Department for Education

Social Care Innovations in Hampshire and the Isle of Wight

Evaluation Report

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Executive Summary

The Innovation Programme in Hampshire and the Isle of Wight has included a number of strands as follows:

- highly skilled administrators or 'PAs' aiming to support social work teams to release their time for more direct work with families
- Family Intervention Teams including specialist domestic abuse, substance misuse and mental health practitioners aiming to improve the quality of direct work with families with a statutory (Child in Need or Child Protection) Plan
- a network of volunteers including family support workers, youth mentors and others aiming to provide significant added value to statutory work with vulnerable children and families
- a new offer for young people on the edge of care and their families including a blend of key worker, structured activities programme, and volunteer mentor support
- a new multi-agency service to identify, protect and reach out to victims or potential victims of child sexual exploitation (the Willow Team)
- Social Work Surgeries to support early help services where there is an element of risk or uncertainty about risk to children

The overall objective of the Programme was to create the right conditions and capacity for professionals to work as effectively as possible with vulnerable children and families in order to safely reduce demand for remedial or repeat interventions.

With some lead-in for recruitment and preparation, the start-up operational time frame to be evaluated for most but not all strands was from October 2015 to August 2016.

This evaluation from the Institute of Public Care at Oxford Brookes University has sought to understand the extent to which each of the programme strands is beginning to work well, for whom, in what circumstances, and why (Pawson and Tilley 1997). Where strands have showed promise, evaluators have also been tasked with identifying the extent to which they are cost effective. A mixed method approach to evaluation has been applied, including rapid research reviews; case file analysis; interviews with families; longitudinal interviews with team managers, social workers and administrators; broader stakeholder interviews and questionnaires; secondary analysis of performance and cost data collected by the host authorities relating to the programme strands. A fuller outline of the methodology used can be found on pages 17-18 of this report.

Key findings relating to each strand of the evaluation are:

Highly skilled administrators or PAs

Highly skilled administrators or PAs have enabled a decrease in social worker time spent on administrative tasks (from 36% to 14%) and an increase in the time they are spending with families (from 34% to 58%). Teams piloting PAs have also experienced a significant (83%) short term reduction in staff sickness rates and improvements in social worker stress levels, and the overall team environment. In the particular context of teams finding it difficult to recruit experienced social workers, the PA model appears to offer a highly cost effective approach. Taking into account reductions in other forms of administrative support implemented as a result of the introduction of PAs, the overall on cost of having a PA is estimated at £13,224, or £4,408 per social worker. The notional savings based purely on reductions in social worker unproductive time are in the region of £27,000 per PA or £9,000 per social worker. These savings are likely to be further enhanced over time through ongoing low rates of staff sickness rates and improved social worker retention.The cost-effectiveness may also be further improved through embedding of the model over time with reference to creating a more stable recruitment and retention strategy for PAs (no longer reliant on a pilot); further refined guidance and training on the role; and continued adjustment of the overall administrative support offer. More information about the PA pilot can be found in pages 19-23 of this report.

Family Intervention Teams (or FITs)

Family Intervention Teams (or FITs) have proved challenging to implement and embed quickly, particularly in terms of recruiting the right people and ensuring that they are well equipped to work with families with a statutory plan. However, these teams have come together albeit in different formations across Hampshire and the Isle of Wight and they have engaged with the right families, in other words those with at least one of the ‘toxic trio’ of domestic abuse, parent substance misuse or parent mental health. A substantial proportion of families involved with this pilot programme had 2 (44%) or 3 (29%) of these issues and a history of referrals into support services. The key positive impact of the pilot to date has been improved levels of initial engagement of these families with support for toxic trio issues from pre-pilot levels of 29% to 70% in Hampshire and 87% on the Isle of Wight. The characteristics of effective engagement of families with services are explored in pages 26-27 of this report.

Although it is not possible to say from this pilot and its evaluation whether, effectively implemented and embedded, a FIT model can impact positively on child outcomes, the early signs are that better child and family outcomes are associated with:

- single, rather than multiple, FIT workers directly involved with the family (others mainly involved behind the scenes, if necessary)

- strongly structured, evidence-based sessions – FIT worker not drifting into hearing and monitoring
- regular sessions – sufficient to create, with other services including social work, a gripping intervention
- worker acting as a bridge into their own or other services, where a more specialist intervention that they can't provide is indicated, and pro-active chasing of these referrals
- a willingness to work with both parents, as indicated and if safe, in particular to develop better ways of communicating
- an ability to work with parent(s) on broader parent wellbeing and family functioning

Indications of why some FIT workers are able to be more effective with families than others suggest that they may have more experience and skills in supporting parents to develop internal motivation to change; working with parents in the family home; working with whole families; working confidently with parents on family support issues more broadly, rather than offering only their narrow area of specialism. It is interesting to note that, both before and during this pilot, team managers reported as the main barrier to families getting help with toxic trio issues parent motivation to get help and to change rather than the actual availability of services. More about the evaluation of FITs can be found in pages 24-31 of this report.

A network of volunteers

Hampshire and the Isle of Wight have piloted a range of approaches to volunteering with vulnerable children and families, including through provision of family support volunteers, mentoring of young people on the edge of care, interviews with young people returning from being missing, and support for children permanently excluded from school. Both the offer and the means of delivering it have been quite different across the local authority areas, but the 2 programmes have been highly successful in recruiting, training and fielding a range of volunteers. The indications are that a single full time volunteer coordinator might be expected, over time, to support around 50 volunteers working at this level at any one time.

Many team managers and social workers have moved from being highly sceptical about the use(fulness) of volunteers for families with a statutory plan, to using volunteers more regularly and with more confidence. The profile, and the perceived value added, has been greatest so far in relation to volunteers providing interviews with children returning from going missing or volunteer mentoring for young people. On both the Isle of Wight and in Hampshire, team managers have remained much more sceptical or wary of the usefulness of family support volunteers, particularly for families with a Child Protection

Plan, although some volunteers had been deployed successfully to support these families. Early indications from the pilot evaluation are that:

- volunteer mentors recruited and trained specifically for this role can provide highly effective supports to young people on the edge of care as part of a broader plan, including through patient, persistent engagement and regular sessions involving a combination of activities (doing something together, led by the young person's interests), talking, and role modelling. Many of the young people involved so far in the pilot have been helped back into education, employment, training and/or positive activities. However, overall outcomes for these young people can still be relatively poor for a range of reasons, including those relating to the overall support package as well as the underlying high level needs of the young person
- having volunteers available to do return from missing interviews has enabled Hampshire to undertake almost double the number of interviews compared with the period pre-pilot. It would be helpful to explore further what are the particular qualities and benefits of a successful volunteer-led interview compared with one that is professionally-led
- volunteers delivering an average of 3 substantive interventions (family support, mentoring or advocacy) result in a unit cost of approximately £396 per intervention. Volunteers who undertake at least 10 return interviews per year result in a unit cost of approximately £92 per interview. However, these estimates are relatively conservative and some volunteers are delivering or have the potential to deliver more, including a varied portfolio of substantive and 'one off' interventions

More in-depth findings from the evaluation of volunteer pilot can be found in pages 32-38 of this report.

The new edge of care offer

The new edge of care offer for young people has been implemented rigorously in Hampshire. For young people referred into the Programme, this offer has consistently involved: a key (edge of care) worker; a structured weekly activities programme; and a volunteer mentor. It is difficult to predict with accuracy whether and when a young person is on the edge of care (defined as being at imminent risk of coming into care). However, most of the young people involved with this pilot were judged to be either on the edge of care or very close to it, with chronic or escalating needs.

Most (65%) young people engaged well with the edge of care programme and even those that didn't were involved in some way. Only 8% failed to engage at all. Evaluators explored the factors associated with better and worse levels of engagement, including the extent to which workers are persistent and resilient in the first few weeks, offer practical support up front, and actively address parent and young parent barriers to

participation. A high proportion of young people completed the activities programme and were matched with a volunteer mentor. Young people engaged with either or both of these aspects of the programme appear to have better outcomes relating to education, employment or training (EET). Longer term outcomes have been harder to evidence so far because, at the time of the evaluation, so many of the young people involved were still open to social care services. However, more effective interventions appear to be characterised by:

- a relatively tight team (for example: social worker, edge worker and volunteer mentor) actively involved with the young person and family
- good early engagement with the family to build trust followed by well-timed, intensive, evidence-informed work with the young person and parent(s)
- young people encouraged and supported successfully into an activities programme
- support to parents to address parenting and broader family issues

Less effective interventions were often delayed in getting going, and lacked these positive features including in particular a whole family focus to the work.

The approximate unit cost of a typical edge of care intervention is £3,273.40 including: £1,812 for the edge worker, £1,065 for the Activities Programme, and £396.40 for the volunteer mentor elements. This is exclusive of the social worker and other service costs associated with a Child Protection or Child in Need Plan. More information about the evaluation of the edge of care pilot can be found in pages 39-44 of this report.

Willow Team addressing child sexual exploitation (CSE)

The newly-formed Hampshire-wide ‘Willow’ Team tasked with addressing child sexual exploitation (CSE) within the wider agenda of being missing, exploited and trafficked (MET) has consisted of 3 social workers, 2 nurses, 1 specialist Barnardo’s worker and 1 team manager. The work of the team includes 1:1 direct work with children at risk; consultation style advice for workers from a variety of agencies; specialist assessments of children at risk; and awareness raising activities. In a short time frame, the team has achieved a high profile and level of awareness of their work across all key agencies. There is widespread support for a dedicated multi-disciplinary team providing a range of services, and many (89%) key stakeholders value particularly highly the quality of advice and consultation support they have received so far. Whilst the evidence-based approaches of the team to direct work around CSE have been effective with lower risk young people, more time, persistence and a broader evidence base may be required for work with higher risk young people. More information about the evaluation of Willow can be found in pages 45-48 of this report.

Social worker surgeries

The social worker surgery pilot involved a well-supervised family support worker providing training for schools on the social care referral process and thresholds; weekly surgeries for school staff who were concerned about a child; and an audit of the extent to which schools' referrals to Social Care Services were at the right level of need. Whilst there is evidence of some improved understanding of thresholds within schools and better quality referrals to Social Care Services about individual children, the pilot hasn't led to any reduction in referral rates. The model isn't considered cost effective based on projected costs of a scaled up model delivered across Hampshire of approximately £304,000 per annum based on a conservative estimate of 8 family support workers that would be required to work in different localities across the county. Although only a small number of stakeholders were consulted for this evaluation, the strong suggestion was that these sorts of physically embedded advisors weren't required, rather a centralised advisory service with named links into particular localities and schools.

More information about the evaluation of the social worker surgery pilot can be found in pages 49-51 of this report.

Overview of the Programme

This has been an ambitious change programme in Hampshire and the Isle of Wight, involving a number of different strands and elements.

The overall objective was to create the right conditions and capacity for professionals to work more effectively with children and families, in order to reduce demand for remedial or repeat interventions, particularly within the social care arena.

The baseline evaluation undertaken immediately prior to implementation of the pilots reinforced the aims of the programme, in particular the need to work more effectively with families with chronic including toxic trio (domestic abuse, parent substance misuse and parent mental health) presentations or repeat presentations (Cleaver et al 2011). The baseline analysis suggested that in 2015 the prevalence of domestic abuse was as high as 74% amongst families with a Child in Need or Child Protection Plan. The prevalence of parental substance misuse was 52% and parental mental health problems 46%. Just below a third of families with a Child in Need or Child Protection Plan (29%) had all 3 features present, and 29% had 2 out of the 3 toxic trio features. Domestic abuse was the common feature in those with 2 features, present in almost all cases.

The Hampshire and Isle of Wight Innovation Programme included 7 sometimes interlocking elements:

- highly skilled administrators or PAs to support social work teams to release their time for more direct work with families
- Family Intervention Teams, including specialist domestic abuse, substance misuse and mental health practitioners to work with families with a statutory (Child in Need or Child Protection) Plan and toxic trio presentations
- a network of volunteers, including family support workers, youth mentors and others to work with children and families with a statutory plan
- a new offer for young people on the edge of care and their families – including a blend of key worker, structured activities programme, and volunteer mentor support
- a new multi-agency service to identify, protect and reach out to victims, or potential victims, of child sexual exploitation (the Willow Team)
- Social Work Surgeries to support early help services where there was an element of risk or uncertainty about risk to children
- a training and development offer to support all of the above

The context in which the innovation took place

Hampshire is a very large county with an overall population of approximately 1,320,000 people. Although often described as predominantly 'healthy and wealthy', it has pockets of significant child and family deprivation coinciding with the positioning of many of the children's social services locality teams. By contrast, the Isle of Wight is a very small geographical area, about a 10th of the size of Hampshire, with a population of approximately 138,300 and a smaller than average proportion of child or adolescent residents. Overall, it is more deprived than Hampshire, although about average for child deprivation nationally, and it also has pockets of significant deprivation in 3 parts of the Island. Children in both local authority areas are predominantly of White British origin.

The key contextual trends and factors relevant to this programme and its evaluation are:

- cuts to spending on early help services, starting during the innovation period
- a significant growth in the number of children and young people requiring a statutory (Child in Need or Child Protection) intervention during the innovation period. This trend was more or less marked in the different social work locality teams across the two council areas. On average an 11- 30% increase in demand was recorded during the key months of the implementation period, compared with March 2015 when the innovation bid was being formulated
- the relative short duration of the programme. Overall, it needed to be operational (including recruitment to new posts) within 6 months of the bid being agreed and ideally demonstrating impact 9 months thereafter
- ongoing difficulties in recruiting social workers in many of the social work locality teams, in particular front line Child in Need Teams close to bordering authorities able to offer London weighting

Did the programme's intended outcomes or activities change in any way?

As with any major change programme, there have been ways in which the innovation pilots in Hampshire and the Isle of Wight have had to adapt to overcome implementation challenges. The key changes relate mainly to the Family Intervention Teams (FITs) and are a direct result of the difficulties associated with recruiting new staff into pilot projects of a relatively short (1 year) duration:

- there was an initial difficulty in recruiting staff to FITs, particularly the mental health roles in Hampshire and domestic abuse roles on the Isle of Wight. The authorities responded quickly to these difficulties by negotiating slightly different roles (mental health workers in Hampshire) or terms and conditions (domestic abuse workers on

the Isle of Wight). However, the impact overall has been a delay in forming whole teams of workers as originally envisaged

- FITs also experienced staffing difficulties as the pilot progressed, for example with some newly recruited staff leaving before the end of their time-limited contract, as there was some understandable uncertainty about whether the pilot would continue

There were also changes to the social work surgery model. Originally, it was envisaged that a consultation and advisory-style model would be provided in a number of localities to benefit community-based services and professionals working there. However, it was difficult to recruit to these advisory posts, so a scaled down model was implemented in one locality area only, focusing mainly on schools.

Overview of the Evaluation

Evaluation questions

The following key evaluation questions were identified at the start of the programme:

- to what extent, and how, has the remodelled administrative support for social work teams (PAs) facilitated an increase in social worker time for direct work with families? What has been the resultant impact?
- to what extent, and how, have the creation of Family Intervention Teams improved ways of working with Children in Need and their families and enabled more children to remain safely at home?
- to what extent, and how, has the recruitment, training and deployment of volunteers to work with vulnerable children and families supported more effective interventions and enabled more children to remain safely at home?
- to what extent, and how, has the development of an improved offer of support to young people on the edge of care enabled more of these young people to remain safely at home and / or to achieve better outcomes?
- to what extent and how has the development of a dedicated multi-disciplinary Child Sexual Exploitation (CSE) service led to better identification of young people at risk of CSE and fewer children going missing or going missing repeatedly; provided improved support to young people at risk of, or victims of, CSE; facilitated better quality investigations of CSE; led to more perpetrators of CSE being brought to justice? To what extent has this service led to better outcomes for a range of children at risk of CSE including, but not exclusively, Children in Care, Children in Need, and other vulnerable children in the community?
- to what extent and how have social work surgeries helped community-based professionals to continue to work with families without recourse to a social work-led plan and to manage risk effectively? To what extent are community-based professionals more knowledgeable about when a referral to children's social care is appropriate, and to what extent has there been a reduction in the number of inappropriate referrals to children's social care as a result of social work surgeries?
- which strands of the Programme provide greatest evidence of cost-effectiveness?

The theory of change documents linked closely with these questions for evaluation can be found at Appendix 1.

Evaluation methodology – a summary

The key characteristics of the methodology applied to this evaluation are:

- mixed method - quantitative and qualitative with a mixture of tools and approaches tailored to the evaluation questions and programme delivery
- realistic – measuring not only whether something works, but for whom, in what circumstances, how, and why (Pawson and Tilley 1997)
- application of a logic model which aims to describe the relationship between the programme's inputs, activities, outputs and outcomes
- an evaluation sequence involving baseline analysis (looking at the period before the innovation began), an interim evaluation (in February – March 2016), and a final evaluation (in July – October 2016). Many of the evaluation activities were repeated at each stage of the evaluation, as outlined in the table below

Table 1: Evaluation Activities and Time Frames

Activity	Detail	Time frame
Rapid research review	Relating to each of the 'strands' of this Innovation Programme.	July – August 2015
Case file analysis	65 case files examined for the baseline evaluation – a randomly selected range of children with a recent Child in Need or Child Protection Plan or on the edge of care. 101 case files randomly selected and examined for the final evaluation (49 relating primarily to the FIT pilot; 24 to the CSE or Willow pilot; 12 to the edge of care pilot; 16 to the volunteering pilot – but with some overlap across these areas). This activity facilitated an in-depth look at: the nature and level of presenting need, what was provided and its quality or positive attributes, and evidenced impact or outcomes on the child and family.	Baseline at July-August 2015 Final at July – August 2016
Interviews with families	Interviews with 35 families who had participated or were participating in the various pilots (including some who had experienced several elements of the programme) and whose case files had already been examined, with consent, for purposes of the evaluation.	Final at August – October 2016

Activity	Detail	Time frame
Longitudinal interviews with team managers, social workers, and administrative workers	Interviews with 48 team managers, social workers and administrators in teams both piloting and not piloting key elements of the programme. There were three 'rounds' of structured interviews involving the same questions at each stage with some additional questions at the interim and final evaluation stages. Insofar as it was possible, the same workers were interviewed at each stage of the evaluation (30/48 of the full sample or 63%). However, in some cases, evaluators 'recruited' additional workers to compensate for others having left the team or organisation.	Baseline at July-August 2015 Interim at February – March 2016 Final at July-August 2016
Broader individual and group interviews	Semi-structured interviews with service leaders, Child in Need teams, FIT workers, volunteers, volunteer coordinators, other agency professionals A range of methods were used including: face to face interviews, telephone interviews, focus group meetings, and on-line questionnaire surveys.	Interim at February – March 2016 and Final at August – September 2016
Secondary analysis of data about trends in demand, activity and impact	For example, data relating to the following and broken down by team / locality: contacts and referrals to Social Services, Children in Need, with a Child Protection Plan or repeat plan, Children becoming Looked After or Looked After	Baseline at July-Sept 2015 Final at July – October 2016
Secondary analysis of performance and cost data relating to the Innovation Programme strands	For example: Social worker individual and team caseloads Return interviews (for children going missing) Social worker sickness rates Activity data relating to each strand Performance and unit cost data relating to each strand	Final (including with reference to trends before and through the innovation period) at October 2016

Findings relating to the PA Pilot

What does the existing research tell us?

The existing research base relates mainly to earlier evaluations of the Hackney or 'Reclaiming Social Work' model within which enhanced administrative support was only one of many features (Cross, Hubbard and Munro 2010 and Forrester et al 2013).

Baginsky et al (2012) found, for example, that shifting to a form of practice which values shared responsibility for cases, including with high level administrative support, was highly rated by participants and may improve social worker recruitment and retention.

Forrester et al (2013) found that the Unit Coordinators embedded within the Hackney model provided 'in some senses the glue that kept units together'.

McFadden et al (2014) identified that addressing levels of 'excessive paperwork' may be a factor in reducing social worker burnout.

However, the exact contribution of enhanced administrative support to improved social worker performance and / or better outcomes for children and families is not well developed in the literature. Neither has it been possible to determine the precise cost benefits of enhanced administrative support.

Finally, whilst increased administrative support has been identified as a potential improvement factor with regard to social worker practice, others have also been hypothesised as being at least as important, for example: reduced caseloads; improved IT systems; improved post-qualifying training (LGA 2014 and Forrester 2013).

What does this evaluation tell us?

The PA Pilot set out to:

- significantly increase social worker time for direct work with families; and
- significantly reduce the amount of time spent by them on purely administrative tasks

The hypothesis was that providing PA-style (rather than general administrative) support would result in better quality social work with, and better outcomes for, Children in Need and their families.

The PA model was piloted in both Hampshire and the Isle of Wight – with mostly Child in Need (CIN) Teams working with children who have a Child in Need or a Child Protection Plan. The pilot made an assumption about the 'right' ratio of PAs to social workers (1:3) and trialled the approach mostly on this basis. PAs reported a high degree of consistency in what they provided in the role, in particular:

- scheduling social worker visits and meetings (pro-active diary management)
- responding to all basic telephone and email enquiries from families and professionals and taking action where appropriate
- formatting and pre-populating key reports with basic information
- monitoring and chasing social worker compliance relating to key performance indicators (e.g. statutory visits on time, assessments and key reports on time, chronologies up to date)
- agency checks and processing referrals to outside agencies
- sending out invitations to key meetings and organising the venue
- minute taking at key meetings

However, the PAs were also encouraged to be flexible, and the extent to which each of the above activities were emphasised in practice depended on the social worker's working style, caseload type and ability to navigate the information management system.

The impact of pilot PAs

- Child in Need social workers piloting PAs reported that their time spent on administrative activities reduced from 36% pre-pilot to 14% after 9 months of piloting. This finding is drawn from an overall sample of 17 Child in Need social workers including 11 piloting PAs who participated in the longitudinal interviews and who were asked to bring with them to each interview a breakdown of activity for the last full week worked prior to it. They were then asked to moderate their estimate of the amount of time spent onadministrative activities with reference to the extent to which the week was for them 'typical' and in what ways. They were asked to include in their estimates only those administrative tasks included in a list agreed with evauators in the early stages of the Innovation Programme and produced here at Appendix 5. Although team managers were not asked to verify individual worker time spent on administrative tasks specifically, the interviews with them suggests that these self-reports were accurate
- Child in Need social workers piloting PAs reported that the average time they spent with families (including face to face assessment, case coordination and direct work with families to achieve the plan) increased from 34% pre-pilot to 58% after 9 months of piloting. Social workers also said that the time they had with

families was more focused in that they were less preoccupied by some other things that needed to be done in the office

- 80% social workers piloting PAs believed they had either quite a lot of time or very much time to spend with families by the time of the final round of interviews, compared with 14% of social workers in teams who were not piloting PAs, and 18% across the board before the pilot started
- however, only 30% of social workers piloting PAs thought they had very much time to spend with families. The greatest proportion (50%) thought that they had only quite a lot of time and 20% not very much time. The workers who said that they had either quite a lot of time or not very much time to spend with families gave caseloads as the reason. This was substantiated by our analysis of trends in both the team-based and individual caseloads. The former suggests a 17%, and the latter a 13%, increase in caseloads between the start and 9 months into the pilot. This appears to be a short term trend and has been more marked in some localities compared with others. Higher caseloads appear, from some social worker and team manager reports, to have impinged less on social worker ability to meet statutory timescales for visits, where these social workers have had a PA. Higher caseloads appear to have impacted rather more on the ability of these PA piloting social workers to undertake high quality direct work including in particular the part of that task that relates to supporting families to change (as opposed to ongoing assessment of risk and case coordination activities). These constraints may not matter, so long as there are other supports within the whole system or team to help families with a statutory plan to change
- PA-piloting Child in Need social workers reported that most of the time spent with families included direct work with the children rather than the adult members of the family or whole family, a similar finding to that at the pre-pilot stage
- social worker sickness rates are reported to have improved significantly where PAs were involved in the team. In Hampshire, these rates reduced by 83% in teams piloting PAs, compared with a 165% increase in sickness rates amongst other teams (possibly as a result of increasing demand during the time frame). The number of social worker vacancies and the use of agency workers is also reported to have reduced in teams piloting PAs. These rates need further monitoring over time to be clear about their relevance
- other benefits of the pilot reported by social workers have included being more likely to enjoy coming to work; being less stressed about work (including because of the absence of worry about what is happening when away from the office and feeling less alone in terms of the overall responsibility for case work); working less out of hours; and believing that families are less frustrated because their immediate and more straight-forward needs are being met earlier. Team managers involved in the pilot perceived the key benefits of the model to be

improvements in the: quality of assessments; timeliness of plans and visits; chronologies and therefore case oversight; responsiveness of the service for families; administrative pressure taken off social workers; and the overall work environment (more positive and efficient in teams piloting PAs)

The cost effectiveness of PAs

A full breakdown of how costs and cost effectiveness have been calculated for the purposes of this evaluation is provided in Appendix 4 to this report.

- overall, the PA model trialled in Hampshire and the Isle of Wight appears to have been highly cost effective, particularly in the context of an overall climate in which it is difficult to recruit social workers
- the annual unit cost including overheads of a PA during the pilot period in Hampshire was £30,456 (including £25,380 actual salary costs). However, taking into account reductions in other forms of general administrative support required as a result of the implementation of PAs, the overall on cost of having a PA is estimated at £13,224 overall, or £4,408 per social worker
- the evaluation findings support the hypothesis that having a PA reduces the amount of administrative time spent by social workers, resulting in a notional saving of approximately £9,000 per social worker or £27,000 per PA. Additional value might also be attributed in time to increased productivity of social workers as a result of reduced days off sick, reduced use of agency social workers to fill vacancies, and the improved quality of social worker activity (with reference to more timely visits or meetings and better quality reports)
- therefore, based purely on reduced time spent on administration, the cost benefits are approximately £2 for every £1 spent
- it was also an ambition of this pilot programme that PAs would free up social workers to become active agents for change within families, an additional added value. The evaluation did not find any evidence of this in practice. The additional value appears to have related rather more to social workers having the capacity to take on more children and families to meet increased demand, worth a notional £20,000 per PA in terms of additional caseload managed in practice by social workers without a decline in quality
- there is evidence that the cost-effectiveness of the model could be further improved with reference to retaining more PA staff (the short term nature of the pilot has meant that a number of PAs left before the end of their contract); improved guidance for PAs and social workers on the role to achieve better consistency; further refined training for PAs, particularly those who are new to

social care systems; and continued review and adjustment of the overall administrative support offer as the model continues to be embedded

Findings relating to the Family Intervention Team (FIT) Pilot

What does the existing research tell us?

Whilst there are helpful research findings about what works in addressing each of the toxic trio features in isolation, not many evaluations have been undertaken in relation specifically to families with these features who are in the statutory arena, or where more than one feature is present - with the exception perhaps of research into promising models such as the Family Drug and Alcohol Courts (Harwin et al 2014), or intervention models aimed at improving parenting in the context of parent substance misuse (Templeton 2014).

The evidence base has also left relatively unaddressed the question of how best to deploy non-social worker specialists to work with these families and whether, for example, it is better to work as a physically integrated team or to facilitate quick referrals to these specialists operating as a completely or semi-separate team.

Linked with this last question, and recognising the significance of what has been described in the research literature as 'internal motivation to change', Forrester et al (2012) have raised the important question of how best to support its development amongst resistant parents (often those with chronic parenting and broader issues) whilst continuing to maintain a focus on the welfare and safety of the child.

What does this evaluation tell us?

The FIT Pilot set out to provide more creative and holistic interventions to improve overall family functioning, particularly for families with 'toxic trio' issues including: domestic abuse, parental substance misuse and parental mental health.

Longer term aspirations of the FIT Pilot were also expressed in terms of:

- more children supported to remain safely at home
- a reduction in the number of Child Protection Plans
- a reduction in the number of children coming into care (by 6%)

The pilot programme involved small teams of 3 workers (FITs) experienced in either domestic abuse, adult mental health or adult substance misuse, working closely with some Child in Need teams in Hampshire or on the Isle of Wight to benefit families with a Child in Need or Child Protection Plan and at least one of the three toxic trio issues.

However, in practice, there were significant difficulties in recruiting and retaining the staff required to provide a full FIT in the planned pilot teams in Hampshire. These difficulties included in particular an under-supply of mental health nurses in the area and the fact that the posts were advertised for a 12 month fixed term contract only. They have made the introduction as well as an evaluation of the originally planned model extremely difficult to achieve. For example, only 1 Hampshire FIT was fully staffed for the key 6 month operational period (January – June 2016). Three out of eight Hampshire teams only ever recruited a Domestic Abuse Worker. Other teams had a mix of mostly Domestic Abuse and Substance Misuse Workers. As it became clear that the model was problematic to implement, some workers who had been recruited left in a very short period of time. In contrast, on the Isle of Wight, 2 full FIT teams were secured for the majority of the pilot period, albeit with the Domestic Abuse Workers being based apart for some of the time.

The impact of these implementation difficulties has included:

- that it has been difficult to establish new ways of working based on the intended model, which was always intended to be evolutionary, rather than set in stone. A key area of uncertainty has been the extent to which FIT workers should provide advisory and assessment focused or more hands on direct work with families – and what evidence-based interventions are appropriate to deliver in the family home
- that both Child in Need and FIT teams have sometimes found it difficult to sustain a high level of faith and optimism about the new ways of working
- that it has been difficult to evaluate the impact or potential impact of the model

However, a total of 502 families participated in some way in the FIT pilot in the most operational period: the 6 months between January and June 2016 (321 in Hampshire and 181 on the Isle of Wight).

- the case file analysis undertaken at the final stage of the evaluation (in July – August 2016) suggests that the pilots in both Hampshire and the Isle of Wight were working with the ‘right’ families i.e. those with at least one toxic trio issue. 29% of the Hampshire families involved were characterised by all 3 toxic trio issues and 44% had 2 out of the 3. 53% had a significant history of involvement with Social Care Services and 26% at least some history, suggestive of a fairly high proportion of families with chronic issues participating in the pilot. Slightly lower proportions of families had all 3 (13%) or 2/3 (53%) toxic trio issues on the Isle of Wight
- most families received direct support from just one FIT worker. However, the broader FIT offer often also included advice and support from the other FIT worker(s) to either the lead FIT worker or to the case-holding social worker. Team

managers and social workers particularly valued the advice and consultation aspect of the model. Some other families received concurrent or consecutive support directly from more than one FIT worker

The impact on family engagement

The key positive impact of the pilot has been improved levels of initial engagement of families in support for toxic trio issues. Case file analysis has demonstrated a dramatic increase in family engagement from pre-pilot levels of 29% to approximately 70% in Hampshire and 87% in the Isle of Wight. In some ways this is unsurprising as FIT workers were going to families in their homes compared with the previous arrangement whereby parents were more likely to be expected to get themselves to these specialist services. In Hampshire, the Domestic Abuse Workers achieved the highest levels of initial engagement compared with other types of FIT worker. On the Isle of Wight, it was the Mental Health Workers.

Characteristics of effective engagement with families included:

- FIT worker establishing a warm relationship with the key family member(s), building trust, offering practical 'quick win' help if appropriate, encouraging open sharing of information and generally helping the family member to develop and sustain their own motivation to change
- the case-holding social worker working hard alongside the FIT worker (and often in advance of their involvement) to create a jointly 'gripping' intervention involving regular visits that continue alongside the FIT intervention, rather than withdrawing slightly once another worker had become involved
- FIT worker spending time at the start of the intervention to understand the issue in more depth, to hone the diagnosis, and to support the family member to sign up to an agreed plan of work

Families involved in the evaluation reminded us that:

- they tend to be mistrustful of any worker in the statutory arena, at least at first, that workers should expect this
- motivation (to change) is hard to develop when parents do not believe they need to change and/or where other workers have already had a significant involvement with them. This finding was echoed by the conversations with team managers and social workers involved in this evaluation who believed at the start of the pilot and 9 months into it that the key barrier to the accessibility of all 3 types of toxic trio support is still parent motivation to change

- it is important to be aware of the stigma of being involved with Social Services, and actively work to address this barrier for families
- effective engagement skills include: giving the impression of having time to listen; detailed exploration of the past with a view to understanding it; being non-judgemental about the past; asking the parent how they want to move forward; offering visits that are flexible to suit the parent (for example when the children are at school)
- ineffective approaches include: feeling forced into a plan without really signing up to it; workers appearing rushed; not having a plan or having an unclear plan; being told that you must fit a certain service model (for example services run mainly for women)

The impact on outcomes for children and families

Many of the cases explored in detail for this evaluation involved children and families who were still the subject of a statutory plan, therefore it was too early to make a judgement about anything other than short term outcomes.

- only 20% of our sample of Hampshire families and 8% of the Isle of Wight sample involved with a FIT were showing clearly positive short-term changes or outcomes at the time of the final evaluation
- as might be expected, a much larger proportion (32% in Hampshire and 69% on the Isle of Wight) demonstrated mixed outcomes, including some improvements and ongoing risks or unmet needs
- the sample of families interviewed in relation to FIT for this pilot identified positive outcomes they had experienced including: improved self-confidence as an individual as well as a parent ("I was invisible, I never wore colours. I'm evolving now into a different person"*);* better recognition of the warning signs of arguing and fighting ("We don't argue as much anymore – we were arguing every day"); improved parenting including boundary setting ("X doesn't punch holes in the doors now. I have better boundaries"); improved sleep and access to medication for mental health issues; and improved awareness of self and others

Better child and family outcomes for families who engaged initially with a FIT appeared to be associated with:

- direct involvement of a single rather than multiple FIT workers
- strongly structured evidence-based sessions – worker not drifting into hearing and monitoring
- regular sessions, sufficient to create with other services, including social work, an

intervention that feels ‘gripping’ or intensely engaging of the family

- worker acting as a bridge into their own or other services where a more specialist intervention (that they couldn’t provide) was indicated and pro-active chasing of these referrals
- willingness to work with both parents, as indicated and if safe, in particular to develop better ways of communicating in the family setting
- an ability to work with parent(s) on broader parent wellbeing and family functioning

The case file analysis also demonstrated that:

- family needs are often much broader than the toxic trio and include, for example, attachment issues; limited skills in positive parenting; poor inter-family communication; children with behaviour problems at school or at home. The outcomes might still be poor for families, even if they engage in work relating to toxic trio issues, where these others remain unaddressed
- where more than one worker provides direct work with the family (for more than one toxic trio issue), this can lead to an overlap and confusion of roles - simply too many people involved for the families concerned
- even initially well-structured interventions can lose focus after a few sessions and can drift into hearing and monitoring only, perhaps because the intervention has not been clearly agreed with the family member at the start and ‘owned’ by them
- there have been some missed opportunities to undertake direct 1:1 work, for example, where FIT workers required rather than merely encouraged the family member to attend a group-based programme and didn’t offer 1:1 alternatives

The anticipated impact on overall trends in Child Protection Plan and Looked After numbers has not yet materialised. Arguably, it was too soon to see any such reductions in these cohorts at the final evaluation stage, in particular in the context of rising demand for Child in Need services overall. In fact, there has been:

- no change in the number of open Child Protection Plans in Hampshire between the period immediately before the start of the pilot and 9-12 months into it (both overall and in the teams piloting FIT). On the Isle of Wight, the number of open Child Protection Plans has decreased by approximately 24%. The number of new Child Protection Plans commencing in each 3 month period during the pilot have been very variable in Hampshire in particular - from as low as 102 in January and March 2016 to a spike of 180 in May 2016

- a strong growth in the number of children becoming looked after in the Hampshire social work teams piloting FIT, particularly in the final months of piloting. These teams have experienced an 80% increase in the number of children becoming looked after between the 3 month period immediately prior to the pilot commencing and the 3 month period after it had been piloted for approximately 9-12 months. This represents even stronger growth than across the whole of Hampshire (53%) during the same period. The number of Isle of Wight children becoming looked after has also increased, but less significantly. Some team managers participating in the longitudinal interviews believed that, as a direct result of the FIT more, not fewer, children had come into care, mainly because access to FIT worker knowledge resulted in a more accurate understanding of the risks to children

The broader benefits of the model identified by team managers and social workers

- team managers of teams piloting FIT believe that they have had increased access to domestic abuse support for families in particular during the pilot period. This finding is sustained across Hampshire and the Isle of Wight. Activities that have been valued include the worker acting as an accessible bridge for parent(s) into a Freedom Programme / refuge / police complaint; provision of a specialist consultant for social workers – giving them insights and tools; and (in some cases) direct 1:1 delivery of the Freedom Programme with a parent
- team managers overall believe that the FIT pilots have only slightly improved access to mental health support for parents. On the Isle of Wight, the perceived improvement in access is stronger. However, Team managers in Hampshire essentially did not change their view about the accessibility of mental health support during the pilot period. Most considered that it was still not very easy to access. In most cases, team managers reflected that this was because of the lack of a worker, or the lack of clarity about what the mental health worker could and should do with families
- team managers believe that the FIT pilots have improved access to substance misuse services mostly on the Isle of Wight (an upwards movement from quite to very easy to access overall), whereas in Hampshire this uplift is not as marked. It is noticeable that, even at baseline, most team managers thought that substance misuse support was quite easy to access and also that, by the time of the final evaluation, all localities could in any event access a new Inclusion Service reported to be ‘quite’ to ‘very’ responsive to the needs of parents in the statutory arena. Particular improvements mentioned by team managers resulting from having a substance misuse FIT worker included: closer links to the specialist service; the ability of the substance misuse worker to access, with consent, more

accurate and up to date information about the parent's substance misuse history; and their ability to act as a specialist consultant to social workers about the likely impact of the substance misuse on individual parents

- other benefits of the FIT pilots were reported by individual team managers and social workers and groups of social workers to be increased availability of specialist advice, and improved knowledge base of the social worker resulting from it; improved multi-agency working and information sharing; improved social worker assessments based on fact rather than supposition (including through an ability to ascertain the status of the parent or carer in relation to substance misuse and mental health); and quick response times addressing loss of momentum that otherwise sometimes occurs with the passage of time between referral and a service
- some team managers thought that the impact of a FIT-type service could be improved by making it more holistic for example by also addressing parenting issues and barriers to change. This was echoed by some of the families interviewed for the evaluation who suggested that a characteristic of unhelpful interventions was worker(s) being unable to help with broader family issues such as child behaviour

The cost effectiveness of FIT

It is impossible to say at this stage whether a fully implemented FIT model is, or could be, cost effective in time, for the reasons outlined throughout this section. However, it is interesting that the greatest value added appears so far to have come from the domestic abuse worker element, as the cases they worked were amongst the most successful in terms of outcomes in Hampshire, and the unit cost of these workers' contribution was lower than the others for the purposes of the pilot (the unit cost of domestic abuse workers per annum, including overheads, was £34,825 compared with £47,511 for substance misuse workers and £37,853 for mental health workers. Mental health workers had the greatest variation in costs in practice from £28,792 to £46,133). A full breakdown of how costs have been calculated for the purposes of this evaluation are provided in Appendix 4 to this report.

Indications of why some workers (including, but not exclusively, domestic abuse workers) are more effective than others suggest that they have more experience and skills in supporting parents to develop internal motivation to change; working with parents in the family home; working with whole families; working confidently with parents on family support issues more broadly rather than offering only their narrow area of specialism.

This evaluation also suggests that an intervention model involving a number of specialist team members working concurrently, or consecutively, with families in the context of a statutory plan is not very effective or cost effective, particularly where these specialist

services are more or less available in the community. More effective interventions appear to be associated with a tighter team involving the case holding social worker and one, or a small number of, support workers who are able jointly to support parents to become motivated to change and to act as a bridge where necessary for the parent(s) into additional services to meet other toxic trio needs. Additional specialist workers can perhaps more cost effectively be involved behind the scenes in a consultancy or advisory role.

Findings relating to the Volunteering Pilot

What does the existing research tell us?

There are very few thoroughly evaluated examples of (cost) effective volunteer support for children and families with a Child in Need or Child Protection Plan.

It is particularly challenging to demonstrate in any definitive way that volunteers have succeeded in creating lasting improvements and outcomes for children and families in need, particularly as often many other workers are or have been involved in the overall statutory intervention.

Some researchers have speculated that it is reasonable to anticipate lower cost benefit ratios where volunteers are working with families with complex problems and high levels of vulnerability (for example, Gaskin 1999).

However, Tunstill (2007 and 2011) has evaluated 2 'Volunteers in Child Protection' (ViCP) projects positively and the findings include that this kind of home visiting family support is valued by professionals and families, and some impact has been noted on family functioning particularly through modelling of good parenting. More recently, the ViCP findings were endorsed in another, albeit small scale, study conducted by Akister and O'Brien (2014) suggesting that a volunteer service for families in need can provide the catalyst for promoting positive outcomes, in particular because of their offer of time that is freely given, emotional and practical support for parents, and enthusiasm for accompanying families to places to which they have been referred. The researchers emphasised that, in order to be effective, these kinds of services need realistic funding; effective selection processes; good supervision, training and other support; and clear and open channels of communication between the paid and un-paid workers.

What does this evaluation tell us?

This pilot aimed to provide volunteers to:

- work effectively with families in need to help them to change and improve outcomes for children
- support children permanently excluded from school (through advice and advocacy)
- support children returning from a period of going missing (by undertaking effective 'return interviews')
- mentor young people on the edge of care

The measurable longer term outcomes were expressed as: more children supported to remain safely at home; families agreeing that their volunteer input has helped them to create a safe environment for their children; children and young people feel helped by their volunteer; return interviews completed within statutory timescales.

The volunteering offer was quite different between Hampshire and on the Isle of Wight.

- the Isle of Wight model involved an existing third sector organisation (Home Start) providing family support volunteers only for families with a Child Protection Plan and a key child up to age 18 years
- the Hampshire model involved a newly recruited team of 4 volunteer coordinators working for the local authority and delivering a model including all 4 strands: volunteer mentoring; return interviews for young people who go missing; family support; and support for young people back into education

However, the role of volunteer coordinators across both authorities was remarkably consistent and included, in particular, the following:

- undertaking ongoing recruitment, DBS checks and interviews
- providing support and supervision for recruited volunteers (1:1 and group based)
- taking referrals and matching referrals with volunteers
- providing a duty coordinator service (Hampshire only) in particular to ensure that requests for return interviews were responded to in a timely way
- tracking and reviewing volunteer involvement
- providing a rolling programme of training, alongside the Hampshire County Council Workforce Development Team, including some generic training and some tailored to the likely role(s) of the volunteers

Some Coordinators had also been pro-actively marketing the volunteering offer with Social Work Teams and/or doing some joint introductory visits with families. The processes and activities were developed and embedded very quickly indeed.

The recruitment and retention of volunteers

Because of its existing presence on the Isle of Wight and background in recruiting early help volunteers, Home-Start merely continued to recruit in the same way including advertising locally and roadshows, albeit offering new, or potential, volunteers the option of volunteering in the social care and/or early help arena(s).

Hampshire advertised widely to attract new volunteers, and a total of 1155 initial enquiries and 383 formal applications resulted in 226 volunteers completing the induction training and being ready to volunteer (20% of the initial enquiries and 59% of those submitting a formal application). Twenty three (10%) of these volunteers have since resigned, and 11 (5%) were withdrawn from their volunteering position, leaving approximately 85% or 192 remaining to work with young people and families. These volunteers had a variety of experience to offer, including teaching, school headship, nursing, university students enrolled in social care or similar courses, council workers, residential care workers.

The key success factors for recruiting the right kinds of volunteer are reported by those involved in the process to include:

- clarity about what the role involves (and the levels of need)
- recruiting people who have empathy, developed either through being in a similar situation themselves and/or through work or training in this field
- targeted recruitment in higher education establishments involved in training social workers or allied professionals

Current volunteers from both sites mostly thought that the training and ongoing support they received was ‘quite’ or ‘very’ helpful in relation to the volunteering tasks required.

On the Isle of Wight, volunteers were recruited exclusively for family support. In Hampshire, 107 (56%) were trained as volunteer mentors, 63 (33%) as volunteer family support workers, 16 (8%) to provide advice and advocacy for permanently excluded pupils, and 94 (49%) to undertake return interviews with children who had gone missing. There was some overlap across these areas, in that some volunteers were trained to deliver in relation to more than one work stream. Key success factors for training successful volunteers were reported by those involved in the process to include:

- having a clear package and pathway for training including induction, followed by relevant training strands and some flexibility for additional training afterwards
- having regular, rolling induction and training programmes that can be delivered in different parts of a large geographical area (like Hampshire)

Several months into the pilot period, the 4 full-time Hampshire volunteer coordinators were each supporting between 33 and 47 active volunteers in different localities and it is thought by them that a figure of 50 per coordinator is manageable over time. The part-time volunteer coordinator on the Isle of Wight was supporting 23 volunteers.

The profile of volunteering activity

At the start of the pilot programme, the profile of volunteering within social work teams (for Children in Need and their families) was low, as would be expected, as there was no real volunteering offer for these families at this stage. Many social workers and team managers were sceptical about their usefulness, particularly for child protection work, because of the complexity of the work. Towards the end of the 12 month pilot, this profile had improved, with team managers of social work teams in Hampshire in particular reporting having used volunteers in greater quantities and with more confidence than at the baseline. The profile and the perceived value added was greatest around volunteers working with young people including the return interviews and volunteer mentor roles. On both the Isle of Wight and in Hampshire, team managers remained much more sceptical or wary of the usefulness of family support volunteers, particularly for families with a Child Protection Plan, although some volunteers had been deployed to support these families.

The quality and impact of volunteers

The evaluation has only been able to explore in depth the quality and short-term impact of volunteers providing mentoring for young people on the edge of care and family support. The other volunteering activities did not involve sufficient case file recording to be able to form a judgement about them, so evaluators have relied on the activity data recorded by colleagues in Hampshire.

Early indications are that:

- volunteer mentors have been successfully matched and engaged at an early stage with 68% (97/142) of young people referred to this service. Almost all of the non-matched young people withdrew themselves, or their circumstances had changed before the matching could occur. Volunteers involved in mentoring have provided patient, non-threatening but persistent engagement (80% engaged effectively) and regular, gentle, even therapeutic ‘sessions’ with young people. These sessions often included a combination of activities (doing something together, led by the young person’s interests), talking, and role modelling. It is difficult to tease out the particular contribution of the volunteer mentor to young person outcomes as these supports were almost always provided in the context of a broader Child in Need or edge of care package including, in many cases, a number of other professional inputs. However, many of the young people involved were clearly helped by their volunteer mentor (back) into education, employment or training and / or positive activities. It is clear that outcomes for young people on, or near, the edge of care can still be poor even where the volunteer mentor input is good or excellent and where the young person seems to have responded well to it, particularly where the rest of the support package is not sufficiently focused, or where there is a degree

of confusion about the roles of the different people involved, or where the young person is already engaged in highly risk-taking behaviours at the start of the intervention

- families with a statutory plan have often found it difficult to engage with family support volunteers (and vice versa) and it is too early to see much impact of those that do. There were not many families who had completed a volunteer family support intervention by the time of the final evaluation stage

  Engagement and disengagement is complicated to evaluate, with some families declining support before, and some after, the first visit, and some suspending visits over long holiday periods with, or possibly without, the intention to continue afterwards. In some cases, the child(ren) had been taken into care before the volunteer could become actively engaged. In some cases, the volunteer themselves disengaged, usually because they felt that the family was not motivated to change.

  A significant proportion (75% or 6/8) of families that had engaged positively with an Isle of Wight family support volunteer were judged by their case holding social worker to have benefitted in some way from the volunteer input. Fifty percent (4/8) had benefitted very much and clear progress against family goals was attributed by the social worker to the volunteer's involvement. In all of these cases, the family had had a significant history of involvement with social care services. The brief for the volunteer was varied but included in particular improving the physical home environment and family connectedness to the community (preventing isolation). In 25% (2/8) cases, the family had benefitted somewhat and some progress against family goals was attributed by the case holding social worker to the involvement of the volunteer. The benefits included a calmer atmosphere in the home; and children engaged in positive play and homework.

  In the limited cohort (8) of families that had engaged positively with a Hampshire family support volunteer, most had been involved in structured sessions with the volunteer, for example in relation to the Parent Nurturing Programme or to develop routines, and there was some evidence on files and from interviews with the families of them changing negative patterns of behaviour, of developing better routines, of improving the cleanliness of the home, and of improved family communications and functioning at least in the short term.

  Hampshire families who have worked with a family support volunteer suggest that the key qualities of effective volunteers include a willingness to help out in a practical way, particularly to establish a clean house, to access funding for furniture, or to apply for a job; being easy to talk to – a good listening ear; non-judgemental, solutions focused – good at joint problem solving; good match for the family with reference for example to age, gender and experience (particularly family experience); modelling effective parenting providing help to establish new

routines such as behaviour charts; referencing the right positive parenting programme (for example one that matches the key child's age and presenting needs e.g. child on the Autistic Spectrum).

Volunteers themselves emphasise, in particular, the following qualities of effective volunteering: timely interventions; continuity of support; clear roles; effective communication with all of the family; non-judgemental; taking time to develop relationships and provide effective support (including expecting some set-backs)

- the return interview element of the volunteering pilot has been very successful in terms of its ability to field someone to do these interviews. In the 9 months from January to September 2016, 583 requests have been made to volunteer coordinators in Hampshire for a volunteer to undertake a return interview with a young person. By the last quarter (July to September 2016) an average of 71 such referrals were being made per month). Of these 583 requests, 274 (47%) were converted into a completed return interview involving a direct conversation between the young person who went missing and the volunteer. The number of children receiving a return interview in Hampshire has increased by approximately 93% between the time immediately prior to the pilot and 12 months into it (from 61 per month to 118 per month). However, this activity has not kept pace with demand, hence trends show a declining proportion of young people going missing who have a return interview in the same time period, as shown in Appendix 3

  The reasons for some return interviews not being completed satisfactorily by volunteers were various but in only approximately 5% of cases were these reasons to do with volunteer availability. The most significant reasons related to the young person themselves, not willing to be interviewed. Most Hampshire social work teams think that the use of volunteers to do return interviews has been effective in terms of increased capacity for this activity. It would be helpful to explore further the particular qualities of a successful volunteer-led interview compared with one that is professional-led

- 35 referrals were made to the advice and advocacy for excluded pupil's volunteer scheme in the 9 months between January and September 2016. Twenty eight out of thirty five (80%) have resulted in a completed piece of work by the volunteer. The reason for non-completion in every case was that the parent refused the service. It would be useful to explore further what is the quality and impact of this type of volunteering

The cost effectiveness of volunteers

A full cost benefit analysis has not been possible in relation to the volunteering strand of this evaluation.

However, on the basis of 50 active volunteers being supported by a full-time volunteer coordinator at any one time, the approximate cost of a Hampshire volunteer per annum has been calculated at £1,189, including recruitment, training and support costs, overheads, expenses and administrative support. On the basis of a volunteer undertaking a conservative number of substantive support interventions (3 per annum), the cost per volunteer intervention (other than return interviews) is calculated at £396.

On the Isle of Wight, family support volunteers cost slightly less (£915 per annum or £305 per intervention based on 3 families per annum). However, these costs are not inclusive of all training, some of which have been provided by Hampshire County Council during the pilot period. Therefore, the unit costs of each model could be said to be broadly comparable for the same types of activity.

On the basis of volunteers completing an average of 5 return interviews per year through this pilot period, the unit cost of a completed return interview is £184. In reality, volunteers may attempt many more than this. This pilot has demonstrated that some volunteers have the capacity to conduct return interviews in much greater numbers (up to 50 per year). Volunteers being encouraged to complete at least 10 return interviews per year would bring the unit cost of an interview down to at least £92.

These calculations are based on the premise that volunteers undertaking return interviews are not also acting as a volunteer in relation to family support or mentoring and vice versa. Volunteers providing more mixed support across the delivery strands may be even less costly again.

On this basis, evaluators consider the various volunteering strands to have at least the potential to be cost-effective.

A full breakdown of these costs can be found in Appendix 4 to this report.

Findings relating to the Edge of Care Pilot

What does the existing research tell us?

In relation to this and other Innovation Programme projects, young people on the edge of care are defined primarily as those who are 'at imminent risk of becoming looked after' (Ward et al 2014), including young people at risk of abuse or neglect; who are in high conflict with families and thought to be difficult to manage; whose parents have toxic trio issues; who are offenders; or who have previously been looked after (Asmussen et al 2012). Unpublished edge of care audits undertaken by the Institute of Public Care suggest that additional groups of young people at risk of late entry into care may include: young people with a disability / learning disability previously cared for by their families; and young people at risk of sexual exploitation or sexual abuse.

Existing research into what works with some of these groups of young people suggests that the quality of relationship between the key worker and the young person is highly significant and that effective features of this relationship are openness and honesty; persistence and reliability; responsiveness and flexibility; and a positive strengths-based approach involving the young person and their family in identifying solutions and shared goals (Ofsted 2011, Mason 2012).

In terms of the organisation of edge of care services, research suggests that the most successful programmes are those with explicit and clearly stated models of intervention, and a repertoire of tools for professionals to use, thus encouraging programme fidelity; strong multi-agency working; preventative interventions that take place alongside assessment; a clear and consistent pathway through services; clear planning for case closure and the sustainability of positive change.

Some off the peg intensive, semi-therapeutic and whole family interventions have been positively evaluated, including: Multi-Systemic Therapy (Fox and Ashmore 2014) or Functional Family Therapy (Bowyer and Wilkinson 2013, Action for Children 2015).

The evidence base has not yet explored the particular value of a structured activities programme and volunteer mentoring in the context of an edge of care intervention.

What does this evaluation tell us?

This pilot aimed to provide bespoke packages of support to young people on the edge of care to enable them to remain safely living at home where possible. The key measurable longer term outcomes of the pilot were:

- more young people aged 14+ years safely prevented from coming into (long term) care
- more young people who have been on the edge of care successfully engaged in education, employment or training (EET) or with better outcomes generally
- all children of the family better parented and with better outcomes

The bespoke packages of support were facilitated and brokered by allocated edge workers recruited often from other social care teams and with a background in family support and/or youth work. The role has evolved a little since the beginning of the pilot (when the focus was setting up the activity programmes for young people) and, at approximately 9 months into implementation, fairly consistently involved:

- working with the provider of activities to plan these on a rolling basis
- helping young people to access the activities programme and a volunteer mentor (pro-active facilitation of both including joint visits, transport at least initially and other proactive approaches)
- working one to one with young people (approximately 50-70% of the time except when activities programmes are in progress)
- working one to one with the broader family (approximately 30-50% of the time except when activities programmes are in progress)

Caseloads have settled at about 10-12 young people (and their families) per edge worker at any one time.

A total of 202 young people and families were referred to the edge of care programme between October 2015 and June 2016, a rate of approximately 269 per annum. 110 young people started the edge of care programme during this time period, a rate equivalent to approximately 147 per annum across 7 teams = approximately 21 young people per annum per team. The key characteristics of this cohort have been:

- 57% male and 43% female
- mostly aged 14-15 years (77%). 15% were aged 16 years and 8% aged 17 years
- 48% had recent school attendance or exclusion issues
- 75% had recent problematic behaviour in school
- 75% had recent problems with family communication
- 58% had a lack of boundaries at home or parents who were unable to set boundaries

- 35% were judged to be at recent risk of CSE
- 34% had diagnosed, or suspected, mental health issues and 25% recent self-harming behaviours
- 21% had a recognised or suspected substance misuse issue
- 32% were involved in anti-social behaviour and 25% in criminal activity (the case file analysis found even higher levels of criminal activity – around 67%)
- 20% lived in families where there was domestic abuse; 20% with a parent with known mental health problems and 12% with a parent with known substance misuse problems
- 17-25% had an Autistic Spectrum Disorder
- most were living in families with significant (42%), or some (42%), previous involvement with Social Care Services and social care-led interventions

It is difficult to predict with accuracy the extent to which a young person is truly on the edge of care (defined as being at imminent risk of coming into care). However, based on a randomly selected sample of case files of 12 young people involved, the evaluation team judged from all the evidence available that 8/12 or 67% of young people in the cohort were truly at imminent risk of coming into care. Two out of twelve or 17% were not at imminent risk of coming into care but had high level and chronic problems necessitating a statutory plan. Two out of twelve or 17% were not quite at imminent risk of care, but had escalating needs and risks that might place them there in the near future and that necessitated a statutory plan.

Although the packages of support were bespoke, a typical edge of care intervention included social worker + edge worker + weekly activities programme + volunteer mentor. Some young people also received support from the newly formed CSE (Willow) Team and many had other agencies involved, such as CAMHS, Youth Offending Team, Young Person Substance Misuse Services.

Young person engagement and the quality of edge interventions

- 65% of young people who were offered an edge of care intervention engaged well with it. 35% disengaged relatively soon after starting. However, even these young people often engaged to a certain extent. Only 8% of the total cohort failed to engage at all. Young people tended to be better engaged in the Programme where the social worker / edge worker worked well together and demonstrated persistence and resilience in the initial weeks, including regular meetings with the young person and family; practical support offered up front, for example: help with transport to school and appointments; good organisation and coordination of services and activities; and evidence of the worker listening well to the parent's as

well as the young person's concerns – actively addressing barriers to them being involved. Where young people were less well engaged, the workers involved had tended to 'stand off' from the families – not going to them pro-actively

- the activities programmes (for example Bushcraft) operated at approximately 76% usage, and a very high rate of young people (91%) completed them successfully (requiring regular weekly and one off residential weekend attendance)
- 87 requests were made for a volunteer mentor through the edge Programme and 76 (87%) young people were matched with one

Team managers and social workers involved in 1:1 interviews with evaluators throughout the Innovation Programme believed that the availability and quality of support for young people on the edge of care improved as the pilot progressed and in comparison to before its commencement. The most highly valued aspects of the Programme to date were reported by these workers to be:

- the activities programme and volunteer mentor elements: structured activities designed in particular for young people on the edge of care are seen as essential to engaging young people and to providing them with opportunities away from their usual environment to try new experiences. "I was initially sceptical but saw young people who don't normally do well in social situations responding positively and helping others"
- the ability of edge workers to engage with some of the most difficult to reach young people, in particular their tenacity and people skills. Families also recognised these skills as essential to effective engagement

  "There was an immediate connection"

  "We all found her friendly and easy to talk to"

  "Persistent and patient for a couple of weeks, took plenty of time to build trust and to find out quickly what he liked, what motivated or might motivate him"

  "She was a good listener and did what she said she would – followed through on promises"

  "She was non-judgemental"
- the creativity and pro-active approach of the edge workers in finding solutions for young people, including in getting them (back) into educational provision

The impact and cost effectiveness of the Edge Programme

12 out of the 110 cohort of young people who started the edge of care programme during October 2015 to June 2016 (11%) subsequently entered care. Overall across Hampshire the number of children becoming looked after aged 14-18 has risen between the period

immediately prior to the pilot and 10-12 months into it (by approximately 50%), but not as markedly as the increase across all ages during the same period (80% increase). A significant element of the increase is the rise in numbers of unaccompanied minors during the same period of time.

Using an Outcomes Star method of gauging progress during the Programme, 101 (or 92%) of young people involved in it have self-reported improvements in their engagement in education, employment or training. However, it is not possible to tease out from this tool which elements of the overall edge offer have been more or less significant in bringing about this change.

At the time of the case file analysis 7- 8 months into the pilot programme, almost all of the 12 randomly selected edge of care cases were still open to Social Care Services. Therefore, it is very difficult to reach a view about anything other than very short-term outcomes for the young people concerned. 5/12 (42%) had clearly positive outcomes at least in the short term – although some of these young people with positive outcomes became looked after for a short period of time; 3/12 (25%) had partially positive outcomes at least in the short term; and 4/12 (33%) had clearly negative outcomes, at least in the short term.

More effective interventions were likely to be characterised by:

- a relatively tight team (for example: social worker, edge worker and volunteer mentor) actively involved with the young person and family
- good early engagement with the family to build trust, followed by well-timed, intensive, evidence-informed work with the young person and parent(s)
- young people encouraged and supported successfully into an activities programme
- support to parents to address parenting deficits and broader family issues

Less effective interventions were likely to be characterised by:

- delays in getting going with, and/or during, the intervention and a resultant loss of momentum for change
- young person with high levels of risk taking behaviour (particularly substance misuse and going missing from the family home)
- key workers standing off from the family and coordinating other service inputs only
- a lack of structure and focus to the work with the whole family
- no work with parent(s) around boundaries or in relation to family communication and the building of empathy

- other underlying family issues not addressed

It is too early in the implementation of this Programme to be clear about its cost effectiveness. There are indications from the pilot so far about what kinds of interventions are more or less successful within the overall model tested, and it would be useful to re-evaluate the cost effectiveness after the model becomes more embedded over time, and to explore in more depth the particular value of the activities programme and volunteer mentor, combined with the key worker element.

The approximate unit cost of a typical edge of care intervention is £3,273.40 including £1,812 for the edge worker, £1,065 for the Activities Programme, and £396.40 (excluding some training costs) for the volunteer mentor elements. This is in addition to the social worker and other service costs relating to the Child Protection or Child in Need Plan. A full breakdown of how costs have been calculated for the purposes of this evaluation are provided in Appendix 4 to this report.

Findings relating to the CSE Pilot

What does the existing research tell us?

Recent national action plans (Department for Education 2011), enquiries (Jay 2014), policy (HM Government 2015), and guidance (LGA 2014) reflect the current priority attached to addressing and, if possible, preventing child sexual exploitation (CSE).

All of these also reflect earlier research into the particular signs of grooming for CSE and how children become involved in different forms of sexual exploitation, and include strong suggestions about what is required (LGA 2014), for example mechanisms to monitor the incidence and patterns of exploitation; support for those who have been, or are being, exploited; training for professionals on the warning signs of CSE and when to report concerns; awareness raising; and either a dedicated CSE coordinator or a co-located team.

Recent research (Berelowitz et al 2012 and 2013) suggests that being a Child in Need or having a history of family involvement with Social Care Services is associated with increased vulnerability to sexual exploitation. However, this research also identifies other vulnerabilities such as having a learning disability, living in a gang neighbourhood, or being unsure about sexual orientation. This suggests that focusing only on Children in Need (including children looked after) is unlikely to tackle the whole problem. Berelowitz and others, for example, Hallett, (2015) also suggest that young people who have been sexually exploited have a very high (85%) risk of self-harm or attempted suicide and are likely to engage in risk taking activities as a way of asserting themselves and feeling in control. From this we can assume that young people presenting with CSE risks need holistic interventions designed not only to educate them about CSE, but also to address their emotional health and wellbeing, drug or alcohol misuse; educational; social; family support and other needs. Finally, a range of studies suggest that young people at risk of CSE are among the least likely to engage with support services or to accept that there is a problem – suggesting therefore that a highly assertive outreach approach will be required in order to be effective in reaching out to them.

Scott and Skidmore (2006) have proposed some key evidence-based features of effective supports for the most at risk young people including:

- multi-agency and coordinated
- intensive – to provide them with a sufficient level of support to resist the extraordinarily strong pull of sexually exploitative relationships and circumstances
- assertive outreach approaches, including daily contact and door stepping even where support is initially or repeatedly rejected

- consistent key working – again vital in building and retaining relationship

What does this evaluation tell us?

The Willow CSE pilot set out to improve support for children at risk of sexual exploitation (subsequently also those at risk of trafficking) including through:

- better identification of young people at risk
- better support to victims of, or young people at risk of, CSE
- better quality investigations
- better awareness-raising of CSE within the professional community
- consistent processes for dealing with CSE that are quality assured.

Ultimately, it was intended that the pilot should lead to better outcomes for young people at risk of CSE including, but not exclusively, Children in Care; Children in Need; and other vulnerable children in the community.

The evaluation has focused on the quality and impact of support to young people identified as being at risk of sexual exploitation.

The Hampshire-wide Willow Team tasked with addressing child sexual exploitation (CSE) within the wider agenda of being missing, exploited and trafficked (MET) has consisted of 3 social workers, 2 nurses, 1 specialist Barnardo's worker and 1 team manager. The activity data is consistent with each team member, other than the team manager, working with about 20 children at any point in time. However, this caseload includes approximately 20-30 children subject to a Child Protection Investigation per month (10-15 per social worker) and the workload of each worker is also increased by broader team activities including consultation or advice and awareness raising. One to one direct work with at risk young people is described as the most significant aspect of the team's work, but it is only the social workers who have been undertaking the statutory investigations and assessments.

Social workers from broader Child in Need Teams across the county have appreciated, in particular, the responsiveness and the specialist advice they have received from the team, in addition to the specialist assessments and, in some cases, the interventions.

Key local agencies have a good understanding of the remit of the Willow Team. There is strong support for a dedicated multi-disciplinary team providing a range of services including 1:1 work with children at risk, or who have suffered from CSE. There is also recognition of the tension between delivering 1:1 evidence-based and sufficiently

intensive interventions at the same time as assessments in relation to children in the statutory arena. Many agencies would like the constitution of the team to be expanded to include a policing element.

An on-line survey conducted at about 8 months into the pilot, with a broad group of professionals who had used the service, suggests that very many (89% or 17/19) consider the quality of the advice and consultation support they have received to be good or very good and 85% (or 17/20) rated the quality of the service overall as good or very good. Many respondents thought that it was very beneficial to have a central team able to provide expertise (particularly expert advice to others) and to pull together intelligence about children at risk as well as perpetrators. In the future, some respondents thought that it would be helpful for the team to hone their experience and methodologies for individual children at risk, and to focus more on working with children at high risk (rather than mostly on assessments), or training others to do this work.

The case file analysis with a sample of 24 young people involved with the Willow service suggests that the direct work undertaken to date has been effective (with reference to distance travelled scores, SERAF scores, and broader information on the case file) with lower risk young people, particularly where the parent(s) engage well, understand the risks their child has been taking, and contribute in some way to the work to keep their child safe. The work with higher risk young people has not been as effective, in part because of the well-rehearsed difficulties in getting these young people to engage, even initially. However, evaluators also considered the interventions themselves to be insufficiently intensive or persistent given these known factors. With missed appointments, holidays and priority given to other work, many of the children did not receive a consistent level of contact with their key worker and this was rarely at the planned level of weekly or fortnightly contact. It was also clear from the case file analysis that the Willow interventions were intended as primarily educational (to enable the child to make better informed decisions) but were not so clearly fit for the purpose of addressing the broader, complex or chronic issues which were often at the heart of the child's vulnerability to CSE, including long-standing attachment issues; parent unable to set boundaries; and poor parent role modelling.

Interviews with 15 families who had received direct Willow support in the pilot period (including 4 with both the young person and their carer; 10 with the carer only; and 1 with the young person only) suggest that:

- where the young person engages with the Willow worker, they and their key carer(s) almost invariably appreciate the warm, non-judgemental approach and the ability of the Worker to educate both the young person and the broader family about risks relating to sexual exploitation (through use of one to one conversations, DVD's, and worksheets). They also appreciate the close working with, and advice for, pastoral workers at the child's school or college to pick up the

baton once the Willow work has come to a close. The young people and / or their parent(s) could identify very positive outcomes including: doing better at school, changing friendship groups for more positive ones, feeling safe, calmer and happier

- where the child and family were already involved with Social Care Services, the family was less likely to consider the involvement with Willow to have been helpful. This might be as a result of many factors including: a number of other services being involved; confusion over roles (particularly between the Willow worker and social worker); insufficient tenacity or persistence in connecting with the young person in chaos; and chronic emotional health and wellbeing issues that got in the way of educational messages about CSE being heard and acted upon by the young person

The number of children reported to have gone missing has increased by 7% between September – December 2015 and April-June 2016 (during the early period of the pilot programme). However, based on intelligence from the sites involved, evaluators suspect that is not necessarily a true reflection of the number of children going missing (actual going missing episodes), rather an improvement in the recording of these incidents.

Findings relating to the Social Worker Surgery Pilot

What does the existing research tell us?

Munro (2011) recommended that social work expertise should be readily available to community-based professionals to help identify and prevent maltreatment of children. Ofsted (2014) requires thresholds across the spectrum of early help and statutory child protection work to be appropriate, understood by partners, and consistently and effectively implemented.

Following a series of child death enquiries over recent years, there is evidence that local areas have witnessed greater levels of anxiety (and referrals) with regard to the safeguarding of children amongst social care practitioners and other professionals (Wolstenholme et al, 2008, Brown, 2010, 2015).

Boody et al (2007) found that, whilst usually welcomed, social worker advice and support regarding thresholds is not sufficient in itself to eliminate the differences in perception about what constitutes the need for protection, or disagreement about the interpretation of risk. Turrini et al (2010) refer to the significance of broader support for the operation of professional networks including the development of shared perceptions and language, and the endorsement of common purpose in improving the ability to solve or resolve these kinds of tensions amongst partners.

There is little published research dealing directly with the constitution, location or impact of this kind of advisory and / or network building function at a statutory level. However, Ofsted has recently (through published inspections of individual local authority children's services) endorsed the deployment by local authorities of Early Help Consultants or similar functions offering advice about thresholds, as well as broader consultation for professionals about their concerns, and careful, supported signposting into early help services where appropriate.

What does this evaluation tell us?

The Social Worker Surgery (SWS) Pilot aimed to reduce the rate of inappropriate referrals into Children's Social Care Services by:

- mapping patterns of demand in different locality areas
- supporting community-based professionals and practitioners to understand social work thresholds
- improving the availability of consultation and advice to community-based professionals who are concerned about a child or family

The measurable longer term outcomes targeted by the pilot were:

- a reduction in the number of referrals (by 8%)
- a reduction in the number of Children in Need

It has not been possible to deliver this pilot as originally conceived. The remit has changed to a pilot within 2 school settings in one relatively deprived area. One is a relatively small school for children with additional needs (50-60 pupils, many of whom have a statutory plan and social worker) and the other, a larger more mainstream secondary school (approximately 600 pupils with an inclusion team of approximately 20 staff).

Since January 2016, the work of the experienced and well-supervised family support worker appointed to deliver the pilot has included:

- training for schools on the social care referral process and thresholds, including use of a chart describing thresholds, in decision making and how cases progress
- subsequent provision of weekly surgeries with individual members of staff in relation to children for whom there were concerns
- a one-off audit of the extent to which recent referrals to Social Care Services from these schools have been appropriate (at the appropriate level of need)

Early indications are that the SWS may have led to:

- quicker identification of children who have a statutory plan
- improved understanding by school staff about the referral process and how referrals to Social Care Services are handled in practice
- helpful advice about whether the circumstances of individual children are likely to meet the statutory thresholds, and how best to obtain the right help at the right time
- better quality referrals to Social Care Services about individual children

However, there has not yet been a discernible reduction in referrals, either from the individual schools or from the locality more broadly, or an increased ability of the schools involved to manage risk and/or work more effectively with families just below the statutory thresholds. The pilot is too small scale and too early in implementation terms to be likely to have an impact on the overall number of referrals received by Social Care Services and Children in Need which have in fact risen by 13% and 19% during the pilot period. Evaluators note that this increase in Child in Need numbers is unlikely (based on

previous numbers and rates per 100,000 child population) to elevate Hampshire above the average rate for comparable authorities in England.

This model of providing tailored training and advice to schools in the community is considered unlikely to be cost effective based on the projected cost of a scaled-up model delivered across Hampshire (of approximately £304,000 per annum based on a conservative estimate of 8 family support workers that would be required to work in different localities across the county). Although only a small number of stakeholders were consulted for this evaluation, the strong suggestion was that these sorts of physically embedded advisors weren't required, rather a centralised advisory service with named links into particular localities and schools.

Limitations of the evaluation and future evaluation

Limitations of the evaluation and key findings

Some of the limitations of the evaluation have already been noted in the Context and Findings sections of this report. The key ones are:

- timescales for implementation – experience suggests that very new or innovative ways of working with families with a statutory plan take time to develop and embed. Therefore, it is a major limitation of the evaluation that it has not been able to explore the impact of a more fully developed or embedded programme. The timescales have also meant that it has been difficult to identify, in time for the final evaluation, sufficient families with completed interventions to understand the impact of these interventions beyond the very short term. Finally, it has not been possible to compare trends in demand (for example for looked after services) in Hampshire and the Isle of Wight with those in other parts of England because the pilot programme was implemented across 2 financial years and published trend figures are not yet available for the latter, in which some change in demand might be expected to figure
- linked with the above, a lack of data about the impact of innovations has meant that it is not yet possible to undertake a full cost benefit analysis in relation to many of the Programme strands. It is in any event difficult to tease out the cost benefits of individual strands of support package for families with a statutory plan and therefore multiple inputs, because of the problems with establishing a sufficiently robust causal relationship between each strand and the outcome(s)
- families participating in social care interventions have very often worked, or are still working, with a number of professionals. Therefore, it is often difficult for families participating in interviews to remember detailed experiences or outcomes linked with one particular worker or team. This generalised experience was sometimes evident in the family interviews undertaken for this evaluation, so it was difficult to draw firm conclusions from this particular aspect of the evaluation alone
- it did not seem appropriate to evaluate the impact of the CSE (Willow) team in relation to investigations into potential perpetrators (and the original pilot aim relating to ‘more perpetrators brought to justice’) as this did not appear yet to be a significant part of their work

Appropriateness of the evaluative approach for this innovation

The mixed method and realistic evaluation approach selected for this evaluation still feels very appropriate for a complex innovation project involving so many, sometimes cross-cutting, elements. The longitudinal study with workers provided a rich source of data about many of the Programme strands, as well as the overall experience of social workers and team managers in teams that might be piloting several (or none) of these at any one time. It also provided a rich source of contextual data relating to the impact of some of the strands, for example caseloads relating to the impact of PAs. Because of the mainly very high quality of case file recording, the case file analysis provided concrete evidence of the ways of working, and early impact on families of several of the Programme strands. Family interviews provided important information about how they had experienced the interventions or Programme overall, including what worked and what didn't in helping them to change. Secondary analysis of data, agreed for collection in the early stages of the pilot programme with colleagues in Hampshire and the Isle of Wight, enabled evaluators to track key trends during the innovation pilot in relation to highly relevant factors like staff sickness levels, or children becoming looked after. Interviews with stakeholders from other relevant agencies, and large scale surveys with professionals enabled important feedback to be gathered about the broader impact of the innovation.

Limitations of the evaluation methodology in practice through this evaluation are explored in Appendix 6.

Capacity and plans for future evaluation of this innovation site

Some resources are still available from the Innovation Programme evaluation budget to further explore the impact of key strands of the programme continuing to be implemented in Hampshire and the Isle of Wight (see next section on 'Implications and Recommendations for Policy and Practice), particularly those where it has been too early to note real impact. IPC and Hampshire are in discussion about how best to utilise these resources and over what time period.

A number of the data collection systems have been put in place by both local authorities to answer key evaluation questions, and these are likely also to provide ongoing sources of data for the authorities themselves about how well they are doing with the embedding or mainstreaming of the Programme.

Implications and recommendations for policy and practice

There is evaluative evidence for the capacity and sustainability of many aspects of the Innovation Programme in Hampshire and the Isle of Wight, particularly the PA, CSE (Willow), edge of care and volunteering strands.

All of these strands are being provided in the context of broader 'background' or ongoing social care-led interventions that will need to be taken into account in terms of mainstreaming. However, it is considered by evaluators highly likely that Hampshire and the Isle of Wight will wish to continue to develop and embed the approaches trialled in relation to all of the pilot streams, if not the exact services piloted. It would be unusual if some adaptations were not to be made after learning from evaluation has been taken on board. Evaluators have recommended that:

- for the CSE (Willow) Team to develop and embed further, it may have to become even more multi-disciplinary, including, for example, the Police. Work more broadly with children at high risk of CSE should recognise that they are likely to require more intensive and persistent approaches recognising all of their vulnerabilities
- for PAs to embed and develop further, they will need to be offered clearly defined terms and conditions and a job outline based on learning about what constitutes the most effective PA support, but the evidence of their cost effectiveness is already clear
- the edge of care offer trialled to date could be further improved and made more cost-effective through more structured and evidence-based work with the broader family
- volunteer mentoring, as well as the wider edge of care programme, could be further developed to work with slightly younger children (for example those aged 12-13 as well as 14+ years) and volunteers more broadly maximised in terms of their deployment across multiple strands of work, both of short and longer term duration

In the future, it would also be useful to explore further:

- how families with toxic trio features, and chronic problems more broadly, can be supported effectively to change in the context of a Child in Need or Child Protection Plan. Although the FIT model was not implemented fully and is therefore largely untested still, the evaluation noted that it was usually a single worker with a range of skills, including in developing and sustaining family motivation to change, that was most effective. Having many workers involved concurrently or consecutively did not seem to be as effective in comparison.

Within an overall model that expects workers, other than the case-holding social worker, to input significantly to the overall intervention for families in the statutory arena, it would be useful to explore what kinds of support is more or less helpful in bringing about positive family change. What should intervention workers be expected to do themselves and when, and how should they involve other specialists? To what extent is a knowledge of, and grounding in, some core areas of expertise (for example: positive parenting; promoting attachment; promoting parent motivation to change) essential for all kinds of intervention worker at this level?

- it would also be useful to explore the relative (including cost) benefits of an alternative model involving the case holding social worker delivering most of the family support task with families in need themselves (including effective engagement of families in change; ongoing assessment and case coordination; and support for families to change) compared with models which assume the involvement of others in significant aspects of the change task

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Appendix 1 Theory of Change Models

These were developed by the pilot sites in the early stages of the Innovation Programme to inform service development and questions for the evaluation.

Table 2: Theory of Change for the PA Pilot

What's the problem? What needs to change?	What do we need to do to effect change?	What will look different by November 2016 if we do these things?	What longer term outcomes will result if we succeed?
Social workers are currently spending too much time (approximately 60%) on administration and not enough time on direct contact with Children in Need and their families. Social workers need to have the capacity to change what goes on in the family in order to improve outcomes and reduce demand for care.	Create or add capacity by ensuring that there will be an administrator or coordinator for every 3 social workers. For the purposes of the Innovation Programme, this will be piloted in some areas. There will be a total of 32 coordinators or administrators in Hampshire and 10 on the Isle of Wight.	A significant increase in social worker time for direct work with families and a significant reduction in the amount of time spent on administrative tasks. More timely and accurate information about families recorded.	Better quality social work with Children in Need and their families. Better outcomes for Children in Need and their families.

Source: Hampshire County Council

Table 3: Theory of Change for the FIT Pilot

What's the problem? What needs to change?	What do we need to do to effect change?	What will look different by November 2016 if we do these things?	What longer term outcomes will result if we succeed?
Some social workers currently have relatively high caseloads and relatively little time for or focus on direct work with children and families. Their work is not sufficiently holistic in terms of effective interventions with	Create or add capacity including from other practitioners (family support workers, coordinators and volunteers) Create intellectual capacity – to think about doing things differently	Social workers working in a different and improved way with families including an increased focus on improving family functioning More effective interventions with families where a child is in need	More children supported to remain safely at home (reduction by 6% of the number of children coming into care) Reduction in Child Protection Plans

What's the problem? What needs to change?	What do we need to do to effect change?	What will look different by November 2016 if we do these things?	What longer term outcomes will result if we succeed?
families. Social workers need to have increased capacity to work with families to change in order to improve child outcomes and safely reduce the need for children to come into care.	Develop models for ways of working with families in a more holistic way Encourage holistic plans and interventions for our work with families Good use of new 'Family Intervention Team' resources and workers to help bring about change for families	More time for effective interventions led by social workers	

Source: Hampshire County Council

Table 4: Theory of Change for the Edge of Care Pilot

What's the problem? What needs to change?	What do we need to do to effect change?	What will look different by November 2016 if we do these things?	What longer term outcomes will result if we succeed?
Too many young people coming into care late in adolescence when this may not be the best option for them.	Create additional capacity within the whole system to enable more creative and bespoke packages of support to be constructed for young people who are on the edge of care for example: respite options; positive activities.	More suitable options available for young people on the edge of care to support continued safe living at home.	More young people (aged 14+) safely prevented from coming into long term care / safely living at home including some with ongoing support packages for example with regular respite. More young people who have been on the edge of care are subsequently engaged in education, employment or training and have better outcomes more generally. Other children of the

What's the problem? What needs to change?	What do we need to do to effect change?	What will look different by November 2016 if we do these things?	What longer term outcomes will result if we succeed?
			family are better parented and have better outcomes.

Source: Hampshire County Council

Table 5: Theory of Change for the Volunteering Pilot

What's the problem? What needs to change?	What do we need to do to effect change?	What will look different by November 2016 if we do these things?	What longer term outcomes will result if we succeed?
Social workers currently have relatively high caseloads and insufficient capacity to undertake effective direct work with families. For Children in Need, there is insufficient focus on holistic work with the family to improve outcomes for children. Social workers need to have the capacity to change what goes on in the family in order to improve outcomes and reduce demand for care.	Create capacity / add capacity including from volunteers, in particular to work with families 'in need'; children permanently excluded; children returning from going missing; and children on the edge of care through the appointment of 4 Volunteer Coordinators (3 in Hants and 1 for Isle of Wight) who will recruit, train and support volunteers as well as help to match them with children and families via either Early Help Hubs or Child in Need Teams	Social workers working in a different way with families including making use of appropriate volunteer contributions More effective interventions with families overall where a child is in need, on the edge of care or vulnerable for other reasons e.g. permanently excluded from school or running away from home Sustainable cost effective use of volunteers to support vulnerable children and families Greater connection and collective support for families between the Council and the community	More children supported to remain safely at home including through support from volunteers Families agree that their volunteer input has helped them to create a safe environment for their child Children and young people feel helped by the volunteer working with them Return interviews for child who go missing completed in statutory timescales

Source: Hampshire County Council

Table 6: Theory of Change for the CSE Pilot

What's the problem? What needs to change?	What do we need to do to effect change?	What will look different by November 2016 if we do these things?	What longer term outcomes will result if we succeed?
Our support to children at risk of sexual exploitation has improved significantly in recent years but there is not enough tailored support available for children, once they are identified as being at risk. Currently, support is spot purchased from approved providers.	Create a dedicated service to be located alongside the MASH including: 1 team manager; 3 qualified social workers; 2 police officers, 2 health practitioners and 2 Voluntary Sector workers from Barnardo's The service will raise awareness of CSE; support young people at risk or victims of CSE including via innovative approaches; share intelligence to prevent CSE; and work closely with partners including the police to effectively disrupt CSE activity in the area.	Better identification of young people at risk of CSE. Better support to young people at risk or victims of CSE. Better quality investigations Fewer children going missing Fewer children with repeat episodes of going missing Better awareness of CSE within the professional community More perpetrators of CSE brought to justice More consistent and formalised processes for dealing with CSE that is quality assured on a regular basis	Better outcomes for a range of young people at risk of CSE including but not exclusively Children in Care; Children in Need; and other vulnerable children in the community.

Source: Hampshire County Council

Table 7: Theory of Change for the Social Worker Surgeries Pilot

What's the problem? What needs to change?	What do we need to do to effect change?	What will look different by November 2016 if we do these things?	What longer term outcomes will result if we succeed?
High rate of referrals into children's social care services. Our hypotheses about this include: Lack of understanding of social care	Helping colleagues outside of social care to manage interventions with children and families in a safe way and to manage risk	People working with children and families in the community feel more able to manage risk safely People working with children and families	Reduction in the number of children inappropriately referred to children's social care (CRT). Reduction in the number of contacts

What's the problem? What needs to change?	What do we need to do to effect change?	What will look different by November 2016 if we do these things?	What longer term outcomes will result if we succeed?
thresholds by other people working with children and families (in spite of joint work on a Continuum of Need and Thresholds document) Risk averse practitioners working with children and families outside of social care services	Building confidence and skills in working in a safe way Through (in 2 pilot areas): • mapping patterns in different localities • understanding the needs within specific districts • supporting the community to understand thresholds • providing ongoing consultation and advice to practitioners who are concerned about a child / family	in the community are more knowledgeable about when a referral to children's social care is appropriate	(10%), referrals, and assessments (8%) Reduction of Children in Need

Source: Hampshire County Council

Appendix 2 Key Evaluation Instruments and Questions

For the longitudinal (semi-structured) interviews

This selection of questions were used in interviewing workers in Child in Need (CIN) teams. Workers in other teams were asked very similar but slightly adapted questions linked to the nature of the team's work (e.g. Child in Care or Children with a Disability Teams). Only social worker and team manager interview questions are outlined below as the responses to administrator questions have not been referred to in any detail in this report.

CIN Social Worker Questions used by evaluators, excluding basic questions about their role, experience and team

- What is your caseload today?
- What proportion / number of cases are 'active'?
- What has been your average caseload over the last 6 month period (approx.)?
- With reference to your timesheet for the last full week's work, what would you say were the main activities you were conducting?
- What proportion of your week was spent on 'direct work' with families e.g. assessment related conversations or work on issues?
- In relation to that direct work, what proportion on assessment related work and what working with families and their issues?
- Of the other activities, what proportion would you describe as 'administration'?
- What activities in particular would you describe as 'administrative'?
- To what extent was this a typical week?
- In what ways was it typical?
- In what ways was it different?
- What activities are being undertaken for you currently by administrative staff in order to support the work that you do?
- Which of these activities are the most useful in terms of supporting your work?
- Which of these activities are least useful in terms of supporting your work?
- To what extent would you describe your administrative support as 'flexible'? (very, quite, not very, not at all)

- To what extent do you feel that you have enough time to work with families? (very, quite, not very, not at all)
- To what extent would you say you enjoy coming to work most days? (very, quite, not very, not at all)
- To what extent does your work give you a feeling of personal achievement? (very, quite, not very, not at all)
- To what extent do you feel stressed by the work? (very, quite, not very, not at all)
- (In relation to a typical 'toxic trio' case scenario) What services could you access for this family to meet their needs?
- For this family, how long would it take to access each of these services?
- What might delay getting access to these services, if anything?
- What services would it be difficult to access? Why?
- Would you undertake any of the direct work with this family yourself? Which bit(s)? What would be your rationale for this?
- What other services do you frequently refer child in need families to?
- Are there any family types or family presentations that are less well serviced by way of support services locally?
- To what extent would you say that the Children in Need (from interim, including children with a Child Protection Plan) you work with are supported to safely live at home where possible?
- What stops the service from being more effective with families?
- What are the main areas of direct work you find yourself involved in with families?
- To what extent can you draw upon the rest of the team to support direct work with families? ((very, quite, not very, not at all)
- To what extent is there a clear vision within the organisation about how you're expected to work with families? (very, quite, not very, not at all)
- To what extent is there a shared theory, or theories, of practice shaping the way in which you work with families? (very, quite, not very, not at all)
- How confident are you about working directly with child in need (including child protection plan) families? (very, quite, not very, not at all)
- What areas of direct work do you feel most or more confident about?
- What training or development activity have you received to help you to be confident in working directly with families?

- What aspects of the training you have received are most helpful in enabling you to feel confident in undertaking direct work with families?

From the interim evaluation stage, additional questions included:

- What have you noticed, if anything, since the pilot(s) started?
- What's been good or effective about the pilot so far?
- What, if anything, has been more challenging?

CIN Team Manager questions used in the longitudinal interviews, excluding basic questions about their role, experience and team

- To what extent do you think it is easy for social workers in your team to access support for families with domestic violence as an issue? (very, quite, not very, not at all)
- Describe the main ways in which these domestic violence services are accessed currently
- What are the barriers, if any, to families accessing help with domestic violence?
- To what extent is it easy for social workers in your team to access support for parents with mental health problems? (very, quite, not very, not at all)
- Describe the main ways in which these mental health services are accessed currently?
- What are the barriers, if any, to families accessing these mental health services?
- To what extent do you think it is easy for social workers in your team to access support for parents with substance misuse issues? (very, quite, not very, not at all)
- Describe the main ways in which these substance misuse services are accessed currently
- What are the barriers, if any, to families accessing these substance misuse services?
- What other services, if any, are difficult to access for families locally and why?
- What other services, if any, are relatively easy to access for families locally, and why?
- To what extent are the right services available locally to support young people on the edge of care and their families (to safely remain at home)? (very, quite, not very, not at all)
- What approaches or services are currently useful in preventing young people coming into care unnecessarily?

- How could support for young people on the edge of care be improved, if at all?
- To what extent does the team draw upon the support of volunteers for work with Children in Need and their families? (very, quite, not very, not at all)
- What are the main ways in which the team has utilised volunteers in the last 6-8 months period?
- To what extent have volunteers been useful in supporting vulnerable young people? (very, quite, not very, not at all)
- To what extent have volunteers been useful in supporting families (including adult members)? (very, quite, not very, not at all)
- How might your team best use volunteer support in the future?
- To what extent do you think that the social workers in your team have time for direct work with families? (very, quite, not very, not at all)
- What are your main priorities for them with regard to the time they have for direct work?
- What would you like to see them doing more, if anything?
- In which of the areas you've mentioned (in relation to the last 2 questions) you're your social workers mostly have existing skills?
- In which of these areas do they mostly need to develop skills?
- What would you like to see them doing less, if anything?
- How many administrators currently support the work of the team?
- What are their different roles in detail?
- To what extent do you think that your team has sufficient administrative support currently? (very, quite, not very, not at all)
- To what extent do you think that your team receives flexible administrative support? (very, quite, not very, not at all)
- To what extent would you say that there is good morale in the team? (very, quite, not very, not at all)
- What are the main reasons for this level of morale, from your perspective?
- What number of permanent social workers and family support workers do you have currently in the team?
- What number of agency social workers or family support workers do you have currently in the team?
- What number of vacancies for either of these posts do you currently have?

- To what extent is it difficult to recruit social workers with the right skills to this team? (very, quite, not very, not at all)
- Give reasons why it is either difficult or easy to recruit to the team.

From the interim evaluation stage, additional questions included:

- What have you noticed, if anything, since the pilot(s) started?
- What if anything has been good or effective about the programme so far?
- What, if anything, has been more challenging?
- Which elements of the pilot programme, if any, do you think should be sustained and why? (final stage only)

For the Case File Analysis

Data was collected in relation to:

- the nature of the intervention (e.g. Child Protection Plan, Child in Need Plan, edge of care)
- date the intervention started and finished and overall duration of the intervention
- allocated child in need team
- key child date of birth and age at the start of the intervention
- key child gender
- key child ethnicity
- brief outline of the family structure and key members
- family history to the point of this statutory referral (including with reference to earlier social care referrals and interventions) and description of needs and issues at the point of this referral
- who was the key worker involved
- a description of the intervention the family received
- whether the family was offered a specialist domestic abuse, parent substance misuse or parent mental health service
- whether the family received a specialist domestic abuse, parent substance misuse or parent mental health service
- in what ways was the intervention effective and what appear to be the reasons for this?

- a description of any obvious limitations to the intervention
- whether timely and accurate information about families recorded?
- additional comments
- whether worth interviewing and why?

Appendix 3 Key Trends in Demand

Hampshire trend data

Table 8: Hampshire Children's Social Care Referrals Oct 2015 – Sept 2016

Time	Significance of Time	Referral Numbers	% Increase / Decrease
October 2015	Approximate month in which the Innovation Programme 'went live'	8582 (of which MASH referrals = 1698)	
March 2016	Approximately 6 months into the Innovation Programme	9055 (of which MASH referrals = 2267)	5% increase since October 2015
September 2016	Approximately 12 months into the Innovation Programme	9703 (of which MASH referrals = 2519)	13% increase since October 2015 (48% rise in MASH referrals)

Source: Hampshire County Council

For 2015-16, the published re-referral rate for Hampshire was relatively high (at 28%) compared with other authorities in the South East (24%) and England (22%).

Table 9: Hampshire All Children in Need March 2015 – October 2016

Time	Significance of Time	Child in Need Numbers	% Increase / Decrease
March 2015	Approximately 6 months prior to the Innovation Programme 'going live' and when the Programme bid was being formulated	5,819	
September 2015	Approximate time the Innovation Programme 'went live'	5,576	4% decrease from March 2015
March 2016	Approximately 6 months into the Innovation Programme	6,553	13% increase from March 2015
September 2016	Approximately 12 months into the Innovation Programme	6,436	11% increase from March 2015
October 2016	Final Child in Need number available to this evaluation	6,903	19% increase from March 2015

Source: Hampshire County Council

It is interesting to note that, at March 2014, the number of Children in Need in Hampshire was much higher (at 8,020) and, at that time, this rate was only just above the

comparator authority average. When at a similar level (6,502) in March 2013, the Hampshire rate was below the comparator authority average.

Table 10: Hampshire overall number of Looked after Children March 2015 – October 2016

Time	Significance of Time	F/T Looked After Child Numbers	% Increase / Decrease
March 2015	Approximately 6 months prior to the Innovation Programme 'going live' and when the Programme bid was being formulated	1,362	
September 2015	Approximate time the Innovation Programme 'went live'	1,340	2% decrease from March 2015
March 2016	Approximately 6 months into the Innovation Programme	1,321	3% decrease from March 2015
September 2016	Approximately 12 months into the Innovation Programme	1,341	2% decrease from March 2015
October 2016	Final Child in Need number available to this evaluation	1,360	Almost exactly the same as March 2015

Source: Hampshire County Council

The trends should be considered in the context of growing numbers of Children in Need (up by almost 20% in the same time period). They should also be considered in the context of rising numbers of Looked after Children in England during the whole financial year period 2015-2016. As illustrated in the table below, these all-England numbers have increased by 14% between March 2015 and March 2016.

Table 11: Number of children looked after in England 2012-2016

	2012	2013	2014	2015	2016
Number	67,070	68,060	68,810	69,480	70,440

Source: Government Data Collection and Statistical Returns

The number of Hampshire children becoming looked after has increased during the Innovation Programme period, in particular since April 2016.

Table 12: Number of Hampshire children becoming looked after July 2015 - Sept 2016

Jul-Sept 15	Oct-Dec 15	Jan-Mar 16	Apr-Jun 16	Jul-Sep 16
133	131	133	160	204

Source: Hampshire County Council

Although the time frame is not exactly the same, this Hampshire trend can be compared with the latest published figures for all-England that suggest that, between 2014-15 and 2015-16, the number of children becoming looked after rose by just 2% (from 31,340 to

32,050). The published figures for Hampshire had previously suggested a downwards shift between 2015-16, as illustrated in the table below:

Table 13: Number of children becoming looked after by year 2012-2016

Year Ending	2012	2013	2014	2015	2016
Children starting to be looked after	470	480	555	600	505

Source: Government Data Collection and Statistical Returns

Table 14: Hampshire children becoming looked after by age July 2015 – Sept 2016

Age	Jul-Sep 15	Oct-Dec 15	Jan-Mar 16	Apr-Jun 16	Jul-Sep 16
14	11	8	10	16	20
15	15	15	10	14	12
16	10	9	8	14	21
17	8	14	2	5	10
18	0	0	0	0	1
Totals by quarter	44	46	30	49	64

Source: Hampshire County Council

Table 15: Hampshire Team Caseloads April 2015 – Sept 2016

Area (CIN Teams only)	Caseloads April 2015	Caseloads March 2016	Caseloads June 2016 and % increase or decrease since April 2015	Caseloads Sept 2016
East Hants	222	189	167 (-25%)	114
Fareham & Gosport CIN 1	269	341	314 (+17%)	284
Fareham & Gosport CIN 2	226	318	289 (+28%)	301
Havant CIN 1	198	245	249 (+26%)	217
Havant CIN 2	190	241	261 (+37%)	209
Havant CIN 3	225	243	249 (+11%)	247
Hart & Rushmoor CIN 1	290	285	273 (-6%)	290
Hart & Rushmoor CIN 2	262	289	265 (+1%)	251
Basingstoke CIN 1	169	191	172 (+2%)	204
Basingstoke CIN 2	174	189	207 (+19%)	175
Basingstoke CIN 3	143	205	173 (+21%)	182

Area (CIN Teams only)	Caseloads April 2015	Caseloads March 2016	Caseloads June 2016 and % increase or decrease since April 2015	Caseloads Sept 2016
Eastleigh & Winchester CIN1	209	254	229 (+10%)	201
Eastleigh & Winchester CIN 2	216	258	270 (+25%)	284
New Forest CIN 1	185	251	235 (+27%)	223
New Forest CIN 2	171	232	235 (+37%)	259
Test Valley CIN 1	168	234	241 (+43%)	229
Test Valley CIN 2	184	200	229 (+24%)	240

Source: Hampshire County Council

Table 16: Hampshire children returning from going missing and return interviews

Number	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept
Returning	95	128	147	166	144	186	186	227	217	353	249	299
Having a return interview	61	88	82	52	53	61	55	87	81	76	84	118
% having a return interview	64%	69%	56%	31%	37%	33%	30%	38%	37%	22%	34%	39%

Source: Hampshire County Council

Isle of Wight (IOW) trends

Table 17: Isle of Wight contacts and referrals October 2015 – September 2016

Time Period	Number of Contacts	Number of Referrals
Oct-Dec 2015	4659	Average 330 to 380 per month throughout the period
Jan-March 2016	4502	
April – June 2016	4637	
July – Sept 2016	No information available	

Source: Isle of Wight Council

Table 18: Isle of Wight Number of Children in Need June 2015 – July 2016

Time	Significance of Time	Child in Need Numbers	Percentage Increase / Decrease
June 2015	Approximately 3 months prior to the Innovation Programme 'going live' and	605	

	when the Programme bid was being formulated		
September 2015	Approximate time the Innovation Programme 'went live'	679	12% increase since June 2015
March 2016	Approximately 6 months into the Innovation Programme	800	32% increase since June 2015
July 2016	Approximately 10 months into the Innovation Programme	790	30% increase since June 2015

Source: Isle of Wight Council

Table 19: Isle of Wight Number of Looked after Children June 2015 – July 2016

Time	Significance of Time	Child Looked After Numbers	Percentage increase / decrease
June 2015	Approximately 3 months prior to the Innovation Programme going live and when the Programme bid was being formulated	204	N/A
September 2015	Approximate time the Innovation Programme went live	199	2% decrease since June 2015
March 2016	Approximately 6 months into the Innovation Programme	203	No change since June 205
July 2016	Approximately 10 months into the Innovation Programme	207	1% increase since June 2015

Source: Isle of Wight Council

However, the rate of Looked after Children in the overall population of the Isle of Wight at March 2016 (at 81 per 10,000 children) was still significantly above the average for England (60 per 10,000 children) and the South East of England (52 per 10,000 children).

Table 20: Isle of Wight Number of children becoming looked after July 2015 – Sept 2016

Jul-Sept 15	Oct-Dec 15	Jan-Mar 16	Apr-Jun 16	Jul-Sep 16
12	27	20	26	No data available

Source: Isle of Wight Council

The rate is in keeping with that of the year 2014-15, during which time 86 children became looked after (approximately 21-22 per month) but higher than the most recent published year (2015-16) during which 75 children became looked after.

The published figures for children becoming looked after on the Isle of Wight year on year also suggest a steadying out of the numbers after a bulge in 2013-14, as illustrated in the table below:

Table 21: Isle of Wight Number of children becoming Looked After 2012-2016

Year Ending	2012	2013	2014	2015	2016
Number of children becoming looked after	70	90	105	85	75

Source: Isle of Wight Council

Table 22: Isle of Wight Team Caseloads April 2015 – August 2016

Area (CIN Teams only)	Caseloads April 2015	Caseloads Sept 2015	Caseloads March 2016	Caseloads June 2016	Caseloads August 2016
IOW 1	208	167	161	187	190
IOW 2	176	164	156	164	167
IOW 3	161	207	195	200	182

Source: Isle of Wight Council

Appendix 4 Unit Cost and Cost Benefit Calculations

For the PA Pilot

The overall annual costs of the PA Pilot are reported by Hampshire County Council and Isle of Wight Council to have been:

- £812,160 in Hampshire, exclusive of overheads (based on an average pay per PA of £25,380 and 32 such workers). Including overheads calculated by Hampshire at 20%, the whole pilot period costs are £974,592.
- £228,420 on the Isle of Wight exclusive of overheads and based on the same assumptions as above. Including overheads calculated by the Isle of Wight at 20%, the costs are £274,104.

Therefore, the starter unit cost of a PA in Hampshire during the pilot period was £25,380 plus overheads = total £30,456 per annum.

However, there have been reductions in broader administrative support in some teams, at least during the pilot period, which reduces the overall spend on administrative support to teams, and these reductions are planned on a more widespread and consistent basis to coincide with the planned future roll out of the Programme. In Hampshire, it has been calculated that the cost of ongoing implementation of PAs beyond the pilot period (and assuming a rate of 3:1 Social Workers to PAs), including a small reduction in general administrative support but full implementation of the pilot across Child in Need teams in all 8 localities, is in the region of £540,000 per annum (£648,000 including overheads) for a total of 49 D Grade PAs.

Taking into account the shifts in broader administrative support (particularly reductions in overall general admin support) the on cost of a PA, inclusive of overheads, is therefore calculated at £13,224.49.

One way of looking at the main costed value of PAs is to compare the amount of time Child in Need social workers have been spending on administrative activities both before (36%) and after (14%) the introduction of PAs. The average cost of a Social Worker is £40,913 (not including overheads). The evaluation suggests that having a PA reduces the amount of administrative time for social workers significantly, from £14,728 per social worker without a PA, to £5,728 for those with PAs. This results in an approximate saving of £9,000 per Social Worker or £27,000 per PA.

Another way of looking at the value added might be to calculate the increase in team and individual Child in Need social worker caseloads that PAs appeared to facilitate, at least during the pilot period: an average 17% increase in reported team caseloads, similar to the self-reports of social workers participating in longitudinal interviews for this

evaluation. However, it is unlikely that these increases in caseloads for social workers are desired or sustainable in the councils concerned. Therefore, evaluators have preferred to calculate the cost benefits based on reductions in time spent on administrative tasks.

Further benefits of PAs might also be calculated over time with reference to:

- the increased productivity of Social Workers in teams with PAs in terms of significantly improved sickness rates and therefore more days in work (if current trends are sustained)
- improved quality of Social Work in terms of more timely visits, reports and meetings and better quality reports (if Team Manager reports are validated by performance monitoring over time)

For the FIT Pilot

- the cost per annum of a full time Domestic Abuse Worker was £32,825 plus overheads calculated by Hampshire at £2,000 (management costs were mostly shared with parent agency) = £34,825
- the cost per annum of a full time Substance Misuse Worker was £45,511 plus overheads calculated by Hampshire at £2,000 (management costs were mostly shared with parent agency) = £47,511
- the average cost per annum of a full time Mental Health Worker was £35,853 plus overheads calculated by Hampshire at £2,000 (management costs were mostly shared with parent agency) = £37,853

Not all teams piloting FIT had access to a full time worker from each of these three disciplines at all points during the pilot.

For the Edge of Care Pilot

Average costs of edge of care interventions (based on an edge worker + structured activities programme + volunteer mentor) are explored in the table below:

Table 23: Costs of the Edge of Care Pilot

Input	Detail	Unit Cost (per intervention)
Edge Worker	The average annual cost of an edge worker is £31,709[1] plus overheads calculated by Hampshire at 20% = £38,050 per	£1,812

[1] Based on an average cost within the overall pay scale for these workers

Input	Detail	Unit Cost (per intervention)
	worker. Approximately 21 young people are engaged with an edge worker per annum. Therefore, the approximate unit cost of the edge worker element per intervention is £1,812.	
Structured Activities Programme	The costs of these programmes are reported to have varied considerably from £2,000 to £675 per young person per programme. The average unit cost is reported to be £1,065.	£1,065
Volunteer Mentor	The average annual cost of a Volunteer Coordinator is £31,709[2] plus overheads calculated by Hampshire at 20% = £38,051 per Volunteer Coordinator. On the basis of 50 active volunteers being supported by each Volunteer Coordinator per year, the cost per volunteer of this element of the offer is £761. This is not the cost per intervention (and we don't yet know how many interventions a volunteer coordinator might undertake per annum). A conservative estimate would be 3 significant interventions (i.e. more than a return interview), making the Volunteer Coordinator (recruitment and support) cost for each of these interventions £254 per intervention. Administrative and marketing costs are £50,761 plus overheads of 20% = £60,913 per annum. Therefore, the administrative costs per Volunteer Coordinator are £15,228 inclusive of overheads. Therefore the administrative 'on costs' per volunteer are £304.56 and to each intervention approximately £101.52. Average monthly expenses per volunteer are £10.22 which suggests an average expenses cost per intervention of around £40.88.	£396.40 (excluding some training costs)
Total (rounded)		£3,273.40 (excluding some training costs)

Source: Hampshire County Council

[2] Ibid

For the Volunteering Pilot

Fairly similar costs per Volunteer and intervention accrue to the two different Volunteer Pilot Programmes.

Table 24: Costs of the Volunteering Pilot

Which Local Area	Detail	Unit Cost per substantive intervention
Hants	The average annual cost of a Volunteer Coordinator is £31,709[3] plus overheads calculated by Hampshire at 20% = £38,051. On the basis of 50 active volunteers being supported by each Volunteer Coordinator per year, the cost per volunteer of this element of the offer is £761. This is not the cost per intervention (and we don't yet know how many interventions a volunteer coordinator might undertake per annum). A conservative estimate would be 3 significant interventions (i.e. more than a return interview), making the Volunteer Coordinator (recruitment and support) cost for each of these interventions £254. Administrative and marketing costs have been at £50,761 plus overheads of 20% = £60,913 per annum for the pilot period. Therefore, the administrative costs per Volunteer Coordinator have been £15,228 inclusive of overheads. Therefore the administrative 'on costs' per volunteer have been £304.56 and to each intervention approximately £101.52 Average monthly expenses per volunteer have been £10.22 which suggests an average expenses cost per intervention of around £40.88. At 12 months into the pilot, volunteers were completing an average of approximately 5 interviews per annum (although they may attempt significantly more). This average figure masks a far greater range i.e. between 1 and 48) which is perhaps a reflection of both the different stages at which Volunteers come 'on stream' and the extent to which they do or don't specialise in return interviews – as well of course as the amount of time they have free to undertake interviews. A mere 5 return interviews per annum would make the cost per return interview approximately £183.80 (for Volunteers only doing this type of volunteering) whereas 10 per year would bring down the cost significantly to £91.90.	£396.40 (excluding some training costs)

[3] Ibid

Which Local Area	Detail	Unit Cost per substantive intervention
Isle of Wight	The annual cost of the Home Start Family Support Volunteer Service is £18,200 (the cost of a part time Volunteer Coordinator). 23 Volunteers were 'on the books' at 10-12 months into the Pilot Programme which suggests a unit cost of approximately £791 per Volunteer per annum (excluding some training costs provided by Hampshire). This is not the cost per intervention (and we don't yet know how many interventions a Volunteer might undertake per annum). A conservative estimate would be 3 'substantive' interventions making the Volunteer Coordinator (recruitment and support) cost for each of these interventions £263.77 Expenses costs have not been provided so we are applying the average monthly expenses costs for Hampshire i.e. £40.88.	£304.65 (excluding overheads borne by the provider currently, and some training costs provided by Hampshire CC)

Source: Hampshire County Council and Home Start (Isle of Wight)

Table 25: Costs of the Child Sexual Exploitation (Willow Team) Pilot

Resource	**Cost per worker (mid scale for the grade)**	**Total Team Cost**
Team Manager x 1	£50,789	£ 50,789
Social Worker x 3	£40,913 per worker	£122,739
Administrator x 1 at D Grade	£25,380	£ 25,380
Administrator x 1 at C Grade	£20,242	£ 20,242
Total Staffing Costs		£219,150
Approximate Overhead Costs (at 20%)		£ 43,830
Total costs including overheads		£262,980

Source: Hampshire County Council

These costs are exclusive of the Barnardo's Worker; 2 Health Safeguarding Nurses; and Police input.

Appendix 5 Definitions of administrative activities

At the baseline and final evaluation stages of the PA pilot programme, social workers participating in longitudinal interviews were asked to define the 'administrative activities' they referred to in answering questions about their use of time.

At the baseline (July 2015)

Activities described as administrative in nature were reported by Child in Need social workers to include (in order top to bottom of most likely to be reported to least likely to be reported):

- recording of visits and new information on the computer system
- taking and responding to telephone calls and emails
- writing assessments, reports and plans (or aspects of these)
- arranging group meetings
- updating the chronology
- filling in referral forms or requesting information from agencies
- typing minutes
- photocopying
- managing the diary

At the final evaluation (July - August 2016)

Activities described as administrative in nature were reported by Child in Need social workers to include (in order top to bottom of most likely to be reported to least likely to be reported):

- recording of visits and new information on the ICS system
- writing assessments, reports and plans (or aspects of these)
- taking and responding to telephone calls and emails
- arranging group meetings
- managing the diary (including arranging visits)
- filling in referral forms or requesting information from agencies
- typing minutes

- preparing travel warrants and organising financial provision for parents
- letters
- photocopying

Overall, there is a good degree of similarity in Child in Need social worker responses to questions about the nature of administrative activities they identified. Responses at the final stage of the evaluation suggest a developing awareness amongst social workers of the full spectrum of administrative activities associated with their work including in particular a greater awareness of the need for diary management.

Appendix 6 Limitations of the Evaluation Methodology

The evaluation methodology was limited as might be expected by the resources available to it, particularly one examining such a wide range of innovations. The key limitations are listed below:

- the longitudinal interview relied heavily upon for the evaluation of many of the pilot strands, but particularly the PA pilot, captured only self-reported or manager reported changes in behaviour, for example increases or decreases in the amount of time spent undertaking direct work with families. Ideally, this information would have been reinforced with other evidence, for example case file analysis showing changes in social worker time spent (on direct work) with families. However, the case file analysis focused more on the incidence and impact of other strands of the Innovation Programme. Following individual social worker case files in this way would have taken up a lot of evaluation resource.
- the baseline (pre-innovation) longitudinal interview contained a question 'To what extent would you say that the Children in Need you work with are supported to safely live at home where possible?'. Researchers undertaking these interviews realised that there was potential for mis-interpretation and therefore, for interviews at stage two and three of the evaluation, the question was re-phrased as 'To what extent would you say that the Children in Need you work with (including those with a Child Protection Plan as well as a Child in Need Plan) are supported to safely live at home where possible?'. This question was not relied upon in relation to key findings.
- as anticipated, some of the participants in our longitudinal study of team managers, social workers and administrators moved on during the 12 month period in which it was undertaken. This meant that some staff who participated at the baseline (in summer 2015) didn't complete their second and/or third interview. Some newer recruits didn't participate in the baseline interview but did complete a second and third one. However, overall, a sufficient proportion (63%) of the sample participated throughout the evaluation period and those that left were replaced by like for like workers. The responses from each of the three waves of interviews provide whole group findings that evaluators believe are still highly representative of the experience of workers in key social work teams as the innovation programme progressed.
- the mixed methodology applied to evaluating the CSE (Willow) pilot didn't acknowledge, at a sufficiently early stage, the balance of work that was actually being undertaken by the team, and arguably focused too heavily on an evaluation of the 1:1 work with young people. It didn't capture in depth what had been the impact of the team's awareness-raising work, or the advice and consultation service for social workers and other professionals working with vulnerable young

people. Information about these two areas of work was limited to a secondary analysis of the team's own data, the on-line survey of professionals and 1:1 interviews with service leaders. Ideally, this information would have been supplemented by other including analysis of the impact 'in real time' on professional assessments and decision making.

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