Department for Education

Scaling and deepening the Reclaiming Social Work model: longitudinal follow up

Evaluation report

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Key messages

Scaling and Deepening the Reclaiming Social Work model aimed to embed 'Reclaiming Social Work' (RSW) in 5 local authorities (Buckinghamshire, Derbyshire, Harrow, Hull and Southwark). RSW was a whole-system reform that aimed to deliver systemic practice in children's services. Key elements included: (1) in-depth training; (2) small units; (3) group systemic case discussions; (4) clinician support; and (5) enhanced administrative support. To assess the longer-term impact of RSW, 4 out of the 5 local authorities (Derbyshire, Harrow, Hull and Southwark) agreed to participate in the longitudinal follow-up study. Data were collected 3 years after the original project was completed. To protect anonymity, local authorities are numbered. Key messages include:

- Key elements of RSW remained in place to some degree in all local authorities. However, only one (LA5) retained all 5 key elements. LA5 had also strengthened its clinician input, creating a clinical service with clear governance structures that enabled access to clinical consultation and direct work with family members
- Commitment to retaining RSW's key elements was dependent on local context, including strong leadership and responses to findings from Ofsted inspections. Wider developments in approaches to social work practice, such as Signs of Safety have also shaped local practice models
- Staff consistently identified the following conditions as being associated with practice improvement: training in systemic practice; the quality of systemically-informed supervision; and contribution of a clinician in supervision
- Families valued practice that was relational, goal focused and non-judgemental. They also emphasised the hopefulness associated with systemic social work practice
- Overall impact across key performance outcome indicators was limited. There were decreases in the number and percent of children who were subject of child in need or child protection plans or looked after in 2 out of 5 local authorities and increases in the 3 other local authorities. Since the original project commenced in 2015, LA5 demonstrated the most significant reduction in overall indication of risk to children
- This suggests that a sustained commitment to systemic social work practice was associated with improvements in outcomes for children and families

Executive summary

The project

Scaling and Deepening the Reclaiming Social Work (RSW) model aimed to embed 'Reclaiming Social Work' in 5 very different local authorities (Buckinghamshire, Derbyshire, Harrow, Hull and Southwark). It was commissioned as part of Round 1 of the Children's Social Care Innovation Programme funded by the Department for Education (DfE) between April 2015 and March 2016. The final report was published in July 2017 (Bostock et al., 2017). The project was a partnership between a social enterprise, Morning Lane Associates (MLA) and the 5 local authorities. RSW was a whole-system service reform that aimed to deliver systemic social work practice in children's services. Key elements included: (1) in-depth training; (2) small units; (3) group systemic supervision; (4) clinician support; and (5) enhanced administrative support. To assess the longer-term impact of participating in the original RSW project, 4 out of the 5 local authorities (Derbyshire, Harrow, Hull and Southwark) agreed to participate in the longitudinal study. Data were collected 3 years after the original project completed. Data collected varied by local authority. MLA was no longer operational and hence, no longer a partner, at the point of follow up. Key elements of the RSW model remain evident in the 4 local authorities but the elements that have been retained differ between sites.

The evaluation

The original evaluation was undertaken in 2015-2016. The following key elements of RSW were associated with improved practice quality: training in systemic practice; the quality of systemically-informed supervision; and contribution of a clinician in supervision. As part of Round 2, the programme commissioned a small-scale, follow-up evaluation. This aimed to assess the longer-term impact of RSW on outcomes for children and families, as well as staff experience of agency culture and practice over the past three years. To capture change over time, the evaluation adopted a mixed methods approach. This consisted of four strands:

1. comparative data on the **process of change** from the perspective of professionals (65 staff surveys and 8 interviews with key stakeholders)

2. longitudinal follow-up of **practice and service experiences** with 3 family members who participated in the original study
3. **case study data** from a single Keeping Families Together (KFT) unit, including interviews with 7 staff members; 6 observations of supervision; 6 observations of direct practice; and 4 interviews with family members
4. comparative analysis of **key performance outcomes** data from across the 5 original participating local authorities and their statistical neighbours

Key findings

- Across all 4 local authorities, RSW principles were reported as continuing to inform their work with children and families. Key elements of RSW remained in place to some degree in all local authorities. However, this varied considerably. LA1 noted a reduction in some of the key elements, including systemic training, clinician input and group supervision. Whereas, LA2 was moving to a systemic unit structure. LA5 had retained all 5 and even strengthened some key elements. This included creating an in-house clinical service with clear governance structures to provide consultation and direct work across the children's services directorate
- Three of the local authorities described evolution in their practice models. This reflected developments in the wider child welfare system whereby there has been a move towards other strengths-based models of practice within child and family social work. For example, LA4 reported that their practice model was more centrally informed by Signs of Safety but dovetailed neatly with systemic approaches
- LA4 and LA5 provided sufficient staff survey data to facilitate comparison with Round 1 data. In both local authorities, practitioners reported an increased confidence to practice systemically with children and families
- Practitioners identified the same conditions associated with improved practice quality in Round 1 - training in systemic practice, the quality of systemically-informed supervision, and contribution of a clinician in supervision - at follow-up
- Families who were followed up reported mixed experiences of children's services. The two families from LA1 had had a positive experience and cited the following as critical factors: trust, clarity, responsiveness and a non-judgemental approach

- In addition to these factors, families who participated in the KFT case study identified: practical and solution focused support; goals and targets; whole family working; and the importance of playfulness and “fun elements to help improve the relationship”
- Analysis of KFT practitioner talk with families revealed examples of systemically-informed conversations, with families empowered to take ownership of their own solutions for any issues identified. Transference of themes discussed in supervision was evident in direct practice talk, underlining its practice shaping function
- Overall impact across key performance outcome indicators was limited. There were decreases in the number and percent of children who were the subject of child in need or child protection plans or looked after noted in 2 out of 5 local authorities and increases in the 3 other local authorities. Since 2015, LA5 demonstrated the most significant reduction in overall indication of risk to children
- Where data were available, LA5 also reported the highest percentage of children returning home after a period of care (2016/17: 47%). LA5 also showed the biggest increase in percentage of children returning home after a period of care (2014/15: 33%; +14%) taking it 15% higher than the English average
- This suggests that a sustained commitment to systemic social work practice was associated with improvements in outcomes for children and families

Implications and recommendations

- RSW remains an approach that aims for excellence in social work practice. There are opportunities for other local authorities to learn from its key elements to support delivery of high quality services that work effectively to keep families together
- Achieving practice change is challenging. Where local authority leaders remained in place, key elements of RSW were more likely to be retained or in the case of clinical support to social work staff, strengthened. Supporting stability of local authority leadership to promote their capacity to innovate should remain a priority
- Practitioner feedback suggests delivery of RSW remains dependent on a good practice pyramid of 3 essential, interconnected elements of practice: systemic training, clinician input and group supervision. It is recommended that at a minimum these 3 core elements are in place to support implementation of RSW

1. Overview of the project

Project context

Scaling and Deepening the Reclaiming Social Work (RSW) model aimed to embed 'Reclaiming Social Work' in 5 very different local authorities (Buckinghamshire, Derbyshire, Harrow, Hull and Southwark). The project was a partnership between a social enterprise, Morning Lane Associates (MLA), and the 5 local authorities. RSW was a whole-system service reform that aimed to deliver systemic social work practice in children's services. Key elements included in-depth training, small practice units with shared cases and group supervision, clinician support, reduced bureaucracy, devolved decision-making as well as enhanced administrative support (see Appendix 1 for explanation of the RSW model).

To assess the longer-term impact of participating in the original RSW project, 4 out of the 5 local authorities (Derbyshire, Harrow, Hull and Southwark) agreed to participate in the longitudinal follow up study. Publicly available key performance indicators have also been collated for Buckinghamshire. MLA was no longer operational and hence, no longer a partner at the point of follow-up. The original evaluation noted differences between MLA and local authorities in respect of their views on the importance of fidelity to the model, with participating local authorities wanting to have freedom to modify the RSW approach to their own local needs, context and priorities.

Local authority context

The 4 local authorities participating in the follow up study differed enormously in terms of geography and demographic diversity: Derbyshire is a county council with a population density of 3.2 persons per hectare; Hull is a city council in the north of England with a population density of approximately 40 persons per hectare; Harrow and Southwark are 2 London Boroughs, 1 outer and 1 inner, with density levels of 40 and 100 persons per hectare respectively (ONS, 2014).

Similarly, demography and levels of deprivation varied enormously across the 4 local authorities. The local authorities also varied with regard to the ethnic profile of their respective populations. Derbyshire and Hull encompassed populations with over 90%

white British residents, while Southwark and Harrow are notable for their striking diversity, with less than 40% of residents self-described as White British (ONS, 2012).

Hull is one of the most deprived authorities in England, with an estimated 31% of children aged under 19 living in poverty (compared with England average of 19%); Southwark is also relatively very deprived with 28% of children living in deprived households compared with 24% in London; Derbyshire varies by area across a large county with an estimated 15% of children living in poverty; and Harrow had relatively low levels of deprivation and child poverty levels are lower than the London average at 18% (ONS, 2015).

Findings from Ofsted inspections

Findings from recent Ofsted inspection also varied by local authority. In January 2019, Ofsted rated the overall effectiveness of Hull children's services as inadequate. Concerns were raised about practice quality and recognition and response to children at risk, although it was recognised that senior leadership had recently been strengthened. A recent focused visit in January 2020, identified insufficient improvement in improving services for children in care. In August 2019, Derbyshire were rated as "required improvement to be good". Evidence was identified of "a sustained trajectory of improvements in many of the services for children". In November 2017, children's services in Buckinghamshire were rated as inadequate. A series of monitoring visits have highlighted progress but improvement remains challenged by recruitment difficulties and poor practice remains. In February 2020, Harrow was rated as good. Strong, stable senior leadership was singled out, alongside an "unrelenting focus" on "sustaining good and excellent practice effectively". At its last comprehensive inspection in March 2017, children's services in Southwark were rated good overall. Southwark's systemic practice model was singled out as promoting "influential and effective direct work with children and families". It should be noted that it is difficult to be certain about the degree to which study findings can be ascribed to the impact of RSW or local authority responses to Ofsted and other environmental factors.

Project aims and intended outcomes

The project intended to scale and deepen RSW approaches across the 5 local authorities. Its overall aim was to improve confidence in identifying and managing risk through high quality, skilful practice with families. Keeping families together, where appropriate, was a fundamental aim of RSW. The project was funded for 1 year between April 2015 and March 2016. Specific stated goals included to:

- increase the overall practice skill of social workers and improve the authorising environment within which they make decisions on their cases
- work systemically with families to effect positive change for children
- recruit and retain talented social workers in frontline practice
- keep families together by reducing the number of teenagers entering care
- reduce the administrative burden to free up time to work with families

Table 1 outlines intended outcomes of RSW.

Table 1: Intended outcomes of RSW

Outcomes	
Impact on practice	• more reflective, supportive and effective interventions with families to affect positive change • release 20% of worker time from administrative tasks to be spent instead working with families • increase worker job satisfaction and fulfilment • recruit and retain talented workers in frontline practice
Impact on families	• improve family relationships resulting in fewer re-referrals and a reduction in children subject to a child protection plan, particularly those lasting over 2 years • keep families together, specifically reducing the numbers of teenagers entering the care system

Impact on the wider system	• ensure that organisational conditions help bring about the success of the programme changes and support embedding RSW more generally

Source: Bostock et al., 2017

Where data were collected, many of the intended outcomes from the original RSW project remained an important focus for the participating local authorities. A focus on the organisational conditions that support good practice remained a priority. This was not linked with embedding RSW, rather the practice model specific to each local authority.

Project activities

The original project was a partnership between a social enterprise, Morning Lane Associates (MLA) and the 5 local authorities. Table 2 outlines project activities at Round 1 and which elements were retained at follow up.

Table 2: RSW Project activities by timeframe

Project activities		
Activity	**Round 1 (2015-2016)**	**Follow up (2019)**
Recruitment and development of 50 consultant social workers (CSWs) to lead small multi-disciplinary teams, known as RSW units.	A total of 41 of 50 CSWs were recruited and trained, although there was some variation in recruitment by local authority. In most local authorities, CSWs joined existing systemic units.	Due to General Data Protection Regulations (GDPR), it was not possible to identify how many CSWs remained in post. At the time of the original evaluation, LA2 had not moved to a systemic unit model but more recently has been restructuring its services

		in line with smaller practice units.
Keeping families together by targeting teenagers on the edge of care through specialist RSW units (known as Keeping Families Together (KFT) units.	KFT units were introduced in all local authorities; in LA2, 2 KFT units were introduced to take account of the size of the local authority.	LA1 and LA4 closed their units when innovation funding ceased at the end of the innovation period; they were later reopened new edge of care services, with LA4's unit practicing within a systemic social work framework. LA2 merged its KFT units into 1. LA5's KFT remained open.
Bureaucracy reduction to streamline administrative processes and forms, freeing up social worker time to work with families.	Bureaucracy reduction proved the most testing of the original project strands in practice, with impact limited in terms of the redesign of administrative processes and changes to the authorising environment.	This was not a feature of the current evaluation per se, but staff surveys provided data on the impact of access to enhanced administrative support.
Coaching the system to support successful implementation of the 3 preceding strands and to support senior managers to embed RSW effectively	Coaching the system was practised at various levels across the innovation, including providing executive coaching to senior managers and practice coaching to CSWs and KFT units.	Coaching completed when funded ceased at the end of the innovation period, although a former MLA coach was subsequently employed in LA5 in a different capacity.

Source: Bostock et al., 2017

2. Overview of the evaluation

Brief summary of Round 1 evaluation methodology

The complexity and ambitious nature of the original RSW project meant that a multi-faceted, multi-local authority approach was required. The evaluation had 3 key questions:

- does RSW provide a better quality of service for families?
- what are the factors that make RSW work well?
- what are the challenges facing scaling and deepening RSW?

To answer these questions the following data were collected across three strands:

- a comparison of practice, service experiences and outcomes between RSW units and service as usual involving 67 coded observations of direct practice with families (27 observations within RSW units and 40 from "service as usual"); 106 research interviews with parents; 4 research interviews with children; and data from computerised records for 51 families
- case study data on KFT units, including 13 group interviews with staff; 5 observations of direct practice; 10 interviews with family members; and secondary analysis of data on 119 children and young people receiving a KFT service to provide an indication of impact on care entry and potential cost savings
- data on the process of change from the perspective of people at every level across the 5 local authorities, including interviews with 213 staff; 29 structured observations of systemic case discussions; and 325 staff surveys

This small-scale longitudinal evaluation builds on the findings of the Round 1 evaluation by assessing the longer term impact of the project.

Longitudinal evaluation questions

To capture the longer-term impact of this complex and ambitious innovation, the following research questions were addressed:

1. Do staff report changes to agency culture and practice over the past three years?

2. Have families experienced improvements in distance travelled?
3. Have the KFT units – where still existing - prevented children entering care and has this impacted on cost savings?
4. What is the longer-term impact of RSW on outcomes for children and families?

Longitudinal evaluation methods

To answer these questions, the evaluation consisted of data collected in four strands (see Appendix 2 for a full description of data collection and methods).

The first strand of the study explored the **process of change** from the perspective of professionals at every level (65 staff surveys and 8 interviews with key stakeholders). Staff survey are compared with baseline data collected from Round 1 to provide an assessment of change over time from the perspective of frontline practitioners.

The second strand involved a longitudinal follow up of **practice and service experiences** with 3 out of 68 family members who participated in the original study. Contacting original participants proved highly problematic with contact details no longer in use (see Appendix 2, Figure 10, for a flow chart tracking contacts made with families).

To address the study limitation in recruiting families at follow up, the KFT strand of the study was redesigned to include a **case study** of a single KFT unit. This included interviews with 7 staff; 6 observations of supervision; 6 observations of direct practice; and 4 interviews with family members. This was not designed to produce generalizable findings to all local authorities, rather indicative of what can be achieved with sustained commitment to an approach.

The **performance outcomes** strand provides a comparison analysis of key performance indicators across all 5 local authorities as well as relevant statistical neighbours.

Changes to evaluation methods

The follow up evaluation aimed to gather data from 4 out of the 5 local authorities that originally participated. At the time of initial contact by DfE (Autumn 2018), 3 agreed to participate and a fourth made direct contact with research staff at TGC. By the time that

the study commenced in Spring 2019, organisational changes and other commitments meant that capacity to participate in 2 local authorities had reduced. This included 1 of the 2 local authorities where the original KFT units were still operating and hence, no KFT data were able to be collected. This location was able to offer an interview with a key stakeholder to update the evaluation team on their current approach to systemic practice but surveys with staff were not able to be administered. In the second local authority, while willing to participate, organisational pressures meant that interviews with key stakeholders were difficult to schedule and staff survey returns minimal.

The central focus of the evaluation was to follow up families that had originally taken part. Follow up studies are limited within child welfare research. Where studies have taken place, the difficulties of re-establishing contact (Fenster, 2009), the potential for discomfort or distress (Masson et al, 2012) as well as the right of participants to make their own informed choices about whether to participant (Helgelard, 2005) have been noted. It quickly became apparent, that making contact with family members was problematic. In total, 3 out of 68 parents agreed to be interviewed (see Appendix 2, Figure 10 for a full description of family recruitment). The small sample, meant the follow-up sample was too small for meaningful comparative analysis.

In light of difficulties in recruiting families, the KFT strand of the study was redesigned to include qualitative case studies. This focused on a single KFT unit that had remained largely faithful to the original RSW model. Where families consented, data collection involved: the observation and coding of a supervision session associated with the family's case; the observation and coding of a meeting between a worker and family; a research interview following the meeting; and a worker questionnaire. It was planned to collect longitudinal data (2015-2020) on every young person that had received a KFT service to assess impact on care entry and costs estimate. However, data collection was halted due to the additional administrative burdens experienced due to the Covid-19 pandemic and these data could not be included for final analysis.

3. Limitations of the evaluation

The study was successful at engaging with 2 out of the 4 local authorities who had agreed to participate at follow up. This reflected an assumption that local authorities were research-ready, which given organisational pressures was not always the case. It was also successful at gaining an in-depth understanding of a single KFT unit that continued to operate along the lines of original RSW principles. It was less successful in obtaining data from families concerning longer-term outcomes as originally envisaged. In practice, a great deal of time was spent negotiating access with local authorities and attempting to contact family members.

The Round 1 RSW study evaluated some of the important components of RSW and the difference they made to the quality of practice in meetings between families and workers. The following 4 factors had a statistically significant impact on quality of practice: training in systemic practice; workers participating in the MLA CSW development programme; the quality of group-based systemic supervision; and the presence of clinicians in systemic supervision (Bostock et al., 2017). The small-scale nature of the follow up evaluation meant that collecting observational data on the quality of direct practice or supervision was beyond the agreed scope of the current study. This limits the ability of the study to answer the question posed in the original RSW evaluation, what factors make RSW work well. However, self-report data were collected from frontline staff in the current study concerning the key elements of their respective local authority's practice model and whether they were perceived to be making a difference to children and families. This was underlined by qualitative analysis of practitioner talk within the KFT case study that revealed examples of systemically-informed conversations, with young people and families empowered to take ownership of their own solutions for any issues identified. Transference of themes or issues discussed in supervision was evident in practitioner talk with families, underlining its practice shaping function.

4. Key findings

Process of change study

This section assesses the degree to which key stakeholders – drawn from both senior leadership teams and frontline practitioners – report changes to agency culture and practice over the last three years. Data were drawn from 8 key stakeholder interviews and 65 staff surveys across 3 out of the 4 local authorities; although return rate varied. Sufficient staff survey data to analyse were collected from LA4 (30) and LA5 (28). These were compared with data collected from Round 1 surveys where data available. Fewer participants took part at follow up due to online rather than face-to-face data collection. However, findings are indicative of trends and provide valuable information on change over time. Although the number of responses from LA1 was too low to undertake meaningful quantitative analysis, qualitative analysis of open ended questions was undertaken. Across all 4 local authorities, RSW principles were reported as continuing to inform their work with children and families. However, this differed by local authority, reflecting both factors specific to the local context and evolutions in approaches to social work practice.

Understanding RSW: Evolution of practice models

Three of the local authorities described evolution in their practice models. This reflected developments in the wider child welfare system whereby there has been a move toward more relational, strengths-based models of practice within child and family social work. These included: restorative practice (Pennell, 2006); Signs of Safety (Turnell and Edwards, 1999); person-centred approaches (Dowling et al., 2006); social pedagogy (Charfe and Gardner, 2019); and trauma-informed practice (Treisman, 2016). Table 3 outlines operation of other practice models alongside or instead of RSW-informed approaches by local authority.

Both LA2 and LA5 identified their model of practice as systemic but informed by other practice methodologies. LA2 reported that social pedagogical and person-centred approaches were used alongside systemic practice. LA5 described RSW and systemic practice as fundamental to their practice model but also drew on other evidence-based approaches, including trauma-informed and restorative practice approach depending on

the presenting issues to inform their work with children and families. LA4 reported that their practice model was more centrally informed by Signs of Safety but integrated well with systemic approaches. LA1 also reported their practice model as systemically informed but noted a reduction in some of the key elements of the RSW model.

Table 3: Approaches that inform practice models by local authority

Local Authority	Practice approach
LA1	Systemic social work practice
LA2	Systemic social work practice Social pedagogical approaches Person-centred approaches
LA4	Signs of safety Systemic social work practice
LA5	Systemic social work practice Secure base or trauma-informed practice Restorative practice

Table 4 outlines elements of RSW by local authority. LA1 noted a reduction in systemic training, group supervision and clinician input with numbers of clinical practitioners decreasing from 5 to 2 across the whole service. LA2 was in the process of restructuring social work services to introduce systemic units and had recently employed a systemic lead to deliver in-house systemic training. At time of participation, LA2 had yet to move fully to systemic units and was offering group reflective meetings rather than group-based supervision. LA4 remained committed to smaller units informed by systemic principles, offering systemic training to frontline staff and managers as well as group-based supervision on a monthly basis. Due to recruitment difficulties, LA4 had reinvested

money ring-fenced for clinician input to support social workers undertake better quality assessments across their child in need services. LA5 continued to embed systemic practice, delivering services via a systemic unit model, offering training and group supervision to frontline staff. LA5 had also strengthened its clinician input, creating a clinical service with clear governance structures that provided both consultation to practitioner's and enabled more complex interventions to be carried with children and families. LA5's clinical service was well embedded with 17 clinicians employed by the local authority. All 4 LAs had unit coordinators in place, although in LA4 business support was provided centrally rather than attached to a specific team or unit.

Table 4: Key elements of RSW by local authority

	LA1	LA2	LA4	LA5
Systemic training	x	√	√	√
Systemic units	x	√	√	√
Unit meetings/group supervision	x	x	√	√
In-house clinician support	√	x	x	√
Business support	√	√	√	√

Shared vision and understanding

Developing a common understanding and in some projects, language has been a feature of successful service transformations (Bostock et al., 2018; Forrester et al. 2017; Luckock et al. 2017; Sebba et al., 2017). This is dependent on strong leadership to communicate the vision for improvement and create the conditions for innovation (Trowler, 2018). All key stakeholders and staff survey participants were asked to describe their local authority's practice model. LA5 provided the most definitive response, with the vast majority of respondents describing their practice model as "systemic". LA4 reported that there was no single practice model, although "signs of safety" underpinned by "systemic principles" was most commonly mentioned. LA1 also reported that their practice model was systemically informed. However, concern was expressed that their practice model was no longer "clearly defined". This appeared to reflect a more compliance-based approach to practice in response to Ofsted findings. See Appendix 3 Figure 11 and 12 for visual representations of the most commonly used descriptors in LA4 and LA5.

Perceptions of impact on practice

Staff survey participants were asked to give an example of how their local authority's practice model was making a difference to children and families. Participants from across local authorities shared multiple ways that their model had impacted their practice. Practice improvements included:

- practice shaping impact of systemically-informed supervision: for example, to explore risk to children from multiple perspectives, including families and other professionals; and pre-plan interventions by turning hypotheses into actionable conversations
- clinical input via supervision and consultations to support practitioners think through practice dilemmas and to plan joint work with family members
- positioning families as experts in their own unique situations: for example, approaching families with an open mind and exploring their circumstances with curiosity rather than making assumptions about their circumstances
- working relationally with families to define their own goals and solutions to their difficulties
- balancing strengths and safety factors against risks and concerns for children, resulting in concerns being more readily understood by family members

Some differences were noted by local authority. Participants from LA5 were more likely to emphasise the relational nature of problems as a means to understand risk to children, whereas practitioners in LA4 focused on strength-based approaches to risk assessment. One respondent in LA1 noted the role of clinicians in supporting reunification of children with families. However, it was noted that access to clinician input had reduced and impact was more limited. See Appendix 3, Table 15 for descriptions of how systemic social work practice had positively impacted work with specific families.

Support for practice

In addition to new questions about practice models and impact on practice, questions asked in the original staff surveys were repeated to assess change over time. These included open and closed questions relating to: working in your local authority; work satisfaction; learning and development; peer and management support; organisational support; supervision; time management; time and resources; and health and wellbeing.

Increases were noted across LA4 and LA5 regarding confidence to practice systemically. 90% of participants in LA5 and 73% in LA4 reported confidence to use systemic approaches when working with children and families (c.f. Round 1 70% and 55% respectively)[1]. Participants from both LAs re-affirmed findings from the Round 1 evaluation and identified the following factors as essential support for practice:

- training in systemic practice
- the quality of systemically-informed supervision
- contribution of a clinician in supervision and access to clinical consultations

In both LA4 and LA5, 77% of participants agreed they got the training and development opportunities needed to do their job well (c.f. Round 1 41% for LA5; this question was not asked in LA4 in Round 1). Practitioners across both LAs emphasised the importance of continuing professional development. While this question did not ask specifically about training related to RSW, practitioners highlighted systemic training in their comments. In LA4, refresher courses on systemic practice were requested to support their practice: "systemic practice, through putting refresher training in place for all practitioners" (LA4). In LA5, advanced systemic trained was highlighted to strengthen and deepen practice: "further systemic training to social workers and staff at foundation level and beyond". This was subsequently implemented by LA5.

Overall respondents were positive about supervision and access to reflective spaces. In LA4 (78%) and LA5 (77%) of participants agreed that one-to-one supervision was helpful or very helpful. A difference was noted with regard to group supervision with 90% of respondents in LA5 rating group supervision as helpful or very helpful compared with 60% in LA4. Where rated positively, participants identified the importance of exploring risk to children from multiple perspectives and the opportunity to "think aloud" with colleagues about practice dilemmas as well as develop hypotheses (Beddoe and Davys, 2016). They appreciated the opportunity to use supervision as a "rehearsal space" to plan difficult conversations with children and families (Bostock et al., 2019a, b).

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[1] Statistical significance tests were not applied due to small sample size.

> I was allocated a case that on paper appeared to be hopeless. The manager, the clinician and my colleagues were able to unpick some of this and come up with good ideas for the initial meeting. This really helped with the relationship-building with the client. Although reluctant to initially engage with the assessment, due to the advice given during group supervision I was able to engage them. Although the outcome was an Initial Child Protection Conference, it was a better outcome than we all originally thought at the beginning. As the case progressed, I was able to have joint visits with the clinical practitioner which really helped - not just my current practice - but also my future practice. It also benefited the client who felt listened to and supported (Practitioner, LA5).

Findings from Round 1, showed that clinicians, in particular, seemed to play a pivotal role in supporting colleagues plan systemically-informed conversations with families. Across both LAs, staff reported that clinicians assisted them in planning assessments and providing interventions more effectively. LA5 reported a marked increase in support from clinicians (Round 1: 53%; Round 2: 77%), perhaps reflecting the development of the clinical service in this local authority. Access to in-house clinical support had reduced in LA4 but where clinical support was available, practitioners reported that this was appreciated (Round 1: 80% agreed; Round 2: 91%).

> Clinicians are amazing people. I love having them around. Where we work on cases they not only help me to work systemically, they help me respond with compassion and renewed energy. They help us to have hope that families can be more resilient (Practitioner, LA5).

The other important feature of the RSW model was enhanced administrative support to reduce bureaucracy. In LA4 just over half (55%) reported having access to adequate business and administrative support. LA5 reported a decrease in the number who felt they had adequate support to carry out their role efficiently (Round 1: 51%; Round 2: 40%). Access to enhanced administrative support is a key element of the RSW model, hence these data suggest that further improvements are required to make this a reality. Nevertheless, unit coordinators were singled out as supportive and released staff from undertaking many administrative tasks. Practitioners in both LAs noted that improved information technology would support direct work with families.

Practice and service experience study

Three families agreed to participate in the follow up study. Two from LA1 and 1 from LA2. All had continued to work with children’s services since they were first interviewed, with cases closed around two years after participation. They had all been involved with children’s services for some years, including one participant that was a care leaver. They were asked to focus on relationships with their last worker to anchor their experience.

Relationships with workers

Two of the participants reported that they had had a positive experience, citing the following factors as critical to working relationships: trust, clarity of issues, responsiveness and a non-judgemental approach: “I think she was brilliant, absolutely brilliant, explained everything really good to you. She didn’t judge you, you get some people that tend to try to judge you, but she didn’t at all” (parent, LA1). Both also identified how workers had supported them make positive changes in their family relationships. This included supporting contact with adopted children and coping with family bereavement.

One parent reported more ambivalence, identifying the fleeting and superficial nature of interaction as well as lack of responsiveness. They reported that the worker had not got to know them as a family, hence no positive changes were identified. Nevertheless, empathic practice was noted: “it did seem as if she cared, because some of the people we worked with almost seemed to blame us for everything that was going wrong with the children, and that’s a horrible feeling when you know you've spent years trying to do your best for them, and she did seem to be understanding” (parent, LA2). This parent also specifically highlighted positive support from the KFT unit, although they noted short-term nature of the service: “they were very good, they really tried, but they only have very limited resources and time, and in that limited time they can't do enough really”.

Life scaling

Participants had been asked to rate on a scale of 1 to 10 (with 10 meaning life is really good) how well things were going in their life at the time of the last interview and their current life rating. Two now identified themselves as a 10, attributing at least part of their improved status to children’s services. This reflected the support that they had received,

including access to therapeutic services and helping them to think differently about family relations: "she helped me see from different aspects and stuff, I had a lot of work to do with the counsellor for stuff like that as well" (LA1). The third family reported that life had stayed the same, rating themselves as an 8 because "there were less ups and downs".

Goals

Identifying and mutually agreeing goals with family members has been found to be a central feature of planning processes and associated with positive outcomes (Lynch et al., in preparation). Participants from LA1 described their goals with working with children's services as achieved. They highlighted improved family relationships, increased empathy for each other and better engagement with children's services: "just working with them, and not fighting against them". Goal achievement in part reflected support from social workers: "she was just so helpful, she did help us through a lot of tough times, and more so for her to be here for the boys so they understood more". Participant 3 did not feel the service received was right for their family and hence, goals remained unchanged since last interviewed.

Best service

Families were asked to identify what was important to them in terms of service culture and service provision. The following features were viewed to be integral to the best service: feeling valued; respectful working relationships; consistency of worker; transparent and quick decision making; access to the right support, personalised to the family: "it's having enough time to get where you need to get with the people, keeping promises and having therapy available".

Case study: Keeping families together

The primary objective of KFT services was to prevent young people coming into care, and to reunify the young people that were in care - where safe and appropriate - back into the family home. All children referred to KFT were identified by a multi-agency resource panel as being at high risk of entry to care. To avoid this, KFT services aimed to work intensively and expertly with families to reduce risk and enable children and young people to stay with their families. Of the 119 children referred to the service in Round 1, 79% remained at home, with only 25 children (21%) subsequently entering care. This exceeded KFT's target of keeping 50% of children safely at home.

In the original project, 6 KFT units were set up (1 per local authority, and 2 in LA2 given geographic size). However, the majority were closed when innovation funding ceased at the end of the innovation period. At the time of follow up, LA1 and LA4 had re-opened edge of care services and LA2 reduced its service from 2 to 1 unit (see Table 5). LA5 had retained its original KFT service and agreed to provide case study data.

Table 5: KFT unit by local authority and time period

	KFT unit (innovation end)	KFT/new KFT unit (2019)
LA1	X	√
LA2	√ (2 units)	√ (1 unit)
LA3	X	X
LA4	X	√
LA5	√	√

Case study

At the time of data collection, the KFT unit in LA5 was working with 13 different families. Eight families gave consent to participate and 6 went on to participate (2 families experienced a crisis and hence it was judged to be inappropriate to introduce a researcher at

that point of the intervention). Data collected included: 6 social worker questionnaire; 5 recordings of supervision, 6 observations of direct practice; and interviews with 4 family members. Interviews were also conducted with the team manager and members of the whole KFT unit. Data on care avoidance were not available due to decision to end data collection in light of additional administrative burdens experienced within frontline children's services due to the Covid-19 pandemic.

The KFT approach

In Round 1, KFT units were staffed in line with the original RSW model (see Appendix 1). At follow up, the KFT unit was larger and comprised of a team manager, two social workers, two family practitioners, a student social worker and a practice coordinator. A clinician (0.5 FTE) was also attached to the unit, although the post was vacant at the time of the observations. In addition, the team now worked more closely with colleagues in assessment services, providing consultation and direct work to target families where it had been assessed that there was a risk of care entry. Children continued to have an allocated social worker in the main service separate to KFT. KFT practice was based on a structured, goals-based intervention, known as the FAMILY approach (see Table 6 for a description).

The FAMILY approach was fundamentally collaborative and focused on working with family members to ensure goals were agreed to create positive change for young people. Generally, each family was asked to identify 3, and a maximum of 4, goals. Once goals were identified, time was spent with the family mapping the activators of problems that they were currently experiencing and what was preventing them achieve their goals. It is only after the process of collaboratively mapping what made things problematic for the family that the team engage the family in thinking about how to tackle those difficulties. At this point, a plan was agreed and interventions are put in place. The plan was then monitored by the unit on a weekly basis.

> The whole idea with both of those approaches is that unless you do that collaboratively with the person you're trying to create change for, you are much less likely to get anywhere. If they don't have any buy-in to creating the change or they want a different change to you, it's you pushing a big boulder up a hill on your own, so a lot of effort put in to training and supporting staff to think about how they

can share their goals and the organisation's goals and match those up with what the young person wants to do (key stakeholder, LA5).

Table 6: The stages of FAMILY

Acronym	Description
F	Find out presenting problems, family aims and resources
A	Agree with family on specific, measurable goals
M	Map out (with family) the factors contributing to difficulties
I	Intervene to address specific factors
L	Look to see if intervention has made a difference (revise if necessary)
Y	Over to You! Help identify how family will sustain changes

What do practitioners say about KFT?

KFT practitioners identified a series of enabling factors associated with improved practice and service experiences for young people and their families. These included:

- the FAMILY model focus on goal agreement and purposeful intervention that was constantly under review with the family: "I guess using the FAMILY model helps our thinking about cases, helps us to get unstuck, helps us think about interventions and what we're going to do with the family, I think that's key"
- co-working cases supported families to have a more consistent service experience, aiding communication and ensuring a more timely response: "even if there's leave, there's sickness, because it's shared, we know where we are with the family, and even for me just taking a message because I know what's happening, it really helps to aid with the communication"
- risk sharing across unit members, meaning practitioners were more confident to take more risks with families to progress cases. This was in the knowledge that they had professional back up: "I think because the responsibility for risk is shared

in the team we're able to take risks in a way that is quite difficult when you're holding a case alone as a social worker, so you can take a bit more risk and know that you've got support and back up in that decision-making, and I think that allows us to make progress in cases where it would be really difficult otherwise"

- group supervision to support reflexivity, generate hypotheses and draw on different perspectives and solutions: "we have quite productive conversations in our group supervision about working out how to get unstuck, and there have been lots of ways that we've done that, so one of them has been, "Why doesn't someone else try and go and do that session?" to see if they can move things, but also using the mapping thing, looking at engagement and why we're struggling to engage with a family, and then everyone putting together their ideas"
- protected caseload numbers reduced pressure on team members to close cases before the intervention was successful: "we're not under pressure to close it because the deadline date has reached, we can look at how cases are going and also when other ones are coming"

Practice and service experiences

To capture practice and service experiences of families, data were collected from a variety of sources: practitioner questionnaires; observations of unit meetings and direct practice; and interviews with family members. Data collected via practitioner questionnaires revealed that families in the study had a range of needs including parent mental ill-health, wider family relationship problems and contextual safeguarding issues. KFT had been working with the families from between 3 and 12+ months. Concerns were rated from low to high and not associated with length of time worked with the family.

Goals

Identifying and mutually agreeing goals with young people and family members was at the heart of the FAMILY model. It has also been found to be a central feature of planning processes and was associated with positive outcomes (Lynch et al., in preparation). Practitioners identified improving family relationships on every occasion when asked about the goals they had working with participating families. Where family members participated (4), in every instance they reported wishing to understand better or improve

the behaviour of their children. Although family members were less likely to explicitly identify improving family relationships, there was mutual agreement concerning improving the safety and well-being of children and young people.

Practitioner talk

Six recorded observations of sessions between workers and young people or families were coded for key social work communication skills across five dimensions of practice They were coded using an established coding framework (Whittaker et al., 2016). This assesses social work skills across five categories: (1) collaboration, (2) empathy, (3) purposefulness, (4) clarity of issues and (5) child focus (See Appendix 2, Table 13 for a full description of the skills categories).

Practice recordings were not rated for quality, given small numbers, rather they were analysed qualitatively to identify examples of systemic practitioner talk. Assessment of practice quality identified examples of systemically-informed conversations, with young people and families empowered to take ownership of their own solutions for any issues identified. Such examples created opportunities for young people and parents to share their perspective and a sense of their unique situation surfaced through conversation. There was attention to the relational nature of problems, emotions as well as family strengths. Table 7 provides examples from three skills (See Appendix 4, Table 16 for examples of skilled practice in each dimension of the coding framework).

Table 7: Examples of skilled practice by practice dimension

Skills **Assesses the extent to which the worker…**	**Example**
Collaboration: Incorporates families' views and perspectives into the session and identifies them as experts in their own experience	What's your view, I know we've had conversations in the past and difficult conversations so where are you at, at the moment?

Purposefulness: Has a clear purpose that is communicated and negotiated with the family	 What we were hoping to do today is to map with you what factors help you to remain positive.
Child focus: Structures the session around the needs of the family and adopts creative ways to build on relationships	 What are the other things that you would say [young person's] strengths are? When things are going well, what are the good things about it?

Transference from supervision to practice

Audio-recordings of supervision were transcribed and the transcripts were analysed using a coding framework developed by TGC (Bostock et al, 2019a). The framework focuses on five essential domains of systemic supervision: 1) relational nature of problems 2) voice of the family 3) risk talk 4) curiosity and flexibility and 5) support for practice (see Appendix 2, Table 12 for an explanation of each domain).

Supervision recordings were not rated for quality, given the small numbers, rather they were analysed qualitatively to identify practice shaping talk. KFT supervision sessions were group-based and noticeably goals-focused. The voice of the child was articulated and risks understood. Goals were mapped and reviewed, activators identified and interventions suggested and suggestions were reviewed. Practice was curious and strengths-based, highlighting both family and practitioner strengths. Discussion was collaborative and knowledge of cases shared across the whole unit, including with the practice coordinator. There was a strong focus on the progress of interventions, in terms of identifying next steps, such as making referrals. However, there were fewer examples of actively generating questions to ask family members: the move from hypothesis generation to actionable conversations with families. This may reflect that the team was well established and shared the same room, hence such conversations were being undertaken outside of formal supervision. The clinician post was also vacant at the time

of observations, meaning that the team were missing a key contribution designed to support application of systemic ideas to social work practice.

To explore the impact of supervision on direct practice from a qualitative perspective, pairs of supervision and direct practice sessions were analysed. Analysis focused on thematic transfer of dilemmas and concerns discussed in supervision to identify if they were evident in practitioner talk with families (Milne et al, 2003). Analysis was undertaken by domain of systemic supervision, highlighting examples of thematic transfer across practice forums (see Appendix 4, Table 17).

Thematic transfer could be identified for all five domains of supervision in both practice pairs, underlining the practice shaping function of supervision (see examples of three domains in Table 8, below). While both practitioners were flexible and responsive to the needs of family members in direct practice, conversations remained planned and purposeful. The structured approach evident within KFT supervision could be mapped against exchanges in direct practice conversations. In this regard, systemically-informed supervision appeared to have offered practitioners the opportunity to consider and '*step-into practice ahead of 'live' interactions with families'* as well as '*craft their intentions and rehearse reflexivity'* (Bostock et al, 2019b: 7).

Table 8: Examples of thematic transfer from supervision to practice by domain

Supervision talk	Direct practice talk
Relational nature of problems	
Thinking about the activator, I just wonder whether as part of wider thinking about sustainability, is whether it's worth still having conversations around, "We've noticed this how well you are supporting the family and that seems really good."	I think this is something that we've spoken to you about before, in that you are very much the centre of the family, you offer support to everyone in the family, but at times of stress for yourself because things are going on in the house, who is supporting you?
Risk talk	

Has there been any change in risk? That's good, that's potentially positive. In a sense it's possibly improved ever so slightly but maybe not majorly?	We're at a stage where things seem to be in a better place, it's far from perfect, but I still think that you guys, as a family, have moved forward in terms of where we first met you. Would you agree or disagree?
Support for practice	
I think we're still doing the work on positive affirmations. I think that's an ongoing thing, that seems to be helping. I think [family member] will respond much better to a conversation where, "We've noticed this thing you've been doing, it's really great", than us saying, "We think you should do this thing."	Now he's been staying in a lot more, is there anything that he's been doing well, is there anything positive that he's been doing whilst he's been in the house? What's the positive?

What do families say about the KFT service?

Families were overwhelmingly positive about their experience of the KFT service. They identified practitioners as "professional" and "non-judgemental" and noticeably more supportive than they had experienced during previous interactions with children's services. They welcomed the focus on the relational nature of problems and support to think differently to achieve mutually agreeable goals. Family views are summarised as follows:

- Young people and families were positive about their relationships with workers. They described their worker as "caring", "understanding" and "approachable" and "committed to achieving the best for my family"
- They also emphasised the relational nature of problems, highlighting how workers were supporting them "build relationships" and recognise that "the person isn't the problem, it's the situation that's the problem"

- Family members valued proactive workers who “deliver” in a timely fashion, opening dialogue where there were difficulties in a “non-judgemental” manner
- Families also commented that KFT practice was more supportive than previous experiences of children’s services. They identified the “strengths-based”, “holistic” and “linked” or collaborative nature of working that was focused on “goals and aims”
- They associated the support that they received with narratives of hopefulness, even where circumstances were emotionally challenging: “I've had so much support from KFT. I'm still not happy with the issues but I'm more hopeful now and I'm working with people who care”
- Families were asked to identify what was important to them in terms of service culture and service provision. They emphasised similar features to families followed up from Round 1 but also highlighted: practical and solution focused; goals and targets; holistic approach to improving family relations; and the importance of playfulness and “fun elements to help improve the relationship”

Performance outcomes study

Comparative analysis was conducted across all 5 original participating local authorities and compared with the English average. In addition, the top three statistical neighbours were identified from the Local Authority Interactive Tool (LAIT) and a singular neighbour agreed with each LA (bar LA3 who did not participate in the main study). This aimed to provide an indication of the success of RSW on population-level outcomes both over time, between participating local authorities as well as compare outcomes with their one of their statistical neighbours.

Analysis of performance data tracked 7 indicators in the in the four year period 2015 to 2019. The 7 indicators were mapped against the 7 outcomes and 7 features of practice identified in Round 1 as associated with successful innovation (Sebba et al., 2017). They included 2 outcome areas, ‘reduced risk for children’ and ‘reduced staff turnover and agency rates’, and 1 ‘feature of practice, ‘enabling staff to do direct work’ (Appendix 2, Table 14 for outcome or practice feature mapped by indicator). Findings demonstrate that overall impact across key performance outcome indicators was limited. Given evolutions in practice models and local authority responses to Ofsted, it is difficult to assess whether overall performance can be ascribed to RSW or other environmental factors. However, LA5 – the only local authority to retain all five elements of RSW - demonstrated the most positive improvements in some but not all indicators. This suggests that a sustained commitment to systemic social work practice was associated with improvements in outcomes for children and families.

Outcome: reduced risk for children

Children receiving any intervention

Table 10 details percentage of children receiving any type of intervention from Children’s Services (CiN; CPP and LAC) by local authorities between 2015-19. While the number of children receiving these interventions are not exclusive (e.g. a child could appear in more than one of the groups), data provided an overall picture of interventions received. Data suggests overall impact was minimal, with some variation by local authority. LA5 demonstrated the largest overall reduction in risk to children which may be associated with their sustained commitment to systemic social work principles and practice.

- Between 2015 and 2019, the English average of percentage of children receiving any type of intervention from Children's Services (CiN; CPP and LAC) remained the same (2015: 4.4%; 2019: 4.4%)
- All 5 local authorities recorded some change over time. While there was variation the overall impact was minimal. 3 local authorities experienced an increase in any intervention (LA2, LA3, LA4) and 2 experienced a decrease (LA1 and LA5)
- LA5 reported the biggest decrease percentage of children receiving any intervention (-1.4%). LA2 reported the biggest increase (1.0%)
- Despite recording a small increase, LA3 and LA4 were the only local authorities to remain below the English average (3.6% and 3.9% respectively)
- The remaining 3 local authorities all reported percentages greater than the English average with LA1 reporting the highest proportion of all the local authorities (8%)

Table 9: Percentage of children receiving any type of intervention from Children's Services (CiN; CPP and LAC) by local authority between 2015-19

Local authority	• 2015		• 2019		• Difference	
	#	%	#	%	#	%
LA1	863.5	8.6%	801.5	8%	- 62	-0.6%
LA2	384.2	3.8%	484.1	4.8%	+ 99	+1%
LA3	291.6	2.9%	354.7	3.6%	+ 63.1	+0.7%
LA4	340.9	3.4%	388.8	3.9%	+ 47.9	+0.5%
LA5	656.1	6.6%	515	5.2%	-141.1	-1.4%
English average	439.5	4.4%	442.9	4.4%	+3.4	0.0%

Proportion of children subject to a child in need plan

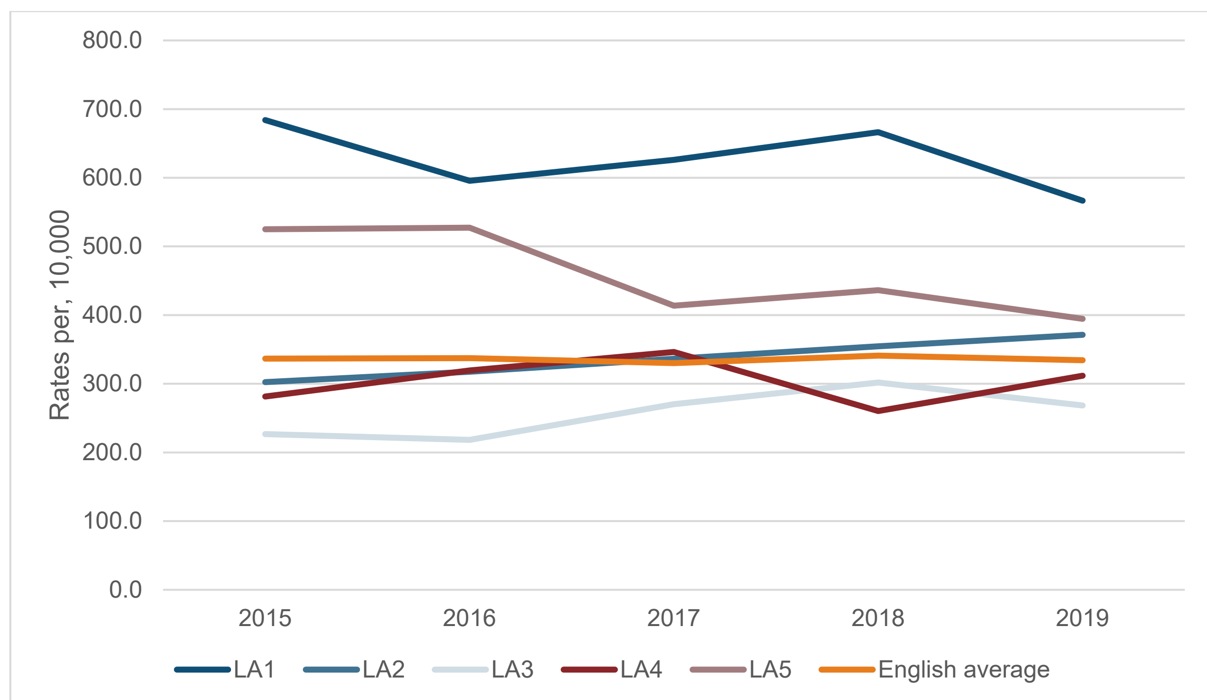
Figure 1 details the child in need rate per 10,000 by local authority between 2015-19. It is difficult to draw firm conclusions from these data given wide variation in rates by local authorities. However, LA1 – who only retained 2 out of the 5 key elements of RSW -

reported the highest rates of children subject to a child in need plan. This may be associated with a move away from RSW principles and practice or other factors.

- The proportion of children subject to a child in need plan varied considerably between the local authorities

LA1 consistently reported the highest rates of CiN over the 4 years with a decrease between 2018 (6.7%) and 2019 (5.7%). While LA1 remained considerably below their statistical neighbour over the time period, rates were consistently higher than the English average

Figure 1: Child in need rate per 10,000



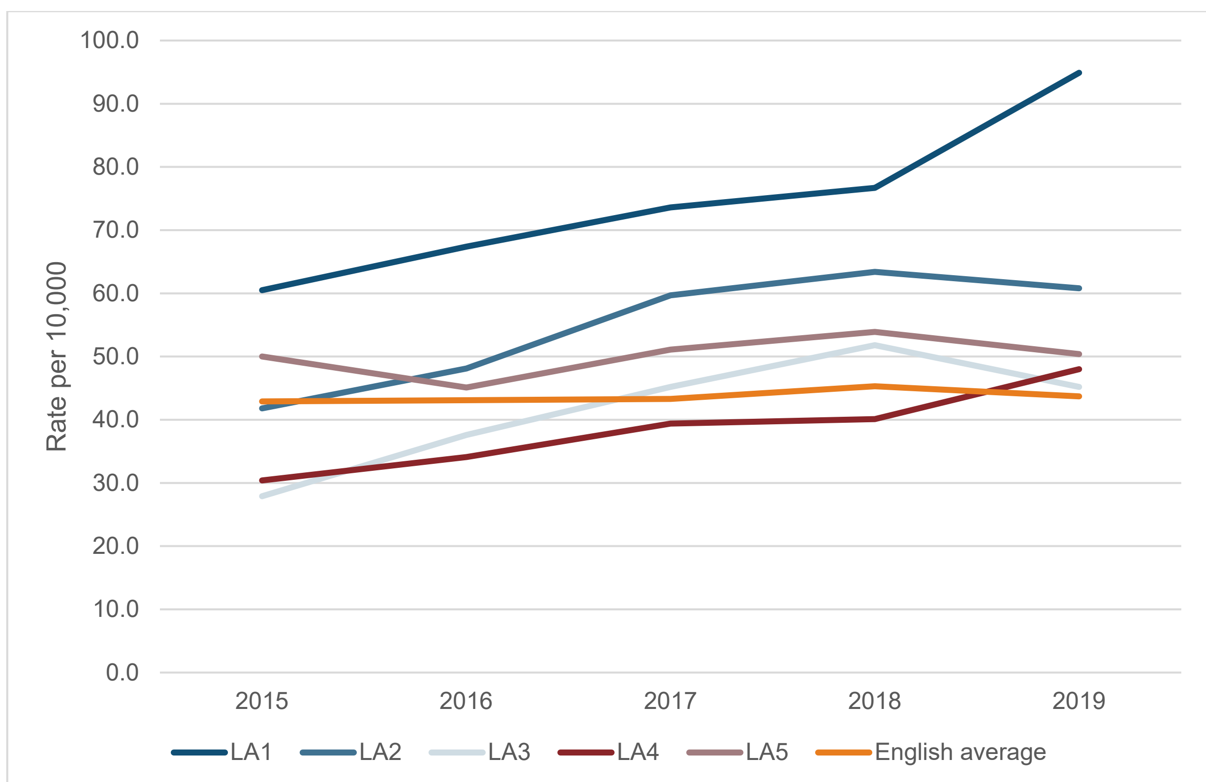
Proportion of children subject to a child protection plan

Figure 2 details children subject to a child protection plan per 10,000 by local authority between 2015-19. While all local authorities showed an increase in the proportion of children subject to a child protection, it is noticeable that rates within LA5 remained relatively stable. This may be associated with their sustained commitment to RSW.

- All local authorities showed an increase in the proportion of children subject to a child protection plan to varying degrees.

- While LA3 and LA4 started below the English average, by 2019, all 5 LAs had a higher percent of CPP than the English average (0.4%)
- LA1 consistently had the highest rates of CPP overtime demonstrating an upward trend to 2019 (0.9%). By 2019, rates of CPP in LA1 were double that of the English average (0.4%) but below that of their statistical neighbour (1.4%)
- LA5 showed the least variability from 2015 to 2019 with a small amount of year on year divergence suggesting a degree of stability

Figure 2: Children subject to a child protection plan per 10,000



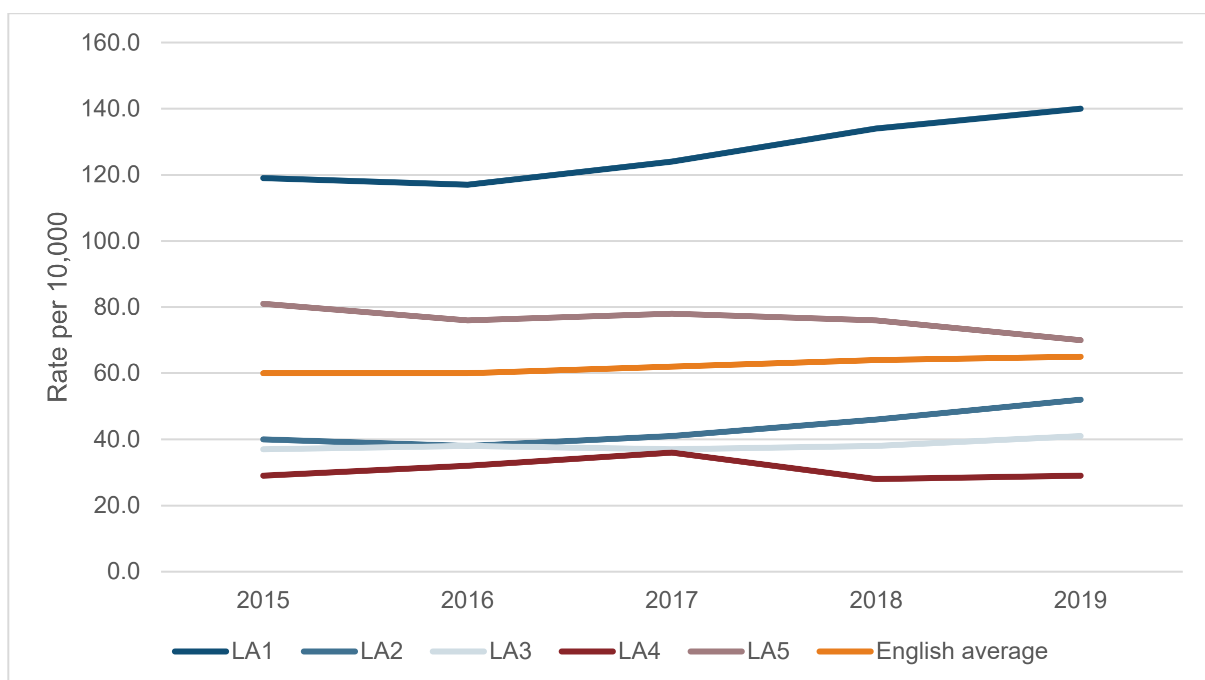
Proportion of Looked After Children

Figure 3 details the looked after children rate per 10,000 by local authority between 2015-19. LAC rates remained relatively stable, the lowest rates of LAC. Both local authorities remained all (LA5) or almost all (LA4) elements of RSW which may have supported children return home – where safe and appropriate to their families.

- There was little variation in rates of LAC over the 4 years to 2019. In all but one case, the rates were maintained or increased

- LA1 reported the highest proportion of LAC. Despite being below their statistical neighbour, LA1 LAC rate was double the English average in both 2015 and 2019 (English average 2015: 0.6%; English average 0.7%)
- LA5 was the only local authority to report a decrease in rates of LAC over time. However, the reduction was modest and by 2019 remained above that of their statistical neighbour (0.6%)
- LA4 consistently reported the lowest rates of LAC over the 4 years despite a small increase in 2017 and in 2019 was in line with the rates reported by their statistical neighbour

Figure 3: Looked after children rate per 10,000



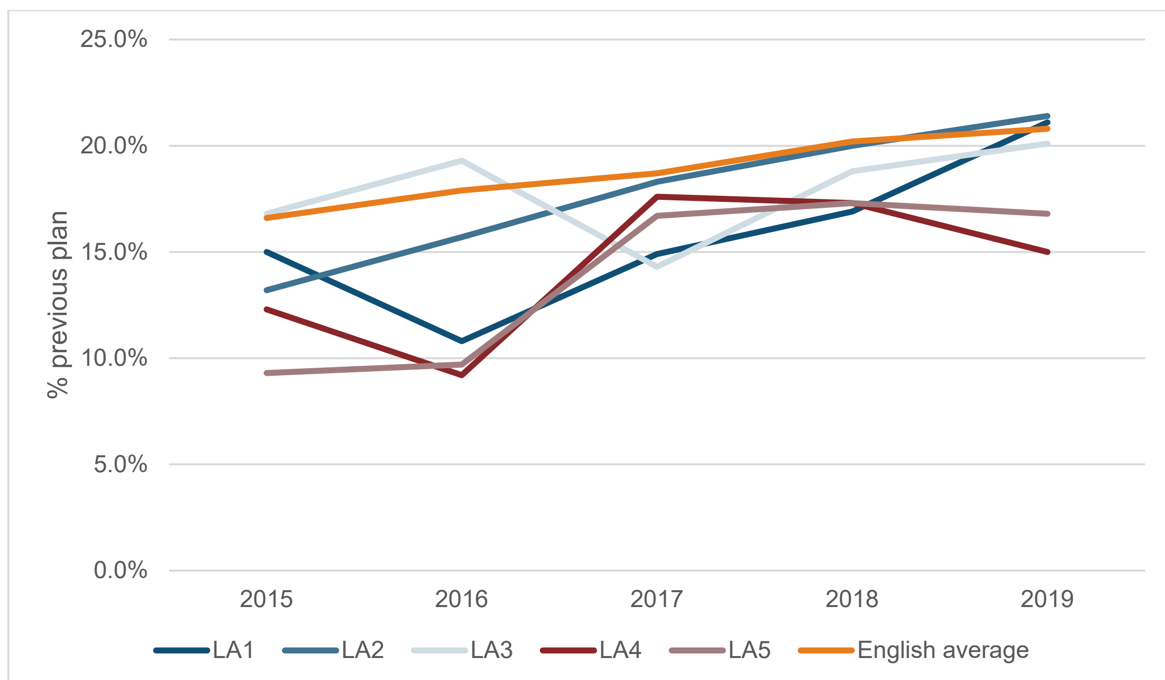
Children who became the subject of a child protection plan for a second or subsequent time

Figure 4 details the percentage of children who became the subject of a plan for second or subsequent time. Given year on year variation by local authority, the impact of RSW is challenging to assess in terms of discernible benefits on the longer-term impact on subsequent child protection plans.

- Overall, the percentage of children who became the subject of a plan for a second or subsequent time increased over the 4 years to 2019 with substantial year on year variance

- Data from LA2 suggests an upward trend in the proportion of children who became the subject of a plan for a subsequent time increasing from 13.2% in 2015 to 21.4% in 2019. By 2019 rates reported by LA2 were lower than those reported by their statistical neighbour (23.8%)
- Despite an initial decrease between 2015 and 2016, data for LA1 also suggests an upwards trend to 2019 doubling between 2016 (10.8%) and 2019 (21.1%). Rates reported in LA1 were also lower than that of the statistical neighbour (25.1%)

Figure 4: Percent of children who became the subject of a plan for second or subsequent time

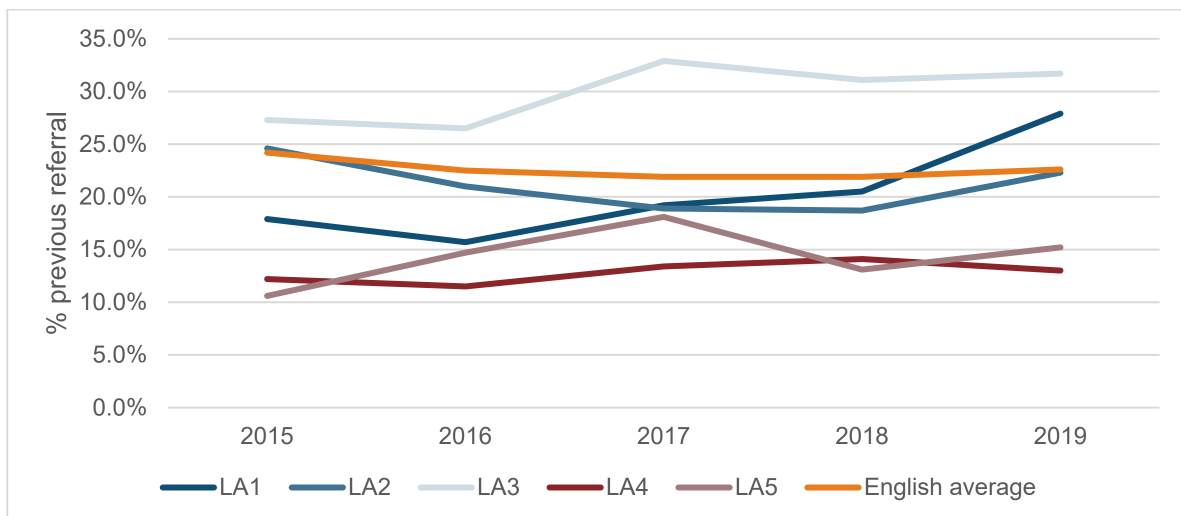


Percentage of re-referral to children's social care with 12 months of previous referral

Figure 5 details that overall there was an increase in re-referrals to children's social care within 12 months of previous referral. LA3 consistently reported the highest percentage of re-referrals to children's services within 12 months of previous referral. LA3 did not participate in the follow up study and hence findings are difficult to interpret. However, findings from Ofsted inspections suggests that poor recruitment has hampered practice improvements in LA3. LA1 also reported the biggest increase over the 4 years to 2019. This may be associated with a move away from RSW or other environmental factors.

- Overall there was an increase in the percentage of re-referrals to children's social care within 12 months of the previous referral. LA2 was the only local authority not to report an increase over the 4 years to 2019.
- LA3 consistently reported the highest percentage of re-referrals to children's services within 12 months of previous referral, reporting the greatest increase between 2016 (26.5%) and 2017 (32.9%). By 2019, LA3 re-referrals were considerably higher than their statistical neighbour (statistical neighbour 3: 25.5%)
- Despite an initial decrease between 2015 and 2016, LA1 reported the biggest increase over the 4 years to 2019. LA1 also reported higher rates of re-referrals than their statistical neighbour (22.5%)

Figure 5: Percentage of re-referrals to children's social care within 12 months of previous referral



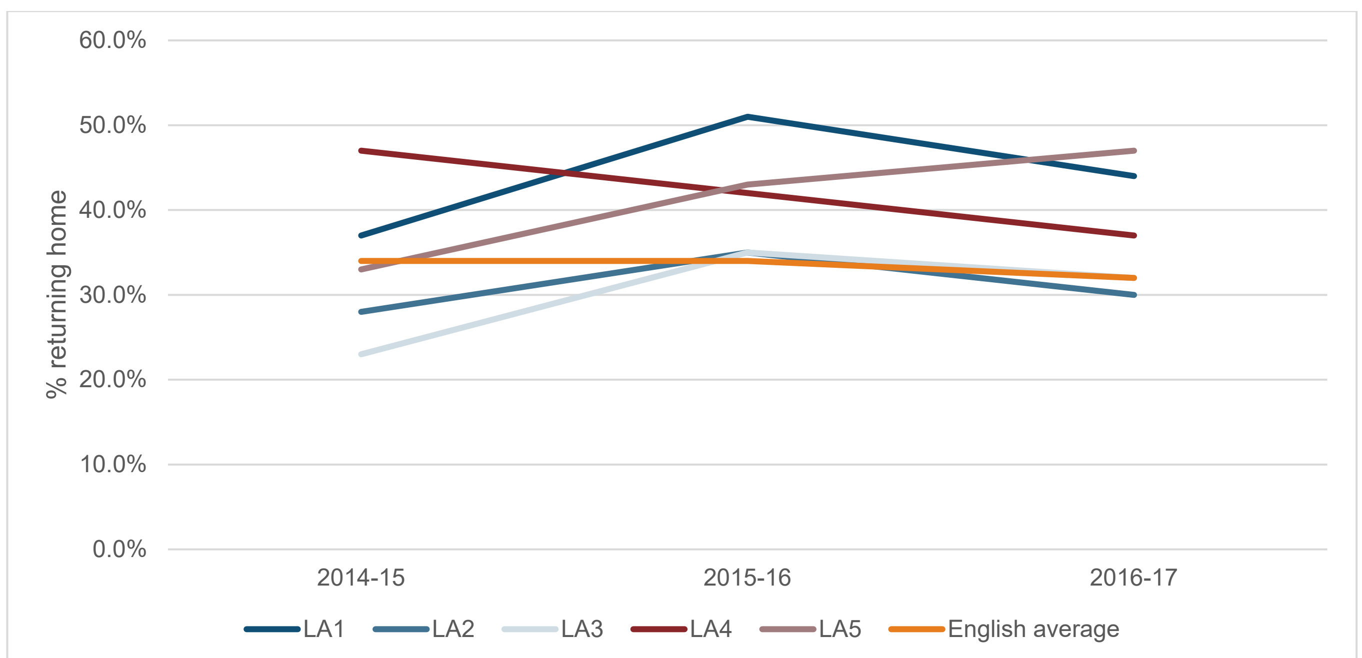
Percentage of children who return home (data only until 2017)

Figure 6 details that overall the percentage of children who returned home decreased between 2015 and 2017. LA5 show the greatest increase in the proportion of children returning home. This may reflect that they were the only local authority to retain a KFT unit with the specified aim of keeping families together. However, due to the limited number of data points available, caution should be exercised when drawing conclusions about trends.

- Overall the percentage of children who returned home decreased over time. LA5 was the only local authority to report an increase over the 3 time points

- LA5 show the greatest increase in the proportion of children returning home in the years to 2017 (+14%) and LA4 showed the greatest decrease (-10%)
- In 2016-17 LA2 (30%) was the only local authority to be below the English average (32%)

Figure 6: Percentage of children returning home after a period of being looked after



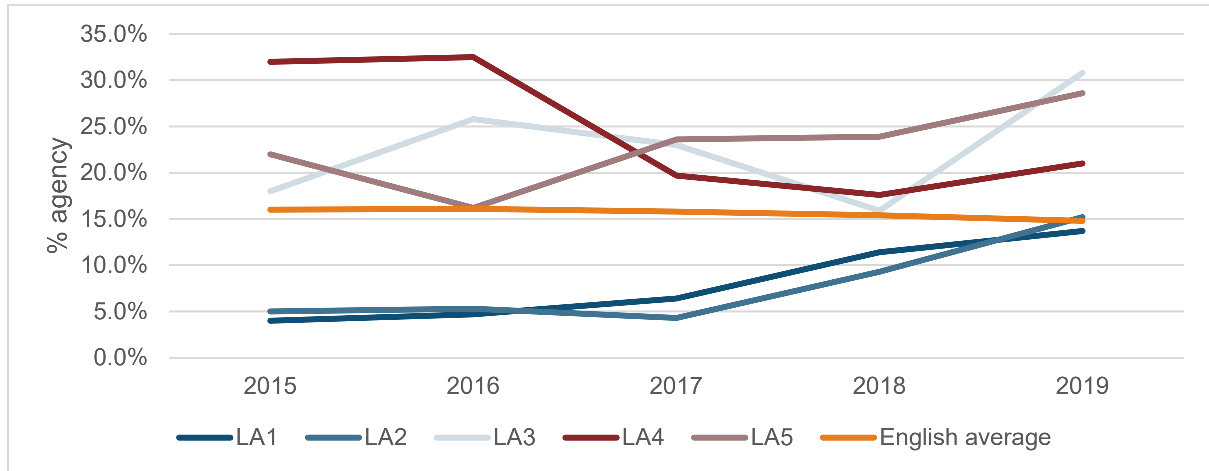
Outcome: reduced staff turnover and agency rates

Percentage of agency workers

Figure 7 details the upward trend in percentage of agency social workers. It is unclear the degree to which this is associated with RSW or other environmental factors associated with social work recruitment and retention.

- There was an upward trend in the percentage of agency workers in the years to 2019 in both LA1 and LA2. Agency worker rates are 3 times greater than in 2015. By 2019, LA1 had lower rates of agency workers than their statistical neighbour (30.2%) and LA2 had higher rates (14.3%)
- Data from LA5 also suggests a slight increase in agency rates despite an initial decrease in 2016
- A more volatile picture is reported by LA3 and LA4 with no clear trend over time

Figure 7: Percentage of agency social workers

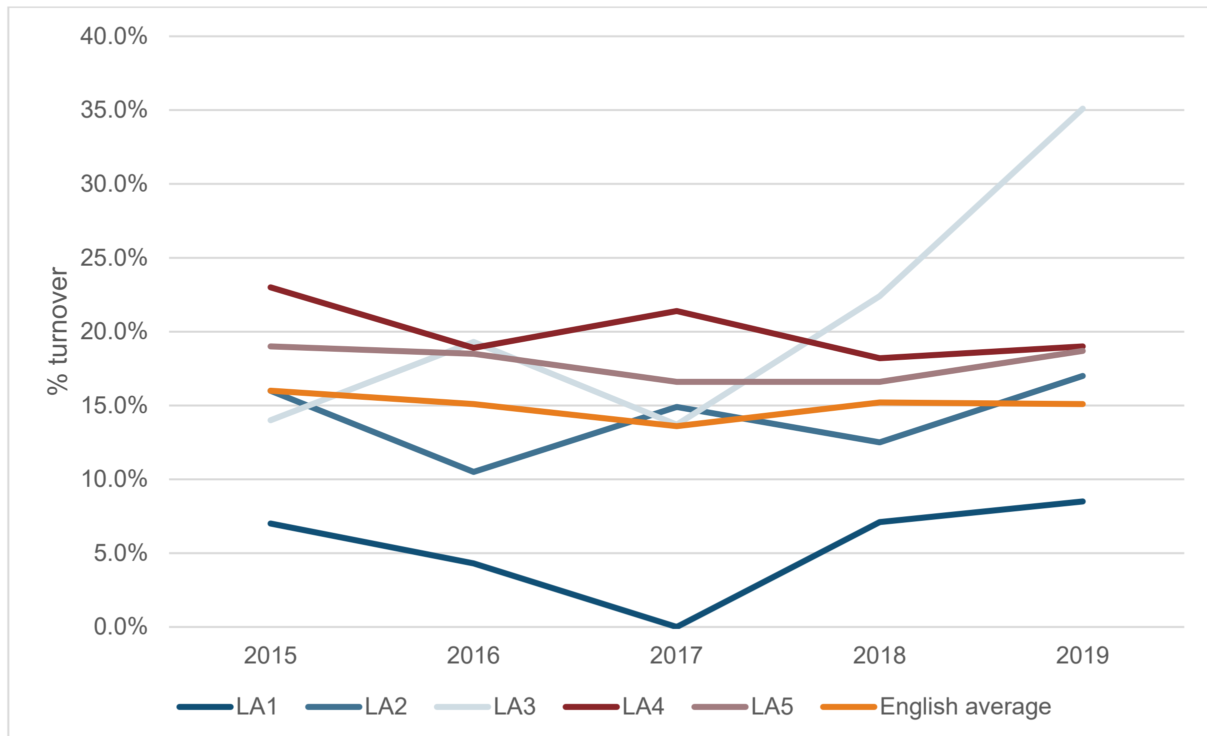


Percentage social worker turnover

Figure 8 details the percentage social worker turnover by local authority between 2015-19. Like agency rates, it is difficult to know whether turnover is associated with RSW or wider environmental factors associated with social work recruitment and retention. LA3 reported the greatest increase in social worker turnover rates which reflects findings from Ofsted inspections.

- The percentage of social work turnover varies significantly between local authorities over the 4 years to 2019
- LA3 reported the greatest increase in social worker turnover with rates more than doubling in the 4 years to 2019. In 2019 LA3 had a higher rate of social worker turnover than their statistical neighbour (29.4%)
- Data from the remaining local authorities is less volatile but indicate no clear trend
- LA5 reported the most consistent rates of turnover over the 4 year period

Figure 8 Percentage social worker turnover



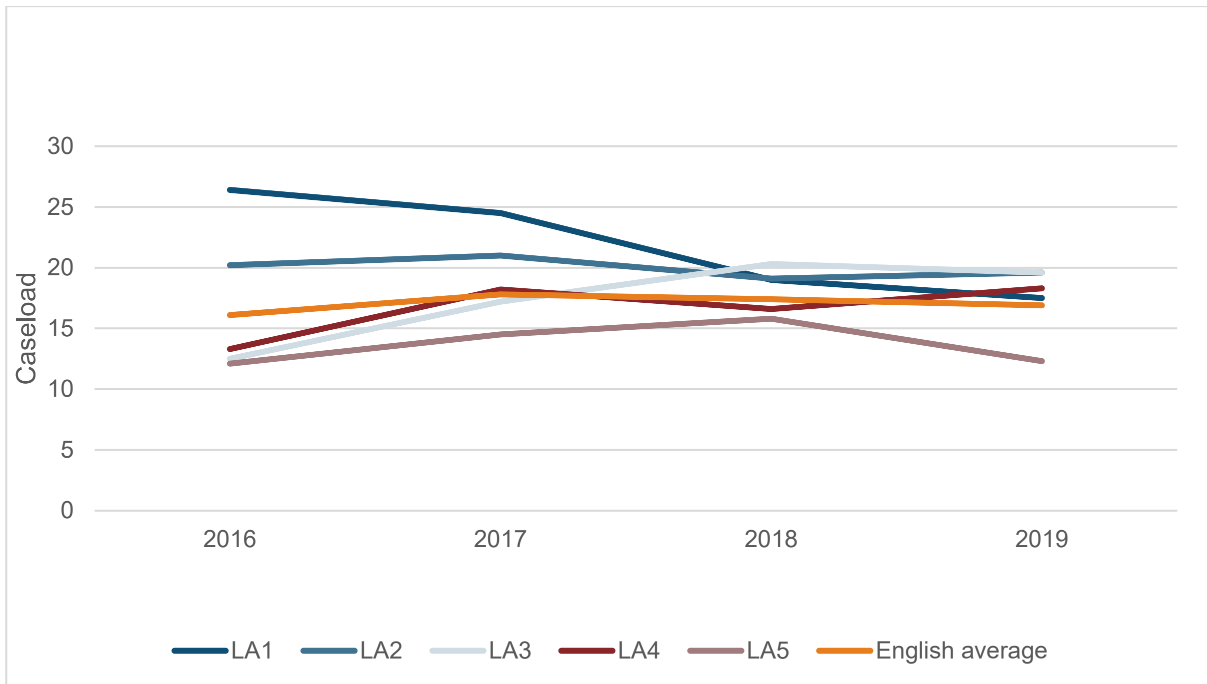
Feature of practice: enabling staff to do skilled direct work

Average social worker caseload (data only as far back as 2016)

Figure 9 details a mixed picture concerning the average number of cases per children and family social worker (based on FTE counts). However, LA5 reported the lowest number of cases. This may reflect their continued commitment to systemic practice.

- Data for the average number of cases per children and family social worker was mixed
- LA1 reported the biggest decrease over the 4 years to 2019 with an average of 26.4 cases per worker in 2015 and 17.5 cases per worker in 2019
- LA3 experienced the greatest increase in average number of cases over the four years from 12.5 in 2015 to 19.6 in 2019. In 2019, LA3 had higher caseloads than their statistical neighbour (14.1)
- LA5 consistently reported the lowest number of cases ranging from 12.1-15.8 over the 4 years to 2019. By 2019 caseloads in LA5 were lower than that of their statistical neighbour (15.1)

Figure 9: Average number of cases per children and family social worker (based on FTE counts)



5. Summary of key findings on 7 practice features and 7 outcomes

Evidence from Round 1 led the DfE to identify 7 features of practice and 7 outcomes to explore further in subsequent programmes (Sebba et al., 2017). RSW longitudinal findings can be summarised as follows by the 7 + 7 framework.

Strengths-based practice framework – key respondents from 3 of the 4 local authorities described evolution in their practice models. They identified drawing on other strengths-based approaches that interlinked with systemic practice, including Signs of Safety and restorative practice.

Using systemic approaches to social work practice – across all 4 local authorities, RSW principles were reported as continuing to inform their work with children and families. However, this differed by local authority, reflecting both factors specific to the local context and evolutions in approaches to social work practice.

Enabling staff to do skilled direct work – practitioners feedback from interviews and surveys suggested that delivery of RSW to an acceptable standard remains dependent on a good practice pyramid of 3 essential, interconnected elements of practice: systemic training, clinician input and group systemic supervision.

Multi-disciplinary skills sets – practitioners identified the importance of clinical input via supervision and consultations to support them to think through practice dilemmas and to plan joint work with family members. This was mostly consistently evident in LA5.

Undertaking group based case discussion – the practice shaping impact of systemically-informed supervision was identified to be important by practitioners: for example, to explore risk to children from multiple perspectives, including families and other professionals; and pre-plan interventions by turning hypotheses into actionable conversations.

High intensity, having a whole family focus and consistency of practitioner – KFT worked to a defined practice model that focused on engagement, mutually agreed goals and sustaining change in family relations to ensure no need for further service intervention.

Reducing risk for children – variations in key performance outcome indicators were noted. Findings were mixed with overall decreases in the number and percent of children who were the subject of child in need or child protection plans or looked after noted in 2 out of 5 local authorities and increases in the 3 other local authorities. Since 2015, LA5 demonstrated the most significant reduction in overall indication of risk to children.

Reduced staff turnover and agency rates – 3 out of 5 local authorities report large percentage increases in use of agency workers. LA4 was the only local authority to show a decrease in the percentage of agency rates (-11%) over the 4 years.

6. Implications and recommendations

The evaluation has provided evidence that where all or most of the key elements of RSW are retained, RSW has the potential to deliver high quality social work services. While resource limitations meant that the quality of practice could not be systematically assessed, there were indications that systemic practice helped families to remain together. Where survey data were collected, workers felt overwhelmingly positive about systemically-informed social work as an approach to practice. Although this differed by local authority, depending on local practice models. For example, practitioners from LA5 were more likely to emphasise the relational nature of problems as a means to understand risk to children, whereas practitioners in LA4 focused on strength-based approaches to risk assessment. Practitioners also re-affirmed that a number of factors were required to deliver RSW to a high standard, including training in systemic practice; the quality of systemically-informed supervision; and contribution of a clinician in supervision. While systemic training was valued, practitioners highlighted the importance of supporting practice through high quality supervision, particularly where there was clinician input. This was supported via the KFT case study, whereby evidence of the practice shaping impact of supervision identified.

However, the overall longer-term impact of RSW on key performance outcomes was limited. Analysis of key performance indicators suggests that trends were volatile or unclear for the majority of indicators analysed. Relative to the other local authorities, poorer performance was reported by LA1 - who only retained 2 out of the 5 key elements of RSW - regarding numbers of children subject to child in need plans, child protection plans and subsequent plans as well as the highest proportion of looked after children. It is difficult to know if this is associated with a move away from RSW principles and practice or other factors. Better performance relative to the other local authorities was reported by LA5 – who retained all 5 key elements of RSW – in relation to stable numbers of children subject to child protection plans, modest reductions in numbers of looked after children and highest percentage of children returning home after a period of care. Overall, LA5 demonstrated the most significant reduction in overall indication of risk to children. Please noted that data on return home was limited to three data points and hence, findings should be treated with caution. Combined with interview and survey data, these data are indicative of the impact of a sustained commitment to systemic practice.

Yet the follow up evaluation identified some dilemmas: despite a reported commitment to delivering RSW principles by leadership teams, and workforce that valued systemic practice as an approach, retaining RSW as it was originally envisioned proved challenging. This both reflects findings from Round 1. Some of this difficulty is likely to be present in many of the other innovation projects, because change, for individuals and for organisations, is in general a difficult thing to achieve (see Munro et al, 2016; Laird et al, 2017). It also reflects the impact of changes of leadership and responses to Ofsted inspections. In 1 local authority, an inadequate inspection resulted in a hiatus and a move away from many of the key elements of RSW in an effort to focus on basics. In another, an inadequate rating had encouraged a re-think of their service structure, resulting in a move to smaller RSW units or teams. Stability of leadership appeared to be associated with a sustained commitment to the elements of RSW. It was noticeable that in the only local authority where the Director of Children's Services had remained in place, all 5 elements had survived and even thrived with the development of in-house clinician service.

As noted in Round 1, the continued commitment of leaders and workers to RSW principles – and strengths-based practices more generally – is testimony to their ambition to improve the experience and outcomes for children and families. There are implications at a national level for how to create better children's services; specifically, how best the inspection regime can encourage a more constructive process focused on excellence in practice quality and outcomes for children and families. From a systemic perspective, this would further embed strengths-based practice approaches.

Recommendations for policy and practice

- RSW remains an approach that aims for excellence in social work practice. There are opportunities for other local authorities to learn from its key elements to support delivery of high quality services that work effectively to keep families together
- Achieving practice change is challenging. Where local authority leaders remained in place, key elements of RSW were more likely to be retained or in the case of clinical support to social work staff, strengthened. Supporting stability of local authority leadership to promote their capacity to innovate should remain a priority

- Practitioners' feedback suggests that delivery of RSW to an acceptable standard remains dependent on a good practice pyramid of 3 essential, interconnected elements of practice: systemic training, clinician input and group supervision. It is recommended that at a minimum these 3 core elements are in place to support implementation of RSW

Appendix 1: What is Reclaiming Social Work?

RSW is an approach developed within the London Borough of Hackney aimed at improving services for children and families. It aims to reclaim social work and re-orientate the child protection system toward practice with children and families that is relational and reflexive, rather than adversarial and punitive. Keeping families together, where appropriate, is a fundamental aim of RSW (Bostock et al, 2017). Central to the RSW model is the creation of small multi-disciplinary teams, known as systemic units. A systemic unit is a small multi-disciplinary social work team. In this model, cases are allocated to a consultant social worker. They are responsible for the unit that collectively works the case. In the original model, RSW units consisted of the following members:

1. A consultant social worker – has a degree in social work, leads the unit, has ultimate responsibility for case decision-making and provides expertise and practice leadership.
2. A qualified social worker – who is a person with a social work degree and works directly with families to enable change.
3. A child practitioner – who may not be social work qualified but also works directly with families.
4. A unit coordinator – who provides enhanced administrative support, rather like a personal assistant and acts as first point of contact for families.
5. A clinician – who is generally a qualified systemic family therapist, providing both therapeutic input for families and also offers clinical supervision to the unit.

(Forrester et al. 2013b: 3).

What is systemic social work practice?

Systemic social work practice is informed by the principles of systemic family therapy and adapted to the child welfare context. It is focused on people's relationships and interactions with the wider social and economic context as a means of understanding their experiences to effect change (Forrester et al., 2013). Consequently, a key concept in systemic theory is considering multiple perspectives and multiple possibilities. Systemic group supervision or systemic supervision provides the pivotal practice forum

for understanding risk to children and planning interventions to support families. It is a group-based forum whereby children and families are discussed by the team.

Appendix 2: Research Design

Research approach

To assess the longer term impact of participating in the original RSW project, 4 out of the 5 local authorities (Derbyshire, Harrow, Hull and Southwark) agreed to participate in the longitudinal follow up study. The study was smaller in scale and restricted to repeating staff surveys and interviews with key stakeholders, follow up of family members and analysis of publicly available data on key performance indicators.

Process of change study

The process of change strand of the evaluation explored the longer-term impact of RSW on organisational change from the perspective of key stakeholders and frontline staff. In total, 65 participants took part in this aspect of the evaluation.

Key stakeholders

Semi-structured interviews were conducted with key stakeholders in each of the 4 participating local authorities. Key contacts were asked to identify relevant participants. Three key stakeholders had participated in the original study while others were new to the local authority. Participation varied by local authority, meaning that opportunities to follow up emerging themes with other participants were limited (see Table 10 for participation by local authority). Interviews repeated questions from the original study focusing on context and the conditions that created practice excellence.

Table 10: Process of change study: Data collected by local authority

Role	Number of participants
LA1	1
LA2	1
LA4	3
LA5	3
TOTAL	**8**

Staff surveys

A survey of all relevant frontline practitioners and managers was carried out in 3 out of the 4 local authorities. A total of 65 surveys were returned. This repeated a core suite of questions asked in the original RSW study (325 surveys returned in the original evaluation). Responses provide baseline data that were compared with follow up data, although caveats apply given differing participant groups and lower response rates.

Respondents were asked to consider to what extent they agreed with statements related to the following headings: working in your local authority; work satisfaction; learning and development; peer and management support; organisational support; supervision; time management; time and resources; and health and wellbeing.

Responses were given using a 5-point likert scale (Likert, 1932) ranging across disagree strongly, disagree, neither disagree nor agree, agree and agree strongly. Surveys incorporated free text questions for respondents to add additional feedback or explanation that they felt had not been fully conveyed in the body of the survey.

Surveys were conducted online and undertaken at timings negotiated with the local authorities. Table 11 below outlines that some surveys were targeted at particular service areas, while others used a whole-service sample frame to meet the aims of the respective local authority. Like the original surveys, some questions were modified at the request of the local authority but consistency maintained as far as possible.

Table 11: Staff survey design by local authority

	Timing	Method	Content	Sample
LA1	Sept-Oct 2019	Online; email-link	Researcher-led	Whole-service
LA3	Aug-Sept 2019	Online; email-link	Negotiated	Whole-service
LA4	Aug-Sept 2019	Online; email-link	Negotiated	Targeted

Practice and service experience study

The practice and service experience study involved following up all families (n=68) across the 4 local authorities who had originally taken part. This strand was focused on

whether any improvements in goals, family functioning and health and well-being associated with their work with children's services have been sustained longer-term. This was a particularly sensitive aspect of the study design. It quickly became apparent, that making contact with family members was proving problematic. In total, 3 out of 68 parents agreed to be interviewed.

Initially, only families (n=28) were contacted who had participated in a second interview (T2) and had consented to take part in further research. Given difficulties with recruitment, it was decided to include all parents (n=79) who took part in a Time 1 (T1) interview to increase the population sample. This group of parents had granted consent to take part in a T2 interview, rather than consent to be followed up for future research. At the time, tight timescales had compromised researcher's ability to follow up as intended. Additional ethical approval from the relevant University's ethics panel was required in light of sensitive consent issues. This was granted on the basis that the benefits of longitudinal research outweighed the risks of contacting parents because of stringent protocols developed to ensure their rights around informed consent.

The following recruitment protocol was developed:

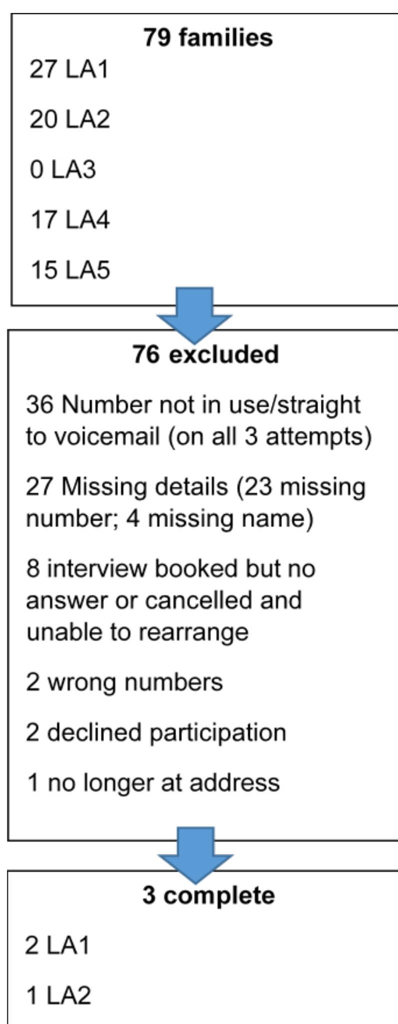
- All parents (n=79) were contacted initially via text message using the mobile numbers provided directly to researchers. The message included: the researcher's name and contact details (including name, phone number and email); reference to previous research participation in 2015/6; and an opt-out request for permission for the researcher to telephone participants within an indicated timeframe. The message stated that researchers wished to discuss taking part in the research study about their experiences of working with children's services.
- In the event that we did not receive an opt-out text, email or phone call within the timeframe, the text message was followed up with a phone-call to outline the aims of the research project and answer any questions. This call emphasised that participation was entirely voluntary.
- Where parent participants granted consent, they were offered the option of a face-to-face interview or telephone interview. If face-to-face, information sheets were provided and consent to take part confirmed in writing. If telephone interview, information sheets and consent forms were sent via email or mail (depending on

preference) prior to the interview, explained verbally during the interview and consent recorded digitally. Written consent was confirmed via email or mail once the interview was completed.

- Participant information sheets and consent forms provided the following details: limits of confidentiality; use of personal data; data storage and security arrangements; contact and complaints procedures; as well as information on where to access support. Timelines for withdrawing consent was made clear to participants.

However, recruitment remained problematic. Reasons included: number no longer in use; number ringing out repeatedly with no answer; missing details; mobile transferred to a new owner or wrong number; contact made but no wish to take part in further research. Figure 10 provides a flow chart of contacts.

Figure 10: Flow chart of contacts



KFT case study

In light of difficulties in recruiting families, the KFT strand of the study was redesigned to include a qualitative case study aspect. This focused on a single KFT unit that had remained largely faithful to the RSW model with the addition of more team members. Ethical approval for this change in research design was granted by the relevant University Research Ethics Panel. The aim of this aspect of the work was to capture both practice and family experiences of RSW-informed approaches.

KFT members identified and invited families to participate in the research. Eight families gave consent to participate and 6 went on to participate (2 families experienced a crisis and hence it was judged to be inappropriate to introduce a researcher at that point of the intervention). Data collected included: 6 social worker questionnaire; 6 recordings of supervision, 6 observations of direct practice; and interviews with 4 family members. Interviews were also conducted with the team manager and members of the whole KFT unit. Where families consented, data were collected in the following areas:

- observations of supervision: supervision associated with the family's case were recorded, transcribed and coded for the essential domains of systemic supervision using a bespoke coding framework (see Table 11 for an explanation of each domain)
- observations of practice: meetings with workers were observed, recorded, transcribed and coded for key social work skills using a skills coding framework with established reliability (Table 12 for an explanation of each skill)
- family interviews: gathered evidence on their experience of the service, relationships with workers, goals, planning and coproduction, using standardised measures for key elements of wellbeing
- social worker questionnaires: social workers completed a questionnaire outlining the degree to which goals in work were achieved and the support that workers felt had been provided for their work

Analysis of supervisory sessions

Audio-recordings of supervision were transcribed and analysed using a bespoke coding framework developed by TGC (Bostock et al, 2019a). The framework focuses on five essential domains of systemic supervision: relational nature of problems; voice of the family; risk talk; curiosity and flexibility; and support for practice (see Table 12 for an explanation of each domain).

Analysis of direct practice sessions

Audio recordings of direct practice sessions were analysed using the practice skills framework developed by TGC and a partnership local authority (Whittaker et al, 2016). The framework includes five skills, in two groups: Relationship-building and Respectful Authority. Relationship-building skills include *empathy* and *collaboration*, underpinned by Motivational Interviewing (Miller and Rollnick, 2012). Respectful authority includes the social work-specific skills of *purposefulness, clarity of issues* and *child focus*, from Ferguson's (2011) concept of 'good authority' (see Table 13 for an explanation of each skill).

Supervisory - practice session pairs

Both supervision and direct practice are generally rated for practice quality. However, given small numbers, a different analytical approach has been taken. Qualitative thematic analysis was used to identify prevalent themes that crossed-over between supervision and direct practice (Milne et al., 2003).

Analysis of social worker questionnaires

The data from social worker questionnaires were inputted into SPSS and analysed using descriptive analysis to provide the profile of the participating social workers; contextual information for the participating families; information regarding where social workers gained support for practice for the participating families and their perspectives on systemic practice.

Table 12: Domains of systemic group supervision

Domain	Description
Relational nature of problems	Are identified "problems" being considered within the context of a system? To what extent are the relationships **between** people discussed? To what extent are these linked to wider systems (community, schools, ethnicity etc.)? How do workers see themselves in this situation? Are they thinking about their own professional position within the system and how this affects relationships?
Voice of the family	Is the family "present" in the conversation? Are the child's needs, wishes and feelings incorporated into the conversation? Were the views of different parties considered, and if they are different, how did workers discuss resolving these differences in perspective?
Risk talk	How is "risk" raised and discussed? Is it viewed as a static label (e.g. a person being a risk) or are risks discussed as dynamic and understood within relational context? How do actions and inactions impact on risk within the family? Did the unit talk about family strengths?
Curiosity and flexibility	In what ways do participants demonstrate curiosity about families? Do they have fixed ideas or challenge taken-for-granted assumptions? Do they explore multiple possibilities and perspectives, including those of the child and family (which may in turn not be unanimous)? How do they approach practice dilemmas or unknowns? How is the group generating new ideas or hypotheses?
Support for practice	How do participants develop their hypotheses into clear, actionable conversations with families? Is there clarity of purpose about how these conversations will influence the family system and effect change for children? Conversely, if it was agreed not to intervene, in what way was this connected to their understanding of the family and wider systems?

Adapted from Bostock et al., 2019a: 519

Table 13: TGC's practice coding framework: summary of five skills assessed

Skill	Description
Collaboration	Draws on the service user's own ideas and perspectives: flexibility, incorporating their views and ideas, division of space, and power dynamic.
Empathy	Understanding the service user's perspectives and feelings and demonstrate that understanding: Demonstrating understanding, Curiosity about perspective, feelings and behaviour, and Acceptance.
Purposefulness	Ability to maintain a clear focus, while also responding flexibly to the young person's agenda: structure and flexibility.
Clarity of issues	Clarity of current issues: explanation of issues, prioritisation of issues, and disclosures.
Child Focus	Extent to which the worker adapts the session to fit the CYP: holistic picture, relationships, direct work tools, and playfulness.

Performance outcomes study

Finally, comparative analysis of publicly available key performance indicators (KPIs) was undertaken. Comparative analysis was conducted across all 5 original participating local authorities and compared with the English average. In addition, statistical neighbours were identified for each local authority via the Local Authority Interactive Tool (LAIT).

This aimed to provide an indication of the success of RSW on population-level outcomes both over time, between participating local authorities as well as compare outcomes with their statistical neighbour. Analysis of performance data tracked 7 indicators in the four year period 2015 to 2019. Table 14 outlines the 7 indicators mapped to 2 outcome areas, 'reduced risk for children' and 'reduced staff turnover and agency rates', and 1 'feature of practice, 'enabling staff to do direct work' (Trowler, 2018).

Table 14: Outcome / practice feature mapped by indicators

Outcome/ Feature of Practice	Specific outcome/feature	Analysis of indicators mapping to specific outcome/feature
Outcome	Reduced risk for children	1. Rate per 10,000 of children identified as: • Children in Need (CiN); • Subject of Child Protection plans (CP) • Children Looked After (CLA) 2. Number and percentage of children who became the subject of a child protection plan for a second or subsequent time 3. Percentage of re-referrals to children's social care within 12 months of previous referral 4. Reduce days spent in state care (Percent of children who return home)
Outcome	Reduced staff turnover and agency rates	5. Agency rates 6. Percent of SW turnover
Feature of Practice	Enabling staff to do skilled direct work	7. Average social worker caseload

Appendix 3: Staff survey findings

This appendix provides further information on data from staff surveys to supplement findings in the main report.

Figures 11 and 12 provide a visual representation of the most commonly used descriptors by practitioners of their practice model in LA4 and LA5.

Figure 10: LA5 practice model description: staff survey responses

Figure 11: LA4 practice model description: staff survey responses

Table 15 provides a systemic practice case study adapted from staff survey data. Details changed to protect anonymity of the family.

Table 15: LA5 case study: impact of systemic practice with families

An adolescent boy was repeatedly referred to children's services by school due to his challenging and unusual behaviours. This was compounded by his mother's aggressive presentation when on school premises. By discussing this in group supervision and trying to take on the position of the child, and then the mother - who was a migrant, Black with limited English as well as a single parent - we were able to generate more hypotheses about what might be happening. By repositioning ourselves in relation to this mother, we were able to appreciate her position and understand that her volatile behaviour with school was because - in her mind - she was protecting her son from perceived racism and discrimination. Once she felt understood and validated as a Black mother in an alien and threatening environment, she was able to sit in a meeting with school staff. This enabled school to reframe her son's behaviours as a response to the stress he experienced when he saw his mum being angry with the school. He had aligned with mum and acted out his anger in class which was then interpreted as him being abused. We used the Burnham's social graces to help us think through differences in beliefs, power, the visible and invisible, voiced and unvoiced by drawing on hypothesising, curiosity and second order positioning. We also used relational reflexivity, reframing, circularity, family systems and structural family therapy models as well as Mason's safe uncertainty quadrant and solution focused and future focused questions to create a change in the system. The child was much calmer in school when he saw his mum and school working together and the school less wedded to the idea that he was being abused. Frontline practitioner, LA5

Appendix 4: KFT case study findings

Table 16 details examples of skilled practice by each practice skill.

Table 16: Examples of skilled practice by practice dimension

Skills **Assesses the extent to which the worker…**	**Example**
Collaboration: Incorporates families' views and perspectives into the session and identify them as experts in their own experience	What's your view, I know we've had conversations in the past and difficult conversations so where are you at, at the moment? So if I start with you [young person], in 6 months if things could look different, what would that look like for you?
Empathy Demonstrates curiosity about, acceptance of and understanding of the family's feelings, thoughts and experiences	How does that make you feel? It's a long drive, it's a really long drive, and then how does it make you feel when you get down there and then it just feels like you're getting this rejection? What do you think [young person] may be feeling where he's got a younger sister who's on path to achieve, his older sister is at uni, uncles, aunties … everyone has reached a certain standard. What's your view?

Child focus Structures the session around the needs of the child and adopts creative ways to build on relationships	How do you think [young person] is feeling about contact? What are the other things that you would say [young person] strengths are? When things are going well, what are the good things about it?
Purposefulness Has a clear purpose that is communicated and negotiated with the family	What we were hoping to do today is to map with you what factors help you to remain positive. I know that there's been a few days at school that have been hard for you…if things are worrying you or upsetting you, if there's a reason why school's been a bit difficult then we can help. But what has been going on for you at school?
Clarity of issues Raises the issues and concerns and draws on the perspectives of the family	Our worry was that he was going out all the time, not saying where he was going, not staying at the house, we were quite panicked that it would instantly fall back to that because he would give up hope, think, 'Well, there's no point and actually, I'm not going to achieve and I may as well just be out there doing what I want'. But it seems like it hasn't gone that way, although at times, yes, he does go out, yes, but generally he is asking more.

Table 17 details examples of thematic transfer of dilemmas discussed in supervision and against issues raised in conversations with family members.

Table 17: Examples of thematic transfer from supervision to practice by domain

Supervision talk	Direct practice talk
Relational nature of problems	
Thinking about the activator, I just wonder whether as part of a wider, thinking about sustainability, is whether it's worth still having conversations around, "We've noticed this how well you are supporting the family and that seems really good."	I think this is something that we've spoken to you about before, in that you are very much the centre of the family, you offer support to everyone in the family, but at times of stress for yourself because things are going on in the house, who is supporting you?
Voice of the family	
She is responding very well to this - obviously because that's reinforcing for her, isn't it, that he's needing her and that he's coming to her - he's basically doing a lot of the things that she wanted him to do in terms of asking to go out and all of that?	I know he's been speaking to you and he's able to express that he was gutted in terms of the way he done it. So, I think out of that negative, something positive has come, maybe a realisation to take more responsibility. What's your view, because I know we've had conversations in the past and difficult conversations so where are you at, at the moment?
Risk talk	
Has there been any change in risk? That's good, that's potentially positive. In a sense it's possibly improved ever so slightly but maybe not majorly?	We're at a stage where things seem to be in a better place, it's far from perfect, but I still think that you guys, as a family, have moved forward in terms of where we first met you. Would you agree or disagree?

	When we first got involved with you and your family, the edge of care concern was about the missing episodes and the stealing and the risky behaviour that he's presented in the community and, at times, in the house. We're at a stage where things seem to be in a better place, it's far from perfect, but I still think that you guys, as a family, have moved forward in terms of where we first met you. Would you agree or disagree?
Curiosity and flexibility	
He's staying home more which then reduces the concern for nan, why he's staying home we don't know, we think maybe he might be scared or maybe he's just, I know that one of his mates has left the area … or maybe he's got bored. I know that we were talking about, it feels like the family are a bit more positive about him at the minute, maybe he feels a bit more comfortable at home?	He might be ashamed of having his place terminated at school and it can be difficult being around family. But do you think, because one of the things, he has been staying home more - which wasn't a factor previously - so what do you think it is about him feeling, do you think he's feeling more comfortable staying at home?
Support for practice	
I think we're still doing the work on positive affirmations. I think that's an ongoing thing, that seems to be helping. I think [family member] will respond much better to a conversation where, "We've noticed this thing you've been	Now he's been staying in a lot more, is there anything that he's been doing well, is there anything positive that he's been doing whilst he's been in the house? What's the positive?

doing, it's really great", than us saying, "We think you should do this thing."	

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