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# Evaluation of the Integrated Family Support Service - Second Interim Report



# **Evaluation of the Integrated Family Support Service**

## **Second Interim Report**

**February 2013**

**SQW**

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Views expressed in this report are those of the researcher and not necessarily those of the Welsh Government

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## **Executive Summary**

SQW, supported by Ipsos MORI and Professor Geoff Lindsey of the Centre for Educational Development, Appraisal and Research (CEDAR) at the University of Warwick, was appointed to undertake an evaluation of the Integrated Family Support Service (IFSS) model in August 2010. This second report presents the findings from the second year of the evaluation (September 2011 to September 2012).

### **Delivery, management and governance arrangements**

The size of the Integrated Family Support Teams (IFSTs) varies across the three Phase 1 sites, with 15 people in Site 1, 10 in Site 2, and 12 in Site 3.

There is a mixed picture in terms of IFST stability across the sites. In Site 1, although IFST membership has been settled and remained stable, there have been high levels of staff sickness due to stress. Site 2 has continued to benefit from a stable IFST membership this year. In contrast, Site 3 has suffered from higher levels of staff turnover and churn. There have been some job uncertainty issues affecting the stability of the IFSTs. The lack of and irregularity of the throughput of cases has also created some difficulties.

Across the three Phase 1 sites, there have been some difficulties around defining and implementing the Consultant Social Worker (CSW) role effectively. Feedback suggested that the issues were often linked to the seniority, salary level and support requirements or expectations of the CSWs. Additionally, the teams appeared unsure about how best to capture added value from the CSW role through the on-going research.

Generally, the IFSTs have become more familiar and confident with implementing IFSS over the past 12 months. Staff felt they have developed an appropriate mix of skills required to meet the needs of eligible families and they are supportive of IFSS.

Different styles of working and IFST staff behaviours are emerging across the sites. Formal structures such as 'reflective' meetings to encourage team-based discussion of cases have worked reasonably well. However, in one

particular site, there was evidence of increased 'self-working', which may create issues in the future.

Staff are spending on average, 40% or less of their time in direct contact with case families. Even allowing for other key activities such as training, team meetings, wider service engagement and travel etc., this suggests that there is capacity amongst IFST workers to take on additional cases.

Although there generally has been a strong core commitment to the IFSS Boards from partners, one or two gaps still remain – noticeably with the Police and Mental Health. Overall, attendance levels have been mixed and are perhaps falling.

The Operational/Implementation/Steering Groups have played an important role in sharing information, raising IFSS awareness and addressing day-to-day operational process issues but some of this activity may need to be re-directed to the Boards as IFSS further develops and is mainstreamed.

There is some uncertainty about the value of the Section 58 agreements, although the process of developing them was regarded as being useful.

### **IFSS throughput**

Although individual IFST staff were able to describe in broad terms the types of family that they thought were most likely to gain from IFSS, this was with a narrower group than described in the IFSS statutory guidance. Therefore, it was thought that the guidance on eligible families would benefit from being honed and refined further. Specifically, the feedback to the evaluators suggested that additional work is required to clearly articulate what types of families it is believed would benefit most from IFSS support. Importantly, the definition will need to focus on the potential responsiveness of the family and their willingness to change.

The general consensus amongst IFST staff and Board members was that the quality of referrals had improved as the social workers' knowledge of IFSS had increased and the IFSTs had become more experienced. However, despite investing significant time and effort in seeking to raise awareness of

IFSS amongst social worker teams, throughput during the year was lower than expected. A total of 228 referrals were made to IFSS across the three Phase 1 sites in 2011/12, which is higher than the 210 referrals recorded in the first year of IFSS but still lower than expected. A total of 174 referrals progressed to the initial IFSS assessment stage, and 26 of these cases were re-referrals.

There were relatively small volumes of eligible families completing Phase 1 (4-6 weeks of intensive support) of IFSS last year. Across all three sites, the total figure was 85, compared to a figure of 89 in Year 1. In part this slight decline is due to non-recording of families who are supported for less than the full Phase 1 period, but even so the lack of overall throughput is apparent. For example, in Sites 1 and 3 (no data are available for Site 2) 41 of the referred cases received advice through IFSS without having a full consultation or progressing to the 72 hour assessment. Going forward, the evaluators think it is important that all three sites accurately record the number of cases where 'advice only' is provided and where consultations take place, as well as those that formally progress to the 72 hour assessment.

A number of families explained that they had made an active choice to sign-up to IFSS. They had accepted that they had reached 'rock bottom' and needed help. Other families saw taking part in IFSS as a way to show that they were willing to 'comply' and do what was asked of them.

The intensity of IFSS meant that families considered it to be a very significant commitment. Some families were surprised about the amount of work they themselves would have to do as part of the Programme. Families and IFSTs suggested that an improved hand-over or induction process using a familiar social worker may help to increase recruitment to IFSS.

### **IFSS implementation**

IFSS referral cases are distributed across the IFST members based on capacity as opposed to professional expertise. This approach brings with it the potential for some risks, albeit so far recognised in only a very small number of cases, that some underlying issues are missed. It is acknowledged

that to some extent, these risks would always exist regardless of how cases were allocated, but they would arguably be reduced if all sites were operating higher levels of team-based working.

Evidence from the three sites shows that over the last 12 months, there has been some variation in terms of how IFSS was delivered, both between the sites and between individual cases in each site. For instance, IFST staff stated that the length of Phase 1 varied depending on the responsiveness or size of the family. Given the flexibility that was designed into the model from its inception, this growing divergence is to be expected and welcomed, as long as local delivery remains within the broad parameters of the model.

Feedback from all three Phase 1 sites suggested that there was some concern amongst IFST staff that the transition from Phase 1 to Phase 2 was too severe for some families. One IFST Manager suggested that there should be consideration of developing an additional stage in the IFSS process, although this may not be necessary as the IFSS model is not intended to be a rigid one.

Some families stated that they had felt nervous about the prospect of a reduction in the level of IFSS support as they moved from Phase 1 to Phase 2. Having access to their IFST worker's telephone number was greatly valued and reassuring.

The evidence collected during the second year of IFSS activity suggests that in places, the Programme is starting to have an influence over wider service delivery. Across the three sites amongst IFST staff, there was evidence of strong and universal support for IFSS as a delivery model, including the innovative tools and techniques used.

Families reported that they were very fond of the IFST workers. They stated that their IFST practitioner often became 'part of the family' – gaining the trust of all the family members. A few family members explained that they felt they had developed genuine friendships with their IFST worker.

## **IFSS outcomes and impacts**

It is still too early to form any robust conclusions about the long-term impact of IFSS on family outcomes and the sustainability or persistence of such impacts. However, the available monitoring or tracking data from the sites suggest that generally, broadly positive trajectories are still being achieved by the majority of the participating families (albeit based on relatively small numbers). Data from Site 1 show that of the 31 cases accepted onto Phase 1 of IFSS, 21 completed this stage of the process. Similar data for Site 3 indicate that of the 34 cases accepted onto Phase 1, 23 completed.

Monitoring data suggest that a major improvement occurs between the beginning and the end of Phase 1. The next stage of the intervention through to the six month review is characterised by a more gradual improvement in terms of family functioning. During the six month review and the final review after 12 months, another significant positive shift is evident.

Consultees identified numerous examples of where the intervention had made a tangible difference in terms of helping family members with substance misuse and tackling complex wider issues as they sought to turn their lives around.

Wider discussions with the three IFSTs highlighted a broader set of factors which led to positive outcomes. Although it is difficult to generalise, it was reported that IFSS seems to deliver most impact to those families that can be characterised as being 'new' to the system or 'early intervention families'.

The majority of the families interviewed felt that the IFSS programme had resulted in a very positive impact on the family. While this can partly be explained by the sample selection, in that those families who had benefited the most were most likely to engage with the evaluation process, it does provide re-assurance and illustration of the model working in some families.

However, not all families interviewed felt that they benefited from IFSS. Three families (out of 23) had a negative experience of the Programme. Others had had more positive experiences but believed that IFSS had done little for them in the longer-term.



## Issues for consideration

A series of issues have emerged from the second year of the IFSS evaluation. These are presented in the table below for consideration.

Issue	Lead responsibility
1. IFSS Boards should review levels of throughput within their teams and set clear annual targets for number of referrals for their IFST based on local capacity and need. Progress against this target should be tracked on a quarterly basis.	IFSS Boards subject to agreement by the Welsh Government
2. Where there is variability and low attendance at IFSS Boards, the respective Boards should consider why attendance is drifting downwards and take action to draw back in key members.	IFSS Boards
3. All newly established IFSTs should ensure that they invest sufficient time, effort and energy into building relationships and raising awareness of IFSS in order to achieve an appropriate flow of suitable referrals in their <i>first year</i> of operation; whilst existing IFSTs should maintain levels of awareness of IFSS to ensure sustained levels of appropriate referrals are achieved.	IFSS Boards and IFSTs
4. IFSS Boards should be tasked with ensuring that effective monitoring and evaluation frameworks are established so that the longer-term impacts of IFSS delivery can be captured at a local level and the findings can be disseminated widely. These should be used to inform future IFSS activity and wider service delivery.	IFSS Boards
5. In updating the statutory guidance on IFSS, consideration should be given to provide further detail on eligibility/target families for IFSS (to further support promoting the service locally); and, the role of the Consultant Social Worker to ensure the added value of the role is maximised. The IFSS model is intended to be flexible. The ability of the sites to tailor and shape the model should be retained, so that they are able to respond to local need. Therefore, it is important that all sites are made aware that there is scope within the model to allow delivery to be adequately tailored to effectively meet the needs of individual families.	Welsh Government
6. Consideration should be given locally to what can be done to support families who are not ready or sufficiently motivated to engage in IFSS	IFSS Lead Officers IFSS Boards
7. Each IFST needs to be careful to maintain collaborative team-based working and reflection to ensure high quality delivery of the model. The IFSS Boards and the IFST Managers should ensure that there is a strong culture of collaborative working and staff interaction within the IFSTs. This should feed through into individual IFST appraisal processes.	IFSS Boards and Lead Officers
8. IFSTs will require access to current thinking and practice across the fields from which team members have come. This is probably best done by the individual development plans of staff including time for them to maintain and build their knowledge, with support	IFST Managers, staff and professional bodies/former

<b>Issue</b>	<b>Lead responsibility</b>
from the IFST Manager and their former employers.	employers
9. Care needs to be taken around handover points within the model. This will help to ensure that families are properly introduced to the IFSS worker and 'inducted' at the start of the process, and then moved back smoothly to working with their social worker (in the absence of the intensive IFSS input). Similarly, signposting and referrals to wider service providers will also need to be managed carefully in order to minimise any adverse effects on the family.	IFST staff and social workers

Source: SQW 2013

## 1: Introduction

- 1.1 SQW, supported by Ipsos MORI and Professor Geoff Lindsey of the Centre for Educational Development, Appraisal and Research (CEDAR) at the University of Warwick, was appointed to undertake an evaluation of the Integrated Family Support Service (IFSS) model in August 2010. The First Interim Evaluation report was published in 2012. It contains background information on the evaluation process and the IFSS model itself, and can be accessed through the Welsh Government website<sup>1</sup>. This second report presents the findings from the second year of the evaluation, covering the period from September 2011 through to September 2012<sup>2</sup>.

### Year 2 of the evaluation

#### *Study design: process and implementation*

- 1.2 This element of the study was designed to capture the development process which each Phase 1 IFSS site had undertaken. In particular, it is gathering data on: the composition and organisation of each local team; and the approaches adopted to referral, as well as the intensive and on-going use of support. It also provides an opportunity to reflect on lessons learned through staff perceptions of key enablers and barriers. This includes analysis of the workings of the IFSS team (IFST), and its fit with wider structures within each local authority and its LHB and other partners. This information in turn provides a basis to guide future approaches in other areas.
- 1.3 Given the relatively limited number of Phase 1 sites (three) it was important that the development in each site was understood fully to ensure that the full breadth of activity and experience was captured. Therefore, an approach based around individual qualitative interviews and discussion groups, augmented by quantitative e-survey of time-use and practice, was applied in

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<sup>1</sup> SQW, 2012, *Evaluation of the Integrated Family Support Service (IFSS)*, First Interim Report, which is available at:  
<http://wales.gov.uk/about/aboutresearch/social/latestresearch/integratedfamily/?lang=en>

<sup>2</sup> The monitoring data from the sites on throughput presented in this report cover the period April 2011 through to March 2012.

all three *IFSS Phase 1 sites*. A second wave of an online survey of the three IFSTs was conducted during September 2012. Table 1-1 below, shows the numbers of staff involved in each of the data collection approaches.

**Table 1-1: Number of consultees<sup>3</sup>**

Phase 1 site	Total bilateral interviews conducted	No. of individual interviews with IFST	No. of people attending staff focus group	No. of interviews with Board & Operational Group staff	No. of responses to staff online survey
Site 1	9	5	3	4	7
Site 2	11	5	5	6	7
Site 3	11	8	9	3	8

Source: SQW 2013

*Study design: service delivery and outcomes*

- 1.4 This strand of the study aims to evaluate the impact of IFSS on families via two methods, by:
- quantitatively assessing the impact of IFSS on ‘hard’ outcome measures;
  - exploring qualitatively the way in which the IFST interacts with families and how this interaction impacts on the achievement of positive outcomes for families.
- 1.5 Following in-depth discussions with the three IFSS Phase 1 sites and other key stakeholders, it was agreed to base the quantitative element of the study on routinely-collected administrative data augmented by commonly used validated tools for those families eligible for IFSS. Routine data is captured by family social workers, as well as associated data from schools, police records and hospital admissions. These routine data have been augmented by asking all families eligible for IFSS to complete the Warwick Edinburgh Well-Being Scale and Strengths and Difficulties questionnaire. The three sites began using these tools in November 2011, and so no data are yet available for this report.

<sup>3</sup> It is worth noting that some IFST members participated in the second year of the evaluation through bilateral consultation, focus group work and an online survey.

- 1.6 The qualitative element involves a small number of family case studies in each site. The benefit of a qualitative, case study approach, is that it will help us to understand in-depth the outcomes that the IFST has on the whole family, i.e. we will not only be able to determine the benefits for the children, but also their parent/s and how the family dynamic alters over time. It will also help us understand the perceptions of the family of the services provided in their area, thus helping us answer elements of the process evaluation as well.
- 1.7 This report draws on the findings from 23 in-depth family interviews conducted during the period July to October 2012. A full list of the participating families is presented in Annex A. A range of families from across the three sites and at different stages of the intervention were interviewed: nine from Site 1; seven from Site 2; and seven from site 3. The interviews ranged in length from between one hour and four hours. Where possible, the parents and children were interviewed together (as part of a family discussion) and then separately (to discuss the process and impacts of the programme). The children's interviews varied in length according to the needs of those taking part and the interview process was flexible to meet the needs of the participants.
- 1.8 A note of caution is needed when interpreting the findings from the family interviews. Only 23 interviews have been conducted so far. The families engaging more positively with the IFSS programme may generally be more likely to engage with the evaluation. Those families who are less engaged with the programme are perhaps less likely to be engaged with the research and volunteer to take part. Therefore, the sample of interviewed families may be somewhat skewed.
- 1.9 Additionally, we are only able to report on families' perceptions and their reported memories of their experiences. In particular, many families struggled to remember specific details such as the timings of the IFSS programme. This is a common finding in research of this nature, and it is important to acknowledge that perceptions held by participants are important - they shape their views and attitudes, and are 'the facts' as they see them.

## **Structure of this report**

1.10 The remainder of this report is structured as follows:

- **Section 2** provides an overview of the main delivery, management and governance arrangements
- **Section 3** explores the throughput of IFSS cases
- **Section 4** considers the main process issues associated with IFSS implementation
- **Section 5** sets out an assessment of IFSS outcomes and impacts
- **Section 6** summarises the main findings and lessons from this second year of the evaluation.

## **2: IFSS delivery, management and governance arrangements**

- 2.1 This section provides an overview of IFSS delivery, management and governance arrangements across the three Phase 1 sites. It describes the composition of the Integrated Family Support Teams (IFSTs), both in terms of size and skills-mix, as well as providing an update on IFST staff development and retention issues. It also considers the role of the Operational/Implementation/Steering Groups and the IFSS Boards.

### **Update on the IFSTs in the three Phase 1 sites**

#### *Team composition and thematic expertise*

- 2.2 The Integrated Family Support Teams (Composition of Teams and Board Functions) (Wales) Regulations 2012 came into force on the 28 February 2012. The regulations specified that an IFST must have a core team of at least five multi-disciplinary professionals, drawn from one of the following three professions: social work; nursing; health visiting.
- 2.3 Additionally, one of the team should be formally designated a Consultant Social Worker (CSW), who is a social worker with a minimum of three years post-qualification experience.
- 2.4 IFSS Regulations and Statutory Guidance issued by the Welsh Government states that an IFST must act as 'change agents', raising the profile and awareness of IFSS amongst wider services and agencies, and influencing the way in which they operate, as well as delivering intensive family-focused support interventions. This wider role may affect the extent to which IFSS influences other services, and how other services feel about referring to IFSS. This will be explored later in the report.
- 2.5 The size of each IFST varies across the three Phase 1 sites, with 15 people in Site 1, 10 in Site 2 and 12 staff in Site 3.
- 2.6 In Site 1, there have been wider organisational changes that have impacted on the size and shape of the IFST. A whole service transformation process covering Family Support Services was implemented to create a continuum of

support for all children and families. It resulted in four teams operating in the locality: the IFST; a new Family Assessment and Support Service (FASS); the Family Support Service (FSS) and the new Early Intervention and Prevention (EIPs) team. FASS became operational in April 2012 and was co-located with the IFST at Site 1. FASS was established to operate in a similar way to the IFST, but it was tasked with providing intensive support to those families whose risks were in respect of domestic violence, mental health and learning difficulty issues.

- 2.7 The increase in the size of the IFST at Site 1 can be accounted for by the four new FASS team members, including one CSW. It was reported by consultees that the additional team members have broadened the expertise and knowledge of the IFST and the former child protection social worker has helped to foster a better understanding of and links to the referral team. The IFST and FASS are managed by the same person.
- 2.8 At Site 2, the IFST has retained all original team members since the beginning of the process. However, going forward, it is expected that as the pan-Wales roll-out takes effect and more IFSTs are established in other parts of Wales this could have an impact on the team at Site 2, as practitioners might seek to further their careers through the newly created CSW posts.
- 2.9 An Independent Reviewing Officer post was created to undertake IFST Reviews that did not fall into the statutory reviewing process within the Child Protection and Looked after Children systems. This post was based within the Reviewing Team in site 2.
- 2.10 Within Site 3, the overall size of the IFST has remained broadly the same as in Year 1, although there has been some staff churn and turnover, as well as some reconfiguring of the roles. One of two family aid workers left to undertake a university degree and this post was replaced with an additional spearhead worker. A health visitor returned to her parent organisation, preferring to work within the core health visiting skills set. A replacement health visitor has been successfully recruited to the team. Finally, the monitoring and support officer post was replaced with a performance manager



position in response to increased demands for business and data analysis skills.

- 2.11 All of the Phase 1 sites have opted for a shared team manager role, (with the local Families First programme and Youth Justice in Sites 1 and 3), and the Site 1 IFST Manager also has responsibility for FASS. Table 2-1 below summarises the composition of the teams in each of the Phase 1 areas.

**Table 2-1: IFST composition in September 2012**

	Site 1 <sup>4</sup>	Site 2	Site 3
IFST Manager	1 (also covers FASS)	1 (50% FTE)	1 (50% FTE)
Consultant Social Worker	4 (1 through FASS)	2	1
IFST multi-disciplinary professional	9 (3 through FASS)	6	6 + 2 Phase 2 support workers
Admin Support/ Performance Management	1	1	2 <sup>5</sup>
Total	15	10	12

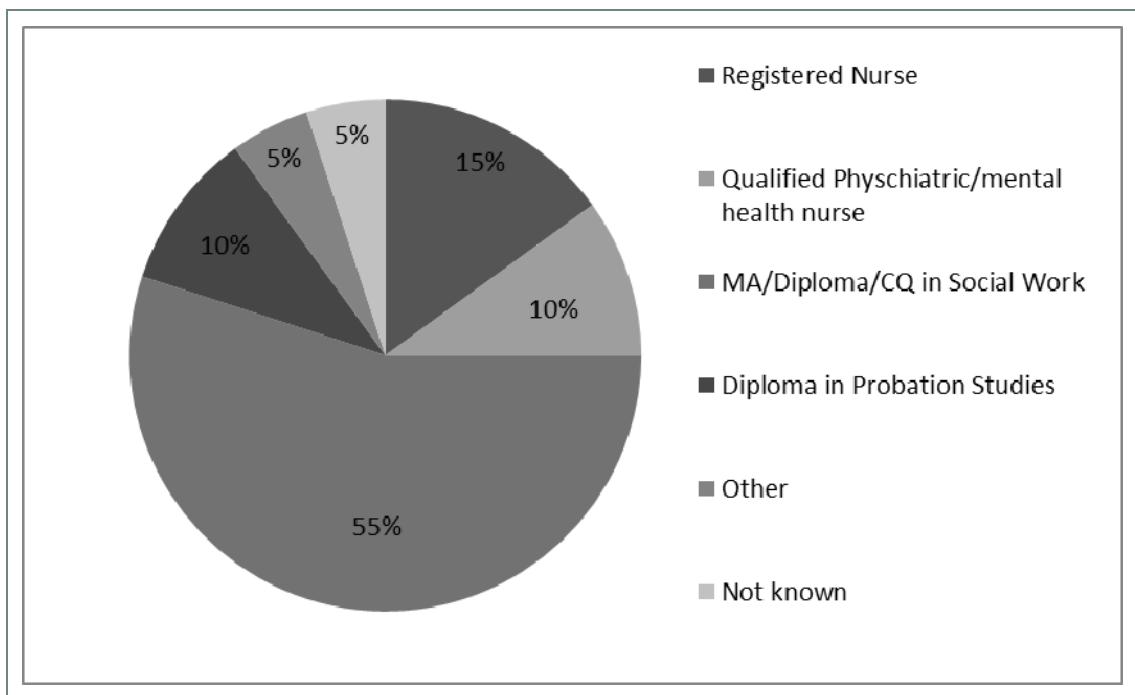
Source: SQW

- 2.12 Over half (55%) of the IFST staff members that responded to our online survey reported that they were qualified social workers, whilst 15% were Registered Nurses, 10% had a background in mental health and 10% stated that they held a Diploma in Probation Studies (see Figure 2-1 for details).

<sup>4</sup> These figures include four new members of the Site 1 IFST (including one CSW) who form part of the sister Family Assessment and Support Service (FASS).

<sup>5</sup> We understand that one of the Site 3 IFST lead administration staff retired at the end of September 2012.

**Figure 2-1: Breakdown of professional qualifications of IFST members**



Source: SQW online survey of IFST staff 2012 (n=22)

#### *The CSW role*

- 2.13 The three Phase 1 sites have different numbers of CSWs in post as part of their IFST: in Site 1, there are four CSWs (including one who is also part of the FASS); in Site 2 there are two; and in Site 3 there is one CSW. One year after the first IFST staff online survey was completed, a second wave was conducted by SQW during September 2012. The survey findings indicate that all of the CSWs are highly experienced members of staff, bringing on average around 13 years of professional work experience (ranging from six to 21 years).
- 2.14 However, across the three areas, some difficulties were reported in defining and implementing the CSW role effectively. Across the sites, there were reports of some tensions linked to the CSW post and there was some uncertainty about how to get most value from this senior position in the team.
- 2.15 Feedback suggested that the issues were often linked to the seniority, salary level and support requirements or expectations of the CSWs. For example, the IFSTs had Team Manager posts, but the structures of the IFSTs were

generally described as being relatively 'flat', and some consultees raised concerns around the teams not having a clearly defined hierarchy.

- 2.16 A common view expressed was that when problems arose between team members (particularly more senior staff such as Band 7 Nurses), the CSWs were, on occasions, unsure about their authority in terms of addressing issues. Similarly, at one of the sites, the CSW felt that there had been insufficient support provided and at times, it had become a somewhat 'lonely' role. The IFST Team Manager and lead officer for IFSS both felt that the seniority and 'lead practitioner' status of the role meant that the CSW should only need limited on-going support.
- 2.17 Additionally, the teams appeared unsure about how best to capture added value from the CSW role through the on-going research projects. Two of the sites took local decisions to support the CSWs through MSc courses on Advanced Social Work Research and Practice. However, they were uncertain as to whether this was proving valuable / appropriate to the job role, and there was some uncertainty about how the research element would be fulfilled beyond the course. From the view of one CSW, the MSc course was interesting, but tended to be lowest priority, and so course work was often done in their own time. The third site encouraged the CSW to conduct more regular and smaller pieces of research (as opposed to a single larger project) that could be better aligned with the needs of the other IFST members. The site did this by building on the partnership relationship it had established with a local university.

#### *IFSS training and development*

- 2.18 IFSS has become firmly embedded with an important core of IFST professionals, and their expertise in delivering the model has grown. As well as benefitting from additional experience, knowledge and insight accrued through working on more cases, all staff accessed the compulsory core IFSS training when they first joined the IFSTs, which was described as being intensive. Furthermore, additional on-going training has also been accessed. Indeed, striking the right balance between training and development, with family contact on the ground has been challenging to all the teams and a

flexible approach has been adopted across the sites, allowing IFST staff to have a certain level of autonomy.

- 2.19 Four specific training modules were available. All IFST members had to attend a four day core training session before they could begin to work with families. Over the next 6-9 month period, the practitioners worked to achieve a level 6 accreditation<sup>6</sup> by completing workbooks and assessments. Those in the wider workforce supplying the 'family support functions' were required to attend the four day core training and look to achieve level three accreditation. Those working in the wider workforce and not working within the IFST or the family support services directly could work to achieve a level 2 accreditation, which recognised the staff members had gained a knowledge of the techniques underpinning the IFSS model.
- 2.20 In order to improve the take-up amongst social care teams, Site 1 took the decision to change the four-day IFSS training course to two tranches of two-day sessions to make it more user-friendly and to raise attendance levels. It was claimed that this had a positive impact on take-up levels so other sites may want to consider this approach in the future. Additionally, they also provided CRAFT (Community Reinforcement and Family Therapy) training to the IFST members. This promoted techniques on how to work with the partners of individuals who are substance misusers. It was reported the training had been well received by staff and that it aligned well with the IFSS model. It was claimed that it had helped the team to take a 'whole family' approach to the intervention and it had equipped them with a wider variety of useful tools.

#### *Factors influencing IFST staff retention and stability*

- 2.21 There are further issues to be faced going forward and a range of different factors will influence future retention:

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<sup>6</sup> The accreditation process for the IFSS is designed to assess learning outcomes and operates at different levels: Underpinning Knowledge & Skills for IFSS (Level 2); Implementing IFSS (Level 3); Managing the Delivery of Family Focussed Interventions (Level 6).

- as IFSTs are established in new areas, it could lead to some staff to look for progression opportunities and for staff turnover within the existing IFSTs to rise;
- the lack of, and irregularity of referrals (this is explored in detail in Section 3) at times during the year has led to some staff to feel disillusioned, especially those that reported they missed the urgency and ‘caseload juggling’ aspects of more regular social work;
- the emotional stress associated with the job have also been contributing factors to some IFST members leaving their posts and being away from work on long-term sick leave.

2.22 Across the three sites, there is a mixed picture in terms of IFST stability. In Site 1, there have been wider organisational changes associated with the service transformation agenda. However, during the twelve month period of September 2011 – 2012, there was evidence of the IFST membership generally becoming more settled and consistent. That said, there have been high levels of staff sickness at the site due to the stress associated with the roles.

2.23 Site 2 has continued to benefit from a stable IFST membership this year. The Year 1 evaluation report detailed the steps that the site had taken in terms of investing heavily in a rigorous and robust recruitment process, which included the use of an assessment centre and psychometric tests. The high levels of staff retention appear to suggest that this was a worthwhile investment.

2.24 In Site 3, there has been less stability. The Operational Manager of IFSS left to take up another post, one of the Family Aid workers left to pursue a university degree and the performance and monitoring support officer was replaced. Additionally, some staff at Site 3 reported feeling ‘nervous’ about what would happen as part of the wider IFSS roll-out and the impact that this may have on their future job security, role and responsibilities. This affected externally contracted staff in particular, who were on fixed-term arrangements, and who were seeking more career certainty and progression opportunities.

2.25 Overall, the IFSTs have become more familiar and confident with implementing IFSS during the past 12 months. Generally, staff felt that they have developed an appropriate mix of skills required to meet the needs of eligible families. However, some staff at one of the sites indicated that at times, they felt they would have benefitted from having access to additional mental health expertise. In particular, staff reported that they wanted to have more knowledge of what to look for in terms of identifying mental health issues amongst family members early on in the IFSS process.

#### *IFST staff satisfaction*

2.26 The second wave of the IFST online survey revealed that staff are generally satisfied with their jobs. The key findings from the survey are summarised below:

- Staff indicated that they felt their jobs required them to be creative and to learn new skills
  - More than two thirds (68%) of the survey respondents strongly agreed with the view that their job required them to learn new things and just under half of the respondents (46%) strongly agreed with the view that their job enabled them to be creative
- Staff reported that although they felt they generally worked hard, they were not asked to undertake excessive amounts of work and there was sufficient time to get tasks done
  - Only three IFST staff members felt they had been asked to carry out an excessive amount of work in fulfilling their roles and responsibilities. However, 77% of respondents felt that their jobs involved a significant amount of paperwork
- Staff felt strongly that they were part of a wider team with colleagues who called on their specific skills. Staff also indicated that they thought their IFSS roles carried a high level of responsibility
  - Only one member of staff reported that they did not feel part of a team and their role did not involve a high level of responsibility

- Staff had mixed feelings when it came to the issue of dealing with conflicting demands and suffering from high levels of work-related stress
  - Nine out of the 22 survey respondents (41%) reported that they did not feel free from conflicting demands and pressures within their roles, and half stated that they felt their jobs involved high levels of stress.

2.27 The feedback also suggests that the way in which the model was being implemented across the three sites has started to diverge over time. In some ways, this was to be expected given the flexibility in delivery that was allowed by the Welsh Government, as the three Phase 1 sites were encouraged to respond to local need. We consider this issue in detail in Section 4.

*Different ways of working*

2.28 There have been some noticeable shifts in the way the IFSTs operate from Year 1. Some changes are linked to formalised changes in the way operational activities are organised and structured, whilst others are associated with changing behaviours amongst IFST staff members.

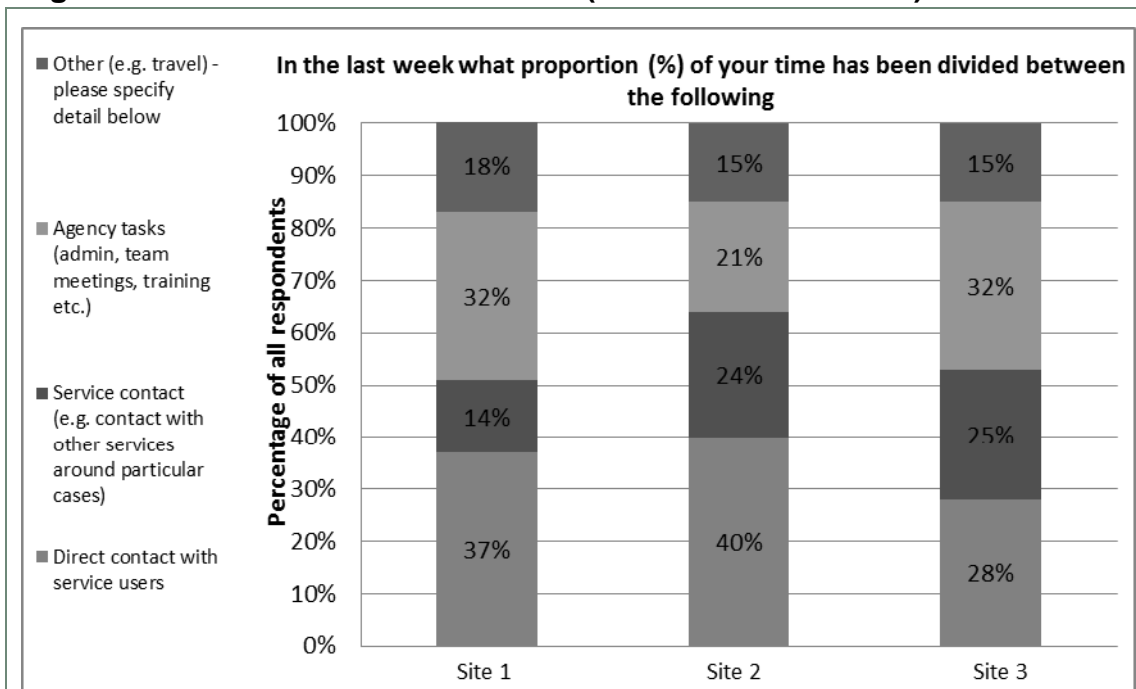
2.29 For example, in Site 3, a formal structure for discussing cases and sharing information amongst team members has been established, through fortnightly meetings. It was claimed that the so-called 'reflective' meetings have helped to foster a genuinely collegiate approach where information sharing, discussion and debate became the hallmarks of IFSS delivery. These meetings have proven to be popular amongst team members and it was reported that the meetings have proved to be effective in terms of developing solutions for cases.

2.30 In contrast, it was suggested that in one of the other sites, staff were increasingly focusing on 'self-working', which may become problematic over time, both in terms of their welfare and in identifying/addressing all of the underlying issues associated with a particular case. The team in this site recognised that this trend was not good.

*Balance of IFST activities*

- 2.31 Results from the online staff survey (see Figure 2-2) show that at Site 1, IFST staff spent on average, 37% of their time in direct contact with families, in Site 2 the figure was 40% and in Site 3, it was 24%.
- 2.32 The survey also showed that as may be expected, administration and monitoring staff were more likely to spend the majority of their time on agency tasks i.e. meetings, supervision, and administrative tasks etc.

**Figure 2-2: IFST balance of activities (admin staff excluded)**



Source: SQW Survey of IFST staff 2012 n=20

*Links to the IFSS Boards*

- 2.33 There was a broad consensus amongst IFST members across the three Phase 1 sites that the flow of information between themselves and the Board (and vice versa) was inadequate. Although IFST staff acknowledged that the IFSS Boards' role was to focus on high-level strategic matters and to leave operational issues to the Implementation/Operational Groups or indeed the IFSTs themselves, they suggested that it may be useful for staff development if they were able to influence board meeting agendas every now and then. Additionally, there may be scope for an annual joint workshop session to be held involving the Board, IFST and Operational/Implementation Group staff to discuss IFSS delivery for the coming year.



2.34 One IFST staff member commented that he would have liked IFST staff to have been invited to attend the Board on a rotational basis to provide an insight into the 'bigger strategic picture' and to provide members with an opportunity to present cases and discuss IFSS issues. He added that to date, IFST members had only been able to discuss board related issues at the IFST team meetings and there had been no formal mechanism for influencing board agendas. He felt that this was somewhat of a missed development opportunity for IFST members and that Board Members would benefit from additional case-specific examples and lessons.

### **Update on the IFSS Boards in the three Phase 1 sites**

#### *Board functions*

2.35 The Integrated Family Support Teams (Composition of Teams and Board Functions) (Wales) Regulations 2012 set out what an IFSS Board must do in order to fully meet the objectives conferred on it by Section 62 of the Children and Families (Wales) Measure 2010. Specifically, the regulations state that in order to achieve the objectives in section 62(1) of the 2010 Measure (functions of integrated family support boards) an integrated family support board must do the following:

- receive and consider regular reports from the person managing the team including information about the levels of service activity and outcomes
- seek to resolve issues in relation to the coordination of services provided by the team and other services provided by the local authority and the local health board
- ensure that the team has procedures in relation to
  - child protection
  - adult protection
- establish a procedure for resolving disputes between the local authority and the local health board about the arrangements for the team

- ensure that there are adequate arrangements for the supervision and professional development of the professional members of the team as set out in regulation 2(1)
- receive reports on the team's income and expenditure and notify the local authority and the local health board of any financial or other resource issues which are likely to affect the team's ability to fulfil its functions.

2.36 The feedback from IFSS board members and wider consultees across the three sites is consistent with those functions listed above. The boards have intentionally sought to remain 'strategic' and to focus their activities on high-level issues. Day-to-day operational matters and service delivery issues have been left in the hands of the Implementation/Operational Groups (which are described below).

2.37 Interestingly, a consistent message from consultees across all Phase 1 sites was that to date, there had been no need for any operational issues to be escalated to the IFSS Boards.

2.38 The evaluators did not receive any feedback to suggest that the current arrangements have not been effective or are not fit for purpose. In the remainder of this report we highlight a series of issues that require detailed consideration at senior level and suggest that the Boards need to take a more active governance role.

2.39 The main issues discussed at the Boards were reported to be (in no particular order of importance):

- On-going strategic oversight and direction
- Post-Phase 1 planning
- Performance monitoring in terms of throughput and financials
- Building links to wider service delivery including children and adult services as well as other services such as housing, training and employment agencies

- Staff recruitment, development and retention.

#### *Board meetings and agendas*

- 2.40 During Year 2, the IFSS boards have continued to meet regularly; the boards at sites 2 and 3 meet on a quarterly basis (Site 3 initially met on a bi-monthly basis during the set-up phase) and Site 1 meets bi-monthly.
- 2.41 Feedback from the Chair of the IFSS Board at one site revealed that the meetings had tended to work best when there was sufficient 'room for discussion' and they had not simply been agenda driven. More generally across the three sites, board members appreciated and valued the case-specific stories from their IFST Managers, which had helped to demonstrate the difference that IFSS was making to local families on the ground.
- 2.42 In Sites 1 and 3, consultees indicated that it was helpful that their IFSS Boards had formal governance responsibility for the Families First programme. This ensured that there was closer alignment and integration between the two initiatives, as well as with mainstream provision. Additionally, it was reported that this had specifically helped with efforts to push for a more consistent approach to the collection of contextual and monitoring information to inform local service delivery, as well as a more streamlined service from referral to the post-intensive phase of intervention.

#### *Board membership and attendance*

- 2.43 All three sites have continued to benefit from having IFSS Boards with a broad senior-level membership. Overall, membership of the boards has been fairly stable, although there have been some changes in IFSS Board composition in Site 1. This has been due to a small number of individual members securing different roles, having limited availability as a result of leading on IFSS roll-out in another area or retiring.
- 2.44 The size of the Boards varies across the three Phase 1 sites, with 28 members in Site 1, 12 in Site 2, and 20 in Site 3. However, despite there generally being a strong commitment from a central core of partners,

attendance levels have been mixed and inconsistent across all three sites, with some members not attending any of the meetings held last year.

- 2.45 It was reported that in Site 3, three board members have attended no meetings out of a possible 10. Elsewhere, in Site 1, four board members attended none of the three meetings that took place last year. In Site 2, one member consistently did not attend the board meetings, whilst two other members initially failed to attend although this situation did improve over time.
- 2.46 It was reported by some board member consultees that some of their fellow board members felt there was less of an imperative to attend meetings now that the initial recruitment and set-up phase of the IFST had been successfully completed.
- 2.47 Nevertheless, it was reported that the IFSS Board in Site 1 would have benefitted from improved attendance from the Mental Health and Police representatives. In Site 2, there has been an on-going issue about the need to gain representation from the Police. Additionally, in Site 2, they sought to strengthen the governance structure by inviting key stakeholders from Housing and Criminal Justice agencies to join the Board. This resulted in a representative from the National Probation Service joining the Board. In Site 3, there have also been attendance issues, particularly with Job Centre Plus, Mental Health, Education Inclusion and the Care and Social Services Inspectorate Wales (CSSIW).
- 2.48 The feedback from IFSS board members has been positive in relation to the performance of the Boards and associated IFSS governance and management arrangements. Despite the contrast in scale of membership and the continuing pockets of poor attendance, consultees were in agreement that the boards were fit for purpose and provided robust oversight of IFSS activity. No concerns were raised about the size or breadth of the larger boards in sites 1 and 3.

### *Links to the Operational/Implementation/Steering Groups*

- 2.49 It is clear from discussions held with consultees in Year 2 of the evaluation, that the Boards and the IFSTs have been supported through the work of the IFSS Operational/Implementation/Steering Groups.
- 2.50 These groups sit above the IFSTs and below the IFSS Boards in all three Phase 1 sites. They have been tasked with addressing operational issues and challenges associated with implementing IFSS, as well as advising the IFSS Boards about on-going programme development matters.
- 2.51 In Site 2, this group usually meets monthly, and in Site 3, on a bi-monthly basis, although on some occasions additional meetings are held to focus on specific work-streams. In Site 1, the Implementation Group initially met on a monthly basis prior to shifting to hold sessions on a six weekly basis. This group in Site 1 evolved from the original delivery group that was established to first develop the service.
- 2.52 The Steering / Implementation Groups also tended to have common or fixed agenda items that were covered at each meeting, such as: service progress/performance and staffing update; case management examples and partner exchange; risks and delivery issues; future planning considerations.
- 2.53 The groups vary in size across the three Phase 1 sites, with 22 members in Site 1, 26 in Site 2, and 18 in Site 3. The evidence from consultees suggests that these groups have generally proven to be effective in resolving operational issues. They have covered staffing issues including those for secondees, performance data to review blockages and case management reviews for identifying where operational process improvements could be made. However, in Site 1, it was reported that the Implementation Group had become less important in Year 2 as many of the operational 'teething' issues associated with the establishment of a new multi-agency team had been addressed previously.

### *Section 58 Agreements*

- 2.54 The three IFSS Phase 1 sites were tasked with developing Section 58 agreements, which detail the services that will be included within the 'Family

Support Functions' available to the IFST in each site. The Section 58 agreement is a record of the services being provided by partners, the level of resources, and objectives for the IFST.

- 2.55 Section 58 agreements have now been drafted in all three Phase 1 sites although they have not all been formally signed-off by their respective IFSS Boards. The Welsh Government has instructed IFSS Boards to use the legal services within their localities to offer advice and support in developing these agreements. However, some Boards/IFSTs reported that there had been some uncertainty about the process.
- 2.56 Although Section 58 agreements have been developed and agreed at board-level, some consultees across the sites reported that they were unsure of the currency of these commitments legally. Local legal departments had been asked to consider the implications of service provision on the ground but generally, consultees felt that the documents were more about establishing an 'agreed understanding' and senior-level buy-in rather than specific service delivery imperatives or detailed commitments.
- 2.57 Overall, the dominant view was that the process of establishing the Section 58 agreements had been useful in raising awareness of IFSS and building relationships.
- 2.58 It was acknowledged that going forward, the agreements may become more important with greater turnover of both staff and board members. Even then however, ultimate decision-making about service delivery and prioritisation is still likely to be influenced by processes of negotiation, personal relationships and levels of trust amongst partners.

### **Summary**

- 2.59 The key messages from this section are as follows:
- The size of the IFSTs varies across the three Phase 1 sites, with 15 people in Site 1, 10 in Site 2, and 12 in Site 3
  - Across the three sites, there is a mixed picture in terms of IFST stability. In Site 1, there have been wider organisational changes

associated with the service transformation agenda, but IFST membership has settled and remained stable. However, there have been high levels of staff sickness due to stress. Site 2 has continued to benefit from a stable IFST membership this year. In contrast, Site 3 has suffered from higher levels of staff turnover

- Across the three Phase 1 sites, there have been some difficulties around defining and implementing the CSW role effectively
- There have been some job uncertainty issues affecting the stability of the IFSTs. The lack of and irregularity of the throughput of cases has also created some difficulties
- Generally, the IFSTs have become more familiar and confident with implementing IFSS over the past 12 months. Staff felt they have developed an appropriate mix of skills required to meet the needs of eligible families and they are supportive of IFSS
- Different styles of working and IFST staff behaviours are emerging across the sites. Formal structures such as 'reflective' meetings to encourage team-based discussion of cases have worked reasonably well. However, in one particular site, there was evidence of increased 'self-working', which may create issues in the future
- Staff are spending on average, 40% or less of their time in direct contact with case families. Even allowing for other key activities such as training, team meetings, wider service engagement and travel etc., this suggests that there is capacity amongst IFST workers to take on additional cases. However, the balance of IFST activities may need to be adjusted in the future so that additional time is spent on cases
- Although there generally has been a strong core commitment to the IFSS Boards from partners, one or two gaps still remain – noticeably with the Police and Mental Health. Overall, attendance levels have been mixed and are perhaps falling

- The Operational/Implementation/Steering Groups have played an important role in sharing information, raising IFSS awareness and addressing day-to-day operational process issues but some of this activity may need to be re-directed to the Boards as IFSS further develops and is mainstreamed
- There is some uncertainty about the value of the Section 58 agreements, although the process of developing them was regarded as being useful.



### 3: IFSS throughput

- 3.1 This section of the report considers the volume of cases that passed through the IFSS programme across the three Phase 1 sites in 2011/12. Specifically, it explores the different referral routes in use, and the quality and appropriateness of referrals to the IFSTs.

#### Referral routes and approval processes

##### *Initial expectations*

- 3.2 As stated in the Year 1 evaluation report, based on modelling work carried out by the Welsh Government, the initial expectation was that each of the Phase 1 sites would work with around 100 eligible families per year<sup>7</sup>. It was assumed that there would be a high level of latent demand for the intensive service and that through the work of the IFSS Boards and Operational/Implementation Groups, in particular, effective local referral routes and mechanisms would be established.
- 3.3 The IFSS Regulations and Statutory Guidance specified that there were three core eligibility criteria for the intervention:
- Children in need, children in need of protection and children in care where the child's plan is to return home
- AND
- Parent/s or carer/s of children in need where one or both parents/carers have a dependence upon alcohol or drugs
- OR
- Expectant parents where one or both parents has a substance misuse problem that is likely to give rise to the child being in need of protection.

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<sup>7</sup> The initial throughput target of 100 IFSS cases per Phase 1 site per year that was established by the Welsh Government no longer exists.

- 3.4 Underpinning these criteria was an expectation that IFSS would focus on helping families most at need within Wales, where these families exhibited substance misuse issues, and that there were concerns around the welfare of the child/ren.

*Introduction of a new referral system*

- 3.5 It was reported that the referral processes across the three sites had evolved and improved over time.
- 3.6 In Site 1 a new referral process was implemented in April 2012. It focused on a new arrangement called the 'information station', which sought to provide a single entry point into all of the Family Support Services.
- 3.7 The social care referrers and domestic violence unit are based at the information station and the Family Support Service (including IFSS/FASS and the Family Information Service) also have desks here. This new system ensured that a member of the Family Support Service was always available to receive referrals or to offer advice, plus it brought together all of the relevant services.
- 3.8 The new referral process in Site 1 required the referrer, a case-holding social worker in children's services, to book an appointment with the on-duty member of the Family Support Service to discuss the case. Following this, a consultation would be arranged on the same day to discuss the chronology and nature of previous service intervention, as well as the recent history of underlying issues or concerns. At this stage, desired behaviour changes and risks would also be covered. The relevant Family Support Worker would then be tasked with providing a set of recommendations for the referrer to trial (recorded as consultation advice) or accept the referral and pass it to the IFST Manager for final approval (recorded as a consultation referral).
- 3.9 The IFST Manager would then potentially approve the case formally and check to see which member of the IFST had sufficient capacity to take it on. Importantly, cases were allocated in response to team member's availability as opposed to specific expertise. This issue is explored further in Section 4 of this report.

- 3.10 According to the referral team manager in Site 1, the new process has been well received by social workers. It was claimed that they valued the more discursive and consultative approach as opposed to completing referral forms and relying on telephone-based discussions. Additionally, the feedback indicated that social workers felt that the new system was more streamlined and accessible.
- 3.11 Across the other sites, there have been no major changes to the referral processes. Local social worker teams continued to populate initial consultation enquiry forms and send these to the IFST Managers (or the CSW in Site 3 via the Administrator) for review, following a one hour consultation with the social worker. If cases were accepted, they were allocated to those IFST members who had spare capacity at that moment in time.
- 3.12 Feedback from consultees in Site 2 suggested that the local Families First<sup>8</sup> programme had strengthened the referral process because it provided an alternative less-intensive solution to IFSS.

### **Quality of referrals**

#### *Efforts to develop stronger relationships with social worker teams*

- 3.13 The monitoring data provided by the sites for 2011/12 show that the number of referrals that were deemed inappropriate across the three sites was low (15 out of a total number of 228 referrals). There were no inappropriate referrals in Site 1, four in Site 2, and 11 in site 3. However, caution is needed when interpreting these figures as the numbers will be different across the sites due to different monitoring procedures and definitions. Additionally, some sites will pre-screen and filter-out inappropriate referrals prior to them being counted.
- 3.14 It was reported by IFST staff that the quality of the referrals into IFSS gradually improved during the second year of the Programme. In Site 1, this was in part attributed to the fact that the new information station had resulted in a much higher level of face-to-face engagement between the social workers and the IFST. Sub-optimal communication between the social worker referrers

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<sup>8</sup> This is a different programme to the Welsh Government's national Families First initiative.

and the IFST members was cited as one of the key drivers behind the development of the new referral mechanism.

- 3.15 Discussions with IFSS Board members from Site 1 highlighted the important role that the CSW 'link workers' played with each of the referral teams. By engaging with frontline staff through team meetings and awareness raising surgeries, it was claimed that this had resulted in an improved understanding of IFSS and the specific circumstances within which a referral would be appropriate. Furthermore, on a personal level, the increased familiarity between social workers and IFST workers, was reported as being helpful.
- 3.16 In the other sites, time and effort had been invested in seeking to build personal relationships with the referral teams and raise awareness of IFSS, although this had not been delivered through formal link workers. A more ad hoc/distributed approach had been deployed, with IFSTs tasked with attending social care team meetings, sitting one day a month at desks beside social work teams in offices across the area, running training sessions and sharing guidance leaflets.
- 3.17 Furthermore, many of the activities were conducted on a rota basis which meant that it was often more difficult for personal relationships to build and this could reduce the longer-term effects.
- 3.18 Regardless of the nature or scale of the outreach efforts of the IFSTs, several consultees reported that it was difficult for operational staff to have the desired impact on colleagues in the social care teams. It was suggested that a more 'top-down' approach was needed through Heads of Service.
- 3.19 However, one consultee from Site 3 suggested that he thought that some social care workers may not want the IFSS to succeed and therefore this may explain why the referral numbers had been lower than expected. This concern had been formed because in some cases although the 'right people' had been on the Board/Implementation Group throughput issues had not been addressed at a senior-level.
- 3.20 In Site 3, efforts to improve the regularity and quality of referrals were initially boosted when a member of the IFST left to become the manager of one of the

social worker teams. The manager promoted the IFSS heavily amongst the social workers, although the improved flow of referrals was not sustained.

- 3.21 Overall, the general consensus amongst IFST staff and Board members was that the quality of the referrals had improved as the social workers' knowledge of IFSS had increased and the IFSTs had become more experienced. It was acknowledged by some consultees that more relationship building and partnership work could have been done in the first year of the Programme.

#### *Targeted referrals*

- 3.22 Although individual IFST staff were able to describe in broad terms the types of family that they thought were most likely to gain from IFSS, this was with a narrower group than described in the IFSS statutory guidance. Therefore, it was thought that the guidance on eligible families would benefit from being honed and refined further. Specifically, the feedback to the evaluators suggested that additional work is required to clearly articulate what types of families would benefit most from IFSS support. Importantly, the definition will need to focus on the potential responsiveness of the family and their willingness to change.
- 3.23 It was suggested that a finer grained definition may help to reduce the level of inappropriate referrals.
- 3.24 So, for example, although there was a broad consensus that the family needed to have reached a 'crisis point' in their lives and to have recognised this themselves, there seemed to be an opportunity to better articulate this in the form of concise referral guidance, which could be captured in any update to the statutory guidance by the Welsh Government. This would also ensure that there is greater consistency of thinking amongst IFST members and across different IFSS sites, as well as helping referrers.
- 3.25 Another important point in relation to the appropriateness and quality of referrals that was raised was the issue of timing. Indeed, one site explained that they would not operate a waiting list because they thought timing was so critical. If they could not take a family at the time it was referred, the IFST

would prefer to revisit the assessment once capacity became available as so much can change in a very short period with some of these cases.

- 3.26 It was reported by a number of consultees across the sites that the IFSS model tended to work best when families had reached a 'crisis point' for the first time. At this point, it was thought that some families realised how bad things had become and wanted to change, and so IFSS became a suitable option for them. It was reported that less progress was often achieved by the IFST workers with those families who had spent lots of time engaging with the care system as these families 1) had become used to the issues they were dealing with and did not feel the same sense of fear/urgency; and 2) had too many underlying issues for IFSS to address fully, at least in the time available in the current model. On the face of it, these comments reinforce one of the issues raised in the Year 1 report, in that some families are thought by the teams to be too challenging for IFSS.
- 3.27 Furthermore, the emerging qualitative evidence suggests that it is vitally important that the IFSTs are able to intervene with a family at just the right moment in time – when they themselves have realised that things need to change and prior to them having spent a considerable amount of time within the mainstream care system. As well as raising important policy questions that we return to later in this report, this also strengthens the call for greater clarity with the referral guidance. However, one consultee indicated that it was helpful to have some flexibility in terms of what constitutes a 'tipping' or 'turning' point for the families so that the IFST worker could use his or her own professional experience to judge a family's specific set of circumstances.

### **Volume of referrals and accepted cases**

#### *Fewer cases recorded than expected*

- 3.28 In the financial year 2011/12, a total of 228 referrals were made to IFSTs across the three Phase 1 sites, which is higher than the 210 referrals recorded in the first year of IFSS. A total of 174 referrals (76%) progressed to the initial IFSS 72 hour assessment stage, meaning that the referrals were

deemed to be in line with the criteria and therefore, were appropriate for assessment. Of these 174 assessments, 26 cases (15%) were re-referrals.

- 3.29 The volume of referrals and assessments is broadly consistent across the three Phase 1 sites. For example, Site 1 received 88 referrals last year (covering the period April 2011 through to March 2012), which represented an increase on the number in Year 1 (69). Site 2 received 66 referrals (compared to 55 in Year 1) and Site 3 received 74, which represents a slight decrease compared to Year 1 (86). Site 1 carried out 49 formal 72 hour assessments, and Sites 2 and 3 completed 62 and 63 respectively. The issue of the significant drop-off in numbers evident between the different stages of the model (particularly at Site 1) is explored later in this section (see Figure 3-1).
- 3.30 Consultations with IFST members revealed that there were no IFSS waiting lists containing eligible families for the service throughout any period of last year. That said, the flow of referrals and appropriate cases was not uniform throughout the year and there were some specific points in the year when the IFST at Site 1 was unable to take on any additional cases due to capacity constraints.

*Referral flows were often irregular*

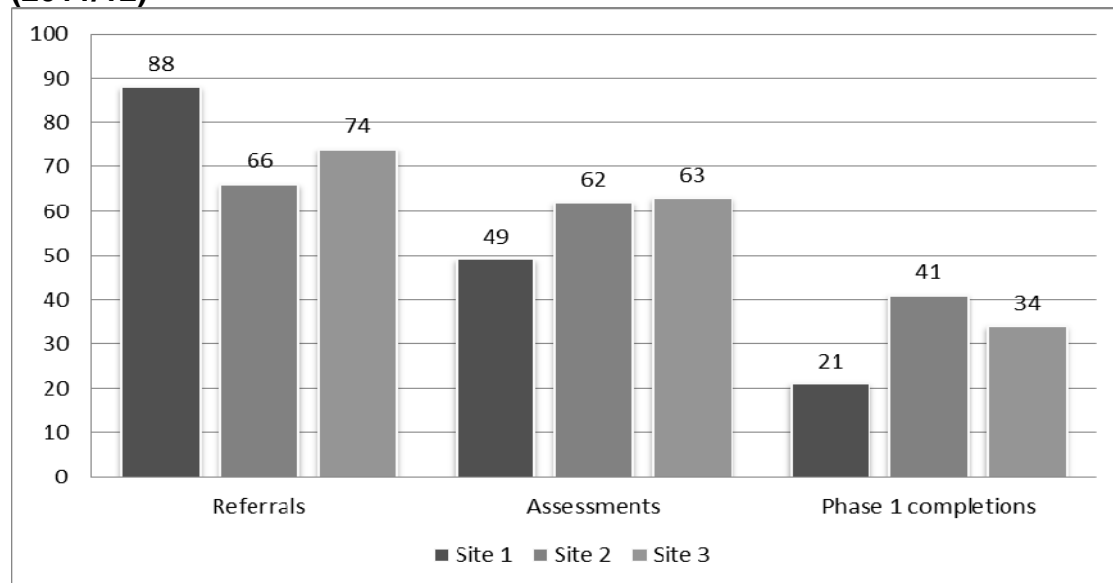
- 3.31 Feedback from consultees indicates that there were often spikes in the numbers around the school holidays and following 'drop-in' or IFSS awareness raising sessions held by the IFST members with local social worker teams. This has implications for the management of the IFSTs in terms of their capacity and utilisation.
- 3.32 It also suggested to some IFSTs that there was more demand than they saw on a regular basis: after they promoted the service families were referred, but this then dropped back soon after. The inference being that had they not promoted the service then some of these families would not have been referred. However, almost two years in to the programme it does demonstrate how difficult it has been to build a profile for IFSS which provides a regular flow of referrals.

- 3.33 It was reported, however, that the increased flows generally tapered off over time and that this was a source of great frustration amongst IFST practitioners. According to consultees across the sites, a realistic annual target for the IFSTs was around 75 to 80 cases based on their current size and capacity. It was also reported by IFST staff that they had some concerns that the referral system was still not capturing all of the 'most in need' families although they did not understand why this was the case. One view that was put forward was that IFSS was still not at the forefront of the minds of wider service providers and that more work needed to be done to address this.
- 3.34 Figure 3-1 shows the number of referrals, assessments and completed Phase 1 cases in IFSS for the period April 2011 through to March 2012. There is a reduction in the numbers at each stage of the process for all three Phase 1 sites, although it is particularly noticeable for Site 1.
- 3.35 According to the sites themselves, the main reasons for the drop-off between referrals and assessments is due to family disengagement or a change in family circumstances. This means that referral to IFSS is no longer suitable at that moment in time. These families may later be re-referred to the programme if appropriate.
- 3.36 In one site, on occasion, referrals could be made so that a family had access to specialist advice or expertise from a member of the IFST. In these situations, the expectation would be that the families would not progress to reach the assessment stage. Furthermore, from time to time, the referral could be deemed to be inappropriate or on some limited occasions, there has not been enough spare capacity within the IFST to undertake the assessment at that particular moment in time.
- 3.37 As with referrals and assessments, the main reason reported by all three Phase 1 sites for explaining the reduction in numbers between the assessments completed and the number of cases completing Phase 1 was family disengagement or a change in family circumstances. Again, this meant that the case was no longer deemed to be appropriate for the IFST.



- 3.38 Although the intervention aims to prevent children from being removed from the family, in some cases, at the assessment stage, children are assessed as being unsafe and are removed from the family. Whilst an IFSS case could still be opened in this situation (with the aim of returning the child/ren back to the family), feedback from IFST staff indicates that families generally were no longer interested in receiving IFSS support at this point.
- 3.39 There have also been some situations where families only receive the initial 72 hour assessment support. This has occurred in cases where the family does not need the full intervention but has benefitted from a limited amount of intensive support, which the social worker was not able to provide.
- 3.40 It is also worth noting the discrepancies in the data. Each of the three sites collect monitoring data in slightly different ways, so it is not always possible to directly compare 'like with like' across all three of the sites. At both Sites 1 and 3, the data may show families that were referred before the April 2011 to March 2012 period, but which were either assessed or accepted in the 12 month period. The data for Site 2 only show those families that were referred within that period. Furthermore, there may be families who were referred in the period April 2011 to March 2012 but who were assessed or accepted after this period.
- 3.41 The definition of cases accepted also varies between the sites, with some Phase 1 sites defining a case as accepted after the referral stage whilst others define a case as being accepted only once a family has fully completed Phase 1 of the model.

**Figure 3-1: No. of Referrals, Assessments & Phase 1 completions (2011/12)**



Source: SQW analysis of site monitoring data for the period April 2011 through to March 2012

3.42 The key headline from the monitoring data for the period April 2011 to March 2012, is the relatively low volume of completed Phase 1 cases (4-6 weeks of intensive support) evident in all three sites (see Figure 3-1 and Table 3-1 for details). Across all three sites, the total figure was 85, compared to a figure of 89 in Year 1. The breakdown across the sites is as follows:

- Site 1 – 21 families (20 in Year 1)
- Site 2 – 41 families (43 in Year 1)
- Site 3 – 23 families (26 in Year 1).

3.43 Furthermore, even fewer families completed Phase 2, with only four families in Site 1, six in Site 2, and 12 in Site 3. The low volume of throughout achieved has important implications for the evaluation and will limit the extent to which any robust assessment can be made of the impact of IFSS on family outcomes.

**Table 3-1: IFSS throughput**

	Year 1 <sup>9</sup> (Sept 2010 – Sept 2011)			Year 2 (April 2011 – March 2012)		
	Site 1	Site 2	Site 3	Site 1	Site 2	Site 3
No. of referrals	69	55	86	88	66	74
No. of referrals deemed inappropriate	22	4	20	0	4	11
No. of referrals progressing to 72 hour assessment	42	51	66	49	62	63
<i>Of which were re-referrals</i>	-	-	-	14	4	8
No. of cases accepted to Phase 1	34	49	-	31	- <sup>10</sup>	34
No. of families having completed Phase 1 during this period	20	43	26	21	41	23
No. of families having completed Phase 2 during this period	0	0	0	4	6	12

Source: SQW analysis of site monitoring data and the Annual Reports

## Feedback from families

### *Family circumstances*

3.44 Families taking part in qualitative interviews provided a view from those who had been referred to IFSS. The families had experienced a range of varied situations and problems prior to their referral to the IFSS programme. Most parents explained that they had been dealing with a number of problems, including:

- Drug and alcohol addictions
- Unemployment
- Poverty
- Domestic violence

<sup>9</sup>Care is needed when comparing data from this Year 2 report with the Year 1 report as the numbering of the sites has changed and there is some overlap in the data reporting time periods.

<sup>10</sup>Data on the number of cases accepted onto Phase 1 of the Programme at Site 2 were not available.

- Mental health problems.

- 3.45 A number of the children taking part in the qualitative interviews also reported substance misuse issues, poor health, and many had behavioural problems such as truancy. In many cases, parents explained that they had faced difficulties and problems in their childhood and throughout their lives. A common theme reported by many families was that they had felt unable to manage problems proactively as they were occurring. Instead, they would often allow problems to escalate and develop.
- 3.46 Families typically stated that they had a long history of previous contact with social workers and other support workers. Indeed, the majority of families had been engaging with social services for many years prior to their participation on IFSS. For example, one participant explained that the family had been through periods where there had been a social worker in the house five times a week for most of the day to help the mum to cope with the family on her own.

#### *Family motivations for engaging with IFSS*

- 3.47 A number of families explained that they had made *an active choice* to sign-up to IFSS. They had accepted that they had reached 'rock bottom' and needed help. The Programme was viewed as an opportunity to manage drug problems or to help the wider family. Often parents taking part in the interviews believed that they had reached some form of 'crisis point' before the Programme took place, in terms of their lives and the circumstances that they were facing. In some cases, this meant a realisation that they had major problems with drugs or alcohol, whilst in others, it meant realising that the threat of their children being put into care had become very real.
- 3.48 In these cases, IFSS often came as a relief, and could go some way to explaining why families were particularly open to the idea of working more closely with an IFST practitioner rather than feeling they were being imposed upon. Those parents who felt they had hit a low point were often amongst the most keen to engage with services as they indicated that they never wanted to experience the same problems again.

- 3.49 There were other families however, who saw taking part in IFSS as a way to show that they were willing to comply and do what was asked of them. They described this as an opportunity to access services and support that they would not otherwise have had an opportunity to engage with. They believed that taking part might reduce the risk of their child being taken into care or it may allow them to gain more access to their children. Families driven by this 'compliance' motivation were, on balance, less likely to actively engage with IFSS.
- 3.50 The third and final category of families was characterised by those who had no clear idea or recollection of why they had been selected to take part in IFSS. These families were generally less clear on the details of the referral process but were aware that something had changed and they were in receipt of more intensive help and support.

**“All I knew at the time was that they were coming in and I thought ‘taking over’. I tried to look at it like a Nanny, a 911 situation”**

**Parent**

*Initial thoughts and experiences*

- 3.51 A few participants stated that initially, the thought of IFSS was daunting. The intensity of the Programme meant that families considered it to be a very significant commitment. Some families were surprised about the amount of work they themselves would have to do as part of the Programme. There were also a number of comments about the time commitment needed to engage during the initial stages, with some families stating a preference for more flexible arrangements to accommodate their full time work<sup>11</sup>.
- 3.52 Participants in Site 3 suggested that clearer guidelines around the nature of the support would help to encourage people to take part. For example, leaflets could be provided to describe IFSS, including case studies of people who had been through the Programme previously.

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<sup>11</sup> The IFSS model was intended to be delivered in a flexible and responsive manner, and Heads of Service have been made aware of this.

**“I wanted more positive [communication], like ‘we are here to help you’... I felt like not wanting to open the door. If I didn’t answer that door, I wouldn’t have been here sitting talking to you.”**

**Parent**

3.53 Concerns were also expressed that, prior to their engagement, families feared that IFSS support would be similar to (negative) experiences of other assistance through ‘regular’ social care routes. Others expressed concerns about a ‘stranger’ spending a large amount of time in their home. Most families however, did not feel this was too much of an issue, with many stating that they were used to ‘strangers’ coming in to the home to talk about family circumstances.

*Encouraging greater sign-up and engagement with the IFSTs*

3.54 Parents made some suggestions as to what might make people more likely to sign up to IFSS in the future. One suggestion was an improved hand-over process with the IFST practitioner being introduced by somebody who already knows the family (such as a past social worker) – to smooth the initial induction process.

3.55 Literature (such as leaflets) describing IFSS was also considered a useful way of giving people a better idea of what to expect – something that may have made the Programme less daunting. Also, more flexible arrangements for those who worked full time could be put in place, although as mentioned previously, the model was designed to be delivered in a highly flexible manner. The issue appears to be that families need to be made more aware of this at the start of the process. Some participants felt that life was put ‘on hold’ during the first intensive phase. Most families would recommend the Programme to others and many say they know others who would benefit from taking part in IFSS. There may be additional interest generated by ‘word of mouth’ recommendations, although the extent to which these would be appropriate referrals would have to be closely examined.

## Summary

3.56 The key messages from this section are as follows:

- Overall, the general consensus amongst IFST staff and Board members was that the quality of referrals had improved as the social workers' knowledge of IFSS had increased and the IFSTs had become more experienced. However, despite investing significant time and effort in seeking to raise awareness of IFSS amongst social worker teams, it remained difficult for operational staff to have the desired impact on colleagues in these social care teams. It was suggested that a more 'top-down' approach was needed through Heads of Service
- Although individual IFST staff were able to describe in broad terms the types of family that they thought were most likely to gain from IFSS, this was with a narrower group than described in the IFSS statutory guidance. Therefore, it was thought that the guidance on eligible families would benefit from being honed and refined further. Specifically, the feedback to the evaluators suggested that additional work is required to clearly articulate what types of families would benefit most from IFSS support. Importantly, the definition will need to focus on the potential responsiveness of the family and their willingness to change
- Throughput during the year was lower than expected. A total of 228 referrals were made to IFSS across the three Phase 1 sites in 2011/12, which is higher than the 210 referrals recorded in the first year of IFSS but significantly lower than expected. A total of 174 referrals progressed to the initial IFSS assessment stage
- There were relatively small volumes of eligible families completing Phase 1 (4-6 weeks of intensive support) of IFSS last year. Across all three sites, the total figure was 85, compared to a figure of 89 in Year 1. Even fewer families completed Phase 2 (22)
- Interviews with IFSS families revealed that most parents were dealing with issues of drug and alcohol addiction, unemployment, poverty,

domestic violence and mental health problems. A number of the children taking part also reported substance misuse issues, poor health, and many had behavioural problems such as truancy

- A number of families explained that they had made *an active choice* to sign-up to IFSS. They had accepted that they had reached 'rock bottom' and needed help. Other families saw taking part in IFSS as a way to show that they were willing to 'comply' and do what was asked of them
- The intensity of IFSS meant that families considered it to be a very significant commitment. Some families were surprised about the amount of work they themselves would have to do as part of the Programme. Some families felt that clearer guidelines around the nature of the support would help to encourage people to take part. For example, leaflets could be provided to describe IFSS, including case studies of people who had been through the Programme previously
- Families and IFSTs suggested that an improved hand-over or induction process using a familiar social worker may help to increase recruitment to IFSS.



## 4: IFSS implementation

- 4.1 This section describes the key operational and delivery issues that have emerged during the second year of IFSS activity. It explores some of the process issues associated with IFSS, including some of the main risks and challenges for the future.

### Case allocation

#### *Driven by capacity – not expertise*

- 4.2 Following the formal approval of a family onto IFSS, the IFST Manager (or on some occasions it is the CSW) allocates the case to an individual member of the team. Across the three sites, case allocation to date has been determined by which worker has immediate capacity, as opposed to trying to best-match IFST expertise with the specific needs of a family.
- 4.3 In this context, it is important to emphasise that the IFSS model works on the basis of a multi-disciplinary team approach: all team members are deemed to be equal in their ability to deliver IFSS interventions. They are not expected to give a 'narrow' perspective based on their particular professional background and can share their previous professional expertise by discussing cases and sharing information

#### *The risks involved*

- 4.4 Whilst it is important to share the workload evenly across the whole team throughout the year, this approach brings with it the potential for some risks, albeit to date in a very small number of cases. Feedback from IFST workers across all three of the sites reveals that there was concern that some underlying family issues could potentially be 'missed' or misdiagnosed. There was apprehension around the identification of mental health issues in particular, which could be the cause of the substance misuse; or substance misuse being hidden and perhaps not getting picked up by workers without a background in that area.

- 4.5 That said, it was clear from discussions with IFST staff that some cases were very complex, often with families characterised by chaotic situations with multiple issues. It is difficult to envisage a worker who could be specialist in all areas, or even to expect that all issues can be identified at the point cases are allocated. The key points then are for the workers to: have sufficient skill to recognise wider issues; and be able to turn to colleagues who do have the specialist skills and draw in their support at the appropriate time. This is the way in which the model was developed originally.
- 4.6 This brings an additional challenge for IFSS delivery going forward, and one that is exercising the teams. Staff come into IFSS from specialist backgrounds, and if this specialism is valued then it is important to ensure that they retain knowledge of current best practice. All three sites have sought to ensure that their multi-agency workers remain at the forefront of their own professional practice by supporting them to access appropriate additional professional training.

### **Flexibility in delivery**

#### *Different phases of the model*

- 4.7 IFSS comprises two core phases of support activity:
- Phase 1 is the intensive intervention stage
  - Phase 2 involves maintaining the Family Plan.

In total across both phases of activity, the IFSS process lasts for around 12 months.

- 4.8 IFSS guidance indicates that within 72 hours of a referral being made, an initial assessment should be completed by the IFST worker to ascertain whether the family should proceed through IFSS.
- 4.9 The guidance also suggests that the Phase 1 intensive intervention should be delivered over a period of four to six weeks and that this should comprise between 16 and 20 hours per week. However, there was some flexibility

designed into the model, and it was expected that IFST workers themselves would determine how best to meet the needs of families through the service.

- 4.10 Phase 2 of IFSS involves providing family members with access to a range of services that are deemed necessary in helping them achieve the goals in the Family Plan. There was also some flexibility in terms of the duration of this phase although the general expectation was that this would last for between six and nine months.

*Signs of emerging variation in delivery divergence*

- 4.11 The evidence from across the three sites shows that over the last 12 months, there has been some variation in how IFSS has been delivered, both between the sites and between individual cases in each site. In many ways, this is neither surprising nor problematic, as the IFSS model was originally intended to be a flexible and dynamic one. Local implementation by the IFSTs was envisaged to be tailored around the needs of local families. That said, even allowing for the growing divergence, it is important to consider whether activity has been delivered within the broad parameters of the model.
- 4.12 The key features of the IFSS delivery process across the three Phase 1 sites are summarised in Table 4-1.

**Table 4-1: Overview of IFSS delivery across the Phase 1 sites**

	Site 1	Site 2	Site 3
<b>Referrals</b>	There is a single point of referrals for both the IFST and FST by the Duty and Assessment Team (DAT), the Child Protection (CP) Team or the Looked After Children’s (LAC) Team. The ‘information station’ where a member of the IFSS is always present to receive referrals and provide advice is where most referrals are received. Consultation will sometimes take place to offer a set of	Referrals for both IFST and Families First <sup>12</sup> are made into the Team Manager by Service Managers. The manager makes the decision on appropriate/inappropriate; this is made on the family situation / circumstances and whether IFST is the last resort. Close links with Families First mean that it can be offered as an alternative to those that require less intensive support. The team do ‘drop in’	Referrals come into the team administrator via telephone, email or through team drop ins in social services. The administrator will then pass referrals on to the team manager and CSW for allocation. The process is aided by the fact that the IFSS is now fully integrated into the Prevention and Social Care Department. All

<sup>12</sup> This is a different programme to the Welsh Government’s national Families First initiative.

	<b>Site 1</b>	<b>Site 2</b>	<b>Site 3</b>
	<p>recommendations on a family (recorded as consultation advice), these are never intended as referrals. Otherwise the referral is accepted and sent to the IFST manager for approval (recorded as a referral). Three interventions are offered by the IFSS: standard, critical and crisis.</p>	<p>sessions within the social worker teams where they are available to discuss potential referrals and give advice on cases.</p>	<p>of the referring agencies attend Prevention and Social Care management team meetings with the IFSS Head of Service.</p> <p>The main referrers are the Children and Families Assessment Team (CAFAT) and Looked After Children (LAC) Teams.</p>
Allocation	<p>Families are allocated on team capacity and then on skills where possible.</p>	<p>Families are allocated to team members on capacity and then on skills where possible.</p>	<p>Generally cases are allocated on a capacity-basis but where circumstances allow, cases can sometimes be allocated within the IFST based on the skills and expertise of the team members.</p>
72 hour assessment	<p>Families are informed that they are being referred into the IFST by their social worker and then the relevant IFST member arranges a meeting with the family, which takes place within two weeks of the referral and subsequently undertakes the three day initial assessment.</p> <p>The three day assessment seeks to explore what the motivations of the family are, what could be done and what outcomes (or goals) could be achieved, the resultant assessment is passed to the social worker for information and the family enter Phase 1 (the 4-6 week intensive intervention phase).</p>	<p>Team members aim to make contact with the families 24 hours after the referral to arrange a visit and the initial three day assessment. This initial assessment is where the team build relationships with the family and discuss what outcomes the family want to achieve.</p> <p>Sometimes the assessments can take longer than 72 hours depending on family circumstances. At this point the team member (often in consultation with the social worker, family and other team members) will make the decision whether the case is appropriate to be accepted by the IFST. This is made on</p>	<p>There is an initial meeting with the family followed by the 72 hour assessment, which also involves the establishment of a family safety plan.</p> <p>This can take longer depending on family circumstances (i.e. how big the family is or the complexity and nature of need). After the assessment has been completed, a decision is made with the social worker and the family as to whether they should progress to Phase 1. This is based on whether it is the right time for the family and they have recognised that something needs to change and they have reached a clear</p>

	Site 1	Site 2	Site 3
		determining whether the family is willing and at 'crisis point'.	'tipping point'. If families are not engaging then they are rejected from IFSS and passed back to the social worker, who will continue to work with the family.
Phase 1 (4-6 weeks)	<p>The family and IFST worker seek to work together to achieve the set of goals in the initial assessment.</p> <p>The Phase 1 intervention varies in length depending on the family situation. The social worker remains involved at all points, and in some cases has been involved during the Phase 1 support if required. At the end of the phase, a report is produced and a maintenance meeting is held with the family and social worker to agree what support is required beyond intervention.</p>	<p>At the start of the intensive phase a date is set for review by the IRO. Regulations require the review to take place within 28 days of the assessment and so to fit with IRO dates, Phase 1 is between 3-4 weeks.</p>	<p>This stage involves intensive working with the family once they have been assessed on the 'model of change', which informs the type of exercises used. The case holding IFST spearhead worker will work with the family both as a unit and individually.</p> <p>Where families previously accessed a broad range of services, this stops during Phase 1 of IFSS, unless they are essential e.g. Child Access Visits.</p> <p>At least 50 hours of support must be provided within the 4 to 6 week period to ensure that the intensity of the model is not diluted.</p> <p>The IFSS programme has also commissioned Action for Children to provide a solution focused counselling service as well as cognitive behaviour therapy for families in Phase 1 (and Phase 2).</p> <p>Barnardos has also</p>

	Site 1	Site 2	Site 3
			<p>been commissioned to provide Family Group Meetings (FGMs) to families with children on the CPR during Phase 1.</p> <p>At the end of Phase 1, a decision is taken with regards to which wider support providers and services should be engaged.</p>
Phase 2	<p>Reviews are undertaken at 1, 3, 6 and 12 months post phase 1 intervention. In addition booster sessions are offered to work through any lapses or recurring issues (these last on average about two to three days).</p> <p>Once a family reaches the 12 month mark and all goals have been achieved the case is then closed. Cases which achieve goals before this point are still kept on the social worker caseload to ensure they can be tracked for the full 12 months.</p>	<p>After the review other services are determined and the family gradually has less contact with the case worker and more contact with multiple other services. Boosters are offered to families thought to benefit from a 'refresher' and this will often happen around nine months from referral.</p>	<p>Once the relevant wider service providers have been identified, these are signposted at the review meetings (at 1, 3, 6 and 12 months) to ensure that the IFST member does not become the default case manager. Similarly, for those families that were accessing a range of services prior to IFSS and these stopped during Phase 1, they often resume during Phase 2 of the model. The reviews are goal focused and are used to determine whether the family plan is still fit for purpose. A Family Aid Worker is used in Phase 2 to support families as directed by the Spearhead worker.</p>

- 4.13 In Site 1, following referral, the assigned IFST worker is tasked with arranging a meeting with the family and this would occur within two weeks. Following this, a 72 hour assessment is conducted, whereby the motivations of the family are explored and a series of outcomes (or goals) are identified. The

resulting Family Plan is shared with the social worker and the Family enters Phase 1 of IFSS.

- 4.14 Staff stated that the length of Phase 1 varied depending on the responsiveness of the family. For instance, one consultee stated that some of his case families had progressed through Phase 1 in fewer than two or three weeks as the intervention had started to work quickly. In contrast, other families who had received support had required the full six weeks and sometimes longer.
- 4.15 Elsewhere, in Site 3, IFST staff also reported some variation in the amount of time spent working with families during Phase 1. Several consultees stated that the size of the family was often an important factor here – in addition to the family’s responsiveness to the support. Those families with larger numbers of children for example, tended to take more time to progress through and complete Phase 1, although IFST staff were becoming more experienced at managing this. Furthermore, Site 3 took the decision that all families would receive at least 50 hours of support during Phase 1 so as not to undermine the intensity of the model. It was also reported that increasingly, IFST staff are giving more consideration to planned endings with cases, as more were reaching the 12 months stage.
- 4.16 A different issue was raised in Site 2. They had sought to tie their end of Phase 1 review in with the Independent Reviewing Officers (IROs) process – both paperwork and meeting dates. This has an advantage of generating staff time efficiency. Similarly, in Site 3, an agreement was reached to formalise the relationship between the IROs and IFSS. This has resulted in better co-ordination of reviews and less bureaucracy. The IROs now act as chair for all IFSS Children in Need (CIN) meetings with IFST staff providing administration support.
- 4.17 However, this integration had caused concerns for the team in Site 2 that:
- They reported undertaking their work and assessment to fit with the IRO’s requirements, which was seen as slightly at odds with the flexibility intended for IFSS. This was a decision that was taken locally

and was not part of the IFSS model. Given the issues that have emerged, it will be interesting to see whether Site 2 revisits this next year

- They had to fit in with the timing of the review meetings. In some cases these were occurring around 23 or 24 days after referral or just over three weeks into Phase 1. This created some challenges for IFST staff as it compressed the time that they had available for Phase 1 work.

4.18 Some IFST consultees acknowledged that they had worked with some families during Phase 1 where limited progress had been made. These cases had 'drifted' somewhat and had not completed Phase 1 within the six week time period. One example that was cited was a mum who was pregnant and who needed to continue to access intensive support until her baby had been born.

4.19 In relation to Phase 2, IFST staff claimed that they had become more experienced and skilled at sequencing support as opposed to seeking to tackle the entire Family Plan at once. It was suggested that this was important, as it enabled the family to better manage the various demands that were being placed upon it. It was also claimed that over the past 12 months, IFST workers had become better at signposting to wider family support services, thus preventing them from becoming the default case managers.

4.20 There was also some evidence of divergence in relation to the targeting of families. For example, Site 1, through the creation of the FASS, had broadened out its offer to provide IFSS-type interventions to families that were suffering from wider problems, such as domestic violence, mental health, or learning disability issues. One other site also provided support to families with 'wider' issues, although this was only carried out on a small number of occasions and the broader approach was never formalised. The third site continued to target those families that suffered from substance misuse.

4.21 Generally, IFST workers felt that it was important to have some flexibility and 'local control' in the model so that it could be sensibly tailored around the



specific needs of individual families. However, a small number of consultees did state that they felt the model worked fine as it was initially prescribed.

#### *Transition between Phases 1 and 2*

- 4.22 Feedback from all three Phase 1 sites suggested that there was some concern amongst IFST staff that the transition from Phase 1 of the intervention to Phase 2 was too severe in some cases. Some families that accessed IFSS support were receiving a wide range of services prior to IFSS, which had to be withdrawn when they entered Phase 1. After completing Phase 1 and entering Phase 2, these various services were reactivated. It was reported that the transition from Phases 1 and 2 was likely to be less severe for these cases.
- 4.23 However, for other families who had limited experience of accessing services prior to Phase 1 of IFSS, the shift to less intensive support in Phase 2 can be extremely challenging. It was reported that during Phase 1, some of these families became heavily reliant on the intensive support they received from their IFST case worker. However, this stopped suddenly. Then, once they had progressed to Phase 2 of the model, some of these families found it overly challenging without access to the regular intensive support. Unfortunately, they lapsed and some of their former problematic behaviours re-appeared. It is not clear to the evaluators why in some cases, the evidence suggests that there has been a sudden and harsh transition between the different phases of IFSS. The model was not designed or intended to be delivered in this manner. Rather, it was expected that activity would be tailored to meet individual family needs.
- 4.24 The sites responded to this challenge in different ways. In Site 1 for example, some IFST staff stated that at the end of Phase 1, they actively ensured that the social worker held regular meetings and contact with the family until they reached the six month review stage, in order to keep them 'on track'. Additionally, it was reported that in some cases, the IFST worker maintained a weekly contact with the family for the first three months after Phase 1 so as to offer a more gradual reduction in IFSS support.

- 4.25 In Site 2 they had sought to smooth the delivery process. This was done by reducing the intensity of engagement in the final week of Phase 1, so that the family began to realise that the worker would be around less in the coming weeks. However, it is important that any scaling (up or down) of the intensity of the intervention must be in response to family need.
- 4.26 In Site 3, staff reported that they needed to do more to manage expectations with the families and to ensure that they were not surprised by the transition. Additionally, the Family Aid worker, who forms part of the IFST, was used to help bridge the gap between Phases 1 and 2, through the use of short-to-medium intensity interventions. The IFST Manager has suggested that there should be consideration of developing an additional stage in the IFSS process. This would formalise a medium intensity phase of support based around the specific needs of the family, which could allow the IFST worker to better manage a gradual withdrawal of provision. However, this would have cost and capacity implications, and given the flexibility that is already allowed within the model, it is not clear that an additional phase is required.

#### *Use of the booster sessions*

- 4.27 Within Phase 2, 'booster' sessions were also available from the IFST worker if they were required. These were delivered with the families when there were any lapses and they were designed to last for around two or three days. However, one member of the IFST in Site 1 thought that the booster sessions needed to be longer and that he had on one occasion, spent an extra 10 days with the family. Another consultee stated that the impact of the booster sessions was often determined by the timing and the quality of the referral from the social worker. It was also reported by several consultees at one site that up to three 'booster' sessions could be delivered. However, this limit of three sessions must have been set locally by the site. The IFSS model did not prescribe how many 'booster' sessions should or could be provided and a limit is not presented in the Guidance.

## **Style of working**

### *Internal collaboration and information sharing*

- 4.28 Consultees reported that it was important to develop a strong culture of team-working, collaboration and information sharing within the IFST. This can help to ensure that staff have regular access to different specialisms and some of the risks highlighted above around 'self-working' can be mitigated.
- 4.29 However, the story across the sites on this issue is rather mixed. In Site 3 for example, reflective meetings were formally introduced and these were held on a fortnightly basis. They were designed around the model and were intended to be solution-focused and goal orientated. In Site 1, a 'pod' structure was developed to deliver group-based peer supervision, which occurs on a weekly basis and is led by a CSW. All IFST workers at the site also benefit from having a 'buddy', to ensure their personal safety, to offer emotional support when needed and to provide a sounding board to discuss particular issues and experiences.
- 4.30 In contrast, in Site 2, it was reported that some of the team had perhaps become 'too comfortable' and there was less evidence of cross-team working and sharing information about cases, lessons or good practice. It was suggested that as the team had become busier over time, there was less commitment to attend reflective meetings and eventually they were no longer held. Similarly, when IFSS was first introduced, a buddy system was established so staff could discuss specific cases and make use of the different specialisms. It was suggested that this was effective initially but it had become more patchy and informal over time. This is an important issue going forwards in terms of delivery culture and behaviour, as reflective meetings and collaborative team-based working formed a central feature of the IFSS model when it was first developed.

### *Influence on wider services*

- 4.31 The evidence collected during the second year of IFSS activity suggests that in places, the Programme is starting to have an influence over wider service delivery.

- 4.32 For example, in Site 1, it was reported that the IFST had built a very strong relationship with the local authority's housing team. As a result the IFST was able to persuade the Housing Manager to act as an advocate for IFSS families and to help foster stronger relationships with Registered Social Landlords in the areas as and when required. At the same site, a local Specialist Substance Misuse Service has now started to conduct home assessments as a result of the work of the IFST, which means that individuals are able to get referred, assessed and to receive suitable medication more quickly.
- 4.33 In Site 2, there are also signs that IFSS has had an impact on partner agencies and service providers in places. However, some IFST members suggested that the large geography meant that it was difficult to become fully embedded in lots of local service networks. One IFST suggested that perhaps each worker should be responsible for a small area. Feedback also indicated that at times it was difficult to get wider services to attend case conferences and review meetings, although the IFST staff appreciated that other services were often under severe pressure due to a lack of resources.
- 4.34 Feedback from Site 3 indicates that the relationships with other services have strengthened during the last 12 months, with links created through staff secondments identified as being helpful. Encouragingly, wider service providers stated that they could see the difference in the way families had engaged with them after they had received IFSS support. Additionally, it was claimed that local health partners had started to cover motivational interviewing techniques. Similarly, because the Head of Service in Site 3 covered IFSS and another service area, it had been possible to actively promote and 'push' IFSS techniques amongst wider staff and the take-up had been impressive. For example, motivational letters had been used on a regular basis within this other service area.
- 4.35 Nevertheless, it was reported that relationships across the three sites with social care worker teams remained sub-optimal. In Site 1, IFST workers reported that there had been some on-going personality clashes between the case holding social workers and members of the IFST. It was suggested that

social care workers felt that not all IFST members had a good enough grasp of child protection issues and vice versa, some IFST members felt that social workers were too rigid in their approaches.

- 4.36 Additionally, it was acknowledged that some wider services would find it difficult to fully embrace IFSS because they did not have sufficient resources available or spare capacity to deliver intensive levels of support during Phase 2 of the model and beyond.

*Continued strong support for the model from IFST workers.*

- 4.37 Across the sites there was strong and universal support for IFSS as a delivery model. IFST staff have remained fully bought into the fundamentals of IFSS and they reported that they felt the tools and techniques that had been used, had in the main, been highly effective.

- 4.38 Specifically, the following were consistently mentioned in a positive manner:

- motivational interviewing techniques
- evidence-based tools
- cognitive behaviour therapy
- the development of a 'whole family' approach
- the ability to spend more time with families to uncover the underlying issues and adopt a long-term view.

### **Feedback from families**

*Views towards the IFST practitioners*

- 4.39 One of the key findings was how fondly IFST practitioners were spoken of and regarded by families. This was often in stark contrast to families' reported experiences of 'regular' social workers that were often typified by less constructive and less positive working relationships. Families who had previous experience and interaction with social services would often describe social workers in a negative light. They typically felt that the social worker was:

- there to *judge* – and make decisions
- there to *observe* – checking up on or spying on the family
- sometimes *disinterested* in the family.

4.40 The relationship with regular social workers was often described as:

- having a short-term focus
- sometimes being defensive/adversarial
- not always open or honest
- overly formal or legal.

**“Whatever I told him [the old social worker] in confidence was always [brought up and] exaggerated towards me that I was the bad person.”**

**Parent**

4.41 This typically was felt to result in families feeling that they could not open-up and ‘be themselves’ with their social workers – something they acknowledged was to the detriment of their working relationship:

**“I’d hold a lot back [from the traditional social worker] because everything I told him he would twist it around.”**

**Parent**

4.42 Most families described the IFST practitioners as being notably different to traditional social workers. They tended to feel that the IFST practitioners were:

- *supporting the family* – helping to tackle the issues behind the problems and referring families to services
- *encouraging and motivating*
- showing *genuine interest* in the whole family and not just focussing on children.

**“With social workers it is just about the children. With [IFSS] it is about helping the parents so they can help the children.”**

**Parent**

4.43 Interestingly, some IFST members made a similar comment. They had come from an adult social services background and explained that while they previously thought that they had taken a family perspective, only since they came to IFSS had they really understood what this meant. It had in effect highlighted to them shortcomings in their previous ways of working.

4.44 Families described the relationship and support they received from their IFST practitioner as being very different to the relationships they have had with social workers in the past. They described it as:

- having a long-term focus
- being more supportive and open
- containing a more joined-up and holistic approach
- comprising a more motivational and therapeutic approach
- consisting of tailored support
- being more honest
- more informal and relaxed.

**“[The practitioner] told me I don’t need to worry about tidying up. I used to tidy up as otherwise they [social services] would think there was something seriously wrong.”**

**Parent**

**“I opened up ...and I told her some things that I’ve never told anybody in my life”.**

**Parent**

4.45 The individual IFST practitioners were described very warmly; often referred to as “just like one of the family”. Having access to someone that the families felt ‘genuinely cared’ about them had a very positive impact, and gave many family members the strength and encouragement to initiate significant change within their lives.

*The types of support delivered*

4.46 Figure 4-1 summarises the different types of support that families talked about.

**Figure 4-1: Menu of support described by IFSS beneficiary families**

Practical	• Parenting skills, conflict resolution, anger management, support with managing problems before they escalate.
Referrals	• Families were referred to a wide range of services including drugs support, carers groups, support with employment and training advocacy services.
Engagement	• Encouraging parents and children (esp. fathers) to engage with service providers.
Holistic	• Both in terms of the support provided and the focus on the whole family.
Advocacy	• Supporting families in courts and tribunals and helping them to work with service providers.
Motivational	• Motivational techniques used to encourage families to have more ownership/ control of their lives.
Therapeutic	• Helping families to understand and overcome deeper underlying problems (such as childhood trauma) that act as a barrier to progress.

*Phase 1: Assessment period*

*Family views towards the assessment period*

4.47 Most families, particularly those in one site, reported having an intensive 72 hour period of support at the beginning of the IFSS programme. Other families recall this being a general period of intensive support. This intensive period of support was often recognised by families as being about identifying the families' problems and their goals.

**“We were told it was going to be intensive. It was about setting goals and boundaries”.**

**Parent**

4.48 Efforts were made during this time to involve the whole family in the process. In some cases the family would be visited together, in other cases where family members lived apart, different family members would be visited



separately over the intensive period. Participants explained that their IFST practitioner would typically spend three or four hours a day with the family in this early period.

*Families' perceptions of the assessment period*

- 4.49 Many of the families reported that this period was emotionally draining as they had to spend a significant proportion of each day, thinking and talking about the problems they had, particularly when a more therapeutic approach was taken. Most of these families felt however, that the process of discussing their past and the difficulties they had faced had been helpful.

**“I could talk to her [practitioner] ... I admitted everything to her. It felt like I had talked for weeks or months... She wasn't shocked by anything I said... it didn't faze her, she was expecting it.”**

**Parent**

- 4.50 There was general agreement that the intensity of the early period of intensive support was necessary as it allowed family members to engage with the programme and get to know the IFST practitioner who would be seeing them. It encouraged some to see the program as being something that they would have to commit to if they wanted to improve their lives.
- 4.51 Some participants explained that they might not have engaged with the programme if the initial support period had been less intensive, particularly in the area where the focus of IFSS support was often felt to be particularly emotional. This was also true of families interviewed in the other areas, though with many of the families having stated that they had reached “rock bottom”, they were quite positive about the impact of their practitioner even at an early stage.
- 4.52 Some parents took time to trust and engage with the IFST practitioner, particularly if they had felt that the programme was being imposed on them and they had not trusted social workers in the past.

**“[My partner] never used to look directly at [the IFST practitioner] [have eye contact]. Now he looks forwards to his meetings [with her].”**

**Parent**

- 4.53 One working family felt strongly that the initial 72 hour period placed too much of a time burden on the family. Further details are available in the case study below.

**“Financially we took a battering because we couldn’t work. For 72 hours it was intensive every day.”<sup>13</sup>**

**Parent**

**A burden on the family**

**What happened?**

One family found the **assessment period a burden** – they had work and caring commitments.

One child felt that the ‘card games’ had seemed ‘pointless’ – and we were told that the father also struggled to engage.

The mother appreciated being able to talk about the family but became frustrated when she felt she was repeating herself without making any progress.

**What could have been improved?**

The mother explained that a **less intensive** assessment would have been easier for her to manage.

She also would have liked to have had **more support** with her caring responsibilities.

*Phase 1: Intensive period*

- 4.54 Families received between 4-6 weeks of an intensive programme after the assessment period. In a few cases this was extended as families needed more time in the intensive stage. Many families spent this time learning how to begin to achieve the goals that had been identified.

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<sup>13</sup> It is important to note that this was an isolated comment and the model was designed to have sufficient flexibility built into it so that no participating families would be prevented from working.

*The techniques used by practitioners*

- 4.55 Families reported receiving a folder of documents that enabled them to keep track of the progress they had made. Many families' referred to this folder throughout the interview.

**“My goals were staying off drugs and drink, getting the children hobbies, doing things with them, getting a routine in...I’m on silver/gold on all of them”**

**Parent**

- 4.56 Families in Site 3 explained that the personalisation of their folders (using pictures and colours that meant something to individual family members) had increased their sense of ownership of and engagement with the family plan.
- 4.57 Participants used similar materials such as “card games” to identify their problems, develop solutions and report their progress. These materials were used by the whole family: most of the children remembered using the card games to think about the different members of the family, and their different emotions and needs.

**“He spent time with the kids on a one-to-one basis and with us on a joint basis... We played card games based on our feelings and [used] scorecards”.**

**Parent**

- 4.58 While the materials used in these sessions were similar, the support was personalised for each family. In general, families in Site 3 were more likely to report receiving more therapeutic support while families in Site 2 often received more practical help around parenting skills. Families in Site 1 reported receiving a mixture of both types of support. These differences may have been as a result of the different needs of the families interviewed and not necessarily a difference in approach taken by IFST's across the three pilot sites.
- 4.59 Many of the family's interviewed felt that the Programme had given them a greater sense of control and the motivation to do things for themselves. An example of this has been described below:

- One mother who had problems with depression, and could easily become reliant on other people, explained that her IFST practitioner had encouraged her to manage things by herself. One example of this was when the mother found it difficult to phone people. The IFST practitioner would help her by talking to her about the best ways of addressing her difficulties but would not make the phone call on her behalf so as to avoid making the mother dependent.

4.60 Some parents in Sites 1 and 3 spent time exploring long-standing problems or traumas (such as experiencing domestic violence as children). Many parents explained that the process had allowed them to express feelings that they had previously kept to themselves. This was particularly important for those who were less comfortable about talking about their problems to friends and relatives. Some participants explained that this process helped them to understand and explore the root cause of some of the problems that they had faced as an adult and how they could overcome these problems.

4.61 Participants in Sites 1 and 2, and one family in Site 3 reported being taught specific parenting skills and support around managing their children's behaviour and setting boundaries. Many parents explained that they had struggled to manage this in the past with the result that children's poor behaviour would be ignored until it escalated. Parents and children felt that parents' improved parenting skills had a positive impact on their children and the wider relationships within the family.

**“[The IFST practitioner] helped the relationship with my mum. Before [the programme] we used to be more like sisters than like mother and daughter. We used to argue a lot about TV and stupid stuff. “**

**Child**

4.62 It was stated by families that the practitioner often became 'part of the family' – gaining the trust of all the family members. A few family members explained that they felt they had developed genuine friendships with their IFST practitioners. The close relationships that practitioners had with families helped them to get a real sense of the family dynamic and allowed them to suggest relevant and appropriate ways of helping the family. Practitioners

understood when families were ready for particular services such as employment support and training. This building of relationships and trusts is the other side of the dependency issue reported previously in this chapter.

**Working closely with the family**

**What happened?**

A mother and child felt they were at “rock bottom”. The mother had mental health and alcohol problems and a poor relationship with her child.

The family worked on a number of tasks to identify strengths and weaknesses in their relationship.

The practitioner also had an advocacy role supporting the family in discussions with the child’s school which enabled them to achieve a more productive working relationship.

**What can we learn from this?**

The relationship that the practitioner developed with the whole family was crucial

The advocacy role was important in helping the family to gain confidence and self sufficiency.

*IFST practitioners’ skills and expertise*

- 4.63 There was some recognition that practitioners were working together to share knowledge and skills. Some families reported that their IFST practitioner had gained knowledge and expertise as the Programme went on. Families who noticed this often felt that they were also helping the practitioner in some way by giving them the opportunity to extend their knowledge and skills. One family felt that the practitioner did not have the specialist knowledge of helping children with chronic conditions that the family needed.

*The transition to Phase 2*

- 4.64 Some participants explained that they had felt nervous about the prospect of a reduction in the level of their support as they moved from Phase 1 to Phase 2. They were helped by having a phone number for their IFST practitioner available at any time. This typically served to reassure families that they were not going to be ‘on their own’ and that their support was still available if they needed it. As the staff turnover increases in the sites this may have a detrimental impact on some families if they cannot remain in contact with their previous IFST members. Therefore, the sites/IFSTs may have to consider

how they can bridge this 'gap' and effectively manage the expectations of the IFSS families.

- 4.65 Some families had been given treats such as cake or sweets, or a trip out to mark the transition between the more and less intensive periods. These were symbolic celebrations which marked the end of one phase of the programme and the beginning of the next phase.
- 4.66 Many of the families were still using their individual folders and other tools such as help cards on a regular basis after they stopped seeing their IFST practitioner. For example, one mother kept a note on the cupboard where she kept her cleaning things to help her calm down. The position of the note was important as she often tidied up as a way of managing her stress and gaining some control over her life. This meant that she would see the note at times when she was becoming most stressed.

#### *The use of booster sessions*

- 4.67 A few of the families had received booster sessions where they had faced a problem or difficulty. For example, one family had received a booster session after the mother and father had got involved in a serious argument. This really helped the family to understand and manage their problems and learn techniques for ensuring that disagreements did not escalate into major arguments that could put their child's well-being at risk.
- 4.68 Families explained that their IFST practitioner would often text them on a weekly or fortnightly basis to see if they were alright. This was seen as reassuring as it reminded them that they had somebody to call if they ever needed any help.

#### **Summary**

- 4.69 The key messages from this section are as follows:
- IFSS referral cases are distributed across the IFST members based on capacity as opposed to professional expertise. Whilst it is important to share the workload evenly across the whole team throughout the year, this approach brings with it the potential for some risks, albeit so far

recognised in a very small number of cases. The key risk is that professional expertise is not being shared as the IFSS model originally intended and this could result in some underlying issues being 'missed'. It is acknowledged that to some extent, these risks would always exist regardless of how cases were allocated, but they would arguably be reduced if the sites were operating higher levels of team-based working

- The evidence from the three sites shows that over the last 12 months, there has been some variation in terms of how IFSS was delivered, both between the sites and between individual cases in each site. For instance, IFST staff stated that the length of Phase 1 varied depending on the responsiveness or size of the family. Given the flexibility that was designed into the model from its inception, this growing divergence is to be expected and welcomed, as long as local delivery remains within the broad parameters of the model
- Feedback from all three Phase 1 sites suggested that there was some concern amongst IFST staff that the transition from Phase 1 to Phase 2 was too severe for some families. One IFST Manager suggested that there should be consideration of developing an additional stage in the IFSS process, although this may not be necessary as the IFSS model is not intended to be a rigid one. The transition and intensity of the support throughout the IFSS process should be guided by the family's needs
- Consultees reported that it was important to develop a strong culture of team-working, collaboration and information sharing within the IFST. This can help to ensure that staff have regular access to different specialisms and undertake less 'self-working'
- The evidence collected during the second year of IFSS activity suggests that in places, the Programme is starting to have an influence over wider service delivery

- Across the three sites amongst IFST staff, there was evidence of strong and universal support for IFSS as a delivery model, including the innovative tools and techniques used
- Families reported receiving a folder of documents that enabled them to keep track of the progress they had made
- Families reported that they were very fond of the IFST workers. They stated that their IFST practitioner often became 'part of the family' – gaining the trust of all the family members. A few family members explained that they felt they had developed genuine friendships with their IFST worker
- Some families stated that they had felt nervous about the prospect of a reduction in the level of IFSS support as they moved from Phase 1 to Phase 2. Having access to their IFST worker's telephone number was greatly valued and reassuring.



## **5: IFSS outcomes and impacts**

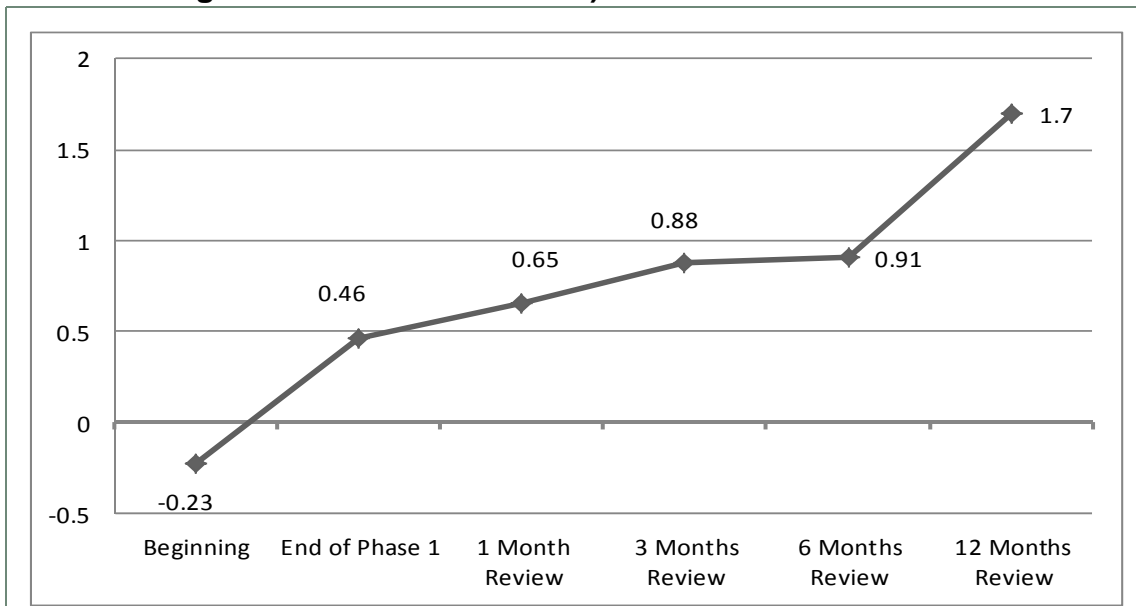
- 5.1 This section explores the impact of IFSS on family outcomes in the Phase 1 sites by considering the quantitative monitoring data collected by the sites and the qualitative evidence generated by the evaluation from IFST consultees and beneficiary families. A note of caution is needed when considering or interpreting these interim findings given the limited number of IFST consultations and family interviews completed thus far. Nevertheless, some interesting messages are emerging.

### **Family progress evidenced through the Goal Attainment Scale**

- 5.2 Phase 1 sites 3 and 1 use Goal Attainment Scales (GAS) to estimate the progress made or the 'distance travelled' by the beneficiary families on the IFSS programme. More specifically, scores are allocated for each family's individual goals. All the goals are strength-based and they therefore require the family to be pro-active in making positive changes which contribute to safer, improved family functioning. Families score themselves at each of the main review stages (at one, three, six and 12 months).
- 5.3 It is still too early to form any robust conclusions about the long-term impact of IFSS on family outcomes and the sustainability or persistence of such impacts. However, the available monitoring or tracking data from the sites suggest that generally, broadly positive trajectories are still being achieved by the majority of the participating families. This finding was reinforced by the feedback from the IFST members and families themselves. Nevertheless, caution is needed when interpreting these interim findings due to the limited volume of monitoring data across the three sites. Additionally, although the positive impact on families is encouraging, this may in part reflect some earlier selection by the sites about who they think they can best help.
- 5.4 Consultees reported that a common pattern is emerging with most of the families receiving IFSS intervention. Initially, there is a significant improvement perhaps as might be expected, and then progress appears to become more slow and steady, prior to a further substantial improvement towards the end of Phase 2. In short, the evidence suggests that a major

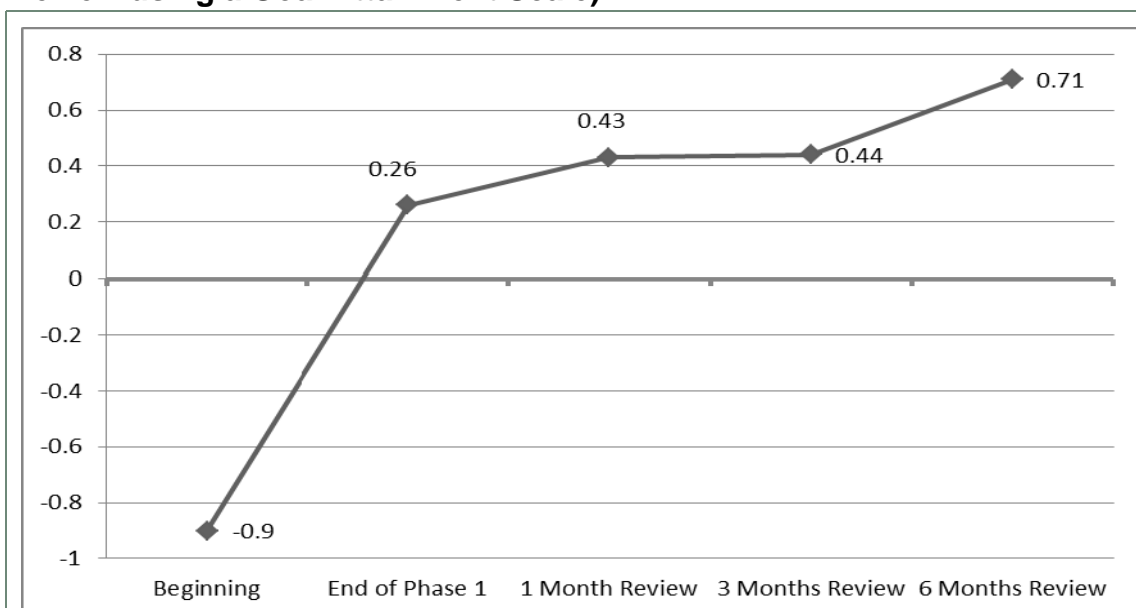
improvement occurs between the beginning and the end of Phase 1. The next stage of the intervention through to the six month review is characterised by a more gradual improvement in terms of family functioning. During the six month review and the final review after 12 months, another significant positive shift is evident (see Figure 5-1 and Figure 5-2).

**Figure 5-1: Site 3 progress (average distance travelled to 12 months review using a Goal Attainment Scale)**



Source: Annual monitoring report 2011/12 for Site 3

**Figure 5-2: Site 1 progress (average distance travelled to 6 months review using a Goal Attainment Scale)**



Source: Annual monitoring report 2011/12 for Site 1

### **Family progress evidenced through the Family Progress Chart**

- 5.5 Site 2 uses a similar Family Progress Chart based on GAS alongside other indicators of distance travelled that include feedback received from referring social workers and the families at the end of the intensive phase of IFSS intervention.
- 5.6 The self-reported Family Progress Chart data from Site 2 suggest that those factors where most progression has been achieved during the intensive phase are as follows:
- The extent or stability of the substance misuse
  - The ability of IFSS to meet a child's emotional needs
  - The level and nature of health risks associated with the substance misuse.
- 5.7 Those factors where least progression has been achieved during the intensive phase at Site 2 were:
- The adequacy of accommodation
  - The life-styles of the family members in relation to their health
  - The appropriateness of the home specifically in relation to meeting the children's needs.

### **Wider evidence of IFSS impact**

#### *IFSS success*

- 5.8 Consultees identified numerous examples of where the intervention had made a tangible difference in terms of helping family members with substance misuse and tackling complex wider issues as they sought to turn their lives around. The most common positive outcomes achieved were identified as follows:
- Ensuring the safety of children and young people within participating families

- Family members accepting responsibility for their actions
- Clearer family functions
- Improved family relationships
- No illicit substance misuse
- No crimes being committed
- Houses kept in a better condition
- Improved parenting skills
- Higher levels of confidence and improved service engagement.

*Examples of successful cases*

5.9 A number of specific successful cases were also reported to the evaluation team by IFST members, including the following:

**Case A: A young pregnant mum was misusing**

**What happened?**

She had no previous engagement with services. At birth, the baby was taken away from the mother and the IFST became engaged. Support was provided, goals were met and the baby was eventually returned to the mum and de-registered. On-going support was provided through children's services and housing.

**What is the lesson from this?**

It was reported that this case was a success because it was the mum's first contact with the support services. She was eager to comply with the IFST worker and to turn her life around so that her child could return home safely.

**Case B: Involving a mum and her 12 year old daughter**

**What happened?**

Mum was drinking alcohol and the daughter was out of control (aggressive and sexualised). Mum was seen to be alcohol dependent, but because of the IFST worker's background, it was discovered that the drinking was masking something else. The underlying problem turned out to be psychiatric issue. It took time to get to this point, which meant slowing the model down to ensure that all the complex details of the case could be fully captured. After this point it was possible to address the underlying issue and get the daughter referred to a specialist service provider. Six months later, mum was no longer seen as a risk and she now has part time job.

**What is the lesson from this?**

The issue of misdiagnosis within children's services was highlighted as a problem but the background and expertise of the IFST worker was also crucial in enabling the discovery of 'hidden' issues.

### **Influences on the success (or not) of IFSS**

- 5.10 Wider discussions with the three IFSTs highlighted a broader set of factors which led to positive outcomes. Although it is difficult to generalise, it was reported that IFSS seems to deliver most impact to those families that can be characterised as being 'new' to the system or 'early intervention families'.
- 5.11 For those families that have received repeated support over many years, it was claimed by consultees in one site, that it is often more difficult to achieve significant positive outcomes because they are less willing to 'comply' or to engage fully. Additionally, if a family has little or no experience of accessing other services, the intensive nature of IFSS can sometimes act as a 'shock', which can motivate families to turn their lives around.
- 5.12 Furthermore, it was stated that the multi-agency approach of IFSS and the mix of expertise across the IFST were also important in achieving success. It was acknowledged that an IFST member cannot be expected to be expert in everything but he or she needs to have sufficient skills and capability to know what to look for from a potentially large menu of issues. This is where information sharing amongst IFST members, the use of reflective meetings, where staff can discuss specific cases, and effective relationships with wider service providers can add real value and remove *some* of the inherent risks.
- 5.13 However, the IFSTs also identified some common factors which tended to reduce the likelihood of success. Consultees indicated that for some families, those with too many goals or problems to address all at once, IFSS interventions are often less successful. Although some progress can often be achieved during the intensive initial phase, it is very difficult to sustain this with the current model as a dependency can be created which cannot be maintained once the family has moved from Phase 1 to 2, as described in Section 4.
- 5.14 That said, where there are multiple 'issues' within a family, it is vitally important that the sequencing of support provision is carefully planned so that problems can be tackled in the right order. For example, it is important that IFST staff are able to spend sufficient time with families to be able to identify

any hidden or underlying issues that may be causing the drinking or substance misuse.

*Examples of less successful cases*

5.15 A number of less successful cases were also reported to the evaluation team by IFST members, including the following:

**Case A: Family with domestic violence and substance misuse issues, plus a three year old baby who was on the CPR having witnessed the violence between the mum and dad**

**What happened?**

Mum also had a 14 year old son who had been in Spain with the paternal side of his family for the past 10 years. He had a different dad to one currently living with the mum for the past 10 years. However, for various reasons, he was now being returned home to live with his mum again having not seen her for the whole period whilst he was away. The ISFT worker sought to work with the step father regarding his anger management and with the 14 year old to build new relationships. The IFST worker sent both the mum and dad to parenting classes for the three year old.

The family reached 'green' on four of the goals in the Family Plan and on the face of it, appeared to be doing well, and were reaching the Child Protection conference stage (i.e. the formal CP review). However, at this point, it was discovered that the step dad had been abusing the mum and step son behind closed doors and he had simply been 'hiding this well'. Both children were removed from the home and legal proceedings were taken.

**What is the lesson from this?**

The IFST worker reflected that he had felt that the family had made improvements and were responding well to the IFSS support, but he had failed to discover that dad was good at 'acting the part' when in reality he had not changed at all. A worker with more specialist skills and experience in this area may have spotted this underlying issue earlier in the process but we cannot be sure of this.

**Case B: Mum, dad and three children, one of whom was a drug user**

**What happened?**

Dad was at the periphery and the step dad was a poly drug user, as was the mum. Grandma was involved but she was very ill. All three children were on the child protection register. It was a complex case with multiple issues to deal with: protection; mum's misuse; coping strategies; and parenting skills. The first month of IFSS engagement went well but progress could not be sustained as the family lost motivation.

**What is the lesson from this?**

The IFST worker was not completely sure why IFSS had not worked but it was suggested that there were simply too many issues to address all at once. Similarly, it was felt that Phase 1 worked because the IFST worker was able to devote so much time to the family and this was not possible under Phase 2, when the social worker would visit every two weeks. The family had not been ready to make the transition from Phase 1 to Phase 2.

## **Feedback from families**

### *Overall impact*

5.16 Most of the families interviewed felt that the IFSS programme had resulted in very positive impacts on the family. While this is partly explained by the sample selection, in that those families who had benefited most from the programme were arguably more likely to talk to us, it does provide reassurance and illustration of the model working. The impacts showed themselves in a variety of ways for the families, some of these positive impacts were practical:

- Families having improved access to children;
- Children being removed from safeguarding arrangements like the Child Protection Register; and
- Families having more access to relevant support services such as educational and employment courses.

5.17 Some of the softer benefits families experienced through taking part in the IFSS programme included:

- Improved life skills amongst the parents such as planning ahead;
- Being more proactive;
- Managing emotions and addictions;
- Increased insights into the different needs and behaviours of family members; and
- Some explained that they felt more able to take responsibility for their lives.

### *Examples of the impact on parents*

5.18 Parents provided examples of the ways in which the programme was currently benefiting them in their everyday lives. We have included some examples below:

- One mother explained that she was currently dealing with an incorrect water bill. In the past she would not have phoned the water company allowing the problem to escalate – potentially until the case was taken to court. At that point she would have become very angry with the company. In contrast, she described how she was able to stay calm and phone the company at an earlier stage to explain their mistake
- Another parent explained how she was able to apply parenting techniques (that she had been taught as part of the programme) in order to stop poor behaviour from her child from escalating. She explained that she had struggled to control their behaviour in the past

**“I brought in a naughty step. She [the practitioner] showed me how to be positive to them. My children have improved but sometimes it slips and we have to get the reward charts out again”.**

**Parent**

- Some of the parents explained that they had started to become more emotionally open with their children as a result of the programme and the fact they were no longer taking drugs that had affected their ability to feel emotions.

#### *Examples of the impact on children*

5.19 Most of the children interviewed felt that they had benefited from the programme:

- An eight year old child (who was at an early stage of the programme) felt there had been improvements at home as his mother was drinking less. The lack of stress at home also meant that he felt more able to concentrate at school. While he was enthusiastic about the progress made he was not sure whether these improvements would continue in the longer term
- The children of one family explained that the family had become better at organising events and spending time together. Recently a number of



the family had been to the seaside together. The children explained that this would not have been possible before the beginning of the programme as the family would not have been able to organise such a trip without something going wrong (such as an argument)

- A thirteen year old girl also spoke about her relationship with her mother changing as a result of the programme, becoming more mother-daughter like where she had previously treated her more like a sister, and argued much more as a consequence.

### *The positive impacts on a family*

- 5.20 Please see below for a case study of the positive impact the IFSS programme has had on a family:

#### **Achieving their objectives**

##### **What happened?**

A mother explained that her life had been transformed after six months of the programme. She was expecting the father to have full access to her baby and she was looking to go to college.

Improvements included: increased stability, closer relationships with her partner and family, and feeling more able to proactively manage problems. Her partner had stopped using drugs and hitting her.

##### **What are the lessons from this?**

She believed that her practitioner was key to this success. A therapeutic approach was taken allowing her to think about and overcome the problems she had faced since childhood.

Having a record of her progress gave her confidence and created a real sense of achievement.

The booster sessions also helped her to recover from some set-backs.

### *Families with less positive experiences*

- 5.21 Not all the families interviewed felt that they had benefited from taking part in the IFSS programme. Three families (out of 23) had a negative experience of IFSS. Others had had more positive experiences but believed that the Programme had done little for them in the longer-term. We have included details of the families with less positive experiences below.
- 5.22 One family explained that the exercises and conversations that they had had as part of the programme had taken a lot of their time. The mother felt that this time could have been better spent looking after her children and earning money through their business. The mother explained that the family's overall

experience of social services was extremely negative. This issue mainly related to a contested restraining order put on the father who was not permitted to see his children rather than the IFSS programme itself. The mother felt that the IFST practitioner was trying to be helpful but that she was coming round to her house to assess the family rather than supporting them.

5.23 A mother and father whose children had been put in to care felt that the IFSS programme had focused more on the needs of one particular child rather than the needs of the whole family. This has led to additional tensions between the parents and their child. Further details are presented in the case study that follows:

**Focus on one family member**

**What happened?**

The parents thought that the IFST practitioner had focused too much on one troubled family member (a teenage boy) to the detriment of the rest of the family. They also thought that too much time was spent befriending the son when in their view he needed help with drugs.

This led to a lack of trust between the parents and their case worker as they felt he was not working with the whole family, not keeping them adequately informed about his work with their son and not helping them to set behavioural boundaries.

The practitioner came to be seen as “another reporter”, like the rest of the social services.

**What could have been improved?**

The parents said that they would have preferred to do more work as a family and some more work as individuals

They would have liked the IFST practitioner to pull in more support for the son to help with his drug and psychological problems. This would have allowed him to concentrate on the whole families’ needs.

5.24 Another parent appreciated the programme and practical support he had been given but felt that the support has not been sufficient to help him cope with difficult life events. After Phase 1 of the programme, the father had had some problems that had led to his child being put into care.

## Summary

5.25 The key messages from this section are as follows:

- It is still too early to form any robust conclusions about the long-term impact of IFSS on family outcomes and the sustainability or persistence of such impacts. However, the available monitoring or

tracking data from the sites suggest that generally, broadly positive trajectories are still being achieved by the majority of the participating families (although to date, there have been limited data due to the low volume of throughput)

- Monitoring data suggest that a major improvement occurs between the beginning and the end of Phase 1. The next stage of the intervention through to the six month review is characterised by a more gradual improvement in terms of family functioning. During the six month review and the final review after 12 months, another significant positive shift is evident
- Consultees identified numerous examples of where the intervention had made a tangible difference in terms of helping family members with substance misuse and tackling complex wider issues as they sought to turn their lives around. The most common positive outcomes achieved were identified as follows: ensuring the safety of children and young people within participating families; family members accepting responsibility for their actions; clearer family functions; improved family relationships; no elicited substance misuse; no crimes being committed; houses kept in a better condition; improved parenting skills; higher levels of confidence and improved service engagement
- Wider discussions with the three IFSTs highlighted a broader set of factors which led to positive outcomes. Although it is difficult to generalise, it was reported that IFSS seems to deliver most impact to those families that can be characterised as being 'new' to the system or 'early intervention families'
- Consultees indicated that for some families, those with too many goals or problems to address all at once, IFSS interventions are often less successful
- Where there are multiple 'issues' within a family, it is vitally important that the sequencing of support provision is carefully planned so that problems can be tackled in the right order

- A majority of the families interviewed felt that the IFSS programme had resulted in a very positive impact on the family. While this is partly explained by the sample selection, it does provide re-assurance and illustration of the model working
- However, not all families interviewed felt that they benefited from IFSS. Several families had a negative experience of the Programme. Others had had more positive experiences but believed that IFSS had done little for them in the longer-term.

## **6: Interim evaluation findings**

- 6.1 This section of the report provides a summary of the interim conclusions from an evaluation of the IFSS model, covering the period September 2010 through to September 2012. Specifically, it presents an update on the progress made in each of the three Phase 1 sites and the key issues arising. These issues for consideration are contained in the text and summarised towards the end of the chapter.
- 6.2 Overall, the findings reinforce many of the issues identified in the first interim evaluation report, although there is also evidence of some important emerging variations in delivery across the sites.

### **Key interim conclusions**

- 6.3 Across the three sites amongst IFST staff, and IFSS Board and Operational group members, there was evidence of strong support for IFSS as a delivery model, including the innovative tools and techniques that had been used. The IFST staff reported that they had become more experienced and comfortable in deploying IFSS practices during the second year of the Programme.
- 6.4 Moreover, this report contains feedback from a number of families whose views also reflected those of the IFST staff. Families stated that they felt IFSS was different to previous social work interventions due to the intensity of the support offered and because a 'whole family' approach had been adopted.
- 6.5 The feedback from families also contained strong examples of where the intervention had made a tangible difference in terms of helping family members with substance misuse.
- 6.6 Furthermore, the available monitoring data from the sites suggest that overall, broadly positive trajectories are being achieved by the majority of the participating families who are able to complete the programme. These data show that a major improvement occurs between the beginning and the end of Phase 1. The next stage of the intervention through to the six month review stage is characterised by a more gradual improvement in terms of family

functioning. During the six month review and the final review after 12 months, another significant positive shift is evident.

6.7 In common with the findings from the interim report from last year, there was also a generally positive set of evaluation messages around the following:

- IFSS Boards have remained strategic in terms of their core functions
- IFSS Implementation Groups have acted as effective fora for resolving day-to-day operational issues, and at local level it was seen as positive that they had avoided the need to escalate issues up to board-level
- IFSTs have largely been stable, with staff indicating that they were generally satisfied in their job roles
- IFSS learning and approaches have started to influence mainstream service delivery and behaviours, through for example, the use of techniques such as motivational letters. This has been achieved in some cases by IFSS managers being able to directly influence other local services, and in other cases through indirect routes as social workers have observed IFSS approaches.

### **Issues arising**

#### *Throughput and targeting*

6.8 The volume of throughput of referrals to the three IFSTs has remained problematic during the second year, and lower than expected. Only 59 families have completed Phase 1 of the programme during the period April 2011 to March 2012. Significant time and effort has been invested by the IFSTs in seeking to boost the flow of referrals by raising awareness levels and building links with social care teams. However, generally, this seems to have had only a short-term impact.

6.9 A smarter approach to building relationships and more 'top-down' direction from the Boards to encourage services to refer to IFSS might be more effective, but this does raise an important issue for policy-makers about the true scale of demand for IFSS. This issue will need to be revisited in more

detail by the evaluation next year, but also needs consideration in the shorter term.

- 6.10 Nevertheless, what is becoming clear, at least in the minds of all three IFSTs in the Phase 1 sites, is which families IFSS has appeared to work best for. Although individual IFST staff were able to describe in broad terms the types of family that they thought were most likely to gain from IFSS, this was with a narrower group than described in the IFSS statutory guidance. Therefore, it was thought that the guidance on eligible families would benefit from being honed and refined further.
- 6.11 They perceive, based on cases they have dealt with (but not knowing what might have happened otherwise) that families need to have reached a clear 'crisis point' and to have recognised this themselves in order for IFSS interventions to be most effective. Where the approach was thought to be less effective was where the scale of problems required more time than the model usually allowed locally; and where the family was not fully motivated to change (which was recognised from the beginning as a key factor for success). Some IFST consultees reported that through their previous jobs and or wider networks, they had become aware of relatively large cohorts of local families that suffered from substance misuse problems. On the face of it, this view appears to be inconsistent with the low volume of IFSS referrals that have been recorded.
- 6.12 However, it might be possible that although such families do exist, they are facing multiple problems, they may not have reached a 'crisis point' as such. Similarly, these families may not be ready to change. They might be stable, even if they are in a poor condition.
- 6.13 Furthermore, the evidence from IFST staff suggests that IFSS delivers most impact to those families that can be characterised as reaching their first 'crisis point'. This issue is reinforced through the feedback from those families that we interviewed. They stated that they had engaged with IFSS because they had recognised that a 'crisis point' in their lives had been reached (as opposed to taking part to show willing or compliance). This could mean that

although many families would benefit from IFSS support, they and their social workers feel that the intervention is not needed or is not appropriate for them.

- 6.14 If this is the case, then it implies that IFSS will work for a particular group of families, and will move them positively away from 'crisis' or 'tipping points'. However, the Programme may not really tackle the existing stock of families who have gone through a crisis, with negative effects in the past.
- 6.15 Another issue relates to whether or not IFSS should also be used to support families that suffer from wider issues such as domestic violence, mental health or learning difficulties. This may help to increase the level of throughput and therefore give rise to high levels of utilisation across the IFSTs. However, this raises important questions about the skills and expertise of IFST staff. An alternative approach may be to accept lower overall demand and to reconsider if IFSTs in all areas need to be as large as first thought.

#### **First group of issues for consideration**

- 6.16 The discussion above about throughput and targeting leads to a series of issues for consideration:
- IFSS Boards should consider the scale of throughput in their site and put in place appropriate direction to local services to increase the volume of appropriate referrals. It may help if each site was to set a clear annual target number of referrals (and agreed this with the Welsh Government) based on team capacity and local need (and some have already suggested possible target numbers in their annual reports) and to track recruitment against this on a quarterly basis
  - Where there is variability and low attendance at IFSS Boards, the respective Boards should consider why attendance is drifting downwards and take action to draw back in key members
  - The Boards should also be tasked with ensuring that effective monitoring and evaluation frameworks are established so that the longer-term impacts of IFSS delivery can be captured at a local level



and the findings can be disseminated widely, and used to inform future IFSS/wider service delivery

- All newly established IFSTs should ensure that they invest sufficient time, effort and energy into building relationships and raising awareness of IFSS in order to achieve an appropriate flow of suitable referrals in their first year of operation; whilst existing IFSTs should maintain levels of awareness of IFSS to ensure sustained levels of appropriate referrals are achieved
- In updating the statutory guidance on IFSS, consideration should be given to provide further detail on eligibility/target families for IFSS (to further support promoting the service locally); and, the role of the Consultant Social Worker to ensure the added value of the role is maximised
- Consideration should be given locally to what can be done to support families who are not ready or sufficiently motivated to engage in IFSS.

#### *Team composition and roles*

- 6.17 Going forward, there is a risk of flux amongst the IFSTs in the three Phase 1 sites. In some cases staff will seek promoted posts in new IFSTs, but others are worried by the uncertainty or have decided IFSS is not for them (often due to a lack of cases or fear of losing touch with their previous area of expertise).
- 6.18 The main issues evident within the IFSTs are around the delivery styles of staff and specifically, the importance of establishing a team-based working culture and the need to draw on the expertise of everyone. Practice within areas has changed over the past year, with some improving in this regard through increased levels of staff interaction, while others have fallen back.
- 6.19 There is also a possible risk associated with allocating cases based on staff capacity as opposed to expertise. However, it is likely that this is a relatively small risk, with ISFTs trained to work in a cross-disciplinary way and that it is not always possible to identify underlying or 'hidden' issues with families. Formal structures such as regular 'reflective' meetings to foster collaboration

and team-based discussions provide a further means to mitigate the risk, and so it is important that they take place as intended.

- 6.20 There have also been some issues linked to the balance of the CSW role between research and case work. The Guidance states that at least 50% of CSW time should be allocated to cases, but it is evident from some discussions with IFST staff, that the 50% figure seems to have become a maximum, rather than a minimum. There was particular concern around how far CSWs were managers/consultants to the team and others and the amount of time that they were meant to spend on research. There was also an issue raised about the level of support that CSWs should expect to receive given that they were intended to be 'lead practitioners'.
- 6.21 The consultancy role should in part help to mitigate some of the risks identified above and improve practice. Early on, some sites had decided their CSW should pursue an MSc course. However, with hindsight, this was not thought to have been the best use of time.

### **Second group of issues for consideration**

- 6.22 The discussion on team and roles leads to a further set of issues:
- Each IFST needs to be careful to maintain collaborative team-based working and reflection to ensure high quality delivery of the model
  - IFSTs will require access to current thinking and practice across the fields from which team members have come. This is probably best done by the individual development plans of staff including time for them to maintain their knowledge.

### *Delivery of the model*

- 6.23 The evidence shows that there has been some divergence in terms of how IFSS has been delivered, both between the sites and between individual cases in each site. For instance, the length of the Phase 1 intervention has varied depending on the responsiveness or size of the family. Generally, this has worked well and appears to be well aligned with the ethos of IFSS. However, going forwards, it is important that:

- New IFSS sites are informed that there is scope for some flexibility in how Phase 1 of the model can be delivered
- IFST Managers carefully monitor the situation with individual cases to ensure that flexibility in the model does not grow to become role creep.

6.24 Feedback from the Phase 1 sites indicates that there was some concern amongst IFST staff that the transition from Phase 1 to Phase 2 was too severe for some families. This reflected the intense nature of the intervention. One IFST Manager suggested that there should be consideration of developing an additional stage in the IFSS process. However, many IFSS workers were dealing with this on the ground by lowering their input towards the end of the Phase 1, and this seemed to have improved the situation.

### **Third group of issues for consideration**

6.25 The discussion about delivery leads to a further set of issues:

- The IFSS model is intended to be flexible. The ability of the sites to tailor and shape the model should be retained, so that they are able to respond to local need. Therefore, it is important that all sites are made aware that there is scope within the model to allow delivery to be adequately tailored to effectively meet the needs of individual families
- Care needs to be taken around handover points so that families are properly introduced to the IFSS worker and 'inducted' at the start of the process, and then moved back smoothly to working with their social worker (in the absence of the intensive IFSS input). Similarly, signposting and referrals to wider service providers will also need to be managed carefully in order to minimise any adverse effects on the family.

6.26 The three core groups of issues set out above are summarised in Table 6-1 and presented for discussion.

**Table 6-1: Key issues for consideration**

Issue	Lead responsibility
1. IFSS Boards should review levels of throughput within their teams and set clear annual targets for number of referrals for their IFST based on local capacity and need. Progress against this target should be tracked on a quarterly basis.	IFSS Boards subject to agreement by the Welsh Government
2. Where there is variability and low attendance at IFSS Boards, the respective Boards should consider why attendance is drifting downwards and take action to draw back in key members.	IFSS Boards
3. All newly established IFSTs should ensure that they invest sufficient time, effort and energy into building relationships and raising awareness of IFSS in order to achieve an appropriate flow of suitable referrals in their <i>first year</i> of operation; whilst existing IFSTs should maintain levels of awareness of IFSS to ensure sustained levels of appropriate referrals are achieved.	IFSS Boards and IFSTs
4. IFSS Boards should be tasked with ensuring that effective monitoring and evaluation frameworks are established so that the longer-term impacts of IFSS delivery can be captured at a local level and the findings can be disseminated widely. These should be used to inform future IFSS activity and wider service delivery.	IFSS Boards
5. In updating the statutory guidance on IFSS, consideration should be given to provide further detail on eligibility/target families for IFSS (to further support promoting the service locally); and, the role of the Consultant Social Worker to ensure the added value of the role is maximised. The IFSS model is intended to be flexible. The ability of the sites to tailor and shape the model should be retained, so that they are able to respond to local need. Therefore, it is important that all sites are made aware that there is scope within the model to allow delivery to be adequately tailored to effectively meet the needs of individual families.	Welsh Government
6. Consideration should be given locally to what can be done to support families who are not ready or sufficiently motivated to engage in IFSS	IFSS Lead Officers IFSS Boards
7. Each IFST needs to be careful to maintain collaborative team-based working and reflection to ensure high quality delivery of the model. The IFSS Boards and the IFST Managers should ensure that there is a strong culture of collaborative working and staff interaction within the IFSTs. This should feed through into individual IFST appraisal processes.	IFSS Boards and Lead Officers
8. IFSTs will require access to current thinking and practice across the fields from which team members have come. This is probably best done by the individual development plans of staff including time for them to maintain and build their knowledge, with support from the IFST Manager and their former employers.	IFST Managers, staff and professional bodies/former employers
9. Care needs to be taken around handover points within the model. This will help to ensure that families are properly introduced to the IFSS worker and 'inducted' at the start of the process, and then	IFST staff and social workers

Issue	Lead responsibility
<p>moved back smoothly to working with their social worker (in the absence of the intensive IFSS input). Similarly, signposting and referrals to wider service providers will also need to be managed carefully in order to minimise any adverse effects on the family.</p>	

Source: SQW 2013

### Next Steps

- 6.27 This report has identified a number of issues and challenges for the final stages of the evaluation. Not least is the lower than expected throughput, which will limit the extent to which we can robustly assess outcomes. That said, we will revisit the families interviewed for this report and so anticipate some rich qualitative information about their experiences of IFSS and the impact of the programme on their lives.
- 6.28 The final year will also include a further round of Phase 1 site case studies in which we will cover:
- The delivery of the IFSS model – how far do the variations noted above continue or change? Why have certain aspects of the Guidance been (mis)interpreted in certain ways in some sites? Does this matter or flag up learning that others should follow?
  - The scale of throughput, and what drives this – we intend to interview staff who should refer in to IFSS to test their understanding of the model and motivations or not for using the IFSTs
  - The operation of the Boards and the extent to which they have been able to direct throughput and delivery, and influence wider service delivery and integration
  - Emerging thinking from local areas about which types of families benefit most from the model, how long these benefits are likely to persist for and to test this against the data being collected locally about effectiveness. This in turn should feed in to guidance about any future targeting of the model

- The usefulness and added value of the S58 Agreements, which are now in place.

## Annex A: List of family interviewees

Interview number	Phase 1 site	Family members interviewed	IFSS intervention stage at the time of the interview
1	1	Mother, two children	Phase 2
2	3	Mother, three children	Phase 2
3	3	Mother	Phase 1
4	3	Mother	Phase 2
5	3	Mother and father, two children	Phase 1
6	3	Mother, four children.	Phase 1
7	2	Father, two children	Phase 2
8	2	Mother and father, three children	Phase 1 – booster sessions
9	2	Mother and father, four children	Phase 2
10	2	Mother, one child	Phase 2
11	2	Mother (two children – one in care, one living with father)	Phase 2
12	2	Mother, two children	Phase 1 – booster sessions
13	3	Mother, two children	Phase 2
14	3	Mother and father, one child	Phase 1
15	2	Mother, one child	Phase 2
16	1	Mother, three children	Phase 2
17	1	Mother and father, three children	Phase 2 – booster sessions
18	1	Mother and father, two children	Phase 2
19	1	Mother	Phase 1
20	1	Mother	Phase 2
21	1	Mother and partner, two children	Phase 2

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<b>Interview number</b>	<b>Phase 1 site</b>	<b>Family members interviewed</b>	<b>IFSS intervention stage at the time of the interview</b>
22	1	Mother, three children	Phase 2
23	1	Mother	Phase 2 – booster sessions

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Source: SQW 2013