‘You Can’t Grow Roses in Concrete’ Part 2

Action Research Final Report
Signs of Safety
England Innovation Programme

Eileen Munro and Andrew Turnell
with Marie Devine and Jack Cunliffe

Version 1.0

‘You Can’t Grow Roses In Concrete’ Part 2

Action Research Final Report, Signs of Safety England Innovation Programme

Professor Eileen Munro and Professor Andrew Turnell
with Marie Devine and Dr Jack Cunliffe

ISBN: 978-0-9924284-6-4

Published by Elia International Ltd.
COM 1, 153 Kensington Street
East Perth WA 6004
Australia

www.elia.ngo

Acknowledgements

With appreciation of the help received from the following colleagues:

Joke Wiggerink, Terry Murphy, Dr Louise Caffrey, Dennis Simpson, Viv Hogg, Tracey Hill, Bev Edwards, Kay Whyte-Bell, Jo Ratcliffe, Damian Griffths, Agi Gault, Wendy Hill and Adrian Gimpel.

Table of Contents

1. Introduction

Munro, Turnell and Murphy Child Protection Consultancy (MTM) have received two grants from the English Innovations Programme to work with eleven local authorities* to implement whole system reform to support Signs of Safety practice. The first grant funded 18 months' work in 2014–16 (hereafter referred to as EIP1) and was written up in a final report: *You can't grow roses in concrete, Part 1* (Munro, Turnell, & Murphy, 2016). This report: *You can't grow roses in concrete, Part 2* covers the second grant (hereafter referred to as EIP2) funding two years' work carried out between 2017–19 but also pulls both projects together and examines progress over the five-year period.

The main finding from these years of endeavour by all concerned is that despite what can be seen as similar input from MTM, the local authority Children's Social Care Departments that we have worked with have followed radically different causal pathways. During the period of the implementations, all received at least two** visits of inspection by Ofsted, the national inspection agency, and figure 1 shows the two overall judgments they received. It reveals dramatically different trajectories, some rising to 'outstanding' and others falling to 'inadequate'. There are four possible judgments: outstanding, good, requires improvement and inadequate.

* *The participating authorities have changed. Ten authorities joined EIP1 but one chose not to participate in EIP2 and is not included in this report because we do not have the necessary data. Another authority joined EIP2 and is included here. A third dropped out part way through EIP2 after receiving an 'inadequate' Ofsted judgment and is included though the most recent data is missing.*

** *Departments receiving an 'inadequate' judgment receive annual monitoring visits.*

1.1 EIP2 Ofsted ratings

The local authorities are in three groups according to progress made during the EIP projects. Group 1 = authorities that have gained an 'outstanding' Ofsted judgment. Group 2 = authorities that have made some progress. Group 3 = authorities that have made no progress or deteriorated. Local authorities are anonymised and given a letter from A to K (omitting I). The order within any group is random.

PROGRESS GROUP	LA	OVERALL	CHILDREN WHO NEED HELP AND PROTECTION	LEADERSHIP	DATE
1	A	Requires Improvement Outstanding	Requires Improvement Outstanding	Requires Improvement Outstanding	2014 2018
1	B	Good Outstanding	Requires Improvement Outstanding	Good Outstanding	2015 2019
1	C	Good Outstanding	Good Good	Good Outstanding	2014 2019
2	D	Requires Improvement Good	Requires Improvement Requires Improvement	Requires Improvement Good	2015 2018
2	E	Inadequate Requires Improvement	Requires Improvement Requires Improvement	Requires Improvement Requires Improvement	2015 2017
2	F	Requires Improvement Requires Improvement	Requires Improvement Requires Improvement	Requires Improvement Good	2017 2019
2	G	Requires Improvement Requires Improvement	Requires Improvement Requires Improvement	Requires Improvement Good	2014 2018
3	H	Requires Improvement Inadequate	Requires Improvement Inadequate	Requires Improvement Inadequate	2016 2018
3	J	Requires Improvement Requires Improvement	Requires Improvement Requires Improvement	Requires Improvement Requires Improvement	2015 2019
3	K	Requires Improvement Inadequate	Requires Improvement Inadequate	Requires Improvement Inadequate	2015 2019

Table 1.1: EIP2 Ofsted ratings

Anonymity is provided as far as possible in this report. We offered confidentiality at the start of the project to encourage open discussion of problems. In general, we report findings only as relating to an authority in one of the 3 groups of progress, not to a specific authority.

The Ofsted judgments are made independently of MTM but are consistent with other findings, judgments and impressions on the progress made in the local authorities. We also have some confidence that they are judging Signs of Safety practice by similar criteria to ourselves based on what they single out for praise in their reports. The inspection judgments are used here to create 3 categories for the purpose of this review of progress. The primary aim of this report is to explore how such variations in progress arose and to draw out lessons on what factors have most influence (positive or negative) on the whole system reform and on how some authorities successfully achieved change and what impeded progress in others. In doing so, we also address the two questions posed by the Department for Education who funded the projects:

- Is Signs of Safety being implemented?
- What organisational forms best support front line Signs of Safety practice?

Since the funding was specifically for child protection work, this report focuses primarily on that part of the work but, where appropriate, reference is made to the work done in the other parts of Children's Social Care Departments' responsibilities since all the authorities chose to implement Signs of Safety across their children's social care services.

There is an independent evaluation being conducted by a team from King's College London headed by Dr Mary Baginsky which will study the outcomes for children but this report also includes some appraisal of the impact on children, young people and their families as well as on the workforce.

1.2 Methodological approach

While the varied progress among the local authorities is disappointing, it is an unsurprising outcome when introducing change into complex, dynamic social systems. To repeat the quote from Ray Pawson cited in *You can't grow roses in concrete, Part 1*:

> *Social interventions are complex systems thrust into complex systems (Pawson, 2006 p.35)*

A complex system contains a dynamic network of people, artefacts and structures that are constantly interacting and reacting to each other and these, in turn, influence behaviour and the network as a whole. This creates a difficulty in attributing any single outcome, such as child safety, to either a single or combination of causes. For this reason, we have used a realist approach both in implementing change and in monitoring the progress and impact of that change. This approach plays close attention to the context in which interventions take place. Assumptions include that how people respond to a programme will depend on the context in which they are operating, and the reasoning and behaviour of participants will vary depending on these circumstances. It addresses the questions, *what works, how does it work, for whom, and in what circumstances?*

A more detailed account of our methodological approach is provided in Appendix A.

Before discussing how we evaluated the implementation of Signs of Safety, it is necessary to describe what it is. The Signs of Safety practice Theory of Change integrates principles, disciplines, learning

methods and tools to guide practitioners in working with families in child protection and child welfare services. Signs of Safety is a process rather than a content model. It draws on people's wisdom, theory and expertise, both professionals and family members, providing a clear structure for how to think, what to think about and how to reason about the situation from the information available and the different perspectives of everyone involved, and then together make judgments and decisions on actions. The Signs of Safety assessment and planning framework operationalises its philosophical and practice theory of change commitments/assumptions that the best way to solve the human problems that child protection deals with is not to impose professional answers on family problems but to bring together everyone involved and think through the situation together. Variations in practitioners' knowledge, in an agency's appetite to tolerate uncertainty and risk, in whether it prioritises process over content will, among many other intersecting factors, contribute to variations in practice and impact. In England, all frontline workers in child protection services are qualified and registered social workers and their training is a valuable resource in using Signs of Safety. The ability to incorporate existing or new knowledge and skills means that Signs of Safety practice can always evolve as research produces new findings, for example, a deeper understanding of the dynamics of domestic violence or better understanding about how to work within cultures, communities and contexts.

The implementation of Signs of Safety is based on both the organisational and practice Theories of Change. The organisational Theory of Change views the organisations as complex systems, rejecting a predominantly top-down approach that assumes it is possible to predict and control the behaviour of the organisation. In its place is the assumption that systems are dynamic and the interaction of their parts cannot be fully predicted or controlled, hence the need for feedback loops so that senior managers can monitor what is happening and adapt when problems emerge. Viewed through the lens of complexity, it is also clear that it is not possible to make sustained changes to the quality of direct work with families without adjusting the organisational system to support it. The Signs of Safety organisational Theory of Change sets out a range of support factors that will make it easier to use Signs of Safety well in working with families and will enable the organisation to monitor the quality of practice and respond to feedback on the impact on families.

The dynamic nature of complex systems is captured in the infinity loop diagram which provides a visual image of the key components of the organisational system and their interactions, with the service experienced by children and their families (the practice) in the centre.

Figure 1.1: Signs of Safety organisational theory of change

In a complex system, resilience arises from good monitoring of how the system is operating and adapting as emerging problems are found.

The purpose of Signs of Safety is to enable child protection agencies to deliver all their services with a rigorous focus on child safety and well-being and to set up their practice, policy, procedures and organisation so that the practitioners can do everything possible to put the parents, children and everyone naturally connected to the children at the centre of the assessment and decision-making, giving them every opportunity to come up with and apply their solutions before the professionals offer or impose theirs. Full involvement of family and network is always pursued, whether the child lives within or outside their family and kin, so that everything is done to sustain the child's lifelong connection with their family, culture and community of origin throughout children's services involvement.

The varied patterns of progress in the local authorities provide an opportunity for testing the hypotheses in the organisational Theory of Change: does progress in implementing the changes recommended by MTM correlate with better practice? The (limited) information we have on outcomes for children provides some indication whether those local authorities using Signs of Safety well are improving their outcomes relative to their past performance and the performance of those authorities where Signs of Safety is not fully used.

There are substantial differences between the implementation framework in 2014 at the start of the project and the implementation framework in 2019, as we have benefited from the learning acquired in both EIP1 and 2 and from other jurisdictions. However, the key components of the theories of change have been constant. The key developments that have emerged over the five years of the project are largely seen in the greater detail of particular practice, learning and implementation methods that enable organisational operationalisation of the theories. The 2014 version was the one used at the start of the project and so is the one used in identifying the hypotheses about key organisational changes needed to support Signs of Safety practice.

The infinity loop above has five components and these are examined in the next five chapters with the relevant sections of the implementation framework being detailed at the start of each of chapter.

In reporting findings, we describe not only *what* was done but also, where possible, offer vignettes to describe *how* it was done. As discussed in detail in Appendix A, tracing the causal pathways should cover more than saying 'A led to B', as is so often all that is done in a Theory of Change, but include some account of how A led to B.

1.3 Context

EIP 1 and 2 were happening in a context with a number of strengths and weaknesses that affected how the reforms were implemented and how well they were implemented.

1.3.1 Practice context

Improving social work practice was the central aim in implementing Signs of Safety and this required paying attention to the chronic weaknesses found in the process of practice, including poor analysis of information, inadequate linking of assessment to planning, delays in decision-making, poorly articulated goals, defensive risk management and limited levels of engagement of parents and children throughout the workflow. On the positive side, social work training had improved after the recommendations of the Social Work Taskforce (2009) on improving the intellectual standards of training and requiring continuing professional development (CPD) as a condition for registration as a social worker.

The English context provided a great opportunity for undertaking major reforms. The Munro Review had described how reform efforts over the years in the English system that had been intended to improve front line practice had, gradually and inadvertently, created a defensive compliance culture where anxiety was high, process took precedence over content, quantity over quality, and social workers were increasingly limited in their time and flexibility to engage well with families (Munro, 2011). Acting upon the recommendations, the Government reduced the extent of central control in the system and created the space for creativity and flexibility within each local authority. It was in this space that the EIP projects were operating.

Moving from a top-down control and compliance culture to the learning and adaptive approach of the Signs of Safety organisational Theory of Change requires fundamental change both in culture and practicalities. This does not mean compliance requirements are completely abandoned — some tasks such as meeting legal and regulatory requirements will always need compliance checking. However, implementing Signs of Safety does require the creation of more autonomy within the system to enable professional judgment and creativity to flourish and for practitioners to be able adapt the service to the variety of families and family needs. The autonomy we are proposing should not be thought of as an isolated individual activity but what Provan et al (2019) call 'guided adaptability'. Social Care Departments had been acting as though children's safety is best protected by compliance with procedures but, in a learning, adaptive system, it is best protected by organisational scrutiny of and support for professional reasoning.

The Signs of Safety organisational Theory of Change reflects this change in its account of the tasks of leaders, the design of recording methods to guide professional reasoning, the need for on-going learning in the Signs of Safety methods to supplement initial training, co-creating with the agency the details of how the practice methods will be applied in the agency's case practice workflow, and the role of the team in sharing and critically reflecting on each other's cases to strengthen the reasoning and manage the emotional dimension of the work. Group supervision is a key method to enable this. Ethnographic studies of social work teams (Helm, 2016) have found this work being extensively done in informal ways. It is highly appreciated by practitioners although its value as a safety mechanism that corrects weaknesses or errors in professional reasoning has not always been recognised by managers.

1.3.2 Socio-economic context

On the negative side, the projects ran at a time of 'austerity economics', when public sector services experienced major cuts in funding and changes to welfare benefit payments led to an increase in families living in poverty.

Local authorities prioritised funding for Children's Social Care, but early help and preventative services received substantial cuts.

> *Between 2009/10 and 2017/18, spending on children's social care increased by 16% in real terms while overall spending on children's services has fallen over the past decade: spending on Sure Start children's centres, services for young people and youth justice was slashed by 56% between 2009/10 and 2017/18 (House of Commons Library, 2019).*

Demand for children's social care has been rising.

> *DfE data on local authority social care activity between 31 March 2010 and 2018 showed an increase in activity across a range of measures: children in need (+8%), child protection enquiries (+122%), child protection plans (+38%) and looked after children (+17%). The number of referrals made to children's social care services per year also increased by 7% from around 615,000 in 2010/11 to 665,000 in 2017/18.*
>
> *Multiple factors have been attributed as potentially contributing to the increase in demand for children's social care services, including:*
>
> - *Wider societal determinants linked to poverty.*
> - *New and greater risks to children and young people — for example, from County Lines, gang violence, and child sexual exploitation.*
> - *An increased number of Unaccompanied Asylum-Seeking Children.*
> - *A growth in the overall child population.*
> - *An increase in the number of assessments of children in need which feature risks to child welfare from domestic abuse, parental mental ill-health and parental substance misuse.*
> - *Cuts to early intervention services, leading to greater demand for acute social care.*
> - *Greater awareness and referrals in the wake of high profile cases, such as those involving child sexual exploitation in Rotherham and other areas, and the murders of Peter Connelly (known as "Baby P") and Daniel Pelka.*
> - *More care leavers as a result of the increase in the number of children looked after and extended care leaver duties to age 25 (House of Commons Library, 2019).*
>
> *Child poverty has also increased with the Dept for Work and Pensions estimating that an additional 500,000 children are living in relative poverty in 2019 compared with 2010. This brings the total to 31%.*

1.4 Sources of evidence

This report draws on a wide range of quantitative and qualitative data: survey data, MTM data on training, consultants' notes on their contact with each authority, reports from the bi-monthly (in EIP1) and quarterly (in EIP2) leaders' workshops, local authorities' entries in the implementation dashboard, and nationally collected data. We have focused on data collected at the time to avoid the threat of bias from using data created with the benefit of hindsight where current performance places details in a particular light. We are restricted in which parts of the implementation framework we can test by the availability of rigorous enough evidence.

Staff surveys have been administered four times over the five years of the projects and parent surveys three times, providing data on change over time and relative to each other. In the graphs, they are reported as surveys 1–4, surveys 1 and 2 being administered during EIP1 and surveys 3 and 4 in EIP2. Staff surveys were developed to capture information about the workforce's views on the reforms, their confidence in using the new methods, and the organisational culture in which they were working. Most of the survey was an attitudinal questionnaire but there were also open-ended questions that generated more qualitative information about people's positive and negative views on the reforms. The average response rate was 43%, ranging from 13 to 74%. Two of the surveys in survey 1 had such a low response rate that the results were deemed too unreliable to be treated as representative.

A limitation on reporting these surveys is that between EIP1 and EIP2, we decided to change the section of the survey that is an attitude questionnaire. In EIP1, we used a version that had been developed in health and adapted, with the help of a psychologist to child protection. In EIP2, we had learned about the Safety Attitude Questionnaire that was originally developed in aviation and subsequently adapted to health where it is extensively used around the world. It is derived from the same conceptual framework in safety management as our original version but it rests upon a wealth of research evidence that continues to be expanded. This evidences how the better the score on the dimensions measured, the fewer the mistakes made (see for example Berry et al., 2016). Therefore we considered it a more reliable measure of organisational culture and potentially more useful in the long term. One set of questions was constant throughout the four surveys and these are cited. A technical report on the statistical analyses is available on https://knowledgebank.signsofsafety.net/you-cant-grow-roses-in-concrete-part-2.

To report the findings of survey questions for all ten partner authorities in a way that illustrates the diversity and is readable, the results for the top two scores of 'agree' and 'strongly agree' and the lowest two of 'disagree' and 'strongly disagree' have been combined. The two numbers reported do not add up to 100 because the 'neither agree nor disagree' answers were not included in order to simplify the tables.

Parent surveys were designed to measure the extent to which parents were experiencing a Signs of Safety service. These surveys drew on Signs of Safety fidelity work done by Casey Family Programs, a major USA child protection philanthropic foundation that incorporates a substantial research arm. These had good response rates in EIP1, but in EIP2 many local authorities had developed their own methods for seeking family feedback so only two were done with an adequate response rate. Brief details on these are provided in Chapter Four on Meaningful Measures.

In places, judgments on progress on particular aspects of the implementation framework are made, drawing on a range of information. To score progress, we have used blind raters, outside the action research team, to assess the evidence and make the judgments.

1.5 Structure of report

The report is framed around the 5 components of the implementation framework (see figure 1.1 on page 4) with the following 5 chapters (2–6) covering: leadership, organisational alignment, meaningful measures, learning and practice.

Chapter 7 explores the available data on what impact, if any, the reforms are having on children, young people and their families and on the workforce and tests our hypotheses on what changes are needed to support good direct work.

The final Chapter 8 summarises the key lessons learned on implementing change in such complex organisational systems.

2. Leadership

2.1 Introduction

Leaders have always been seen as highly influential in an organisation, both at a practical and a cultural level:

> *Leaders create cultures through what they systematically pay attention to (Schein, 1990).*

In the EIP projects, senior leaders faced not only the standard tasks of leadership but the task of achieving whole system reform to move away from the heavily proceduralised, compliance culture described in the Munro Review and toward a child-centred system using Signs of Safety as the practice approach. This included shifting the balance of rules and flexibility to allow more professional judgment in adapting to individual families and strengthening the organisational ways of supporting and scrutinising professional practice.

Leaders in an organisation have a pervasive influence on what happens in practice and this will be illustrated in later chapters on the different aspects of implementation. Here, the focus is on the demonstrated commitment of senior managers to implementing Signs of Safety and the associated organisational reforms, their focus on the practice and their progress in fostering a safe organisation.

Although not included in the implementation framework, we also report on the stability of the senior roles in the local authorities because turnover had a significant negative effect on progress in some authorities.

The relevant section of the implementation framework is presented on the following page.

LEADERSHIP IMPERATIVES

To start

- Stated organisational commitment
- Clarity and focus — on organisational implementation of Signs of Safety
- Strong, visible senior management engaged with the day to day experience of staff

Over time

- Parallel process/organisational congruence with the practice framework
  - leading with a questioning approach
  - exemplifying the framework principles (working relationships, prepared to admit you are wrong, focus on what works in practice) and disciplines (particularly plain language, focus on behaviour)
  - using the three-column assessment and planning framework for review and planning across the organisation
- Fostering a safe organisation — building confidence that practitioners will be supported through anxiety, contention and crises
  - anxiety is shared upwards and never carried alone
  - if workers do their best, within the organisation's capacity, are frank and open and a tragedy occurs, they will be fully supported by the organisation through to the chief executive
- Leadership that is demonstratively focused on practice
- Distributed leadership, "from the front counter to the chief executive"

2.2 Visible commitment of senior leaders and focus on practice

Participation in the EIP projects was dependent on the Directors of Children's Social Care, the Chief Executive and the Lead Member for Children's Services making written commitment to the reforms. However, the subsequent behaviour of Directors varied in how closely involved they were in the reforms. The independent report on EIP1 (Baginsky, Moriarty, Manthorpe, Beecham, & Hickman, 2016) found that

> *Where senior management did not give the project its wholehearted support progress had not been as rapid as where this had been in place.*

This judgment is borne out by our examination of progress in EIP1 and 2.

Ofsted judgments include a rating on leadership and show a similar pattern to their overall judgment. The judgments on leadership in the final inspection reports are as follows:

OFSTED JUDGMENTS ON LEADERSHIP IN LATEST INSPECTIONS		
Group 1	A	Outstanding
	B	Outstanding
	C	Outstanding
Group 2	D	Good
	E	Requires Improvement
	F	Good
	G	Good
Group 3	H	Inadequate
	J	Requires Improvement
	K	Inadequate

Table 2.1: Ofsted judgments on leadership

The differences in the behaviour of senior leaders in the local authorities provided information to test the hypotheses in the implementation framework about what they should do and why.

2.2.1 Participation in key implementation meetings

Throughout the EIP programme, recognition of the importance of the role of senior leadership was reflected in the governance structure developed as part of the project. A key strategy involved establishing workshops that brought together senior leaders and other key implementation personnel from all the local authorities (bi-monthly during EIP1, quarterly during EIP2). The key purpose of the leadership workshops was to develop knowledge, capacity and strategies to progress implementation of key deliverables in the context of full implementation of Signs of Safety. They also acted as a place for local authorities to share progress, learning and struggles in implementations.

SCORING ATTENDANCE AT LEADERS' WORKSHOPS			
Attendance at these meetings was checked against the progress of the reforms to test whether senior participation correlated with better overall progress. This was blind-rated on the criteria: **Criteria:** • Seniority of attendees • Frequency of some senior attendance (DCS or AD) **Score:** 3 = High seniority and good attendance 2 = Medium 1 = Few seniors, infrequent attendance by any of top 3 grades	**Group 1**	**A**	**3**
		B	**2**
		C	**2**
	Group 2	**D**	**3**
		E	**2**
		F	**2**
		G	**2**
	Group 3	**H**	**1**
		J	**1**
		K	**1**

Table 2.2: Attendance at leaders' workshops

There were other governance structures and processes. Local authorities established a Signs of Safety implementation steering committee to

- Oversee Signs of Safety implementation
- Oversee EIP2 deliverables implementation
- Bring together key positions from within the LA for implementation
- Ensure logistical arrangements for implementation are in place
- Monitor, provide strategic leadership and problem solving to progress the implementation

Signs of Safety Consultants were assigned to authorities to work with them on the EIP deliverables within their full Signs of Safety implementation. MTM Principal Consultants were assigned to oversee the implementation and support the consultants.

Throughout EIP2, the Signs of Safety Consultants had quarterly on-site visits with their authorities and monthly phone calls with key leaders. One day each quarter was used to meet and workshop with leadership groups, i.e. senior and executive leaders, service and policy managers, and the steering

group. The focus and content of the face-to-face visits aligned with the EIP deliverables and were consistent with the focus and content of the leaders' workshops. The purpose of the monthly calls with key senior and project leaders were designed to review progress and plan priority action, helping the local authority stay focused and keep the implementation on track.

2.2.2 Focus on the practice

In a compliance culture, there is a tendency to assume that best practice will arise from complying with rules that embody what we currently know about being effective. Such an assumption has been very influential in child protection in England and, as noted previously, English child protection had become proceduralised and compliance-driven to a dysfunctional degree. Some compliance (e.g. with laws and statutory regulations) is good but leaders need to understand why compliance has limited applicability. On this score, Klein et al's work is relevant. They report how 35 years of research in human-machine systems and naturalistic decision making

> *has shown a gap between work as imagined from distant parties and work as done, because practitioners have to cope with inevitable complexities* (2018 p.227).

Leaders in child protection need to operate with the reality of work as done and so must not be 'distant parties' but need to get close to the practice. Hence the importance in the implementation framework of having a focus on the practice and understanding the realities of day to day practice. We were able to compile information from consultants' notes about how senior managers displayed a focus on practice and this was blind rated:

SCORING LEADERS' FOCUS ON PRACTICE			
Criteria: • Strong, visible senior management engaged with the day to day experience of staff • Leadership that is demonstratively focused on practice • Fostering a safe organisation — building confidence that practitioners will be supported through anxiety, contention and crises **Score:** 3 = very good achievement on above factors 2 = some achievement on above factors 1 = poor achievement on above factors	**Group 1**	**A**	**3**
		B	**3**
		C	**3**
	Group 2	**D**	**2**
		E	**2**
		F	**2**
		G	**1**
	Group 3	**H**	**1**
		J	**1**
		K	**1**

Table 2.3: Leaders' focus on practice

EXAMPLES OF HOW SENIOR MANAGERS DEMONSTRATED A FOCUS ON PRACTICE

- DCS and ADs opening and/or closing training sessions reinforcing its importance on a regular basis
- Undertaking the 5-day intensive training in Signs of Safety
- Monthly learning sessions for Senior Leaders and Practice Leaders on key areas of practice and live case work
- Senior Managers carrying out Collaborative Case Audits on a regular basis
- ADs turning up for and participating in group supervisions on a regular basis
- Holding one day conferences to showcase practice and staying throughout the day
- Walking through the social work offices and stopping to talk to people
- Regular 'All Manager' meetings introduced to focus on risk sensible practice led by AD
- Practice week where Senior Leaders spend a week shadowing practitioners on home visits or in meetings
- Practice Focus week where DCS and senior management team used Appreciative Inquiry techniques as they met with practitioners, going out on visits to see their work with families up close and take family feedback
- Practice Observation week focussed on how well Signs of Safety principles, techniques and tools are being used by practitioners
- Chairing the steering group implementing Signs of Safety

The open-ended questions in the staff surveys provide some anecdotal evidence of how senior leaders are experienced by staff members. Although the survey asks for what is working well, as well as what is worrying you, most comments on senior managers appear in the category of worries. This may illustrate how negative experiences of managers are far more salient and worthy of comment to staff rather than being evidence that no-one had positive experiences.

[worried about] lack of senior managerial support should things go wrong.

Senior managers don't share the risk and workers are still left holding the majority of it.

I wish senior managers were more aware of the need for us to learn through practice how to 'get' SOS right for families and not expect that we have fully implemented every aspect of this approach from day one.

My worry is that there is not a top down approach in X so staff that are trying to implement it are hindered by not having managers that are embracing or modelling the framework.

Senior Managers not signed up to the model and not used in supervision with me, not reflected in direct discussions.

[worried about] The ability of the senior leadership team to fully commit to the pilot, truly allow experimentation and mistakes to be made for the purpose of learning.

Modelling of the approach is not consistent across the service, in particular it is lacking in the senior management group.

Deputy director doesn't believe in Signs of Safety.

Senior management do not communicate well with frontline staff, senior management/director presents one position to public and another to staff.

The senior managers are mostly removed from day-to-day Social Worker practice and have little appreciation of practice issues and practicalities when working with families, so are they the right people to lead on this?

2.3 Fostering a safe organisation

In England, transitioning to support more relationship-based children's services practice and use of professional judgment requires major changes in the overall management approach. Compliance checks are still appropriate for the rule-based parts of the work but not for monitoring the quality of professional expertise. Whereas one can rate actions that are following rules as 'right' or 'wrong', it is inappropriate to rate judgments and decisions by these criteria since they always incorporate uncertainty. A judgment can be 'reasonable' i.e. well reasoned from the available evidence, or 'unreasonable', i.e. poorly reasoned from the available evidence. It is in the nature of a judgment that there is no single 'right' answer and two well-informed people can disagree because of nuances in the weight they give items of evidence or their values. In child protection, a judgment about what is best for the child's future safety and well-being can lead to actions that are followed by a tragedy. Predictions are fallible and low probability events can happen. This does not make the original judgment 'wrong' in the sense that the practitioner *should have* reached a different judgment because *should* implies *could* and it is only with hindsight that we can see the prediction as wrong.

Encouraging the use of professional judgment requires organisations to develop more robust methods for supporting the reasoning that leads to judgments and their subsequent actions and for monitoring practice.

Here, we can draw on some of the questions in the staff survey's attitude questionnaire to provide evidence of change over the period of EIP2 and between the local authorities. Changes in the staff survey mean that we lack comparable data from EIP1.

The overall theme of the Safety Attitude Questionnaire (SAQ) is organisational safety and the results on all the dimensions are reported in Chapter Seven Findings. Here however it is relevant to report on the specific dimension on Safety Climate. The following graph illustrates change between the third and fourth staff surveys in EIP2 and between the groups on this dimension:

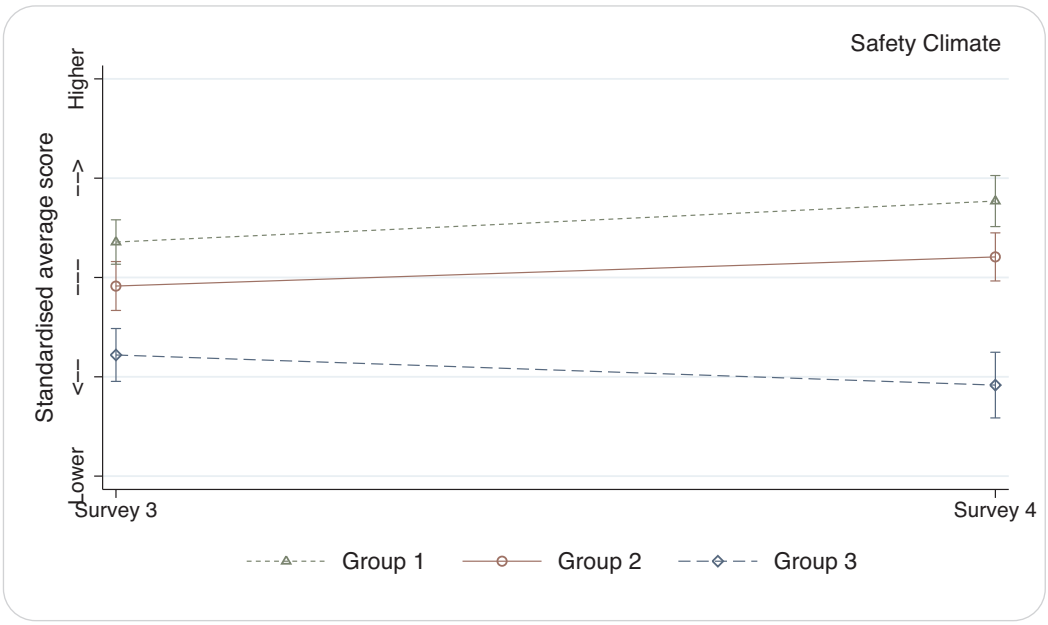

Figure 2.1: Safety climate

It shows both a higher starting point and some improvement for Groups 1 and 2 and a lower starting point and worsening safety climate for the one authority in Group 3.

One statement in the attitude questionnaire section of the staff survey also picks up on whether staff feel they are working in a blame culture where the first reaction of management to a perceived mistake is to blame the individual rather than ask questions about what happened: *'management usually assumes that a person who makes a mistake is incompetent or not conscientious'*. This was included in all four surveys with the following results.

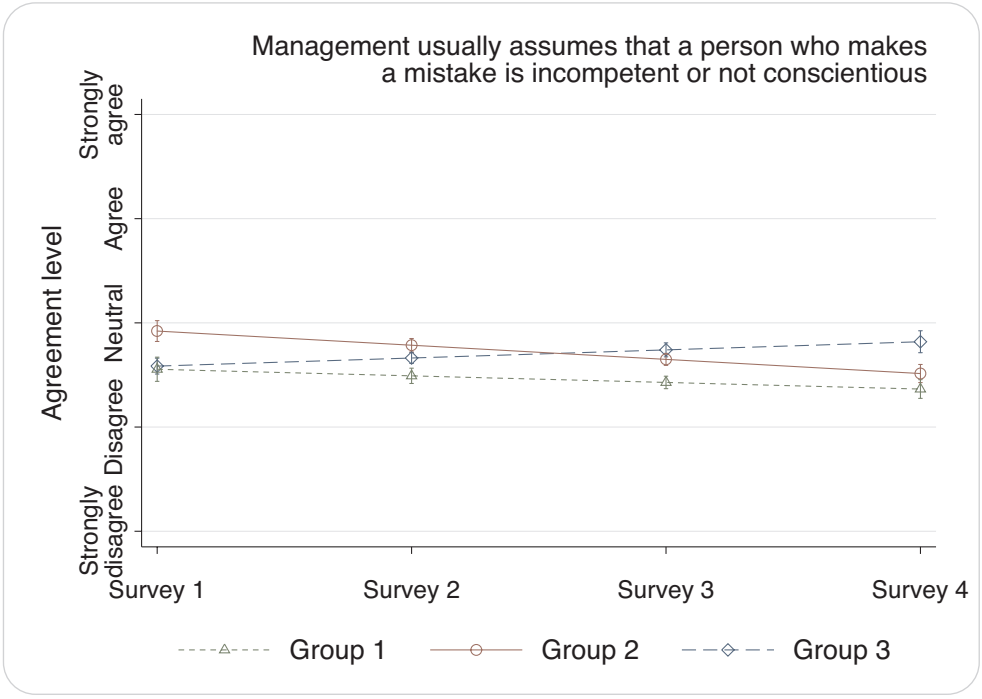

Figure 2.2: Management usually assumes that a person who makes a mistake is incompetent or not conscientious

The results show a small drop in agreement for Groups 1 and 2 and a rise in agreement for those in Group 3. Since the graph shows the average result, the data also shows that a substantial number in all the authorities feel that they are working within a blame culture.

2.4 Stability of leadership

There is a great deal of turnover at senior levels in the children's social care sector. Some turnover is obviously unavoidable but the children's social care sector in England has a very high turnover in recent years, with the average length of appointment being 37 months. In the EIP projects, a new DCS being appointed was, in some cases, a point of instability in the implementation process. In the two local authorities that withdrew from EIP, this decision was made by a new DCS who had not been involved in the original decision to join. We tracked the turnover of leaders during the projects and the data was blind rated.

SCORING STABILITY OF LEADERSHIP			
Criteria for scoring: 3 = stable at DCS and AD level through most of the EIP projects 2 = few changes at DCS and AD level 1 = several changes and/or interim appointments	**Group 1**	**A**	**3**
		B	**3**
		C	**3**
	Group 2	**D**	**3**
		E	**1**
		F	**3**
		G	**2**
	Group 3	**H**	**2**
		J	**1**
		K	**1**

Table 2.4: Stability of leadership

2.5 Development during the EIP projects

Because of the importance of the leaders' contribution to leading the radical changes needed to move from a compliance to a learning culture, MTM developed guidance on acquiring the relevant skills. With ongoing support from their Signs of Safety consultant, leaders had the opportunity to be guided by the *Leadership Development Trajectory* which sets out learning activities in line with the implementation framework and the implementation trajectory.

2.6 Conclusion

The evidence from EIP 1 and 2 supports the assumptions in the organisational Theory of Change that leaders' visible commitment to the reforms and focus on practice are important factors in driving through the reforms. Their influence on progress is also perceptible in the next chapters on specific aspects of the organisational reforms.

3. Organisational Alignment

3.1 Introduction

Existing policies, forms and case management processes were designed to fit another type of practice and so needed revising to reflect the language and the practice methodology of Signs of Safety. This was an ongoing process and the guidance and forms were successively refined during EIP1 and 2. In the organisational Theory of Change summarised in the infinity loop diagram, reforms of organisational alignment include engaging with partner agencies because working together is a core element of the English child protection work system. The relevant sections of the implementation framework are:

Over time

- Policies and procedures (case practice guidance) alignment with the Signs of Safety practice framework

Key parallel organisational reforms

- Continual streamlining of all policies and procedures (and client information collection)
- Formal partner agency engagement, with e.g. Police and Family Courts as well as service agencies (agreements, collaborative structural arrangements, information sharing)

This chapter begins by reporting on the need for alignment of documents, discussing how forms and software interact with users, and how radical the needed changes were as local authorities moved from the case management process, nationally standardised forms and technological infrastructure of the Integrated Children's System (ICS), developed by the Government, to Signs of Safety-aligned alternatives. It then gives an account of what was done and the different ways the authorities went about this task. Finally, the chapter collates the evidence on how much and how quickly reforms were implemented and analyses the data against our hypotheses about how organisations can support good Signs of Safety practice. The final section reports on what was done to explain the reforms to partner agencies and their responses.

3.2 The importance of aligning forms and software

Since the 1990s, the UK government has been very keen on e-government, believing that improved technological support can improve the efficiency and effectiveness of public sector services. While the design of the software does not *determine* what gets done, it is a major influence and can set limits on what is possible for practitioners; it becomes part of a socio-technical system where the outcomes arise from the interaction between users and the software.

Research on ICS, the software in use in the local authorities during EIP1 began, provides some detail of how ICS design impacts on users and this reveals the need for re-design to support Signs of Safety practice.

Parton (2006), who has studied the evolution of child protection social work in England since the 1970s, has concluded that the introduction of ICS played a key role in re-shaping social work. A fundamental shift has occurred in the forms of knowledge valued and used in social work:

> *A central part of my argument is that the nature of practice and the knowledge which both informs and characterises it is increasingly less concerned with the relational and social dimensions of the work and more with the informational* (Parton, 2006 p.2).

In Parton's analysis, information embodied as data in computer systems differs from knowledge in being disembodied, decontextualised and objectified. *'While knowledge usually involves a knower, information is usually treated as an independent and self-sufficient entity'* (Parton, 2006 p.10). Citing Manovich (2001), he argues that the database represents the world as a collection of items upon which a user can perform a variety of operations. This *'does not tell a story which has a beginning, a middle and an end or any coherent theme at all'* (p.9). This is in sharp contrast to the narrative approach that had been dominant in social work. In place of a story that provided a picture of a service user *'social work increasingly acts to take subjects apart, and then reassembles them according to the requirements of the database'* (p.11).

Reasoning that supports practice decision making was also hampered by the dominance of data-gathering to inform compliance requirements:

> *The privileged form of knowledge shifted as public administrators prioritised their reporting requirements in the design of the system, impacting the affordances of that technology for front-line workers* (Vogl, 2020).

White's (2009) study of the impact of ICS on practice provides more empirical detail. The team studied the daily work in five authorities at the front door, the referral and assessment teams, and in longer term teams working with families where children had been deemed to be suffering or likely to suffer significant harm from maltreatment. Meeting the demands of the IT system absorbed 60–80% of their time, reducing time with families. Even on home visits, tasks prescribed by the IT to monitor the family's compliance (check the child's room, see the child alone etc.) structured the nature of the interaction, limiting the opportunity for relationship-based practice. The software had been designed more to meet the needs of managers reporting to Government and auditors checking compliance than to support the challenging professional tasks of assessing problems, weighing up alternatives and taking action.

Within organisations dealing with complex tasks, workers must be supported to respond both flexibly and intelligently to the variety of challenges that emerge in the work. Ashby (1991) describes this as having the *'requisite variety'* to meet the variety of demands of the task. The standardising effect of ICS has diminished this role: *'our findings show that procedures and rules (inscribed in ICTs) increasingly constrain what can be done'* (White, p.5), thereby reducing the scope for professional judgment.

Another study by Bell et al (2007) for the Department for Education, prior to the ICS national roll-out, concluded:

> *We believe that the ICS has yet to demonstrate the degree to which and how it is fit for purpose.*

Unfortunately, the Department for Education deemed that this study was not fit for purpose and ignored it, only releasing its findings after a Freedom of Information request in 2008.

This account of the problems with ICS is relevant when considering how much revision is needed to create software that works constructively with the relationship-based process as opposed to content focussed approach of Signs of Safety. Key areas include having an assessment process that provides some structure but allows for co-production with families and inclusion of factors that both family and professionals deem important in the particular circumstance. The Signs of Safety mapping process also differs from the ICS assessment forms. ICS sets out the categories of information that are needed but practitioners themselves then analyse it. In Signs of Safety mapping, the basic three columns contain analytic categories (e.g. harm, danger, complicating factors) so that practitioners are guided on analysing the information as they record it. This format also makes it easier for supervisors to monitor what has been done because it is easy to see if there is little or nothing under a heading. Signs of Safety places the voice and experiences of the children at the heart of the work and ideally their opinions will be clear and evident in the recording. Finally, since working with families is central to the practice, the software should generate forms that are easy for families to read and understand.

While recognising that local authorities still need to collect data to demonstrate compliance with law and regulation and to meet their reporting requirements to central Government, software is needed that can capture the professional judgment as well as the creativity of the practice and that allows managers to monitor the quality as well as the quantity of practice. It is another area in which the scope of the compliance culture needs to be reduced to create space for professional expertise and guided adaptability.

3.3 What reforms were made

Reforming documentation was included in the initial implementation plans in EIP1. Some authorities had been using Signs of Safety to some degree already so some work had already begun on this task. Others were completely new to Signs of Safety. However, even taking this into account, there was considerable variation in how quickly the task was tackled, how it was done and how it was received by the workforce. Since recording documents were embedded in software, revisions involved not just changing the wording on paper but on altering software. This involved liaison with the relevant software company and expense.

While authorities were making their own changes, work was being done by Signs of Safety staff in collaboration with two of the major software providers in England — Servelec and Liquidlogic — to design software specifically to support Signs of Safety practice. The products have been co-produced with users and are now being used in some local authorities in England, including two in EIP.

Staff survey respondents in the EIP projects expressed a number of common complaints about the recording software that was not aligned or incompletely aligned to Signs of Safety. These were:

- it led to duplication of recording because ICS did not capture their Signs of Safety practice (by far the biggest complaint),
- it hindered practice by having a workflow at variance with Signs of Safety,
- it was difficult for supervisors to see how well Signs of Safety was being used,
- the child's voice had to be filed as an appendix, rather than in recording form itself
- it weakened the message from senior managers that the authority was now committed to using Signs of Safety.

Because progress on alignment had been slow in EIP1, this was made a Key Deliverable in EIP2. The details of what was recommended by MTM in aligning to Signs of Safety included:

- Case work forms and prescribed processes include provision for:
  - Genograms
  - The family's network
  - Mapping including analysis categories with danger statements and safety goals agreed with the family
  - My Three Houses work with the child(ren)
  - Words and Pictures explanation
  - Safety plan in written detail
  - Safety plan in Words and Pictures
  - Case plan goal and timeline of steps (trajectory)
- Contradictory case work forms and prescribed actions are removed
- The recording system allows the record of these processes either to be the focus of recording or to satisfy different recording specifications by appending the record of these processes (with guidance published to this effect).

A variety of reasons were seen as slowing down the alignment of documents and software.

Changing documentation presents a difficult decision about how soon and how thoroughly to alter it. Making the changes at an early stage will present problems to those not yet competent in using Signs of Safety. Waiting longer means that those starting to use Signs of Safety struggle to record the new practice in forms organised around the old practice arrangements. A solution adopted by many was to make small changes, gradually working towards a fully Signs of Safety-aligned system.

A danger with this incremental approach is that it can lead to practitioners feeling that senior managers are not wholeheartedly supporting the reforms. This is reinforced when the task of aligning documentation is delegated to lower level managers without the authority to make radical changes.

The authorities also varied in how much they co-produced or trialled documentary changes with staff. Co-production while it tends to be slower, is also more likely to produce documents that are more useful and easier to use.

In local authorities' straitened circumstances, the expense of changing software was also a significant factor in decision making.

Each local authority reported their progress quarterly on aligning their documentation. This provided useful information to score progress during EIP2.

SCORING CASE MANAGEMENT ALIGNMENT			
Scoring criteria: • Speed with which the authority commenced alignment • Extent of co-production with workforce • Progress in alignment 3 = high achievement 2 = some achievement 1 = poor achievement	**Group 1**	**A**	**3**
		B	**3**
		C	**3**
	Group 2	**D**	**2**
		E	**3**
		F	**2**
		G	**2**
	Group 3	**H**	**1**
		J	**2**
		K	**1**

Table 3.1: Case management alignment

This data demonstrates the variation in how the alignment task was tackled. At one extreme, the DCS took considerable interest in progress on the whole project of reforming the organisational alignment and the Signs of Safety-specific software was bought and installed within two years. At the other extreme, it was left to middle managers who worked in a piecemeal way on some necessary adaptations and lacked the authority to make major decisions such as radically changing the IT software. One authority began revising documents prior to EIP1, and 9 years later at the end of EIP2 introduced a revised assessment form that was rated highly by the workforce.

3.4 Partner agencies

There was insufficient information available to allow us to report on differences in what was done in this area of reform. All local authorities held briefings with partner agencies to explain and discuss the implementation of Signs of Safety. Training in Signs of Safety was offered to all key partner workers. Any changes to the administrative process of case management and guidance would be communicated with partner agencies. This was a challenging task since Children's Social Care partners with so many other services and so, at times, there were complaints that it was inadequately done.

While Signs of Safety had been developed specifically to work with families in child protection services, it was readily adapted to the family work being done in early help services, who are very close partners with Children's Social Care. All chose to adopt Signs of Safety and adapted their assessment forms and practice methods accordingly.

The example below gives an illustration of adopting Signs of Safety in one of the local authorities:

ADOPTING SIGNS OF SAFETY TO USE IN EARLY HELP SERVICES

Many families, over the years, will receive help from both Early Help and Children's Social Care and in one local authority, the Director and the Assistant Directors for Early Help and Children's Social Care saw Signs of Safety as achieving their vision of providing families with a more coherent service as they moved from one service to the other. They thought that Signs of Safety would help them provide services that helped families to make changes for themselves, to obtain support easily and to be understood as a whole family. Practitioners were consulted and supported the reform.

The Early Help service developed robust implementation plans and made faster progress than Children's Social Care in aligning documentation because they did not have the same level of statutory requirements and bureaucracy to consider to get in their way.

They were soon running their own briefing sessions to promote the framework and language and were video recording evidence of the positive impact this was having at the front line, not only for themselves but for their partners too. In addition, Early Help promoted the use of group supervision and opened their doors to partner agencies within their localities so that they had the opportunity to grow their confidence, skills and knowledge of the approach together. Some of the benefits were that they were able to evidence their concerns both verbally and in writing to families, each other and to social care much better and reported feeling that they were listened to much more. They also reported feeling more confident to challenge social care decision making, particularly when they felt that transferring a family to them was inappropriate or premature, or when they were not provided with tangible evidence to support this.

Practice Leads were identified from across Early Help Services and there was a clear drive from senior leaders to promote and monitor that group supervision was happening. Senior leaders from within the service also attended sessions and workers reported back that they could see their managers' commitment to and enthusiasm for the approach and could see this in the way leaders interacted with them and managed the service.

Group supervisions helped strengthen safety planning within the service because there was an increased use of family networks and family owned safety plans. This also extended to seeing greater use of this in partner agencies too. The time spent undertaking direct work with children was increased and the use of tools such as My Three Houses, Words and Pictures and Safety House became more widespread. The evidence of this was seen within early help assessments because the voice of the child was much stronger and was noted by Ofsted when they inspected the authority.

3.5 Conclusion

Our research shows the importance of aligning organisational arrangements to the practice if the agency is to secure the benefits of the approach and that senior leaders are a major influence in encouraging or inhibiting this organisational alignment. For practitioners, using Signs of Safety in their work with families yet having to record it in a system designed for another practice approach is highly frustrating and can make them doubt their managers' commitment to reforming practice. The accounts of how reforms of the software and documentation were done show variation in how strongly frontline practitioners heard the message that using Signs of Safety was not an option but how the authority was now working.

As Weick (1987 p.124) sagely observed: *'[A] system in which both centralisation and decentralisation occur simultaneously is difficult to design. And this is where culture comes in. Either culture or standard operating procedures can impose order...but only culture also adds in latitude for interpretation, improvisation, and unique action.'*

4. Meaningful Measures

4.1 Introduction

When Children's Social Care Departments are conceptualised as complex social systems, the traditional top-down approach to implementing change and monitoring performance becomes inappropriate. The organisational implementation of Signs of Safety requires structures and methods that not only enable and support the practice but also enable organisational learning by assessing its quality, picking up weaknesses and reinforcing good practice. The audit and inspection systems in use when EIP1 began gave most priority to counting process and outputs and less to measuring the quality of what was being done or to the impact on children's safety and well-being. They were also seen to be major driving forces behind practice becoming more and more focused on compliance so that 'good practice' was often defined as 'meeting the compliance requirements'. The inspection system has been revised to focus more on the quality of work and children's outcomes. The local authority's own audit system needs radical revision, in the first instance to drive the reforms and subsequently to play a central role in the learning organisation.

A widely repeated business maxim is 'what gets counted gets done'. A variant is 'what gets counted becomes what counts'. Therefore, it is essential to ask 'what do we want to see happening in the service we offer?' to help us decide what we want to measure. Put simply, this is that families experience a service using Signs of Safety methods and that this contributes to improvement in children's safety and well-being. The audit system therefore needs to look for evidence on these matters.

In Signs of Safety, audit is called 'Meaningful Measures' because its aims are providing information that is meaningful (making sense) to all in the organisation and that can be used constructively.

It was a clear goal in both EIP projects to envision with the participating local authorities a meaningful measures programme that applied the following principles:

- Focuses on data related to good outcomes for vulnerable children
- Has meaning across the whole organisation from Directors to those who knock on the doors and is equally meaningful for the institutions that have oversight of children's services
- Delivers useful data in a timely fashion as close as possible to the time services are actually delivered
- Involves service delivery staff in interrogating their application of the practice approach, the quality of their work and its outcomes
- Incorporates feedback from service recipients

The relevant section of the implementation framework is:

> Formal arrangements to access feedback, including from workers and families, on how Signs of Safety practice is working and the organisation is functioning; as well as relevant operational measurement and reporting.
>
> *The concept of becoming a "learning organisation" can encompass these interconnected structural arrangements, learning strategies and leadership imperatives, and is a useful parallel commitment to putting practice in the centre and the implementation of the practice framework.*

The scale of change needed to move from a compliance to a learning culture is reflected in the scale of innovations created during the EIP projects (with additional learning from other jurisdictions) to support this transformation. Quality assurance that incorporates meaningful measures that are aligned to Signs of Safety practice requires measuring the breadth of the Signs of Safety practice that is occurring, the depth or quality of that practice and then its impact. Measuring breadth and depth are essential to know what is driving or is missing when looking at the impact measures. Monitoring the breadth of the practice informs where to target leadership, learning and organisational alignment strategies to drive the adoption of the practice. Measuring depth informs learning strategies particularly.

Implementing reforms to the quality assurance system was a key deliverable in EIP2:

- QA processes are in place to enable workers, teams and the organisation to assess:
  - The breadth of Signs of Safety practice that is occurring
  - The depth or quality of the (Signs of Safety) practice
  - The impact of the (Signs of Safety) practice
- QA processes are collaborative and transparent

The Meaningful Measures guidance includes a collaborative case audit system, parent and staff surveys, case management dashboard and a set of core performance data. Figure 4.1 on the following page illustrates how they act in combination to enable close monitoring and assessment of the service that children and families receive. Details of these will be presented before reporting on progress towards using them in the local authorities and what their findings were.

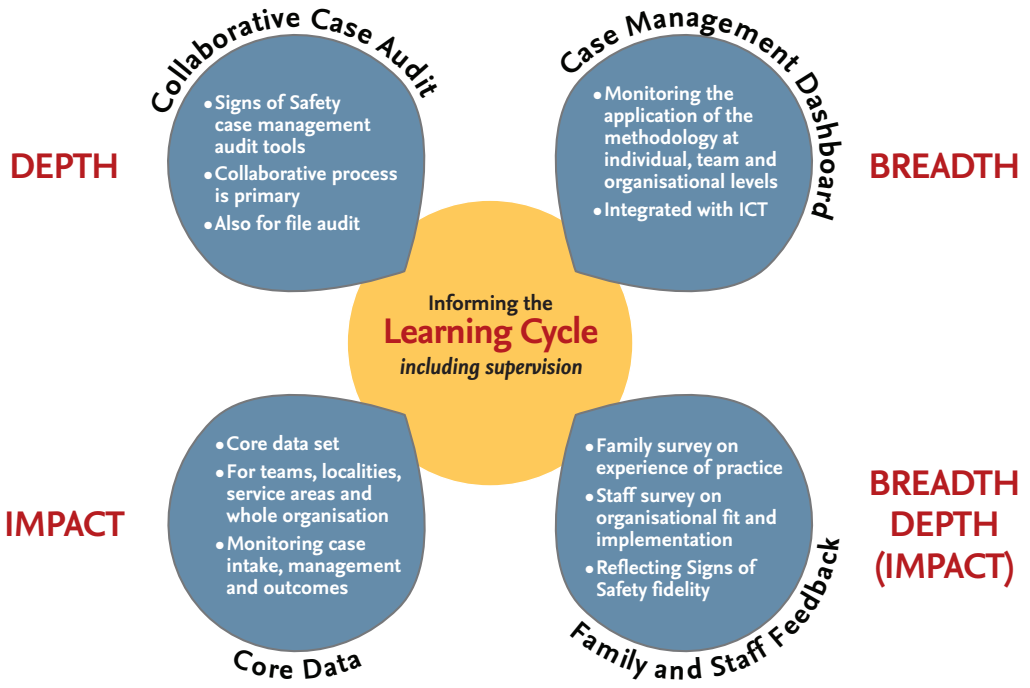

Figure 4.1: Quality assurance system

4.2 Collaborative Case Audit (CCA)

Signs of Safety Collaborative Case Audit matrix and methodology offers a participatory methodology for reviewing and improving key dimensions of recorded Signs of Safety case practice. Most audit processes are record-based and done independently of the professionals whose work is being audited to avoid bias. Feedback is then given to the relevant professionals either in person or in writing. While this approach can be used with CCA, it is recommended that more learning is achieved for both auditor and professional if done in collaboration with the person whose practice is being audited. This collaborative effort reclaims the original meaning of 'audit' — to listen. Case records are incomplete and professionals can provide significant information on the reasoning processes leading to their judgments, decisions and actions while questions from the auditor can help them reflect on their work and draw out lessons for both of them.

Audit involves making a judgment about the quality and/or quantity of the work. Social workers are given more autonomy to be responsive to individual children and families but this does not imply 'anything goes'; the freedom is closer to the 'guided adaptability' concept in the safety management literature. It is important that their use of that autonomy is open, monitored and assessed. Therefore, it is important that auditors are measuring factors that also capture the value of the practice for the children who are at the centre of the work. The collaborative audit process and the relationship it requires between auditor and professional mirrors the collaborative learning process practitioners foster with parents, children and their network and the simultaneous oversight role workers must also sustain to undertake effective safety planning with families.

CCA examines the whole trajectory of working with a family. It focuses on both metrics (addressing the quantitative aspect of the work) and analytics (a qualitative inquiry methodology providing guided judgment on quality).

Many local authorities did not switch to using the Signs of Safety version in its entirety but incorporated parts of it to their existing audit tools and methods including checks on regulatory compliance. There was sufficient information available from the local authority entries on the project dashboard and consultants' notes to score progress on introducing a collaborative dimension to their audit system. This was blind rated with the following results:

SCORING COLLABORATIVE CASE AUDITS			
Scoring criteria: • How quickly work started on making audit more collaborative • Seniority of those leading the reform • Extent of usage of collaborative audits 3 = Work started early and CCA is well developed and senior managers involved 2 = Medium progress 1 = CCA at initial stage and senior managers absent	**Group 1**	**A**	**3**
		B	**2**
		C	**1**
	Group 2	**D**	**2**
		E	**3**
		F	**2**
		G	**1**
	Group 3	**H**	**1**
		J	**1**
		K	**1**

Table 4.1: Collaborative case audits

These results show little progress in several authorities on making audits more collaborative and the reasons for this need to be explored further with them.

4.3 Dashboards to monitor practice

Quality assurance of practice first requires knowing what practice is actually being applied in cases and by staff members. The dashboard lists each case in the team against the elements of Signs of Safety practice, recording the practice as it occurs. This enables monitoring of the progression of each case and directs attention to where the practice may have become stuck. This makes it easier for all to see the extent to which Signs of Safety practice and its specific elements are actually being applied within the team and by individual workers. It also provides senior managers with data on how much Signs of Safety practice is occurring across the organisation. The data can inform supervision, learning and implementation of the approach but, on its own, provides insufficient information to check the quality of practice.

The following account from Viv Hogg explains why she developed this visual way of monitoring the progress of cases.

WHITEBOARDS — THE FORERUNNER TO DASHBOARDS

The idea to create a visual system for understanding and managing the work of my team came about for two main reasons. The context we were working in was a very large duty team of 20+ social workers, 2 assistant team managers and 1 team manager and that of course meant that there were a very high number of cases at any one time requiring assessment, closure or transfer and more arriving daily needing to be allocated. So firstly, how to achieve an equitable workload in a way that the whole team could see was fair was one of our aims.

Also, we were a team striving to implement the Signs of Safety approach the best way we could and figured that if we broke down all of the tasks we would hope/expect workers to do with the families that they were working with into steps from the approach, that would help us to understand what we actually were and were not doing in terms of our practice. For example, we would want to see if workers had developed danger statements, safety goals, scaling questions, identified examples of strengths and safety, found networks, spoken meaningfully to children etc. etc.

All of this was happening in the 'pre-open plan era' when workers had their own desks and there were walls. The team were all together in a very large space and so we developed a system whereby there was a whiteboard for every worker attached to the wall, listing all of their cases, the status of the case, where they were up to in terms of the steps that needed to happen and when they needed to happen by. It was really important to have target dates because these were a requirement and helped to avoid drift but we absolutely did not want these to become something to beat workers up with. Instead we used deadlines to understand what was happening for each worker, to consider the pressures they were experiencing and to incentivise and introduce healthy competition.

We recognised that ticking off that workers had created danger statements, identified strengths/safety etc. did not necessarily equate to quality but we hoped to counter that through weekly group supervisions and through good quality reflective individual supervision. I believe that optimism paid off mainly due to the commitment to the Signs of Safety approach from those managers who supervised the work leading with enthusiasm and passion.

This system ran for years and I can confidently say that workers found it valuable. They would get pleasure from seeing names removed from their boards as they closed/transferred a case; everyone could see who was taking new work; who had high numbers of complex work; where things were up to if a worker was on leave or off sick. I know that all of the workers looked at the boards every day and through doing that felt less under pressure personally, had more compassion for colleagues under pressure, sometimes would feel irritated if they thought

someone wasn't moving work on quickly enough but this was a team who showed kindness and respect for each other and would apply gentle pressure to each other if needed.

Did we achieve what we set out to? Well we certainly achieved the closest we could possibly get to fair allocation practices and we became the leading exponents at the time in our use of the Signs of Safety approach.

There is a danger of the dashboard being subverted to fit a pre-existing compliance culture where ticking the box that a method has been used is seen by workers as sufficient without engaging with the need to be creative and judge how to use them with a specific family, or by supervisors as being sufficient evidence that Signs of Safety is being used without assessing the quality of the work. This links to the wider danger of distortion as Signs of Safety is implemented in an organisation that has a compliance culture. The fact the Signs of Safety equips practitioners with a range of specific tools or methods to undertake tasks throughout the case work process is a significant strength of the approach but it comes with compliance culture danger that practitioners and leaders see using the tools and methods as an end in themselves. It is apparent from staff survey comments that some are 'doing' Signs of Safety without understanding what each method is designed to achieve.

For example, some use the My Three Houses tool with a child without incorporating the information gained into their assessment and planning. Nor do they bring the information and insights gained to the parents and those who have primary responsibility for caring for the child. Some complain that having the analytic categories in mapping 'complicates' things and have not been able to appreciate that the structured analysis supports their practice providing the rationale for their decision-making.

One practitioner complained that children were 'fed up with doing My Three Houses'. It would seem the worker or workers around these children have formed a view that each time they see a child they do another My Three Houses without an understanding that the My Three Houses usually is not repeated but rather provides the foundation for subsequent work with the child, their family and those responsible for them.

At no stage should any of the Signs of Safety methods or tools be seen as an end in themselves. Each is a tool designed to inform and support a successive safety and solution building process where the family and their naturally connected support network are given every opportunity to take responsibility for the safety and well-being of their children. The Signs of Safety safety planning roadmap distils and illustrates this successive process. The table below provides a summary explanation by method of *'what'* is being done when using the method and *'why'* it is being done, with the final column showing the method that provides the *'how'* to perform the task.

WHAT THE TASK IS	*WHY* DO IT	*HOW* TO DO IT
Collect and analyse information to make a balanced assessment of both strengths and dangers in the child's care	To inform a decision about what action to take	Mapping or Signs of Safety assessment and planning form
To gain understanding of the child's experiences and wishes	To include the child's views within the assessment and planning and to give both professionals, carers and family a clear understanding of the child's perspectives	My Three Houses or equivalent
Work with the parents to create a story of child protection concerns understandable to children now or when older	To provide the children with a clear explanation that both family and professionals agree with to help the child process their experience of what has happened, and reduce the possibility of the distressing events being traumatising	Words and Pictures document
Work with the family to identify their support people	To provide on-going support in providing safer care for the children	Involving a naturally connected network of support people
Work with the parents and safety network people to create and use a safety plan	To create a safety plan that the parents and their support people take ownership of and will use that satisfies professionals and family that the children will be safe even when difficulties arise	Safety Planning
Foster a learning culture among practitioners within their team and agency	To equip professionals to regularly meet to reflect, analyse and plan their casework and discuss practice they feel proud of or worried about with their colleagues	Using the Signs of Safety learning methods of group supervision and appreciative inquiry within teams
Foster a learning culture among the family and their support network	Enable the capacity for the family system to think through their problems and how they can work together to resolve them so the professionals are no longer needed	Using Appreciative Inquiry and regularly map the middle column (what is working well) with family
Build the capacity of the family and their support people to consistently provide safety and good enough care for their children	To give the family and their naturally connected support network every opportunity through specific tasks and activities to take responsibility for the safety and wellbeing of their children and maximise the possibility that the child can stay with the people they belong to	Utilise a successive safety building process with the family as reflected in the Signs of Safety Safety Planning Roadmap

Table 4.2: Explanation of methods

4.4 Staff survey

Obtaining feedback from both staff and parents is a critical part of a Meaningful Measures programme, helping an organisation move from a culture dominated by checking compliance with aspects of prac-

tice to one that is learning about how well the system is functioning. This is important not just at the stage of implementing Signs of Safety but as an on-going improvement task. We report on both staff and parent surveys conducted throughout both EIP projects, looking at the staff survey first.

Complex systems evolve over time and are influenced by external and internal factors in ways that are often unintended and unpredictable. Studies in safety management have highlighted the extent to which organisational factors support or hinder good performance and how improving individual performance crucially involves improving the system around them (Reason, 1990; Woods, Johannesen, Cook, and Sarter, 2010). Managers therefore need to monitor the quality of service being provided on an ongoing basis and learn of emerging areas of weakness or difficulties at an early stage. Organisational staff are a key source of this information.

The staff survey has three sections. Section One is for those who are involved in direct work with families and asks about their confidence in using the various Signs of Safety methods.

Section Two measures organisational culture. As mentioned in the Introduction, at the beginning of EIP2 it was decided to change the way organisational culture was measured, replacing the attitude questionnaire section with the Safety Attitudes Questionnaire (SAQ) developed in aviation. The SAQ is developed from the same literature in safety management as the one used in EIP1 but has the advantage of having been more extensively studied and refined (Sexton et al., 2006). Extensive research in aviation and in health has identified organisational factors that make mistakes or poor performance more or less likely.

This body of research has illustrated how improving safety is not simply a matter of better training for front line workers but also of modifying the work environment so that it is easier to work well and harder to make mistakes (or for mistakes to go unnoticed). The survey has also been adapted for use in health sectors in several countries and therefore creates the opportunity for making comparison between child protection services and other helping professions. It is beginning to be used in child protection with some use in Tennessee, USA and in Norway. We made minor adaptations of language in the health sector version to make it suitable for Children's Social Care.

The third section of the staff survey has open-ended questions to allow the workforce to feedback their opinions and worries about the implementation of Signs of Safety. It uses the three key Signs of Safety questions: 'what's worrying you; what's working well; what needs to change?'. While it is time consuming to analyse this qualitative data, it is a valuable source of information about the organisational culture, revealing the sometimes surprising distortions emerging as messages are passed around the organisation and the range of ways in which the reforms are being implemented and experienced by the workforce. The comments give vivid life to the statistics describing the quantitative data.

The dominant positive themes in these surveys are:

- Statements about using Signs of Safety, the main two categories of praise being allowing practitioners to do the type of practice that they want to, and the perceived benefits for families of being empowered to be more involved and achieving more progress in the care of the children

- Positive comments on the training and the opportunities for on-going learning being implemented in their authority
- Positive views on the commitment shown by senior managers
- Praise for having a unified approach across the department

The dominant negative themes are:

- Concern that workloads are preventing them for achieving the quality of practice to which they aspire
- Worries about not using the Signs of Safety methods well enough and needing more help
- Experiencing inconsistent messages from managers causing concern that the reforms are not wholeheartedly supported
- Complaints that the compliance culture is still dominant with more attention given to quantity than to the quality of their practice
- Criticisms of the friction between Signs of Safety practice and organisational documents and processes
- Criticisms of Signs of Safety for being too formulaic and not allowing creativity, or for not being well adapted to their specialist area
- Concern that Signs of Safety encourages over-optimistic risk assessments because of the inclusion of strengths in the assessment

Specific findings from these surveys are used as appropriate in this report.

When managers have sought feedback from the staff about their work experience, it is necessary to close the feedback loop by responding to the messages that have been sent. The following vignette describes how one authority showed that they were listening and responding to the survey results.

Senior managers in one authority studied the survey findings and summarised the key messages in a series of PowerPoint slides. They then held a one-day conference for staff to present these messages from both frontline staff and managers. This was followed by a discussion of what could be done to maintain the strengths and address the concerns. The Director re-iterated the principles that underpin English childcare legislation and Signs of Safety practice before setting out a list of 'bottom lines' — goals for managers to achieve in better supporting those doing direct work and for all staff. Finally, the presentation ended with a set of danger statements and safety goals for each of the six dimensions in the Safety Attitude Questionnaire. For example, on safety climate, the danger statement was:

> We are worried that almost 50% of managers are unsure/disagree that the culture makes it easy to learn from difficulties in practice. We are worried that unless we have an honest conversation, understand what this means and identify what we all need to do to change this, that practitioners and managers won't feel able to speak openly about weaknesses in the system and poor practice will be unrecognised and uncorrected.

The corresponding safety goal was:

> Managers are open and honest with each other and report, listen and act on evidence of weaknesses in the system. When mistakes are made, or weaknesses are identified, these are used as opportunities for learning.

Following the presentation, groups were formed and each examined one danger statement and safety goal, answering the two questions: (1) look at the scaling question for your paired danger statement and safety goal. Where would you scale things now? What is it about what we are doing in X that makes it this number? (2) What do we need to do to move the number up the scale?

4.5 Parent survey

The survey focuses on the parent's experience of working with their social worker. It does not request any personal case information. It asks questions that capture the extent to which the principles and disciplines of Signs of Safety are reflected in the practice and the presence of other factors that have been identified as contributing to successful helping relationships. In Signs of Safety practice, the aim is to work in partnership with parents as much as possible to address the issues of concern. Communication is central. Speaking in clear language, especially in explaining what professionals are worried about and what they want from families, and listening to what the family members have to say are equally important. Practitioners should also be aiming to take a balanced view of the family's strengths as well as the dangers. Work is more effective if families feel they have been involved in making plans and agree with the aims of the intervention. Feeling that their worker cares about what

happens to them is also associated with better outcomes. Part of respectful engagement involves practitioners being reliable and keeping their commitments. Finally, evidence is sought on whether children are being involved in line with the aims of Signs of Safety where the voice of the child being heard is central. Development of this survey drew on work done by the Casey Foundation in the USA.

At the end of the survey, parents are given the opportunity to comment freely on their experience with their social worker and raise points that are not covered by the preceding questions. The first specifically asks parents what one thing they would change about the way their social worker worked with them, and the second asks if they had anything else they would like to add.

In EIP2, many of the local authorities had developed their own methods for seeking family feedback and either chose not to participate in the MTM survey or received so few responses that they could not be reported on with any validity. Only two authorities received an adequate response rate, therefore it's not possible for us to report on parent feedback from across the authorities. However, it's worth noting that the findings from the two valid authorities were similar to the findings in the EIP1 surveys which received adequate responses from a higher number. In both iterations, the majority of parents were highly positive, agreeing or strongly agreeing with the statements in the survey which included:

- feeling listened to by their worker;
- the worker noticing what was working well;
- the worker being clear about plans and doing what they said they would do.

There was slightly lower agreement from parents feeling involved in making plans and being in agreement with their worker's concerns.

The surveys also had an open-ended section asking the parents what one thing they would change about the way their worker was working with them and any other comments they wished to make. These qualitative comments were reported back to local authorities regardless of their overall response rates as they provided useful feedback on parents' relationship with the worker and the service they were receiving from the authority.

In answer to the question *'If you could change one thing about the way your worker is working with you, what would it be?'*, over half of the respondents (54%) said they wouldn't change anything. Many of them responded with a simple *'Nothing'* or *'No, everything's fine'* while others elaborated further, for example:

> *I don't think I would, she's upfront and honest, she does what she says she will do.*
>
> *She does everything that she says she will do and is really supportive, I don't want her to change anything.*
>
> *Nothing I would change, she is perfect the way she is, open and honest, couldn't ask for a better social worker.*

Seems quite open minded and understanding about what we need to be helped. I don't think there is anything. He hasn't been sneaky or twisting our words and I can feel I can actually trust him. He has been upfront and honest, and getting to know my child and understanding the situation.

Nothing. She has been brilliant. She has been really understanding and quite open. She's supported us and helped out a lot.

Nothing. Nothing at all. She is straight talking, tells you how it is — which is what we need.

She has been very flexible and accommodating. Comes when is convenient for us and listens and I can't think of anything more that you can do.

In terms of changes respondents said they would make to the way their worker was working with them, better or more communication was the most common issue raised:

I can't always get hold of her because she's sick or in court. She forgets to ring me back and I get that she's busy and there's a lot going on but I'm focussed on my situation. Maybe she needs to be more organised.

I wish she would communicate more frequently and visit more often so she can see how my son is when things escalate at home. It's been weeks between visits, and I've felt like I'm in limbo. I didn't realise she'd be looking around the house and upstairs, it was a mess on the landing when she came.

I feel that they could have been a bit more proactive about getting in touch. They said they were looking at a possible placement break down but then left me to it. I felt they haven't talked to me about the problems I've been having.

I'd like to be updated as and when things happen rather than a week later.

It can be frustrating if I can't get to speak to my worker if she isn't in the office — there is always a duty worker, but they don't know the case.

Many also reported feeling not listened to and not being involved in making plans:

That they actually work with us, they just don't listen. It would help if they would work with us.

More involvement with the decisions about the children.

To involve me more, and to actually explain things better than what they have done.

I would want my worker to be professional. He is unreliable, has poor communication and he doesn't seem to care.

I don't agree with what she says, she brings up the same thing again and again and moans at me for not listening.

I feel misunderstood by the social worker.

I don't get along with my worker because he has made comments I don't agree with. He doesn't listen to what I have to say and just stands his ground.

Despite being unable to report on parent feedback from all the local authorities, it's worth noting that the findings from the two valid authorities were similar to the findings in the EIP1 surveys which received adequate responses from a higher number. In both iterations, the majority of parents were highly positive, agreeing or strongly agreeing with the statements in the survey which included feeling listened to by their worker; the worker noticing what was working well; the worker being clear about plans and doing what they said they would do. There was slightly lower agreement from parents feeling involved in making plans and being in agreement with their worker's concerns.

4.6 Core data set

Working with the local authorities, a core data set was identified within the larger set of data that they are required to collect for audit and reporting requirements. The local authorities recognised that an emphasis on quantitative, computer-based data is not sufficient on its own to evaluate the quality of services to children and families. They also hoped that a focus on core data could reconnect practitioners with their data through its relevance and usefulness to them.

CORE DATA SET

- Cases referred to children's services
- Cases progressed and managed through family support (early help)
- Cases progressed for child protection assessment
- Cases subject to child protection intervention
- Children brought into care
- Children reunified with parents
- Children in out of home care
  - kinship care
  - foster care
  - special guardianship
- Children adopted (as relevant to jurisdictions)
- Re-substantiation (or re-referral) rates
- Staff separation rates

4.7 Conclusion

This chapter has covered a major strand of work during the EIP projects: working with the local authorities to develop and implement ways of monitoring their functioning that would capture whether the organisation was achieving its goals. Complex organisations are dynamic and do not reach a 'steady state' where life will continue on the same predictable path. They are changing both in response to external factors and to the interactions occurring within their system. They therefore need to monitor continually how they are functioning, to assess what is working well and to pick up evidence of emerging problems. This meant making radical changes from their existing methods.

The suite of methods in the quality assurance developed seek to capture the breadth, depth and impact of the work with families, regulatory compliance, and organisational culture which, in combination, supply the information needed to function as a learning organisation.

5. Learning

5.1 Introduction

Implementation research repeatedly concludes that training staff in any particular approach, policy or initiative, while necessary, is never sufficient to ensure that the initiative is implemented effectively. Alongside training, a shared understanding across the organisation needs to be developed about the reasons for, and the goals of adopting the new approach. In addition, an understanding of how the new intervention will interact with existing policies, resources, etc. is needed and this requires a detailed understanding of how it works. For example, Signs of Safety will prioritise searching for and involving those who have natural connections to the child in formulating, enacting and refining the safety plans. This involves a major culture and practice shift from professionals formulating the plans and often prescribing attendance at professional services. Senior leaders need to understand and make such a change possible, for example redirecting some resources from expert services toward processes and positions that better support full family, child and network involvement across the entire case practice workflow.

Like the previous two chapters, this chapter examines the areas of organisational and cultural change needed to support Signs of Safety practice. As well as the challenges of applying the practice approach, the cultural change needed to promote a learning culture also holds significant challenges including:

- Shifting from a defensive culture that encourages one-sided, deficit-focused assessments of family functioning to a balanced appraisal of dangers and strengths
- Fostering the ability to have honest and open discussions about cases where practitioners are confident that their seniors and other professionals will judge them by reasonable, attainable standards and if weaknesses are seen, that the worker will be helped to improve rather than blamed
- Establishing workloads that provide time for reflection and learning as well as time to engage with families and build relationships

The biggest challenge in creating an authentic learning culture lies in growing and sustaining an organisational wide appetite for slow thinking and analysis. The challenge of analysis lies in the fact that slow thinking takes time and energy, and human beings generally — and professionals with heavy workloads in particular — default to making decisions quickly, intuitively and without explicit rationale. Developing an authentic learning culture in any organisation requires incorporating shared, stuctured and repeatable processes where staff can actively and regularly participate in the analysis or 'slow thinking' that is required to utilise and implement the practice approach consistently and effectively. Within the Signs of Safety implementation framework these processes are called Signs of Safety learning methods.

After detailing the relevant section of the implementation framework, this chapter reports on the training provided and the strategies used to provide on-going coaching and support.

The relevant section of the implementation framework is:

LEARNING STRATEGIES

To start

- Basic training in Signs of Safety
- Advanced training in Signs of Safety for supervisors and other practice leaders
- Coaching for supervisors and other practice leaders

Over time

- Basic training in the practice framework being integrated into compulsory introductory training
- Advanced training for all staff over time
- Practice skills formal training workshops
- Workplace based learning
  - Group sessions mapping sample cases
  - Appreciative Inquiries (workers showcasing good case practice)
  - Practice skills through coaching and mentoring and workshops
- Aligning all formal learning pathways and opportunities with the Signs of Safety practice framework
- Supervision with an approach aligned to Signs of Safety
  - Group supervision (teams working on live case mappings or aspects of practice for live cases as a group)
- Signal organisational learning events that showcase practice (desirable)
- Dedicated organisational positions supporting case practice, centrally and locally (desirable)

5.2 Training

An extensive training programme was provided in EIP1, consisting of 2-day introductory and 5-day advanced training, and regular Practice Leaders coaching sessions. All of the authorities used matched funding to access the training for their Children's Social Care staff throughout the project enabling them to provide the majority of their staff with the basic training and their identified practice leaders with the 5-day advanced training. Full details were provided in the final report: *You can't grow roses in concrete, Part 1*.

In preparing for EIP2, it was clear that the local authorities had made uneven or limited progress in safety planning and in involving naturally connected networks around the children and family so the EIP2 training programme offered each local authority targeted training on safety planning and networks and family finding training as well as practice leader development sessions and coaching sessions for delivery of in-house basic training beyond EIP.

Safety planning and networks:

- *Ten days were available for each LA*
- *Training targeted to the LAs specific needs for developing safety planning and networks*
- *A limited number of days can be traded for places at an advanced five-day training held in combination with other LAs.*

Practice Leader development sessions:

- *Practice leader groups, allowing for around 20 people, will meet for half day sessions, 4 times per year for the 2-year period*
- *A maximum of 160 days is available across all the LAs. Calculated on original EIP1 staff estimates that included staff beyond social care. This enables some flexibility as to both composition and size of the groups for the sessions allocated to individual local authorities.*

Family Finding (Building family networks):

- *Two 5-day bootcamps*
- *Provided by Kevin Campbell (founder of Family Finding and developer of the Lifelong Networks approach)*
- *Places for 270 staff from EIP agencies. Number of places for each LA are weighted to the size of the LA*
- *Coaching and QA and for In-House Basic Training. Two days were available for each LA.*

The family finding training was a new addition to Signs of Safety suite of practice methods. Kevin Campbell's Family Finding training was included because of the North American experience of successfully utilising the Family Finding tools and approach together with Signs of Safety. The connection of the two approaches was forged from Kevin Campbell and Andrew Turnell working together in a number of jurisdictions to establish the alignment of each with the other. The Family Finding model provides a strong philosophical base and clear methods and strategies to locate and engage the community and kin of children that can be utilised to enhance Signs of Safety practice across the children's service practice continuum including investigation, assessment, ongoing casework and looked after and permanency work. The goal of Family Finding is to support ongoing connection for each child to the immediate and extended family and the communities belong to whether they live with those people or not (Campbell, 2017; Turnell, 2017).

Local authorities were allocated a number of places weighted to the size of their authority and take up was very good. Variation was seen, however, in how the training was subsequently developed in practice in being disseminated within the organisation and on-going coaching being provided to build up expertise. Data from the authorities' dashboards and consultants' notes allowed us to have their implementation of Family Finding blind rated.

SCORING FAMILY FINDING			
Scoring criteria: • Evidence of disseminating the learning throughout the organisation • Family Finding being used • Managerial encouragement for using it 3 = good dissemination, lots of use after the training, well supported 2 = some, dissemination, use and support 1 = little/zero use or support	**Group 1**	**A**	**3**
		B	**3**
		C	**3**
	Group 2	**D**	**3**
		E	**3**
		F	**2**
		G	**2**
	Group 3	**H**	**1**
		J	**1**
		K	**2**

Table 5.1: Family Finding

The number of 2s and 3s here indicates how relevant the family finding training was seen to be and how well its use was encouraged.

One authority, inspired by the Family Finding training, was very motivated to develop skills in developing family networks and running network meetings. The authority developed a Family Finding Coaching group, the members of which acted as coaches for their colleagues. A one-day training 'Finding Naturally Connected Networks' was run by this team and all other training adapted to include insights and methods from the Family Finding approach. Senior managers attended 'awareness' sessions to learn about the work. A survey was conducted to find out who attends family network meetings and how they contribute to planning and managing the plan. A local Signs of Safety Gathering was held as a whole agency signal event with the overall theme of increasing the size of the naturally connected network. 'Running Naturally Connected Network Meetings' workshops were added to the suite of learning opportunities.

5.3 Learning at the team level

We have long known of the cognitive and emotional challenges of child protection work, of the risks of bias from intuitive reasoning (Kahneman, Slovic, & Tversky, 1982; Munro, 1999) and the impact on a practitioner of dealing with intense painful emotions of child who is terrified, a parent who is

angry or distressed (Morrison, 2010). Workers also face a high level of violence and threats of violence (McFadden, Campbell, & Taylor, 2014; Regehr, Leslie, & Howe, 2005) . Traditionally, supervision has been seen as the mechanism for improving practice though, in recent decades, research shows that for most child protection workers this had become more concerned with checking the management of the case rather than a detailed examination of professional judgment and decision making (Turner, Daly & Jack, 2014; Wilkins, Forrester, & Grant, 2017).

Within the Signs of Safety implementation framework, one-to-one supervision is seen as essential and locates individual supervision as one of several key mechanisms for supporting practitioners and assisting them in improving practice. The implementation framework sees making practice public, sharing with colleagues, as a crucial mechanism for reviewing and improving the work. This is operationalised for example in the collaborative case audit processes discussed in Chapter 3 where the purpose is not simply to check that tasks have been completed but to discuss and review collaboratively the reasoning behind the judgement and actions. Making practice more transparent and shared is also a function of the ongoing group supervision processes and regular Appreciative Inquiries within the ongoing life of the practice teams. The aim is not to have a team of experts operating in isolation, but as an 'expert team' which is more than the sum of its parts:

> *A set of interdependent team members, each of whom possess unique and expert-level knowledge, skills and experience related to task performance, and who adapt, coordinate, and cooperate as a team, thereby producing sustainable, and repeatable team functioning at superior or at least near-optimal levels of performance (Salas, Rosen, Burke, Goodwin, & Fione, 2006 p.440).*

Ethnographic studies of child protection teams show how much the practitioners use the informal support provided by their team in reflecting on and managing the intellectual dimensions of their work and that it can provide a secure base to help them cope with the emotional demands of the work (Avby, Nilsen, & Ellström, 2017; Biggart, Ward, Cook, & Schofield, 2017; Helm, 2016).

To function effectively, all teams have to guard against the dangers of group thinking and uncritically reinforcing each other's biases and the structure of Signs of Safety group supervision and shared learning methods is designed to address this challenge. Like conferences with family and network, team support that is facilitated and guided well is invaluable in helping workers to have justified confidence in using their judgment in creative work with families because they know they have canvassed their thinking with colleagues who will be honest in questioning and challenging poor judgment.

To foster the strongest possible children's service practice, whether organised through the Signs of Safety or other practice approaches, it is important for the team's contribution to the quality of practice and hence to the safety of children to be recognised, supported and preserved. Faced with burgeoning demand and funding cuts there are significant challenges leaders need to address to support team functioning and shared decision-making. Funding pressures have led many local authorities to introduce 'hot-desking' where workers no longer have their own desk but have to take whatever is available. This was a feature in the ten local authorities and strongly disliked by the workforce in all but one authority because of the loss of collegial support for thinking through their cases. The one exception was an authority which utilised hot-desking but within designated team areas and this made

the arrangements more acceptable to the workers since it helped to preserve opportunities for case discussions.

Besides the informal support provided by colleagues, two other support mechanisms were introduced at the team level: group supervision and practice leaders.

The Signs of Safety group supervision process is designed for groups of 4 to 10 people. It revolves around the caseworker who brings forward the case and the group works in a structured way to assist the worker in thinking through their decision making and application of the Signs of Safety practice methods in that case (sometimes, of course, there are a number of people bringing forward the case). The facilitator leads the group process by asking questions, including helping the caseworker have a clear focus on what they want from the discussion. They are assisted by an advisor who does not themselves talk to the caseworker. Other group members are involved as observers/participants who present their thinking on the case with a view to helping the caseworker plan the next steps in managing the case. Information from local authorities and from consultants allowed us to have the use of group supervision blind rated.

SCORING GROUP SUPERVISION			
Scoring criteria: 3 = lot of use, strongly encouraged by seniors 2 = moderate use, some encouragement from seniors 1 = little or only starting to use and little encouragement from seniors	**Group 1**	**A**	**3**
		B	**2**
		C	**3**
	Group 2	**D**	**2**
		E	**1**
		F	**3**
		G	**1**
	Group 3	**H**	**2**
		J	**1**
		K	**1**

Table 5.2: Group supervision

5.4 Practice Leaders

The role of practice leaders in each team was created by all local authorities designating particular experienced practitioners or Team Managers to help with coaching and skill development and the use of the learning within their team and agency. Across the different authorities there were variations in how many were appointed and how they functioned. At their best, practice leaders played a major

part in developing expertise and confidence in the workforce and helping establish a learning culture and spirit of inquiry around the practice. The implementation framework included a two-year practice leader's learning and development trajectory that provided regular coaching sessions to deepen their knowledge and skills in all of the Signs of Safety practice and learning methods and equipped them to support workers to develop the Signs of Safety practice skills. As they progress through the two-year trajectory, they are expected to disseminate their learning to their teams through Appreciative Inquiry, Group Supervision, targeted learning sessions or workshops, providing day-to-day advice and guidance when needed and continually provide agency leadership and steering group with detailed information about progress.

However, the success of the practice leader development programme and in turn its success in achieving the whole organisation learning aims depends on several factors:

- Regular coaching sessions
- Practice leaders having the time, support and explicit backing of leadership to prioritise all coaching sessions
- Practice leaders having the time within their day-to-day role to lead the learning methods, disseminate the learning and support others
- Encouragement from senior managers supporting the practice leader team to meet the challenges they will always face

Information on how the role was being developed and used was provided by consultants, enabling their contribution to be blind rated.

SCORING PRACTICE LEADERS			
Scoring criteria: 3 = Clear role and visible impact on developing expertise 2 = variable impact on developing expertise 1 = little or no impact on developing expertise	**Group 1**	**A**	**2**
		B	**2**
		C	**3**
	Group 2	**D**	**2**
		E	**2**
		F	**2**
		G	**2**
	Group 3	**H**	**1**
		J	**1**
		K	**1**

Table 5.3: Practice leaders

5.5 The importance of the team in survey comments

The importance of colleagues and teams is shown by how frequently they are mentioned in the open-ended comments in the staff surveys.

Examples of positive comments about their teams are:

[working well] That as a team we learn together and practice on one another to feel more confidence in our own practice.

Staff have a shared understanding and constant topic of discussion in all supervisions, practice, team meetings and reflections on cases.

Everybody is working the same way which makes it good for the team if any difficulties arise or support is needed.

I feel my team is extremely supportive and this aids me to feel confident about developing my practice and emotionally supported. Peer support is crucial in the challenging environment of child protection, to know someone is at the end of the phone following a visit is empowering. The managers/supervisors in my specific team are very approachable and accepting that we are developing practitioners and this makes me feel very confident in being able to admit and reflect upon things I should do differently. This is crucial for children and families to receive a dynamic and adapting service. I feel that my managers and supervisors share their knowledge and accountability with me. This helps me enjoy my role and ensure I am working in the best interest of those I am working with.

I feel that our team are supportive and I am proud to work in a team that works well together, even though this is a new team that has been created.

Negative comments about teams relate mainly to the problems created by high turnover rates or high workloads, i.e. to problems in functioning well as a team.

High staff turnover has adversely affected my team and team morale. Social workers are tired and prone to burn out.

The number of agency staff and the turnover does not help our team environment, and nobody wants to stay because there is no support and too many demands within our team. It is impossible to work well in this kind of environment and I think implementing Signs of Safety is great but the organisational culture needs a complete overhaul if you are actually going to keep any staff and make any progress with becoming a 'Signs of Safety innovator'.

The entire model of working has the potential to transform social work practice, but the main hurdle is the capacity per team.

5.6 Conclusion

A great deal of training was provided during the EIP projects at both a basic and more advanced level. A new development was the introduction of Family Finding training, offering an enhanced skill set in tracing and engaging a wider range of family and naturally connected community members to act as a resource and on-going support for the parents and children in the family. The Family Finding training was widely valued and well implemented in several of the authorities.

To support the greater use of professional judgment in practice, the role of Practice Leader and group supervision were introduced in a more structured way. These functioned with varying degrees of effectiveness and scoring on them generally followed the level of progress shown by Ofsted judgments.

The team plays a central role in providing the intellectual and emotional challenge and support for helping practitioners who have operated in a compliance culture for many years to have more confidence in using their professional judgment and being creative in adapting the general principles and specific methods to the unique family with whom they are working. There are threats to the contribution that teams can make both from heavy workloads reducing time available for shared discussions and from funding cuts leading to removal of team rooms and individual desks. This carries the danger of reducing the quality of reasoning and hence the safety and well-being of children.

6. Practice

6.1 Introduction

The previous chapters have considered the extent to which organisational factors were supporting expert use of Signs of Safety in direct work with families. Here we examine the evidence about practitioner:

- enthusiasm for implementing Signs of Safety
- confidence in using Signs of Safety methods
- feedback on what is helping or hindering the achievement of high quality work

We also report on the developments in the practice methods that have been made in response to feedback from the local authorities and the evolution of learning methods that better support quality practice.

6.2 Enthusiasm for implementing Signs of Safety

Evidence on people's views on the decision in their local authority to implement Signs of Safety is drawn from the open-ended comments in the four staff surveys. Where comments relate to this topic, the very large majority are positive. Examples are:

> *It helps to focus on the families' needs and how best to address meeting them. It helps the families to work from positives and identify the negatives and how to work around them. I think that the SOS theory is brilliant but it does depend on the workers interpretation of the methods and whether they use their initiative to make it suit the family in how it is presented, as well as adapting it for the child/family member.*

> *Signs of Safety is really easy to understand and makes sense when you implement it. Families are clearly easily able to understand how the process works and, in my experience, get along well with the format. The simplicity of it is what makes it useful.*

> *All staff are well versed with the processes and have received ample training in SOS, more importantly they believe in the process and that the family is the source of many of the answers to difficult situations and relationships are key to working positively to effect change.*

> *It works really well in Team Around The Family meetings with families and associated professionals and can be a very positive experience. I like that it is a simple language that everyone understands and has a good focus on the positive as well as worries.*

> *There has been a constant drive to develop SOS practice and there are workers that are strongly committed to using the model. Workers feel that they have the flexibility to think about the children they work with creatively and are able to think outside the box in the best interest of the particular child they are working with.*

Staff are committed to working within this framework.

Many of the positive comments relate to the benefits for families of using this practice framework:

It involves family, it is a doing with not doing to approach.

I am confident in using Signs of Safety with the families that I work with. This shows them that I want to work on and develop their strengths rather than just focusing on the worries we have for them. Families need to feel that they can achieve a better outcome for their children, and Signs of Safety sets it out simply for them and us as practitioners.

The emphasis on using jargon-free, plain language in our work is helpful, to ensure everyone is clear about risk, safety and the associated plans. Children, young people and families have provided positive feedback about the use of the model in the borough. Tools such as Words and Pictures effectively remind practitioners and their managers to focus on the child /young person's needs e.g. How do they understand what is happening and why and if they don't understand how will we help them to?

It is a comprehensive approach to engage well the family in social care assessments and direct work. That helps us lots in order to be more focused on specific dangers for children and how we can reach the safety goals. Creating a safety plan with will help the family to keep children safe. We can see the situation from the family side, and we can support the family to build up the own safety and they will own this plan and will implement them.

It involves the young people and families more, it uses child-friendly language to highlight what are the strengths and areas of improvement, the YP are clear of what is expected of them and what support they can access to achieve their best potential. The purpose and aim of intervention and services being involved is clear, it is the YP and family that completes the plan, so it encourages them to take ownership of their lives and what they can do to help themselves. It looks at a wide range of resources and network where the family are the best suited to resolve their problems with a bit of support and guidance. YP and families feel more involved as it is a strengths based approach and more likely to cooperate.

I feel that it helps when working with children and families and allows us to highlight what is working well which then enables us to discuss what the family and us are worried about and how things can change. It allows the family to have autonomy to come up with their own plans as a family with support from the professional.

There are a small number of people reluctant to make the change or criticise the way it is being implemented.

Social Workers should be supported and encouraged to use more than one model of working. Signs of Safety has made some positive changes but has also resulted in creating a work force that sounds the same and that can result in poor practice not being identified if the process becomes to formulaic.

[worry] That it can sometimes overlook past difficulties.

I believe that Signs of Safety stifles creativity. I don't think that anyone believes there is one way to social work, one way that will solve the complex social issues that families we work with are dealing with. Signs of Safety, as a tool in our social work box to use can be creative. When it's right for the family, different tools can facilitate conversation and improve transparency. However, once it becomes the framework moral and effective work with families goes downhill.

I do not think this model is working well at all. I see no proper use of it from my training and my experiences of mapping and safety planning are that they are too long, too complicated and do not provide clear enough and realistic goals for the family to achieve.

I find Signs of Safety over complex. There is a focus on paperwork and fitting information into a framework; this encourages inflexibility rather than open minds. I would ditch the whole system and opt for a much more straightforward approach that parents might understand better.

6.3 Use and confidence in using the Signs of Safety methods

Data on people's usage and confidence in using the different Signs of Safety methods was collected in the four staff surveys. The table below summarises the changes in usage of each method between survey 2 in 2016 and survey 4 in 2019. It shows that up to survey 3, there was a steady increase in usage for all methods so that they are all being extensively used. Then there is a puzzling drop in usage reported in survey 4. One can only speculate about why this is so. It may just be an artefact of the surveys being answered by different samples. Or it could be more worrying and raise the possibility that there is in reality a decline in usage. If it is an actual decline in usage, it is possible to imagine a range of possible causes including the impact of staff turnover and time constraint pressures or that new initiatives are taking attention away from the Signs of Safety practice. Whatever the meaning and cause, this data suggests any organisation wanting a sustained implementation of the approach needs to have a weather eye on its usage rate and be alert to the possibility of decline.

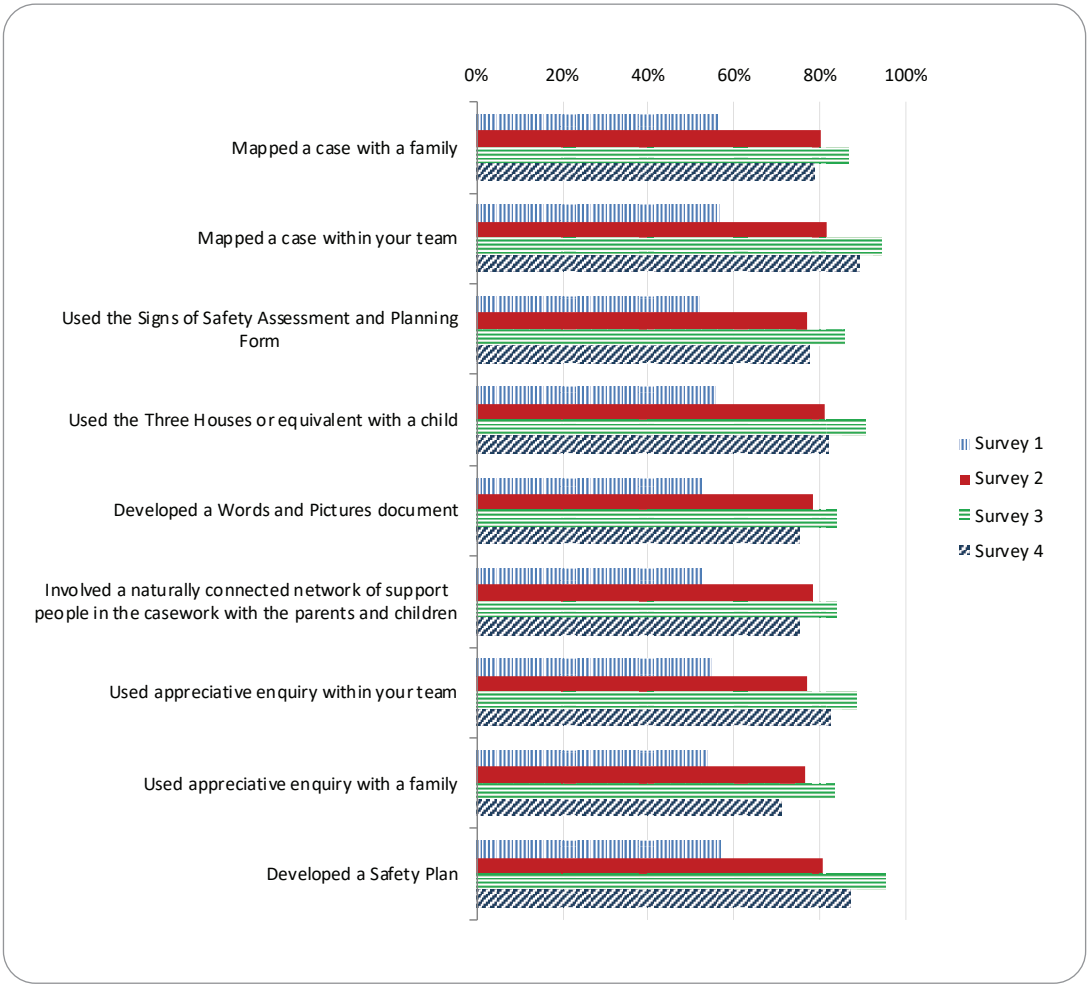

Figure 6.1: Use of methods

This second chart shows practitioners' confidence in using each method.

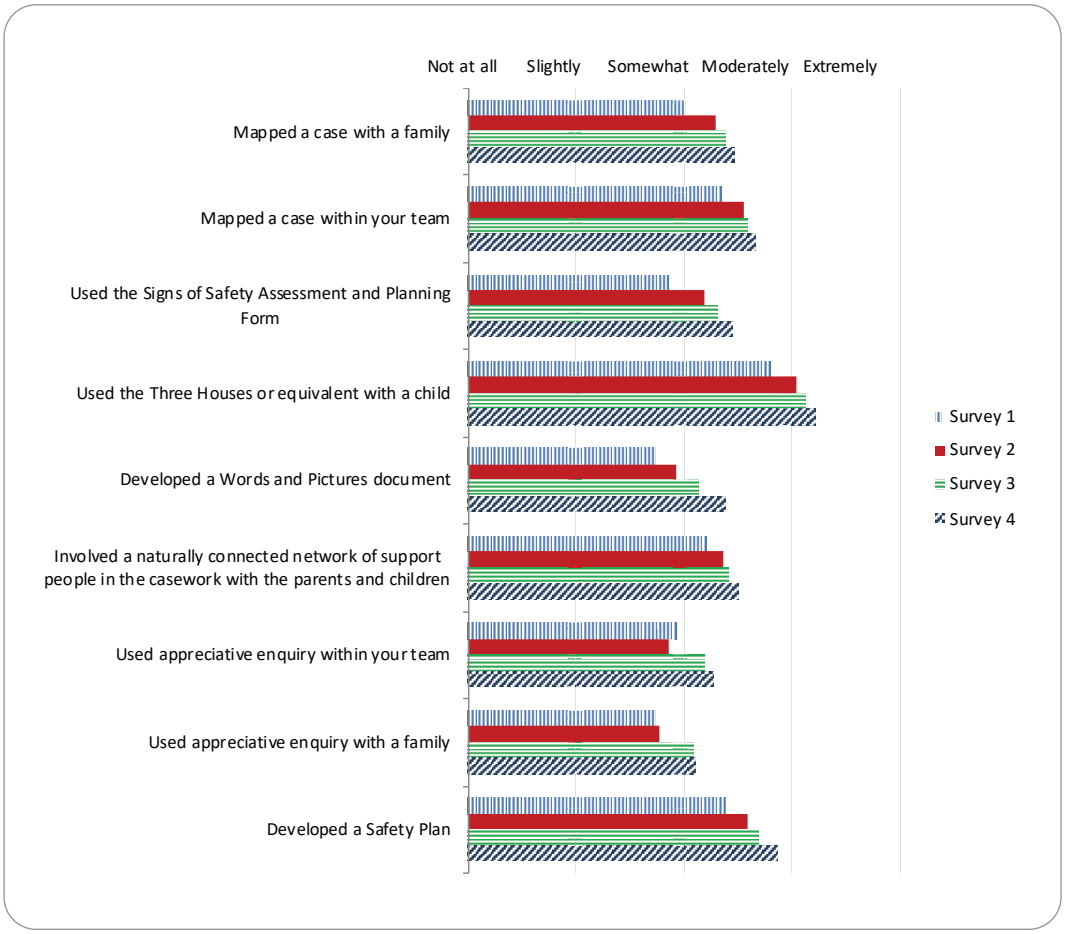

Figure 6.2: Confidence in methods

The figures here are lower than those in the chart on usage and there is clearly room for improvement. Only *'used the Three Houses or equivalent with a child'* reaches beyond 'moderate'. There is however a steady rise in confidence over the four surveys and perhaps the key message to draw from these statistics is for senior managers to continue to encourage the use of learning methods that support the use of the practice methods as reported in the previous chapter to develop expertise further.

The set of graphs for individual methods is provided below. These show variation in levels of progress for each of the three groups in terms of progress. The authorities in Group 2 start at a lower level of confidence but improve steadily and achieve the highest scores by survey 4. Those in Group 1 start well and make modest progress on most but show some slight drop in survey 3, rising again in survey 4. Such variations may well just be an artefact of different samples. Group 3 shows a very variable progress, growing in confidence for some methods, making little progress for some and reducing for others.

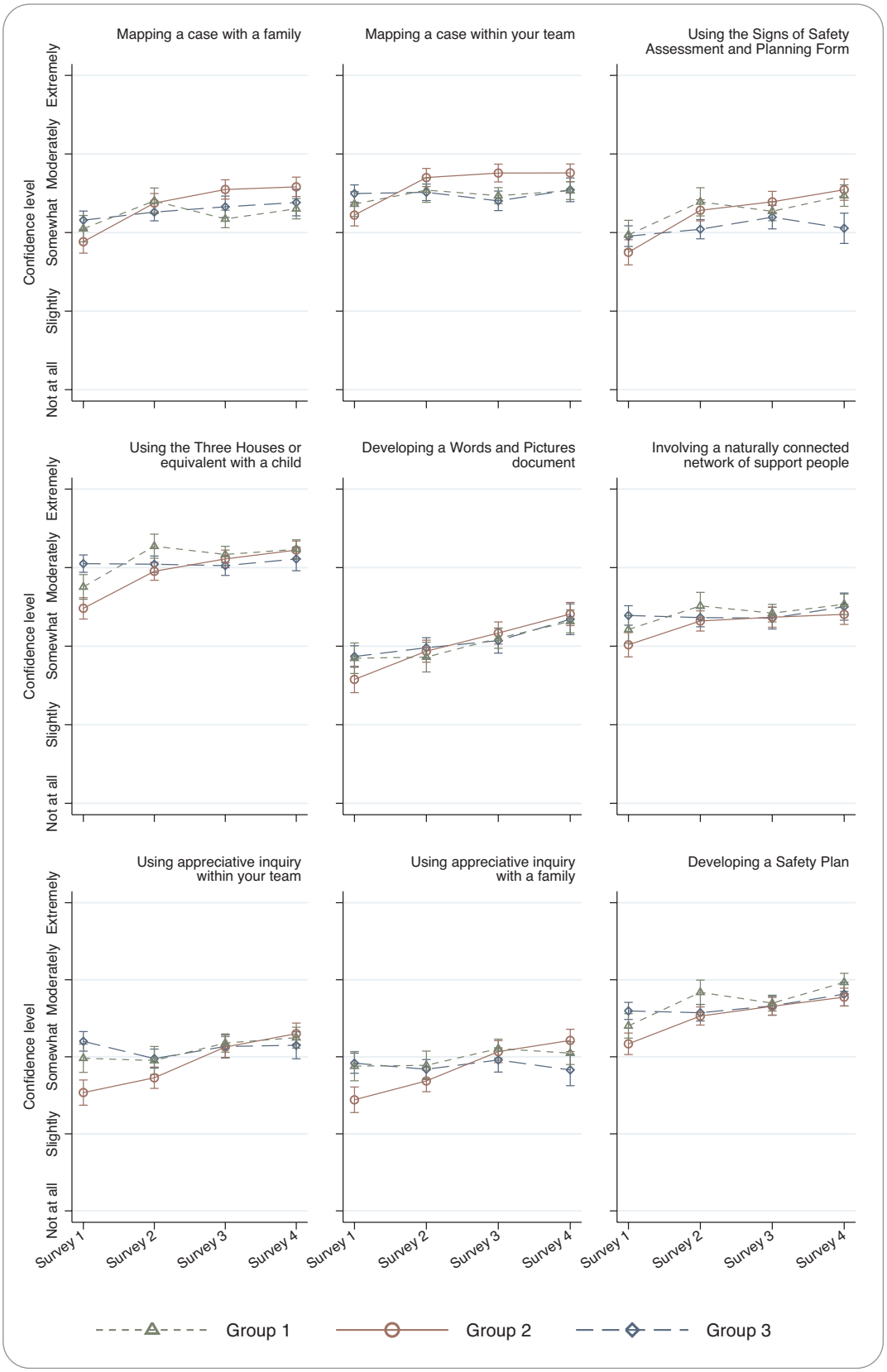

Figure 6.3: Confidence in using individual methods

6.4 Feedback from workforce on what was helping or hindering progress

Here we draw on evidence from the staff surveys that relate specifically to the practice experience. A number of the questions that were constant across the 4 surveys are relevant here and provide a useful overview of change (or lack of it). Time to do the work and risk management are the key themes.

Responses to the statement: *'I do not feel able to spend enough time in direct work with the family'* show a rising level of agreement over the four surveys for all the authorities. In fact, this is the statement with the highest level of agreement in the surveys.

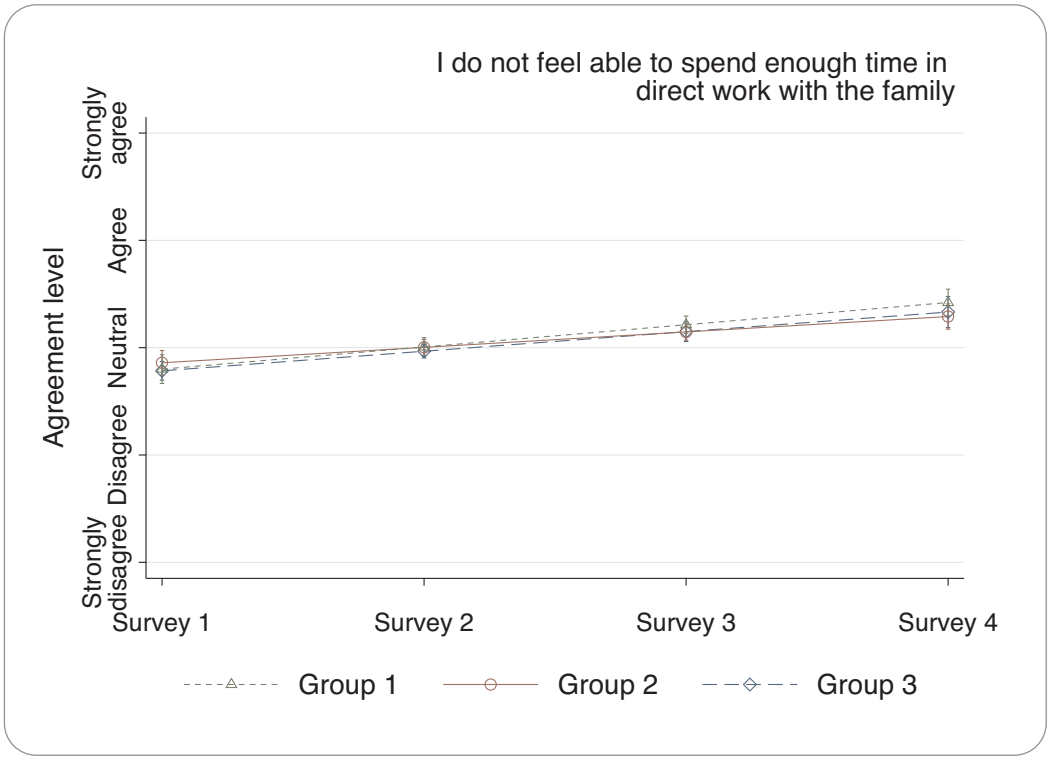

Figure 6.4: I do not feel able to spend enough time in direct work with the family

The next chapter on Findings includes a discussion of the nationally collected data on caseloads and it endorses their concerns. The statistics show rising caseloads in all but the three authorities in our Group 1. One of these has an unchanged caseload and the other two report reductions.

Comments in the staff survey illustrate how frustrating practitioners can find the workload pressures and their impact on the ability to work at the level they aspire to.

> *More time to plan and reflect would improve practice e.g. More time to write Danger Statements before CP conferences.*
>
> *You need time to build a relationship with the families to get a truthful answer.*
>
> *If we all had less cases we would provide a better service to the families we hold. Time is what most families need and a consistent named person to rely on. They need to be able to have one person support them not be passed to several along their journey for support.*
>
> *As caseloads and pressures have risen, attention to Signs of Safety and working in this framework has become less embedded and less encouraged.*
>
> *I am worried that I, or those within my team such as the Child & Family Workers, may not have enough time, due to rising caseloads, to spend the time needed to properly implement SOS with families.*
>
> *[needs to change] the recognition that direct work with families takes time. Performance indicators are not helpful for families who have differing needs as it takes time to work through the complexities of the family and their needs. Managers and operations managers need to give social workers more time. Preventative work is not about performance it's about spending time with the family. Assessment tools are only as good as the person using them and more time needs to be permitted to doing this. I have had a range of case loads from 35 children up to 50 children this is not good enough. It does not promote a healthy working environment and social workers are at a loss as to what can be done. Children's needs should come before time scales.*

Some performance targets are imposed by central government and should be met but, since the Munro review, these have been radically reduced in number and many are locally established. Monitoring practice with a focus on quality over quantity is more challenging. Timescales, for instance, provided a measure that was technically easy to measure. Applying the principle of timeliness, as is now recommended, requires making a judgment about what is appropriate timeliness in relation to a specific child. Yet, if supervisors monitor for meeting timescales not timeliness, practitioners will be hearing the wrong messages about priorities or will feel stressed by hearing conflicting messages (as some of the comments in staff surveys show).

Creating more time for relationship-based work with families requires changing priorities within the organisation and the following graph shows that people are still operating in a culture where they believe that compliance with targets is prioritised over time with the family. While Group 2 show little

change, Group 1 shows a drop in agreeing with this statement while Group 3 shows an increase (with a reminder that only one local authority in Group 3 answered survey 4).

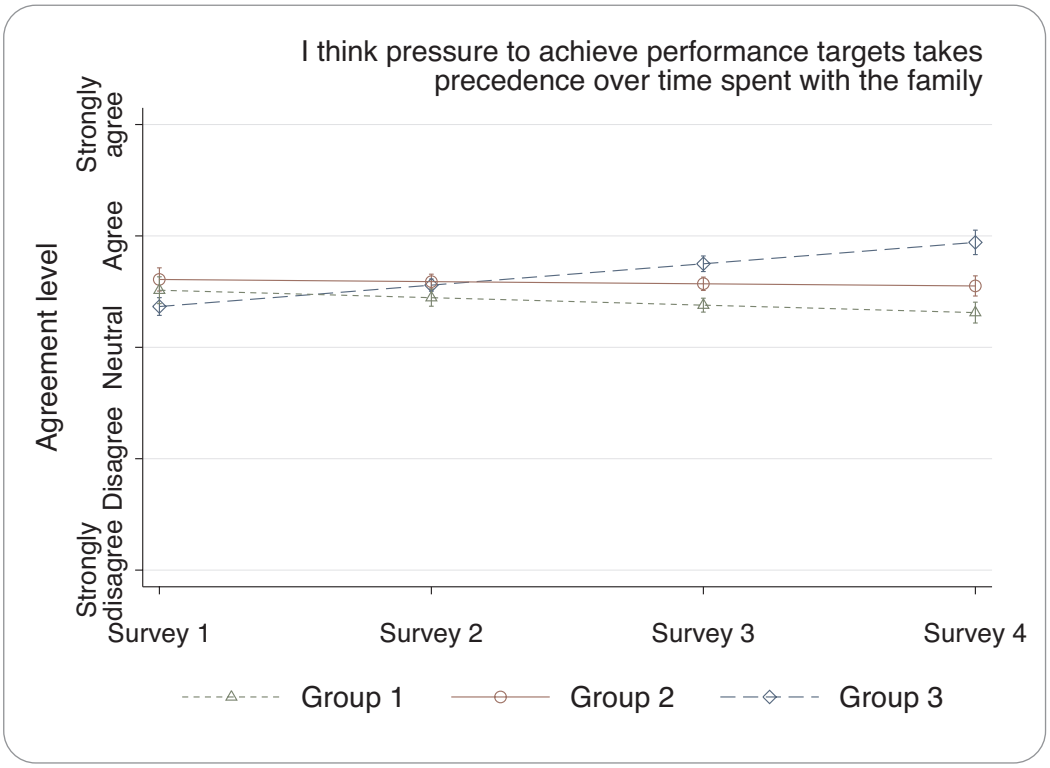

Figure 6.5: I think pressure to achieve performance targets takes precedence over time spent with the family

Time as well as motivation are factors in relation to the next statement: *'My team/LA is organised so that we spend planned time on critical reflection of cases'*. There is a similar pattern here to the previous graph: improvement for Group 1, little change for Group 2 and worsening for Group 3.

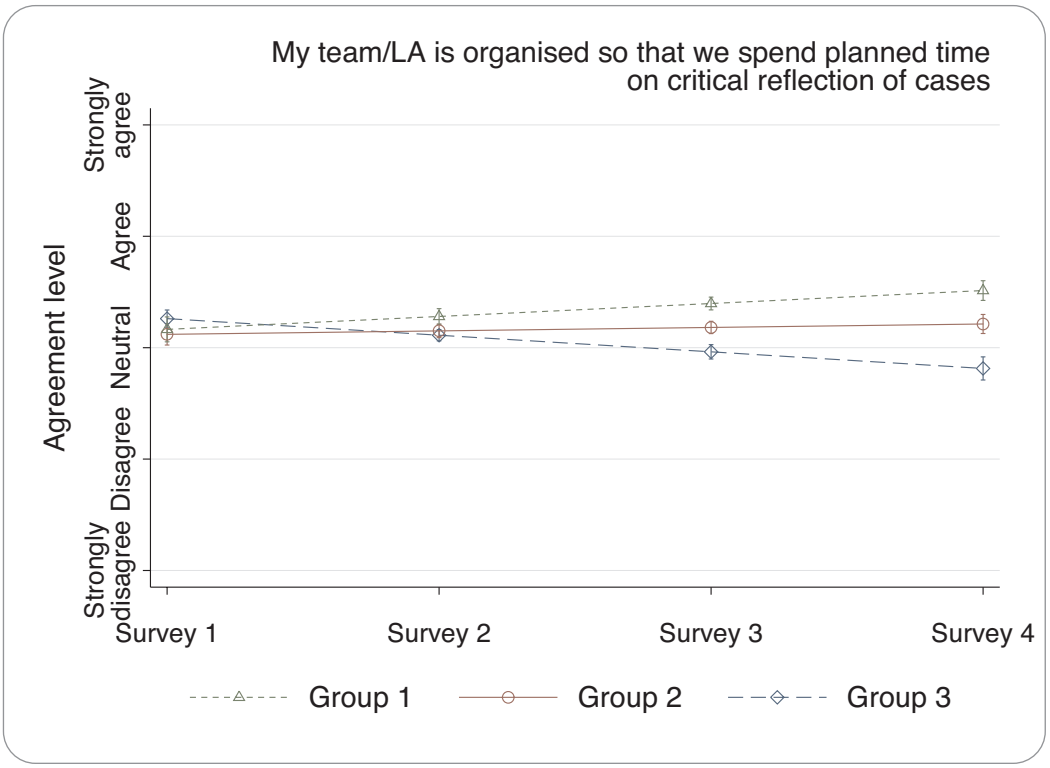

Figure 6.6: My team/LA is organised so that we spend planned time on critical reflection of cases

The surveys show that those who are experiencing regular group supervision value it highly and it is a key part of both developing expertise and of monitoring and enhancing the quality of professional reasoning as people become more engaged with working with families and co-producing assessments and plans of action.

The final two graphs to report here concern risk management. Putting more emphasis on professional reasoning about children's safety and well-being, and less on compliance with process reduces the possibility of claiming 'I was only following procedures' if there is a bad outcome. The individual professional is more responsible for a judgment than for applying rules. This is one reason the Signs of Safety implementation framework places so much emphasis on sharing professional reasoning. Group supervision and informal team discussions help the individual to test and check out their reasoning with their colleagues. The group process seeks to address the aloneness that practitioners often feel and help to create an atmosphere of shared responsibility for difficult decisions thereby promoting better decision making. The following question captures some feedback on how well this is achieved.

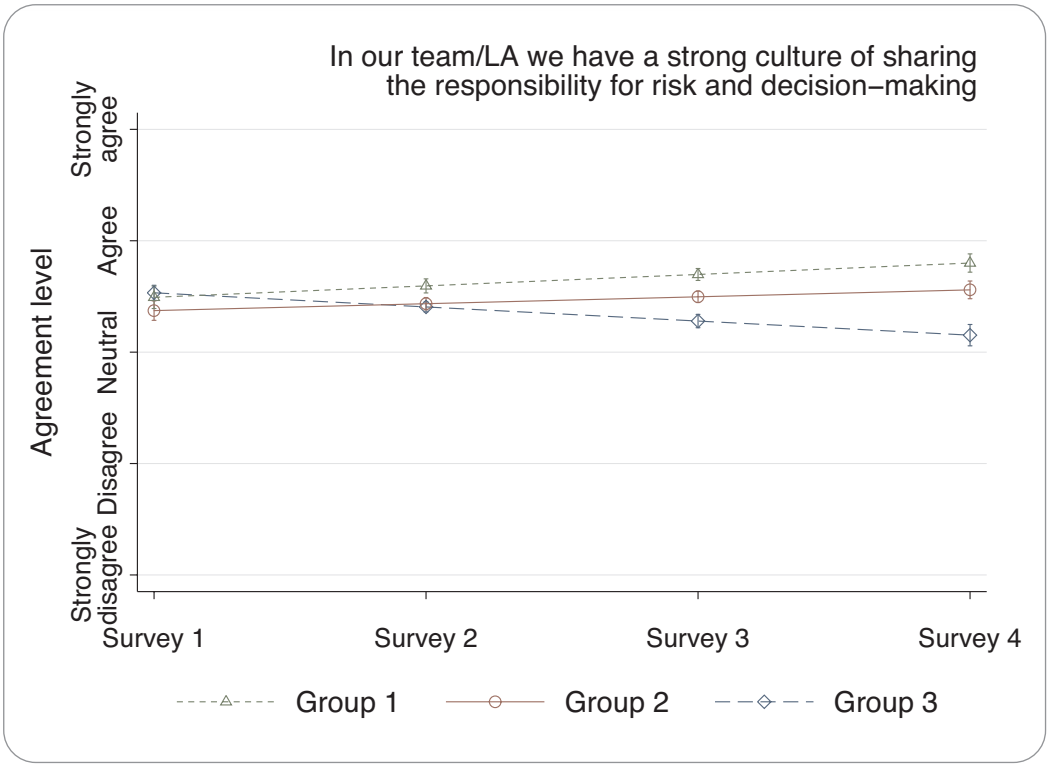

Figure 6.7: In our team/LA we have a strong culture of sharing the responsibility for risk and decision-making

Similar to the previous graphs, we see improvement for Group 1, some for Group 2 and worsening feedback from Group 3.

Another statement on risk adds to this finding. Both show there is scope for improvement in all the local authorities on risk management. One aim of the reforms is to move from one-sided, deficit-focused assessments of what might happen to a child to balanced appraisals of the benefits and dangers of the different options available for action. Without a sense of sharing the reasoning and the responsibility for the difficult decisions child protection workers have to make, it is difficult to eradicate defensive practice where protecting the self or agency from blame is prioritised over protecting the best interests of the child.

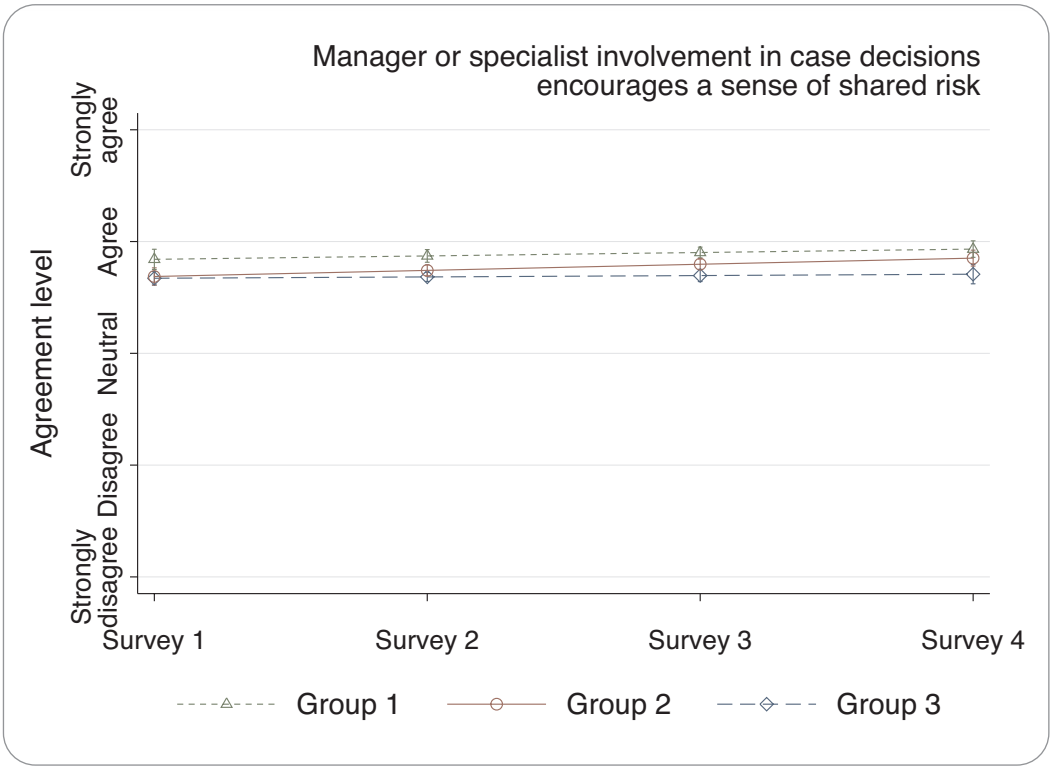

Figure 6.8: Manager or specialist involvement in case decisions encourages a sense of shared risk

6.5 Signs of Safety practice and learning method developments during EIP2

The international Signs of Safety community of agencies and professionals using the approach is considerable and this generates substantial feedback from:

- Signs of Safety Trainers and Consultants;
- children's services field staff, managers and leaders;
- organisational data and audits and
- formal evaluations and surveys about the impact of the approach, what is working well and about weaknesses of the approach in practice within organisational contexts.

This feedback about what works and what doesn't is the foundation of the continuing evolution of the Signs of Safety practice, learning and implementation methods. During the period of EIP 2, apart from aligning Family Finding methods with the Signs of Safety, there have been three significant developments that have been important for the authorities in the English project: the harm matrix, practice intensives and whole system learning cases.

6.5.1 Harm Matrix

Signs of Safety is a *guided professional judgement approach* for assessing child safety and wellbeing. What this means is that while many assessment methodologies implicitly or explicitly promote the notion that the assessment tool carries primacy in analysing and forming judgments, the Signs of Safety

explicitly identifies that it is the professional, their analysis, slow thinking and judgement that are the centre piece of effective assessment.

Through looking closely at Signs of Safety assessments and reviewing the depth of thinking used in applying the Signs of Safety analysis categories and from feedback from 'critical friends' such as conference chairs, judges and legal representatives, it became evident in England and abroad that practitioners were often struggling with analysing harm and this was contributing to poor quality danger statements. Often descriptions of harm were general in nature, utilised professional jargon, lacked behavioural detail of the harm-causing actions (usually by adults) and the current or future impact of actions on the child.

Since analysis of past harm is the foundation for crafting explicit, plain language danger statements that are both rigorous and fair and make sense to families, it became clear that a methodology was needed to assist practitioners in their analysis of harm. The harm analysis matrix was created in 2016 along with corresponding training and practice guidance. The methodology and matrix were refined through field testing in the EIP authorities and elsewhere 2017/18.

6.5.2 Signs of Safety Practice Intensives

Feedback, file review, internal and independent evaluations including the evaluation work within EIP1 evidenced the fact that while practitioners in the main liked the Signs of Safety and valued the training, they often struggled to understand how to apply it within the demands of their everyday work and within the workflows of their agency.

Practice intensives were created in 2017 as a key learning and implementation method to bridge the gap between training and consistent application of the approach in the field. The purpose of the practice intensive is to design and co-create an agency-specific case practice workflow that spells out the anticipated application of the Signs of Safety approach for agency casework at each stage such as intake, investigation and assessment, ongoing casework and children in care.

Since the casework application of the Signs of Safety approach is shaped by all levels of the agency, practice intensives always involve staff from across the hierarchy, including senior leaders, managers, policy makers, trainers, and field staff.

Practice intensives are usually conducted over three days and they always focus on multiple open case files (sometimes many hundreds) and involve all participants working in small groups thinking through the application of the Signs of Safety to these cases. The small group case file work is guided through a draft file review template that has been co-created by Signs of Safety consultants with agency leadership and field staff in advance of the practice intensive. Full group reflection and learning is elicited throughout and together all participants learn what works and what doesn't and where the barriers are within the agency. Through the three-day programme, the group successively adjusts the template and the practice workflow that makes best sense for the agency.

In summary, the Signs of Safety practice intensive is an action learning and implementation method that enables the agency to co-design the case practice workflow that best enables its staff to apply the approach within its context and conditions.

6.5.3 Whole System Learning Cases

Signs of Safety implementations have always involved external Signs of Safety consultants working alongside field staff focusing on specific cases to assist practitioners to understand how to apply the approach in their casework. Over the past four years, this work has been formalised into a more structured learning and implementation method to enable a cross agency learning team to be directly involved in the application of the approach through the life of the chosen cases and thereby create a deeper, whole system understanding about how to utilise the approach to deliver high quality practice.

The learning case process focuses on particular open cases chosen by the agency. Since the practice application of the Signs of Safety approach is shaped by all levels of the organisation, the learning team includes practitioners, supervisors, agency leaders and a range of internal (and sometimes external) observers working together in regular consult sessions to apply the practice model as fully as possible to that case. The process usually involves six to twelve sessions over a period of three to six months.

The entire team focuses throughout on assisting the caseworker and supervisor to get the best possible outcome for the case and the best possible application of the practice approach. As the Signs of Safety approach is applied in the case, the group learns about the realities of using the approach in practice while also learning about the aspects of agency function and culture that support the practice as well barriers that need to be addressed and the adjustments that are needed to better enable system-wide implementation. To ensure there is time to consider the system-wide learning, a review session is held every third or fourth consultation during the life of the learning case work.

For the learning case process to be of most value, it is important to choose the cases thoughtfully. Rather than choose a particularly difficult, complex or high-profile case, the learning case process will usually be most productive with more typical cases that represent the situations field staff would say they regularly struggle with and would most want help with.

Once the casework is completed, a record of the work and the learning is co-created by the participants and the Signs of Safety consultant so that the learning from the case can be disseminated throughout the agency and where appropriate out to wider audiences. Very often, work from the learning cases is also utilised within internal (and with agency approval also external) training and guidance materials.

6.6 Understanding the fit between Signs of Safety and other sources of knowledge

Since Signs of Safety is a process rather than a content model, practitioners will draw on many sources of knowledge and expertise for the content. In England where those undertaking the statutory duties of child protection will be qualified and registered social workers, Signs of Safety practice harnesses and augments rather than supplants that training and, indeed, the wisdom and expertise they have subsequently acquired since qualifying. Many of the criticisms of Signs of Safety in staff surveys are

based on a perceived but inaccurate view that it is meant to replace their existing expertise. There are numerous areas of specialist knowledge that are used in working with families, e.g. on drug misuse, domestic violence, mental illness where new developments in knowledge need to be integrated into practice. During the EIP projects, the local authorities provided training in additional areas of knowledge, both about family problems and how to practice more effectively.

In terms of additional training, restorative practice was the most frequently added — in five authorities. Other training programmes included systemic practice, Family Group Conferencing, brief solution-focused training, and current knowledge on ACEs and trauma. However, just as in the previous chapter where we reported on the varied responses to undergoing training in Family Finding, so here were differences in how well additional areas of expertise or knowledge were integrated with the overall framework. When poorly done, introducing new approaches, skillsets and knowledge without giving attention to how they can align with existing practice leaves practitioners confused or unsure of what they should be using and is likely to create considerable diversity in what is being done across the authority.

MTM has worked with the local authorities to produce guidance on how to integrate these into the Signs of Safety framework. Papers on Restorative Practices and Systemic Practice, Adverse Childhood Experiences, and Family Group Conferences are available here: https://knowledgebank.signsofsafety.net/you-cant-grow-roses-in-concrete-part-2.

6.7 Conclusion

This discussion of what is happening in direct work with families shows a varied set of experiences. The majority of staff are enthused by Signs of Safety — though it may be as accurate to say of some that what they are mainly enthused by is that their organisation is seeking to make a cultural shift to relationship-based practice and Signs of Safety offers a means for doing this. For most practitioners the data reveals a steady increase in use and confidence in using Signs of Safety methods. However, the variation found here echoes the variation in overall progress as rated by Ofsted judgments. There are worrying indications of worsening experiences for those in poorly performing organisations. There are also worrying signs that work conditions are making it harder for practitioners to provide the level of service to families that they wish to achieve and to feel supported by their seniors in avoiding defensive decision-making and being more balanced in their making risk assessments and decisions.

7. Findings

7.1 Introduction

Having reported on the several strands of work carried out during the EIP projects, we now look at the evidence available on whether they were useful actions to take.

- Do we see improved use of Signs of Safety and is this linked to implementation of the organisational Theory of Change?
- Is there any benefit for the workforce as evidenced in our staff survey data and national performance data?
- Is there any positive impact on children, young people and families?

This final question will be answered in detail by the independent evaluation that is being conducted so we shall only report on some key performance data to give an overview of changes.

7.2 Testing the organisational Theory of Change

Does the evidence we have collected support the claim that making progress in creating the work environment set out in the organisational Theory of Change, operationalised in the implementation framework, tends to lead to better Signs of Safety practice? Or, to re-phrase in our methodological approach, are these changes support factors for good Signs of Safety practice? When they are a part of practitioners' work environment, do we see more practitioners achieving a high level? The answer is a cautious 'yes'.

Throughout the report, we describe instances where we collected information on what had been done in relation to implementing the organisational Theory of Change and had them blind rated on a range of 1–3, 3 being the highest. The results are displayed in table 7.1 and show support for the hypotheses in the implementation framework: 'if these supports are put in place then they will make it more likely that there will be good Signs of Safety practice'.

The limitations of this data need to be noted. We have sought to avoid the bias of hindsight by using information recorded at the time, using the local authorities' own information and consultants' feedback. We have also had scoring done by people outside the team who worked from anonymised information. However, the scores relate to only parts of the implementation framework. The range of data is limited by information available to us. In addition, some parts are omitted because everyone completed them. For example, all local authorities set up a steering group and had a project manager.

Future monitoring of implementations can benefit from this work. During these projects, we have learned where you see most diversity in how the implementation framework is followed and this can inform better ways of collecting information to monitor implementation and hence lead to better testing of whether, in fact, these are significant support factors.

Table 7.1: Summary of blind-rated scores

Chapter	Leadership			Organisational Alignment	Learning/Practice			Meaningful Measures	Total
Subject	**Overall Leadership**	**Workshop Attendance**	**Stability**	**Case Alignment**	**Practice Leads**	**Family Finding**	**Group Supervision**	**Collaborative Audits**	
Criteria	Strong, visible senior management engaged with the day to day experience of staff. Demonstratively focused on practice. Fostering a safe organisation: building confidence that workers will be supported through anxiety, contention and crises. **3.** Very good achievement on above factors **2.** Some achievement on above factors **1.** Poor achievement on above factors	Seniority of attendees Frequency of some senior attendance (DCS or AD). **3.** High seniority and good attendance **2.** Medium **1.** Few seniors, infrequent attendance by any of top 3 grades	**3.** Stable at DCS and AD level through most of the EIP projects **2.** Few changes at DCS and AD level **1.** Several changes and/or interim appointments	Timeliness of reforming docs during EIP2. Extent of trial and responding to feedback from staff. Progress made: **3.** Good **2.** Some **1.** Poor	**3.** Clear role and visible impact on developing expertise **2.** Variable impact on developing expertise **1.** Little or no impact on developing expertise	**3.** Good dissemination, lots of use after the training, well supported **2.** Some, dissemination, use and support **1.** Little/zero use	**3.** Lot of use, strongly encouraged by seniors **2.** Moderate use, some encouragement from seniors **1.** Little or only starting to use and little encouragement from seniors	Scoring criteria: How quickly work started on making audit more collaborative Seniority of those leading the reform Extent of usage of collaborative audits **3.** Work started early and CCA is well developed and senior managers involved **2.** Medium **1.** CCA at initial stage and senior managers absent	
Group 1									
A	3	3	3	3	2	3	3	3	23
B	3	2	3	3	2	3	2	2	20
C	3	2	3	3	3	3	3	1	21
Group 2									
D	2	3	3	2	2	3	2	2	19
E	2	2	1	3	2	3	1	3	17
F	2	2	3	2	2	2	3	2	18
G	1	2	2	2	2	2	1	1	13
Group 3									
H	1	1	2	1	1	1	2	1	10
J	1	1	1	2	1	1	1	1	9
K	1	1	1	1	1	2	1	1	9

The staff surveys, especially the safety attitudes questionnaire (SAQ) section, provide further evidence of how differently the local authorities are progressing. The SAQ has the limitations of measuring change only between surveys 3 and 4, conducted in EIP2, and of including only one local authority in Group 3. The SAQ clusters questions in five dimensions in all of which higher scores have been shown to correlate with better performance. In the graphs below, data is presented for the three groups 1,2, and 3 in terms of progress.

7.2.1 Team climate

This rates the level of satisfaction with the quality of teamwork and cooperation experienced with colleagues. The questions cover the ease with which one can ask questions, have support from colleagues, speak up if you disagree, and feel that disagreements are resolved well. A more collegiate atmosphere which includes open discussion and critical review of each other's work tends to produce fewer errors possibly because of the amount of informal help and support that everyone gets in reviewing their reasoning and thereby reducing the bias that arises from intuitive reasoning and emotional reactions.

The results show group 1 started EIP2 with a higher level than the other groups and improved slightly, with Group 2 falling slightly. Group 3 however began lower and ended even lower between survey 3 and 4.

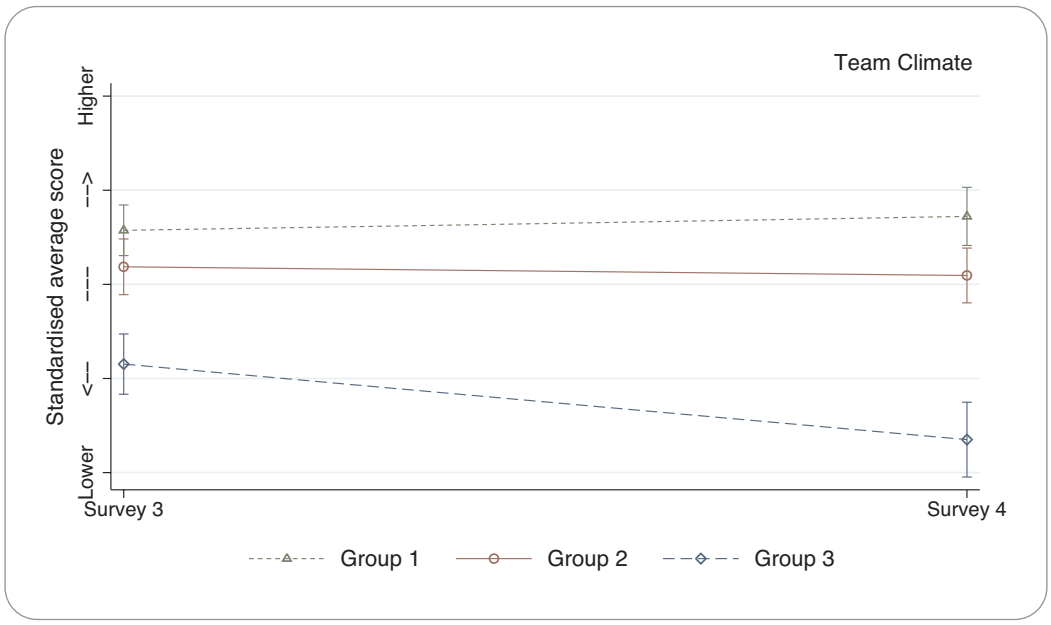

Figure 7.1: Team climate

7.2.2 Safety climate

This captures the extent to which individuals perceive a genuine and proactive commitment to safety in their organisation and, similar to the team climate dimension, is looking for evidence of good ability to ask for help and discuss poor practice. A blame culture will stifle this and thus contribute to poor practice going unrecognised and so uncorrected. A willingness to report, listen and act on evidence of weaknesses in the system increases the chances that the organisation will be able to adapt and strengthen the area of weakness before there is a serious bad outcome. This section also contains the telling statement *'I would feel safe if I or a family member were to receive a service from my team*'.

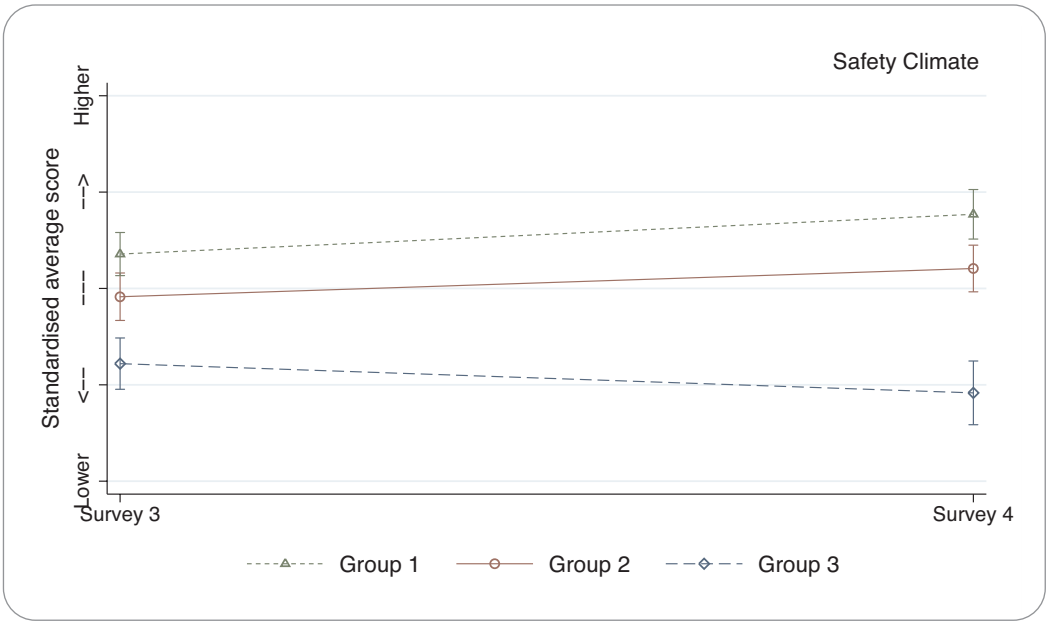

Figure 7.2: Safety climate

The data here show progress for Groups 1 and 2 and deterioration for Group 3.

7.2.3 Perceptions of management

This relates to the extent to which people feel the wider system supports rather than hinders their work. 'Management' covers both local and senior managers. Some of the current reforms have clear relevance here e.g. the amount of progress that has been made with aligning forms and processes with Signs of Safety practice. Feeling that you have a manageable workload is also important.

Here, Group 1 started at a much higher level than the others and made progress. Group 2 made very good progress after starting at a low level. Group 3 shows no change.

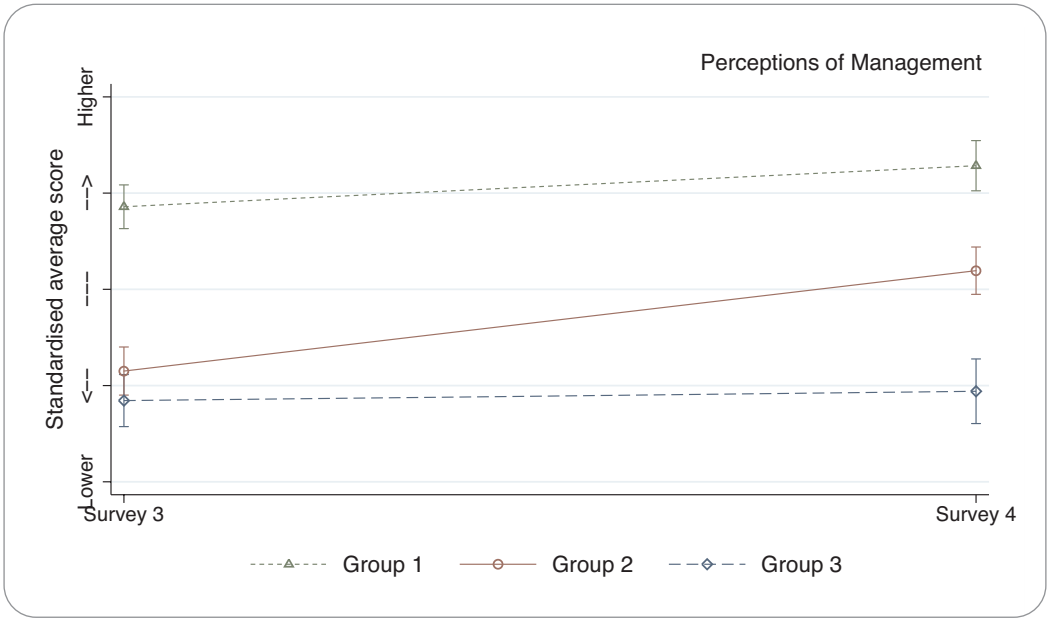

Figure 7.3: Perceptions of management

7.2.4 Job satisfaction

This captures people's level of satisfaction with their organisation and the individual's morale. Questions cover whether people feel the team is a good place to work and whether it has high morale, whether they are proud of the area office and then the simple statement *'I like my job*'. Again, Group 1 starts relatively high and makes progress, Group 2 also progresses from lower starting point and Group 3 gets worse.

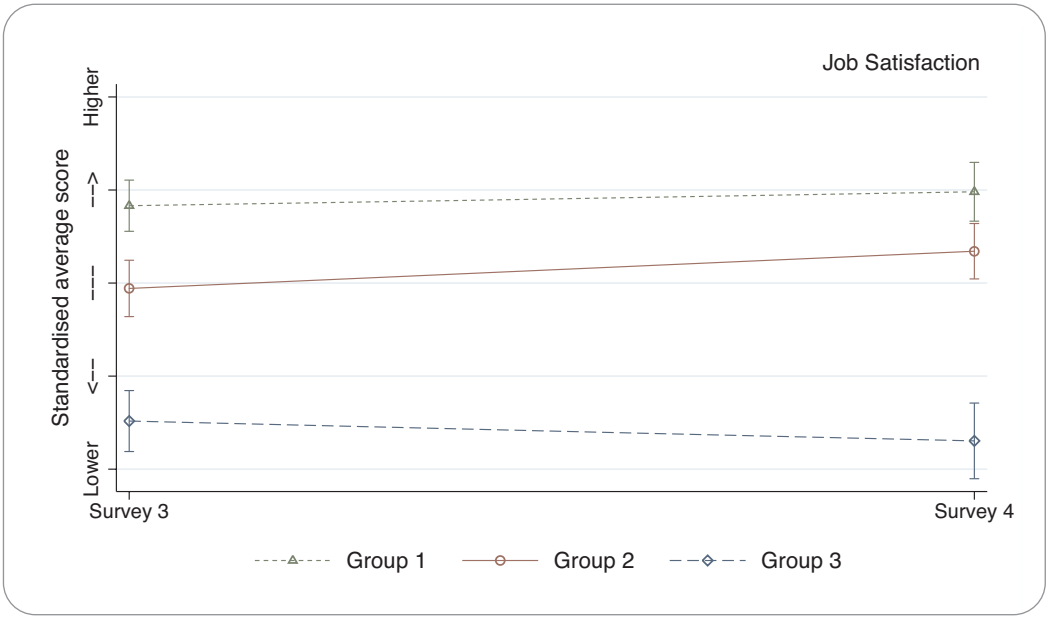

Figure 7.4: Job satisfaction

Since recruitment and retention are such big issues in England, it is interesting to explore in more detail what seems to contribute to high or low job satisfaction so graphs for the individual questions are presented on the next page. There is a thought-provoking contrast in the results on team morale, which average at neutral, and *'I like my job*'. A high rating on this latter statement features in many surveys both in England and other jurisdictions and it does suggest that social work is a profession that attracts a very committed workforce.

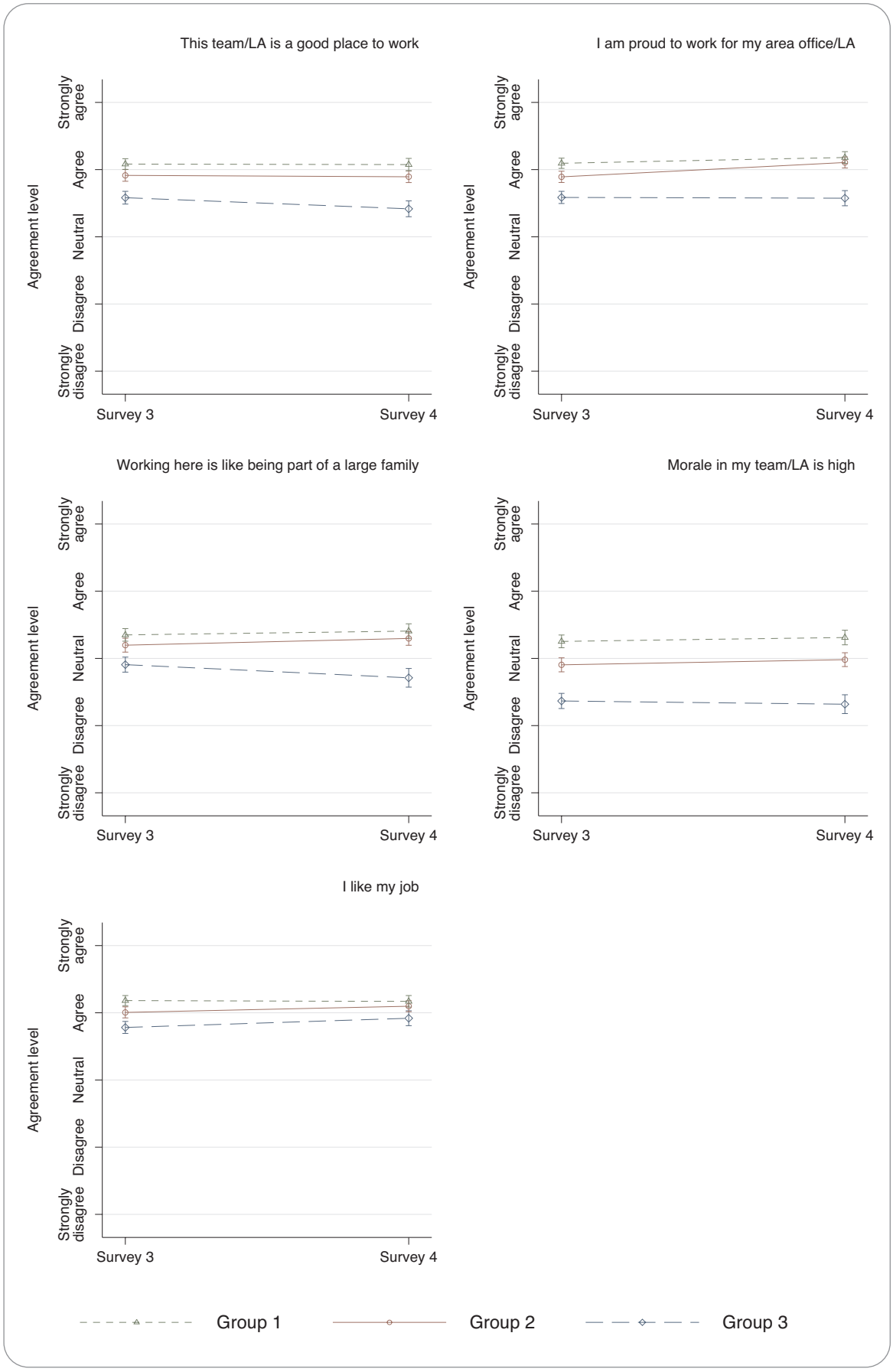

Figure 7.5: Contributors to high or low job satisfaction

7.2.5 Working conditions

This measures the extent to which the organisation gives priority to key aspects of their work. The most influential messages that people hear are often not the overt statements by senior people but the covert communications that are widely known and followed. For example, time to spend with families may be overtly given high priority but, at a day-to-day level, people may know from experience that they will be criticised for failing to keep recording up to date but not for missing a family meeting. Two of the statements in this section were discussed in Chapter Six Practice, reporting on all reporting less time to spend with families, and low agreement with the statement on the team having planned time for critical reflection. Many still felt the culture prioritised performance indicators over time with families.

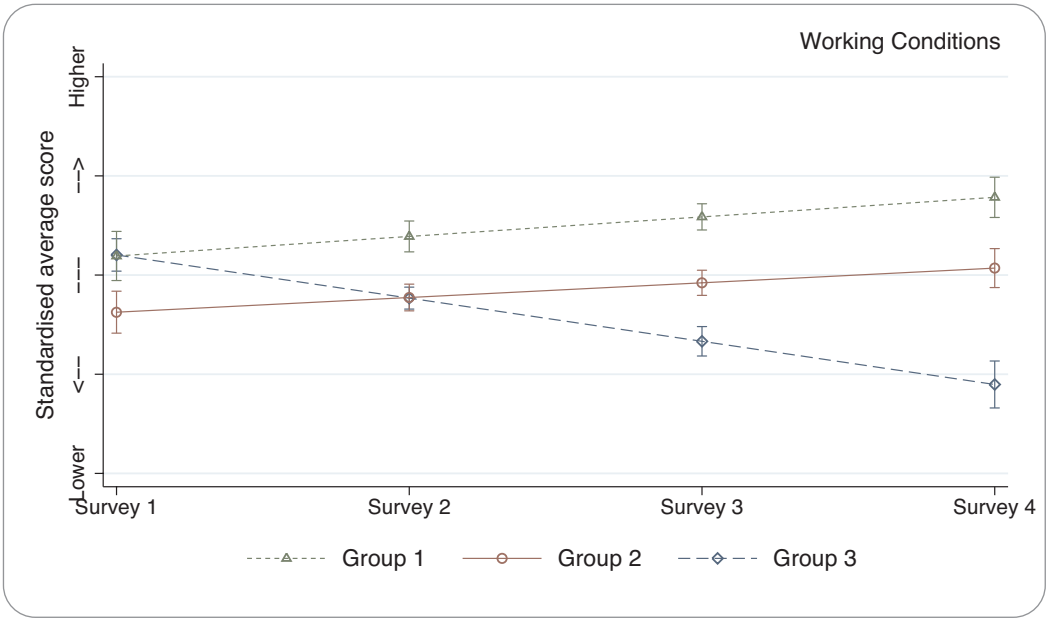

Figure 7.6: Working conditions

7.2.6 Stress recognition

Organisational cultures vary in how realistic an idea they have of human resilience. Some may encourage a 'can do' culture that discourages recognition of the negative consequences of being exhausted. This can distort individuals' ability to recognise their personal vulnerability to stressors and the negative impact they can have on performance. Statements in this section include whether respondents agree that when their workload becomes excessive, their performance is impaired, and they are less effective when fatigued.

Here, the one authority from Group 3 starts from a higher level and shows the most improvement in appreciating how much stress affects the quality of their work. One hopes that this is not because they have had more experience of feeling stress but because they experience a more realistic work culture.

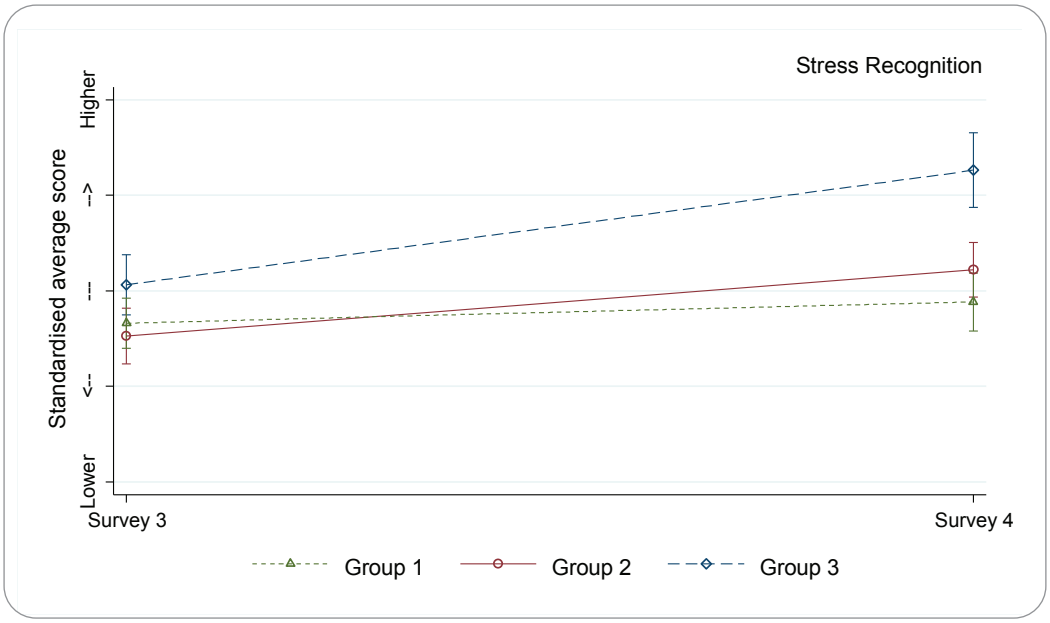

Figure 7.7: Stress recognition

In summary, the evidence in this section gives more detail to what might be contributing to the differences in Ofsted judgments on the quality of practice. It supports the organisational Theory of Change in that the more progress on implementing it, the higher the Ofsted rating.

At the beginning of the chapter, we gave a cautious 'yes' to the question whether our hypotheses on the support factors needed to achieve good Signs of Safety practice with families were supported by the evidence. Further work needs to be done to make a more confident judgment and, drawing on the learning in the EIP projects, it would be possible to be more systematic in collecting robust information on progress and hence provide a more robust test of the contribution made by the factors in the organisational Theory of Change.

7.3 Does more use of Signs of Safety show a positive impact on the workforce?

The purpose of a child protection system is to improve the safety and well-being of children and young people but this requires having a workforce who can provide the help; a serious problem in England where there are problems of recruitment and retention.

We have already discussed the findings in the 'job conditions' section of the SAQ. They showed a high rate of people liking their job but also reporting that morale in their team was low. There was no significant change over the five years for Groups 1 and 2, although Group 3 showed a lower score.

The evidence from the staff survey open-ended questions, discussed in the previous chapter, shows that most of the workforce are positive about adopting Signs of Safety as the practice approach in their local authority, both because it allows them to work with families as they wish and because they see it as beneficial for the family.

Performance data on the workforce is another source of relevant data. The nationally collected data on numbers of caseload, agency staff, turnover rate, are presented here. In presenting the workforce data for the years 2013–2019, we divide the results of the ten local authorities into two graphs, each reporting the data of five local authorities, to improve their readability. They show the % changes for each authority relative to the changes in the national average which is presented as line zero and displayed with a black line. The colours used differentiate our 3 groups on progress. Group 1 is in green, Group 2 in blue and Group 3 in yellow.

7.3.1 Average caseload per SW

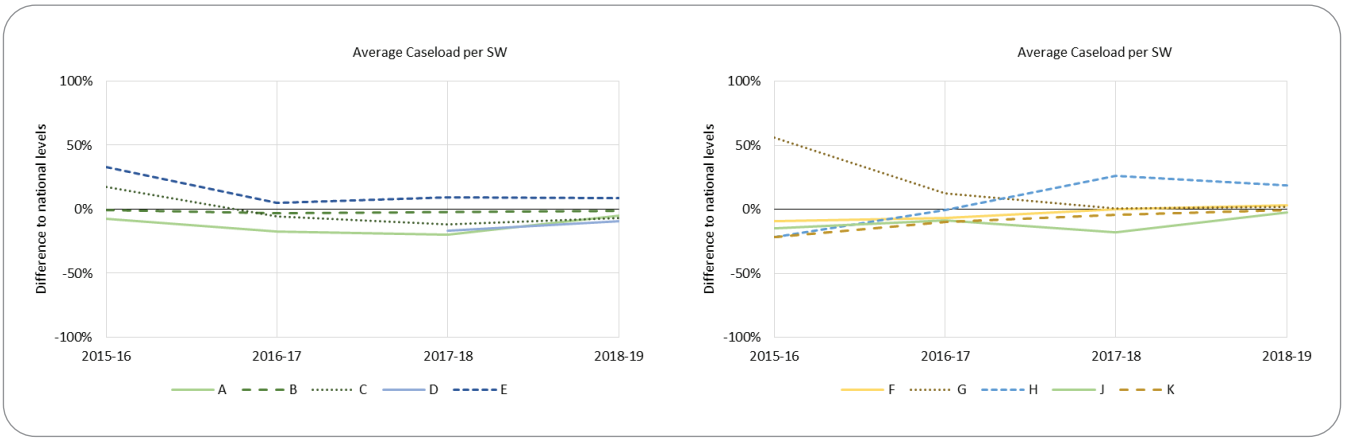

Figure 7.8: Average caseload per SW

Here, authorities C, E and G started with higher than average and have reduced their caseloads, while H has increased.

7.3.2 Turnover rate

High turnover rates create obstacles to any attempt to improve the expertise of the workforce (Farber & Munson, 2010) and can be symptomatic of an unhappy work environment but are also influenced by practical matters such as the ready availability of alternative posts — something that is easier in cities than in country areas. Reductions over time however may indicate an improving work environment.

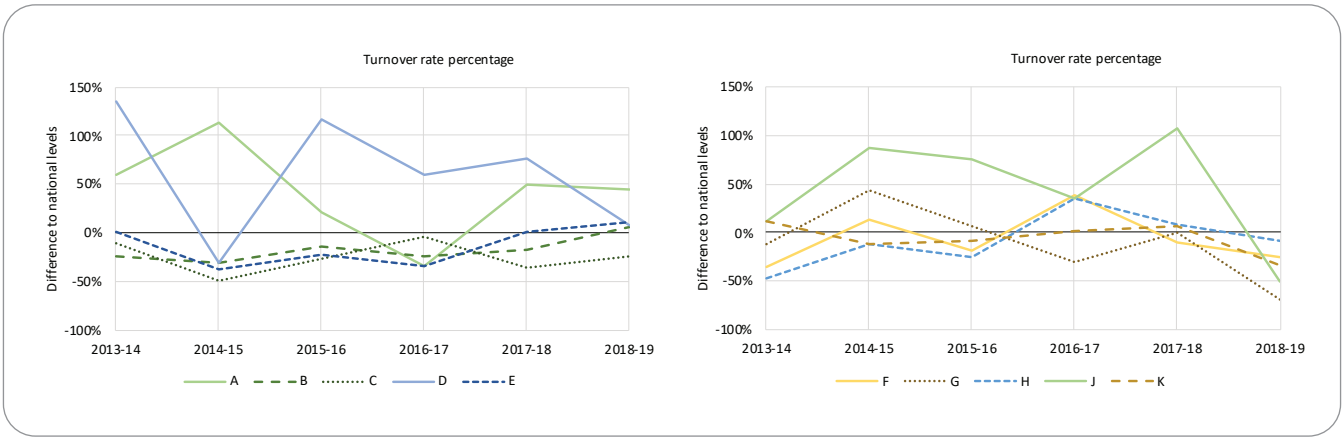

Figure 7.9: Turnover rate

7.3.3 Agency rates

Like turnover, rates of agency staff are an ambiguous indicator but a falling rate is a positive indicator.

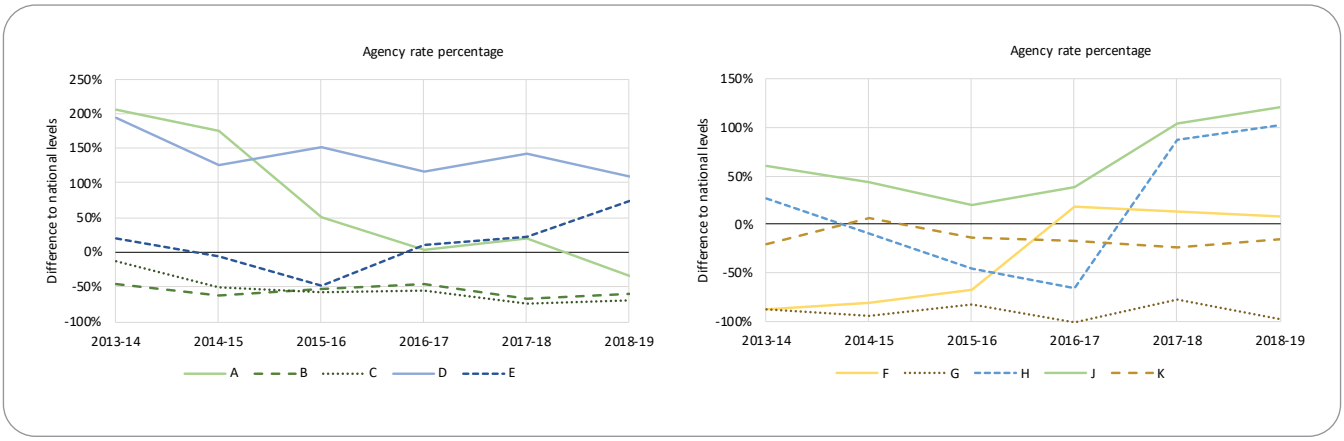

Figure 7.10: Agency rates

Authorities A and D show the most dramatic reductions over the years of the project while authorities H and J show major increases in recent years.

7.3.4 Absence rates

Absence rates are another ambiguous indicator of unhappiness at work but the figures here show a very varied pattern.

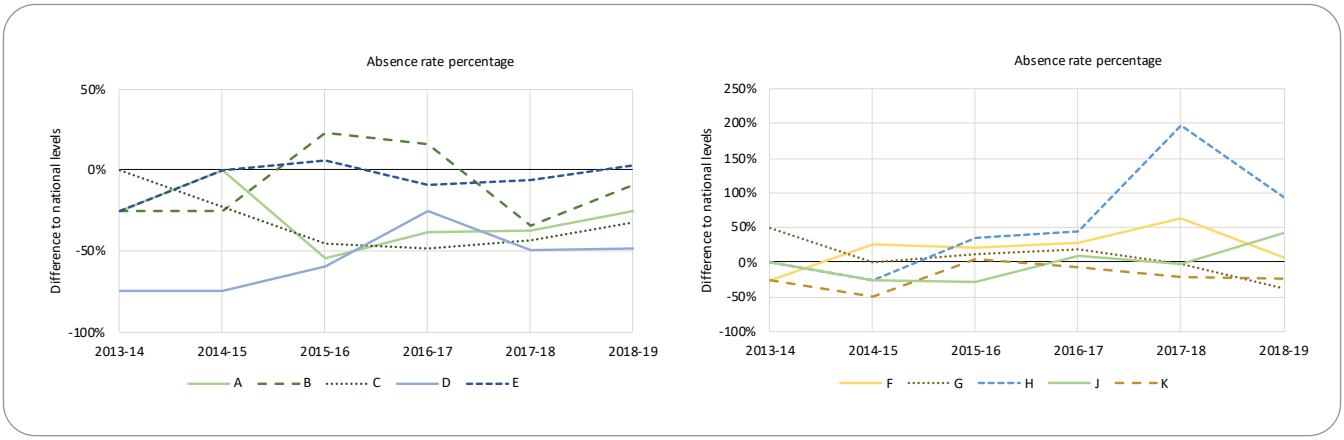

Figure 7.11: Absence rates

7.4 Does Signs of Safety lead to better outcomes for children?

The King's College London team who are conducting an independent evaluation of the EIP projects will also be analysing the performance data. However, we have chosen to report on a few core data where we would hope to see some changes as progress is made in implementing Signs of Safety. Since performance is affected by so many external factors such as increases in population or poverty, we measure progress relative to the national average which will also be affected by those factors.

As with the workforce data, we present the performance data for the years 2013–2019 in two graphs, each reporting the data of five local authorities, to improve their readability. They show the % changes for each authority relative to the changes in the national average which is presented as line zero and displayed with a black line. The colours used differentiate our 3 groups on progress. Group 1 is in green, group 2 in blue and group 3 in yellow.

7.4.1 Referral rates

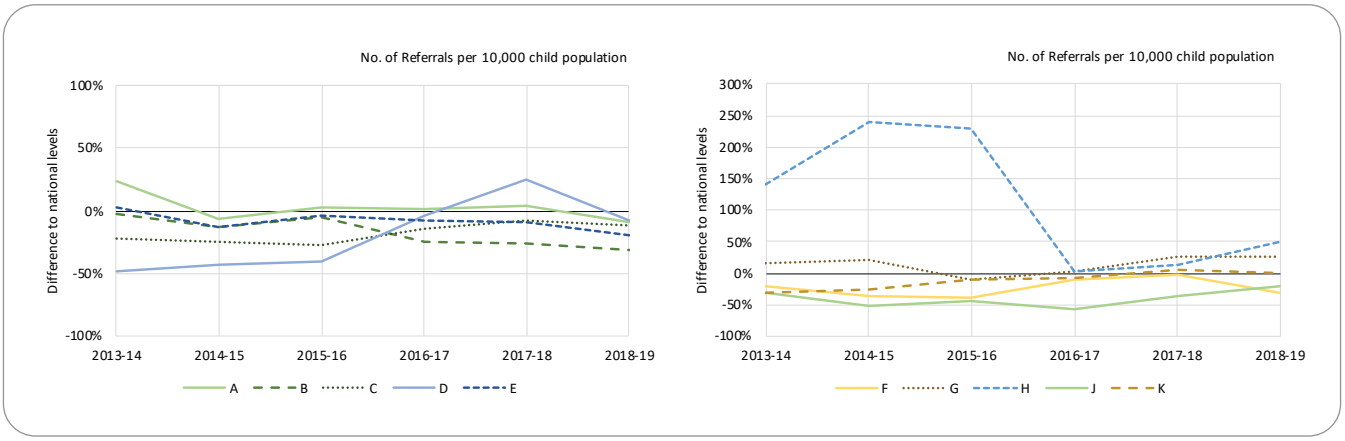

Figure 7.12: Referral rates

These show that most of the ten authorities had a lower referral rate than the national average. Exceptions were D, which had a big rise in 2015–17 but then starting to fall again, and H, which began at a much higher rate than the national average and then fell, before rising slightly again.

7.4.2 Re-referrals

A rise in re-referrals may indicate that cases are being closed without the child's safety being adequately protected.

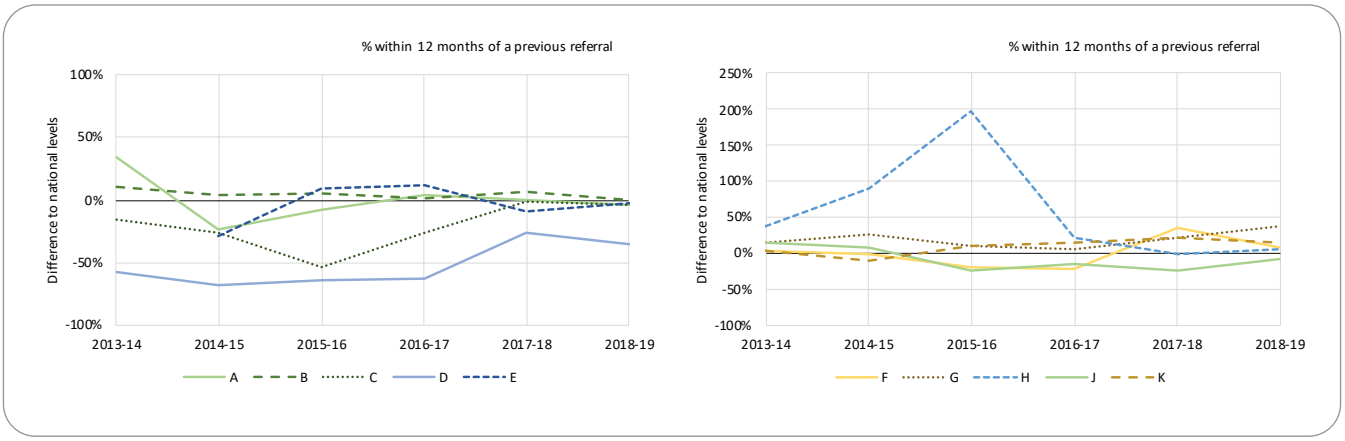

Figure 7.13: Re-referrals

The graphs show variations in previous years but most getting close to the national average by 2019.

7.4.3 Section 47 (child protection investigations)

Hood et al's (2019) study reports a trend across England of local authorities investigating more families and in more depth so more children are being screened out at a later stage than previously. The data on child protection plans shows slight fluctuations from year to year for most, staying below the national average. Authority H started at a high level and fell significantly.

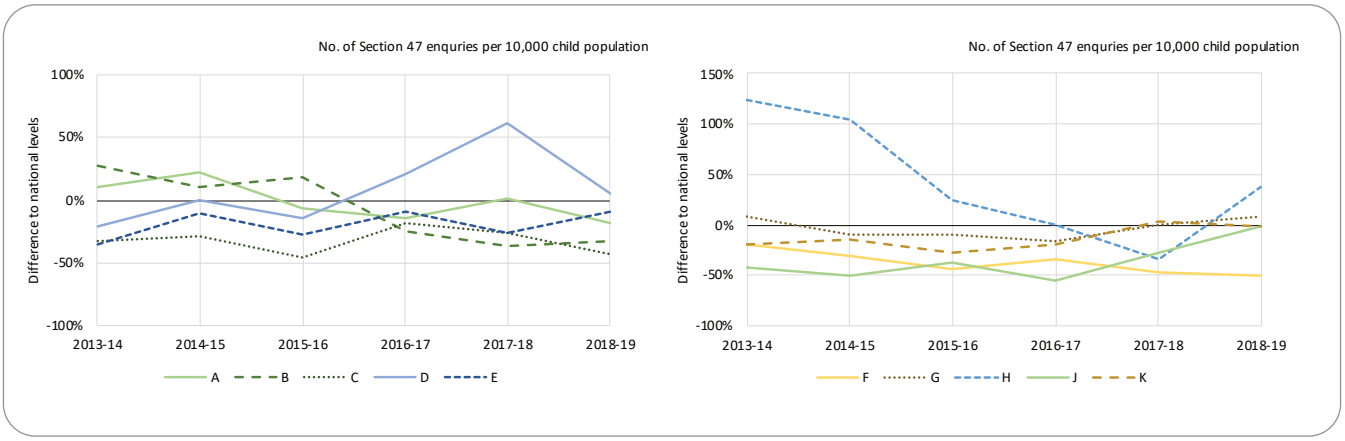

Figure 7.14: Section 47 (child protection investigations)

7.4.4 Number of Section 47 who progressed to a child protection plan

Here, the ten authorities have lower than average rates of child protection plans, with the exception of H.

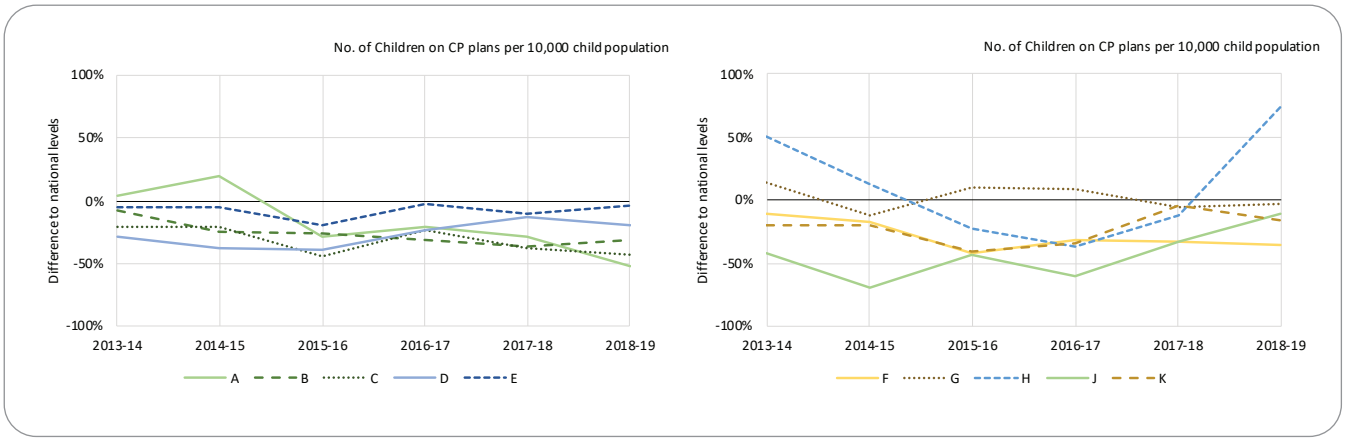

Figure 7.15: Number of Section 47 who progressed to a child protection plan

7.4.5 Care order applications

There is a persistent myth that in Signs of Safety practice 'you don't remove children'. This is nonsense. But, as the law requires and as other practice approaches also strive, in Signs of Safety practice the first goal is to achieve enough safety for the child for removal into care to be avoided. When this cannot be done, then the first choice would be to find kinship care but, if necessary, stranger care will be sought. The following graph reports the numbers of care order applications.

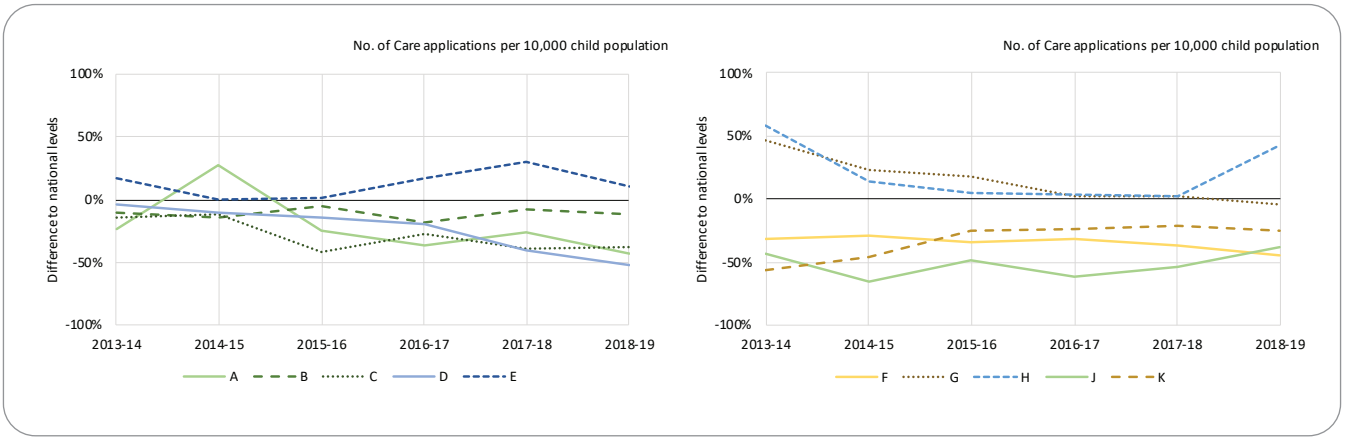

Figure 7.18: Care order applications

The number of care order applications is below average for all but authorities E and H.

7.5 Conclusion

There is a correlation between progress on the quality of service to families, as judged by the Ofsted inspectors, and progress on implementing the organisational Theory of Change. There has also been a steady increase in practitioners confidently using Signs of Safety methods in direct work with families, as shown in Chapter 6 (though there is room for further progress). The SAQ results also show that implementing the organisational Theory of Change correlates with creating a work environment that tends to lead to a higher level of performance.

The action research remit is to answer these questions but the impact on children and young people, which is the main goal, is to be assessed by the independent evaluation. Nevertheless, there are some indications that relative to the national average, the agencies are achieving results in the desired direction.

8 Conclusion

The Department for Education, who funded the two EIP projects, posed two questions to us:

- Is Signs of Safety being implemented?
- What organisational forms best support front line Signs of Safety practice?

This report provides our answers to these questions. As explained in the Introduction and, in more detail in Appendix A, we viewed the work through the lens of complexity and so we did not expect the causal influence of the EIP projects to be simple and linear: *if you do x then y will happen*. The diverse progress made by the local authorities, in fact, illustrates the complexity of causation. Even where two local authorities take the same or similar action in broad terms, there is always variation in how it is then adopted and adapted within their organisational system and hence on its effect.

We have used a realist approach both in implementing change and in monitoring the progress and impact of that change. Assumptions in this approach include that how people respond to a programme will depend on the context in which they are operating, and the reasoning and behaviour of participants will vary depending on these circumstances. It addresses the questions, *what works, how does it work, for whom, and in what circumstances?*'

The report has been organised by the infinity loop diagram that encapsulates both the key components of the implementation framework and their interactions. The data collected has allowed us to draw some conclusions about what supports and what hinders the use of Signs of Safety at both the organisational and the case level. The mixed results achieved by the local authorities correspond to the comprehensiveness and effectiveness of the implementations they undertook.

Leaders in authorities that made most progress, were very visible and committed, getting close to the practice and showing that they understand its challenges. To repeat Klein et al's (2018) distinction between work as imagined from distant parties and work as done, leaders demonstrating direct involvement gave them a realistic, up-to-date understanding of practice and this will have informed their actions.

If whole system reform is delegated to middle managers, it is likely to falter because they lack the authority to make major changes. In a sector that has become hardened to recurrent reforms, leaders need to be proactive to overcome the understandably 'cynical' view of many field staff that Signs of Safety is just 'flavour of the month'.

Turnover at leadership level was clearly a problem in some of the local authorities. Some turnover is, of course, inevitable and a new Director has the authority to decide to stop using Signs of Safety. But if he or she decides to stay with the reform, our experience indicates the change will create a sense of uncertainty for the workforce and hence the importance of the new Director showing on-going commitment to and involvement in the project.

The causal influence of organisational processes and documentation on practice became clear to front line workers as they tried to use Signs of Safety practice in a context that was not aligned to it. Where case management forms and processes do not fit the practice that workers are being asked to implement, they will either have to do the work twice or they will choose one directive over the other and their choice will be strongly influenced by the messages that they are receiving from senior and team managers. Practitioners' frustration on meeting this obstacle was clearly expressed in comments in the staff surveys. Aligning the documentation and altering the software is also a clear message of commitment to implementing Signs of Safety.

Aligning the documentation with the practice not only supports the frontline worker's reasoning processes but helps the supervisor and senior managers monitor the practice. Implementing Signs of Safety requires addressing some of the chronic weaknesses in child protection practice reasoning reported in research — weak analysis, poor or no clear link between assessment and plan of action, and unclear goals. When recording (or case management) system software is reformed to replace the boxes in the Integrated Children's System with the Signs of Safety methods and analytic components, it becomes simpler to see whether, for example, there is a clear differentiation between harm (what has happened), danger (what might happen), and whether there is coherence between danger statements and safety goals. One local authority with well-aligned software, for example, noticed that the third column of the safety map 'what needs to happen' tended to contain a list of next steps but no safety goals, i.e. what the steps were meant to achieve. This allowed them to focus on strengthening this aspect of practice.

In a complex, adaptive system, monitoring what is happening in an organisation is crucial. A dynamic system is going to be influenced by processes both within and outside itself. A major strand of implementing the Signs of Safety organisational Theory of Change is the organisation embedding ways of monitoring itself. The full quality assurance system provides methods for monitoring the depth, breadth and impact of Signs of Safety practice with families as well as gaining both positive and negative feedback about what is happening within the organisation.

The extent to which the local authorities adapted their QA system influenced what was prioritised and supported. Having operated for many years in a compliance culture where process was examined more than content, it was a big change for all. For managers, it requires accepting the need for more complicated ways of monitoring practice than checking compliance. For practitioners it requires exposing their practice to outside scrutiny in more depth. We encourage a collaborative approach to audit because this fosters a learning process for both the auditor and the practitioner whose work is being examined. A collaborative approach also helps create a shared understanding of what good practice looks like and of the standards for judging the quality of practice.

The learning component of the organisational Theory of Change includes introductory and advanced training and also stresses the importance of continuous learning and coaching. The practitioner in social work has tended to be seen as an individual operating with some supervision. The contribution of individual supervision has declined in England in recent years becoming for many a review of case management, checking compliance and reduced opportunity for in-depth reflection on casework. In Signs of Safety as a model that privileges professional analysis, the importance of shared and open reasoning is crucial for achieving high levels of practice.This is not new wisdom. There is a wealth of

research to show how practitioners' close involvement with families introduces the risk of bias from emotional and cognitive factors. The tasks are challenging because reasoning has to be based on information that is often ambiguous and incomplete and decisions have to be made in conditions of uncertainty both about what has happened and what might happen. Discussing your reasoning with colleagues who, operating from the stance of a critical friend, can help to identify and remove errors or omissions. Research also shows how many practitioners tend to look for informal discussion but in Signs of Safety this is more formal. The aim is to create expert teams not teams of experts with high quality practice being seen as a shared goal and achievement.

Practitioners' willingness to be open about their reasoning is more likely if they know they will be judged by reasonable standards and that they will be engaged in the review of their work. The collaborative case audit process contributes to developing an organisational understanding of what good practice looks like and reduces the dangers of practitioners' work being judged with the benefit of hindsight and driving up defensive practice.

In the staff surveys, practitioners in the best performing local authorities convey in their comments a vivid sense of being intellectually engaged in deepening their expertise and of this being within a shared activity. Practice leaders and group supervision are both well developed in these authorities.

Effective and strong team functioning is jeopardised by funding cuts such as those that lead local authorities to replace team offices and individual desks with hot desking arrangements. The negative impact of funding cuts on team functioning can be reduced if there is recognition of its importance in improving casework and hence child safety and efforts made to establish and sustain mechanisms such as designated rooms.

The implementation of Signs of Safety can be described, as we have in this report, by mainly looking at the visible changes made — changes to documentation, QA or learning opportunities. The other, less obvious dimension to consider is cultural change. The key cultural change task of EIP 1 and 2 was to move from a compliance and defensive culture that erodes time for direct work with families and the use of professional judgment to an organisation with a learning culture where the quality of work with families is the key driver. A cultural change that permeates the reforms is centred on dialogue and co-production within the organisation, replacing a more top-down approach to management.

The Safety Attitude Questionnaire (SAQ) was completed twice in EIP2. As reported in the previous chapter, the results show:

- Improvement on all the dimensions for the best performing local authorities, Improvement on all but one dimension (team culture) for Group 2
- Worsening scores for the one authority in Group 3 who completed both surveys (except on the dimension of stress recognition).

The changes are so consistent and in line with the other evidence that we can say that significant cultural change occurred, generating improvements of a type that safety management research shows support good practice.

While most of the report looks at the efforts within the local authorities, it is important to remember the context in which the reforms were taking place; especially the rising demand and reducing funding which contributed to staff in all the authorities reporting growing difficulty in managing their workload. Time with families is a core ingredient in being able to work well and deliver effective services while working under time pressure will adversely affect what can be achieved in improving children's safety and well-being.

As a counterbalance to this evidence on what constrains full implementation, we would like to draw attention to the responses in surveys to the question *'I like my job'*. The highly positive answers here (75–85%) indicate that staff motivation to do this job well is an invaluable support factor in making the reforms work.

The two questions set by the DofE are difficult to separate entirely since they are so interconnected. Their first question: *Is Signs of Safety being implemented?* is answered partly by referring to the evidence on use and confidence in using Signs of Safety methods, reported in Chapter Six, Practice. But this is incomplete. If the practice is occurring in an organisation that does not provide opportunities for discussing one's practice with others and which does not have a just culture that gives practitioners' confidence that they will be judged by achievable standards, then merely using the Signs of Safety methods is insufficient. The quality of direct work is so shaped by the context in which it takes place that evaluations need to look at both practice and organisation. The earlier chapters in which we explored how each authority implemented Signs of Safety provides some answers to the latter question: *What organisational forms best support front line Signs of Safety practice?*

A third question is also relevant indeed crucial if the implementation of the approach is to avoid the danger of becoming an end in itself: *What impact is this having on children, young people and their families, and on the workforce?* The impact on families is being examined by the independent evaluation being conducted by a team at Kings College, London. We have been able to provide some evidence on the impact on the workforce. The survey responses from those working in the authorities making good or some progress report an improving context while the one which has received a worse

Figure 8.1 Mission critical implementation

rating by Ofsted reports the opposite. The possibility that this indicates that poor implementation of Signs of Safety is positively detrimental needs to be further studied since it is an extremely worrying possibility.

We have learned a lot during the EIP projects on the challenges of implementing Signs of Safety in an organisation and of achieving a high standard in using the Signs of Safety methods with families. This has led to many developments in the guidance for managers and practitioners, as we have reported in earlier chapters. The learning has also led to the production of a revised graphic to capture the mission critical components of the implementation process.

Overall, this report has been able to describe how local authorities and their staff are implementing Signs of Safety, who is using it well, providing detail about the contextual factors that support or detract from good implementation. The findings are a strong endorsement of the need to have and actually implement both an organisational and a practice Theory of Change to produce good Signs of Safety practice with families.

References

Ashby, W. R. (1991). Principles of the self-organizing system. *Facets of Systems Science*, 521–536. Springer.

Avby, G., Nilsen, P., & Ellström, P. E. (2017). Knowledge use and learning in everyday social work practice: a study in child investigation work. *Child & Family Social Work, 22*, 51–61.

Baginsky, M., Moriarty, J., Manthorpe, J., Beecham, J., & Hickman, B. (2016). *Evaluation of Signs of Safety in 10 Pilots*. London, Department for Education.

Bell, M., Shaw, I., Sinclair, I., Sloper, P., & Rafferty, J. (2007). *The Integrated Children's System: An evaluation of the practice, process and consequences of the ICS in councils with social services responsibilities*. York, Dept. of Social Policy and Social Work, University of York.

Berry, J. C., Davis, J. T., Bartman, T., Hafer, C. C., Lieb, L. M., Khan, N., & Brilli, R. J. (2016). Improved Safety Culture and Teamwork Climate Are Associated With Decreases in Patient Harm and Hospital Mortality Across a Hospital System. *Journal of patient safety, 7th Jan 2016*.

Biggart, L., Ward, E., Cook, L., & Schofield, G. (2017). The team as a secure base: Promoting resilience and competence in child and family social work. *Children and Youth Services Review, 83*, 119–130.

Farber, J., & Munson, S. (2010). Strengthening the child welfare workforce: Lessons from litigation. *Journal of Public Child Welfare, 4*(2), 132–157.

Helm, D. (2016). Sense-making in a social work office: an ethnographic study of safeguarding judgements. *Child & Family Social Work, 21*(1), 26–35.

Hood, R., Goldacre, A., Gorin, S., & Bywaters, P. (2019). Screen, Ration and Churn: Demand Management and the Crisis in Children's Social Care. *The British Journal of Social Work*. Online https://doi.org/10.1093/bjsw/bcz035

House of Commons Library. (2019). *Children's social care services in England*. London: UK Parliament.

Kahneman, D., Slovic, P., & Tversky, A. (1982). *Judgement under Uncertainty: Heuristics and Biases*. Cambridge: Cambridge University Press.

Klein, D., Woods, D., Klein, G., & Perry, S. (2018). EBM: Rationalist fever dreams. *Journal of Cognitive Engineering and Decision Making, 12*(3), 227–230.

Manovich, L. (2001). *The language of new media*: MIT press.

McFadden, P., Campbell, A., & Taylor, B. (2014). Resilience and burnout in child protection social work: Individual and organisational themes from a systematic literature review. *British Journal of Social Work, 45*, 5, 1546–1563.

Morrison, T. (2010). The Strategic Leadership of Complex Practice: Opportunities and Challenges. *Child Abuse Review, 19*, 312–329.

Munro, E. (1999). Common errors of reasoning in child protection work. *Child Abuse & Neglect, 23*(8), 745-758.

Munro, E. (2011). Munro Review of Child Protection, Final Report: A child-centred system. London: Department for Education.

Munro, E., Turnell, A., & Murphy, T. (2016). *'You can't grow roses in concrete' Action Research Final Report*. Perth: Resolutions Consultancy. Online https://knowledgebank.signsofsafety.net/you-cant-grow-roses-in-concrete-part-1

Parton, N. (2006). Changes in the Form of Knowledge in Social Work: From the 'Social' to the 'Informational'? *British Journal of Social Work*, 38, 2, 253–269.

Pawson, R. (2006). *Evidence-based Policy: A Realist Perspective*. London: Sage.

Reason, P. (1990). *Human Error*. Cambridge: Cambridge University Press.

Regehr, C., Leslie, B., & Howe, P. (2005). Stress, trauma, and support in child welfare practice. *APSAC Advisor, 17*, 12–18.

Salas, E., Rosen, M., Burke, C., Goodwin, G., & Fione, S. (2006). The making of a dream team: When expert teams are best. In K. Ericcson, N. Charness, R. Hoffman, & P. Feltovich (Eds.), *The Cambridge handbook of expertise and expert performance* (pp. 439–453). Cambridge: Cambridge University Press.

Schein, E. H. (1990). *Organisational culture. American Psychological Association, 45*, 2, 109–119.

Sexton, J. B., Helmreich, R. L., Neilands, T. B., Rowan, K., Vella, K., Boyden, J., . . . Thomas, E. J. (2006). The Safety Attitudes Questionnaire: psychometric properties, benchmarking data, and emerging research. *BMC health services research, 6*(1), 44.

Turner-Daly, B., & Jack, G. (2014). Rhetoric vs. reality in social work supervision: The experiences of a group of child care social workers in England. *Child & Family Social Work, 22*(1), 36–46.

Vogl, T. (2020). *The Impact of Information Technology Evolution on the Forms of Knowledge in Public Sector Social Work: Examples from Canada and the UK.* Paper presented at the Proceedings of the 53rd Hawaii International Conference on System Sciences.

Weick, K. (1987). Organizational Culture as a Source of High Reliability. *California Management Review, XXIX*(2), 112–127.

White, S. (2009). Final report for ESRC grant RES-166-25-0048-A.

Wilkins, D., Forrester, D., & Grant, L. (2017). What happens in child and family social work supervision? *Child & Family Social Work, 22*(2), 942-951.

Woods, D., Johannesen, L., Cook, L., & Sarter, N. (2010). *Behind Human Error: Cognitive Systems, Computers and Hindsight* (2nd Edition ed.). Wright-Patterson Air Force Base, Ohio: CSERIAC.

Appendix A

Causality and its implications for Theories of Change and evaluations of complex systems

1. Introduction

Signs of Safety is being increasingly adopted in England and other jurisdictions and agencies. It's clear value base, practical methods for working with families and attention to organisational factors that support the provision of high-quality child protection service makes it a credible and appealing way of working to many people. However, it is reasonable to ask whether this initial credibility stands up to more rigorous scrutiny. A report from the What Works Centre for Children's Social Care (What Works Centre for Children's Social Care, 2019) concluded that 'there was no evidence' that Signs of Safety is effective in reducing the number of children removed from their families. By 'evidence', the authors meant primarily no results from randomised, controlled trials (RCTs) or quasi-experimental studies. To us, the lack of RCT evidence for or against any of the impacts of Signs of Safety is because it is not the right research methodology to use in evaluating a whole system reform of how an organisation provides a service to children, young people and their families. Nor would we be willing to endorse any simple claim that 'Signs of Safety works' because we also need to ask 'what works, how does it work, for whom, and in what circumstances?' for research to provide useful information on how to improve children's safety and well-being.

We value empirical research and are not in any way anti-science. Indeed, it is from science and the philosophy of science that we have learned how the behaviour of complex systems cannot be studied by methods such as RCTs that assume a simple linear causality between the input and the output. We have been able to benefit from the efforts in other sectors such as public health and international development in developing robust methods for studying how organisational systems function.

The crux of the issue is the nature of causal processes in complex social systems such as Children's Social Care departments. The wide variation in the progress of the eleven local authorities in the EIP project while cause for regret is not at all surprising. Making a major change in a system leads to numerous interactions with other parts of the system so there is no standard way that systems will respond to an equivalent input.

Although in everyday life we usually talk of causes and effects in a straightforward, linear '*a causes b*' way, the concept of cause has long been problematic to philosophers and many researchers in both the natural and social sciences. The purpose of this Appendix is to explain some of the many ways that complex causes can be theorised and thence studied and why the question is not 'does Signs of Safety work?' but the several questions: what works, for whom and in what circumstances?

This explanation, while abstract and philosophical, has the practical aim of providing a more detailed understanding of three issues:

1. Why the Signs of Safety theories of organisational and practice change take the form they do;
2. Why a major strand of work in the EIP projects has been to develop methods for measuring the quantity and quality of Signs of Safety practice so that it is possible to form a judgment on whether the family have experienced a Signs of Safety service of sufficient depth and breadth to justify the name. Just as studying the efficacy of a drug requires some measure of how much was ingested by each patient, so does studying the impact of Signs of Safety practice need a measure of the quantity and quality of the service that was delivered and of what has been experienced by the family;
3. How the analysis of progress in the ten case studies* was conducted.

2. Causal connections

A common way to talk of causes is to differentiate necessary from sufficient conditions. A necessary condition is one that must be present for the outcome to occur. A sufficient condition is a condition or set of conditions that are sufficient to bring about the outcome. However, in child protection work, the research evidence that we can draw on identifies neither necessary nor sufficient conditions. Our understanding of child development exemplifies this. Research on adverse childhood experiences (ACEs) for instance, concludes that they may contribute to physical and psychological problems later in life. However, adults can experience serious problems without experiencing any ACEs while others can experience several ACEs in childhood without perceptible difficulties later (Finkelhor, Shattuck, Turner, & Hamby, 2015).

Research that evaluates interventions in child protection work produces a similar pattern. Even where an RCT has shown better results for the treatment group compared with the control group, the average result covers families who showed a lot of progress, no progress and even some deterioration (see e.g. Littell, 2006). The control group shows a similar variety of outcomes. So the intervention being evaluated cannot be claimed to be either necessary or sufficient for achieving the positive outcome sought. It has however a greater tendency than the control intervention to achieve it in the population studied in the RCT. The average effect reported in an RCT misses the complexity of how interventions produce effects.

Mackie (1965) offers a way of thinking about such causes that helps illustrate the complex causality that produces social problems and social solutions. He proposed the concept of INUS conditions: an

Insufficient but
Necessary part of an
Unnecessary but
Sufficient condition.

** Omitting the one that dropped out after EIP1*

So, for example, when treating an adult A with severe depression, his experience of physical abuse as a child may be seen as a cause. However, this is not to claim that it was a *necessary* condition — many people develop depression without experiencing childhood abuse — nor is it seen as *sufficient* — many can experience childhood abuse without becoming depressed. But for this person, the abuse experience is a necessary part of how depression developed for him as it combined with other factors that, together, were sufficient to lead to depression. Hence the abuse was a necessary but insufficient part of an unnecessary but sufficient condition to cause depression.

Another individual B could share many of the experiences that were causal conditions in creating A's depression but other factors in B's life interacted with them in ways that neutralised their potentially harmful effects.

An 'INUS pie' offers a simple way of visualising this complex interplay of factors for an individual. Suppose we are explaining what caused Mr Smith to be abusive, the whole INUS pie is the 'sufficient condition'. It is sufficient in the sense that it can bring about the effect (adult perpetration). However, this happens if (and only if) all the constituent parts are present. Each sufficient condition is made up of insufficient, but necessary parts. They are necessary because, if they are removed, the remaining cluster of factors alone will not lead to abuse. These parts are also insufficient, because none of them by themselves will result in adult perpetration. So, for example, the INUS pie for Mr Smith shows all the factors indicated are present at the same time (Figure 1.1).

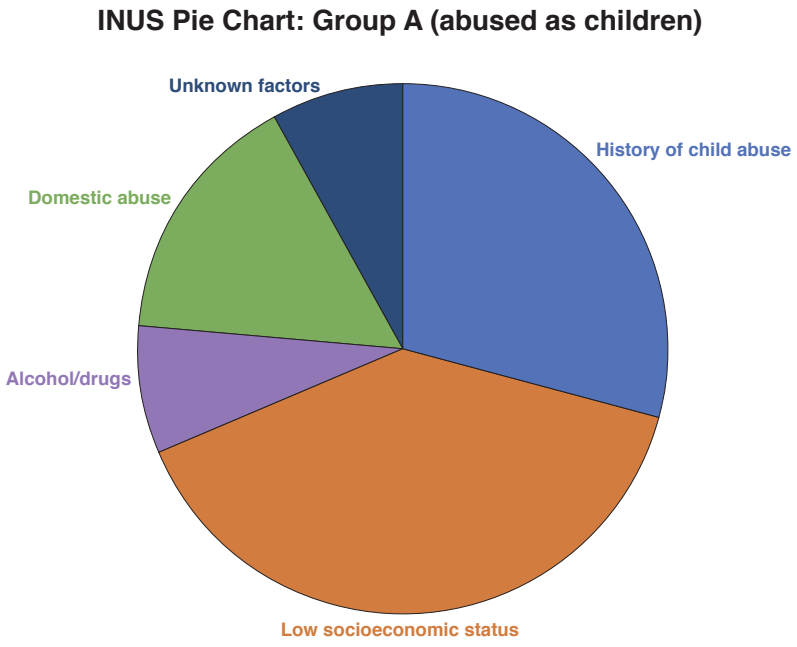

Figure 1.1: INUS Pie Chart Group A (abused as children)

In this particular context, for this particular man, all these factors are necessary to bring about the outcome of becoming an adult perpetrator of abuse. One slice of the pie is marked 'unknown factors' because the current state of knowledge does not allow us to identify all the conditions that contributed to individuals becoming an abuser. A history of child abuse is by itself insufficient to cause the effect. It requires all the other factors to be present at the same time in order to 'cause' the abuse. This fits with the observation that some people go through periods of abusing then not abusing; at some

times, some factors will be missing and, at other times, present. So a childhood history of abuse is only ever a part of a sufficient condition.

However, research findings do not lead to the simple conclusion that the factors that are present for Mr Smith are applicable to all. The conditions vary between individuals, as demonstrated with the example of Mr Brown (Figure 1.2).

Mr Brown was not abused as a child, but a different set of 'insufficient but necessary' factors combine to lead to adult perpetration. For him, a different set of factors is associated with being a perpetrator of abuse. He was not abused as a child, but a number of factors combined to create the causal conditions for becoming a perpetrator of abuse.

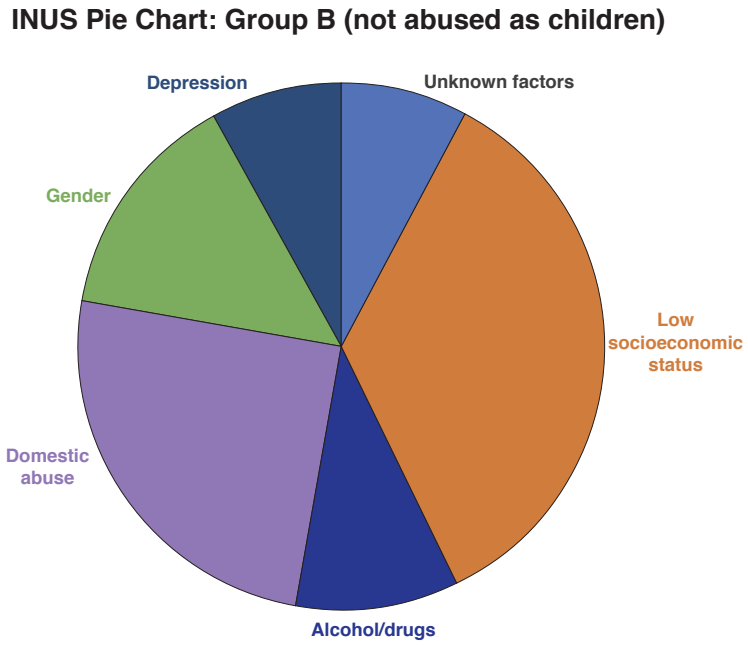

Figure 1.2: INUS Pie Chart Group B (not abused as children)

3. INUS conditions and Signs of Safety Theories of Change

The Signs of Safety Theories of Change sets out INUS conditions rather than universal claims.

The Theory of Change for practice recognises that families are affected by numerous other factors that will influence the course of events so Signs of Safety alone cannot guarantee a good outcome. However, it does claim that addressing the problems with Signs of Safety practice tends to be helpful.

The organisational Theory of Change makes the same point. It recognises that an individual worker is not a free agent to choose independently what he or she does but is always shaped, helped and constrained by their organisational system and the requirements placed on it. Indeed, many aspects of the organisation, such as quality assurance, resources, managerial oversight, are explicitly designed to influence front line work. Some organisational factors are 'support' factors that make it easier to perform well and harder to perform badly, such as having software for case recording that is aligned to

the practice framework. If we think in terms of an INUS pie, then the claim is that when these support factors are present, they will tend to make the desired outcome (of improved outcomes for children) more likely. Others however can be 'derailers'; when they are present they stop the causal pathway, for example, a new Director who is opposed to Signs of Safety can stop its use, i.e. the Director being at least tolerant of using Signs of Safety is a necessary condition. 'Detractors' have the opposite effect to support factors: they tend to diminish the causal impact. Heavy workloads can have this detracting impact in Signs of Safety.

The following two figures 1.3 and 1.4 illustrate how the presence or absence of the components of the organisational Theory of Change are postulated to make it more likely that Signs of Safety practice will be done well, and the child will have better outcomes. The size of the slice of pie in these figures is not a precise calculation. Figure 1.3 illustrates a scenario where the outcome was good.

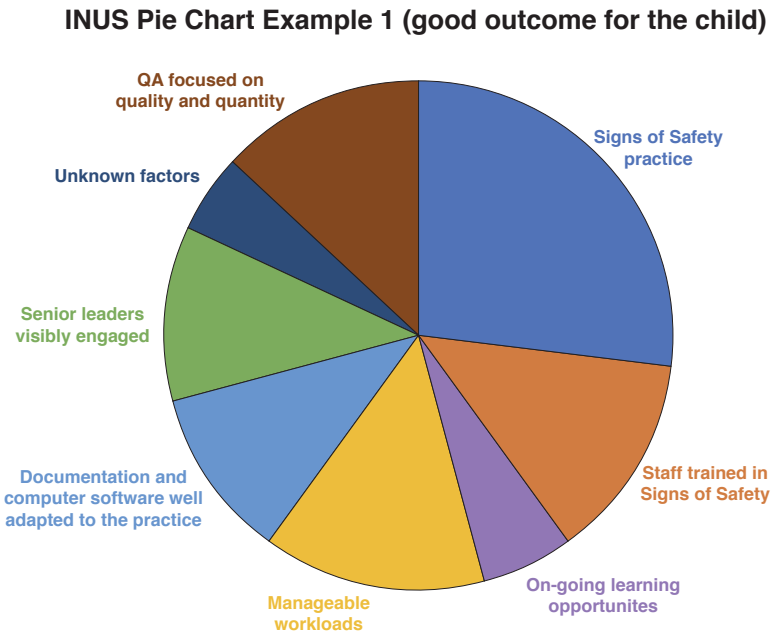

Figure 1.3: INUS Pie Chart Example 1 (good outcome for the child)

Figure 1.4 illustrates how some factors can be 'derailers', stopping the causal pathway to the intended outcome or 'detractors', diminishing the effects of Signs of Safety on the problems.

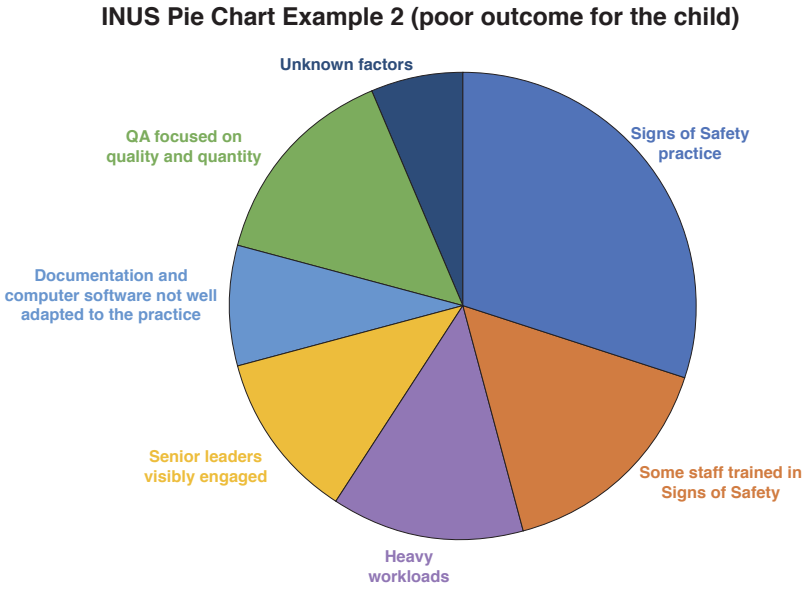

Figure 1.4: INUS Pie Chart Example 2 (poor outcome for the child)

4. Causal pathways

Causality is not just one inert event after another, but causes are active in producing their effects. Aligning the organisational documents (e.g. policies and forms) to Signs of Safety practice has an impact on workers' actions by some causal pathway. These are sometimes called mechanisms in the literature but this term is used so ambiguously that we prefer 'causal pathway'. Typical Theories of Change ignore the activities by which the effects are produced, and contain diagrams showing only variables at the nodes, with thin arrows in between. Such a strategy is reasonable if the aim is to offer a brief overview of the Theory of Change (such as in the Signs of Safety infinity loop diagram on page 4) but more detail is needed for others to be able to use it.

Causal pathways, how one variable has a causal impact on another, are frequently neglected in the literature. In their introduction to *Social Mechanisms,* Hedsrom and Swedberg (1996) write:

'*…the increasing use of [survey analysis and statistical techniques] has…fostered the development of a variable centered type of theorising that only pays scant attention to explanatory mechanisms*'.

Pawson & Tilley (1997) leading experts on realist evaluation make a similar point: '*…in most survey and evaluation research, theory is 'flattened' so that it is expressible only in X → Y propositions [p.301] Theory is indeed flattened so that middle-range questions about contexts, mechanisms are squeezed from the agenda*' [p303].

Inattention to how one variable has an effect creates problems in knowing in what context the causal effect may be produced, what support factors need to be in place to help the causal process to occur and what detractors or derailers might threaten it.

In this report, we seek to give a more detailed account of *how* the variables in the Theory of Change, such as leadership, have an influence on the subsequent causal pathways leading ultimately to the work done with families. Hence, we include a number of vignettes that provide stories of what was done and how it was experienced by those on whom it had a causal impact. For example, *strong, visible senior management engaged with the day to day experience of staff* is listed as a support factor. In the projects, those directors who implemented this used a wide range of activities that made them visible to staff and were seen by staff as demonstrating an interest in and understanding of the practice, e.g. shadowing front line workers and conducting collaborative case audits.

5. Signs of Safety work with families is not necessary to achieve the desired improvements in children's safety and well-being

The above sections have primarily discussed the contribution of the organisational Theory of Change to creating the supportive context that makes it easier for direct work to be implemented in line with the practice Theory of Change. They explained why the organisational and the practice Theory of Changes did not provide a *sufficient* condition to bring about the desired outcome for children. This section explains why, even assuming that the practice has the breadth and depth to be called Signs of Safety, they are also not a *necessary* one. They are not necessary because there are other practice approaches that can help and families are often able to solve their problems without professional help so if you do not use Signs of Safety good outcomes may be achieved by another route. The INUS pie may contain other factors that provide a similar contribution to the causal chain and the desired outcome is reached by a different causal pathway.

This does not negate the claim that Signs of Safety has a tendency to be helpful. In a particular case Signs of Safety work with the family was part of the causal pathway and therefore was a factor in producing the desired outcome. The questions of more relevance are *'when is Signs of Safety helpful?'* and *'how is it helpful?'*

In child protection, the comparison group in a RCT receives services since a child protection agency in all jurisdictions has a legal duty to respond if a child is 'suffering or likely to suffer from significant harm'. In trials the comparison group is usually a poorly specified 'service as usual'. Evidence of better outcomes in the experimental group is often interpreted as meaning it is effective — 'this works' — a misleading simplification of the more modest result that more families in the experimental group showed progress than in the control group. For all the reasons presented here, causal claims for Signs of Safety show that it cannot be usefully evaluated by an RCT since such a research methodology does not provide enough detail to enable someone to decide whether to adopt Signs of Safety and what factors will help the agency to provide families with a good Signs of Safety service.

6. How we are studying progress in the innovations project?

So, what methods can you use to study the impact of using Signs of Safety? Most of this report on the action research undertaken in the project details how quickly and how much each local authority implemented the organisational and practice Theory of Change — creating the organisational support factors and training staff to use Signs of Safety methods correctly. The degree of progress can be checked against the quality of the service at the end of the project. As explained in the report, we are using the Ofsted judgments as a measure of quality because they are an independent judge and their conclusions do not differ significantly from internal assessments of quality. Major developments within the project have been in creating methods for measuring the breadth and depth of practice so that future researchers can better assess whether a family received the type of service specified in Signs of Safety. This allows for future research that can study whether those families receiving a complete Signs of Safety service tend to show more improvement than those receiving a partial or non-Signs of Safety service.

Finkelhor, D., Shattuck, A., Turner, H., & Hamby, S. (2015). A revised inventory of adverse childhood experiences. *Child Abuse & Neglect, 48*, 13-21.

Littell, J. (2006). The case for Multisystemic Therapy: Evidence or orthodoxy? *Children and Youth Service Review, 28*, 458-472.

Mackie, J. L. (1965). Causes and Conditions. *American Philosophical Quarterly, 2*, 245-264.

Pawson, R., & Tilley, N. (1997). An introduction to scientific realist evaluation. *Evaluation for the 21st century: A handbook*, 405-418.

What Works Centre for Children's Social Care. (2019). *Signs of Safety: Findings from a mixed-methods systematic review focussed on reducing the need for children to be in care*. Retrieved from London: