Department for Education

Systemic conditions for innovation in children's social care

Children's Social Care Innovation Programme

Thematic Report 4

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Executive summary

This report presents the key messages about the conditions in the children's social care system that support or limit innovation that leads to improvement. The evidence is drawn from the evaluation of the first phase, known as Wave 1 (2014-2016), of the DfE's Children's Social Care Innovation Programme. The meaning of innovation and the contextual conditions that assist innovation to be a driver for change are considered, in particular in children's services. The conditions that enabled some of the 57 innovation projects to progress effectively, and in some cases, improve outcomes for children and families, are identified. Conversely, those factors in the system that limited innovation from driving positive change are identified. Recommendations are made for the future development of innovation projects in children's social care. Services are encouraged to self-audit against these recommendations, using the tool provided in Appendix 1.

Recommendations

- Use the evidence base for children's social care generated by Innovation Programme Wave 1 evaluations in planning future innovations
- Assess whether there is sufficient capacity in the service to support innovation – is innovation the best way to achieve the priorities for change identified?
- Establish strong, consistent senior leadership, communicating a clear vision in order to create conditions conducive to effective innovation
- Undertake wide-scale stakeholder engagement early in the innovation in order to clarify aims and secure the commitment of those in the wider services beyond the staff involved in the specific innovation project, to avoid a 'them and us' culture developing
- Define the target population clearly and ensure that information about the benefits of engagement in the project are clearly articulated to them and to staff involved in the referral pathways
- Consider recruitment strategies early for those young people and families targeted and aim for higher numbers than needed in the innovation
- Anticipate 6-12 months minimum lead-in for innovations requiring significant restructuring, new models of commissioning or delivery and de-regulation
- Build in time and flexibility to sustain and progress the project in the face of unpredictable pressures
- Develop effective multi-professional working; draw on the established models from Partners in Practice
- Establish from the outset what data are available, what new data are needed and for what purpose, and how greater consistency of data collection across local authorities and services might be achieved

- Identify comparative data (or preferably controlled trials) in order to be able to link improvements to the interventions. Local authorities and other providers should offer to act as one another's control group
- Consider embedded/practitioner researchers as a potential way to address the research-practice gap; however, if adopted, they will need significant resources with practitioners requiring support to develop necessary skills and not be drawn back into the practice role.

Introduction

In 2016, the DfE's policy statement *Putting children first*[1] acknowledged the need for a better understanding of the systemic conditions supporting innovation:
"We need to use the next phase of the Innovation Programme to make progress on two fronts:

- deepen our understanding of the system conditions needed for excellent practice building on the messages emerging from phase one of the programme; and
- support more local authorities to rethink their whole practice system around these conditions".

This report addresses the emerging messages from evaluation of the first phase, known as Wave 1, of the DfE's Children's Social Care Innovation Programme.
A brief introduction to the Programme is given, followed by a suggested definition of innovation and the contextual conditions that assist innovation to be a driver for change, in particular in children's services. The conditions that facilitated the innovation projects to progress effectively, and in many cases, improve outcomes for children and families are identified. Those conditions that the evaluations suggested inhibited progress, which are the converse of these facilitators, are reported alongside them. Further barriers identified are then considered and recommendations made for the future development of innovation projects in children's social care. Services are encouraged to self-audit against these recommendations, using the tool provided in Appendix 1.

Evaluation of the Children's Social Care Innovation Programme

The first Wave 2014-2016 of the Children's Social Care Innovation Programme received a major investment of £100m in 57[2] projects and their evaluations. The evaluations were undertaken by 22 evaluation teams and the reports of these evaluations can be found on the DfE Publications website. Two-page summaries of these reports designed to engage the interest of a wider community can be found on the Spring website.

Most projects were funded in late 2014 so implementation started in early 2015 - evaluations in Wave 1 therefore ran for 10-18 months. In some cases (e.g. Safe

[1] p.31, DfE (2016) *Putting Children First: Delivering our vision for excellent children's social care*. London: DfE

[2] Elsewhere, Wave 1 of the Innovation Programme is referred to as 53 projects because the 5 National Implementation Service projects are treated as one. As they are separate interventions individually evaluated, we treat them as 5 projects.

Families, Match) the delays to implementation and small group sizes limited the validity of any quantitative evaluation of impact, providing some early outcomes, but rather more on process. Some projects commissioned evaluations that extended beyond this window, but they sit outside the scope of this report.

The Rees Centre as Evaluation Coordinators had responsibility for the standards of evaluation in the first Wave of the Innovation Programme. The Evaluation Coordinator was also responsible for the over-arching evaluation. Five issues were identified that merited cross-cutting thematic reports drawing on findings from across the projects:

1. What have we learned about social work systems and practice?
2. Adolescent service change and the edge of care
3. Child sexual exploitation and mental health
4. Systemic conditions for innovation in children's social care
5. Informing better decisions in children's social care

The purpose of the thematic reports is to provide a summary of evidence that emerged from across projects about innovation in children's social care, thus demonstrating the added value of a Programme of projects rather than 57 unconnected innovations. The teams evaluating projects in specific areas – e.g. adolescence, children's social work – shared their findings and identified issues across projects. Furthermore, the Evaluation Coordinator synthesised messages from across evaluation reports in each of these areas. The thematic reports of these messages are designed to support future innovation in children's social care in local authorities and other providers, by promoting learning across the sector.

What is innovation and when and how is it a driver for change?

What is innovation?

A commonly used definition of innovation is the development and dissemination of a new product, service or process that produces economic, social or cultural change[3]. Within the Innovation Programme, the definition of innovation provided by the Spring Consortium[4] who were the delivery partner responsible for supporting projects, was that it:

> "describes a new practice, model or service that transforms mainstream ways of doing things. While improvement focuses on achieving better outcomes

[3]Nesta, cited in Sebba et al., (2009) *Youth-led innovation*. London: Nesta
[4]Spring Consortium Innovation Insights Board 1: The value of innovation in children's social care

> through more efficient use of the same resources, innovation looks to achieve better, *different* outcomes using new resources (or using existing resources in new ways)."

Innovation can be distinguished from 'invention' which is defined as: 'the first occurrence of an idea for a new product or process', while innovation is the first attempt to carry it out in practice. Research on innovation in general, suggests that ideas, which initially may be regarded as unusual or marginal by people other than those proposing them, are often subsequently brought into the mainstream[5]. A successful service innovation requires the initial idea to become widely available.

Innovation as a driver for change

Innovation and change are overlapping but not equivalent concepts[6]. Change implies growth or development, in this context of a public service or element of the service. Innovation is a specific form of change implying discontinuity from existing policies or practice. It might involve changes to organisation, staffing, priorities, skills or resources. Fincher[7] reviewed the factors contributing to innovations that failed (mainly in an education context) and the tendency to mistake change for innovation, along with the need for an explicit rationale for learning from failure. He noted that the assumption that removing artificial barriers will enable innovation to flourish is flawed since the impact of 'passive resistance' and adherence to daily routines are often underestimated and act as greater barriers than specific perversity. For example, the evaluation of Morning Lane's *Scaling and deepening the reclaiming social work model* noted that while the quality of direct practice was much higher in most *Reclaiming Social Work* units, perceived tensions between this approach and the wider risk aversive child protection system in some sections of the organisations, led to passive resistance that inhibited transformative change. Successful innovation, Fincher suggested, needs to recognise the respective roles of both initiators and implementers.

Glisson[8] noted that effective innovations are as much about creating appropriate organisational contexts as they are about the ideas themselves. He clarified the important distinction between organisational climate, as the psychological impact of the work environment on employees' well-being, motivation and performance, and organisational culture as the shared norms, values and expectations within the organisation. This distinction is relevant to our experience in the first wave of the Innovation Programme, for example, Munro, Turnell and Murphy's *Signs of Safety*

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[5] Bessant, J. and Tidd, J. (2007) *Innovation and Entrepreneurship*. London: Wiley.
[6] Brown, K., and Osborne, S. P. (2012). *Managing change and innovation in public service organizations*. London: Routledge.
[7] Fincher, C. (1980). AIR Between Forums: The Failures of Innovation. *Research in Higher Education, 12*(4), 373-376. Retrieved from http://www.jstor.org/stable/40195340
[8] Glisson, D. (2015) The Role of Organizational Culture and Climate in Innovation and Effectiveness, Human Service Organizations: *Management, Leadership & Governance*, 39:4, 245-250.

action research report notes that organisational culture requires the embedding of 3 principles if it is to effectively support good practice – working relationships, shared reflective practice and being grounded in everyday experience and the project accessed information about these through regular staff surveys.

What is known about innovation in children's services?

It is relatively straightforward to identify areas of children's social care that need economic, social or cultural change, but more challenging to know when innovation is the best way to achieve this. Existing research on innovation confirms that it is not always the best way to achieve progress[9] but the evidence base is lacking for helping to identify which services or situations in children's social care are most likely to benefit from innovation.

In a children's services context, Glisson and colleagues developed the Availability, Responsiveness and Continuity (ARC) model of organisational effectiveness[10] and demonstrated its use to support innovation that led to increased job satisfaction, reduced staff turnover and improved service outcomes. This approach is a 'team-based, participatory, phased intervention designed to improve organisational culture and climate in mental health and social service organisations, support innovation, and remove barriers to effective services'[11]. It involves five principles:

- **mission-driven** as in Wigan and Rochdale's CSE project which developed a shared mission through co-design work over a 4-month period
- **results-orientated** as in Leeds' *Family Valued* and North East Lincolnshire's *Creating Stronger Communities* use of the Outcomes-Based Accountability framework
- **improvement-directed** as in Coram's *Permanence Improvement Project* in which successful reduction in time taken to place a child was associated with single-minded activation and intensification of family-finding practice
- **relationship-centred** as in Pause's project with women who experience repeat removals of children from their care. The establishment of trusting relationships was crucial in supporting women to make sustainable changes
- **participation-based** as in Stoke's *House Project* in which the young people co-designed their housing through a co-operative run for and by them.

Glisson's approach involves evidence-based improvement strategies such as feedback, teamwork and participatory decision-making. These strategies are

[9] Fincher, *opp.cit*

[10] Glisson, C., and Williams, N.J., (2015). Assessing and changing organizational social contexts for effective mental health services. *Annual Review of Public Health*, 36:5. doi:10.1146/annurev-publhealth-031914-122435.

[11] Glisson, C. (2015) *opp. cit.*, p.247

reflected in the coaching model adopted by the Spring Consortium and by most of the projects in Wave 1 that made good progress in both implementation and outcomes. The rest of this report identifies the conditions in the wider context in which projects in Wave 1 were being implemented that facilitated or inhibited that progress.

What have we learned about the conditions which facilitate or inhibit innovation projects to progress effectively and produce good outcomes?

As many of the factors which inhibit innovation are the converse of those that facilitate innovation, these two are taken here together. Some additional barriers to innovation are identified in the next section.

Clarity of objectives

All projects were required to submit a theory of change with their bid. Some (e.g. Leeds' *Family Valued*), spent the first few months refining these with their staff to clarify objectives and secure commitment from staff. In Glisson's terms this might be expected to enhance organisational culture through the development of shared values and expectations, and also reflects his principles of being mission-driven and participation-based.

Lack of clarity of initial objectives or changes to objectives after the start were common barriers to progress. Wigan and Rochdale's CSE project lacked clarity at the start, but the co-designing stage went on for 4 months after the service started and similarly to Leeds, enabled the project to develop with a shared mission. Some projects revised their objectives after the start which reduced their ambition. In the Fostering Network's *Mockingbird*, ambiguity regarding the aims and delivery amongst those involved and those who were not, inhibited progress initially. Similarly, the evaluation of *Family Insights* in Newcastle reported confusion between partners about aims due to an 'us and them' culture being fuelled by perceptions that those involved in the project were more privileged than the rest of the children's services. Similarly, in Morning Lane's *Reclaiming Social Work* questions were raised about who 'owned' the innovation, perhaps due to the project involving teams within wider services in each local authority in which other staff were not involved.

Coram's *Permanence Improvement Project* evaluation noted that consensus had yet to be achieved in the target local authority about 'timeliness' and the need to balance the focus on 'family finding' with the wider needs for improvement of children's social work. Communication challenges in general and in particular, early misunderstandings about the need to build relationships with the child's social

worker, were barriers in Wigan's *Specialist Health and Resilient Environment* (SHARE) mental health project. Gloucestershire's systems transformation programme's ambitious objective of creating a more integrated countywide service was implemented on a smaller scale than planned.

Case Study – Clarifying objectives, stakeholder commitment

NE Lincolnshire's *Creating Strong Communities*, combined Outcomes Based Accountability (OBA), Signs of Safety (SoS), Restorative Practice (RP) and Family Group Conferencing (FGC) in order to reduce the high demands for statutory provision. They used OBA, a conceptual approach to planning services and assessing performance that focuses attention on outcomes with strong stakeholder engagement in the process. It provided a way of securing strategic and cultural change through providing a clear focus on the objectives relating to improving children's outcomes and towards making these outcomes the primary purpose of their organisation and its employees.

Extensive involvement of stakeholders, including service users and the wider community was undertaken to ensure shared commitment to the key objectives. 187 managers were trained in the principles and practical application of OBA, an OBA Champions' Network was established which actively supported and cascaded good practice and a Whole Population Outcomes Framework was established by the Leadership Team, which sets out the objectives for authority wide practice. One manager commented:

> "The setup of the scorecards [*which regularly record performance*] and the use of the simple language, how much? how well? so what? story behind baseline…has been useful in terms of getting the team and partners on board and meeting outcomes for the service."[12]

While not all targets were met in the short timescale of the Wave 1 project, some positive outcomes were achieved including:

- referrals and re-referrals to social care fell by 25% and 11% respectively
- FGC team worked with 154 families and delivered 65 conferences leading to 15 children per year avoiding going into care
- Using fiscal return on investment, based on 20 FGC cases, gave an average return on investment of 18.2. The annual return on investment of the FGC service is calculated to be 6.8. This represents a saving of £6.80 for every £1 spent.

Wide scale commitment to shared objectives has enabled Creating Strong Communities to be effective as part of a wider change agenda to support families across the authority called "Families First". The IP project has acted as a catalyst for change within this and all 4 strands will be sustained and continued.

[12] p.21, York Consulting. (2016). *Evaluation of North East Lincolnshire Innovation Programme – Creating Strong Communities*. London: DfE

Strong senior leadership and the capacity to innovate

Ofsted has reported consistently[13] that highly rated children's services and safeguarding are characterized by strong senior leadership. Projects in Wave 1 that made good progress usually benefitted from strong, consistent leadership, for example in NYCC's *No Wrong Door*, Leeds' *Family Valued*, Hampshire's *Social Care Innovations* and Triborough's *Focus on Practice*. In Leeds for example, strong leadership and consistent vision regularly communicated, were reported to have been crucial in bringing about improvements in the wider children's social care services. Action for Children's *Step Change* benefitted from good communication systems but struggled with lack of strategic buy in by the senior managers in some of the local authorities with whom they worked.

Conversely, one local authority initially made less, and another no progress because the leadership lacked the capacity to innovate, due to key posts being vacant, leading to multiple senior roles being held by the same individuals and needing to focus on an improvement plan following inspection. Changes in senior leadership were also a barrier in some of the local authorities involved in (NIS) KEEP. In one project, team leaders in the local authority did not encourage frontline social workers to engage in the project even when senior leaders were committed perhaps due to 'passive resistance'. North London Children's Efficiency Programme (NLCEP*)* began to make swifter progress when senior leaders provided additional project management capacity despite competing demands for administrative support.

Focus on relationships

Glisson suggested that effective innovation was more likely to occur in organisations which were relationship-centred – this was also associated with a positive organisational climate in which the workforce was motivated, and reported high levels of well-being. Many of the projects (see our final evaluation report) reduced the number of children coming into care and/or the number on child protection plans although relatively few (e.g. Leeds' *Family Valued* and MTM's *Signs of Safety*) reported corresponding reductions in social worker caseloads. More projects noted improved relationships between families and social workers though only a few (e.g. Enfield, Hampshire) attributed this to increased contact with families. Enfield's *Family and Adolescent Support Hub* (FASH) increased face-to-face working and introduced greater flexibility of operation in order to establish effective relationships and support. In Hampshire, the introduction of personal assistants for social workers was attributed to an increase in social workers' time spent with families from 34% to 58%.

[13] Ofsted (2016) *The report of Her Majesty's Chief Inspector of Education, Children's Services and Skills 2016*. Manchester: Ofsted

Effective collaboration across services

Many projects identified the need for effective multi-professional working as a key feature of the services they intended to develop. Some (e.g. NYCC's *No Wrong Door*, The Mayor's Office for Police and Crime - MOPAC's *Female Genital Mutilation Early Intervention Model*, Doncaster's *Growing Futures* and Priory's *Belhaven*) achieved this to the benefit of the populations targeted. MOPAC's evaluation reported strong co-working between highly skilled and reflexive health and social care professionals, therapists and community advocates to the benefit of the women involved. The evaluations of *Family Valued* in Leeds, and Surrey's *Extended Hope* and Wigan's *SHARE* (both focusing on mental health) provided evidence of the importance of effective multi-professional work with widespread stakeholder engagement in bringing about change. Hampshire's project evaluation concludes that the strong interagency working together with highly effective management oversight led to the innovation being delivered in an impressively efficient manner and challenges being overcome. In Norfolk and Suffolk's *Compass*, multi-professional work gave staff the opportunity to learn from and support colleagues, and to come together to share knowledge and experience about a (mental health) case.

Conversely, other projects experienced major challenges in getting some services to cooperate and differences in cultures or priorities remained major barriers to progress. However, some overcame these initial barriers, for example Sheffield's *South Yorkshire Empower and Protect (SYEP),* which developed the South Yorkshire-wide approaches to foster carer training, payment and a recruitment strategy though they found that as the direct work with young people increased, their capacity to work across the services reduced. Implementation was inhibited by lack of collaboration across services, especially in areas such as mental health and child sexual exploitation in which effective multi-professional work was essential to progress. The evaluation of Doncaster's *Growing Futures* which introduced Domestic Abuse Navigators to support families, noted that the demands of effective multi-professional work included clarity about referral pathways, service protocols, models of working, roles and responsibilities, and information and risk sharing.

Case Study – Multi-professional working using group case discussion

Family Safeguarding Hertfordshire (FSH) is a whole system reform of children's services which aimed to improve the quality of practice with over 1700 children from 940 families. It involved multi-professional working between the police, health, probation, social care, mental health, domestic abuse workers, and substance abuse workers. The evaluation highlights the importance of creating the structures within which the different professionals could contribute to changed team dynamics.

In particular, the multi-professional teams engaged in group case discussions of individual children and families which the evaluators identified as allowing the different perspectives of specialist adult workers to create more informed risk assessments. The specialist workers provided immediate support to families. They developed a more multi-professional way of talking about families as well as working with them, for example:

'the role is going really well, we are all in one room and can quickly form an action plan, different expertise is shared' (Domestic Abuse Officer)[14].

While there was relatively little change in observed quality of practice over the year of the evaluation, 86% of the families achieved their goals, the number of days that children spent in care was reduced by more than a half (from an average of 20.5 days/family to 9.8), there were reductions in child protection plans (with estimated costs savings of £2.6m in the first 12 months from savings on care/child protection plans), substantial reductions in contact with the police and in emergency admissions of adults to hospital. Social worker caseloads were reduced.

The evaluation concludes that the further development of an interagency set of key performance indicators would enable the service to quantify the impact of changes to the service and multi-professional teams to adopt a strategic, coordinated oversight of service provision. Hertfordshire is now rolling out the model to other local authorities.

[14] p.25, Forrester, D. et al. (2016) Family Safeguarding Hertfordshire Evaluation Report, London: DfE

In some projects the adoption of, and multidisciplinary training in, a specific model for their interventions improved understanding and relationships between services. The evaluation of Tri-borough's Alternative Provision (TBAP) *Multi-Academy Trust* found that more effective communication between the different alternative provisions across the Trust improved understanding of the role of the intervention and support for it.

Availability and use of the evidence base

Use of previous evidence to inform the innovation

Seven projects included a review of research at the outset due to a lack of a well-established evidence base in that area. Oxford Brookes produced 6 short reviews in response to the lack of evidence on the strands in Hampshire's project on topics such as CSE, domestic abuse, use of volunteers and edge of care. In total, there are 13 literature reviews available that provide a helpful evidence base relating to key areas of children's social care. The evaluation report of Coram's permanence project states that there was insufficient evidence to inform the social work practice systems most likely to enhance timely and child-centred decision-making and action in adoption.

Lack of a robust evidence base was a particular challenge to the larger projects operating over multiple local authorities and services (e.g. MLA, MTM, *Mockingbird*, *Safe Families*). An established evidence base often provides experience of what is needed to maintain fidelity to the model, whereas most of these projects were challenged by lack of consistency across service providers.

Availability and use of data

In Thematic Report 5 *Informing better decisions in children's social care*, we discuss what emerged from the evaluation of Wave 1 projects on availability and use of data to inform decisions. In some of the target areas for innovation there were very little data at the outset of the Innovation Programme and generation of better data was a key target for these projects. For example, the evaluations of the four CSE projects (Sheffield, Aycliffe, St Christopher's and Wigan and Rochdale) noted the lack of relevant available data. Pause and Doncaster's evaluations noted the poor accuracy of data on domestic abuse.

Data-sharing agreements were a necessary but challenging requirement for some projects as discussed further in all the other Thematic Reports. This can involve sharing information about individual children and families across services (children's social care, police, health, etc.) within one local authority as exemplified in NYCC's *No Wrong Door*, or sharing across local authorities, as was attempted in two of the CSE projects. Both Sheffield, and Wigan and Rochdale's CSE projects instigated

data-sharing agreements across local authorities in an attempt to improve the use of data. In West Sussex, the project established a data-sharing protocol across local authorities but reported that it remained difficult to pool information on expenditure, numbers of children being supported and use of different providers across the region, because the approaches to data collection varied so significantly. Similarly, in the (NIS) KEEP evaluation, variability across teams and inconsistencies in the data received across authorities were noted, though having established tools for evaluation enabled better use of data. The Council for Disabled Children and their evaluator assumed that comparable data on the assessment of disabled children would be available across the 5 local authorities but it was not so.

Not only did different recording systems create a barrier, but different local assessment and decision-making systems limited comparability. In Sefton's *Community Adolescent Service*, ambitious plans to integrate data from a variety of services foundered when it became clear that they lacked practical commitment to this. Additional data gathering proved burdensome for staff and for young people and families entering the service in some projects (e.g. Calderdale *Right Home*, Sefton and Gloucestershire), and some of the planned data collection was abandoned.

As noted in Thematic Reports 1 on social work and 5 on informing better decisions, in some project evaluations, effective use of data was a facilitator. Increased identification rates were reported to reflect better use of data, for example, in the MOPAC evaluation. Here, an increase in the recorded numbers of cases referred to the FGM clinics and safeguarding services, was assumed to partly reflect improvements in identification. In Newcastle, improved use of data enabled the creation of an evidence base and this was increasingly used by staff. Where there was either an existing data-sharing agreement or a specific appointment was made to act as the central data processing hub (e.g. North Yorkshire County Council's *No Wrong Door*, Family Drug and Alcohol Court (FDAC), Barnardos), the resulting rich data set was very helpful in demonstrating impact. Where 'embedded researchers' were part of the project staff (and, in most cases, evaluation teams), the collection and use of data was usually enhanced.

Embedded and practitioner researchers

Eight projects had 'embedded or practitioner researchers'; 5 of these were social work systems change innovations – Durham *Families First*, Stockport, Islington, Newcastle and MLA; 2 were adolescent service change projects – NYCC and Enfield. The other one was Norfolk and Suffolk's *Compass*, a mental health project.

These roles were of two kinds. The first were research-experienced practitioners, referred to as 'practitioner researchers', usually seconded from within the social work service (e.g. Newcastle, Durham), though in Norfolk and Suffolk's *Compass* outreach service, the researcher was appointed by the Trust. Part of their role was allocated to

collecting data within the service and regularly feeding back findings in order to better inform decisions. The second type of embedded researcher was seconded into the service from a university or the evaluation team itself (e.g. NYCC, Enfield, Islington, MLA), in order to undertake a similar role. Stockport had both.

The key question is whether these embedded researchers improved the capability of the evaluation to capture and report on outcomes, and developed the capacity of the local authority or organisation to collect better data in future. Their effectiveness was reported to vary significantly with strong claims made in some of the evaluation reports about their contribution (Stockport, Islington, NYCC and Norfolk and Suffolk). In Islington, they captured social work practice improvement and advised the local authority how best to mainstream aspects of their data collection. In several projects, but particularly Stockport, they provided more immediate access to young people, families, schools and social workers as they were trusted and could establish a climate of openness. In some cases, their role provided immediate and ongoing feedback which led to a 'design by doing' process in the service.

Where they were less effective, this was due to lack of research expertise or status of some of the practitioner researchers, being pulled back into their practice teams due to caseload pressures and university researchers having insufficient understanding of the detailed practice needs. In some projects, there was a single researcher embedded in each authority which proved too challenging as it allowed no back-up in the event of illness and assumes a research-ready environment, which was not always the case. Embedded researchers are a potential way to address the research-practice gap but also require significant resources which even in some projects in which they were successful, was not available to sustain them beyond the life of the innovation project. In Newcastle, they have been made permanent appointments. The roles and contribution to outcomes of embedded and practitioner researchers are also discussed in the final report of the evaluation and Thematic Report 5.

What have we learned about other conditions that act as barriers to innovation projects making progress in implementation and outcomes?

Turnover of staff

Many projects experienced high turnover of staff, in particular senior managers and social workers, which limited continuity and consistency and inhibited their progress. Reduced turnover of social workers was achieved in 3 projects though in 2 of these, only in part of the project. In NE Lincolnshire's *Creating Stronger Communities,* turnover fell from 11.9% to 7.4%. In Hampshire's *Social Care Innovations,* the

vacancy rate and use of agency workers reduced when personal assistants were introduced for social workers. One borough in Triborough's *Focus on Practice* reported that the turnover rate halved from 21.7% to 10.6%, but it increased in a second borough and remained static in the third one. In all 3 boroughs, social worker absence rates reduced which was attributed to changing the organisational climate which Glisson reminds us impacts on motivation and well-being of employers. In the Match project on supporting long-term foster care placements, in which the role of the supervising social worker was merged with most of the functions of the local authority (or child's) social worker, turnover decreased and job satisfaction increased but numbers were too small to draw robust conclusions.

For many of the projects in which social work reform was not the main focus, such as those on FGM, fostering or adoption, the capacity to innovate sometimes depended on the effectiveness of the social work practice system. High social worker turnover further reduced this capacity in some projects, partly reflecting Glisson's principle of the need for a relationship-centred, organisational climate to support innovation.

Time requirements of recruitment and changes to regulatory or legal framework

Recruitment of staff and negotiation with partners led to unanticipated delays, in particular when any deregulation or new commissioning models were involved. West Sussex, NLCEP, Safe Families, Match, Cambridgeshire, CDC, Catch22, Barnardos, Hackney FLIP, and Achieving for Children (AfC) all involved new commissioning or delivery models, or de-regulation of existing services. Action for Children's evaluation commented on the lack of flexibility needed for the proposed procurement arrangements.

For example, in Safe Families, Barnardos and Match, initial concerns about changes to statutory functions including aversion to possible risks, led to the withdrawal or reticence of a few local authorities, which in turn delayed implementation, resulting in much smaller than anticipated samples, and limited capacity for comparisons. In Stoke's *House Project* (HP), lengthy and complex processes were necessary to create a robust legal framework for establishing the HP as a company, negotiating contracts for leasing properties and creating governance structures and tenancy agreements. Similarly, Cambridgeshire's intention to create a mutual was only achieved at the end of the extension period because elected member support took much longer to mobilise than expected. Priory, Surrey and St Christopher's experienced delays in Ofsted registration and Surrey, NIS RESuLT and TBAP experienced delays in building adaptations. Hackney encountered significant local planning opposition when seeking to develop a residential provision and the project proceeded with a different model than that proposed initially. TBAP also modified its

intervention to fit around available accommodation which was gradually changed to come closer to the original plan.

Referral pathways

Innovation projects had defined the target numbers for their intended population. The referral pathways in many projects failed to result in these numbers being recruited. This partly reflected the short timescale of Wave 1, slowness of the referral process in some services and lack of accurate intelligence about the numbers that might benefit. Additionally, unanticipated barriers to recruitment included challenges of recruiting hard to reach groups for example, women who have experienced FGM or domestic abuse (e.g. Barnardos, MOPAC, Pause, Doncaster), or specialist foster carers (e.g. Norfolk and Suffolk, Sheffield) or education professionals (Achieving for Children). Recruitment of out-of-hours nursing staff (Surrey) and residential staff (St Christopher's) was also challenging and the demands and stress associated with that work also had implications for the training and supervision needed (Wigan and Rochdale). NIS MST-PSB was challenged by the lack of a developed system for identifying young people with problematic sexual behaviour.

Most projects ran with lower numbers than intended, many with significantly lower numbers which is likely to lead to higher unit costs, in addition to limiting the capacity of the evaluation to demonstrate outcomes. Furthermore, changes in the care status of young people led to attrition in some projects, which additionally lowered target populations. Having a referral pathway through the emergency duty team delayed referrals in Surrey, which led to low numbers. Action for Children experienced insufficient demand. Some projects managed to address referral issues. For example, NIS MST-PSB was delayed by the processing in the criminal justice system but their therapists trained social workers in understanding what the intervention offered, which led to better recruitment of young people.

Referral criteria and intended populations

The programme management questioned whether projects were really engaging with the intended populations (e.g. those who would have entered care, those who would have been admitted to hospital). Some projects did not get the referrals they wanted. For example, Aycliffe did not achieve sufficient local referrals so instead took young people from far away which made it impossible to provide the follow up support central to the model. In Calderdale's *Right Home* project, some of the young people referred had higher levels of need than those targeted, partly because the initial use of the service was for crisis placements. Aycliffe similarly had some young women who were a greater challenge than anticipated (as did Priory and the House project). These differences between the needs of the intended populations and those young

people actually referred, led to lack of suitable longer term placements after transition from the project (e.g. in Aycliffe, Priory, Calderdale).

In NIS MST-PSB, the parents were in denial about the young people's behaviour which led to lower numbers being recruited and less engagement once they started on the programme. St Christopher's experienced problems with the accuracy of referral information. TBAP selected participants likely to work well together rather than adopting the stricter edge of care criteria initially intended, and failed to recruit families of young people, perhaps because there was insufficient social worker involvement. Lack of local clarity in the role of the new intervention teams in Sefton led to referral of cases that were too challenging for the teams and a refining of the criteria for involvement towards Early Help.

Issues related specifically to use of the referral criteria in projects focused on adolescents are addressed in Thematic Report 2 *Adolescent service change and the edge of care.*

The role of competing pressures

Sustaining innovations in the longer term requires the continuity of commitment in ever-changing contexts. Events such as local council elections, an Ofsted inspection or a high-profile child abuse case triggered massive pressures that threatened the continuity of projects. NLCEP experienced some changes in borough representation which led to delays, previous decisions being revisited and changes in priorities. In one local authority, the Ofsted inspection confirmed that the IP project was a distraction from the priority of 'providing good quality frontline services' and that they did not have the capacity to implement it. A national policy change shortly after the projects began, introduced the regional adoption services which impacted on Cornerstone and Coram's project implementation. Building in sufficient flexibility (e.g. through identifying a second-in-command) enabled some projects to 'ride' these occurrences.

Would improvements have happened without the Innovation Programme?

A key challenge is to consider how far the implementation achieved might have occurred without the Innovation Programme. The impact of budget cuts and austerity measures suggest that most of these innovations would not have happened without the major investment provided by the Innovation Programme (the Action for Children evaluation makes this point).

Where used, counterfactuals help here in linking improvements in outcomes back to the specific projects. Many projects who planned to use them did not do so, due to

difficulties of getting agreement from LAs to act as a 'control'. Where no such 'control' data were available, views differed on what would have happened without the project. For example, in Daybreak's *Family Group Conferencing* project, proceedings were initiated in 29% of cases in which a conference had been held compared to 50% of cases where no conference was convened. Such comparisons provide a more compelling case for future implementation of the innovation.

Sustainability of innovations requires embedding the changes in practices and supporting structures into the whole service at local authority and national level. As the Spring Consortium note in their Innovation Insights Board 5: *Creating the conditions for innovation in children's social care*:

> "Creating new services and practices in isolated pockets will not deliver the step-change required of children's social care system to deliver dramatically different, better outcomes for children and families. For the best new approaches to be embedded, sustained and scaled, we must also change the local and national system conditions that enable, and constrain, innovation."

It is heartening that many of the Wave 2 projects are seeking to scale and spread the innovations for which encouraging outcomes emerged in the Wave 1 evaluations. For example, City of Bradford's Wave 2 project is implementing the learning from NYCC's *No Wrong Door*, The Fostering Network's *Mockingbird* and MTM's *Signs of Safety*. Fostering Network are extending *Mockingbird* to 5 further providers and Stoke's *House project*, now led by Warwickshire County Council is being scaled up in 5 further local authorities. Hertfordshire are scaling and spreading their *Family Safeguarding* model to 4 other local authorities and Coventry City Council are implementing Catch 22/East Cheshire County Council's *Project Crewe* for targeted support to children in need. Frontline, Barnardo's and MTM are all continuing and extending their Wave 1 innovations. These developments, through embedding and scaling up innovations taking into account earlier learning, should contribute to changing the local, regional and national conditions needed to achieve the step-change required in children's social care.

Conclusions and Recommendations

The Innovation Programme was itself an important part of the context in providing the funding and support. Without it, many of the projects would not have taken place. The evaluations provide rich and varied evidence of the ways in which systemic conditions support or inhibit innovation for positive change in children's social care.

The evaluations in Wave 1 suggest that innovations are supported by:

- clear objectives which have been agreed across the service thereby establishing a strong commitment to the project

- strong leaders who create the capacity to innovate
- relationship-centred ways of working which usually involve a high proportion of time on direct contact with families and/or young people
- multi-professional work which give staff the opportunity to learn from, and support colleagues
- using the existing evidence base and ongoing data collection and analysis to inform decisions

Recommendations for future innovation and practice include:

- Use the evidence base for children's social care generated by Innovation Programme Wave 1 evaluations in planning future innovations
- Assess whether there is sufficient capacity in the service to support innovation – is innovation the best way to achieve the priorities for change identified?
- Establish strong, consistent senior leadership, communicating a clear vision in order to create conditions conducive to effective innovation
- Undertake wide-scale stakeholder engagement early in the innovation in order to clarify aims and secure the commitment of those in the wider services beyond the staff involved in the specific innovation project to avoid a 'them and us' culture developing
- Define the target population clearly and ensure that information about the benefits of engagement in the project are clearly articulated to them and to staff involved in the referral pathways
- Consider recruitment strategies early for those young people and families targeted and aim for higher numbers than needed in the innovation
- Anticipate 6-12 months minimum lead-in for innovations requiring significant restructuring, new models of commissioning or delivery and de-regulation
- Build in time and flexibility to sustain and progress the project in the face of unpredictable pressures
- Develop effective multi-professional working; draw on the established models from Partners in Practice
- Establish from the outset what data are available, what new data are needed and for what purpose, and how greater consistency of data collection across local authorities and services might be achieved
- Identify comparative data (or preferably controlled trials) in order to be able to link improvements to the interventions. Local authorities and other providers should offer to act as one another's control group
- Consider embedded/practitioner researchers as a potential way to address the research-practice gap; however, if adopted, they will need significant resources with practitioners requiring support to develop the necessary skills and not be drawn back into the practice role.

Appendix 1 Audit of Service

Conditions which support innovation	What happens now in your service?	What needs to happen?	How will you progress this?
Use the evidence base generated by Wave 1 to clarify the needs and define the innovation			
Assess the capacity in the service to support innovation – is their sufficient stability to cope with the potential disruption of redesigned services?			
Establish strong, stable senior leadership who can communicate a clear vision			
Undertake wide-scale stakeholder engagement including families and young people to clarify aims and secure commitment			
Define the target population clearly and ensure that information about the benefits of engagement in the project are clearly articulated			

Conditions which support innovation	What happens now in your service?	What needs to happen?	How will you progress this?
Identify recruitment strategies (staff and families/young people) and target a higher number of participants than needed			
Develop effective multi-professional working drawing on the Partners in Practice experience			
Establish what data are available, what new data are needed and for what purpose, how consistency will be achieved and whether it needs to be shared across services			
Identify comparative data and consider whether to approach other providers to act as one another's control group			
Consider embedded/practitioner researchers as a potential way to address the research-practice gap			

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