Department for Education

Informing better decisions through use of data in children's social care

Children's Social Care Innovation Programme

Thematic Report 5

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Executive summary

This report addresses the emerging messages about informing better decision-making in children's social care from evaluation of the first phase, known as Wave 1, of the DfE's Children's Social Care Innovation Programme. The report focuses on the process of informing better decisions through the use of data collected on children, young people, families and those working with them such as social workers, foster carers and specialist workers. It draws on the findings that emerged from the evaluations of the 57 projects in Wave 1. A brief introduction to the Programme is given, before setting out the data that evaluation teams accessed in evaluating projects. The use of data in decision-making is discussed. The report concludes that the Innovation Programme has made an important contribution to building capacity for better use of data, but that further developments are needed to embed this throughout the system. Services are encouraged to self-audit using the tool provided in Appendix 1 and Appendix 2 provides 2 templates for a Theory of Change.

One conclusion noted is the lack of a common framework of indicators for measuring outcomes of children's social care services. The Key Performance Indicator dataset developed in Hertfordshire, covers data on police involvement, emergency hospital admissions, school attendance, substance misuse and mental health service use as well as children's social care indicators. This will be used in Wave 2 in the local authorities in which the Hertfordshire model is being rolled out, thus informing future developments and highlighting limitations. Progress on developing common measures is also taking place through the Nuffield Foundation funded work by La Valle et al.

Recommendations

- Services should use a Theory of Change at the start of innovations. This should set out what is intended to be achieved, intermediate outcomes that might be expected and how these will be assessed, and long-term outcomes and how these will be measured.
- DfE, Ofsted and ADCS should support the progress on the development of a set of common measures to evaluate the impact of services and interventions in children's social care. This should also take account of the work being undertaken by La Valle et al. creating an outcomes framework for children's social care services, and identifying the most appropriate indicators and measures that could be collected, noting Munro's concern that performance information should not be treated as an unambiguous measure of good or bad performance.

Introduction

This report addresses the emerging messages about informing better decision-making in children's social care from evaluation of the first phase, known as Wave 1, of the DfE's Children's Social Care Innovation Programme. In this report, the process of informing better decisions is assumed to involve the use of data collected on children, young people, families and those working with them such as social workers, foster carers and specialist workers. A brief introduction to the Programme is given, before setting out the data that evaluation teams accessed in evaluating Wave 1. The use of data in decision-making is then considered. The ways are then described, in which evaluation teams developed and supported capacity for the use of data for ongoing evaluation and decision-making in local authorities and other organisations that led the projects. Barriers and facilitators to using information in decision-making are then identified and recommendations made for the future. 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[1] projects and their evaluations. The evaluations were undertaken by 22 evaluation teams and the reports of these evaluations, together with their two-page summaries 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 Families*, Match's *Supporting long-term foster placements*) the delays to implementation and small group sizes limited the validity of any quantitative evaluation of impact, providing some information on 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] Elsewhere, Wave 1 of the Innovation Programme is referred to as 53 projects because the 5 National Implementation Service (NIS) projects are treated as one. As they are separate interventions individually evaluated, they are treated here as 5 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 these 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 data did evaluation teams access?

Data checklist

The Munro Review identified the role of high quality data in driving improvements in practice but noted the importance of not using this information in isolation to judge good or bad performance. Munro set out the minimum information requirements of central government and recommended data for use by local areas. At the beginning of Wave 1 of the Innovation Programme, the Evaluation Coordinator team had discussions with the evaluation teams about the potential use of common outcomes and measures across the range of disparate projects, and received very helpful comments that informed the development of a Data Checklist. Evaluation teams were asked to complete the Data Checklist at the start of the Programme for each project they were evaluating; the Checklist asked them to identify which outcomes would be assessed as part of the evaluation, and the specific measures that they would use to evaluate the outcome. This allowed us to identify opportunities for comparison across projects, to describe and evaluate the initiative as a whole, and to promote the pooling of expertise from across the evaluation teams.

A number of potential measures for each outcome was identified, some of which are already available in national datasets or potentially available in data held by the DfE (e.g. in the SSDA903 or Social Work Workforce Data); others were available in local authority information systems and many included in those set out in the Munro review. Some required the identification of existing standardised measures or the creation of bespoke measures for specific projects. It is acknowledged that it is not

always clear that increases or decreases on a particular measure are necessarily positive, e.g. if more young people are remaining at home rather than entering care, can the outcomes be assumed to be beneficial or might there be any negative effect on their well-being in the longer term, and what evidence is there of this? Teams were therefore asked to be prepared to assess unintended negative consequences that might occur as well as positive outcomes.

The (non-exhaustive) list of outcomes recorded on the Data Checklist is shown below, including definitions and examples of the measures as available in national data or those developed by evaluation teams where there are no relevant national data. The findings from this data collection are reported fully in the Final Report of the Evaluation of Wave 1. In this report, approaches taken to data collection and findings are presented with examples of how they were used to improve decision-making.

1. Reducing the number of children looked after

Definition: Reduction in size of the care population in the local authority (or area focused upon).

Example measure: Number of children looked after (available in SSDA903)

2. Increasing the number of children looked after who return home safely and in a timely manner

Definition: Increased proportion of those entering care who return to birth families in a timely manner and without adverse consequences.

Example measure: Children who cease to be looked after who return home to live with their parents or relatives - mean and range of length of time before return home (in days or months, available in SSDA903)

3. Reducing re-referrals

Definition: Children are less likely to be re-referred for services.

Example measure: Number and proportion of re-referrals (defined as children referred to children's social care within 12 months of a previous referral, available in CIN national data)

4. Reducing the number of children in residential care

Definition: Reduction in size of the residential care population in the area being studied.

Example measure: Proportion of children looked after who are in residential care (available in SSDA903 which defines this as secure units, residential homes and semi-independent living)

5. Increasing the use of local placements

Definition: Increased proportion of children looked after who are placed within the local authority's boundaries.

Example measure: Number and proportion of children in foster placements outside the council boundary (available in SSDA903)

6. Increasing placement/worker stability

Definition: Children are less likely to be moved between placements (whether the move is voluntary or involuntary) and between workers.

Example measure: Number of placements within the previous 12 months (available in SSDA903)

7. Reducing youth crime

Definition: Reduction in young people's involvement with the youth justice system as perpetrators and as victims, and reduced anti-social behaviour.

Example measure: Number and proportion of arrests for young people over a given period (available from local data)

8. Reducing gang affiliation

Definition: Reduction in young people's involvement with gangs.

Example measure: Self-reported gang involvement (collected through questionnaires/interviews)

9. Reducing homelessness

Definition: Reduction in young people classed as homeless.

Example measure: Number and proportion of young people who are classed as homeless over a given period (available from local data)

10. Reducing number missing

Definition: Reduction in young people classed as missing (defined as not at their placement or the place they are expected to be (for example school) and their whereabouts is not known).

Example measure: Number and proportion of young people who are classed as missing from placement or home (available in SSDA903 and for those not in care, local data)

11. Reducing crisis presentations

Definition: Reduction in presentations to health and social care services that are classed as 'crisis presentations'.

Example measure: Number of presentations at Accident and Emergency Departments of hospitals (available in national health statistics)

12. Reducing CSE

Definition: Reduction in reported (and unreported) cases of child sexual exploitation.

Example measure: Self-reported CSE

Note: In addition to/instead of incidence levels, some projects also used measures of young people's attitudes to sex and relationships, e.g. Sara Scott's TASAR self-report questionnaire

13. Increasing number of young people/families in education, employment and training (EET)

Definition: Increase in number of those in EET.

Example measure: Number/proportion of unauthorised school absences (under-17s) or Number, proportion of young people (within a specified age group and over a given time) who are in EET (over-17s) (available in the National Pupil Dataset for under 17s and SSDA903 for care leavers)

14. Reducing social work caseloads

Definition: Reduction in caseload size for social workers.

Example measure: Average number of cases per FTE social worker (available from national Children's Social Work Workforce Survey)

15. Saving money

Definition: Reduction in spend per young person and any associated spend on alternative provision (e.g. increased family outreach work as an alternative to care placements) does not outweigh the savings made. The reduced costs by (for example) keeping children local and reduction in very high cost of externally purchased placements, and/or by increasing placement stability, reduces costs.

Example measure: Cost-benefit analysis using data provided by the local authority

16. Improving young people's and families' resilience

Definition: Resilience is defined in many ways in the literature (for example, see Ungar's work in this area).

Example measure: Child and Youth Resilience Measure (CYRM)

17. Improving young people's mental and emotional health

Definition: To some extent this overlaps with definitions of resilience and sense of control, but could also include prevalence of mental health issues or clinical disorders, and use of CAMHS services.

Example measure: Referrals to and use of CAMHS (data available from local authority), Strengths and Difficulties Questionnaire (SDQ)

18. Improving young people's physical health

Definition: Young people will be more physically healthy, more likely to access health services and less likely to be involved in behaviours that risk their health.

Example measure: Self-completion mental health questionnaire - General Health Questionnaire

19. Providing adolescents with complex needs with a secure stable base

Definition: Adolescents' placements offer "a reliable base from which to explore and a safe haven for reassurance when there are difficulties" (Schofield and Beek's definition in the Secure Base Model).

Example measures: Qualitative assessments using the Secure Base model

20. Improving the quality of relationships between young people and parents/carers/social workers

Definition: Improvements in relationships measured through self-reporting/ scaling questions. (To include the ability to voice concerns and be listened to, to feel supported, to have concrete assistance.)

Example measure: Self-reports from both parties, e.g. on satisfaction, such as Pianta's Child-Parent Relationship Scale

21. Improving the quality of relationships between young people and their peers

Definition: Young people will have one or more 'good quality' friendships with peers.

Example measure: Self-reports, for example using the Harter Self-Perception Profile or Friendship Quality Questionnaire

22. Improving recruitment/retention of the workforce

Definition: Ability to recruit greater numbers of staff and foster carers, and to retain them (by reducing turnover).

Example measure: Vacancy rate of social workers (available from national Children's Social Work Workforce Survey)

23. Improving job satisfaction of the workforce

Definition: Staff/carers feel more satisfied in their role.

Example measure: Satisfaction ratings from workforce surveys (available from some local authority surveys)

24. Improving staff knowledge, attitudes and self-efficacy

Definition: Carers/staff receiving training show increased knowledge on related issues, more positive attitudes and greater self-efficacy in their role.

Example measure: Customised survey relating to specific training content (available from some local authority surveys)

How the data checklist was used

All evaluation teams were asked to complete the Data Checklist for each project at the beginning of Wave 1, which gave an indication of where common outcomes and

measures being assessed across the Programme. The Evaluation Coordinator team revisited the Data Checklist at the end of Wave 1, to show the outcomes, measures, and findings as published in the final evaluation report. This enabled us to explore:

a) the value added of the Programme through multiple evaluations using the same measures;
b) how similar outcomes can be conceptualised and measured differently; and
c) how some evaluations faced challenges that meant they were unable to collect all of the planned data – this is further discussed in the section on barriers and facilitators below.

How was data used in assessing cost benefit?

Two main methods were used in estimates of cost benefit: comparison of costs of the intervention with costs avoided and/or 'business as usual' and Fiscal Return in Investment (FROI).

Use of comparative data on costs avoided

Sixteen evaluations took the first approach, comparing the costs of the intervention with costs avoided (such as costs of a young person entering care) and costs of the existing service. There are several models of this type of cost benefit analysis used in public services: The New Economy Model used in the Greater Manchester Combined Authority has been applied to health, social care and criminal justice services; University of Loughborough's Cost Calculator has been used to calculate the cost benefit of children's services in many local authorities and the Troubled Families Cost Savings Calculator published by the Department of Communities and Local Government has similarly been used by many local authorities. In all these models, the data on costs include units of cost such as staffing, training (sessions and materials), investment in buildings where relevant, travel and accommodation/respite. Costs avoided included services such as length of stay in the care system, police, probation, education of young people excluded from school, legal costs of care/court proceedings, those needed to address domestic violence, alcohol or substance abuse, foster care, residential care (including secure units) and hospitalisation.

Leeds *Family Valued*, Daybreak and N.E. Lincolnshire evaluations all reported savings from Family Group Conferencing using comparisons to families not offered the conferencing and historical data, though each used slightly different data and NE Lincolnshire's evaluation used a FROI approach. Leeds reported savings of £280 per family and Daybreak noted £66 saving per child. While this data is encouraging, they illustrate the need for greater consistency in use of measures and methodology for calculating cost benefit across evaluations so that more meaningful conclusions can be drawn.

Most evaluations noted that some estimates of costs had been used since the projects had not been running long enough to provide accurate average costs per annum. For example, the evaluation of *Pause* reported estimated net cost savings per year after the 18-month intervention period but further potential cost savings from reductions in levels of domestic violence, harmful alcohol use, and Class A drug use needed a longer timeframe so that actual data could be used.

Fiscal return on investment

Seven evaluations provided fiscal return on investment figures, all positive and ranging from £1.84 saved for every pound invested (Enfield, see case study below) to £6.80 saved for every pound invested (N.E. Lincolnshire). Cost benefit analysis using a Fiscal Return on Investment methodology involves calculating the cost of the innovation and setting it against the observed benefits (adverse outcomes avoided, such as becoming LAC). Benefits are then divided by cost to show the return on investment. The costs take account of the level and duration of involvement required to, for example, supporting the family to an agreed outcome. Time spent supporting families is then estimated using a combination of management information for core children's social care costs and the average resource input based on figures provided by the projects. This includes direct work with the family, as well as indirect support (for example, liaising with other services).

The evaluation of Hampshire and the Isle of Wight's Social Care Innovations provides an example of this methodology. In the strand of work that involved the use of Personal Assistants (PA) to support social workers, the evaluation report notes that the annual unit cost including overheads of a PA during the pilot period in Hampshire was £30,456. 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 (average 3 social workers supported by each PA).

Case study of Enfield's Annual Fiscal Return on Investment (FROI)

The cost-benefit analysis of Enfield's *Family and Adolescent Support Service (FASH)* involved estimating the costs of support provided to a young person and their family, and the application of financial proxies to outcomes achieved as a result of the support. The cost-benefit model calculated the return on investment of the support provided. Potential savings were calculated by undertaking a cost comparison using an historical group of 20 young people who had been in social care and had similar profiles to edge of care cases (thereby meeting the FASH criteria) and a cost benefit study analysing the potential return on investment of the whole service. Costs and benefits have been calculated using information collected on the Enfield social care Management Information System (MIS). This includes the

duration and intensity of support (children in need, child protection and looked after children) and outcomes achieved as a result of the support.

The total cost of FASH support across the 121 cases was £251k, an average of £2,075 per case. This includes a combination of FASH housing cases that, typically, incurred low support costs, and more intensive support for families with multiple needs. The average benefit for closed FASH cases was £6,218, with total benefits reported at over £750k. Benefits related mainly to the case worker suggesting that the young person avoided entering care or suitable housing was found, thus reducing the need for expensive foster care placements.

The evaluation team projected the return on investment for the whole FASH service. This was calculated by combining the projected total spend to deliver FASH, with the average benefits associated with each team, multiplied by their annual throughput of cases. The 121 cases were statistically representative of the total annual throughput (246) of cases, with a confidence level of 88%. Running costs for FASH were based on projected expenditure of DfE and Enfield funding over the course of the Innovation Programme of £2,309,206 over 3 years, making an annual cost of £769,735.

The return on investment at a whole service level is 1.84: for every £1 invested in FASH there is a return of £1.84. The FROI for the observed cases was 3.0. The difference between the observed and annual FROIs can be explained by overhead costs. This fall is in line with high-level overheads associated with a project of this nature.

Despite the apparent cost savings, Enfield had to make funding cuts which weakened the longer-term stability of the project. They also had to re-direct resources to new demands thus demonstrating that while data is necessary to inform improvement through innovation, they are not sufficient to guarantee sustainability.

This case study has been edited from The Final Evaluation Report of the Enfield FASH project completed by York Consulting.

Use of data to improve decision-making

The local authorities and other organisations leading projects were highly variable in their existing use of data, some having more data expertise and others making insufficient use of data. Increased identification rates were reported to reflect better use of data, for example, in the Mayor's Office for Policing and Crime (MOPAC)'s *Female Genital Mutilation (FGM) Early Intervention Model* 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.

Where there was either an existing data-sharing agreement or a specific person was appointed to act as the central data processing hub (e.g. NYCC's *No Wrong Door*, Barnardo's *National FGM Centre*), the resulting rich dataset was helpful in contributing to the demonstration of impact.

Accessing information on how projects used the data in their decision-making was challenging. While evaluation teams attempted to track decisions in their projects, most decisions will have been made outside the meetings with evaluators and might not be seen as relevant to report back to the evaluation team. Some of the reports specifically noted the value that project teams had placed on the evaluation process. For example, a partner agency in Wigan and Rochdale's *Achieving Change Together* (*ACT*) noted that having an embedded evaluator had helped keep the project on track through the better use of data and contributed insight and ideas into the project. Elsewhere, the decision to collect cost-savings data for the *Compass* Service had arisen as a result of the cost-benefit analysis.

In Ealing's *Brighter Futures*, the evaluation team completed Social Network Analysis (SNA) to explore, map and assess the working relationships and links between professionals, the young person and family/carers, in a small number of *Brighter Futures* cases (Innovation model) and to compare these with cases held by locality and looked after children teams (traditional model). In the SNA *Brighter Future* cases, it was clear from the data, that the lead professionals had received input from a higher number of other professionals than their counterparts in locality teams. Overall, the SNA maps and data from interviews and focus groups showed that the lead workers in the *Brighter Futures* teams had drawn upon a far wider range of multi-disciplinary expertise to inform their direct work. This, in turn, was perceived by workers to have supported positive changes. The LA used this data to help inform decisions about team configurations and case management responsibility to identify the 'essential ingredients' of the model moving forward.

In *Pause*, at the Project's request, the evaluation team used data to establish learning logs for front line workers, analysed the data arising from these and provided workshops to reflect and improve their practice. These uses of data were then embedded in the project.

Case Study: Newcastle's Family Insights - Information-sharing and better use of management information

Data Analysts

In Newcastle's *Family Insights*, strengthening analytics was a key focus of their Innovation Project. Two Unit Analysts were employed to provide specific data analysis expertise, informing both strategic and operational staff and work with

families. Initially, a lack of clarity around their role limited their direct work with practitioners, but subsequently they provided insights on effective systemic practice and segment-specific practices. They have also helped practitioners to recognise data as a tool and an asset. The analysts provided evidence and insights that potentially improved service quality for families, including for example, targeted case file analysis and new training in parenting that was developed together with the NHS and a mental health specialist. There was evidence that this is increasing satisfaction of families and resulting in fewer complaints. They have also supported social workers to work more effectively with schools. However, there was some evidence from the evaluation that their work was seen by practitioners as being too diverted into performance management.

Increasing practitioner use of data

ChildStat, a monthly performance focused meeting was introduced for case reviews, performance metrics of different teams, and in-depth case analysis. Overall, ChildStat meetings were well received and supported the intended culture change by encouraging the use of data to underpin best social work practices.

Alongside ChildStat, the introduction of caseload management dashboards provided data to practitioners to facilitate and support better case handling, time management and recording. This was seen to be supportive of effective performance management and accountability, subject to data being accurate. The preparation required for the meetings to be effective was reported to be intensive and demanding with a significant time commitment from senior staff.

The evaluation noted that both the analysts and managers felt the caseload management dashboards demystified performance for social workers. They were used to structure discussions and review performance in line management and practitioners used them to review caseloads, manage workload and prioritise tasks. Social workers understood that if data was not recorded in the system then the dashboard became a less useful resource for them and hence it improved data quality and timeliness.

Development of a data warehouse

The data warehouse brought together information on families from multiple sources including the case management system, Capita (education placement, attendance and attainment data) and eCAF (common assessment framework). The evaluation reported that it was seen as offering the potential for exploring trends, for example, reviewing 300 single assessments across 15 schools, though it was too early to assess its impact. The evaluation team noted that the poorer quality of datasets outside children's social care presents a challenge for the evidence collated in the data warehouse.

This case study has been edited from The Final Evaluation Report of the Newcastle *Family Insights* project completed by Kantar.

In N.E. Lincolnshire's *Creating Strong Communities*, there are 4 strands including Signs of Safety (SoS), Restorative Practice (RP), Outcome Based Accountability (OBA) and Family Group Conferencing (FGC). The evaluation team established feedback loops within each strand, to share and discuss emerging data and findings with practitioners and leaders. This included the cost benefit analysis given the invest-to-save emphasis of the programme activity. On the basis of this data, the decision was made to roll out RP and SoS across the LA, informed by the evaluation team's reporting that social workers have shown improved satisfaction and dropout rates were halved in the areas in which they were introduced. Furthermore, the initial cost benefit analysis of FGC showed a net cost saving with increased investment. These findings were presented to the LA's Scrutiny Committee and senior management team who decided to extend the technique more widely across the authority.

In Triborough's *Focus on Practice*, the evaluation team supported the LAs to undertake further work on the data on domestic violence with clinicians/senior social workers to inform practice guidelines on working with domestic violence from a Focus on Practice perspective. The evaluators attended several programme board meetings and reported data from the evaluation, which enabled the FOP team to adapt the project, for example, making changes in the use of recording methods on which they had received some negative feedback.

In Hampshire and the Isle of Wight, the LA reported that the evaluation had been integrated into their on-going project work. Baseline case analysis and staff interviews provided senior managers with data against which the pilots were measured but also raised the profile of the project. The data, including the cost benefit analysis, gave greater credibility to the programme and was the basis for decision-making going forward. The evaluation of the use of Personal Assistants (PA) for social workers made recommendations of ways in which the cost effectiveness could be strengthened (e.g. retaining more PA staff; improved guidance for PAs and social workers on the role to achieve better consistency), and these are being addressed.

How did evaluation teams develop and support capacity and sustainability for longer term evaluation?

There was an expectation that evaluation teams would provide projects with the tools to continue to evaluate their innovations after the Wave 1 evaluation was complete. Many of the evaluation teams did so, in particular but not exclusively, those evaluating the 46 projects that continued after the end of the Wave 1 Programme. For example, the evaluation team for Leeds' *Family Valued* worked in partnership with the relevant senior staff in the local authority (i.e. performance and information managers) to ensure that ongoing evaluation could monitor changes including cost benefit analysis, subsequent to the Wave 1 evaluation being completed. A framework for evaluation was developed and use of data from statistical neighbours were incorporated, in order to provide a robust comparison to the data from Leeds.

Some evaluation teams developed monitoring and evaluation tools with the local authorities and agencies and front-line workers (e.g. National Implementation Service's (NIS) *AdOpt*, Hackney's *FLIP*, Ealing's *Brighter Futures*, Daybreak's *Family Group Conferencing,* Match's *Supporting long-term foster placements*, Munro, Turnell and Murphy (MTM)'s *Signs of Safety*, Hampshire's *Social Care Innovations*, Royal Borough of Windsor and Maidenhead (RBWM)'s *Culturally-attuned Family Support*, and N.E. Lincolnshire's *Creating Strong Communities*). The evaluation team for NIS *AdOpt* has trained the project team in the use of the databases and coding methods used in the evaluation. The evaluation team for *Pause* developed an assessment and monitoring tool which was co-produced with key workers during 2 workshops. The team evaluating MTM has worked with a senior practitioner and social workers in 2 of the 10 authorities to develop, refine and pilot the case record tool and diary instrument which will be fed back to all 10 local authorities.

Where the same evaluation team worked with more than one project which had a similar focus, this capacity-building was particularly helpful as it provided an investment in a wider evidence base. NatCen and University of Bedfordshire's Child Sexual Exploitation Centre evaluated all 4 CSE projects. They worked with Sheffield's *SYEP* team on the evaluation tools to maximize future evaluation capacity and similarly did this with St Christopher's *Safe Steps*, noting that staff were open to learning and development thus supporting capacity-building for further evaluation.

The *Firstline* team and their evaluators discussed the nature and future availability of impact or outcome indicators. Distinctions were made between capturing organisational and workforce related outcomes, and those in relation to the children and families that are served by the social care system. The evaluators

recommended a more sensitive scoring system for the Capability Framework during the selection process, to try to better reflect the quality and detail of the assessors' decision-making. For internal monitoring of programmes, the *Firstline* team included a member with skills and expertise in data management, both to collate new data and carry out secondary analysis of existing national and local datasets

The University of York evaluation team set up local systems in Stoke and Calderdale for recording referral routes and basic characteristics in order to monitor whether services are working with the intended client group. This included co-designing a system from scratch in one service, emphasising the importance of using a monitoring framework that can help the service to identify who their service users are, what is happening to them during and post intervention (including dropouts) and how to use soft as well as hard measures to demonstrate impact. They also trained staff on the use of a measure of subjective wellbeing and independent living skills which contributed to the LA's decision to gather their own case study examples of families' experiences to take to sustainability meetings to demonstrate impact.

What has been learned about the facilitators and barriers in the use of evidence in decision making?

As many of the factors which facilitate use of evidence in decision-making are the converse of those that are barriers to it, these two are taken here together. A summary of the main facilitators and barriers is given in Table 1 below.

Table 1: Summary of facilitators and barriers in using evidence in decision-making

Facilitator	Barrier
Use of previous evidence	Lack of robust previous evidence
Using commonly defined outcomes and measures	Variations in definitions of outcomes and measures
Data addressing main focus of project easily accessed e.g. reducing entries to care	Lack of data, or lack of accuracy of data on main focus of project e.g. domestic abuse
Established data sharing agreements between services within an authority or across authorities	Legal, ethical or workload concerns about data sharing
Data collection plans agreed from outset and implemented as planned	Obstacles to data collection including changes to project activities, short timeframe, samples smaller than intended, lack of comparative data
Use of embedded researchers to collect data, feedback findings, inform practice development	Embedded practitioner researchers pulled back into service delivery due to pressures, external

	researchers insufficient grasp of practice needs

Use of previous evidence to inform the innovation

The evaluators of 7 projects produced a review at the outset of the existing evidence, in order to provide an evidence base for the innovation. 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. The literature and evidence reviews provide a helpful evidence base relating to key areas of children's social care.

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, a particular challenge for these projects being lack of consistency across service providers.

Differences in definition and measurement of outcomes

There was no core set of outcomes or measures that was used across all 57 project evaluations. The outcomes to be measured were determined by the theories of change that were developed in the initial stages of Wave 1, and given the broad range of project work being undertaken (from whole-service reform, to interventions targeting just a handful of young people), variation in expected outcomes was unsurprising. The Data Checklist partially addressed this but significant variations remained.

Even where different evaluations indicated that they had measured the same outcome, the way in which this was defined and measured varied considerably across projects. As an example, 'reducing the number of children looked after' was defined as 'reduction in size of the care population in the local authority', but in some cases the outcome being targeted was a reduction in the number of children entering care, whereas in others it was a reduction in the overall numbers living in care. This reflected a difference in focus across the projects measuring this outcome: for some, the aim was to prevent cases escalating to the point where children would enter care; for others, there was a different (or additional) focus on increasing family reunifications for children already living in care.

The differences in focus were compounded further by variations in the measures used to assess an outcome. Using the same example, whereas some evaluations (e.g. *Better by Design*) recorded the raw numbers of children entering care, others (e.g. *Family Valued*) recorded both the number of looked after children and the rate per 10,000 children in the local authority. Moreover, the comparison periods used as

baseline and follow-up time points in each evaluation differed: some evaluations (e.g. *Compass*) covered only the immediate period pre- and post-intervention, others (e.g. NIS *MST-PSB*) included follow-ups of up to 20 months, and others (e.g. *Creating Strong Communities*) had up to 3 years of data available for the period before the intervention. Overall, this meant that programme-level analysis of outcomes data such as meta-analytic techniques were not possible. Instead, the Evaluation Coordinator team was limited to producing a summary table of measures and findings (see Final Report), which does, however, provide an indication of the level of 'positive change' across projects in the programme.

Availability of data

The availability of data is further discussed in the Final evaluation report of Wave 1 and in Thematic Report 4 on *Systemic Conditions for Innovation in Children's Social Care*. 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 4 CSE projects (Sheffield, Aycliffe, St Christopher's, and Wigan and Rochdale) noted the lack of relevant available data. The *Pause* and Doncaster 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 2 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 NYCC's *No Wrong Door*, the central support team contributed data to the Risk Analysis Intervention Solution and Evaluation (RAISE) process. The RAISE process was introduced to facilitate the sharing of intelligence and information between all partner agencies, all of whom have ownership and shared accountability. The RAISE process was not operationalised until 12 months into the implementation of the model, as a result of the various protocols that needed to be in place to allow young person specific data to be shared between agencies. To date, the RAISE process has supported the *No Wrong Door* model to safeguard the young people, particularly in relation to risks within the community in which they live, by the sharing of real time intelligence.

In West Sussex's *Developing a Regional Purchasing System*, 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.

Not only did different recording systems create a barrier, but different local assessment and decision-making systems limited comparability. In one local authority, ambitious plans to integrate data from a variety of services foundered when it became clear that some of the services involved lacked practical commitment to this.

Data collection challenges

Only 3 of the 57 projects had published evaluation reports that included all of the outcomes that they originally planned to measure, as indicated on the initial Data Checklist. In the majority of cases, 2 or more of the outcomes that were part of the initial evaluation plan were not included in the published report. In many cases, the short timeframe available to monitor outcomes once the project was up and running meant that greater focus was put on short- and mid-term outcomes than on longer-term outcomes (e.g. *Family Insights*, Gloucestershire, Hampshire's *Social Care Innovations*, *House Project*, Match's *Support for long-term Foster Care*, *Mockingbird Family Model*, Stockport's *Family Evaluation*, *Triborough Academy Residence Evaluation*).

Changes to project activities also meant that planned outcomes changed (e.g. *Family Learning Intervention Programme* [FLIP], *Firstline*). Some project activities coincided with Ofsted inspections, meaning that attention was diverted away from providing data for the evaluation (e.g. *Brighter Futures*, *Focus on Practice*, *Social Work Innovation Fund Torbay* [SWIFT]). A number of projects dealt with smaller numbers of families and young people than originally anticipated, limiting the available data (e.g. Priory's *Belhaven*, Achieving for Children's *Better by Design*, Match, NIS *MST-FIT*, *Safe Families*, *SYEP*).

Evaluations that relied on collecting existing data from local authorities and partner agencies suffered when case management systems were not set up or relevant data was not available (e.g. *Better by Design*, CDC's *Assessments for Disabled Children*, Gloucestershire's *CAS*, NIS *MST-FIT*), or when data was not accessible (e.g. CDC's *Assessments for Disabled Children*, *CAS*). Some comparison local authorities declined to participate, or provided incomplete data (e.g. Daybreak's *Family Group Conferencing*, *Family Valued*).

Outcome data was limited in some evaluations following negotiations with practitioners collecting information at the point of referral or as part of routine monitoring, and this was expressed as a desire to limit the burden on practitioners (e.g. *Better by Design*, *Right Home*). Finally, difficulties recruiting families and young

people to the evaluation (e.g. *ACT*, *Brighter Futures*, Daybreak's *Family Group Conferencing,* MLA's *Reclaiming Social Work*, *Safe Steps*) and high rates of attrition between data collection points (e.g. Daybreak's *Family Group Conferencing*, Islington's *Doing What Counts*) limited the amount of data available and the conclusions that could be drawn.

Embedded and practitioner researchers

The roles of 'embedded and practitioner researchers' are reported on in the Final Report and in Thematic Report 4 but they are also key in this discussion of use of data in decision-making. Eight projects had 'embedded or practitioner researchers'; 5 of these were social work systems change innovations – Durham, Stockport, Islington, Newcastle and Morning Lane; 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 2 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 Health 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 role played by these embedded researchers in collecting data and encouraging its use was illustrated in the Newcastle case study earlier. They also contributed to developing the capacity of the local authority or organisation for future data collection. 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 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 and being pulled back into their practice teams due to caseload pressures. Conversely, university researchers sometimes had 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 improve the collection and use of data but also require significant resources which even in some projects in which they were successful, were not available to sustain them beyond the life of the innovation project. In Newcastle, they have been made permanent appointments.

Conclusions and Recommendations

Evidence emerged from the evaluations in Wave 1 of the Innovation Programme of increasing capacity to evaluate and to use data, including that needed to undertake robust cost benefit analysis. In particular, better use of routinely collected data was evident for example, in most projects in which the samples were large enough to enable their use. Evaluation teams worked closely with projects to help them collect and use data in ways that will allow the LAs and organisations leading projects to continue to make use of evaluation to inform decisions and shape their services.

As has been shown, however, the variation in definitions, measures and timing adopted by evaluations focusing on the same outcomes, including cost benefit, make comparison across evaluations challenging. This thematic report therefore has only 2 overriding recommendations, which are for services to draw up a theory of change when innovating, and to progress the development of common measures in children's social care as strongly recommended and justified by Forrester and colleagues in the evaluation reports of *Family Safeguarding Hertfordshire* and MLA's *Reclaiming Social Work*. Developing common measures should heed Munro's warning not to use this information in isolation to judge good or bad performance.

Drawing up a theory of change for innovations

This thematic report has identified the need for services to be clear about their aims, objectives, intended outcomes and the measures that will support these outcomes when implementing new policies and procedures. There are resources available to assist in this process including Friedman's Outcomes Based Accountability (OBA) approach. This starts with a focus on outcomes and provides a framework for planning and performance managing services. The OBA model was used in several projects in Wave 1 of the Innovation Programme including Leeds and NE Lincolnshire as a way of structuring planning to improve outcomes. It provides key stakeholders with a framework for considering, discussing and planning, emphasising the importance of a shared language across agencies.

Evaluation teams used a Theory of Change at the start to do this with their projects. A Theory of Change (TOC) is a framework for developing solutions to complex problems. It sets out what is intended to be achieved, intermediate outcomes that might be expected and how these will be assessed and long-term outcomes and how these will be measured. More information on developing a Theory of Change is

given here. Two simple templates are provided in Appendix 2 to help those services unfamiliar with this process to get started.

Developing common measures in children's social care

In the evaluation reports of both *Family Safeguarding Hertfordshire* and *Reclaiming Social Work*, the recommendations highlighted the need for development of common measures to evaluate the impact of services and interventions in children's social care. In this thematic report, this need has been further verified, having identified the discrepancies in definitions, timescales and measures currently used and the limitations this creates in terms of comparison across innovations or across the same innovation in different areas.

The *Family Safeguarding Hertfordshire* partnership developed a Key Performance Indicator dataset covering data on police involvement, emergency hospital admissions, school attendance, substance misuse and mental health service use, as well as all the usual children's social care indicators. This was unable to provide a full assessment of the impact of the innovation in the evaluation of Wave 1 because of the short timescale. However, the innovation is being rolled out to 4 further local authorities in Wave 2, which provides the opportunity to not only look at outcomes and sustainability in Hertfordshire, but transferability to other areas. The evaluation report in Wave 1 noted that the outcomes such as police involvement and emergency hospital admissions are important indicators of child welfare, as well as having economic cost implications.

Progress on developing common measures is also taking place through the Nuffield Foundation funded work by La Valle et al. who conducted a feasibility study that "aimed to understand how to define 'good' children's social care services" (p1). It included a rapid evidence review on the definition, measurement, and outcomes of 'good' or 'effective' social work practice, and analysis of Ofsted ratings of children's services and DfE data on looked after children, children in need, and the children's social work workforce.

The report notes that policy documents generally outline target outcomes for children in broad terms, and that greater consistency is needed around expectations about outcomes and how to measure them. The literature review revealed little in the way of validated quantitative outcome measures: much of the evidence was qualitative and based on professional opinions and narrative descriptions.

There was very little association between the DfE outcomes data for a given local authority and Ofsted ratings of the local authority's children's services.

The authors of the report are following up this work with a project that aims to create an outcomes framework for children's social care services, and to identify the most appropriate indicators and measures that could be collected.

Were this to be effectively progressed through both the Nuffield Foundation project and the Hertfordshire Wave 2 project, many other issues raised in this report such as who collects the data, data-sharing across agencies within an authority and across local authorities, and capacity building in local authorities to collect and use data, could more easily be addressed. Furthermore, the use of common measures might inspire and incite local authorities and other organisations to make better use of data to inform decisions as they could compare the outcomes more easily.

Appendix 1 Audit of Service

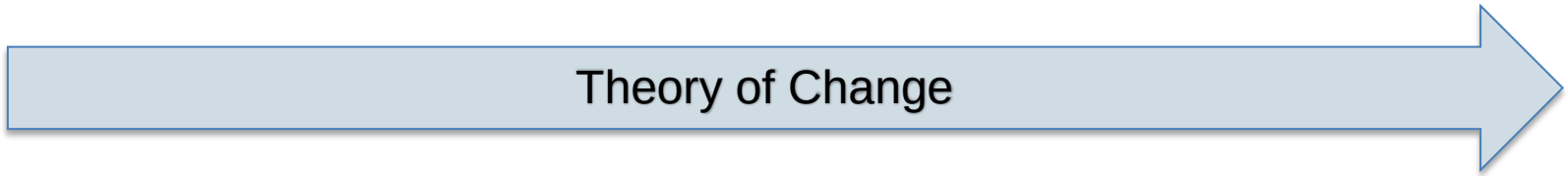
Conditions which support effective use of data	What happens now in your service?	What needs to happen?	How will you progress this?
Use the evidence base generated by Wave 1 to clarify the needs and define the innovation			
Establish what data is available, what new data is needed and for what purpose, how consistency will be achieved			
Identify data that needs to be shared across services within a LA, or across LAs/organisations and agree data-sharing protocols			
Establish capacity to analyse the data collected			
Ensure comparisons are undertaken of LA data to a) historical data to look at trends; b) statistical neighbours; and c) national datasets			
Make available evidence from analysed data when all major decisions are taken relating to children's social care			
Consider the potential role of practitioners in collecting data and enhancing its use			

Appendix 2 Templates for a Theory of Change

What changes do you propose?	What will happen as a direct result of these changes that will influence the outcomes?	How will you measure these changes?	What are the outcomes you hope to achieve for young people/families?	How will you measure these outcomes?

Your Theory of Change

Where are we now?	Activities	Milestones	Outcomes	Where do we want to be?
What are the issues, needs or problem we want to address? What needs to change?	What will we do to achieve change? Why this and not something else?	If we're to achieve long term outcomes, what interim changes will we need to see?	What are the ultimate changes or improvements we're trying to achieve?	What's the overall goal of our project?
Evidence: Eg Mapping/ needs analysis; Research on causes & solutions	Evidence: Eg Research on what works Practice Experience Monitoring of what we're doing	Evidence: Eg indicators of change: Numbers engaged Changes in policy and practice	Evidence: Eg indicators of change: People's views and experiences Better lives	



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