Department for Education

Suspected Inflicted Head Injury Service (SIHIS)

Evaluation of pilots to reduce unnecessary family court delays

Research report

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Preface

We would like to thank all those who gave their time to take part in the interviews for sharing their experiences openly. Their contributions were essential in shaping the findings and recommendations presented in this report.

We would also like to thank colleagues at DfE for their valuable input, guidance, and support throughout the research. We are also grateful to delivery partners, Mutual Ventures, Gate One and Mott MacDonald for their input and support across the evaluation. Finally, we would like to thank our colleagues and associates at Verian, NCB, and Alma Economics for their work in delivering this evaluation: Ramla Attah, Frances Hansford, Ruth Atkinson, Nathan Turner, Emma MacKay, Ellinor Ottosson, Michael Ratajczak, Peter Mathews, Oriol Bosh, Alex Hurrell, Elisabetta Pasini, Lawrence Newland, Lucille McKnight, Dustin Hutchinson, and Jemima Colahan.

It is with great sadness that we acknowledge the significant professional contribution of our colleague, Phoebe Penfold, to this evaluation, and to her wider work at Verian. Her insight and commitment were highly valued, and she will be greatly missed.

Abbreviations

A note on unintended consequences and unexpected outcomes:

Unintended consequences are effects generated by the pilot which were not anticipated and/or intended, these can be positive or negative.

Unintended positive consequences are effects generated by the pilot which, although positive, would not directly contribute to the primary aim of the pilot.

Unexpected outcomes are any outcomes or effects from the pilot which were not included on the Theory of Change but can be seen as contributing to the primary aim of reducing unnecessary delays.

CBA	Cost-benefit analysis
CMH	Case Management Hearing
CPI	Consumer Price Index
CQC	Care Quality Commission
CT	Computed tomography
DfE	Department for Education
DFJ	Designated Family Judge
DGH	District General Hospital
HMCTS	His Majesty's Courts and Tribunals Service
HMT	His Majesty's Treasury
KEQ	Key evaluation question
MDT	Multidisciplinary Team
MRI	Magnetic Resonance Imaging
NAO	National Audit Office
NCB	National Children's Bureau
NHS	National Health Service
ONS	Office for National Statistics

QALY Quality Adjusted Life Years

SIHIS Suspected Inflicted Head Injury Service

ToC Theory of change

VfM Value for money

Executive Summary

The Department for Education (DfE) commissioned Verian and partners (Alma Economics and National Children's Bureau (NCB)) to deliver an independent evaluation of three pilot interventions, implemented between April 2024 and March 2025, that were designed to reduce unnecessary family court delays:

Pilot 1: The Designated Family Judge (DFJ) Trailblazers pilot aimed to identify local causes of delays and implement targeted interventions in response to the issues identified.

Pilot 2: Introduced a consistent approach to conducting pre–Case Management Hearing (CMH) meetings, to take place before the first CMH.

Pilot 3: Introduced a new multidisciplinary Suspected Inflicted Head Injury Service (SIHIS) for children 0-8 years old in three National Health Service (NHS) Trusts.

This report presents findings from the evaluation of the SIHIS pilot (Pilot 3).

Context

SIHIS provided a streamlined model for assessment of suspected inflicted head injuries of 0 to 8 year olds, prior to a local authority decision as to whether a case should be escalated to court. The pilot established a multidisciplinary team (MDT) of seven clinical disciplines who were responsible for providing senior-level medical opinion on the cause of head injuries in children seen at hospital, where there was reason to suspect abuse. It also introduced a proforma template for reporting assessments. This was a departure from usual practice, whereby court staff receive multiple reports from individual clinicians. The pilot was implemented by three NHS Trusts with a total of £586,697 in grant funding.

A theory of change (ToC) was developed in collaboration with DfE, an expert panel and key stakeholders, at the start of the evaluation. It demonstrated the multiple pathways by which the pilot was expected to help reduce unnecessary delays in the family courts, while also reducing costs for courts and local authorities, improving family experience of the court system, and encouraging more clinicians to undertake court work. The ToC was tested and refined during the evaluation.

Evaluation methodology and implementation

This evaluation had three objectives, organised as three types of evaluation:

1. To understand how the pilot was designed and implemented, and how acceptable it was to key stakeholders (process evaluation).

2. To assess whether, how, and why the expected pilot outcomes — outlined in the pilot ToC — were achieved (impact evaluation).
3. To evaluate the pilot's likely value for money (VfM) through a comprehensive, ex-post cost-benefit analysis (economic evaluation).

The evaluation spanned two years (April 2024 – May 2026) and used a rigorous mixed-methods, theory-based approach. It triangulated primary and secondary, quantitative and qualitative data from multiple sources to provide a comprehensive response to nine Key Evaluation Questions (KEQs). Secondary data included monitoring data provided by the NHS Trusts on implementation and outputs, and information from relevant documents and literature. Primary data was collected via in-depth interviews with 26 stakeholders - NHS clinicians from across the three NHS Trusts, and judges, Cafcass staff, and a legal professional covering two local authorities in which SIHIS patients resided.

A panel of experts in the family justice system contributed to our evaluation design and ToC, reviewed and commented on our evaluation findings, and worked closely with us on the final evaluation outputs.

Findings for the SIHIS pilot

Process evaluation findings

KEQ1: How was SIHIS set up and implemented by the NHS Trusts? Was the SIHIS pilot implemented as set out in Application Guidance provided by the DfE? To what extent did implementation vary across the NHS Trusts and why?

Three NHS Trusts were selected against pre-determined criteria and received £586,697 between them in grant funding, plus support from DfE and two seconded clinicians. There was a total of 32 SIHIS cases across the three Trusts during the implementation period. Fifteen reports were sent to the courts (seven cases were ongoing when the pilot ended), and 10 cases were diverted from court.

All three Trusts implemented SIHIS as set out in the Application Guidance from DfE, except for minor deviations (in relation to the number of lead clinicians in each Trust, and the clinical disciplines contributing to the SIHIS reports).

KEQ2: What were the barriers and facilitators to implementing SIHIS?

The main facilitators were administrative support, protected time for meetings, pre-existing MDT meetings, professional commitment, and support of the secondees and cross-site meetings organised by DfE. The main barriers were the structure of the initial proforma (which was subsequently improved), the short pilot length, and limited engagement with neurosurgery.

KEQ3: Is the SIHIS pilot acceptable to key stakeholders (Trusts, families, other organisations affected by the pilots)? (relevance, coherence, resourcing, buy-in, and family views)

SIHIS was considered a relevant approach to help reduce unnecessary delays, and was seen to be coherent with existing services. DfE funding was felt to be sufficient, although there were some challenges with staff time for implementation. Interviewees from the NHS, Cafcass and the judiciary supported continuation of the service, and rollout for other injuries and to other hospitals, although NHS staff felt that it cannot be sustained in its full form (e.g. production of a full SIHIS report) without ongoing funding. Some NHS staff reported pushback among local authority legal teams and courts who, they believed, perceived SIHIS as a threat to established expert witness processes. Families were not made aware of SIHIS and so had no experience of it as a distinct service.

Impact evaluation findings

KEQ 4: What do key stakeholders (e.g. leaders, practitioners, and families) perceive as outcomes of the pilot? How do they believe the outcomes came about?

Interviewees reported that most intermediate outcomes on the pilot ToC had, to some degree, been achieved. The SIHIS process was generally felt to result in better quality information for the courts, and judges indicated that SIHIS contributed to faster and better-informed decision-making in the courts, along with fewer Part 25[1] expert requests. NHS staff and judges also felt that with SIHIS team assessments, cases arriving at hospital were more often correctly classified as accidental or non-accidental. NHS interviewees indicated that collective responsibility for assessments, and the supportive setting of the MDT meetings, helped to reduce anxiety and increase confidence among clinicians, but most did not feel that this translated into improved overall wellbeing for clinicians due to the distress associated with traumatic cases. Interviewees did not feel that the existence of the SIHIS could be expected to make a difference to multi-agency collaboration and communications, as the procedures for multi-agency working were not materially altered or affected by the SIHIS.

In terms of expected downstream pilot outcomes, interviewees felt that SIHIS had the potential to contribute to reduced costs for courts and local authorities, and reduced case durations, if relevant intermediate outcomes (a reduction in the number of Part 25 experts and associated waiting times and fewer hearings) were realised. Some interviewees indicated that the SIHIS could help to improve family experiences by reducing time waiting for assessments and court verdicts, as well as through more holistic medical care for children. NHS interviewees did not believe that SIHIS would lead to more clinicians

[1] A Part 25 expert refers to an expert witness, such as a medical expert, a psychologist, or an independent social worker, instructed by the court to provide an independent and impartial report under Part 25 of the UK's Family Procedure Rules (FPR).

interested to take on court work. They did indicate that the pilot had created a model for future rollout.

Interviewees believed that the SIHIS could not contribute to the long-term impacts on the ToC (improved care outcomes for children, a wider pool of NHS clinicians interested in child social care and court processes).

Unexpected outcomes identified were: deeper knowledge of head trauma and enhanced learning about child protection and legal processes among clinicians; clarification of organisational safeguarding procedures; stronger relationships among disciplines; extension of the SIHIS to some district general hospitals (DGHs) in the Birmingham and Manchester areas; and improved clinical care for children.

Contextual enablers of positive outcomes included: existing safeguarding and child protection expertise; well-established safeguarding procedures; and strong collegiate relationships among clinicians.

KEQ 5: What does the refined pilot ToC look like?

We refined the original ToC based on our evaluation findings. A few changes are for clarity of expression. Stakeholder perceptions suggest that two intermediate outcomes, one pilot outcome, and both long-term impacts, did not come about due to 'theory failure' (the premise on which they appeared in the ToC did not hold), rather than 'implementation failure' (insufficient implementation time or shortcomings in implementation).

KEQ 6 What, if any, were the unintended consequences (positive and negative)?

Interviewees did not identify any positive unintended consequences[2]. One negative consequence was identified - relationships among some professionals were negatively affected in one Trust, due to tensions engaging neurosurgeons in the MDT.

Economic evaluation findings

KEQ7: To what extent does the pilot represent value for money?

Due to the lack of quantitative estimates of the impact of the pilot on case durations, whether this pilot represented VfM is inconclusive. The overall costs associated with the pilot were £0.69 million. Given that there were 32 SIHIS cases across the three Trusts, an average decrease of 24.4 weeks in case length would have been necessary for the pilot to breakeven. As the average duration of cases across the three NHS Trusts was 36

[2] Unintended positive consequences are different to unexpected outcomes. The latter are any outcomes or effects from the pilot which were not included on the ToC but can be seen as contributing to the primary aim of reducing unnecessary delays. The former are effects generated by the pilot which, although positive, would not directly contribute to the primary aim of the pilot.

weeks in 2023/24, a 24-week reduction in case lengths would represent a significant decrease. Even though interviewees indicated that there may have been time savings in some cases, a reduction of 24 weeks or more seems highly unlikely, indicating that the pilot likely did not represent VfM.

KEQ8: How do cost reductions caused by the pilot vary by group, e.g. between court costs and costs faced by local authorities and households?

The cost of SIHIS-related family court cases is borne by local authorities, courts, and to a lesser extent, households. Case lengths influence these costs through weekly placement and legal staffing costs, as well as per-hearing costs associated with legal staffing and court running costs. Our analysis indicates that cost reductions to local authorities and courts would make up the vast majority of cost savings if a 24-week reduction in case lengths were achieved, with 91.7% of cost reductions accruing to local authorities and 7.8% of cost reductions accruing to courts. Benefits and cost reductions to households are negligible under a 24-week reduction, contributing approximately 0.4% to total benefits. There are also small wider societal benefits in the form of avoided public service costs.

Summative evaluation: learning to inform future rollout

KEQ9: What have we learned across pilot NHS Trust sites that can help to guide rollout of the SIHIS to other NHS Trusts/for other types of injuries?

Considerations for rollout from interviewees included: clear guidelines and support for new NHS implementers; consideration of staffing in the NHS (administrative support and integration of clinician time); clear briefing and early involvement and consultation of staff in affected agencies (local authorities teams, the police, and the legal profession); revisions to the SIHIS proforma; and suggestions for possible rollout models to include hospitals with less safeguarding expertise.

Limitations to the evaluation

Limitations included:

- participation in interviews was lower than aimed for despite comprehensive recruitment efforts and this may have introduced bias into our findings - we interviewed only one staff member from Cafcass, and one from a local authority in which SIHIS patients reside, and none from HMCTS, so we have little insight into how the SIHIS affected local authorities, Cafcass or administrative staff in courts;
- families were not directly involved in the evaluation due to ethical concerns around re-traumatisation, and insights into family experiences were limited as most interviewees had minimal contact with families;

- evidence on pilot outcomes is based on stakeholder perceptions as it was not possible to provide more robust quantitative estimates of outcomes due to the small number of SIHIS cases;
- we have provided breakeven analysis of the pilot, rather than a full cost benefit analysis, due to the lack of robust quantitative data on the primary outcome, reduction in case durations.

Conclusions

Interviewees indicated positive effects of the SIHIS on the court system which should theoretically contribute to shorter case durations and lower costs for local authorities and the courts. Due to the small number of SIHIS cases processed by the three Trusts, we were unable to conduct the planned quasi-experimental analysis that would have allowed us to estimate the reduction in case durations attributable to the pilot. NHS interviewees also pointed to additional benefits for clinicians, who felt more confident and less anxious when working on traumatic cases due to the MDT approach to assessments. They did not feel, however, that this could translate into a greater number of clinicians willing to take on court work. Some interviewees indicated that the SIHIS could help to improve family experiences of the system by reducing time waiting for assessments and court verdicts, as well as through more holistic medical care for children.

The economic evaluation could not reach a definitive conclusion on pilot VfM, given that the planned quasi-experimental analysis proved to be infeasible. The 24-week reduction identified by the break-even analysis as the necessary threshold for the pilot to have achieved breakeven would represent a significant decrease given the average duration of cases across the three NHS Trusts was 36 weeks in 2023/24. Even though interviewees indicated that there may have been time savings in some cases, a reduction of 24 weeks or more seems highly unlikely, indicating that the pilot likely did not represent VfM. This finding should be understood in the context of the unavoidable limitations of the cost-benefit model, with some assumptions made in the absence of quantitative impact data, and some potential benefits excluded. It is important that the positive findings in this report are not disregarded in light of a less positive VfM finding.

VfM may be higher if the SIHIS were to be rolled out to other Trusts/hospitals, if, as might be expected, costs are lower, given that the pilot incurred one-off start-up, training and consultancy costs. The VfM would also likely increase if the existing three SIHIS sites were to assess children older than eight years with head injuries, or other types of injuries, or if other hospitals were to refer cases into the existing SIHIS sites. This would allow for a higher volume of cases to flow through the same sites at little additional cost (assuming that ongoing costs do not increase proportionally with the number of cases). It will be important, in any future scenario, to consider the impact on the care and safety of other patients, and on other staff members of diverting NHS staff to the SIHIS.

1. Introduction

The Department for Education (DfE) commissioned Verian and a consortium of partners (Alma Economics and National Children's Bureau (NCB)) to deliver an independent evaluation of the following three pilot interventions, designed to reduce unnecessary family court delays:

- Pilot 1: Designated Family Judge (DFJ) Trailblazers
- Pilot 2: Pre-Case Management Hearing (pre-CMH) meetings
- Pilot 3: Suspected Inflicted Head Injury Service (SIHIS)

The pilots were delivered over a 12-month period between April 2024 and March 2025. The evaluation ran in parallel, spanning two years (April 2024 – May 2026) and used a mixed-methods, theory-based approach. It included three key components: a process evaluation, an impact evaluation, and an economic evaluation.

This is the final report of the evaluation of the Suspected Inflicted Head Injury Service (SIHIS) (pilot 3)[3]. DfE is the primary user of this evaluation. The evaluation will support DfE's Family Justice Policy team's decision-making on whether to roll out the pilot intervention nationally, by advising NHS England on scale-up of the SIHIS.

Further users of the evaluation include pilot implementers (agencies and stakeholders involved in implementation), other agencies involved in the family justice system, and NHS Trusts and hospitals not involved in this pilot. The evaluation provides learning and insight to support future delivery of the intervention and may inform decision making within the wider system regarding this.

Structure of this report

The report is structured as follows:

- Section 2 presents an overview of the SIHIS pilot and its theory of change (ToC);
- Section 3 presents details on the evaluation methodology, fieldwork implementation and analysis;
- Section 4 presents the evaluation findings, structured around the Key Evaluation Questions (KEQs);
- Section 5 contains our conclusions.

[3] The Verian consortium also produced final reports for the other two pilots: Verian, Alma Economics and NCB (2026). Evaluation of pilots to reduce unnecessary family court delays - Designated Family Judge Trailblazer Final Report; and Verian, Alma Economics, and NCB (2026) Evaluation of pilots to reduce unnecessary family court delays - Pre-Case Management Hearing Meetings Final Report.

A separate technical annex accompanies this document. It includes

- Annex A: KEQs and sub-questions
- Annex B: Evaluation matrix
- Annex C: Documents reviewed for this report
- Annex D: Monitoring data
- Annex E: Technical detail on primary data collection for the process and impact evaluations
- Annex F: Technical detail on cost benefit analysis
- Annex G: Expert panel composition
- Annex H: Decision not to interview families for this evaluation

2. Context: The Suspected Inflicted Head Injury Service (SIHIS) pilot

This section provides an overview of the initiative evaluated in this report: the SIHIS pilot. The pilot was developed and funded by the DfE. It aimed to help to reduce unnecessary delays in family court proceedings through the introduction of a new multidisciplinary NHS clinical service – the SIHIS.

Lengthy case durations for public law cases are a serious problem in the family courts system. Longer cases mean increased risk of physical and emotional harm to children, and higher costs for the taxpayer (Mutual Ventures, (2022), p4[4]. In 2014, a statutory 26-week time limit was introduced for care and supervision proceedings to encourage reduction in case durations – this is called the Public Law Outline (PLO). However, the average case duration remains consistently high, at 36 weeks in 2024, with significant regional and local variation. For example, in December 2024, the average duration ranged from 24 weeks in Wales to 53 weeks in London (National Audit Office (2025), p6. The DfE and others have undertaken work[5] to identify the causes of unnecessary delays in the system, and this pilot, along with others funded by the DfE, is aimed at reducing some of those causes.

In the remainder of this section, we describe how the SIHIS intervention was intended to work, and how it was expected to contribute to the aim of reducing unnecessary delays in the courts.

SIHIS provided a streamlined model for assessment of suspected inflicted head injuries of 0- to 8-year-olds, prior to a decision as to whether a case should be escalated to court. The pilot established a multidisciplinary team (MDT) of clinicians, led by a named lead paediatrician and including the following disciplines: safeguarding paediatrician, paediatric radiologist, neurosurgeon, neuroradiologist working in paediatrics, paediatric ophthalmologist, haematology, and genetics. The pilot also established a standardised process for completing SIHIS reports using a proforma template provided by DfE. This was a departure from usual practice, whereby court staff receive multiple reports from individual clinicians.

The MDT of clinicians provided senior-level medical opinion on the cause of head injuries in children arriving at hospital where there was reason to suspect abuse, with the aim of providing a faster assessment. The SIHIS followed a systematic approach to assessing suspected inflicted head injuries:

[4] Recent modelling suggests that each one-week reduction in average proceedings duration could generate a financial cost avoidance of approximately £24 million across all English local authorities
[5] For example, in 2023, DfE commissioned Mutual Ventures to undertake this study: https://www.mutualventures.co.uk/care-proceedings

- The MDT of clinicians met to conduct an initial assessment. The assessment was documented in the proforma template. The MDT meeting and completion of the proforma were coordinated by a designated administrator.

- As per statutory child safeguarding procedures, if abuse was suspected, a multi-agency strategy meeting determined if legal processes were needed.

- If participants in the strategy meeting agreed that the threshold for Section 47 enquiries had been met[6], the SIHIS team sent the completed proforma to the local authority where the child was residing as evidence to be used in the family care proceedings.

- If the case proceeded to court, court staff could approach the SIHIS team for clarification regarding the medical assessment via a single point of contact – the designated administrator.

The pilot was implemented in three NHS Trusts selected by DfE against a set of pre-identified criteria. Total grant funding of £586,697 was provided to the three Trusts combined. The three Trusts were:

- Sheffield Children's NHS Foundation Trust (Sheffield Children' Hospital)
- Birmingham Women and Children's NHS Foundation Trust (Birmingham Children's Hospital)
- Manchester University NHS Foundation Trust (Royal Manchester Children's Hospital)

Implementation was supported by core DfE team members and two seconded NHS clinicians appointed by DfE. DfE spent £105,934 (inclusive of VAT) on staff to support the pilot.

A ToC demonstrating how the pilot was expected to help reduce unnecessary delays in family court proceedings was developed in collaboration with DfE, the Expert Panel and key stakeholders, at the start of the evaluation. This original ToC, developed before pilot implementation, can be seen below in Figure 1. The ToC was tested and refined during the evaluation.

The ToC posited that improved quality and transparency of clinical information, in the form of a single assessment report, would facilitate faster and better-informed court decision-making, including a reduction in the overall number of Part 25[7] medical assessments requested for each case. These outcomes were expected to help to reduce unnecessary delays in the courts. It was also expected that the SIHIS would result in more cases being correctly classified as non-abusive and diverted away from court,

[6] A Section 47 enquiry (under the Children Act 1989) is an investigation by local authorities into suspicions that a child is suffering, or likely to suffer, "significant harm", and to determine whether protective actions are necessary.
[7] A Part 25 expert refers to an expert witness, such as a medical expert, a psychologist, or an independent social worker, instructed by the court to provide an independent and impartial report under Part 25 of the UK's Family Procedure Rules (FPR).

thereby reducing the pressure on courts and further reducing delays. These efficiency gains were also expected to help to reduce costs for local authorities and courts. It was also expected that information contained in initial SIHIS reports would enhance understanding and facilitate decision-making across staff in relevant agencies – local authority social work and legal teams, the police and court staff – thereby improving multi-agency communication and collaboration.

Families were expected to benefit primarily through shorter case duration. Some would also benefit where clear medical opinion identified accidental causes of head injury and an unnecessary court case was avoided.

Alongside the pathways expected to reduce unnecessary court delays, it was hoped that the collective working environment provided by the pilot could improve the experience of NHS clinicians involved in providing evidence in cases that can be experienced as traumatic, and eventually encourage more clinicians to take on court work.

Finally, it was expected that by the end of the pilot, the three Trusts would have developed a consistent approach to assessment and reporting through the SIHIS, thereby providing a model which can be rolled out for other injuries and across other Trusts.

The pilot was expected, in the long-term, to contribute to improved care outcomes for children (for example, through fewer placement moves if case durations were reduced), and to a wider pool of NHS clinicians able to work on family court cases involving traumatic injuries.

Figure 1: Original ToC guiding the evaluation

<table>
<tr><th>Activities</th><th>Change mechanisms</th><th>Intermediate outcomes</th><th>Pilot outcomes</th><th>Impacts</th></tr>
<tr>
<td rowspan="4">SIHIS implemented in 3 Trusts: assessment by MDT; proforma drafted; multi-agency Strategy Meeting to determine if legal processes are needed; proforma completed if case progresses, and sent to local authority and court
Administrator coordinates SIHIS, lead paediatrician provides quality control.

Wellbeing support for clinicians providing testimony in court.

Learning and support activities across Trusts
Ongoing support from secondees.</td>
<td><u>PATHWAY 1: Local authority and court processes</u>
Senior clinicians collaborate and use standardised proforma template to produce single assessment report for the court.

Clinicians provide clearer, single opinion to the court on cause of injury based on multidisciplinary working and collective responsibility.

Court staff able to work more efficiently due to single point of contact provided by SIHIS.</td>
<td>PATHWAY 1:
Improved quality and transparency of information provided to LAs, courts, police.
Fewer further Part 25 medical expert assessments requested, reduction in associated waiting times.
Faster and better-informed decision-making by the court.
More cases deemed not abusive diverted from court.</td>
<td rowspan="2">Reduced costs for courts and local authorities.

Reduction in unnecessary delays in family court proceedings.

Improved family experience of the system.</td>
<td rowspan="4">Improved care outcomes for children, e.g. fewer placement moves.

Wider pool of NHS clinicians with interest and expertise in child social care and court processes.</td>
</tr>
<tr>
<td><u>PATHWAY 2: Multi-agency collaboration</u>
Staff across agencies attend multi-agency Strategy Meetings to enhance their understanding of cases and share decision-making.</td>
<td>PATHWAY 2:
Improved multi-agency collaboration and communication.</td>
</tr>
<tr>
<td><u>PATHWAY 3: Clinician wellbeing</u>
Clinicians have collective responsibility for assessment, and are supported in a group setting.</td>
<td>PATHWAY 3:
Increased confidence, and reduced anxiety, among clinicians working on traumatic cases
Improved clinician wellbeing.</td>
<td>PATHWAY 3:
More clinicians interested and willing to take on court work.</td>
</tr>
<tr>
<td><u>PATHWAY 4: Pilot model</u>
Trust staff and strategic stakeholders apply learning from across Trusts to strengthen pilot implementation and model for potential rollout.</td>
<td>PATHWAY 4:
Consistent medical assessment and reporting across pilot Trusts.</td>
<td>PATHWAY 4:
Model for potential rollout for other injuries and across NHS Trusts.</td>
</tr>
</table>

3. Evaluation methodology and implementation

Evaluation objectives and approach

In line with client requirements, this evaluation had three main objectives:

1. To understand how the pilot was designed and implemented, and how acceptable it was to key stakeholders.

2. To assess whether, how, and why the expected outcomes — outlined in the ToC — were achieved.

3. To evaluate the pilot's likely value for money (VfM) through a comprehensive, ex-post cost-benefit analysis (CBA).

As agreed with DfE, to meet these objectives we designed and employed a rigorous theory-based, mixed methods approach. At the core of this approach was the pilot ToC (shown in Figure 1), which outlined how stakeholders expected the pilot to generate change. The ToC guided our data collection and shaped our analysis of how activities led to outcomes. It set out expected outcomes, mechanisms of change (the pathways linking activities to outcomes), and contextual factors that enabled or hindered progress.

Over the course of the evaluation, the ToC was tested and refined to reflect how the pilot worked in practice. Evidence was gathered on:

- Activities delivered by the pilot.

- Outcomes triggered by the activities, as perceived by interviewees.

- Mechanisms of change: The shifts in knowledge, attitudes, behaviours, and processes which underpinned outcomes.

- Contextual factors: Factors such as organisational culture, inter-agency relationships, workforce stability, and system constraints (e.g. judge availability) which affected pilot delivery and outcomes.

Our mixed methods approach allowed us to triangulate primary and secondary, quantitative and qualitative data from multiple sources to build a credible narrative.

The evaluation comprised three interlinked components:

- The process evaluation focused on how the pilot was designed, implemented, and accepted by key stakeholders, drawing on interviews to capture staff perceptions of implementation and acceptability.

- The impact evaluation examined our interviewees' perceptions of whether and how expected outcomes were achieved, the causal mechanisms underpinning the outcomes, and contextual factors which enabled outcomes to be realised.

- The economic evaluation used breakeven analysis to assess the extent to which the pilot would have to reduce court durations in order to represent good VfM. The CBA used cost data from the pilot and data on projected benefits from the impact evaluation and the wider literature.

We planned to conduct quasi-experimental analysis using administrative data provided by His Majesty's Courts and Tribunals Service (HMCTS) to demonstrate the estimated reduction in case durations attributable to the pilot. This analysis was also intended to provide estimates of the effect of the pilot on key intermediate outcomes that could contribute to reduced case durations[8]. However, it was not possible to conduct the analysis because the number of eligible cases processed by the three Trusts (n=32) was too small to support meaningful estimation, and relevant identifiers were not captured in the dataset that would have been used for the analyses.

The lack of quantitative data from the impact evaluation meant that the planned CBA was replaced with breakeven analysis (i.e. an estimate of the reduction in average case duration needed to neutralise the costs of the pilot).

Evaluation questions

The overarching key evaluation questions (KEQs) are shown below. They are organised by the evaluation components outlined above, followed by a summative KEQ. The detailed sub-questions for each KEQ are shown in Annex A.

Process evaluation

1. How was the SIHIS set up and implemented by the NHS Trusts?
2. What were the barriers and facilitators to implementation of the SIHIS?
3. Is the SIHIS pilot acceptable to key stakeholders (Trusts, families , other organisations affected by the pilot)?

Impact evaluation

4. What do key stakeholders (e.g. leaders, practitioners, and families) perceive as outcomes of the pilot? How do they believe the outcomes came about?
5. What does the refined pilot ToC look like?

[8] Number of assessments requested and associated waiting times; number of cases deemed not abusive diverted from court; and timeliness and accuracy of court decision-making.

6. What, if any, were the unintended consequences (positive and negative)?

Economic evaluation

7. To what extent does the pilot represent value for money?
8. How do cost reductions caused by the pilot vary by group, e.g. between court costs and costs faced by local authorities and households?

Summative KEQ

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

Data sources

The evaluation drew on a wide range of secondary and primary data sources, described below, to answer the KEQs and test the ToC. The evaluation matrix in Annex B shows which sources were used to respond to each KEQ.

Secondary data

Secondary data were central to the process end economic evaluation components. Data include documents related to the pilot, monitoring data provided by the Trusts, and published evidence. Each type of data provided a different lens through which pilot design, implementation, and potential benefits could be understood.

Pilot documents

Pilot documents provided insight into the design and delivery of the pilot. We mostly analysed these documents to identify implementation fidelity of the pilot. Annex C provides a summary of pilot documents we reviewed.

Monitoring data

Monitoring data from implementers provided insights into pilot activities, outputs, the role of the seconded clinicians, and associated learning and support activities. Monitoring data used in the evaluation are shown in Annex D.

Evidence from literature

For the economic evaluation, we used evidence from the literature to estimate potential long-term and indirect benefits such as cost savings to the public sector and families, and improvements in child wellbeing associated with reduced delays in family court proceedings.

Primary data

Primary data played a key role in generating rich, contextualised insights into how the pilot was implemented and perceived, as well as capturing perceived outcomes not available through secondary data.

In depth interviews

We conducted in-depth, semi-structured interviews with pilot implementers and others affected by the pilot in sampled locations. The interviews explored individual and organisational implementation experiences, acceptability, perceived outcomes and unintended consequences, mechanisms and contextual factors underpinning outcomes, and learning for potential rollout.

Evidence received by email

We received evidence by email from one judge via contact with an HMCTS executive.[9]

Evaluation implementation

This section summarises the research activities that were implemented to generate and analyse the evidence we used to address the KEQs. This is in line with the final approach developed and formally agreed with DfE in the extensive design phase. Where the approach has evolved since the sign-off of the inception report, this is explicitly flagged in the final sub-section.

Primary data collection for the process and impact evaluations

Primary data for the process and impact evaluations was collected via interviews between February - April 2025, and November 2025 - February 2026. In the first round of data collection we focused on issues related to pilot design and implementation, facilitators and barriers to implementation, and pilot acceptability, alongside some preliminary data on outcomes. In the second round, we focused on outcomes and mechanisms, unintended consequences, and learning for rollout.

We conducted interviews in all three NHS Trusts, and in purposively sampled local authorities in which SIHIS patients resided. The local authorities were selected in

[9] The HMCTS Executive responded to a request for interview. He was not aware that the pilot was underway, and had seen no change on the administrative side (email, 9th December, 2025), so he was not interviewed. He forwarded information for the evaluation provided by a judge.

consultation with DfE. Details on the location sampling criteria and processes are set out in detail in Annex E. The selected local authorities were:

- Birmingham NHS Trust: Birmingham and Dudley
- Manchester NHS Trust: Salford and Tameside
- Sheffield NHS Trust: Sheffield and Doncaster

In total we interviewed 26 individual respondents (with five of these respondents from the NHS interviewed twice). Respondents included NHS clinicians, judges, Cafcass staff and one member of a local authority legal team. Details on the identification and recruitment of respondents for interviews, and the number and categories of interviewees, are set out in Annex E.

Primary data for the process and impact evaluations were triangulated across sources and stakeholders to capture multiple perspectives. The monitoring data were analysed using descriptive statistics. Qualitative data were analysed using thematic analysis via a Framework Approach, mapping and summarizing data from across interviews in line with the KEQs. Our data analysis followed an iterative process. The evaluation team engaged in weekly post-fieldwork debriefs during the fieldwork process and participated in an analysis workshop at the end of each stage of fieldwork.

Economic evaluation

In the absence of quantitative data on outcomes from the impact evaluation, VfM analysis focused on developing a structured methodology and modelling framework to assess costs and potential benefits, drawing on existing literature, available monitoring data, and informed assumptions.

In line with HM Treasury's Green Book guidance, the evaluation centres on the development of a social CBA model. Specifically, due to the lack of quantitative estimates of the impact of the pilot, the model utilises breakeven analysis. Breakeven analysis estimates the minimum reduction in case duration per case affected by the pilot that would be required to achieve cost neutrality. In other words, the minimum level of success (in terms of reduction in case duration) needed to generate a "break even" level of economic value equivalent to the total costs of designing and implementing the pilot. For the breakeven analysis, we compare pilot costs with the estimated benefits from reduced case duration assumed to occur.

Further detail on methodology, assumptions and modelling decisions is discussed in Annex F. This includes methods for estimating programme costs (both direct and indirect), financial savings from reduced court time, and broader societal benefits associated with reduced delays in care proceedings.

Expert Panel

We worked closely with an expert panel composed of five senior figures involved in family courts work and related areas. They included: a barrister; a Senior Advocate; a child and family social worker; an NHS Safeguarding Deputy Director; and an Assistant Director from Research in Practice, a leading research and evaluation provider in Children's and Adults Services. Short biographies of the expert panel members are provided in Annex G.

Expert panel members contributed to our evaluation design and ToC, reviewed and commented on our evaluation findings, and worked closely with us on the final evaluation outputs.

Limitations

This evaluation faced several limitations.

First, participation in interviews was lower than we aimed for. We interviewed only one staff member from Cafcass, and one from a local authority in which several SIHIS patients reside. We did not secure any interviews with administrative staff working in the family courts. As a result, our findings primarily reflect the perspectives of NHS staff; we have little insight into the views of local authority, Cafcass and administrative court staff on implementation, acceptability and outcomes (KEQs 1, 2, 3, 6, 7, and 8). This led to inconclusive findings on a small number of outcomes. It may have introduced bias into our findings, as it is possible that court-related staff, and staff affected downstream where SIHIS patients reside, would have had a materially different view on the pilot.

These gaps occurred despite a comprehensive recruitment effort. With support from DfE, we developed a contact list of possible interviewees in each selected area. We started recruitment early, four weeks before the planned start of data collection. We also extended data collection beyond the initial end date in order to accommodate scheduling difficulties. Potential participants were contacted across two recruitment rounds, with each round including up to three follow-up emails. We also liaised with Cafcass leadership to help facilitate recruitment and encourage participation. To increase the likelihood of engagement, we offered flexible interview times, and used a snowball sampling approach, asking participants to suggest additional contacts who may be able to contribute. After several weeks of recruitment activity, we sought further support from HMCTS to identify additional potential participants. Despite these efforts, few potential respondents outside the NHS came forward. This may reflect limited awareness or involvement in the pilot among some local stakeholders.

Second, families were not involved in the evaluation. Following discussions with DfE and experienced professionals, we chose not to interview families due to ethical concerns around re-traumatisation. This decision, outlined in Annex H reflected a shared judgment that the potential harm outweighed the likely benefit, given the limited number of families involved and the potential sensitivity of their experiences. Indirect insights into family experiences were also limited as most interviewees had minimal contact with families. While this has limited our ability to understand family views on the SIHIS, particularly its acceptability to them (KEQ3), clinicians reported that they did not usually mention SIHIS or describe it as a separate service, such that most families would not have been aware of the change in procedure.

Third, evidence on outcomes is based only on stakeholder perceptions of the outcomes they believe to have come about due to the pilot. We could not provide more robust quantitative estimates due to the small number of SIHIS cases. This limits the strength of our evidence on outcomes for which we planned to use HMCTS data (number of expert assessments, number of further CMHs (after the first CMH), and case durations) (KEQ4), as interviewees did not have access to verifiable data on these outcomes.

Fourth, we could not conduct a full CBA of the pilot due to the lack of robust quantitative data on the primary outcome, reduction in case durations. Instead, we have provided a breakeven analysis (KEQ7), demonstrating the number of weeks reduction in average case duration required to reach cost neutrality.

Changes to the original design agreed with DfE

As outlined earlier, we were unable to conduct the planned quasi-experimental analysis on case durations and associated intermediate outcomes due to the small number of SIHIS cases. This also meant that we conducted breakeven analysis to assess pilot VfM, rather than a CBA.

4. Evaluation findings

This section presents the findings from the evaluation, structured around the three core workstreams: process, impact, and economic evaluation. Together, these strands provide a comprehensive assessment of how the pilot was implemented, what it achieved, and the value it represents. In this findings section we present our evidence against each KEQ in turn. We then interpret the evidence from across the KEQs in the conclusion.

Process evaluation findings

The process evaluation findings are structured around three KEQs:

- KEQ1: How was SIHIS set up and implemented by the NHS Trusts?
- KEQ2: What were the barriers and facilitators to implementing SIHIS?
- KEQ3: Is the SIHIS pilot acceptable to key stakeholders (Trusts, families, other organisations affected by the pilot)?

KEQ1: How was SIHIS set up and implemented by the NHS Trusts? Was the SIHIS pilot implemented as set out in Application Guidance provided by the DfE? To what extent did implementation vary across the NHS Trusts and why?

KEQ1 Summary

- Participating Trusts were selected against pre-determined criteria and received grant funding and support from DfE and seconded clinicians.
- The Application Guidance developed by DfE was deliberately broad to ensure relevance to Trusts regardless of their size and set up. All three Trusts implemented SIHIS as set out in the guidance, except for minor deviations.

How was the SIHIS set up and implemented by the NHS Trusts?

The design of SIHIS was informed by DfE consultation with key stakeholders, including social workers, the Royal College of Paediatrics and Children's Health, the Family Justice Council including their Experts Working Group, local authorities, NHS England, and clinicians from the National Network of Named and Designated Healthcare Professionals for Children.

The pilot was implemented in three NHS Trusts between April 2024 and March 2025, with variation in the time taken for each Trust to get up and running. Trusts were selected against pre-identified criteria such as Care Quality Commission (CQC) ratings, having relevant clinicians available, and wellbeing support available. These criteria, as well as expectations regarding the SIHIS model and how it should be implemented, are detailed in Application Guidance documents made available to applicant Trusts. DfE provided a total of £586,697 grant funding for the set up and delivery of SIHIS, divided between the three selected Trusts.

Implementation was supported by core DfE team members as well as ongoing support from two appointed secondees. Trusts were also supported by a number of different meetings and forums (see Tables 2 and 3 in Annex D). These included:

- A site visit by DfE staff to each Trust
- Other technical meetings organised by DfE
- A SIHIS pilot peer review session bringing all Trusts together in December 2024
- Attendance of SIHIS clinicians at quarterly Northern Heads meetings, where two SIHIS cases were discussed at each meeting to facilitate cross-Trust learning.

Trusts collected monitoring data agreed in advance with DfE. The complete data are shown in Table 1 in Annex D. We summarise some key pieces of this data throughout the response to KEQ1 to illustrate how the pilot was implemented. The data reveal significant differences across Trusts on some variables. These differences were explored in interviews, but no consistent explanations emerged. We therefore put them down to the very small samples in each Trust.

Table 1 summarises the key activities delivered by SIHIS through the duration of the pilot. The total number of SIHIS cases varied from seven in Sheffield to fourteen in Birmingham. The mean number of MDT meetings per SIHIS case ranged from two in Birmingham and Manchester to three in Sheffield. The number of SIHIS reports completed during the pilot ranged from three in Manchester, to seven in Birmingham, with some Trusts in the process of completing further reports at the end of the pilot.

Table 1: Summary of SIHIS pilot implementation April 2024 – March 2025

	Birmingham	Manchester	Sheffield
Total number of SIHIS cases during the pilot	14	11	7

	Birmingham	Manchester	Sheffield
Mean number of MDT meetings per SIHIS case	2	2	3
Number of final SIHIS reports sent to court	7*	3**	5

Notes to table: *5 cases were ongoing at the end of the pilot, with SIHIS reports still to be submitted; **2 cases were ongoing at the end of the pilot, with SIHIS reports still to be submitted.

Source: Pilot monitoring data provided by NHS Trust Administrators.

Table 2 shows the mean number of different clinical disciplines contributing to all SIHIS reports produced by each Trust during the pilot – around five for each of the three Trusts. It also shows the mean number of individual clinicians (i.e. some of whom may represent the same discipline) contributing to all SIHIS reports produced by each Trust - varying from five in Birmingham to seven in Manchester.

Table 2: Number of different clinical disciplines and number of clinicians involved in completing SIHIS reports, by NHS Trust

	Birmingham	Manchester	Sheffield
Number of different clinical disciplines required for completion of each SIHIS report - mean per case	5.5	5	5.5
Number of clinicians who contributed to final SIHIS report – mean per case	5	7	6

Source: Pilot monitoring data provided by NHS Trust Administrators.

Finally, Table 3 shows the number of weeks from the first hospital visit by the patient to submission of the final SIHIS assessment report to court, by Trust. The mean number of weeks varies from 9.5 in Birmingham, to 21 in Sheffield.[10]

Table 3: Number of weeks from admission to hospital to production of final report to the court, by NHS Trust

[10] The significantly higher number in Sheffield is in part due to an outlier of 34 weeks for one case. Without this outlier, the mean number of weeks falls to 18 weeks – still higher than the other Trusts.

Number of weeks from admission to hospital to production of final report to the court	Birmingham	Manchester	Sheffield
Average (mean) weeks per case	9.5	10	21
Range across all cases	4-14	3-19	11-34

Source: Pilot monitoring data provided by NHS Trust Administrators.

Was the SIHIS pilot implemented as set out in Application Guidance provided by the DfE? To what extent did implementation vary across the NHS Trusts, and why?

In February 2024, DfE published guidance (DfE 2024a) to support applicant NHS Trusts to bid to take part in the SIHIS pilot and access grant funding. The guidance also provided key details to support successful applicants in their implementation of the pilot, by providing an outline of SIHIS model, and detailing key expectations such as how grant funding would be spent, timelines for delivery, clinicians expected to participate, and identification of team members to lead and coordinate the service. The process evaluation explored SIHIS stakeholder perspectives of the guidance materials, as well as the extent to which the guidance was followed.

Interviewees in strategic or leadership positions had on the whole engaged with DfE's guidance as they were often involved in the application process on behalf of the Trust. Not all clinicians and administrators were aware of the guidance, but this did not seem to affect understanding of expectations and compliance with the proposed model of delivery in each of the Trusts.

Interviewees who had accessed the guidance from DfE found it to be clear and agreed that the guidance was generally followed. The guidance was deliberately broad to ensure relevancy and appropriateness for all Trusts regardless of size or how the Trust was set up and considering the hope that the pilot would be rolled out to other Trusts after the pilot.

> "The initial guidance was kept fairly broad to allow the Trusts to implement how they wanted to do things without too much deviation from what they were already doing…What we wanted was the MDT would have specific people as part of it, and it would be formalised, and it would be run as a proper MDT…But we left it to them as to how they specifically implemented that". - *Clinician seconded to DfE*

This allowed Trusts to make key decisions about processes depending on their context, infrastructure and systems. For example, Trusts were left with scope for

agreeing their own approach in relation to the frequency of meetings, mode in which meetings were convened, and membership of the MDT beyond the identified core clinicians. This therefore led to variation in implementation while maintaining compliance with the guidance.

By the end of the pilot, all Trusts were delivering the core elements of the pilot as set out in the guidance:

- Identification of a named lead clinician to oversee coordination
- Regular MDT meetings
- Completion and submission of SIHIS reports using a proforma
- Providing local authorities and court staff with a single point of contact
- Using grant funding to appoint coordination and administrative support for the pilot – one of the ways in which the guidance suggested funding could be used.

There were a couple of deviations from the guidance. First, all Trusts had more than one lead clinician overseeing coordination; in Birmingham there were two leads and in Manchester and Sheffield there were three. Second, the guidance stipulated that the following clinical disciplines should contribute to the proforma/final report: paediatricians, neurosurgeons, neuroradiologists and safeguarding doctors. Table 4 shows the clinical disciplines contributing to completion of all the SIHIS reports prepared during the pilot in each Trust. While the data show that all three Trusts involved paediatricians, neurosurgeons, neuroradiologists, and a number of other disciplines as relevant to each case, the data provided by Manchester suggest that no safeguarding doctors were involved in the completion of any of their reports.

Table 4: Clinical disciplines contributing to final SIHIS reports, by Trust

	Birmingham	**Manchester**	**Sheffield**
Burns	X		
Emergency Dept	X		
Genetics		X	
Haematology	X	X	
Metabolics	X		
Neuroradiology	X	X	X
Neurosurgery	X	X	X
Obstetrics	X		

	Birmingham	Manchester	Sheffield
Ophthalmology	X	X	X
(General) Paediatrics	X	X	X
Radiology		X	X
Safeguarding	X		X

Source: Pilot monitoring data provided by NHS Trust Administrators.

Our findings also indicate ways in which Trusts delivered *beyond* the expectations outlined in the guidance. For example, Birmingham allocated funding for dedicated SIHIS wellbeing support for clinicians, beyond general support available to all staff members. According to monitoring data from Birmingham Trust, four clinicians received formal wellbeing support in the form of a 60-minute group debrief session facilitated by two staff members and a psychologist. Sheffield Trust extended the MDT membership invitation to all junior team members within relevant departments to support their learning and development.

> "We invite all of those teams who should be involved, if they wish to come or if there is a need for them to come, plus all their juniors…We review cases that have gone before and where there's follow up imaging, and sometimes we'll review some other cases like…accidental injury just to show to the juniors the difference." - *Clinician*

In addition, Manchester provided the full SIHIS service (cases discussed in MDT meetings and reported on using SIHIS proforma), and Birmingham provided a partial service (cases discussed in MDT meetings, not reported on using SIHIS proforma but advice provided) to other hospitals in their areas, such as district general hospitals (DGHs). These hospitals were technically out of scope for the pilot; by doing this, the reach of the pilot activity and beneficiaries was extended.

> "With this pilot, we wanted to make sure that…cases [from other hospitals] were included, which necessitated the general paediatrician at our Trust doing a face-to-face physical examination of the child. We ended up making a recommendation to send the patient to us and we'd do the full face-to-face assessment, and that was probably above and beyond what the guidance suggested." - *Manager*

KEQ2: What were the barriers and facilitators to implementing SIHIS?

KEQ2 Summary

- The main facilitators were administrative support, protected time for meetings, pre-existing MDT meetings, professional commitment, and support of the secondees and cross-site meetings organised by DfE.
- The main barriers were the structure of the initial proforma, the short length of the pilot, and limited engagement with neurosurgery.

What factors facilitated implementation, and how (includes seconded clinicians' support activities)?

Stakeholders in NHS Trusts identified the following factors as facilitators to implementation:

- Administrative support.
- Protected time for meetings.
- Pre-existing MDT meetings.
- High level of professional commitment.
- Support of the seconded clinicians and cross-site meetings organised by DfE.

Administrative support and protected time for meetings emerged as strong facilitators across Trusts. SIHIS meetings generate significant documentation requirements, including the collation of multidisciplinary input, the formatting and submission of the SIHIS report, and the management of meeting schedules and attendance. As such, dedicated administrative support relieved logistical pressure on clinical staff, with the time when administrators came into post often reported as a turning point that enabled Trusts to move from a challenging set-up phase to a smoother rhythm. Administrative staff acted as a single point of contact for others; by managing queries, scheduling, and coordination, they helped reduce duplication and made the system easier for everyone else to navigate.

> "We have administrative support which is extremely helpful…having a dedicated part of the team makes the process so much smoother." - *Clinician*

> "It was like all of a sudden you provided air traffic control, so the planes all know what they're doing. That was the biggest thing." - *Clinician*

By allocating a fixed, protected time slot for SIHIS meetings, teams were able to ensure that the right professionals were present and available. Protected time meant

that participation was not reliant on last-minute availability or squeezed into gaps between other clinical duties. Instead, SIHIS became part of the schedule - something that was expected, planned for, and attended - with the flexibility of cancelling if not needed that week.

> “We needed to have a date and time in the diary...we could then stand down as opposed to having to find time to meet on an ad hoc basis*.” - Clinician*

In Manchester and Sheffield Trusts, pre-existing MDT meetings enabled a smooth implementation of SIHIS. These pre-existing meetings allowed Trusts to integrate SIHIS into familiar routines, rather than having to build new systems from scratch. They reduced the need to coordinate new time slots or overcome resistance to another recurring meeting, although it is worth noting that the frequency, focus and membership of meetings changed. For example, prior meetings in Manchester took place between paediatricians and radiologists on a monthly basis and were not focused on head trauma specifically.

The pre-existence of these meetings also promoted staff buy-in among clinicians working in safeguarding, paediatrics and radiology, as the process felt like a natural extension of what was already in place rather than a disruptive addition, although for some specialisms such as haematology, neurosurgery and ophthalmology, the MDT meetings were new. One interviewee in Manchester highlighted that having pre-existing meetings allowed them to set up the SIHIS quickly.

> “I think the fact that we already had a tertiary safeguarding service was the primary reason we were able to just get on and do this very quickly.” - *Manager*

Finally, stakeholders in Birmingham and Manchester Trusts noted the high level of professional commitment as an important facilitator. Clinicians demonstrated a strong sense of responsibility to engage with the pilot which was crucial throughout in order to overcome barriers. For example, while Birmingham had to create a completely new meeting and the administrative support role was not filled until several months in, they found that the high degree of commitment from staff helped overcome these challenges.

> “It's been really well supported actually by all the different specialties involved...They've been happy to take part in conversations.” - *Clinician*

Although mentioned less frequently than the other factors described above, the support of the seconded clinicians’ and the cross-site meetings organised by DfE were seen as facilitators to implementation by some interviewees. Some Manchester stakeholders reported that one of the secondees (who works within their Trust) had

been helpful during pre-pilot discussions and throughout pilot delivery. They also appreciated Northern Heads meetings as an opportunity for discussion of cases and shared learning across the Trusts (for example on how to fill in the proforma) and benchmarking against other Trusts.

However, several interviewees had hoped for earlier and more frequent peer reviews with the secondees, with the only peer review session taking place in December 2024.

> "The original plan was that there would be monthly peer reviews between the different centres and that never happened. By Christmas time I was kind of going, what about our peer review?" - *Clinician*

Others felt, however, that this was appropriate, given the low number of cases assessed in the three SIHIS Trusts.

What difficulties/barriers did the Trusts face, were they overcome, and if so, how?

Stakeholders in NHS Trusts identified the following factors as barriers to implementation:

- Initial SIHIS proforma.
- Short duration of the pilot.
- Engagement with neurosurgery.

Stakeholders across Trusts perceived the initial SIHIS proforma as too long and repetitive (e.g. asking for a conclusion and executive summary), making it difficult to navigate and time-consuming to complete and have oversight on. The length of the proforma meant that in some cases stakeholders had been unable to provide a full report ahead of strategy meetings so had had to deliver an interim report instead. There were also complaints about the formatting and that completing the proforma seemed like wasted effort for cases that were not going to court. The barrier was overcome with the help of the secondees, and the final iteration of the proforma was seen as much more user-friendly.

> "The proforma was very, very long. For cases not going to court, there's a lot of effort for no obvious net gain." - *Clinician*

Stakeholders across Trusts consistently described the short duration of the pilot as a significant barrier to SIHIS achieving its full potential. They described the early weeks and months as being taken up with start-up tasks: recruiting administrative support, understanding the proforma, coordinating between specialities, and agreeing local processes. Many participants felt that the pilot was stopped just as it

was beginning to work and that more time was needed for the pilot to embed and for processes to become streamlined.

> “Towards the end we were much slicker...experience is everything.” - *Clinician*

Because the pilot ran for such a short period, many clinicians had exposure to only a small number of SIHIS cases (especially those clinicians on rotating schedules, such as Sheffield’s paediatric consultants ‘of the week’), reporting that that this made it harder to build confidence. Further, the limited length impacted the composition of the SIHIS team. For example, a stakeholder in Birmingham highlighted that, had the pilot been longer, they would have liked to include more radiologists from the Trust in SIHIS, but instead went ahead with just one radiologist. They expressed that two or three radiologists would have made for a more robust service and better coverage (for example during annual leave). Seconded clinicians commented that time lost during the pre-election and election period made the pilot even shorter and meant that no communication could go out to gain broader legal sector buy-in or explain the pilot.

Low engagement from neurosurgery was noted as a barrier in both Sheffield and Manchester and was not overcome in either location. In Manchester low engagement was attributed to intense workloads and scheduling conflicts, with interviewees emphasising it was not about a lack of commitment. In Sheffield, MDT meetings clashed with neurosurgeons’ weekly handover meeting. As a result, neurosurgeons did not attend the weekly MDT but instead input into SIHIS via the report. This was seen to dilute the value of the multidisciplinary approach, because their input had to be gathered after the meeting rather than as part of MDT discussions.

> “The handover meeting is the most important meeting we do that week...and we weren't going to leave it to come to the MDT.” - *Clinician*

Another Sheffield stakeholder suggested that, as neurosurgeons’ main employer was a different Trust (Sheffield Teaching Hospitals NHS Foundation Trust rather than Sheffield Children’s NHS Foundation Trust), they were not able to prioritise their work in the children’s hospital the way they would otherwise.

Differences in professional perspectives also emerged as a factor in one Trust. Some stakeholders noted challenges in engaging neurosurgery colleagues in safeguarding processes generally, while neurosurgeons reflected that their attitudes towards safeguarding were misunderstood, as they felt they were being asked to provide information that they felt was unrealistic. Issues relating to hierarchies were also raised, with some stakeholders mentioning a culture of deferring to neurosurgeons’ views.

KEQ3: Is the SIHIS pilot acceptable to key stakeholders (Trusts, families, other organisations affected by the pilot)?

KEQ3 has multiple sub-questions which together illustrate acceptability of the pilot to stakeholders. These sub-questions address issues of:

- relevance (whether the pilot can help to address the problem of unnecessary delays in the family courts)
- coherence of the pilot with existing organisational processes and systems
- resourcing for the pilot
- the level of buy-in to the pilot among stakeholders
- and family perspectives on the pilot.

KEQ3 Summary

- Relevance: SIHIS is considered a relevant approach to reduce unnecessary delays, although stakeholders in NHS Trusts see an improved medical service as the primary benefit.
- Coherence: SIHIS is coherent with existing services, especially in Trusts where there were MDT meetings in place beforehand.
- Resourcing: DfE funding was seen to be sufficient; there were some challenges with staff time for implementation.
- Buy-in: Interviewees from the NHS, Cafcass and the judiciary supported continuation of the approach, and rollout for other injuries and to other hospitals, although NHS staff felt that it cannot be sustained in its full form (e.g. production of a full SIHIS report) without funding. NHS staff reported some pushback among LA legal and social care teams.
- Families were not made aware of SIHIS and so had no experience of it as a distinct service.

Is the SIHIS perceived to be relevant to the problems being addressed (unnecessary delays in family court proceedings)?

Stakeholders from NHS Trusts agreed that in principle, SIHIS is relevant to the goal of reducing unnecessary delays in family courts. They felt that both key components of SIHIS were relevant to the goal: (1) the MDT, because it facilitated discussion and consensus-building and provision of a more rounded opinion to the courts; and (2) the proforma, because it collated all information into one report, making information more accessible and useful to other agencies.

There was agreement across Trusts and roles that SIHIS offered a faster and more streamlined process compared to before, when a lot of time was wasted on obtaining input from colleagues in an ad-hoc fashion, thereby potentially saving time in the

early stages of cases that progress to court. Nevertheless, they saw the primary benefit to be about providing a better medical service for children, with impact on family court delays forming a secondary benefit. Further, a few NHS interviewees raised reservations that SIHIS can only reduce unnecessary delays if it is valued by other agencies, expressing concern that courts and legal teams were not fully bought in or had not adapted to the model.

> “I think it's a better quality of service for the children that we're supporting, and I think that goes well beyond [the] family court[s].” - *Clinician*

> “It should [reduce delays] if they have faith in our reports and use them as they were intended, but I’m not sure that they’re on board with that at the moment.” - *Clinician*

Is the SIHIS coherent with existing services and provision?

There was broad agreement among stakeholders from Trusts that SIHIS is coherent with existing services and provision, as it mirrors the aims of existing safeguarding practices and provides a structured way of doing what clinicians should already be doing, rather than forming a radically new approach. Stakeholders in Sheffield and Manchester, with their existing MDT meetings, reported the highest levels of coherence, whereas it was less of a natural fit in Birmingham were MDT meetings had to be started from scratch.

Is there sufficient resourcing for implementation of the SIHIS (staffing, budget, guidance etc)

Views on whether there was sufficient resourcing for implementation were mixed. The funding provided by DfE was seen to be sufficient, and many noted that dedicated SIHIS funding meant the Trusts could attract high performing individuals, including for management.

> “We appointed really high calibre, well performing individuals to manage the service...We've got the creme de la creme now with that dedicated resource.” - *Manager*

Many clinicians reported inadequate time for undertaking SIHIS work, as their SIHIS responsibilities were not integrated into their job plans and had to be undertaken in addition to their full-time jobs. Although there were opportunities to claim payment for working overtime, it was difficult for staff to accurately track the time spent on SIHIS, meaning that some staff were effectively working for free.

> “All that's been done is extra work on top of existing full-time jobs…We definitely would never have done this in a million years if we hadn't had a reason to.” - *Clinician*

Is there broad buy-in to the SIHIS across stakeholders? Are there any objections to continuing implementation of the SIHIS after the pilot ends and without pilot funding?

All interviewees from the NHS, Cafcass and the judiciary supported continuation of the approach, and rollout for other injuries and to other hospitals. Interviewees from Cafcass and the judiciary found the SIHIS report useful for understanding the case. One judge suggested that the SIHIS would be especially valuable if the service covered other hospitals with less clinical expertise in identifying potential non-accidental harm than the hospitals covered by the large Trust selected for the pilot.

Buy-in to SIHIS was generally strong among NHS interviewees. They saw the model as an improvement on previous safeguarding processes and even where challenges (e.g. workload, form usability, resourcing) were raised, these did not undermine their support for the core aims of SIHIS. NHS staff caveated that it would not be possible to continue implementing SIHIS in its full form without funding; while there was broad appetite for continuing the MDT meetings, production of the full SIHIS report as per the proforma was considered unsustainable due to its time-consuming nature and the lack of administrative support to coordinate it, with a few suggesting they could continue with a less comprehensive version.

> "I think the majority of us will want to carry on with the MDT, which is something we can do without huge impacts on our workload. However, the proforma report writing is very time consuming, and without extra funding that might not be as comprehensive." - *Clinician*

Despite this, there were objections to the model among some interviewees in the NHS Trusts. A few were concerned that the SIHIS report was meant to 'stop' the need for expert witnesses and emphasised that it should not replace expert witnesses. This suggests a lack of clarity among a few NHS interviewees on SIHIS' aim to reduce, rather than replace, expert witnesses.[11] A neurosurgery stakeholder expressed that they would support continuation on the understanding that they would only provide facts and not speculate on mechanisms, suggesting a lack of buy-in to the purpose (to provide an opinion, not simply what can be observed).

Some NHS stakeholders reported a perception of low buy-in to SIHIS among local authority legal teams and courts. In Sheffield especially, NHS interviewees felt that SIHIS reports were not valued by the courts, and that SIHIS was perceived among legal stakeholders as a threat to established expert witness processes. They attributed this to a perceived lack of involvement of the legal sector in SIHIS design, alongside poor early communications about the pilot.

[11] See further discussion on this under KEQ4 (intermediate outcomes, pathway 1).

NHS clinician views on buy-in among local authority social care staff with whom they had contact were inconsistent. Some reported that social workers found the SIHIS reports helpful. Others noted resistance when conclusions from the SIHIS introduced uncertainty in relation to suspected inflicted injury or differed from initial safeguarding assumptions.

We do not have sufficient evidence from local authority teams and court staff to compare to NHS staff perceptions, although the judges we interviewed were supportive of the pilot service.

Based on information from those working closely with families, was the SIHIS acceptable to families, did they have any objections to its continuation beyond the pilot phase?

A consistent finding across Trusts was that families were not explicitly informed that their cases were being reviewed through SIHIS. Clinicians reported that while they may discuss medical concerns or safeguarding assessments with the family, they did not usually mention SIHIS by name or describe it as a separate service and did not see the need to do so. This means that most families likely experienced SIHIS as part of the usual safeguarding process, not as a distinct intervention.

While families may not have been directly aware of SIHIS, some stakeholders in NHS Trusts believed that the clarity, confidence, and structure provided by the process could improve families' experience if it led to faster decision-making.

However, where SIHIS reversed earlier assessments through conflicting clinical opinions it led to mixed messages and created distress. This suggests that families should be made aware of an MDT approach at the first presentation of injury, rather than a sole clinician discounting the possibility of suspicion and then needing to go back to the family and reverse the opinion after further discussions have taken place.

> "If you've got a patient that you've seen and made a decision about, and then later on somebody comes with a different view, by that point the patient and their family may have gone home...That actually happened with the second case, that we had to phone them and say we were happy, but someone else has looked and we're not so happy about this anymore." - *Clinician*

Impact evaluation findings

The SIHIS pilot impact evaluation findings are structured around the following key evaluation questions:

- KEQ4: What do key stakeholders (e.g. clinicians, practitioners,) perceive as outcomes of the pilot? How do they believe the outcomes came about?

- KEQ5: What does the refined pilot ToC look like?
- KEQ6: What, if any, are the unintended consequences of the pilot (positive and negative)?

As described in section 3 (methodology), it was not possible to conduct quantitative impact evaluation due to the small number of SIHIS cases. The impact evaluation is therefore based on stakeholder perceptions collected during interviews, in line with the theory-based evaluation approach.

KEQ4: What do key stakeholders (e.g. leaders, practitioners, and families) perceive as outcomes of the pilot solutions? How do they believe the outcomes came about?

KEQ4 Summary

- Interviewees believed that the following intermediate outcomes on the pilot ToC had, to some degree, been achieved: improved quality and transparency of information provided to local authorities, courts, police; fewer Part 25 medical expert assessments requested, and reduction in associated waiting times; faster and better-informed decision-making by the court; more cases deemed not abusive diverted from court; increased confidence and reduced anxiety among clinicians working on traumatic cases; consistent medical assessment and reporting across pilot Trusts
- They did not believe that the following intermediate outcomes had been achieved: improved multi-agency collaboration, and improved clinician well-being.
- In terms of expected pilot outcomes, interviewees felt that SIHIS had the potential to contribute to reduced costs for courts and local authorities and reduced case durations, as well as to improve the family experience of the courts, *if* relevant intermediate outcomes were realised, but that SIHIS would not lead to more clinicians interested to take on court work. In addition, they felt that the pilot had created a model for future rollout.
- Interviewees believed that the SIHIS could not contribute to either long-term impact on the ToC (improved care outcomes for children, a wider pool of NHS clinicians interested in child social care and court processes)
- Interviewees indicated a number of unexpected outcomes in the NHS: deeper knowledge of head trauma and enhanced learning about child protection and legal processes among clinicians; clarification of organisational safeguarding procedures; stronger relationships among disciplines; extension of the SIHIS to some DGHs in the Birmingham and Manchester areas; and improved clinical care for children.
- Contextual enablers of outcomes in hospitals included: existing safeguarding and child protection expertise; well-established safeguarding procedures; and strong collegiate relationships among clinicians.

KEQ4 has multiple sub-questions which together illustrate stakeholder perceptions of the changes which came about due to the pilot:

- To what degree do stakeholders perceive that the intermediate outcomes on the ToC were achieved?
- Were any intermediate outcomes not realised, if so, why?
- Were there other unexpected outcomes?
- How did the pilot generate the changes needed to reach the intended, or other, outcomes (mechanisms[12])?
- To what degree do stakeholders perceive that the pilot outcomes on the ToC were achieved? Were any not realised, and if so, why?
- Do stakeholders perceive that the pilot is likely to contribute to the long-term impacts shown on the ToC, or other long-term impacts?
- Were there other unexpected outcomes?
- Under what conditions did the pilot lead to the intended, or other unexpected, outcomes (contextual enablers)?

The changes examined correspond to the outcomes and impacts shown on the refined ToC in Figure 2.

Intermediate outcomes and mechanisms

For this question, we explore mechanisms and intermediate outcomes along four pathways on the ToC. The pathways represent clusters of linked mechanisms and outcomes. Each pathway is shown in a different coloured frame on the refined ToC in Figure 2.

The pathways are:

- Pathway 1: Local authority and court processes
- Pathway 2: Multi-agency collaboration
- Pathway 3: Clinician wellbeing
- Pathway 4: Pilot model

Pathway 1 Effect of the SIHIS on local authority and court processes

The ToC hypothesises that the following mechanisms/behaviour and practice changes:

- Senior clinicians collaborate and use standardised proforma template to produce single assessment report for the court

[12] These are the behaviour and practice changes incentivised by the pilot. We examine whether interviewees believe these came about and led to the expected outcomes on the ToC.

- Clinicians provide clearer, single opinion to the court on cause of injury based on multidisciplinary working and collective responsibility
- Court staff able to work more efficiently due to single point of contact provided by SIHIS

will lead to the following outcomes:

- Improved quality and transparency of information provided to local authorities, courts, police
- Fewer further Part 25 medical expert assessments requested, reduction in associated waiting times
- Faster and better-informed decision-making by the court
- More cases deemed not abusive diverted from court

Interviewees in NHS Trusts confirmed that the SIHIS brought together the views of a range of senior clinical specialists into a single assessment report for the local authority and the court, in contrast to the more fragmented approach that typically exists without SIHIS. They felt that the SIHIS process supported meaningful discussion, allowing them to test opinions, acknowledge uncertainty, and resolve disagreements, resulting in a clearer medical opinion on the cause of injury than was often provided without SIHIS, and higher quality and more transparent information to local authorities, the police and the courts. The MDT process often allowed clinicians to converge on a single opinion; however, if opinions on the cause of injury differed, this was reported.

> "We were producing better and clearer team information and highlighting when there was more than one opinion." - *Clinician*

All three judges who provided evidence indicated that SIHIS reports had been helpful to them, or that they had heard from other judges that the reports had been helpful, because they received what they perceived to be higher quality evidence than without the SIHIS, and because it was provided in a single report.

> "Having heard a few of these cases, the SIHIS report has always been helpful, particularly the expertly prepared summary." – *Judge*

> "Because it would bring together into one report all of the clinical reports which were sometimes spread across many reports or thousands of pages of medical notes [the judges] thought it was a wonderful idea…My feedback from the judges was that they found...[it] a very useful resource." - *Judge*

However, a legal professional in one local authority disagreed with these views. They felt that the information required in the SIHIS proforma was generally insufficient for the courts. They attributed the problem to the absence of consultation with legal

teams and court practitioners ahead of the pilot, adding that medics cannot be expected to know what information lawyers and judges need.

> "It's going to be very difficult [for] a group of medical experts to write a report for a different discipline. It would be almost impossible for me to write a report for clinical eyes, I've got absolutely no training in that." – *Legal professional*

All judges providing evidence for the evaluation, based on their own experience with SIHIS cases and feedback from colleagues, reported that judges presiding over SIHIS cases had requested fewer Part 25 experts than they tended to in non-SIHIS cases. This was because the SIHIS report gave them greater clarity from the outset on which Part 25 experts were relevant to the case.

> "You can really narrow it down to what the dispute is rather than going off in a scattergun approach in every possible direction." - *Judge*

All legal profession interviewees – judges and a local authority legal team member – insisted that SIHIS is not about eliminating Part 25 experts[13]. All judges stated that they and their colleagues had ordered relevant Part 25 expert assessments for all SHIS cases. They emphasised that a judge's right to request further evidence and opinion, and the parental right to a second opinion, are critical to the judicial process and the right to a fair hearing They felt that the suspicion and hostility towards the SIHIS among some members of the legal profession had come about because this key premise had not been clearly and widely communicated and understood. NHS clinicians were also aware of hostility and similarly attributed it to insufficient briefing of the legal profession and the courts.

Judges interviewed for the evaluation felt that SIHIS had contributed to faster and better-informed decision-making in the courts, because the SIHIS report helped them to get an 'earlier grasp' on the issues and to narrow down which Part 25 experts should be authorised by the court. Without SIHIS, judges would usually request an initial paediatrician report, and only then be able to determine which other clinical disciplines should be involved.

> "The SIHIS involvement has resulted in early investigations rather than these becoming apparent and then being carried out after Court appointed experts have reported." - *Judge*

One judge had heard from a colleague in the judiciary that having a single point of contact at SIHIS had allowed the court to work more efficiently.

[13] This was clearly set out by the DfE (DfE, 2024a; DfE, 2024b).

> "One of the judges…said they had had some questions, and they went back to the SIHIS lead and got the answers. Their view was that if they hadn't had that…they wouldn't have really known who to go to, to get it." - *Judge*

On the other hand, a member of a local authority legal team noted that SIHIS felt remote, with no clear means of communication between SIHIS clinicians and the local authority legal team or courts.

> "I didn't feel that I had a route…in to say, '…could [you] answer some questions. We felt like we're in different silos rather than part of an integrated process." – *Legal professional*

The ToC posits that the SIHIS could help to divert more non-abusive cases from court. Monitoring data provided by the Trusts (see Table 5) show that two SIHIS cases were diverted from court in both Birmingham and Sheffield, and five in Manchester. These data reflect the cases diverted from court after a Strategy Meeting had been triggered. They do not include cases which the MDTs deemed as accidental and therefore did not trigger safeguarding procedures. It is important to note that we cannot know whether or not these cases would have been diverted anyway, without the existence of the SIHIS pilot.

Table 5: Cases diverted from court across Trusts

	Birmingham	**Manchester**	**Sheffield**
Number (percentage of total) of SIHIS cases diverted from court	2 (15%)	6 (55%)	2 (29%)

Source: Pilot monitoring data provided by NHS Trust Administrators

Some NHS interviewees and a judge felt that SIHIS had led to cases being correctly diverted from family court proceedings that otherwise wouldn't have been. This was indicated to be because the opportunity for in-depth discussion across multiple specialists helped to resolve uncertainty and give clinicians greater confidence to classify cases as accidental where, in the absence of collective discussion, they might have erred on the side of caution. Clinicians in Manchester and Birmingham highlighted that the SIHIS had been particularly helpful for diverting cases which were assessed to be non-abusive from court in DGHs, because these hospitals tend to have less safeguarding experience, and so are more hesitant to classify a case as accidental. One judge noted that he had seen fewer suspected inflicted head injury cases, possibly due to the pilot.

> "Fewer suspected [inflicted] head injury cases have been issued, perhaps because the multidisciplinary team at the hospital has been able to identify those cases which are unlikely to be from abuse." – *Judge*

While the SIHIS may have helped to divert non-abusive cases from court, some clinicians indicated that MDT discussions were also instrumental in identifying potential abuse that might have been missed without those team discussions.

> "I think…there were more cases [where]…initially it may have been…accepted [as accidental] by one discipline, and when the rest of us got together we said, 'No, actually there's a worry here'". *Clinician*

This suggests that, rather than just diverting more cases deemed not abusive from court (as is posited in the ToC), the benefit of SIHIS may actually have been to ensure that cases arriving at hospital were more often correctly classified, i.e., more accidental cases were diverted from court, and more cases of potential abuse were identified and progressed to court. We cannot say what the net effect of the SIHIS pilot was on the number of cases progressing to court – whether the number of cases that progressed was lower or higher than it would have been without the pilot.

> "The sense was that…it was better at identifying whether cases were potentially abusive or not." - *Judge*

Pathway 2 Multi-agency collaboration

The ToC hypothesises that the following mechanism/behaviour and practice change:

- Staff across agencies use information from the SIHIS[14] to enhance their understanding of cases and share decision-making

will lead to the following outcome:

- Improved multi-agency collaboration and communication

Interviewees from Birmingham Trust believed that information in initial SIHIS reports helped to enhance understanding of cases and improve shared decision-making in Strategy Meetings.

> "I think it made decision-making much more simplified, and the [SIHIS] would have given the other partners like police,…children's social care, increased confidence in the decision." – *Clinician*

However, some NHS clinicians were not convinced that the courts used their evidence to improve their understanding in every case. Clinicians in Manchester and

[14] Note that this mechanism has been reworded. This is explained under KEQ5.

Sheffield were aware of instances when a local authority or court had requested a Part 25 expert assessment before receiving the SIHIS report, and clinicians in Sheffield commented that the courts had not approached them for further information or as witnesses, as was expected in the SIHIS design (DfE, 2024a).

> "I don't think we've been asked to provide further statements or to attend court in any of the SIHIS cases, which I would expect if we were being used as professional witnesses in these cases." - *Clinician*

Overall, NHS clinicians felt that even if information in the SIHIS report was used to enhance understanding of cases and shared decision-making, the existence of the SIHIS could not be expected to make a difference to multi-agency collaboration and communications, as the procedures for multi-agency working are complex and were not materially altered or affected by the SIHIS.

Pathway 3 Clinician wellbeing

The ToC hypothesises that the following mechanism/behaviour and practice change:

- Clinicians have collective responsibility for assessment, and are supported in a group setting

will lead to the following outcomes:

- Increased confidence, and reduced anxiety, among clinicians working on traumatic cases
- improved clinician wellbeing.

Clinicians confirmed that the collective responsibility for SIHIS assessments and the supportive setting of the MDT meetings generally translated into reduced anxiety and increased confidence among clinicians who provided medical assessments on traumatic cases. While this was especially true for clinicians with limited experience in safeguarding or medico-legal work, even the more experienced interviewees reported that the discussions increased their confidence around writing reports and engaging with legal processes.

> "There is really good support in the team. You know you're not working in isolation - I think that makes a huge difference." - *Clinician*

There was one exception among interviewees. Neurosurgery interviewees from one Trust reported increased anxiety from being asked to give opinions on mechanisms underlying head injuries which they did not feel comfortable with (see KEQ3[15]).

[15] See sub-question 'Is there broad buy-in to the SIHIS across stakeholders? Are there any objections to continuing implementation of the SIHIS after the pilot ends and without pilot funding?'

Views among NHS staff as to whether less anxiety and more confidence translated into improved wellbeing among clinicians working on traumatic cases were mixed and largely cautious. While one interviewee felt that the peer support in the MDT helped to improve wellbeing, others felt that this was insufficient to improve overall wellbeing, given the anxiety and distress associated with traumatic cases.

> "I think the team support to each other…people felt supported being the lead author on the report and felt… less isolated, and therefore I think probably there was some improved clinician wellbeing." *Clinician*

> "If [SIHIS] improved her wellbeing, I don't know…I suspect that's a bit of a leap." *Clinician*

Pathway 4 Pilot model

The ToC hypothesises that the following mechanism/behaviour and practice change:

- Trust staff and strategic stakeholders apply learning from across Trusts to strengthen pilot implementation and model for potential rollout

will lead to the following outcome:

- Consistent medical assessment and reporting across pilot Trusts

NHS clinicians believed that a consistent approach to assessment and reporting had been developed across the Trusts by the end of the pilot, albeit with local modifications to suit each setting, as was allowed in the guidance provided by DfE. There were reported to be inconsistencies in the way that the proforma was completed early in the pilot, but with the simplification of the template during the pilot, reporting became more consistent.

> "[We had] a unified approach, [although] I suspect there were local variations." - *Clinician*

As hypothesised on the ToC, this 'unified approach' was attributed to the sharing and learning about the pilot during 'Northern Heads' meetings of NHS Trusts, a peer review meeting, and other technical meetings organised by DfE (see KEQ1[16]) which staff from all three pilot Trusts attended.

Pilot outcomes

The ToC hypothesises that the pilot may contribute to the following pilot outcomes:

- Reduced costs for courts and local authorities

[16] See sub-question 'How was the SIHIS set up and implemented by the NHS Trusts?'

- Reduction in unnecessary delays in family court proceedings
- Improved family experience of the system
- More clinicians interested and willing to take on court work
- Model for potential rollout for other injuries and across NHS Trusts

While our interviewees could not comment with certainty on the effect of the SIHIS on costs for courts and local authorities[17], and on case durations, some from the NHS and the judiciary felt that higher quality information for the courts, a reduction in Part 25 experts and the waiting times for additional assessments, and the knock-on effect on hearings, could reduce both costs and case durations in some instances.

> "If…you reduced the number of Part 25 experts and then you reduced the length of hearings and the number of hearings, it has a very potentially significant cost advantage to the legal aid agency, to local authorities and to the court, and frees up time within the court estate to deal with other cases." - *Judge*

NHS interviewees believed that the SIHIS made the process of gathering information within the hospital faster, and that this should also contribute, at least in a small way, to reducing overall case duration.

> "I think…it probably reduced delays in our process…SIHIS provided [the] opportunity to very quickly agree what tests were required, what information was needed, how it was going to be obtained." – *Manager*

On the whole, NHS staff felt unable to comment on whether the existence of SIHIS had improved family experience of the courts system. Two interviewees from Birmingham Trust felt that the family experience could improve if SIHIS information was used to reduce the number of medical experts requested and associated waiting times, and to reduce legal challenges in court.

> "With SIHIS, that would reduce the time to come to a decision, therefore reduce their levels of anxiety." – *Clinician*

It is worth noting that, although not mentioned by interviewees, the better classification of cases in the hospital (as reported above under pathway 1) would improve the experience of some families by eliminating the distress of an unnecessary court case for cases assessed as accidental in the hospital that may have been classified as abusive without the SIHIS assessment.

[17] See also KEQ8 'How do cost reductions caused by this pilot vary by group, e.g. between court costs and costs faced by local authorities and households?'

While many clinicians reported that the SIHIS process had improved their confidence around providing medical assessment on traumatic cases, only one cited an instance of a fellow clinician showing an interest in taking on court work due to their experience in the SIHIS MDT. The remainder believed that SIHIS had not led to more clinicians becoming interested and willing to take on court work. They described court work as intimidating, adversarial, or outside their professional comfort zone, and some expressed that the premise of SIHIS leading to increased interest in court work was flawed. One interviewee suggested that the value of SIHIS for clinicians lay precisely in avoiding the need to appear in court, if possible, by offering a robust report that could be relied upon without further testimony.

> "We're all very nervous about going to court because it's not our safe space… I'd probably be more confident...[but] it wouldn't make me want to go." - *Clinician*

Interviewees from across NHS Trusts believed that by the end of the pilot the SIHIS model had been well tested and was suitable for rollout across NHS Trusts and for other injuries.

> "Yeah, we'd cracked it by the end. Everybody knew what they're doing, knew what…was expected of them. The MDT meetings were chaired really effectively. People turned up on time. We'd worked it out." – *Manager*

Long-term impacts

The ToC hypothesises that the pilot may, if implemented consistently over time, contribute to the following long-term impacts:

- Improved care outcomes for children, e.g. fewer placement moves
- Wider pool of NHS clinicians with interest and expertise in child social care and court processes.

NHS staff felt that, while SIHIS can help to improve the medical care of a child, it was too far removed from legal proceedings to have any effect on the care outcomes for children.

As the clinicians we interviewed did not believe that more clinicians were interested and willing to take on court work due to the pilot, they also did not believe that the pilot had contributed to a wider pool of clinicians with interest and expertise in child social care and court processes, or that it could do so with more time. One clinician pointed out that there is already a pool of designated doctors with appropriate expertise, but the courts do not make use of them, suggesting that there is not so

much a need to widen the pool, as there is for the courts to acknowledge and make use of existing clinical expertise.

> "There already is a pool of clinicians with interest and expertise in child social care and court processes…the designated doctors who work within provider and commissioning organisations…Unfortunately the courts do not recognise them and do not approach them for support and advice." *Clinician*

Unexpected outcomes?[18]

Interviewees identified a number of unexpected outcomes in addition to those already shown on the ToC. These outcomes are all related to improved medical care and safeguarding in NHS hospitals.

NHS interviewees indicated that MDT meetings served an educational function related to head trauma. In Sheffield, junior doctors were regularly invited to attend MDT meetings as part of their training. Even among more experienced clinicians, the meetings were described as a space to deepen knowledge of injury patterns, radiological interpretation, and thresholds for concern among specialities.

> "I feel like I've learned masses about abusive head trauma and the language to describe it…I could spot things on a CT and MRI now that I couldn't before." - *Clinician*

One interviewee from Birmingham highlighted learning for medical staff around child protection processes and legal processes.

> "I think there was learning for some of the staff involved about where their medical opinions fit into the child protection decision-making and…how their clinical opinion works within the wider context of a multi-agency decision for a child, including the subsequent legal process." – *Manager*

In Birmingham, the pilot was reported to have helped to clarify organisational processes around safeguarding, particularly who responsibility sat with for escalation of cases and for discharge decision-making.

Clinicians indicated that the pilot had, on the whole, helped to strengthen relationships across specialities in all three Trusts. This was of benefit to the clinicians involved in the MDT, professionally and personally, in their day-to-day work, and was seen as contributing to better care for children.

[18] Unexpected outcomes are any outcomes or effects from the pilot which were not included on the ToC,but can be seen as contributing to the primary aim of reducing unnecessary delays.

Although the pilot was intended to test the SIHIS in the three selected Trust hospitals, staff and patients in some DGHs in the Birmingham and Manchester areas benefitted from specialist SIHIS feedback, thereby extending the reach of the SIHIS, and underlining its value in medical care.

> "We had Bolton, for example, wanting to take part and their paediatrician wanting to present…it clearly demonstrated…just how much the NHS was crying out for this, because people had heard about it and [they were] saying, 'oh gosh, can we tap into this please?'" - *Clinician seconded to DfE*

Some clinicians and a judge suggested that an important outcome was the potential of the SIHIS to produce better clinical care for children.

> "Better clinical outcomes for the children, because…the multidisciplinary report would result in better identification of the source of the injury and how to treat it…we thought [this] was a huge benefit." - *Judge*

Contextual enablers

Staff from NHS Trusts identified a number of factors which they believed had helped generate some of the intermediate and pilot outcomes, as discussed above.

One factor was the existence of significant safeguarding and child protection expertise in each Trust, given that these three centres see a significant number of cases of possible abuse.

> "I think the fact that we deal with lots of child protection cases helped us, because we knew what we were doing." – *Manager*

The existence of established safeguarding procedures for rapidly escalating, and then managing, suspected cases of abuse in all three Trusts was also considered key. For instance, Birmingham Children's Hospital already had a safeguarding decision pathway detailing required investigations for head injuries in children under two prior to SIHIS.

One clinician indicated that strong collegiate relationships in their hospital helped with implementation of the SIHIS.

> "We…knew and respected each other's expertise, and that did make the whole process easier, particularly when it came to disagreements." – C*linician*

KEQ5: What does the refined pilot ToC look like?

KEQ5 Summary

- Changes to the original ToC are shown in the refined ToC diagram. Some of these changes are for clarity of expression.
- Stakeholder perceptions suggest that two intermediate outcomes, one pilot outcome, and both long-term impacts, did not come about due to 'theory failure' rather than 'implementation failure'.

Figure 2 presents a modified, post-evaluation version of the pilot ToC. The original ToC is shown in Figure 1. A brief explanation of the modifications follows the diagram. The full evidence underpinning these changes has been presented under KEQ4.

Figure 2: Refined pilot ToC for the SIHIS

Activities	Change mechanisms	Intermediate outcomes	Pilot outcomes	Impacts
SIHIS implemented in 3 Trusts: assessment by MDT; proforma drafted; multi-agency Strategy Meeting to determine if legal processes are needed; proforma completed if case progresses, and sent to local authorities and court Administrator coordinates SIHIS, lead paediatrician provides quality control. Wellbeing support for clinicians providing testimony in court. Learning and support activities across Trusts Ongoing support from secondees.	**PATHWAY 1: Local authority and court processes** Senior clinicians collaborate and use standardised proforma template to produce single assessment report for the court. Clinicians provide clearer opinion to the court on cause of injury based on multidisciplinary working and collective responsibility [AMENDED]. Court staff able to work more efficiently due to single point of contact provided by SIHIS.	**PATHWAY 1:** Improved quality and transparency of information provided to LAs, courts, police. Fewer Part 25 medical expert assessments requested, reduction in associated waiting times [AMENDED]. Faster and better-informed decision-making by the court. Cases more accurately classified as accidental or non-accidental [AMENDED]	Reduced costs for courts and LAs. Reduction in unnecessary delays in family court proceedings. Improved family experience of the system.	[ALL LONG-TERM IMPACTS REMOVED]
	PATHWAY 2: Multi-agency collaboration Staff across agencies use information from the SIHIS to enhance their understanding of cases and share decision-making [AMENDED]	**PATHWAY 2** [OUTCOME REMOVED]		
	PATHWAY 3: Clinician wellbeing Clinicians have collective responsibility for assessment and are supported in a group setting.	**PATHWAY 3:** Increased confidence, and reduced anxiety, among clinicians working on traumatic cases	**PATHWAY 3:** [OUTCOME REMOVED]	
	PATHWAY 4: Pilot model Trust staff and strategic stakeholders apply learning from across Trusts to strengthen pilot implementation and model for potential rollout.	**PATHWAY 4:** Consistent medical assessment and reporting across pilot Trusts.	**PATHWAY 4:** Model for potential rollout for other injuries and across NHS Trusts.	

A few of the modifications are for clarity of expression:

- Clinicians provided a clearer opinion on the cause of injury, but not necessarily a 'single' opinion if their opinions diverged
- The word 'further' has been removed in reference to Part 25 medical experts, because Part 25 expert assessments are different to the assessment provided by clinicians as part of SIHIS
- 'Staff across agencies attend multi-agency Strategy Meetings to enhance their understanding of cases and share decision-making' has been changed to 'Staff across agencies use information from the SIHIS to enhance their understanding of cases and share decision-making. This is because the change introduced by SIHIS is the availability of clinical information in a single report, not whether or not staff from agencies attend the Strategy Meeting.

We also moved some of the boxes and arrows on the ToC around for further clarity.

One intermediate outcome has been modified to more accurately reflect what was perceived to have happened by stakeholders:

- 'More cases deemed not abusive diverted from court' has been replaced with 'Cases more accurately classified as accidental or non-accidental'. This is because evaluation evidence suggests that the SIHIS resulted in more accurate classification of accidental cases – which can then be diverted from court - and of non-accidental cases which may then progress to court

Stakeholder perceptions suggest that some intermediate outcomes, one pilot outcome, and both long-term impacts, did not come about. This was because the premise on which they appeared in the ToC did not hold, rather than due to insufficient implementation time or shortcomings in implementation (i.e., theory failure rather than implementation failure):

- Improved multi-agency collaboration and communication. NHS interviewees did not believe that the SIHIS could be expected to make a difference to multi-agency collaboration and communications, as the procedures for multi-agency working are complex and were not materially altered or affected by the SIHIS.
- Improved care outcomes for children, e.g. fewer placement moves. NHS staff felt that, while the SIHIS can help to improve the medical care of a child, it was too far removed from legal proceedings to have any effect on the care outcomes for children.
- Improved clinician wellbeing. There was insufficient evidence to suggest that increased confidence and reduced anxiety among clinicians working on traumatic cases within the SIHIS led to overall enhanced clinician wellbeing.
- More clinicians interested and willing to take on court work. Interviewees from the NHS did not believe that the existence of the SIHIS had led to more clinicians becoming interested and willing to take on court work, as court work

is experienced as intimidating, adversarial, or outside their professional comfort zone.

- Wider pool of NHS clinicians with interest and expertise in child social care and court processes. Given the above point, interviewees did not believe that the pilot had contributed to a wider pool of clinicians with interest and expertise in child social care and court processes, or that it could do so with more time. One clinician pointed out that there is already a pool of designated doctors with appropriate expertise, but the courts do not make use of them, suggesting that there is not so much a need to widen the pool, as there is for the courts to acknowledge and make use of existing clinical expertise.

KEQ6: What, if any, were the unintended consequences (positive[19] and negative)? Who did the negative or positive unintended consequences affect?

KEQ6 Summary

- Interviewees did not identify any positive unintended consequences
- One negative consequence was identified - relationships among some professionals were negatively affected in one Trust, due to tensions engaging neurosurgeons in the MDT.

Interviewees did not identify any positive unintended consequences.

Despite the overall benefit of stronger relationships across specialities, relationships among some professionals were negatively affected in one Trust, due to the tensions created by the difficulties of engaging neurosurgeons in the MDT.

Economic evaluation findings

The economic evaluation findings are structured around two KEQs:

- KEQ7: To what extent does the pilot represent value for money?
- KEQ8: How do cost reductions caused by the pilot vary by group, e.g. between court costs and costs faced by local authorities and households?

[19] Positive unintended consequences are effects generated by the pilot which, although positive, would not directly contribute to the primary aim of the pilot, to reduce unnecessary delays.

KEQ7: To what extent does the pilot represent value for money?

KEQ7 Summary

- Due to the lack of quantitative data on reduction in case length from the impact evaluation, whether this pilot represented VfM is inconclusive.
- The total costs were £0.69 million, made up of funding for the three NHS Trusts and support staff costs.
- Given that there were 32 SIHIS cases across the three Trusts during the pilot, a decrease of 24.4 weeks in case length would have been necessary for the pilot to break even. This seems highly unlikely to have happened, since the average duration across the three NHS Trusts was 36 weeks in 2023/24, indicating that the pilot likely did not represent VfM.
- This conclusion on pilot VfM reflects unavoidable limitations in the CBA model: some potential benefits of the SIHIS could not be quantified and included in the model, and assumptions have been made where data were unavailable. These limitations may have depressed the VfM finding, such that fewer weeks reduction in case duration may have been needed in order to breakeven.

What are the social and economic costs of the pilot? What are the social and economic benefits of the pilot? What is the estimated benefit-cost ratio for the pilot?

Due to the lack of quantitative data from the impact evaluation on the reduction in case length attributable to the pilot, whether this pilot represented VfM is inconclusive.

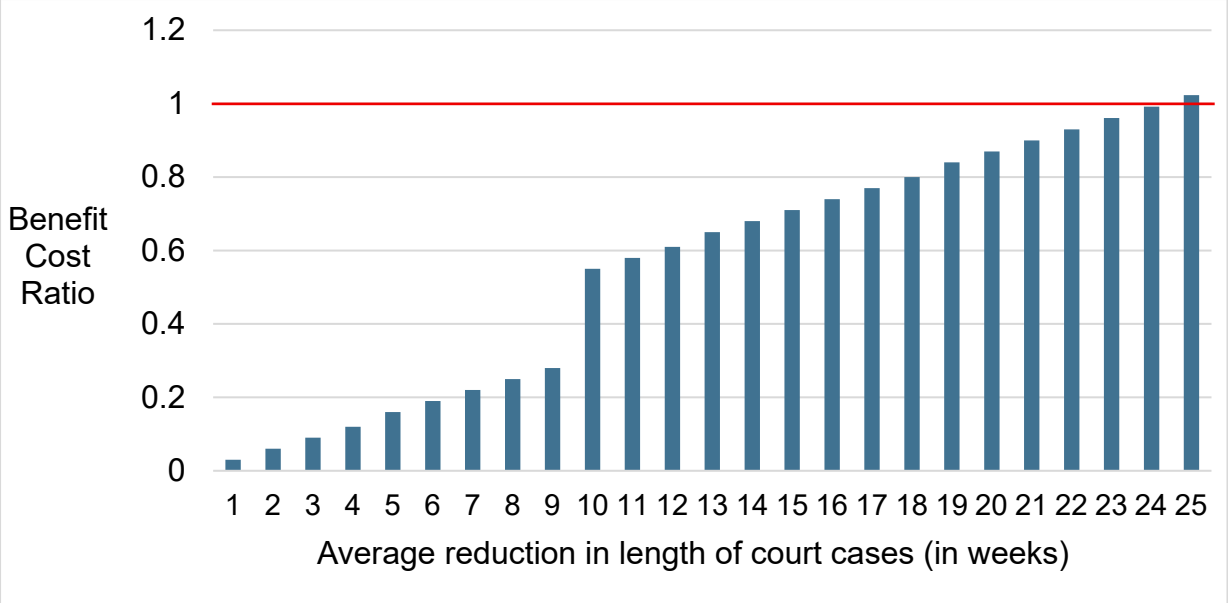
Figure 3 presents the benefit to cost ratios for different scenarios of average reductions in court case duration, based on the 32 SIHIS cases across the three Trusts. It shows that an average decrease of 24.4 weeks in case length per case affected by the pilot would be necessary for the pilot to have reached cost neutrality. As the average duration of cases across the three NHS Trusts was 36 weeks in 2023/24, a 24-week reduction would represent a significant decrease. Even though interviewees indicated that there may be time savings in some cases, a reduction of 24 weeks or more seems highly unlikely, indicating that the pilot likely did not represent VfM.

It is important to note that this analysis examines the breakeven threshold for the pilot intervention, which included only head injuries to children 0 to 8 years of age. In our conclusion, we explore the VfM implications if the SIHIS were to be extended within the three Trusts and/or rolled out to other Trusts/hospitals.

Within our model, the majority of benefits are cost savings to the local authorities associated with a reduction in case lengths and the number of hearings, including court running costs, legal staffing costs, and placement costs. However, under a 24-week reduction, there are also some benefits to households. These are driven by (i) a reduction in foregone income from fewer days spent in court, and (ii) a reduction in adverse outcomes leading to increased wellbeing and savings to public services.

Due to a lack of robust quantitative data from the impact evaluation, the model focuses on financial savings, with benefits to families intentionally presented conservatively. These benefits include improved children's wellbeing and reduced costs to public services due to children's adverse outcomes (e.g. poor mental health). A minimal reduction in case length is unlikely to generate meaningful outcomes for children and families. Therefore, we apply a conservative staggered framework to estimate benefits from reduced proceeding lengths and assume that the relationship between delay and outcomes is non-linear, with benefits increasing progressively as delays are further reduced. Annex F provides more detail on this assumption and the underlying evidence.

Figure 3: Benefit-cost ratio depending on the average reduction in case length



Source: Alma Economics analysis

Costs associated with the pilot

The three NHS Trusts received funding equating to £0.59 million in the pilot year. In addition, there were further costs for DfE support staff in both 2023/24 and 2024/25 (a total of £106,180 in 24/25 prices). In total, £0.69 million of public money was spent on the pilot. These costs are shown in Table 6.

Table 6: Pilot costs

Cost category	Amount (£) in 24/25 prices
Support staff costs 2023/24 (in 24/25 prices)	7,270
Support staff costs 2024/25	98,910
NHS Trust costs	586,697
Total	**692,877**

Benefits associated with the break-even analysis

Benefits from a reduction in case length can be separated into two categories: (i) financial benefits based on operational savings, and (ii) wider societal benefits from increased wellbeing and avoided costs to public services from a reduction in adverse outcomes. Fuller detail on the breakdown of benefits across groups is provided in KEQ8.

Table 7 outlines the benefits associated with the breakeven analysis. It shows benefits of £290,486 in placement cost savings, £234,045 in legal staff cost savings due to reduced case length and £110,581 in legal staff cost savings due to fewer hearings, £54,349 in running court cost savings, £850 in family foregone labour savings, and £2,565 in savings due to reduced adverse outcomes.

Table 7: Benefits associated with the breakeven analysis

Benefit Category	Costs per week / hearing (£)	Number of cases	Reduction in case length/hearing	Discount factor Year 1	Total Benefits (£)
Placement Cost Savings	386	32	24.37 weeks	96.5%	290,486
Legal Staffing Cost Savings (due to reduction in case length)	311	32	24.37 weeks	96.5%	234,045
Legal Staffing Cost Savings (due to fewer hearings)	3,581	32	1 hearing	96.5%	110,581
Running Court Cost Savings (due to fewer hearings)	1,760	32	1 hearing	96.5%	54,349

Benefit Category	Costs per week / hearing (£)	Number of cases	Reduction in case length/hearing	Discount factor Year 1	Total Benefits (£)
Foregone Labour Savings (due to fewer hearings)	27.54	32	1 hearing	96.5%	850
Savings due to reduced adverse outcomes (summed across the whole time horizon)					2,565
Total					**692,877**

Source: Alma Economics analysis

Additional benefits

In addition to the benefits quantified and monetised in the CBA model, there are other benefits that have been excluded due to a lack of robust evidence. This includes the potential benefit of cases being diverted from court, which may lead to cost reductions in terms of legal expenditures, and improved wellbeing for children and families. While 10 of the 32 cases were diverted after the production of a SIHIS report, in the absence of a counterfactual, we cannot assess the extent to which these diversions were attributable to pilot activities. These benefits may also be offset if some cases that would have been missed under business as usual were identified as potentially inflicted injuries by the SIHIS and progressed to court (as described under KEQ4). Therefore, we do not monetise these benefits.

Other benefits identified in the evaluation that were not monetised in the CBA-model included more accurate classification of cases, reduced clinician anxiety, reduced family distress, and more holistic medical care for children.

Model limitations

While the breakeven analysis provides an illustration of the estimated costs and benefits, it also has a few limitations. Firstly, in some places, the model relies on informed assumptions where data was not available. Therefore, changes to these assumptions could change the result of the breakeven analysis and the overall assessment of the pilot's VfM. Details on the assumptions used in the modelling and the evidence underpinning them are provided in Annex F. Second, a lack of robust evidence meant that some benefits, including those associated with diverted cases, more accurate classification of cases, reduced clinician anxiety, reduced family distress, and more holistic medical care for children, were not included in the model.

If these benefits could have been included, the pilot could have been shown to represent better VfM.

What might the costs look like if the SIHIS is rolled out?

While the exact costs of future delivery will depend on the number of cases and the time clinicians spend on each case, the cost per affected case is expected to decrease if the SIHIS is rolled out. This is because a portion of the costs incurred for the pilot were one-off costs associated with pilot design and set-up, including support staff costs borne by DfE, and initial staff training in two Trusts[20]. Our interviewees suggested that guidance and support should be provided for new SIHIS implementers. If this is done, there would be some further initial spend on support, but it would not need to be as high as the set-up costs for this pilot.

If the service were rolled out, the main ongoing costs would be implementing staff costs in each NHS Trust or hospital – an administrator, and clinicians who are part of the MDT. NHS interviewees were clear that the administrator role was key to effective implementation. Clinicians told us that the introduction of the SIHIS required additional time on their part, on top of existing workloads. They reported that completing the lengthy proforma was the most time-consuming element of the SIHIS for them, so lower reporting requirements would ease the additional burden on clinicians. It is also reasonable to assume that staff costs may fall over time due to efficiency gains as the service becomes embedded in each site.

KEQ8: How do cost reductions caused by the pilot vary by group, e.g. between court costs and costs faced by local authorities and households?

KEQ8 Summary

- Cost reductions to local authorities and courts make up the vast majority of cost reductions under a 24-week reduction in case lengths, with cost reductions to local authorities accounting for 91.7% of total cost reductions, and cost reductions to courts making up 7.8% of total cost reductions.
- Benefits to households are negligible under a 24-week reduction, contributing approximately 0.4% to total benefits.
- In addition, there are wider societal benefits (avoided public service costs) of £938.

[20] Cost data from the Trusts show that some initial staff training was provided in Manchester and Sheffield. In Sheffield this was for “Report Writing and Witness Skills Training”. No details on the type of training were provided by Manchester.

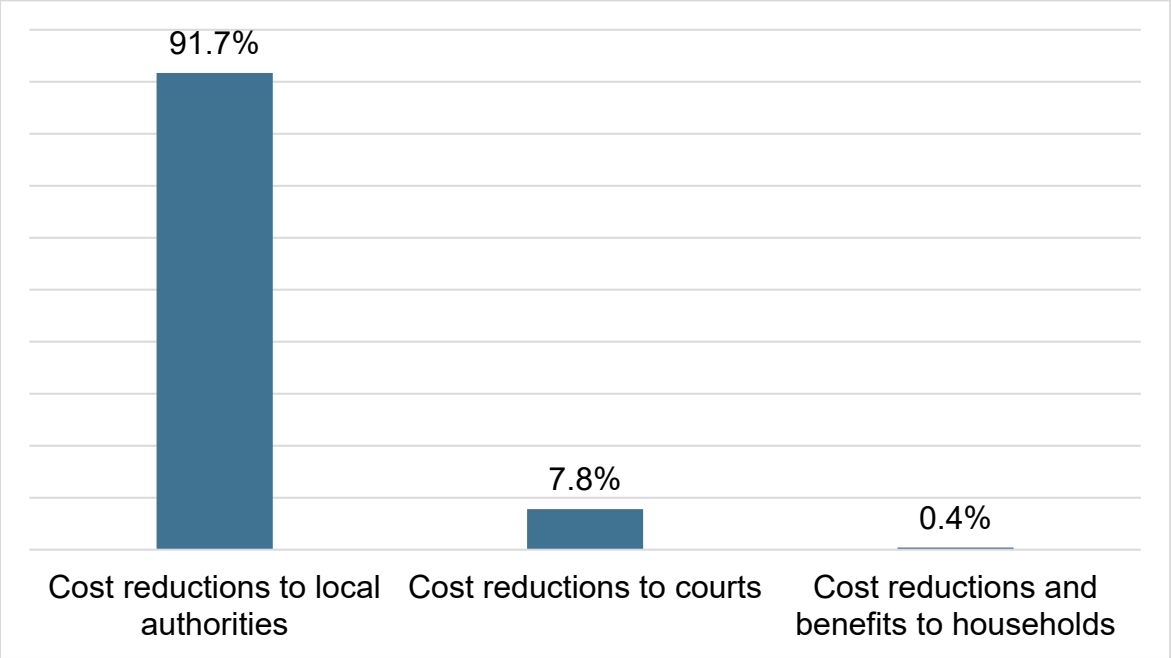
Due to the lack of quantitative data from the impact evaluation on the reduction in case length attributable to the pilot, we cannot assess how actual cost savings varied across households, local authorities, and courts. Instead, we use estimates from our breakeven analysis (with a 24-week reduction in case durations) to illustrate the proportion of cost savings attributable to each group. These estimates are shown in Table 7.

Operational cost savings to local authorities make up the vast majority of cost reductions associated with a reduction in case length. A 24-week reduction (the reduction needed to reach cost neutrality) in case length is associated with placement cost savings of £290,486 and legal staffing cost savings in local authorities of £234,045 for 2025/26. In addition to operational cost savings associated with a reduction in case lengths, there are also savings associated with a reduction in the number of hearings, accounting for £110,581 of total cost reductions for local authorities. In total, cost reductions to local authorities make up 91.7% of total cost reductions and benefits.

A reduction in the number of hearings also results in cost reductions for courts, driven by lower court running costs, accounting for £54,349 in total cost reductions under a 24-week reduction. In total, cost reductions to courts make up 7.8% of total cost reductions.

Cost reductions and benefits to households are estimated to account for less than 1% of total benefits under a 24-week reduction in case lengths. These are benefits from a reduction in foregone labour income (£850) and a reduction in adverse outcomes (£1627). There are also wider societal benefits (avoided public service costs) of £938. In the absence of quantitative evidence from the impact evaluation, estimates of wider societal impacts from wellbeing benefits to children and families are based on limited assumptions, and should be treated as conservative lower bound estimates. Figure 4 shows the proportion of cost reductions and benefits attributable to each category, under a 24-week reduction in case lengths.

Figure 4: Share of total benefits and cost reductions attributable to each group under a 24-week reduction in case lengths



Source: Alma Economics

Summative evaluation findings: learning to inform future rollout

KEQ9: What have we learned across pilot NHS Trust sites that can help to guide rollout of the SIHIS to other NHS Trusts/for other types of injuries?

KEQ9 Summary

- Considerations for rollout from interviewees included: clear guidelines and support for new NHS implementers; consideration to staffing in the NHS (administrative support and integration of clinician time); clear briefing and early involvement and consultation of staff in affected agencies (local authority teams, the police, and the legal profession); revisions to the SIHIS proforma; and suggestions for possible rollout models to include hospitals with less safeguarding expertise.

We reported on the level of support for SIHIS under KEQ3[21]. Here we summarise considerations for wider rollout identified by our interviewees, should DfE decide to scale up the SIHIS to other hospitals and/or for other injuries.

Interviewees felt that guidance and support for staff in other Trusts and hospitals will be fundamental to a successful rollout. The NHS staff we interviewed were aware that many hospitals have less safeguarding and child protection expertise and experience (largely because they see fewer cases of potential abuse), so they will need clear guidelines and support.

Staff from all three NHS Trusts indicated that there needs to be consideration as to how the SIHIS is staffed. All clinicians agreed that dedicated administrative support is essential to the smooth running of the SIHIS.

> "[We]…need administrative support because whenever we had a complex case that was multidisciplinary,…they would have responsibility for pulling together all the right people in a room really quickly." - *Manager*

One NHS interviewee pointed to the need to find a sustainable way to integrate clinician time on the MDT into existing job structures, rather than the 'drawdown' function of the pilot, whereby clinicians could claim for extra time working on SIHIS.

> "If it was to be more formal as part of an extension of SIHIS, I think the way it's staffed and funded would need some thought." - *Manager*

NHS staff and a judge pointed to the importance of clear briefing and early involvement of other agencies – local authority teams, the police, and the legal profession – in order to avoid the misconception among some that SIHIS was designed to remove the court and parental rights to request Part 25 expert witnesses in addition to the SIHIS assessment. Some felt that broad consultation was also important to ensure that the SIHIS meets the needs of different stakeholder groups.

> "…getting more input from a broader range of people early on, to make sure that actually it [does] what the police,…the court[s],…[and] the legal professions would like it to do, as well as what the clinicians want it to do, would…be better." - *Judge*

A local authority legal professional concurred with this view, highlighting that legal profession input to the SIHIS design, and the SIHIS proforma, were essential to meeting the aims of the pilot.

A judge suggested that the proforma needs some revision, particularly to remove some legal terminology used in some of the questions. They felt that the use of terms related to the standard of proof required in the courts (e.g. 'on the balance of probabilities was this an inflicted injury or not?') blurred the boundaries between clinical evidence and expert assessment in an unhelpful way.

[21] See sub-question 'Is there broad buy-in to the SIHIS across stakeholders? Are there any objections to continuing implementation of the SIHIS after the pilot ends without pilot funding?

Some NHS staff reflected on the format for rollout. One suggested that a ‘hub and spoke’ model could be adopted, with larger ‘hub’ hospitals with more expertise serving smaller hospitals. Another suggested that SIHIS be piloted in a DGH in order to learn if and how the model can function in smaller centres with less safeguarding and child protection expertise.

> “The pilot landed in a lot of specialist centres, when actually the difference could have come if you'd gone to your normal DGH [where] it's much more difficult to get that specialist opinion.” – *Manager*

5. Conclusion and implications for future rollout

Interviewees from the NHS, Cafcass and the judiciary generally supported continuation of the SIHIS approach and its rollout for other injuries and to other hospitals/Trusts, with some caveats. They considered the SIHIS to be a relevant approach to reducing unnecessary delays, and to be coherent with existing services.

In the view of our interviewees, the SIHIS pilot had positive effects on the court system. Courts were provided with a single report summarising clinical views on the cause of injury, based on considered, multidisciplinary discussion. Judges reported that this allowed them to develop a comprehensive understanding of the case earlier than without the SIHIS. This enabled them to narrow down and therefore reduce the number of Part 25 experts and to request these expert assessments earlier in the process. NHS staff indicated that having clear processes in place in the SIHIS also contributed to time savings in hospitals, by reducing the time spent on initial medical assessments. Judicial and clinical stakeholders believed that these changes have the potential to reduce case durations, and to reduce the costs for courts and local authorities.

Our interviewees also indicated that nuanced, multidisciplinary discussion of cases meant they were more likely to be accurately classified as accidental or non-accidental. While this would not necessarily reduce overall delays in the family court system, it would reduce delays caused by the unnecessary progression of some cases to court that might have been deemed potentially abusive in the absence of SIHIS, but which the SIHIS correctly concluded to be accidental.

Due to the small number of SIHIS cases processed by the three Trusts during the pilot (32 cases across the three Trusts), we were unable to conduct the planned quasi-experimental analysis that would have allowed us to estimate the reduction in case durations attributable to the pilot, along with any changes in intermediate court-related outcomes that were expected to contribute to reduced case durations[22].

Interviewees pointed to additional benefits from SIHIS on the clinical side. Clinicians involved in SIHIS cases found that working as a team rather than alone, and drawing on multidisciplinary perspectives, helped them to feel more confident and less anxious while working on traumatic cases. However, according to interviewees this new way of working on traumatic cases did not improve clinician wellbeing overall, or lead to a greater number of clinicians interested in taking on court work; most clinicians expressed that they and their colleagues would prefer to avoid court work.

While we have limited information on the effect of the SIHIS on families who arrive at hospital with an injured child, our evidence suggests that SIHIS may help to improve

[22] Number of assessments requested and associated waiting times; number of cases deemed not abusive diverted from court; and timeliness and accuracy of court decision-making.

the experience of some families in several different ways. The time savings described above could help to reduce distress while waiting for initial medical assessments, and during court cases for those that progress to court. Better classification of cases in the hospital would eliminate the distress of a court case for those cases assessed as accidental in the hospital that, without SIHIS, would have progressed to court. And discussion of the cause of injury by a MDT, rather than a series of uncoordinated uni-disciplinary assessments, could lead to more holistic medical care for children, irrespective of whether the injury is deemed abusive or not.

Interviewees indicated that SIHIS could not be expected to improve multi-agency collaboration in the family justice system, nor to contribute to improved long-term care outcomes for children, both of which were felt to be beyond the influence of the SIHIS.

Due to the lack of response among stakeholders (managers, social workers, and legal teams) in local authorities in which SIHIS patients were residing, the evaluation has been unable to comment on views on the SIHIS at local authority level or from Cafcass. A legal professional interviewed in one local authority had a less positive view of the SIHIS than our interviewees in the NHS and the judiciary. However, we cannot say whether their views were in any way representative of others in affected local authorities.

The economic evaluation could not reach a definitive conclusion on pilot VfM, given the infeasibility of the planned quasi-experimental analysis. Break-even analysis established that in order to neutralise costs, the pilot would have had to result in a reduction of 24.4 weeks in average case duration. As the average duration of cases across the three NHS Trusts was 36 weeks in 2023/24, a 24-week reduction would represent a significant decrease. Even though interviewees indicated that there may be time savings in some cases, a reduction of this magnitude seems highly unlikely, indicating that the pilot likely did not represent VfM.

This finding should be understood in the context of the unavoidable limitations of the cost-benefit model. In the absence of quantitative impact data, the model is based on a number of assumptions. It also does not include a number of potential benefits (such as more accurate classification of cases and the potential for some cases to be diverted, reduced clinician anxiety, reduced family distress, and more holistic medical care for children) that have not been monetised. It is important that the positive findings summarised in this conclusion are not disregarded in light of a less positive VfM finding.

If the SIHIS were to be rolled out – by setting up similar services in other Trusts/hospitals - the VfM may potentially be higher than the pilot breakeven analysis suggests**.** This could be the case if, as might be expected, costs are lower than during the pilot, given that the pilot incurred one-off start-up, training and

consultancy. While some support may be needed for new sites, costs would likely be lower and fall away over time. This would reduce the number of days by which average case duration would need to fall in order for a future SIHIS to break even.

The VfM would also likely increase if the existing three SIHIS sites were to expand the remit of the SIHIS to include children older than eight years with head injuries, or other types of injuries. This would allow for a higher volume of cases to flow through the same sites at little additional cost (assuming that ongoing costs do not increase proportionally with the number of cases). Similarly, VfM could increase if other hospitals were to refer cases into the existing SIHIS sites. In this scenario, the main limiting factor on the number of additional cases would be geography, with referrals needing to come from hospitals within a reasonable distance from the three sites (assuming that children with injuries need to be seen in person and could not be expected to travel long distances).

It will be important, in any future scenario, to consider the extent to which any continuation or rollout of the SIHIS diverts NHS staff away from other work, with a potential negative impact on the care and safety of other patients, and on other staff members. This will need to be weighed up against the benefits of the SIHIS, and mitigated for wherever possible.

In terms of potential cost savings, if a case length reduction of 24.4 weeks could be achieved, the majority of savings would accrue to local authorities and courts from shorter case lengths and fewer hearings, although families would benefit from reduced foregone income and improved wellbeing.

Implications for rollout

Based on the evaluation findings, the following considerations may help with a smooth rollout, should the DfE decide to roll out the SIHIS to other Trusts/hospitals, and/or for other injuries.

Intervention design

- Understand what is feasible within the NHS without dedicated funding, and consider what adaptations can effectively reduce the time and costs associated with the SIHIS (e.g., a less comprehensive SIHIS report). This includes taking into account the impact of the diversion of staff time to SIHIS on other patients and other staff members.
- Consider how to integrate the service into NHS administrative and clinical job structures so that staff have time to effectively implement the SIHIS without unnecessary burden.

- Determine minimum organisational requirements for an NHS Trust/hospital to establish a full or modified SIHIS, and if and how to extend the service to hospitals that do not meet those requirements, so that populations served by smaller district and rural hospitals with less child protection expertise receive the same level of service.
- Review the content and language used in the proforma with input from local authority and court staff to ensure that the type of information, and the level of detail needed by local authority staff, police and the courts, is provided, and appropriate language is used.
- Hold cross-sectoral discussions (NHS, local authorities, judiciary) to ensure the SIHIS meets the needs of different agencies, and to provide a space for resolution of some of the apparent cross-sectoral differences in understanding, such as the circumstances in which a court may order Part 25 experts without waiting for a SIHIS report, and under what circumstances courts would call SIHIS clinicians to give evidence in court.
- Put comprehensive guidance and support in place for hospitals with less safeguarding and child protection expertise than the three Trusts which implemented the pilot.
- Consider, and mitigate for, potential impacts on families of an MDT approach to medical assessments of potentially non-accidental injuries, for example ensuring that families are provided with one final position on the possible cause of injury, and associated safeguarding concerns, rather than interim opinions from different attending clinicians.

Communications strategy

- Design and undertake a broad communications strategy to reach key stakeholders in affected agencies in order to avoid misconceptions about the aims of the SIHIS (such as the widely-held misconception in the legal sector that SIHIS is intended to largely eliminate the need for the court to request Part 25 expert assessments).

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