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Interviews with strategic managers and front line workers

Dates of fieldwork:	May to September 2016
Country:	United Kingdom
Geography:	Greater Manchester
Method of data collection:	Interviews
Language	English
Kind of data:	Field notes and transcripts
Population:	Staff involved in the management and delivery of the Troubled Families programme
Sampling	Purposive
Number of units	4 strategic mangers and 2 key workers
Key words	Multi-agency work, PbR, families outcomes, referrals.

Strategic manager 1

Purpose: The key outcome of the Early Help Hub is to decrease the number of referrals to social work and make sure the situation doesn't escalate. 5 days per week, there is triage in the morning. The families come in, through the hub. Once they are identified as being Troubled Families (TF), we put them on the system. There are different systems with different log systems. It provides you with a log number.

Service integration and co-production: Before, when you got a referral in, you had to talk to people and there was a while before you would get to an interagency meeting. Now the discussion takes place the minute we receive the referral. If there is an housing issue, you can talk to everyone within one hour. The hub allows for a multi-agency response so co-location is a massive thing. Allocation meetings are quite new. On the triage, we identify the needs and get all the information together. Then during the allocation we look at the provision of services. Before you spoke only to professionals, now you speak to the family. There is a massive issue between time and quality, it is time consuming and somethings you would need an extra day. We need to work out what impact this has, some agencies still don't get it. Allocation meetings need more diversity (e.g. Chinese family or asylum seeking child). We are looking at the voluntary offer and third sector. There is some resistance for referrals. We work towards inviting organisations to link with us, to consider what the services does, who for, to whom, and how to access them. The core service gaps include parenting courses and offer for youth, especially emotional support for teenage and adults that don't meet the threshold.

Benefits: no waiting list for the family, gets the right offer. Before they case could get picked up by the wrong service. At triage, we speak to the families. Also through visits. They self-identify their needs. There is greater clarify about what is on offer, so the dropout rates are lower because

families know what to expect. For the agencies point of view, when they get a reference, it should be very clear why they got it. They shouldn't need to make another assessment, so it cuts out time. It's an easier process. It is about the most appropriate referral, this should impact the outcomes.

Outcomes: Too new to say, this has only been running for six months. We get informal feedback. Everyone who comes through the hub gets an offer, unless they don't give consent. Consent is an ongoing discussion. Without the family's consent, you can't check the data. The MASH team do home visits, they do what they can to get consent. There is a cultural shift, the intervention managers will need time to get it. Some services perceive the hub as being more work than before.

PbR: We record the information at triage, this is a massive consideration. There is an awareness. It doesn't drive the nature of the work, but it makes sure you record the work. Everyone who comes to the hub gets an offer, regardless of whether they are TF or not. We link in with key workers for TF, so the information is shared. The TF families indicators such as school attendance.. we consider that when we think about the offer. The pros are motivational, it is all very clear that PbR funds people wages. It's good at focusing the work. You might think you are doing well, but when you look at the indicators you see no improvement. There is nothing wrong with having an oversight from a national agency. The cons are that is it missing the narrative. They are hard outcomes, such as school attendance for disabled child. Improving the attendance rate is not always possible and that is not always reflected. Also, it involves lot of data recording and it is time consuming.

Strategic manager 2 (Joint interview with two managers)

Two teams that use to work separately now come together under the new hub. We are working towards working at the same level, the hub is supposed to work with level 3 to 4, but some families reach level 5 (statutory help). The teams vary in number and roles, and have separate processes and systems. After the allocation meeting, a case can be allocated to anyone, it goes to the first team that has capacity. Sometimes there are considerations around gender, whether it would be best if the key worker is a male or female. We also try to match with partners and the area. We meet on a weekly basis to check capacity and allocation needs. We have many informal meetings. There is no difference between the support offered. All cases we work on are TF. We have consent for all of them, to share data and do research. We have a snap survey to capture data.

TF programme influences how you log the cases. There is the MyCare system, but research and intelligence have access to other information to capture it. The TF number comes up on MyCare. Now we have new paperwork and we need to evidence the work on MyCare. It reassures us about progress and make sure we are on track. The key workers do regular reviews, every 3 to 6 months, or every 6 to 9 months depending on the team. This will come inline in the next 3 to 6 months. It is a working partnership.

PbR: this is dealt with by research and intelligence. It ensures that the information is captured. Everyone was briefed on PbR and the sustainability of outcomes. So we record the percentage and sustainability, we don't get feedback. Before they would have LIT meetings and the research and intelligence team would attend and feed some information back to them. It's being looked at as Hub is settling. We can't tell which areas are working well and which are not working.

Benefits: There is a wealth of skills around here, with the amount of people and communication. It is good to have police and social workers.

Pitfall: It is hard to fit everyone in as the team is growing. Space issues. Some need their own computers system so they can't hot desk. Also there is no private space, only one meeting room. So this is difficult when there is a last minute meeting.

Family: They have access to what they need. Social work will speak to them, it goes quicker. They speak face to face.

Information sharing: PCSO / police can't share information, but if we have a query they are there and can answer. Get information from job centre and education can share attendance. We have a written agreement so we can share. Families might not want you to find out everything, but so far no family has kicked out.

Multiagency working: we always had meetings before the hub, so this hasn't changed, but co-location makes it easier.

Outcomes: Best outcomes are for the family. All families are different and have different needs. We focus on Ofsted and early help strategy and signs of safety.

Challenges: Still new to it. We are working with different processes. We have two different models on IT, so it's hard for people. They are not very flexible either so it is hard to capture outcomes. Also we are constantly changing processes so this is hard for staff and requires training. It can be confusing. The teams are frustrated with the model, they really want to go through the change, but at the moment one size doesn't fit all. So we have to be creative. The model is co-created, but with multi-agency working it is hard to keep it.

Strategic manager 3

Purpose: the hub is about having intervention workers, interagency working and creating an offer.

Part of the funding and remit of the hub are in line with the TF cohort. People coming through the door are the same cohort. Prior to the hub the programme was more in people's faces. Now it's in the background, but we meet it in the nature of the demand anyway. So each family has a number and is tracked. The work itself didn't change. If anything, with the lowering of criteria, the work became more preventative. On the intervention side, there is a tracking reference. But at triage, the numbers are much bigger, referrals come from health, education, social work, police, job centre. Some self-reffer, the hub is advertised on the local authority's website. We never turn a family away.

The objectives are prevention and multi-agency work so offer is more effective if all partners are working together and information is shared for the best interest of the family. So the families don't have the repeat their stories again.

Communication: we have multiple systems, they were all very separate before the hub. It is good to filter referrals, so they don't get lost. People know to come to hub for support, the message is getting out there, we do network events and strategic meetings.

Challenges: information sharing and shared responsibilities. The pace is very quick, we need time to reflect on what works and what doesn't. The processes are still challenging, we are still not sure whether we have the right staff and resources. Last week, we got 49 referrals in 4 days, which was half of the number of referrals received in the previous month.

Co-location: it's very good. In theory, it's excellent, but in practice you need to work to make it work. The roles and responsibilities of people.. and getting to know them. So we do development days, team building days, training.

Gaps: In service provision, refugee and asylum seekers. We have no resources to public fund. One of our areas has a changing cohort of families.

PbR: we get asked to provide information, it's a secondary side line. It doesn't really matter as long as we are meeting the family's needs. It gets us funding. At operational level, it isn't something we think about, we think about the family needs and gaps etc.

Data sharing: At the strategic level this is still new, same at the operational day to day. It is more about information sharing than data sharing. For example, the police have their own computer, and share information on a need to know basis. They share with the manager, not the entire group. Health is a bit behind and talk around how they fit, this is still being worked out. It's a case by case on a needs to know basis.

Allocation meeting: Quite clear what gaps are and where the waiting list is. Waiting list fluctuates, it's different every week. We are in a high demand area.

Keyworker 1

Career history: Leisure services on reception. Career change – [Borough] College – Community Care course – Social work? Decided to do Open University *Social science*. Job with Children's Services. Women's Royal Voluntary Service contact centre as a volunteer.

Seconded to a National Children's Homes (NCH) project working with children and families – evictions re. ASB. [Neighbourhood] based. 8 years – back to [borough] – recalled. Nearest was family support role. 4/5 years – higher case load, but similar work.

Difference re. case loads. NCH – 5-7 families, housing law expertise. Family support: 10-15 cases, but lots of referring – guy from housing come in and they sort it out.

New job – keyworker. Often children's centre role to keyworker.

A lot of families referred – not appropriate for this. KW role – 7 families – pulling it all together. Cases are child in need/ child protection – social work led. Needs tweaking to appropriate

e.g. 2 year old – strengthening family project – so we won't be involved

Early help

Keyworking roles – to prevent

We're supposed to do: 0-25

Outreach workers – they have waiting list – family support helping out with that. Policy –

To be good at this? Flexible, skills, knowledge. Courses – e.g. working with families with drug and alcohol. NCH – learned so much. Interested in law and policy and how to get round them.

Empathy – a lot of life experience yourself. Want to help people.

Single parent. Empathy. Not judgemental. Not every case is the same.

NCH – ex-service users group. Encouraged them to take ownership. Sometimes negative aspects to this.

Aims – prevent children from going into care. Foster independence. Educate people.

Over the years – parents haven't parented.

The different approach means going to the need (family support have waiting list). If KW roles there will be less capacity. A lot of non-engagement – families referred… they either scared – Children's Services. At NCH could say not social services.

Approach is friendly / non-judgemental. Talk to them on a level. Trying to find a way of connecting.

Not mandatory referral – not here to force things on you.

Injustices – don't like injustices. Families – are in work, but struggling financially. Other families… know how to negotiate the way. Hard for families that are really trying – want to work, but it puts them in a worse position.

Money – comes up a lot – more and more. Large family – food parcels.

PbR – I suppose when at NCH – voluntary agency. Don't find partnership model helpful. Other paperwork useful. Always had outcomes – drummed into me at NCH. Focus on outcomes – meeting the children's educational/ social needs.

Keyworker 2:

Career history: Nursing degree at [Borough] Uni – dropped out for child – got a diploma health care. Worked in a shop. Admin job at Children's centre. Children's centre worker – running stay and play. Home visits. Home safety scheme. New baby visits – baby massage. Started 2009 – June 2016. Full-time centre worker. Plodding along in job. Made expression of interest for KW role.

Doing this since June 2016.

Families – higher level problems. No groups. Lot more home visits. Much higher needs.

Worries whether we are doing the right thing.

What aims?

Trying to improve outcomes – stopping them coming back into system.

Equip them. Aware of services. Sort themselves out.

Others – do everything for them. Helpers and not doers.

Worked with one of my mums: kids tired. Will it slip back? Informal support and awareness continuing.

What works? Honest. Don't lie to them. Another family support worker says, no – shows imperfections. Reassure. If I don't know – I say I'm not sure. First few visits – just get to know the family – about building a relationship with the family. No rush: we're not on a timescale.

If in charge: I would do my job better – laptops or iPads – to take notes.

Work from home to do the paperwork.

Behind with paperwork.

Outcomes focused? Try to do best for the family.

If they get escalated, then we should close. It's too late. Not going to affect our outcomes. Leave them with social workers.

Outcomes – not the main thing in my mind. 'That needs my time'. Probably are all related.

Child with disability – Downs Syndrome. Less attention on other child. Low attendance/ behaviour – tantrums.