Signs of Safety

Evidence Base and Implementation

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How do we know if Signs of Safety is improving children's safety and wellbeing?

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Introduction

To those considering whether or not to use Signs of Safety, a key question is whether they have good reason to think that it will help improve the safety and wellbeing of children exposed to abuse or neglect. This is not a straightforward question to answer because of two main challenges. First, measurement is needed of whether and how well Signs of Safety has been used, taking account of how the Theories of Change emphasise the interconnectedness of organisational factors and individual worker skills. If, for example, front line workers do not have access to good team support and supervision, then the risk of weaknesses or biases in reasoning increases and if the recording system does incorporate the Signs of Safety practice logics the capacity to utilise the approach increases. Secondly, families are influenced by numerous factors so identifying the contribution that Signs of Safety makes to the overall progress (or deterioration) of a child's safety and wellbeing is complicated.

In this chapter, we begin by clarifying what evidence can help us answer this question, explaining how Signs of Safety has an impact on practice and subsequently on children, young people and families†. It then provides an overview of what evidence is currently available to answer the question of helpfulness, drawing on three categories of evidence from:

- A realist synthesis of the empirical evidence supporting the theoretical assumptions in the Theories of Change
- Empirical studies of the use of Signs of Safety
- Administrative data on what happens within organisations who have implemented Signs of Safety

How does Signs of Safety make a difference?

Both families and child protection agencies are complex social systems. Introducing a new factor into them does not have precisely predictable effects. People working in child protection will be familiar with this because it is apparent in much of the relevant research. Research on adverse childhood experiences (ACEs) for instance, concludes that they may contribute to physical and psychological problems later in life. However, adults can experience serious problems without experiencing any ACEs while others can experience several ACEs in childhood without perceptible difficulties later (Finkelhor, Shattuck, Turner, & Hamby, 2015).

Research that evaluates interventions in child protection work produces a similar pattern. Even where a study has shown better results for the group receiving the intervention being evaluated compared with the control group, the average result for the group covers families who showed a lot of progress, no progress and even

† A more detailed account is available in Appendix A of the Action Research report on implementing Signs of Safety in ten English local authorities.

some deterioration (see e.g. Littell, 2006). The control group shows a similar variety of outcomes.

So because of the complexity of the causal links, the claim about Signs of Safety is not the simple: 'this will be effective' but a claim that it has a tendency to improve children's safety and wellbeing, in the way that an aspirin has a tendency to alleviate headaches — sometimes it will and sometimes it won't, depending on other factors in the situation. The aim of research on Signs of Safety is to develop our understanding of what works, how it works, for whom, and in what circumstances. Answers to this set of questions help potential users decide not only whether the evidence of positive impact looks credible but also whether the context in which they would implement Signs of Safety provides or can be reformed in order to provide the support factors to enable it to be implemented and used well.

The previous chapter has presented two Theories of Change for Signs of Safety: for the organisation and for the practice with families. The organisational Theory of Change captures our current understanding of the key organisational factors that influence how well workers implement the process, the principles and the methods of Signs of Safety. The practice Theory of Change outlines how the process, principles and methods contribute to greater safety and wellbeing of children and young people.

How often and how well Signs of Safety practice is being used in work with children, young people and families is crucial for judging whether Signs of Safety itself has contributed to the outcome. A failure to have a measure of the extent to which the families experienced a Signs of Safety service is a major flaw in some research studies. A major development of Signs of Safety has been to develop quality assurance methods for measuring the quantity and quality of Signs of Safety practice so that it is possible to form a judgment on whether the family have experienced a Signs of Safety service of sufficient depth and breadth to justify the name. Just as studying the efficacy of a drug requires some measure of how much was ingested by each patient so does studying the impact of Signs of Safety practice need a measure of the quantity and quality of the service that was delivered and of what has been experienced by the family.

The Theories of Change also take account of how front line workers' actions and inactions are influenced by the organisational system in which they are operating. This is of course true for all personnel in the organisation. Indeed, the fact that there is a Theory of Change for the organisation as well as for the direct work undertaken with families illustrates this. It recognises that an individual worker is not a free agent able to choose independently what he or she does in direct work but is always shaped, helped and constrained by their organisational system and the requirements placed on it. Indeed, many aspects of the organisation, such as quality assurance, resources, supervision, and managerial oversight, are explicitly designed to influence front line work. The organisational factors listed in the infinity loop are 'support' factors that make it easier to perform well and harder to perform badly. For example, having software for case recording that is aligned to the practice framework reinforces the reasoning processes in the approach. Our claim is that when these support factors are present they will tend to make the desired outcome (of improved safety and wellbeing of children) more likely. Other organisational factors however can be 'detractors', having the opposite effect to support factors: they tend to diminish the causal impact. Heavy workloads can have this detracting impact in Signs of Safety by reducing the time available to form good working relationships with families and their networks. A third category of factors is 'derailers': when they are present, they stop the causal pathway. For example, a new CEO who is opposed to Signs of Safety can stop its use.

Similarly, the Theory of Change for practice recognises that families are affected by numerous other factors that will influence the course of events so Signs of Safety alone cannot guarantee a good outcome. However, it does claim that addressing the problems with Signs of Safety practice tends to be helpful.

What evidence is there that Signs of Safety improves children's safety and wellbeing?

There are several sources of evidence that inform us about the impact of Signs of Safety practice. Within an organisation implementing Signs of Safety and aiming to create a learning organisation, the quality assurance system (detailed in chapter 7) provides an on-going mechanism for finding out how well the organisation is providing a Signs of Safety service and meeting its outcome goals for children and families. However, in this chapter, the focus is on the evidence available to inform someone considering whether to use Signs of Safety. There are three main sources: a realist synthesis of the research evidence that supports the components of the Signs of Safety Theories of Change, research studies of Signs of Safety in use, and administrative data within organisations.

Realist synthesis of Signs of Safety

Signs of Safety is a complex intervention operating in complex children's services systems, making it difficult to effectively evaluate using traditional evaluation methodologies. Dr. Louise Caffrey, Assistant Professor Social Policy at Trinity College Dublin, is leading a Realist Synthesis of Signs of Safety. Realist Synthesis is a literature reviewing methodology that goes beyond the traditional evidence-focus on "what works", asserting instead that this is not an especially useful question since nothing works for everyone everywhere. Therefore, rather than asking the traditional question, "Does Signs of Safety work?" or, more specifically, "Does Signs of Safety work on average?" the Realist Synthesis aims to better our understanding of *how* Signs of Safety works, *for whom* and *in what circumstances.*

Identifying Signs of Safety's Underlying Theory: Self Determination Theory

At the heart of the Realist Synthesis approach is a focus on identifying and making explicit theories that underpin Signs of Safety. In a Realist Synthesis, these theories may come from the literature on Signs of Safety as well as from diverse fields outside of child welfare. Realist Synthesis then seeks to use the available literature and stakeholder focus groups to support, refute or refine these theories.

We found that Self-Determination Theory (SDT) (Ryan & Deci, 2000) can help explain the psychological processes at play in Signs of Safety and our work offers a deeper explanation of how Signs of Safety expects to get from its strategies to its intended outcomes. SDT is a theory of human motivation that is supported by a strong evidence base across a very wide array of fields including health care, education, work, sport and psychotherapy (Ryan & Deci, 2017). The theory suggests that people's performance and wellbeing are affected by the type of motivation they have for the activities they are expected to engage in, whether as employees or service-users. It demonstrates that human beings can be proactive and engaged or else passive and alienated, largely due to the social context surrounding them. This has relevance for Signs of Safety since, at the practice level, the approach aims to motivate families to change their behaviour to support child safety. Further, at the organisational level, Signs of Safety aims to motivate social workers to engage in changing their practice in line with Signs of Safety's framework, to have a greater sense of ownership of their practice using the approach and to

better their social work performance. Therefore, an attempt to engage both staff and service-user motivation is central to Signs of Safety.

The large evidence base supporting SDT suggests that motivation that is 'autonomous' (i.e. engaged in while feeling some element of voluntariness or willingness) is more effective than motivation that is 'controlled' (i.e. feeling coercive pressure to engage in it) for promoting people's performance, satisfaction and wellbeing. Autonomy here is not the same as independence or freedom from external influence. Indeed, limit setting can be an important part of the process, but limits can be set in either controlling or autonomy-supportive ways (Ryan & Deci, 2017, p. 445). Rather autonomy, it is about helping individuals recognise that they can make choices regarding their behaviours such that behaviours become self-endorsed, feel in keeping with the person's own interests and values and are engaged in willingly (Ryan & Deci, 2017, p. 10).

Psychologists have typically further differentiated between motivation that is 'extrinsically' and 'intrinsically' motivated. When people are extrinsically motivated they perform an activity in order to obtain some separable outcome (e.g. doing homework to pass exams) whereas, when they are intrinsically motivated they do the activity for its inherent satisfaction (e.g. doing homework because it is enjoyable) (Ryan & Deci, 2000). Contrary to what might be assumed, SDT suggests that, under the right circumstances, people can feel autonomous motivation — some sense of voluntariness — even if the activity is extrinsically motivated. This research suggests that, in the right conditions, it is possible for people to internalise behaviours that are extrinsically motivated so that they come to personally value them, feel ownership of them, accept and choose them. This is important in the context of Signs of Safety as it suggests that, even though families and staff may initially engage with the approach because they are extrinsically motivated in order to obtain an external goal (e.g. as families, to maintain care of their children or, as staff, to maintain their work position) they may nonetheless, in the right conditions, experience a feeling of 'autonomous' rather than 'controlled' motivation, which is more likely to promote performance as well as feelings of satisfaction and wellbeing.

SDT has demonstrated, through a large and high-quality evidence base, that people tend to experience 'autonomous motivation' when three basic human needs are satisfied. The basic needs are for autonomy (feeling of willingness, of being the origin on one's own behaviours), competence (feeling effective) and relatedness (feeling social connection to others, usually brought about by feeling understood and cared for by others, but people may also feel relatedness through caring for others).

The SDT literature indicates that certain practices support the satisfaction of these needs and Signs of Safety's strategies, at both the practice and organisational levels, are strikingly congruent with many of these practices.

SDT research suggests that Signs of Safety's practices mirror those that SDT research has found can satisfy a need for 'autonomy' in both staff and service-users by:

a) enabling choice and participation and avoiding pressure and manipulation and

b) providing help to find personally meaningful reasons to change.

Signs of Safety strategies mirror those that SDT has found support the need for feeling 'competence' by:

a) helping to develop clear, realistic and achievable goals

b) providing informational feedback (i.e. focusing on the behaviour not the person) and incorporating positive feedback and

c) setting incremental goals.

Finally, Signs of Safety would seem to mirror strategies that have been found to support a feeling of 'relatedness' by:

a) judging the behaviour rather than the person and showing compassion

b) understanding all perspectives and showing empathy

c) providing full transparency of expectations, process and possible outcomes.

Overall therefore, a large body of research from the field of Self-Determination Theory would seem to support the logic of Signs of Safety's strategies. Many of Signs of Safety's strategies to engage both staff and families match those that SDT research has found support basic human needs for feeling autonomy, competence and relatedness. The SDT evidence base indicates that Signs of Safety strategies are therefore likely to support 'autonomous motivation' in families and staff, which, compared to controlled motivation, is more likely to lead to better performance and wellbeing. Some studies of Signs of Safety (e.g. Skyrypek, Idzelis & Pecora, 2012) provide tentative supportive evidence but it would be helpful if future research could be structured to test more explicitly whether SDT is substantiated in the context of Signs of Safety, as it has been in other practice fields.

Contextual factors

While SDT literature lends empirical support to the underlying logic of Signs of Safety, the Realist methodology emphasises that, although a sound programme theory is crucial, having a sound programme will not in itself guarantee expected outcomes. Rather, the effects of Signs of Safety will also depend on the context it is introduced into.

For example, factors like workload, extent of bureaucratisation, alignment of forms and IT systems can influence *how much* Signs of Safety families experience since these factors can reduce the time social workers can spend with each family. If organisational factors draw workers time away from families, workers may not be able to spend enough time with families to sufficiently build families' sense of competence, relatedness and autonomy. Ineffective leadership may mean that Signs of Safety is not implemented in full, particularly where leaders do not sufficiently support workers to feel a sense of competence, relatedness and autonomy. Additionally, Signs of Safety relies on workers having sufficient prior social work knowledge and skills so that they can draw on these in the process of Signs of Safety. In the absence of sufficient baseline social work skills and knowledge, families may not experience quality Signs of Safety practice.

Suffice to say that if, for whatever reason, families only experience parts of Signs of Safety, we would not expect it to have the intended effects. This should not imply that Signs of Safety is ineffective but rather that it has not had *the opportunity* to have an impact and so the effect of Signs of Safety has not been tested. Borrowing a metaphor from medicine, families may not experience a sufficient "dose" of Signs of Safety for it to be effective.

The Realist Synthesis will set out in detail the theory of how and why key factors, including leadership, organisational culture, engagement of other services, high workloads, organisational alignment and the individual skills and mindsets of workers can affect Signs of Safety outcomes for children and families.

Conclusion

Overall therefore, by demonstrating the relevance of Self Determination Theory to Signs of Safety, the Realist Synthesis of Signs of Safety aims to offer an explanation of how and why Signs of Safety expects to achieve its outcomes that is grounded in a strong body of empirical literature spanning across a wide array of domains from healthcare to psychotherapy. However, the Realist Synthesis also emphasises that a sound programme alone is unlikely to be sufficient to consistently achieve expected outcomes. The context Signs of Safety is implemented into can result in families not experiencing the entirety of Signs of Safety or not experiencing enough of it for it to have an effect. Initial findings from the Realist Synthesis emphasise the need for future research that looks to say something about the effectiveness of Signs of Safety to thoroughly investigate whether or not services users are fully experiencing Signs of Safety. Where Signs of Safety has not been implemented in full, outcomes do not logically say anything about the effect of Signs of Safety. For this reason, the Realist Synthesis will investigate how key elements of context may combine with Signs of Safety to influence outcomes. The full report on the Realist Synthesis of Signs of Safety will be available on the Knowledge Bank when it is complete.

Empirical studies

A large body of literature has been published specifically about Signs of Safety. Some of these publications discuss the model's underlying theory, others report on experiences of implementing Signs of Safety, and others still on the impact Signs of Safety is seen to make. A full list of Signs of Safety related publications is available here. Table X illustrates the nineteen publications that specifically assess the impacts of Signs of Safety on children and/or families, along with the various factors that were considered in each analysis.

Before presenting details of the publications, there are some general considerations to take into account. Several researchers have undertaken, in various ways, the work of better understanding the difference Signs of Safety can make for children and families. To understand the difference Signs of Safety has made, it is first crucial to know how often and how well Signs of Safety practice and organisational alignment occurs so that any findings can be more confidently linked to Signs of Safety. Table X includes data on whether each study provided relevant information on breadth and depth.

Table X

	CONTEXT		BREADTH			DEPTH			IMPACT		
Publication	Organisational Factors (caseloads, IT alignment, form/policy alignment, collaboration with partner organisations)	Implementation Efforts (implementation strategies undertaken)	Frequency of practice methods used with families	Frequency of learning methods used in supervision	Frequency of leadership methods used within organisation	Practice Quality (including family engagement)	Supervision Quality	Leadership Quality	Child Safety Impacts (service trends or family/worker perceptions)	Family Impacts (wellbeing, court involved cases or rate of children in care or kin placement rates)	Organisational Impacts (job satisfaction or retention or workplace culture)
Baginsky et al (2017)		X	X			X	X	X	X		
Baginsky et al (2020a)	X	X	X			X		X	X		X
Baginsky et al (2020b)	X	X	X	X		X			X	X	X
Bunn (2013)			X			X			X		X
City and County of Swansea (2014)	X	X				X			X		X
Holmgård Sørensen (2013)			X			X			X	X	
Lohrbach & Sawyer (2004)						X				X	
Lwin et al (2014)									X		
Munro et al (2016)	X	X	X				X	X	X		
Munro & Turnell (2020)	X	X	X	X	X	X		X	X		X
Nelson-Dusek & Idzelis Rothe (2015)									X	X	
Nelson-Dusek et al (2017)									X	X	
Reekers et al (2018)						X			X	X	
Reeves (2018)	X	X							X	X	
Rodger et al (2017)		X							X	X	X
Rothe et al (2013)		X							X	X	
Skrypek et al (2012)						X			X		
Vink et al (2017)						X			X	X	

The majority (12 of 20) of the impact reports we have found do not consider either the breadth or the depth of Signs of Safety practice with families in the cases they are evaluating. Those that did (Baginsky et al, 2017; Baginsky et al, 2020a; Baginsky et al, 2020b; Bunn, 2013; Munro et al, 2016; Munro & Turnell, 2020) have consistently found that the implementation of the practice is inconsistent and incomplete. Fewer still consider how often and how well Signs of Safety methods have been incorporated into supervision, leadership, or other aspects of organisational alignment, while Munro & Turnell (2020) found these are the major factors in determining the relative success or failure of the implementation. Bunn (2013) has identified that the success of the implementation is associated with increased impact.

Some authors report point-in-time findings, Bunn (2013) found that 'using Signs of Safety means that action and change is more likely to happen with children and families' (p. 116). Holmgård Sørensen (2013) found 'the openness about the concerns and the involvement of the network results in a much better result for the child' (p. 21). Skrypek et al (2012) found that Signs of Safety 'holds promise as an effective method of engaging families in assessing and planning around child safety' (p. 2), but small sample sizes, minimal consideration of how often or how well Signs of Safety was utilised, and a reliance on only perception interviews limit the strength of these findings.

Various publications track impact over time, either in a pre-post or time series analysis. Lohrbach & Sawyer (2004) findings suggest a positive reduction in repeat child maltreatment. Nelson-Dusek & Idzelis Rothe (2015) and Nelson-Dusek et al (2017) found that those families using Signs of Safety were less likely to have a re-report within 6 and 12 months (frequently used time frames for studying impact on reducing recurrence). But again, small sample sizes and limited consideration of the presence or quality of the Signs of Safety practice, compromises these findings.

Pre and post-test comparison group evaluations have also been undertaken, which is considered a stronger research methodology by some. Lwin et al (2014) found that investigations using Signs of Safety mapping had significantly higher substantiation rates than the comparison group, while re-investigation rates within 12 months of closure were low (6%).

Vink et al (2017) and Reekers et al (2018) found that Signs of Safety did not significantly out-perform the comparison group in the area of parental empowerment or risk reduction. All these findings of difference can be questioned since there is little to no consideration for the 'dose' of the treatment; the breadth and depth of the Signs of Safety. Some may say that 'non-significant' differences suggest Signs of Safety does not have a significant impact, but this is difficult to assert without evidence about the extent to which Signs of Safety existed in the first place. These and other authors, including Sheehan et al (2018), have noted the small sample sizes of these studies as an additional limitation. Conversely, Baginsky et al (2020b) analysed a larger sample size as well as made attempts to consider 'dose' in spite of data limitations, and also found 'little evidence to support the claim that Signs of Safety leads to better practice or reduced risk for children' overall (p. 12).

There are no randomised controlled trials (RCT) of Signs of Safety and, in our view, this is not an omission but a realistic consequence of the complexity of the intervention. While the RCT methodology is useful in testing drug treatments in medicine, it does not produce equally useful results in complex social systems. The average effect reported in an RCT misses the complexity of how interventions produce effects. This can be less of a problem in testing a drug where the input can be precisely defined in chemical terms and where it is added to

a liver which has many similarities in its functioning whatever part of the world the patient lives in.

It is our position that pursuing evaluations with a focus on investigating the links between context, breadth, depth and impact is more appropriate and informative to understand what, how, for whom, and in what circumstances Signs of Safety works.

Administrative data

Child protection agencies typically collect an extensive range of data about how cases are processed through their system. Often the data collection is required by governments to monitor whether the organisation is meeting legal duties and as an indirect form of monitoring the quality of work done. Generally the data are of a quantitative not qualitative nature and provide, at best, only proxy evidence for the positive or negative impact that the service is having on the lives of the children and young people who need the help.

No single variable provides reliable evidence on impact on its own. A drop in numbers of children removed from their families may be due to improved skill in helping parents provide good enough care or to poor risk assessment leaving children in dangerous homes. However, administrative data can be useful in raising questions to investigate further what lies behind them. Also, the pattern of several sources of data can strengthen our understanding.

Several publications (City and County of Swansea, 2014; Reeves, 2018; Rodger et al, 2017; Rothe et al, 2013) have shown how many different service trends have shifted together in positive ways after implementing Signs of Safety. For example, Reeves (2018) illustrates how child in care rates declined by more than one third and court involved cases halved while re-occurrences of maltreatment remain stable from 2012 through 2018. City and County of Swansea (2014) saw a reduced rate of entry into care (from 47.21% to 39.25%) as well as a reduced re-referral rate (from 30% to 21%). Rothe et al. (2013) found a decrease in the number of placements and a decrease in the number of children re-entering placements after being reunified. Rodger et al (2013) noted a 23% reduction in children being looked after in care and a reduced re-referral rate, in addition to improved behaviour and school attendance of involved children. In each case though, the evidence is suggestive but not conclusive in showing that Signs of Safety was a major factor in creating the change.

Conclusion

The evidence available, taken together, suggests that Signs of Safety can have a positive impact on the safety and wellbeing of children and families, but not necessarily. Since Signs of Safety doesn't always lead to better practice or outcomes for children and families, more research is needed and there is a particular need for studies that include a measure of the breadth and depth of the Signs of Safety practice being experienced by families.

For those considering adopting Signs of Safety, a further question that needs to be addressed is whether they would be able to implement it AND make the organisational changes necessary (context) to make it easier for the front line worker to engage with families using Signs of Safety methods (with breadth and depth), supported by aligned supervision and leadership.

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Signs of Safety Implementation

Terry Murphy

1. The Challenges of Implementation

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

Adopting a practice framework is indeed thrusting a comprehensive change agenda into the complex system that is the child welfare agency. The challenges of implementation are substantial. Child welfare agencies are invariably mature organisations and as such Signs of Safety is brought into a dense environment of existing practice requirements set out in detailed forms, procedures, policies, protocols and measures, many of which are in turn embedded in an information system. Child protection agencies are busy, highly scrutinized organisations managing high levels of risk amidst uncertainty. These are not conditions that are naturally conducive to comprehensive organisational reform.

Practice requirements have usually been established over a long time, may rarely be considered afresh and are unlikely to be streamlined. When a new approach is adopted this is usually taken up as an add-on to everything else. Moreover, every form, procedure, policy, protocol and measure has its rationale and impact, author and advocates, making change and particularly letting go of established ways of working challenging. It is not difficult to foresee agencies becoming stuck in the face of making difficult alignments such as revising practice procedures, implementing information systems consistent with the practice and redeveloping quality assurance to be consistent with the practice.

Organisations will also have strongly ingrained cultural mores and implicit values, "the way we do things around here", some of which will be positive and conducive to the new practice approach and others that may not be. Many child protection organisations around the world face a defensive and compliance-focused culture that has become embedded. Entrenched reliance on experts and a focus on pre-determined risk factors can work against family participation and empowerment.

The cultural change potential of Signs of Safety practice has been emphasised throughout this briefing paper, as the purpose of Signs of Safety has it, "to create a system that rigorously addresses the issue of child abuse while doing everything humanly possible to put children, parents and every person naturally connected to the children at the centre of the assessment and decision-making, always giving these people every opportunity to propose and try their ideas to solve the problems before the professionals and agency offers or imposes theirs".

Meeting this purpose is a fundamental cultural shift in child protection work for many agencies, both in the practice and the organisation, and it takes courage and perseverance to see it enacted.

Implementation of the Signs of Safety, or any transformational improvement journey that has a real impact on outcomes, must be grounded in the practice. It is how practitioners actually do the direct work with children and families that needs to be the central concern of agencies. Much past reform work, from national reviews to local strategies, have addressed structures, procedures and professional development without addressing the question of how the work actually occurs with families and how that is enabled.

2. The Implementation Framework

The Signs of Safety implementation framework has the practice at the centre making it clear that it is the extent of deliberate organisational implementation that will determine the how much the practice is adopted and grows in quality. The practice both informs and is driven by the organisational developments involved in implementation. How the agency is led, the systems that direct and guide practitioners and what is measured are as critical as learning the new practice. The dynamic nature of implementation and the interaction of these key focuses of organisational development are reflected in the framework's depiction of a continuous learning and development cycle.

Illustration 1: Signs of Safety Whole System Implementation

The domains for action within the implementation framework are:

Learning	Core training followed by continuous learning in the workplace through collaborative learning methods grounded in practice.
Leadership	Congruence between how the organisation is led and managed and how the work is expected to occur alongside families.
Organisational alignment	Case management processes and systems — workflow, procedures and the information system for case recording and data — fitting the practice.
Meaningful Measures	Monitoring the breadth of the practice, the depth or quality of the practice and its impact for children and families.

The framework has been developed from the experience, successes and struggles in leading and consulting on implementations of Signs of Safety in jurisdictions around the world. The beginnings of the implementation approach, in Western Australia, have been critically reviewed and found to be broadly consistent with the tenets of implementation science (Salveron et.al. 2014). However, while the framework corresponds in some key respects to established theoretical approaches in implementation science (see for example Roger's diffusion of innovation theory (2003) and Fixsen's five stage implementation model (2013)), it has developed to reflect how child protection agencies are organised and the factors that make for relevant organisational change. As such, it wrestles with the complex and dynamic challenges pointed to in Pawson's quote.

The Signs of Safety implementation framework developed significantly through the work of the England Innovation Project from 2014 to 2019 (Baginsky et al 2017, Munro, Turnell and Murphy 2016, Baginsky et al 2020 and Munro and Turnell 2020). It continues to evolve with the experience of organisations and research.

Munro and Turnell's (2020) analysis of the reasons for some organisations doing exceptionally well with Signs of Safety, as reflected in independent inspectorate (Ofsted) assessments of "outstanding" and others struggling to make any progress, is most informative. It shows clearly that where leadership actively leads the implementation and in doing so is well engaged with the practice, and the organisation determinedly aligns its procedures and systems with the practice, progress is pronounced. On the other hand, where leadership is unstable and/or disengaged and the procedures and systems remain poorly aligned with the practice, there is either no progress or organisations can in fact go backwards.

It should not be surprising that a poor implementation could make an organisation's performance worse. Introducing a new way of practicing creates another set of demands into a busy, complex and contentious environment. Without clear leadership and making the parts of the system fit to allow space and clarity for the work, it is to be expected that there will be frustration as well as traction.

There are a set of key and overarching activities that experience has indicated to be mission critical, that is essential for effective implementation. This mission critical version of the framework provides a streamlined roadmap for Signs of Safety implementation.

3. Preparation to Implementation

The recommended Signs of Safety organisational implementation involves:

- A preparation phase of six to twelve months
- Two to three years of intense activity (or likely three for larger organisations)
- Continuing implementation activity and development through a five-year commitment.

Successful implementation requires preparation before a launch. Six to twelve-months' preparation is likely though it is understood that the real world may intervene and either truncate or extend this time.

As well as making and articulating a clear commitment to the decision to adopt Signs of Safety and establishing management and governance arrangements for the implementation, there are four key activities that provide a strong foundation for implementation:

- Introductions to the practice through briefings and written material for staff and possibly introductory training for leadership, with plenty of opportunities for discussion amongst staff and leadership.
- Whole system learning cases, described in more detail below, where the practice is applied to an end-to-end case with the participation of a cross section of staff and leadership, both to demonstrate the full practice and to begin to show up what enables and what impedes the practice in the organisation.
- Identifying the immediate potential blockages to the practice, such as contradictory procedures and recording in the IT system, and developing interim solutions to these, such as new interim guidance substituting Signs of Safety processes into the practice workflow and workarounds in the IT system.
- Detailed implementation planning with the involvement of as many leaders and staff as possible. The Signs of Safety implementation trajectory provides the basis for implementation planning, and templates are available (see the Knowledge Bank) but it is fundamentally important that the organisation identifies its own purpose and goals for the implementation, builds on its own unique strengths and addresses its own unique circumstances and challenges in its plan.

During the preparation phase the organisation will also be introduced to key Signs of Safety resources, described in some detail below, for early consideration in the implementation:

- Accredited Signs of Safety IT Solution
- Children and young people, family and staff feedback surveys
- Methods for measurement of practice breadth (dashboard) and practice depth (collaborative case review) and impact (core data and the feedback surveys)

The Implementation phase involves a period of two to three years. This is considered to be the shortest time possible to achieve the developments that have been demonstrated to be decisive in successful implementa-

tion. Doing so, however, requires a very strong and focused leadership effort and determined project management. All managers and leaders will have had the experience that "everything takes longer than expected", and this can be especially so in the contested, complex, cautious and highly scrutinised environment of child protection. Continuing implementation activity and development should be expected through the full five-year period that is the recommended commitment for organisations to make. Continuous practice and organisational development beyond this period should also be anticipated as the Signs of Safety evolves, new staff come into the agency, changes in leadership and political direction are experienced, and new social challenges affect the families with whom the agency works.

Annual reviews of progress and adjusting the implementation plan for the following twelve months is considered essential.

As the implementation proceeds it is likely that the agency will develop specific plans for different areas of service. This may include the areas of service that will be guided by adaptations of the Signs of Safety — Signs of Wellbeing for family support or early help services, Signs of Success for youth justice or youth at risk services and Signs of Belonging for children in care. Key workflow points such as Intake and conferencing if the agency has formal conferencing requirements may also warrant specific plans. Service localities should also have plans that identify their practice development priorities.

4. Learning

The most frequent error that organisations make in implementing new initiatives is to mistake training for implementation. For the majority of staff in the organisation training in the Signs of Safety will be the first step in their learning journey with the Signs of Safety within their agency and it is important that training is framed in this way.

Signs of Safety learning starts with two key trainings, an introductory training for all staff and advanced training. There are two alternatives to managing advanced training. Most commonly, advanced training is provided to supervisors and leadership, with supervisors and other key practice support positions taking on the formal role of practice leader and being expected to take the learning to teams particularly through group supervision. Alternatively, a reduced course of advanced training focusing on safety planning is provided to all staff on top of an extended introductory training.

The descriptions of training below set out a core program that most agencies undertake.

Programs tailored to an agency's specific needs at any time can be developed and are encouraged.

4.1 Introductory Training

The two or three day introductory course should be provided to all staff including all management and senior and executive leaders and key staff of partner agencies. The introductory training involves exploration of:

- The Signs of Safety practice methods
- The application of Signs of Safety practice through case examples

- Signs of Safety live application to an agency case
- Signs of Safety group supervision

Participants in the two-day introductory training will be introduced to these Signs of Safety practice methods:

- Mapping (assessment and planning)
- Questioning
- My Three Houses™ (child's voice)
- Words and Pictures
- Network Building (Family Finding)
- Participatory Conferencing/Family Network Meetings
- Safety Planning
- Trajectory/Timeline

Staff should have enough knowledge and confidence to commence using Signs of Safety mapping, questioning, My Three Houses™ and network building.

Practice and organisational leadership positions should be the first to be trained so that they can be confident in their leadership of field staff.

4.2 Advanced Training

Advanced training courses for practice leaders, and ideally all leadership of the organisation including senior and executive leadership, is provided through a five-day (or six-day on-line) course that looks to begin 3 to 6 months following the introductory training.

Alternatively, organisations may choose a core training package that includes three-day advanced training for all staff following three days basic training.

The advanced training for practice leaders and organisational leadership focuses on:

- Building a deeper understanding of the application of the Signs of Safety across the full gamut of cases and casework processes
- Building the key skills of questioning and family network meeting facilitation
- Teaching and practicing the group supervision and Appreciative Inquiry processes focusing on agency cases that supervisors and other practice leaders will be utilising with practitioners
- Preparing participants for their participation in the practice leader learning and development programme

The three-day advanced training course for all staff is similar but with less emphasis on the preparation of practice leaders and casework centred more around safety planning.

4.3 Practice Leader Learning and Development Trajectory

After the advanced training, the practice leader learning and development trajectory should commence. This involves a formal programme of coaching sessions with small groups of practice leaders every six weeks. The programme is focused always on how participants and the practitioners they are responsible for are using the approach, looking at successes and struggles. In this environment supervisors and practice managers build their individual and collective vision of the application of the approach in their agency and learn from each other.

The programme progressively builds participants confidence in using the Signs of Safety learning methods of group supervision and Appreciative Inquiry to deepen the use of the practice methods.

The practice leader learning and development sessions equip the supervisors and other practice support positions to lead the learning of field staff. Practice leaders can use the material and activities from their coaching sessions and apply these directly with staff in their own workplaces.

4.4 Learning in the Workplace – Group Supervision and Appreciative Inquiry

Group supervision is the key learning method to bring continuous learning about the practice into the workplace while assisting with the management of cases on a day-to-day basis. Its importance and impact as a regular practice cannot be overstated.

The Signs of Safety group supervision process (see Knowledge Bank) is designed to assist professional teams to become more agile and confident in operationalising the action learning cycle in practice — gathering information, analysing information, making judgement, taking action, tracking results, and reflection.

The group supervision method involves one person who has a case and a specific goal for the session to assist with their work on the case, a facilitator who helps the case holder narrow their goal so it can be realised, asks the case holder questions and sets case work for the group, and an advisor to the facilitator. The whole group works on aspects of the case (for example danger statements, safety goals and safety scale sets, or questions to use with the family). Sessions should take only between one half and a full hour and so be feasible on a regular basis.

By focussing on current cases and particular aspects of the practice, and involving whole teams, the continuous learning afforded through group supervision is integrated into the everyday work and experience of practitioners.

Deliberate Appreciative Inquiry in practice teams is a focused method for sharing good practice and building the culture of doing so. This should be reinforced through Appreciative Inquiries focused on both practice and other organisational issues being undertaken by leaders more broadly across the organisation. The method and theory of Appreciative Inquiry are described in the Comprehensive Briefing Paper.

Appreciative Inquiry as a method for deliberately seeking out and analysing successes and looking for where these can be replicated and generalised, and building the culture of generally looking for the positive, are quite critical for child protection organisations. Child protection practice, practitioners and agencies can readily become problem saturated, reactive and/or stuck. And this in turn can result in practitioners and management slipping into the default settings of authoritative practice — practitioners being the expert and telling families what to do — and the ever-growing proceduralisation of the practice that are increasingly counter-productive.

4.5 Agency Signs of Safety Practitioner Trainers

All implementing agencies need to be able to take over the core learning tasks of providing introductory training to new staff and continuing practice leader development. This should occur by the end of the two-to-three year implementation period.

To achieve this, agencies need to identify staff who will be both practitioners and trainers as it is critical that training staff remain grounded in the practice. They will participate in development and progressively work alongside the Signs of Safety consultant in delivering training and practice leader development coaching.

This is a substantial commitment to development by the agency and is a key aspect of sustainability.

5. Leadership

The complexity of child protection, and the contentious environment in which it operates, means that there is enormous potential for both confusion and lack of direction, and attempting to redress this with an over-reliance on procedures and oversight inquiries.

Effective implementation that results in Signs of Safety being used consistently across the organisation, and not just among the more enthusiastic practitioners in pockets of the organisation, requires active and engaged leadership.

5.1 Commitment and engagement

Leadership begins with a clear and explicit commitment to the decision to adopt Signs of Safety and undertake the system developments on which effective implementation depends. Commitment is not static, it needs to be restated and repeatedly demonstrated to a workforce that is likely to be subject to multiple pressures and competing organisational priorities and skeptical from having witnessed grand initiatives in the past that have faded.

The implementation needs to be actively led. Leadership commensurate with the scale of the change is required. The practice methods will be new and affect all practice, and for many will be a paradigm shift moving away from expert assessment and service brokerage towards participation, empowerment and balancing strengths against danger. The leadership effort and investment required for all the organisational systems and measurement to become aligned with the practice is substantial in the face of an already saturated organisation. Implementing Signs of Safety is not a change process that is another project, delegated by the executive to a competent manager with reports awaited.

Each organisation differs in its structures and child protection may be part of a larger service agency. Endorsement of the decision to adopt Signs of Safety and undertake the whole system implementation needs to be at chief executive and political levels. Leadership of the implementation needs the active involvement of the most senior executive leadership responsible for child protection. And it needs effort and participation from all levels of leadership from the senior to service and/or locality, and policy and quality assurance directors and managers. Comprehensive project management using the implementation plan and subsidiary plans is necessary.

Successful leadership of the implementation will be distributed leadership — building responsibility for the work of the organisation from the front counter to the chief executive. In an organisation where frontline and supervisory staff hold substantial authority, leadership must be distributed for the work to be effective. Distributed leadership means senior leadership both conferring an organisational leadership dimension to all roles throughout the organisation and expecting leadership to be exercised from all roles. Ghandi's exhortation for each of us to be the change we want to see captures this sentiment and possibility as well as the personal responsibility involved.

5.2 Modelling Signs of Safety

Leaders who are regarded by subordinates as "walking the walk as well as talking the talk", that is demonstrating congruence in their behaviour with the principles and the practice that workers are being directed to enact, have the most impact.

Modelling Signs of Safety practices means managing and leading in the same way that staff are expected to work with families. Sometimes called the parallel process, leadership can model the Signs of Safety approach particularly in the following visible ways:

- Asking questions and being curious, deliberately 'inquiring before requiring' particular actions.
- Applying the Signs of Safety principles (setting an expectation and example for effective working relationships across the organisation, being prepared to admit you are wrong, and being guided by the actual experience of families and workers),
- Applying key Signs Safety disciplines (using plain language, focusing on actual behaviour and avoiding labels) in everyday interactions.
- Building a culture of Appreciative Inquiry, deliberately seeking out practice and organisational strategies that are effective and examining these and how they can be extended. This means both undertaking specific Appreciative Inquiries periodically and demonstrating that the norm is to look first for what has worked, even in situations where it is counter-intuitive such as reviewing critical incidents.
- Using the three-column assessment and planning framework for strategic and operational planning and to address organisational challenges.

5.3 Fostering a safe and robust organisation

Modelling Signs of Safety should have the pivotal impact of fostering a safe and robust organisation. This is an essential counterbalance to the anxiety inherent in child protection work.

Fostering a safe organisation means building staff confidence that workers will be supported through anxiety, contention and crises. All child protection organisations have stories of when workers have not been supported by executive and political leadership. These stories corrode trust and lead to practitioners focusing on compliance and defensive practice rather than on outcomes for families. Fostering a safe organisation for the effective implementation of Signs of Safety involves two imperatives:

- Practitioners and immediate supervisors must be engaged to share anxiety upwards and never be left feeling that they alone are carrying the risk inherent in cases. This means having a good flow of contentious case briefings through management and ensuring there is questioning looking for rigor at each stage. When senior management does intervene in decision-making, it is important to support and involve the staff by doing so through the Signs of Safety processes of analysis and planning.
- An explicit commitment by executive leadership that, should a tragedy occur, they will fully back up workers who have done their best, within the capacity of the organisation, and have been frank and open. Sadly, tragedies are part of the child welfare landscape so this commitment will be tested. With every test handled well, trust and resilience increases. Any failed test has an exponentially greater negative impact. Executive child protection leaders should proactively prepare for tragedy. Turnell, Munro and Murphy (2013) describe leading for learning through a child fatality, based on a case study, and set out a step-by-step approach that exemplifies leadership that fosters a safe organisation.

Fostering a robust organisation is the counterpoint to fostering a safe organisation. This should flow from leadership demonstrating a stance of critical inquiry, modelling that it is OK not to have all the answers and on occasion to be wrong, and accordingly show that vulnerability and openness are critical strengths. Leaders need always to model the openness and vulnerability they expect from staff and can themselves 'give the practice a go' in public learning forums and lead by questioning. This promotes openness to the challenging professional development that adopting Signs of Safety can involve.

5.4 Leadership Trajectory

Parallel with the practice leaders learning and development sessions, the Signs of Safety leadership trajectory sets out a programme of leadership development activities for all leaders and specifies implementation developments where senior and local leadership is crucial.

The activities and focuses are under the categories of:

- Connection to the practice, to build the practice knowledge of leaders, know what is actually occurring in practice and demonstrate engagement to staff
- Leadership consistent with the Signs of Safety, demonstrating commitment and congruence with the approach
- Leading major alignment issues, for the systems and measurements that have the strongest impact on practice
- Leading planning, review and priority setting.

The activities in the trajectory are geared to meet the needs of the top tiers of management, and it best for there to be as much participation as can be achieved with the:

- CEO (and/or position responsible for child protection if in a larger agency)
- Senior and executive leadership
- Service, locality, policy and quality assurance directors and managers.

6. Organisational Alignment

6.1 Case management processes

Critical to success over time is that case management processes and recording come to match the Signs of Safety. This enables the practice and reduces time spent on redundant activities. If it is not achieved, contrary case management processes and recording impede the practice and significant amounts of workers time that could be spent with children and families is spent in front of computers.

Many agencies will have layers of policy, procedures, guidelines, priority instructions, accountability requirements, and reporting arrangements that have been developed over an extended time, and that are complex, prescriptive and time consuming and these must be addressed.

Most important are the forms that workers have to fill in and the case management procedures through which workers must progress cases and that are embedded in the IT system. These fundamentally drive how the work is conceived and carried out. Case management procedures also typically embed practice assumptions that may be inconsistent with Signs of Safety practice, creating for workers the confusion of working in two inconsistent conceptual frameworks.

Policies in comparison are not widely read and even in their slimmest versions generally constitute a voluminous amount of guidance. They are nevertheless essential, as they are the formal thinking and terminology of the agency and are a pillar for accountability, as well providing procedural direction for a wide range of actions.

The challenge is to have case management processes and forms that match how the Signs of Safety practice work occurs with families and children. Prescribed policies and procedures beyond the actual practice need to be limited to those that that are truly essential — the yardstick being the extent to which they actually contribute to the safety of children. And serious effort should go into ensuring that these requirements are streamlined.

The theory of change, set out in the Comprehensive Briefing Paper, explicitly recognises that implementation will involve workers and the organisation being caught between 'old' and 'new' policies, processes, operating systems and cultures. As alignment work proceeds, this disjuncture should be acknowledged and the aim of Signs of Safety being the approach for how to do the work and not another layer of work should be emphasised.

The key focuses will be on achieving case management processes and forms and guidance based on Signs of Safety and defining the Signs of Safety practice that applies at each stage of the agency's organisation of the workflow and making adaptations as necessary.

Given the starting point for many agencies, streamlining will be an important principle. This means simplifying, combining and culling procedures and policies including identifying and letting go of those that give an illusory sense of security to the organisation, particularly those that may have been developed after a crisis or review. At least some and likely many procedures and policies are retained largely because of the fear of political, oversight agency and partner agency reactions to their removal. However, if procedures add only to process and not to outcomes, they serve no purpose and add only burden, the hard work of achieving their removal should be undertaken.

Clear leadership coupled with engagement of front-line staff are necessary to proceed with both clarity and practicality about how the alignments should occur. The Signs of Safety implementation trajectory (see the Signs of Safety Knowledge Bank) envisages this alignment commencing after a significant proportion of staff are familiar and working with Signs of Safety and continuing through the two-to-three year implementation phase, Whole system learning cases can inform these alignments the necessary alignments and practice intensives can clarify and define the Signs of Safety practice at each stage of the workflow.

6.2 Whole system learning cases

The learning case process focuses on selected open cases chosen by the agency. The Signs of Safety consultant then leads a learning team made up of a cross section of agency staff including practitioners, supervisors, agency leaders and observers working together in regular sessions to apply the practice as fully as possible to that case. The process usually involves six to twelve sessions over a period of three to six months or longer, consistent with the life of the case.

The entire team focuses throughout on assisting the caseworker and supervisor to get the best possible outcome for the case. As the full Signs of Safety approach is applied in the case, the group learns about the realities of using the approach in their agency while identifying the organisational barriers that need to be addressed and the adjustments and support that are needed to enable the practice. To ensure there is time to consider the system wide learnings a review session is held every at every third or fourth consultation.

6.3 Practice intensives

The workflow for case practice is not a one-size-fits all product. What works in one agency while it may be a useful guide is unlikely to be fully applicable in another jurisdiction. Moreover, case practice decision-making and thresholds at each workflow stage are defined and constrained as much by taken-for-granted or intangible factors such as social conditions of families, agency culture, its appetite for innovation and worker's perceptions of management expectations as they are by policy and procedures.

Practice intensives are a key Signs of Safety learning and implementation method to design and co-create an agency specific case practice workflow that details how the Signs of Safety will be applied at each stage including intake, investigation and assessment, ongoing casework and for children in care. Since the casework application of the Signs of Safety approach is shaped by all levels of the agency, practice intensives always involve staff from across the agency, including senior leaders, managers, policy makers, trainers, and field staff.

Practice intensives are usually conducted over three days and they always focus on multiple open case files (sometimes many hundreds) and involve all participants working in small groups thinking through the appli-

cation of the Signs of Safety to those files. The small group case file work is guided through a draft file review template that has been co-created by the Signs of Safety Consultant with agency leadership and field staff in advance of the practice intensive. Whole group reflection and learning is elicited throughout the intensive and together all participants learn what works and what doesn't and where the barriers are to apply the approach within the agency. Through the three day programme the group successively adjusts the case review template preparing it for field application across the agency.

Practice intensives should be followed with policy and measurement developments to progress and monitor alignment.

6.4 Information system alignment

Aligning the IT system with the practice is the most effective means for aligning case management processes with the Signs of Safety.

IT systems are perhaps the most significant organisational driver of worker behaviour. Encompassing the forms and procedures, the prescribed steps in the agency's workflow, workers respond to the information that must be collected and recorded and its contingent steps and can come to see that as the work itself. As such, IT systems can be the biggest impediment to implementing a new practice approach or if aligned can be a major enabler.

The challenge with integrating the practice approach into the IT system is to be consistent with the assessment and planning, safety planning and timeline and trajectory of Signs of Safety without reducing or constraining these processes to filling in set forms. Consequently, implementing aligned IT goes hand in hand with Signs of Safety learning.

Implementing an IT system aligned to the Signs of Safety practice creates the necessity and opportunity for rethinking the existing proceduralisation of the practice. The effectiveness and efficiency of adopting the Signs of Safety practice will be maximised by streamlining proceduralisation. The agency's statutory framework will impose some requirements while frontline staff need to be the strongest voices in determining if and where recording over and above the Signs of Safety processes and statutory requirements are retained.

Flavell et al (2021) have reported on the process of development and implementation of the aligned IT system in North Tyneside in England. This included a time and motion study comparing the time workers spent in front of the computer recording cases before and after the implementation of an IT system effectively aligned to the Signs of Safety practice (an accredited Signs of Safety IT Solution). Time savings of over 50% were demonstrated. Ofsted (2020) also noted in its report on the agency assessing it as "outstanding", that "Particularly impressive is the way in which the local authority's electronic case recording system has been adapted to ensure that it helps rather than hinders this approach."

IT systems are also usually integral to data reporting, so it is important to give attention to automating practice measures that provide real time data that can inform supervision and leadership and be cross tabulated against outcome measures. This is discussed in the following section on meaningful measures.

Aligning the IT system occurs over the short and longer term. A new IT system is a potentially large investment and takes time to install and introduce to staff, so it is unlikely to occur immediately.

In the short term, to address immediate blockages to the adoption of the practice, guidance and/or workarounds can indicate placement of Signs of Safety analyses and plans within existing sections of the IT system's case record, while copies of the direct work with children, parents and the network can, if possible, be attached to electronic case files in the IT system.

Consideration and planning for a long term aligned solution should commence as soon as possible.

6.4.1 Signs of Safety IT Solution

Elia International, the home of Signs of Safety, has partnerships with several IT companies to provide an accredited Signs of Safety IT Solution.

The Signs of Safety IT Solution provides a case management system aligned with the practice and delivers data to inform supervision and leadership. The Signs of Safety IT Solution embeds the practice and implementation logics and tools of the Signs of Safety approach into an agency's IT system through the following components:

- Case management, with a suite of detailed forms to manage and record the overall Signs of Safety practice. Signs of Wellbeing for family support cases, Signs of Success for youth justice and Signs of Belonging for Children in Care are also included.
- Forward facing software tools that practitioners use directly with children, young people and their families.
- A system of business intelligence, equipping the organisation, both leaders and practitioners, to interrogate and make sense of the gathered data including practice activity and service delivery outcomes.
- Practice guidance documentation and integration with the Signs of Safety Knowledge Bank to support the use of the model at each stage of involvement.

The Signs of Safety IT Solution is always delivered through the agency's IT system. Elia International can work with the agency to integrate the solution into its existing IT system which is the more cost effective and quickest approach. Alternatively, the Signs of Safety IT Solution can be built into a full replacement system.

6.5 Partner agency engagement

From the outset and throughout the implementation, organisations will look to build engagement with partner agencies. Child protection work often occurs in tandem with law enforcement, many families are (or have been) working with multiple welfare agencies, all have links with universal education and health services, and many will have or need engagement with specialist services like mental health and drug and alcohol services. Partner agencies need to understand how the child protection organisation works with families and children and look to participate in that on occasion and work in a compatible way.

Harnessing and co-ordinating the interdependency of different professional services is complex. Each profes-

sional service tend to have its own philosophical foundations, language and priorities. Child protection may be regarded by other services as either to be avoided or solely responsible when there is risk of harm to children, as a direct result of their experience of authoritative child protection practice, gatekeeping and/or weak partnerships. Therefore, real issues encountered by other social services can either be overlooked or exaggerated. As the first principle of Signs of Safety emphasises, working relationships are fundamental, and this applies to relationships between professionals as well as with families.

What is required is a combination of:

- Formal collaborative arrangements including committees, of which the English Local Children's Safeguarding Boards remain the best example, and the necessary agreements for effective information sharing.
- Targeted practice learning, so that partners are introduced to the practice approach, both its philosophy and the practice methods in which they will participate.
- Aligned referral and reporting forms so that the way of thinking about cases and interacting with families is more consistent between partners and child protection, from referral and as the case proceeds.
- Shared day-to-day practice with the families in assessment and planning as part of family network meetings.

6.6 Structural adjustments

Most child protection agencies or divisions of larger agencies understand the necessity for short and direct management and accountability lines and have these in place.

Occasionally child protection can find itself embedded in an organisation where there are extended lines of accountability and convoluted responsibilities for core business support functions that distort direct lines of accountability and work against leadership's understanding, connection to and ability to effectively lead front line service delivery. Two damaging behaviours tend to accrue with elongated and convoluted accountability lines. First, there is slippage into the default position of management adding new practice requirements and accountabilities and reporting whenever shortfalls in practice are revealed or there are reviews. And there are always apparent shortfalls and reviews. Second, the most contentious and stuck cases tend to reach the highest level of accountability and there is a natural tendency to intervene. Case management from 30,000 feet as Turnell describes it in the Comprehensive Briefing Paper is rarely effective and invariably damaging to the frontline of the organisation. If this case direction is coming from the political level of leadership the negative impacts are exacerbated.

While the immense costs of organisational restructuring need to weighed carefully — organisational inertia, loss of direction, diverted focus from core business — if there are serious distortions being caused by the lines of accountability, these should be adjusted to be as short and direct as possible. Similarly, if support functions are convoluted, this should be addressed with a view to minimising multiple oversight and development centres and the key areas of child protection policy and professional development being adjusted to be as close to and embedded with the front line as possible.

7. Meaningful Measures

Organisations are, to a significant extent, driven by what they measure and record. Most child protection organisations measure and attempt to analyse an enormous amount of data. Organisations can nevertheless struggle to connect the data they collect with the outcomes for families and children and what is needed to drive improvements in the adoption and quality of practice. And similarly, frontline staff may struggle to see that their day to day work is assisted by much of what they have to measure and record.

It should be self-evident that what organisations measure needs to be meaningful to the people who do the work and helpful for the practitioners and leaders to improve practice and the organisation.

The underlying rationale for the Signs of Safety approach to measurement is that organisations understand and learn from inquiry into the lived experience of service recipients (children, and young people parents, extended family and naturally connected support people) and practitioners. It is the experience and interactions of the people who are living the recipient and delivery sides of the practice that the organisation is seeking to shape and that are the basis of outcomes.

To understand what practitioners are doing and experiencing and what children and families are experiencing and how they are responding, meaningful measures focus on the breadth, depth and impact of the practice:

- Breadth of the practice measures what practice has occurred in each case and informs the strategies of practitioners, supervisors and organisational leadership
- Depth of the practice assesses the quality of the practice in a way that can assist the practitioner and the supervisor
- Impact of the practice measures outcomes for children, young people and families.

7.1 Signs of Safety Measures of Practice Breadth, Depth and Impact

7.1.1 Children and young people, parent and staff surveys

Surveys for children and young people, parents and the workforce have been developed drawing on research on Signs of Safety fidelity and safety and organisational performance literature and these have evolved through successive implementations. The surveys provide a formal and quantitative means of collecting the representative view of children and young peoples' and parents' experience of the practice and staff's experience and confidence with the practice and attitudes towards their organisation. As such they provide indications of the breadth, depth and impact of the practice.

It is recommended that children and young people, parent and staff surveys provide baseline data for the implementation and are repeated regularly. Parent and staff surveys completed over five years of the England Innovation Project provided the primary source of data for Munro and Turnell (2020).

7.1.2 Case management dashboards

The case management dashboard measures the breadth of the practice. It is designed to monitor application of the practice methodology for each open case as it progresses. It can provide data at individual, team and

organisational levels.

The practice methods in line with the theory of change and outcomes logic constitute the dashboard categories with simple yes/no/how many reporting. The dashboard illustrated below encompasses the end-to-end practice methods that can then be tailored to work at each stage of the agency's case management workflow.

	Harm Matrix	Mapping Internal	Mapping with family	My Three Houses	Danger statement	Safety goal	Safety scale	Timeline and trajectory	Words and Pictures	Network	Safety plan (adult version)	Safety plan (child version)
Child												
Child												
Child												

Illustration 2: End-to-end Signs of Safety dashboard

The dashboard shows the extent to which the practice is actually being applied and the data for groups of closed cases can be cross tabulated with their case outcomes to provide indications and of impact.

It is possible and indeed the dashboard was developed as a manual tool used by supervisors. Spreadsheet data recording enables broader tabulation and use of the data. Ideally the dashboard is integrated into the IT system and so collected automatically.

7.1.3 Collaborative case review

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

Collaborative case reviews assess the depth of the practice.

7.2 Core data

The collection and reporting of data can be so comprehensive as to compromise its interpretation and effectiveness, and compliance with data driven practice requirements can distort the practice.

Working with a collection of agencies in the England Innovation Project in 2016, Munro, Turnell and Murphy and these agencies proposed that a limited set of data that is already in place be collected and used for national reporting and to measure case trends. This demonstrated that meaningful and comprehensive data collection can be achieved with a substantial streamlining. This is published in the Signs of Safety Meaningful Measures — QA System (see the Knowledge Bank).

In establishing a core data set for an agency, the goal is to focus and simplify data collection and analysis rather than establish new elaborate data collection and reporting processes. The core data are likely to be built around the following basic indicators and their timeliness:

- cases referred to child intervention
- child intervention assessments
- cases managed through family support
- child intervention court orders
- children being brought into care
- re-substantiation of abuse
- staff separation rates

These data provide for an assessment of the impact of the practice. They will, however, be affected by the multiplicity of factors affecting the work of the child protection agency from levels of resources to the social conditions of communities. Cross tabulation of the practice dashboard and core data provides for some causal analysis more closely focussed on the impact of the practice.

7.3 Signs of Safety Quality Assurance System

Initially developed through the England Innovations Project and published in 2016, Munro, Turnell and Murphy have sought to operationalise meaningful measures by combining the Signs of Safety measures of breadth, depth and impact with core data to form the Signs of Safety Quality Assurance System (see the Knowledge Bank).

The system anticipates that the data from these measures will inform learning cycles in the organisation. Dashboards and collaborative case audits provide data in real time close to the practice and should be useful in day-to-day management. Surveys and core are point in time and periodic measures but provide whole of organisation views. The cross tabulation and analysis of data from these sources can provide for causal analysis of the impact of the practice.

Signs of Safety Quality Assurance System

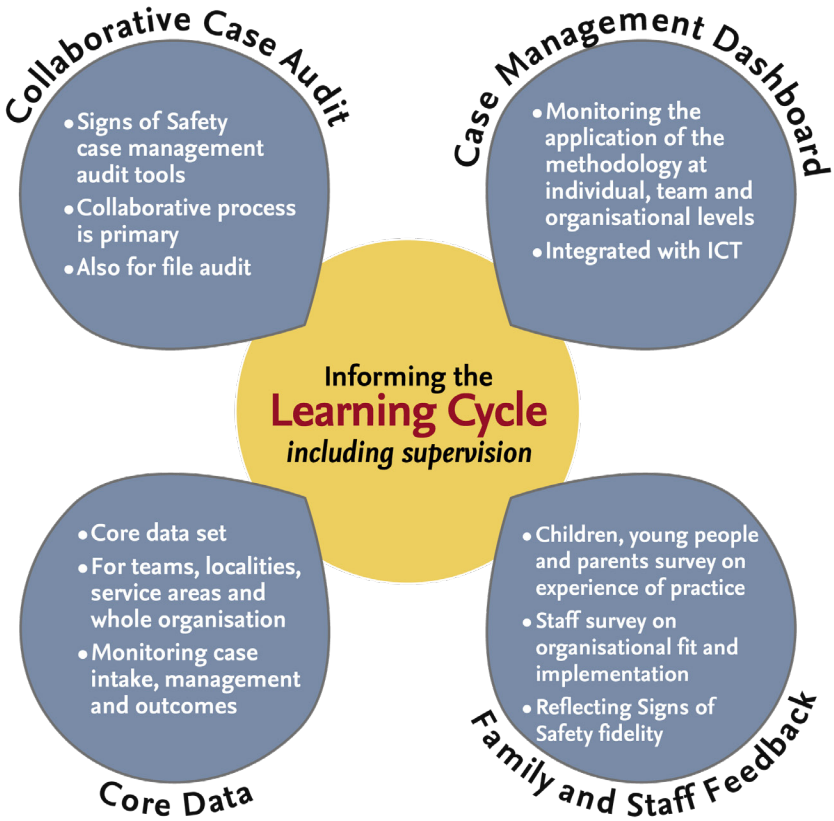

Illustration 3: Signs of Safety Quality Assurance System

It is fundamentally important that agencies review their own data and quality assurance arrangements and determine how they will achieve alignment with the practice. Many organisations have comprehensive systems and substantial resources devoted to the collection, analysis and reporting of quality assurance and activity data. The Signs of Safety quality assurance system and the specific measures of breadth, depth and impact can inform such a review and the following principles are recommended:

- Measures prioritise the experience of children and young people, parents and practitioners
- Measures are meaningful to the people responsible for the work
- Measurements include data that is collected and available as close as possible to real time

8. Whole of Person, Whole of Organisation

Implementation of Signs of Safety recognises that children's services are very complex human services delivered in highly contested and anxious environments.

The quality, consistency and reliability of services rest ultimately on the humanity and abilities of the people delivering the services to the children and families. In addition to adopting the practice approach and aligning the organisation to enable the practice, to improve child protection services the agency should also be attuned to a 'whole of person' perspective. Such a perspective aims to support the growth of the analytical, emotional, social, cultural and spiritual intelligence of frontline and leadership staff, so they can think and act wisely as they

navigate the family, practice and organisational complexities entwined in every case.

'Whole of person, whole of organisation' thinking is primarily about connection and compassion. The aim must be to infuse the child protection endeavour, from the boardroom to the family's living room, with compassionate and holistic intelligence.

So, the implementation framework touches all aspects of how the agency works, the leadership, learning strategies, organisational arrangements, how the work is recorded and measured. All of these, as well as the practice model itself must be fit for purpose and the ultimate arbiters of what works are the families and the practitioners.

This does not mean, however, that families on their own somehow magically have the solutions or that practitioners know all the answers. Distilling the wisdom of the families requires refined expertise of practitioners; and that expertise develops in organisations that aim to grow and nurture their practitioners. For all staff in children's services organisations, leaders and frontline workers, growing their expertise rests somewhat with being emotionally, psychologically and physically well.

Developing this focus of implementation is perhaps the final challenge.

Distributed leadership sets the context and drives commitment if everyone, from the front counter to the executive suite, shares responsibility for success or failure in the work and the culture of the organisation in which it occurs. Goffee and Jones' (2000) work on authentic leadership is also helpful here. It emphasises that successful leadership is always relational. Drawing on substantial research, Goffee and Jones argue that leaders must do three things: really care about the work and the people doing the work, expose themselves and so be vulnerable, and act as leaders, knowing when to be one of the team and when to rise to define the consensus and/or direct the team. In turn, they identify that followers want four things: authenticity, knowing that what you see is what you get, a sense of significance in their role, some excitement and a sense of being part of something bigger and worthwhile. And we need to remember everyone in the organisation is both a leader and a follower.

Implementation of the Signs of Safety will continuously involve activities through which staff and leaders will have the opportunity to be challenged and grow as professionals and as people. It will regularly call on our empathy, humility, vulnerability and compassion.

9. Staying the journey

Agencies seek out the Signs of Safety practice framework and it generally gains substantial immediate traction and then becomes progressively well understood and accepted by the majority of staff. In contrast, agencies tend to discount the criticality of whole system implementation without which full adoption of the practice and its continuing growth in effectiveness is compromised.

Most agencies have a history of pursuing new developments and many will have multiple practice improvement initiatives underway, not necessarily with clear integration or prioritization, and this can result in as much confusion and skepticism as development.

In a lot of agencies, leadership does not actively engage in the implementation to the extent necessary for essential developments to occur. External pressures and crises can draw leadership away from the core endeavour of the agency. Leadership can instead be focused on what it sees as higher order strategic priorities such as political relations and agendas, partner relations, budget, governance and accountability, public relations and initiating new developments.

It is readily understandable that agencies can become stuck in the face of making substantial and difficult alignments such as revising practice procedures, redeveloping information systems and overhauling quality assurance.

The implementation of the Signs of Safety can involve paradigm shifts that are belied by the obviousness of its approach. Authoritative practice and over proceduralisation are more entrenched than organisations may realise. Organisational transformation may be more necessary than originally considered when committing to the approach. Implementation and the attendant transformations indicate a journey that requires perseverance, agility and courage. The same courage that is demanded of workers as they knock on the door of a referred family for the first time.

Staying the journey is likely, at times, to require managing politics not only within the organisation but with executive government, partner agencies, oversight authorities and with the media, and it will be occasioned by inevitable setbacks. Being positioned to do so successfully requires:

- building 'capital' with partners and politicians by helping them to understand the real nature of child protection work and the practice,
- building recognition that growing people and organisations takes time,
- building recognition that tragedies and contention are inherent in child protection, and
- being credible and reliable, and demonstrating the early and continuing good practice and outcomes that come with Signs of Safety.

Finally, there are significant benefits to engaging with other agencies, nationally and internationally, that are also implementing the Signs of Safety across jurisdictions and collaborating in research. It is the agencies that are implementing Signs of Safety that drive continuing innovation in the practice and the implementation approach. The community of agencies, and increasingly the community of Aboriginal-First Nations practitioners and agencies (Elia 2020), create powerful shared practice learning, as outlined throughout earlier chapters of this briefing paper. The community of agencies also provides the means for sharing organisational implementation experience and resources across organisations.

Signs of Safety Resource Documents for Implementing Organisations

Available through the Signs of Safety Knowledge Bank:

- **Signs of Safety Implementation Framework and Trajectory**
- **Signs of Safety Practice Leaders Learning and Development Trajectory**
- **Signs of Safety Leadership Trajectory**
- **Signs of Safety Meaningful Measures — QA System**

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