



Department  
for Education

# **Focus on practice in three London boroughs: an evaluation**

**DfE Children's Social Care Innovation  
Programme Evaluation**

**July 2016**

**Claire Cameron, Heather Elliott, Humera Iqbal,  
Emily Munro and Charlie Owen**

**Thomas Coram Research Unit**

**UCL Institute of Education, University College  
London**

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## Acknowledgments

The authors would like to acknowledge the very constructive partnership with the Focus on Practice management team, in particular the helpfulness of Julie Rooke, project manager. All requests for information and advice, and access to data sources, were responded to in a timely way. We would like to thank all the social workers, managers and other staff in the boroughs whose views and experience are documented in this study. Particular thanks go to the families who participated in the study and those who agreed to participate but circumstances meant they could not, in the event, take part.

We are also grateful to Joanna Gzik, project administrator, for her constant support of the work and to Dr Lisa Holmes, Loughborough University, for expert advice and support.

# Executive Summary

## Introduction

Focus on Practice introduced systemic training and systems level changes to family social work in three London Boroughs. Beginning in 2014, the local authorities employed clinicians (family therapists and clinical psychologists), embarked on a programme of training for over 500 social workers and other related practitioners, over 160 supervising practitioners, and senior managers. In addition, changes to recording were introduced. Other elements of Focus on Practice were investment in an observation and coaching and motivational interviewing programme, parenting programmes and Signs of Safety. The programme was designed to bring greater coherence and confidence to social work practice, and aimed at embedding a new culture based on systems thinking, reducing the number of re-referrals of family cases and reducing the number of children in care.

Thomas Coram Research Unit, UCL Institute of Education was commissioned to evaluate the programme between May 2015 and March 2017. Given the broad scope of Focus on Practice, the evaluation focuses more narrowly on the implementation context and the impact of the systemic training and allied systems changes to social workers, team leaders and managers in assessment practice, and those working with families in the longer term. Practice scenarios were used to ascertain the extent to which respondents aligned their work with the intended learning outcomes of the training, alongside interviews designed to elicit perspectives and experiences. Families' views were also investigated through interviews, network maps and a family functioning tool called SCORE-15. Administrative data was used to assess child and cost outcomes and changes in how time was spent were assessed using a survey informed by focus group discussion.

## Findings

Evaluation findings to date are that:

- A new cultural norm around systems theories and systems thinking was becoming evident in the language, concepts, tools and practices employed by social workers, supervisors and senior staff
- There was widespread enthusiasm for the training and the programme overall and widespread agreement about the objectives of the programme
- The organization of implementation of Focus on Practice was exemplary, maximizing the chances of success on the ground.

- Supervision and reflective practice were becoming more familiar and more oriented towards Focus on Practice intended learning outcomes.
- Focus on Practice emphasis on building relationships using systemic techniques with families was often seen as difficult to reconcile with the requirements of practice within assessment teams, leading to partial implementation of learning from the training.
- Responses to practice scenarios suggested that practitioners were less oriented towards the Focus on Practice methods and concepts than the interview responses indicated.
- Changes to recording practices to introduce case summaries were not fully implemented or perceived to have saved time. Barriers were social workers' perception of senior manager support for holding any risk associated with less detailed recording and the perception of requirements for court practices.
- Placement costs reduced over two years since baseline, but staff salary cost increased.
- Reduced use of agency staff and reduced rate of staff absence indicating better value for money.
- Families' perceptions were difficult to relate to Focus on Practice explicitly but the qualities they appreciated in social workers aligned well with Focus on Practice values and intentions.

## **Implications and Recommendations for Policy and Practice**

- Continue to employ family therapists in clinician posts that are available on a flexible consultancy basis to social workers
- Rethink structure of service to reduce changes of practitioner and maximize opportunities to build relationships with clients
- Invest in supporting changes to recording in order to maximize the potential to save time and aid analytic thinking
- Consolidate practice change and refocus on specific types of case where systems approach might help reduce re-referral rate.

# 1. Overview of project

## 1.1 What was the project intending to achieve (outcomes)?

Focus on Practice is a children's services change programme in the Tri-borough area of central and west London. Launched in October 2014, Focus on Practice is an investment in the staff working with families to transform practice with three intended outcomes. These are to:

- Embed a new 'cultural norm' for practitioners based on systemic theory
- Reduce the number of families who are repeat clients
- Reduce the number of children in care.

## 1.2 What was it intending to do to achieve these?

The change programme consists of four elements:

1. Skills development through: a) 15 day courses that lead to a foundation year in systemic practice for 502 social work and related family service practitioners between October 2014 and December 2016; b) foundation year in supervising systemic practice (both recognised qualifications) for 161 supervisors; c) six day course in systemic practice for senior leaders; d) parenting theory and skills courses; e) motivational interviewing and coaching; and f) investment in Signs of Safety (a strengths-based and safety-focused approach to child protection work);
2. Embedding learning through: a) recruiting heads of clinical practice in each borough and clinicians, who also co-tutor on systemic practice courses; b) developing a specialist practitioner model; c) rolling out observation/coaching programme; and d) running reflective groups in teams;
3. Changing systems conditions, principally through introducing analytic case summaries as a means of recording;
4. Using data to predict families where more intensive intervention might be warranted, particularly children at risk of care at transition to secondary school (e.g., 'On track').

### **1.3 Have there been any major changes to the project's intended outcomes or activities?**

The progress of the programme was good. By the time of writing (March 2016) 276 trainees had completed their systemic practice training; a further 203 would finish by end 2016 (see Appendix 1 for description of systemic practice). Twenty three had started in the first cohort but not yet completed. Among supervisors, 90 had completed, 65 had started in the second year and six had not yet completed. Twenty clinicians and three heads of clinical practice (family therapists or clinical psychologists, some with social work experience) had been appointed for two years in each of the boroughs (contracts began between July 2014 and June 2015) and were embedded in the social work teams. Work was ongoing to find funding to secure the positions as permanent.

Four specialist practitioner posts to reward forging a practice based career were in place in two boroughs but the third had opted not to have these due to a pre-existing role of Principal Social Worker. Training for senior leaders in systemic thinking had taken place. Reflective groups were in operation, although not always successfully (as we discuss on p.26). The programme board met regularly and monitored progress. The Ofsted inspection of January 2016 found that Focus on Practice was making an effective contribution to practice and all three boroughs scored highly. The boroughs had been designated Partners in Practice by government in recognition of their strength and ability.

There was notable lack of progress in relation to some elements of the programme. In particular the coaching and observation part of the motivational interviewing programme failed to take off. This was largely due to staff capacity and additional burden issues although some reported a reluctance to be recorded and observed in practice when already doing joint work with clinicians.

### **1.4. Describe the context within which this innovation has been taking place**

'Tri-borough' refers to working arrangements between three Focus on Practice boroughs – London Borough of Hammersmith and Fulham (LBHF), Westminster City Council (WCC) and the Royal Borough of Kensington and Chelsea (RBKC) forged in relation to some services in 2010. An Executive Director was appointed to lead on the overall direction and accountability of children's services. The Tri-borough arrangement is a hybrid model: some services, such as adoption and fostering, are cross-borough, while others, such as field social work, remain the responsibility of individual boroughs. Local accountability is ensured through a weekly meeting of the Executive Director, the Director of Family Services, and



the lead member for children's services in each borough. Each borough can decide to opt out of or in to joint initiatives that are proposed. All participated in Focus on Practice.

The three boroughs are small, densely populated local authorities. All three are characterised by high levels of cultural diversity. Almost half the children in schools have English as an additional language and over 100 languages are spoken in the boroughs. Approximately one fifth of the population moves out of the borough in any one year. Over a quarter of households live in poverty and around a third of children receive free school meals (Trust for London and New Policy Institute 2016). Schools, however, perform very strongly and have a good record on inclusion. Even within the high performing London context, pupils eligible for free school meals in Kensington & Chelsea and Westminster did better than pupils not eligible for free school meals outside London at GCSE scores in 2014 (Mayor of London 2015).

## 2. Overview of the evaluation

### 2.1 What were the evaluation questions?

The aim of the evaluation was to assess whether the intended outcomes of the change programme were achieved in the short term (up to March 2016), with provision for medium term outcomes to be assessed in early 2017. Given the wide scope of the change programme, and limited time and resources for the evaluation, the study focused on changes in field social work practice and not broader family or children's services practitioners (e.g., residential care, youth justice). Nor did it aim to cover all the elements of the change programme.

The intended learning outcomes from the change programme are detailed below but broadly aimed to ensure that social workers were planning in advance of meeting families, generating hypotheses about family relationships, eliciting their perspectives, using a range of techniques to support practice, and were engaged in review and reflection on practice. All the above was to be underpinned by a stance of 'open curiosity' about families, their capabilities and their circumstances and an absence of prejudging what they would find.

Changing practice in line with the above intended learning outcomes should be visible in terms of the following short term evaluation objectives:

- Social workers perceive local authority systems as responsive and supportive
- Social workers will spend longer undertaking direct work with children and their families and less time on recording processes/bureaucracy
- Social and familial networks are strengthened
- Recruitment and retention of social workers and staff satisfaction improve
- Children are safer and family functioning improves
- Reduction in costs (considered in the context of the outcomes achieved).

## 2.2. A summary of the methodology and changes to methodology

This was a mixed method evaluation. It combined interviews and responses to vignettes with contact and assessment and family social workers, interviews with managers, clinicians and specialist practitioners, senior leaders and councillors, with focus groups and a survey of time use by social workers, interviews, network maps and completion of SCORE-15 (a family therapy diagnostic tool), with families who were clients of social workers, and analysis of administrative data.

There were difficulties in recruiting suitable families, leading to a change of method. Random sampling was replaced by direct recruitment via nominations from social workers. Cumulative delays and practical logistics meant that the evaluation did not achieve the originally envisaged number of social work and family interviews and led to a shorter interval between time one and time two than originally envisaged. As a consequence comparisons are more limited than originally envisaged.

Second, in order to capture changes in time use, and on expert advice, we introduced focus groups and a survey of social workers. Cumulative delays in completing data collection were caused by local authorities' delays in supporting fieldwork, and an Ofsted visit. Findings from this survey are not yet available.

### Analysis

Data relating to assessment social workers was coded using SPSS. Data relating to family social workers was summarized and coded by hand, producing a profile of each study participant. On the basis of family social workers' responses across the interviews, three analytic groups were produced: *enthusiasts*, who embrace the values of Focus on Practice and / or put them into practice and /or value the training as career development; *cautious*, who see some value in the training but have some concerns; and those who have *limited knowledge*, and had not had any training or been exposed to Focus on Practice culture. A similar exercise was carried out in relation to vignette responses.

Data from family interviews was summarized and reported by theme; family networks were evaluated by size and family members' assessment of the helpfulness of the network. SCORE-15 ratings were ranked according to Association of Family Therapy guidance. Data from stakeholders was thematically analysed.

### This report

In this report, 'assessment' practice refers to those social workers and assistants interviewed in relation to Focus on Practice in their child and family assessment practices. In two boroughs these were drawn from specific assessment teams; in the third they were drawn from a locality team. 'Family social workers' refers to those social workers, senior social workers and specialist practitioners who were

interviewed in relation to their practice with specific families, who were also interviewed. These social workers were drawn from a range of teams including disability, long term, and locality teams. Some social workers were interviewed even when 'their' families had withdrawn. 'Stakeholders' refers to councillors, senior leaders and managers of services who were interviewed. Due to numbers and methods of sampling there is no claim to represent all social workers or children's services practitioners in each borough but there is no reason to believe the views presented here are untypical in any way. Data sources are summarized in Appendix 2 and study respondents are summarized in Appendix 3.

## 3. Key findings

### 3.1 How far has the project achieved its intended outcomes?

The aim of Focus on Practice is that it 'does what it says on the tin' (Senior leader). The practice in focus is all the day to day practice with families, children and young people under the broad umbrella of social work. It includes residential care, youth offending and leaving care services as well as assessment, early help for children in need, child protection and looked after children. The main idea is that social work, broadly defined, should be encouraging families to seek solutions for themselves, through the creative and holistic support of practitioners.

Focus on Practice was described as the 'brainchild' of the Director of Family Services in RBKC. Prior involvement in the Reclaiming Social Work initiative (Cross, Hubbard and Munro, 2010) and other innovative projects helped formulate her ideas for 'transforming' practice in RBKC. Her motivation, and that of the other senior leaders, leading from the Munro Report (2011), was to improve the professional confidence of social workers through a 'consistent model of practice across three boroughs [...]; that's what will make the biggest change for families'.

Stakeholders interviewed believed that the project's intended outcomes in relation to volume of clients and numbers of children in care, and so lower spend, would not be visible until 2017-2018, once a critical mass of practitioners had been through the training programme and systems had adjusted to the transformed practice. It is therefore too early to assess achievement of intended outcomes on these two indicators. However, interview data showed very active signs of the third intended outcome, a new 'cultural norm' based on systemic theory. Practitioners, managers and stakeholders such as councillors reported changes in professional language, use of techniques taught in systemic practice courses, and widespread enthusiasm for the employment of clinicians who supported systemic theory in practice. Analysis of the practice scenarios (vignettes) showed that there was considerable variation in the deployment of Focus on Practice tools and terminology.

Overall, most respondents were enthusiastic about Focus on Practice. This was the case among all stakeholders; and about two thirds of social workers and managers interviewed. Families were less knowledgeable about Focus on Practice.

## 3.2 Evidence of Focus on Practice impact on the Innovation Programme objectives and areas of focus

### 3.2.1 Better value for money across children's social care

The main aim of Focus on Practice was to improve practice; saving money was secondary and 'never promoted as the [main] factor ... It's much more about the service to the families' (Training provider). A senior leader reinforced this point:

Just to be really clear about it, we didn't start down this road because we needed to save money. So that was, it became clear, as we thought this through, that that was actually one of the benefits, and that's what the DfE impressed us on, because it's a kind of, that virtuous kind of spiral of better outcomes, less spend, is what we are all pursuing isn't it.

However, by the time of the stakeholder interviews in late 2015, the secondary aim of 'less spend' was uppermost in the minds of councillors:

And at the same time that...applying that kind of practice to the work they did, did have the potential to bring about savings, which is obviously in the current financial climate a key consideration for everybody (Councillor).

Achieving less spend was considered achievable through more effective practice in every social work-client encounter, which would, in theory, lead to fewer families returning to social worker services; and fewer cases of children becoming looked after, or subject to child protection plans.

In addition, reorienting the use of time away from linear recording and towards analytic case summaries was said to lead to more time being released for practice with families (for further details see 'recording' on p.28).

*Findings from the survey of time use will be available at a later date.*

Spend figures for staffing (permanent and agency), and children's placement costs (fostering; residential; and adoption/Supervised Guardianship order (SGO)) are given for the year prior to Focus on Practice (2013-2104) and two years into the change programme (2015-16). Clearly, the latter figures are provisional. In addition, costs at March 2016 are not definitive outcomes from the change programme, which still has another nine months to run. Reports on spend in March 2017 and 2018 will give a better estimation of reductions over time related to Focus on Practice. Table 3.1 gives figures for permanent and agency social work staff in the three boroughs as the most accessible demonstration of changes in cost.

Table 3.1 Staffing costs (social workers only) at baseline (2013-2014) and after two years (2015-2016)

Social work staff costs £	LBHF		RBKC		WCC	
	2013-2014	2015-2016	2013-2014	2015-2016	2013-2014	2015-2016
Salaries	6,962,927.90	6,904,510.14	5,744,250.33	6,483,811.88	6,408,376.98	7,107,329.21
Agency staff	1,080,752.01	1,340,526.40	333,484.71	255,678.95	194,960.33	602,776.88
Total	8,043,679.91	8,245,036.54	6,077,735.04	6,739,490.83	6,603,337.31	7,710,106.09

Data supplied by Triborough data analysis team.

There was an increase in salary spend in RBKC and WCC and an increase in the expenditure on agency staff particularly in WCC. In LBHF expenditure on staff remained largely the same. However, the Local Authority Children's Social Work Workforce Data Collection shows a decreasing use of agency staff in LBHF and WCC one year into the programme.

Table 3.2 Agency staff at baseline (2013-2014) and after one year (2014-2015)

borough	LBHF		RBKC		WCC	
	2013-14	2014-15	2013-14	2014-15	2013-14	2014-15
Agency number	29	18	5	5	16	10
Agency rate	15.6	12.0	3.2	3.1	9.0	6.3

Numbers are shown as fte (full-time equivalent)

The agency worker rate is defined as agency workers as a proportion of agency workers plus social workers based on FTE at 30 September (see DfE, 2016). The three boroughs differ markedly on this rate. LBHF is by far the highest, four to five times higher than RBKC, with WCC in between. There was some decrease in the rate between 2013-14 and 2014-15.

Table 3.3 Staff turnover at baseline (2013-2014) and after one year (2014-2015)

borough	LBHF		RBKC		WCC	
	2013-14	2014-15	2013-14	2014-15	2013-14	2014-15
Social workers	157	132	150	154	162	149
Starters	26	22	25	20	18	35
Leavers	34	14	21	22	26	24
Turnover rate	21.7	10.6	14.0	20.0	16.0	16.4

Numbers are shown as fte (full-time equivalent)

The number of social workers in post reduced slightly in LBHF and WCC, but did not change in RBKC. One of the aims was to reduce the turnover of social workers. There a large reduction in the number of staff leaving during the year for LBHF, but no change for the other two boroughs. The number of new social workers starting reduced a little in both LBHF and RBKC, but almost doubled in WCC. This gave a turnover rate (defined as number of leavers divided by the number of workers in place at 30 September: see DfE, 2016) which halved in LBHF, went up by a half in RBKC but remained static in WCC. Thus there is no consistent pattern in turnover across the three boroughs.

From 2014-15 The Local Authority Children's Social Work Workforce Data Collection includes a question on the total number of cases held, although this was not included for 2013-14. However, the question is voluntary, and none of the three boroughs chose to include this data, so it has not been possible to estimate a caseload per social worker.

Table 3.4 Staff absence at baseline (2013-2014) and after one year (2014-2015)

<b>borough</b>	<b>LBHF</b>	<b>LBHF</b>	<b>RBKC</b>	<b>RBKC</b>	<b>WCC</b>	<b>WCC</b>
year	2013-14	2014-15	2013-14	2014-15	2013-14	2014-15
Absence: days	1084	541	1005	567	970	724
Absence rate	2.7	1.6	2.6	1.5	2.4	1.9

Staff absence due to sickness is thought to be an indicator of a lack of wellbeing. These figures from Children's Social Work Workforce Data show a halving of the number of social worker days of absence for sickness in both LBHF and RBKC and a 25% drop in WCC. These are very big reductions in a very short space of time. The absence rate is the average number of working days lost due to sickness per social worker. It is calculated as total number of days missed due to sickness absence during year divided by number of social workers (FTE) at 30 September times 253, where 253 is the number of working days in a year taking account of bank holidays (see DfE, 2016). The rates are very similar for the three boroughs, and each shows a reduction, of over 40% for LBHF and RBKC and 20% for WCC.

Although not yet available for the full two year period post baseline, workforce data shows encouraging signs of stabilising social work staff and greater value for money, with decreasing use of costly agency staff and decreasing staff absence. A fuller assessment of the impact of Focus on Practice on staff recruitment, retention and satisfaction will be possible in 2017 and 2018.

Table 3.5 sets out the costs of placements for children and young people who are in care or supported by the local authority. There was a reduction in spend in all three boroughs.



Table 3.5 Placement costs at baseline (2013-2014) and after two years (2015-2016)

<b>£, borough</b>	<b>LBHF</b>	<b>LBHF</b>	<b>RBKC</b>	<b>RBKC</b>	<b>WCC<sup>1</sup></b>	<b>WCC</b>
year	2013-2014	2015-2016 forecast	2013-2014	2015-2016 forecast	2013-2014 actual	2015-2016 forecast
Fostering Incl in house and agency	4,539,742	4,042,809	1761,940	2,100,367	3,652,700	3,157,350
Adoption, kinship, SGO, residence orders	2,961,688	2,533,307	968,966	893,507	1,484,250	1,465.06
Residential care	1,873,126	1,764,186	1,855,180	608,211	2,195,940	1,692.24
Semi- independent living			168,000	644,900	866,610	1,048.78
<b>Total</b>	<b>9,374,556</b>	<b>8,340,302</b>	<b>4,754,086</b>	<b>4,246,985</b>	<b>4,546,800</b>	<b>3,577,958</b>
UASC (under 18s and leaving care)	572,350	588,000	346,895	720,803	341.160	916.88

<sup>1</sup> WCC include disabled children's placements; LBHF does not. Data supplied by Triborough data analysis team.

The three boroughs differ markedly in their rates of children being in the care of the local authority (Table 3.6). The rate is calculated as the number of children in care per 10,000 children in the area. In 2013-14 LBHF was the highest, with 61 children in care per 10,000; WCC had a lower rate, of 45, and RBKC was the lowest, at 36. In 2014-15 these rates had hardly changed at all.

Table 3.6 Numbers of children in care at baseline (2013-2014) and after one year (2014-2015)

<b>borough</b>	<b>LBHF</b>	<b>LBHF</b>	<b>RBKC</b>	<b>RBKC</b>	<b>WCC</b>	<b>RBKC</b>
year	2013-14	2014-15	2013-14	2014-15	2013-14	2014-15
Total	205	185	95	105	175	180
Rate	61	55	36	38	45	44
Care entries	120	95	75	70	90	95

The per child cost of placement has been calculated by dividing the total placement by the total number of children in care during the year 2013-2014 (Table 3.7). This is an overall figure and does not take into account the cost per type of placement. The figures for numbers of children in care in 2015-2016 were not available at the time of writing.

Table 3.7 Childcare placement costs at baseline (2013-2014)

<b>borough</b>	<b>LBHF</b>	<b>RBKC</b>	<b>WCC</b>
year	2013-14	2013-14	2013-14
Cost per child		45,730	50,043
			25,982

Table 3.8 sets out the referral and re-referral rates. Re-referral means the referral of the same child within 12 months of a previous referral. This is a narrow

definition that excludes notification for example, of children of the same family being re-referred. The reasons for referral and re-referral are not given in the data; sources of referral are given but numbers are small at borough level. It is not possible to link type of case to re-referral. For example, it is not possible to identify cases that recur due to domestic violence through the national data set and so to track the impact of Focus on Practice on particular types of case.

Table 3.8 Referral and re-referral of family/child cases at baseline (2013-2014) and after one year (2014-2015)

<b>Borough</b>	<b>LBHF</b>	<b>LBHF</b>	<b>RBKC</b>	<b>RBKC</b>	<b>WCC</b>	<b>WCC</b>
Year	2014	2015	2014	2015	2014	2015
Referral	1782	1957	2406	2305	1545	1674
Rate	536.4	579.4	881.6	830.1	402.0	411.4
Re-referral	269	317	537	595	90	145
Percent	15.1	16.2	22.3	25.8	5.8	8.7

Finally, Table 3.9 concerns the rate of use of child protection plans. There was no clear pattern of change across the three boroughs in the use of these plans to date. Further data will make any shifts more clearly visible.

Table 3.9 Child protection plans at baseline (2013-2014) and after one year (2014-2015)

<b>borough</b>	<b>LBHF</b>	<b>LBHF</b>	<b>RBKC</b>	<b>RBKC</b>	<b>WCC</b>	<b>WCC</b>
year	2014	2015	2014	2015	2014	2015
Year end	161	169	92	61	99	113
Rate	48.5	50.0	33.7	22.0	25.8	27.8
New	198	192	102	80	112	132
Rate	59.6	56.8	37.4	28.8	29.1	32.4

### 3.2.2 Better life chances for children receiving help from the social care system

The Focus on Practice ‘theory of change’ is that systemic practice will support better life chances. The theory of change (Appendix 4) argues that families will have more effective, relational, systemic and structured interventions from social workers and that this will promote parents’ functioning and responsibility for their children, who will be safer and better nurtured. Among 25 family social workers 18 thought their ‘research cases’ (child/ren who were in focus in the study) were safer since Focus on Practice /social work involvement started, four thought it was ‘hard to say’ and one said the issue was not child safety as such (no data for two).

The foundations for better life chances for children can be assessed through the extent to which the change programme is achieving its intended learning outcomes. We defined the intended learning outcomes as:

- i. *Planning (planning in advance of meeting the family, mapping out the family network, showing open curiosity about the family and how it works;*
- ii. *Generating hypotheses (the ability to generate hypotheses about the family relationships, in an open way, without prejudging what she/he will find at first interview);*
- iii. *Engagement (can engage with family in such a way as to elicit their perspective on the issues facing them);*
- iv. *Using a range of techniques (can utilise a range of techniques (talk, activities) to intervene in family to support change; and*
- v. *Review and reflect (can use supervision to review and reflect on what is happening in the family).*

Analysis of responses of family social workers showed that nearly all (22/25) referred to planning prior to visits; most talked about engagement and using a range of techniques (17 each); and fewer referred to review and reflection (11). Further examination showed that responses to *planning* that were 'Focus on Practice-minded' (i.e., they fulfilled the criteria in i) above) usually involved the clinician and joint visits, with preparation of a plan of the topics to cover, division of roles around leading and reflecting and the goal of the session:

So for example we did a session on Monday this week, with a mum and a dad and a 16-year-old son. And I've been working with this family for a year, and it's the first time that we've got mum and dad and the son in a room together, all three of them. ...So we did lots of planning around how we were going to manage the situation so that it wouldn't escalate what the expectations would be from everybody in terms of how they communicate, and taking time if it was needed, and how we were going to try and make sure that mum and dad delivered the clear message together without it coming from us. (Family social worker, Focus on Practice enthusiast)

In another example of a joint visit the plan included time to debrief and review of the information that emerged. A specialist practitioner stated that planning was intrinsic to systemic practice and involved 'planning cases in a structured systemic way, like a piece of therapy rather than 'control' intervention. [It requires a] clear plan for the family from the outset, over several sessions, not reactive. For example ... working on behaviour over four progressive sessions, to develop family rules'.

Frequently, however, preparation for a solo visit took place en route to the appointment, and was thought-based rather than written. Social workers referred to 'thinking through the risk ... the purpose' and the 'most creative approach'. Focus on Practice influence was seen in terms of 'being more curious, and when you are more curious you are more understanding, because I think you are not making judgements straight away'. On duty, there was 'not enough time to

prepare for duty cases [and] there's a little bit of a culture where you've got this information and you need to go without sort of fully exploring things'. One social worker, a Focus Practice enthusiast, explained the pressure:

Like this morning ... I had to go to go to a school at 9.00 because a child was threatening to harm himself quite seriously last night. And then I was interviewing him and mum and I was thinking about that dyad paper<sup>1</sup> and was like, I wish I had it in front of me so I could... But I tried to use it and I was going, 'how did you feel when this happened'?

Twelve social workers mentioned generating hypotheses, or canvassing possible scenarios in advance. Overall, little detail was given about doing this 'in an open way'; a few social workers thought they were better able to hypothesise as a result of the Focus on Practice training, and/or through working with clinicians: it 'means that [you] can go to [the] family with a clear hypothesis of what is going on and plan for change'. A few others concurred that it is 'hard to hypothesise. You do try and hypothesise, but it's difficult because things are always changing so you can't...you can't really just predict'.

Seventeen social workers discussed engaging parents and/or children and/or using a range of techniques to do so. Focus on Practice enthusiasts referred to being more 'realistic' since their training about what the family are likely to achieve; employing an 'interested' style of questioning (like open/curious), and using 'reflective questioning'. A Focus on Practice enthusiast stated she:

Thinks of strategies to break unhelpful patterns ... The questions I was asking in this case seems to always come back and it's similar reasons, because of the parents and their relationship and their communication difficulties. So I was trying to think, OK, what can we do different this time that hasn't worked before, to try and progress. Because otherwise they're going to keep getting re-referrals...

Not all family engagement was successful, even with clinicians to support the work. One social worker we identified as 'cautious' about Focus on Practice described the difficulties of engaging family. She gave an example of a 'hard to reach' case:

We have 'thrown everything at them' including systemic therapists but it has not worked ... The first one was difficult because the family therapist had to go off ... so I think it just enabled mum to want to disengage with her ... And then this time around...again I think the family therapist was struggling to pin mum and dad down...to meet with them. And so ...she's happy to meet...so she sort of does...the first two sessions with the family therapist which is all I think the joining work, because obviously there's

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<sup>1</sup> 'Dyad paper' refers to an academic paper supplied on the training course attended. No further details are available.

nothing ... un-enjoyable about that. And then when it gets into more the nitty gritty and the more sort of risk taking questions... [...]. That makes her feel uncomfortable and then she disengages. And she's got a complex relationship with us ... and he's connected to me, the family therapist; he's within the social services umbrella. And she's had enough of us; fair enough, we've been around, breathing down her neck for quite a long time.

This social worker also thought that what she perceived as a Focus on Practice strategy of 'constant questioning' was 'frustrating' and she wondered if families shared that feeling.

Just 11/25 family social workers referred to review and reflection as part of their practice. Those that did referred to multiple opportunities for reflection, such as reflective groups and across the desk with colleagues, or simply having to think more about the implications of particular courses of action. Comments were that 'developing reflective practice means that case analysis is much improved'; and that Focus on Practice had prompted a new focus for reflective practice workshops: 'these opportunities were available pre-Focus on Practice but [now] people can see the need and ...the usefulness of what we've been trying to do' (enthusiast). One social worker, defined as 'cautious', discussed the limits of reflective practice in an organisational context. She said: it 'makes me reflect what it means for clients when they are asked to do it. And how sincere does it ever end up being, and how useful, and how honest. Reflective practice has become disjointed and 'resistible' [whereas it] had felt natural before. People don't know what to do with their reflective logs: there are boundaries that come with being part of an organisation: limits to what can be revealed. [There are] challenges to and ethics of reflective practice'.

The main opportunity for reflection and review in the intended learning outcomes was given as supervision. For most social workers, supervision was embedded in the line management structure (one respondent accessed supervision through an outside agency in addition to in-house supervision). Fourteen social workers said that their supervision was an opportunity to review and reflect on their work in broad terms, and to enable them to reframe their practice according to systemic thinking. Eight social workers did not think their supervision was like this, and for two there was insufficient information.

Overall the responses on achieving the intended learning outcomes showed that social workers, supported by clinicians, were shifting their practice in line with these outcomes. The language deployed in, and the principles of, systemic practice, were becoming evident. This was more to be seen in terms of planning, engaging and using techniques taught during the training and less in evidence in relation to generating hypotheses. Review and reflection was evident not just through systemic supervision – and there was more of this in Kensington and

Chelsea than the other two boroughs – but also through reflective groups and workshops. Some of these predated Focus on Practice; the change that Focus on Practice brought was a particular focus on ways of questioning and reframing problems from multiple perspectives.

### **3.2.3 Analysis of responses to practice scenarios/vignettes**

Twenty four respondents from across assessment and long term teams gave a view on one or two practice scenarios (Appendix 1). One of these concerned a potential domestic violence case; and the other was about a mother of a three old collecting from nursery while apparently intoxicated. Both scenarios had an escalating step designed to prompt rethinking and, for each, social workers were asked what they would do and want to think about in response to the situation.

Preliminary analysis of responses to vignettes showed that more volume of response was given in relation to planning and engagement than in relation to generating hypotheses or review and reflection. This may have been influenced by the open prompts of the vignette, which were perhaps more focused on action than thought. However, this finding is in line with responses in the interviews reported above.

Overall, 11 respondents showed *some* Focus on Practice practices (two to four); three showed *developed* Focus on Practice practices (five or more); and eight did not describe any more than one Focus on Practice practice. Three of these eight had not done any Focus on Practice training.

Second, there was no correlation between the number of training sessions completed and the degree of Focus on Practice mindedness. Some of those who had not done training showed some Focus on Practice practices; some of those who had completed the training did not demonstrate highly developed Focus on Practices practices. More detailed analyses tracking individual responses and/or larger numbers of responses would be needed to assess this fully.

Third, there was a clear ‘assessment minded’ framework in play among the responses. Many of the respondents wanted to find out more before making a decision, which would be done by consulting records and other professional agencies, interrogating the referral for possible complicating or contextual factors, and verification of the claims made by family members (e.g. checking with GP). These methods are not mentioned as part of the Focus on Practice tools and terminologies, which stress awareness of the impact of the wider social context; different types of questioning; using genograms in mapping family networks and as collaborative assessment tools; using stories and conversations in direct work with children; and working with reflection and reflexivity. In both approaches social workers would also talk to the child and family members, separately or together, but the degree of match between these two approaches needs to be investigated and mapped further. At the time of fieldwork, it would appear that social workers responding to a ‘front door’ scenario were more focused on the

first set of concerns than the second. This finding resonates with other comments made that Focus on Practice approaches are more appropriate for some aspects of social work practice, such as longer term work with families (see p.25 & p.42).

Fourth, there was not always a clear association between vignette responses and the degree of Focus on Practice mindedness in the rest of the interview. Some who had showed considerable enthusiasm during interviews did not assert this knowledge and enthusiasm in addressing the vignette. A tentative conclusion here is that the enthusiasm shown for Focus on Practice in the interviews did not translate into actual practice in quite the same confident way. This may of course change over time and with further 'bedding in' of the change programme. However, the findings from the vignettes do cast a note of caution over those from the interviews.

### **3.2.4 Professional practice in social care**

Besides the training, the introduction of clinician posts was almost universally welcomed and appeared to be making a difference to social work practice. Family therapists and clinical psychologists by background, some with social work experience, they were seen as authentic experts on the ground, an extra resource to help resolve 'stuck' cases. They were accessible as they were embedded in teams, and provided social workers with new, systemic, ways of thinking about problems. They bridged theory and practice, so supporting continued learning about systemic practice. Clinicians accompanied social workers on family visits and all reports of this were of it being a positive and useful experience. As discussed, joint visits enhanced planning. Team managers pointed to the usefulness of the clinicians. They were an additional professional working in overstretched teams and they acted as a source of emotional support for social workers. Part of the value of the role was its flexibility and presence 'on the floor' in social work teams. This meant their role varied and was responsive to social work needs. Consultation with clinicians were said to offer a 'fuller assessment of risk', helping create 'a clear hypothesis of what is going on and plan for change', 'looking at the system around the family', opportunity to gain 'their ideas on stuck cases', engaging in 'early meaningful work to avoid escalation' and in 'creating safe ways to have meaningful conversations' among other benefits. A family therapist interview respondent gave an example of a 'stuck' case:

...it was a CP case and we went out and met the mother with the social worker.... I mean the relationship between the mum and the social worker was quite difficult and then something had happened to cause it to be sort of super difficult. And it was really interesting because they talked about...without necessarily using the word, but power in the relationship and what it's like for a mother knowing she could lose her children and having to...and yet she's not getting on with this person. ....And it all came

out in the conversation, which the social worker had, and the social worker was able to say...you know, I'm the worker and this is terrifying for me as well. But you know, I have a role and responsibility; and it's just the beginning of some conversations, but it sort of, there was a lot of emotion, a lot of passion....it just felt like there was some shift, and the fact that they both were able to have that conversation.

Four social workers perceived clinicians as more relevant for long term work than assessment practice. The clinicians' style was said to be too discursive and insufficiently focused on planning for safety in the immediate. One social worker's example of this was:

[The meeting] ... ended up going on so long I had to chip in quite a few times and say, no, we need to safety plan because this man's leaving on Sunday, where will you be, where will your children be, what will you do if he gets violent? I find it quite airy fairy as well in a way. Sometimes you'll sit down and you'll...there's a risk to the child and they'll be like, we'll do a genogram together and it will be like...so I wonder what went on in her childhood; and I was like...you know sometimes I get all of that stuff, but it does seem...there's a lot of wondering and searching for...for stuff. And I feel like in the assessment team I just don't know if you've got time for that. I feel sometimes you just...it's either safe or it's unsafe.

Despite this, there was a general view that such was the benefit to social workers and families that the clinician posts should be retained after the end of the DfE supported programme.

### **3.2.5 Systems and processes in children's social care**

#### **Models of delivery and transition points**

This study was able to compare two organisational types of delivery of social work assessment and longer term service for children and families. In two boroughs, the assessment teams constituted a 'front door' for accessing social work services. Cases were transferred from this team to locality teams, staffed by different social workers and other staff. The third borough had integrated social work services, with social workers located in neighbourhood teams, who take turns to do 'duty', and hold onto cases for the entire duration they are open. Differences in models of delivery have consequences for the duration of the relationship with the client, as the former model builds in potentially disruptive transition points while the latter does not.

Among assessment social workers and managers there was a particular concern with the fit between Focus on Practice and the structures in place. In RBKC, where assessment is integrated into neighbourhood teams, the fit was seen as better. Seven (of 21) assessment social workers reported that the time sensitive



work they undertook with very few visits to families, meant that relationship building, direct work and systemic thinking were difficult. An advanced practitioner summed up the view of many: 'I think it's more useful when you're working with the child throughout'. Further, the protocol and procedural demands of high risk cases (e.g., s.47) meant there was insufficient time and opportunity to use Focus on Practice. A senior social worker said, 'there are some cases where there's lower end risk where you can use it properly. But the higher end ones ... Because we're only involved for such a short time, it's really hard to use it properly'.

Concerns about the fit were expressed by social workers with and without Focus on Practice training and by managers. One manager stated:

Speaking to my colleagues on the Focus on Practice course who are from [other two boroughs] ... they're getting a very disjointed delivery because they're sort of starting that work with the family and then they're having to stop, because it gets passed on to another team. I think there is something to be said for the way we actually manage in [RBKC].

Another manager said, 'how in the world can you possibly create that relationship if you're going to see them for three or four times and then pass them on to somebody else?' This manager articulated the fit between their model of delivery and Focus on Practice: our 'whole ethos is to form a relationship and you know that's...that's really at the heart of systemic thinking'.

The model of delivery in RBKC was not the only factor that supported the fit with Focus on Practice. At the time of fieldwork, family social workers reported the following range in caseloads:

Table 3.10 Range in number of cases per family social worker

	<b>LBHF</b>	<b>RBKC</b>	<b>WCC</b>
Cases	7-13	10-11 (not including one practitioner working with 4 families)	9 families – 35 children

Where caseloads were lower, social workers reported more time to plan practice and build up relationships:

I'm having a lot more time with families in terms of meetings...usually using the family therapist. And ... a lot more time ... talking things through with the families, a lot more time in kind of case discussion...than I was before. Which then ties in with the direct working with the families as well. So I think yeah, a bit more time.... As I say, we're very lucky, we've got well-managed, low caseloads... (RBKC social worker)

On the other hand, in WCC, reports of high caseloads combined with high staff turnover meant that, in the perception of one clinical practitioner interviewed,

assessment social workers end up 'gatekeeping' and working in a 'haphazard' way:

It's a team that works with a really high volume of caseloads, it is phenomenal how hard they work, and the tricky part has been difficulties with turnover, and staff turnover has been quite high in the time that I've been here.... I think it adds to how much it just keeps piling up ... And each of the different places have their own way of doing transfers, and Local Area Management meetings and things like that. But I think the way some of the workers here have described it is as gate keeping is how they feel this is happening, and because it's slow to move through and they hand on so many cases you end up doing work in a haphazard way, because really you don't want to get involved and get your hands dirty, and develop those relationships, knowing that they are going to get passed on. Then you've got crisis after crisis happening while you are there.

It was clear that building relational breaks into the system by transitioning cases after child and family assessment was at odds with the Focus on Practice ethos and there was a tendency to defer application of the new techniques and ways of thinking until after the assessment phase. There was also a tendency to see Focus on Practice as a set of tools that add on to practice in certain circumstances rather than being a fundamental reorientation of professional practice.

### **Supervision**

Supervision is, or should be, a mixture of accountability and case progression, and social worker support. According to Skills for Care (2007) and BASW (2011:3), social work supervision should 'combine a performance management approach with a dynamic, empowering and enabling supervisory relationship. Supervision should improve the quality of practice'. Systemic supervision should support systemic practice. Social workers working in assessment teams had seen Focus on Practice inspired changes in supervision, such as more evidence of valuing social workers' own judgements, reframing thinking and using/valuing creative practices or different questioning was occurring. Three social workers referred to 'therapeutic' supervision that made links between the person and the professional. Among 24 assessment social workers, ten said there had been change in practice towards systemic supervision; and the remaining 14 thought there had been no change, or very little. Barriers to systemic supervision were the volume of cases to be discussed, the (in) frequency of supervision, and the challenges of translating training into practice. Of the nine managers interviewed, seven thought their practice had turned towards being more systemic, but three of these seven referred to challenges in translating training into practice.

## **Reflective groups and reflective dialogue**

Overall, the concept of reflection on practice was becoming accepted, or more accepted, as a valuable learning and evaluation tool. This was more evident in RBKC than the other two boroughs. Reflection was taking place in specifically re/formed groups for discussing cases; in informal dialogue; and as part of team meetings. Eleven of 33 assessment social workers and managers said reflective groups were helpful but all said time constraints meant they could not always attend.

Among family social workers, reflective groups and reflective dialogue were well developed in RBKC. Social workers reported that they were familiar with reflective approaches, that reflective practice had been introduced into team meetings and reflective dialogue occurred in the course of routine work among those who were Focus on Practice trainees. However, respondents mentioned that some reflective groups had not got off the ground yet and that effective group work could be compromised by inconsistency among attendees.

In WCC, social workers reported that several groups and opportunities for reflective dialogue, usually adapted from pre-existing groups, were available, although it was often difficult to attend due to workloads. Opportunities for reflective practice among agency workers, who were not included in Focus on Practice training, were limited. Some social workers had noticed a general shift to thinking systemically and talking reflectively, although there were concerns that reflective work could be disjointed and exposing. In LBHF, no reflective groups were mentioned but supervision had become more reflective.

## **Recording**

A leadership mandated shift to producing case summaries rather than case recording based on logs of activity had been introduced shortly before fieldwork. This was intended to free up time and to promote reflection and contribute to constructive analysis of cases, in line with Focus on Practice thinking.

Recording is a 'neglected issue in social work' (O'Rourke 2010) and a complex one as it combines a values agenda around making decision making transparent with an accountability one around performance audits. In O'Rourke's survey of 460 social workers, 70% believed recording reinforced the sense that their role was administrative and 95% believed it to be a professional task. Øvretveit (1986) argued that analysis and thinking combined in recording, so that it was, or could be, a productive activity and not time wasted.

In the current study, interview respondents thought little time had been saved through the move to case summaries. With the exception of one or two in RBKC, social workers did not think less time was spent on recording as a result of the change. Some social workers were double recording; they were writing both summaries and descriptive records. Others said the process of writing summaries

in themselves took more time than previously. Some said they recorded more than they should in case the information was needed. One specialist practitioner was offering one to one sessions to support social workers to use summaries as the new administrative forms had not altered recording behaviour. There were also acute problems with software that frustrated attempts at case summaries.

In relation to the case analysis role of recording, some social workers thought case summaries had the advantage of prompting a clearer analysis, promoting reflective thinking, and giving a direction to practice.

A key area of concern was whether integrating case summaries were appropriate or sufficient for particular areas of work, namely fast paced high risk investigations, such as s.47 cases, where social workers needed to record all aspects of the case as it unravelled, and court reports, where evidence would be sought from case records, and subject to scrutiny from professionals who were not working to a systemic practice model. Social workers felt individually liable if their records were found wanting. Among the assessment social workers, nine expressed concerns about recording enough detail for evidence in cases that went to court.

Perception of time spent on activities is just that: perception. Tasks that are easier or more familiar tend to be perceived as faster to achieve than the unfamiliar or more difficult. Further, more detailed, work would be needed to investigate whether case summaries actually take more time than case recording, and would need to take into account the benefits of case summaries, such as the thinking and analytic time, which aids practice.

While few social workers found that the introduction of case summaries had freed up time from to work with families, some reported that other initiatives to reduce administration had proved effective, in particular the provision of administrators to minute statutory meetings. Some social workers also highlighted the value of being able to write notes and send emails while on visits, using tablets and phones.

### **3.2.6 The lives of children, young people and families**

Family interviews recorded information about the size and helpfulness of professional, family and community support networks using a network map tool (See Appendix 6) and in dialogue with the researcher and social worker. They also responded to interview questions and completed a SCORE-15 diagnostic tool<sup>2</sup>; three interviews were completed with translators present.

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<sup>2</sup> SCORE-15 is a measure of closeness of relationships and indicator of change at early stages of systemic therapy. It measures family functioning through three subscales: i) Strengths and adaptability; ii) Overwhelmed by difficulties; iii) Disrupted communication (AFT 2013)

Of the 17 family network maps, 5 expressed strong support from family and community, five moderate and seven low levels of support. Strong levels of support were when the respondent could call on practical help with looking after children and/or on emotional support; moderate support was recorded where they reported fewer or weaker ties or because they were in less frequent contact with people in their networks or, alternatively, because within the networks, regardless of size, support was less available or less adequate. Low support was where respondents identified themselves as isolated or reported very little contact or support from family and friends or were mainly dependent on professionals for support.

Family respondents were asked to define their family and rate their perception of functioning in relation to various aspects of family life. When asked what words summed up their family, most respondents used positive terms, such as close, happy, normal, good, lovely or great. Some struggled with the question, pointing to the complexity and difficulty of 'summing up' the ups and downs of everyday family life. Respondents tended to locate problems outside the immediate family, relating difficulties to particular people outside of or on the fringes of their close networks or to challenging circumstances. Families tended to hold onto the image of themselves as intact and loving, if beleaguered, by excluding problematic members from their immediate circle when completing the SCORE-15 assessment and to a lesser extent the Network map.

Within each family network type there was a wide range of SCORE-15 marks: from 16 – 27 among those with strong networks; 20 – 51 among those with a moderate network and 25- 48 among those with low levels of support in their network map<sup>3</sup>.

### **3.2.7 Relationships with professionals**

Over half (9/17) of those interviewed said they did not experience problems talking to professionals, although some differentiated between different social workers and also between different professions. One mother noted that she had no problem talking to health visitors but found social workers difficult, for example. Another noted the reverse. Most respondents (14/17) were confident about their capacity to get help when they needed and just under three quarters (12/17) felt they knew how to deal with social workers.

Barriers to communicating with social workers included a mistrustfulness born of previous poor relationships with social workers; expectations of language difficulties, and not understanding how social care systems in England worked or what they were able to provide. Some were unclear about which professionals

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<sup>3</sup> Stratton (und.): 'The total score could in theory be 15 if they rated every question absolutely positively and 75 if every question absolutely negatively. So the higher the total, the worse the person is rating their family. On our first samples we found that families at the start of therapy averaged 39, and non-clinical families averaged 26'.

had been responsible for delivering services, interventions and referrals (for example, for counselling). A facilitator to professional engagement was continuity of individuals. For example a support worker who had supported a child with disabilities for several years was an invaluable source of information when the child's brother was involved with children's services.

Table 3.11 Perspectives on relationships with professionals

	Disagree	Agree	Not Sure
I don't like talking to professionals like social workers, health visitors and so on	9	5	3
I am good at getting help when I need it	01	14	02
I don't understand how to deal with social workers	12	03	02

### 3.2.8 Relationships with Social Workers

Ten of 17 families interviewed said they felt positive about social work involvement and there were high levels (12/17) of agreement on the nature of the problem.

Table 3.12 Feelings about being involved with social workers

	Positive	Negative	Neutral	Mixed Feelings
Feelings about being involved with services	10	2	2	3

Table 3.13 Agreement with social workers about priorities

	Yes	No	Some disagreement	Not sure
Agreement with social workers about priorities for change	12	1	3	1

Most respondents were in relatively frequent contact with their social workers, seeing them several times a month, and in three cases, several times a week. During the Family Network exercise, almost half of all respondents reported very close relationships with social workers and nearly three quarters reported moderate or close ties.

Table 3.14 Closeness of contact with social workers

Frequency of contact with social workers	Very close	Moderately Close	Loose Tie	Difficult
Daily – Weekly	3	-	-	-
Less than once a week – Monthly	4	2	2	-
Less than once a month – six monthly	1	2	1	-
Rarely / Never	-	1	-	-

When completing the network map together, no difficult relationships with current social workers network were revealed (perhaps related to recruitment method: we used social workers to recruit families). However, in three cases, tensions in relations emerged during fieldwork. Examples of these cases included when a

parent needed more support than resources were available, and where a child was the subject of a child protection plan and respondents perceived social workers to have the power to take away their children. A third case was where respondents felt that social workers were overinvolved but were anxious about negotiating less involvement.

### 3.3 Qualities respondents valued in social workers: from accounts of social work interventions

Respondents appreciated **responsiveness** to practical problems. For example:

- Helping to arrange modest financial support for everyday family life such as arranging bus passes and small amounts of money to top up mobile phones so teenagers could stay in touch, where the costs involved were small but hard to cover within tight budgets.
- Support and expertise when navigating court systems about access arrangements and negotiating about housing, although there was frustration at how little could be accomplished in relation to housing.

Conversely, when social workers were perceived as not being able to help with practical problems, there was considerable frustration and anxiety. Bringing up children in inadequate housing, or in poverty or when looking for work caused a great deal of difficulty and made existing problems worse, and there was little that social workers could do to alleviate this. Two mothers thought that social workers who had families themselves would be well positioned to distinguish between the everyday ups and downs of family life and problems requiring intervention.

#### 3.3.1 Qualities in social workers which respondents found unhelpful

Respondents complained about **poor and patronizing communication**. For example, one mother stated that it would be helpful if families were involved in discussions about what resources were available and how they could be used. She did, however, acknowledge that social workers often had to deliver bad news where resources were inadequate to meet what clients needed or wanted, and that this was likely to be related to time and resource constraints beyond individual social workers' control.

There were also examples, from earlier social work interventions, where social workers had settled for **superficial understandings of problems** and had not engaged in-depth with them. An example of this was where, during a previous intervention, a social worker had failed to pick up on signs of domestic violence,

although the mother was visited weekly for a year because of concerns about her child.

Other difficulties arose when social workers had ***no training in, or understanding of, particular problems or health conditions***. For example, one mother with learning disabilities described how her previous social worker had responded to the ‘symptom not the problem’, when she asked for help as a single parent of a newborn child, with post-natal depression and living in a hostel. She experienced the subsequent interventions as punitive, culminating in unsuccessful proceedings to have her child taken into care.

Problems also arose when professionals ***failed to appreciate how particular family dynamics worked and made assumptions that support was available when it was not***. For example, one mother stated that children’s services assumed that all families were ‘like the Peppa Pig family’, able and willing to provide care for each other. This was not true in her case and she was absolutely dependent on children’s services for respite care for a family member.

Respondents also reported social workers failing to consider parents’ needs and prioritising children’s needs.

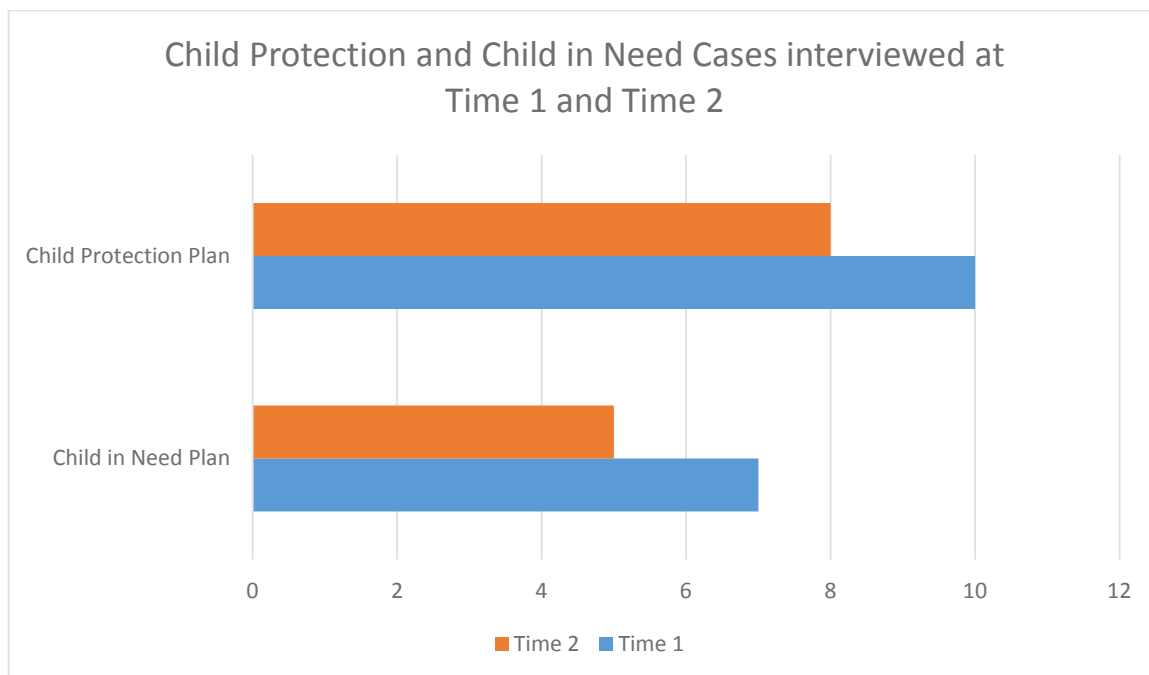
### **3.3.2 Families at time two**

Follow up interviews with families took place in January/February 2016, 4 - 6 months after first interview. The original rationale for the follow up interviews had been to identify any changes which the social work intervention – and specifically Focus on Practice had made to families’ lives. However, the interval between the 2 interviews was shorter than anticipated and too short to show change. Moreover, many of the families interviewed were experiencing multi-faceted and entrenched difficulties, which were only partly amenable to social work intervention, if at all, and, for some, new difficulties had arisen in the months between the interviews.

However, time two interviews were helpful in demonstrating the complexity of families’ lives and challenges and what they valued about social work interventions over time. We re-interviewed 13 of our original 17 families: the remaining 4 were uncontactable or refused to be re-interviewed. Of these 13 cases, 5 were child in need cases and 8 were child protection cases (Figure 1). Seven still had a social worker and 6 cases had been closed.



**Figure 1 'Step down' status over time 1 and time 2**



Of the 6 closed cases, 3 reported positive experiences with their social worker and 3 negative: they cited not enough help being offered, housing difficulties which the social worker was not able to help with and not agreeing with social worker's perspective on how to resolve their problems.

When asked how they would feel about social workers becoming involved in their lives again in the future, 2 of the 6 families (all mothers) said that they would not mind further social worker involvement. The other 4 were adamant that they didn't want to have a social worker again. Reasons for not wanting to resume contact with social workers varied. They included: a breakdown in communication with previous social workers (including loss of trust and perceiving the social worker to be giving misleading information); feeling much more in control of their own lives; and not wanting extra support. There was also a general feeling that being involved with children's services was stigmatizing.

Six mothers reported positive working relationships with social workers. Social workers had helped resolve practical problems, had listened and offered help.

There was no conclusive evidence about changes in social networks as a result of Focus on Practice. Further work would be needed, over a longer timeframe, with specifically selected cases, to track the impact of Focus on Practice on family work and on families' community engagement. Among families interviewed, 3 had not seen any change in social networks, and 5 had had some level of change, due to changes in circumstances, such as now working with a new professional (e.g., solicitor or lawyer), or having wider support from

community organisations. For 5 families, there had been major changes in their networks, such as family bereavement or imprisonment of a family member, or losing many friends (cf example in Appendix 6).

### **3.3.3 Lessons for Systemic Practice from families' data**

Families reported (usually past) difficulties in their interactions with social workers that inhibited their investment in the professional–client relationship. The legacy of difficulties for forging new relationships is one of guarded engagement. For example, one mother whose child was subject to a child protection order and had been involved with children's services since her son's birth, said she would be careful about what she revealed to children's services now as she felt that when she had opened up about some difficulties in her life in the past, this information had been used to initiate child protection proceedings. Rather than open-ended communication, she wanted communication that was clear and precise about what she needed to do for her son to be removed from a child protection plan. Likewise, during crises, or when time was extremely short, the conditions for reflective and open-ended work were not ideal. There is a clear lesson for Focus on Practice engagement, particularly in the early, assessment stages, and in relation to safeguarding processes.

Further difficulties for discursive systemic methodologies are when dealing with a completely non-verbal child or in cases when practitioners and clients did not share a language: working through interpreters who were unfamiliar with the method could be problematic. An example of this from our research interviews which used interpreters was that it proved difficult to convey the purpose and process of the network task. This pointed up usefully the key role of interpreters in mediating social work interventions and raises questions about whether it is possible to deliver some aspects of systemic practice through interpreters who have not been trained in the methods.

### **3.3.4 Stronger incentives and mechanisms for innovation, experimentation and replication**

Implementation of the change programme was notable for the clarity of vision and the strength of organisation on the ground. However, according to stakeholders, no specific model or theory of organisational change management shaped the design of the programme but the accumulated experience of senior leaders and shared histories of professional collaboration informed the design. One senior leader said she knew:

That you have to get people *excited and interested*, you have to have hearts and minds, there's no point just telling people they are going to do this. You have to be *absolutely honest about what the additional demands*

will be, and we said to them at the first conference ... 'it's going to be a stretch, it's going to be a hard year, you are going to have lots of people out on training within your team, so you'll have less resources', although we have got a bit of backfill, and 'you will also be having to do essays ... you will have to be doing the work yourself, it's *going to stretch you*'.  
(emphasis added)

Despite the absence of a specific model, the way implementation was carried out contained all the ingredients set out by Kotter (1996) for successful change management. Kotter's eight steps were:

i) increase urgency; ii) build a guiding team; iii) get the vision right; iv) communicate for buy in; v) empower action; vi) create short term wins; vii) do not let up; viii) make change stick.

In the case of Focus on Practice, steps i) – iii) were in place before the start of the programme: the Munro report on child protection social work (2011) provided the catalyst for change focused on practice and not on structure; the appointment of an experienced and visionary senior leader in one of the boroughs along with the Executive Director and other senior leaders, constituted a guiding team. Stakeholder interviews showed remarkable consistency in their assessment of drivers for change: an absence of negative factors and a commitment to replacing procedural and task focused practice with systemic thinking that relied on the judgements of professionals and had the added benefit, in time, of reducing spend on children's services.

In order to communicate the vision (step iv), for what was essentially a top-down initiative, the Focus on Practice theory of change outlined 'key building blocks we believe will be required to bring about the long term outcomes, and makes explicit the underpinning assumptions behind the causal links between the steps in the change pathway' (Appendix 3). The theory of change included consideration of Kotter's step v) through recognition of the role of leadership in giving permissions and resources to practice differently, and step vi) through sharing success and encouraging recognition of small changes that 'build confidence & resilience'. The model also includes step vii) in explicitly promoting social workers' tenacity and not giving up, and step viii) is covered through attention to organisational dialogue and continual priority given to the new approach.

However, the model differed from similar initiatives in other local authorities (e.g., in London Borough of Hackney). In the Focus on Practice case, the programme was committed to whole system change and to incorporating several strands of work that were theoretically coherent by '[...] bringing together some core elements that ... enabled practitioners to have a ... wide repertoire' (training provider) such as a relational focus and a consideration of wider contexts. 'Because the overall approach permits everything to hang together ... is basically the way that family and other systems interconnect, then I think all of these other

approaches (such as motivational interviewing, work on parenting, Signs of Safety) neatly fit inside' (training provider).

Kotter (1996) argued that 'more than 70% of all major transformation efforts fail ... because organizations do not take a consistent, holistic approach to changing themselves, nor do they engage their workforces effectively'. Evidence from stakeholders suggest these preconditions for success were in place in Focus on Practice.

### **3.3.5 Evidence of shared objectives**

There was a good level of communication about the programme and its intentions among senior leaders and councillors. Nearly all stakeholders cited better, more effective and productive relationships between social workers and families as the key mechanism to drive down the number of repeat referrals and have fewer young people coming into local authority care, which were the main two indicator measures. Some respondents referred, in addition, to i) an anticipated reorientation of practice away from assessment and towards intervention, ii) creating a more stable workforce, with reduced recruitment costs and higher staff retention, and iii) delivering budget savings.

### **3.3.6 Evidence of communicating vision**

Stakeholders reported extensive communication within the boroughs about the intended changes, but much less Focus on Practice communication with partner agencies. As one senior leader said, 'this is really about concentrating on our own workforce'.

The strategy for communication with the workforce as a whole included two conference days and regular newsletters as well as introduction of reflective groups and invitations to take part in the training. A senior leader confirmed that the programme was well understood at all levels:

Within the borough my perception is that everybody understands it to a greater or lesser extent, the frontline understand it, frontline practitioners, they talk about it, they have clinicians who they can refer to so they are constantly changing and examining, so I think within the organisation there isn't an issue.

Social workers similarly understood the objectives well. Engagement with partners was much less well developed. Few partner agencies such as the police, schools, health services, children's safeguarding boards and voluntary sector agencies from whom they receive referrals and to whom they refer families would know about Focus on Practice from direct communication. One manager summarised the position:

We seem to have done very well ... it seems to be very inclusive in terms of who gets sort of the training package, if you like, and where...where sort of a culture change is...it's being attempted to bring about a culture change in that we've got early help covered, it seems like we've got the YOT covered, you know, and leaving care, it would be very easy for somebody within children's social care to get sort of left behind, but it seems like that's very well covered. What I don't really know about is how things are sort of permeating out.

Five (of 21) assessment social workers thought there was a mismatch in expectations between external agencies and their new practice. One social worker expressed her concern that:

One of the things that I think will be difficult with [Focus on Practice], is when you're saying to health visitors or schools...OK, we're just going to work with the family really...and try and improve things. And they think it's almost mystical; ... Or a dad said to me the other day, why haven't you written a letter to the mum telling her not to do this? And I was like, because it's not going to work. But you know ... people want things sorted out and they want kids removed, or they want the Child Protection plan...And I think that might worry other professionals.

However, one senior leader stated that the priority was to establish Focus on Practice within the social work teams before attempting to influence other professional groups:

'At the moment I can't see why we'd necessarily need more [multiagency involvement in Focus on Practice]. We've invited stakeholders along to, for example, our annual review event, so we had people from the NHS and so on, you know, our health partners and so on, at it. Whether we had any third sector partners I can't remember'.

The first priority of the programme, was 'we've got to get our own house in order and be a confident profession, and then I don't think the conversations that we have about children will be that difficult'.

### **3.3.7 Resourcing of programme**

All stakeholders believed there was adequate resourcing for the Focus on Practice programme although all thought this was because of the finance available through the Children's Social Care Innovation Programme and it would not have been possible to implement the programme on the scale necessary to generate cultural change in social work practice without such funds. Equally, stakeholders expressed concern about the ability to sustain change without funds to continue to employ clinicians after the project ended in 2016.

All these indicators suggest that the personnel, resources and organisational strength were in place to implement the programme effectively. However, there was also some evidence of fatigue with initiatives. Places in the training programme were reportedly less easy to fill in the later cohorts, although they did fill eventually; the observation and coaching programme failed to take off as planned; arranging focus groups and completion of a time use survey for the evaluation study were problematic. While the intellectual capacity and organisational drive to innovate is evident, practitioner fatigue may have an impact on continuing to innovate in new directions. A period of consolidation and renewed focus might be more welcome.

## **4. What lessons have been learned about the barriers and facilitators to this innovation**

The Innovation Programme funding enabled a strong vision within one borough to be given scope and scale across all 3 boroughs. This fortuitous timing, combined with a well-developed conceptual model of Focus on Practice (and not organisational structures) and visionary leadership constituted important facilitators for the innovation. A strong project manager with 'on the ground' authenticity and expertise in the field was a clear advantage to implementation along with selecting programmes that cohered well and had a good evidence base in their own right, even if the context, statutory social work, was innovative. Importantly, there was an absence of negative drivers for change. As a systemic approach, senior leaders were asked to engage in a change agenda, and they were equipped by attending a 6 day systemic course.

Barriers in implementation concern the scale and pace of change across the 3 boroughs. The scale of the project meant training was staggered into several cohorts over 2 years; staff turnover during the period of training meant impact on practice was diluted. By the time of the evaluation, budgetary concerns were coming to the fore and threatened ongoing implementation, e.g., continuing employment of clinicians.

## **5. Limitations of the evaluation and future evaluation**

### **5.1 Limitations of the evaluation and key findings**

This report has already noted some limitations of the evaluation and Appendix 5 gives details of the limitations of the evaluation methodology. There were 3 main limitations. First, the scale of the evaluation was small compared to the scale of the change programme, so the evaluation is focused on some elements of the programme. It did not cover practitioners who were working in other parts of the family services, such as residential care. It would have been instructive to identify the impact of the programme among those who did not already hold a social work qualification, for example. Second, because of the timing of the evaluation and design of the programme, the study does not document practice prior to the intervention of Focus on Practice, nor after the 'intervention' was completed (which would take much longer to carry out). A third limitation, detailed in Appendix 5, was that the study team were reliant on participants' cooperation with, and practical logistics for, research interviews, leading to some potential for bias in those who took part, fewer participants than anticipated and less comprehensive data than would be ideal (in the time use survey). These limitations curtailed the range of comparisons possible. Nevertheless, much of the evaluation data shows a high degree of consistency across data sources, and participants gave full accounts of their experiences and perspectives. Despite the limitations noted, the evaluation provided rich evidence to support the implementation of Focus on Practice.

### **5.2 The appropriateness of the evaluative approach for this innovation**

A largely qualitative approach was highly appropriate given the lack of suitable data from other sources; findings based on process and implementation are suitable for an innovation which is 'transforming' practice over time rather than having a predictable endpoint as they enable amendments to be considered or made to the programme as it develops.

### **5.3 Capacity for future evaluation and the sustainability of the evaluation**

The funded evaluation will be concluded by March 2017. Remaining work in 2016-17 includes:



1. Report on costs and outcomes in March 2017 in relation to child outcomes (children in care; re-referrals), staffing and placement costs, and in relation to staff retention.
2. Briefing report on time use survey in 2016
3. Dissemination of project methods and evaluation findings at the ADACS conference, November 2016
4. Briefing paper and workshop in relation to responses to domestic violence in the qualitative data

## **5.4 Plans for further evaluation by project**

The evaluation will not capture child outcomes and cost outcomes at the time point when stakeholders believed they would be most clearly evident: financial year 2017-2018. Therefore the boroughs' project team should ensure these are measured.

## 6. Implications and Recommendations for Policy and Practice

### 6.1 Evaluative evidence for capacity and sustainability of the innovation

The Focus on Practice change programme is ambitious: it aims to transform social work practice, and that of all work with families, across three boroughs, through a new knowledge base, changes to systems to support new ways of thinking, and new staff posts. The study has documented very real and positive steps being taken in the boroughs towards their goals. The programme was well organised and supported at all levels of its operation. Familiarity with programme objectives was high. Cultural change was becoming embedded in the language, methods and tools deployed by practitioners. Families clearly supported social work that was empathic, respectful and responsive to practical difficulties; values that were in tune with the new knowledge base.

In terms of the short term objectives set by the evaluation and considered in the light of the limitations outlined above, we offer the following concluding remarks based on evidence presented:

- *Social workers perceive local authority systems as responsive and supportive.* Changes were noted in respect of supervision, and availability of support through clinician posts, but in relation to case recording there was no clear evidence of saving time and IT systems for recording were not responsive and supportive.
- *Social workers will spend longer undertaking direct work with children and their families and less time on recording processes/bureaucracy.* This is not yet clearly the case (survey data not yet available). Reports of more direct work were associated with better resourced boroughs and lower caseloads rather than Focus on Practice as such. However, some social workers reported that the training had enabled them to use more effectively the time they did have with clients.
- *Social and familial networks are strengthened.* There was no evidence from family data of unequivocally strengthened networks. This may be to do with sampling/time frame for the study.
- *Recruitment and retention of social workers and staff satisfaction improve.* Rates of use of agency staff, staff turnover and staff absence all show changes towards more stable staffing, which indicate better staff retention and greater satisfaction.
- *Children are safer and family functioning improves.* Social workers reported the children were safer since their intervention. Families reported

improved functioning. But this may be to do with social work intervention and with self-evaluative capacities of families rather than Focus on Practice.

- *Reduction in costs (considered in the context of the outcomes achieved).* Not yet shown in staffing costs but placement costs are reducing.

## **6.2 Conditions necessary for this innovation to be embedded**

Through the evaluation, we have identified the following conditions necessary for embedding the innovation: stability and continuity of the workforce; reinforcement of learning through continued employment of clinicians; protected workloads and expert support for family case work particularly around the number and complexity of cases held per social worker; and, perhaps most strikingly, revisiting structural disruption in client-social worker relationships. This most clearly occurred in the built-in transition between assessment and long term work. It was clear that follow-through from duty to long term cases was a better fit with Focus on Practice than transfer of cases between teams. This leads to the following implications for policy and practice to embed the innovation:

1. There is a good case for continuing to employ family therapists with statutory social work experience in social work teams. Their approach facilitates ongoing learning about systemic practice, and provides emotional support to social workers.
2. Systemic practice suggests a rethink of structures of engagement with families. An effective focus on building supportive relationships through which to engage families in resolving family problems needs to start on day one of social work involvement, not post-assessment phase.
3. The enthusiasm and momentum generated by Focus on Practice across the boroughs' family social work teams is a worthwhile outcome in its own right; in a time of austerity and downward pressure on resources, building human resources through team work, collaboration and a sense of reward at work is to be valued.

For the future development of the project and its wider application, Focus on Practice could consider:

1. Continuing to mandate systemic training to new recruits, so as not to dilute the impact of the change programme to date, and for this to be for senior staff, as well as for social workers.
2. More work to resolve the difficulties of recording in case-summary format through a) specific workshops/training/bespoke support; b) ensuring any risks associated with less detailed recording processed are held with

senior staff and not (only) social workers; c) dialogue with judiciary about requirements.

3. Focusing on specific kinds of 'high stakes' family cases where systemic training can potentially make most difference. For example, family violence cases, where referrals recur, and where the adult relationships have immediate but indirect impact on children.
4. Further work to examine the impact of Focus on Practice among other services such as residential child care or youth justice, where the impact might be different.

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# Appendix 1 Systemic Practice – Key points

## What is it?

- An evidence based therapeutic approach, which refers to a range of psychological interventions for individuals, couples and families based on systemic concepts and theory,
- Systemic theory holds that people make sense out of their lives and derive meaning through relationships. Relationships are all important in the construction and therefore the dissolution of problems,
- Systemic interventions are designed to help people make changes in their thinking, behaviour and understandings to relieve distress, improve the quality of significant relationships and make positive changes in their lives: this gives the systemic approach a particularly good fit with the aims of intervention in children’s social work,
- A systemic approach focuses on the key relationships around children, young people and their families, in order to build on strengths and resources and make lasting change, thereby reducing the future demand on services from the identified child, young person and their family.

## The evidence base

- Systemic family therapy has a strong evidence base (Carr, 2009, 2014, Stratton 2010) in the treatment of: child and adolescent mental health problems including conduct problems, emotional difficulties, ADHD, eating disorders, depression; the impact of parental mental health difficulties on children and families; abuse and neglect; trauma; poverty and social marginalisation; the needs of looked after children; family and couple relationship difficulties; changing family structures,
- Systemic family therapy forms the basis for intensive family-based interventions such as Multi Systemic Therapy (MST) (Henggeler and Sheidow, 2002) and Functional Family Therapy (FFT) (Alexander et al, 2002),
- Systemic family therapy has been shown to be highly cost-effective (Crane, 2008), and lead to improved engagement (Carr, 2009).

## The training

- Training in systemic family therapy helps practitioners deliver systemically informed care and interventions to support children, young people and their families,

- Introductory and intermediate level training is sufficient to support this shift in practice, together with support from fully qualified family and systemic psychotherapists and family therapists qualified in systemic supervision,
- The Association for Family Therapy and Systemic Practice (AFT) is the accrediting body for training in systemic family therapy.

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NB: This appendix supplied by Focus on Practice project team.

## Appendix 2 Data sources

Interviews with:

- 11 key stakeholders (councillors, directors of family services, training provider, senior managers)
- 33 social workers and team leaders involved in assessment work
- Three focus groups to inform survey of all staff on time use
- Heads of clinical practice group interview
- 25 social workers responsible for working with families
- 19 families – two unused in analysis due to i) withdrawal of consent; ii) termination of interview as distressing. Family network map and SCORE-15 in addition to interview.

Statistical data at three time points (year to March 2014; March 2016; March 2017) to assess progress against following indicators:

- Staff turnover, use of agency staff, and staff satisfaction
- Numbers of looked after children
- Numbers of referrals and re-referrals

Survey of time use among social workers carried out February 2016.

Vignettes (practice scenarios) undertaken with assessment workers and with family social workers. The scenario questions were:

‘These questions are a little different. I am going to read out a short case example and I would like you to say how you would approach it and what you would do. Each case is in two parts. [Show laminated card]. There is no right or wrong answer, we are just interested in practice.

*1. A school telephones to say an 11 year old girl has reported that her father grabbed her mother by the throat yesterday and the girl sat up all night in case something else happened to her mother.*

Given your training and experience, what would be your response to this call? What would you want to know, do and think about next?

*On a visit to the mother she reports that her husband does not want her to leave the house, work or attend English language classes and requires that she accounts for every item of expenditure.*

How would you react to this information? What would you do?



*2. Imagine you are on a duty. A referral comes about a mother who often picks up her 3 year old child from nursery when she seems drunk.*

With your knowledge (of Focus on Practice (if relevant)), what would you do?

*You visit, and explain the nature of the referral to the mother. The mother replies 'That's not true. I am on antidepressants and they make me appear drunk'.*

What would you do, think about and talk to?

Thank you very much for your thoughts'.

## Appendix 3 Descriptions of respondents

Table 1 Assessment social workers and others interviewed/number of sessions of training completed

ID	Role/Team	Training (days)
LBHF	Social worker	11
LBHF	Social worker	7
LBHF	Social worker	0
LBHF	Principal Social Worker	7
LBHF	Social worker	0
LBHF	Senior Social Worker	8
LBHF	Social worker	11
LBHF	Team Manager	10
LBHF	Team Manager	0
LBHF	Social worker	10
LBHF	Team Manager	10
LBHF	Social worker	8
RBKC	Team Manager	12
RBKC	Social worker	6
RBKC	Social worker	9
RBKC	Senior SW	11
RBKC	Social worker	0
RBKC	Social worker	6
RBKC	Team Manager	6
RBKC	Senior SW	10
RBKC	Team Manager	10
RBKC	Team Manager	8
RBKC	Social worker	0
RBKC	Social worker	9
WCC	SW Assistant	6
WCC	Senior SW	10
WCC	Social worker	7
WCC	Senior SW	10
WCC	Clinical Practitioner (Family Therapist)	Trainer
WCC	Social worker	9
WCC	Social work assistant-	9
WCC	Team Manager	9
WCC	Service Manager	9
WCC	Social Worker	13
WCC	Family Therapists	Trainer

## Appendix 3

Figure 2 FOP and Early Assessment (N = 33)

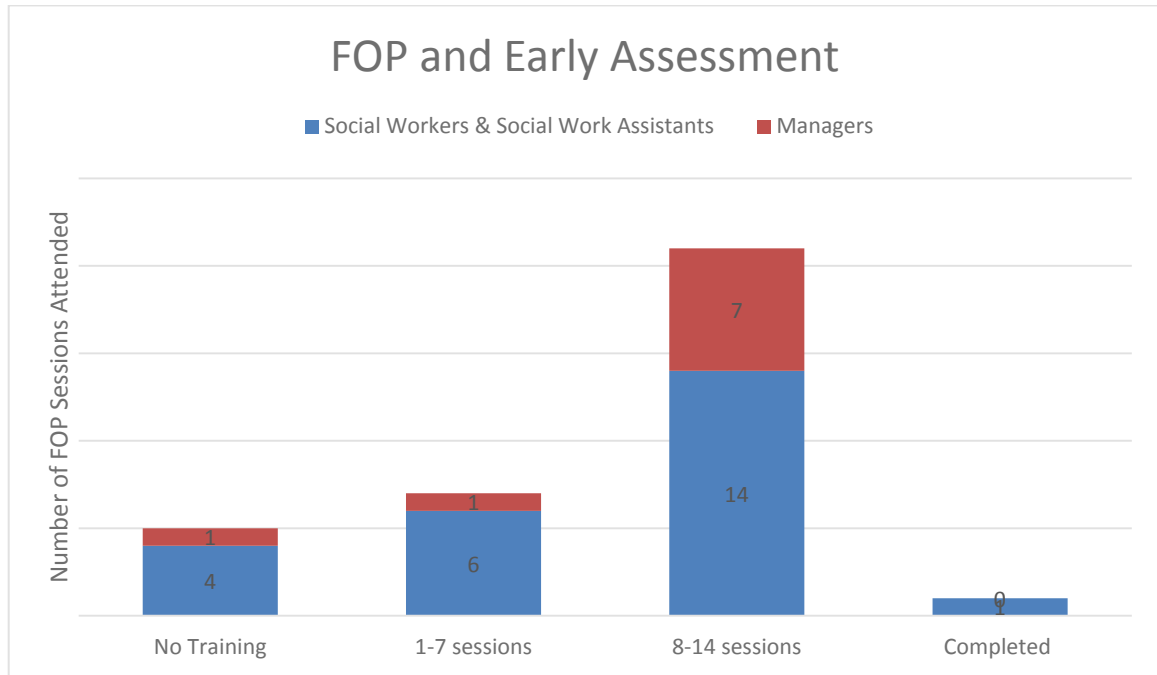
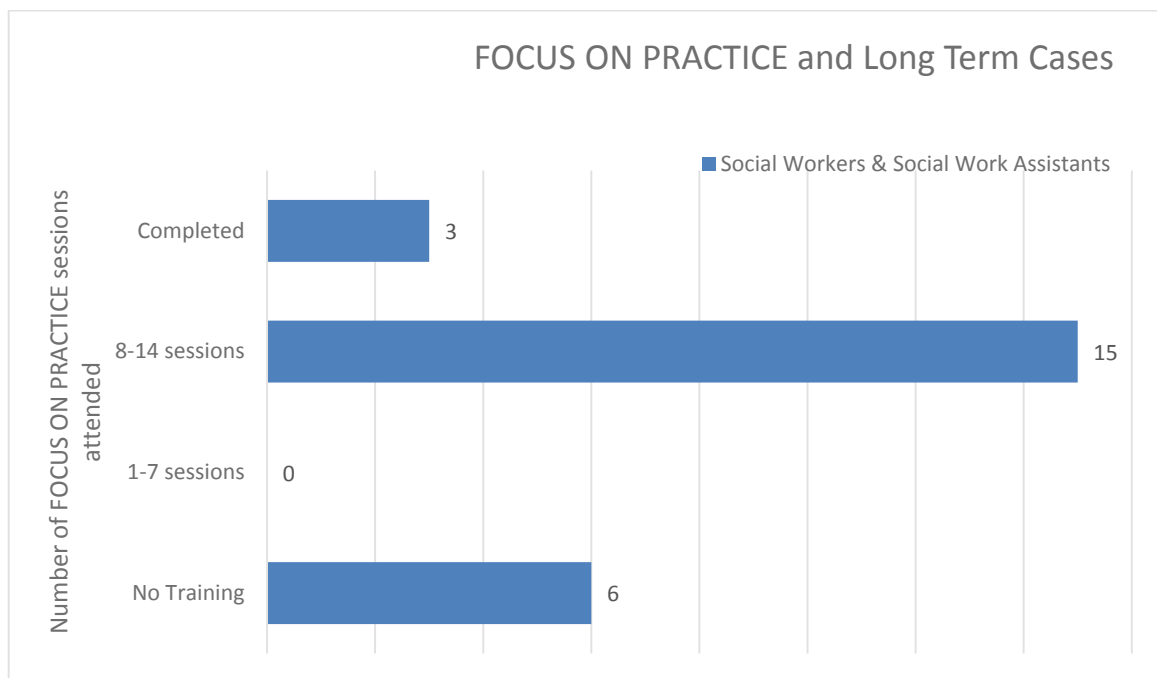


Table 2 Family social workers interviewed/training days completed

ID	Role/Team	Training (days)
RBKC	Long term	0
RBKC	Long term	11
RBKC	Long term	15
RBKC	Specialist practitioner/Long term	15 (Systemic qualification predates Focus on Practice)
RBKC	Long term	10
RBKC	Long term	0
RBKC	Long term	10
RBKC	Long term	11
RBKC	Long term	0
RBKC	Long term	0
RBKC	Long term	10
RBKC	Long term	14
WCC	Long term	12
WCC	Short term (SP)	12
WCC	Short term	10
WCC	Short term	15
WCC	Long term (SP)	13
WCC	Early assessment	13
WCC	Long term	0 (Agency staff)

ID	Role/Team	Training (days)
WCC	Senior practitioner/long term	9
WCC	Long term	15
LBHF	Long term	11
LBHF	Disability/long term	13
LBHF	Senior social worker	9
LBHF	Long term	0 (Agency staff)

**Figure 3 Focus on practice and Long Term Cases (n = 25)**



**Table 3 Families interviewed/type of case/time 1/time 2**

SW	Case Type	Interviewed Time 1	Interviewed at Time 2
LBHF	CiN	x	x
RBKC/ RBKC	CiN	x	x
RBKC	CiN	x	x
RBKC	CiN	x	x
WCC	CiN	x	x
WCC	CiN	x	NA
WCC	CiN (although still undergoing assessment)	x	NA
LBHF	CP	x	
LBHF	CP	x	x
LBHF	CP	x	x

SW	Case Type	Interviewed Time 1	Interviewed at Time 2
RBKC	CP	x	x
RBKC	CP	x	x
RBKC	CP	x	x
WCC	CP	x	NA
WCC	CP	x	x
WCC	CP	x	x
RBKC	CP (came off register in research period)	x	x

**Table 4 Stakeholders interviewed/role/borough (reference in text in bold)**

Job title	Job scope	Borough
<b>Councillor</b>	Member for Children and Education for Hammersmith and Fulham council since June 2014.	LBHF
<b>Councillor</b>	Lead member for family and children's services. Three years	RBKC
<b>Councillor</b>	Cabinet member for children and young people since February 2013	WCC
Chief Executive <b>Senior Leader</b>	In charge of the children's services across the three boroughs.	Triborough
Director Family Services <b>Senior Leader</b>	Most social care services in but not anything that's got a Tri-borough manager attached to it. Few services no direct line management. In post five years	LBHF
Director Family Services <b>Senior Leader</b>	All the children in need services: child protection, looked after children, social work services, all the early help services, which includes some targeted teams, an edge of care team, some children's centres and under five services, play at the moment, although that's in the process of being commissioned out. Youth offending service, two children's homes, one hostel, leaving care service. Disabled children's services.	RBKC
Director Family Services <b>Senior Leader</b>	All family services	WCC
Director of Commissioning <b>Manager</b>	Across children's services for each of the three authorities for just over a year. System-wide perspective, looking at the outcomes, accountabilities and responsibilities of children's services as a whole, and how we are achieving that.	Triborough
Assistant Director Looked After Children and care leavers	In-post since May 2014. Specialist looked after children and care leavers service (WCC and LBHF), and leaving care service,	Triborough

<b>Job title</b>	<b>Job scope</b>	<b>Borough</b>
<b>Manager</b>	with a kind of dotted line to the locality based model within RBKC. Manages the tri-borough virtual school.	
Social Work Manager <b>Manager</b>	Head of service in Kensington and Chelsea, children's social care. Management oversight of the social work teams in the borough, and the social work teams carry a range of work.	RBKC
Training Provider <b>Training Provider</b>	Director of the Institute of Family Therapy and in post for nine years.	External

# Appendix 4 Theory of Change

## Theory of Change

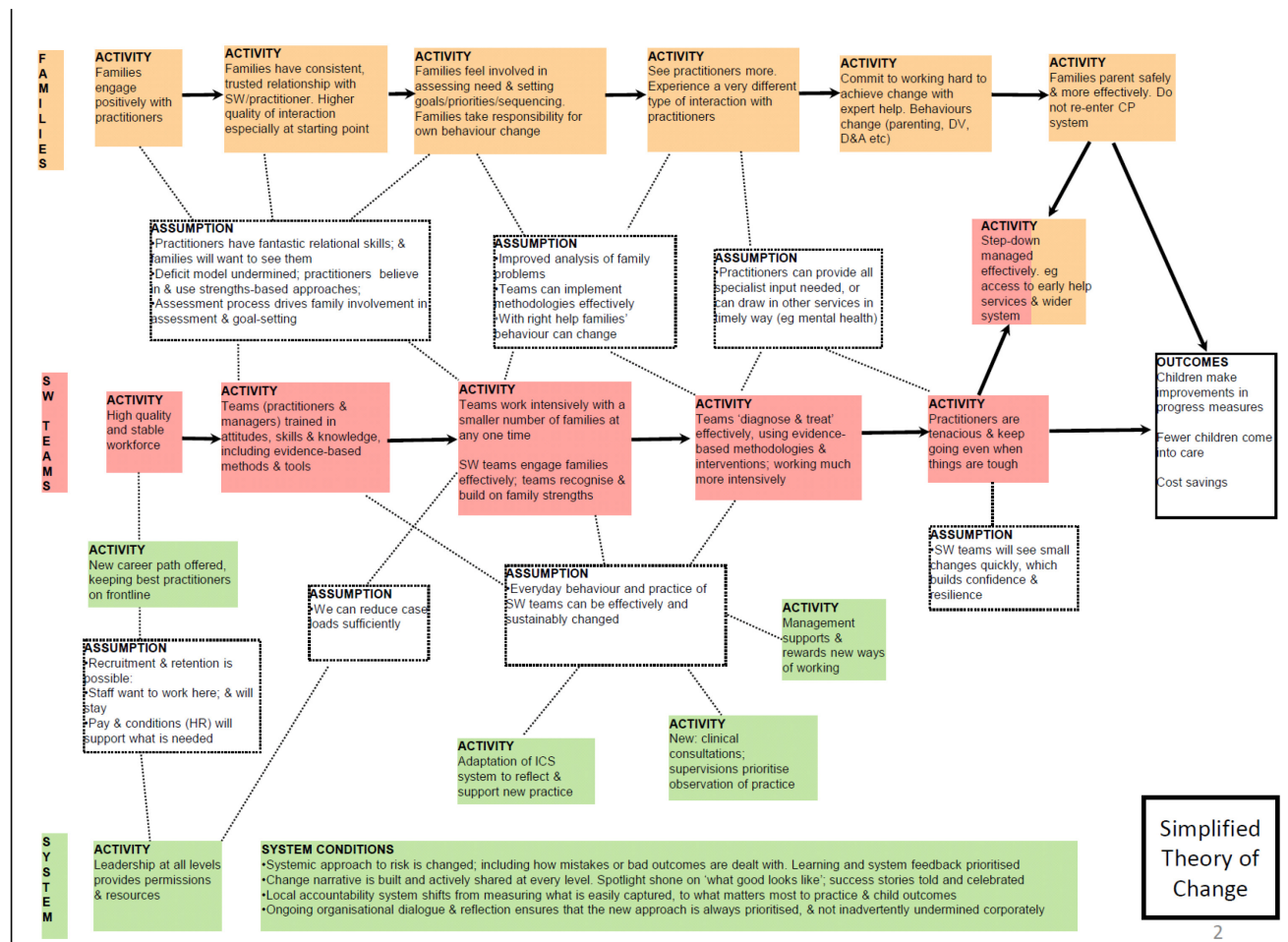
The following slides show a simplified version of our Theory of Change. A complex web of activity will be required to bring about the final outcomes we are looking to achieve:

- Children make improvements in progress measures
- Fewer children come into care
- Cost savings

This Theory of Change defines the key building blocks we believe will be required to bring about the longterm outcomes, and makes explicit the underpinning assumptions behind the causal links between the steps in the change pathway. We have identified the changes we need to bring about:

- Changes in Families
- Changes in SW Teams
- Changes in the underpinning system

The second slide identifies indicators that will show that the system is changing in the way that it needs to, and the dates when we expect to be able to start measurements. We are particularly keen to have proxy measures that will give us confidence that change is happening (for example in families' experiences, in practitioner behaviour), long before outcomes for children and referral numbers start to shift.



## Appendix 5 Limitations of the evaluation

### **Recruitment of families**

Recruitment was designed on the basis of random selection of families referred to the boroughs in April and May 2015 who had had a previous referral and who were likely to be connected to social workers for some months ahead to enable a second interview to be carried out. There were several difficulties with this method, namely i) databases could not accurately identify families meeting the criteria; ii) hand searching of referrals was undertaken but was excessively time consuming; iii) there was a high rate of noncontact and withdrawal by families; and iv) in some cases social workers deemed research contact unhelpful at the time of new work. We supplemented this method by securing senior staff support for visiting social work teams in situ and recruiting families who met criteria directly through social workers. Interviews with families took place until end August 2015 (two months later than originally envisaged). Time two interviews took place by telephone in January/February 2016. Four families were unable to take part either because they were uncontactable or because they refused to take part. We aimed for 24 families at time one and time two; we obtained 17 useable interviews at time one and 13 at time two. The limitations of this method is gatekeeping by social workers, who made decisions about which families met the criteria and would be willing to be interviewed, leading to potential for bias. Families who were in particularly difficult or chaotic circumstances or who were in dispute with children's services were more likely to refuse to take part in research interviews, so these groups are underrepresented in our work.

### **Recruitment of social workers**

Recruitment of assessment social workers and team managers was through a focused period of fieldwork in one team in each borough in July 2015. Desired numbers were achieved. Clinicians in post were also interviewed.

Recruitment of family social workers was connected to recruitment of families in that we aimed for an interview with each social worker allocated to the family we interviewed. In the event, 4 social workers were interviewed where their families had refused or withdrawn. There were 25 family social worker interviews (in one case 2 social workers for one family). Due to logistics and timing, not all the social worker interviews supplied the entire component data requested.

### **Recruitment of stakeholders**

This was facilitated by the Focus on Practice manager and desired numbers were achieved.

### **Focus groups + survey**

Two of three focus groups took place as planned. In the third borough there were



significant delays in arranging the work, which led to delays in securing the survey of staff. 44 responses to survey.

### **Limitations of the data gathering tools**

The conjunction of SCORE-15, a family therapy diagnosis tool and the family network map showed illuminating differences in families' (mothers') perceptions of family membership. The network map showed wide membership of families; the SCORE-15 tool led mothers to define family as immediate household members. SCORE-15 was difficult to administer, especially through translators, and, in one case, over the telephone, as some of the terms were not readily understood. For this reason, we did not repeat the SCORE-15 measure in the follow up interviews as these interviews were undertaken by telephone.

## Appendix 6 Example of change in one family interviewed at time one and time two

At time 1:

Mother X had become involved with children's services after a referral by a hospital. Her son's father, with whom she did not live, had been aggressive in the hospital after child who was 2 years at the time had been admitted for a routine operation. Mother X's own mother allowed her to stay at her home. At the time of the first interview, she was still at her mother's home. Mother X also had learning difficulties. When she drew her network map, she placed her child in centre of map, and her sister, mother and herself close by and wider family and nursery teachers and social workers in next circle. When she was prompted about her child's father, mother X said he was nowhere on the map and she had not got a father either.

When mother X was asked about services she used, she reported the nursery for child, doctors and speech and language therapist every week for child (which he needed after his operation). The social worker had helped her set up these. She had also put Mother X in touch with a lawyer, to get an injunction against the child's father as well as helping her access adult education, to help her improve her self-esteem and get a job. When asked about services which she had not been able to access, she discussed wanting her own place to live with her child. Mother X said her social worker listened to her concerns, and asked her own mother's opinion which was important. She also recognised that she could call up her social worker if she had any questions.

At time 2:

Mother X said that things were a lot better and more settled. Children's services were no longer involved with her. Her son was at school and was doing well and Mother X discussed him as being confident, chatty and of having friends. Mother X is no longer in touch with her child's father and he has not attempted to get in touch.

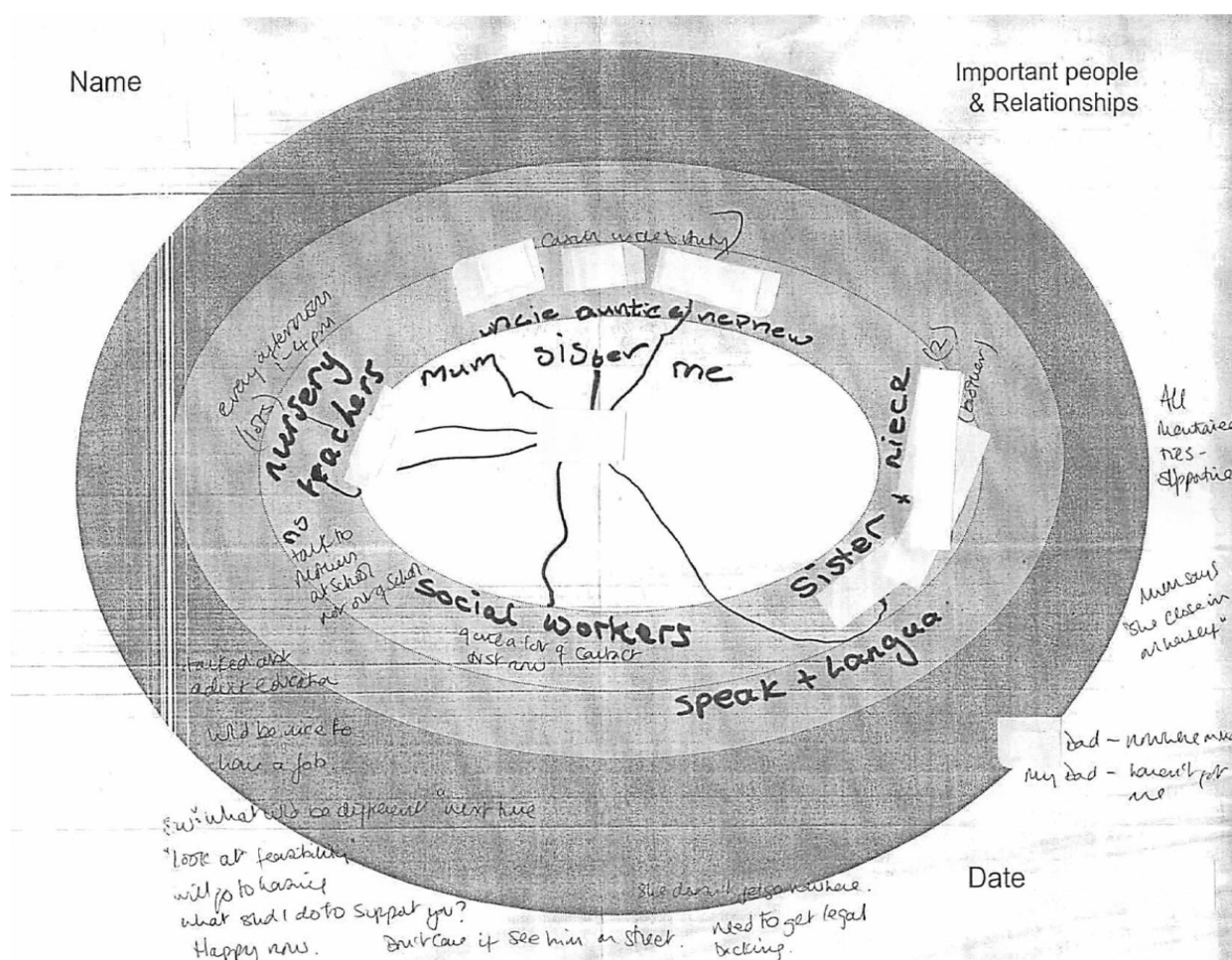
A big change in their social network was that Mother X had another baby, a daughter who at the time was 4 months old. She was not in touch with the father of her daughter either. Her own mother is still a big part of her life and helps with her children. Another friend N has been supportive also. Mother X said she felt more in control of things. Children's services did get in a little involved again during her pregnancy, but they were satisfied with her parenting skills and support network and closed her case.

Another change at time 2 was that Mother X had been provided with her own housing (something which she really wanted at time point 1) and moved out of

her own mother's house. However, this is a small one bed and she finds it inadequate in terms of space. Her baby doesn't sleep in her cot, so all 3 of them end up sleeping in the bed. She prefers to live separately from her mum and have her own independence but at the same time the space is very small. She has no changes in terms of new professionals or organisations that she is in touch with.

Mother X reflected on how pleased she was that social workers were no longer involved in her life. She discussed feeling more in control and although she was overall satisfied with her experiences with her social worker she does not want her to be part of her life again.

Figure 4 Family Network Map for Family X





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**Reference: DFE-RR521**

**ISBN: 978-1-78105-573-1**

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Any enquiries regarding this publication should be sent to us at:

[richard.white@education.gsi.gov.uk](mailto:richard.white@education.gsi.gov.uk) or [www.education.gov.uk/contactus](http://www.education.gov.uk/contactus)

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