IMPLEMENTATION EVALUATION OF THE SCALE-UP OF GRADED CARE PROFILE 2

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EVERY CHILDHOOD IS WORTH FIGHTING FOR
Impact and Evidence series

This report is part of the NSPCC’s Impact and Evidence series, which presents the findings of the Society’s research into its services and interventions. Many of the reports are produced by the NSPCC’s Evaluation department, but some are written by other organisations commissioned by the Society to carry out research on its behalf. The aim of the series is to contribute to the evidence base of what works in preventing cruelty to children and in reducing the harm it causes when abuse does happen.

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EXEcutIVE SUMMARY

The Graded Care Profile 2 (GCP2) is a reliable and validated assessment tool, designed to help practitioners identify when a child is at risk of neglect (Johnson et al, 2015). As part of the NSPCC strategy (2016–2021), the GCP2 has been scaled up so that other organisations are supported to effectively use the tool. An implementation evaluation was conducted to identify how well the scale-up worked in practice.

The evaluation was mixed-methods, involving surveys and interviews at two time-points: straight after training and ten months later (post-implementation). There were 46 interviews and 446 surveys in total, involving a range of professionals involved in the roll-out.

The key findings are as follows:

- Feedback on both the training and the tool was positive. Despite the majority of practitioners feeling confident following training, only 48 per cent reported using the GCP2 in the post-implementation (PI) survey. The reasons respondents gave for not using the tool included it not being appropriate for their role (for example, a midwife) or that they had not had any relevant cases yet. Research also suggests that full implementation of a new model can take two to four years (Fixsen et al, 2005). Encouragingly, 92 per cent of practitioners surveyed in the PI survey said they planned to use the tool within the next six months.
• Participants who had received post-training support from the NSPCC felt that this had been helpful. However, local support systems varied, with some areas providing good support systems, such as regular GCP2-related supervision, whereas in other areas the support was described as minimal. This could lead to participants feeling isolated and may potentially impact on their motivation to use the tool.

• When the tool was well embedded, practitioners felt it improved their practice and that families had benefited from their involvement in the assessment when the GCP2 was used. Referrals were felt to be clearer and more likely to have an impact. Some families were reported to make positive health and lifestyle changes as a result of the use of the tool.

• Factors that seemed to facilitate the GCP2 roll-out included sites following a clear implementation plan, having specific GCP2-related roles, champions, management buy-in and commitment, and appropriate support systems, such as refresher training.

• Barriers that hindered the implementation process included difficulties funding the training, organisational restructures and choosing the ‘wrong team’ for the first stage of roll-out. Practitioners were concerned that the GCP2 would add to their workload; however, some asserted that the additional workload was worthwhile due to the benefits for the families involved.
• Fidelity to the model was largely seen as important and core principles appeared to be followed by sites that were continuing to roll-out GCP2.

• Participants illustrated high levels of commitment to continuing the GCP2 roll-out and there were strong indications that this would be sustained. Positive indicators included GCP2 being referenced in policies, contracts for key staff being extended and the tool being promoted.
Background

There is wide-ranging evidence that identification and assessment of neglect presents particular difficulties for practitioners. For example, a survey across English LSCBs showed inconsistency in the criteria for establishing the presence of neglect; confusion about definitions; fear of making negative value judgements; assumptions about cultural factors and children’s resilience; and many examples of children left in damaging situations without support (Gardner, 2008). An Ofsted report (2014) on 11 local authorities also found neglect practice to be “too variable” and reported that “standardised approaches (such as the Graded Care Profile) and comprehensive frameworks…were more likely to achieve consistency in standards of practice”. Additionally, a review conducted by Barlow et al (2012) found the GCP to be one of only two “promising” assessment approaches but recommended further testing.

The original GCP was developed by Dr Srivastava (1997) as a practical tool to give an objective measure of the care of children across all areas of need where there are concerns about neglect. The scale draws on the concept of a continuum of care rather than compartmentalising care into neglectful and non-neglectful. There are five grades\(^1\), based on three different factors: the level of care, commitment to care and the quality of care, and four domains: A) Physical Care, B) Care of Safety, C) Emotional Care, and D) Developmental Care. It is designed to be used by professionals involved in evaluating the

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\(^1\) The grades are applied to Maslow’s model of human needs: physical, safety, love and belongingness and esteem (Srivastava & Polnay, 1997)
care of a child, such as social workers, and is often used again after a period of time to monitor change.

Evaluations of the GCP provided encouraging evidence that the tool could help professionals to identify and address neglect (for example, Johnson & Cotmore, 2015). However, there were some concerns about some aspects of the tool, in particular that the language used was considered too complex and confusing. The tool was subsequently amended by the GCP Review group (Dr Srivastava, Richard Fountain and NSPCC representatives) and is now known as ‘GCP2’. Psychometric testing of the tool revealed that it had moderate to high levels of inter-rater reliability, strong concurrent validity and fairly high face validity (Johnson et al, 2015).

Evaluation of GCP2 scale-up

Part of the NSPCC’s strategy for 2016–21 (Link) is to give more children and families access to NSPCC-evaluated services, where results have been promising. The NSPCC has subsequently started scaling up some of its models. This process involves supporting other organisations to implement these models. An implementation manager leads this process with the support of the development manager. GCP2 is one of several evidence-based tools and programmes being scaled up to other organisations. The GCP2 scale-up began in 2015.

Implementation approach

Sites in Phase 1 of the GCP2 scale-up were recruited using social media and over 100 expressions of interest were received, which translated into 27 applications from local authorities. Drawing on Implementation Science principles (Fixsen et al,
2005), the final ten\(^2\) ‘Early Adopters’ were carefully selected for their implementation readiness. The selection process was more stringent in the early stages as the GCP2 implementation team felt it was important that the first sites were successful in order that this would be ‘contagious’ and encourage Phase Two sites to get on board. This approach was based on the diffusion of innovation model, which explains how new ideas are communicated over time in a social system (Rogers, 1962). The next 17 sites were invited to be part of Phase 2 but were not subject to such stringent vetting.

Each early adopter site received implementation support through site visits and telephone calls to assist with project planning, stakeholder engagement and troubleshooting any implementation challenges. The scale-up of GCP2 involves a ‘Train the Trainers’ (TTT) model, whereby individuals from each local authority are trained to deliver training on the use of the tool. They then deliver the training to practitioners within their localities. A total of 311 people had been trained to be trainers during the course of the evaluation (February 2016–May 2017), with an estimated 2,849 practitioners trained to use the tool across 36 sites.

\(^{2}\) Originally 11 sites; however, one site decided to postpone until Phase 2
Implementation evaluation

An implementation evaluation is being carried out for each tool/programme the NSPCC is scaling up, so we can learn more about how we scale-up programmes to other organisations, what works well and what needs to be improved.

The objectives of the GCP2 scale-up evaluation were:

1. To identify the extent to which the GCP2 is embedded in practice
2. To identify and explore the facilitators and barriers associated with implementing GCP2
3. To explore perceptions and experiences of the support received by the NSPCC
4. To identify the extent to which the use of the GCP2 appears sustainable in the longer-term
Methodology

A mixed-methods approach was adopted, with data being collected both quantitatively through surveys and qualitatively through interviews. There were two time-points for data collection:

- Post-training – soon after facilitators had received their initial training
- Post-implementation – around 10 months after initial training had been received

Surveys

Online surveys were developed with SNAP software and the GCP2 trainers from local authorities were asked to send these via email to all training participants. The first post-training survey was completed by 243 practitioners across 27 sites. The post-implementation survey was completed by 128 practitioners across ten sites. Survey questions focused on perceptions of the training, the tool, support needs and use of the tool. A questionnaire was also sent to all 311 trainers and was completed by 75 respondents (response rate = 24 per cent). Descriptive statistics were calculated from the survey results and a few of the key findings are summarised in this report.

3 We are unable to calculate accurate response rates as some trainers were unable to give details about the number of trainees to whom they had sent the survey. However, we know that the survey respondents make up a low proportion of the 2,849 practitioners who they estimated were trained; therefore, this is a limitation of the research. Additionally, some respondents completed the post-implementation survey too soon, as only 86 of the respondents had been trained more than six months prior to the survey. However, this was taken into account in the analysis as appropriate.

4 Only ten sites were eligible to complete the post-implementation survey due to the date they were trained.
**Interviews**

Forty-six qualitative interviews were carried out, across half the sites. Twenty of these were conducted soon after the training and 26 were carried out ten months later (post-implementation). Interviews were semi-structured and carried out over the telephone or face to face, typically lasting between 30 and 45 minutes. Interviews focused on views of the training and the tool, reflections on using it, implementation issues, support needs and future plans.

Interviewees were recruited through the surveys. The sampling strategy entailed obtaining a cross section across different sites, professional roles and views of the training and tool (as stated in the questionnaire) as far as possible. Interviews took place with people with a range of roles in relation to GCP2 including practitioners (for example, social workers, health visitors, police) who had been trained to use the tool, implementation leads, managers, trainers and NSPCC implementation and development managers overseeing the GCP2 scale-up project. Interviews were recorded, transcribed and analysed using ‘Framework’, which involves coding and summarising the data thematically, while also taking into account the data source.
RESULTS

Views of the tool, training and post-training support

Overwhelmingly, the views of the tool, training and post-training support provided by the NSPCC was positive. However, there were some teething problems reported and suggestions for improvement.

The tool

Overall, interviewees felt that the GCP2 was a unique and much needed tool that filled a gap in practice. It was highly rated, with the vast majority (95 per cent) of survey respondents giving it an overall rating of 4 or 5 (with 1 being very poor and 5 being very good). In terms of how well it supported neglect assessments, it was considered to be a huge improvement from the original GCP as issues like the ‘dated’ and ‘middle class’ language had been addressed and subsequently the GCP2 was considered more family friendly and easier to use. The tool was overwhelmingly described as attractive, up to date, engaging and clear. Participants reported that the colour coding aspect made it easier for parents, particularly those with learning difficulties, to understand. The resources, in particular the newly developed parent leaflet, were considered good quality, attractive and accessible. Participants felt the tool broke down concepts clearly, which helped with parents’ engagement and understanding. The clear and detailed descriptors also helped to illuminate ‘less obvious’ forms of neglect, like emotional neglect or financial insecurity. These helped to provide clarity in ambiguous situations.
where practitioners were unsure whether certain behaviours/symptoms, for example those that may be related to a child’s disability, constituted neglect:

“...I think it’s a really useful, really good, assessment tool. It’s quite black and white. There are no grey areas. Obviously, I’m coming from a disability background, where we have lots of people, me included, where you’re thinking, ‘Is [the behaviour/symptom related to] the disability? Is it [neglect]?’ [The GCP2] makes this quite clear cut.”

(Family Support Worker)

Despite a largely positive picture, there were some criticisms of the tool. Many of these criticisms have already been addressed by the NSPCC following early feedback from sites (See Table 1 in Recommendations section). For instance, participants felt that in some places the scoring descriptors were overly complex, off-putting and created unrealistic standards. For example, the descriptor: “meticulously or painstakingly prepared the food” could be particularly difficult for those with learning difficulties to comprehend. The language and scenarios used were also not always seen as appropriate for some populations, such as teenagers and children with disabilities. However, some practitioners addressed these issues by making slight changes when presenting the tool, for example by using different language or illustrations.
Some aspects of neglect were considered to be missing or not explored in enough depth, especially more serious emotional neglect. There were also concerns that the GCP2’s ‘snapshot’ approach would not identify cases of lower-level neglect that had persisted over a period of time. Some participants complained that the tool lacked space to record comments from both parents/carers and felt that they could not include the voice of the child in the assessment. However, some of these criticisms appear to be a result of misunderstanding of how the tool could be used, for example, the GCP2 development team clarified that two different parents/carers are able to use the GCP2.

**The training**

Both the training of trainers (TTT) by the NSPCC and the subsequent training of practitioners by local authorities\(^5\) were highly rated, with 93 per cent of respondents on the TTT and 89 per cent of those on the GCP2 training rating this as a 4 or 5. Participants were impressed by the trainers’ extensive knowledge, infectious enthusiasm and experience. They felt their explanations of neglect and the tool were clear, detailed and that an appropriate amount of background research was referenced. Participants particularly enjoyed working through the case study and scoring this with their peers, as this helped to build their confidence in the tool and in their ability to use it in practice. They were particularly reassured when other practitioners got similar scores in this activity. Participants felt they were given a large amount of high quality and useful resources, including booklets and a training pack. They really valued the experience of training with a range of

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\(^5\) Both types of training are discussed together as there were many overlapping themes and issues.
professionals from different agencies. This enabled them to learn how other agencies, such as health visitors, schools or social workers, were addressing neglect, dealing with challenges and planning to use the tool.

Although interviewees felt that there was a good balance of practical activities and discussion, some participants wanted more focus on the practical aspects of using the tool, such as how to introduce it or how to deal with avoidant families:

“I think one of the things that might've been useful on the training is how to have difficult conversations with families because obviously if you want to go and look in the children's bedrooms or in the fridge and things like that and the family refuses then how do you overcome that, so some top tips on that sort of thing would've been beneficial.”

(Implementation Lead)

There were some other criticisms of the training and resource. Some of these criticisms, such as those related to technical errors or typos on resources, were teething problems that have been addressed, but others may need further consideration. One criticism was that the TTT training did not cover delivery skills. Trainers wanted tips on responding to questions and engaging with trainees and suggested that role-play and practical delivery skills would have been useful. Some felt that training was too short to cover the considerable amount of content and get enough practice, particularly for those who were expected to go on and be champions of the tool.
NSPCC post-training support

Local authority trainers and implementation leads were overall happy with the level of support provided by the NSPCC and felt comfortable approaching the NSPCC trainer with questions. They were happy with predominantly email support, which was largely considered timely and efficient. Other information/support that was described as helpful included the newsletter, training resources, evaluation guidance and practice development days. However, some participants would have liked more regular and closer contact with the NSPCC, for example supervision for more isolated trainers. Some suggested there should be more online support, such as forums, for people unable to attend events. Other suggestions of support participants would value included providing more information about how to sell the tool to management and different formats of the GCP2, such as a template that could be used in court.

Local post-training support

Some trainers or implementation leads followed up with staff soon after the training to encourage them to start using the tool quickly. This was considered important so that practitioners did not lose confidence or momentum after training. Practitioners were also encouraged to choose a family that they already had a good relationship with rather than starting “cold”. Further support included one-to-one regular supervision but also support on a needs basis to work through complicated cases.
Some participants were offered ongoing training to keep the tool alive in practice, for example discussion groups about the tool or relevant theory, catch-ups for staff and making GCP2 part of the annual LSCB training. Practitioners valued this peer support in a group setting but also on an individual level as their colleagues were an approachable source of information. However, there were instances reported where participants were not offered any further supervision or support for GCP2, despite their manager attending the training. This lack of formal support combined with a lack of meetings or peer support was considered to be isolating and could potentially impact on individuals’ confidence, motivation and ability to use the tool. For instance, some health visitors felt quite isolated and unsure due to not knowing many peers who used the tool, and because of inadequate GCP2-related supervision. One participant felt that health visitors may benefit by working alongside social workers in order to increase their confidence with using the tool and identifying neglect:

“Perhaps it would have worked better if we could have been paired up with a social worker, perhaps co-work that case…I wanted to learn alongside other professionals, what are their thresholds for neglect? What are we seeing? What are they seeing?”

(Health Visitor)
Implementation

There were two main approaches that sites used to roll-out the GCP2:

1) Staged roll-out

Sites using the staged approach either identified and trained a small number of key teams, such as social workers, or ran a pilot before considering rolling out on a larger scale (See Case Study B in Appendix for an example). When strategic leads felt confident that the first stage of roll-out was successful, they would build on this by rolling out to further teams or areas. They felt that by starting on a small scale they could keep more control of the quality of the assessments and identify and address barriers at an early stage. The first teams trained could also potentially act as a source of support and inspiration for the next cohort. There were examples of this working well in practice, with the first staff trained advocating the tool to others, which was considered very powerful and persuasive:

“…I think it was positive that it was other staff that were verbalising, actually this works and it’s useful…Word of mouth has been huge.”

(Implementation Lead)

However, in some areas the first stage was not successful so roll-out either discontinued or a new approach was attempted on the basis of this learning. Some teams felt that they chose the wrong team and the wrong approach for the first stage of the roll-out, and subsequently revised their approach once this transpired. For example, one team had chosen
to roll the tool out to social workers initially, which they later felt did not fit their priority of ‘early help’, as the assessments done by social workers were with families already known to services. Retrospectively, they felt that health visitors would have been a better fit in order to identify and assess ‘new’ families earlier.

2) Large-scale roll-out

Another approach used was to roll the tool out on a much larger scale, involving a number of different teams at once (See Case Study A in Appendix for an example). This approach involved large numbers of staff being trained to use the GCP2 in a short time period. In some areas, teams also received briefings about the tool, whether or not they were using it. These briefings were considered important in order that all practitioners were aware of the GCP2 and managers could understand how to support staff using it and commission other teams to use the tool. Participants involved in this approach felt that the benefits of training different teams at once helped to provide ‘support groups’ from the very start of the roll-out:

“I think the beauty was that because people are all trained together at the same time, they can actually support each other, so you actually create the support groups as you go along.”

(Implementation Lead)
Factors affecting implementation success

There were examples of both staged and large-scale roll-out approaches that appeared to be very successful; therefore, it is difficult to indicate which worked best. Other factors affecting implementation success were as follows:

Fit with local authority need and priorities

Neglect was recognised as a huge issue by local authorities, which practitioners were reportedly struggling to identify. Therefore, neglect was chosen as a priority for many local authorities who felt that a tool such as the GCP2 was needed to enable practitioners to identify and address neglect more effectively. Although the original GCP existed, issues reported, such as the language being considered dated, meant that it was not being used as much, or as effectively as it could be. The GCP2 also fitted well with ‘early help’ priorities, as it was believed that early identification of neglect and related support could potentially prevent cases escalating further. As strategic leads felt the tool fulfilled their local needs and matched their priorities, this hugely helped in terms of ascertaining their commitment to roll-out the tool.

A clear implementation strategy

When strategic leads and managers developed and followed a clear and carefully considered implementation strategy, this helped to get the tool embedded in practice. Participants reported that the NSPCC strongly emphasised the importance of having a clear implementation plan in place, so they followed this advice. However, it was considered critical to ensure that there was a key member of staff identified to lead on this plan.
Specific GCP2 roles/groups

Creating specific GCP2-related roles for staff really helped to get the tool embedded in practice, in particular having implementation leads and GCP2 coordinators. Having an implementation lead with the key responsibility of driving the tool forward helped it to become embedded operationally. Implementation leads were also able to monitor progress while providing ongoing support to practitioners and managers:

“...if people have an issue, they can email me or ring me or speak to me, and they know that I’m tracking and auditing and feeding back all the time. I think because there’s a named person you can keep that drive behind it.”

(Implementation Lead)

Some sites also had multi-agency steering groups, which were viewed as useful in terms of encouraging multi-agency collaboration and partnership working.

Management buy-in and commitment

In order for the GCP2 roll-out to be successful, management buy-in and commitment was considered crucial to provide a ‘top-down push’, which cascaded down to frontline practitioners. When there was a lack of management direction, the tool was used rarely or not at all. Interviewees emphasised that all levels of management needed to be committed and enthusiastic about the tool in order for roll-out to be fully successful. If managers attended GCP2 training or briefings about the tool, this helped to ascertain their buy in and commitment:
“Our Head of Service, our Director, he came along to the second half of the training as well and pledged his support for it and that he was on board...So we know we’re supported from above and hopefully from the practitioner’s level as well.”

(Implementation Lead)

Appropriate support systems

In order for implementation to be fully effective, sites needed adequate support systems in place, such as GCP2-related supervision, training and encouragement from managers and trainers. When GCP2 was included in annual training cycles, this helped to mitigate the issue of staff turnover, which could otherwise have a huge impact when key staff left.

Mandated or self-selection

Some sites made the use of the tool and training mandatory, whereas others used a ‘self-selection’ approach. Both of these methods appeared to be successful. However, when a ‘champions’ approach was adopted, it seemed important that individuals volunteered for this role – rather than being told they were going to be a champion. When champions self-selected due to a genuine interest and passion for the tool, this was felt to hugely facilitate the implementation process. One site, however, chose a ‘compulsory champions’ approach, where practitioners were nominated as champions. This approach was reported to fail as the ‘champions’ did not end up using the tool, either because they had no desire to be a ‘champion’, or because they thought the tool was not suitable for their role.
Attitudes to GCP2

When key people were passionate and vocal advocates of GCP2, this clearly helped to embed the tool in the organisation. The enthusiasm of these ‘GCP2 champions’ could be contagious and would therefore encourage others to use the tool, as they became convinced of its value. Conversely, some attitudes, or apprehensions and misunderstandings about the tool, could act as a barrier to GCP2 being implemented. For example, some health visitors were reported to be resistant to the tool, feeling that it did not fit in with their usual way of working. They found certain aspects of the tool uncomfortable, or inappropriate, such as the requirement to look in people’s fridges to see what food was available for the children:

“…they’re not used to observing and going into the detail that they need to evidence for the Graded Care. If there are issues around nutrition and meals, they are maybe uncomfortable asking to see what kind of food is in the house. If it’s home conditions, they may not want to ask to go upstairs.”

(Implementation Lead)

Misunderstandings about neglect and the tool could also be a barrier. For example, some practitioners felt that the GCP2 should not be used for children with disabilities. However, these misconceptions were reportedly challenged, with managers giving explanations, for instance, about how children with disabilities can be neglected in the same way as non-disabled children.
Resource

Resource was a factor that frequently cropped up when discussing barriers to implementation. In the first instance, it was difficult for staff to find the time to attend the training. There were also perceptions that the GCP2 was more time consuming than previously used methods of assessment. Developing recording systems and quality assurance protocols could also be time consuming. However, some implementation leads were able to address these concerns by promoting the tool as something that could save time in the long run, as well as have more of an impact than other forms of assessment. For instance, the GCP2 assessments were promoted as something that would make report writing easier and more straightforward. Furthermore, many interviewees emphasised that any additional time spent on the assessment was worthwhile due to the potential benefit for children:

“I think the negatives for the practitioners, it does take a long time to complete, but then if you’re talking about a child’s welfare then what is time?”

(Detective Inspector)

Another resource-related barrier was funding. Where sites had underestimated or misunderstood the resources needed for implementation or did not have enough funding to sustain the model, this had a clear impact on the roll-out. One site subsequently withdrew and reverted to using an adapted version of the original GCP.
External factors and logistical issues

Other external and logistical issues that affected the roll-out included organisational restructures, high staff turnover and negative Ofsted reports. Restructures and negative Ofsted reports could be very unsettling and put organisations under considerable strain. Therefore, it could be very difficult to introduce a new tool at a time when staff were worried about keeping their jobs. Additionally, changes in staff could result in the loss of GCP2-related roles and skills. This had a greater impact when an individual leaving was key in the roll-out process. Having a rolling training programme and ensuring that new starters have GCP2 training was one way that sites managed to address this issue.
Use of the tool

Despite most practitioners saying they felt confident following the training, only 48 per cent (n = 41) had used it six months after the training had ended, and their use of the tool was fairly limited at this stage. Reasons for not using the tool included that they had not yet had any relevant cases, that they would not use the tool as part of their role (for example, a speech therapist) or that they preferred an alternate method. Additionally, research on implementation suggests that it can take two to four years to embed a new initiative (Fixsen et al, 2005); therefore, it is important to bear in mind that this figure is based on tool use at a relatively early stage in the process. Encouragingly, 92 per cent of respondents in the post-implementation survey said that they were likely to use the tool in the next six months.

Practice improvements as a result of GCP2 use

When the tool was well-embedded, participants described a range of ways in which practice at their site improved as a result. There were three key ways in which the GCP2 was described to facilitate the referral process:

1) The GCP2 increased practitioners’ confidence and ability to identify neglect and make related referrals when necessary. This could be particularly useful when practitioners were relatively inexperienced or did not have social work training.

2) The tool gave practitioners a ‘shared language’ so that issues raised would be clearly communicated and understood between different agencies.
3) The GCP2 provided strong, clear evidence about the extent of neglect. Interviewees felt that the tool was well-respected and the evidence it produced carried some weight in the child protection arena. Therefore, referrals referencing GCP2 results were considered more likely to have more of an impact than when neglect was reported using alternate methods:

“The school had concerns around parenting and made the referrals to all sorts of agencies, but it was always just dismissed. Using the (GCP2) we were able to evidence it, that there is emotional neglect.”

(Family Support Worker)

Other ways in which the GCP2 was being used included in courts, in case conferences, in Child and Family Conference reports, as part of the Early Help Assessments and with families who have a Common Assessment Framework. The tool also could support multi-agency working by enabling the comparison of results between agencies so that change could be measured over time for cases.

Engaging families in an assessment where the GCP2 was used could sometimes be a challenge for a range of reasons, including parents being concerned that they may be referred to social services and some aspects feeling intrusive. However, it was acknowledged that this challenge was not just associated with GCP2, as it was reportedly often difficult to engage families in work of this nature. Interviewees said that when practitioners took time to build a relationship with the family before introducing the tool, this helped with engagement.
Nevertheless, there were ways in which the tool was described to help to raise the topic of neglect with families in a more objective and sensitive way.

**Positive changes for families**

Practitioners reported a number of positive changes for the families they had assessed using the GCP2. They felt that the tool helped practitioners to highlight how parents’ behaviours might be harmful to their child in a way in which they were able to understand. The focus on strengths encouraged parents to engage with the tool and, in some cases, participants felt that this appeared to boost the parents’ self-esteem. This focus on strengths as well as weaknesses was useful because positive scores could reinforce the parents’ positive behaviours while motivating them to make further changes in order to improve scores. Some interviewees gave examples of positive changes parents had made as a result of the assessment and the work that followed. These included lifestyle and behavioural changes, such as de-cluttering their houses, no longer leaving children unsupervised, helping to support a healthier lifestyle for an obese child and improved interactions with babies and children:

“One health visitor used GCP2 with mother on cusp of post-natal depression – she had no ‘natural warmth’ for her 10-week-old baby. The health visitor and mum then did a very focused bit of work which also involved the dad. Six months [later] she was ‘happy to get on the floor with her baby and be silly’. The health visitor said,
‘you know it’s just absolutely lovely to be part of that’.”

(Implementation Lead)

Interviewees also described instances, when GCP2 scores were high, where the child ended up being removed from the home. Although not considered ideal by the participant, they felt this was a positive outcome for the child.

Model fidelity

Fidelity to the model was largely considered to be important. In fact, there were some misinterpretations about how the tool could be used in a more flexible way – for instance, not understanding that they were able to change the way the tool was presented to participants, such as by using simpler language or visual aids, so that those with learning difficulties could find it more accessible. On the whole, the messages that were emphasised in the training about the importance of model fidelity appeared to have resonated with participants. However, while not compromising fidelity, some practitioners did not follow all of the GCP2 guidance – for example, not checking rooms on home visits.

Sustainability

There were high levels of commitment to GCP2 and strong indications that the roll-out would be sustained, which seemed much more apparent than with some of the other evaluations of NSPCC programmes that had been scaled up. Positive indicators included GCP2 being referenced in policies like the service guidance and business plans, contracts for key staff being extended and the tool
being promoted at events. Areas were planning to continue or increase training, increase numbers of trainers and GCP2 training uptake was high. Sites were also running sessions to raise awareness about the tool, management briefings, planning their continued roll-out and collecting feedback to see how this could be improved. There were also plans to audit use of the tool and conduct evaluations and multi-agency case audits to demonstrate outcomes and inform future actions. This was supported by including GCP2 in recording systems and integrating IT systems across agencies. However, some areas were not continuing roll-out, mainly due to funding and resource shortfalls.
Conclusion

The GCP2 was overwhelmingly viewed as a clear, comprehensive and attractive tool, which practitioners felt supported their assessments of neglect and benefitted families. Interviewees believed that it led to better identification of neglect, increased practitioners’ confidence in their decisions and helped to contribute to clearer, more comprehensive reports and referrals. Due to the strength and clarity of evidence the tool provided, and because it is validated and well respected within the child protection field, referrals using the GCP2 were considered more likely than other assessment methods to lead to actions to support the child. Interviewees gave a number of examples of how families had made positive changes as a result of the tool, such as de-cluttering houses and making healthier choices; the tool helped to reinforce these changes when practitioners showed them the evidence of these improvements. Although interviewees were, on the whole, positive about the tool and training, there were a number of criticisms. The majority of these have already been fed back to the GCP2 development team and addressed to some degree. For example, further guidance has been developed for those using the tool with adolescents and a new module on delivery skills has been incorporated into the TTT programme.

Following the training, some participants requested further support from the NSPCC and this was well received. Although a number of interviewees said they had not required any post-training support from the NSPCC, they felt that staff were approachable and would have contacted them if they had needed help. Although there were examples of good local support and supervision, there were instances where
this seemed to be lacking. This particularly seemed an issue for health visitors who may need more support and encouragement, due to their initial concerns about the GCP2 and because they did not tend to work closely with other professionals who used this tool.

Despite most practitioners reporting they were confident after training, just under half had used it six months later and use was fairly limited, though the majority of respondents indicated that they would use it in the following six months. Although this may be considered disappointing, research (for example, Fixsen et al, 2005) suggests that full implementation of a model can take between two and four years; therefore, some sites may have needed more time to get on board. A longer-term follow-up survey may therefore be useful. Additionally, some participants had not had the opportunity to use the measure yet because of a lack of relevant cases or would not do so as part of their role, though the training could still be useful for them to raise awareness of the tool.

The roll-out of the GCP2 seemed to be successful in many areas, with strong indications that the model would be sustained. Fidelity to the model was considered important and was largely followed. Participants felt that the GCP2 filled a gap in practice and fit in well with organisational priorities and this contributed to a successful roll-out. Sites took slightly different approaches to roll-out and there were examples of staged and large-scale approaches that were working well. Factors that facilitated the roll-out process included creating specific GCP2 roles, such as an implementation lead, commitment from all levels of management, champions, a clear implementation plan and
ongoing training and supervision. Barriers included restructures, staff turnover, negative attitudes and resource issues. Nevertheless, although the tool was considered by some to be resource intensive, interviewees also described how it could save time, for example, in terms of more efficient report writing. Overwhelmingly, where the tool was well embedded, participants asserted that any additional time spent was worthwhile, due to the potential benefit for children.

How these findings are being used

The GCP2 scale-up team were already aware of and had addressed a number of these issues from the interim evaluation findings or feedback from sites. Table 1 details the key barriers identified along with how NSPCC have addressed, or plan to address, these issues
Table 1: Barriers and NSPCC responses

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| **Resource issues:** time to attend training, time to use the tool, set up admin systems, funding cuts | • Offering strategic workshops to encourage senior management to give their support  
• Linking local authorities with each other to help with resource requirements  
• Holding face-to-face strategic briefings with every site to explain the resource implications of GCP2 |
| **More practical delivery skills needed (TTT)** | • A Micro Teach module on delivery skills is now included in TTT                                                                              |
| **Resistant attitudes to using the tool:** in particular from health visitors, who do not see using the tool as part of their role | • Trainers can tailor their training, and are made aware of potential resistance of health visitors  
• Benefits of the tool and why it is a worthwhile investment emphasised in training  
• Community of practice events held to share best practice, challenges and support. A GCP2 coordinator, who is a former health visitor, is speaking at the next event to promote how health visitors have successfully used GCP2  
• GCP2 team are planning an article about engaging health visitors in the next newsletter |
| **Sites choosing wrong teams for roll-out/wrong roll-out approach:** for example, the ‘compulsory champions’ approach | • Implementation is covered extensively in the training, initial briefing and strategic workshop. Self-selection is strongly advised |
| **Tool not considered suitable for some populations:** for example, adolescents and parents with learning difficulties | • A leaflet for young people to explain how the GCP2 is being developed  
• There is now a section in the handbook about adolescent emotional development, relationships and peer groups  
• USB stick containing training material and resources for sites has been refreshed and now includes research about adolescent neglect for further reading  
• Practitioners encouraged to amend the language for different populations  
• An ‘easy to read’ parents leaflet that uses ‘smiley face’ scales has been produced to support the use of the tool |
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| **Misunderstandings about some aspects of the tool:** for example, practitioners not understanding that the tool can include multiple perspectives in cases of co-parenting/voice of the child, can be presented differently to aid understanding and the types of neglect that the tool addresses | • GCP2 trainers to be aware of these misunderstandings and to promote how the tool can be used more flexibly, for example, including 'a voice of the child' section in the assessment  
• Trainers to also promote clear messages about how the tool can be used more flexibly, while not compromising fidelity  
• GCP2 trainers to emphasise that practitioners should also refer to the handbook, which gives further advice and examples of the different types of neglect assessed by the tool |
References


Appendix

Case study A

**Approach:** Large-scale roll-out with mandatory tool

**Details:** The tool was rolled out across the local authority to 115 staff in a short space of time by running a training session every week for three months. This area had support from management on various levels including Early Help and Children’s Social Care Service Managers, the LSCB, the Assessment Team and the Family Support Team. Management’s support and knowledge about the tool was encouraged with a targeted half-day seminar about the tool or going to the training:

“I think we’re lucky because we have got the support of all the different levels of management to keep it rolling forward”.

(Implementation Lead)

**Evidence of success:** Strategy described as a success at the time of interview – 83 assessments had been completed.

**Sustainability:** Site A planned to continue using the tool over the next few years and make it a natural part of early assessment. It was written into their Neglect Strategy, Early Help Strategy, the LSCB Business Strategy and the area’s business plan. They were also auditing the use and impact of the tool and had committed to putting it into their electronic recording system.
Case study B

**Approach:** Staged approach with self-selection

**Details:** This site began with a pilot involving a health team and then trained each team in the entire county. Allowing staff to self-select to attend the training was considered a good approach as it meant “word of mouth” enthusiasm spread throughout the agency. Management on all levels were supportive and this was underpinned by a full day of condensed management training. Implementation was also supported from the top by an LSCB steering board.

**Evidence of success:** The roll-out was considered a huge success. Enthusiasm for the tool led to the implementation lead’s secondment being extended and the employment of an overall GCP coordinator. A large number of staff (287) were trained.

**Sustainability:** GCP2 is to become the “tool of choice” for every neglect case in this area. In order for the tool to become the common language for multi-agency meetings, this site trained everyone, even if they were not doing assessments so that they would have a good understanding of the tool. The tool was further embedded by following up assessments with supportive supervisors and reflective group supervisions. This was supported by significantly increasing the training team from two to 18 trainers, who were running two GCP2 training days per month.