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# Reclaiming Social Work? An Evaluation of Systemic Units as an Approach to Delivering Children's Services

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Summary report of a comparative study of practice and the factors shaping it in three local authorities

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## **1. Introduction**

### **1.1 Overview**

This is a summary report of a descriptive evaluation of systemic units as a model for delivering Children's Services. The systemic unit model was developed in Hackney and was more commonly known as the "Hackney Model" or "Reclaiming Social Work". However, with the approach being used more widely we refer to it by a more generic name. Regardless of the name given, the move to small units working in systemic ways is receiving considerable attention in the UK and beyond. This study tries to develop an understanding of the nature of the model and how it impacts on practice.

This report is primarily aimed at managers, policy-makers and practitioners. It therefore presents the findings in a relatively brief form. This is a particular issue for qualitative data, and in particular the observational findings which form the core of the study, where it is only possible to summarise conclusions from the data collected. Full information, including detailed presentation of qualitative data and more information on underlying theory, analytic methods and statistical tests, can be found in the accompanying full report.

The study is a comparison between three LAs: LA1 (a London local authority delivering services using the systemic unit model) and two other authorities with a more conventional structure for the delivery of Children's Services: one is a London local authority with many similarities to LA1 (LA2) and the second is a small unitary authority in the south of England (LA3). The evaluation provides a description of the *context* within which services are delivered in each agency. It then considers in some detail the way in which context shapes *practice*. Finally, evidence for particular patterns of *outcomes* related to different practices is explored. This element of the evaluation is particularly focussed on describing experiences of those using the service and of practitioners. The intention is not to find out something as simplistic as whether the systemic unit model "works"; at this stage that seems premature, as there is a lack of clarity about the nature of the systemic unit approach, how it shapes practice and the complex ways this may affect outcomes. Indeed, one of our findings is that comparisons across local authorities are problematic because the reasons for differences are so varied and complex. Instead, the aim of the study is to identify in what ways the systemic unit model works, for whom and – most importantly – where it works, why this is so. In doing so we found we have much to say about what makes for effective delivery of Children's Services more generally.

The report has four parts. This first introductory part is concluded with a summary of the systemic unit model. The next section provides an overview of the local authorities involved and the data collected. The bulk of the report is taken up with presentation of the findings in Part 3. This involves:

1. An overview of the work of Children's Services across the authorities that provides a context for all other data collected,
2. A description of differences in organisational support for social work practice at higher levels across the authorities,
3. Identification of the key elements of the systemic unit model,
4. A summary of differences in practice with families and in assessments when the systemic units are compared to more conventional structures for delivering practice and
5. Evidence on experiences of the service from a variety of sources are reviewed.

The final part is a discussion of the findings, including general implications for the effective delivery of Children's Services and an evaluation of systemic units as a way of delivering services compared to the more conventional model.

### ***1.2 What is the systemic unit model?***

One of the central aims of the evaluation is to describe in some detail the systemic units in practice. Here a brief overview of the approach is provided. The conventional approach to delivering Children's Services involves allocating families or children to individuals, who are supervised by an immediate line manager (such as a Deputy Team Manager or Team Manager). The systemic unit model allocates cases to a consultant social worker. They are responsible for a small unit that collectively works the case. Units in LA1 consist of:

1. a consultant social worker (CSW) – who leads the unit, has ultimate responsibility for case decision-making and provides expertise and leadership,
2. a qualified social worker (SW) – whose role is similar to that in other authorities
3. a child practitioner (CP) – who may not be qualified, though in practice is often a newly qualified social worker,
4. a unit coordinator (UC) – who operates to provide enhanced administrative support, rather like a PA for the unit and
5. 0.5 Clinician (C) who is a qualified systemic therapist, able to provide therapeutic input for families or children who require it.

Cases are worked with as the consultant thinks best. This may involve in practice individual allocation to a worker, but it will often involve input from various members of the unit.

The units are informed by systemic theory. systemic approaches see families as systems rather than individuals, with the family system interacting with wider systems such as the broader family, the neighbourhood or professional systems. Problems in the family are therefore seen to arise from systemic difficulties and to require interventions that help the family system change or that alter its interaction with wider systems. Systemic theory has a long history within social work, and there is some evidence for it being an effective way of helping families with serious problems.

## **2. Data Collected**

### ***2.1 Brief Overview of the Three Local Authorities***

The study is focussed on practice and the factors shaping it in three authorities. It includes child in need and looked after children for all authorities, assessment (in LA1 and LA3), and leaving care services (LA1 and LA2). Services for disabled children or other specialist teams or units were not studied.

LA1 is an inner London borough. It has some of the highest levels of deprivation in the UK and a very varied ethnic profile. LA1 Children's Services are organised in an innovative way we call the systemic unit model. Referrals within LA1 are dealt with first by a First Response service. This does an initial prioritising and where considered appropriate closing of referrals. Families requiring further assessment work are passed to Assessment Units. Other work is provided in units devoted to working with families in the community (Child in Need units) and Looked After Children (LAC) and Leaving Care (LC). LA1 had an Ofsted inspection shortly after our study, which was positive and a more recent one that found them to be "outstanding".

LA2 is in many respects a similar borough to LA1. It is geographically close, is of a similar size and has a broadly similar level of socio-economic problems. Ethnicity is somewhat different, with a higher Asian population. In LA2 at the time of the study social work was organised in more conventional teams of 12-15 workers, with a team manager (TM) and deputy team managers (DTMs). An Assessment team covered the work of First Response and Assessment units in LA1. Unfortunately, this team had to withdraw from the research at short notice. Two large Child in Need teams dealt with a very similar range of work to that dealt with by Child in Need units, while specialist teams covered Looked after Children and Leaving Care. All of these were observed, with the focus usually being on specific supervision groups within teams. During the course of the study LA2 had two Ofsted inspections. The first raised serious concerns about assessment (which contributed to us not being able to carry out research in the assessment services) but found the rest of the service to be adequate. The follow-up inspection suggested services were generally adequate.

LA3 is a large town in the south of England. The population is similar in size to that of the other LAs. Overall levels of deprivation are not as high as those for LA1 or LA2, however this is due to a wider range of incomes. There are substantial areas of poverty and significant social problems. LA3 has a very varied profile of ethnicities, with a higher Asian population than LA1. The service in LA3 was organised on an adapted version of the conventional model. Assessment was undertaken in a large team of 20 workers split into 3 sub-teams led by deputy team managers. Services for Children in Need and Looked after Children were provided in five neighbourhood teams. These teams were in the process of moving from an “integrated” multi-professional model to more conventional social work teams during our period of research. Neighbourhood teams had between 8 to 10 social workers/social work assistants and possibly one or two student social workers at any one time. Teams had two Team Managers: one a trained social worker and the other a manager who is not qualified in social work. Each supervised a separate group of workers, who operated in most respects during our period of observation as different teams. Our study focuses almost entirely on the social work sub-team.

There were other important differences that influenced the study. The Ofsted inspection in LA2 led to changes of manager, and understandably a great deal of activity aimed at ensuring a better inspection next time. It is fair to say that LA2 was going through a very challenging time during the period we were gathering data in the authority. While it had a positive Ofsted inspection, LA3 was going through a period of restructuring and were anticipating an imminent Ofsted inspection while we were gathering data in the authority. In contrast, LA1 was relatively stable having moved to the systemic unit model some time previously. LA1 was therefore different in a variety of important ways to LA2 and LA3. These differences are explored at length in the full report and returned to below. They obviously influence many elements of the findings of the study.

## **2.2 Data Sources**

Data was collected between June 2011 and March 2012. Data was drawn from the following sources:

1. *Observational data* was collected through c.46 weeks of direct observation of practice, primarily through shadowing workers. This took place over 6 months in LA1 and LA2 and 8 weeks in LA3.
2. Survey for social workers of currently allocated families in child in need or assessment services (*social worker family survey*)
3. Questionnaires returned by currently allocated families (*family survey*)
4. *Interviews with professionals* (social workers, managers and unqualified staff in teams and units)

5. Tapes of interviews with an actor playing a client (*simulated interviews*)

The sources of data are presented in Table 1.

**Table 1: Data Sources for Study**

	LA1	LA2	LA3	Total
Ethnographic/observational	c.6 months	c. 6 months	8 weeks	46 weeks
Interviews with professionals	40	26	38	104
Survey for families currently allocated	26	12	29	67
Survey of social workers for currently allocated families	131	66	228	425
Tapes of simulated practice	20	14	No	34

### 3. Results

#### 3.1 *The nature of the children and families*

One of the clearest findings shapes everything else: the families worked with almost all had very complex and difficult problems. Here we provide a summary, as those who work within Children's Services will be aware of these features of the work of Children's Services:

1. Families had complex problems, usually with multiple interacting difficulties
2. Social workers experienced high levels of threatening and violent behaviour from families
3. Workers often had to make very difficult decisions in conditions of considerable uncertainty, for instance choosing between undesirable options with substantial implications for children
4. Resources available for family support were limited, whether in relation to material provisions (e.g. housing and finances) or access to other services
5. Children's Services were generally a service of "last resort"; as a result across all the authorities there was a tendency for other agencies to expect social workers to work with the problems that they could not resolve

*ALL of the LAs were dealing with very high levels of need in families.* It is this very high level of complexity that shapes almost all our other findings as it provides the context for the provision of Children's Services in general: Children's Services across all three authorities, and we believe in general across the country, are dealing with large number of families with very serious and often entrenched problems in a context where the number of families requiring services far outstrips the resources available.

### ***3.2 Differences between local authorities in structure and support for practice***

Key differences between LA1 and LA2 and LA3, based on our qualitative observational data and interviews with staff, identified a number of broader factors within the authority that enabled or supported the Unit model.

#### ***Enabling conditions for the systemic unit model***

General enabling conditions are primarily provided at the level of the whole LA. Specific conditions are those created within Children's Services in order to support practice. There was *at a general level a notably higher level of organisational support for workers within LA1* independent of the specific features of the unit way of working. This included an accretion of apparently minor issues that cumulatively had an impact. Examples of issues dealt with well in LA1 included:

1. Workers having enough desks and computers
2. Bins emptied for workers
3. Equipment that did not work relatively swiftly replaced or repaired
4. Provision of spaces for workers to have breaks or informal discussions

We saw almost daily examples of workers finding their work impeded by fairly straightforward obstacles, such as printers not working, in LA2 and LA3. In LA1 the organisation seemed to be geared toward letting workers get on with their work. This had practical advantages, but it also led to workers feeling valued.

There were also *specific conditions within Children's Services that seemed geared toward making the work less burdensome*. One key innovation was the Unit Coordinator, however there were others that any LA could implement without taking on the systemic unit model in whole. These included reducing the burden on workers by:

1. Devolving decision-making (e.g. in LA2 we observed a payment for £1.50 taking a social worker over an hour and three forms to complete)
2. Streamlining processes so that there were fewer forms
3. Better IT systems.

Attention to getting the enabling conditions right allowed workers to concentrate on the (already challenging) business of social work.

*A specific and important difference between the LAs was in case load size: based on our data there are approximately half as many cases per worker in LA1 compared to LA3. The position was less clear in comparison to LA2, but here too LA1 had fewer cases per worker.*

There is no doubt that the lower caseloads in LA1 contribute substantially to all the other positive differences we discuss here. Two important questions relate to this. First, how much of the positive picture of practice described here is simply a matter of reduced caseload? It is not possible to answer this question definitively, however *our overall impression is that reduced caseloads may be necessary to allow better practice but on their own they are not sufficient.*

The second question is: how were the reductions in caseload achieved? Participants in our research from LA1 suggested that the lower caseloads were because of (a) better work with families that creates change and (b) better risk assessment that allows clearer decisions to be taken and avoids drift. There was qualitative evidence to support these contentions as making at least a contribution to the reduction of cases (as discussed in the Practice section), though it is a difficult issue to collect conclusive evidence on.

A final important difference in the systemic unit model that is not necessarily a specific feature of the units themselves was the proportion of managers to workers. The consultant has a dual function as practitioner and worker, but nonetheless their leadership of a small unit meant that workers had one manager for 3 or 4 workers. In contrast in LA2 and LA3 the manager to worker ratio was always higher, ranging from one manager to six workers up to one to twelve. This made a very substantial difference to the practice we observed across teams in LA2 and LA3 and highlights that *workers require not only sufficient administrative support but also access to management and supervision.*

### ***Values shaping the service***

Finally, in all three LAs senior management communicated three fundamental considerations (or sets of values) shaping services:

1. Avoiding negative publicity (eg particularly through poor Ofsted inspections)
2. Reducing or controlling costs
3. Improving the welfare of children and families

In each LA the balance between these varied. Nonetheless, it was striking that in LA1 the welfare of children and families seemed the most important value, communicated

through meetings, policies and in day to day practices. In LA2, completion of paperwork for Ofsted while controlling costs appeared to be the dominant considerations. LA3 mixed a concern for children with high levels of focus on a forthcoming Ofsted inspection. These variations may be in part due to the specific time of our observations. This seems particularly likely in LA3, when our observations were over 8 weeks and at a particularly challenging time.

### ***3.3 Specific features of the systemic unit model***

We identified the following 6 core features of the systemic unit model:

1. *Shared work*: Cases are allocated to the consultant and held within units. This means families and children receive input from multiple workers as appropriate. It allowed a higher level of input for complex families or during a crisis. It contributed to a far more consistent service for families. It also moved social work from being primarily a private activity between worker and parents or children to being a shared activity. As a result workers were provided with explicit and implicit feedback on things they had done well – and areas they might improve on.
2. *Quantity and quality of case discussion*: Shared working necessitated far more discussion of cases. As the unit held case responsibility, there was informal debriefing after almost every visit and there was structured in-depth discussion of every child and family on a regular basis. The impact of this on the quality of decision-making is discussed below. It also appeared to contribute to emotional support and containment for workers. Discussion again involved learning from each other. Here the clinician was particularly important but all unit members contributed to an approach that inevitably involved learning from one another.
3. *Shared systemic approach*: A consistent feature of our observations in LA1 was that systemic ways of thinking informed much of the discussion and decision-making for children and families. These approaches seemed well suited for encouraging the exploration of alternative viewpoints and explanations and for mobilising family resources. In this sense it provided a common language for creatively thinking about cases. In contrast, there was very little evidence of the use of theory in the work of the other authorities. Discussions of cases tended to be focussed around more practical issues and decision-making, with little generation of alternative hypotheses.
4. *Role of the Unit Coordinator*: UCs are more than administrators: they coordinate the work of the team. They are more like a “Personal Assistant” or PA for the unit than a conventional administrator as they cover a wide range of tasks. They almost always had a good understanding of what was

going on in every case and dealt with many practical arrangements. UCs were often well known to children and parents involved with units. They dealt with emergencies, providing back-up and support for workers and families from minor issues such as problems with transport through to staying late supporting workers in emergency proceedings. UCs provided in some senses the “glue” that kept units together.

5. *Other Roles:* The consultant obviously had a key role to play. They were similar to a DTM in other LAs, but the fact that they both worked with families and managed cases meant that they had more direct insight into families. We only observed good or very good consultants. It is a moot point how a unit would work with a less than adequate consultant. It would certainly be difficult for the unit, but it would also be very difficult for the consultant as the role involves constant display of one’s practice and analysis skills.

Clinicians had a crucial role in the units. Their expertise and authority without managerial power provided a constant source of input, skills development and alternative viewpoints in teams. It is hard to imagine the units working as well without clinicians.

The roles of child practitioner and social worker were less distinctive. We rarely observed the CP being a specific “voice for the child”. They appeared closer to a social work assistant role in more conventional teams – though practice varied between units.

6. *Skills development:* LA1 specifies the methods it wants workers to use, namely systemic and social learning approaches. It has invested heavily in these approaches, expecting workers to undertake externally provided courses. LA1 did not take part in conventional Post-Qualifying social work training, prioritising these ways of working instead. LA2 and LA3 had a more conventional approach, delivering programmes of time-limited in-house training and sending workers on more in-depth post-qualifying training.

Workers in all the LAs appeared to appreciate the training they had received in the LA and rated it as meeting their needs, though in LA1 they were far more satisfied with the training they had received. There was also a difference in our ability to observe the impact of training in practice. In LA1 the systemic approach was ever-present: training and education was reinforced by organisational structure and values. In the other LAs we do not believe we observed any evidence of a worker explicitly using or referring to anything they had done in training in practice. In the interviews with workers few outside LA1 were able to provide evidence of any particular method for working with people.

### ***3.4 Practice in the different authorities***

How did these organisational differences impact on practice in the LAs? There were very marked differences in the nature and quality of practice between workers, between teams and between each of the three authorities. The differences between local authorities were the most striking and consistent difference and are the focus of this report. (The differences between workers and between units/teams are discussed at greater length in the full report). Three areas were particularly important. For all three, LA1 was exceptionally consistent and delivered high quality services.

#### ***3.4.1 Amount of work with children and families***

Workers in LA1 spent on average slightly over 2 hours per day with family members, compared to between one and a half (in LA2) and one and three quarters (in LA3) hours. However, they also had considerably fewer cases per worker (roughly half as many as LA3 and about 25% less than LA2). The amount of time each family see of their worker is a product of the amount of time workers spend with families *and* the number of families they are working with. As a result, *children and families were therefore seeing 2 to 3 times more of their worker*. These differences were greatest in the CiN teams and units, where LA1 workers reported spending 50% more time with families than those in LA3 and twice that in LA2. This was supported by the social worker survey of allocated families which found almost twice as many meetings with families in LA1 compared to LA2 and LA3. Perhaps of equal importance was who was seeing the families. In LA1, consultants had high levels of client contact. DTMs and TMs in LA2 and LA3 saw very little of families.

The diaries and observations also revealed other important differences in the ways that workers spent their time. LA1 and LA2 workers spent significantly less time doing admin than those in LA3 (4 hours per day compared to around 6), while workers in LA1 combined more client contact time with working the shortest day, those in LA2 working 40 minutes later and those in LA3 an hour more. These differences need to be understood in the specific context of the time of the data collection and are likely to have been influenced by restructuring and Ofsted inspections.

#### ***3.4.2 Quality of work with children and families***

There was high quality work undertaken with parents and children in all the LAs. Nonetheless, there were three major differences in the work observed in LA1 compared to the authorities with more conventional models:

*Consistency of relationships with parents, children and young people*

There were positive relationships between workers and parents or children in all three authorities. However, the quality of relationships observed between workers in LA1 and families, children and young people were markedly warmer than those in the other authorities. This contrast was particularly stark with LA2 where workers' relationships with young people in care or after care and parents were often rather administrative in tone and not infrequently marked by arguments or hostility. The relationships with children in care or after care were particularly warm and close in LA1, with obvious affection and concern from workers and trust exhibited by children and young people. Relationships with families were also in general more positive. While the families seemed to have very similar levels of difficulty to those we observed in the other LAs, the relationships were rarely as fraught or challenging. The primary reason for this seemed to be the quality of the social work service being provided for families. For instance, we observed workers being cold and appearing uninterested in their work with children in care and families in LA2 (though not in LA3).

#### *Consistency of practice across authorities*

We observed good and even outstanding work in all three authorities, which we describe in detail in the main report. Yet in LA2 and LA3 even very good workers in supportive teams were sometimes aware that they were not working at the level that they wished to. For instance, we observed workers hanging up the phone on a client or feeling that they were not making the right decision for a child. In this – crucially important – respect, the systemic unit model appeared to achieve more *consistency* in good practice than more conventional approaches. We observed a great deal of exceptionally high quality practice in LA1, and perhaps more importantly in 6 months of observation we did not note any work with parents or children that concerned us, seemed uncaring or unprofessional.

Our rating of the simulated interviews supported this finding about the quality and consistency of practice. Simulated interviews provide a standardised test of practice with the same scenario and actors. The rating for these considered average clarity about concerns and level of empathy. We compared the ratings for workers in LA1 (18) and LA2 (15) with raters blind to the local authority. There were statistically significant differences on a 5 point scale (higher being greater) suggesting that workers in LA1 were able to be *both* clearer about concerns (3.8 to 2.6) *and* more empathic (2.9 to 2.2).

*Even the high quality work was of a higher standard than in the comparison local authorities for complex cases or crises in LA1.*

Practice in LA1 benefited from the fact that cases were allocated to a unit not an individual. In the comparison LAs even if a complex case was being dealt with by an excellent social worker they were to a large degree on their own. In LA1 a complex case might have the consultant working with the parents, a children's practitioner going in to provide practical support, a clinician talking to the child about a specific issue while the UC liaised with housing about some practical issues. It was not possible for this type of

service to be offered in the other LAs, which made it more difficult to respond to crises and meant that a complex case could take up almost all a social worker's time.

### **3.4.3      *Quality of decision-making***

The final crucial difference in practice between LA1 and both LA2 and LA3 was in the nature and quality of decision-making about cases. In the conventional models, decisions were made by a worker and usually their immediate line manager. There were some exceptional managers and many good social workers, yet even for the best there was a qualitative difference in the *nature* of case decision-making. In the conventional model many decisions were made as events arose, with informal discussions in the office to decide the best response to a specific event. Outside this the primary forum for case decision-making was supervision of the worker by a manager. Even the best managers were rarely able to discuss all the families that a worker had allocated. Discussions tended to focus on agreeing tasks and goals; they had an instrumental focus, deciding a course of action, and good managers helped provide structure and support to workers by ensuring that cases had clear plans.

In contrast, in LA1 the primary forum for case decision-making was the unit discussion. (Supervision was provided but focussed mainly on professional needs and personal welfare). Practice varied but all units ensured that cases were discussed on a regular basis, so each family would be discussed on average each fortnight. Very active cases might be discussed each week. Discussions of cases would often be an hour or longer. Different members of the team were actively encouraged to formulate hypotheses. A particularly important dynamic was that between the consultant (who had lead responsibility and considerable authority) and the clinician (who tended to have considerable influence due to their expertise), though in most units all members (including coordinators) were encouraged to participate. This institutionalised debate, and discussions were characterised by a high level of creative disagreement. As a result case discussions often led to different understandings of the issues in a case, new approaches or ways of working. This was helped by the consistent use of a “systemic” way of working that focussed on generating hypotheses about what was going on in families and what could be done about it. Most discussions we observed started with a “genogram” (a type of family tree) which was elaborated on during the discussion. This ensured that members of the wider family and other networks were actively considered in assessment and work with families. Notes were taken by UCs, and reviewed at each subsequent review. Often professionals from other agencies or services working with a family would participate in the case discussions. The overall quality of the unit discussions was a consistent feature that impressed all of the researchers and seemed to lead to more informed and thought-through decision-making.

We felt that the process of unit decision-making was likely to tend to be better than even the best decision-making in the conventional model. It is difficult to evaluate “good” decision-making, so readers will need to make their own decision about whether

such an approach is likely to produce better decisions. In conventional teams there were some very experienced, wise and thoughtful managers working with committed and skilled social workers and they were often making good decisions. In the final results sections evidence on the views of workers and parents on assessments is presented.

Whatever the merits of hierarchical compared to unit decision-making when each was carried out well, we had no doubt that unit discussions were far better than poor decision-making processes in comparison LAs. Unit discussions meant that all cases were discussed in-depth on a regular basis and therefore considered in the way outlined above – this was necessary because they were jointly allocated. In contrast, even good workers and managers in conventional LAs tended to have to prioritise discussion of certain families. There were also some teams where supervision was often cancelled or workers reported receiving it infrequently. As a result, a relatively high proportion of cases appeared to receive little active decision-making. There were obvious effects of this lack of decision-making:

1. Workers talked about families and children in care “drifting”.
2. Workers were often anxious, feeling either that they were not providing a good service or that children were being left in risky situations with inadequate reflection and explicit decision-making about this.
3. There was far more responsive work to emerging crises in conventional LAs – indeed, this often appeared to take up most of their time. This happened in LA1, but it was the exception rather than a common feature.

When workers in LA1 and LA2 were asked to rate their confidence in their assessments, workers in LA1 were significantly more confident. Of particular importance for this increased confidence was greater input from other professionals and more confidence in having the “resources available to make a decision”. Workers in units seemed to feel better supported in decision-making and more confident in decisions made.

Furthermore, in practice because workers and managers could not deal with all their cases they prioritised certain cases, and as a result others received less attention. For instance, in LA3 (where workers held a combined caseload of children in care and with their families) children in care appeared to receive less active planning and input compared to child protection cases as immediate risks were lower. In LA2 some teams appeared to have few processes for prioritising high risk cases and practice varied depending on the worker’s identification of which cases needed to be discussed.

A problem for the current study, however, is that it is of work that is being done. We cannot know what is happening for children and families who are low priority. What was clear though was that there were significant numbers of children and families who were

allocated but receiving relatively little in terms of active social work assessment or intervention.

### 3.5 Experiences of services and outcomes

The primary focus of the current study is on describing in detail the nature of the systemic unit model. Nonetheless, it seems important to indicate some key differences in experiences of services that may be related to the practice differences described above.

#### 3.5.1 Survey of currently allocated families

Table 2 sets out the ratings parents gave for the services that they received. It compared LA1 with all the responses received from LA2 and LA3. The sample is small, which is why the (broadly similar) responses from LA2 and LA3 need to be combined, but there are nonetheless some clear findings. Respondents were asked to rate how strongly they agreed with each statement on a 5 point scale from 1 (strongly disagree) through 3 (neither agree nor disagree) to 5 strongly agree. Scores under 3 are therefore negative, and over 3 are positive. For every question LA1 received a more favourable rating and for most there were statistically significant differences. This tends to corroborate the observational data.

**Table 2: Parental ratings of social services**

Parents' ratings for services:	LA1 mean n=24	LA2+LA3 mean n=41	t-test score
Our worker understands my family and our situation	3.83	3.07	$t=2.55^*$
Our worker talks to us respectfully	4.13	3.37	$t=2.44^*$
Social services are professional	3.88	3.10	$t=2.47^*$
Our worker turns up on time	4.17	3.05	$t=4.24^{***}$
Things have got better since our worker got involved	3.50	2.85	$t=1.93$
Our worker and I agree on the reasons for social work involvement	3.92	3.15	$t=2.80^{**}$
Overall I am pleased with the service from social services	3.79	3.15	$t=1.58$
I can talk to my social worker about my problems	3.88	3.02	$t=2.51^*$
Our worker has helped my family change for the better	3.33	2.85	$t=1.55$
I would recommend social services to a friend	3.54	2.66	$t=2.40^*$
<b>Average score for service</b>	<b>3.67</b>	<b>3.10</b>	$t=2.13^*$

\*  $p < .05$     \*\*  $p < .01$     \*\*\*  $p < .001$     +  $p < .10$

Families were also asked for any comments on social services. In LA1 positive and negative comments were roughly equally common (5 of each), while in the comparison LAs negative comments were twice as common as positive comments (11 to 5).

### 3.5.2 Social worker interviews

In LA1 and LA2 social workers were asked to rate various elements of their experience of practice on a 4 point scale (1=never, sometimes, often and always). The results are set out in Table 3. It is noteworthy that workers in LA1 generally reported better relationships with parents and that there were particularly significant differences in relation to levels of violence or aggression experienced by workers.

**Table 3: Workers ratings of parental responses to them**

	Local authority		t-test scores
	LA1 (n=36) Mean	LA2 (n=25) Mean	
Parents listen to what I have to say to them	3.74	3.88	t=0.84
Parents and I disagree	3.11	3.21	t=0.83
Parents are happy to see me	3.56	3.33	t=1.31
Parents behave aggressively towards me	2.11	2.54	t=2.85**
Parents do not turn up to meetings	2.91	2.96	t=0.31
Parents put my recommendations into practice	3.36	3.29	t=0.51
Parents threaten me verbally	1.97	2.38	t=2.38*
When I make recommendations to parents they respond negatively	2.58	2.50	t=0.51
Parents tell me the truth	3.35	3.13	t=1.45
Parents do not answer or return my phone calls	2.65	2.71	t=0.35
Parents do not let me into their homes	1.92	1.78	t=0.82
Parents talk to me about the issues they face	3.95	3.88	t=0.39
Parents threaten me physically	1.38	1.75	t=2.63*
Parents avoid talking about why I am working with them and their family	2.41	2.38	t=0.15

\*  $p < .05$     \*\*  $p < .01$     \*\*\*  $p < .001$     +  $p < .10$

Workers also rated their satisfaction with decision-making and completed standardised instruments looking at their current level of stress (the General Health Questionnaire (GHQ-12)) and level of organisational support and “burn-out” (using the Copenhagen scales). The findings from the Copenhagen scales (Table 4) suggested that across all three local authorities there were relatively high levels of stress and self-reported “burn-out”. This might be expected to some extent given the type of work they are doing, however compared to large Danish samples of caring professionals levels of client “burn out” were roughly twice as high. An important finding was that there were very considerable variations between teams. While numbers are too small for statistical analysis the congruence of qualitative observation and quantitative data points to the potential for strong teams or team managers to make a positive difference to workers.

There were however some important differences between the authorities. The Copenhagen scales found significant differences in workers’ levels of satisfaction with their working conditions, use of their abilities and their job as a whole. In all instances workers in LA1 were more satisfied. Differences were also found in relation to levels of

current stress and anxiety using the GHQ. Overall levels of stress were lower in LA1 than the other authorities, and highest in LA3. Neither finding achieved statistical significance, though both were in line with our observational data and qualitative evidence from interviews. It is important to emphasise that LA3 excluded leaving care and that LA2 had a high proportion of leaving care and looked after workers and no assessment workers. The composition of the sample undoubtedly influenced the overall levels of stress.

The somewhat higher level of stress identified in LA3 is also perhaps not surprising given the restructuring and preparations for an Ofsted inspection during our period gathering data. Our qualitative data identified that these were putting specific strains on workers at the time of the study. However, what is perhaps most interesting is that when the figures for LA3 are compared with national samples of newly qualified social workers and other studies of social workers, the level of stress in LA3 is close to average. It is the low levels of stress and anxiety in LA1 and LA2 that are unusual. This highlights the very high level of stress involved in this most challenging area of work. In LA1 this stress seemed to be managed comparatively effectively within the systemic units. In LA2 levels of stress in child in need teams were high, but in the looked after and leaving care service were much lower.

**Table 4: How satisfied are workers with work and levels of current stress**

<b>Copenhagen Scales</b>	<b>LA1</b>	<b>LA2</b>	<b>LA3</b>	<b>Significant?</b>
How pleased are you with...	Satisfied?	Satisfied?	Satisfied?	
Your prospects?	92%	78%	79%	
Your physical working conditions?	100%	71%	79%	<i>p</i> <.001
The way your abilities are used?	95%	83%	73.5%	<i>p</i> <.05
Your job as a whole?	92%	79%	82%	<i>p</i> <.05
<b>Subscales:</b>				
Level of social support	82%	79%	77%	
Sense of community	84%	84%	83%	
Level of work burnout	48%	52%	55%	<i>P</i> <0.1
Level of client burnout	32%	29%	32%	
<b>General Health Questionnaire</b>				
Total GHQ item score per worker	9.88 (2.98)	11.21 (5.23)	13.05 (7.70)	<i>P</i> <0.1

### **3.5.3 Agreement between family and social worker on key issues**

It is not always possible for workers and families to agree about the presence of an issue. Nonetheless in general an ability to arrive at an agreement about what the key issues are tends to be a foundation for effective work. Table 5 sets out the correlation

between the worker and family rating for the presence and seriousness of a problem in the family where both returned survey data. Correlations were converted to z-scores. (A z-score is a measure of standard deviation, with a score of 1 = one standard deviation). The significance of the differences was then calculated. For eight of the nine areas LA1 had higher levels of agreement with families, five of these were over one standard deviation. Three were statistically significant and two had a trend toward significance. Workers and families in LA1 had a higher level of agreement about the nature and seriousness of the issues in the families. This supports the observational data described above and the workers' ratings of their own assessments in suggesting better assessments were being undertaken in LA1.

**Table 5: Level of agreement between family and social worker on key issues in family (comparison of LA1 with other LAs)**

<b>Issues in the family:</b>	<b>LA1 Correlation score (n=26)</b>	<b>LA2+3 Correlation score (n=35)</b>	<b>z-score</b>
Problems with housing	0.398	0.352	0.02
Not enough money	0.346	0.267	0.32
Child's disability	0.576	0.064	2.64**
Child's behaviour	0.471	0.334	0.6
Parent finding caring for a child difficult	0.635	0.060	2.52***
Parent with depression	0.390	0.574	-0.88
Parent with other mental health problems	0.668	0.289	1.86*
Parent drug use	0.666	0.420	1.3 <sup>+</sup>
Parent alcohol use	0.610	0.380	1.13*

\*  $p < .05$

\*\*  $p < .01$

\*\*\*  $p < .001$

<sup>+</sup>  $p < .10$

## **4. Discussion**

### **4.1 Strengths and Limitations**

The study is based on one of the most extensive observations of practice across local authorities in the UK, involving more than 200 days of observation of all elements of practice. It benefits from a mixture of types of data that allows findings to be checked across sources (parents, workers, direct observations) and data types (questionnaires, simulated interviews, observational data etc.). The fact that there were 6 researchers collecting, sharing and analysing data also helped create a more rounded picture of practice. There are nonetheless some important limitations to take into account. Most

notably some of the sources, and particularly those that obtain data directly from families, involve relatively small numbers.

The two main limitations of the study readers may identify are rather more general than this. The first is that there is little data that could be considered to relate to “outcomes” for children or parents. The second is that the differences identified in our results cannot be attributed as necessarily being due to the “systemic unit model”. Indeed, here and at greater length in the main report it is important to emphasise that the differences we observed had multiple causes. These included different levels of local demand and patterns of local services other than Children’s Services. Just as important were unexpected events, such as Ofsted inspections, or factors beyond the unit or team structure, such as local authority support for practice. The challenges in drawing conclusions are exacerbated by the fact that we are comparing just three authorities. We would no doubt find different things if more authorities using systemic units and conventional models were compared. Perhaps most importantly of all, work undertaken with families or children within an authority cannot be understood in isolation: it is shaped by the process of deciding which families get allocated, whether cases are closed and other operational factors within a complex system. One of the key challenges in evaluation of Children’s Services is therefore that the focus should be not just on the quality and outcomes of work undertaken but also on what happens to families where work is *not* undertaken. A family not allocated a worker due to a decision to prioritise high risk cases, or a child who is allocated in theory but barely ever sees their worker, are just as legitimate foci for study as those who receive intensive input.

These two limitations of the study are in an important sense in direct opposition: the reason we did not focus more on child outcomes is because of the difficulty in ascribing the reason for any differences in “outcomes” to the systemic unit model. For instance, if we found that children in LA1 had fewer problems after 6 months than those in LA2 and LA3 it might be tempting to say that this is because of the systemic units. Yet it might be because of all sorts of other factors – from which cases are allocated through to the quality of line managers. If anything our findings have confirmed our belief that there are very complex reasons for differences in practice and outcomes between authorities; it is therefore difficult to imagine a wholly satisfactory way to compare outcomes. Indeed, comparing outcomes may be very misleading unless a thorough picture of the workings of the service is also presented. Instead the focus of this evaluation has been to *describe* in depth and by doing so to try to *understand* the key features of the systemic unit model. In doing so we feel we have learnt some more general lessons about factors that shape effective practice in Children’s Services as well as having a clearer picture of the nature of the systemic units.

## ***General lessons for Children's Services***

As outlined above, and summarised below, we felt that there was strong evidence that the systemic unit approach provided an excellent level of service for families. However, in considering why that was so, and in looking at differences between teams and workers in the other authorities, and between LA2 and LA3, a number of other key factors that influenced the quality of practice were identifiable. All of these we found in the systemic unit approach, but they are likely to have had an independent positive impact on practice even in more conventional teams. The seven key factors in supporting good practice independent of systemic units were:

1. *Wider practical organisational support for Children's Services:* providing adequate space, good IT systems and other practical support for practice was crucial.
2. *Strong administrative support:* social workers require good administrative support, and administrative support that is closer to a PA than a bureaucratic filer of forms is most helpful in carrying out the social work role.
3. *Small teams:* one of the key insights underlying the systemic unit model was that smaller teams work better, and we found this in conventional teams too.
4. *High ratio of supervisors to staff:* with the complexity of the families that workers deal with, supervisors can only effectively manage a limited number of social workers. An adequate ratio of supervisors to staff was crucial for the organisation to work.
5. *Recruitment of high quality staff:* LA1 introduced the systemic unit model by asking all staff to reapply for their posts. This resulted in a significantly changed workforce, which was maintained through an ongoing selection process. It is beyond the scope of this study to evaluate this element of LA1, however it is undoubtedly true that the quality of staff recruited and retained shapes the ability of Children's Services to deliver services effectively.
6. *Limited workload:* given the complexity of the work, social workers can only work effectively with a relatively small number of families. Allocating more than they can manage means that workers and managers formally or informally decide to prioritise some and give limited attention to others. Controlling caseloads – even if that involves making difficult decisions about only working with high priority families – is necessary to allow effective service delivery.

7. *Articulating clear values*: one of the most impressive features of LA3 was that while the levels of stress and workload of the staff were exceptionally high at the time of the study, staff in general seemed highly motivated and committed to the welfare of the families they worked with. This was also true for some teams in LA2. A key factor explaining this seemed to be managers' articulation of clear values that put children's welfare first.

Our sense is that where these seven factors are present Children's Services would usually be delivering work of a high standard. All seven were present in LA1. Did they alone explain the positive practice we identified? In the absence of clear data differentiating the specific impact of systemic units this is open to discussion. Nonetheless, we felt that overall systemic units added significant value beyond these basic features of good Children's Services.

### ***Specific key features of the systemic unit model***

We outlined above the six key features of the systemic unit model that made it distinctive. In describing the approach we have tried to bring together our key findings into a model (see Diagram 1). This model posits three key LA level factors that shape practice (general enabling conditions, specific enabling conditions and organisational values). (These overlap with the seven factors that are the key to good practice in Children's Services in general noted above, however they are conceptually separate as some of the seven are integral to systemic units while others are necessary to allow Units to function). The diagram then highlights the importance of the six key elements of the systemic unit model and reduced caseloads at the level of the team/unit. These interact but they also exert separate positive influences on practice. Together these influence our primary findings: that workers in LA1 spent more time with children and families, that their work was consistently of a high standard and that the process of assessment decision-making was likely to be better within the units. These are then linked to some outcomes we have evidence for (namely that families' appreciated the service more, that there was greater agreement between worker and parents on family needs and that there was less violence and aggression and better engagement of families and young people) and others that are hypotheses based on qualitative comments from workers or managers.

We felt that these core elements of the systemic unit approach improved practice beyond the more general key factors of effective Children's Services outlined above. In particular, shared allocation required a radically different approach to delivering services. It meant that workers had to discuss cases constantly. It allowed specific inputs to be provided by particular workers. It created a "motor" that drove ongoing professional development through constant sharing and learning from one another. And when one considers the very challenging types of families being worked with, it seemed a logical approach: is it, in fact, sensible to expect social workers to work alone with families with complex problems and sometimes very challenging behaviour?

The systemic approach seemed very well suited to shared allocation, as it provided a framework for both assessments and interventions with families. LA1's move to training and skills development that focussed on one particular approach has been criticised in theory, but in practice it seemed to provide a very helpful way of focussing shared working.

The roles within the unit all made important contributions, but the consultant, clinician and unit coordinator were particularly distinctive, and it is probably these roles that add most value to the unit way of working. They help transform the unit from a small team of social workers to a more varied group able to provide a range of different types of help.

Yet it is equally apparent that the move to systemic units is about far more than restructuring. Systemic units are only likely to work when the whole system is designed to allow them to work. Our study describes at some length some of the broader organisational factors that are necessary to allow systemic units to function effectively. All of these point to the crucial importance of effective leadership and commitment from the whole organisation to make units work. The systemic unit model is about far more than systemic units; it is more fundamentally about whole-system reform aimed at delivering a vision of excellent social work.

## **Conclusion**

This evaluation began with a sceptical interest in the systemic unit model. It appeared promising, but experience with other innovations suggested that it was unlikely to be as impressive as its proponents believed. In this respect our findings suggested we were perhaps overly sceptical. The approach to work in LA1 is exceptional. This is perhaps best captured by a comment made by one of our researchers during analysis: "if we were starting child protection from scratch and comparing the LA1 approach and conventional children's services, there is no question that you would opt for the systemic unit model." As outlined above, there are several reasons for this but at the heart of it is joint allocation in small teams. Shared allocation also ensures that the unit is a genuine team with a shared purpose, rather than a group of workers each with their own cases.

In contrast, the conventional hierarchical model operates in a linear way, like a chain of command from senior management to worker. This can work when each link is strong and well supported, for instance where the seven key requirements for effective Children's Services identified above are present. Yet it is essentially a "brittle" system; any weak links caused by personality or circumstance are likely to lead to breakdowns in assessment and work. Such a system may appear easier to manage, but it is particularly vulnerable to failure – ironically the very thing which Children's Services seek to avoid as it can have such disastrous consequences. It is possible that such an approach worked when it was created in the 1960s and 1970s, but our study suggests serious questions about whether it is appropriate for the very high levels of need and risk found in almost all families worked with in contemporary social work.

Ultimately, however, perhaps what is most important about the systemic unit model is not the model itself. Rather, it is the fact that it opens up a different way of delivering Children's Services. In doing so, it allows us to question some of the fundamental assumptions that have tended to pervade the way services are organised and run in the UK and many other countries, such as the almost universal tendency to allocate families to individual workers and the rarity with which Children's Services specify and then support the intervention methods they think workers should be using. When developing the approach the originators – Steve Goodman and Isabelle Trowler – started off by asking some relatively simple questions such as: “How do we want our social workers to help people?” and “How should the organisation support workers to do these things?”. This evaluation suggests that the systemic unit model is an innovative and effective way of developing a service that addresses such questions.

Yet the most important impact of the development of systemic units may not be the particular approach developed and evaluated here. Rather, it may be the opportunity to return to fundamental questions about how Children's Services should be organised and managed. The systemic unit model allows us to re-imagine the delivery of services in fundamentally different ways. As such, it opens up the opportunity not just to decide whether systemic units are better or worse than more conventional teams, but to think and debate more deeply about what is needed to allow social workers and other professionals to deliver Children's Services in an effective and humane way. We hope that this evaluation may contribute to such debates.

**Figure 1: How the systemic unit model works**

