'You Can't Grow Roses in Concrete'

**Action Research Final Report
Signs of Safety
English Innovations Project**
November 2014 – March 2016

Eileen Munro, Andrew Turnell and Terry Murphy

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Organisational reform to support high quality Signs of Safety practice

Action Research Final Report
Signs of Safety English Innovations Project

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PARTICIPATING LOCAL AUTHORITIES

Brent • Bristol • Leicestershire • Lincolnshire • Norfolk

Suffolk • Tower Hamlets • Wakefield • West Sussex • Wokingham

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Introduction

In mid-2014, Munro, Turnell and Murphy Child Protection Consulting (MTM) succeeded in securing English government innovations funding to work intensively with ten local authorities over eighteen months. The project became known as the Signs of Safety English Innovations Project (referred to in this document as Innovations Project or EIP or the project). Funding was provided to implement Signs of Safety practice in each local authority and to work with each authority in re-designing organisational procedures and functioning to better support this approach in helping children, young people and families. The ten local authorities involved were Brent, Bristol, Leicestershire, Lincolnshire, Norfolk, Suffolk, Tower Hamlets, Wakefield, West Sussex, and Wokingham. This selection provided a rich mixture of urban and rural areas.

During the life of the project, it was described by some as being about 'training front line social workers in Signs of Safety'. This misinformed observation illustrates the tendency to assume that improvement in children's services is all about training that changes how front line staff deliver services to children, young people and families. While the nature and quality of services delivered to families are indeed an acid test of children's service reform, the Munro Review of Child Protection (2011) demonstrated clearly that service delivery is strongly shaped by organisational culture, leadership and procedure. The Munro Review described how, over the years in the English system, reform efforts that had been intended to improve front line practice had, gradually and inadvertently, created a defensive compliance culture where anxiety was high, process took precedence over content, and social workers were increasingly limited in their time and flexibility to engage well with families (Munro, 2011). These developments create 'latent conditions for error' (Reason, 1990), resulting in organisational conditions where mistakes are more likely be made. For example, a rushed interview with a family to meet a prescribed timescale can lead to a poor assessment of a child's safety and wellbeing; the supervisor whose priority is checking for process compliance may fail to notice the inadequacy of the assessment, and subsequent planning may miss significant problems in the child's life.

The quality of the service that families receive is influenced so strongly by the organisation and its work environment that reforms cannot succeed if they focus only on improving the skill of front line practitioners. Creating positive practice improvements requires whole system organisational change that embeds the core disciplines and principles of Signs of Safety in the organisation's culture and practices. Where leaders believe a Signs of Safety implementation need involve only front line staff, and where managers continue to give priority to scrutinising process compliance, managers will not play their necessary part in creating a culture where critical reflection is promoted and engagement with families is prioritised. In reality, this is no implementation at all; it is more likely to escalate pessimism about the approach and staff frustration that, while they are being asked to work collaboratively and reflectively with families, the organisation's anxiety-driven focus on compliance and procedure remains unchanged. In an unsupportive climate, front line change will

slowly atrophy as it is squeezed out by the pressures to achieve conflicting goals. This, then, is the meaning of the report's title *You Can't Grow Roses In Concrete**.

The Signs of Safety Innovations Project has sought to help local authorities achieve a fundamental shift in their functioning and assist them to move from the fearful compliance culture described in the Munro Review to a learning culture where all in the organisation have a focus on the wellbeing and safety of children and young people, and where Signs of Safety is the overarching framework for how the work is done. To achieve this, changes have been needed, for instance, in procedures, policy documents, forms workers use and how they are used to focus practice, quality assurance and the IT system. Less tangible factors were also addressed, what Peter Senge (1990) called 'soft' factors like organisational priorities, management of the inherent uncertainty in the work, and the sense workers have about whether leadership supports them and understands their challenges.

Since the project focused on whole system change and organisational alignment, it was critical to have corporate support for the reforms from elected council members and also from the senior children's services leaders. This was secured as a key criterion for participation in the project. In finding participants, it was also important to MTM that there was diversity among the participating authorities, including a spread from small to large, urban to rural, and other significant differences. Some were already using Signs of Safety in work with families to some extent; others had no experience at all. Some had 'good' Ofsted** inspections ratings; others were 'inadequate'. In addition to the 'whole system, whole service' focus, as the project progressed the local authorities chose different priorities. For example, some extended the use of Signs of Safety to early help services, some focused on the QA system, and some focused on the front door to conferencing. This points to the reality that there was no uniform journey that every local authority followed over the eighteen months. At the same time, senior leaders reported that bringing the leadership teams together from all the local authorities every two months and using other mechanisms to continuously share developments, struggles and successes created a learning community among the ten authorities that was energising for all.

When the project was set up, the Department for Education that funded the project posed two questions to MTM:

- Is Signs of Safety being implemented?
- What organisational forms best support front line Signs of Safety practice?

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* Schorr, L. (1998). Common Purpose: Strengthening families and neighbourhoods to rebuild America. New York: Anchor Books.

** Ofsted is the Office for Standards in Education, Children's Services and Skills that inspects and regulates services for children and young people.

To us, these questions are not distinct. Implementation requires whole system reform. Experience has also shown us that it is more accurate to ask, '*To what extent is Signs of Safety being implemented?*' This report seeks to summarise how the ten partner authorities have implemented reforms, where they are in their journeys toward full implementation, and how they have changed and continue changing.

More information on the impact of the reforms on families will be provided by the independent evaluation that is being conducted by a team from King's College, London. That research report is expected to be available concurrently with this report.

Reporting on transformational and necessarily extensive reforms in ten local authorities is potentially a vast task and the action research was a modest strand of the work. Therefore the following report provides a broad brush picture of what has happened, picking out key themes and illustrating the diversity of the implementations. It is structured as a list of key elements of the reforms, but attention is given to reporting on how successfully these elements must interact to produce the desired changes. Readers who want more detail will find it within the documents and worked examples of reforms that are available at http://munroturnellmurphy.com/eip-report.

Sources of evidence

Much of what is reported here describes what was done by all involved in the Innovations Project. It draws on minutes of consults between MTM and senior managers, local documentation (especially of project management meetings), observations from the bi-monthly leadership workshops, and focus groups conducted in August 2016. Local Safeguarding Children Board (LSCB) annual reports and Ofsted reports are also cited. In addition, staff and parent surveys were administered, providing quantitative and qualitative findings about what was happening and how it was being experienced.

Staff surveys were developed to capture information about the workforce's views on the reforms, their confidence in using the new methods, and the organisational culture in which they were working. Most of the survey was an attitudinal questionnaire but there were also open-ended questions that provided more qualitative information about people's positive and negative views on the reforms. These surveys were administered twice: in February 2015 and again in January 2016. The administration of the first survey was problematic with low participation in some local authorities and it was concluded that only six had sufficient and representative responses to be useable. The second survey was administered more efficiently and the response rates averaged 53%, a total of 1,526 responses that provided a good level of representativeness. Comparison of the two sets of results showed a consistent trend towards improvement but these were not statistically significant. Ideally, the interval between the surveys should have been longer but this was not feasible within the relatively brief eighteen-month time period of the project.

To report the findings of survey questions for all ten partner authorities in a way that illustrates the diversity and is readable, the results for the top two scores of 'agree' and 'strongly agree' and the lowest two of 'disagree' and 'strongly disagree' have been combined. The two numbers reported do not add up to 100 because the 'neither agree nor disagree' answers were not included in order to simplify the tables.

Parent surveys were designed to measure the extent to which parents were experiencing a Signs of Safety service. These surveys drew on Signs of Safety fidelity work done by Casey Family Programs, a major USA child protection philanthropic foundation that incorporates a substantial research arm. Problems were encountered in administering the surveys, but these difficulties gave us the opportunity of learning what works in securing a good response rate while also complying with ethical, legal and technical research requirements. The most successful surveys obtained response rates of 65% and the main reason for non-response was that the parents could not be contacted because the supplied phone number was out of date. In reporting the parent survey findings, we used only data from the surveys that had a reasonably representative response rate: three surveys administered in July 2015 and two administered in July 2016. Across the initial three, 437 parents were targeted and a total of 238 responded, giving an overall response rate of 54%. In the two in 2016, 203 parents were targeted and a total of 134 responded, an overall response rate of 66%. One local authority had good responses from both surveys, allowing comparison to be made to see what change, if any, has occurred.

In reporting findings, local authorities are identified as A, B, C, etc., because confidentiality was promised at the beginning of the project to encourage open discussion of problems. The chart showing performance data contains their names since these data are in the public domain.

The implementation framework

'Social interventions are complex systems thrust into complex systems.'
(Pawson, 2006 p.35)

As procedural change has lost its lustre for governments and child protection systems around the world, increasing attention has been given to broader organisational functioning as a central factor in implementation success. Over the past decade, thinking about organisational transformation has been increasingly shaped by implementation science (e.g., Fixen, et.al., 2005; 2013) that comes from the USA. Much implementation science thinking focuses on simpler, more linear reforms than the complexity pointed to in Pawson's quote and implementation science's key concepts need adapting to fit the complex and dynamic challenges that are always evident in children's services. Implementation science is usually framed and focused on the installation of an intervention with demonstrated fidelity. By contrast, our work in the Innovations Project set out to enable local authorities to use the Signs of Safety as a vehicle to create a learning organisation that monitors how it is implementing the work, that reviews outcomes, successes and failures, and that establishes across the organisation participatory learning methods focused on the practice, allowing them to continuously adapt to change as necessary while keeping to the key principles of the approach. To achieve this, attention needs to be given to how the new way of working interacts with existing parts of the system, and how the system in turns aligns with the intervention. This a more dynamic way of thinking about implementation than the more common static framing that implementation involves where installing a new intervention into a fixed system is rather like pumping a new, more powerful petrol into the fuel tank of a motor car.

Further, the concept of 'resilience' has a different meaning once an organisation is viewed as a complex, constantly changing system. The engineering concept of resilience was developed in relation to stable systems and focused on efficiency, control, constancy and predictability. This concept is aimed at achieving a steady-state equilibrium where management and policy emphasise micro-command and control approaches. All of these features were visible in the managerial-driven system that had developed in England. With a static concept of resilience, evaluation focuses on stable and constant elements in the system. By contrast, in a complex system, resilience focuses on persistence and adaptability through absorbing and adjusting to changes by evolving adaptive structures and processes. Management and policy then emphasises the adaptive interplay between stabilising and destabilising properties, and evaluation focuses on the adaptability of the system. A useful metaphor representing these different concepts of resilience is provided by thinking about the fragility of rigid houses compared with the robustness of houses designed to sway when an earthquake hits.

Our understanding of the dynamic nature of implementation in complex systems has deepened throughout this project and is captured in a revised framework that illustrates how implementation is a continuous learning and development cycle with the practice framework at the centre.

Figure 1: Signs of Safety Organisational Implementation

So often children's service transformation has focused on procedures, training, measurement or leadership practice. While all these are important, this diagram emphasises the centrality of the practice approach as the foundation of organisational transformation. That is why it is at the centre of the continual learning and development cycle. At its simplest we are seeking to illustrate the obvious point that everything an organisation does – its leadership, procedures, measurement and learning – must always focus on what practitioners actually do with children and families. Without a fit-for-purpose, end-to-end practice approach that the organisation can align with, transformation will derail.

The key implementation activities are seen as follows:

- Learning, including core training, that flows into specific continuous learning methods.
- Leadership development that builds congruence between how the organisation is led and managed and how work is expected to occur with families.
- Organisational alignment so that structures and processes enable the practice.
- Meaningful measurement through participatory quality assurance encompassing key practice data matched to the results logics of the practice approach.
- Information technology to provide case and performance information consistent with the practice.

The concept of 'fidelity to method' is still important but is also framed more broadly, first in focusing on fidelity to the principles and disciplines of Signs of Safety rather than solely on the specific tools or processes, and second in expecting that fidelity to be apparent throughout the organisation, not just in the actions of the front line staff.

The approach taken by MTM in working with the ten local authorities was collaborative, seeking to form a shared understanding of the problems and co-creating solutions among all the authorities that have been faithful to Signs of Safety within the English context. This deliberately parallels the participatory approach that grounds the work between families and practitioners using the Signs of Safety practice framework. An agency's pattern of working relationships will always tend to be defined, and cascade down, from the top and in England the dominant 'command and control' approach of previous political reform efforts was thereby often duplicated in the relationships between managers and front line workers and, in turn, between front line workers and families (see, for example, Forrester et.al., 2008). Signs of Safety aims to achieve respectful engagement with families, that harnesses their strengths and resources as a hopeful foundation to rigorously explore highly personal and anxiety-producing problems, and then together to find solutions. Social workers will feel much more supported and able to practice in this way when they themselves experience this same kind of participatory and respectful relationship with their seniors. Thus we are pursuing leadership where practitioners are continually engaged in learning together how to navigate the ongoing anxious environment that exists in every children's services agency.

This collaborative approach in the Innovations Project not only helped each authority design its own implementation journey, but also was flexible enough to allow and encourage new innovations. For example:

- Extending Signs of Safety from child protection work to other parts of children's services like early help and looked after children.
- Developing the My Three Houses app with practitioners for working directly with children.
- A user-designed collaborative project to create a Signs of Safety/Wellbeing/Success IT recording system.
- A Signs of Safety quality assurance system including participatory audit.

This project operated with two theories of change: a theory of how change is produced in families and a theory about the organisational environment that is required to enable and promote practice with families of the kind envisaged. Both theories of change presented below are revised from the theories that informed us at the start of the project. The revisions to both theories were made based on the learnings from the project.

The revised practice theory of change clearly distinguishes between the assessment and action cycles and is more detailed than the latter. The English Innovations Project enabled us to see that the 2014 theory of change focused excessively on the training, supervision and practice of front line practitioners, almost completely overlooking organisational leadership and culture as key factors that define and shape practitioner performance and resilience. The revised organisational theory of change parallels the infinity loop implementation illustration that locates the Signs of Safety practice approach, and the principles that underpin it, as the vehicle through which whole organisation learning and improvement can be achieved.

Revised Signs of Safety practice and organisational theories of change

Children's services practitioners' ability to deliver quality, timely Signs of Safety services is always dependent on the level of support and alignment their agency provides around the practice. Therefore, the Signs of Safety practice theory of change is paired with the Signs of Safety organisational theory of change.

Signs of Safety practice theory of change
If all Signs of Safety practice methods are used by practitioners with quality and in a timely way, and this work is undertaken collaboratively with the children, parents and naturally connected support network, the child's safety will improve significantly.

Signs of Safety organisational theory of change
When the Signs of Safety practice methods and the organisation learning, measurement, alignment and leadership methods are implemented across the whole agency, this creates a continuous organisational learning system built around the practice approach and focused on service delivery. When every tier of the organisation, from field staff to the CEO, is engaged in the learning system through position specific learning and feedback methods, the agency will secure significantly enhanced practice consistency and improved outcomes for children.

Signs of Safety practice theory of change

The practice theory of change articulates the hypothesised goal as above and the minimum steps, or result logics, of the Signs of Safety approach to ensure it is delivered with fidelity. This constitutes what researchers call the logics model of the theory of change.

The Signs of Safety practice theory of change involves two interconnected iterative cycles: an assessment and analysis cycle and an action cycle.

Assessment and analysis cycle

The assessment and analysis cycle involves the following minimum steps:

1. A referral that details concerns about a vulnerable child or young person is made to children's services. The referral usually arises from behaviours of parents or carers that are seen to be harmful to a child or young person. However, a referral can also occur because the child's or young person's behaviour is creating problems and/or is seen as dangerous to themselves or others.

2. Assessment begins with the intake professional inquiring and sorting information into the Signs of Safety map under the *What's Working*, *Worrying* and *Needed* headings.
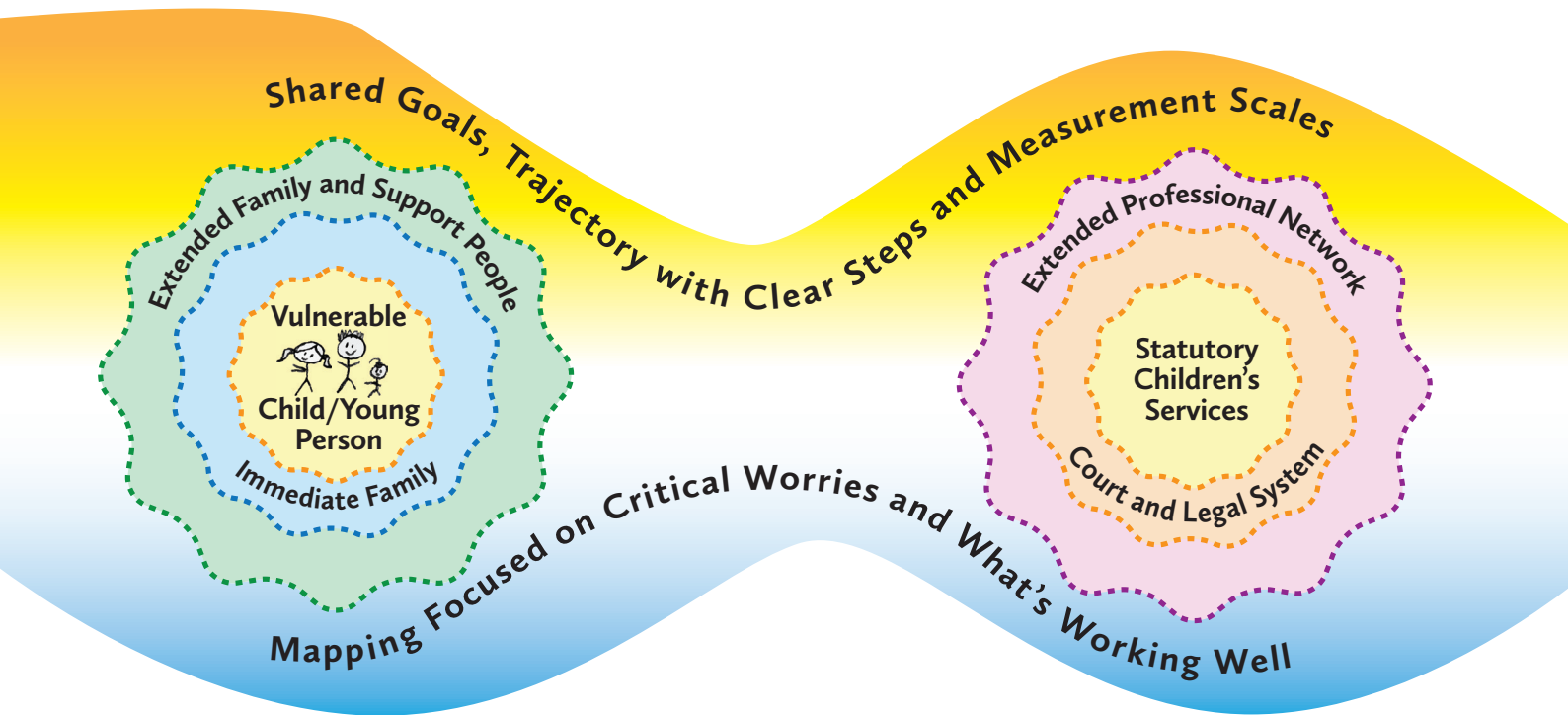
Figure 2: Assessment and Analysis Cycle

3. The intake professional inquires judiciously in a risk-intelligent way, gathering needed additional information. The information is then analysed. Initial danger statements and safety goals are formulated and matched with aligned safety scales (establishing the case specific judgement criteria). This stage usually involves work with other key professionals and court proceedings may be initiated.

4. Intake professionals undertake initial mapping (assessment) work with children (My Three Houses or similar), parents and extended family while simultaneously finding and involving all possible naturally connected support people, be they next door or around the world. See: http://www.familyfinding.org.

5. Once the children, parents and support network understand the professional concerns about harm and danger (even if they don't agree), and the shared goals and aligned safety scales are agreed and finalised, this establishes the key parameters of the assessment map for the particular case.

6. The final stage of completing this first iteration of the assessment and analysis cycle involves formulating a safety planning trajectory, including critical steps and timeline. Once agreed by all, the Signs of Safety map and trajectory provide the focus for the working relationships between family and professionals.

The assessment and analysis cycle steps move interactively through the three stages of assessment:

- Information Gathering
- Analysis
- Judgement

Child protection assessment always tends to become bogged down in information gathering with professionals feeling too anxious to analyse and judge. The Signs of Safety assessment and analysis cycle aims for agility, asking practitioners to move quickly through all three stages. Completion is expected in around fourteen days. The capacity for practitioners and their supervisors to work in this way is supported by a comprehensive framing of risk, considering strengths, existing and future safety, as well as harm and danger, and tools that support this framing alongside structured group supervision methods that build and sustain a practice culture where decision making and risk are shared. The focus throughout is on analysis, family participation and setting up the whole map and trajectory as quickly as possible, then moving into action. The action and learning from it will iteratively refine the assessment as the solutions are built with the children, family and support people always at the centre of planning and action.
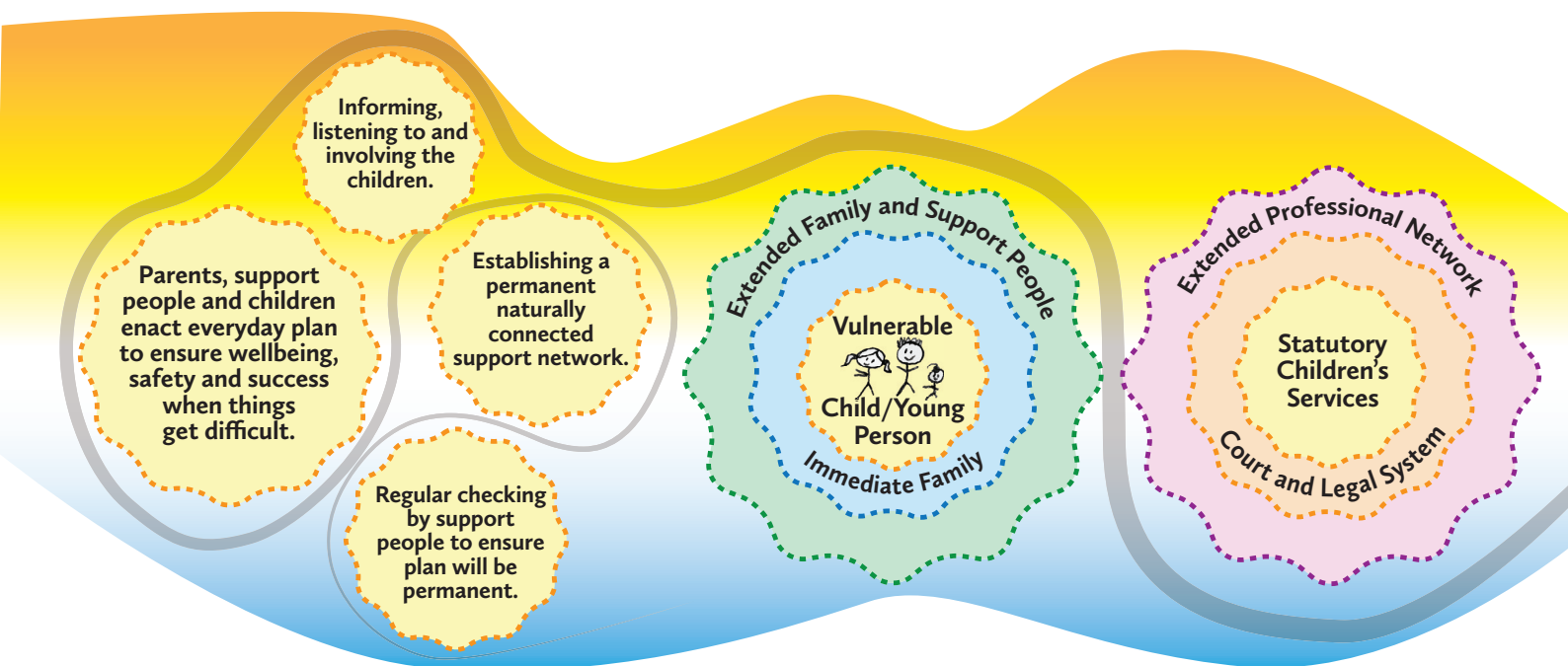
Action cycle

Figure 3: Action Cycle with the Assessment and Analysis Cycle

The action cycle focuses on building the family's and network's capacity to act to ensure the child's safety when circumstances could, or do, become dangerous. The action cycle involves the following minimum steps:

1. Listening to, informing, and involving the children through the whole action cycle.

2. Finding support people and establishing them as a permanent, naturally connected support network around the immediate family.

3. Professionals leading the parents, support people and children in developing an everyday safety plan to ensure the children will always be safe when family life could, or does, become dangerous.

4. Parents, support people and children demonstrating they can, and will, always use the safety plan.

5. Naturally connected support people providing a watchful eye and all support necessary to ensure the safety plan will be permanent.

6. Professionals leading the parents, support people and children in continually thinking though their current assessment of safety.

7. The iterative action – assessment and analysis – cycles continue (represented diagrammatically by the interactional flows linking assessment and analysis with action) until everyone judges the safety to be high enough and permanent (usually everyone scoring 7 or above on the safety scale). When this occurs the case is closed.

Signs of Safety organisational theory of change

Signs of Safety implementation involves a comprehensive organisational transformation process since agencies usually have extensive entrenched and interconnected policies, processes and systems that define both direct practice and organisational culture. Aligning the organisation to enable, rather than impede, the Signs of Safety paradigm shift requires organisational change on multiple fronts. Leaders need to be alert to the reality that both organisation and staff will inevitably be caught between 'old' and 'new' policies, processes, systems and cultures. Leaders must also understand that organisational alignment takes time and concerted effort.

The Signs of Safety organisational theory of change illustrates the centrality of the practice approach as the foundation for organisational transformation. Organisational change involves continuous cycles of learning and development. As alignments that enable the practice in day-to-day work are assessed against outcomes, learning and improvement become successively focused on, and congruent with, front line practice.

The Signs of Safety organisational theory of change and the implementation framework emphasise the continuing organisational action learning process of gathering information, setting strategies, taking action, learning from results, adjusting and starting again. The infinity loop also implies the agility and responsiveness required to lead and drive change in large organisations operating within larger human service and political systems.

At every level, leaders are managing complex and contentious work.

The organisational theory of change is illustrated as flowing directly from, and interlinked with, the practice theory of change.
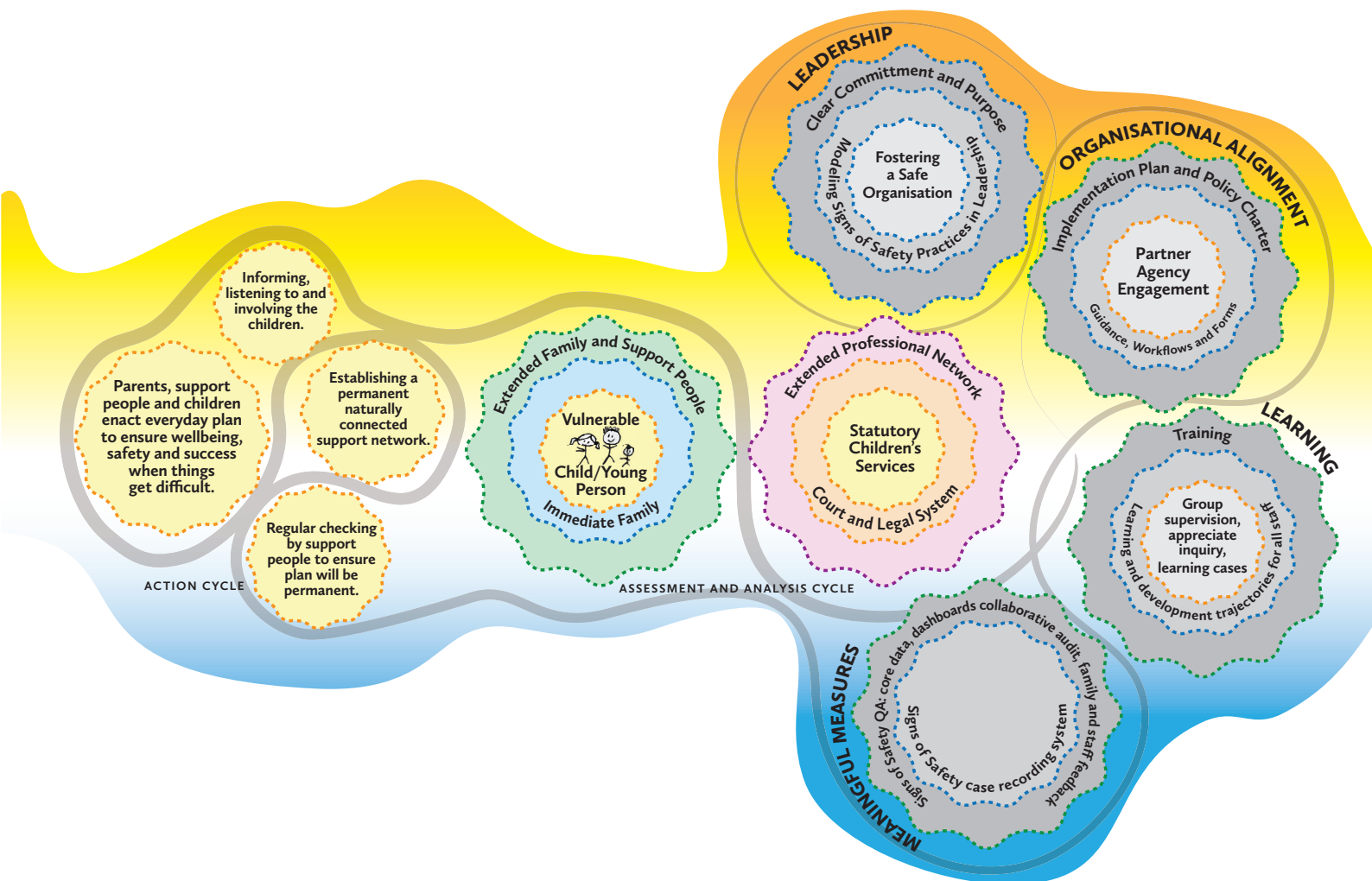

Figure 4: Signs of Safety Organisational Theory of Change

While the organisational theory of change steps are presented here in a notionally linear fashion, in practice they are iterative and interactive.

Preparation phase

- Leadership makes a clear and explicit commitment to the implementation of Signs of Safety.
- Leadership determines a focused set of goals for adopting Signs of Safety practice, with corresponding measures, that are tested and adjusted with the workforce.
- Targeted briefings and introductions to Signs of Safety are implemented for practice leadership staff, key partners and political leadership.
- Consultation on a number of typical cases to seed the practice, create examples for the coming training, and begin whole agency learning focused on the practice.

- Develop the implementation plan, including an organisational policy or charter, that describes the practice and reflects the organisational commitment and purpose.

Implementation phase

- Launch event and strategic communications.
- Basic training for all staff, including leadership and key partners, with clear permission and direction to start using the practice.
- Comprehensive briefings for partner agencies appropriate to their roles within children's services and universal services.
- Commence core data collection to measure achievement of implementation goals.
- Encourage and drive modelling of Signs of Safety practices in day-to-day leadership, including fostering a safe organisation for staff.
- Identify guidance, processes and forms that create barriers to practice. Remove or align these as a priority.
- Conduct first annual baseline family and staff feedback surveys.
- Commence learning and development trajectories for all leadership levels.
- Provide advanced training for practice leaders (supervisors, practice consultants), implementation leaders (service managers and quality assurance staff), and senior management.
- Practice leaders and front line staff commence group supervision.
- Commence targeted appreciative inquiries at various levels across the organisation.
- Commence collaborative case audits.
- Introduce dashboards at team level through manual technology to monitor use of the practice approach.
- Map out work plan and ongoing process, involving front line staff, to align workflows, guidance and forms, based on identification of barriers and what works in practice.
- Map out work plan to align the overall quality assurance (QA) processes further.
- Map out work plan and process to align IT consistent with the practice methodology and also automate dashboards to monitor the practice use at all levels.
- Continue learning and development trajectories for all levels of staff incorporating learning from quality assurance, group supervision and appreciative inquiries.
- Continue learning case work for whole agency learning.
- Review progress. Incorporate learning from quality assurance, group supervision and appreciative inquiries. Revise implementation strategies at team, service, senior leadership level regularly and for the entire organisation annually.

The theory of change elaborated in the Signs of Safety organisational implementation framework is based on two years of intense activity within a five-year organisational commitment. The framework sets out in more detail the various steps involved in leadership, organisational alignment, learning and meaningful measures, and forms the basis for the organisation's implementation plan and review.

The implementation framework is underpinned by learning and development trajectories for all leaders within the organisation: practice leaders (supervisory level), senior leadership, service management, corporate policy and QA. The trajectories involve defined programmes of activities specifying the learning content and action learning methods for both practice skills and their leadership roles.

The implementation process

Project management

All the authorities developed implementation plans based on the MTM transformational framework, although those plans varied to suit local circumstances. The revised framework in line with the redeveloped theory of change is available at http://munroturnellmurphy. com/eip-report.

All the authorities managed the implementation process by appointing a Project Director and creating a steering group comprising key executives, representative field, policy and learning directors, the project director, and the organisational consultant from MTM. Each local authority steering group had regular meetings to monitor progress and plan next steps. In addition there were monthly consultations with Andrew Turnell or Terry Murphy, either in person or via video link.

Bi-monthly leadership workshops were held in London and there was good attendance from senior managers throughout the project. These workshops provided the opportunity to discuss key elements of implementation such as reforming the quality assurance process, revising the range and use of performance data, and the role of leadership in managing uncertainty. Each workshop included a session called 'It's all about the practice' where senior managers were actively engaged in tackling a particular practice issue, reflecting the importance of senior staff having a good understanding of the challenges of front line work. In most leadership workshops, managers practised and refined their appreciative inquiry skills in exercises targeted at organisational or practice successes.

After each workshop, a detailed report and a public newsletter was prepared. The newsletter was intended particularly to keep the workforce and partner agencies informed about the project and was widely distributed within each local authority. A sample newsletter is available at http://munroturnellmurphy.com/eip-report.

Organisational culture

At the heart of the Signs of Safety framework are three principles that need to be embedded in the organisational culture in order for them to be fully demonstrated in work with families. The three principles address key challenges of the work:

1. Working relationships are paramount. Relationships must enable honest and respectful discussions of concerns and worries, draw on and honour everything positive, consider multiple perspectives, and always incorporate skilful use of authority. Research shows that, irrespective of the type of intervention, professionals see better outcomes when there is shared understanding of what needs to change, agreement on purpose and goals, and family members feel their worker understands them.

2. Thinking critically and maintaining a stance of critical inquiry. In order to minimise error, a culture of shared reflective practice and a willingness to admit you may be wrong are vital. Risk assessment is a core task and requires constant balancing of strengths and dangers to avoid the common errors of drifting into an overly negative or positive view of the situation.

3. Grounded in everyday experience. Assessment and safety planning is always focused on the everyday lived experience of the child. Service recipients and front line practitioners are the key arbiters of whether practice works or doesn't.

Evidence about the extent to which these principles are entering the organisational culture was taken from a number of sources. The primary source is the staff survey that collected people's views on how much they experienced the desired culture. In addition, focus groups, interviews and discussions at workshops added to our understanding.

Working relationships are paramount

For many, implementing this principle requires a shift of priorities from process compliance and meeting performance indicators to having time and flexibility to form effective relationships with families. Responses showed a varied experience in relation to believing there was sufficient time available with families and feeling that the organisational culture prioritised performance indicators over time with families.
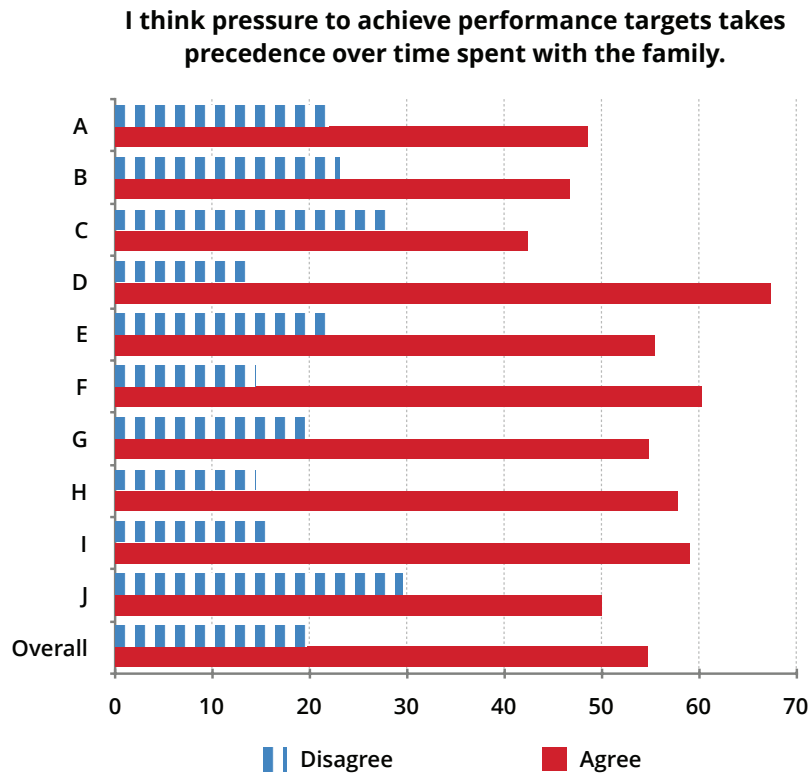
I think pressure to achieve performance targets takes precedence over time spent with the family.

Figure 5: "I think pressure to achieve performance targets takes precedence over time spent with the family."

In the surveys and focus groups, time pressure was a frequently expressed cause for concern. In addition to the general problems of heavy workloads, practitioners expressed Signs of Safety specific worries that:

- developing new skills made additional demands on their time, and
- Signs of Safety emphasised the importance of spending more time with families at case commencement to create a good basis for future work by engaging well with all family members, reaching a shared understanding of the worries and good things for the children, and what needed to change.

The focus on good fit-for-purpose working relationships also highlights the importance of paying attention to the emotional dimension of the work. Workers are exposed to intensely painful human emotions: fear, despair, anger, sadness. Unless their organisational environment helps them there are two major dangers. First, the worker may get pulled into the emotional dynamics of the family and develop an unbalanced assessment of the problems. Second, the worker may feel so stressed that they burn out and/or emotionally disengage from the work, evidenced in depersonalisation, emotional exhaustion and compassion fatigue.

Several survey questions looked for indicators of factors that contribute to burnout. For example, feeling stressed, having a manageable workload, congruence between working well with families and meeting other organisational demands, and a sense of personal accomplishment.
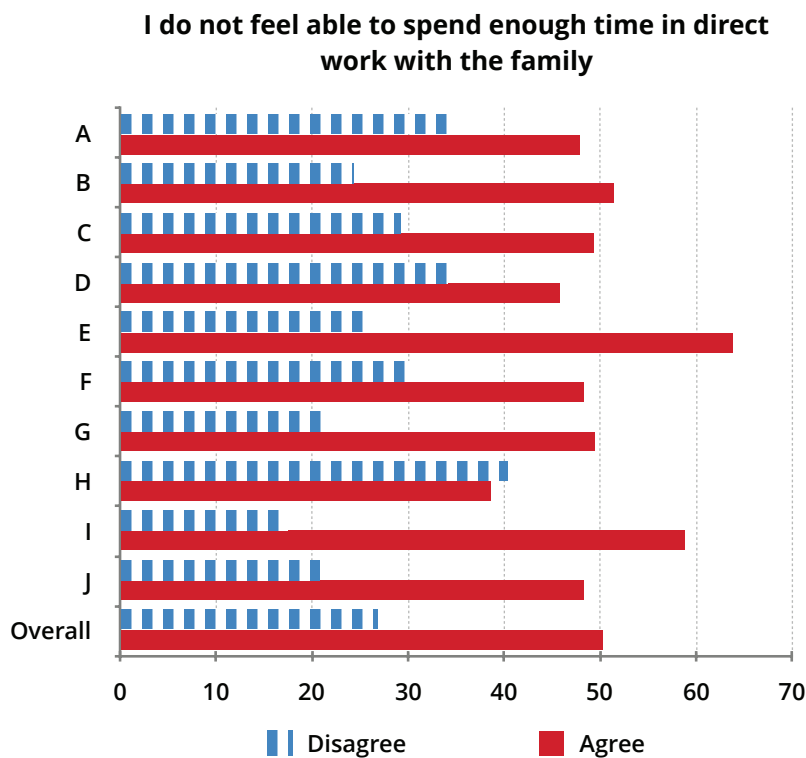
I do not feel able to spend enough time in direct work with the family

Figure 6: "I do not feel able to spend enough time in direct work with the family"

Self-reports on stress showed considerable variation, but a worrying percentage reported high levels of stress.

By separating responses from managers and responses from those who work directly with families, a significant difference is visible, with managers generally reporting lower levels of stress.

With the data available, we can only speculate about the reasons for this difference in reported stress levels. One possibility is that managers have more control over their work per se and hence over their workloads. If they have too much, they can delegate more or do less of a particular facet of the work. In contrast, workers largely must do what is on their plate or be stressed by not keeping up with cases and compliance. Research suggests that having control over one's workload mitigates stress. If this explanation is correct, it highlights the importance for workers of having manageable and stable caseloads so that the volume of work is predictable as well as within their capacity. It also indirectly indicates the importance of having clear, understood methodology and streamlined processes for doing the work, while allowing for adaptation by the worker, which together also provide a sense of control of their own work.

There is some evidence (McFadden, Campbell & Taylor, 2014) that poor working relation-ships are positively correlated with experiencing more aggression from families, so the survey contained a question on this and again revealed a varied pattern both within and between the local authorities.

Agree or strongly agree with "I feel stressed by the workload in my job"

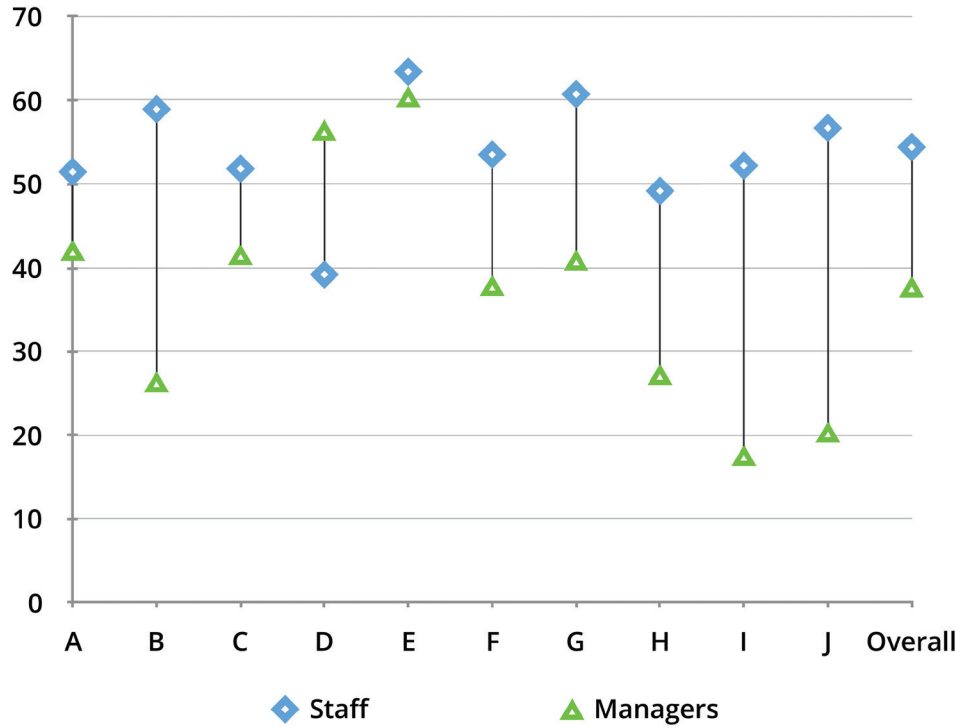*Figure 7: "Agree or strongly agree with 'I feel stressed by the workload in my job'"*

I feel stressed by the workload in my job

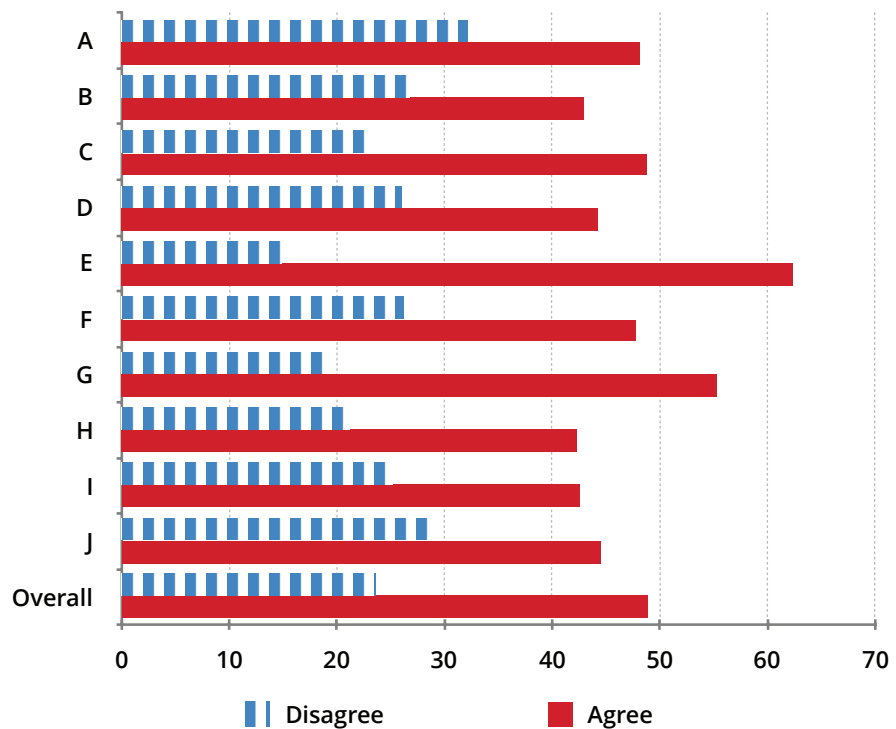*Figure 8: "I feel stressed by the workload in my job"*
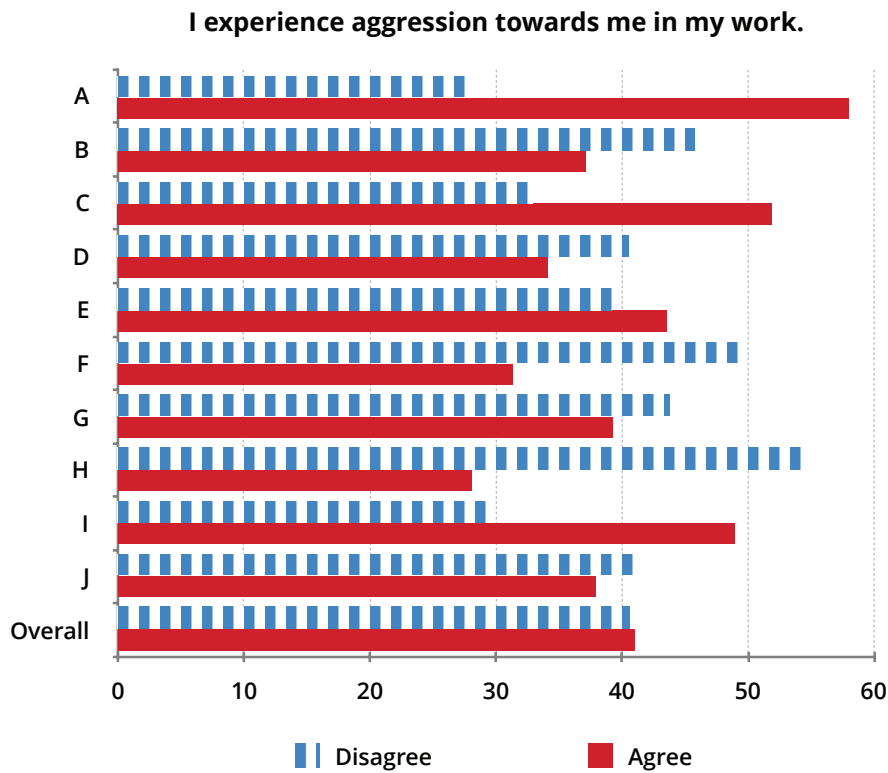
I experience aggression towards me in my work.

Figure 9: "I experience aggression towards me in my work"

There is time my supervisor to give me support.
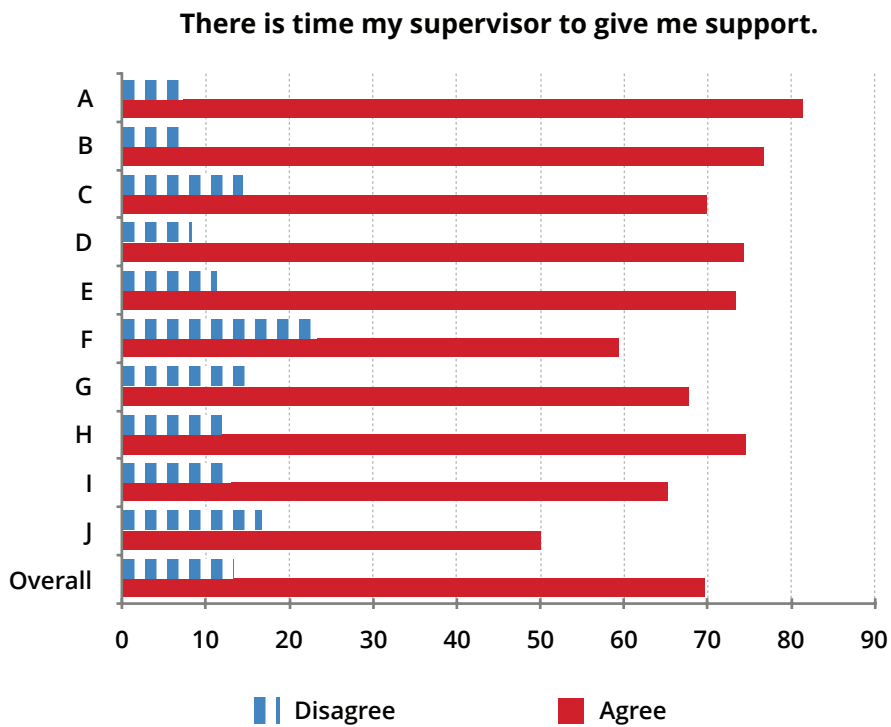
Figure 10: "There is time my supervisor to give me support"

There is support within my team/authority when I am under pressure or have difficult or emotional decisions to make.
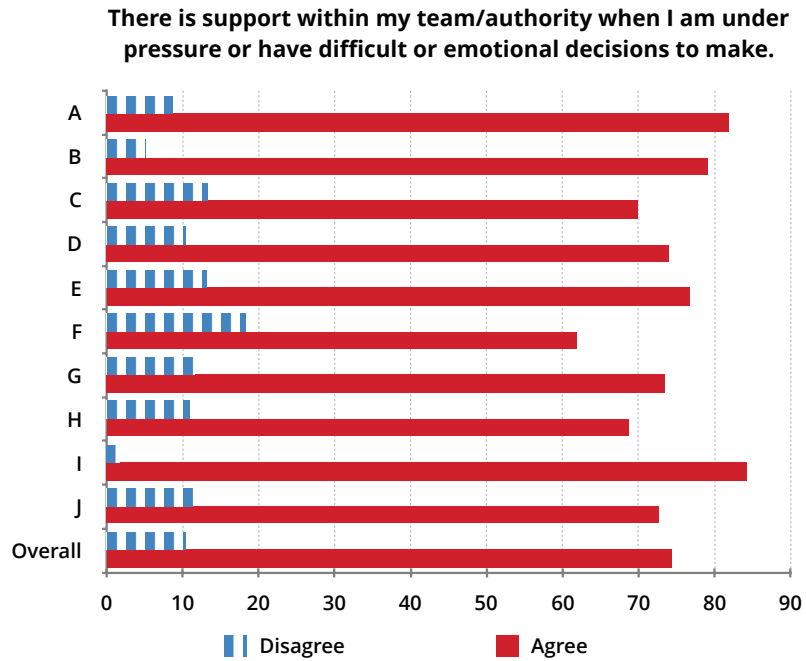
Figure 11: "There is support within my team/authority when I am under pressure or have difficult or emotional decisions to make"

Management do not provide emotional support for difficult or stressful decisions.
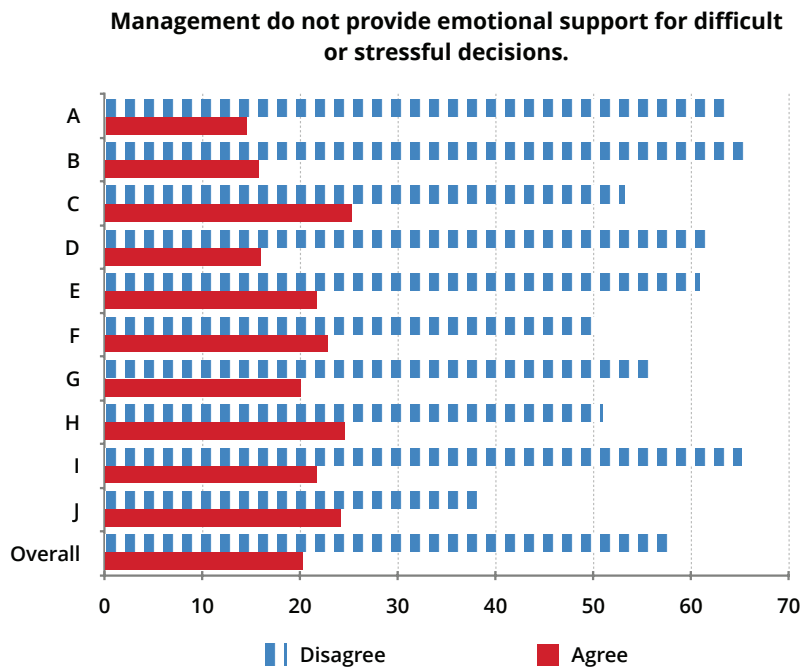
Figure 12: "Management do not provide emotional support for difficult or stressful decisions"

Survey questions also asked about how much workers felt supported within their organisations and responses to these questions were far more positive than to the stress-related items. There were generally positive findings about support from their supervisors, feeling supported when under pressure, and receiving managerial support when facing difficult decisions.

Thinking critically

A crucial aim of the Signs of Safety is to improve assessment and decision making; it seeks to help workers move quickly and with confidence from information gathering to explicit analysis, judgement, and then action. Organisational factors have a strong influence on reasoning. A major problem we are trying to address is moving away from a defensive culture that removes far too many children because practitioners feel solely responsible for decisions and actions to make children safe. The culture shift we are pursuing is one where social workers not only have the expertise, time and encouragement to engage well with families and their natural support networks and to engage them in the assessment, decision-making and planning, but where those workers also place them at the centre of taking action that secures their children's wellbeing and a safe enough home.

The Signs of Safety organisational implementation framework prioritises the creation of a safe environment for workers through supportive leadership as well as clear participatory learning, supervisory, leadership and review methods that together build confidence and demonstrate to workers that they will be supported through anxiety, contention and crises. This is fundamental to reducing defensive decision making as well as naïve assessments, such as those found in many child death reviews, where workers developed an optimistic assessment of a family and overlooked what, with hindsight, seemed very obvious evidence that the children were suffering harm. In challenging cases it is much more pleasant to work with strengths and to support families (so they like you) than to ask difficult questions or challenge their accounts of what is happening (potentially stirring up hostility). Given the Signs of Safety has a strong focus on what's working well, the organisation must actively develop and support a culture that is 'risk savvy' and always alert for danger. Balancing dangers and strengths is one of the key achievements of Signs of Safety when used well. Achieving this risk savvy balance requires purposeful leadership at all times to avoid drifting into a culture that is either too optimistic or too pessimistic.

In the surveys and focus groups, many respondents expressed concern that colleagues were being unduly optimistic about families and overlooking dangers. Some allied professionals made similar criticisms. It must always be recognised that some workers do become too focused on the strengths in families, either through misunderstanding the rigour of the Signs of Safety assessment process or simply because they have a proclivity toward the comfort of a dominant strengths focus. Likewise, it is important to be aware that children's services have become so risk averse that it is hard for many professionals to understand how they can honour positive attributes and behaviours in families without this being an act of collusion. Time will tell if this is a short-lived reaction as people shift from an overly negative risk averse view of families. Organisations always need to be aware that there is an attraction to a naïve interpretation of Signs of Safety for many reasons. If and when this occurs, leaders will hear workers saying that they believe in using the Signs of Safety, children are never removed, and they must always focus on strengths to the exclusion of concerns. Leaders should be particularly alarmed if they hear the sloppy phrase 'That's not very strengths-based of you' from one professional to another when one has identified things they are worried about.

Supervision, peer discussion, participatory leadership review of decision making, a culture of shared decision making, and rigorous exploration of the difference between strengths and safety that addresses danger are all crucial in helping practitioners reflect critically on what they are doing and sustain a rigorous focus on strengths, safety and dangers. Survey data on the priority given to critical reflection reveal it is insufficiently prioritised for many practitioners.

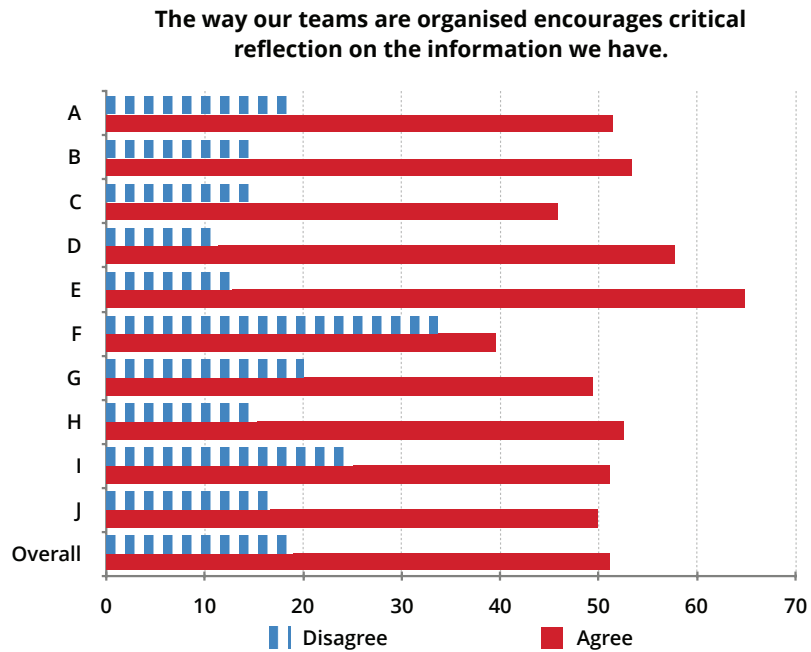**The way our teams are organised encourages critical reflection on the information we have.**

Figure 13: "The way our teams are organised encourages critical reflection on the information we have"

My team is organised so that we spend planned time on critical reflection of cases.

Figure 14: "My team is organised so that we spend planned time on critical reflection of cases"

Organisational learning

Grounded in everyday experience

The Signs of Safety approach is called a practitioner's approach because it has been created, and continues to evolve, using action learning methods to focus on what works in the lived experience of the practitioner and the service recipients. In an exact parallel, this is the same learning process that the approach applies to safety planning work with the family and network, and it also applies equally at the organisational level. Therefore the Signs of Safety approach requires the organisation to understand, learn from and make its implementation decisions and adjustments through careful and ongoing inquiry into the lived experience of service recipients (children, parents, extended family and naturally connected support people) and practitioners. The experience and interactions of the people who are living the recipient and delivery sides of the practice are the events that the entire children's services system is seeking to shape. This is where the services and outcomes happen or are determined, so it is essential that the organisation's learning methods are focused there.

The culture around learning

The data provided in the previous section on attitudes to critical reflection and willingness to challenge or be challenged provide evidence on an important aspect of learning culture. The challenge of creating a more constructive culture around the management of risk was discussed at an early leader's workshop and draft risk principles were circulated for discussion and amendment. The final version of these principles is available at http://munroturnellmurphy.com/eip-report.

In one local authority, the Director of Children's Services used learning from air traffic controllers in reforming the risk management culture so that the organisation moved toward a culture that is interested in *why* systems fail rather than apportioning blame when things go wrong. This way the potential for learning is maximised.

The literature on risk management also provides useful lessons on how accurately organisations can learn about how the system is operating and, in particular, about problems. Reason (1997) identifies various aspects of a developed safety culture but, above all else, he says a safety culture is a reporting culture in which people are prepared to report errors, near misses, unsafe conditions, inappropriate procedures and any other concerns they may have about safety. In child protection this will show up most in case discussions that are able to include challenging questions and where workers are willing to consider that they got it wrong. Therefore a set of questions in the staff survey covered how able or willing people are to talk of mistakes, weaknesses, and whether these are all right or are treated as signs of weakness.

If, with hindsight, I think I should have handled something differently, I am embarrassed to admit it.

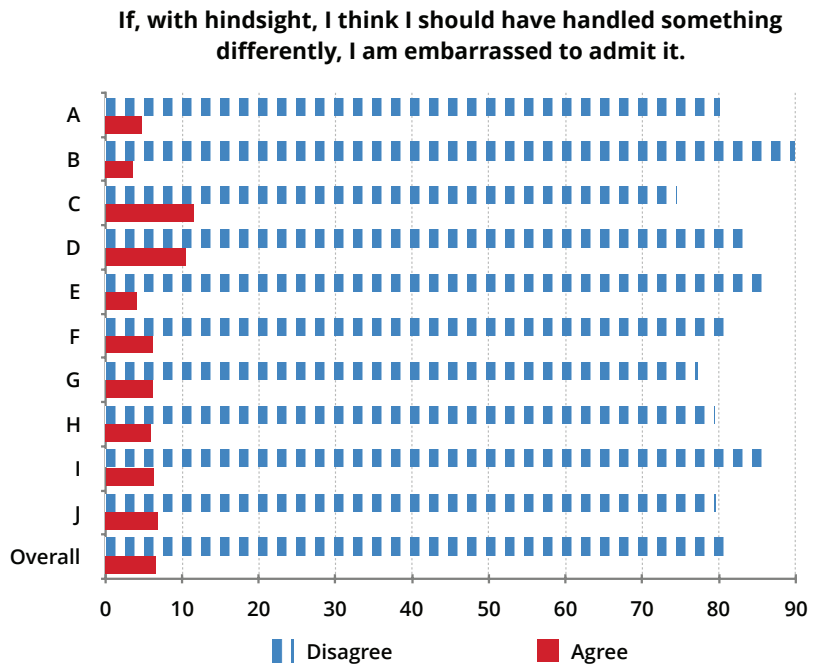*Figure 15: "If, with hindsight, I think I should have handled something differently, I am embarrassed to admit it"*

I worry that if I re-assess a case colleagues/people will think I have done something wrong the first time around.

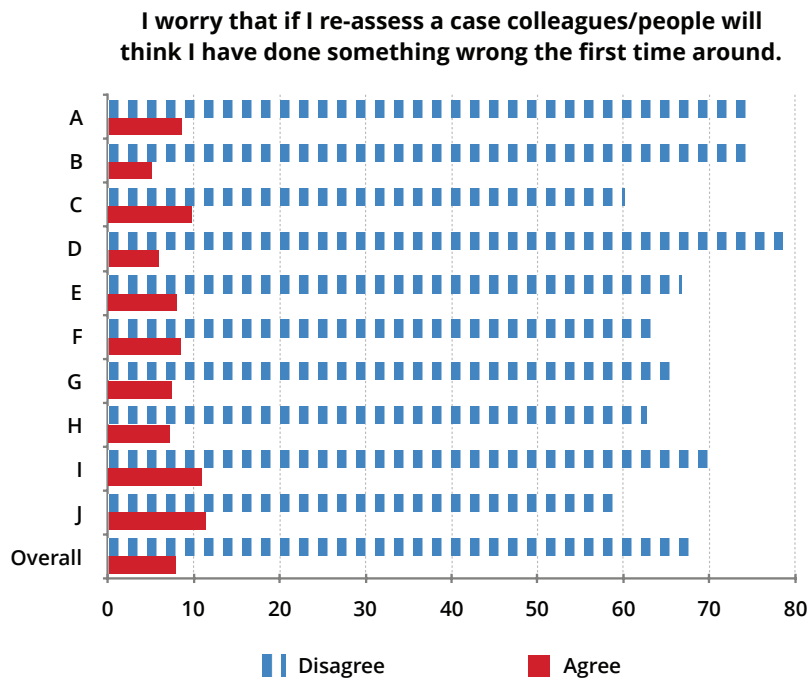*Figure 16: "I worry that if I re-assess a case colleagues/people will think I have done something wrong the first time around"*

Case reviews when things have gone wrong usually focus on who can be blamed.
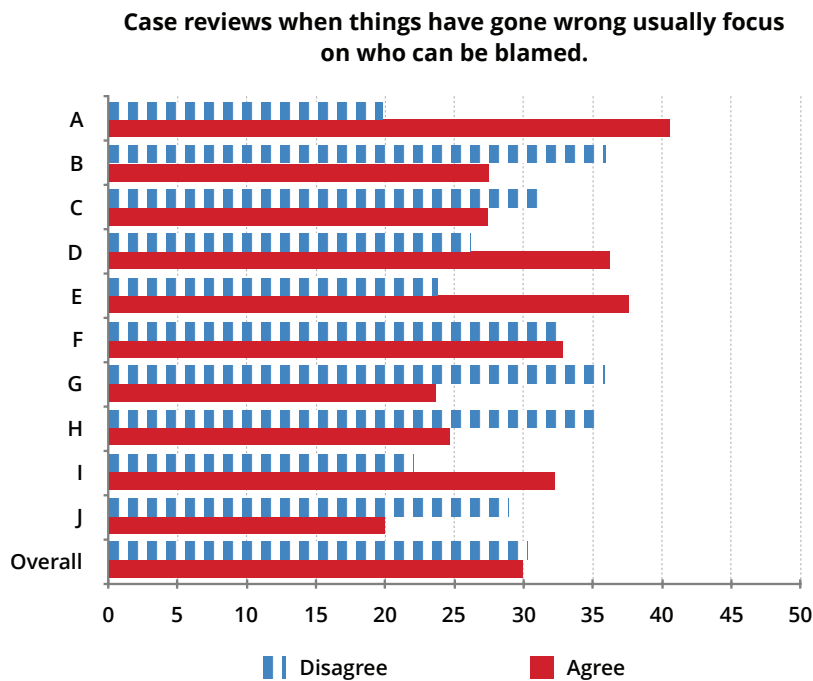
Figure 17: "Case reviews when things have gone wrong usually focus on who can be blamed"

Understandably, if workers believe that mentioning a mistake will be seen as evidence of incompetence and they will be blamed, then they are likely to keep quiet. Survey responses provided a generally very positive picture on this.

One indication of people feeling like they are working in a blame culture is whether they believe that serious case reviews set out to find someone to blame. The responses to this survey question show that a significant number of people feel they do, though there is considerable variation across the various authorities.

Mechanisms for learning

Work here involved reforming existing mechanisms for learning and, through collaborative discussions, culminated in the development of a participatory Signs of Safety Quality Assurance system that creates a better alignment between how practice occurs and how its quality is assessed. As such, it is considered to be increasingly central to the organisational implementation of Signs of Safety.

As well as learning the approach, organisational implementation for Signs of Safety involves the development of leadership in line with the practice, along with alignment of the organisation to support the practice, and meaningful measures of agency activity and outcomes that are recorded in ways that actively assist practitioners and managers rather than simply being an exercise in recording for others. Implementation is a continuous process of organisational adjustment based on timely feedback, received by those directly involved, about the actual Signs of Safety practice. The Signs of Safety learning methodologies and quality assurance system provide the improvement engine to generate

progressive alignment of learning, leadership, organisational arrangements, measure-ment and practice. When used in full, these will genuinely establish the children's service as a learning organisation.

The Signs of Safety Quality Assurance System is based on Signs of Safety organisational and practice theories of change – the essential elements of the practice that deliver out-comes and Signs of Safety fidelity – focusing attention on how workers practise and how organisations manage and lead learning consistent with Signs of Safety principles and practice.

The Signs of Safety Quality Assurance System encompasses:

- collaborative case audit reflecting the Signs of Safety theories of change;
- family feedback on practice and staff feedback on organisational fit and leadership reflecting Signs of Safety fidelity; and
- core data for monitoring case trends and outcomes with a small set of key indicators that are already collected.
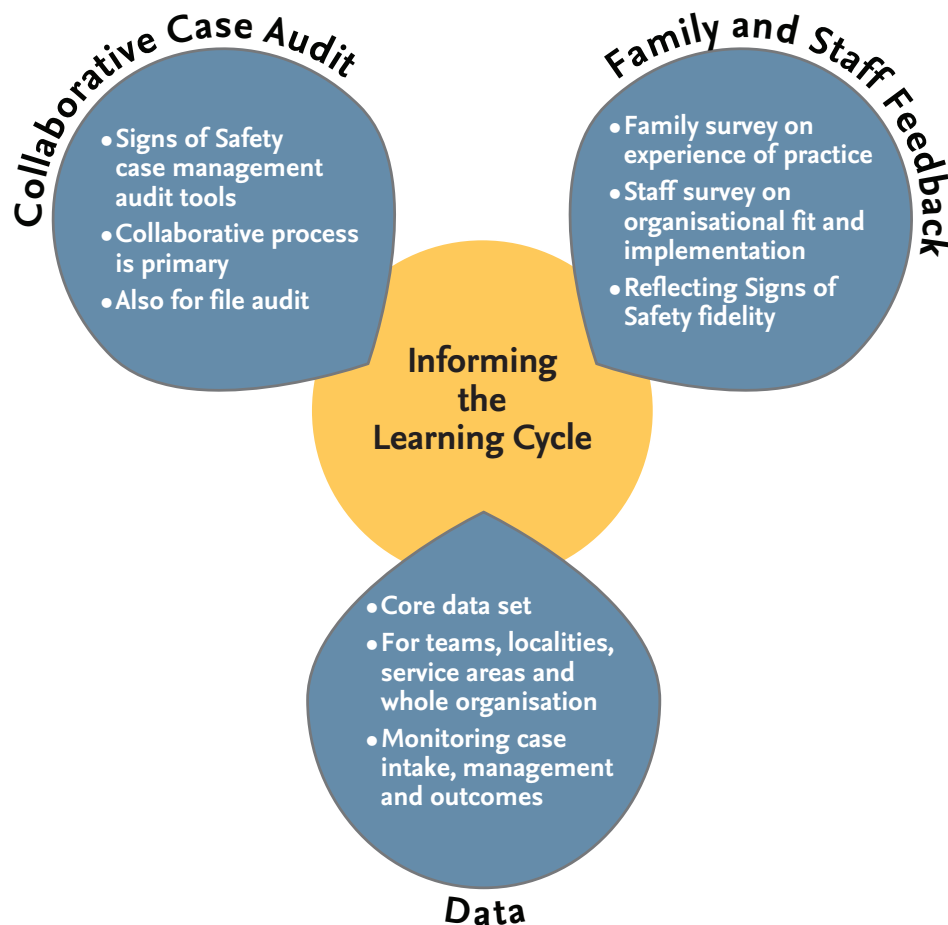

Figure 18: Signs of Safety Quality Assurance System

All three elements of the Signs of Safety Quality Assurance System are necessary since one alone cannot provide a definitive and continuous picture. Case audits cannot capture all cases, formal surveys occur at single points of time, and data is explicable only with reference to qualitative information about the practice that produced the numbers. All aspects nevertheless provide critical information. While the collaborative case audit is transformative in its approach to quality assurance, the whole Signs of Safety Quality Assurance System is recommended for adoption or adaptation in order to best deliver measurement that is meaningful for the organisation's implementation of Signs of Safety practice.

Finally, the Signs of Safety Quality Assurance System is designed to inform across the agency a cycle of learning that uses quality assurance information to better understand the fit and interaction between the practice and the organisation, then to identify the actions that will best drive practice development and organisational alignment. This is an action learning cycle. The Signs of Safety implementation framework anticipates the active involvement of practitioners and all levels of leadership in collaborative quality assurance processes and learning forums, as part of defined cycles of learning and review.

Collaborative case audit

Case audits are most often conducted by an independent person reviewing written case material and providing feedback, usually in writing. The underlying ethos of Signs of Safety seeks always to operationalise the idea of '*nothing about us without us*'. The audit methodology is therefore designed to be undertaken through a participative learning process together with the practitioner(s) and team manager(s) responsible for the direct work. This consistently delivers a more robust and detailed picture of the practice, constructed by and with those who have the best intelligence about the case. A collaborative audit methodology that directly involves the responsible practitioners is also far more likely to drive practice improvement and minimise the perverse outcome of increasing defensiveness that audit work often triggers.

Staff and parent surveys

The set of quality assurance methods developed in the MTM England Innovations Project seeks to help organisations move from a culture dominated by checking process compliance to one that is learning continually about the quality of help received by families. Two surveys, drawing on Signs of Safety fidelity research, have been developed as part of the QA system, one for parents and the other for the workforce.

Core data: proposal for reforming national performance datasets

Nationally collected performance data have long been major mechanisms for interpreting how an organisation is functioning. However, there has been widespread discontent with the prescribed dataset. The concerns regularly identified within the project are reflected in this quote from a senior leader:

There are currently nine national statutory dataset returns; local authorities and Local Safeguarding Children's Boards then create additional data demand burdens. The extent of time, effort and resources expended by local authorities does not provide value for money. This also creates distraction onto the items being counted and so distorts our focus away from practice. In turn, this leads to a disconnection for practitioners who do not see the value in the data they collect and so are less careful in its recording. The emphasis on quantitative computer data is not sufficient on its own to evaluate the quality of services to children and families.

Full details of the proposed reforms are available at http://munroturnellmurphy.com/eip-report.

The key proposal is to streamline national data reporting by adopting a national core dataset comprised of items that are most focused on actual outcomes for children and families, and that provide a reasonable basis for comparative data across local authorities. It is anticipated that the clarity provided by focusing on core data and their alignment with the quality assurance system will reconnect practitioners with their own data as its relevance and usefulness to them becomes more readily understood.

Organisational processes

Adopting a new practice framework requires the alignment of organisational processes to support the practice. Terminology, guidance and the actual forms practitioners use all need to be changed, at least to avoid workers having the confusing and time-wasting experience of operating two sets of documentation. Bureaucratic processes also typically embed practice assumptions that may be inconsistent with Signs of Safety practice, giving workers the confusion of working in two inconsistent conceptual frameworks. An example of this latter problem is explored below, looking at the timescale exemption regarding the use of strategy meetings within the intake to child protection conference workflow.

Practice reform projects

Four practice reform projects were established within the overall project. Local authorities self-selected which practice reform project they would involve themselves in. Each project gave particular attention to developing the application of Signs of Safety practice and its alignment with organisational processes and documentation in key areas of service. The projects were as follows:

- Continuum of Service Practice Reform. This drove a continuum of service across early help, family support, child protection, and looked after children. It used the common practice framework to enable more seamless transition and service provision. This project anticipated the Signs of Safety methodology being applied in all cases in Children's Services. As children and families move between services, this supports the objective of 'one case, one plan', providing service recipients with a more coherent experience.
- Front Door to Conferencing. This project was realised through a simplified, single assessment and plan using the Signs of Safety framework for intake/first response and applying Signs of Safety methodology through into child protection conferences, family support/child in need meetings, and family group conferences.
- Partner Integration. This recognises that England has the most formally joined up children's services system in the world. The Local Safeguarding Children Boards and the named and designated officers in various agencies carry responsibilities for governance, co-ordination and collaboration, and reporting. These arrangements remain a cornerstone of partner integration. Integration on a deeper level, however, was the goal in some of the authorities where the Signs of Safety principles and disciplines were applied by other professionals and the Signs of Safety practice methodology was adapted for use in partner agencies. This created a more coherent experience for families. For example, the Signs of Safety framework was adopted in health services and schools as well as most MASH teams (Multi-Agency Safeguarding Hub).
- Public Law Outline (PLO). This focused on the Signs of Safety methodology being applied in all PLO meetings and reflected clearly in the documentation for meetings and communications with families.

As part of the 'Front Door to Conferencing', an exemption from statutory guidance was given by the Minister of State for Children and Families, waiving the fifteen working days timescale from strategy meeting to child protection conference. It was provided to a number of the local authorities in the following terms:

> *Where a decision is taken, following enquiries under section 47 of Children Act 1989 having been undertaken, to convene an initial child protection conference, the social work manager should determine the date on which the initial child protection conference is to be held.*

Only one authority used the exemption substantially, though others planned to make use of it as their systems alignment allowed. The statutory timescale reflects the practice assumption that risk assessment and planning are primarily tasks for professionals, so it is urgent that they come together to do this. In Signs of Safety, involving family and naturally connected support people in the assessment and decision making is prioritised alongside the professional work, so professional meetings need to be scheduled with more responsiveness to enable full family participation.

The one authority using the exemption stated in its evaluation report to the Department for Education that use of the exemption built on the development of good Signs of Safety practice, enabling it to engage the family and its support network much more routinely, and enabling more cases to be held as 'Section 17 children in need' (CiN) rather than 'Section 47 child protection'.

The authority's own assessment brought out examples including the following:

- A case involving a three-year-old child in a household where there were concerns about heroin use and possible drug dealing in which a S47 'family's network meeting' produced great support from both sets of grandparents.
- A neglect case where buy-in from family resulted in them taking action quickly once the danger statement had been explained.
- An unborn child case where the flexible time allowed assessments of parents, even though decisions about the siblings had been made, avoiding the need to invoke EPO, ICPCC, removal and legal applications.

The authority uses the term 'family's network meeting' for all CiN meetings to indicate both types of meeting are the same thing and that a family can bring whomever is relevant, including professionals.

The practice reform projects assisted local authorities to make progress towards aligning their organisational processes with the Signs of Safety practice and to extend and adapt the practice beyond child protection to early help, youth offending teams, and looked after children services.

The progress in aligning documentation and amending guidance with resulting revisions has been made available through the Yammer Policy Clearing House for MTM and local authorities.

The detail and extensiveness of established process, the classification of clients, and consequent delineation of different processes and reporting all mean that the practice reform projects and the wider effort to align processes to practice remain incomplete. These issues remain an important focus for continuing work at the end of the project.

Restructuring

Some local authorities (LA) restructured their services primarily to improve direct work with families but also, to some degree, to accommodate reduced resources. In one case the LA was implementing the Reclaiming Social Work model as well as Signs of Safety so social workers were reorganised into units. In another authority the Early Help services were restructured to create neighbourhood hubs that dealt with the full range of needs, replacing services that previously had been organised around the age of children.

It is a reality that major restructures cause significant delays in improving performance and quality because attention is taken up with executing the structural changes, establishing new roles, and the movement of people between roles. The restructures occurring during the EIP shared this feature. With respect to the longer term impact for Signs of Safety practice and implementation, it is too soon to say whether they contributed to greater success in that longer term.

Information management system

Reforming the computer software to record Signs of Safety practice was a major thread of the project. An information management system prototype was developed through direct work with the ten partner authorities and with industry advice and input.

That prototype focuses on case recording and thus does not incorporate the administrative aspects of existing systems. It comprises screen shots, populated with cases, with a degree of interactivity, presented in a PowerPoint format, supported by an online mock-up. The design philosophy is that all key information should be easily accessible from the 'front page' and that the system is designed to assist practitioners in their direct work with families and children.

Further work would be needed to translate this prototype or any other aligned forms into a shape that can be fitted into ITC systems and to develop the forms that incorporate all mandatory English early help, child in need, child protection and looked after children workflows.

My Three Houses

Figure 19: Signs of Safety My Three Houses app

The Munro review identified the need to significantly improve the involvement of children and young people in the social work that is about them, seeing this as a key requirement of moving to a child-centered system. For this to occur, practitioners need fit-for-purpose tools that make sense to them and also engage the young people and children. The My Three Houses app was created, tested and refined together with English practitioners during the Innovations Project and is the first purpose built app for statutory children's service work.

The My Three Houses app adapted, refined and made contemporary the Three Houses tool, conceived in New Zealand in 2003. The app incorporates video explanations, interactive animation, extensive worker guidance and a drawing pad for workers and children to use together. It is available for use on iOS and Android devices. The app is designed to make the most important and often hardest part of children's services work easier, even incorporating some fun. For more information, go to http://mythreehouses.com.

Developing expertise

Human beings are action learners, but the learning derived from action is most often intuitive and unexpressed. In this regard the mantra many high performance coaches use makes an important point: 'Practice doesn't make perfect. *Perfect* practice makes perfect.' In essence, when humans are in action, whether driving a car, playing an instrument, learning to cook or relating to others professionally or personally, they unconsciously make a particular way of doing things into a routine. Once a human being does something a particular way, homeostasis tends to set in and he/she will tend to repeat those practices, whether they are effective or not.

To create a learning culture and a learning organisation requires a learning theory much more sophisticated than the implicit, dominant and mistaken 'theory' that workers will learn to do something by going to training. The Signs of Safety approach utilises the interactional 70:20:10 theory to underpin the learning component of the Signs of Safety implementation cycle. The 70:20:10 model locates training in its proper place and frames learning itself as an ongoing process equally applicable to the practitioner and organisational leaders.

The 70:20:10 learning model

The smallest amount of learning comes from **formal training** (10%). This does not in any way diminish the reality that training remains critical, since it sets the learning content and offers a clear vision of successful practice. Signs of Safety training encompasses the formal two-day basic training for all staff, five-day advanced training for 'practice leaders' (team managers, senior consultants and in-house trainers), as well as targeted training for specific issues (application to court proceedings, working with 'denial') and particular groups (such as child protection conference chairs and other IROs).

Humans learn in action, so in human services most learning occurs, and practices are habituated, through **daily work** (70%) as practitioners, supervisors and other leaders put the skills and methods into everyday practice.

While the action of daily work is 70% of learning and habituates how a skill is used, the pace of doing the work means that most learning from action is intuitive and largely unconscious. Improvement and change requires feedback and analysis through structured **reflection methods**. This is the critical 20% of learning where the individual and group can improve by reflecting on what they are doing. To be effective the reflection must be based on quality timely feedback.

Feedback and reflection are usually intended to occur in children's services within individual supervision. That individual supervision is always a necessary part of the children's services learning environment, but tends to foster one-at-a-time privatised worker-to-supervisor learning, which also puts enormous strain on the supervisor. There tends to be

little long-term feedback about the impact on the child from decisions made and actions taken – information that is essential for learning. Individual supervision is also a poor method for developing a shared practice culture; therefore in the Signs of Safety approach, group supervision is the primary vehicle for structured reflection. The revised Signs of Safety organisational theory of change also includes other participatory ongoing reflection methods, including the collaborative case audit and Signs of Safety dashboard that provide both quantitative and qualitative feedback loops for analysis and reflection.

The key point of the 70:20:10 learning theory is that feedback and reflection are central to learning and improvement!

With this in mind, outlined below are the activities, outcomes, experiences and challenges involved in developing expertise across organisations.

Formal training

Throughout the programme, all ten local authorities received extensive training and coaching for their Children's Social Care staff, as well as staff from other departments and partner agencies. The core basic and advanced training were delivered by UK licensed Signs of Safety trainers, while other introductory training, briefings or workshops were delivered internally by the authorities. Across all authorities during this programme training was delivered to a total of 7,180 staff by our licensed trainers. The full report on training is available at http://munroturnellmurphy.com/eip-report.

All levels of seniority were encouraged to attend the training since it is crucial that senior managers have a thorough understanding of the practice framework to effectively implement the approach within their organisations. The full report on training (http://munro-turnellmurphy.com/eip-report) shows the training received by senior managers. Nine out of the ten Directors of Children's Services and one Deputy Director attended the two-day basic training, and Heads of Service and Service Managers from all ten attended. In all authorities, Heads of Service and Service Managers received the five-day advanced training; the Director and Assistant Director attended from one authority as did the Assistant Directors from two authorities. This shows a good overall level of training among senior management. We would recommend that all senior managers attend the five-day advanced training as it gives a better understanding of how Signs of Safety differs from the practice it replaces, which is crucial for leading a whole system implementation.

As can be seen in the Signs of Safety Staff Training Data Report available at http://munroturnellmurphy.com/eip-report the extent and breadth of training throughout the programme was excellent and this was a tremendous achievement by both the licensed trainers and the authorities themselves. The feedback below from some of our trainers describes 'what worked well' in the overall training delivery:

- Good working relationships and pre-planning between Signs of Safety Trainers and Consultants and Signs of Safety leaders within the authorities (senior managers,

project leads, workforce development staff). This helped with effective planning of the training.

- A shared vision or action plan for implementation developed and owned by the implementation team, especially where this team was led by the Head of Service or Director. This also made for effective planning of the training.
- Deciding who needed to be trained first and who later was important, in particular ensuring Practice Leaders were trained early on so that they could then support practitioners once they were trained.
- Staff having good communication from senior leaders before, during and after training reinforced that organisational commitment to the implementation was strong and would be sustained.
- Training sessions being introduced by a senior manager or the project lead, thus reinforcing key messages.
- The Project Lead/Manager attending for all or part of each training cohort. They could then answer detailed implementation questions (which the trainer usually could not and should not answer) and gather feedback to take back to the implementation team, thus connecting each successive training cohort to the leadership. This helped staff to see that the organisation was serious about implementation and was listening and responsive.
- Practice Leader work was seen as more effective when practice leaders were supported to attend by having protected time and by emphasising the importance of the sessions. But practice leaders attending was often a problem because of the 'day job' demands. One consultant recommended that each practice leader be supported to develop a safety plan for their attendance.
- When staff were trained in relatively quick succession, it avoided a 'catch-up' gap developing.
- Aligning of systems and processes at the same time supported practice change.

Reflection methods

Reflecting on learning the Signs of Safety approach was undertaken in a variety of ways across the authorities and to different extents:

- Regular, ongoing practice leader coaching sessions from UK consultant trainers.
- Staff mentoring and coaching with social work consultants internally.
- Local authority Signs of Safety conferences presenting examples of practice (a number of which involved MTM in active roles).
- Online knowledge libraries.
- Internal Signs of Safety newsletters to regularly update staff on implementation and practice across the organisation.

Practice Leader coaching

The practice leader coaching sessions are designed to deepen practice leaders' skills and knowledge of the framework and how to apply it in theory and practice. The expectation is that they then lead practice in their authority by sharing the learning and supporting staff

through making their own practice behaviours visible to others (role modelling) as well as through mentoring, coaching, group supervision and individual supervision of staff.

The regular, ongoing nature of the sessions meant that practice leaders were able to bring examples of case work they were pleased with as well as cases they were struggling with. This allowed the consultants to deliver sessions and lead learning focused on the application of the framework to actual current cases. The groups worked together to enhance their skills in the core practice elements of the model through activities like appreciative inquiry, effective mapping, developing good danger statements, and best questions to help families create rigorous safety plans.

Feedback from the UK consultant trainers tells us 'what worked well' for staff in terms of session content:

- Revisiting the basics of the model within a safe, supportive space helped practice leaders to learn and deepen their practice, especially those who attended all or the majority of sessions whose questions became noticeably more sophisticated.
- Appreciative Inquiry (examining examples of good practice, what makes it so and enables it to occur) – a focus on developing good questions and identifying 'what worked' as the basis for learning and improvement made the link with casework for participants.
- Having a case focus and being clear that practice leaders were not going to get something new every time was important.
- Asking the group, 'What is the most important question you want answered by the end of the session?' and focusing the session around this.
- Practice leaders found the sessions helped them think through how the model could fit within their authority's way of working.
- Where the groups were more or less the same people each time helped usefully build positive group dynamics and trust.

The importance of regular practice leader coaching sessions cannot be overstated. One of the key worries raised in the staff surveys was that practice leader skills and learning need to continue to be developed after the initial training. Many called for ongoing coaching and mentoring from their supervisors and managers beyond the training, and the opportunity to seek support in developing their skills in specific Signs of Safety tools (such as danger statements, safety goals, mapping with families). Practice leader sessions provide the base from which learning can be disseminated to all practitioners within the authority so that the skills base is enhanced and kept updated. If this is not achieved there is a danger of staff falling into practicing a 'light' version of Signs of Safety.

One challenge for local authorities is ensuring practice leaders are able to attend the sessions on a regular basis. In the EIP, each authority received sessions every six to eight weeks, typically consisting of four half-day sessions run over two days to give all practice leaders the opportunity to attend one session on each occasion. In practice, attendance levels across the authorities were variable, from good to poor. The key consequence for authorities of sporadic or low attendance is that it results in inconsistency in implementing

practice. Depth of practice within teams is reduced if supervisors or managers don't role model behaviours or share skills and knowledge.

Consultants' experience of delivering sessions in authorities where attendance was good tells us that attendance levels can be improved as follows:

- A clear message sent from senior management to practice leaders that the sessions are a high priority.
- Setting the session dates in advance for a 12-month period and letting practice leaders know the dates so they can book them into their diaries.
- Delivering the sessions in suitable locations. A fixed central location can be a barrier for staff located some distance away. Consider more flexible arrangements like locality delivery or moving location on a rota basis.
- Practice leaders having a back-up plan to find someone to attend in their absence so that the learning from the session can be fed back to them and the team.

Daily work – putting it into practice

The staff survey collected data about people's use of Signs of Safety tools and their views on using them. There was a consistent pattern across the ten authorities about which tools were used first, summarised in this table:
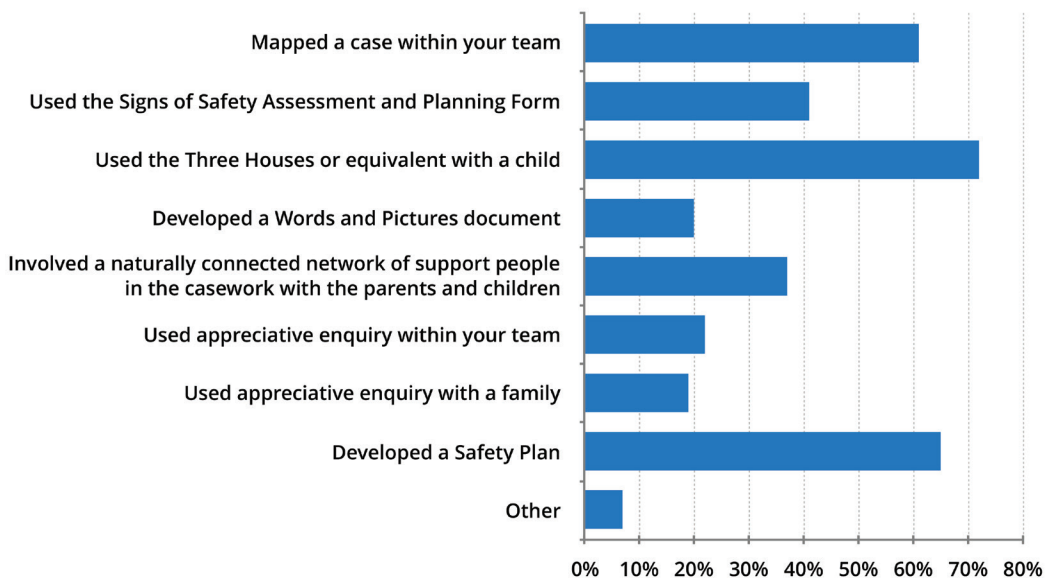

Figure 20: "Percentage of all respondents who had used each tool"

The above table shows widespread adoption of the Three Houses or equivalent tools to use with children to understand their lived experience and their wishes and feelings, with workers also reporting a high level of confidence in doing so.
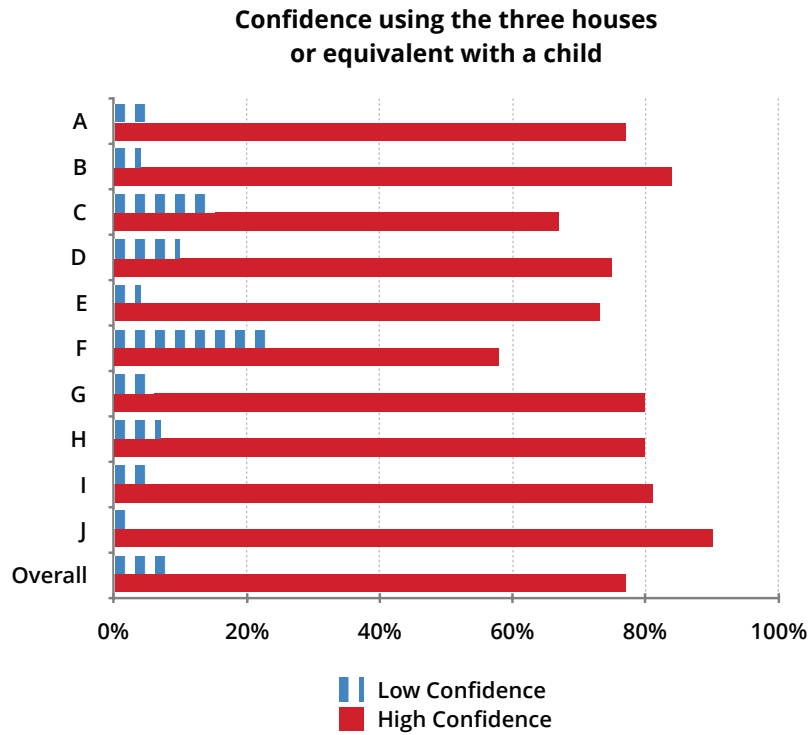
**Confidence using the three houses
or equivalent with a child**

Figure 21: "Confidence using the three houses or equivalent with a child"

In view of the decades of criticism of social workers for not talking with children enough, it is interesting to see such enthusiasm and confidence, suggesting that the poor practice of not talking enough to children arose from organisational rather than individual factors.

The survey asked about confidence in using each of the tools. When responses were collated, they showed that there is still far to go in achieving a confident expert workforce.
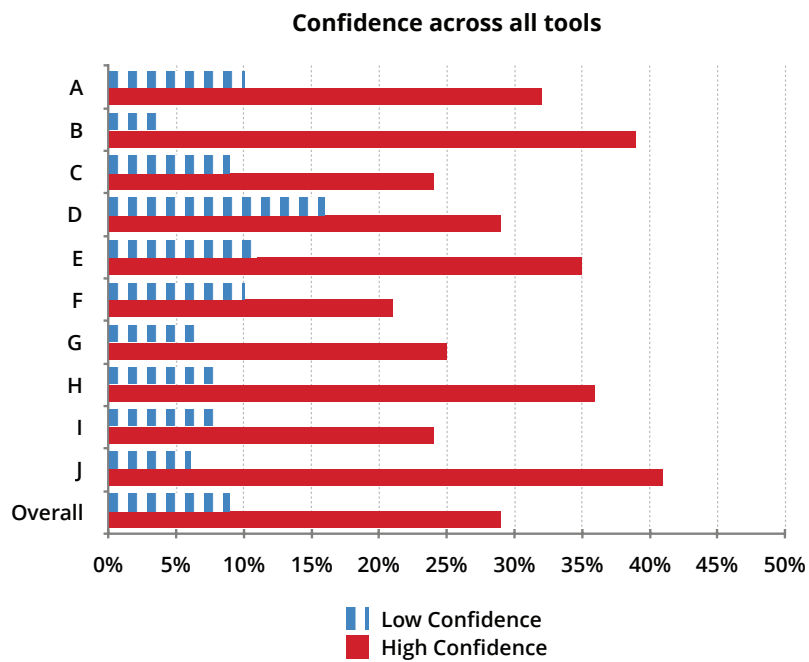
Confidence across all tools

Figure 22: "Confidence using the three houses or equivalent with a child"

The qualitative data gathered from both the staff surveys and the focus groups carried out by MTM further illuminate how practitioners from across the ten authorities have experienced using Signs of Safety in their daily work.

Key positives:

- Families like it – clear and simple, focused on positives, gives ownership to them.
- Child and family centred.
- Increased job satisfaction, reflected in comments such as 'This is how I wanted to work' or 'It brings me back to enjoying the work again'.
- Empowering for families.
- Direct approach – brings the issues to the surface.
- More collaborative with families and partner agencies.
- Gives clear structure.
- Strengths-based with focus on positives.
- Reduces 'blame' culture.
- Brings honesty.

Key concerns:

- Lack of consistency in use – not fully implemented.
- Difference in skills levels – not all using correctly/fully.
- IT and recording systems not yet aligned.
- High caseloads have impact on time needed to use and develop skills.
- More ongoing coaching needed after initial training.
- Will it be sustainable?
- Worry that existing skills and other tools/approaches will be lost.

Parent feedback

The feedback from parents was drawn from the surveys administered in July 2015 and, in two places, also in July 2016. The two sets are discussed separately here because different lessons can be drawn from them.

From the first set of surveys that had responses from 238 parents, combining the top two possible responses of 'agree' and 'strongly agree' indicates that the majority reported an overall positive experience with their social worker, with positive views on one statement being highly correlated with positive views on others. The statements on which they commented are indicators that relate to the disciplines and principles of Signs of Safety. The findings show that:

- 82% of parents felt listened to and understood,
- 73% said that their worker does what they say they will do,
- 85% said that their worker was clear about their concerns and about what needs to happen to stop them being concerned,
- 79% agreed with what their worker was concerned about,
- 79% said that their worker involved them in making plans to tackle the concerns,
- 76% agreed with the plans made to tackle the concerns,
- 81% thought that their worker cared that the family solved their problems, and
- 73% said that their worker had spent time with their child(ren) and listened to what they had to say about the problems and what should happen to solve them.

The two surveys administered in July 2016 with good enough response rates produced very similar results.

For one authority, it was possible to compare the results of the two surveys administered a year apart and there was some evidence of progress being made in working better with parents. In the second survey, there were statistically significant improvements in the number of parents rating their worker highly on 'My worker does what they say they will do' and 'I have felt involved in making plans about what to do'. There was also emergent significance for 'My worker has spent time with my child(ren) and has listened to what they say about the problems and what should happen'.

A final lesson from the parent surveys is that many parents said they appreciated being asked for their feedback and this had not happened before.

The evidence of good practice revealed in the surveys cannot be attributed simply to Signs of Safety implementation since the items are widely accepted disciplines and principles of social work and workers may have been practicing according to the principles before the reforms.

The answers to the open-ended questions offer some illustration of how parents experience social workers in both positive and negative ways. The biggest single answer to the

question 'If you could change one thing about how your worker is working with you, what would it be?' was 'Nothing', often with some amplification of why they had a good opinion of their worker. For example, 'He is very professional', 'She is so good at what she does, she is caring and supportive', or 'This one is good, wish we had had this help and support three years ago'.

On the negative side, the main desired changes were concerned with the workers' reliability, communication, consistency and amount of time spent with children. Complaints about unreliability tended to point to organisational, rather than personal, factors: the frequent changes of social worker ('I've had four different social workers in the past three months. So more continuity needed.'), social workers not having sufficient time, or social workers not having the authority to make decisions but needing to go back to managers before acting on plans made with parents. Complaints about communication were mainly about the difficulty of getting hold of the social worker and the infrequency of visits.

One question that is hard to answer firmly is: 'What percentage of parents *should* strongly agree with all the statements describing a good social worker?' While 100% agreement might be something to aspire to, realistically the fact is that there are several factors that act against it. Few parents are voluntary users of the service. Even parents of a child with disabilities are not voluntary since there is no other way they can access the services their child needs. Many parents will have had poor experiences in earlier contacts with Children's Social Care or be influenced by the negative criticisms of social workers that appear so often in the media that they expect, and pay more attention to, the negative. In addition, social workers may be influenced by systemic factors that make it hard for them to give the necessary time to be with parents and later reflect on how they interacted; a more coercive approach is generally quicker to take. Therefore, it is unrealistic to expect social workers to counteract these negative factors in all cases.

Working with others

Although we have referred to the Innovations Project as entailing whole system reform, the Children's Social Care system is itself constantly interactive with other systems, so attention was paid to communicating with these connected systems.

The local authority

Children's Social Care is part of a local authority and it was important that the Chief Executive and the local councillors understood and supported the reforms. To this end, Eileen Munro, representing MTM, met with the Chief Executive, the Lead Member for Children and the DCS prior to the start of the project to explain the plans and obtain their backing. Partner authorities kept them well informed throughout the project and councillors attended conferences the authorities held to showcase practice. The bi-monthly newsletter was also a means of keeping them informed.

Multi-professional and multi-agency

Multi-agency and multi-professional working is central to child protection, so all the authorities made considerable effort to explain the reforms to those other professionals who would be affected by the changes in social work practice. Somewhat to our surprise, in many instances the other professionals chose also to adopt the Signs of Safety framework. This was particularly apparent in the willingness of other professionals to implement the Signs of Safety framework in early help services. Consequently, basic training was provided for large numbers of allied professionals. (One LSCB Annual Report for 2014–15 states that 1,100 were trained and another quoted a figure of 500.) Additionally, adapted versions of the common assessment form were created (an example is available at http://munro-turnellmurphy.com/eip-report). Extending Signs of Safety to children's services outside Children's Social Care was done in all local authorities to varying extents.

Signs of Safety was developed specifically for the statutory child protection end of children's services, so this broadening of its use to earlier, more voluntary services for families was a significant development. The way this was undertaken provides a good example of how 'fidelity' in complex interventions cannot require compliance with the micro-details but with the broad principles and core methodology. Collaborative work with local authorities led to the production of guidance for the terminology to be used in different areas of use (an example is available at http://munroturnellmurphy.com/eip-report). Signs of Safety terminology was adapted to other areas of practice through a 'Signs of Something' framing. In this way the approach was adapted to Signs of Wellbeing (early help), Signs of Success (looked after work) and Signs of Good Relationship (child sexual exploitation).

Feedback from training sessions provided to allied professionals and from Local Safeguarding Childrens Board (LSCB) annual reports suggests that the Signs of Safety

framework is intuitively easy to grasp and appealing to those working with children and their families.

In one authority, another Innovations Project involved building better co-ordination between the local authority and mental health services for children. In this instance, the project adopted Signs of Safety as the practice framework for mental health services, producing a coherent experience for children and their families.

The LSCB annual reports for 2014–15 were scrutinised for references to Signs of Safety. All comments were neutral or favourable and illustrate how it is being accepted and, in many instances, adopted by allied professionals.

For example, one report noted:

> *Audit had found its (Signs of Safety's) introduction had strengthened multi-agency engagement with children and improved the quality and consistency of our approach in listening to, recording and utilising the wishes and views of children within the overall CP planning process.*

One report showed acceptance of the Signs of Safety framework to the extent of using it to structure the annual report itself.

The legal system

Child protection work involves contact with the legal system in the most problematic of cases. Work was done on adapting the Public Law documents to incorporate Signs of Safety (a copy of the full guidance is available at http://munroturnellmurphy.com/eip-report).

No problems arose in presenting cases to Family Courts using Signs of Safety with the judiciary able to understand the new terminology and framework. Indeed, some singled out such reports out for praise, saying that they made the dangers for the child much easier to see.

Local authorities anecdotally reported varied levels of acceptance of the approach by their own legal services that represent the authority in legal proceedings, with some having difficulty moving away from an adversarial presentation of evidence and an insistence on professional services being at the core of all families' plans for the future.

Ofsted

A series of meetings were held between Ofsted staff and representatives of the Innovations Project to keep them informed about what we were doing. Basic training on the Signs of Safety approach was provided in 2015. There are no incompatibilities between Signs of

Safety and the Ofsted inspection framework and work was done on mapping Ofsted criteria onto Signs of Safety practice.

Eight of the authorities were inspected by Ofsted during the project. Two were judged 'good', five judged as 'requires improvement', and one continued to be seen as 'inadequate' overall, though progress had been made on the category of 'children in need of help and protection'. In the report on the 'inadequate' authority, inspectors wrote:

> *The inspection saw early evidence in casework, case recording and supervision of this model [Signs of Safety] providing a clear and analytical approach to social work. Social workers reported it being helpful in their practice.*

In a 'requires improvement' authority, inspectors wrote:

> *With strong leadership provided by the director of children's services and the chief executive, [the authority] has been successful in making a number of important improvements in the quality of services children receive and the outcomes they achieve. The Signs of Safety approach has made a significant difference to how well social workers work with children . . . In the better assessments seen by inspectors, the Signs of Safety approach is having a positive impact. In such assessments the child's voice is strongly evident and their wishes and feelings captured to inform assessments and planning. The introduction and use of the Signs of Safety approach has led to professionals across agencies working more effectively with children and their families. When the Signs of Safety approach is used, assessments are mostly good. Where it is not used, they lack full information, analysis and a clear focus on children's wishes and feelings.*

In another 'requires improvement' authority inspectors noted:

> *The practice framework underpinned by Signs of Safety is leading to stronger assessments with a clearer focus on the voice of the child, reduced caseloads and increased parental understanding of what needs to change. In most cases seen by inspectors, the use of the Signs of Safety model has resulted in a greater clarity of risk and need, ensuring that the right interventions are in place.*

In a 'good' authority, the report stated:

> *The change in the whole service approach, using the new casework model [Signs of Safety], is positive and has resulted in a rapidly improving focus in recorded planning. Similarly, while management guidance and direction had also not been consistently recorded, practitioners were able to clearly describe routine and positive casework supervision, challenge and oversight by their managers.*

What progress has been made?

Before the project began, we estimated that the task of implementing the whole system reforms needed to embed Signs of Safety into children's social care departments would take approximately five years. This project ran for eighteen months and so we would not expect to see complete implementation yet. However, the amount of progress made has impressed us, with all showing some indications of solid progress. Each of the ten local authorities began the project at different stages of implementing Signs of Safety and these variations are still visible in the level achieved at the end of the project. However, there is some evidence that authorities starting to implement Signs of Safety within a whole system approach make progress faster than authorities that, prior to the project, had been making partial use of Signs of Safety at the front line without commensurate changes in the organisation.

Underlying the solid progress in practice and aligning organisational processes to Signs of Safety practice has been an improvement in the ways authorities understand how well children and young people, and the organisation, are doing. The Signs of Safety practice is built on a methodology that puts the family in the centre of the process and their experience and progress is at the forefront, while workers' day-to-day experience of how the organisation supports the practice is central to implementation. The key to making real and sustainable progress here is the implementation of tools that actually bring these voices to the fore. The practice methodology does this for children and families. Bringing the voice of workers through has drawn deliberate leadership strategies to do so. The development of a quality assurance system that makes case audit a collaborative process and includes formal surveys of families and staff has made a significant start in building a learning ethos into core systems. This area of work has been identified as a priority for further development with authorities.

Progress has occurred in a national environment that is increasingly supportive of focusing on practice rather than on procedural compliance. This wider context of reform has an overt focus on driving quality and effectiveness in children's social care in England and this is removing blockages for authorities and encouraging a more confident and innovative culture of leadership. The Munro Review perhaps marked the high water mark of the system, described in that review as defensive, bureaucracy-laden, and compliance focused. MTM considers particularly that the revised Ofsted inspection framework, and the DfE proposals to introduce accreditation and ambitious standards for practice supervisors, set the tenor for shifting the focus to practice quality.

The wider context did however bring some problems. In particular, funding cuts were experienced across public services and this affected staffing levels along with the work of social workers and other professional groups concerned with children's safety and wellbeing.

In the following section on reviewing progress, we comment on performance data but mainly leave it to the local authorities to report their own assessment of progress.

Performance data

It is expected that when fully implemented, Signs of Safety practice will lead to improved staff retention, a lower rate of removals of children, and a lower re-referral rate. However, we have provided little evidence here on what changes, if any, are occurring. There are two reasons for this. First, there is limited data available for the whole period of the project. For example, the data on the workforce are available to 2013–14 and 2014–15, but we have been able to secure data from only four authorities for 2015–2016. Second, most of the analysis of performance data is being carried out by the independent evaluation team and it is therefore not duplicated here. However, one set of data is included to illustrate how difficult it is to attribute any change to the project because of the pattern of fluctuations over time and the impact of external factors.

The performance data on removals of children were collected in March 2016 and trends over the past eight years were analysed and compared with the national average. The long time frame was chosen because these figures are known to fluctuate. The following graph gives these statistics relative to 2013–14 just before the project began, illustrating how much change there has been across the country both before and after the start of the project. It shows that, since that time, there has been a national trend to increased rates that has been matched within four of the partner authorities. Six of the partner authorities are showing a lesser increase than the national average but the overall picture of the degree of variation, both over time and between authorities, makes it difficult to interpret the significance.
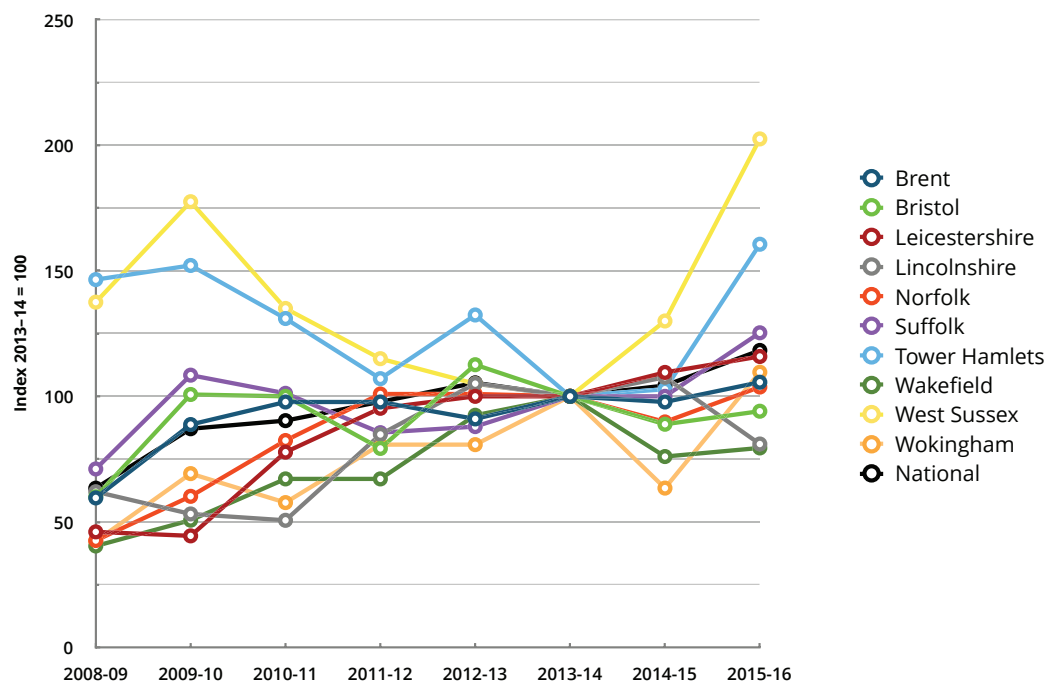

Figure 23: Local Authority care applications, relative to 2013–14

Partner authorities own evaluation of progress in implementation

At the final workshop in March 2016, the ten authorities were given the following exercise to scale their progress towards full implementation.

On a scale of 0 to 10, rate your authority's progress. 10 means we have fully implemented and this is what it looks like:

- Staff are thoroughly familiar with Signs of Safety practice – the principles, the tools, the disciplines, the processes – and working with it.
- Supervision is occurring and is aligned with Signs of Safety.
- We have continuous learning strategies in place.
- We are organised in our work teams to support practice.
- We have our policies, procedures and forms aligned with Signs of Safety practice, and streamlined.
- We are managing and leading in ways that are consistent with Signs of Safety practice, speaking the language, living the principles, mapping issues, and connected to practice.
- Staff would say they are supported to learn through contention, anxiety and crises.
- We are on an ongoing journey of growing our depth of practice.

0 means we have barely begun:

- There has been training.
- You see some of the practice.
- Mostly though staff think they are being asked to do something extra.
- A lot of people are just waiting for this to fade away.

Each authority then scored itself and gave some notes on what had been done well and what needed to be done.

Local Authority A, score: 4

Senior management, IRO engagement, 5 days done and paperwork is catching up.

Local Authority B, score: 4–7

Many good things, not consistent, the more we do the more we realise there is to do, come a long way, most staff trained, substantial number of practice leaders who are supporting and developing the approach, evidence in supervision, can see improvements in practice.

Local Authority C, score: 3–4

Comprehensive training in social care and early help, momentum among senior managers and Local Children's Safeguarding Board, seeing it in practice and received positive feedback from early help, hearing positives in supervision.

Local Authority D, score: 4–5

Already come a long way being new, staff familiar, positive about using the tools and in supervision, continuous learning strategies and plan in place and happening.

Local Authority E, score: 4–7

Consistency of practice growing, focus on supported learning, application, everyone shares the same approach whether this be just using the same language and all are working towards the same goal, thinking through things reflectively, workers have pride.

Local Authority F, score: 5

Front line engagement, group supervision and partners 'buy in'.

Local Authority G, score: 4–6

Staff enthusiasm, keen leadership to drive forward, staff training, feedback from families.

Local Authority H score: 3–4

Increasingly seeing Signs of Safety in front line practice (both social care and early help) as well as conferencing, feedback from the judiciary is positive, can feel movement and momentum.

Local Authority I, score: 4–7

More consistency of practice notwithstanding geography of county, good examples of practice, good 'buy in', creativity, momentum and its coming together.

Local Authority J, score: 4

Identified the areas we need to improve on, strong leadership, strong bottom-up approach, clear implementation plan and linking to other strategies such as Troubled Families and workforce development.

All local authorities stated that major drivers in development were authorities coming together in the EIP, being part of the Signs of Safety community beyond the EIP, and involvement of local partners.

Things that are not yet in place and/or holding scores down:

- IT systems.
- Quality assurance.
- Increased demand at the front door.
- Leadership bottom line – 'What are we prepared to accept in terms of change?' – in decision-making and understanding, sharing and defining risk.
- Legal – support from court/solicitors.
- Staff changes and restructure.
- Getting the basics right, too.
- Getting around to everyone.
- Resisting the urge to proceduralise.
- Ofsted.
- Compliance and tick box dominance.
- Making sense in areas other than social care (fostering and adoption, adult care etc.).
- Full system leadership with partners.
- Funding issues and constraints.
- Pace – so busy and so much to do.
- Making the time to increase the depth of practice.
- Local political leaders.
- Lack of involvement of CAFCASS.
- How we position social work and our child protection system so that they free up the family to be part of the process.
- Deficit focus.
- Practitioner confidence.
- Worker anxiety – will workers have jobs next year?

Conclusion: some key lessons of the Signs of Safety EIP

At both the national and the local levels, a defensive, compliance-focused culture had become embedded. It takes courage to break out of this mind-set, to undertake the substantial effort required to realign the organisation, and to develop an organisation that allows and supports workers to practice in a way that understands and accepts the complexity and uncertainty of risk decision making and management. Local authorities regularly reported that their journeys of transformation had been more confident and bold because they were working within a group of agencies on similar journeys. The Signs of Safety community of agencies and people, nationally and internationally, supports collective action and learning. Sharing practice across organisations, as well as within organisations, is a crucial driver for developing a consensus about what good practice looks like. Importantly, too, sharing policies and procedures has encouraged agencies to go further in alignment and streamlining than they otherwise might have. As well as workshops sharing examples, the EIP has established a Yammer-based Signs of Safety Policy Clearing House for this purpose. Significantly, the existence of a community of Signs of Safety organisations has encouraged the information technology industry to develop a Signs of Safety aligned information system confident in the market for the product.

This project has reaffirmed that transformation of child protection must be grounded in practice: how practitioners actually do the direct work with children and families. The problem with so much past reform work, from national reviews and local strategies, is that they have addressed structures and professional development without addressing the question of how the work actually occurs with families. The corollary of this has been that organisational development has not been built to support how front-line work is actually practiced.

It is well understood that leadership is critical to all organisational performance. Since competency is quiet and the most effective leadership is often invisible, what constitutes effective senior leadership in children's services has perhaps been less well understood. The experience of the project has highlighted that senior management is required to understand and drive the implementation, be deliberate, agile and responsive, and not delegate the responsibility and activity. Moreover, to drive a transformation of practice demands leaders being close to the practice and understanding the approach and the experience of families and front line staff. As noted, all EIP leadership workshops included hands-on practice work and exposure to examples of good practice. In the face of relentless demands on leadership – financial, organisational and political – the focus on practice requires sustained deliberate effort. The Signs of Safety implementation framework also emphasises leadership building an organisation that is safe for staff, where they will be supported through the anxiety, contention and crises that are inherent in the child protection work. In the face of a sustained history of gratuitous blaming of individuals for poor performance and tragedies, both nationally and locally, and the high levels of anxiety that accompany the potential for tragedy in all children's service work, building safe organisations takes

time and is a major culture shift in itself. The progress of the local authorities in this regard has been significant.

Aligning the organisation to the practice – removing blocks, enabling practice and building resilience – is critical and has been discussed repeatedly throughout this report. The reality is that achieving organisational alignment can be slow and painful in mature organisations that have entrenched policies and procedures that pass largely unquestioned and have been built up over decades of national direction and are interlinked with critical infrastructure in quality assurance and information technology. The progress that all authorities have made is significant but partial and, as noted above, those authorities have identified that the full alignment of case management with Signs of Safety practice remains the next priority for continuing development.

Although quality assurance and information technology systems should monitor and enable good practice, it is clear that they can, in fact, impede practice transformation. What and how we measure, the information that we require to be recorded, and how we assess whether the work is satisfactory all have a significant determining impact on practice, and these systems change more slowly than the speed at which it is possible to change the practice itself. The Signs of Safety QA system has made a substantial step towards becoming clearer about what and how we measure in order to actually make a difference together with workers and to inform the organisation.

As local authorities embrace and apply Signs of Safety practice, the frustration with legacy information technology systems is profound and the costs of redevelopment are large. The prototype developed by the project is a promising indication of the way forward. Work is now being undertaken with industry to develop an information recording system that is fully compatible with both Signs of Safety and the English system. The development of the first Signs of Safety app for the children's tool My Three Houses, and authorities' attempts to integrate it within their information technology systems, has shown both the potential for mobile technology and for the barriers to integration with entrenched systems. Further development in data systems and mobile tools, for practice and assessing and supporting performance in line with quality assurance, are a priority for the international Signs of Safety community.

The importance of a national environment that is conducive to reform and the focus on quality practice have been noted. Ofsted exerts an enormous direct and indirect impact on how organisations manage and report and the expectations they set for practice. It is appropriate that there is a tension between the inspection authority and the local authorities, while at the same time it is essential that both share an understanding of what constitutes good practice. It has become evident through the time of this project that Signs of Safety practice, when done well, constitutes such good practice to Ofsted.

An overall appraisal of this project rests on the reality that implementation is a long journey. As the theory of change reflects, the paradigmatic shift in practice to the Signs of Safety involves organisational change on multiple fronts and must resolve the disjunctions of

an organisation and its staff being caught between the 'old' and 'new' policies, processes, systems and cultures. The transition is truly huge and difficult. In this context, as Ofsted attests, the data suggest, and the local authorities themselves modestly assess, they have made good progress. For all of us, there is more to be done, and the journeys continue.

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Above (from left): Dr Andrew Turnell, Professor Eileen Munro and Terry Murphy

Above: Participants at the inaugural EIP leaders workshop, London, 24 November 2014

For more information regarding Signs of Safety go to

www.signsofsafety.net

munroturnellmurphy.com