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Randomised Controlled Trial of the ISAFE Training and Organisational Development Programme (Improving Safeguarding through Audited Father-Engagement)

Intervention Developer	The Fatherhood Institute CASCADE, Cardiff University
Delivery Organisations	The Fatherhood Institute CASCADE, Cardiff University
Evaluator	Ipsos UK
Principal Investigator	Raynette Bierman
Protocol Author(s)	Raynette Bierman, Karl Ashworth, Ellis Akhurst, Jessica Ozan
Type of Trial	Non-blinded two-armed cluster randomised controlled trial with social worker teams randomised to a treatment or control group
Age or Status of Participants	Professionally registered and qualified children and family social workers Trainee social workers, including apprenticeships
Number of Participating Sites	8 English local authorities Cohort A: Somerset, Havering, Wiltshire, Birmingham Cohort B: Merton, Durham, Norfolk, Surrey
Number of Beneficiaries	c.480 social workers
Primary Outcome(s)	Father engagement practices (multi-dimensional measure)
Secondary Outcome(s)	Rates of father engagement Self-efficacy (intermediate outcome/mechanism) Team culture (intermediate outcome/mechanism)
Contextual Factors	Age Gender Professional experience Caseloads

Summary

In response to incidents of services' failure to routinely and systematically engage, assess, support and challenge men in families, ISAFE (Improving Safeguarding through Audited Father-Engagement) is a training and organisational development intervention, developed by the Fatherhood Institute (FI) and CASCADE, to improve engagement with fathers by local authority children's services. In the context of this project, the term 'fathers' includes other male caregivers such as stepfathers, parents' partners, and other significant men in children's lives. The intervention is delivered by FI and CASCADE trainers over a 4-month period and includes:

1. Training programme for children and family social workers covering two modules:
    a. i) father engagement techniques and
    b. ii) motivational interviewing.
2. Quality assurance (QA) audit training focused on monitoring father engagement.
3. Champion training of middle-management social workers.
4. A webinar delivered to local authority senior leaders.

Overall, there is a relatively small evidence base on the effectiveness of interventions, like ISAFE, that aim to improve how social workers engage with fathers. This is in part due to the limited number of interventions focused on engaging fathers specifically, given that most training and models for social work encompass the whole family. This evaluation will contribute to building this evidence base by assessing the efficacy of ISAFE using a non-blinded, two-armed cluster randomised controlled trial (RCT). Eight local authorities will identify six teams to take part in the trial, totalling 48 teams. The teams will be randomly allocated to the treatment or control group (24 in each). It is expected that each team will have approximately 10 social workers, totalling 480 social workers for the trial.

The primary outcome for the RCT will be father engagement practices among social workers in children's social care services, measured using an adapted version of the Father Engagement Questionnaire (FEQ; Jiang et al., 2018). The FEQ is a multidimensional measure of father engagement practices, and the following sub-scales will be used:

Confidence in Working with Fathers; Competence in Using Engagement Strategies; Perceived Effectiveness of Engagement Strategies; Frequency of Strategy Use; and Organizational Practices for Father Engagement.

The secondary outcome will be rates of father engagement based on questions adapted from Scourfield et al. (2012) that ask about social workers' caseloads and their self-reported engagement with fathers. Recognising limitations of self-reported data, the evaluation will also examine aggregated, anonymised administrative data on father engagement. This data is not readily available across local authorities and typically requires case reviews. Part of the ISAFE intervention involves working with QA staff to review case files and/or create systems and processes (e.g. dashboards) for collating this information, which will be made available to the evaluation team to help triangulate with self-reported data. Other intermediate outcomes that will be measured include social workers' self-efficacy and team culture using scales adapted from two previous studies that informed the development of ISAFE (Scourfield et al., 2012; Scourfield et al., 2015). These are understood to be potential mechanisms through which the primary and secondary outcomes arise. Outcome measures will be collected through an online survey at three timepoints: baseline (before ISAFE begins), endline (after ISAFE finishes), and a 3-month follow-up.

An implementation and process evaluation (IPE) will explore factors affecting implementation to understand how and why ISAFE does or does not have the desired impact. This is especially important given that the intervention in its proposed form has not been previously delivered or evaluated. The IPE will involve qualitative research with the programme implementers (FI/CASCADE), social workers, and QA staff. The IPE will also include analysis of attendance data to understand the typical amount of the intervention received by social workers. Furthermore, the IPE includes a small number of interviews with service

users (fathers and mothers) to capture their experiences and any perceived downstream effects of the training.

The evaluation team will collect costs from the programme implementers between February – March 2024. Costs for set-up (one off) and recurring costs will include staff time, recruitment and training costs, equipment costs (e.g. online platform, website), and any other overheads. Estimates of costs per team and per LA will be calculated.

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Intervention overview

Services' failure to routinely and systematically engage, assess, support and challenge men in families has been highlighted repeatedly over several decades, in inquiries into cases where children have died or been seriously injured. A recent report by the National Child Safeguarding Practice Review Panel called for urgent reform to services' response to men (NCSPRP, 2021). Lack of attention to fathers has featured in numerous high profile child murder cases, including 'Baby P' (Community Care, 2010), Kyrell Matthews (Guardian, 2021), Arthur Labinjo-Hughes (Guardian, 2022) and Logan Mwangi (Mail Online, 2022).

Some fathers pose a risk to children. For example, an average of eight infants per year are killed by homicidal fathers, and evidence suggests infants may be more likely to be killed or seriously injured by fathers than by mothers (Davies and Goldman, 2021). However, fathers, like mothers, can also be a resource for their children, as can paternal relatives. Social work should routinely engage with *all* parents and adults around the child with both risk and potential benefits in mind. A key assumption underpinning this intervention is that social workers would be better able to engage and assess fathers – more successfully and systematically – through a father-focused intervention.

ISAFE (Improving Safeguarding through Audited Father-Engagement) is an online learning and organisational development package, developed by the Fatherhood Institute (FI) and CASCADE (the Children's Social Care Research and Development Centre, based at Cardiff University), to improve engagement with fathers (including stepfathers, parents' partners and other significant men in children's lives), by local authority (LA) children' social work services. The intervention is new but builds on two previous initiatives developed, delivered, and evaluated by FI/CASCADE, which showed promising findings (Scourfield et al., 2012; Maxwell et al., 2012; Scourfield et al., 2015).

ISAFE is delivered online to teams of children and family social workers, including their team leaders, quality assurance (QA) managers who monitor their work, and LA leaders who shape the design and delivery of services. The programme works through two pathways:

- A practice pathway that aims to achieve positive changes in: 1) social workers' awareness and knowledge of fathers' impact and the importance of father-inclusion; 2) in their skills and confidence including skills for more effective engagement with fathers; and 3) in their beliefs, attitudes and everyday practice.
- A systems pathway to bolster the practice pathway, aiming to achieve: 1) improvements in routine collection and analysis of data about fathers; 2) enhanced support for social workers; and 3) stronger leadership around, and advocacy for, team-wide father-inclusive approaches.

The intervention includes:

- training for social workers, to help them understand the need for, and do the best possible job of, engaging with men in families (including men ranging from very low to high risk); and to develop their practice skills for difficult conversations with fathers about child protection concerns, in ways more likely to foster meaningful dialogue, via an introduction to motivational interviewing.
- training for QA staff, in how to monitor social workers' father-engagement routinely and systematically.
- training for team champions, to help them lead and support their colleagues to do the best possible job of engaging with fathers.
- support for senior leaders through a webinar, to push through changes in policies and systems that will make father engagement part of LAs' routine, everyday work.

It is anticipated that ISAFE will lead to measurable increases in engagement with fathers. In turn, this is expected to enable better identification of risk in families and better-informed, more assertive decision-making. In some cases, this may lead to greater inclusion, where it is safe, of fathers and/or other male caregivers in child protection plans and kinship care placements. In other cases, this may lead to strengthening protective measures.

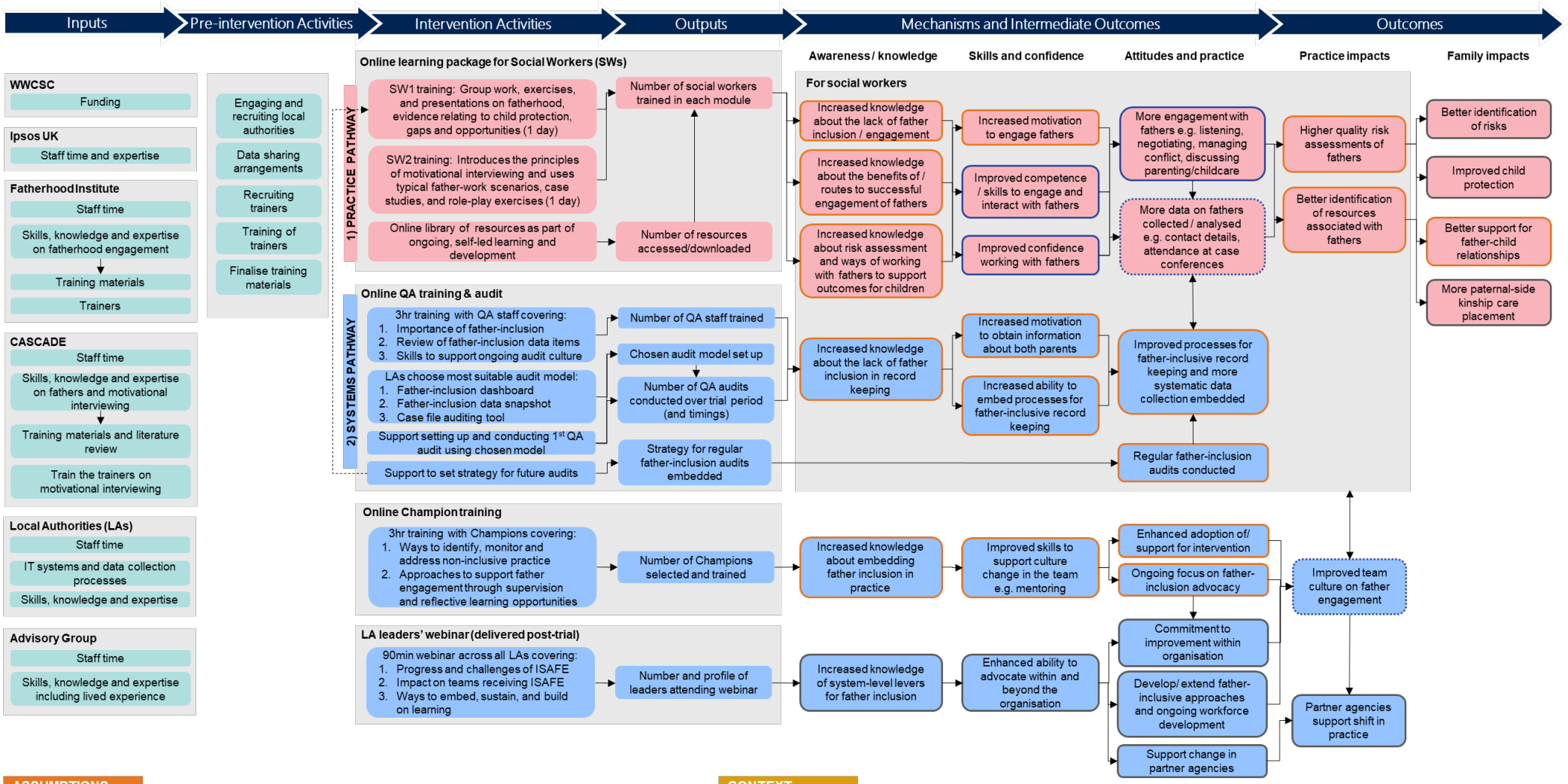
This study will involve FI/CASCADE delivering ISAFE in eight English LAs that face different social and geographical challenges. This includes:

- Birmingham
- Durham
- Havering
- Merton
- Norfolk
- Somerset
- Surrey
- Wiltshire

The logic model for ISAFE is provided below, which provides further detail about the intervention activities and anticipated pathways leading to the intended outcomes. This was collaboratively developed by team members from FI, CASCADE, Ipsos (and academic advisor Dr Jon Symonds), and the What Works for Children's Social Care (WWCSC).

More information about ISAFE is provided in the Intervention Protocol.

Rationale: Fathers, like mothers, can be a resource for their children. However, some fathers pose a risk to children. Although social work should routinely engage with all parents and adults around the child with both risk and potential benefits in mind, high-profile inquiries into cases where children have died or been seriously injured highlight a systemic failure in children's social care to routinely and systematically engage, assess, support and challenge men in family cases. The reasons for this are complex and multi-layered, including fathers being less likely to engage as well as social workers' beliefs, attitudes, confidence and individual practice. The evidence also suggests a lack of systemic focus on father-inclusion in local authority processes, leading to low recognition of this issue.



ASSUMPTIONS

- (Delivery) SWs need distinct father engagement training to achieve outcomes.
- (Delivery) SW teams and wider LA staff have the willingness, capacity and resources to engage in the training.
- (Delivery) Trainers deliver training of a sufficient quality to achieve outputs.
- (Delivery) Staff continuity/ retention sufficient to support training delivery.
- (Theory) Increase in awareness/knowledge/ skills confidence lead to improved motivation to engage fathers (and practice).
- (Theory) Better father engagement by social workers leads to better outcomes for children in social care (there is limited evidence to support this, though there is evidence to demonstrate the reverse of this).
- (Delivery) Data collection contains relevant and quality data on father engagement to support case file review processes.
- Performance management in local areas supports the delivery of systems change regarding fathers engagement.

CONTEXT

Enabling factors:

- Ability to show good practice in response to National Safeguarding Panel Report
- Acknowledged need to reduce looked-after-children rates
- Low baseline of father engagement so good potential for progress
- Good practice to show Ofsted
- Avoidance of negative publicity around lack of attention to fathers in isolated cases of child death

Inhibiting factors:

- Traditional assumptions about gender in practitioner culture
- Fear of aggressive men and lack of services to refer to
- Very high percentage of domestic abuse on caseloads
- Very high staff turnover & lack of time for training

Key

- RCT primary outcome
- RCT secondary outcome
- Broader evaluation
- Out of scope
- Practice pathway
- Systems pathway

Evaluation Questions

There is a well-established evidence base demonstrating the importance of the role of fathers to children's development and wellbeing. Simultaneously, studies repeatedly find that multiple services, including social work, tend to focus on mothers and deprioritise, or sometimes actively exclude, fathers – even when there are potential risks of harm for the child. Despite this, there is a relatively small evidence base on the effectiveness of interventions, like ISAFE, that aim to improve how social workers engage with fathers – in part because there are limited interventions of this nature. This evaluation will contribute to building this evidence base by assessing the efficacy of ISAFE using a non-blinded two-armed randomised controlled trial (RCT).

Alongside the RCT, an implementation and process evaluation (IPE) will explore factors affecting implementation to understand how and why ISAFE does or does not have the desired impact. This is especially important given that the intervention in its proposed form has not been previously delivered or evaluated.

The table below details the key evaluation questions, in line with WWCSC seven core evaluation questions.

Generic Questions	Specific Questions	Study
Does the intervention work?	Q1. What effect on social workers does taking part in ISAFE have on their father engagement practices (primary outcome), compared to social workers who do not receive the intervention?	Impact Evaluation
	Q2. What effect on social workers does taking part in ISAFE have on rates of father engagement (secondary outcome), compared to social workers who do not receive the intervention?	Impact Evaluation
Does the intervention work as expected?	Q3. What effect on social workers does taking part in ISAFE have on their self-efficacy associated with engaging fathers in child protection assessments, interventions, and safeguarding (intermediate outcome/mechanism), compared to social workers who do not receive the intervention?	Impact evaluation IPE
	Q4. What effect does taking part in ISAFE have on organisational / team culture relating to father engagement (intermediate outcome/mechanism), compared to social workers who do not receive the intervention?	Impact evaluation IPE
	Q5. To what extent is the ISAFE theory of change validated?	IPE
Does the intervention work differently for some groups?	Q6. Do outcomes (and experiences) vary by characteristics of social workers (gender, age, experience i.e. years since qualified)?	Impact evaluation IPE
Does the intervention work differently in some	Q7. Do outcomes vary across teams and/or local authorities?	Impact evaluation IPE

places?		
Was the intervention implemented as intended?	Q8. **Fidelity**: To what extent was ISAFE delivered as intended/planned? This will be considered as a whole and a more granular level looking at 1) QA audit training 2) social worker training 3) the role of champions.	IPE
	Q9. **Feasibility**: What are viewpoints on the feasibility of implementing ISAFE? What barriers and enablers were encountered, and how were these addressed?	IPE
	Q10. **Reach / Dosage**: What is the intervention's reach? How much of the training do social workers receive (vs. intended dosage)?	IPE
	Q11. **Quality / Responsiveness**: How acceptable do participants find ISAFE (e.g. content, number of training sessions, online material)?	IPE
	Q12. **Adaptations**: What adaptations have been made to make the programme more acceptable to participants?	IPE
Is the intervention a good use of resources?	Q13. What is the **cost** of ISAFE a) in total, b) per LA, and c) per team?	Cost analysis
What else have we learned?	Q14. **Programme differentiation**: Is it viewed as an improvement on services as usual? Is ISAFE seen as a good fit with professional/service norms and with needs of parents, carers and families?	IPE

Impact Evaluation

Specific Evaluation Questions

The specific evaluation questions for the impact evaluation are:

Q1. What effect on social workers does taking part in ISAFE have on their father engagement practices (primary outcome), compared to social workers who do not receive the intervention?

Q2. What effect on social workers does taking part in ISAFE have on rates of father engagement (secondary outcome), compared to social workers who do not receive the intervention?

Q3. What effect on social workers does taking part in ISAFE have on their self-efficacy associated with engaging fathers in child protection assessments, interventions, and safeguarding (intermediate outcome/mechanism), compared to social workers who do not receive the intervention?

Q4. What effect does taking part in ISAFE have on organisational / team culture relating to father engagement (intermediate outcome/mechanism), compared to social workers who do not receive the intervention?

Q6. Do outcomes (and experiences) vary by characteristics of social workers (gender, age, experience i.e. years since qualified)?

Q7. Do outcomes vary across teams and/or local authorities?

The RCT will focus on Q1 as the primary outcome with additional analyses for Q2-7. The RCT design is detailed below.

Design

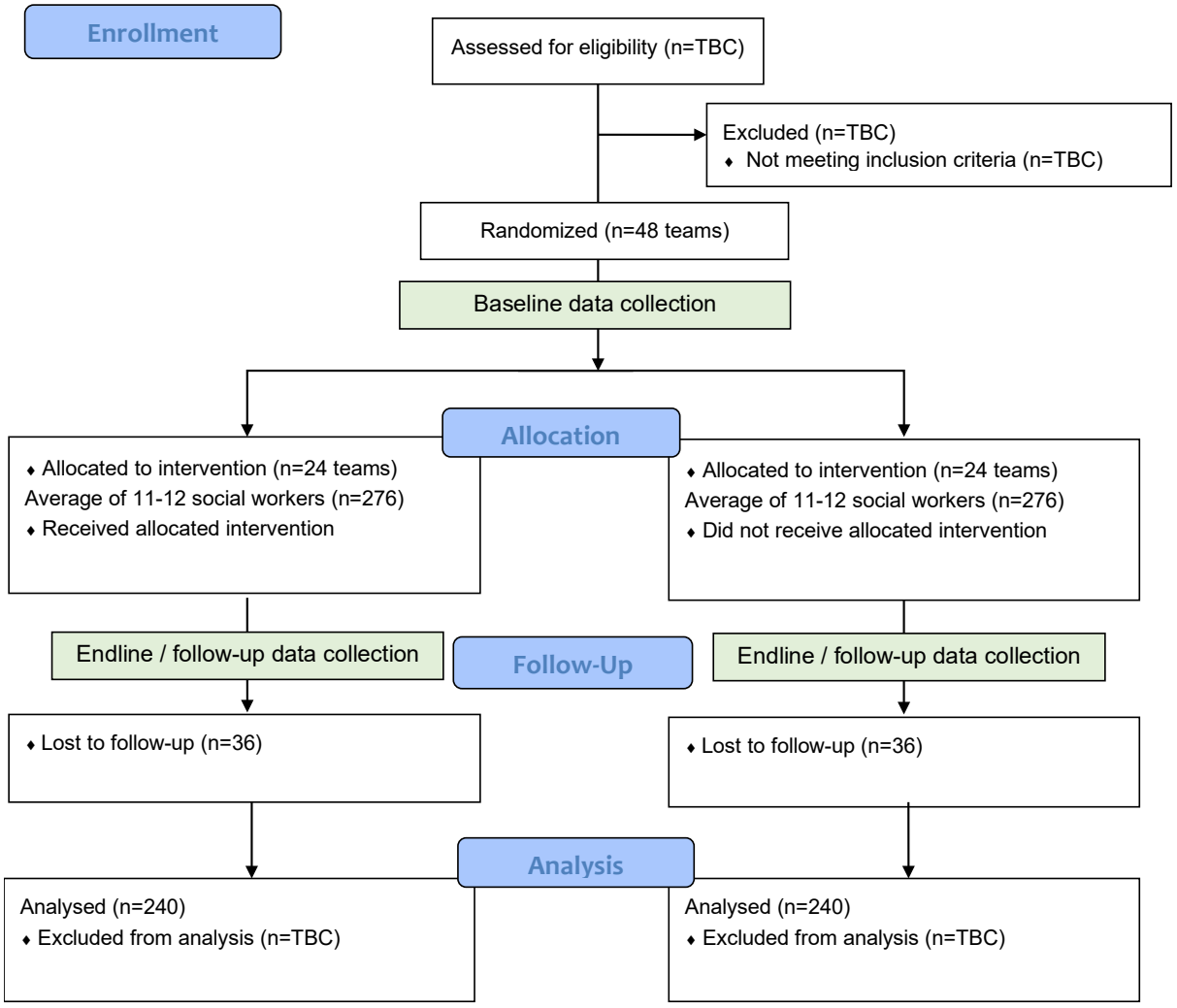
ISAFE is delivered to teams of social workers so it would not be appropriate or practical to randomise at the individual-level. Doing so would lead to significant contamination within the study i.e. social workers randomised to the control group would be exposed to the intervention. Instead, the evaluation will use a cluster RCT with a two-level design with social worker nested within teams and LAs treated as strata. Teams will be allocated at random within LAs to treatment or control to ensure a balance of trial arms across LAs.

A total of eight LAs will be recruited, each identifying six social work teams to take part in the trial, totalling 48 teams. The teams will be randomly allocated to the treatment or control group (24 in each). It was initially expected that each team will have approximately 10-15 social workers, though initial consultations with LAs suggest some teams include <10 social workers (e.g. 5-8). As such, assuming an average of 11-12 social workers per team, a total of 276 social workers will be allocated to the treatment group and 276 social workers will be allocated to the control group.

All social workers will be invited to complete surveys at three timepoints for baseline, endline, and follow-up outcome measurement. It is expected that some social workers will be lost to follow-up between baseline and the latter two data collection points. Strategies to minimise attrition to 10-15% will be employed e.g. using direct contact details, sending reminders, offering incentives, and working with senior leaders/team manager to encourage completion. As such, the calculations set out further below assume approximately 10 social workers per team will provide endline data (n=240 social workers per trial arm, 480 total).

Trial type and number of arms		Non-blinded two-armed cluster randomised control trial with social worker teams randomised to a treatment group or a control group (who does not receive the intervention)
Unit of randomisation		Social worker teams
Stratification variables (if applicable)		Local Authority and potentially one other, yet to be identified (see below)
Primary outcome	Variable	Father engagement practices (multidimensional measure)
	Measure (instrument, scale)	Father Engagement Questionnaire (Jiang et al., 2018) Mean treatment group scale score compared to mean control group scale score collected at endline (after completion of training programme).
Secondary outcome(s)	Variable(s)	Rates of father engagement
	Measure(s) (instrument, scale)	Questions adapted from Scourfield et al., 2012 Mean treatment group rates compared to mean control group rates collected at endline (after completion of training programme)
	Variable(s)	Self-efficacy
	Measure(s) (instrument, scale)	Self-efficacy scale (Scourfield et al., 2012; Scourfield et al., 2015) Mean treatment group scale score compared to mean control group scale score collected at endline (after completion of training programme).
	Variable(s)	Team culture
	Measure(s) (instrument, scale)	Team culture scale (Scourfield et al., 2012; Scourfield et al., 2015) Mean treatment group scale score compared to mean control group scale score collected at endline (after completion of training programme).

CONSORT 2010 Flow Diagram



Randomisation

Randomisation will take place in two batches – one for each cohort with four LAs each (24 teams for each randomisation) – because LAs in cohort B will not select which teams will take part until closer to the start of delivery in Autumn 2023. Randomisation will be conducted after LAs have identified teams, and details of the teams have been shared with the evaluation team. This will take place during baseline data collection. However, teams of social workers will not be informed which group they are in until after baseline data collection is completed. This was agreed as a practical solution to enable FI to schedule training dates with LAs (at a senior level) and plan delivery i.e. creating mailing lists for the treatment group.

Randomisation will be done so that there is equal allocation of teams between treatment and control groups within each LA to ensure that LA cannot confound the impact analysis. Other features of an LA may also potentially confound the analysis. For example, the levels of local-level deprivation of operational areas covered by teams within LAs might vary substantially. Prior to randomisation, we will explore this issue in further detail to assess the extent of such variation. Currently, we plan to stratify by LA and within each LA, we may use

an ordering of social work teams by the associated deprivation rank of their area of operation. Using a random start-point and odd-even allocation to treatment and control, we would ensure a proper spread of deprivation between treatment and control groups within each LA to ensure that all less (or more) deprived areas within the LA were not allocated solely either to treatment or control group.

Participants

Local authorities: FI led the recruitment of LAs and identified eight LAs to take part – at present, four in cohort A have formally agreed (through signing a MoU) and four in cohort B have provisionally agreed. There was not a defined set of eligibility criteria for LAs to take part in the trial.

To support recruitment, the evaluation team provided information about the evaluation requirements, before conducting a formal consultation with each LA once they had signed up for the trial.

Teams: Each of the eight LAs have been requested to identify six teams to take part in the trial, totalling 48 teams. FI and Ipsos are working with LAs to support this process. To date, the four LAs in cohort A have selected six teams each.

Social workers: It is expected that each team will vary in size, but that there will be an average of 11-12 social workers per team, meaning the trial should include approximately 500-600 social workers that receive the intervention. Between one and two quality assurance (QA) staff per LA will also take part in the trial but will not be randomised as they will work across both treatment and control group teams. The teams must include professionally registered and qualified children and family social workers though it is anticipated that some will also include trainee social workers e.g. completing apprenticeships or the Step Up to Social Work programme.

Social workers in both treatment and control groups will be recruited to the evaluation via an email inviting them to complete baseline and follow-up surveys. Assuming 10-15% attrition, we anticipate a total of 240 social workers with endline data in each arm.

Sample Size / Minimum Detectable Effect Size Calculations

MDES (Proportion of a Standard Deviation)		0.26
Proportion of Variance in Outcome Explained by Covariates[1] (R^2)	Child	NA
	Family	NA
	Social Worker	.45
	Stratification	.05
Intracluster Correlations Coefficient (ICCs)	Family	NA
	Social Worker	NA
	Team	.05
Alpha		0.05
Power		0.8
One-Sided or Two-Sided?		Two-sided

[1] This includes, and will most likely be most influenced by, a baseline measure of the outcome.

Level of Intervention Clustering		
Average Cluster Size (if Cluster-Randomised)		10 social workers per cluster team
Sample Size	Intervention	24 clusters = 240 social workers
	Control	24 clusters = 240 social workers
	Total	48 clusters with 480 social workers

From a technical perspective, we calculate that a MDES of 0.26 standard deviation units is possible from the study. The MDES calculation assumes a two tailed Type I error rate of 5%, a Type-II error rate of 20% and the availability of individual level baseline measures accounting for 45% of the outcome variance, with a further 5% of outcome variance explained by stratification. This is based on notable correlation between baseline and endline, which is reasonable given moderate to good test-retest stability of the primary outcome measure (FEQ) and the relatively short timeframe between baseline and endline (4 months). It also assumes a multi-site, cluster design with 48 existing children's social worker teams nested across 8 LAs, giving a two-level design with social worker nested within teams (estimating 10 social workers per team), and LA treated as strata. We further assume the cluster nature of the design will result in an intra cluster correlation (ICC) of 5%. This value was derived from earlier work on a small number of respondents within a few local authorities on measures deemed similar to father engagement outcomes for ISAFE (Scourfield et al. 2012). A table showing the varying assumption of the ICC and MDES is provided in Appendix A.

We originally anticipated that around 10-15 social workers would be included per team, and we had assumed in the original power calculations that an average number of 13 would be available for analysis, which gave an MDES of 0.25. On reflection, we have erred on the side of caution to account for smaller teams and a higher level of attrition and reduced the number of social workers (that complete endline data) to an average of 10 per team, which increases the MDES to 0.26.

The power calculations were carried out using PowerUp (Dong & Maynard, 2013)[2] entering the above details into the CRA2_2r spreadsheet. A copy of the detail is provided in Appendix A.

Two primary outcome measures are proposed and following the WWCSC guidance for multiple significance testing adjustments, no adjustment is required for tests of less than three primary outcomes. However, we have proposed to measure these two outcomes at two different time points. Consequently, whilst testing of the outcomes at the first timepoint will require no adjustment to the significance testing, a Hochberg step-up procedural adjustment (as recommended in the WWCSC guidelines) will be used at the second follow-up.

Outcome Measures

As part of the scoping stage, the evaluation team reviewed the literature and a range of potential outcome measures, including:

- Father Engagement Questionnaire (FEQ) (Jiang et al. 2018)
- Two scales on self-efficacy and team culture used to evaluate two previous interventions that informed ISAFE (Scourfield et al. 2012; Scourfield et al. 2015)

[2] https://www.tandfonline.com/doi/abs/10.1080/19345747.2012.673143

- Myths and Attitudes About Fathers (MAAF) Scale (Cosentino et al. 2014)
- Dakota Father Friendly Assessment Tool (White et al. 2011)
- Attitudes Toward Father Involvement Scale (ATFI) (McBride & Rane, 2001)
- The Role of the Father Questionnaire (Palkovitz, 1984 / adapted version: Christiansen, 1997; McBride & Rane, 1996)
- Father-Friendliness Organizational Self-Assessment And Planning Tool

Primary outcome measure

Following feedback from FI, CASCADE, and our academic adviser, the FEQ was considered most appropriate and relevant for the primary outcome measure. The FEQ is a practitioner-report measure of father engagement practices for parenting interventions. It was developed by a team of researchers and clinicians at the University of Sydney through a review of the literature related to father engagement, including barriers to participation, practitioner competencies, and potential father engagement strategies at the practitioner and organizational levels; and in consultation with a team of 10 researchers and clinical psychologists with extensive experience in delivering parenting interventions with families. It was pilot tested with a small convenience sample of 30 researchers and practitioners and then with 589 practitioners delivering parenting interventions in Australia. Based on feedback from the pilot test, the items were revised to improve clarity in wording before inclusion in the questionnaire. After pilot testing, this questionnaire contained 49 items that assessed 5 content areas. Factor analysis revealed the following five factors:

- Confidence in Working with Fathers
- Competence in Using Engagement Strategies
- Perceived Effectiveness of Engagement Strategies
- Frequency of Strategy Use
- Organizational Practices for Father Engagement

Overall, the scales are related but distinct, and it is recommended that the FEQ is used as a multidimensional measure. Findings suggest adequate internal consistency, reliability, and test-retest stability. It also showed good predictive validity with higher scores on scales 1, 4, and 5 associated with a higher likelihood of practitioner-reported father attendance.

Many of the items on the scale are clear, simple and relevant to ISAFE. However, it was developed and tested for measuring father engagement in parenting interventions in Australia (Jiang et al. 2018) rather than in child protection work. It has since been used in other studies of parenting interventions in Australia (Burn et al. 2018), with practitioners from service organisations that delivered child and family services in the UK and Canada (Sawrikar et al. 2021), and with therapists delivering Parent-Child Interaction Therapy in the US (Klein et al. 2022). Feedback from FI, CASCADE, and Dr Jon Symonds highlighted that some statements may not make sense or be appropriate in the ISAFE context. As such, small adaptations were made (see Box 1 below). In particular, the final factor on organisational practices was amended to focus on their team's practices, rather than organisation's, to make sense in the ISAFE and trial context and compliment Scourfield et al.'s (2012) scale on team culture.

Given the limited evidence on measures of father engagement in this context, the evaluation team conducted 20 cognitive interviews with child and family social workers in February 2023 as part of the set-up period. The aim of the cognitive interviews was to test the baseline survey. All participants were current social workers employed by LA children's social care services, including:

- Bristol
- Manchester
- Nottinghamshire
- Leeds
- Liverpool

- Oxfordshire
- South Gloucestershire
- London boroughs of:
    - Croydon
    - Haringey
    - Islington
    - Sutton
    - Wandsworth

These interviews lasted 1-hour and took place using Microsoft Teams. Interviewers shared their screen to show participants the survey questions on their screen to simulate an online survey. Participants were asked to 'think aloud' as they went through the survey questions, providing answers as well as any feedback on the content, terminology, and structure of questions. Participants were given £50 as a thank-you for their time. Feedback from the interviews was collated in two rounds, with the first round of feedback used to amend the survey for remaining interviews. The baseline survey is included in Appendix B.

The modified FEQ scales (see Box 1 below) will be collected from the treatment and control group at three timepoints:

- Baseline: before the first training session for the treatment group and the equivalent timepoint for the control group.
- Endline: after completion of the final training session for the treatment group and the equivalent timepoint for the control group.
- Follow-up: approximately three months after the final training session for the treatment group and the equivalent timepoint for the control group.

The measurement will be administered consistently through an online survey link delivered via email to each social worker using a dedicated survey email address. The delivery and evaluation teams have engaged with LA contacts before the survey launches to generate buy-in and seek their support in encouraging social workers to complete this, and Ipsos will send regular reminder emails to support response rates. Social workers will have approximately three weeks to complete each survey.

Box 1: Father Engagement Questionnaire

Below shows the amendments to the original FEQ scale: removed words have a ~~strikethrough~~ and additional words are underlined.

1. Confidence in Working with Fathers

How confident do you feel in the following?
Likert scale: Not at all confident (1) to Extremely confident (5)

1. Dealing with resistance from fathers
2. Engaging fathers who are reluctant ~~to attend~~ to do so
3. Managing conflict between myself and fathers
4. Managing distress from fathers
5. Communicating with fathers
6. Managing conflict between ~~mothers and~~ fathers and other parents/caregivers
7. Understanding fathers' needs
8. Eliciting fathers' expectations of ~~treatment~~ social work involvement ~~and their goals~~
9. Working with separated/divorced ~~parents~~ fathers

2. Competence in Using Engagement Strategies

To what extent do you feel competent to implement the following strategies with fathers?
Likert scale: Not at all competent (1) to Extremely competent (5).

1. Exploring feelings underlying anger, hostility, powerlessness or blame when it arises
2. Managing conflict (practitioner-~~client~~ father and mother-father)
3. Listening reflectively and creating a shared understanding about both parents' perspectives (even when they differ)
4. Negotiating shared goals and expectations (practitioner-father-mother)
5. Listening to fathers and exploring their barriers to engagement

3. Perceived Effectiveness of Engagement Strategies

To what extent do you believe the following strategies are effective for increasing the engagement of fathers?
Likert scale: Not at all effective (1) to Extremely effective (5)

1. Exploring feelings underlying anger, hostility, powerlessness or blame when it arises
2. Managing conflict (practitioner-~~client~~ father and mother-father)
3. Listening reflectively and creating a shared understanding about both parents' perspectives (even when they differ)
4. Negotiating shared goals and expectations (practitioner-father-mother)
5. Listening to fathers and exploring their barriers to engagement

4. Frequency of Strategy Use

Over the last two months, to what extent have you used the following strategies when working with fathers ~~and families~~?
Likert scale: Never (1) to Always (5). Participants will also have the option to select 'N/A (e.g. caseload does not include any fathers/male caregivers or require use of strategy)'

1. Exploring feelings underlying anger, hostility, powerlessness or blame when it arises
2. Managing conflict (practitioner-~~client~~ father and mother-father)
3. Listening reflectively and creating a shared understanding about both parents' perspectives (even when they differ)
4. Negotiating shared goals and expectations (practitioner-father-mother)
5. Listening to fathers and exploring their barriers to engagement

5. Organizational Practices for Father Engagement

How often does your ~~service/program~~ team use the following strategies to engage fathers?
Likert scale: Never (1) to Always (5).

1. ~~Advertising~~ Communicating that the ~~program/treatment~~ service is for fathers as well as mothers
2. Obtaining information (about parenting or child behaviour) from fathers as well as mothers
3. Emphasizing the importance of father attendance at meetings
4. Offering meetings outside work hours to enable fathers to attend

Secondary outcome measures

We will also include the following secondary outcome measures:

Rates of father engagement: While the FEQ is able to capture some outcomes around behaviour by looking at frequency of strategy use, this provides minimal insights about social workers' actual practice and behaviours. As such, the surveys will also include a set of questions about their current caseload and their engagement with fathers (see Box 2). These questions were adapted from Scourfield et al. (2012) and will be used to calculate rates of father engagement among social workers.

Box 2: Caseload and father engagement

1. How many children are in your current caseload?
2. And how many families/households does this involve? For example, if siblings live in different households/with different parents or children live separate from their parents with other caregivers, please count these separately.
3. Of those families/households, how many include a father or similar male caregiver(s) (e.g. stepfathers, parents' partners)? Please include both those you actively work with and those you've not been able to engage.

Now we would like to know a little more about the families/households which include a father/male caregiver. Out of those [TOTAL FATHERS VALUE] families/households, in how many…
Please only count each family/household once. If you are unsure, please give your best estimate.

6. Is the father(s)/male caregiver(s) named in the child(ren)'s casefile?

7. Are the contact details (i.e. telephone number) for the father(s)/male caregiver(s) known?

8. Is the father(s)/male caregiver(s) living with the child(ren)?
    a. Have you engaged these fathers/male caregivers in discussions about parenting and childcare?
    b. Have these fathers/male caregivers attended their most recent meeting?
    c. Are these fathers/male caregivers the main (or equal) contact for their family/household?

9. Is the father(s)/male caregiver(s) not living with the child(ren) but their whereabouts / home address is known?
    a. Have you engaged these fathers/male caregivers in discussions about parenting and childcare?
    b. Have these fathers/male caregivers attended their most recent meeting?

10. Does the father(s)/male caregiver(s) display behaviours which put their child(ren) at risk of harm?
    a. Have you discussed with these fathers/male caregivers about their behaviour that is putting their child(ren) at risk of harm?
    b. Have these fathers/male caregivers attended their most recent meeting?

As part of the quality assurance audit activity of ISAFE, QA staff will be asked to evidence the following separately for intervention teams and control teams before and after the intervention:

1. Percentage of fathers who are named on case files in relationships at time of referral
2. Percentage of mothers who are named on case files in relationships at time of referral
3. Percentage of fathers for whom there is a. date of birth, b. phone number and c. address
4. Percentage of mothers for whom there is a. date of birth, b. phone number and c. address

5. Percentage of fathers invited to and attending Initial Case Conferences and most recent Review case conferences
6. Percentage of mothers invited to and attending Initial Case Conferences and Review case conferences

Self-efficacy measured using the scale from Scourfield et al. (see Box 3): Improved self-efficacy is expected to be an intermediate outcome/mechanism through which social workers improve their father engagement practices. This scale includes 17 statements to measure self-efficacy on a 10-point scale in relation to practitioners' confidence in working with fathers. It is an adaptation of Holden, Meenaghan, Anastas, and Metrey's (2002) social worker self-efficacy scale. The Holden et al. scale measures self-efficacy across a wide range of social work tasks and since the priority outcome for the intervention (training course) was readiness to work with fathers, the items were heavily adapted. The scale has not been validated but had high reliability at pre and post-test. This scale has notable overlap with the first factor in the FEQ, which could introduce some burden. However, it was developed specifically for a similar training programme and this study presents an opportunity to look at both scales together. To minimise this burden, 7 statements already covered in the FEQ were removed, meaning the scale includes 10 statements. A Likert scale was used instead of the 10-point scale to improve consistency with the FEQ.

Box 3: Self-Efficacy Scale from Scourfield et al.

Below shows the amendments to the original Self-Efficacy Scale: removed words have a ~~strikethrough~~ and additional words are underlined.

How confident are you that you can.....?
~~10-point scale~~
Likert scale: Not at all confident (1) to Extremely confident (5)

1. ~~Apply knowledge of the law on parental responsibility~~
2. Assess fathers' positive qualities
3. Assess risk in relation to fathers
4. ~~Assess when father engagement is most likely to be successful~~
5. ~~Develop a relationship with father where you feel able to be open and honest with them~~
6. ~~Develop a relationship with fathers there they feel able to be open and honest with you~~
7. ~~Employ empathy to help fathers feel that they can trust you~~
8. Engage fathers in ways that don't jeopardize the safety of ~~mothers~~ parents/caregivers and children
9. Engage ~~men~~ fathers who are abusive in discussion about their behaviour
10. Help fathers to changes ways of thinking that contribute to their problems
11. Help fathers to understand better the consequences of their behaviour ~~for~~ on their partners and children
12. ~~Help fathers to understand better the consequences of their behaviour for on their children~~
13. ~~Highlight fathers' successes to increase their self-confidence~~
14. Motivate fathers to change their problematic behaviours without increasing their resistance
15. Provide emotional support for fathers
16. ~~Teach~~ Support fathers to learn specific skills to deal with certain problems
17. Work with ~~men~~ fathers who appear hostile or aggressive

Team culture using the scale from Scourfield et al. (see Box 4): To assess wider attitudinal changes as a result of the ISAFE intervention at the social worker team level, participants will be asked to assess their team's culture towards fathers. Improving team culture is understood to be an intermediate outcome/mechanism that will support social workers in

changing their father engagement practices. This 8-item scale from Scourfield et al (2012) on team effects includes items taken from the agency self-assessment used by English et al. (2009). The scale demonstrated adequate internal consistency. Minor amendments have been made to ensure it is relevant to ISAFE.

Box 4: Team Culture Scale from Scourfield et al.

~~*6 point scale from Strongly Disagree to Strongly Agree*~~
Likert scale: Strongly disagree (1) to Strongly agree (5). Participants will also have the option to select 'Don't know' and 'Not applicable'

1. In my team there are clear expectations that ~~fathers of children~~ staff should support fathers of children to engage with social services.
2. ~~The majority of front-line staff~~ In my team, staff are open and receptive to working with fathers.
3. In my team, staff are comfortable working with fathers.
4. In my team, staff are comfortable working with fathers from different cultural backgrounds.
5. In my team, case reviews, child protection plans and/or child in need plans always include fathers.
6. In my team, the message is given to fathers that their role as active parents is crucial to their children's development.
7. My team views fathers as a ~~resource~~ important only if they have parental responsibility.
8. There is someone on my team who I could turn to for advice and consultation on work with fathers.
9. I myself would feel able to offer advice and consultation to others on work with fathers.

Analysis Plan

Does the intervention work?

Q1-4 Analysis

The primary and secondary impact analysis will use cluster robust single-level regression models to establish impact. For each primary outcome, the post-implementation FEQ score will be the outcome variable. We anticipate this will be treated as a continuous measure. A binary indicator identifying whether the social work team was allocated to treatment (scored as one) or control (scored as zero) will be included as a main effect in the model. The coefficient for this variable will carry the impact effect as the average difference in the FEQ score outcome between the treatment and control group. The coefficient will be significance tested with a two-tailed alpha of $P < 0.05$, to establish the significance of the impact effect. Additionally, further variables will also be included in the regression, including the baseline measure of the FEQ and an identifier for the stratification group. A single level OLS regression model with an identity link and clustered error term around social work teams, will be used.

$$\hat{Y} = a + bD + \sum_j^J z_j X_j + e \qquad (1)$$

Where $\hat{Y}$ is the predicted outcome score, *a* is the intercept, *b* is the coefficient carrying the impact effect, *D* is the binary indicator equalling one for the treatment group and zero for the control group, and z_j represents coefficients for the baseline measure and the 16 stratum group indicator variables, with X_j representing the baseline score and the binary indicator variables for the 16 stratum indicator variables, and e is assumed to be clustered by social work team. *J* runs from 1 to 16, with 1 representing the baseline FEQ score and 2-16 the 15 stratum indicator variables. The excluded 16th stratum will be represented in the intercept.

There is the potential to increase the statistical power of the analysis further by including other predictor variables in the regression model. However, calculation of the standardised effect size will use the conditional total variance of the impact effect in its calculation. Using a minimum specification for the model means that the standardised effect size will only be conditioned on the baseline measure and the design variables. Consequently, the effect size can be used in a meta-analysis study without concerns over comparability caused from effect sizes adjusting for different variables across different studies.

The impact estimator will be calculated using an intention to treat (ITT) analysis to maintain the integrity of randomisation in the allocation stage. This is the fundamental test of the success of the impact effect for this study. This ITT average treatment effect (ATE), however, is based on an 'offer to treat'. It is possible that some social workers in the treatment group are non-compliant with treatment and do not attend any sessions (non-compliers). In such cases, the ITT effect is diminished by those who have not participated. We can calculate the size of the impact effect on those who have participated using formula (2) below, which will be greater than or equal to the ITT average effect.

To adjust for the presence of non-compliers in the treatment group, and assuming we can collect outcome scores for these people, we will also calculate the treatment on the treated, following equation 8 in Bloom (2006), as:

$$TT = \frac{\bar{Y}_t - \bar{Y}_c}{\underline{\bar{D}}|Z=1} \qquad (2)$$

Where the denominator is the proportion receiving treatment in the treatment group

There is also the potential for crossovers from the control group to the treatment group arising from transfers between social workers in control teams moving to a treatment team. Consequently, whilst we are not anticipating this to occur often, we may have cases who were allocated to treatment and either received treatment as intended or, through non-compliance, did not. Similarly, we may have people allocated to the control who, as intended, received no treatment, but also those who received treatment. In such a situation, we will also include an estimate of the Local Average Treatment Effect (LATE), also described by Bloom (2006; equation 11):

$$LATE = \frac{\bar{Y}_t - \bar{Y}_c}{(\underline{\bar{D}}|Z=1) - (\underline{\bar{D}}|Z=0)} \qquad (3)$$

Where the denominator is the difference in treatment rate between the treatment and control group.

In addition to the estimators described above, we will provide a standardised impact effect (Glass' Δ) based on the control group unadjusted standard deviation (in line with WWCSC guidelines).

Each impact estimate will be provided with an associated standard error and 95% confidence intervals. Further, we will calculate the intracluster correlation coefficient (ICC) for each outcome variable observed in the impact data.

Secondary Analysis (Q2-4)

Analysis of secondary outcomes follows the same approach as described above for primary outcomes. The secondary outcomes will be regressed onto the treatment indicator, controlling for the appropriate baseline measure and stratification membership. The same single-level regression model, adjusting for robust cluster errors, will be used. We will also mirror the ITT average treatment effect, treatment on the treated and local average treatment effects described above and provide a standardised impact effect (Glass' Δ).

Sub-Group Analysis (Q7-8)

The study is not powered to detect differences in the impact effect across sub-groups. Nevertheless, subgroup analysis is proposed through extending the regression models described above using an interaction term between the impact effect indicator and the LA identifier. This will look at age, gender, and experience of social workers, and differences in teams or local authorities.

Additional analyses

Attrition

Attrition may arise because social workers may leave the team or refuse to participate further in the study. We propose to use baseline data to model the characteristics associated with attrition using a logistic model. From a model using only baseline characteristics associated with the probability of leaving the survey, we will develop a weight from the propensity score and rerun the primary and secondary analyses with this attrition weight as sensitivity tests.

Social workers may remain in the study but not provide complete data for the variables used in the impact analysis. Where outcome data are missing, we will initially run the primary and secondary analysis excluding these cases. If outcome data are missing for more than 5% of the sample, we will first explore patterns of missingness using the approach described above for complete-case attrition and develop a weight which adjusts for missingness. This will be run alongside the complete-cases analysis as a sensitivity test.

Where data are missing on the baseline score, a binary indicator identifying missing or not will be included in the regression analysis of primary and secondary outcomes to control for the impact of missingness.

Dosage Response Analysis

We will record how many times each social worker in the treatment group attends a session, which will give us the total number of sessions. Using an indicator of number of sessions attended in a regression model on the primary and secondary outcomes, we can test if those who attended more sessions had more improved FEQ scores than those who attended fewer/no sessions.

Analysis of Harms

Unintended consequences of the intervention, including harms, will be explored in the IPE. For example, social workers may experience low morale if they perceive ISAFE as highlighting additional work and they are time-stretched.

Exploratory Analysis

Additional analyses can be conducted after the trial is completed that are not specified in the trial protocol. However, it is useful to specify areas of potential future interest here.

We anticipate two further sets of additional analysis. The first looks at characteristics associated with compliance and dosage. The second explores the impact of social worker characteristics on outcomes.

Regression models will be used to explore compliance with the treatment status, using binary logistic regression to predict which social worker characteristics are associated with compliance and non-compliance. The characteristics will include various baseline measures from the survey data along with sociodemographic details such as age and years of social work experience.

Additionally, socio-demographic data will be added to the primary and secondary outcome analysis models to assess how each is related to the outcomes and any effect the inclusion of these characteristics has on the impact estimate.

Implementation and Process Evaluation

Specific Evaluation Questions

The specific evaluation questions addressed by the Implementation and Process Evaluation (IPE) are structured using Humphrey et al.'s (2016) framework from the Education Endowment Foundation's (EEF) implementation and process evaluation handbook[3] and seek to assess the fidelity of the intervention and support a deeper understanding of the findings from the impact evaluation (such as mechanisms of change).

The key research questions for the IPE are:

Q3-5. **Mechanisms of change**: To what extent is the ISAFE theory of change validated?
Q6-7. **Variation in outcomes**: Do outcomes (and experiences) vary (i) by characteristics of social workers (gender, age, experience i.e. years since qualified); and (ii) across teams and/or local authorities?
Q8. **Fidelity**: To what extent was ISAFE delivered as intended/planned? This will be considered as a whole and a more granular level looking at 1) QA audit training 2) social worker training 3) the role of champions.
Q9. **Feasibility**: What are viewpoints on the feasibility of implementing ISAFE? What barriers and enablers were encountered, and how were these addressed?
Q10. **Reach / Dosage:** What is the intervention's reach? How many social workers attended the training? How much of the training did social workers attend?
Q11. **Quality / Responsiveness:** How acceptable do participants find ISAFE (e.g., content, number of sessions, online material)?
Q12. **Adaptation**: What adaptations have been made to make the programme more acceptable to participants?
Q14. **Programme differentiation**: Is it viewed as an improvement on services as usual? Is ISAFE seen as a good fit with professional/service norms and with needs of parents, carers and families?

Design

IPE Design Table	
Indicators	**Method and Time Point**
Q3-5. Mechanisms of change: To what extent is the ISAFE theory of change validated?	
• Intervention logic model • Perceived changes in service and case outcomes including unintended consequences.	• Interviews with programme implementers • Interviews with social workers and QA staff • Interviews with service users

[3] Humphrey, N., Lendrum,A., Ashworth, E., Frearson,K., Buck, R. and Kerr, K. (2016) *Implementation and process evaluation (IPE) for interventions in education settings: An introductory handbook*, Education Endowment Foundation

Q6-7. Variation in outcomes: Do outcomes (and experiences) vary (i) by characteristics of social workers (gender, age, experience i.e. years since qualified); and (ii) across teams and/or local authorities?	
• Perceived changes and variations in SW outcomes including unintended consequences. • Perceived changes and variations in service and team outcomes including unintended consequences.	• Interviews with programme implementers • Interviews with social workers and QA staff • Interviews with service users • Administrative data on training attendance
Q8. Fidelity: To what extent was ISAFE delivered as intended/planned?	
• Completed sessions • Attendance of social workers • Delivery of planned sessions / content	• Interviews with programme implementers • Interviews with social workers and QA staff • Analysis of programme documentation • Administrative data on training attendance
Q9. Feasibility: What are viewpoints on the feasibility of implementing ISAFE? What barriers and enablers were encountered, and how were these addressed?	
• Perceived feasibility • Perceived barriers and enablers • Perceived strategies for overcoming barriers and facilitating enablers	• Interviews with programme implementers • Interviews with social workers and QA staff
Q10. Reach / Dosage: What is the intervention's reach? How many social workers attended the training? How much of the training did social workers attend?	
• Number of intervention participants • Training attendance	• Administrative data on training attendance
Q11. Quality / Responsiveness: How acceptable do participants find ISAFE (e.g. content, number of sessions, online material)?	
• Perceived acceptability • Perceived quality	• Interviews with programme implementers • Interviews with social workers and QA staff
Q12. Adaptation: What adaptations have been made to make the programme more acceptable to participants?	
• Adaptations made	• Interviews with programme implementers • Analysis of programme documentation

Q14. Programme differentiation: Is it viewed as an improvement on services as usual? Is ISAFE seen as a good fit with professional/service norms and with needs of parents, carers and families (e.g. addressing mechanisms for change)?	

• Perceived improvement on service as usual
• Perceived fit within children's social care
  ○ Perceived fit for professional norms
  ○ Perceived fit for needs of parents, carers and families
	• Interviews with social workers and QA staff
	• Interviews with service users

Methods

Sample and Recruitment

Social worker and QA staff contact details will be shared with the research team directly by local authorities under the terms of the agreed data sharing agreement(s).

Social worker and QA staff interview participants will be purposively sampled from chosen local authorities per the target numbers below under data collection. We will recruit participants via email invitation providing information sheets attached to the email. We will provide information on the evaluation and data collection to the programme implementers and local authority gatekeepers to support recruitment throughout the evaluation.

Interviews with service users (fathers and mothers) associated with social workers in the treatment group will take place after the three month follow up survey (i.e. Sept 2023; March 2024). The exact sampling frame will be decided in consultation with each individual local authority based on demographics and their views on participants' suitability for interview. We will not aim for a representative sample, but we will aim to sample purposively for a diversity of case types (e.g. those where parents live together vs separately). As such, service users will be identified by social workers who will introduce the research to them. We will brief social workers to do this and provide them with the relevant materials, ensuring that participation is entirely voluntary and that there is understanding in order to be able to consent to participation. Social workers will collect service users' consent to pass on their contact details to Ipsos and we will then manage the recruitment process to ensure informed consent. Information sheets and consent forms will be translated into accessible and appropriate language. Interviews will be one-to-one with either the mother or father to share their experiences of how their social worker engages with fathers. We plan to compensate participants £30 for 1-hour of their time for interviews.

Data Collection

Administrative data on training attendance will be collected by programme implementors and shared with researchers for analysis after completion of the cohort's training programme.

We will use semi-structured interview guides for all interviews. For interviews with service users, we anticipate using an interview guide covering the same topics for both mothers and fathers, with interviewers will frame questions appropriately, as needed. We anticipate that most, if not all, of the interviews will take place over the phone and or video conference (per the preference of the interviewee).

Data collection will take place with the target sample sizes and time points in the data collection schedule below.

Method	Sample size	Time point
Administrative data on training attendance	All ISAFE training participants	Cohort A: April 2023 – November 2023 Cohort B: September 2023 – April 2024
Interviews with programme implementers	5 interviews	Post-delivery: March 2024 – April 2024
Interviews with social workers (including champions) and QA staff	40 interviews in total: 32 social workers (from 4 LAs) 8 QA staff (1 from all 8 LAs)	Cohort A: September 2023 – October 2023 Cohort B: March 2024 – April 2024
Interviews with service users (fathers and mothers)	Between 2-3 interviews per LA (all 8 LAs) – totalling c.20 interviews	Cohort A: October 2023 – November 2023 Cohort B: April 2024 – May 2024

Analysis

All interviews will be transcribed. Qualitative analysis will begin by using coding by using NVivo coding software. The coding framework will be developed both deductively (e.g., reflecting elements of the questions, and logic model) and inductively, including unexpected issues emerging in the data. This will be an iterative process with multiple researchers to ensure the quality of coding structures. A framework analysis will be used to chart at the key themes across interviewee types as cases of implementation, thereby examining trends in findings between and across categories of interviewees and local authorities.

Cost Analysis

Specific Evaluation Questions

The cost analysis aims to answer:

Q13. How much does it cost to deliver ISAFE?

Methods

The evaluation team will collect costs from the programme implementers between February – March 2024. Costs for set-up (one off) and recurring costs are to be broken down by:

- staff time for delivering SAFE (proportion of FTE multiplied by salary),
- any costs associated with recruiting and training staff,
- any costs related to training (e.g. travel costs, use of platforms (Zoom, phone calls), postage and stationary),
- any other overheads including facilities (cost of office and venue hire associated with face-to-face training) and equipment costs.

Estimates of costs per team and per LA will be calculated.

Project management

Personnel

The table below outlines the roles and responsibilities of evaluation team members.

Team / Institution	Role	Responsibilities
Jessica Ozan, Head of Education, Children and Families	Quality Director	Providing quality assurance and critical input at key milestones (e.g. trial protocol, reporting); Supporting the Project Director in overseeing the evaluation.
Raynette Bierman, Associate Director	Project Director / Principal Investigator	Overall responsibility for the design and delivery of the evaluation, working closely with the project manager; Overseeing data collection and analysis (including costs); Managing / mitigating risks; Reviewing and quality assurance of all deliverables.
Ellis Akhurst, Consultant	Project Manager	Managing the delivery of the evaluation with oversight of the Project Director; Inputting into the design of the IPE and RCT; Managing teams for data collection (including costs), analysis, and reporting; Managing / mitigating risks.
Karl Ashworth, Head of Analytics	RCT technical lead	Leading on the design of the RCT with support from the Project Director; Overseeing the RCT data collection and analysis, including risk mitigation.
Simona Banerjee, Freelancer	Survey manager	Managing the surveys for baseline and endline data collection, from set-up through to analysis.
Alexander Pangalos, Consultant	IPE manager	Managing the IPE data collection, including material development, recruitment, fieldwork, analysis, and reporting.
Lottie Hayes, Senior Research Executive	Project executive	Supporting data collection for the RCT and IPE.
Partner/Collaborator		
Dr Jon P Symonds, University of Bristol, Senior Lecturer in Social Work with Children and Families, School for Policy Studies	Academic Adviser	Providing subject-matter expertise and advice to inform the design and delivery, as well as the analytical and reporting framework.

Timeline

Dates (Cohort)	Activity	Staff Responsible/ Leading
Dec 2022-Feb 2023	Recruitment of LAs and teams of social workers	FI
A: March 2023 **B: July 2023**	Randomisation	Ipsos
A: March 2023 **B: July/August 2023**	Baseline data collection	Ipsos
A: April – July 2023 **B: Sept – Dec 2023**	Intervention delivery	FI/CASCADE
A: July 2023 **B: December 2023**	Post-intervention data collection	Ipsos
A: October 2023 **B: March 2024**	3-month follow-up data collection	Ipsos
A: Sept – Oct 2023 **B: March – April 2024**	Interviews with social worker and QA staff	Ipsos
A: Sept – Oct 2023 **B: March – April 2024**	Interviews with service users	Ipsos
March – April 2024	Interviews with programme implementers	Ipsos
Feb – March 2024	Collect and collating programme costs	Ipsos/FI
June - July 2024	Analysis (all strands)	Ipsos
Aug – Sept 2024	Reporting	Ipsos

Risks

The table below sets out the key risks that have been identified and planned mitigation strategies for each.

Risk	Mitigation
Recruitment issues - Lower than expected numbers at recruitment would reduce the sample size, which could reduce the chances of detecting an effect (unless there is a large effect). *Likelihood: Low* *Impact: High*	The evaluation team has worked closely with FI who have led on recruiting LAs. All eight LAs have confirmed their interest in participating, and the four LAs in cohort A have signed MoUs. There is some outstanding risk about the selection/recruitment of teams, though this is mitigated as a requirement in the MoU set up with LAs.
Low response rates for outcome measures - Decrease statistical power of the analysis and reduce the chance of finding a positive impact, where one exists (i.e. incorrectly accepting the null hypothesis). *Likelihood: Medium* *Impact: High*	The following will be done to encourage participation in outcome measurement: • Setting out requirements in MoUs with LAs. • Sending a warm-up email to explain the importance and value of taking part. • Keeping the survey short and questions relevant. • Sending reminder emails and asking team leaders to remind social workers. • Following up with telephone reminders as required. • Offering incentives.
Retention and attrition - Severe attrition would reduce the sample size, which could reduce the chances of detecting an effect (unless there is a large effect) and reduces the internal validity of the trial. *Likelihood: High* *Impact: High*	Staff turnover will very likely occur during the evaluation meaning some participants will be lost to follow-up. The evaluation team will gather contact details for social workers for follow-up measures to mitigate this and offer an incentive for follow-up survey completion, including for staff who took part in the training and left in the follow-up fieldwork period.
Potential for contamination - Contamination across teams within a LA is possible, which could dilute the observable effect of the intervention. *Likelihood: TBC once teams are selected* *Impact: Medium*	The evaluation team spoke with LAs about the structure of their services to understand the likelihood of contamination, which was not expected to be high. FI are also asking LAs to request that social workers in the treatment group do not discuss ISAFE with other teams (especially those in the comparison group). This will also be emphasised for QA staff who work across both groups. The webinar with senior leaders will take place after the final data collection to minimise system-level effects that could influence the control group.
Data access and quality – It is still unknown how much administrative data on father engagement is available and its	We explored the availability of existing data during the scoping consultations with LAs, which reiterated that there is no single

quality, meaning the primary outcome relies on self-reported data. *Likelihood: High* *Impact: Low*	approach to collecting data on father engagement and this information is generally in case files / not easily 'pulled out'. Some LAs had actively reviewed case files in relation to father engagement but most did not.
Timetable delays - Preparing for an RCT and ensuring all partners are aware of the requirements can take time, which could result in delays to the timetable. *Likelihood: Medium* *Impact: Medium*	The timetable for the set-up stage was extended to account for recruitment, material development, and data protection processes. It is not currently expected that there will be timetable delays once the trial begins.
Impacts of COVID e.g. staff sickness *Likelihood: Low* *Impact: Low*	Most training and evaluation activities will be delivered remotely e.g. online training and online surveys. The window for data collection will be sufficiently long to mitigate issues of staff sickness (excluding long-term sick leave).

Compliance

Registration

In line with WWCSC requirements, this trial is registered with the Open Science Framework (OSF) at [add OSF link]. The trial registry will be updated with results at the end of the project.

Ethics

The evaluation team submitted an ethics review form with detailed information on the project to the Ipsos UK Public Affairs Ethics Group. This was reviewed by two members of the group, who were independent and not otherwise involved in the evaluation team. Feedback and approval were received on the 14th December 2022. If any changes relating to ethical considerations occur during delivery, the Principal Investigator will make these known to the chair of the Ethics Group and seek advice where appropriate.

Key ethical considerations and processes for this study are described below.

- **Nature of the participants:** The main participants for the study include staff of children's social work teams, and staff delivering training. A small number of interviews will be conducted with fathers/mothers of children receiving support from social care who may be considered vulnerable, for example, they could be struggling with health or finances. We will not interview children for the purpose of this evaluation as the risk of harm is greater than the scientific benefit.

- **Ethical consent:** Consent to take part in the evaluation will be sought from all participants prior to data collection activities. Information sheets and consent forms will include information regarding the evaluation, confidentiality, and highlight participants' right to withdraw. Given the nature of the participants (i.e. mostly staff), the risk of participants not being able to able to make an informed decision about whether to provide consent is low. However, all materials will be written in accessible language to support this and interviewers will explain the research ahead of data collection to confirm that participants understand the purpose of the research, how we will use their data, and their rights. Furthermore, social work teams will be gatekeepers for accessing fathers/mothers and the evaluation team will take their advice on whether potential participants may be vulnerable to enable appropriate precautions/responses (i.e. choose not to proceed with the interview or take extra steps to ensure informed consent).

- **Minimising burden and distress**: Although the interviews with fathers/mothers will focus on the support they are receiving from their social workers, there is a possibility that this may trigger distress relating to the context why they have a social worker or other issues. Several mitigations will be in place:

    - Interviewers will be experienced in conducting research with vulnerable groups and know how to recognise signs of distress. The fieldwork briefing will cover potential scenarios and how to handle them – for example, moving on from topics and questions that appear to be more sensitive for the

participant. Interviewers will offer breaks or stop the interview where appropriate, and signpost participants to support helplines where appropriate.
    - Recruitment will be done in collaboration with gatekeepers and take mental health and other sensitive issues into consideration.
    - Interviews will not focus on personal histories (i.e. why they have a social worker) and make this clear during the introduction and information sheet. They will be focused on asking questions about whether they have noticed any changes in how their social worker engages with them e.g. more or less contact, different types of contact.
    - Interviews will be kept short (no more than 1 hour).

- **Disclosure of harm / Safeguarding**: We expect the risk of participant disclosure to be low, however we know that social workers will be handling cases where domestic violence is present and they may refer to this when discussing how they engage with fathers. We will clearly state upfront that they should not share confidential information with us about cases. In cases where the interviewer considers the participant or someone else to be at risk of serious harm, they will follow safeguarding processes and the disclosure protocol for reporting this. We will follow WWCSC safeguarding protocols, including reporting any incident to their Designated Safeguarding Lead within 10 working days.

- **Confidentiality and anonymity**: The evaluation team will send WWCSC an anonymised dataset of RCT participants' (adult social workers) survey data for storage in WWCSC's Data Archive, held by the Office for National Statistics (ONS) within the Secure Research Service (SRS). This data will be anonymous (not identifiable) and not be linked. No qualitative data will be shared outside Ipsos other than recordings for transcription (via an approved supplier, TakeNote). All data will be aggregated and anonymised in final reports.

- **Risk for researchers**: The risk for researchers is low. The surveys will be online and distributed via email to participants. Interviews will primarily be conducted via telephone or online. Where interviews are requested to be face-to-face and deemed most appropriate, these will take place in an appropriate and private room or space, ideally in the offices of the social worker team. Interviewers will be expected to check in with another team member while conducting fieldwork. Interviews could potentially raise sensitive or triggering information about social work with vulnerable families e.g. domestic violence. Interviewers will participate in regular debriefs and have access to Ipsos' Employee Assistance Programme.

Data Protection

Our overarching 'Research Data Protection Statement' is available here. The below is specifically relevant to the project to which this document applies. Any questions about this section can be submitted to dpo@theevidencequarter.com with a reference to the Data Protection Identifier (DPID) found in the table below.

Regulatory framework

Relevant legislation	UK Data Protection Act 2018 (DPA) UK General Data Protection Regulation (GDPR)
Data Protection Identifier (DPID)	#3043
DPIA outcome/ risk level	Low
Type of data processing	Surveys Interviews Administrative data
Categories of data subjects	Intervention delivery staff Social workers Allied professionals Parents / Legal Guardians
Privacy notice	See Appendix C
	Personal data
Lawful basis	Legitimate interests Public task
Justification for the lawful basis	Ethical practices within research require informed consent to be gathered for the data subject's participation in the evaluation of the effectiveness of the Intervention and for research to be conducted using their personal data. For the avoidance of doubt, informed ethical consent shall be regarded as a sufficient safeguard for the processing of personal data including the capture and storage of personal data up to the point analysis of the data is being conducted. Once analysis is being conducted, depending on the dataset in use, a data subject is unable to withdraw consent insomuch as this would detrimentally affect the analysis process intrinsic to the research being conducted therefore reliance on consent as the legal basis for personal data processing is not appropriate. Where ethical consent has been withdrawn by a data subject, where possible and dependent on the stage of the research process, each party agrees to discontinue the processing of the data subject's personal data and either fully delete, partially delete, pseudonymise or anonymise all identifiers associated to the data. The lawful basis for processing personal for the purposes of research shall be in accordance with GDPR Article 6.1(f), and GDPR Article 9.2(j) and DPA18 Schedule 1 Part 1.4(a),(b)&(c) for special category data including data

	considered to be a protected characteristic under the UK Equality Act 2010. For the processing of personal data to set up interviews and meetings with data subjects and the management of the project we shall rely upon Article 6.1(f) 'legitimate interest', of the UK GDPR. Upon completion of the Project the lawful basis WWCSC, as sole independent controller, shall rely on, for the purpose of archiving and any subsequent secondary analysis of the data, GDPR Article 6.1(e), and GDPR Article 9.2(j) and DPA18 Schedule 1 Part 1.4(a),(b)&(c) for special category data including data considered to be a protected characteristic under the UK Equality Act 2010. What Works for Children's Social Care (WWCSC) is acting upon the instructions from the DfE in accordance with Annex K of the Grant Offer Letter to WWCSC, where it is stated that WWCSC acting as a Processor on behalf of the DfE as Data Controller, and the subject matter of the processing "is needed in order that the Processor [WWCSC] can effectively deliver the grant to provide a service to the Children's Social Care sector". WWCSC is therefore acting under the authority vested upon it by the DfE as its funder which appropriately corresponds to WWCSC conducting its research under Article 6.1(e) of the UK GDPR: "Processing is necessary for the performance of a task carried out in the public interest." Data archived within the WWCSC instance of the Office for National Statistics Secure Research Service ("ONS SRS") for the purposes of secondary research on the data within this evaluation shall be non-identifiable data and governed under the UK Digital Economy Act 2017 and the UK Statistics and Registration Service Act 2007.
	Special category data
Lawful basis	Archiving, research and statistics (with a basis in law)
Justification for the lawful basis	As above
	Roles

Data controller(s)	Ipsos (Joint Controller) WWCSC (Joint Controller) Fatherhood Institute (Independent Controller) Local authorities (Independent Controllers)
Data processor(s)	Take Note (for transcriptions) Rackspace UK (for data storage)
Data sharing mode	SFTP File Transfer – Ipsos Transfer
	Archiving
Archiving	Yes, an anonymised dataset of the survey data will be shared with WWCSC and stored in their Data Archive.
Archive used for this project	WWCSC Data Archive based in the Office for National Statistics
	Linking to NPD and use of SRS
Name of the organisation(s) submitting data to the NPD team	N/A
Name of the organisation(s) accessing the matched NPD data	N/A
	Retention and Destruction
Expected date of report publication	September 2024
Expected date of data destruction	November 2024

If you are looking for further clarification regarding our data protection notification requirements they will either be found in the project specific Data Privacy Notice and/or our Privacy Policy on our website. If you have any further questions around either of these please submit them to dpo@whatwork-csc.org.uk with a reference to the Data Protection Identifier (DPID) found in the above table.

Appendices

Appendix A: MDES Calculations and Varying Assumption

MDES Calculations

Model 3.1: MDES Calculator for Two-Level Cluster Random Assignment Design (CRA2_2)— Treatment at Level 2		
Assumptions		**Comments**
Alpha Level (α)	0.05	Probability of a Type I error
Two-tailed or One-tailed Test?	2	
Power (1-β)	0.80	Statistical power (1-probability of a Type II error)
P	0.50	Proportion of Level 2 units randomized to treatment: $J_T / (J_T + J_C)$
Rho (ICC)	0.05	Proportion of variance in outcome that is between clusters
R_1^2	0.45	Proportion of variance in Level 1 outcomes explained by Level 1 covariates
R_2^2	0.05	Proportion of variance in Level 2 outcome explained by Level 2 covariates
g*	7	Number of Level 2 covariates
n (Average Cluster Size)	10	Mean number of Level 1 units per Level 2 cluster (harmonic mean recommended)
J (Sample Size [# of Clusters])	48	Number of Level 2 units
M (Multiplier)	2.87	Computed from T_1 and T_2
T_1 (Precision)	2.02	Determined from alpha level, given two-tailed or one-tailed test
T_2 (Power)	0.85	Determined from given power level
MDES	**0.262**	Minimum Detectable Effect Size

Table showing the varying assumption of the ICC and MDES

ICC	MDES
0	0.195
0.05	0.262
0.1	0.315
0.15	0.361
0.2	0.4

Appendix B: Baseline survey

WELCOME
SHOW ALL

Welcome to this survey.

As you may know, your team is taking part in a research and evaluation project about children's social care services' engagement with fathers, funded by What Works for Early Intervention and Children's Social Care (WWEICSC).

Your participation is key to this project. This is the first of 3 short surveys we will ask you to complete over the next 9 months or so. The survey will take approximately 10-15 minutes to complete, and you can do it on a mobile, tablet, or laptop/PC.

In the survey, we will ask about your current caseload and the fathers and other male caregivers within it. You may want to have information about this at-hand whilst completing the survey. **You can close and resume the survey from where you left it as many times as you need – your responses will be automatically saved.**

Some teams in your local authority will be invited to attend the ISAFE (Improving Safeguarding through Audited Father Engagement) programme, which is a new online training and organisational development programme.

Your participation in the surveys is critical whether or not you are invited to attend the training. What you tell us in the surveys will help us understand whether and how the ISAFE programme affects father/male caregiver engagement compared to normal practice. Our findings will be published at the end of the evaluation.

Your survey responses will be kept secure and confidential. Anonymised responses will be shared with WWEICSC at the end of the project. More information about how we will use your personal data and survey responses is provided in the Privacy Notice, which you can read **here**.

Why this project matters

The ISAFE programme will be delivered by the Fatherhood Institute and CASCADE, Cardiff University. Ipsos UK are independent from the Fatherhood Institute, CASCADE, and WWEICSC.

Our findings from this project will inform whether the programme should be rolled out elsewhere to support best practice – for example, across your local authority – and/or whether any changes to the programme are needed.

If you have any questions about this survey or the evaluation, please contact us at UK-PA-ISAFEevaluation@ipsosresearch.com.

By clicking "Next" you agree to give your views. It is up to you whether you take part, and you can change your mind at any time.

1.1 SECTION A: Intro

First, we would like to know a little more about you.

TEAM
ASK ALL
SINGLE CODE
Which of the following best describes the team you work in? Please select one.

1. MASH / Front Door / First Response Team
2. Assessment Team
3. Early Help Team
4. Child in Need Team
5. Child Protection Team
6. Looked After Children Team
7. Leaving Care Team
8. Children with Disabilities Team
9. Adoption and Permanence Team
10. Locality/area-based Team (that spans multiple teams above)
11. Quality Assurance Team
12. Other, please specify [open text]

TEAM LOCALITY
ASK if TEAM=10 OR 11 OR 12
SINGLE CODE
Which parts of the service does your team cover? Please select all that apply.

1. MASH / Front Door / First Response
2. Assessment
3. Early Help
4. Child in Need
5. Child Protection
6. Looked After Children
7. Leaving Care
8. Children with Disabilities
9. Adoption and Permanence
10. Quality Assurance
11. Other, please specify [open text]

ROLE
ASK ALL
SINGLE CODE

Scripting note: include a tick box that says: 'Please tick this box if you are an agency worker'

Which of the following best describes your current job role? Please select one.

1. Trainee social worker / support worker (including apprenticeships)
2. Newly qualified social worker (less than 2 years)
3. Social worker (qualified)
4. Senior social worker (qualified)
5. Advanced Practitioner
6. Social work team manager
7. Another role in children's social care, please specify [open text]

FULL OR PART-TIME
ASK ALL
SINGLE CODE

In your current role, are you currently working full or part time? Please select one.

7. Working full-time (30 hours or more per week)
8. Working part-time (8 – 29.5 hours per week)
9. Working part-time (Under 8 hours per week)
10. Other, please specify [open text]

LENGTH IN ROLE
ASK ALL
SINGLE CODE
How many years have you worked in your current role?
Please round to the nearest year.

1. [VALUES ONLY]
2. Don't know

LENGTH QUALIFIED
ASK IF ROLE=2-7
SINGLE CODE
How many years have you been a qualified social worker?
Please round to the nearest year.

1. [VALUES ONLY]
2. Don't know
3. N/a – I am not a qualified social worker

LENGTH IN SECTOR
ASK ALL
SINGLE CODE
How many years have you worked in Local Authority Children's Social Care Services?
Please round to the nearest year.

1. [VALUES ONLY]
2. Don't know

1.2 SECTION B: FEQ, Self-Efficacy and Team Culture Questionnaires

SECTION B INTRO
SHOW ALL

Next, we would like to ask about your views and experiences of working with fathers.

By fathers, we mean both biological and non-biological fathers and similar male caregivers, such as stepfathers, parents' partners, and other family members.

Please note, all responses are anonymous.

FEQ1 CONFIDENCE
SHOW ALL
SINGLE CODE – GRID
How confident do you feel in the following?
ROWS [RANDOMISE]

1. Dealing with resistance from fathers

2. Engaging fathers who are reluctant to do so
3. Managing conflict between myself and fathers
4. Managing distress from fathers
5. Communicating with fathers
6. Managing conflict between fathers and other parents/caregivers
7. Understanding fathers' needs
8. Eliciting fathers' expectations of social work involvement
9. Working with separated/divorced fathers

COLUMNS

1. Not at all confident
2.
3.
4.
5. Extremely confident

FEQ2 COMPETENCE
SHOW ALL
SINGLE CODE – GRID
To what extent do you feel competent to implement the following strategies with fathers?
ROWS [RANDOMISE]

1. Exploring feelings underlying anger, hostility, powerlessness or blame when it arises
2. Managing conflict (both between practitioner-father and mother-father)
3. Listening reflectively and creating a shared understanding about both parents' perspectives (even when they differ)
4. Negotiating shared goals and expectations (practitioner-father-mother)
5. Listening to fathers and exploring their barriers to engagement

COLUMNS

1. Not at all competent
2.
3.
4.
5. Extremely competent

FEQ3 EFFECTIVENESS
SHOW ALL
SINGLE CODE – GRID
To what extent do you believe the following strategies are effective for increasing the engagement of fathers?
ROWS [RANDOMISE]

1. Exploring feelings underlying anger, hostility, powerlessness or blame when it arises
2. Managing conflict (both between practitioner-father and mother-father)
3. Listening reflectively and creating a shared understanding about both parents' perspectives (even when they differ)
4. Negotiating shared goals and expectations (practitioner-father-mother)
5. Listening to fathers and exploring their barriers to engagement

COLUMNS

1. Not at all effective

2.
3.
4.
5. Extremely effective

FEQ4 FREQUENCY
SHOW ALL
SINGLE CODE – GRID
Over the last two months, to what extent have you used the following strategies when working with fathers?
ROWS [RANDOMISE]

1. Exploring feelings underlying anger, hostility, powerlessness or blame when it arises
2. Managing conflict (both between practitioner-father and mother-father)
3. Listening reflectively and creating a shared understanding about both parents' perspectives (even when they differ)
4. Negotiating shared goals and expectations (practitioner-father-mother)
5. Listening to fathers and exploring their barriers to engagement

COLUMNS

1. Never
2.
3.
4.
5. Always
6. N/A (e.g. caseload does not include any fathers/male caregivers or require use of strategy)

FEQ5 ORGANISATIONAL
SHOW ALL
SINGLE CODE – GRID
How often does your team use the following strategies to engage fathers?
ROWS [RANDOMISE]

1. Communicating that the service is for fathers as well as mothers
2. Obtaining information (about parenting or child behaviour) from fathers as well as mothers
3. Emphasizing the importance of father attendance at meetings
4. Offering meetings outside work hours to enable fathers to attend

COLUMNS

1. Never
2.
3.
4.
5. Always

SELF-EFFICACY
SHOW ALL

SINGLE CODE – GRID

How confident are you that you can…?

ROWS [RANDOMISE]

1. Assess fathers' positive qualities
2. Assess risk in relation to fathers
3. Engage fathers in ways that don't jeopardize the safety of other parents/caregivers and children
4. Engage fathers who are abusive in discussion about their behaviour
5. Help fathers to change ways of thinking that contribute to their problems
6. Help fathers to understand better the consequences of their behaviour on their partners and children
7. Motivate fathers to change their problematic behaviours without increasing their resistance
8. Provide emotional support for fathers
9. Support fathers to learn specific skills to deal with certain problems
10. Work with fathers who appear hostile or aggressive

COLUMNS

1. Not at all confident
2.
3.
4.
5. Extremely confident

TEAM CULTURE

ASK ALL

SINGLE CODE – GRID

To what extent do you agree with the following about your team? Please think about your specific team rather than your local authority overall.

ROWS [RANDOMISE]

3. In my team, there are clear expectations that staff should support fathers of children to engage with social services.
4. In my team, staff are open and receptive to working with fathers.
5. In my team, staff are comfortable working with fathers.
6. In my team, staff are comfortable working with fathers from different cultural backgrounds.
7. In my team, case reviews, child protection plans and/or child in need plans always include fathers.
8. In my team, the message is given to fathers that their role as active parents is crucial to their children's development.
9. In my team, staff view fathers as important only if they have parental responsibility.
10. There is someone on my team who I could turn to for advice and consultation on work with fathers.
11. I myself would feel able to offer advice and consultation to others on work with fathers.

COLUMNS

1. Strongly disagree
2.
3.
4.
5. Strongly agree

6. Don’t know
7. Not applicable

1.3 SECTION C: Current Caseload

SECTION C INTRO
SHOW ALL

Next, we would like to know about your current caseload and the fathers you work with.

By fathers, we mean both biological and non-biological fathers and similar male caregivers, such as stepfathers, parents’ partners, and other family members.

You may wish to have information about your current caseload at hand to help complete this section.

Please note, all responses are anonymous.

HAS CASELOAD
ASK ALL
MULTI CODE
In your current role, do you have your own caseload of children and families?
1. Yes
2. No

Scripting note: If =2, please skip to Section D.

CASELOAD TYPE
ASK ALL
MULTI CODE
Which types of cases are in your current caseload? Please select all that apply.
1. Front door referrals, MASH, and assessments
2. Looked After Children (CLA)
3. Pre-proceedings / Public Law Outline (PLO)
4. Children in need (CiN)
5. Children with protection plans (CPP)
6. Children with disabilities and complex needs
7. Other, please specify [OPEN TEXT]
8. Don’t know [Validate]

SHOW NEXT TWO QUESTIONS ON SAME PAGE
Scripting note: include a tick box that says: ‘Please tick this box if this is an estimate’
TOTAL CHILDREN
ASK ALL
SINGLE CODE
How many children are in your current caseload?

1. OPEN TEXT [VALUES ONLY] with text after box ‘children’

TOTAL FAMILIES
ASK ALL
SINGLE CODE

And how many families/households does this involve? For example, if siblings live in different households/with different parents or children live separate from their parents with other caregivers, please count these separately.

1. OPEN TEXT [VALUES ONLY] with text after box 'families/households'

TOTAL FATHERS
ASK ALL
SINGLE CODE
You said your current caseload includes [TOTAL CHILDREN VALUE] children, involving [TOTAL FAMILIES VALUE] families/households.

Of those families/households, how many include a father or similar male caregiver(s) (e.g. stepfathers, parents' partners)?
Please include both those you actively work with and those you've not been able to engage.

1. OPEN TEXT with text after box 'families/households' [VALUES ONLY, MAX=FAMILIES VALUE with error message 'Your answer is higher than the number of families/households']

FATHERS STATUS
ASK IF TOTAL FATHERS= 1 or more
SINGLE CODE

Scripting note: include a tick box that says: 'Please tick this box if this is an estimate'

Scripting note: at the bottom of each page in this question but above the 'next' button, say "Responses to the sub-questions should not exceed your response to the first question (in bold)."

Now we would like to know a little more about the families/households which include a father/male caregiver.
Out of those [TOTAL FATHERS VALUE] families/households, in how many…
Please only count each family/household once. If you are unsure, please give your best estimate.

ROWS [New page for each bold question (including non-bolded questions underneath)]

2. **Is the father(s)/male caregiver(s) named in the child(ren)'s casefile?**

3. **Are the contact details (i.e. telephone number) for the father(s)/male caregiver(s) known?**

4. **Is the father(s)/male caregiver(s) living with the child(ren)?**
    a. Have you engaged these fathers/male caregivers in discussions about parenting and childcare?
    b. Have these fathers/male caregivers attended their most recent meeting?
    c. Are these fathers/male caregivers the main (or equal) contact for their family/household?

5. **Is the father(s)/male caregiver(s) not living with the child(ren) but their whereabouts / home address is known?**
    a. Have you engaged these fathers/male caregivers in discussions about parenting and childcare?
    b. Have these fathers/male caregivers attended their most recent meeting?

6. **Does the father(s)/male caregiver(s) display behaviours which put their child(ren) at risk of harm?**
    a. Have you discussed with these fathers/male caregivers about their behaviour that is putting their child(ren) at risk of harm?
    b. Have these fathers/male caregivers attended their most recent meeting?

COLUMNS

1. OPEN TEXT PER ROW with text after box 'families/households' [VALUES ONLY, MAX=TOTAL FATHERS VALUE with error message 'Your answer is higher than the number of families/households including fathers']

FATHERS BARRIERS
ASK ALL
MULTI CODE

Thinking about your current caseload, what, if any, barriers do you face when working with fathers and similar male caregivers? Please select all that apply.

[RANDOMISE LIST]

1. I am managing a high caseload
2. They do not attend meetings when invited
3. They do not respond when I contact them
4. They are not actively involved in caregiving responsibilities
5. They have substance misuse issues
6. They are aggressive and/or show violent behaviour
7. The other parent(s) does not want them involved
8. They are not available due to work commitments
9. They are experiencing poor mental health
10. I am unsure how best to engage them
11. I feel less confident engaging them
12. Other, please specify (OPEN ENDED TEXT BOX)
13. Don't know

1.4 SECTION D: Previous relevant training

SECTION D INTRO
SHOW ALL

Next, we would like to know more about any previous training you have taken part in focusing on fathers.

Scripting note: Please add a definition box for 'fathers' in the line above with 'By fathers, this can include both biological and non-biological fathers and other involved male caregivers, such as stepfathers, parents' partners, and other family members.'

TRAINING
ASK ALL
GRID - SINGLE CODE

Thinking about any training you have attended in the past 5 years, to what extent do you agree with the following:

ROWS [RANDOMISE]

1. The training sufficiently focused on how to work with fathers/male caregivers.
2. The training sufficiently focused on how to work with mothers/female caregivers.
3. The training differentiated working with fathers/male caregivers from mothers/female caregivers.
4. The training focused on working with father and mother as equal caregivers.
5. The training taught me strategies for working specifically with fathers/male caregivers.
6. The training improved my practices working with fathers/male caregivers.
7. The training explored different cultural norms and expectations regarding fathers/male caregivers.

COLUMNS

1. Strongly disagree
2.
3.
4.
5. Strongly agree
6. Don't know

PREVIOUS TRAINING
ASK ALL
SINGLE CODE
Have you ever attended previous training on working specifically with fathers/male caregivers?

1. Yes
2. No [validate]
3. Don't know [validate]

TRAINING AMOUNT
ASK IF PREVIOUS TRAINING=1
SINGLE CODE
Thinking about the training specifically on fathers/male caregivers, roughly how many training sessions have you attended?

1. 1
2. 2-3
3. 4-5
4. 6-9
5. 10 or more
6. Don't know

EXTERNAL1
ASK IF PREVIOUS TRAINING=1
MULTI CODE
Thinking about the training specifically on fathers/male caregivers, how was this training delivered? Select all that apply.

1. Face-to-face by internal trainers / colleagues
2. Face-to-face by an external organisation(s) / trainer(s)
3. Online by internal trainers / colleagues
4. Online by an external organisation(s) / trainer(s)
5. Don't know

EXTERNAL2
ASK IF EXTERNAL1=2 or 4
SINGLE CODE
Thinking about the training specifically on fathers/male caregivers, who delivered this training? You can include names of multiple organisations.

[100-word word count]

1. OPEN ENDED TEXT BOX
2. Don't know

TRAINING COVERAGE
ASK IF PREVIOUS TRAINING=1
SINGLE CODE
Thinking about the training specifically on fathers/male caregivers, what did this training cover i.e. key topics relating to fathers? You can include multiple training sessions.

[100-word word count]

1. OPEN ENDED TEXT BOX
2. Don't know

MOST RECENT TRAINING
ASK IF PREVIOUS TRAINING=1
SINGLE CODE
Thinking about the training specifically on fathers/male caregivers, when did the most recent training take place?

1. Within the last 6 months
2. Between 6 months and 1 year
3. Between 1 – 2 years
4. Between 2 – 4 years
5. 5 years ago or longer
6. Don't know

TRAINING IMPACT
ASK IF PREVIOUS TRAINING=1
SINGLE CODE
Thinking about the training specifically on fathers/male caregivers, to what extent, if any, did this impact how you engage with fathers?

1. Not at all
2. Not very much

3. A fair amount
4. A great deal
5. Don't know

1.5 SECTION E: Demographics

SECTION E INTRO
SHOW ALL

In our last few questions, we would like to know a little bit more about you.

AGE
ASK ALL
SINGLE CODE
How old are you?

1. OPEN TEXT [VALUES ONLY 18-99]
2. Prefer not to say

GENDER
ASK ALL
SINGLE CODE
Which of the following describes how you think of yourself?

1. Male
2. Female
3. In another way
4. Prefer not to say

ETHNICITY
ASK ALL
SINGLE CODE
What is your ethnic group? Choose one option that best describes your ethnic group or background.

A. White
    a. Scottish/English/Welsh/ Northern Irish/British
    b. Irish
    c. Gypsy /Traveller
    d. Any other White background, please describe
B. Mixed / multiple ethnic groups
    a. White and Black Caribbean
    b. White and Black African
    c. White and Asian
    d. Any other Mixed / Multiple ethnic background, please describe
C. Asian / Asian British
    a. Indian
    b. Pakistani
    c. Bangladeshi
    d. Chinese

e. Any other Asian background, please describe

D. Black / African / Caribbean / Black British
   a. African
   b. Caribbean
   c. Any other Black / African / Caribbean background, please describe

E. Other ethnic group
   a. Arab
   b. Any other ethnic group, please describe

1.6 Thank you and close

OUTRO
SHOW ALL
Scripting: This should be the page where they submit their answers (rather than selecting next)

Thank you for taking the time to participate in this survey.

You will receive another survey like this one to complete in approximately 4 months.

We have provided you with further information in the Privacy Notice linked below. This explains the purposes for processing your personal data as well as your rights under data protection laws.

If you have any questions about the survey or your data, please contact UK-PA-ISAFEevaluation@ipsosresearch.com.

To submit your answers, please select 'Submit'

SUBMISSION PAGE
SHOW ALL
Scripting: This should be the page after they clicked submit

[To scripter – submission page to say "Thank you for your time. Your survey has been submitted."]

Appendix C: Privacy Notice

ISAFE Evaluation – Privacy Notice for Surveys

1. What is the purpose of this privacy notice?

You have been identified by your local authority to participate in a research and evaluation project. As part of this project, you will be invited to take part in three surveys. This Privacy Notice explains who we are, the personal data we collect, how we use it, who we share it with, and what your legal rights are.

2. What is this survey for?

Ipsos (market research) Limited is a specialist research agency, commonly known as "Ipsos UK". Ipsos UK have been commissioned by What Work's for Early Intervention and Children's Social Care (WWEICSC) to conduct an independent evaluation of an online training programme and organisational development programme about engaging fathers (including stepfathers, parents' partners, and other male caregivers e.g. family relatives) in children's social care services. As part of the this, you will be invited to complete three surveys, with approximately 3-4 months between them.

As part of the project, your team may or may not be invited to attend the training. However, your participation in the surveys is critical regardless of whether you attend the training or not. This will help the evaluation to assess whether and how the training affects father engagement compared to normal practice.

Ultimately, your participation is voluntary and you can choose not to take part.

3. What personal data has Ipsos UK received and what additional data will be collected?

Your local authority has shared a limited amount of your personal data with us for the purposes of inviting you to take part in this survey. This includes your:

- First name(s) and surname;
- Email address and telephone number;
- Job title and employer name.

If you choose to take part, the survey will collect further information about you and ask about how you work with fathers as part of your day-to-day practice and your views on father engagement strategies.

4. How will Ipsos UK use information about you and ensure it is secure?

Ipsos UK will use your personal data and responses solely for research purposes. Ipsos UK have used your personal information to invite you to take part in this survey. Your responses to the survey will be de-identified and combined with responses from other participants to inform the evaluation. Ipsos UK will write a report of the findings at the end of the evaluation, which will be published by WWEICSC. The report will not include your name or any other identifiable information.

Ipsos UK will keep your personal data and survey responses in strict confidence in accordance with this Privacy Notice. Ipsos UK takes its information security responsibilities seriously and applies various

precautions to ensure your information is protected from loss, theft or misuse. Security precautions include:

- Files containing your personal data will be protected by encryption to at least AES 256 standard and transferred to Ipsos UK via a secure transfer mechanism.
- Files containing your personal data will be protected by encryption to at least AES 256 standard and stored on secure servers, only accessible to a small number of researchers. Ipsos UK works with authorised sub-processor, Rackspace UK Ltd, for the purpose of managed hosting services – this is a dedicated infrastructure for Ipsos only.
- The survey platform, Dimensions, is also hosted in the data centre RackSpace UK. All applications and data are managed by Ipsos UK.
- Ipsos UK has appropriate physical security of offices and controlled and limited access to computer systems.
- Ipsos UK has regular internal and external audits of its information security controls and working practices and is accredited to the International Standard for Information Security, ISO 27001.
- Your personal data will be stored and processed in the United Kingdom.

5. Who will my personal data be shared with?

Personal data will **not** be shared outside of Ipsos UK.

However, your survey responses will be **de-identified** and shared with WWEISCSC at the end of the evaluation to be archived in a manner which will aid secondary analysis of the data to inform further research conducted for the benefit of society and, in particular, societal practices in the children's social care sector. Data is archived by the WWECSC in the Office for National Statistics Secure Research Service (ONS SRS) and governed under the UK Digital Economy Act 2017 and the UK Statistics and Registration Service Act 2007.

6. How long will Ipsos UK retain my information for?

Ipsos UK will only retain your data in a way that can identify you for as long as is necessary to support the project. In practice, this means that once we have satisfactorily reported the anonymous findings and shared your de-identified data with WWEICSC, we will securely remove your personal, identifying data from our systems. For this project, we will securely remove your personal data three months after completion of the research and evaluation project, which is anticipated to be no later than November 2024.

7. What is the lawful basis for processing the information?

Ipsos UK and WWEISCSC are 'joint data controllers' for the evaluation and require a legal basis to process your personal data. For the processing of your personal data to invite you to take part in this survey and processing your survey responses, we rely upon: GDPR Article 6.1(f) 'legitimate interest'; GDPR Article 9.2(j) 'Archiving, research and statistics'; and DPA18 Schedule 1 Part 1.4(a),(b)&(c) for special category data including data considered to be a protected characteristic under the UK Equality Act 2010.

Upon completion of the evaluation, WWEICSC shall become the sole data controller of the de-identified survey data. For the purpose of archiving and any subsequent secondary analysis of the data, WWEICSC shall rely upon 'public task' because WWEICSC is acting under the authority vested upon

it by the Department for Education as its funder, which appropriately corresponds to WWEICSC conducting its research under Article 6.1(e) of the UK GDPR. The WWEICSC's Privacy Notice can be reviewed here.

8. Your data protection rights

The rights you have are set out in the General Data Protection Regulation (GDPR) as it applies in the UK, tailored by the Data Protection Act 2018. These include the right in certain circumstances to:

- be informed if your personal data is being used
- get copies of your data
- get your data corrected
- get your data deleted
- limit how we use your data
- object to the use of your data.

If there are any problems with our handling of your data we will notify you and the organisation that is responsible for regulating this (The Information Commissioner's Office) where we are legally required to do so. There are other rights not listed here and exemptions may apply. For more details see here: https://ico.org.uk/for-organisations/data-protection-act-2018/ or contact our Data Protection Officer.

For further information about your rights see here: https://ico.org.uk/your-data-matters/

9. How to contact us

If you have any questions about this privacy notice or the evaluation, please email Ellis Akhurst (Ellis.Akhurst@Ipsos.com) or Raynette Bierman at Ipsos UK (Raynette.Bierman@Ipsos.com) with '22-038027-01 ISAFE Evaluation' in the subject line.

If you wish to exercise any of the above rights or have questions about how we handle your personal data, please contact: Data Protection Officer, Compliance Department, Ipsos (market research) Limited, 3 Thomas More Square, London E1W 1YW, United Kingdom; Email: UK-compliance@ipsos.com and reference '22-038027-01 ISAFE Evaluation'.

If you wish to contact WWEICSC, please contact: Data Protection Officer, The Evidence Quarter, Albany House, London, SW1H 9EA; Email: dpo@theevidencequarter.com and reference 'ISAFE Evaluation'.

You have the right to make a complaint at any time to the Information Commissioner's Office (ICO), the UK supervisory authority for data protection issues via https://ico.org.uk/concerns/ or by sending an email to: casework@ico.org.uk.

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