there isn't actually anybody now that can do it. So there is a bit of a sort of gap in terms of taking sort of monitoring roles what they might call what seniors managers might call "Runners" that type of thing, which might undertake these other little tasks. These other tasks that other people used to do,

they don't go away because you have a Unit model...that's probably what I am trying to say. (Partner Agency 3)

Other partner agencies thought there was a down side to having the alternatively qualified staff in the Units, as previous experience had shown that they were sometimes asked to perform tasks that were only meant for the social worker to complete and thus bringing risk to families and to the local authority.

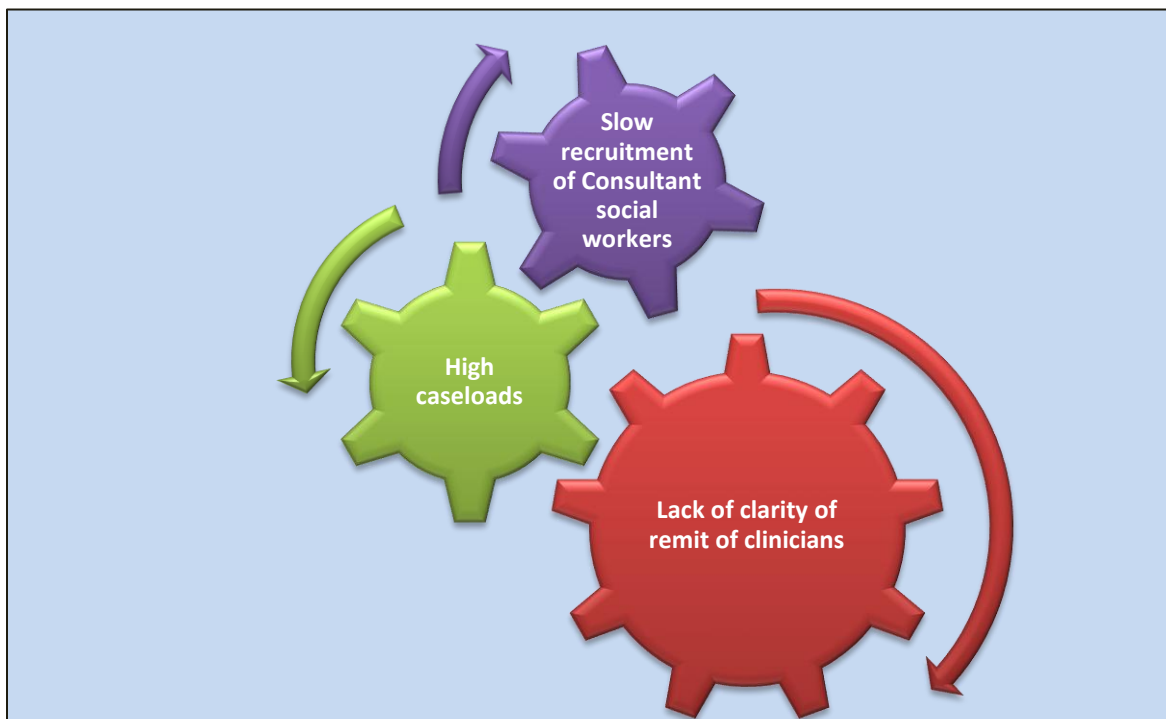
Comment from SW:WFF leadership team:

Since the interviews, work has been done with the IAT to review the thresholds for Social Care.

3.4.4.2. Variability of practice

Very closely related to concerns about the levels of direct work, was the theme of variability of practice across the Units. This was one of the main challenges discussed by participants. There were various factors that were described as contributing to the inconsistency of practice including high caseloads, lack of clarity of the remit of clinicians and the slow recruitment of consultant social workers into post as indicated in figure 4 below:

Figure 4: Factors contributing to variability of practice



It was the perception of some of the participants that the high and fluctuating caseloads meant that Units were unable to consistently provide the same levels of direct work with families. There were some opinions that when demand was high, Units were overwhelmed and did less work with families than when case loads were lower.

It was the perception of some of the participants that there was variability in the level of involvement of the clinicians in the different cases:

Some clinicians will do hands on work with families...whereas others seem to see their role as purely advisory to the frontline social workers....Erm, and therefore are more inclined to want to pass on more work, direct work on to us, clinical work which my colleague feels should be in the specialist clinicians remit; given that they are often quite highly qualified and clinically trained. (Partner Agency 1)

While all participants were pleased about the addition of the clinicians to the Units, there was some uncertainty about the actual role and remit of the clinicians. Some teams from the partner agencies reported being unclear on whether clinicians were meant to be supporting assessments made by social workers or if they were supposed to make relevant clinical assessments of the families and provide therapeutic intervention. Participants therefore reported some inconsistencies between the Units in that some clinicians played an advisory role to social workers while others provided interventions to the families.

Furthermore, in some instances, the clinicians were able to support the social workers to make assessments and determine the required interventions before making referrals to specialist services whereas in some instances Units did not make a very informed assessment or determine the exact support they required before making a referral to specialist services:

I think probably one of the other difficulties with it is the inconsistency across the county because you have so many different units, erm, what works, how people work in one unit might be very very different to how people work in a different unit that could be their geographical bases or their discipline, actually. It can work differently. (Partner Agency 3)

It seemed important to the partner agencies to be able to clearly define the roles and remits of the clinicians and thus be able to manage expectations on what they could do with families. It was unclear from the data why some clinicians were able to do more direct work with families than others. Some

participants thought it was because there were not enough clinicians employed by the local authority to enable them to do direct work:

The perception, from the frontline workers from our team is there's not enough clinicians, therefore, it's difficult to get hold of the clinicians, err it's difficult to get them engaged with, relevant cases. But I wouldn't be able to statistically evidence that. (Partner Agency 4)

Others participants thought variability in clinical input was possibly because management had not clearly defined to the Units and or the partner agencies the roles and the remit of the clinicians. Thus it was unclear how much work they were expected to do before making referrals.

Furthermore, the variability in practice was perceived as lack of recognition on the part of management of inconsistencies that could emanate from clinicians having very different skills, qualifications and experiences. This was thought to give clinicians different capability to handle or support the families. Although they were using the systemic and social learning approach, there was some suggestion that a more basic and universally-provisioned set of pragmatic interventions, that all the clinicians could give to families, would be of value - rather than relying on the happenstance of individual trainings, skills and experiences:

When I see clinicians, everybody is doing a little bit of what they know. They're doing the best they can but there is no consistent model. It's not systemic theory that will make an intervention effective; you need much more hands on pragmatic interventions, rather than to do the broader systemic therapy or social learning theory. So the management don't understand what clinicians need. (Partner Agency 2)

Similar perceptions were raised in the family interviews when some participants thought a clearly defined "loading dose" intervention/introduction would clarify and simplify expectations from families on what Units were able to do and whether or not they were able to provide therapeutic interventions.

Variability of practice was also explained as a product of the challenges that the local authority had faced in recruiting people to the post of Consultant Social Workers. Some of the partner agencies thought that the Units without access to consistent consultant social workers struggled to provide consistent practice. This was to do with the team dynamics changing when Units had interim consultant social workers followed by a new appointment to the substantive post. Having several changes in the

consultant social workers effectively meant a change in the management of the Unit and thus variability in practice.

Comment from SW:WFF leadership team:

There has been work since the interviews to reduce variability in practice, including: improving the clarity of the clinicians' role; and making the 'clinical offer' in Cambridge more clearly defined, focusing on evidence-based interventions, involving more joint work between clinicians to share skills base, and providing more equity across the interventions provided for families. This is seen as a set of developments that are ongoing, and that over time has been produced by a clinical team with greater experience of working together in this setting, and working with more integration in the organisation as a whole between the systemic approaches and the social work task. It would be interesting to return to these partner agencies to establish whether this change is also experienced by them.

3.4.4.3. High staff movement

It was the perception of some of the partner agencies that the Unit model had not addressed high staff movement. This theme was pertinent to several partner agencies. Two partner agencies explained the high staff movement as a product of high stress levels emanating from the high caseloads as well as the low salaries paid to social workers in Cambridgeshire:

Interviewer: Do you have any idea why there is such a mass turnover of people?

Partner Agency 3: I mean I do see people very distressed, very upset, very stressed about you know the amount of work they have ...if you go into any of the areas and you sit there and any point in time you can see people in tears , very very stressed ...not wanting to stay....and... So without going up to them like why are you so stressed why you do want to leave I don't know but I can only surmise from that they are not happy and they don't want to do the work whether it's just this county or they just don't want to do the work I don't know.

The salary scale, for social workers, in Cambridgeshire, is comparable with, a whole host of other, erm, professional roles, that do not carry the same risk and responsibility as social workers. As far as I'm concerned, you need to be paying social work staff, err a wage that's construing with the risk and the responsibility that they hold. (Partner Agency 4)

It seemed important to partner agencies to resolve the issue of high staff movement, as it is seen as impacting negatively upon the continuity of their collaborative work with families. High staff movement meant that it was difficult to build collaborative relationships with the Units:

And, you know you go back to the Unit and think such and such is in the Unit alright, but no they are not they have moved on to this unit now or they have gone on maternity leave (laughs) or gone somewhere and it's really difficult to know where people are. That's probably one of the hardest things and you didn't have that as much in the teams obviously people left and moved on but it was more it felt more stable.
(Partner Agency 3)

Due to the Units being smaller than the teams, the impact of high staff movement was much more noticeable than in the teams. It was more challenging for partner agencies to be able to build relationships with a fragile workforce as new staff were sometimes unsure about the services they provided, and partner agencies were unable to keep visiting the Units as they changed to tell them about the services they offered. Some partner agencies had been able to get round this by attending practice meetings when they got invited or passing information to senior managers with the hope that this would be filtered down to the relevant Units. However there were narratives to show that meetings with high level managers where there was an expectation that information would be passed down to relevant people, did not always have this intended outcome:

There is little engagement there and sometimes I have emailed XXX (managers), I invite them to all kinds of things, I send documentation around but then it goes into their little pot and they close the doors. So they are not working very collaboratively with other agencies as a team. I'm not saying individually but as a team. ... I have provided information to the managers but it doesn't go anywhere (Partner Agency 2)

I mean we go to the Managers meetings that's what we tend to do so they can disseminate down. What ...what can happen is sometimes the meetings get cancelled or they don't take place. (Partner Agency 3)

Furthermore some partner agencies were not actually invited to practice meetings for various reasons, including the perception from senior management that the Units were well aware of the services they provided and did not need to be reminded. However the partner agencies reported that this was not always the case as their referral patterns indicated that referrals were usually from the same Units and the same professionals. When staff left the Units then this link and referral pathway was lost and this affected collaborative practice.

3.4.4.4. Families being moved between different social workers and Units

One of the issues partner agencies expected to be resolved by the Unit model was transition of families between social workers as well as between Units:

Erm ... I guess it's important to be clear about what's realistic cause it feels like quite a lot of, of promised commitments were given at the time. So, having one unit working with the family for the whole duration. The reality is its probably five units. (Partner Agency 6)

Well I think that...you know one of the things that I was a bit disappointed with right at the beginning was having Access and CiN Units. Cause I thought some of the principles were about kind of keeping continuity and consistency and not too many changes. (Partner Agency 7)

As highlighted in the quotes above, some participants expressed disappointment about the number of transitions that families made between Units and social workers. Movement between the Units was perceived as reducing continuity for a family who had to build new relationships with workers each time they were transferred to a new Unit. Data from the family interviews indicates that Unit transfers potentially reduced engagement of the family with the social workers as they often had to retell their stories.

3.4.4.5. Differences in professional practices

In some of the reports by participants, the SW:WFF model had made the differences in professional practices more pronounced. For example some partner agencies had thought that adopting the systemic approach would result in a more holistic approach rather than the focus on safeguarding as discussed by partner agency 7:

I've observed a Unit meeting actually and I don't think it was really a move in the right direction. I still felt it was a little bit narrow in its focus. It was very sort of focused on the emotional needs, safety needs and I suppose I had an aspiration for the Unit model being much more holistic And I feel a bit sad about that because I think it's a missed opportunities in terms of really changing families lives but then again I think its demand safeguarding is our business we need to tackle that and then we need to move then on because actually there's more coming in. (Partner Agency 7)

However, it was acknowledged that safeguarding was a core value for social work. Furthermore various partner agencies recognised that the differences in professional practices required sensitivity and an

acknowledgement of the importance of each professional approach in addressing the needs of the families as discussed in earlier sections.

There is a perceived need to be accommodating in organising inter-agency meetings, such as safeguarding conferences or child in need or review meetings, in order to enable partner agencies to attend and support the children:

It's just sort of logistical things, such as, erm, er, safeguarding conferences being called at such short notice. We kind of understand they have to be, but my team work to capacity, they book work up to three months ahead, sometimes more, and sometimes we can't just drop things in order to attend the meetings. And I don't think that's a complaintbecause I don't think that there's a solution about, but, sometimes, you know, we feel we really need to be at meetings, but they got called and we can't go to them. (Partner Agency 1)

I think ability to attend meetings is something that needs to improve because we are all busy. In the past if someone from our organisation was unable to attend a child care review or something (pause). It is frowned upon if no one attends and sometimes we feel that Social Care do not have an appreciation of the fact that we tight schedules, we have our core business and we can't just drop it and so on but vice versa. When we have a meeting that we feel is essential for a young person and we try and arrange a multiagency meeting to accommodate everybody so that we can address the needs of the young person sometimes there isn't always a social worker able to attend. (Partner Agency 5)

As illustrated in the discourses quoted above, the logistical problems were not necessarily to do with the Unit model but more to do with the differences in professional practices and priorities and schedules which sometimes hindered attendance at meetings. It appeared that the significance of meetings is measured differently in the different partner agencies. With this came disappointment over the short notice sometimes given to attend meetings organised by the Units, or not having representation from Children's Social Care at other meetings that were judged important to some partner agencies.

Although it was acceptable to some partner agencies that Children's Social Care services had not been able to attend important professional meetings or conferences, other participants felt that persistent inability to attend strategic meetings by senior management for example communicated a message that that particular partner agency is not important to Children's Social Care. This hindered collaborative partnership working, interpreted as it was as a lack of acknowledgment by senior management in Children's Social Care services of these partner agencies' efforts to help families.

3.4.4.6. Sustained staff engagement

While it was recognised that Children's Social Care Services had made every effort to engage various partner agencies before the service transformation, it was the perception of some of the partner agencies that engagement could have been sustained even after the service transformation had taken place. It was reported in some instances that there was no clear communication of the implications of the service transformation on partner agencies. Some agencies reported a lack of communication to warn them that the Unit model would increase demand for their services, a shift that was attributed to the Units' adoption of systemic thinking which is interpreted as affecting expectations about the work loads of their own teams.

Some other agencies reported some animosity, stemming from a perception that in the Units their services were seen as no longer being required following the service transformation. Although in the experience of these agencies, collaborative work had continued at the same level, and in some instances increased demand had to be accommodated, the process of feeling excluded included what they saw as subtle communications that their services are no longer needed at the same level since the transformation; this appears to have affected working relationships. This animosity was more apparent at management level than at the team and Unit level as indicated in the discourse below:

Partner Agency 2: Before the model.....the managers were very much involved with us. They came to our conferences..... But well... since the Unit model they don't see us anymore.

Interviewer: That's surprising because I have heard you mentioned a lot in the Unit meetings.

Partner Agency 2: It is much better. I think people are now much more settled. That is on the ground but not high up.

Interviewer: Are you saying within the Units there is recognition of your services and your input but probably in management or higher up your role is not quite recognised?

Partner Agency 2: Yeah, the managers have cancelled nearly every single meeting. So it's not important enough to them. It says something when they are not turning up for the meetings.

The teams represented by the different managers had also expressed the need to be kept informed about practical issues such as how to contact the different Units, who the people in the Units were and where they were located:

So when we had the teams, erm, (pause) I suppose it was much easier to be able to identify where people where, and what, erm,.... (pause) ... whether they were in access or whether they were in CIN. Whereas if

you just tell me the unit number, it can be quite difficult to know where people are; both in terms of geographical base, erm, what discipline they are sitting under, erm, and actually whether they are still within that unit. That can be quite difficult to stay on top of really. So that, (pause) that really I suppose is more of a negative. (Partner Agency 3)

Erm but, but err well I suppose one of the things was around confusion, given that the dozens of different numbers and, numbers don't really help you identify where, where people are and what they're, what they're about so that's been there, a complexity I think (Partner Agency 6)

Clearly from the excerpts above, these apparently minor details of interagency communication were very important to teams in partner agencies, as it made it so much easier to be able to find relevant people and Units and thus improve timely support for families.

Having presented the improvements and challenges in the services after the adoption of SW:WFF, we present the recommendations from partner agencies on how to improve the services provided to families.

3.4.5. Recommendations

Based on the discussions in the above sections, the following are some of the key recommendations from the partner agencies:

3.4.5.1. Manageable caseloads.

In order to enable Units to practice systemically and to do the direct work with families expected in this model, it was important to several partner agencies that Units have manageable caseloads. There were four suggestions on addressing caseloads for the Units:

- One of the suggestions made to manage caseloads was to increase the number of Units. It was suggested that management re-examine referral patterns and make an accurate determination of the number of Units that would actually be able to meet the current and future demands for Cambridgeshire. It was also suggested that there be some contingency in the planning of Units.
- Alternative suggestions to managing the case load included employing the alternatively qualified staff in the Units to do some of the routine tasks for social work staff so that the social workers could do more demanding direct work with the families.

- The third suggestion was around re-examining and reorganising IAT in particular a critical examination of the thresholds so that only the cases that were in need of social care services got into Access.
- The fourth suggestion was to remove systemic practice from the Access Units so that Access Units only focused on assessments and the systemic practice was left to the long term Units CiN, LAC and Disability Units. (This point has been partially addressed within point 3.2.1.4.1 regarding the learning about the usefulness of systemic practice to the core social work task.)

It was the perception of some of the partner agencies that addressing the caseloads would reduce the work related stress and possibly improve staff retention. Moreover addressing the caseloads was thought to be an important strategy for addressing variability of practice.

3.4.5.2. Improving staff recruitment and retention policies

There were three main suggestions around staff recruitment and retention:

- It was suggested that the requirements for the consultant social worker posts be much clearer at advertisement and recruitment. It was reported that there had been several applications from staff that had been unsuccessful when the posts were still left unfilled. It was suggested that the recruitment process be tailored in such a way that applicants are made more aware of the requirements for the post and better prepared to ensure timely recruitment to the post.
- Cambridgeshire was said to have lower salaries for social workers than other local authorities in the region; it was the perception of some partner agencies that if salaries were increased to match other counties and working conditions improved this would improve staff retention.

Given the importance of continuity to partner agencies and families and the implications of high staff movement that have been discussed in this chapter, it is important to improve staff retention.

Comment from SW:WFF leadership team:

Salaries are currently being reviewed. Unfilled posts reflects the reflects the retaining of high standards re: recruitment of suitable candidates

3.4.5.3. Reducing work related stress

It was suggested that managers make the effort to reduce the work related stress for front line staff in an effort to ensure that staff stayed in the posts for a longer time. This was important for reducing staff

movement and providing continuity for families. It is important to put this into context from the findings from staff that the new SW:WFF model is less stressful than its predecessor.

3.4.5.4. Providing continuity for families

There were some suggestions around re-organising the Units so that there transfers between Units and changes of workers could be minimised. One of the suggestions to achieve this was by having Units that did both assessments and long term work, and ensuring that the number of transitions was reduced.

3.4.5.5. Pragmatic interventions for clinicians

One of the findings of the research at that time was to address the variability of practice by providing clear definition of the roles and remits of the clinicians. Although all units and clinicians were using the systemic and social learning approach, there was some suggestion about developing universal pragmatic interventions that all the clinicians could give to families, rather than relying on a matching of individual skills and experiences which are very varied. Independently of the report the clinician team is responding to this ongoing challenge as outlined in point 3.4.4.2.

3.4.5.6. Setting realistic expectations

One of the findings of the research at that time was a key recommendation from partner agencies regarding the importance of setting realistic expectations of the outcomes of the service transformation. It was also important to be able to openly discuss with partner agencies when these outcomes were not met.

3.4.5.7. Maintaining good working relationships with partner agencies

Sustaining partner agency engagement was important to most of the participants. It was suggested that good working relationships be maintained by increasing invitations to relevant practice meetings and or Unit meetings and giving more notice for meetings. It was also suggested that regular communication on changes in the Units be made available to teams in the partner agencies so that team members would know where to find people. It was also important to partner agencies to have very clear referral protocols.

3.4.6. Summary and Conclusions

In this chapter, we have described the experiences and the impact of the adoption of SW:WFF model on collaborative working relationships between the Children's Social Care and its partner agencies.

Partner agencies were able to clearly identify the improvements in the services post the service transformation. There was a definite improvement in communication within the Units and with partner agencies. This enabled effective information sharing and timely provision of support and services to families. Partner agencies have acclaimed highly the broadening of the knowledge base from which the Units operate, and thus value the systemic and social learning theory as it gives Units innovative ways to address some of the challenges faced by vulnerable families. The support provided by clinicians to the Units was also very much appreciated.

There were some challenges that were identified by the partner agencies at the time of the interviews. These were: levels of direct work with families; variability of practice; the number of transitions families made between Units; high staff movement; differences in professional practices and levels of partner agency engagement post the transformation.

We have also managed to highlight some ways to improve the delivery of social care services. These include:

- Ensuring that the Units have manageable caseloads.
- Improving staff recruitment and retention policies.
- Setting realistic expectations.
- Increasing continuity of care for families.
- Maintaining good working relationships with partner agencies.

4. Discussion and Implications of Findings

4.1. Introduction to Discussion

This discussion will start with describing the strengths and limitations of the evaluation.

There will then be a chapter where the most important key findings from all four participant groups will be presented in brief (one page each), as a quick and easy summary.

We shall then bring together the results from all participants into a discussion chapter, again splitting this into improvements, challenges and recommendations. This will draw on all the data presented in section 3, and will not be limited to those key findings summarized in section 4.3.

We shall finish by presenting our final conclusions.

4.2. Strengths and Limitations

4.2.1. Strengths

The main strength of this evaluation is in the in depth qualitative interviews and subsequent detailed qualitative analysis from four key participant groups working in, and being affected by, the transformation of Cambridgeshire children's social care: families themselves, social care professionals working in units, social care managers, and managers of partner organizations. Such analysis has given us a wide range of ideas about the strengths and challenges of the SW:WFF model, and suggested some recommendations that could be considered by managers. Our findings carry particular resonance when confirmed by multiple participant groups, as has occurred.

4.2.3. Limitations

The evaluation had ambitious plans to carry out longitudinal quantitative and qualitative data collection and analysis from multiple participant groups. Due to the difficulties in recruiting client families, the research was scaled back (as detailed in sections 1.3 and 1.4). This meant that we were not able to achieve the primary goal of this study: to evaluate whether input from the SW:WFF unit model improved outcomes for families.

We were still able to collect large amounts of baseline data. In particular, we were able to carry out the planned baseline in-depth interviews and subsequent qualitative analysis on all four participant groups. Qualitative research is designed to do some things, but not others. Its primary purpose is to map the range of perspectives and meanings that participants take in respect of the subject under study, trying to illuminate the fullest range of themes that emerge. Qualitative research does not summate emerging themes as if that might determine which are the most important ones for the target audience; although they do detail the themes most important to the participants that have been included. One way of understanding this is that an insight about something (particularly something as complex as a service redesign) may only be held by one person, but it may still be correct and very important; qualitative methods are designed to ensure that such an insight is not simply lost because it has not (yet) been

noticed or generally accepted amongst the wider participant body. Qualitative research may thus stimulate further *quantitative* research in its turn, in order to test the validity and deepen understandings of those themes seen as being of the greatest importance.

However, it is crucial to emphasise that just because one person expresses an opinion that we quote and draw from in our analysis, *it does not mean that these opinions are representative of all people in that participant group; and indeed the majority may disagree.* This is particularly important when it comes to potentially contentious/expensive recommendations from our data, such as ideas that services may benefit from greater staff pay and larger unit sizes. We simply suggest in these cases that managers listen to these ideas and consider them in the context of the wider picture and other information. If they think they are worthy of being followed up on, we would recommend gathering quantitative data on what the majority of people believe, rather than making large changes on the basis of a few people's opinions.

As quantitative data collection is easier than qualitative data collection, it is not surprising that we obtained questionnaires from a lot more people than we interviewed. Out of 303 staff members approached, 175 (58%) returned questionnaires. Some of the non-response was due to staff movement, some was due to staff choosing not to be in the study. As we do not know the opinions of staff who did not return questionnaires, we cannot state whether these results would apply to all social care professionals. In particular, staff who were more negative about the SW:WFF transformation may have been less likely to co-operate in the evaluation; conversely, staff with very strong negative views may have been more motivated to respond so these views could be heard.

Due to the aforementioned difficulties in recruiting families, we only obtained questionnaires from 29 individuals from 13 families. These are not likely to be representative of the wider client group; indeed family factors that would impact on results (such as greater deprivation, poorer family function, greater illness and poorer co-operation with services) could be reasonably expected to reduce willingness to complete the questionnaire, or be asked by a social work professional to complete the questionnaire.

4.2.3.1. Limitation – Subjectivity of Qualitative Analysis

Special attention needs to be drawn to the fact that qualitative analysis and interpretation is by nature subjective. Therefore the researchers' own biases have the potential to influence their findings. For example, if the research team had a desire (conscious or unconscious) for this report to paint the SW:WFF evaluation in a positive light, then this may have made them overplay positive comments and downplay (or ignore) negative comments. In particular, three of the research team have ongoing links with social care: these may make them wish results for their partner agency to be more favourable, or alternatively less favourable if they have an axe to grind based on poor experiences with the organisation; and they may let their own individual experiences cloud the data from research participants. While we cannot remove this bias, we hope that awareness of it will reduce such bias leading to our findings being based on what we might want to find, rather than the truth from our data.

We reduced bias through multiple methods:

(i) Independence of the Final Research Output from Social Care

The research team have worked alongside social care in trying to make this evaluation work as well as possible. We have let social care management see the draft report to allow them a chance to put some findings into context. However, the final decision on what to include lies with the research team, and social care have never had power to make them redact or change sections.

(ii) Personal Recognition of our Links and Potential Biases

Paul Wilkinson and Dickon Bevington are child and adolescent psychiatrists working in Cambridgeshire. They are employed by the local mental health trust in this work, but do work alongside social care in some cases. Jane Akister is an academic in social work, whose university department trains social workers in Cambridgeshire.

(iii) Employment of Qualitative Researchers with Minimal Prior Links with Social Care

While the senior members of the research team have links with social care, the researchers employed on the project have minimal such links. Esther Mugweni and

Becca Bishop carried out the initial qualitative analyses (EM: families, managers, partner agencies; BB: staff). Both are social science researchers with no prior links with social care.

(iv) Investigator Triangulation

After initial analysis by EM/BB, all six members of the research team continued the analysis of the qualitative data and contributed to the writing of the final chapters. The use of multiple researchers reduces the effects of bias from one person.

4.3. Key Findings

4.3.1. Key Findings from Families

Positives

1. 72% of families felt listened to; 71% found social care helpful (see 3.1.2.1)
2. Families praised communication skills of social care staff (see 3.1.1.5.1.1)
3. Families praised good communication between social care and partner agencies (see 3.1.1.5.1.3)

Challenges

1. Sometimes staff raised expectations of families and then did not deliver what the families thought they would (see 3.1.1.5.2.1)
2. Families struggled with multiple changes in staff, including when they changed units (see 3.1.1.5.2.1)
3. There was sometimes poor inter-agency collaboration (see 3.1.1.5.2.3)

Recommendations

1. There should be clearer interagency working (see 3.1.1.6.5)
2. Staff should continue to build on changes to set realistic expectations for families (see 3.1.1.6.6)

Progress Since Completion of Research

1. There have been multiple changes to the service delivery as detailed in several sections of the report

4.3.2. Key Findings from Staff

Positives

5. 93% of staff stated they prefer the SWWFF model. 87% of staff thought the SWWFF model has led to decreased risk for children and families, and 76% thought it has led to decreased risk for staff. In addition, 92% felt well-supported and 99% felt it provides a helpful service for the families (see 3.2.2.2, 3.2.2.3).
6. Staff found the reflective approach of the new model beneficial to themselves and families (see 3.2.1.3.1)
7. The diversity of the new units, with clinicians and unit co-ordinators, is beneficial (see 3.2.1.3.2)

Challenges

1. There have been some challenges in incorporating the systemic approach and traditional social work practice (see 3.2.1.4.1)
2. High staff movement leads to increased workloads, is destabilising to families and makes reflective discussions harder (see 3.2.1.4.2)
3. There was some confusion at the time of interviews about staff roles, especially clinicians (see 3.2.1.4.3)
4. There is some inconsistency in training (see 3.2.1.4.4)

Recommendations

1. Consider increasing unit size (see 3.2.1.5.6)
2. Improve staff retention (see 3.2.1.5.8)

Progress Since Completion of Research

1. Training has improved and has become more consistent, Cambridgeshire Social Care routinely evaluate the impact of their training on social work practice (see 3.2.1.5.2, 3.2.1.5.3)
2. Clinicians' roles have been further clarified and work is underway in clarifying the priorities for clinicians in each function. This work is supported by the recruitment of a Lead Clinician for each Function. (see 3.2.1.5.4)

4.3.3. Key Findings from Managers who Implemented SW:WFF

Improvements

1. Social Work Practice was more transparent (see 3.3.2)
2. Social Work Practice was enhanced by improved theoretical and knowledge base (see 3.3.3)
3. Staff were better supported and were carrying out more direct work (see 3.3.3.1)

Challenges

1. Difficult to recruit consultant social workers and manage high staff movement resulting in use of agency staff without systemic training, training and induction of these staff has been reviewed (see 3.3.4.1.B)
2. Retaining staff when salaries in neighbouring areas are higher (see 3.3.4.1.B)
3. High caseloads and small units together with lack of clarity about when to transfer/close cases (see 3.3.4.2)
4. Understanding the role of the clinicians and using them appropriately (see 3.3.4.4)

Recommendations

1. Manage demand – including policy of transfer from IAT to Access, improved links with locality teams (3.3.6.1) and being clearer about when to close cases (3.3.6.6)
2. Increase the size of the units from 4.5 to 6 staff to cover absence and retention (see 3.3.6.2)
3. Continue to clarify the role of the clinician and group managers (3.3.6.9, 3.3.6.10)
4. Sustain engagement with partner agencies (3.3.6.8)

Progress Since Completion of Research

1. Training and induction of agency staff, particularly in systemic practice, has improved
2. There is now greater clarity about staff roles, particularly the clinicians
3. Transfer/case closure policies have been clarified
4. Staff salaries are being reviewed

4.3.4. Key Findings from Partner Agencies

Improvements

Partner Agencies experience social care units as:

1. More positive and better informed (3.4.3.1, 3.4.3.2)
2. Easier to access (3.4.3.1)
3. Using theoretical perspectives to identify the strengths and positives within families (3.4.3.2)
4. Providing valuable input to pre-legal proceedings (3.4.3.2)

Challenges

1. Maintaining consistent practice across the units (3.4.4.2)
2. Maintaining manageable caseloads (3.4.4.1)
3. Difficulties in understanding the role and function of clinicians (3.4.4.2)
4. High staff movement (3.4.4.3)

Recommendations

1. Ensuring that the Units have manageable caseloads (3.4.5.1)
2. Improving staff recruitment and retention policies (3.4.5.2)
3. Continue to work to sustain progress made on setting realistic expectations (3.4.5.6)
4. Increasing continuity of care for families (3.4.5.4)
5. Maintaining good working relationships with partner agencies (3.4.5.7)

Progress Since Completion of Research

1. Further clarification of the role of the clinicians
2. Ongoing review of staff salaries

4.4. Discussion of Results

As with previous chapters, this chapter summarizing our results is split into improvements, challenges and recommendations. We are stating which participant groups provided data that led to these key findings. Most of these key findings are based on similar data given by multiple groups, improving their robustness.

It is important to remind readers here of the potential non-generalisability of these results, as discussed in chapter 4.2 (strengths and limitations). In particular, the qualitative findings are based on interviews from a small number of the potential participants. We therefore cannot say that most people share these views. Instead, these results should be seen as suggestions offered by some interviewees, that readers could consider and take forwards. They should be interpreted in the wider context of other opinions and knowledge.

4.4.1. Improvements in the Service

Our reasonably representative quantitative data from staff in 2013/2014 demonstrated that there was at least a preference for staff for the new model of care: 93% stated they prefer the SWWFF model. 87% of staff thought the SWWFF model has led to decreased risk for children and families, and 76% thought it has led to decreased risk for staff. In addition, 92% felt well-supported and 99% thought it provides a helpful service for the families. While our data from families is only from a small proportion of families, and is hence unrepresentative, it is nevertheless positive: 72% of families felt listened to; 65% found it easy to talk to social care professionals; 71% found social care helpful; 72% knew what their unit was trying to help them work on. We do not have such data from before the transformation, so we cannot state whether that is an improvement.

We have categorized the improvements into three themes: improvements due to the unit model; improvements due to the systemic approach; and improved communication and respect.

4.4.1.1. Improvements due to the unit model

Staff, managers and partner agencies all described significant improvements due to the unit model, in particular the unit meetings, the reflective discussions they generated, and the resultant shared responsibility. Staff felt well-supported and described greater emotional well-being as they were able to discuss both events and their feelings. Staff, managers and partner agencies felt that the reflective discussion of cases, with input from multiple professionals, has led to better, more creative and safer practice. Questionnaires (from large numbers of staff) demonstrated that staff who felt more supported at work were more likely to believe that the service was likely to be helpful to families. In addition questionnaires demonstrated that staff who believed that risk has reduced to families were more likely to think that risk has also reduced to staff. This suggests that staff believe that improvements in their own support has led to improvements in the quality and safety of the service they provide to families.

The unit model also had practical advantages, in particular, staff and managers stated that cases are better covered when staff were absent, as the whole unit now has responsibility for a case rather than an individual. Managers also stated that this reduced the impact of staff movement: if somebody left the unit, there would be remaining members who knew their cases.

4.4.1.2. Improvements due to the systemic approach

Two features of SW:WFF enable the systemic approach: all unit members get specific training in systemic theory and practice; all units have access to a clinician, who is usually trained and experienced in systemic practice. As well as providing direct work with some families, the clinician supports systemic social work practice by the rest of the unit.

Staff stated that they appreciate the clinicians, and learn from them. Partner agencies have noticed the broader knowledge base of social care teams and social workers, and commented that social workers are now creative and explore more areas. They also commented that the presence of clinicians leads to better quality referrals. Managers agree that the model and systemic training has led to multiple plausible scripts about families rather than relying on one dominant script from the worker. Managers also stated that this has led to better intervention, as social workers are now better trained to intervene. Managers confirmed the hope that clinicians are crucial in helping the units to implement the systemic training and ensure it has been used.

This appreciation of the broader range in skill sets was reflected in quantitative results from staff, where 71% of respondents stated that they agreed that 'It's more important to have people who can offer

a range of very different methods of understanding and working than it is to have a shared model'. However, the 27% of staff who disagreed shows that a substantial minority did not think such a range of skills is helpful.

4.4.1.3. Improved communication and respect

All participants commented on improved communication and respect, with/towards families and other professionals.

Families interviewed commented on some good communication from their social care professionals, including informing them what is happening, being empathetic and discussing safeguarding well and in a non-threatening manner. There was a comment about the approach being respectful and non-judgemental, not basing views of a family on previous views of social care/other agencies. They state that such improved communication and approach leads to better engagement from families.

Such interview data from families just states communication was good in those cases, not that the SW:WFF transformation has led to better communication. However, some data from other groups suggests that the transformation has led to improvements. Staff stated that their training has specifically led to improved, more respectful language towards families, and a shift in emphasis to working 'with' them. Managers stated that the previous way of talking to families was sometimes 'atrocious', and that the SW:WFF approach has led to improvements, in particular the way staff speak is now more transparent. Partner agencies stated that they have observed social care staff now being more respectful of families.

Families commented on good working together with and use of partner agencies. Partner agencies stated that communication with them has improved, particularly due to the unit co-ordinator. They find it helpful that it is now easier to speak to social care about cases, as there is usually someone in the office who knows what is happening; if not, messages are passed on more reliably. They state that the presence of clinicians (who often previously worked for other agencies) has seemed to improve communication and has reduced historical mutual suspicion between agencies. This has led to increased appreciation of other professional perspectives from social workers, and less defensiveness their interactions with other agencies. Partner agencies also spoke positively about the great efforts made by social care to engage them before transformation; and as part of this protocols and thresholds were made clearer.

4.4.2. Challenges During and Since the SW:WFF Transformation

While most interviewees were positive about the SW:WFF transformation, many stated significant challenges in its delivery. We have grouped these into seven themes relevant at the time, some of which have significantly changed since the research was undertaken:

- High staff movement
- Families moving between units
- High caseloads
- Role confusion
- Training issues
- Tensions between the systemic approach and traditional social work practice
- Poor communication

4.4.2.1. High staff movement

Participants from all groups commented on the high staff movement and the problems this caused. Several possible explanations were given for the reasons for such high movement: staff, managers and professionals all stated their belief that low salaries in comparison to neighbouring areas were a significant factor. Other explanations given were: lack of career opportunities for social workers, due to the large gap between social worker and consultant social worker (the older system has more levels); a total lack of promotion potential for unit co-ordinators; difficulties in recruiting consultant social workers, which led to many social workers being promoted and hence leaving vacancies; high rates of maternity leave, inevitable in a workforce with large numbers of young females; staff being frequently moved to units where there were even more vacancies; and high stress levels (although some stated that stress levels may be lower in the new SW:WFF model).

Clearly, there has always been staff movement in social care, as in all professions. However, both managers and partner agencies commented that the impact of losing a member of staff is much greater for a team as small as 4.5 whole time equivalents than a larger old-style team.

The high movement of staff had multiple impacts. Most importantly, families found this difficult and did not like having to keep re-telling the same story. The effect of this was magnified by the fact that they

saw multiple professionals from the same unit and sometimes changed unit (see 4.3.1). All participant groups agreed that staff movement caused problems for families. High movement had multiple effects on staff: workloads increased and this impacted negatively on the reflective discussions, a core component of the SW:WFF model: staff often only felt comfortable discussing difficult things when with colleagues they knew well and trusted – when there were new staff, they could not. Managers also agreed that movement in staff caused changes in unit working relationships. They also made the point that movement of consultant social workers led to changes in leadership style. Managers and partner agencies felt that the staff movement impaired relationships between the social care team and partner agencies. Partner agencies said that that new staff were sometimes unsure what other agencies offered.

One important impact of the staff movement was that new staff often ended up being newly qualified social workers or agency staff. Newly-qualified social workers have limits on what they can do, such as not being able to do child protection work/go to court. So the burden of this work would fall on consultant social workers or sometimes group managers. Both permanent and agency staff spoke of problems in relationships between them; this may have arose from the lack of systemic/SW:WFF training given to agency staff, which has now been addressed. Permanent staff felt that agency staff were more rejecting of the systemic approach and agency staff felt less accepted and trusted by permanent team members. Agency staff often found reflective discussion challenging. This sometimes led to agency staff working cases more independently, as in the old model, and inconsistent with SW:WFF practice.

Comment from SW:WFF leadership team:

This is now being addressed through agency workers training.

4.4.2.2. Families moving between units

Families moved between units for two reasons. Firstly, the systematic design of SW:WFF is that families (except disabilities and looked after children) start in access and then, if longer-term work is necessary, are transferred to child in need. Secondly, staff shortages sometimes meant families were transferred to better-staffed units, or experienced a change in their main social worker when they transferred to another unit to meet a staff shortage there. An element of SW:WFF is that families will work with multiple team members. When this is added to by multiple changes in unit and when there is staff movement (4.3.1), families end up seeing many different professionals. Families do not like this, in particular having to re-tell their stories, and, according to families and partner agencies, this hinders engagement.

4.4.2.3. High caseloads

Important parts of the SW:WFF model are that social work professionals are freed to spend time doing intensive direct work with families, and units have a weekly unit meeting time for reflective discussions of cases. For this to happen, units need to have a manageable caseload. Staff, managers and partner agencies all stated that caseloads were much higher than initially intended. Multiple possible explanations were offered: underestimation of demand when the service was set up (this reflects the national picture of social care referrals increasing); staff leaving (increasing workloads for remaining staff); lack of clarity about why cases were open; cases were coming into units that could probably not need to come into social care and could have been managed by locality teams; paperwork was not reduced as much as had been hoped (partly due to the Ofsted review leading to increased paperwork); and the lack of unqualified staff (who were present in the Hackney model), who could do some of the work done by social workers.

The high caseload impacted on the work carried out. In particular, unit meetings changed and became more focused on factual discussions and review of process, with less time for the reflective discussions described as so valuable in 4.4.1.1.

4.4.2.3. Role confusion

All participant groups described problems from being unsure about the role of particular staff members. All stated that there was particular confusion about the role of the clinician, given that this was a new role within children's social care. Families said that when they saw introduction letters saying that units had a clinician, they assumed the clinician would be able to do direct therapeutic work with them, and were disappointed if they did not. Staff agreed these expectations also caused problems for families and also stated this caused difficulties with inter-agency relations. Managers commented that different people within social care had different views on what clinicians should be doing, leading to variation in practice, some of these may have been unrealistic. In some cases, there were concerns that clinicians were taking over social work practice, and so managers had to support the Units to understand the role of the clinician in supporting them to deliver social work systemically, not to deliver the social work intervention. They also described a problem of cases kept open when clinicians were doing therapeutic work, when in fact there was no longer a social care role.

Comment from SW:WFF leadership team:

As described in point 3.2.1.4.3, the clinician role is now much clearer and their interventions clearly defined. It is learning for those wishing to implement the model as an issue likely to cause confusion at the outset due to introducing clinicians into a social work service.

Managers (who included group managers themselves) complained about the lack of clarity about the role of group managers. They stated that there were many components to their work, yet their exact role was unclear.

Some staff stated that they were confused about the whole organisation's theoretical and practical approach to social care, demonstrating that this vision needed to be communicated more clearly at the outset of the SW:WFF transformation.

4.4.2.5. Training issues

At the time of the research, staff in particular described inconsistencies in training. This was a particular issue for unit co-ordinators, many of whom were not able to attend some/all of the systemic training. This meant that they did not fully understand it, limiting their ability to help families (especially important as they are often the first port of call for families who ring) and compromising the quality of unit meeting minutes. This qualitative finding about unit co-ordinators was supported by findings from the questionnaires that unit co-ordinators had lower levels of confidence that they have the skills to do effective work with complex families, compared with social workers and clinicians (26% vs 11%). Group managers also complained about not initially receiving systemic training – some felt it essential so they fully understood the work of the teams they were managing. This training was eventually given to GMs. There were also complaints that agency staff did not receive adequate systemic training, which some staff members felt contributed to their rejection of the systemic approach, impairing teamwork and reflective unit functioning.

Comment from SW:WFF leadership team:

Systemic training at these levels was addressed prior to receiving the research findings. The findings indicate that it may be helpful for authorities contemplating the approach to invest in training at all levels from the beginning.

4.4.2.6. Tensions between the systemic approach and traditional social work practice

The systemic approach and the traditional social work model are different, and this raised some tensions, as described in section 3.2.1.4.1. Staff felt that the wider organization, while expecting them to practise differently, had not adjusted its procedures to fit better with systemic practice (in particular paperwork demands and caseloads). Some staff felt that the systemic model, in being more positive about families, left children in difficult situations for too long. Some felt that the emphasis on the systemic model meant they had less flexibility than before.

Managers commented that the initial focus on innovative work meant that procedures/frameworks for record keeping and timescales were not as good as before the service transformation, leading to the negative Ofsted review.

Comment from SW:WFF leadership team:

There was certainly a difficult balance to strike between direct work, creativity, productivity and procedure. This tension was hard to resolve in a public sector system with limited funding and a statutory child protection duty, where staff all have great pressures on their time. We have tried to improve this balance since the Ofsted inspection, leading to a good report in the subsequent review.

We have commented on this in point 3.4.4.2, where learning from embedding the model has led to innovative practice where the models are seen as compatible rather than competing.

4.4.2.7. Poor communication

Some families complained of poor communication from social care units, in particular: raising expectations then not carrying through what they said they'd do; families not being sure what units are supposed to be doing; and poor inter-agency collaboration, in particular both agencies saying the other should be doing the work.

Partner agencies complained that while they were well-engaged in the lead up to the SW:WFF transformation, this engagement was not sustained after transformation. Some also felt that the unit model had led to increased demand for their services, which they wished they'd been warned about. Conversely, some partner agencies felt they were not required nor valued as much. Some partner agencies found the unit numbers confusing, as they do not indicated the geography nor type of unit. It would be interesting to return to this now the approach has been more embedded.

4.4.3. Recommendations

Our data lead us to make several recommendations: (some of these were addressed between the time of the interviews and the writing of the report; they are still kept in as the learning from this is likely to be useful for other services planning a similar transformation).

4.4.3.1. Better clarification of roles

In particular, the role of the clinician needs to be made clearer to families, social care units and partner agencies. The role of the group manager needs to be made clearer.

Comment from SW:WFF leadership team:

This has been addressed since the interviews.

4.4.3.2. Improvements in training

All professionals working in and managing the units (including unit co-ordinators and group managers) need training in the systemic model, so they understand this key component of the units' work. Managers also recommended that consultant social workers have improved specific training, in particular in staff management, of which they often have little experience. It was recommended that social workers are prepared for the differences between systemic practice and what they may have learnt in their social work training.

Comment from SW:WFF leadership team:

This has been addressed since the interviews.

4.4.3.3. Improved recruitment and retention

High staff movement was recognised as a significant problem by all participant groups. Improved recruitment policies, especially at consultant social worker level, were particularly recommended. All professional participant groups recommended increased staff pay. I am sure such a recommendation was not mentioned lightly at a time of public sector austerity. However, a good case was made for this: social worker pay is currently lower than neighbouring counties (despite cost of living being greater in Cambridgeshire); improved staff retention may lead to reduced costs through lower agency costs, reduced staff stress (and sickness) and improved quality of care (and hence sooner closure). Given the

potential contentiousness of this recommendation, it is important to reiterate here that these were the opinions of the small number of people that we interviewed, and may not be representative of the majority (please see 4.2.2 for fuller discussion of the limitations of qualitative analysis).

In the interests of a balanced discussion, we have discussed this potentially-difficult recommendation with Cambridgeshire children's social care management. They are of the opinion that the lower staff pay in Cambridgeshire is more than offset by other attractions to working here including training and the SW:WFF model itself. Some evidence for this is given by the lower staff vacancy rates of 10% in Cambridgeshire as opposed to about 25% nationally (figures correct October 2014). They also stated that some of the movement has arisen from positive events, in particular maternity leave and staff promotions (from social worker to consultant social worker), rather than staff leaving, hence pay is certainly not an issue in those cases. A consequence of such staff leaving their posts is that staff sometimes need to be shuffled between units. While this is perceived as staff movement by families and other agencies, it is not staff leaving Cambridgeshire Children's Social Care, and would not be rectified by higher pay.

Comment from SW:WFF leadership team:

Nonetheless, pay is now being reviewed across Cambridgeshire Children's Social Care.

4.4.3.4. Consider changing unit size

It is difficult to decide on the ideal size of a unit. A significant problem identified by managers and partner agencies was that with a unit size of 4.5 whole time equivalents, if one member of staff left (or was sick, or on leave, or in court), then that was a very high proportion of the staff gone. Staff members said units could often cope with being one member of staff down, but could not cope with more than that. If staff movement (especially without immediate replacement) is high, this will cause a particular problem here. However, it is important to contextualize this in reference to study findings that staff found the unit model in its current format helpful. A downside of increasing unit size would be that there would be less time per case for the reflective discussions so valued in section 4.4.1.1; in addition, too much of an increase would make a consultant social worker feel like more of an old-style team manager. Therefore any advantages of increasing unit size may be outweighed by these disadvantages. It is easy to see problems in a current model, but any unit size would create some problems. At the time of writing the report, we recommended that management further considered optimal unit size taking these findings into account; it may be worth trialing a small increase in unit size (possibly by just one person).

Comment from SW:WFF leadership team:

We have trialled enhanced units, with 1-2 extra social workers, and found that the increase in team caseload reduced the many advantages of shared caseloads.

4.4.3.5. Consider increasing staff numbers

Staff, managers and partner agencies all stated that caseloads were much higher than initially intended in the planning of the SW:WFF transformation, which meant that the SW:WFF model was difficult to follow as intended, with less time for both intensive intervention and reflective discussion.

Recommendations were made to consider the increasing staffing (by increasing number of units or number of staff per unit). It was also suggested that some of the increased staff could be child and family workers, which would be less expensive than qualified social workers. Opinions differed on whether this was appropriate. While a staff increase would cost more, it may lead to more productive work with earlier closures and improved outcomes (including possibly reduced numbers of children in care and in the criminal justice system – two huge societal costs). However, we appreciate that this may not be affordable in the current fiscal climate. If this is the case, a decision needs to be made on which is more important out of providing high quality work to more realistic caseloads (by raising thresholds – which would need agreement from other agencies), or continuing to provide a service to many families at the current threshold. Of course, improved referral pathways through work with other partners in Children’s Services may prevent some cases coming into social care. Although this is not easy given funding pressures to all services.

4.4.3.6. Improved communication with families and partner agencies

Improved communication would greatly help relationships with, and engagement from, families and partner agencies. In particular agreeing what work will be done and setting realistic expectations will reduce disappointment and negative perceptions of the service. Clearer interagency working would be of benefit to families.

4.4.3.7. Reconsider service pathways

A change in the filtering by IAT (and increased thresholds) may reduce the high workloads of SW:WFF units. However, we accept that it can be difficult to signpost families to other agencies when they themselves are facing budget cuts.

Under the current system, some families spend a long time in Access and are then moved to CIN. Families found this hard as it means they need to form new relationships with new professionals. It was suggested this distinction between Access and CIN were removed. Alternatively, families could be moved more quickly between Access and CIN when it was clear that they would need longer work from CIN; or IAT could refer obvious long-term cases straight to CIN.

Comment from SW:WFF leadership team:

The filtering by IAT and thresholds have now been reviewed and referral pathways changed.

Families now only spend an average of 12 weeks in Access (August 2015).

4.4.3. Summary

The overall opinions of all participant groups were that the SW:WFF transformation has benefitted client families and staff. Questionnaire data from staff suggested that they are overwhelmingly prefer the new model. In particular, the unit structure helps staff feel more supported and may lead to better practice as more ideas are available to help each case; the systemic training has led to improved quality of intervention; communication is improved. There were initial challenges, in particular: the high staff movement, families seeing too many different professionals, higher-than-planned caseloads and confusions about professional roles that have learning for other local authorities at the point of implementing this model.

The data suggested some recommendations, which could be considered by managers of Cambridgeshire social care, and managers of other organisations considering a similar service transformation, some of which were points for development already actioned by Cambridgeshire before receiving this report. These suggestions are offered with the caveat that they only represent the opinions of the small number of respondents and so may not represent the views of all. Some recommendations suggest changing the service structure – although not changing annual staff costs, such a transformation is disruptive and may lead to more problems than it solves. Suggestions were changing the Access-CIN pathway; increasing the unit size (cost neutral if the number of units is reduced) and increasing referral thresholds. Some recommendations have clear cost implications at a time of austerity and may be unrealistic. But they may also lead to cost savings: improving staff pay to parity with neighbouring counties may improve staff recruitment/retention, saving on agency costs and improving quality; increasing the number of staff may lead to improved systemic working which may improve outcomes and hence save costs.

Of note, social care have become aware of some of these issues, and have made changes since the time of the interviews, such as reviewing staff pay and the Access-CIN pathway, and trialling different unit sizes.

APPENDICES

APPENDIX 1a: Initial Study Protocol 25 January 2013

Social Work Working for Families Evaluation

Background

Social Work Working for Families

Cambridgeshire County Council are currently completing a major reorganisation of the social care system for children and families, to the 'Social Work Working for Families' (SWWFF) model. SWWFF represents a significant shift in the way that Social services for children and families are organised, and work. It is drawn from a "systemic" model of care first deployed in Hackney, NE London, that has been positively reviewed and evaluated [3]. Some of the key changes from "Care as Usual" include the organisation of social workers into small teams ("Units"), that include a clinically-trained practitioner (in most, but not all, cases a Family therapist) so that they are able to address simple mental health and relationship problems as an early intervention. With administrative support, the emphasis is on supporting Social Workers to be in more of a practitioner role, rather than a more "hands off" managerial/care coordinating role.

While there is some evidence to suggest that the changes to practice and managerial reorganisation involved in SWWFF have been effective in the densely populated inner city setting of Hackney, there is no such evidence for how such a reorganisation might translate into a mixed urban, suburban and rural setting such as Cambridgeshire. Nor was the evaluation of the first iteration of this method in Hackney definitive - in terms of its sampling methodology, the length of follow up, and the kinds of outcome measures applied. As is always the case, the model deployed in Hackney has continued to develop, and will need to be adapted to fit the different demands of the Cambridgeshire setting. Given, also, the fact that many other Social Services departments across the UK (and beyond) are subject to major reorganisations that are costly and disruptive (though with the intent to improve outcomes for complex and vulnerable families), an evaluation of this process and this model of care appears very necessary.

It is important to evaluate whether this service leads to improvements in client families. Given the statutory role of social care to improve the wellbeing of all the population, not just the families that it sees, this study should also evaluate population-level measures, such as school attendance and child mortality. Given the relatively high levels of stress, burnout and high staff movement in social services,

it is important to evaluate the effects of this new service on staff job satisfaction and attitudes. We shall also evaluate whether differences in staff attitudes and experiences of the model influence outcomes for families. Finally, it is important to collect information from the managers of this service transformation about the process of change itself, what worked well and where problems occurred. This evaluation will both guide Cambridgeshire County Council as to how effective current care is, and how it may need to be developed; and also guide other local authorities as to whether (and how) they should change to a similar service structure.

Adolescent Mentalization-Based Integrative Therapy

AMBIT is an approach that encourages the use of simple and previously evidence-based practices (such as basic Cognitive Behavioural Therapy, basic Family work, or basic physical and sexual health promotion, etc) in a coherent psychologically-oriented framework that includes two further elements: (a) a strong emphasis on developing and sustaining active peer-to-peer support and improved communication between team members, and (b) proactive work to address relationships across the wider multi-agency network, particularly to reduce the instances of poorly-integrated care [2].

The theoretical "glue" that holds this approach together is the concept of "Mentalization" - which is defined as the imaginative activity of "making sense of one another's actions on the basis of what might be going on in the mind of the actor (their intentions, beliefs, hopes, fears, etc)". This is an approach that has been developed over the past decade, and applied in a powerfully evidence-based (NICE-approved) therapy for adults with personality disorder ("Mentalization-Based Treatment" or MBT) [1]. Because of the strong developmental themes in this way of making sense of emerging patterns of behaviour, there has recently been a lot of research and development activity in applications of this same concept with children and families. Crucially, mentalization-based approaches have a very good "fit" with many other theoretical approaches (for instance "Systemic" approaches, or "Cognitive-behavioural" ones), so that integrating AMBIT with the systemic training that the SWWFF units will receive is relatively simple.

AMBIT is used in a wide range of statutory and non-statutory settings across the UK (see <http://www.tiddlymanuals.com> - and follow links to AMBIT), and early evaluations in these settings are promising, though to date there have been no randomised trials. AMBIT recently won a national award

for innovation (the Guardian/Virgin Business Media "Innovation Nation" award for the use of technology to support Collaboration.)

AMBIT offers a manualized framework to support and guide practice with complex cases particularly where there may be "co-occurring" social, physical and psychological problems and disorders (e.g. clear protocols that are recorded so that these can guide and shape the management of a case, as well setting the ethos within which the team operates. See <http://ambit.tiddlyspace.com> for the online manual.) In this respect it represents a different approach from "Care as Usual" by a Social work team - hence the need to examine whether it offers any additional value.

Part of the AMBIT method, however, is also designed to support and encourage local teams to develop their own locally-"attuned" adaptations of practice. Local teams are encouraged to edit and author their own local versions of AMBIT's 'open-source' web-based manual - so that these come to represent more accurately the nature of local practices and expertise and ideally come to be identified by teams as a place where they "define themselves and their approach to the work, and their ongoing learning about improving outcomes".

In this way, AMBIT is not a "one-size-fits-all" approach to therapeutic work, but rather seeks to offer a structured framework which supports local services to marry elements of externally-validated evidence-based practices with their own locally-derived "practice-based evidence".

AMBIT is being used by 20 services around the UK across a wide range of service settings; from non-statutory (voluntary sector) street-level services for gang-involved youth, to NHS 'Early Intervention in Psychosis' or Adolescent Outreach teams serving. While individual AMBIT-supported services are evaluating their own outcomes, there has not been an opportunity to examine the outcomes for AMBIT and non-AMBIT trained teams in more direct and valid comparisons. The present SWWFF study offers such an opportunity.

As a non-commercial "open source" approach to therapy (hosted by the charity the Anna Freud Centre, and supported by a grant from Comic Relief) that aims explicitly to share knowledge about best practice via freely available web-based treatment manuals and training materials (such as streaming video role-plays and lectures that are built into the web-based manuals), AMBIT has the opportunity to offer evidence-based support very widely to services that often struggle to find the budget for more

expensive training packages. The proposed study offers the opportunity to evaluate evidence of its effectiveness in terms of the outcomes for families and for workers.

Purposes of Evaluation

The main aims of this study are to evaluate how effective social work delivered in the SWWFF model is at improving the mental health, wellbeing and family function of its client families; and how acceptable this model of social care is to client families and professionals working within SWWFF. It will also investigate how the teams function and the degree to which team characteristics influence client outcome. As one secondary aim, six teams will be selected at random to train in Adolescent Mentalization-Based Integrative Therapy (AMBIT). We shall investigate whether AMBIT leads to better outcomes for clients and staff. As a further secondary aim, we shall collect information from service transformation managers about the process of change itself, what worked well and where problems occurred. We shall also interview managers of partner agencies, within and outside the local authority, for their opinions on whether the change to SWWFF has changed the service social care provides for families, and whether it has influenced working relationships between their teams and children's social care.

Methods

A. Cluster Randomisation

6 consenting units from the 44 social work units will be trained (and subsequently supervised) in Adolescent Mentalization-Based Integrative Therapy (AMBIT). The teams will be selected using stratified cluster randomization. Six similar sized groups of units will be defined, based on unit type, deprivation levels and degree of urbanization. One consenting team from each group will be randomly selected using the online programme www.random.org. Agreement to be randomized to AMBIT/non-AMBIT will be obtained before randomization takes place, to maintain allocation concealment.

B. Quantitative Evaluation

B1. Participants

This study will evaluate three levels of research participants:

B1.1. SWWFF Client Families

SWWFF will have 44 units (teams) of care. Each is likely to have a current caseload of 12-45 cases at any one time. The aim is to have 10 families recruited per unit. Therefore we shall aim to recruit 440 consecutive consenting families at intake to social care. Families will use self-ratings (parents and children), parent ratings (of children) and will receive observer-based ratings from social work units.

B1.2. Cambridgeshire Population

We shall collect population measures of child health/wellbeing over each year of the intervention, and the preceding three years. Such data will be available from public, health or local authority databases. We shall compare this against changes over the same time periods of non-SWWFF local authorities (both across England, and of comparative socio-economic need) to help to control for the effects of changes in national policy and national socio-economic changes.

B1.3. SWWFF Staff

We shall collect information from all consenting SWWFF staff members on an annual basis.
SWWFF aims to employ 220 staff.

B2. Materials

B2.1. SWWFF Client Families

Ratings of Child/Adolescent Mental Health and Wellbeing

KIDSCREEN-10 (self-rating by children old enough, to be judged by social work team in conjunction with parent(s), usually ≥ 8 years) [6]

Strengths and Difficulties Questionnaire (by the parent who has most contact with the child) [4]

Parental Mental Health and Wellbeing

Adult Wellbeing Scale [7]

Family Function

SCORE 15 (to be completed by all family members old enough to complete it) [8]

SWWFF Family Experience Questionnaire (to be completed by all family members old enough to complete it)

John Risk Direction Scale (weekly, at the social work unit team meeting)

Demographics and Environment Questionnaire (by a parent, with assistance from social work professional)

B2.2. Cambridgeshire Population Under 18 years

Hard data. The following data are less likely to be confounded by changes in practice/thresholds other than the development of SWFF:

Mortality rate

Admissions to hospital

School attendance rate

The following data will also be collected, although we accept that factors other than the development of SWWFF (such as changes in child protection thresholds) may strongly influence results:

- Number of contacts per case in children's social care

- Number of children given a child protection plan for the first time

- Number of children placed in care

- Proportion of looked after children with no change in placement in the last two years

- Proportion of care leavers in suitable accommodation

- Proportion of care leavers in employment, education or training

B2.3. SWWFF Staff

- SWWFF Staff Attitude Questionnaire

- SWWFF Staff Experience Questionnaire

- Staff sickness rates (collected at start of project, at yearly intervals thereafter, and preceding 3 years)

B3. Procedure

B3.1. SWWFF Client Families

All families referred to social care will be informed about the evaluation and given information sheets at the initial Access assessment. At the second meeting, they will be asked if they would be happy to take part and, if so, the first set of questionnaires will be administered then. All family members aged 16 or over will be asked for separate informed consent. This will include parents and children not living at the index household but who are actively involved in the casework (to be decided by the social work team). Children under the age of 16 who are judged to be old enough to understand the study and complete questionnaires will be given age-appropriate information sheets and asked for assent. If parent(s) consent but one or more child does not assent to data collection, then the family will still be recruited using available data, to maximize representativeness of the sample. A potential complication can occur if children are in care under section 20. In these cases, parents and the local authority have joint parental responsibility. It is good research practice for parents to consent for their child to take part in

the study in most cases, but that each case should be judged on a case by case basis. If possible parents should be approached. It is possible for them to consent for their child to take part but not themselves (if the bulk of the work is being done by foster carers, who themselves have consented to take part). In some cases, where parental contact/consent is inappropriate, then the local authority can consent. These cases should be discussed with a manager and, if necessary, the research team. A designated member of the social care team should sign the social care parental responsibility consent form.

If the family do not want to take part at that second meeting, they will be asked if they would be happy to be asked at future meetings, or would rather not be asked again. This would be respected. Families will be eligible to enter the study for up to two months after the initial Access appointment.

The set of parent and child/adolescent questionnaires will be administered at the following time-points:

- Initial assessment by social care

- When changing between social care units

- At six months from initial assessment

- At six month intervals since the previous assessment

- When discharged from social care

- Six months after discharge from social care

- At the end of the study period for all families still receiving input from social care

Questionnaires will be administered during normal professional-client contacts, which are often (but not always) at the family's home. The social work professional will help the family if needed. Families will be given the option of completing the questionnaire without the professional seeing the answers, and returning it to the professional in a sealed envelope or posting them in a reply-paid envelope. Families will also be given the option (when feasible) of a different member of the team who has not been treating them administering the questionnaire.

The six months post-discharge questionnaires will be administered by the research staff, at home or other suitable place (such as NHS clinic or GP surgery). Other questionnaires will be administered by the social work team. All questionnaires will be given to be completed with the staff member present to help if needed, and to ensure that questions are not accidentally missed off.

B3.2. Population Measures

Population measures will be obtained from local authority, health or public databases.

B3.3. SWWFF Staff

All consenting staff will be asked to complete their questionnaires at the start of the study (or start of employment), at 12 month intervals thereafter, at the end of the study (if no questionnaire in the last 4 months), and if they move social work units or stop working for social care. Managers will explain the importance of this to staff face to face, and give information sheets and regular newsletters will also explain the importance of high levels of participation in the study. Team members will be explicitly told that management will not know if they are participating and will not think nor act unfavourably towards them if they do not participate. Researchers' details will be provided on information sheets so staff can ask any necessary questions. Completed consent forms will be sent to researchers. For consenting staff members, questionnaires will be sent by and returned to researchers, not local authority management. Questionnaires will not be anonymous, as it is important that we assess changes over time within individuals, compare results between AMBIT and non-AMBIT teams, and assess whether differences in staff characteristics influence outcomes for families. However, questionnaires will only be seen by the research team and not be seen by members of social services management. We shall also use results from the Staff Attitudes Survey completed by consenting staff members before the study period (it was used as a routine staff survey before this study).

B3.4. Duration of Study

There will be two years of data collection. All families giving baseline data and one follow-up data point will provide useful and useable data for longitudinal data modeling. End of data collection will be variable, as it will be 6 months after a case is closed. To maximize study efficiency and value, clients will be recruited until 6 months before the study end, and all data will be used, whether that is 6 months or 2 years of follow-up.

Hypotheses and Statistical Analyses

1. We hypothesise that there will be a significant improvement in client family, individual and population-level outcomes over time (single arm repeat measures design).
2. We hypothesise that families receiving care from AMBIT-trained teams will have better outcome than families receiving care from non-AMBIT teams (parallel cluster randomized comparison).
3. We hypothesise that baseline factors of staff attitudes within a cluster will influence outcomes of families. We shall investigate this by regressing outcomes on individual items from the SWWFF Staff Attitudes Questionnaire.
4. We hypothesise that staff attitudes and satisfaction will improve, and sickness rates will decline, over the course of the study (single arm repeat measures design).
5. We hypothesise that staff attitudes and satisfaction will be more closely correlated between staff members within a cluster than between staff members from different clusters (significant intra-class correlation).
6. We hypothesise that staff working in AMBIT-trained teams will have greater improvements in attitudes, satisfaction and sickness rates than staff in non-AMBIT teams (parallel cluster randomized comparison).

Conventional statistical analysis assumes that all results are independent. This assumption is not met in this study, due to intracluster correlation. Firstly, individual scores of individuals within a family are likely to be correlated more than are scores from independent individuals (due to shared genes and environment within a family); secondly, scores of families treated within a social care unit may be more correlated than independent families, because features of a unit may influence outcome of the families it treats. Data for families will therefore be at three levels: level 1 (individuals), level 2 (families), level 3 (social work units). Data for staff members will be at two levels: level 1 (individual staff members), level 2 (social work units). This will be accounted for in multi-level modeling using the xtreg function of Stata [5].

We shall apply estimates for typical costs of service use to families in the study, based on items in the demographics questionnaire (including child protection status, school attendance, use of other agencies). We shall use this to demonstrate how cost levels for families change during the social care

intervention, and predict that there will be a rise in costs as intervention starts, but a fall in costs to below baseline levels after the intervention.

Sample Size Estimation

Because of the nature of the major re-organisation, and the inevitable exigencies relating to such a process that cannot be predicted, it is difficult to predict accurately the sample size that will be captured.

Several issues have governed planned sample size:

1. It is important to recruit all units to ensure that all units are offering a good service.
2. It is important to recruit a sufficient number of families per unit to evaluate reasons for differences between units.
3. Intra-cluster correlation (ie similarities between members of the same family) mean that individuals are not independent, and a larger sample size is needed
4. In terms of recruitment, an average of 10 families over one year per unit was deemed feasible by social work colleagues

C. Qualitative Evaluation

C1. SWWFF Client Families

Interviews will enquire about users' perceptions of services, expectations of and beliefs about efficacy of interventions, comprehension of aims and objectives of service. These families will be interviewed using both a whole family approach and interviewing consenting/assenting family members alone. Tape recordings of the full responses will be used for subsequent thematic analysis. We shall undertake these interviews using a semi-structured approach to obtain reliability for the family probes and cues and to ensure we capture contextual data to consider compliance and adherence to interventions. We shall interview families, who have all received at least six months of care. We shall select families such that they are cover the full range of families seen by social care, on demographic measures (eg family structure, urban vs rural) and clinical measures (family and child wellbeing, family function, degree of improvement over the study). Latent class analysis will be used to identify clusters of families that share similar characteristics (demographic and clinical). Families will be selected randomly from within each

of these latent classes, ensuring a spread of family types. This will lead to more representative families than a more common approach of selecting 'convenient' families. We shall use grounded theory, collecting data, establishing themes and comparing new data with existing data, until we reach a point of theoretical saturation. We are expecting to interview around 40 families. Families will be interviewed at home or other suitable location, depending on family preference. Interviews will be conducted by the research associate and research assistant, not social work staff.

C2.2. SWWFF Staff

Staff members will be interviewed at the start of the project and 12 months later. These semi-structured interviews will characterise in depth their perception and anticipation of their roles, their predictions for service success and where risks and threats to implementation and good outcomes may arise; and their opinions on the service and whether their experience has met expectations. We shall evaluate how the process of change has felt for social workers, and whether (and how) new team cultures have developed.

Again, we shall interview staff representing a wide range of unit types, geographical areas, and baseline scores on staff attitudes and experiences. We shall use weighted sampling to ensure a larger number of staff members from AMBIT teams, such that the AMBIT : non-AMBIT staff ratio will be 1:2 (as opposed to 1:6 which will be the staff distribution across teams). Again, we shall use grounded theory, collecting data, establishing themes and comparing new data with existing data, until we reach a point of theoretical saturation. We are expecting to interview around 30 staff members.

C3.3. SWWFF Service Managers (Process of Service Transformation)

Managers who have effected this service transformation will be identified by the Head of Social Work and asked if they would agree to take part in this evaluation. Each consenting manager will have three qualitative semi-structured interviews with the researchers (at the start, middle and end of the study) to discuss the ongoing service transformation, including what has worked well, what has not worked well, and key learning points for future similar service transformations. Consenting managers will be asked to collect a log of important developments between these research assessments, to help them to remember important events. A focus group of all consenting and available managers will be held at the end of the project, to discuss what has worked well, what has not worked well, and key learning points for future similar service transformations.

We aim to integrate information from all the interviews and focus group to develop a narrative of the change process over time. Details of this will include: what worked well and didn't work well overall; particular difficult points in the change process and how these were overcome (or not); important lessons managers would advise managers of other social care organizations planning a similar transformation.

C3.4. Managers of Partner Agencies

The research team and social care management will identify managers of partner agencies to children's social care, both within and outside the local authority (including the Youth Offending Service, Child and Adolescent Mental Health Services, Family Courts, Education, Children's Disability Social Care). Researchers will interview them individually, asking for their opinions on whether the change to SWWFF has changed the service social care provides for families, and whether it has influenced working relationships between their teams and children's social care. They will be asked in detail about what works well and does not work well, and be asked for suggestions as to how children's social care could work even better.

We aim to integrate the experiences and opinions of these managers into an account of how they see SWWFF as improving (or not improving) the care given to families; and how this service transformation has impacted other agencies.

References

1. Bateman A, Fonagy P (2008) 8-year follow-up of patients treated for borderline personality disorder: mentalization-based treatment versus treatment as usual. *Am J Psychiatry* 165:631-638
2. Bevington D, Fuggle P, Fonagy P, Target M, Asen E (2012) Innovations in Practice: Adolescent Mentalization-Based Integrative Therapy (AMBIT) – a new integrated approach to working with the most hard to reach adolescents with severe complex mental health needs. *Child and Adolescent Mental Health* Online publication ahead of print, 4 May 2012

3. Cross S, Hubbard A, Munro E (2010) Reclaiming Social Work. London Borough of Hackney Children and Young People's Services. In: Human Reliability, Dalton, Lancashire
4. Goodman R (1997) The Strengths and Difficulties Questionnaire: a research note. *J Child Psychol Psychiatry* 38:581-586
5. Rabe-Hesketh S, Skrondal A (2008) Multilevel and Longitudinal Modeling Using Stata. Statacorp, College Station, Texas
6. Ravens-Sieberer U, Erhart M, Rajmil L, Herdman M, Auquier P, Bruil J, Power M, Duer W, Abel T, Czemy L, Mazur J, Czimbalmo A, Tountas Y, Hagquist C, Kilroe J, Group EK (2010) Reliability, construct and criterion validity of the KIDSCREEN-10 score: a short measure for children and adolescents' well-being and health-related quality of life. *Qual Life Res* 19:1487-1500
7. Snaith RP, Constantopoulos AA, Jardine MY, McGuffin P (1978) A clinical scale for the self-assessment of irritability. *British Journal of Psychiatry* 132:163-171
8. Stratton P, Bland J, Janes E, Lask J (2010) Developing an indicator of family function and a practicable outcome measure for systemic family and couple therapy: the SCORE. *Journal of Family Therapy* 32:232-258

APPENDIX 1a: Amended Study Protocol 2 July 2013

Social Work Working for Families Evaluation

Background

Social Work Working for Families

Cambridgeshire County Council are currently completing a major reorganisation of the social care system for children and families, to the 'Social Work Working for Families' (SWWFF) model. SWWFF represents a significant shift in the way that Social services for children and families are organised, and work. It is drawn from a "systemic" model of care first deployed in Hackney, NE London, that has been positively reviewed and evaluated [3]. Some of the key changes from "Care as Usual" include the organisation of social workers into small teams ("Units"), that include a clinically-trained practitioner (in most, but not all, cases a Family therapist) so that they are able to address simple mental health and relationship problems as an early intervention. With administrative support, the emphasis is on supporting Social Workers to be in more of a practitioner role, rather than a more "hands off" managerial/care coordinating role.

While there is some evidence to suggest that the changes to practice and managerial reorganisation involved in SWWFF have been effective in the densely populated inner city setting of Hackney, there is no such evidence for how such a reorganisation might translate into a mixed urban, suburban and rural setting such as Cambridgeshire. Nor was the evaluation of the first iteration of this method in Hackney definitive - in terms of its sampling methodology, the length of follow up, and the kinds of outcome measures applied. As is always the case, the model deployed in Hackney has continued to develop, and will need to be adapted to fit the different demands of the Cambridgeshire setting. Given, also, the fact that many other Social Services departments across the UK (and beyond) are subject to major reorganisations that are costly and disruptive (though with the intent to improve outcomes for complex and vulnerable families), an evaluation of this process and this model of care appears very necessary.

It is important to evaluate whether this service leads to improvements in client families. Given the statutory role of social care to improve the wellbeing of all the population, not just the families that it sees, this study should also evaluate population-level measures, such as school attendance and child mortality. Given the relatively high levels of stress, burnout and high staff movement in social services,

it is important to evaluate the effects of this new service on staff job satisfaction and attitudes. We shall also evaluate whether differences in staff attitudes and experiences of the model influence outcomes for families. Finally, it is important to collect information from the managers of this service transformation about the process of change itself, what worked well and where problems occurred. This evaluation will both guide Cambridgeshire County Council as to how effective current care is, and how it may need to be developed; and also guide other local authorities as to whether (and how) they should change to a similar service structure.

Adolescent Mentalization-Based Integrative Therapy

AMBIT is an approach that encourages the use of simple and previously evidence-based practices (such as basic Cognitive Behavioural Therapy, basic Family work, or basic physical and sexual health promotion, etc) in a coherent psychologically-oriented framework that includes two further elements: (a) a strong emphasis on developing and sustaining active peer-to-peer support and improved communication between team members, and (b) proactive work to address relationships across the wider multi-agency network, particularly to reduce the instances of poorly-integrated care [2].

The theoretical "glue" that holds this approach together is the concept of "Mentalization" - which is defined as the imaginative activity of "making sense of one another's actions on the basis of what might be going on in the mind of the actor (their intentions, beliefs, hopes, fears, etc)". This is an approach that has been developed over the past decade, and applied in a powerfully evidence-based (NICE-approved) therapy for adults with personality disorder ("Mentalization-Based Treatment" or MBT) [1]. Because of the strong developmental themes in this way of making sense of emerging patterns of behaviour, there has recently been a lot of research and development activity in applications of this same concept with children and families. Crucially, mentalization-based approaches have a very good "fit" with many other theoretical approaches (for instance "Systemic" approaches, or "Cognitive-behavioural" ones), so that integrating AMBIT with the systemic training that the SWWFF units will receive is relatively simple.

AMBIT is used in a wide range of statutory and non-statutory settings across the UK (see <http://www.tiddlymanuals.com> - and follow links to AMBIT), and early evaluations in these settings are promising, though to date there have been no randomised trials. AMBIT recently won a national award

for innovation (the Guardian/Virgin Business Media "Innovation Nation" award for the use of technology to support Collaboration.)

AMBIT offers a manualized framework to support and guide practice with complex cases particularly where there may be "co-occurring" social, physical and psychological problems and disorders (e.g. clear protocols that are recorded so that these can guide and shape the management of a case, as well setting the ethos within which the team operates. See <http://ambit.tiddlyspace.com> for the online manual.) In this respect it represents a different approach from "Care as Usual" by a Social work team - hence the need to examine whether it offers any additional value.

Part of the AMBIT method, however, is also designed to support and encourage local teams to develop their own locally-"attuned" adaptations of practice. Local teams are encouraged to edit and author their own local versions of AMBIT's 'open-source' web-based manual - so that these come to represent more accurately the nature of local practices and expertise and ideally come to be identified by teams as a place where they "define themselves and their approach to the work, and their ongoing learning about improving outcomes".

In this way, AMBIT is not a "one-size-fits-all" approach to therapeutic work, but rather seeks to offer a structured framework which supports local services to marry elements of externally-validated evidence-based practices with their own locally-derived "practice-based evidence".

AMBIT is being used by 20 services around the UK across a wide range of service settings; from non-statutory (voluntary sector) street-level services for gang-involved youth, to NHS 'Early Intervention in Psychosis' or Adolescent Outreach teams serving. While individual AMBIT-supported services are evaluating their own outcomes, there has not been an opportunity to examine the outcomes for AMBIT and non-AMBIT trained teams in more direct and valid comparisons. The present SWWFF study offers such an opportunity.

As a non-commercial "open source" approach to therapy (hosted by the charity the Anna Freud Centre, and supported by a grant from Comic Relief) that aims explicitly to share knowledge about best practice via freely available web-based treatment manuals and training materials (such as streaming video role-plays and lectures that are built into the web-based manuals), AMBIT has the opportunity to offer evidence-based support very widely to services that often struggle to find the budget for more

expensive training packages. The proposed study offers the opportunity to evaluate evidence of its effectiveness in terms of the outcomes for families and for workers.

Purposes of Evaluation

The main aims of this study are to evaluate how effective social work delivered in the SWWFF model is at improving the mental health, wellbeing and family function of its client families; and how acceptable this model of social care is to client families and professionals working within SWWFF. It will also investigate how the teams function and the degree to which team characteristics influence client outcome. As one secondary aim, six teams will be selected at random to train in Adolescent Mentalization-Based Integrative Therapy (AMBIT). We shall investigate whether AMBIT leads to better outcomes for clients and staff. As a further secondary aim, we shall collect information from service transformation managers about the process of change itself, what worked well and where problems occurred. We shall also interview managers of partner agencies, within and outside the local authority, for their opinions on whether the change to SWWFF has changed the service social care provides for families, and whether it has influenced working relationships between their teams and children's social care.

Methods

D. Cluster Randomisation

6 consenting units from the 46 social work units will be trained (and subsequently supervised) in Adolescent Mentalization-Based Integrative Therapy (AMBIT). The teams will be selected using stratified cluster randomization. Six similar sized groups of units will be defined, based on unit type, deprivation levels and degree of urbanization. One consenting team from each group will be randomly selected using the online programme www.random.org. Agreement to be randomized to AMBIT/non-AMBIT will be obtained before randomization takes place, to maintain allocation concealment.

E. Quantitative Evaluation

B1. Participants

This study will evaluate three levels of research participants:

B1.1. SWWFF Client Families

SWWFF will have 46 units (teams) of care. Each is likely to have a current caseload of 12-45 cases at any one time. The aim is to have 10 families recruited per unit. Therefore we shall aim to recruit 460 consecutive consenting families at intake to social care. Families will use self-ratings (parents and children), parent ratings (of children) and will receive observer-based ratings from social work units.

B1.2. Cambridgeshire Population

We shall collect population measures of child health/wellbeing over each year of the intervention, and the preceding three years. Such data will be available from public, health or local authority databases. We shall compare this against changes over the same time periods of non-SWWFF local authorities (both across England, and of comparative socio-economic need) to help to control for the effects of changes in national policy and national socio-economic changes.

B1.3. SWWFF Staff

We shall collect information from all consenting SWWFF staff members on an annual basis. SWWFF aims to employ 220 staff.

B2. Materials

B2.1. SWWFF Client Families

Ratings of Child/Adolescent Mental Health and Wellbeing

KIDSCREEN-10 (self-rating by children old enough, to be judged by social work team in conjunction with parent(s), usually ≥ 8 years) [6]

Strengths and Difficulties Questionnaire (by the parent who has most contact with the child) [4]

Parental Mental Health and Wellbeing

Adult Wellbeing Scale [7]

Family Function

SCORE 15 (to be completed by all family members old enough to complete it) [8]

SWWFF Family Experience Questionnaire (to be completed by all family members old enough to complete it)

Demographics and Environment Questionnaire (by a parent, with assistance from social work professional)

B2.2. Cambridgeshire Population Under 18 years

Hard data. The following data are less likely to be confounded by changes in practice/thresholds other than the development of SWFF:

Mortality rate

Admissions to hospital

School attendance rate

The following data will also be collected, although we accept that factors other than the development of SWWFF (such as changes in child protection thresholds) may strongly influence results:

- Number of contacts per case in children's social care
- Number of children given a child protection plan for the first time
- Number of children placed in care
- Proportion of looked after children with no change in placement in the last two years
- Proportion of care leavers in suitable accommodation
- Proportion of care leavers in employment, education or training

B2.3. SWWFF Staff

SWWFF Staff Attitude Questionnaire

SWWFF Staff Experience Questionnaire

Staff sickness rates (collected at start of project, at yearly intervals thereafter, and preceding 3 years)

B3. Procedure

B3.1. SWWFF Client Families

The aim is that all families referred to social care will be informed about the evaluation and given information sheets at the initial assessment with social care, or in the phone call with the unit coordinator that will set up this meeting. At a subsequent (ideally next) meeting/phone call, they will be asked if they would be happy to take part. The social work team and family will have a range of options open to them for administration of the questionnaires: they could be given by a member of the social work unit, or by a member of the research team.

All family members aged 16 or over will be asked for separate informed consent. This will include parents and children not living at the index household but who are actively involved in the casework (to be decided by the social work team). Children under the age of 16 who are judged to be old enough to understand the study and complete questionnaires will be given age-appropriate information sheets and asked for assent. If parent(s) consent but one or more child does not assent to data collection, then the family will still be recruited using available data, to maximize representativeness of the sample. A

potential complication can occur if children are in care under section 20. In these cases, parents and the local authority have joint parental responsibility. It is good research practice for parents to consent for their child to take part in the study in most cases, but that each case should be judged on a case by case basis. If possible parents should be approached. It is possible for them to consent for their child to take part but not themselves (if the bulk of the work is being done by foster carers, who themselves have consented to take part). In some cases, where parental contact/consent is inappropriate, then the local authority can consent. These cases should be discussed with a manager and, if necessary, the research team. A designated member of the social care team should sign the social care parental responsibility consent form.

If the family do not want to take part at that second meeting, they will be asked if they would be happy to be asked at future meetings, or would rather not be asked again. This would be respected. Families will be eligible to enter the study for up to two months after the initial Access appointment.

The set of parent and child/adolescent questionnaires will be administered at the following time-points:

- Initial assessment by social care

- When changing between social care units

- At six months from initial assessment

- At six month intervals since the previous assessment

- When discharged from social care

- Six months after discharge from social care

- At the end of the study period for all families still receiving input from social care

A range of methods can be used to administer the questionnaires: they could be given in person, they could be sent by post, they could be administered by telephone. If sent by post, the research team will track whether they arrive and contact the family if they do not, asking the family if they are still happy to take part; and if so, asked whether they need any assistance and reminded to return them. When questionnaires are given in person, the social work professional or researcher will help the family if needed, and if the family are happy, will check that questions are not missed out. If administered by the social work professional, families will be given the option of completing the questionnaires without the professional seeing the answers, and returning them to the professional in a sealed envelope or posting them in a reply-paid envelope. Families will also be given the option (when feasible) of a different member of the team who has not been treating them administering the questionnaires.

The six months post-discharge questionnaires will be administered by the research staff, by telephone, at home or other suitable place (such as NHS clinic or GP surgery).

B3.2. Population Measures

Population measures will be obtained from local authority, health or public databases.

B3.3. SWWFF Staff

All consenting staff will be asked to complete their questionnaires at the start of the study (or start of employment), at 12 month intervals thereafter, at the end of the study (if no questionnaire in the last 4 months), and if they move social work units or stop working for social care. Managers will explain the importance of this to staff face to face, and give information sheets and regular newsletters will also explain the importance of high levels of participation in the study. Team members will be explicitly told that management will not know if they are participating and will not think nor act unfavourably towards them if they do not participate. Researchers' details will be provided on information sheets so staff can ask any necessary questions. Completed consent forms will be sent to researchers. For consenting staff members, questionnaires will be sent by and returned to researchers, not local authority management. Questionnaires will not be anonymous, as it is important that we assess changes over time within individuals, compare results between AMBIT and non-AMBIT teams, and assess whether differences in staff characteristics influence outcomes for families. However, questionnaires will only be seen by the research team and not be seen by members of social services management. We shall also use results from the Staff Attitudes Survey completed by consenting staff members before the study period (it was used as a routine staff survey before this study).

B3.4. Duration of Study

There will be two years of data collection. All families giving baseline data and one follow-up data point will provide useful and useable data for longitudinal data modeling. End of data collection will be variable, as it will be 6 months after a case is closed. To maximize study efficiency and value, clients will

be recruited until 6 months before the study end, and all data will be used, whether that is 6 months or 2 years of follow-up.

Hypotheses and Statistical Analyses

7. We hypothesise that there will be a significant improvement in client family, individual and population-level outcomes over time (single arm repeat measures design).
8. We hypothesise that families receiving care from AMBIT-trained teams will have better outcome than families receiving care from non-AMBIT teams (parallel cluster randomized comparison).
9. We hypothesise that baseline factors of staff attitudes within a cluster will influence outcomes of families. We shall investigate this by regressing outcomes on individual items from the SWWFF Staff Attitudes Questionnaire.
10. We hypothesise that staff attitudes and satisfaction will improve, and sickness rates will decline, over the course of the study (single arm repeat measures design).
11. We hypothesise that staff attitudes and satisfaction will be more closely correlated between staff members within a cluster than between staff members from different clusters (significant intra-class correlation).
12. We hypothesise that staff working in AMBIT-trained teams will have greater improvements in attitudes, satisfaction and sickness rates than staff in non-AMBIT teams (parallel cluster randomized comparison).

Conventional statistical analysis assumes that all results are independent. This assumption is not met in this study, due to intracluster correlation. Firstly, individual scores of individuals within a family are likely to be correlated more than are scores from independent individuals (due to shared genes and environment within a family); secondly, scores of families treated within a social care unit may be more correlated than independent families, because features of a unit may influence outcome of the families it treats. Data for families will therefore be at three levels: level 1 (individuals), level 2 (families), level 3 (social work units). Data for staff members will be at two levels: level 1 (individual staff members), level

2 (social work units). This will be accounted for in multi-level modeling using the xtreg function of Stata [5].

We shall apply estimates for typical costs of service use to families in the study, based on items in the demographics questionnaire (including child protection status, school attendance, use of other agencies). We shall use this to demonstrate how cost levels for families change during the social care intervention, and predict that there will be a rise in costs as intervention starts, but a fall in costs to below baseline levels after the intervention.

Sample Size Estimation

Because of the nature of the major re-organisation, and the inevitable exigencies relating to such a process that cannot be predicted, it is difficult to predict accurately the sample size that will be captured.

Several issues have governed planned sample size:

1. It is important to recruit all units to ensure that all units are offering a good service.
2. It is important to recruit a sufficient number of families per unit to evaluate reasons for differences between units.
3. Intra-cluster correlation (ie similarities between members of the same family) mean that individuals are not independent, and a larger sample size is needed
4. In terms of recruitment, an average of 10 families over one year per unit was deemed feasible by social work colleagues

F. Qualitative Evaluation

C1. SWWFF Client Families

Interviews will enquire about users' perceptions of services, expectations of and beliefs about efficacy of interventions, comprehension of aims and objectives of service. These families will be interviewed initially with all consenting family members, then individual interviews with consenting/assenting family members (a maximum of three, the choice of which will be a joint decision between the head of family, the social work professionals and the researcher). Tape recordings of the full responses will be used for subsequent thematic analysis. We shall undertake these interviews using a semi-structured approach to obtain reliability for the family probes and cues and to ensure we capture contextual data to consider compliance and adherence to interventions. We shall select families such that they cover the full range of families seen by social care, on demographic measures (eg family structure, urban vs rural), on clinical measures (family and child wellbeing, family function, degree of improvement over the study) and on length of social services involvement. Latent class analysis will be used to identify clusters of families that share similar characteristics (demographic and clinical). Families will be selected randomly from within each of these latent classes, ensuring a spread of family types. This will lead to more representative families than a more common approach of selecting 'convenient' families. We shall use thematic analysis to analyse the qualitative interviews. We are expecting to interview around 40 families. Families will be interviewed at home or other suitable location, depending on family preference. Interviews will be conducted by the research associate and research assistant, not social work staff. Interviews will be audiotaped and transcribed by CPFT staff (the NHS trust hosting the research and employing research staff) staff, before analysis. Interviews will be kept within the secure CPFT electronic network and transcribed using secure CPFT equipment. Transcribed interviews will then be transferred to the University of Cambridge project database using a secure memory stick.

C2.2. SWWFF Staff

Staff members will be interviewed at the start of the project and 12 months later. These semi-structured interviews will characterise in depth their perception and anticipation of their roles, their predictions for service success and where risks and threats to implementation and good outcomes may arise; and their opinions on the service and whether their experience has met expectations. We shall evaluate how the process of change has felt for social workers, and whether (and how) new team cultures have developed.

Again, we shall interview staff representing a wide range of unit types, geographical areas, and baseline scores on staff attitudes and experiences. We shall use weighted sampling to ensure a larger number of staff members from AMBIT teams, such that the AMBIT : non-AMBIT staff ratio will be 1:2 (as opposed

to 1:6 which will be the staff distribution across teams). We shall use thematic analysis to analyse the qualitative interviews. We are expecting to interview around 30 staff members. Interviews will be audiotaped and transcribed by CPFT staff, before analysis.

C3.3. SWWFF Service Managers (Process of Service Transformation)

Managers who have effected this service transformation will be identified by the Head of Social Work and asked if they would agree to take part in this evaluation, up to a maximum of 12. Each consenting manager will have three qualitative semi-structured interviews with the researchers (at the start, middle and end of the study) to discuss the ongoing service transformation, including what has worked well, what has not worked well, and key learning points for future similar service transformations. Consenting managers will be asked to collect a log of important developments between these research assessments, to help them to remember important events. Two focus group of all consenting and available managers will be held at the end of the project, one for Group Managers, one for Heads of Services. The total maximum number of participants will be 10 per focus group. These focus groups will discuss what has worked well, what has not worked well, and key learning points for future similar service transformations.

We aim to integrate information from all the interviews and focus group to develop a narrative of the change process over time. Details of this will include: what worked well and didn't work well overall; particular difficult points in the change process and how these were overcome (or not); important lessons managers would advise managers of other social care organizations planning a similar transformation. We shall use thematic analysis to help us to analyse the data. Interviews/the focus group will be audiotaped and transcribed by CPFT staff, before analysis.

C3.4. Managers of Partner Agencies

The research team and social care management will identify managers of partner agencies to children's social care, both within and outside the local authority (including the Youth Offending Service, Child and Adolescent Mental Health Services, Family Courts, Education, Children's Disability Social Care).

Researchers will interview them individually, asking for their opinions on whether the change to SWWFF has changed the service social care provides for families, and whether it has influenced working relationships between their teams and children's social care. They will be asked in detail about what works well and does not work well, and be asked for suggestions as to how children's social care could work even better.

We aim to integrate the experiences and opinions of these managers into an account of how they see SWWFF as improving (or not improving) the care given to families; and how this service transformation has impacted other agencies. We shall use thematic analysis to help us to analyse the data. Interviews will be audiotaped and transcribed by CPFT staff, before analysis.

References

1. Bateman A, Fonagy P (2008) 8-year follow-up of patients treated for borderline personality disorder: mentalization-based treatment versus treatment as usual. *Am J Psychiatry* 165:631-638
2. Bevington D, Fuggle P, Fonagy P, Target M, Asen E (2012) Innovations in Practice: Adolescent Mentalization-Based Integrative Therapy (AMBIT) – a new integrated approach to working with the most hard to reach adolescents with severe complex mental health needs. *Child and Adolescent Mental Health* Online publication ahead of print, 4 May 2012
3. Cross S, Hubbard A, Munro E (2010) Reclaiming Social Work. London Borough of Hackney Children and Young People's Services. In: Human Reliability, Dalton, Lancashire
4. Goodman R (1997) The Strengths and Difficulties Questionnaire: a research note. *J Child Psychol Psychiatry* 38:581-586
5. Rabe-Hesketh S, Skrondal A (2008) Multilevel and Longitudinal Modeling Using Stata. Statacorp, College Station, Texas
6. Ravens-Sieberer U, Erhart M, Rajmil L, Herdman M, Auquier P, Bruil J, Power M, Duer W, Abel T, Czemy L, Mazur J, Czimbalmo A, Tountas Y, Hagquist C, Kilroe J, Group EK (2010) Reliability, construct and criterion validity of the KIDSCREEN-10 score: a short measure for children and adolescents' well-being and health-related quality of life. *Qual Life Res* 19:1487-1500
7. Snaith RP, Constantopoulos AA, Jardine MY, McGuffin P (1978) A clinical scale for the self-assessment of irritability. *British Journal of Psychiatry* 132:163-171

8. Stratton P, Bland J, Janes E, Lask J (2010) Developing an indicator of family function and a practicable outcome measure for systemic family and couple therapy: the SCORE. *Journal of Family Therapy* 32:232-258

APPENDIX 2: Value for Money in Social Welfare Services?

Dr Jane Akister⁸ and Niamh O'Brien

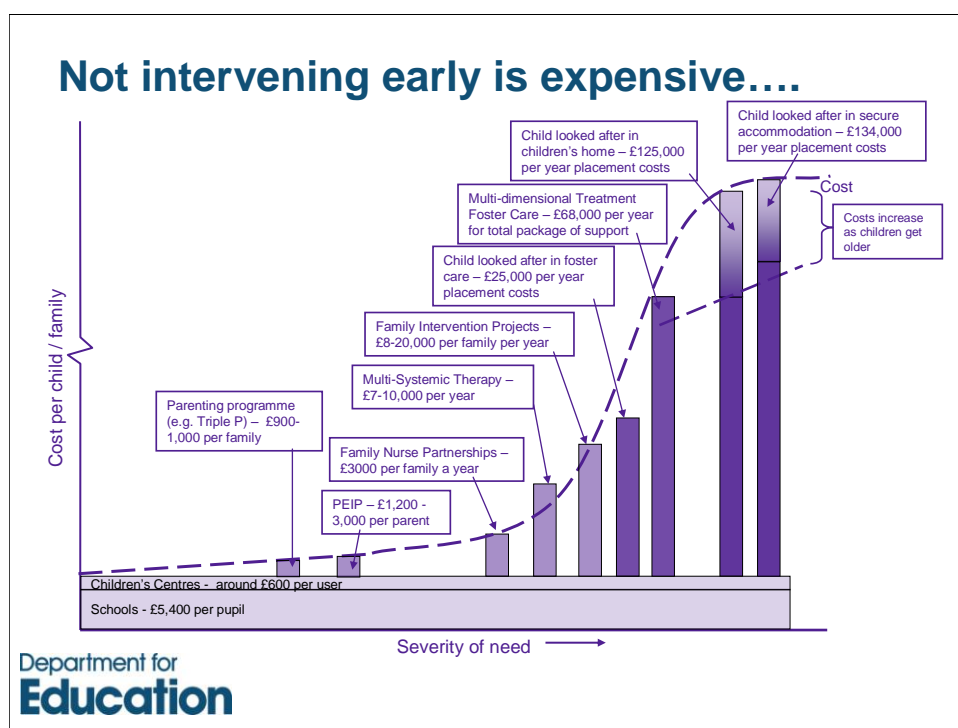
⁸ jane.akister@anglia.ac.uk

Introduction

This chapter was submitted as a paper to Cambridgeshire County Council on 31.8.13 as part of the SWWFF project. An abridged version is included here as it offers useful information about how to conceptualise 'value for money' and suggests approaches to this for differing situations. We planned to use this methodology in the longitudinal SWWFF evaluation that did not eventually take place. However we are including it here as it may be helpful for people planning future social care evaluations. Evaluating the effectiveness of practice is key to the efficient use of resources, which is very important in times of scarcity.

For example, not intervening early is presented as being expensive (see Diagram 1), but intervening without evidence of effectiveness is also expensive. Some early interventions at population level (available to all), such as children's centres, are expensive and take resources from more targeted interventions. This is only justifiable if we can evidence that such interventions are effective in preventing need at a later stage. Thus despite the complex question of 'what is value for money?' we have to address it in order to know how best to use our limited resources.

Diagram 1



There is an increasing focus on gaining 'value for money' in all areas of public spending in the UK and worldwide⁹. It is hard to conceptualise what this 'value for money' means in relation to social welfare provision since the range of services provided through the public sector are so diverse.

In relation to children's welfare and protection, the services must cover:

1. protection from harm: physical and emotional;
2. protection from neglect;
3. prevention of harm and neglect.

Protection from harm and neglect may take place in the family environment or in out-of-home care. Prevention from harm normally takes place while the child remains in the family environment and requires the early identification of risk to a child together with an intervention designed to prevent progression to harm. Immediately we can see that there will be a complex system of services designed to meet children's needs in these situations.

It is important to recognise that while the family is viewed as the ideal environment to provide for the needs of the child, the legal remit to work with families is based in legislation to protect the welfare of the child. For this reason the work undertaken with the family needs to deliver improved outcomes for the child/children.

Where to start? The whole conception of children's services is aimed at improving life chances for children and was captured in the propositions in the government paper, Every Child Matters¹⁰, that every child has a right to opportunities. We could argue that the aim of children's social welfare services is to improve outcomes either through preventing the circumstances from getting worse or through an actual improvement in the circumstances. Where there is statutory involvement in a family, things need to get better or legal action will

⁹ Burley, M. and Lee, S. (2010) Extending Foster Care to Age 21: Measuring Costs and Benefits in Washington State.
<http://www.wsipp.wa.gov/pub.asp?docid=10-01-3902> Accessed 25.7.13

¹⁰ Department for Education (2003) Every Child Matters. HMSO.

be taken. Where the involvement is an early intervention the outcome we seek is that things do not get worse, to avoid moving towards statutory involvement. Theoretically this is quite simple. If there is a statutory involvement and things do not improve we can argue that the intervention is not worthwhile and that it is not value for money. If the involvement is preventative and things get worse, again this is not value for money. Of course, because there are many complexities in each family or child welfare concern it is tempting to say this is much too simple. However, if we do not look at outcomes, in some way, we risk practising in ways that are not evidence-based and may actually be harmful. The 'value for money' in children's welfare services has to be concerned with effectiveness and outcomes.

As well as fulfilling statutory duties, current government policy emphasises both early intervention and prevention strategies (Allen, 2011¹¹) and recognises the need to have sufficient resources to support those with greatest need, including children with disabilities (Department of Education, 2011¹²) and children subject to Child Protection Plans (Munro, 2011¹³). Balancing the cost implications is challenging and one approach, the Cost Calculator (Holmes and McDermid, 2012¹⁴), uses what they describe as 'bottom up' methodology, analysing the components of social care provision and gives costings of the main activities which can be used to cost a specific case or a group of cases. Conversely, it can be used to estimate savings achieved through a specific intervention.

Who wants to know if a service is value for money?

Value for money questions in social welfare services are usually posed in three ways:

1. Where a local authority has commissioned a service is it cost effective?

¹¹ Allen, G. (2011) Early Intervention: The next steps. London: HM Government.

¹² Department for Education (2011) Short Breaks for Carers of Disabled Children: Advice for local authorities. London: Department for Education.

¹³ Munro, E. (2011) The Munro review of Child Protection final Report. London: Department for Education.

¹⁴ Holmes, L. and McDermid, S. (2012) Understanding Costs and Outcomes in Child Welfare Services: A comprehensive costing approach to managing your resources. Jessica Kingsley Publishers: London and Philadelphia.

2. Where a third sector organisation is providing a service, is there independent evidence of cost effectiveness?
3. Where a local authority is providing a service is it cost effective?

These questions can be considered in relation to a specific intervention or time period or in relation to the lifetime costs. Coles et al.¹⁵ estimated the life time costs of people not being in education, training or employment (NEET). This was an ambitious approach and in the case of the cost of being NEET over a lifetime, the huge lifetime costs identified would suggest that there is value in any strategy that is proven to improve outcomes. Based on the lifetime approach, it could (and perhaps should) be argued that once children and families are subject to child protection legislation that all interventions have value in attempting to alter the young persons' life trajectory. However, resources are limited and we will propose an approach that looks at cost effectiveness in a limited time frame.

Methods for calculating cost effectiveness

To be cost effective a service needs to deliver savings that are greater than the costs. This is difficult to establish as most of the service users are involved with multiple services and estimating costs and savings is difficult.

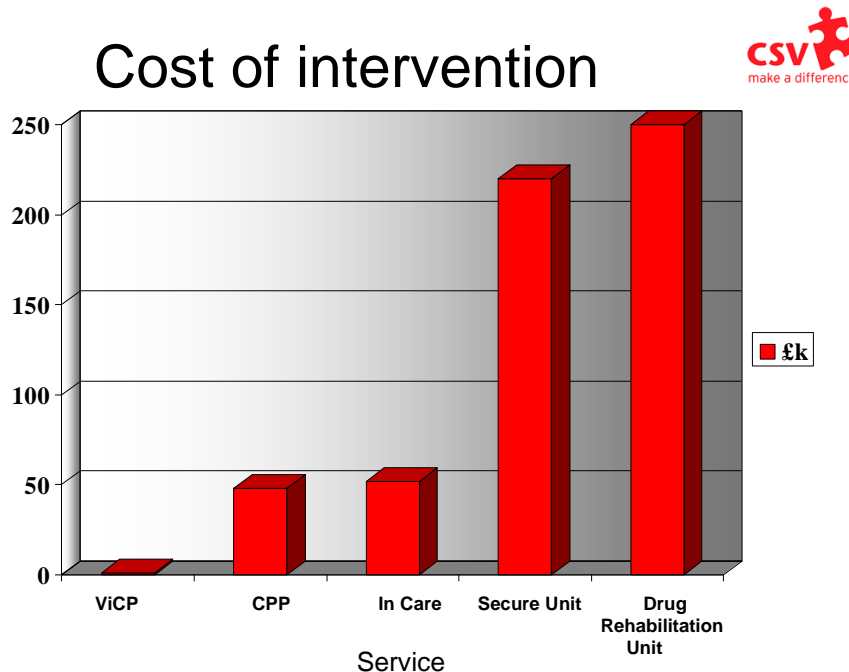
Health economists have tried to look at whether an intervention leads to a decrease in service use, but this is notoriously hard to track. Service users are poor at reporting their range of service use, and even though they are referred to services they do not always take up these services. So the methodology for calculating cost effectiveness based on levels of service use is often inaccurate.

Currently, there is a move to consider the costs of interventions. For example, the cost to the welfare services of a child being placed in care is greater than the cost when they are able to stay in their own home. If we can show that a service leads to a child returning from out-of-home care to their parents' care we are clear that there have been savings. If we can show that

¹⁵ Coles, B., Godfrey, C., Keung, A., Parrott, S. and Bradshaw, J. (2010) Estimating the life-time cost of NEET: 16-18 year olds not in Education, Employment or Training. University of York.

a service prevents a child coming into the care system we can estimate from this the costs that would have been incurred had they come into the care system.

The diagram below provided by a third sector provider (Community Service Volunteers, CSV) gives an idea of how this works. The CSV ViCP (Volunteers in Child Protection) intervention is very cheap compared to the cost of a child on CPP (Child Protection Plan), which in turn is much cheaper than maintaining a child in a secure unit, and so on.



The critical question therefore is does a specific service lead to improved outcomes for the child, thus evidencing direct savings and/or does the specific service prevent the need for more expensive interventions?

Continuing with the CSV example, does the ViCP intervention contribute to a child coming off a CPP? If so, the intervention contributes to the costs saved. If a child is in out-of-home care and returns home but is still subject to a CPP there is an identifiable cost saving, but the costs are still high and so on. This methodology can be applied to any intervention including work with the whole family system or work with an individual child or young person. (It can also be applied to other service user groups).

Attributing value for money is not easy when there is such a complex interplay of agencies intervening with these families.

For these reasons, the only way to approach this with confidence is to take the known costs and establish whether the intervention has led to improvement and therefore reduced these. If not then there have to be questions about whether the intervention is worth continuing with. This is particularly pertinent to interventions commissioned by the local authority and delivered by external providers and to preventive interventions where current service costs are low.

We can make these calculations using indicators of concern about the family (levels of concern reflected in the CAF levels or local equivalent) and the costs saved using the cost calculator¹⁶. Details of this approach are given below.

Approaches to calculating 'Value for Money'

This section begins by presenting some thoughts from young people on what might have helped to prevent them coming into care as a backdrop to the pressure for early intervention, without an evidence base. Developing an evidence base at the locality level remains important (CAF levels 1-2). It then looks at some of the core outcomes that can confidently be costed for use in value for money calculations.

Preventing reception into care

In the study '*Children on the edge of care*' led by Dr Roger Morgan¹⁷ a vast number of the 122 children and young people participating in the study (43%) held the view that they would not have needed to come into care if there had been more support provided for them and their families. Most of these young people felt that the following (and other) support might have prevented them from entering the care system:

¹⁶ Holmes, L. and McDermid, S. (2012) Understanding Costs and Outcomes in Child Welfare Services: A comprehensive approach to managing your resources. Jessica Kingsley: London and Philadelphia.

¹⁷ Morgan, R (2011) Children on the edge of care: A report of children's views by the Children's Rights Director for England. Ofsted: Manchester.

Support	Percentage of young people
More support for parents/carer	58%
A social worker or other worker visiting us until things are settled	46%
Someone checking up on how we are getting on	43%
Help with somewhere good to live	42%

Other ideas offered by young people for further support included: practical help for parents around maintaining the family home, group meetings to support parents and their children together, guidance on parenting skills and both practical and emotional support for parents caring for children. The young people proposed “*an independent visitor, rather than a social worker*” (p.9) to visit regularly and provide the types of support mentioned previously. National survey data suggests that unless support and services are offered early there is a high risk of situations escalating and thus necessitating higher level intervention at a later date as well as further costs.¹⁸

What are the costs?

In 2009 the House of Commons, Children, Schools and Families committee report on Looked after Children¹⁹ highlighted the average costs per week of children in the care system:

Average cost per looked after child per week (£)	
All placements	774

¹⁸ Holmes, L., Munro, E.R., and Soper, J. (2010) *Calculating the cost and capacity implications for local authorities implementing the Laming (2009) recommendations*. Centre for Child and Family Research: Loughborough University.

¹⁹ House of Commons Children Schools and Families Committee (2009) *Looked After Children: Third Report of Session 2008-09* Volume 1. The Stationary Office: London.

Residential home placement	2,428
Foster Care	489

Previous studies show the estimated costs per annum associated to risks linked to vulnerable families. These estimates are based on the likely spend required by public agencies in response to each risk:

Risk and estimated cost per annum (£) ²⁰		
Risk	Cost	Source
Foster Care	20,500	Jones et al. 2006
	34,400 - 46,800	Nixon et al. 2006
Local Authority residential care	72,800	Walker et al 2006
Local Authority Secure Care	193,700	Walker et al 2006

Cost models

The cost calculator has been developed by researchers at the Centre for Child and Family Research at Loughborough University. The methodology for the cost calculator lies in the work of Beecham²¹ who designed the ‘bottom-up’ costing methodology. This methodology has been successfully used in a number of studies exploring the costs and outcomes associated with child welfare interventions including the costs of placing children in care, short break services for disabled children and key policy and practice developments.

“It allows for the development of a detailed and transparent picture of costs of providing a service, and of the elements that are necessary to support service

²⁰ Flint, J. (2011) *Evaluation of Rochdale Families Project: Briefing paper on Economic Cost-Benefits of Family Interventions*. Centre for Regional Economic and Social Research: Sheffield Hallam University.

²¹ Beecham, Jennifer (2000) *Unit Costs: Not Exactly Child’s Play*. Project report. Department of Health, Personal Social Services Research Unit and Dartington Social Care Research Unit. <http://kar.kent.ac.uk/32449/> Accessed 24.7.13

delivery. This method facilitates comparisons of costs and allows for variations in costs according to the needs of children, decision making processes and approaches to service delivery to be considered.”²²

This approach focuses on the personnel required for each activity or service and estimates the time spent on it. These are then calculated using the appropriate hourly rate. The ‘bottom-up’ approach is therefore associated with the amount of time spent on the activity and the salaries of those involved including management overheads and other expenditure. The cost calculator has been used to quantify the costs associated with social work time. At a time when young people themselves are proposing an increase in social work time in order to improve their situation it is worth determining the costs associated with this activity. In the case of initial contact the time spent by social workers ranged from 15 minutes to over 3 hours but on average this was 49 minutes. Additionally referrals averaged at about 4 hours and 40 minutes of social worker time. The average time spent by social workers on initial assessment was 10½ hours. The following table gives a break-down of these costs:

Social work activity	Cost
Initial contact (based on average unit cost per hour)	£36.94
Referral costs	£117.41
Initial assessment (social worker, team manager and administrator costs)	£361.70

In 2010, the cost calculator was extended to include the cost calculations for all ‘children in need’ evidencing that it was possible to show the various costs incurred for children with different levels and types of need. For children under the age of six increased involvement from social care was identified and therefore higher costs. Increased costs were also identified for children on a child protection plan or those with emotional or behavioural difficulties.

²² Holmes, L., Munro, E.R., and Soper, J. (2010) *Calculating the cost and capacity implications for local authorities implementing the Laming (2009) recommendations*. Centre for Child and Family Research: Loughborough University.

As an example, we can look at 'Ongoing Support' calculations. Variations in the amount of direct time spent by social care practitioners working with a particular child or family were determined by the level of need and circumstances:

Process	Standard or Variation cost	Out of London unit cost to social care (£)
Process 3: Ongoing Support (per month)	Standard cost: No additional need	107
	If child under 6	192
	If Child Protection Plan	263
	If 6 or under and CPP	410
	If emotional or behavioural difficulties	199
	If EBD plus another factor	499

The costs of case management activities for children's social care over the time period 1st October 2008 – 31st March 2009 is shown below:

Average total cost over 6 months (£)						
All children in the sample	Children in need with no specified additional need type	Children under 6 years	Children who have a child protection plan	Children under six years who have a child protection plan	Children with emotional or behavioural difficulties	Children with emotional or behavioural difficulties and another factor
1,416	905	1,387	1,864	3,069	1,494	3,205

These costs are helpful as it can immediately be seen what type of situation escalates costs. This also highlights where you can make the most effective savings, and evidence these.

Concluding thoughts

There is no simple way to show cost effectiveness in social welfare services. For this reason any claims to cost effectiveness need to be clearly evidenced and not over optimistic.

Returning to the three core questions concerning 'value for money':

1. Where a local authority has commissioned a service is it cost effective?
2. Where a third sector organisation is providing a service, is there independent evidence of cost effectiveness?
3. Where a local authority is providing a service is it cost effective?

The answers to the first 2 questions should be relatively simple. Does the service deliver improved outcomes for the service user? If so, what is the cost of the service and how many service users would need to benefit to make it cost effective (see Box 1 below)?

Box 1: Commissioning Cost Effective Services

Local Authority B commission a service from the NSPCC. The normal calculations of profit and loss would expect a return of 100% on expenditure to remain viable, anything less would not take account of the cost of other factors that may be contributing to improvements, and would be overstating the effectiveness of the service. The service costing £100,000 p.a. is to be delivered to 20 children, the cost per child is £5,000. To be clear that the service is cost effective there would need to be savings evidenced of £10,000 per child, that is £200,000 overall. If the service delivers savings that are less than this, say £8,000 per child, then they would need to be able to provide the service to a minimum of 25 children to make the service cost effective. The Local Authority may budget for start-up time and low referral rates to the service in the first year, but should then look for clear returns.

Clearly the profit margin can be altered but if the costs and benefits approach equality then it is very hard to argue that the service is worthwhile.

The answer to the question of whether a local authority service is cost effective is slightly more challenging. If the service is fulfilling a statutory function those identified needs have to be met. The best way to look at this is to provide services with an evidence base (known to work) and to keep cost to a minimum. For preventative services the methodology above is proposed such that the rigour of examining cost effectiveness is applied and services that are not cost effective make way for new approaches. For preventive services, you are trying to establish either improvement or at least no worsening. These calculations should be made separately as improvements suggest effective intervention, while 'things not getting worse' hypothesises cost savings, but perhaps they would never have got worse.

Finally, we propose that estimates of 'value for money' should be done, at least using the simple approach described here. Hiding behind complexity paralyses decision making. It is not acceptable to support public services that have no evidence of cost effectiveness, simply because the detail is impossible to calculate. We actually do not need the detail because we can deal in averages using costs calculated from existing research.

Value for Money in Social Welfare Services? – Key Findings

Value for money questions in social welfare services are usually posed in three ways:

- 1. *Where a local authority has commissioned a service is it cost effective?***
- 2. *Where a third sector organisation is providing a service, is there independent evidence of cost effectiveness?***

The answers to the first 2 questions should be relatively simple. Does the service deliver improved outcomes for the service user? If so, what is the cost of the service and how many service users would need to benefit to make it cost effective?

- 3. *Where a local authority is providing a service is it cost effective?***

If the service is fulfilling a statutory function those identified needs have to be met. The best way to look at this is to provide services with an evidence base (known to work) and to keep cost to a minimum. For preventive services the methodology above is proposed such that the rigour of examining cost effectiveness is applied and services that are not cost effective make way for new approaches.

Notes:

- a. There is no simple way to show cost effectiveness in social welfare services.
- b. Basing effectiveness on decrease in service use is unreliable.
- c. For these reasons, the only way to approach this with confidence is to take the known costs and establish whether the intervention has led to improvement and therefore reduced these. If not then there have to be questions about whether the intervention is worth continuing with.
- d. Any claims to cost effectiveness need to be clearly evidenced and not over optimistic.

APPENDIX 3: The Changing context of the Evaluation – Lessons Learnt

A3.1 Introduction

The SWWFF evaluation research project was ambitious in its aim to carry out a rigorous evaluation of the introduction of the unit model in Cambridgeshire. If the project had been completed it could have added significantly to the evidence-base for social work with children and families. Despite its premature termination the SWWFF project has delivered valuable insights into the experience of the implementation of the unit model from the viewpoints of service users, social workers, managers and other professionals who interface with social workers.

The SWWFF project was terminated prematurely, before the planned completion of information gathering, and there are learning points in this process that the research team see as valuable, if somewhat painful, not just in contextualising the strengths and limitations of the research findings as they are presented here, but also in providing pointers to how services and research teams might get the best possible value out of one another in future collaborations.

Here we lay out some of the key ways in which the context of the SWWFF evaluation required adaption to fit changing circumstances, under the guidance of a committed steering group, and in the face of considerable organisational and wider national challenges. The rationale for describing this in some detail and reflecting upon the process is to draw out learning about:

- What makes researching Social Work practice difficult
- Why this project failed in its primary objective
- What secondary, or incidental learning was gained from SWWFF in spite of its premature demise.

A3.2 Key contextual challenges:

Critical challenges from the **wider organisational context** that are seen as having had an impact upon the project included:

- A background of significant financial austerity in all public services.
- A background of very major service reorganisation (the subject of the SWWFF study) that took longer to implement than had initially been predicted, and which entailed significant organisational challenges.

- A background of intensified external scrutiny and regulation of all public services, which included a specific externally-led (OFSTED) inspection in Cambridgeshire. This occurred in the midst of the reorganisation, and carried very significant implications for services involved. Occurring as it did whilst the Service was in the full throes of retraining and reorganisation, the resulting report was significantly less positive than many might have hoped. It's criticisms focused on systems and procedural details, and the timetable for re-inspection was sufficiently tight that, quite reasonably, a significant resource reallocation was required to address the perceived shortcomings.
- A background of political change in local government, with inevitable reviewing and adjustment of political priorities.
- A communication problem arose whereby the county council IT systems stopped accepting e-mails from the university, hence messages sent by the principal investigator were not received by the head of children's social work, causing frustration and delays

The critical factor *from **within the project*** itself concerns the recruitment of families.

Early predictions made in the planning/commissioning stage of the project about the recruitment of families, were over optimistic. As the study was naturalistic and descriptive, using mixed methods (qualitative and quantitative), without formal randomisation other than the small planned AMBIT adjunct (see below), formal 'power calculations' to estimate the number of clients required in the study in order to generate statistically significant results were not appropriate. Instead, in discussion with Social Work colleagues a broad target of recruiting 10 families per unit over 2 years was agreed upon, totalling 460 families. The research team were encouraged by SWWFF service managers who at the time agreed this was a reasonable goal, with an assumption that unit staff could play a central and active role in recruitment. SWWFF managers, largely inexperienced in research, were relying on the researchers to advise them as to whether this was a realistic goal or not. We should have spent more time checking out each other's assumptions, rather than assuming the other knew best and were correct. Both the research team and SWWFF managers share responsibility for this joint decision and not challenging each other better.

The key difficulties faced in recruiting families were:

- We underestimated the *practical challenges* that unit staff would face once the challenges of implementation were fully active, and notwithstanding the other wider systemic challenges upon the system referred to above. Given pressure to deliver changes required by OFSTED,

family recruitment was experienced by hard-pressed Units as an additional burden, which at that time had to be a lower priority.

- We underestimated the *extent of ambivalence towards services that many families feel* (at least in the early stages of engagement) and the additional challenges this places in terms of recruitment to a study. The agreed strategy (in order to measure progress in outcomes across a family's journey through contact with the Unit) was to recruit families within the first eight weeks of contact. This decision, while fully justified (necessary, even) in terms of setting a baseline against which to measure change, placed high demands on Social Workers in Units whose struggle to engage these families in productive work necessarily took precedence over the secondary imperative to recruit them for this study.
- We were not able to recruit families directly. Ethics approval for a study such as this required that the "first approach" to families must be made by Unit (Social Care) staff on behalf of the research team (who would then approach the family to collect the data). Some staff reported experiencing this as a kind of conflict of interest balancing their duty to the family as a helping agency, against their duty to the research. Anecdotally, it seems there was some ambiguity – in the minds of some workers and some families - about the extent to which the research was truly independent from Social Services managers. The researchers reported that it was only at the point of data collection (from those families who did consent) that families were convinced of the extent of the research team's independence.

To address these difficulties in future research with social care we would seek to:

- Emphasise the rigorous *independence* of the research, and Social Services' genuine *interest* to learn about the family's own experiences (both positive and negative), the study may have been promoted as a way of "giving voice" to families who were feeling negative about their experience.
- Work directly with the social workers to deal with their sense of recruitment to the research being a conflict of interest to their work with the families.

A3.3 Key adaptations to the project

a) DROPPING AMBIT

AMBIT (Adolescent Mentalisation-Based Integrative Therapy) is an augmentative and integrative approach, focused on strengthening face to face work with complex hard to reach clients, improving team working practices and staff support systems, and improving/integrating the operation of complex multi-agency networks. It has recently been favourably reviewed in an external evaluation by the UCL CORE group led by Prof Steve Pilling in an upscaling pilot for the Camden 'Troubled Families' initiative. See section 1.2.3.2 for further details. It was initially planned to randomly allocate 6 units to training and supervision in AMBIT, and compare family and staff outcomes between AMBT and non-AMBIT units.

The roll out and training of all 46 training of units took longer than had been predicted. The challenges of such a bold re-training and re-organisation of Social work practice across the county began to manifest themselves in the details of implementation soon after the SWWFF project went 'live'; particularly after the OFSTED inspection referred to above, there was a pragmatic (and entirely understandable) requirement to "redraw the boundaries" for workers in the units

A much clearer focus on the conduct and recording of very primary and core functions (risk management, safeguarding, documentation, etc) was required, in order to satisfy the outcomes and demands flowing from the OFSTED inspection. With the delayed rollout of systemic retraining, the challenge of setting aside time for more training, this time in AMBIT, was seen as overwhelming, and potentially destabilising at a time that called for stability and "bedding in".

There were real and fully understandable concerns that there may be "training overload" in the service if the AMBIT trainings went ahead. There were observations by senior staff that enthusiasm (particularly by more newly qualified staff) for new techniques or orientations might paradoxically be serving to undermine attention to those very "basic core functions" upon which, quite properly, any service must rely. There was a concern that new training in AMBIT might serve to augment these problems. In addition, we were aware that it was proving much more difficult than expected to recruit families for the quantitative study, and therefore we were not sure whether we would have enough families in the AMBIT and control arms for a meaningful comparison. On the basis of this, the planned AMBIT training and comparative (partially randomised) evaluation was cancelled.

While we understand that in this context the timing for an augmentative AMBIT training was simply not felt to be right. It is, however, important to document what knowledge the AMBIT element of the SWWFF project would have contributed:

- The introduction of AMBIT to some of the units would have given the opportunity to compare different units to see if augmenting the SWWFF model with AMBIT improved practice.
- An AMBIT-influenced approach to focus training in SWWFF would have addressed precisely the concerns that were being voiced by OFSTED— these would have been the “post-training outcome goals”²³ that any team undergoing AMBIT training is obliged (with facilitation) to self-define prior to undertaking training.

b) FAMILY RECRUITMENT

In the early stages of family recruitment it became apparent that the pressures on unit staff to cover their statutory duties left little if any additional time for the recruitment of families (describing the nature and aims of the study, sharing information leaflets, and inviting consent to join the study.)

Other factors that may have contributed to making this task harder include:

- The *perceived level of independence* of the research from Social Services (see A3.2).
- *Lack of working English language skills was initially an exclusion criterion* for the study, as is commonly the case in psychiatric research.. Information leaflets were only available in English, limiting scope for recruitment in some areas of the county where there are higher percentages of non-English-speaking families. Social Workers found this ‘discrimination’ unacceptable. By the time it was agreed to translate study materials into other languages, it looked likely that the study was going to end.
- Lack of incentives - in many similar studies the offer of small financial incentives (shopping vouchers, for instance) for participants has formed part of the recruitment strategy, but this was not approved as part of the study.

In response to the difficulties in recruiting, a number of strategies were tested:

- Creation of postcards with basic details of the research and support for units in posting these out to families.

²³ See [http://ambit.tiddlyspace.com/#\[\[Post-training%20outcome%20goals\]\]](http://ambit.tiddlyspace.com/#[[Post-training%20outcome%20goals]])

- Creation and distribution to all Units of introduction packs containing information sheets, contact details, etc, that Social Workers could take with them on home visits.
- Creation of an open “blog” ²⁴ describing the work and rationale of the study, as well as recruitment “tips” for social workers.
- During the quantitative (questionnaires) and qualitative (interviewing) phase of information-gathering with staff and stakeholders, researchers from SWWFF also began making regular visits to Unit meetings, reminding workers about the project, and offering support and encouragement to staff around the task of recruitment and consent.
 - Initially, SWWFF researchers were visiting all unit meetings in a rotational manner.
 - Following helpful discussion with the steering group this strategy was further adapted, focusing on providing much more regular input to a much smaller number of Units (mainly Intake and Treatment Units) - judged to be the ones with the highest throughput of families most likely to be “recruitable”.
- At the time of cancellation, family recruitment, after a very slow start, had finally started to accelerate and in the preceding weeks 24 families had given verbal consent to take part, with 14 having returned the signed consent forms..
- Despite beliefs that a ‘tipping point’ may have been reached and that recruitment would likely gather pace, it was abundantly clear that (even though the initial target was essentially arbitrary rather than being dictated by specific statistical requirements) there was by this point no hope of reaching the initially defined, and over-optimistic, target for family recruitment.
- It was mainly in the light of this failure that the decision was made to terminate the project prematurely, but we acknowledge the many other factors in play at this time.

c) **CLOSING DOWN, MAXIMISING VALUE**

A new challenge was faced, once the decision to terminate the project had been announced; this was to do justice to the data already gathered, out of respect for the time and effort of

²⁴ See <http://cambs-swwff.tiddlyspace.com/>

those who had provided it, but also out of the firm belief that the dataset gathered, though incomplete, may still be of real value to Cambridgeshire as they move forwards with the SWWFF retraining and reorganisation, and to other services who might consider retracing these steps in retraining and reorganising staff, and evaluating this process.

This task required rapid prioritisation, as both of the full time members of the research team quickly found new employment and served their notice to leave. Re-recruitment to these posts was not feasible, not only in terms of timescales before the end of funding, but also because of the lag time that it would take for a new worker to develop familiarity with the study and the databases.

- Recruitment of new families was stopped and priority was given to a preliminary analysis of the all the data: quantitative data (limited amounts from families and a large amount from staff) as well as to transcribing all of the recorded interviews from staff, families, and stakeholders, and conducting a qualitative analysis of the data.

A3.4 Discussion

The priorities for any service commissioning research, such as the SWWFF study, are multiple, reflecting wider concerns than the research element of the project alone. This can present a dichotomy between:

- Requirements for outputs with which to justify ongoing investment in service reorganisation that are different from (even directly opposing) those which the research team may see as the priorities at any given time.
- Responses to emerging challenges for a large retraining/up-skilling project, as part of an even larger organisational system, that may threaten the research team's best laid plans for achieving academic rigour. This is a common point of

friction in such collaborations, and in some respects the SWWFF project was no different.

How do we explain this “trans-cultural” divide? One observation is that generally (though perhaps counter-intuitively from the commonly held perspective that science is defined by notions of *precision* and *certainty*) academic researchers’ tend to eschew certainty in favour of cautious and evidence-oriented progress into areas that are populated by many “known unknowns” and even more “unknown unknowns”.

In an organisational context that is quite properly focused and constrained (by costs, by political necessity, by service demands) to manage a more or less predictable set of *deliverables*, there is a poor fit with this territory of almost inevitable uncertainty, albeit that areas of uncertainty mark out where the development of academically rigorous new learning is most likely. We suggest that a willingness on both sides to expect, predict and proactively manage requirements for such flexibility and adaptation, and to understand the costs of this to and from both perspectives (from the commissioners of research, and from the research team) is an important factor in determining success in any such project.

Our experience in the SWWFF evaluation was that the requirement for such flexibility was initially, perhaps understandably, underestimated on both sides. However, with the help of the Steering group, learning did take place, evidenced by the analyses in this report, but also at a meta-level, about the process of marrying practical service reorganisation and delivery with research. Some learning points arise:

- Research teams that become focused on preserving the academic “purity” of their work, ignoring the brute organisational realities of the context within which that work must take place, are at great risk of reducing the fruitfulness of any collaboration.
- At the same time one cannot overestimate the importance of early and repeated clarification between commissioners and researchers of the nature of what is (and is not) being commissioned, and the constraints within which a fully independent,

academically rigorous, research team must properly operate. As discussed above, the *demonstrable* independence of a research team (different from commissioned strategic or management consultations, for instance) may be helpful in engaging both hard-pressed staff (*"this is not a means for service managers to conduct staff appraisals by stealth!"*) and families (*"this is not the service recruiting me as an advert for their work!"*). However, the counter risk is of timescales and priorities emerging that simply do not fit together.

- When different organisations work together, they need to realise e-mails may get filtered out. There therefore needs to be a clear system in place for acknowledging that e-mails are delivered

Through regular meetings the wider SWWFF project group (including the Steering Group as a whole) was able to identify quite marked cultural differences between the worlds of *academic research* (on the one hand 'pure' in intent, but on the other muddy with all the uncertainty and unknowing that research entails) and of *social work delivery* (on the one hand dealing with chaotic human realities, but on the other achieving this through the use of robust, managerial structures). In the light of this it is not surprising that this makes for a serious and complicated undertaking.

In common with any research activity, evaluating and learning about the SWWFF project has involved the judicious combination of *predictable* tasks of information gathering and analysis, along with exploration of areas that are not known, or not so easily predictable. Tolerating the level of uncertainty that this entails, and the faltering progress towards objective outputs that most research into complex psychosocial phenomena inevitably involves, presents a challenge at the best of times, and the SWWFF project was no different in this respect.

It can be argued that Social Work has traditionally had a somewhat less well developed culture of integrating rigorous evidence gathering and routine practice than the field of Health does – though it would be important to emphasise that this element of the work remains a serious struggle in the field of health as well. If this is so, then Social Work organisations face additional

challenges in embedding a research culture within day to day practice. The argument for a move towards more rigorous academic and independent research was made cogently by Marsh and Fisher (2005)²⁵, and recent developments in Social work practice clearly indicate that this is a desired direction of travel. The Munro report (2011)²⁶ describes how the move from a compliance culture towards a *learning culture* is critical in developing more effective interventions with children and families: *“This move from compliance to a learning culture will require those working in child protection to be given more scope to exercise professional judgment in deciding how best to help children and their families.”* This is not in any way an invitation to a ‘practice free-for-all’, because the same report offers robust encouragement (and a selection of tools) to engage in robust research into practice outcomes, recognising the extent and range of unknowns in this field.

In the same report, Munro highlights one of the barriers to such a shift in culture and practice:

“...the cumulative effect of previous reforms has been to create a very regulated and prescribed working environment. This has been particularly apparent in social work, where the over-bureaucratisation is reducing the time workers spend with children and families, building strong relationships, so that they can better understand and help them. Reforms have been implemented through top-down direction and regulation, which has contributed to problems and led to an over-standardised response to the varied needs of children. Managerial attention has been excessively focused on the process rather than the practice of work.”²⁷

This description of the intense pressure on Social Work systems to deliver to prescriptive and highly regulated targets, and the unintended consequences whereby such a framework undermines the creation and research of new and more effective ways of working, was well demonstrated in the instance of the SWWFF project. Following the OFSTED inspection in Cambridgeshire referred to above, very real threats to the system were introduced, that would follow from any failure of the Service to respond adequately to its criticisms. In such circumstances it would be understandable if capacity to tolerate *uncertainty* in the learning process (such as a project as bold as SWWFF surely represented) diminished. Opportunities for learning were supplanted, as it were, by the need to respond to much more urgent threats to survival.

²⁵ Marsh and Fisher (2005) Developing the evidence base for social work and social care practice. Report, Social Care Institute for Excellence <http://www.scie.org.uk/publications/reports/report10.pdf>

²⁶ Prof Eileen Munro (2011) The Munro Review of Child Protection: Final Report. A child-centred system. HMSO. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/175391/Munro-Review.pdf

²⁷ Ibid. p 128, para 8.3.

The above propositions reflect much of the qualitative data gathered from senior managers and stakeholders, where preoccupation with the inspection report was abundantly clear. The given explanation for early termination of the project recorded a belief not shared by the research team; that insufficient value would accrue from continuation of the project to its fulfilment because, in particular, recruitment of families had been much slower than anticipated. Despite this disagreement, it is our experience that at all times both sides of this equation were acting in extremely good faith and that, notwithstanding different estimations of the predicted value and worth of continuing to the planned end as opposed to closing prematurely, the project has already delivered benefit.

Perhaps an additional output worth noting here (implicit, rather than explicitly-planned) is something akin to what might accrue from a cross-cultural learning event such that, when properly conducted, both sides are left clearer about and more respectful of each other's differences, as well as the common ground they share.

A3.5 Reflections of the SW:WFF Implementation Team

This report comes a time where there have been many developments in Cambridgeshire, and some of these changes are reflected in the body of the report.

There has also been learning about commissioning an outside agency to evaluate the service that we would like to include here.

There were many valid reasons for commissioning an evaluation from an outside agency. Notwithstanding the fact that setting up and delivering a new service is all consuming, and independence in researchers is valued, it is worth considering that social care services can often reflect their client group in a lack of confidence in their own ability. At the point of commissioning, the expertise for research and evaluation was considered to lie elsewhere, in our view to the cost of the project. On reflection given our capacity to engage families in a social care context and our growing confidence in our own research expertise, much could have been gained by us considering further the original research design and methodology . Maybe we could have thought more about how to focus the

evaluation on the impact of our transformation on outcomes for families as this has been the main driver for the changes which we have implemented.

One of the most disappointing aspects of the research was the failure to recruit families, and in discussion with the research team it is understood that a complex set of circumstances were at play. In the original commissioning structure carried out jointly between the research and implementation teams there was a good deal of optimism regarding how many families it would be possible to reach. The original design precluded researchers communicating with service users directly and required social workers to add this to their workload, and hold the research in mind. These, and a myriad of other factors, meant that the focus of the findings of the research remain with the staff and outside agencies and not families whose voice we were most interested in capturing. As the model has become more embedded, we recognize more clearly our own expertise in this social care context in Cambridgeshire, and the specific knowledge and skills it takes to negotiate the unique and complex landscape of social care services and their tasks, and their relationship with families with complex needs. Whilst we had meetings to monitor the progress of the research, we have reflected on how, if we had owned our expertise initially and incorporated this more into the research design with the research team, then our ability to work with families may have made it possible to gain their voices more clearly in this evaluation. We encourage other local authorities to reflect on these design issues if they are considering a similar process.

We are grateful to the research team for this rich report that captures some of the dilemmas we faced in the early days. We have identified and addressed issues of role confusion, training, and transition between units independently of the report and it was useful to revisit these on publication of the results of the research. Our learning in integrating, balancing, and working with the similarities and differences of the social work and systemic approaches have resulted in a 'good' OFSTED report currently. It has been useful to have the opportunity to update the report to make it more relevant to our current situation.

APPENDIX 4. Bespoke Questionnaires Used

290 SWWFF Family Experience Questionnaire

291 SWWFF Demographics and Environment Questionnaire

295 SWWFF Staff Attitudes Questionnaire

300 Staff Experiences of SWWFF Questionnaire

SWWFF Family Experience Questionnaire

I would be grateful if you would let me know how you have found it being helped by your social services team. Can you please complete this questionnaire? Thank you.

1. On a scale of 1 to 5 how well do you think that you are being listened to by those in your social care unit?
(1 is not at all and 5 is as much as you want them to listen)

1 2 3 4 5

2. How easy has it been for you and your family to talk to members of the social care unit?
(1 is not at all and 5 is very easy to talk to)

1 2 3 4 5

3. How helpful have the social care unit been to you and your family?
(1 is not at all and 5 is very helpful)

1 2 3 4 5

4. What have you found helpful about the way that your social care unit is working with you?

5. What has been unhelpful about the way that the social care unit is working with you?

6. Could you please give me a yes/no answer to the following question: Are you clear about what the social care unit is trying to support you to work on? *(If the answer is 'no' - Reply: Thank you for letting us know, I will pass this on to the unit).*

7. Is there anything else that you would like me to pass on to the social care unit that might help them to provide a better service?

SWWFF Demographics and Environment Questionnaire

Please complete this questionnaire describing the current family structure and environment for the family. For family members, please use ID numbers, not names. Name-ID links should be completed on the separate Evaluation ID form. Please use the same ID for each family member at each assessment, and assign new ID numbers for people who enter the household at later assessments.

1. Structure of Index Household

For each family member, please provide age and main relationship to the rest of the family (eg mother of numbers 3,4; son of 1; step-father of 3,4; grandmother of 3,4; boyfriend of 1; lodger). Please detail employment status (paid employment, voluntary work only, unemployed, not working as disabled, prison, retired, student, pre-school).

ID	Age	Sex	Relationship	Employment/Education
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

2. Contact with Family Members Outside the Household

Please provide details of regularity of contact with parents outside the household; and with children outside the household. Please do this for each index family member with parents/children outside the household. If frequency of contact differs for relations of the same index case (eg if the mother sees one child weekly, but another once a month), then please record as separate rows.

ID	Relationship	Frequency of contact

3. CP / CIN / LAC Status

Please provide ID numbers for any children in the family who:

- a. Have a current child protection plan:
- b. Currently have child in need status:
- c. Currently have looked after child status:
- d. Have current emotional/behavioural difficulties (glossary 1)

4. School attendance

For all family members under 18 and of school age, please state education status: school/college, training, employment, or not in education, employment or training (NEET). Please state name of school/college for those in education/training. Please state regularity of school/college attendance for those in education/training (permanent exclusion, never, less than half, more than half, greater than 90%).

ID	Education Status	School/College	Attendance

5. Use of Other Services

Please state other services accessed, and the approximate number of times those services have been accessed, since the last assessment (or in the last 6 months if this is the first assessment). Please state ID numbers if for an individual child. Please see glossary 2 for possible services.

6. Social Stressors

Please state important life events that have affected family members since the last assessment (or the previous six months if this is the first assessment). This could include bereavement, separation/divorce, house move, moving schools, children being taken into care, major illness, imprisonment of family member. Please also detail relevant chronic stressors such as poor housing, bullying, debt problems.

7. Other

Please state any other information about this family that you think is important for us to know.

Glossary 1

A child counts as having an emotional/behaviour difficulties (EBD) if they would answer yes to any of the following questions at the present time:

- Permanent exclusion from school
- Currently in receipt of (or refusing) CAMHS or similar
- Recorded history of recent self-harming or eating disorder
- Diagnosis of EBD by health worker or recording by social worker of behaviour consistent with EBD (such as fire setting)

Glossary 2

The following is a list of possible other services which may be providing help. It is not an exhaustive list and other services are possible.

- Health
- CAMHS
- Locality team
- YOS
- Education welfare
- Probation
- Police
- Housing department
- Family support worker
- Children's centre
- Parenting course
- After school club paid for by local (authority)

SWWFF Staff Attitudes Questionnaire

This questionnaire is to help us to assess staff beliefs and feelings about, and experience, in social care. Please answer each question, rating your current feelings and beliefs. Can you please complete your SWFF Evaluation Study ID number and unit, as it is important to see how individual team members change over time, and whether team members' answers influence the outcomes of the units. Answers will be stored in the NHS trust offices and questionnaires will be processed by the NHS research team; ID numbers will be allocated to all professionals and the databases will only include ID numbers, not names. Answers will not be shared with members of the social work team nor Cambridgeshire County Council management. The only exception to this would be where your answers make us have strong concerns about the safety of yourself or other people.

ID Number:

SWWFF Unit:

Date:

1(a) ROLE within the organisation:

Tick ONE box that most closely fits your current level of training/education:

☐

I am primarily in face-to-face work with families or children

☐

I am primarily in a supervisory role, with some face to face contact

☐

I am primarily in a management or administrative role, with some supervisory and/or face to face contact.

1(b) Training and Experience:

- ☐ **Administration training**, and life experience applying to the role of unit coordinator
- ☐ **Formal training/education** relating to work with children and young people, but **not in social care**. Applying skill to the role of unit coordinator
- ☐ **Degree**, in social work
- ☐ Currently **in training** for a professional clinical qualification
- ☐ Qualified as a **Health professional** (e.g. occupational therapist, family therapist, nurse, clinical psychologist, etc) working as a Specialist Clinician
- ☐ **Professional Social Work** qualification **AND additional specialist therapeutic** training.

1(d) How long have you worked having direct client contact in a statutory setting?

- ☐ - Less than one year
- ☐ - 1 - 2 years
- ☐ - 3 - 5 years
- ☐ - 6 - 10 years
- ☐ - Greater than 10 years

2. ABOUT YOU: your EXPERIENCE of, and your BELIEFS about the WORK

(Please remember to answer “as it is” rather than as you think if “should be”)

2(a) I am **interested** in theories about the nature of the problems faced by complex families, and the different ways workers can respond to them.

Circle the number that best fits your response to the statement			
Strongly AGREE			Strongly DISAGREE
1	2	3	4

2(b) At times I feel **anxious** working with complex families in distress

Circle the number that best fits your response to the statement			
Strongly AGREE			Strongly DISAGREE
1	2	3	4

2(c) In a unit/team doing this work, it is more important to have **people who can offer a range of very *different* models of understanding and working**, than it is to have a ***shared* model**.

Circle the number that best fits your response to the statement			
Strongly AGREE			Strongly DISAGREE
1	2	3	4

2(d) I **want** to work with vulnerable families in distress.

Circle the number that best fits your response to the statement			
Strongly AGREE			Strongly DISAGREE
1	2	3	4

2(e) In general you need **creativity and instinct** in this work, **more than technical knowledge from books**.

Circle the number that best fits your response to the statement			
Strongly AGREE			Strongly DISAGREE
1	2	3	4

2(f) If I felt the need when working with my clients I could easily find **a work colleague with whom I could discuss any difficulties with the work** that I might encounter.

Circle the number that best fits your reponse to the statment			
Strongly AGREE			Strongly DISAGREE
1	2	3	4

2(g) I am confident I have the skills to do **effective work** with complex vulnerable families.

Circle the number that best fits your reponse to the statment			
Strongly AGREE			Strongly DISAGREE
1	2	3	4

2(h) As a result of the change in working practices I believe the risk to staff will decrease.

Circle the number that best fits your reponse to the statment			
Strongly AGREE			Strongly DISAGREE
1	2	3	4

2(i) As a result of the change in working practices I believe the risk to children and families will decrease.

Circle the number that best fits your reponse to the statment			
Strongly AGREE			Strongly DISAGREE
1	2	3	4

3. Finally:

Please help the research team better understand your experience and beliefs about the work you do. Write down anything else that you think is particularly important. Feel free to write as little or as much as you wish (go over the page if you need to!):

Staff Experiences of SWWFF Questionnaire

This questionnaire is to help us to assess staff experiences of working in the Social Work – Working for Families Model. Please answer each question, rating your current experience of your working life. If this is your first job in social care, then please circle 'Not Applicable' for questions 4 and 5. Can you please complete your SWWFF Evaluation Study ID number and unit, as it is important to see how individual team members change over time, and whether team members' answers influence the outcomes of the units. Answers will be stored in the NHS trust offices and questionnaires will be processed by the NHS research team; ID numbers will be allocated to all professionals and the databases will only include ID numbers, not names. Answers will not be shared with members of the social work team nor Cambridgeshire County Council management. The only exception to this would be where your answers make us have strong concerns about the safety of yourself or other people.

ID Number:

SWWFF Unit:

Date:

Please state how much you agree with the following statements, by circling the answer that most fits with how you feel/think:

1. I feel well supported at work

Strongly
Disagree

Slightly
Disagree

Slightly
Agree

Strongly
Agree

2. I believe we provide a service that is helpful for the families we see

Strongly
Disagree

Slightly
Disagree

Slightly
Agree

Strongly
Agree

3. I feel stressed by my work

Strongly
Disagree

Slightly
Disagree

Slightly
Agree

Strongly
Agree

4. SWWFF has significantly changed the way I work compared to previous models of social work practice

Strongly
Disagree

Slightly
Disagree

Slightly
Agree

Strongly
Agree

Not
Applicable

5. Overall, I prefer working in the SWWFF model compared to previous models of social work practice

Strongly
Disagree

Slightly
Disagree

Slightly
Agree

Strongly
Agree

Not
Applicable