APPENDIX: Full Evaluation Report:

Section 1: Background and Rationale for service delivery:

1.1 The Complex Child in Need and Rapid Response Team is a new forward thinking and dynamic initiative that has been established by Gateshead Council within Safeguarding and Care Planning services. The CCiN and RR team has been developed in line with the principles and practice of the national agenda 'Reclaiming Social Work' and Keeping Families Together.

1.2 The CCiN & RR team has been established as a spend to save initiative working intensively with children, young people and families who have been assessed by a Social Worker as being a complex child in need, with the aim of preventing the safeguarding risk escalating to child protection or looked after.

Section 2: Team Profile and Collaborative Partnership Working:

2.1 The team is overseen by Steve Day Service Manager and Principal Social Worker (Children). Deb Loraine is the Senior Practice Supervisor supported by Gillian Hammell-Purvis as the Practice Supervisor. The team is staffed by 9 Experienced Social Workers and 2 family Advocates who all bring complementary qualities and experience designed to meet the pressing complexity of needs in play with children on the edge of care.

2.2 Of the 9 Social Workers; 6 undertake the statutory child in need responsibilities within office hours and 3 work on a rota basis evening and weekend to provide intensive social work intervention outside of normal working hours. The 2 family Advocates work within office hours and support the engagement of the child and parents in both a planned and crisis basis.

2.3 It is recognised that for the intervention to be successful then the intervention delivered by the team will require close collaborative partnership working from our key partners such as, CYPS (children and young people's service) Education, Health 0-19yrs, Paediatrics, Drug and Alcohol Services and Adult Services. Developing these relationships and understanding referral pathways will be part of the role out of the service. The ethos of the team working with the family and the care team will be to have a transparent understanding of the risks within the family and the collaborative intervention plan that aims to address them. The focus of the team will be on the childs' lived experience and this will be used as a measure of progress.

Section 3: Methodology and Approach:

3.1 The CCiN & RR team aims to deliver systemic social work practice that is relational and strengths based that positions the families as experts in their unique family situation.

3.2 The team works on the principle that an effective relationship with the children and family is key to deliver effective social work intervention.

3.3 The model is strengths based so recognises that there are exceptions to the presenting problem and the family are part of the solution. Using a systemic model the focus of the intervention isn't on a 'problem child' but multiple perspectives from the family and other professionals which allows for multiple explanations including multiple solutions.

3.4 The CCiN team delivery model is centred round the 'unit meeting' which is a model of practice that supports group supervision. The 'unit meeting model' is where social workers, family advocates and managers meet to discuss different cases they are managing.

3.5 The unit meeting is underpinned by systemic practice: the whole family system is mapped out, difficulties in the family are viewed relationally and intergenerational patterns and family scripts are explored. Considering the family circumstances in this way discourages blame and prevents the problem being located within individuals. Any intervention takes a family approach and aims to support change within the system through offering ideas to establish different patterns of behaviour and ways of relating.

3.6 The caseloads are capped to 5 families per social worker to allow the level of intensity deemed appropriate to support a family to achieve sustained change to safeguard their children.

3.7 It is envisaged that the team will be able to respond to the needs of the family and increase the level of support if required. As such a family could have a statutory social worker, a rapid response (out of hours) social worker and a family Advocate. Where the family requires this level of intensity the response will be planned and co-ordinated with the family to ensure continued engagement.

3.8 As the team will provide intensive intervention it is expected that the length of time the team would be involved with a family would be less than that of mainstream CiN cases.

3.9 The team has a unique Business support post, which in the reclaiming social work model is referred to the unit coordinator, we have used this as a blueprint to develop the post. The main purpose of the business support manager is to reduce the administration burden on the team to free up to do the work with children and families.

Section 4: Access to the Team and Referral pathway:

4.1 Access to the Complex Child in Need & Rapid Response Team is through the current referral process into Referral & Assessment Team (R&A) where a child is living in an environment that significantly compromises their welfare and may be a child in need of help or protection.

4.2 There is **no direct referral** route into CCiN & RR Team.

4.3 The criteria for transfer **from** Referral and Assessment (R&A) or the Safeguarding and Care Planning Team (SGCP) to the Complex Child in Need Team is:

4.4 There is an assessed need for a **substantial** multi-agency response **and coordinated intervention because the child's development and safety is significantly impaired due to the impact of complex parental mental ill health or learning disability or substance misuse, domestic abuse or family dysfunction**, and professional judgement based on further assessment indicates an escalating risk that the family arrangements are likely to breakdown requiring the child to become either looked after or subject to a CP plan.

Section 5: Review and Monitoring:

5.1 All cases active to the team will have a CiN plan and these will be developed with child(ren) and parents/carers and involve our partner agencies.

5.2 All cases within the team will be subject to robust monitoring and review, multi-agency care team meetings will be 4 – 6 weekly based on the needs of the child and family and plans will be reviewed initially at 3 months and every 6 months subsequently, reviews will be chaired by a Manager.

5.3 If a Child in Need Plan fails to bring about significant positive change in a child's circumstances over a period of 6 months and the goals identified in the Child in Need Plan have not been achieved, formal consideration will be given to escalating the case to the child protection arena.

Section 6: Update of the first 6 months:

6.1 The complex child in need team went live on 2nd January 2018.

Section 7: Recruitment / Staffing:

7.1 Whilst the team went live in January 18, it took the first 2 months to recruit 8 of the 9 social workers and we are currently carrying a rapid response Social Work vacancy.

7.2 We were able to recruit 3 social workers and the Practice Supervisor internally and whilst they could move into post quickly, they also brought outstanding work with them, which included longer term court work. Currently we have a Social Worker and the Practice Supervisor working with a case each that is in court. This has had an impact on the ability of the team to take cases as expected.

7.3 The 2 family Advocates were recruited and in post by mid-April 2018, which has also meant the team wasn't fully operational in terms of the intensive service it offers to children and families.

Section 8: Roles and Responsibilities:

8.1 Each member of staff appointed to the CCiN and RR team were recruited on the basis of their diverse experience and skills with the view they would complement each other. Whilst the team has been live from 2nd January, it is fair to say that it has only been since mid-April that we have been sufficiently resourced to implement the package of intense support to families. Since this time the team have begun to truly develop their roles and responsibilities, the team have embraced their roles and working with young people and families has allowed these roles to be tested and embedded.

8.2 As such it is now established that whilst the statutory social worker holds case responsibility, they share the responsibility for delivery of intervention into families with the rapid response (out of hours) social worker. Embedding the principle that the rapid response social worker delivers social work intervention out of hours.

8.3 The role of the family advocate has been clear from the outset they were recruited to engage and work with children and young people on key issues such as education training and employment, substance misuse, constructive activity, whilst actively addressing their cognitive understanding (consequential thinking) of unsafe choices and actions.

8.4 Communication has been vital within the team due to the fast pace of working with children and families and the unit meeting underpins this.

8.5 The small caseload and unit meeting model has meant that all of the workers within the team have a good understanding of all of the families, which means that anyone of them could respond to a crisis if required.

8.6 As stated above the role of the Business support manager was modelled on the unit coordinator in the reclaiming social work model, however this wasn't reflected in the job profile which lead to some misunderstanding of the role. As stated this is a unique role to the council, so the person recruited to that role didn't fully appreciate their baseline function was to support the frontline workers to spend more time with families by releasing them from the day to day bureaucracy. Additional to this the worker recruited to the post was continuing to offer support to his previous team. This meant that systems and processes weren't established as quickly as expected. This role is now fully operational and the team benefits from it.

Section 9: Multi agency response:

9.1 The Senior Practice Supervisor has established a close working relationship with CYPS. Through discussions it is recognised that the work of the CCiN team complements the work of CYPS and closer collaborative working will enhance the effectiveness of outcomes for the family for both services. As such we have agreement that the Team manager, of the Neurodevelopmental Pathway, who is systemically trained, has committed to attending the unit meeting every 3 weeks, this is proving very effective.

9.2 The Senior Practice Supervisor is also in discussions with the CYPS Community Clinical Manager, NTW looking at a model for closer collaborative working, where a CYPS clinician will work with the team to help with case formulation, identify risks and support the team to identify the correct intervention to engage both the parents and young people.

9.3 It is evident through a number of cases that collaborative working with CYPS has enhanced the understanding of the needs of the young person and family and assisted with a more focused intervention.

9.4 Working jointly with CYPS has helped us understand the risk and manage it together, social workers in the team report this helps with professional anxiety across the care teams.

9.5 We have been proactive in inviting partners to the unit meeting to discuss specific cases and with one case paediatrics and CYPS came to explore our understanding of the young person and family we were working with. In this instance the challenge for the workers has been understanding the impact of Foetal Alcohol Spectrum Disorder on the young person's cognitive ability and risk-taking behaviour. Being able to explore the physical impact of the brain damage on the young person's cognitive ability and her drive to understand and make sense of her identity (she was adopted), has widened the scope of exploring various hypothesis and how to address them. It also provided an opportunity to share concerns and agree a plan to manage the risk with professionals.

9.6 Through the caseload we have developed very close working relationships with Sanctuary and the social worker and police officer in the team, as such they have been an active part of the disruption plan and supported the team with intelligence as well as engaging the young people.

9.7 The Family Advocates hadn't worked in Gateshead prior to joining the team so have worked hard to establish links with services to meet the needs of the young people we work with.

9.8 Developing partnership with Northumberland college giving young people we work with opportunities to attend construction courses such CSCS card.

9.9 Working with Sport England (Tyne and Wear) to access active communities grant for sport activities that we can engage the young people we work with in, especially in terms of longer term funding so this isn't a cost to the service.

9.10 Established contact with the Princes Trust, who provide opportunities for vulnerable young people to thrive and support them to build the skills and confidence.

9.11 Established contact with the Safety Works project in Newcastle who offer session on ASB, DV, CSE awareness, Community safety and more.

9.12 We recognise that we are in the early stages of establishing closer working relationships with key partners and this will continue as we go forward.

Section 10: Workload:

10.1 It was agreed that the team would have a maximum caseload of 30 families and this has been established over the initial months. The table below shows which teams the cases have come from:

Team	Cases	%
Referral & Assessment Team	45	52.33%
Safeguarding & Care Planning Team 1	8	9.30%
Safeguarding & Care Planning Team 2	15	17.44%
Safeguarding & Care Planning Team 3	9	10.47%
Safeguarding & Care Planning Team 4	9	10.47%
Grand Total	**86**	**100.00%**

10.2 The referral route is for the allocated (SGCP or R&A) social worker to identify that the family may be eligible for the complex child in need team, to have an initial discussion with the team (practice supervisor / senior practice supervisor), where it is agreed, the case will then be discussed at a unit meeting.

10.3 The focus of the unit meeting will be to establish an understanding of the family dynamics using the genogram and understand what has been happening in the family which constitutes the risk statement, this is balanced by the safety statement. The social worker will present their 'current dilemma' and a reflective discussion is held to generate different hypothesis that might help us understand what is happening within the family, this will inform if the case is suitable for the CCiN team.

Section 11: Needs of the families:

11.1 The needs of the families were identified through the cin assessment and Carefirst data show the following:

The table shows the highest presenting needs within the families:

Factor Identified	P No	%
[01] Alcohol Misuse - Child/Parent/Other	35	40.2%
[03] Domestic Violence - Child/Parent/Other	35	40.2%
[04] Mental Health - Child/Parent/Other	52	59.8%
[14A] Socially Unacceptable Behaviour	49	56.3%
[15A] Self Harm	35	40.2%
[17A] Emotional Abuse	42	48.3%

This table presents the medium level of needs within the families:

Factor Identified	P No	%
[07A] Young Carer	21	24.1%
[10A] Missing	22	25.3%
[11A] Child Sexual Exploitation	23	26.4%
[16A] Neglect	33	37.9%
[18A] Physical Abuse	23	26.4%

11.2 As a service that works predominantly with families with challenging teenagers, we quickly realised that the data available on Carefirst through the CiN assessment doesn't provide a good reflection of the needs of teenagers.

11.3 Overall the tables above do highlight the key issues the team have been working with such as: substance misuse, mental health, socially unacceptable behaviour, self-harm, emotional abuse, child sexual exploitation and missing. However, what isn't are key issues that are specific to adolescence such as: Education Training and Employment, lifestyle (such as negative peer influences, age appropriate friends, risk taking behaviour) and behavioural issues (poor emotional regulation, violence towards others or property, manipulative / controlling behaviour).

11.4 The team in conjunction with the performance team will profile the young people we work with and develop a monitoring tool that can capture the baseline concern and evidence progress against them.

Section 12: Delivery – length of intervention:

12.1 It was recognised at the outset that whilst the intensive intervention would potentially reduce the length of time the team would be involved with a family, it also has the potential to unveil greater concerns within the family that would meet the safeguarding threshold.

12.2 It was clear from the outset that whilst the ethos of the team was keep children with their families there will be on occasion times when it isn't safe enough for the child to do this.

12.3 As such in the initial 6 months we have worked with 14 families where the risk is significant enough to escalate to child protection proceedings:

12.4 Of the 30 cases we have held:

	Strategy Meetings	S47s initiated	ICPCs Held	Legal Gateway meetings	LAC Cases Starting
Jan 2018	0	3	1	0	0
Feb 2018	2	0	0	0	0
Mar 2018	1	0	0	0	0
Apr 2018	1	0	0	2	0
May 2018	3	6	0	1	0
Jun 2018	7	5	1	1	1
Total	**14**	**14**	**2**	**4**	**1**

Section 13: Performance:

13.1 The team has recently established its Performance Service Standards and one area of interest for the team is the level of contact with families. Our initial performance standards focused on how often each child was seen, but we quickly realised the data didn't give an accurate reflection of the intensity of the work as for some families have 4 children and it may be that 3 of them aren't being worked with intensively, so we felt the best measure would be contact with families which would incorporate contact with parents where the child isn't seen, alongside specific work with the teenager.

13.2 The data below also shows the level of contact the team have had with families' month by month and by worker role. As you can see from the data it shows the profile of the caseloads alongside the recruitment of the team. As you can see the Advocates only came into post mid Aril so their contacts start from their and significantly increase the overall contact with families.

Number of Cases and Level of contact in the team:

	Cases Starting	Cases Closed	Cases held each month (Team)	Visits Completed	Advocate Contacts Recorded	Total Visits
Jan 2018	40	0	40	51	0	51
Feb 2018	9	0	49	57	0	57
Mar 2018	9	3	55	140	1	141
Apr 2018	12	1	66	231	35	266
May 2018	15	7	74	168	71	239
Jun 2018	2	2	74	147	53	200
Total	**87**	**13**	**74**	**794**	**160**	**954**

13.3 The above table shows the number of cases (children) that the team are currently working with. This translates into 5 families per Social Worker. Through this period of time this has fluctuated with on occasion a worker carrying 6 families where there has been a focused piece of work.

13.4 Outside of the normal referral route, the team have been creative and undertaken specific pieces of work on 2 cases that have remained open to the SGCP teams. Each case posed the risk of the child being accommodated and the role of my team was to deliver a systemic intensive intervention to prevent this.

13.5 The data above shows we have closed 13 cases that equates to 5 families, of these 3 stepped down to Early Help and 2 closed completely.

Section 14: Cost savings, known and predictive TYE

14.1 To establish a baseline for financial savings we identified a cohort of young people (excluding disabled children) who became LAC from 01/01/2016 – 18/04/2018 who were aged between 10 – 17 at the time they became LAC. Using this cohort, we established their journey to becoming LAC which included length of time LAC and if there were multiple LAC episodes, including if the young person was also subject to child protection. Also included was the type of placement: in-house fostering, residential, IFA etc and where possible the name of the residential unit to specifically identify costs.

14.2 Using this cohort finance looked at each placement and allocated the current cost for each placement to then come up with an average placement cost per annum per

child within the cohort, which is £50,129. This will then be used as the unit cost for placement costs avoided as a result of the RRT/CCIN successfully keeping/ delaying a young person from coming into care.

14.3 It is proposed that the we will only claim the saving once the young person has been successfully kept from coming into care for a period of 12 weeks from the date they were first worked with.

14.4 Using this baseline offset against cost of the service, the current saving for the first 6 months of delivery is **£281,607,** with the potential that if all the current young people being/ have been worked with don't come into care, the annual saving will be **£757,999**. The savings **target for 18/19 is £670,000**, which means the projected savings based on the current caseload have exceeded the target.

14.5 Many of the active cases in CCiN came from SGCP and had commissioned services working on their plan, which ceased when transferred, it is recognised that additional financial analysis of these cases would show further real time savings made by CCiN for the local authority.

Section 15: Case Studies:

The following gives the highlights from cases within the team, further detail of the cases can be found in the appendix. The purpose of this is bring to life the work of the team:

P Family came to the attention of children's services after Mam reporting she wished to drive her car into a wall due to the demands on the children. Mam had previously been a victim of domestic violence from the children's father and it appeared she not only had issues around confidence, but also possibly some mental health and alcohol too. The children, age 13,9 and 7, had behaviours which were extremely poor, in particularly their attitude towards their mother. The eldest child was not attending school and they did not have any routines or boundaries within the home. The children's behaviours had escalated to the point that they were threatening their mother with a knife and harming the family pet dog. An intensive support plan was put place utilising the CCIN social worker, rapid response and advocate with the aim to address the issues within the home and empower her to be able to care for her children. The family are at the early stages of intervention however measured improvements have been made. Parenting interventions have been completed with Mam and the children's behaviours in the home are starting to change and it appears the violent behaviours in the home stopped. Mam is reporting to feel more confident, has met with her GP to address her mental health and is no longer using alcohol as a coping mechanism.

M Family transferred to CCIN in January after being open to Social Care since January 2017. Concerns were around a young person S and how she had been a victim of CSE. S had extremely risk-taking behaviours in terms of attempted overdoses, binge drinking and drug

misuse and youth offending. S was in a current abusive relationship, had previous raped at a party and was not willing to work with any professionals. The successes of this case were dependent on relationship-based practice – regular visits and being consistent and reliable to enable Sophie to build up trust and engage in the intervention. This approach also gave parents faith in professionals whereas they had not felt this before. Completing interventions within the team, eg on substance misuse, rather than referring to other agencies such as Platform was important in this case due to history of non-engagement and risk of introducing too many professionals. The setup of the team gave the time and flexibility to be able to do this. Key partnership work has been with Operation Sanctuary to both address the safeguarding risks related to CSE and complete interventions to reduce future risks. Partnership work with the Princes Trust supported a future focussed intervention on helping S work towards her goal and improve self-esteem.

W Family: Case transferred directly from R&A to CCIN. The presenting issues for the family at the time were mams mental health, previous domestic violence within the home and the four children, age 8 to 17 years were displaying challenging behaviours and self-harm. Mam previous DV relationships. It appeared that the self-harming behaviours appeared to be a learnt coping strategy for the children from their mother. CCIN worked with the eldest daughter, who had already moved into the Naomi Project and identified that she had an undiagnosed learning disability and was able to ensure that she was then transferred to the right services to meet her needs. R now lives in a shared lives placement and is open to both CWD and Transitions team. Partnership working has been a key part in helping driving change particularly for R and her family, with CYPS being key. Social worker and CYPS were able to support staff at Naomi to maintain that placement. CYPS were able to provide strategies to professionals to ensure Rebecca's behaviours around her mental health could be managed. Work is on-going with Mam and the younger children – this case remains open to CCIN team

B family referred from R&A with presenting issues focused around the eldest child E, her mental health, lack of education attendance, her behaviour which was linked to her diagnosis of autism which had got to the point of being violent and she had used knives and made threats with them towards her parents. At Referral E was living with her maternal grandparents as a form of respite for parents – residential care was a real possibility as parents felt they were unable to manage her behaviour and protect the younger siblings within the family. Their relationship was close to breaking point. E had also been out of education since November 2017 as she had been refusing to attend. CCIN team initiated Intensive direct work with each individual family member and then brought them all together as a family to have meetings. Direct work was completed with parents on an individual basis to look at their history of being parented and how they parent to identify any conflicting styles. An EHCP for E was pursued, agreed and implemented alongside direct with her to increase her emotional wellbeing and confidence. In terms of progress E is now living back with her family full time, and able to identify when she is feeling stressed and can

take herself to Granma's. The family and the care team understand E better and can tackle issues using different techniques. Parents have with support identified their own parenting styles and work with each other to try and complement each other rather than tackle an issue using different techniques.

These case studies emphasis the level of need and intensity of intervention delivered by the team.

Section 16: Feedback:

Families and Young People:

Mother of twin boys, asked how has the CCiN team helped you……

'*I seem a lot calmer, knowing the support is then when I need it*'

Boy (14yrs), when asked is there anything about your life that has changed because of working with the CCiN team …..

'I got better at decision making'

When asked what do you like most and why ….

'when we go out and play snooker, cos he relates to us'

Boy aged 17years, when asked what support did you receive ….

'I got helped to do my benefits…. and also discuss what my future prospects would may be, also offer support to help me wherever I needed it'

What did you enjoy most and why?

'the chance to do something productive in boxing and also glad about getting my benefits sorted'

Professionals:

Peer review feedback from colleagues from Doncaster, in respect of observing a unit meeting:

'*this was fantastic, I got a real sense that that worker was fully supported with next steps in their case, they went away with things to try out with the family, and I have no doubt if this didn't work, they could go back and find alternative strategies'. I liked it so much we are going to pinch the model' …..*

Carole Mason, Consultant Paediatrician

'I have been really impressed with the work of the CCiN team. It is refreshing to work with a team who are so keen to engage with, and work alongside, health and other agencies, and to 'dig deep' to really analyse and understand the roots of the families' difficulties. My impression is of a team of workers who are going above and beyond to support these vulnerable young people, the only negative I can think of is that more families are not able to access this level of service'.

Kim Pearson, Social Worker, Operation Sanctuary

I have found good partnership working, relevant information is regularly shared and discussed….. the workers have a comprehensive knowledge of their cases which is assisted by the regular contact that is achieved.

The advocates offer an additional support to the young people but also to parents/carers; I feel (this) also assists to promote links with other agencies.

The workers are transparent when working with parents, i.e. openly sharing what is worrying, balanced with what is going well, this is shared both verbally and visually within meetings.

Suggested improvement: when the family have agreed to work with the CCIN Team; it is clearly explained the purpose and level of contact that is likely to be received from the service and this is understood. Being clear about the level of commitment required from parents and young people will increase the benefit from the service.

Steve Graham, Education Support Services

the presence of your team at the EIP is a great help, that formal and free sharing of information and the mechanism to formally align work means that the chances of gaps appearing between the two services is reduced.

Judith Turner, Community Clinical Manager, Newcastle/Gateshead Children and Young People's Service

What you think has worked well? *Closer working relationships and understanding between front line LA and CYPS. Meeting regularly to enhance the relationship aids in understanding the roles. It also prevents any misunderstanding or miscommunication*.

What do you think we could improve? *A joint funded approach to enhance supervision and case understanding and formulations*

Any other comment? *This is an excellent approach from LA to work closely with families to prevent a child deteriorating or becoming looked after*

Dr Jeanne Pratt, Service Manager, Education Support Service

What you think has worked well? *There has been a degree of joint working that I have never previously experienced. That has been so positive.*

There have been many cases where I have had the opportunity to have my work regarding education supported by the CCiN team to get better outcomes and hopefully therefore also contributed to the CCiN achieving better outcomes also. Some have been successful, others not, but in every case there has been aligned and co-ordinated action that was much better than the degrees of unilateral and often misunderstood actions that may have been undertaken in the past.

What do you think we could improve? *The joint meeting, we had was really positive and I felt promoted a better working together. Maybe we need to repeat that from time to time to update on developments / trends etc. which would be useful but just to maintain that face to face connection. This meeting would also give an opportunity to share solutions for joint issues.*

Any other comment? *There are several members of the CCiN with whom I have very strong relationships. I assume this is down to opportunity and would like to think that every CCiN Social worker would react the same in the similar situation. Therefore, I will not name names, but it has been really a great working experience.*
If wanted, I could easily provide examples of good working practice, where small actions amounted to a bigger success (or did not, being totally honest, but at least we all tried)

Mrs Adele Brown, Assistant Head Teacher, River Tyne Academy Gateshead

Can you please provide a brief summary of how you have experienced working with the team?

What worked well:

At first I was slightly frustrated by the progress we made as a team – I was very concerned about the child we were working with and I felt that action wasn't being made fast enough. However, within the last 4 months, I have found that the action and planning has become really robust. I feel that the level of concern around the child has been appropriate and that there is a real effort from all parties to try and achieve the best outcomes – we are making small but measurable progress steps now.

What you think has worked well?

4 week meetings to keep contact regular. Myself and Nicole have kept in regular contact which has really helped to ensure we keep the student safe.

What do you think we could improve?

I think we need the rapid action that we have had in recent months initially for every case to try and make progress quicker.

Section 17: CCiN team feedback:

17.1 It is recognised in the reclaiming social work evaluation that training the social workers in systemic practice was crucial to the success of the team, they reported higher success when teams fully utilised the unit model.

17.2 In the CCiN team we were fortunate to recruit 2 social workers who had been trained systemically.

17.3 However, obtaining feedback for this evaluation the Social Workers who were trained systemically were of the view that they were unable to deliver systemically planned intervention as the cases within the team were regularly in crisis, especially the teenagers and the focus moved to sustaining engagement with the young person as opposed to systemically supporting the family to change.

17.4 The remaining social workers who weren't trained systemically reported feeling deskilled and their practice being inferior to those who were trained, despite the teams attempt to embrace the model.

17.5 One rapid response social worker came from Barnardo's so was very experienced in delivering interventions and it was reported from social workers who had predominantly trained and practiced in the 'process / referral out' culture that they felt deskilled in comparison.

17.6 From the outset the team has been asked to commit to the weekly unit meeting, however it has been evident that through the initial 6 months the commitment to this has been inconsistent and where unit meetings have been held it hasn't ran true to the model.

17.7 In the reclaiming social work evaluation, they defined for a unit meeting to be assessed as systemic, the following 8 features were recorded:

- family relationships were set within the wider social context
- genograms were used to understand patterns of family relationships
- discussion was curious and reflective: for example, open to different ways of thinking about the family
- generation of different hypotheses and/or evidence of challenging established theories about the family
- development of hypotheses into clear and actionable conversations with families
- discussion was collaborative and involved all group members, although it was recognised that the unit coordinator may not always fully contribute
- child and family were present within the conversation
- there was clarity around potential risks to the child or children

17.8 It was felt by the team that when these were present the unit meeting was very productive and drove intervention with the family. The main area that was frequently missing was the *'development of the hypothesis into clear and actionable conversations with families'.*

17.9 It is acknowledged that the unit meeting has been used to predominantly determine if the case was suitable for the team so the focus hasn't been on the actionable conversations with families.

17.10 The Business Support Manager has identified that his role is fundamental in ensuring the Complex Child in Need/Rapid Response Team are freed up from the day to day bureaucracy of the safeguarding framework to be able to work intensively with children and families.

17.11 Reflecting on his experience of working in safeguarding for X years, the business support manager is clear that his role is unique and through this allows the practice within the team to bring a fresh approach to working with children and families.

17.12 Feedback from the team echo that this role supports them to achieve their outcomes with families.

17.13 Without doubt all of the staff recruited to the CCiN and RR team are very experienced and confident workers. All of them are committed to the ethos of the team and want to develop their skills to work systemically enabling families to change.

Section 18: Challenges:

18.1 The demands and complexity of the young people we are working with has taken precedence over planned intervention. However, evidence through the case studies shows building a trusting relationship with the young person has been critical to engagement and enabling change.

18.2 Hence, the challenge to the team has been managing the emotional impact of working intensively with teenagers with presenting complexities. Whilst a few staff had experience working with a similar cohort of young people there was greater number of social workers who hadn't worked so intensively with families. The impact of the crisis led work and demands from the young people and families had an impact upon the emotions of social workers. This in turn led to an unforeseen emotional demand on both the practice supervisor and senior practice supervisor.

18.3 To address this, we have reviewed the practice within the team, we recognised that potentially as a team we were too willing and available and in turn set unrealistic expectations of the team. The unintended consequence of this was disharmony between teams when we couldn't pick up cases or the team was at capacity.

18.4 We also believe the team was potentially too optimistic in terms of expectations on families to overcome their issues and in fact we agreed to work with cases that were beyond the team remit.

18.5 The impact of not achieving this was significant and ultimately assisted with the team coming together to review practice and support each other in redefining purpose and align closer to the model.

18.6 We also reviewed the level of risk on a case by case basis and determined if the family were receiving the correct support, both from the team and also key partners. This has led to a clearer message to the young person and family about what they can expect from the intervention.

18.7 Equally we have also been able to ensure we are more flexible by evaluating the impact of the intervention and look at reducing the intensity as things settle, to reinforce the focus is to enable young people and families to build their resilience.

18.8 A further challenge to the team has been getting the focus of the intervention right and in particular direct intervention with parents to enable them to address the challenges they face to parent effectively.

18.9 The demands from the young people has led the focus to be on them and the worker taking over the parenting role. This leads to risk of the social worker resolving the problem rather than enabling the parent (s) to do this or by focusing on the child we are then reinforcing that the problem is the child. It is recognised that the unit meeting will provide the forum to explore if the social worker is becoming part of the solution

Section 19: Roles and responsibilities:

19.1 The role of the Rapid Response SW has been work in progress for the team. There has been a challenge to establish clear boundaries of the role and how they work alongside the statutory social worker preventing duplication of work. Through reflecting on different case experience, we have been able to define a model of working that requires tight clear communication between the workers in the team, to define what the plan is with the family and who will do what. The more intensive the intervention the greater the need for regular communication and case reviews. We have established that the RR SW is responsible for undertaking social work intervention with the family outside of office hours.

19.2 When the team was established it was also recognised that the RR SW could be available to support R&A and SGCP and these pieces of work have been varied. At one point there was a concern that the RR SW was being requested to complete work outside their remit such as unannounced visits on weekends to see if the father was at the home, or visit to gather information for an assessment as the father worked away. Whilst initially, in an attempt to support our colleagues, we undertook these requests, the increased demand meant we had to be firm about our criteria and purpose of the intervention had to be in line with the teams focus of preventing LAC.

19.3 Area of challenge for Rapid Response and potentially across the team is experience and knowledge of programmes of intervention to deliver to families, this is an area of development.

19.4 A further challenge for rapid response is the title of the team, the concern is the title does not fully reflect the role and may suggest to families and colleagues a more crisis response role as opposed to planned social work intervention with families. I also understand that there is a team in adult services titled rapid response that deals with older persons that provides domiciliary care.

Section 20: Summary:

20.1 In summary I would conclude that the team has been on a journey that has provided opportunities and experiences to establish a baseline of practice that can be built on going forward.

20.2 Overall, without doubt the model of work and the intensity of intervention given to families has shown to be effective. This is evidenced through the feedback from young people and families.

20.3 It is also recognised that the effectiveness of the intervention delivered will be enhanced further once all the team are trained systemically.

20.4 Roles and responsibilities are now informed by a clear model of practice that is underpinned by regular case discussions with the relevant workers.

20.5 The importance of attendance at the unit meeting and the adhering to the agenda with a focus on the development of a hypotheses into clear and actionable conversations with families has also been reinforced and is embedded.

20.6 We have built effective working relationships with key partners and this is evidenced in the feedback we have received. However, we recognise this is an area of ongoing development and we need to establish close working relationships with other partners such as the police and health (0-19yrs) to specifically help us address the needs of the young people and families we are working with.

20.7 We are continuing to review procedures, with a focus on getting the paperwork right for the team, this is in conjunction with Carefirst.

20.8 In terms of performance, as stated above we recognise we need to be able to measure performance related to teenagers and we are taking this forward with the performance team.

20.9 We recognise that the biggest challenge both within the team and also from external monitoring is the safeguarding framework which the team is currently operating.

20.10 It is recognised that nationally addressing the safeguarding needs of teenagers is a challenge, especially when parents are doing everything expected of them. We currently manage a few critical cases that could be deemed as child protection but in each of those cases we have discussed the concerns with partners and had consensus that it is the plan that will protect the young people and not what we call it. Despite this we do acknowledge that we do have a national safeguarding framework and will be challenged on such decisions.

20.11 Very timely I attended a workshop entitled ‘Contextual safeguarding’ supported by Frontline.

20.12 The presentation was delivered by Jenny Lloyd who is a researcher at Bedfordshire University and the presentation was based on a paper compiled by Carlene Firmin, Lead Researcher November 2017.

20.13 The presentation outlined the development of Contextual Safeguarding, it has been developed at the University of Bedfordshire over the past six years to inform policy and practice approaches to safeguarding adolescents. Initially emerging from a three-year review of operational responses to peer-on-peer abuse, Contextual Safeguarding provides a framework to advance child protection and safeguarding responses to a range of extra-familial risks that compromise the safety and welfare of young people.

20.14 It is recognised that the current child protection system, and the legislative and policy framework which underpins it, was designed to protect children and young people from risks posed by their families and/or situations where families had reduced capacity to safeguard those in their care.

20.15 Traditional safeguarding practice would intervene with families to increase their capacity to safeguard young people from harm or relocate them away from harmful contexts.

20.16 This doesn't consider that as young people develop they spend less time at home and more time in the community with their peers. At this stage of development, it is recognised that generally the influence over teenagers shifts from their parents to their peers.

20.17 Contextual Safeguarding considers the importance of extra-familial risks for teens and acknowledges that when young people are exposed to violence or exploitation in their school, community or peer group this may fracture their family relationships and undermine the capacity of their parents/carers to keep them safe. Yet the current safeguarding framework continues to target parents to keep young people safe.

20.18 It recognises that the existing safeguarding framework is based on protecting children in families and doesn't extend to protecting teenagers in the community with their peers.

20.19 From 2013-2017, the emerging Contextual Safeguarding framework was applied to develop local responses to peer-on-peer abuse with 14 multi-agency safeguarding partnerships across England.

20.20 This research reflects the challenges that we are experiencing in the complex child in need team, it also reinforced that the work we are undertaking the drive to work closer with our partners with young people in their communities is the framework that should be developed to safeguard teenagers.

20.21 The report concludes a safeguarding framework would be contextual if it had the following 4 domains:

1. Was designed to identify, assess and intervene with the social conditions of abuse (i.e. targeted the nature of the contexts in which abuse occurred rather than just the individuals affected by it)

2. Drew extra-familial contexts into child protection and safeguarding processes (which were traditionally focused on families)

3. Built partnerships with sectors and individuals who managed extra-familial settings where young people spent their time (such as those responsible for the management of schools, transport services, shopping centres, libraries, take-away shops)

4. Measured its impact in relation to a change in the nature of the contexts where young people were vulnerable to abuse or harm (rather than just focusing on a change in the behaviour of individuals who continued to spend time in harmful spaces).

20.22 These four domains provide the foundations for a systemic change in the way that services describe, and respond to, abuse in adolescence.

20.23 A Contextual Safeguarding system supports the development of approaches which disrupt/change harmful extra-familial contexts rather than move families/young people away from them.

20.24 While parents/carers are not in a position to change the nature of extra-familial contexts those who manage or deliver services in these spaces are; and they therefore become critical partners in the safeguarding agenda. This approach would extend the concept of 'capacity to safeguard' beyond families to those individuals and sectors who manage extra-familial settings in which young people encounter risk.

20.25 This is an area that I propose we explore further, I have contacted Jenny Lloyd with the view of discussing how we can use the support of Bedfordshire University to develop the model in Gateshead that safeguards teenagers.

Section 21: Recommendations:

- Training in systemic practice a priority – this was highlighted as a requirement to the success of the RSW model

- Commitment to the 'unit model' and ensuring the integrity of it is maintained: allows for practice planning such as planning conversations trying them out safely with the team – also a requirement to the success RSW model

- Develop leaflets to set out the purpose of the team for young people and families and professionals.

- Expectations of the team: 'edge of care' would this define the team better as opposed to complex child in need, with the focus on children on the edge of care on a cin plan.

- Continue to work with partners and establish close working relationships with those linked to the needs of the young people and families we work with.

- Explore further Contextual Safeguarding with Bedfordshire University to help Gateshead develop the underlying principles of the complex child in need team.

- Roles and responsibilities in the team: improve communication between the workers in the team to coordinate the intervention

- Develop performance framework that captures the needs of adolescents.

- Consider removing the 'Rapid Response' title and call them all Social Workers who work out of hours.