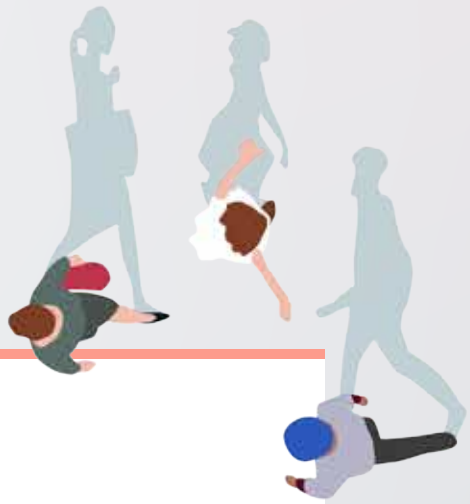
What Works *for* Children's Social Care



STRENGTHENING FAMILIES, PROTECTING CHILDREN: FAMILY SAFEGUARDING

PILOT EVALUATION REPORT

CAMBRIDGESHIRE

June 2021

What Works *for* Children's Social Care

Acknowledgements

We would like to thank Hertfordshire County Council for supporting the design of the evaluation as well as staff and families at Cambridgeshire County Council for supporting the evaluation and sharing their experiences with us. We would also like to thank Hertfordshire and Cambridgeshire County Councils for supporting our interpretation of findings from this pilot evaluation. We would like to thank the Department for Education for providing funding and support throughout the evaluation process. We are also grateful to evaluators from the Children's Social Care Innovation Programme waves one and two for sharing insights from their work with the Family Safeguarding model to help with planning our evaluation.

Funding

Department for Education, England.

Authors

Hannah Collyer, WWCSC

Abby Hennessey, WWCSC

Michael Sanders, WWCSC

Aoife O'Higgins, WWCSC

About What Works for Children's Social Care

What Works for Children's Social Care (WWCSC) seeks better outcomes for children, young people and families by bringing the best available evidence to practitioners and other decision makers across the children's social care sector. We generate, collate and make accessible the best evidence for practitioners, policy makers and practice leaders to improve children's social care and the outcomes it generates for children and families.

To find out more visit the WWCSC at: whatworks-csc.org.uk

If you'd like this publication in an alternative format such as Braille, large print or audio, please contact us at: info@whatworks-csc.org.uk

ACRONYMS AND ABBREVIATIONS

ASYE: Assessed and Supported Year in Employment

CiN: Child in Need

CLA (LAC): Child / Children Looked After (Looked After Child)

CP: Child Protection

DfE: Department for Education

FTE: Full Time Equivalent

IPE: Implementation and Process Evaluation

IRO: Independent Reviewing Officer

LA: Local Authority

MI: Motivational Interviewing

PLO: Public Law Outline

RAG: Red-Amber-Green (rating)

RCT: Randomised Controlled Trial

SFPC: Strengthening Families, Protecting Children

WWCSC: What Works for Children's Social Care

CONTENTS

EXECUTIVE SUMMARY

Introduction

This report presents findings from a pilot evaluation of the Family Safeguarding Model in Cambridgeshire. This was commissioned by the Department for Education as part of the Strengthening Families, Protecting Children (SFPC) programme. SFPC involves scaling three models of social work practice which aim to improve the safety and stability of children in need of support and / or protection and reduce the need for families to access services.

Family Safeguarding is a whole system approach to children's safeguarding. This involves establishing multi-disciplinary children's safeguarding teams where **Specialist Adult Practitioners in domestic abuse**, **mental health and substance misuse** are co-located with Social Workers under a unified management structure and participate in **group case discussions**. Staff use **Motivational Interviewing**, and a **structured assessment and intervention programme** with families. An **electronic workbook is used for case recording** and information sharing between professionals.

Cambridgeshire began training and recruitment in Autumn 2019 and launched the Family Safeguarding Model in February 2020. Early delivery coincided with the national lockdown of social and economic activity introduced on 23rd March 2020 in response to the Covid-19 pandemic in the UK. This had implications for the lives of children and families, social work practice, implementation of Family Safeguarding and data collection in the evaluation.

Research questions

This pilot aimed to provide early insights into the rollout of Family Safeguarding, and inform the next phase of the evaluation (Schoenwald et al., 2020), by answering three key research questions.

1. **Evidence of Feasibility** i.e. Can the intervention be delivered as intended, is it acceptable to those delivering and receiving it, and what are the contextual facilitators and barriers?

2. **Evidence of Promise** i.e. What evidence is there that the intervention mechanism operates as expected and that it can have a positive impact on outcomes?

3. **Readiness for Trial** i.e. How consistently can the intervention be delivered and is the programme sufficiently codified to operate at scale?

Methods

Data collected between October 2019 and December 2020 included interviews, focus groups and a survey of staff in Family Safeguarding teams. We also carried out interviews with families, observations of social work practice, and collected administrative data about intervention delivery. Qualitative data were analysed using thematic analysis. Quantitative

data were analysed descriptively. The findings from the different data collection methods were triangulated together to draw conclusions.

Key findings

Evidence of Feasibility

Was the intervention implemented as intended and how does implementation vary?

Many elements of the model were implemented as planned, even in the context of a global pandemic. All five Domestic Abuse Survivors / Victims Worker posts, and one Substance Misuse Worker role were filled shortly after the model went live, with most other posts recruited over the following months. Adult Specialist Practitioners in post reported many ways in which they were integrated within teams. Most staff reported attending the initial and follow-up Motivational Interviewing training, and confirmed that group case supervision was largely taking place at the expected frequency, with a mix of practitioners in attendance. A majority of staff reported using the electronic workbook and had begun to use the parenting intervention modules contained within the workbook with at least some of their cases.

There were, however, a number of challenges in fully implementing the model in the time frame covered by this evaluation. Mental Health Practitioner roles in particular largely remained vacant, and group case supervision was not always attended by all required practitioners. Staff reported varying confidence in case recording within the workbook. Although staff felt greater confidence in applying Motivational Interviewing, it was clear that certain elements of Motivational Interviewing will also take time to fully embed. Sustainability planning was in place to support ongoing training and embedding of the model.

Is the intervention acceptable to key stakeholders?

Staff were mostly positive and welcomed the Family Safeguarding model. Motivational Interviewing training in particular was well received. Staff were also satisfied in their jobs. Suggestions from a small number of staff interviewed for how Family Safeguarding workshops could have been improved included ensuring they were more in-depth, interactive and tailored. Some staff would have liked more examples of what good practice and recording looks like. These suggested improvements to training were based on qualitative data so it is not possible to say what proportion of staff overall held these views. Families also provided positive feedback about Adult Practitioners.

What are the contextual barriers and facilitators for delivery of the intervention?

Staff felt they had a good understanding of the model. However, less than half of survey respondents felt they had received sufficient training and support to prepare them to deliver the Family Safeguarding Model[1]. Staff felt that local processes could benefit from being better aligned with the workbook, to avoid the need for duplication of work. It was felt that more support was needed to build Team Managers' confidence in chairing and facilitating group case supervision. Fully integrating Adult Specialist Practitioner support was hindered by the remaining vacancies in these roles. Staff also reflected that introducing a new model was demanding on their time. Despite stable caseloads and greater workforce stability,

1 The interim survey was completed by 69% of potential respondents and the follow-up survey was completed by 48% of potential respondents.

some staff reported that high workloads that included complex cases affected their ability to fully take advantage of Family Safeguarding.

Evidence of Promise

Is there evidence to support the theory of change as set out in the logic model?

There were a number of mechanisms via which the Family Safeguarding Model appeared to operate. It was felt that shared responsibility and input from a range of professionals gave better insight into cases' risks and progress. In addition, staff felt families received more immediate and intensive support from Adult Specialist Practitioners than they would have received through referrals to external agencies. Some Social Workers also reported they had more time and skills for direct work with families. Staff reported that this involved working in partnership, listening more to families' voices, and focusing on strengths. This was perceived to help empower parents to make and sustain change. Staff were observed and reported to use components of Motivational Interviewing practice. These included open questions, recognising strengths and using tools such as the 'Cycle of Change'. However, there was potential for further development of these skills, and a continued programme of training to fully embed the model was being delivered. These mechanisms were largely consistent with, but in some places expanded on, the logic model developed at baseline.

What potential impacts of the intervention do stakeholders identify?

Potential benefits of Family Safeguarding reported by staff and families included improved engagement of families, improved outcomes particularly for parents, as well as de-escalation of statutory involvement and greater momentum, i.e. less drift and delay in cases. This evidence is anecdotal and not evidence of impact. Administrative data indicated reductions over time in the number of children subject to Child in Need, Child Protection, Looked After Children, and Public Law Outline (PLO). While these early indicators are promising, they are not evidence of impact since there is no comparison group, and they are likely to have been influenced by other factors such as Covid-19.

Readiness for Trial

Is there a clear description of the intervention and the contextual facilitators and barriers that would allow it to be implemented and evaluated in other places?

The initial logic model at the outset of this pilot evaluation was largely supported by the pilot findings. A revised logic model which includes additional mechanisms identified in this pilot evaluation is presented in Appendix B outlining the intervention and the facilitators and barriers to implementation. This can be used to inform future implementation and evaluation.

Can the intervention be delivered consistently across teams?

This pilot evaluation identified variation in practice between practitioners and between different teams. The facilitators and barriers considered in this report are factors that should be taken into consideration to ensure more consistency in delivery.

Are any changes needed to the theory, materials or procedures before rollout?

Future implementation would be improved by further developing guidance on integrating Adult Specialist Practitioners in usual practice, providing more in-depth training on the workbook, the assessment and intervention programme and reflective supervision, and review of the group case supervision process. Although caseloads in Cambridgeshire were consistent with national averages, variation in workloads for some staff are also identified as a key factor affecting ability to engage with the model.

Discussion

This evaluation only captures the early stages of implementation of the Family Safeguarding Model. Interpretation of findings from this pilot evaluation should consider the context in which Family Safeguarding in Cambridgeshire was being implemented and evaluated. As well as a narrow window to develop materials, prepare for and undertake implementation in Trailblazer Cambridgeshire, Family Safeguarding in Cambridgeshire launched immediately before the first Covid-19 national lockdown. Implementation was also affected by national factors including statutory requirements for case recording, and shortages in certain roles, particularly Probation and Mental Health Workers with suitable experience. Staff in Cambridgeshire also had to adapt to a new case recording system alongside a new model of practice, and had not always seen the new system before they were trained in the workbook.

Conclusions and Recommendations

The recommendations below are based on what worked well in Cambridgeshire, as well as ways in which delivery could be improved. When introducing Family Safeguarding in a new area, local decision makers should:

- Work with partners, as Cambridgeshire have done, to establish locally tailored and flexible strategies for recruitment of Adult Specialist Workers. This should include consideration of local and national pressures that might affect recruitment of certain roles and identification of creative solutions for these. This also relies on a national pipeline of practitioners suitable to hold Adult Specialist Practitioner roles.
- Provide induction processes which consider the need for relationship building and knowledge sharing between Adult Specialist Practitioners

and social care staff, as Cambridgeshire have done, including where teams may be working remotely.

- Ensure that a more in-depth training programme is available for staff in respect of use of the workbook, including the use of the parenting intervention programme and modules, and the facilitation of group supervision.
- Coordinate a comprehensive package of ongoing support and guidance for using the model, particularly the workbook, either via the intervention developer or locally developed and run in each area. This should include support for teams outside of Family Safeguarding, as well as partners.
- Ensure that, particularly in the early stages of the model, all staff have time in their workload to develop and embed the necessary skills.
- Facilitate consistent messaging and modelling of Motivational Interviewing from managers and senior leaders.
- Review local systems and processes to ensure alignment with the workbook as far as possible. This may interact with statutory requirements and existing IT systems.

The next step to build on these findings is an impact evaluation being led by What Works for Children's Social Care[2]. This is being undertaken in five local authorities introducing Family Safeguarding between 2020 and 2022. This will consider the impact of Family Safeguarding on the likelihood of children being looked after as well as how the intervention is being delivered to further improve understanding of the model.

2 Details are set out in our trial protocol (Schoenwald et al., 2020)

INTRODUCTION

Project background

This report presents a pilot evaluation of the Family Safeguarding Model. Family Safeguarding supports a whole-system change to a local authority's child protection approach, focusing on supporting the needs of children and adults in order that children can safely remain within their families. This evaluation is part of the Department for Education's Strengthening Families, Protecting Children (SFPC) programme. SFPC involves the scaling of three distinct models of social work practice which aim to improve the safety and stability of children in need of support and / or protection and to reduce the need for families to access services. These are Family Valued, Family Safeguarding and No Wrong Door (Department for Education, 2020). The programme was set out to be delivered through a phased rollout in 18 participating local authorities, beginning in 2019.

The total number of children looked after in the UK has increased every year since 2010 (NSPCC, 2021). In March 2020, the number of children looked after by local authorities in England rose to 80,080, equivalent to a rate of 67 per 10,000 children - up from 65 in 2019 and 64 in 2018 (Department for Education, 2021a). The Family Rights Group's sector-led review of the care crisis (Family Rights Group, 2018) suggests change should focus on relationship building within children's social care and the family justice system, within and between families, practitioners and agencies. A systematic scoping review (What Works for Children's Social Care, 2018) asking what works to safely reduce the number of children in statutory care found evidence for the importance of practice and structural changes. Exploratory analyses of the rates of children looked after in English authorities (2012-2017) identified participation in the DfE's Children's Social Care Innovation Programme as one of three factors associated with a decrease in the rates of children in care (Department for Education, 2021c).

Family Safeguarding

Key components of the Family Safeguarding Model include:

- **Establishing multi-disciplinary children's safeguarding teams** where specialist Adult Practitioners in domestic abuse, mental health and substance misuse are co-located with Social Workers under a unified management structure. This enables a multi-disciplinary whole family response through direct assessment and support from specialist Adult Practitioners as well as multi-professional **group case discussions** and sharing of knowledge and skills across disciplines.
- **Use of Motivational Interviewing** as a framework for practice for all staff within children's safeguarding teams. Staff undergo training and ongoing skills development workshops and follow a structured solution-focussed **assessment and intervention programme** with families which aims to

work collaboratively with families and increase engagement.

- **Use of an electronic assessment workbook** which provides a single data tool for all professionals and links to the work programme. This increases ease of information sharing between professionals and reduces Social Worker time spent recording and sharing information. It also encourages a move from descriptive to analytical case recording.

Introducing Family Safeguarding in a new local authority involves workshops and ongoing support provided by the intervention developer, Hertfordshire County Council, as well as commissioning training in Motivational Interviewing. Embedding the model also requires the adopting local authority to secure buy-in from leadership, frontline staff and partner agencies, recruit specialist roles and introduce the workbook for case recording. Recruitment of adult specialist roles is dependent on engagement of partner agencies, who have the expertise to train and supervise these professionals, as well as there being an available pool of applicants.

A revised logic model setting out the assumptions and contextual factors, interventions, mechanisms and outcomes for the Family Safeguarding Model, based on the findings of this pilot evaluation, is available in Appendix B.

Previous evaluation

Findings from previous evaluation of Family Safeguarding are based largely on pre-post data without a robust counterfactual and as such cannot conclusively attribute impact to the Family Safeguarding Model. Evaluation of Family Safeguarding in Hertfordshire (Forrester et al., 2017) reported a reduction in children on Child Protection plans, a reduction in domestic abuse call-outs by police, a reduction in adult A&E admissions and an improvement in school attendance. Evaluation of Family Safeguarding in Luton, Peterborough, Bracknell Forest and West Berkshire reported reductions in Children Looked After and numbers of Child Protection plans, as well as reductions in police call-outs and mental health crisis contact (Rodger et al., 2020). A randomised controlled trial in the UK (Forrester et al., 2018) found that Motivational Interviewing training (a component of Family Safeguarding) led to an increase in social worker Motivational Interviewing skills, but did not impact engagement of parents or other child and family welfare outcomes.

Pilot context

Pilot local authority

Local authorities eligible for SFPC were those with an Ofsted rating of 'requires improvement to be good' at the point

of application, and high or rising rates of Looked After Children. These were identified and selected by the Department for Education following a rigorous process, covering assessments of need, suitability and commitment to making a whole system change. Cambridgeshire was selected by the Department for Education to be the first local authority to receive Family Safeguarding under SFPC. Training and recruitment began in Autumn 2019 and Cambridgeshire launched the Family Safeguarding Model in February 2020.

Cambridgeshire is a mixed urban-suburban-rural County Council in the East of England. The most recent Ofsted inspection of children's social care services in Cambridgeshire in January 2019 gave a judgement of 'requires improvement to be good'. High caseloads were one of the most significant challenges highlighted in the Ofsted report. In March 2020 Cambridgeshire's rate of Children Looked After was 52 per 10,000 children aged under 18 years (Department for Education, 2020). The proportion of Children Looked After in Cambridgeshire is lower than national figures but was seen to increase from 36 children per 10,000 in 2013, at a rate of growth faster than in the national population, peaking in 2019 at 57 per 10,000 children.

Cambridgeshire's children's safeguarding service is delivered by 10 teams across five district areas (increased from nine teams prior to Family Safeguarding). Two heads of service cover North (two districts) and South (three districts). Assessment and adolescent teams were separate from children's safeguarding teams but also situated under these same heads of service. Teams comprise a Team Manager, a Senior Practitioner, as well as three to six Social Workers including those in their Assessed and Supported Year in Employment (ASYE), and Children's Practitioners. Family Safeguarding is being delivered across the county, with specialist Adult Practitioners newly introduced within all children's safeguarding teams. The remit of work undertaken by Safeguarding Teams includes Child in Need, Child Protection, court work. Cambridgeshire shares some processes, including shared senior leadership and a shared integrated front door, with neighbouring unitary authority Peterborough. Peterborough has been delivering Family Safeguarding since 2017.

Covid-19

Family Safeguarding in Cambridgeshire had just launched, and Adult Specialist Practitioners were only just starting to come into post as a national lockdown of social and economic activity was introduced on 23rd March 2020 in response to the Coronavirus pandemic. This lockdown affected how Social Workers, other professionals and safeguarding partners were able to practice. Schools were closed to all but children of critical workers and vulnerable children (Department for Education, 2021d). Many services were provided only virtually or not at all, and guidelines and restrictions were in place affecting direct work. Families experienced health, employment, financial, social and emotional challenges. These changes may have simultaneously affected the level of need but also the identification of need in children and families. Family Safeguarding continued to be rolled out in Cambridgeshire during this period, and Social Workers continued to work with families in person where needed. However, there were also delays to staff recruitment and changes to ways of working such as holding training and many meetings virtually rather than in person.

Evaluation by WWCSC

The pilot evaluation which is the focus of this report is the first of a three-part evaluation. For each of the three models in SFPC, WWCSC are undertaking:

1. **A pilot evaluation** in one 'Trailblazer' local authority (LA). This is the focus of this report.

2. **An impact evaluation** in five subsequent local authorities[3]. This stepped wedge cluster Randomised Controlled Trial (RCT) and Difference in Differences approach will provide a robust comparison group and the most reliable impact evaluation of Family Safeguarding so far.

3. **An Implementation and Process Evaluation (IPE)** across these same five local authorities, to understand the delivery during the rollout of the model.

3 Trailblazer local authorities are not included in the impact evaluation of SFPC

METHODS

Research questions

This pilot evaluation aimed to build on previous evaluations of Family Safeguarding. It sought to provide early insights into the rollout of the model, in a local authority outside of the one in which it was developed, develop and refine a logic model setting out a detailed understanding of the programme theory, provide an in-depth focus on the early stages of implementation, and inform the next phase of the evaluation (Schoenwald et al., 2020). The pilot sought to test three objectives:

1. **Evidence of Feasibility**

   a. Was the intervention implemented as intended (i.e. as set out in the logic model) and in what way does implementation vary (if at all)?

   b. Is the intervention acceptable to key stakeholders including senior leaders, frontline practitioners and families?

   c. What are the contextual barriers and facilitators for delivery of the intervention, and are these accurately captured in the logic model?

2. **Evidence of Promise**

   a. Is there evidence to support the intervention theory of change as set out in the logic model, including the mechanisms by which change is achieved and the facilitators and barriers to change?

   b. What potential impacts of the intervention do stakeholders identify?

   c. Do there appear to be any unintended consequences or negative effects?

3. **Readiness for Trial**

   a. Is there a clear description of the intervention and the contextual facilitators and barriers that would allow it to be implemented and evaluated in other places?

   b. Can the intervention be delivered consistently across teams?

   c. Are any changes needed to the theory, materials or procedures before rollout?

Research design

This pilot evaluation employs a mixed-method approach, including both qualitative and quantitative data collection and analysis. The full research design and methods are presented in the pilot protocol (Sanders et al., 2019).

Data Collection

Between October 2019 and December 2020 we undertook data collection in Cambridgeshire, spanning three distinct timeframes. Baseline (October - December 2019), and interim (February - April 2020) data collection were largely complete by the time of the national lockdown. Evaluation

activities planned at follow-up were affected. Due to delivery delays, the timing of follow-up was delayed (to September - December 2020) to allow more time for the Family Safeguarding Model to be rolled out in Cambridgeshire. Further, all data collection activity at follow-up needed to be undertaken virtually.

Baseline data was collected in October to December 2019 during the early stages of change. Seven interviews were undertaken with leaders and managers with oversight for children's safeguarding services. Two focus groups were undertaken with Social Workers and Child Practitioners within children's safeguarding teams. Four observations of home visits with families and one of a core group meeting were undertaken with Social Workers within children's safeguarding teams. Most data was collected in person, although some interviews were undertaken in person and some by phone where the attendees couldn't be present on the day researchers were visiting.

Interim data was collected in February to April 2020, following the recruitment and training of staff. Three phone interviews were undertaken with Team Managers of Family Safeguarding teams. Two phone interviews were undertaken with Senior Practitioners. Three phone interviews were undertaken with Social Workers from Family Safeguarding teams. 54 staff (out of approximately 78 staff in post at the time) responded to the interim survey. This included Team Managers, Social Workers, Children's Practitioners, Senior Practitioners and Adult Practitioners. Respondents came from all five districts across Cambridgeshire.

Follow-up data was collected in September to December 2020 after a sustained period of early implementation. Six interviews were undertaken with senior leaders and managers with oversight for Family Safeguarding. Two interviews were undertaken with Adult Specialist Practitioners. Four interviews were undertaken with family members being supported by the Family Safeguarding teams. Two focus groups were undertaken with Social Workers and Senior Practitioners within Family Safeguarding teams. Four observations of group case supervision covering ten cases were undertaken. Follow-up qualitative data collection was undertaken during the Covid-19 pandemic and therefore completed by video link or by phone. As such, it was not possible to observe home visits with families. However, two observations of virtual Core Group meetings with multi-disciplinary professionals from children's services and partner agencies were completed instead. A total of 43 staff (of approximately 89 in post at the time) completed the follow-up survey. Similar to the interim survey, this included all roles and all districts from Family Safeguarding in Cambridgeshire.

Sample recruitment and selection criteria

Participants were sampled purposively to cover a range of characteristics, particularly different staff roles and teams. Participants received study information sheets, and written or recorded consent was obtained.

Data management and processing

Interviews and focus groups followed semi-structured topic guides, and were audio recorded. Recordings were transcribed and pseudonymised prior to analysis using Nvivo 12. The survey was distributed using Qualtrics.

Table 1. Data collected in this pilot evaluation

	Baseline (Oct - Dec 2019)	Interim (Feb - Apr 2020)	Follow-up (Sept - Dec 2020)
Interviews with leaders and managers	7	3	6
Focus groups with frontline practitioners	2	N/A	2
Interviews with Social Workers	N/A	5	N/A
Interviews with Adult Specialist Practitioners	N/A	N/A	2
Interviews with families	N/A	N/A	4
Observations of practice	5	N/A	2
Observations of group case supervision	N/A	N/A	4
Survey of staff in Safeguarding Teams	N/A	54	43
Admin data Period	Aug 2019 - Jan 2020	Feb - Apr 2020	May - Jul 2020

Analysis

Qualitative data from interviews, focus groups, observations and open text survey questions were analysed using Thematic Analysis. We followed a mixed deductive-inductive and iterative approach - initially developing the codebook based on the overarching research questions, however allowing for inductive development of codes based on the data collected. Thematic Analysis involved labelling data with descriptive codes and developing themes which describe patterns across the data to answer the pre-specified research questions. We looked for patterns across different informants and time points to help us answer the research questions. To enhance trustworthiness of the qualitative findings we triangulated across different respondents and with different methods of data collection. We followed a transparent approach to analysis and reporting as set out in our protocol (Sanders et al., 2019). Interpretation of findings considered contrasting and inconsistent accounts and findings from previous research, as well as consideration of contextual factors.

Quantitative survey and administrative data were analysed descriptively, to present characteristics of delivery and acceptability. The results were triangulated with the qualitative findings, looking for consistencies and inconsistencies between the different data sources. Survey and administrative data are presented in tables in Appendix A, and summarised in the next section. A revised logic model is presented in Appendix B based on the findings of this pilot evaluation.

FINDINGS

Findings for each of the research questions are presented below. For each sub-question (i.e. 1a - 3c as set out in the methods section above), we first present a summary of findings for that research question. This summary is followed by more detailed findings for each indicator we set out to measure for that question. These indicators, including any specified thresholds, were set out in our pilot protocol (Sanders et al., 2019).

Evidence of Feasibility

a. *Was the intervention implemented as intended (i.e. as set out in the logic model) and in what way does implementation vary (if at all)?*

Summary of Findings

Many elements of the model were implemented as planned. However some parts of the model were only partially implemented, and some elements of practice varied between practitioners.

All five Domestic Abuse Practitioner (survivors / victims workers) posts were all filled shortly after the model went live. However, delays were experienced in recruiting some of the other Adult Specialist Practitioner posts, particularly Mental Health Practitioners. This was felt to be a particular concern by staff we spoke to, given the perceived mental health and domestic abuse implications of the global pandemic and national lockdowns. In line with this, mental health was one of the most common secondary categories of need amongst cases held by Family Safeguarding Teams, but also the area that received the least Adult Specialist Practitioner support due to vacancies. Despite remote working, the Adult Specialist Practitioners who were in post were often still able to work closely with Social Workers and integrate within teams. However, they were not always felt to be fully integrated into day to day practice, particularly where they were shared across multiple teams. Group case supervision frequency and content was largely consistent with expectations (i.e. monthly), although attendance of all relevant professionals could still be improved, and these discussions could also have benefitted from more opportunities for reflection.

Most staff reported attending the initial and follow-up Motivational Interviewing training, although follow-up support didn't always happen at the intended frequency, i.e. monthly. The follow-up support received included Motivational Interviewing workshops, drop-in sessions organised by the practice lead, team discussions on key topics as well as the use of resources, tools and guides to support ongoing practice. Systems were in place to identify and address arising practice issues or areas for development. Sustainability planning was in place to support ongoing training and embedding of the model. Training and guidance was also provided for wider teams including Assessment Teams, Independent Reviewing Officers (IROs), Child Protection Chairs and Legal Services Teams.

A majority of staff reported using the electronic workbook and the eight module assessment and intervention programme. However, around two thirds of staff were using the assessment and intervention programme with less than half of their cases at the interim survey, although this decreased to closer to a third at the follow-up survey. Some staff lacked confidence in case recording, and felt more confident in certain elements of Motivational Interviewing than others.

Cases held by Family Safeguarding Teams were largely consistent with those specified by the model in terms of the age of children and types of risk, i.e. a focus on parental risk rather than contextual safeguarding or criminal exploitation. Some cases held by teams were outside of the primary age range that Family Safeguarding is expected to be most likely to reduce care entry for.

Indicators

At what date is the model fully operational?

The Family Safeguarding Model was launched in Cambridgeshire on 10th February 2020 following workshops and Motivational Interviewing training. From this point the electronic workbook case recording system was live, although no adult specialist practitioners were in post at this date.

Were teams structured as intended (co-located and with 80% of Adult Specialist posts filled)?

While none of the 20 Adult Specialist Practitioner posts (five posts for each of the four roles) were in post when the model was launched, five Domestic Abuse Survivors / Victims Workers, and one Substance Misuse Practitioner were in post by March 2020, which was just five weeks after going live. Three further Substance Misuse Practitioners and four Domestic Abuse Perpetrator Workers (locally titled Domestic Abuse Officers) were appointed over subsequent months. However, only one Mental Health Worker was appointed, in September 2020. This Mental Health Worker only remained in post until January 2021. As such, by the end of the first year of Family Safeguarding in Cambridgeshire, there was one Recovery Worker vacancy, one Domestic Abuse Officer vacancy, and five Mental Health Practitioner vacancies. Adult Specialist Practitioners largely worked across one to two teams as planned, but some at follow-up reported working across three teams. Whilst increasing access of adult specialist support to a larger number of teams, this also risked reduced Adult Specialist Practitioner capacity per team where this was happening. The local authority however confirmed they did not have any capacity issues during this time.

Staff discussed that not yet having their Adult Specialist Practitioners in place affected the ability to undertake key elements of the model. The gaps for Domestic Abuse Perpetrator Practitioners in the short term, and Mental Health Workers in the longer term were felt by some staff to be a particular concern in a climate of rising domestic abuse and mental health issues under national lockdowns.

> “ *COVID has exaggerated a lot of mental health issues for a lot of people, who are more isolated, more stressed.* **[Senior leader, follow-up interview]**

Despite remote working due to the Covid-19 pandemic, and not being physically co-located, Adult Specialist Practitioners often

Figure 1. Recruitment of Adult Specialist Practitioners (Feb-Dec 2020)

felt part of social work teams. This included being co-supervised by Team Managers, attending key team meetings, carrying out joint visits with Social Workers, regular communication in between meetings and more frequent involvement in case meetings than they would have done as external professionals. Team Managers also encouraged communication and shared learning between staff.

> *"My team feel really welcoming, and I'm part of the daily meetings and the team meetings that happens every month in the district really.* [**Adult Specialist Practitioner, follow-up interview**]

However, some staff noted that the Adult Specialist Practitioners were not always present at meetings, or could be hard to reach to discuss cases. Staff suggested that the time commitment of Adult Specialist Practitioners being shared across multiple teams contributed to these difficulties integrating.

Do group supervision discussions (including all involved professionals) take place monthly in 70% of cases that have specialist Adult Practitioner involvement?

At the interim survey, 55% of respondents reported participating in group case supervision, for cases where it was needed, at least once a month. By the follow-up survey 77% of respondents reported participating in group case supervision, for cases where it was needed, at least once a month. The local authority was unable to provide administrative data on the frequency of group case supervision by case. However, observations and staff reports indicated that there were still some difficulties with getting all professionals together for supervision. In some cases the adult specialist practitioner sent in written reports where they were not in attendance, although this was not always found to be the case.

> *"There's no recording on the system, and he's not here to work on that discussion.* [**Team Manager, follow-up interview**]

Did group case discussions operate as specified?

Group case supervisions largely followed the specified format. The workbook, into which all professionals had contributed, was reviewed. Discussions considered what was working well for families, and the child's voice. Families' position on the Cycle of Change was often discussed. This is a key tool in Motivational Interviewing for assessing the stage of change that a family has reached (Bundy, 2004). We observed staff using the Cycle of Change to review what stage the parent was currently at, providing a rationale for this, and considering what further progress might be needed before the next stage is reached. We observed reflection on cases, often centred upon the family's experience, and how children might be affected. Red-Amber-Green (RAG) rating was also used to identify the level of risk in a case. In some instances Social Workers were encouraged to share their views first, although other times this was directed by the Team Manager, which was less consistent with the Family Safeguarding approach.

Did 70% of frontline practitioners receive monthly clinical supervision from their own professional background?

At the interim survey, 75% of Social Workers, 78% of Children's Practitioners and 66% of Senior Practitioners who responded reported receiving case supervision at least once a month. At the follow-up survey, 92% of Social Workers, 91% of Children's Practitioners and 80% of Senior Practitioners who responded reported receiving case supervision at least once a month.

All Adult Specialist Practitioners who responded at interim and follow-up reported receiving supervision from their own professional background at least once a month. This included joint supervision with their partner agency and a manager from Cambridgeshire County Council. Supervision from their partner agency became less frequent over time, and focused more on professional development. The monthly per family group case supervision in Cambridgeshire was the primary place where cases where discussed.

Did 70% of staff undergo initial Motivational Interviewing (MI) training?

Motivational Interviewing training was two days with a half day follow-up. At the interim survey, 96% of respondents reported having attended the initial Motivational Interviewing training in Cambridgeshire. Forty-two percent of respondents reported also having previously attended training in Motivational Interviewing. At follow-up, 85% of respondents reported having attended the initial Motivational Interviewing training. Thirty percent of respondents had previously attended training in Motivational Interviewing. Reduced numbers of staff who had attended training by follow-up may reflect differences in the survey respondents, or staff turnover. It was reported in interviews that agency workers were not entitled to the training in Motivational Interviewing, which affected consistency of practice within teams.

Other initial training staff reported having received included training about thresholds, the workbook, the parenting assessment and intervention programme. Managers also reported attending training about providing supervision. Staff also attended training in Liquid Logic as this case recording system was being newly introduced at the same time as the model.

Assessment Teams also received Motivational Interviewing training as part of the implementation of Family Safeguarding, and received briefings on Family Safeguarding. Independent Reviewing Officers (IROs) and Child Protection Chairs received internally delivered sessions over the course of the year which considered things like working in a strengths based way and wording plans consistently with the Family Safeguarding approach. Legal Services Teams also received internally delivered briefing sessions about the Family Safeguarding Model starting a few months after the model had been introduced.

Did 60% of staff engage in follow-up support for MI following initial training?

At the follow-up survey, 36% of respondents reported receiving monthly follow-up support for Motivational Interviewing. Only 13% of respondents reported never receiving any follow-up support for Motivational Interviewing since the initial training. Interviews and focus groups also indicated that the regularity of these follow-up sessions was not as consistent as set out in the model. Independent Reviewing Officers (IROs) and Child Protection Chairs were also involved in skills development sessions for Motivational Interviewing over the course of the year.

How was follow-up support for MI delivered?

The follow-up Motivational Interviewing skills and development workshops were delivered virtually over Teams. Interview and focus group respondents reported that these were valuable in strengthening skills and offering a chance for reflection, problem solving and sharing ideas about cases.

> *"So you get to look at you know, how we're using it, what's working, what's not working, discussing cases as a team. To be able to look at you know, I've tried this, I've tried that, but I still don't think this is working and kind of bring together suggestions.* **[Follow-up focus group]**

Staff also reported one to one support and refresher drop-in sessions provided by the practice lead that offered support in areas where it was needed such as the modules or the workbook. Other informal support and discussion was also received within their teams, where issues such as case recording in the workbook or undertaking

assessment and intervention with parents were considered. Staff also discussed resources, tools and guides that were available to support practice. Arising issues experienced by staff were discussed at the Family Safeguarding operational board, a Liquid Logic operations board as well as a supervision task group. Staff reported feeling that issues they raised were being listened to and that these were acted on to make changes or inform support being offered.

Did Social Workers follow the structured intervention programme for 70% of cases?

Case holding respondents reporting using the Family Safeguarding electronic workbook with at least some of the cases they worked with was 89% at interim and 87% at follow-up. Staff using the Family Safeguarding electronic workbook with all cases they worked with was 77% at interim and 68% at follow-up.

The proportion of staff (for whom it was part of their role) who reported using the assessment and intervention programme with at least some cases they worked with was 62% at interim and 76% at follow-up. However, at the interim survey, around two thirds (68%) reported using it with less than half of cases or not at all. By follow-up this had decreased to just over a third (38%) of respondents reporting using it with less than half of cases or not at all. Due to limitations of the data recorded by the system, the local authority was unable to provide administrative data on the proportion of cases for which Social Workers followed the structured intervention programme.

Staff used the parenting assessment and intervention programme in a range of ways. This included understanding the reasons for social care involvement, supporting parenting, boundaries, and direct work with children. This was felt to offer more structure to the work that Social Workers undertook with the families they worked with.

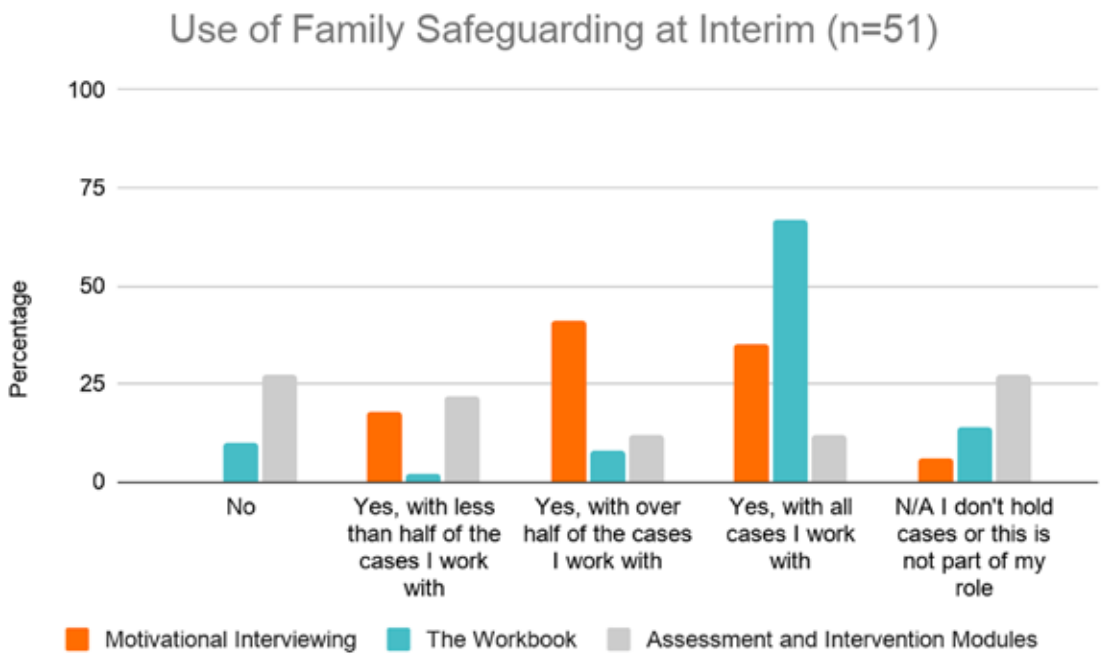


Figure 2. Use of Family Safeguarding at Interim (n=51)

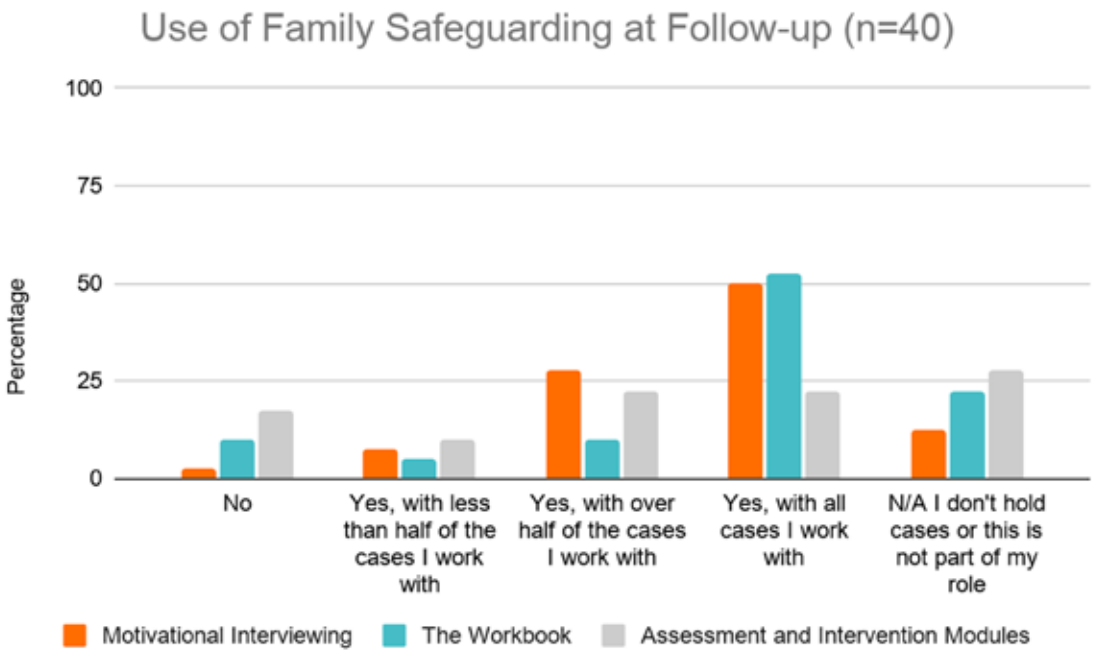


Figure 3. Use of Family Safeguarding at Follow-up (n=40)

The number and characteristics of cases that teams have worked with

Details about the cases open to Family Safeguarding Teams during the rollout of Family Safeguarding in Cambridgeshire are available in Appendix 1. Referral and case characteristics over this period are likely to have been affected by the Covid-19 pandemic. Before the model was introduced, 49% of cases held by Children's Safeguarding Teams were Child in Need, 35% were Child Protection and 15% were Looked After Children. Three months after the model was introduced, 56% of cases were Child in Need, 29% were Child Protection and 15% were Looked After Children. Six months after the model was introduced, 53% were Child in Need, 34% were Child Protection and 13% were Looked After Children.

Over the study period, cases open to Family Safeguarding teams had an average age between 6.3 and 6.8. The primary category of need for new cases referred to Family Safeguarding teams was 'abuse or neglect' for over 70% of new cases at each time period. Consistent with the Family Safeguarding Model's focus on parental risk rather than contextual safeguarding, mental health (8-61%), domestic abuse or violence (15-51%), and substance misuse (6-40%) were the most common secondary categories of need before and months after Family Safeguarding went live in Cambridgeshire (after 'abuse or neglect'). While some cases held by Family Safeguarding teams were over the primary age range of the Family Safeguarding model (cases ranged up to 17 years of age), support for contextual risk factors in Cambridgeshire is provided through a separate Adolescent team.

The number of cases open in the first three months after the model was live who had Adult Specialist Practitioner involvement

were 69 cases with Domestic Abuse Practitioner involvement, 10 cases with Mental Health Practitioner involvement, and 20 cases with Substance Misuse Practitioner involvement. The number of cases open in the three to six months after the model was live who had Adult Specialist Practitioner involvement were 72 cases with Domestic Abuse Practitioner involvement, 12 cases with Mental Health Practitioner involvement and 22 cases with Substance Misuse Practitioner involvement. Across both time points, domestic abuse was the most common type of Adult Specialist Practitioner involvement, with many more cases receiving this type of support than mental health or substance misuse. This difference is likely to be driven largely by vacancies, but may also interact with level of need.

Were there adaptations to any components of the model, and what were these?

Although there were no formal adaptations made to the model that was delivered, there were areas where the model was only being partially, or inconsistently implemented. This included vacancies in Adult Specialist

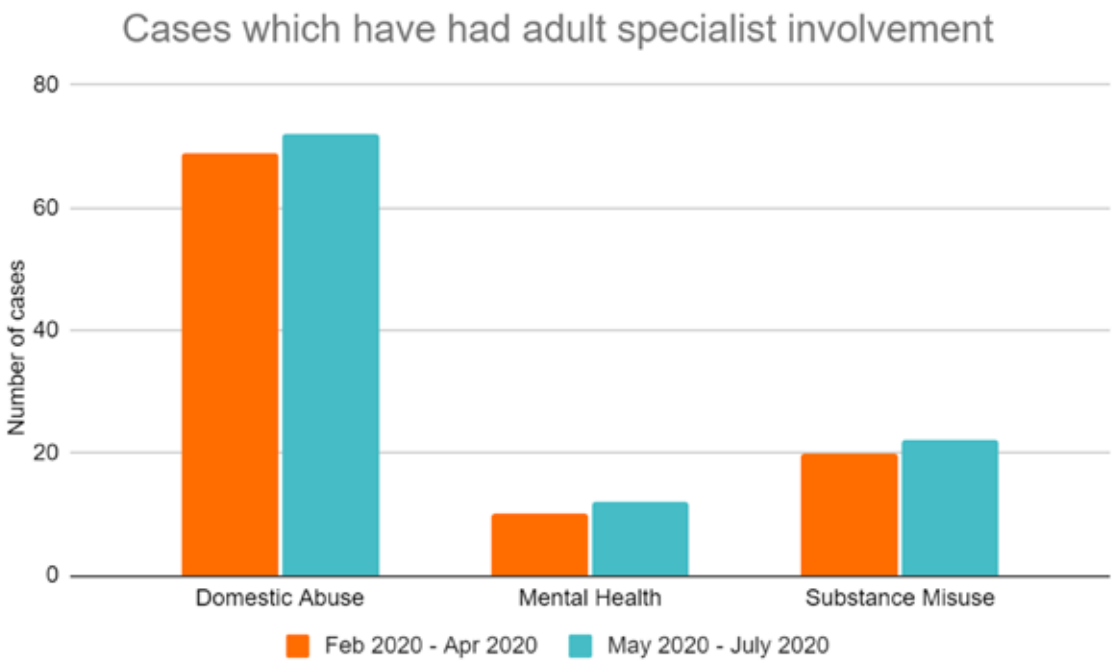


Figure 4. Cases which have had adult specialist involvement

Practitioner roles, and challenges in some instances integrating Adult Specialist Practitioners within teams. Whilst the majority of staff were using the electronic workbook for case recording, there was variation reported in ways in which staff used the workbook and recording. In addition, there were some elements of Motivational Interviewing that staff favoured more often, and others that were not used consistently, or where it was felt that improvements could be made. This included suggestions that families could still be more involved in goal setting. This also appeared to be reflected in families' experience of the model, for example a parent who reported they were not aware of the goals they had been working on with their Social Worker.

b. *Is the intervention acceptable to key stakeholders including senior leaders, frontline practitioners and families?*

Summary of Findings

Staff were mostly positive and welcomed the Family Safeguarding approach. Motivational Interviewing training in particular was well received as useful and an effective way to improve outcomes for families. Staff were also satisfied in their jobs and largely felt that leadership and management kept them informed about changes affecting their work.

However, fewer staff were confident that the training and support provided were sufficient to improve their practice, or satisfied with how the introduction of the model had been managed. Concerns highlighted included the time the model took staff to implement, or feeling sceptical, after lots of recent change, whether the model would be successfully implemented. Staff felt that elements of training including the workbook could have been more in-depth, more interactive and more tailored to the needs of the local authority. Rollout of the training could also have been more organized. Staff also worried about the interaction between focusing on parents and managing risk within statutory Child Protection. While there were examples of positive practice, there was evidence of mixed engagement with partners, with more partner engagement work needed.

Families were not always aware of changes in Social Workers' practice, but were particularly positive about Adult Specialist Practitioners. Some families reported that they had difficulties in their relationship with their Social Worker, didn't always feel understood or listened to by the Social Worker or were distrustful at times of the Social Worker's motivations. This may be a reflection of the different focus of practitioners who work with families where children are subject to child protection plans. However, families we spoke to tended to have at least one positive relationship, with either a Social Worker, Child Practitioner or Adult Specialist Practitioner.

Indicators

Is the model well received by 70% of staff?

Eighty-four percent of staff at the interim survey and 94% at follow-up (of those who reported attending Motivational Interviewing training) reported that the training they attended was useful. Further, 82% of respondents at interim and 88% at follow-up agreed or strongly agreed that Motivational Interviewing is an effective way to improve outcomes for families. However, only 35% of respondents at the interim survey and 45% at follow-up felt that using the Family Safeguarding Model had improved their practice.

Practitioners welcomed the model and staff felt engaged with Family Safeguarding. Staff were positive about potential benefits for practice and families, and particularly welcomed perceived similarities between Family Safeguarding and previous ways of working that staff had valued. Some staff who had seen several restructures in recent years were attached to previous ways of working, hesitant whether recruitment, reduced caseloads and other changes would really be possible, or worried about the additional work the model might require.

> *Unless workers see it, they're going to be suspicious because they've been promised things before.* **[Team Manager, Baseline Interview]**

Staff interviewed were particularly satisfied with the Motivational Interviewing training, which was felt to have been engaging, included a good mix of theory and interaction, and the opportunity to talk about real case examples. There was also some positive feedback about other components of the training covering useful content. This included training on the workbook as well as the training for managers. However a number of staff felt that the Family Safeguarding workshops could have been more tailored to the needs of the local authority and more interactive. Some content, such as undertaking parenting assessments, was already familiar and didn't need to be covered. Other content that would have been helpful wasn't covered, such as examples of workbooks or how to use the modules and accompanying tools.

> *We know what a parenting assessment looked like. We felt like - what does a parenting assessment look like and did we know that - we don't need to discuss it. We know what goes in it. It's more, show us the workbook, how do we do it, how do we physically open one. Because when we got to it we had no idea of how to open one.* **[Team Manager, interim interview]**

Some staff were particularly worried about risk, and balancing the positive, strengths based approach with meeting the requirements of statutory child protection and keeping children safe. Increased emphasis on parents, with more modules that were parent focused than child focused, led to worries about maintaining sufficient focus on the child's needs. Reducing the amount of case recording raised concerns about accountability. Hesitation about risk from partners was also reported, particularly early on in the process.

> *I think sometimes the emphasis is too much on the parents and not enough on the children and having it sometimes being a bit more positive than it realistically is.* **[Follow-up focus group]**

Are 70% of staff satisfied with how the change process has been managed?

Seventy percent of staff at the interim survey, and 74% of staff at the follow-up survey reported they felt that leadership and management kept them well informed about changes affecting their work. Thirty-six percent of respondents at the interim survey and 38% at follow-up reported being satisfied with how the introduction of the Family Safeguarding Model has been managed.

In the early stages of introducing the model, staff were positive about the structured and organised introduction of the model.

Information sharing was felt to be important to secure staff buy-in.

> *I think what's been helpful recently is [project manager] has been out to the teams, speaking to teams individually to help them understand what is. To answer their questions, to think about it.* **[Senior Leader, Baseline]**

However, there were later concerns that the training was disorganised at times. Some staff felt a clear overview of the changes was lacking, and some sessions could be difficult to make time for due to being booked or changed at short notice.

Are 70% of staff satisfied in their jobs and intend to remain in their roles?

Seventy-two percent of respondents at the interim survey and 68% at follow-up reported feeling satisfied in their job. Thirty-two percent of respondents at interim and 30% at follow-up reported feeling stressed in their job. Seventy-four percent of respondents at interim and 78% at follow-up expected to remain within Children's Safeguarding in Cambridgeshire for the next year.

Family reported acceptability of the model and their experience of their relationship with the Social Worker, decision making and the support provided.

Social Workers

Staff noted that often families wouldn't be aware that the Family Safeguarding Model

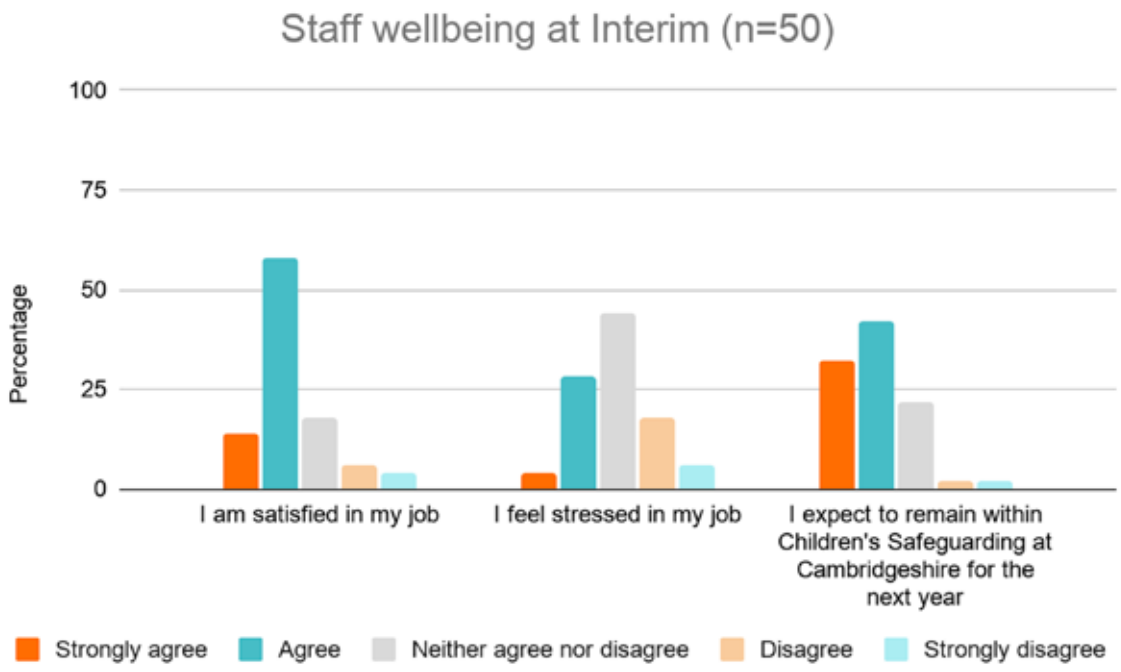


Figure 5. Staff wellbeing at Interim (n=50)

Figure 6. Staff wellbeing at Follow-up (n=37)

was being used, and some families we spoke to had not noticed any changes in practice from Social Workers. Despite the challenges of working with a Social Worker, there were reports of positive feedback from families about their Social Workers, and Social Workers also shared that certain families were positive about the way of working under Family Safeguarding.

> *Obviously, I think having a Social Worker come into your life I don't think it really ever starts off good. And then, yeah now I wouldn't really change her now, she's really good with everything.* **[Family member, follow-up interview]**

However, some parents interviewed reported challenges working with their Social Workers during the time that Family Safeguarding was in place. Some families reported that Social Workers did not always listen to, understand or take seriously parents' experiences of abuse. It was also noted that in some cases Social Workers did not engage sufficiently well with children, or did not understand the experiences of the children they worked with. Some families felt that their Social Worker was untrustworthy, or were worried about Social Workers' motivations, with some of these families having had previous negative experiences with children's social care.

> *You know Social Services are so serious but if they're not like taking it seriously it's the feeling of absolute hopelessness and real fear.* **[Family member, follow-up interview]**

Adult Specialist Workers

In one staff focus group it was reported that feedback from families about Adult

Specialist Practitioners wasn't always positive. However, the parents we spoke to were mainly positive about the Adult Specialist Workers they were involved with. Families felt understood, listened to and supported by their Adult Specialist Workers. One concern was that the access to Adult Specialist Practitioner support did not come when it was needed and could have been provided much sooner.

Although not all families we spoke to had positive relationships with their Social Workers, they did all report feeling supported by at least one of the professionals they worked with, whether that was the Social Worker, a Child Practitioner or the Adult Specialist Worker.

> *"They can give lots of support, you need a lot of support, you know, sometimes from social care. But if you get the right person you'll get that support.* **[Family member, follow-up interview]**

c. *What are the contextual barriers and facilitators for delivery of the intervention, and are these accurately captured in the logic model?*

Summary of Findings

A key challenge staff identified was insufficient training and support. Staff felt they had a good understanding of the Family Safeguarding Model and felt confident to use Motivational Interviewing with Families. However, less than half of respondents felt they had received sufficient training and support to prepare them to deliver the Family Safeguarding Model. Staff particularly lacked confidence in using the workbook. A contributing factor to this was felt to have been receiving a lot of new information within a short space of time, including the timing of introducing a new IT system. Follow-up support was helpful, but guidance from Team Managers was inconsistent at times. It was felt that training and support could have been improved by having more examples in the initial training, more modelling of the approach by leadership as well as easy access to tools and resources. A programme of ongoing support delivered in Cambridgeshire to address this challenge included continuing workshops and one to one support for the Family Safeguarding Model led by the practice lead and learning and development team. Regular Motivational Interviewing skills development for existing staff were also planned, as well as Motivational Interviewing training for new staff, and the introduction of a 'train the trainer' approach.

Although there were examples of good integration of Adult Specialist Practitioners, integrating Adult Specialist Practitioners was another challenge experienced by some staff. This was felt to have been exacerbated by issues of vacancies, staff perceived workload capacities and referral criteria excluding certain cases from Adult Specialist Practitioner support, such as domestic abuse perpetrators with low insight. Ensuring that Adult Specialist Practitioners and Social Workers understood each others' roles and perspectives was felt to be a key component of integrating the multi-disciplinary teams. It was also felt that group case supervision could be improved by providing more training for managers on holding reflective group discussions, improving scheduling and attendance, and ensuring minute taking by business support as well as the supervision proforma facilitated rather than disrupted the reflective discussion.

Another challenge identified was the time needed to deliver the model, at least initially

whilst staff became familiar with it. Despite a culture change around application of thresholds as part of the introduction of Family Safeguarding, and recently increased workforce stability, there were still some vacancies and turnover, and some staff still reported that high workloads that included many cases they perceived as complex affected their ability to fully take advantage of Family Safeguarding. The proportion of staff at follow-up who reported having sufficient time to undertake effective direct work with families on their caseload (40%), and the proportion who reported having sufficient time to take full advantage of the Family Safeguarding Model (30%) was low. In addition to this, some staff felt that the workbook did not translate easily into existing processes such as court reports, leading to frequent duplication of work. This is inconsistent with the logic model which indicates that staff would be expected to spend less time producing separate reports under the Family Safeguarding model and therefore see improved workloads. This appears to be a key assumption of the success of Family Safeguarding and an area that requires further development to be achieved. By their nature, cases held by children's safeguarding teams such as those on Child Protection plans are likely to be complex, and staff interviewed indicated that case complexity may have been increased during the pandemic. Variation in caseload size and complexity between staff (although with actual caseload figures remaining relatively stable and at a level consistent with national averages), as well as variation in confidence with using the workbook, may explain why some staff felt they had time to do more direct work, whilst others, although positive about Family Safeguarding as an approach, struggled to find time to fully embed the model.

Family Safeguarding in Cambridgeshire was introduced just before the start of the 2020 Coronavirus pandemic and this was felt to have affected the introduction and embedding of Family Safeguarding in Cambridgeshire. Although staff found creative ways to work with families and with each other, reduced face to face direct work and isolation from colleagues affected relationships and peer support. Social workers also reported increased domestic abuse and mental health needs amongst families they worked with, making the cases they held more complex.

Indicators

What is the vacancy rate, turnover rate and average caseload for Social Workers pre and post introduction of the Family Safeguarding Model?

Staff noted at baseline that there had been improvements in workforce stability, including new and more stable senior leadership, following instability and understaffing six to twelve months previously. At the point at which the Family Safeguarding Model was launched, 20% of Senior Practitioner posts and 5% of Social

Worker posts were vacant. Turnover in the three months preceding the introduction of the model was 3% for Social Workers. Three months after the model was introduced, there was still one Senior Practitioner vacancy (equivalent to 10% of posts), and 5% of Social Worker posts were still vacant. No staff were reported to have left their posts in the initial three months of the model. Six months after the model was introduced, there was still one Senior Practitioner vacancy, and Social Worker vacancies had increased to 7%. Turnover in social worker roles from three to six months after the model was introduced was 5% (2 of 41.5 FTE posts having left their role in the past three months),

Team Manager and Child Practitioner posts across the Family Safeguarding teams were largely filled and stable throughout, with one Team Manager and a part-time Child Practitioner leaving between three to six months after the model was introduced. Some staff interviewed reported that changes in management had affected supervision or led to gaps in having consistent supervision.

In their 2019 report, Ofsted stated that the size of Caseloads was a key issue. The focused visit undertaken by Ofsted around the launch date of Family Safeguarding in Cambridgeshire noted that caseloads had decreased but that there were still instances where they remained high for some individual workers. Staff interviewed at baseline also reported that they had high workloads. Some staff noted they had started to see improvements in caseloads, but that the remaining cases tended to be cases they perceived to be more complex. Senior leaders spoke about aiming for maximum caseloads of 15 under the Family Safeguarding model. Caseloads before the model was introduced were on average 17 FTE which was slightly higher than this target, and similar to the national average of 16.3 (Department for Education, 2021c) (although figures may not be directly comparable as national figures are based on all social work teams rather than just Child Protection teams, which can at times have higher caseloads than some other teams). Caseloads varied by practitioner role, with ASYE's holding fewer cases and Senior Practitioners holding more cases, ranging from a minimum of 6 cases to 27 cases held by a case holding Social Worker. At three and six months after the model was introduced, caseloads were on average 17.5 FTE, which was similar but slightly increased relative to baseline.

Do 70% of frontline staff feel they have enough time for direct work and to take full advantage of the model?

At the interim survey, 48% of case holding practitioners (not including Adult Specialist Practitioners) reported having sufficient time to undertake effective direct work with families on their caseload. Thirty-two percent of all respondents reported having sufficient time to take full advantage of the Family Safeguarding Model. This remained an issue at follow-up, where 40% of case holding practitioners (not including Adult Specialist Practitioners) reported having sufficient time to undertake effective direct work with families on their caseload, and 30% of all respondents reported having sufficient time to take full advantage of the Family Safeguarding Model.

Do staff feel prepared and supported by the information, training and support provided, and are they motivated and confident to make changes to practice?

At the interim survey, 81% of respondents reported having a good understanding of the Family Safeguarding Model, and 83%

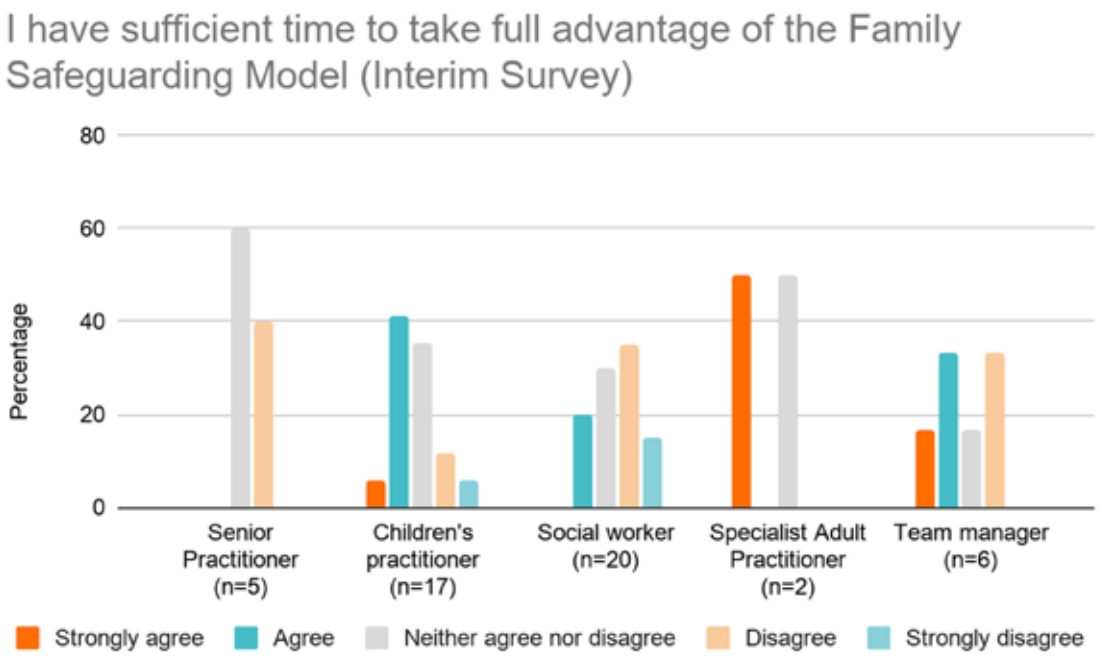


Figure 7. I have sufficient time to take full advantage of the Family Safeguarding Model (Interim Survey)

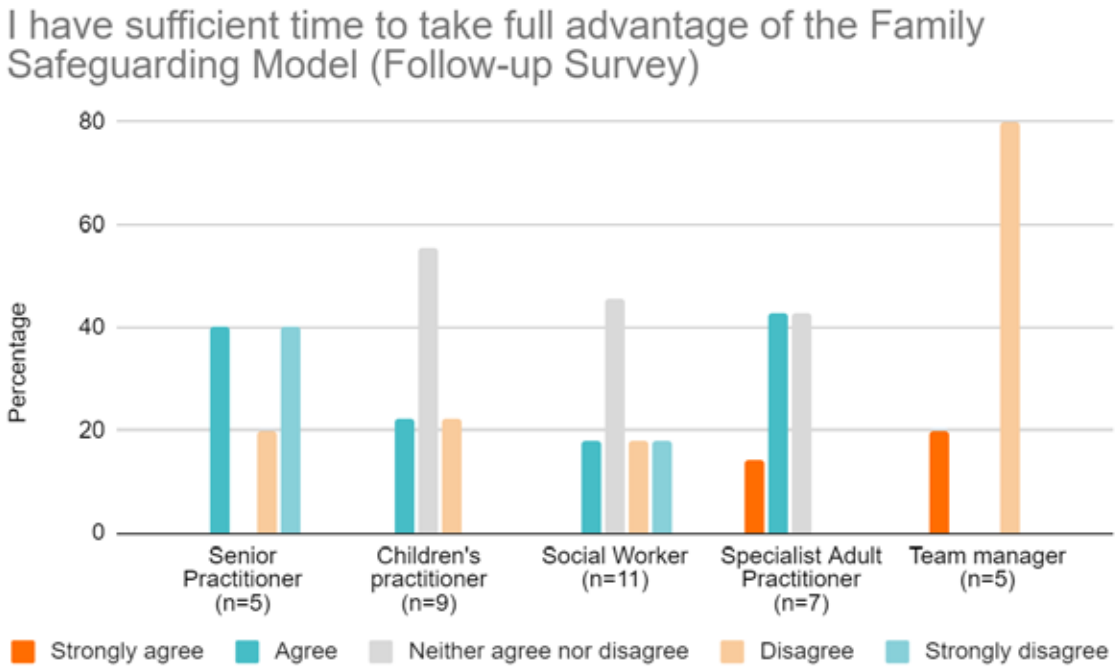


Figure 8. I have sufficient time to take full advantage of the Family Safeguarding Model (Follow-up Survey)

of case-holding staff felt confident to use Motivational Interviewing with families. These figures were similar at follow-up, with 85% reporting having a good understanding of the Family Safeguarding Model and 86% of case-holding staff feeling confident to use Motivational Interviewing with families.

At the interim survey, 76% of respondents reported that the supervision they received was helpful in supporting decision making and practice with families they worked with. However, only 44% of respondents felt they had received sufficient training and support to prepare them to deliver the Family Safeguarding Model. At follow-up 84% of respondents reported that the supervision they received was helpful in supporting decision making and practice with families they worked with. However, still only 45% of respondents felt they had received sufficient training and support to prepare them to deliver the Family Safeguarding Model.

Following training, many staff interviewed felt confident and prepared to use Family Safeguarding and began using it very quickly. However, particularly in the early stages, but even at follow-up, some staff did not yet fully confident. Concerns were particularly raised in relation to the workbook, where staff felt they had been insufficiently prepared and were not confident in using it.

> *"As yet not wholly confident because I think I can't work the Family Safeguarding Model in isolation. So I can do bits and pieces, but until the multiagency colleagues in terms of mental health, drugs and alcohol, DV [Domestic Violence] are absolutely in post and sitting across the table as they were. then I think I'm very limited in terms of what I can achieve.* **[Senior Practitioner, interim interview]**

Do 70% of frontline staff perceive there is sufficient buy-in and support from leadership?

At the interim survey, 48% of respondents reported that support from leadership and management to implement the Family Safeguarding Model was effective. At follow-up it had increased to 67% who reported that support from leadership and management to implement the Family Safeguarding Model was effective.

What is the level of understanding of, engagement with and support for the model from senior leadership, partners and referrers?

In baseline interviews, leadership and management reported a positive attitude and enthusiasm toward the model. Practitioners echoed this view that leadership were on board with Family Safeguarding, and largely reported that the change process was managed well. It was felt at baseline that there may be a potential risk in getting buy-in from partners due to having had a number of service changes in recent years.

> *"Because this is probably like our third [change of model], I suppose the resistance from partners might be greater and then might need to do more work on that.* **[Senior Leader, Baseline Interview]**

Some staff reported that following work to inform and engage partners, some partners such as health visitors or schools were engaged with the Family Safeguarding Model, and participating well in delivering family led plans. However, others reported more was needed to get full engagement, particularly where partners challenged recommendations from Children's Social Care to step down cases

> *I think the biggest thing that we're still battling with is external professionals' understanding of our change in our model.* **[Follow-up focus group]**

In what ways are case and area characteristics perceived to affect delivery and outcomes?

Some staff reported concerns that Motivational Interviewing was too optimistic, or it was difficult to use Motivational Interviewing in certain circumstances. For example, it was felt that Motivational Interviewing wasn't always appropriate where families were hostile or aggressive, or where they were working with a high risk issue.

> *It's more difficult to use when working with someone who has got quite a long history of violence or like being really hostile or aggressive and that kind of thing. I just think generally they're not going to engage.* **[Follow-up focus group]**

Area characteristics described included the logistics of rolling the model out in a large, rural local authority, as well as bringing in a number of changes at the same time, with the case recording system changing simultaneously. Workforce instability at baseline in some of the five districts was also a factor that might affect rollout of the model. The more urban district experienced issues affecting staff recruitment and retention, including a higher cost of living, high referral rates, long commutes and a lot of traffic congestion, relative to more rural areas. However, the most rural district was also considered to have challenges with workforce stability due to being more remote.

> *So property is cheaper out there. People who tend to live out there work out there as well so they have more of a stable workforce historically.* **[Senior Leader, Baseline Interview]**

What is the pre-existing culture, practice model, approach to decision making and infrastructure?

Practice pre-Family Safeguarding

Since restructuring out of the Systemic Unit Model and prior to introducing Family Safeguarding staff reported that there was no clear model or framework that was consistently used to guide practice. Some practice continued to be informed by the Systemic Unit Model. Being in-between models, staff felt there was a lack of focus. Staff also reported being dissatisfied with the current case recording system, which was ICS (Integrated Children's System). Relationships with multi-agency partners showed a mixed picture at baseline. Some difficulties were reported with education, although this varied between schools and districts, as well as challenges with engagement from GPs and with drug and alcohol services. Challenges with partner relationships were attributed to factors including long waiting lists, not attending meetings, different interpretations of thresholds, or difficulties sharing responsibility. Good relationships were reported with health, police, probation, housing, voluntary agencies and Early Help. Multi-agency partners were seen to be valued for their expertise.

> *When a [health] worker comes, around a mental health problem, absolutely exceptional when they do attend. Really good. Because they have got that insight and that knowledge about that person's*

mental health and what support they're able to put in place. **[Baseline Focus Group]**

Leadership and Management

Organizational vision and values at baseline were felt to be centred around empowering families to make and sustain change for themselves. Keeping children's experience and their safety central in order to improve their outcomes was also a key value. Another organizational value that was reported was having quality service and partnerships. Despite efforts to communicate clearly, provide regular updates and be visible to staff, there was some dissatisfaction with communication from leadership. Senior leadership were not always seen to be visible, and decision making was not always clearly explained.

> *Decisions are cascaded down to everybody else and we just have to act on it. Without them knowing what we're dealing with on the ground… So yes I am particularly frustrated with that and I don't think communication is good.* **[Baseline Focus Group]**

Pre-existing culture

Although caseloads were consistent with national averages, high workloads self-reported by some staff at baseline were linked to staff regularly working overtime. Workloads were also felt by some staff at times to affect the time available to get the best out of direct work with children and families. It was reported that managers and leaders sometimes had to step down in their roles in order to get the work done, leaving less time to focus on leadership. Practitioners were concerned about their ability to implement a new model if their workloads remained high.

> *There is no time for thinking about what model we might be using because… I think that's a luxury that can only be afforded when your caseloads, caseloads are lower, quite frankly.* **[Baseline Focus Group]**

Culture change as part of Family Safeguarding around application of thresholds, was felt by some staff to have started to improve caseloads, enabling Social Workers to work with families at the right level, and to do more work with families.

Staff interviewed at baseline shared experiences that the culture could be hierarchical. There were several layers of managers involved in decision making, leaving staff with a sense of being 'done to' and 'not consulted'. Decision making could also be inconsistent between managers. There was also a focus on procedural compliance and metrics, requiring lots of paperwork and bureaucracy. These issues could at times create delay in decision-

making for the child, and left some social workers risk averse or anxious about decision making or being held accountable for risk. Others we spoke to felt they were able to hold accountability for their cases and at least with day to day decisions, and efforts were being made to start to encourage more accountability to be held by managers and Social Workers.

> *Now it's going back to more you know giving us our responsibilities back and saying you know you are more supported to. Because we have to take the risks, we have to try and manage them…* **[Senior Leader, Baseline Interview]**

Workforce Support and Wellbeing

At baseline, it was noted that while there was excitement about the new model, there was also frustration or anxiety. This was in part attributed to the amount of service and practice model changes there had been previously in the local authority. Wellbeing and morale at baseline varied between individuals and between teams. Some team cultures were positive, but others felt less stable and more anxious. It was suggested that staff as well as Team Manager stability may have affected this workplace wellbeing at baseline, and the ability to bond for some teams. Staff also reported feeling less supported by their colleagues than they had under the previous Systemic Unit Model. While some staff in interviews and focus groups prior to the Family Safeguarding Model being introduced still described feeling stressed and working long hours as a result of high workloads, other staff reported that this had improved significantly over recent months.

> *[Six months ago] we didn't have many staff. We were really really struggling and having a full team and it just I think so many things have changed so dramatically. Staff morale is higher, and people are just, they want to come to work and they want to do a good job. And that's, yeah a really positive change I think.* **[Team Manager, Baseline Interview]**

What is the perceived compatibility of this context with new practice and how does this differ from the context in the LA where the model was developed?

Some staff interviewed reported that Family Safeguarding was similar to or compatible with previous practice. There were some perceived similarities to the previously used Systemic Unit Model which staff reported, this included having additional specialists within the children's safeguarding team, and having group case discussions. Some staff reported having Family Safeguarding or Motivational Interviewing training in the past. Others felt they were already using similar techniques or working in a way that was similar to Family Safeguarding already. Others reported that the training reinforced or expanded on existing knowledge.

> *I think we use a lot of, like, the change talk stuff they talk about in Motivational Interviewing, we do naturally.* **[Baseline Focus Group]**

Some specialist Adult Practitioners also noted that the interventions they delivered were the same as those they had previously offered outside of Family Safeguarding.

On the other hand, it was hoped that the new model would change practice by enabling more time for meaningful direct work with families. Having Adult Specialist Practitioners was expected to provide new expertise for the safeguarding team,

and reduce the need to refer out to other services. Further, there would be increased focus on keeping children at home with their families, where safe to do so.

> *It has been much more about thinking and stopping and thinking what can you do to keep that child in rather than just immediately try and remove. So I think that's quite different.* **[Senior leader, baseline interview]**

What are the reasons for any adaptations to delivery, perceptions of facilitators to successful delivery, and barriers and challenges faced or overcome?

Sufficiency of Training and Support

Facilitators of training and support included learning from staff working in other areas delivering the model, at the workbook training or at launch events, as well as sufficient and early introductions about the model to partners and other internal teams, to allay any anxieties about the implications of the changes and ensure a consistent approach.

Being provided with a lot of information in a short time frame and simultaneously introducing a new case recording system was intense and overwhelming for social workers at times, particularly alongside high workloads. Training sessions were felt to be quite rushed at times, with a lot of information provided in one go. Some staff also felt that the tools and resources needed to support their work could have been made more organised and accessible. Staff acknowledged that it would take time to reach a point where the model was really embedded in practice. Further learning in Motivational Interviewing was felt to be needed by some staff, and a number of staff also reflected that more could be done by leadership and management to model Motivational Interviewing and keep Family Safeguarding live in order to support and encourage using and embedding the model in practice.

> *I think it needs to be modelled from the top down. I think it needs to be part of Child Protection plans and reports. I think staff need like the challenge back about it, so it needs to be live all of the time. It needs to be like an active thing that everyone kind of thinks about and talks about more.* **[Senior leader, follow-up interview]**

Integration of Case Recording

Some staff struggled with navigating and case recording in the workbook. It was felt there had not been enough support or clear examples of what good case recording in the workbook should look like in the training provided. Despite ongoing support led by the practice lead, nervousness and uncertainty continued at follow-up, and staff felt they received different messages from different managers. Difficulties using the workbook were also attributed to some staff having missed training, or training being delivered before staff were familiar with the new case system.

> *There is still no clear direction on how the workbook should be completed and I am still waiting for an example of good practice for recording in the workbook modules. This makes it difficult to use the workbook in the most effective way impacting on my case recording.* **[Advanced practitioner, survey]**

There were also some difficulties aligning the workbook with certain elements of usual practice. It was felt that the workbook added complexity and fragmented information

rather than presenting it holistically. There were gaps in key areas of work undertaken by staff, such as resources for working with unborn babies. The workbook was also not being accepted by court as a Parenting Assessment. Staff reported duplication of work where they needed to copy information into different formats or expand on what was included in the workbook. The workbook was also reported to be difficult for other professionals such as IROs or Family Workers from Early Help to navigate and find or input information.

Optimizing Adult Specialist Support

Staff highlighted the importance of Adult Specialist Practitioners having support in understanding their new roles and what the expectations were for them. This included developing an understanding of child protection and the perspective and time-frame of the child rather than coming solely from an adult focused point of view. Whilst this process had been successful in some cases, it was felt there was more that could be done.

> *I have noticed [Adult Specialist Practitioner role] are very adult focussed and are struggling sometimes in what the role looks like.* **[Team Manager, follow-up interview]**

Social Workers also needed to understand the role of the Adult Specialist Practitioners, and to see the Adult Specialist Practitioners as an expert and somebody they could go to. This was facilitated by drop-in workshops and having clear and easy to use referral pathways. However, in some circumstances Adult Specialist Practitioner professional opinions were felt not to have been fully taken into account.

Continuity with existing adult support was also important, where existing support was already in place before Family Safeguarding involvement, or transitioning to follow-on services after Family Safeguarding. Vacancies in Adult Practitioner roles affected capacity for all the adult support that was needed. Social Workers also experienced frustrations around criteria for referral, including the need for perpetrator insight to access support.

> *We're stuck in a catch-22, where that person might not want to admit to their Social Worker for example that they have perpetuated unhealthy behaviours in a relationship, and that might benefit from a Domestic Abuse Officer. But the Domestic Abuse Officer's Manager is saying that this person needs to show insight before that person will do that work with them.* **[Team Manager, follow-up interview]**

Supporting Effective Group Supervision

Reflective discussions in group case supervision were limited by a number of things. This included having only a limited amount of time to discuss each case, a supervision form felt to be too long, repetitive and not user friendly, as well as technical issues sometimes experienced. In addition, the right professionals were not always invited and coordinating diaries was difficult. Minute taking sometimes directed the conversation in a way that didn't allow for sufficient reflective discussion, although additional training was being delivered to business support to improve this. Training provided to managers on supervision was also felt to be too focused on basics which managers already were familiar with, and didn't sufficiently prepare them for the group nature of supervision in Family Safeguarding.

> *"It felt like we were being sort of told how to do supervision, which you kind of already knew. So I don't think it taught us necessarily what group supervision and in this new model would look like.* **[Team Manager, interim interview]**

Preparation was felt to be key to successful supervision, and where staff weren't able to attend, it was helpful where they had still prepared a summary in the workbook, which could be used in the discussion.

Time Demands

Several areas of the model were felt to take up a lot of time, at least initially whilst staff familiarized with them. Time demands included making time in busy schedules for training, preparing for and attending supervision as well as case recording in the workbook, particularly while staff were still getting used to it. It was felt supervision time could be reduced if information - such as previous actions - would pull through to the supervision form more easily. Undertaking increased intervention with families, and working in a less directive way also took more time, although it was acknowledged that there may be long term time benefits of this approach, and may lead to plans being more effective.

> *"I think sometimes that's not acknowledging how much more effective plans are, despite the time it takes to initially set it up.* **[Team manager, follow-up interview]**

For some staff, high workloads, exacerbated by absences, turnover or increased case complexity even where caseloads had decreased, meant sometimes having insufficient time to think about or use the model, or that the model didn't get prioritised.

> *"Some of us are at higher caseloads than we should be. Some of us do have quite complex cases, so we don't always have that time to do that work that we want to do with families.* **[Follow-up focus group].**

Covid-19

The national lockdown affected the amount of direct work that was possible, particularly for Adult Specialist Practitioners whose services discouraged in person direct work at the time. Social Workers also found that some families refused or were anxious about visits, making face to face or joint visits more difficult. It was felt that more in depth discussion, picking up on non-verbal communication and seeing home conditions were harder to do when working virtually.

However staff found creative responses to virtual working, such as visiting in the garden, or setting homework so the time spent face to face on the visit was shorter.

Whilst teams were able to integrate virtually, not working side by side affected the building of trust and relationships between Adult Specialist Practitioners and Social Workers, and the opportunity for case discussion with Adult Specialist Practitioners as well as other colleagues. This was felt to hinder the development and embedding of new practice. Virtual training was also felt by some staff to be less effective than when delivered in person. There was also less multi-agency input from partners who were no longer seeing families or seeing less of them.

> *"Where we would ordinarily work in a multi-agency setting, and we would be reliant on feedback or checks and balances from other multi-agency, professionals and Social Workers didn't have that. So then they became very reliant on their own assessments and their own risk.* **[Senior leader, follow-up interview]**

This was in the context of what some staff reported as a perceived initial decrease but then a perceived increase in caseloads. In addition there was perceived increased need, for example in terms of mental health or domestic abuse, leading to increased case complexity and increased workloads. This was compounded by absences and workforce instability driven by the pandemic.

What sustainability planning is in place?

A return to office based working was expected to facilitate overcoming challenges and further embedding the model.

The Cambridgeshire practice lead had developed an ongoing monthly schedule of Motivational Interviewing workshops for all staff, as well as initial Motivational Interviewing training for new starters. Child Protection chairs were also due to receive bespoke Motivational Interviewing training shortly after the end of the pilot evaluation period, and a 'train the trainer' model for ongoing Motivational Interviewing training was planned. Ongoing workshops and one to one support on Family Safeguarding and the workbook would continue to be co-delivered internally by the practice lead and learning and development team. The staff portal had also been updated in early 2021 to include key information and a resource library for all staff and practitioners to access. Training briefing sessions with other service areas, education and health around the model throughout 2020 were also part of the sustainability plan.

Evidence of Promise

a. *Is there evidence to support the intervention theory of change as set out in the logic model, including the mechanisms by which change is achieved and the facilitators and barriers to change?*

Summary of Findings

There were a number of mechanisms via which the Family Safeguarding Model appeared to operate. These mechanisms were largely consistent with, but in some places expanded on the logic model developed at baseline. One key mechanism was changes to the case management and decision making process. It was felt that shared responsibility and input from a range of professionals gave better insight into cases' risks and progress. Another key

mechanism was increased support available to families. Staff felt families received more immediate and intensive support from Adult Specialist Practitioners, who overcame barriers to accessing external services. While workloads were felt to remain high, and there was variation in experiences of this, some Social Workers also reported they had more time and skills for direct work with families. Having more time was seen by some staff to be a result of smaller (although more complex) caseloads, as well as Adult Specialist Practitioners undertaking some work they would have previously undertaken. A further mechanism involved increasing families' motivation. Staff were reported to communicate more clearly with families, work more in partnership and listen more to families' voices, and increasingly focus on strengths. This was perceived to help empower parents to make and sustain change.

Staff were observed and reported to use components of Motivational Interviewing practice in at least some of the cases they worked with. These included open questions, empathy, recognising strengths and progress as well as using tools such as the Cycle of Change and Cost Benefit Analysis. However, there was potential for further development of these skills. Motivational Interviewing was also used internally, such as in supervision by managers. Some practice consistent with Motivational Interviewing had also been observed at baseline, suggesting that some staff had already been using some components of Motivational Interviewing before Family Safeguarding was introduced. Some types of Motivational Interviewing practice were not observed, although this may have related in part to the more restricted contexts we were able to observe at follow-up due to collecting data remotely. Social Workers may feel more comfortable and have more opportunity to use Motivational Interviewing techniques when working one to one with a family member. In addition, in contrast to the expectations of the logic model, some practice remained compliance focused, with a focus on updates and information gathering over goals and progress. This may pose a barrier to the success of Family Safeguarding.

Indicators

What is the understanding and use of Motivational Interviewing in practice by Social Workers?

Practice consistent with Motivational Interviewing was observed and reported at baseline. This included affirming i.e. recognising progress or achievements parents had made, as well as working in partnership with parents such as allowing parents to lead the discussion, encouraging them to set their own goals, consider their own progress against these goals or take responsibility for certain actions that were needed such as contacting other services.

> "*There's things that I would add to the plan, but what would you add to that plan?* **[Baseline Observation]**

Another element of Motivational Interviewing, empathy, was observed towards parents at baseline, for example reflecting on the difficulties new parents face or empathising with difficulties a young person was having with school. Staff also used open questions, another component of Motivational Interviewing, to ask about how parents were feeling or their views on specific issues. Staff did however also use closed questions, for information gathering purposes about specific issues or concerns. Some Social Workers at baseline were directive rather than working in

partnership with parents as recommended by Motivational Interviewing, for example taking the lead in reviewing progress against goals, or guiding a parent through a form that needed completing.

By the interim survey, 94% of respondents (including Team Managers) reported using Motivational Interviewing. 76% reported using it with over half of the cases they worked with. At follow-up, 85% of respondents reported using Motivational Interviewing, with 78% using it with over half of the cases they worked with. Motivational Interviewing was felt to give staff a framework when talking to families about things that have been going well and things that need more work. It was used by Team Managers in supervision at follow-up to change or challenge a worker's thinking, and in other places in the system such as panels, to help workers think about cases. A range of Motivational Interviewing techniques were observed and reported at follow-up. Staff were observed frequently affirming or recognising the strengths and efforts of family members such as positive engagement with services. Staff used open questions such as when asking about how children are getting on or what their experience might be, and there were some displays of empathy such as directly acknowledging to families that things they are going through are hard, or commenting on the feelings of a child they are working with. Staff also used Motivational Interviewing tools. This included Cost Benefit Analysis to help families think about the pros and cons of making changes. The Cycle of Change was useful working directly with families to think about where they are in the cycle, and also reflecting on the case and barriers that need to be addressed to help families move forwards.

> "*I always bring out the Cycle of Change with me when I go to see families. Likewise, when we're doing supervision and when we talk about cases, we're always talking about the whereabouts that we think that the parents are on in the Cycle of Change. Then we talk about where they are and what we can do to help them move forwards. So always kind of thinking about it.* **[Adult Specialist Practitioner, follow-up interview]**

Some Motivational Interviewing techniques such as 'softening sustain talk' (i.e. the practitioner making efforts to shift focus away from or reduce family member's use of language that is in favour of things staying the same), or 'complex reflections' (i.e. where the practitioner repeats and adds, e.g. additional meaning or interpretation, to what the family member has said) weren't as evident in observations at follow-up. Language often focused on 'actions' and whether or not these had been completed,

seeking 'updates' and using closed questions for information gathering. Less time was spent discussing 'goals', or whether and why actions were successful. It was not always clear how actions on the plan were identified and what role family members played in identifying their own goals. There was also some discussion that focused on expectations for families or disguised compliance rather than partnership working.

> *They're good at agreeing with what we say but they're not actually showing or implementing anything to show they've taken it on board.* **[Adult Specialist Practitioner, Group Case Supervision]**

How do understanding of risk, decision making, care plans, partnership working and support for families operate in practice? Is this consistent with the logic model and how does this differ from previous ways of working?

Case management and decision making

The Family Safeguarding Model was reported to lead to a greater sense of shared responsibility for cases, with the Social Worker and Adult Specialist Practitioner working jointly, rather than in silos, to assess and support families. Staff felt less isolated and more confident holding risk, and this ensured more effective work. Group case supervision was seen as an opportunity to reflect and discuss issues with other professionals, and for more challenge than there had been previously. Other professionals such as Child Practitioners, as well as partner agencies also played a role in this shared responsibility for cases.

> *Having someone else there with you alongside is really useful for helping manage professional anxiety. Therefore, ensuring we're more effective in our work with families.* **[Team Manager, follow-up interview]**

Information and case notes from Adult Specialist Practitioners were more readily available than relying on external agencies in the past, and provided another perspective on cases in addition to the Social Worker view. Managers and staff were therefore able to have more oversight of cases and what was happening with them. RAG rating at supervision, the workbook structure and regularly using the Cycle of Change, helped better identify families' risks and strengths, and to observe progress, change and future goals.

> *So then I've got a good account with what I've done with a child, what they've told me, and I can just go to that section and look at it.* **[Follow-up focus group]**

This better quality multi-disciplinary information from assessments and monitoring and better evidencing of work undertaken was felt to improve decision making by Social Workers and at panels. This information also made identification of non-engagement from families easier than if they had been referred to an external agency.

> *What I am seeing at the panel is an improvement in the quality of the work that's presented to enable us to make an informed decision to determine a threshold or whether we need legal planning.* **[Senior leader, follow-up interview]**

Support available

Reports varied as to whether cases and workload were perceived to have increased or decreased. Some Social Workers reported that holding what they perceived to be fewer cases (although which were more complex) meant less time recording and greater capacity for more and better quality risk assessment, reflection and intervention. Adult Specialist Practitioner involvement also meant that Social Workers were less overwhelmed with adult needs and had more time to focus on the child. Motivational Interviewing and the workbook modules also helped Social Workers to plan and undertake direct work with children and families that was more purposeful, evidence based and goal focused, using more evidence based practice and developing more specific plans.

> *I think Social Workers were able to kind of stop and pause with the model and think more about direct work, and more about what they're doing with families, rather than it being like a tick box exercise and to see families.* **[Senior leader, follow-up interview]**

Social Workers' knowledge and confidence to work with issues such as substance misuse and domestic abuse were also supported by Adult Specialist Practitioners providing advice on cases, as well as resources and running sessions on specific topics to share their multidisciplinary expertise. The more proactive intervention that these processes facilitated was felt to increase Social Workers' sense of accountability for their cases, and reduce reactivity and case escalation.

The Adult Specialist Practitioner services available were felt to be key areas of specialist support often needed by the families Social Workers worked with. These were areas where previously there had been gaps in support available, or where Social Workers may not have had the specialist expertise themselves.

> *Never really before had a resource where we could you know direct work with people who are you know, perpetrating domestic abuse.* **[Team Manager, follow-up interview]**

Under the Family Safeguarding Model, access to these specialist adult services was felt to be more immediate, overcoming barriers such as referral processes, waiting lists, not meeting thresholds for external specialist services. Having lower caseloads relative to practitioners in mainstream services, and working in the home environment, enabled Adult Specialist Practitioners to attend more case meetings than they would have been able to do before, and to work more in depth with parents. This meant families were more likely to be able to access the right specialist support for mental health, domestic abuse and substance misuse which was tailored to their needs. This support was also able to be accessed much sooner and therefore at the right time when they needed it. Parents we spoke to also felt that this work was more in-depth than services they had accessed previously.

> *I think when you come to their home, you get to know like I dunno you get to know them on a more personal level. So all the past judgement that you had on them, you don't have.* **[Family member, follow-up interview]**

Motivating families

Social Workers reported communicating and using language differently with families

under the Family Safeguarding model, as well as when writing assessments and reports. This made plans more understandable, encouraged parents to provide answers rather than Social Workers doing so, and kept parents informed. Motivational Interviewing tools and resources were found to be particularly useful to prompt discussion with families and communicate visually about goals and change needed, or to help children express their views. Social Workers were also felt to be better able to provide respectful and positive challenge to families.

> *"I think it helps parents understand about where we look at change and try and evaluate it. By showing the model physically I think that helps them to kind of understand as well.* **[Follow-up focus group]**

Social Workers also worked increasingly alongside or in partnership with families to meet children's needs, with increased focus on positives and strengths. Parents were also encouraged to think about the bigger picture and their child's perspective, and become more invested in actually making change rather than just ending social care's involvement. There was also increased responsibility placed on parents rather than dictating or telling parents about what they needed to do. As such, parents' voices were reflected much more in assessments and plans than they had been in the past.

Parents felt they were able to be open with professionals, particularly the Adult Specialist Practitioner who advocated on behalf of parents and whose specialist training and knowledge helped parents feel listened to and understood about issues that were important to them. Parents also reported feeling more trusted. It was felt that this increased ownership and openness would empower and motivate parents to be more likely to make and sustain changes that were needed.

Are there any differences in how the model operates depending on family characteristics, including interaction between co-occurring parental mental health, substance misuse or domestic violence issues?

Family characteristics perceived to be affecting how the model operates include the ability to use Motivational Interviewing in families with high risk or high hostility, as discussed earlier. Where more than one risk factor was present in a family, more than one Adult Specialist Practitioner could be involved. In one core group we observed, it was noted that co-occurring domestic abuse and mental health would interact with each other, but perceived by professionals at the time that the two areas of intervention should happen consecutively rather than concurrently. None of the families we interviewed were working with

multiple Adult Specialist Practitioners, so we were unable to gain insight into their experience of this process, such as whether it was helpful or unhelpful to have additional professionals involved.

b. *What potential impacts of the intervention do stakeholders identify?*

Summary of Findings

The majority of staff surveyed reported that the Family Safeguarding Model helps manage risk with families more effectively, improves family engagement, and improves outcomes for children and families. Potential benefits of Family Safeguarding identified by staff and families in interviews and focus groups included improved engagement of families, improved outcomes particularly for parents, less drift and delay in cases, as well as de-escalation of statutory involvement. Administrative data also indicates reductions in the number of children subject to Child in Need, Child Protection, Looked After Children, and PLO, but also increased duration of Child Protection Plans over time. However, it is important to note that at this stage this is not evidence of impact. There is no comparison group, and there are likely to be other factors that play a role in these outcomes. De-escalation of cases was reported to be happening before the model was introduced, and Covid-19, may also have played a role in changes in statutory intervention and outcomes. In addition, there were parents we spoke to who, whilst they felt that their experience working with the Adult Specialist Worker had been positive, reported that working with their Social Worker had not helped them.

Indicators

Key indicators pre and post introduction of the Family Safeguarding Model

Changes in the case recording system, from ICS to Liquid Logic, undertaken just as Family Safeguarding was introduced, made it difficult to monitor change in cases over time in Cambridgeshire over the evaluation period. There were gaps in data from January 2020, just before the model launched.

Case data that was available indicated that the proportion of referrals which were re-referrals increased from 23% in August to October 2019 to 61% in November to January 2020. This then decreased to 47% in February - April 2020 and 49% in May to July 2020. The average duration of Child Protection plans was 38 weeks in August to October 2019, 36 weeks in November - January 2020, 43 weeks in February to April 2020 and 48 weeks in May - July 2020.

The number of children in Family Safeguarding teams who were subject to Child in Need plans in October 2019 was 712. This had decreased to 369 in July 2020. The number of children in Family Safeguarding teams who were subject to Child Protection plans in October 2019 was 519. This had decreased to 239 in July 2020. The number of children in Family Safeguarding teams who were Children Looked After in October 2019 was 233. This had decreased to 88 in July 2020. The number of children in Family Safeguarding Teams who were subject to Public Law Outline (PLO) in January 2020 was 68. This had decreased to 30 children in July 2020.

These findings show some changes in these areas of children's social care intervention over time. However, these should not be taken to indicate evidence of impact of the model. This evaluation has not included a comparison group and is not designed to measure impact. Further, the introduction of the model also took place at the same time

as the global Covid-19 pandemic, which is also likely to have affected cases.

To what extent and through what mechanisms is the intervention perceived to affect: Staff self-reported workload, stress and wellbeing? Family engagement and outcomes, including relationships, wellbeing and risk/safety?

At the interim survey, 68% of respondents reported that they expected the Family Safeguarding Model to improve outcomes for children and families in Cambridgeshire. At the follow-up survey, 69% of respondents agreed or strongly agreed that the Family Safeguarding Model helps manage risk with families more effectively. At follow-up, 64% of respondents agreed or strongly agreed that the Family Safeguarding Model improves family engagement with Children's Social Care. At follow-up, 69% of respondents agreed or strongly agreed that the Family Safeguarding Model improves outcomes for children and families.

Family engagement with CSC

Using Motivational Interviewing to bring out parents' voices, highlight their strengths, and challenge in a positive way was felt in many cases to improve relationships with families as well as families' engagement and willingness to work with Children's Social Care.

> "*They were so scared about what we were going to do, what our intentions were, and we'd criticise them. So through continually acknowledging their actions rather than being problem saturated in how we work with them. They are then coming back to us saying thank you for your help. You've been really helpful.* **[Team Manager, follow-up interview]**

Involvement of Adult Specialist Practitioners who built relationships with parents and supported parents with their own needs in a way that felt slightly detached from statutory services, was also felt to increase engagement. Adult Specialist Practitioners also noted that because they were able to work more flexibly with families, including visiting families at home, parents were more likely to engage with their offer than they may have done in mainstream services.

Outcomes for families

It was generally felt too soon to assess whether the model had helped bring about sustainable change for families. In addition, there were parents we spoke to who, whilst they felt that their experience working with the Adult Specialist Worker had been positive, working with their Social Worker had not helped them. However, a number of staff shared examples of cases where they had observed improvements in a range of outcomes for parents who were working with the Family Safeguarding Model, particularly those who were working with Adult Specialist Practitioners.

> "*She then ended that relationship and sort of became really protective of the children. She then sought help for her mental health, and by the end of my involvement that was stepped down to a Child in Need, which I think was really positive for the family.* **[Adult Specialist Practitioner, follow-up interview]**

Changes in outcomes were also noted by parents we spoke to.

> "*Even in the short time that I've known [Adult Specialist Practitioner], I'm so much stronger. I am so much better able to cope with things.* **[Family member, follow-up interview]**

A number of staff also reported that there was less drift in cases. Immediate, targeted intervention with families, rather than having to wait for external services was felt to keep momentum and reduce the length of plans.

> *I think it makes it easy in terms of taking up resources which families may need in an easier way instead of delaying the Child Protection plan because we don't have the resource for them.* **[Follow-up focus group]**

De-escalation of children's social care involvement

At baseline it was expected that Family Safeguarding would reduce the risk of harm to children posed by parental risk factors such as domestic abuse, substance misuse and mental health, and consequently the number of children on Child Protection plans or looked after. This was expected to lead to cost savings for the local authority.

Anecdotally at follow-up, some staff did report that there were more cases being de-escalated, for example from Child Protection to Child in Need, and less cases that went into care proceedings or where children became Looked After.

> *When we didn't have the capacity to do the intervention using the model that we did, there was lots of scenarios where there would be a big incident that would meet thresholds. So there was lots of escalations of cases that you would have to get into court very, very quickly. I just don't have those anymore.* **[Senior leader, follow-up interview]**

Again it is important to note that these perceived changes over time are anecdotal.

These should therefore not be taken to indicate evidence of impact of the model.

c. *Do there appear to be any unintended consequences or negative effects?*

At baseline there were worries from some staff that Social Workers could become reliant on the Adult Specialist Practitioners. However, as demonstrated by the mechanisms considered above, staff at follow-up largely reported that Social Workers were skilled up by the Adult Specialist Practitioners' involvement rather than de-skilled.

Another potential unintended consequence of the model which is considered in the barriers above is increased workload reported by some staff. This was driven by the time demand of learning a new model as well as more intensive supervision or intervention as part of it, coupled with some staff perceiving that they were holding more complex caseloads where cases that can be held by Early Help or Universal Services had been closed. However, for some staff this change was perceived to have reduced their caseload. This potential for reduced

caseloads, as well as shared responsibility for cases, and potential longer term benefits for sustained change, may mitigate this initial increased workload to some extent. In addition, staff did not report being more stressed in their jobs at follow-up than they were at the interim point, although stress pre-intervention was not measured.

Readiness for Trial

a. *Is there a clear description of the intervention and the contextual facilitators and barriers that would allow it to be implemented and evaluated in other places?*

A revised logic model is presented in Appendix B outlining the intervention and its facilitators and barriers. This is simplified and adapted from the version presented in the pilot evaluation protocol (Sanders et al., 2019). The initial logic model developed at the outset of this pilot evaluation was largely supported by the findings in this report. However, there were certain elements that have been added based on these pilot findings.

Assumptions and contextual factors

Most contextual factors were already captured in the logic model. We added a number of additional assumptions and contextual factors. These included culture change around application of thresholds, compatibility of the workbook with existing processes. We also ensured that adult specialists and Social Workers understood each others' roles and perspectives, and that information of Family Safeguarding was communicated to staff in partner agencies. The role of modelling Family Safeguarding from the top down was also made more explicit.

Intervention

The intervention itself was largely captured as described in the logic model. We added detail to specify the length and frequency of Motivational Interview training and indicate staff attendance at workshops on Family Safeguarding.

Mechanisms

The logic model already captured mechanisms relating to shared decision making, staff workloads, families receiving more immediate access to specialist support, increased quality of social work and empowering families. We added to the model more collaborative ways of working across professionals. We also added Social Workers receiving training and guidance from Adult Workers on their specialist topics, leading to Social Workers having increased skills and confidence working with parent domestic abuse, mental health and substance misuse. We also added working in partnership, focusing on positives and strengths, and using Motivational Interviewing tools and language that help families think about goals and change. These, as well as Adult Specialist Practitioners advocating on behalf of parents were linked in the logic model to parents feeling understood and trusted, and able to be open with professionals.

Outcomes

This evaluation was not designed to test whether outcomes were achieved, but the potential outcomes identified in this pilot evaluation were largely already captured in the logic model. We added less drift and delay in cases, i.e. decisions and progress happening more quickly, a potential outcome identified in this pilot report not yet captured in the logic model. Workforce outcomes, including social

worker wellbeing and satisfaction were not particularly identified in this pilot evaluation as areas where the model could lead to improvements, but may be linked to workload and areas to explore in future research.

b. *Can the intervention be delivered consistently across teams?*

This evaluation identified variation in practice between practitioners and between different teams. The facilitators and barriers considered in this report are factors that should be taken into consideration to ensure consistent delivery.

c. *Are any changes needed to the theory, materials or procedures before rollout?*

This report identifies a number of factors that would support rollout. Improved guidance from the intervention developers on integrating Adult Specialist Practitioners in usual practice would help ensure that these roles are used optimally. Training on the workbook, the assessment and intervention programme and reflective supervision would benefit from being more in-depth, with more examples and tailored to the local authority's context and needs. This should include support for Team Managers to enable them to give consistent messaging about case recording, and guidance for how senior leadership can better model a Motivational Interviewing ethos within the adopting local authority. Consistent guidance on how the local project team can provide ongoing support for staff, including wider teams outside of Family Safeguarding, would also be beneficial. Training and guidance for business support taking minutes in group case supervision, and review of the supervision proforma to ensure it maximises opportunities for reflection on cases would be another area for consideration. Guidance for how local authorities adopting the model might adapt their local systems to ensure compatibility with the Family Safeguarding approach and workbook would also be beneficial. Ensuring staff workloads allow time for engagement with the new model and embedding of learning, is important particularly in the early stages of the model being introduced. A targeted approach is also needed to improve recruitment of Adult Specialist Practitioner roles, Mental Health Practitioner roles in particular. However, this is linked to national shortages in potential candidates and may be wider than the Family Safeguarding model can address on its own.

DISCUSSION

Discussion of Findings

Findings suggest that many elements of the Family Safeguarding Model are feasible to implement in a new local authority, even in the context of a global pandemic. The model is also well received by staff and families, particularly Motivational Interviewing. Although this evaluation is not designed to test impact, a range of potential benefits for children and families are identified. A number of challenges in implementation are identified which may be fundamental to address when rolling out Family Safeguarding in new areas in future. These findings are line with the Children's Social Care Innovation Programme wave 2 evaluation of the Family Safeguarding Model (Rodger et al., 2020), which showed successful embedding of many aspects of Family Safeguarding, and identified a number of similar areas where the process could be further improved.

Any conclusions drawn from this pilot evaluation should keep in mind the context in which Family Safeguarding in Cambridgeshire was being implemented and evaluated. As the first local authority to receive Family Safeguarding under the SFPC programme, the intervention developers had a narrow window to develop materials for the model rollout and to recruit and prepare their implementation team. This team was also largely operational staff experienced in the model, rather than specialists in training and coaching. Cambridgeshire also had a narrow window to prepare and plan for implementation and achieve buy-in from staff. Cambridgeshire had also introduced a new electronic case recording system immediately prior to the launch of Family Safeguarding, meaning staff had to adapt to a new recording system alongside a new model of practice and had not always seen the new system before they were trained in the workbook. Delivery of Family Safeguarding in Cambridgeshire was also affected by the Covid-19 pandemic. Whilst integration of multi-disciplinary teams and embedding training may happen more quickly as ways of working return towards normal, the effects of Covid-19 may be felt for some time and some degree of remote working may become part of usual practice in some areas. It may therefore still be important for model developers and adopters to consider how to support integration of virtual teams and ensure virtual training can be as successful as in-person training. It is also important to note that this pilot evaluation is only able to capture the early stages of implementation of the Family Safeguarding Model. With appropriate ongoing local support, components of the model which have taken longer to adopt will have the opportunity to embed further. It will, however, be important for local authorities adopting Family Safeguarding to keep momentum in the model in the face of staff turnover and other longer term local changes.

Although the context for each Local Authority introducing Family Safeguarding will differ, findings from this pilot evaluation

may be useful to inform refinement of training, materials and support provided by the intervention developer, as well as informing plans and activities undertaken by the local authorities who are introducing Family Safeguarding themselves. Further, this report highlights some considerations that affect policy and practice more widely than Family Safeguarding which underpin key elements of the model. As well as NHS partners, who employ the Mental Health Worker roles, responding to the national pandemic, a national short supply of suitably experienced mental health and probation candidates[4] in particular is likely to be a significant contributing factor to recruitment delays in Family Safeguarding. Collaboration and investment from Central Government and national bodies responsible for mental health and probation services may be key to developing a pipeline of practitioners able to fill these roles, and ensuring that investment in programmes such as Family Safeguarding is able to achieve its aims. Further to this, even at full capacity there are likely to be limitations to the number of cases that Adult Specialist Practitioners are able to be involved with, or meetings they are able to attend. To be able to offer Adult Specialist Practitioner support to all families who might need it, even greater investment in Adult Specialist Practitioner capacity may be needed than the model currently offers. Similarly, improvements to the workbook and a culture change from descriptive to analytical recording highlighted in this report may be partly dependent on statutory guidance and case recording requirements by the Department for Education, and limited by IT systems such as Liquid Logic.

Refining support available from the intervention developer and adopting local authority, as well as overcoming local and national barriers to successful implementation of Family Safeguarding as intended by the model developers, will ensure that any impact evaluation is an evaluation of the true model, rather than a partial version of it. This would enable accurate conclusions to be drawn about the effectiveness of Family Safeguarding. If the model is found to be effective, being able to deliver the model in a way that changes practice as intended will also be important to achieve optimal outcomes for children and families, such as supporting parents to reduce risk and keeping families together.

4 Reforms to reinstate a single National Probation Service, including recruiting and training a new workforce are expected to take some time.

Quantitative evaluation would be needed to establish whether the mechanisms identified in this pilot evaluation are actually happening more in Family Safeguarding than in practice as usual, as well as whether they are leading to actual impacts in the range of potential child and parent outcomes that the model was felt to be likely to achieve. Some of the perceived change, such as momentum in cases, may have related to reductions in caseloads perceived by some staff, rather than the new model specifically, given that at baseline staff had already reported a more stable workforce and workload linking to reductions in drift in cases.

Limitations

Recruitment, direct practice and training were all affected by the Covid-19 pandemic. This affects how much the findings from this pilot evaluation can be generalised in the future, although it is likely that the Covid-19 pandemic will continue to affect children, families and social work practice for some time to come. There were also limitations to the types of observations that were possible at follow-up due to collecting data virtually. As such conclusions cannot be drawn about the use of Motivational Interviewing when working one to one with families at follow-up.

Due to IT limitations, certain delivery data was not available from the local authority monitoring system. Therefore, conclusions cannot be drawn about the proportion of cases for which certain elements of the model were used, such as the assessment and intervention programme. Similarly, a formal rating of fidelity to Motivational Interviewing was out of scope of this evaluation. This means concrete conclusions about whether the components of Motivational Interviewing practice became more prevalent or better quality from before to after the model was introduced cannot be drawn. Interpretation of findings should also consider that staff who chose to respond to the survey may not be representative of all staff in the Family Safeguarding service. Although survey data was anonymous, responses may also have been affected by desirability effects such as reporting using a certain approach that they are expected to be using. Without a formal observation it is not possible to conclude whether or how much staff are actually using this approach, or the quality of implementation.

This evaluation aims to report on feasibility and promise of Family Safeguarding in a new area, and gain understanding of its mechanisms. It is not able to and should not be used to draw conclusions about the impact of Family Safeguarding. The stepped-wedge randomised controlled trial of Family Safeguarding being undertaken by What Works for Children's Social Care as part of the Department for Education's Strengthening Families, Protecting Children programme is the next step in this evaluation process. This project now underway aims to draw conclusions about the impact of Family Safeguarding relative to a robust comparison.

Conclusions and Recommendations

Based on findings of what worked well in Cambridgeshire, as well as ways in which delivery could be improved, the following processes should receive particular attention when introducing Family Safeguarding in a new area, to ensure successful implementation.

- **Recruitment of Adult Specialist Practitioners** should include locally tailored and flexible strategies, working closely with partner agencies,

particularly Mental Health, from early in the process of setting up the programme. This should include consideration of local and national pressures that might affect recruitment of certain roles and identification of creative solutions for these. Considerable resources are already dedicated to recruitment of these roles. Adopters should begin the process of securing shared buy-in and progressing recruitment pathways as early as possible to optimise chances of success. Having good relationships with partners, well framed job descriptions and appropriate salaries relative to the cost of living are all important for this. A pipeline of practitioners able to fill these specialist roles, developed with support and investment from Central Government and national bodies with oversight for these professions, may also be key to achieving success in this key component of Family Safeguarding.

- **Relationship building and knowledge sharing between Adult Specialist Practitioners and social care staff should be facilitated** through ensuring Adult Specialist Practitioners are embedded in the day to day processes of the teams they are a part of. This includes ensuring that Adult Specialist Practitioners are visible and are able to attend meetings and group case supervision with all the teams they are a part of. Building on the experience of Cambridgeshire and other local authorities during the pandemic, guidance on how this can be best achieved when working in a virtual or hybrid environment would be helpful. Ensuring they work across only one or two teams would also be helpful for this. Introductory sessions to support familiarisation between Adult Specialist Practitioner and Social Worker roles, ensuring Adult Specialist Practitioners understand the children's social care context and adapt their work accordingly, as well as ongoing forums for sharing expertise are also key activities to achieve this which were used by Cambridgeshire. Findings also suggest the importance of early engagement work that might prepare an individual for being ready to work with adult specialists, particularly a Domestic Abuse Perpetrator Worker.

- **Initial training for the workbook and the assessment and intervention programme should be more in-depth, with clear examples, and tailored to the local authority's context and needs.** Building on what was delivered in Cambridgeshire, this should be supported by a comprehensive package of ongoing training and support provided by the local authority into which the model is being introduced, as well as training for partners. Clear guidance for case recording should be available, and Team Managers should be supported to provide consistent messaging on case recording. Timing of workbook training in particular should be carefully considered, particularly if a new case recording system is being introduced at the same time, so that staff are able to apply their learning immediately or soon after. Further consideration of how virtual training is able to be as useful as in person training is another key area for development.

- **Alignment between the workbook and existing local systems and legal processes** is important. Local authorities introducing Family Safeguarding should consider, with support from the intervention

developers, how local systems might need to be adapted to avoid duplication and ensure the workbook is useful in different contexts and accessible to a range of professionals outside of Family Safeguarding teams. Building on what was delivered in Cambridgeshire, developers and local authorities adopting Family Safeguarding should also ensure that a consistent approach to support for assessment teams, Independent Reviewing Officers (IROs) or Conference Chairs, and legal panels is available from the outset, and sufficiently in-depth, with ongoing support.

- **Training and guidance for Team Managers leading reflective group case supervision** should be more in-depth, supporting them for the group and reflective nature of the discussion. In addition, consistent guidance for coordination and the minute taking process for **business support staff** should be provided by the intervention developer. The intervention developer should also review and streamline the supervision proforma to facilitate more reflective discussions, for example, avoiding repetition and if possible ensuring information such as previous actions pull through to the supervision form more easily to reduce time spent on this component. Group case supervision should also include sufficient reflection on the risk staff are accountable for, and ensure the child's needs are kept central.

- **Ensuring staff have enough time to think about and use the Family Safeguarding model, and engage in the training and support available.** This is particularly important in the early stages of delivery whilst they familiarise with the process. This may include ensuring sufficient opportunities for reflection and skills development. This includes ensuring staff are able to make time for the Motivational Interviewing skills development workshops and that these are available monthly as intended. Staff capacity may be facilitated by, for example, temporarily investing in over-recruitment to reduce workloads just while the model embeds. Ensuring there are also informal opportunities for learning as staff familiarise with the model, within supervision, team meetings and bespoke sessions, is also helpful. Ensuring case recording is set up to avoid duplication of work, and that staff feel supported by leadership to record only what is needed, i.e. analytically rather than descriptively, would also make a big difference to the time staff are able to dedicate to embedding the model. This change in approach to recording may be partly dependent on statutory guidance and case recording requirements by the Department for Education, and may be limited by IT systems such as Liquid Logic.

- More time to reflect and develop practice would be particularly useful for further development of some of the more complex elements of Motivational Interviewing which are less commonly used as part of usual social work practice. This should be supported by **top down modelling of a Motivational Interviewing approach from leadership** to ensure staff are immersed in this way of thinking, as well as support for other internal teams as well as partners in this approach. This would be important to help staff to balance the Family Safeguarding approach with the risks and expectations that come with working in a children's safeguarding context.

Directions for Future Research

The next step to build on these findings is the stepped-wedge cluster randomised controlled trial (RCT), supplemented by a Difference-in Differences analysis, being led by What Works for Children's Social Care (Schoenwald et al., 2020). This is being undertaken in five local authorities who are introducing Family Safeguarding between 2020 and 2022. Implementation in this next phase will take into account where possible learning from this pilot evaluation. The next phase of the evaluation will consider the impact of Family Safeguarding on the likelihood of children being looked after. Secondary outcomes this evaluation will also be measuring are the likelihood of re-referral, duration of time spent on Child Protection plans, the likelihood of progressing to care proceedings and school absence rates. Secondary outcomes also include re-referral for domestic abuse, parental mental health or substance misuse. This impact evaluation will be accompanied by an Implementation and Process Evaluation (IPE) seeking to measure implementation to help understand and explain any identified intervention effects (or lack thereof) in the concurrent stepped-wedge cluster randomised controlled trial, and continue to improve understanding of the model.

This next stage will take into account key learning from this pilot evaluation about the availability of data and which components and mechanisms to measure. It will be important to consider how outcomes will be monitored consistently over time where case recording systems may be changing, and whether systems can be set up to monitor certain aspects of delivery that were not possible in the current pilot. Some components not able to be measured may require changes to underlying IT systems to be possible to capture comprehensively. Given there were some staff who were already trained in Motivational Interviewing, it will also be important for the Implementation and Process Evaluation to capture practice and knowledge before Family Safeguarding is introduced to help explain any impact or absence of impact that may be detected. The Implementation and Process Evaluation should also seek to measure whether implementation challenges in this pilot are overcome in the local authorities participating in the trial. This will have important implications for interpreting the impact findings and whether an effect, or absence of effect, might be attributed to differential implementation rather than the Family Safeguarding model as specified. It will also be possible to consider whether mechanisms operate similarly in different local authority contexts, and whether components of Family Safeguarding were already in place before the model was introduced.

Future research may also consider further testing the logic model. This may

include whether the mechanisms of Family Safeguarding can be measured quantitatively and establishing the key active ingredients and mediators of the model, including whether certain outcomes may be driven by factors other than Family Safeguarding. Further, workforce outcomes such as social worker wellbeing, satisfaction, sickness and retention, which feature in the logic model, could be a further area of potential impact to explore. Finally, research may also be useful to help test and refine any amendments to the Family Safeguarding training and support package as it currently stands.

REFERENCES

Bundy, C. (2004). Changing behaviour: using motivational interviewing techniques. Journal of the royal society of medicine, 97(Suppl 44), 43.

Department for Education. (2020). Strengthening families, protecting children (SFPC) programme. Retrieved from https://www.gov.uk/guidance/strengthening-families-protecting-children-sfpc-programme

Department for Education (2021a). Children looked after in England including adoption: 2019 to 2020

Department for Education. (2021b). Children's Social Care Innovation Programme: insights and evaluation. Retrieved from https://www.gov.uk/guidance/childrens-social-care-innovation-programme-insights-and-evaluation

Department for Education (2021c) Children's social work workforce 2020

Department for Education. (2021d) . Guidance for schools: coronavirus (COVID-19). Retrieved from https://www.gov.uk/government/collections/guidance-for-schools-coronavirus-covid-19

Family Rights Group. (2018) Care Crisis Review: A sector-led Review of the rise in applications for care orders and the number of children in care. https://frg.org.uk/policy-and-campaigns/the-care-crisis-review/

Forrester, D., Lynch, A., Bostock, L., Newlands, F., Preston, B., & Cary, A. (2017) Family Safeguarding Hertfordshire: Evaluation Report. Department for Education: London

Forrester, D., Westlake, D., Killian, M., Antonopoulou, V., McCann, M., Thurnham, A., ... & Hutchison, D. (2018). A randomized controlled trial of training in Motivational Interviewing for child protection. *Children and Youth Services Review*, 88, 180-190.

NSPCC. (2021). Looked after children: statistics briefing. Retrieved from https://learning.nspcc.org.uk/research-resources/statistics-briefings/looked-after-children

Rodger, J., Allan, T., Elliot, S. (2020) Family Safeguarding Evaluation Report. Department for Education: London

Sanders, M., Reid, L., Collyer, H. (2019). Strengthening Families, Protecting Children Family Safeguarding Model: Pilot. https://whatworks-csc.org.uk/wp-content/uploads/WWCSC_SFPC_Pilot_Protocol_-Family_Safeguarding_Oct_2019.pdf

Schoenwald, E., Collyer, H., Sholl, P., Sanders, M., Reid, L., Lee Luca, D. (2020). Trial Evaluation Protocol: Strengthening Families, Protecting Children - Family Safeguarding Model. https://whatworks-csc.org.uk/research-project/family-safeguarding-model-trial-evaluation/

WWCSC (2018) Mapping the evidence about what works to safely reduce the number of children and young people in statutory care: a systematic review. London: England

APPENDICES

Appendix A: Tables

What is your role?	Interim			Follow-up		
	Agency	Permanent	Total	Agency	Permanent	Total
Senior Practitioner	1	5	6	1	4	5
Children's practitioner	0	18	18	0	11	11
Social Worker	0	22	22	3	10	13
Specialist Adult Practitioner - domestic abuse (survivors/ victims)	0	2	2	2	2	4
Specialist Adult Practitioner – substance misuse	0	0	0	1	3	4
Student or Apprentice Social Worker	0	0	0	0	1	1
Team Manager	3	3	6	1	4	5
Total	4	50	54	8	35	43
Respondents: All						

	Which district do you work in?	
	Interim	Follow-up
Cambridgeshire City	14	16
East Cambridgeshire	12	5
Fenland	12	7
Huntingdon	2	12
South Cambridgeshire	14	4
Total	54	44[a]

Respondents: All

[a]This is 44 because one staff member reported working in two districts

	Is this role in your team?	
	Interim	Follow-up
Domestic abuse (survivors / victims) practitioner	22	29
Domestic abuse (perpetrator) practitioner	7	12
Mental Health Practitioner	1	7
Substance Misuse Practitioner	3	26
None of these	24	5
No. of Respondents	50	34

Respondents: All except Adult Specialist Practitioners

How often do you participate in group case discussion for cases with multiple professionals involved? (Interim)								
	Once a week	Once a fortnight	Every 2-3 weeks	Once a month	Every 2 months	Every 3 months or longer	Never	N/A
Senior Practitioner				2			4	
Children's practitioner	1	1	2	5	1	1	4	3
Social Worker			2	6			7	5
Specialist Adult Practitioner - domestic abuse (survivors/ victims)		2						
Total	1	3	4	13	1	1	15	8

Respondents: All case holding practitioners

How often do you participate in group case discussion for cases with multiple professionals involved? (follow-up)								
	Once a week	Once a fortnight	Every 2-3 weeks	Once a month	Every 2 months	Every 3 months or longer	Never	N/A
Senior Practitioner		1		2			2	
Children's practitioner	1		1	3	3		1	2

Social Worker / Student SW	1	2		5			1	4
Specialist Adult Practitioner - domestic abuse (survivors/ victims)	1			3				
Specialist Adult Practitioner - substance misuse		1	1	2				
Total	3	4	2	15	3	0	4	6

Respondents: All case holding practitioners

How often do you receive case supervision? (Interim)						
	Every 2-3 weeks	Once a month	Every 2 months	Every 3 months or longer	Never	Total
Senior Practitioner		4	1	1		6
Children's practitioner		14	4			18
Social Worker	1	14	3	2		20
Total	1	32	8	3	0	34

Respondents: Social Workers, Children's Practitioners, Senior Practitioners

How often do you receive case supervision? (Follow-up)						
	Every 2-3 weeks	Once a month	Every 2 months	Every 3 months or longer	Never	Total
Senior Practitioner	0	4	1	0	0	5
Children's practitioner	1	9	1	0	0	11
Social Worker / Student Social Worker	2	10	1	0	0	13
Total	3	23	3	0	0	29

Respondents: Social Workers, Children's Practitioners, Senior Practitioners

Prior to the introduction of the Family Safeguarding Model, I had previously attended training in Motivational Interviewing, e.g. in a previous local authority or role?		
	Interim	Follow-up
No	30	28
Yes	22	12
Total	52	40

Respondents: All

Since the initial training, I have received follow-up support (such as workshops or reflection in supervision or team meetings) for Motivational Interviewing	
Weekly	0
Fortnightly	0
Monthly	14
Less often than monthly	20
Not at all	5
Total	39

Respondents: All

Follow-up support received since the initial training	
Follow up / refresher Motivational Interviewing skills and development training	12
Supervision	6
Team Meetings / Discussions	4
Refreshers or 1:1 support on the modules or workbook	5
MI resources from the training provider	1
Reflective groups for MI	1
Workbook support from a colleague	1
FS Information emails	1

Respondents: All

I use the Family Safeguarding electronic workbook		
	Interim	Follow-up
Yes with all cases I work with	34	21
Yes, with over half of the cases I work with	4	4
Yes, with less than half of cases I work with	1	2
No	5	4
N/A I don't hold cases	7	9
Total	51	40

Respondents: All

I use the eight module assessment and intervention programme		
	Interim	Follow-up
Yes with all cases I work with	6	9
Yes, with over half of the cases I work with	6	9
Yes, with less than half of cases I work with	11	4
No	14	7
N/A I don't hold cases or this is not part of my role	14	11
Total	51	40

Respondents: All

Cases open to Family Safeguarding Teams

	Before FS go-live		After FS go-live	
	Aug 2019 - Oct 2019	Nov 2019 - Jan 2020	Feb 2020 - Apr 2020	May 2020 - July 2020
Cases open to FS teams during the 3 month reference period				
Average age	6.47	N/A	6.8	6.3
New cases opened to FS teams during the 3 month reference period				
Number of new cases	159	545	505	414

Proportion of new cases which are re-referrals to statutory services	23%	61%	58%	62%
Primary Category of Need of children in new cases opened within the period to FS teams (one primary category is assigned per case)				
Abuse or Neglect	108 (70%)	491 (90%)	422 (84%)	371 (90%)
Parental Illness	10 (6%)	19 (3%)	16 (3%)	6 (1%)
Family in Acute Stress	3 (2%)	11 (2%)	27 (5%	23 (6%)
Family Dysfunction	17 (11%)	9 (2%)	10 (2%)	14 (3%)
Socially Unacceptable Behaviour	2 (1%)	7 (1%)	1 (0.2%)	0
Absent Parenting	0	3 (0.5%)	0	0
Cases other than Children in Need	8 (5%)	3 (0.5%)	0	0
Disability	0	2 (0.4%)	2 (0.4%)	0
Unborn Baby	7 (4%)	0	0	0
Honour based violence	4 (3%)	0	0	0
Secondary Category of Need of children in new cases opened within the period to FS teams (Multiple secondary categories can be assigned per case)				
Abuse or Neglect	25 (16%)	347 (64%)	149 (30%)	110 (27%)
Mental Health	12 (8%)	335 (61%)	147 (29%)	112 (27%)
Domestic Abuse / Violence	24 (15%)	267 (49%)	133 (26%)	103 (25%)
Substance Misuse	10 (6%)	202 (37%)	110 (22%)	80 (19%)
Learning Disability	1 (1%)	64 (12%)	27 (5%	20 (5%)
Young Carer	0	59 (11%)	25 (5%)	11 (3%)
Socially Unacceptable Behaviour	0	21 (4%)	27 (5%)	10 (2%)
Physical Disability / Illness	0	47 (9%)	29 (6%)	25 (6%)
Other	5 (3%)	17 (3%)	28 (6%)	18 (4%)
Self Harm	0	14 (3%)	15 (3%)	6 (1%)
CSE	0	4 (0.7%)	7 (1%)	10 (2%)
Missing	0	3 (0.6%)	9 (2%)	6 (1%)
Trafficking	0	3 (0.6%)	3 (1%)	2 (0.5%)

Gangs	0	1 (0.2%)	8 (2%)	3 (1%)
Abuse linked to faith or belief	0	0	2 (0.4%)	0
Cases open to FS teams at the end of the reference period				
Number of cases subject to a Child in Need plan	712 (49%)	N/A	383 (56%)	369 (53%)
Number of cases subject to a Child Protection plan	519 (35%)	N/A	197 (29%)	239 (34%)
Number of Children Looked After	223 (15%)	N/A	104 (15%)	88 (13%)
Cases in Pre-Proceedings / Public Law Outline (PLO)	N/A (data unreliable prior to January)	68	54	30
Cases open to FS teams during the reference period				
Domestic Abuse	N/A	N/A	69	72
Mental Health	N/A	N/A	10	12
Substance Misuse	N/A	N/A	20	22
Cases closing (de-escalating) CP plans during the reference period				
Average duration of CP (weeks)	38	36	43	48

Posts (Vacancies)[a]				
	31 October 2019	31 January 2020	30th April 2020	31st July 2020
Team Manager	9 (0)	9 (0)	9 (0)	10 (1)
Senior Practitioner	11 (3.5)	10 (2)	10 (1)	10 (1)
Social Worker	41 (3)	39 (2)	38 (2)	41.5 (3)
Child Practitioner	23 (0)	21 (0)	18 (0)	20 (0.5)
Domestic abuse (survivors / victims) practitioner	N/A	All vacant	5 (0)	5 (0)
Domestic abuse (perpetrator) practitioner	N/A	All vacant	5 (5)	5 (2)
Mental Health Practitioner	N/A	All vacant	5 (5)	5 (5)
Substance Misuse Practitioner	N/A	All vacant	5 (4)	5 (2)

Source: Admin data | [a]The first three data points are based on 9 teams, the final data point is based on 10 teams

Average Current Caseload (Survey Data)[a]		
	Interim	Follow-up
Senior Practitioner	19	15
Children's practitioner[b]	15	11
Social Worker	16	13
Specialist Adult Practitioner - domestic abuse (survivors/victims)	6	11
Specialist Adult Practitioner - substance misuse	N/A	11
Student or Apprentice Social Worker	N/A	5

Respondents: Case Holding Practitioners | [a]Not FTE, we didn't ask for full or part-time status | [b]Includes joint working

I have sufficient time to undertake effective direct work with families on my caseload (Respondents: SW, CP, AP)		
	Interim	Follow-up
Strongly agree	1	0
Agree	19	10
Neither agree nor disagree	9	5
Disagree	9	7
Strongly disagree	4	3
Total	42	25

Respondents: Social Workers, Children's Practitioners, Senior Practitioners

I have sufficient time to take full advantage of the Family Safeguarding Model		
	Interim	Follow-up
Strongly agree	3	2
Agree	13	9
Neither agree nor disagree	17	13
Disagree	13	9
Strongly disagree	4	4
Total	50	37

Respondents: All

I have a good understanding of the Family Safeguarding Model		
	Interim	Follow-up
Strongly agree	5	7
Agree	37	27
Neither agree nor disagree	7	5
Disagree	2	0
Strongly disagree	1	1
Total	52	40

Respondents: All

I feel confident to use Motivational Interviewing with families		
	Interim	Follow-up
Strongly agree	5	5
Agree	33	25
Neither agree nor disagree	6	4
Disagree	1	0
Strongly disagree	1	1
Total	46	35

Respondents: All case holding practitioners

The supervision I receive is helpful in supporting my decision making and practice with families I work with		
	Interim	Follow-up
Strongly agree	12	13
Agree	23	18
Neither agree nor disagree	5	3
Disagree	1	0
Strongly disagree	5	3
Total	46	37

Respondents: All case holding practitioners

I have received sufficient training and support to prepare me to deliver the Family Safeguarding Model		
	Interim	Follow-up
Strongly agree	6	1
Agree	17	17
Neither agree nor disagree	16	13
Disagree	11	7
Strongly disagree	2	2
Total	52	40

Respondents: All

Support from leadership and management to implement the Family Safeguarding Model is effective		
	Interim	Follow-up
Strongly agree	7	3
Agree	17	23
Neither agree nor disagree	19	9
Disagree	3	2
Strongly disagree	4	2
Total	50	39

Respondents: All

The Motivational Interviewing training I attended was useful		
	Interim	Follow-up
Strongly agree	17	13
Agree	25	19
Neither agree nor disagree	5	2
Disagree	1	0
Strongly disagree	2	0
Total	50	34

Respondents: All who reported attending MI training

Motivational Interviewing is an effective way to improve outcomes for families		
	Interim	Follow-up
Strongly agree	14	12
Agree	29	23
Neither agree nor disagree	7	4
Disagree	0	0
Strongly disagree	2	1
Total	52	40

Respondents: All

Using the Family Safeguarding Model has improved my practice		
	Interim	Follow-up
Strongly agree	2	2
Agree	16	16
Neither agree nor disagree	29	19
Disagree	3	2
Strongly disagree	2	1
Total	52	40

Respondents: All

My leadership and management team keeps me well informed about changes affecting my work		
	Interim	Follow-up
Strongly agree	9	7
Agree	26	22
Neither agree nor disagree	11	8
Disagree	3	1
Strongly disagree	1	1
Total	50	39

Respondents: All

I am satisfied with how the introduction of the Family Safeguarding Model has been managed		
	Interim	Follow-up
Strongly agree	3	2
Agree	15	13
Neither agree nor disagree	17	19
Disagree	14	2
Strongly disagree	1	3
Total	50	39

Respondents: All

I am satisfied in my job		
	Interim	Follow-up
Strongly agree	7	7
Agree	29	18
Neither agree nor disagree	9	8
Disagree	3	4
Strongly disagree	2	0
Total	50	37

Respondents: All

I feel stressed in my job		
	Interim	Follow-up
Strongly agree	2	6
Agree	14	7
Neither agree nor disagree	22	8
Disagree	9	11
Strongly disagree	3	5
Total	50	37

Respondents: All

I expect to remain within Children's Safeguarding in Cambridgeshire for the next year		
	Interim	Follow-up
Strongly agree	16	12
Agree	21	17
Neither agree nor disagree	11	6
Disagree	1	1
Strongly disagree	1	1
Total	50	37

Respondents: All

I use Motivational Interviewing in my work		
	Interim	Follow-up
Yes with all cases I work with	18	20
Yes, with over half of the cases I work with	21	11
Yes, with less than half of cases I work with	9	3
No	0	1
N/A I don't hold cases	3	5
Total	51	40

Respondents: All

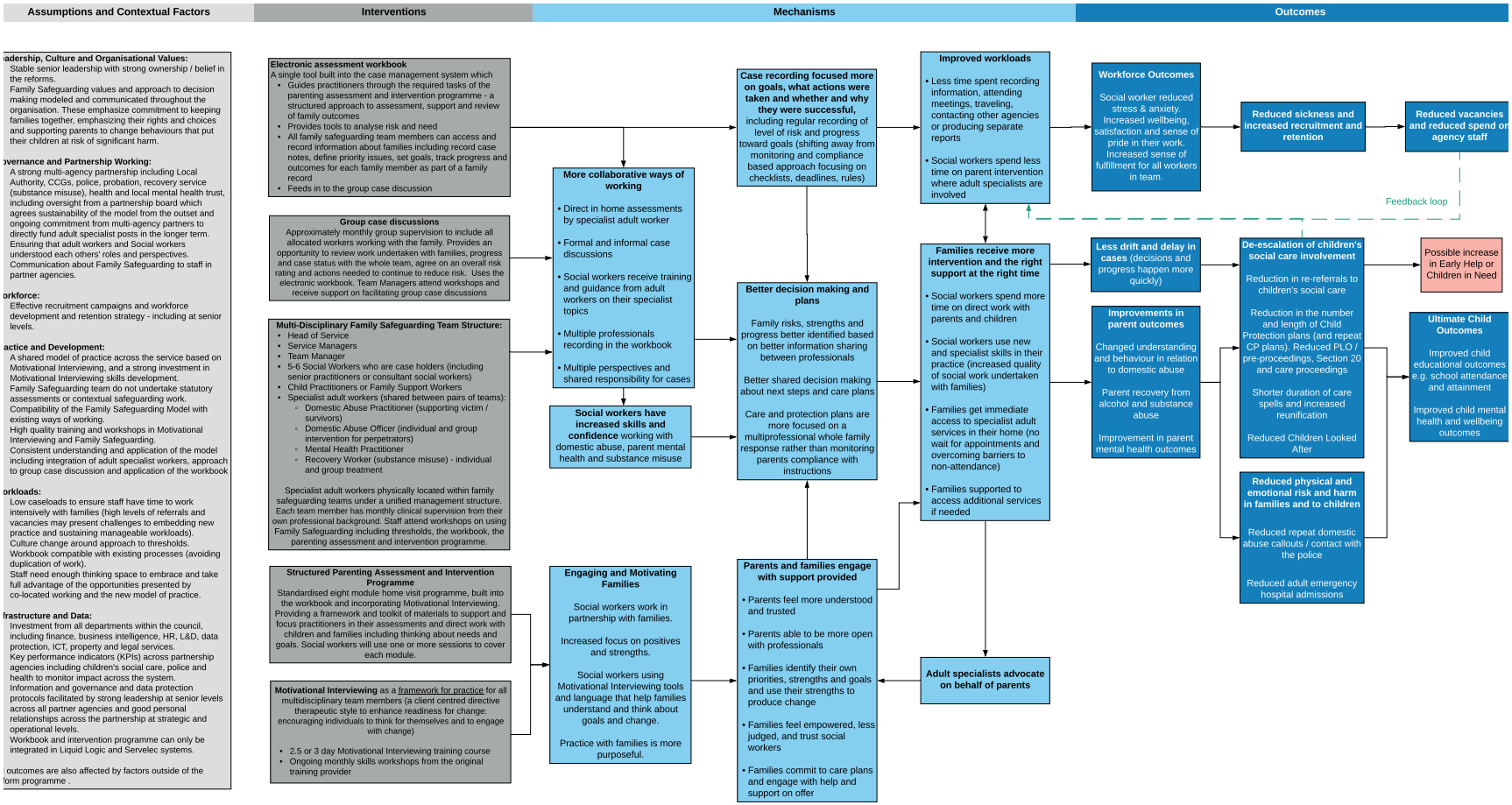
I expect the Family Safeguarding Model to improve outcomes for children and families in my area	
Strongly agree	13
Agree	22
Neither agree nor disagree	15
Disagree	0
Strongly disagree	1
Total	51

Respondents: All

	The Family Safeguarding Model helps manage risk with families more effectively	The Family Safeguarding Model improves family engagement with children's social care	The Family Safeguarding Model improves outcomes for children and families
Strongly agree	4	6	6
Agree	23	19	21
Neither agree nor disagree	9	11	9
Disagree	1	1	1
Strongly disagree	0	0	0
Total	39	39	39

Respondents: All

Appendix B: Revised Logic Model



What Works *for* Children's Social Care

info@whatworks-csc.org.uk
@whatworksCSC
whatworks-csc.org.uk