Appendices: Children's social services and care rates in Wales – A survey of the sector

This document comprises appendices from the full report: Forrester, D., Wood, S., Waits, C., Jones, R., Bristow, D., and Taylor-Collins, E. (2021). **Children's social services and care rates in Wales: A survey of the sector**. Wales Centre for Public Policy.

Appendix A: Survey

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Appendix B: Respondents

Table B1: Gender of respondents

	N	%
Female	657	83.2
Male	126	15.9
Other	1	0.1
Missing	6	0.8

Table B2: Age of respondents

	N	%
18 – 24	10	1.3
25 – 34	180	22.7
35 – 44	233	29.4
45 – 54	214	27.0
55 – 64	142	17.9
65 – 74	11	1.4
Missing	2	0.3

Table B3: Ethnicity of respondents

	N	%
Asian / Asian British	7	0.9
Black - African / Caribbean / British	4	0.5
Mixed / Multiple ethnic groups	11	1.4
Other ethnic group	4	0.5
White	756	95.5

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Missing	10	1.3

Table B4: Current role of respondents

	N	%
Social worker or senior social worker	354	43.5
Student social worker	24	2.9
Team manager / deputy team manager	160	19.7
Senior manager/ head of service/ director of service	74	9.1
Other (please specify)[1]	180	22.7

Table B5: Current Team* of respondents

	N	%
Child in need / child protection	176	22.2
Disability services	79	10.0
Fostering and adoption	98	12.4
Looked after children	95	12.0
Referral and assessment	73	9.2
Other (please specify)	197	24.9

*Workers only

Table B6: Respondent is a qualified social worker?

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[1] Those in the "other" category covered many roles, from Independent Reviewing Officers to various support services for families. Administrators or those who didn't specify their role were excluded from all analyses (n=22).

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	N	%
Yes	584	73.7
No	208	26.3

Table B7: Level of education held by respondents

	N	%
BA/BSc	431	54.4
MA/MSc	190	24.0
No degree/certificate/diploma	168	21.2
PhD/Professional Doctorate	3	0.4

Study sample representativeness

The latest data (2019) on social workforce statistics show that there were 3,916 individuals working in children's social services (StatsWales, 2019) and 1,694 qualified social workers (Social Care Wales, 2020). Based on these figures, removing respondents who described their role as "administrative, other" (but left the description blank) and leaders (who are categorised separately by StatsWales) we are left with 718, a response rate of about 18.3%. For qualified social workers (n=584) working in CSC our response rate is 34.5%.

LA response rates ranged from 2.2% to 58.0% (see Table B8). The LA with a response rate of 2.2% would have been excluded from the LA comparative analysis, but in fact was in neither group. To work out the minimum sample size needed to have a statically valid response rate, a sample size calculation was used with 5% margin of error, a confidence level of 95%, and a standard deviation of 0.5 (Smith, 2020). Based on the population sizes stated above, to produce results representative of these population averages we needed a sample of 350 for all CSC workers and 314 for qualified social workers.

Our study sample is also representative of social worker demographics in Wales. Data shows that 82.3% and 17.7% of social workers in Wales are female and male respectively (StatsWales, 2020). Our sample of qualified social workers includes

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84.5% female and 15.3% male.[2] Likewise, our age profile is also representative. Most qualified social workers in our study were aged between 35-44 (29.3%) and 45-54 (26.2%); the average age of a qualified social worker in Wales is 46. Where our sample differs slightly from the Welsh average is for ethnicity: 95.9% of qualified social workers in our sample were white, compared to the national average of 88% (breakdown by sector is not available so it is not possible to tell how representative this is of CSC). Finally, missing data ranged from 1–16%; as the survey progressed the amount of missing data increased, but there was no evidence of missing data being greater in certain demographic groups or LAs.

Table B8: Response rate by LA

	Number of CSC workers[a]	Our sample*	Response rate by LA (%)
LA1	179	50	27.9
LA2	142	35	24.6
LA3	242	43	17.8
LA4	277	47	17.0
LA5	279	22	7.9
LA6	122	12	9.8
LA7	120	34	28.3
LA8	56	19	33.9
LA9	114	38	33.3
LA10	122	53	43.4
LA11	91	29	31.9
LA12	59	18	30.5
LA13	144	15	10.4

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[2] One participant identified their gender as 'other'.

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LA14	299	39	13.0
LA15	217	28	12.9
LA16	184	25	13.6
LA17	194	52	26.8
LA18	453	25	5.5
LA19	231	5	2.2
LA20	157	91	58.0
LA21	127	18	14.2
LA22	107	20	18.7
Wales	3916	718	18.3

*Minus respondents who described their role as administrative, other (but left the description blank) and leaders

[a] Source: StatsWales (2019)

Appendix C: Methods and approach to data analysis

Survey development

A stakeholder group consisting of heads of children's services, Welsh Government officials, and academics in Wales were consulted throughout the development of the survey. Areas for inclusion were identified through review of the literature, consultation with the stakeholder group and meetings with CASCADE's group of mothers with experience of CSC. An initial long version of the survey was piloted by a small number of social workers not based in Wales (n=5) and was trialled and commented on by the stakeholder group. Following this, questions were clarified, refined and several were removed to ensure the survey could be completed more quickly. The questionnaire took approximately 15 minutes to complete and was available in both Welsh and English. As an incentive for completing the survey,

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respondents were entered into a charity prize draw and one respondent per LA won a £250 contribution to a charity of their choice.

Ethical approval was provided by the University of Cardiff School of Social Sciences ethics committee.

Types of data

The survey consists of four types of data:

1. *Individual closed questions* (quantitative Likert ratings) – related to respondents' views on key factors influencing care decisions and rates.
2. *Responses to short case studies* – four responses to two case study vignettes, designed to elicit different responses to high-risk scenarios.
3. *Worker values* – a questionnaire with three subscales used in other international research to identify worker values.
4. *Open-ended qualitative responses*

Closed questions were developed from reviewing the literature and in consultation with the stakeholder group to reflect key issues considered relevant in influencing care rates. They were then refined through the piloting process.

Case study vignettes were developed from a pilot study. This had two stages. First, workers and managers in Wales were asked to provide anonymised and non-identifiable case studies of families in which they or others had found decision-making around care to be difficult. Eight such case studies were provided, which we then further shortened and adapted to ensure anonymity. The eight case studies were then responded to by 18 social workers in England and the two case studies which elicited the most diverse responses were selected for the questionnaire. Each case study had an immediate and a longer-term response. Responses to the case studies were ranked from 1–3 based on level of risk appetite, with 3 being the most "risk focused" response (i.e. removal of the child from home). Mean responses to the case studies were calculated per respondent, taking their "risk score" into account. Internal consistency of the risk scores across case studies were calculated using Cronbach Alpha (Cronbach, 1951).

The worker value component was developed from the work of Davidson-Arad and Benbenishty (2010). Three attitude subscales were chosen which consisted of several questions (see Appendix A for a copy of the survey with questions). As directed by the steering group and with advice from Benbenishty, some questions in these subscales were grouped to reduce the number of questions asked and make the survey a more acceptable length for respondents to complete. In each of these

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areas both positive and negative attitudes were included (reverse coding was used to create an index for each attitude). The subscales included several questions on a specific theme. Respondents were asked to indicate their agreement with each item on a five-point scale, from 1 = strongly disagree to 5 = strongly agree. Cronbach Alpha was used to measure the internal consistency of the scale. The subscales and associated Cronbach Alpha scores were: *Against removal from home of children at risk* (0.6); *Positive assessment of ability of foster care to promote children's development and well-being* (0.6); *Favours reunification and optimal duration of alternative care* (0.5). The scale reliability coefficient of 0.6 means the scale has an average internal consistency. A coefficient of 0.5 has adequate though relatively low internal consistency, but is still a usable measure. Mean scores for each subscale were calculated.

Open-ended qualitative responses were sought at several points in the survey. Respondents were asked for their views on the recent increase in care rates and on what actions could reduce care rates. They were also asked for their views on whether and which practice frameworks they used.

How valid and reliable were the case study measures?

Responses to case studies have some "face validity", in that one might expect the way that workers respond to be an indication of the way they make decisions with actual families. They also had "discriminant validity" – in other words, they elicited a variety of responses. Statistically, the combined risk score had relatively low, though acceptable, internal consistency (Cronbach Alpha= 0.5). This means that an individual's answer to one question did tend to relate to their answer to other case study questions, but that the relationship was relatively weak. We therefore tested responses to each case study as well as a combined case study score. We found stronger differences in response to Case study 2, and therefore used this in most analyses. We sometimes also refer to Case study 1 or the combined score.

Given the developmental nature of responses to the case studies we also explored whether they were related to other features of LAs. The case study measures were positively correlated with deprivation in LAs (r_s= 0.1, p=0.004). In other words, more affluent LAs were more likely to respond in a risk-focused way. This may be an example of a phenomenon called the inverse intervention law, where families with problems stand out in areas with lower levels of deprivation and are therefore more likely to have child protection or court intervention (Bywaters et al., 2015). This is a weak relationship, and given the fact that the measure is not validated we should be very careful in interpreting it. But it does point to some of the complexity underlying

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our analysis of the relationship between practitioner responses and LA characteristics.

Levels of analysis

Our analysis was informed and guided by the literature and by input from the steering group. The following types of analysis were carried out:

Descriptive analysis

Purpose: To provide an overview of worker views on factors influencing care decisions, worker responses to risk, and worker values in Wales and as a basis for the comparative analysis outlined below.

Approach: Quantitative data were summarised (mean, standard deviation or distribution depending on variable). The values questionnaire presents overall and subscale data. Responses to case studies are provided for each question, each case study and overall. Qualitative data were categorised into simple themes and sub-themes. Codes were developed through iterative thematic review by one researcher, and then independently checked by a second. This led to a combination of some themes which seemed similar. Multiple codes could be present in each response. Non-codable responses were excluded. These typically contained responses in which the respondent has no answer or contained no information to code, e.g. "no"; "not applicable", "unsure", "tackle the above", etc.

Factor analysis

Purpose: Factor analysis simplifies the data by grouping questions that are related to each other. A smaller number of factors allows for a simpler presentation of findings and a clearer comparative analysis.

Approach: Exploratory Factor Analysis (EPA) was used to understand the underlying structure of the data and reduce data dimensionality. EFA is a statistical technique used to detect a smaller set of underlying factors (latent variables) that explain the covariance/correlation among a larger set of variables (Mehmetoglu and Jakobsen, 2017). We entered all questions from the survey about the LA and their practice into the analysis. First, a correlation matrix was used, which included all the observed variables about the LA and their practice to be factor analysed. All variables from the survey were included, except questions specifically about leaders, as only workers completed these questions. The factor extraction method used was the principal (axis) factor, which inserts estimates of the common/shared variance (communality) in the diagonals of the starting correlation matrix. Fourteen factors were uncovered in

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the data. The number of factors to retain initially was decided using a combination of the eigenvalue rule, scree test and parallel analysis. These suggested the first eight factors should be retained. They explained 93.5% of the variance in the data. To obtain a more easily interpretable factor solution, the initial factor solution was rotated using oblique rotation. An oblique rotation is preferred over an orthogonal rotation when measuring behavioural phenomenon, as it is more realistic that factors (latent variables) are somewhat correlated (Harman 1976).

Confirmatory factor analysis

Results from the EPA were used to select parameters for confirmatory factor analysis (CFA). CFA was then used to test the validity and reliability of factors and to determine factor loadings. Variables with factor loadings of over 0.4 were selected for the initial confirmatory factor analysis (CFA) model (Mehmetoglu and Jakobsen, 2017). The model was estimated using maximum likelihood. Factor/scale reliability was assessed using Raykov's (1997) reliability coefficient. Factors with reliability coefficients less than 0.7 were dropped from the model. Factor convergent and discriminant validity were assessed using STATA's command *condisc*. This calculates the average variance extracted (AVE) by the latent variable which, for the factor's convergent validity to be present, should explain at least 50% of the variance in its associated indicators. This left us with four latent variables.

To establish discriminant validity the latent variables should be distinct from each other. The higher the correlation between a latent variable and its indicators as compared to its correlation with other indicators in the model, the more distinct the latent variable is. To measure this, the latent variable's AVE should be larger than the squared correlation between other latent variables in the model. Only factors which established discriminant validity were included. Model fit was tested using the Chi-squared (X^2) test, the standardised root mean squared residual, root mean squared error of approximation, comparative fit index and Tucker-Lewis index. We concluded our model fit was good. Labels for the four factors were decided by the researchers based on the variables included (see the Findings section in the main report).

Comparative analysis

Choice of comparative analyses

In deciding how best to group responses to help us understand differences in rates between LAs, there were some comparisons we decided not to undertake. First, we did not compare at the level of individual LAs (though individual LAs will be given

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feedback on their results compared to the average for other authorities). This is because variations in response rates and who responded within each authority mean considerable caution would be needed in interpreting findings at the level of individual authorities. Individual LA comparisons are also complicated by the fact that each LA is unique and care rates are influenced by multiple factors, notably deprivation. There was therefore a high likelihood of false negatives (i.e. failing to identify genuine differences in survey results related to care rates).

An approach more likely to identify important differences is to combine similar LAs and compare responses in them to those in other LAs – a between-group analysis rather than individual LA analysis. The key for such an analysis is to identify meaningful groups.

LAs with increasing or decreasing rates of care were identified by the steering group as of key interest. We therefore identified LAs with increasing care rates greater than the Welsh average (21%) in the last five years and those with a decrease greater than 10%. We wanted to ensure increases and decreases were substantial enough to warrant comparison – in other words, there were likely to be differences in practice.

A risk with such a comparison is that LAs with unusual rates of care five years ago (e.g. very high or very low) might be identified as "increasing" or "decreasing", while they are in fact just returning to the mean. To do this we calculated an expected care rate for each LA once deprivation was allowed for. As discussed in the Introduction of the main report, underlying levels of deprivation exert such a strong influence on care rates that comparing authorities with high or low care rates is primarily a comparison of high or low deprivation. We therefore calculated the care rate that might be expected based on the level of deprivation in the authority, and then identified those authorities that varied substantially from this. Predicted care rates were calculated using a linear regression equation (Fig. C1) for rates of children in care and deprivation (WIMD 2019). Residuals (the difference between observed care rates and predicted care rates) were calculated.

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Figure C1. Scatterplot with overlaid linear prediction plot for care rate and deprivation (Source: StatsWales, 2021; WIMD, 2019)
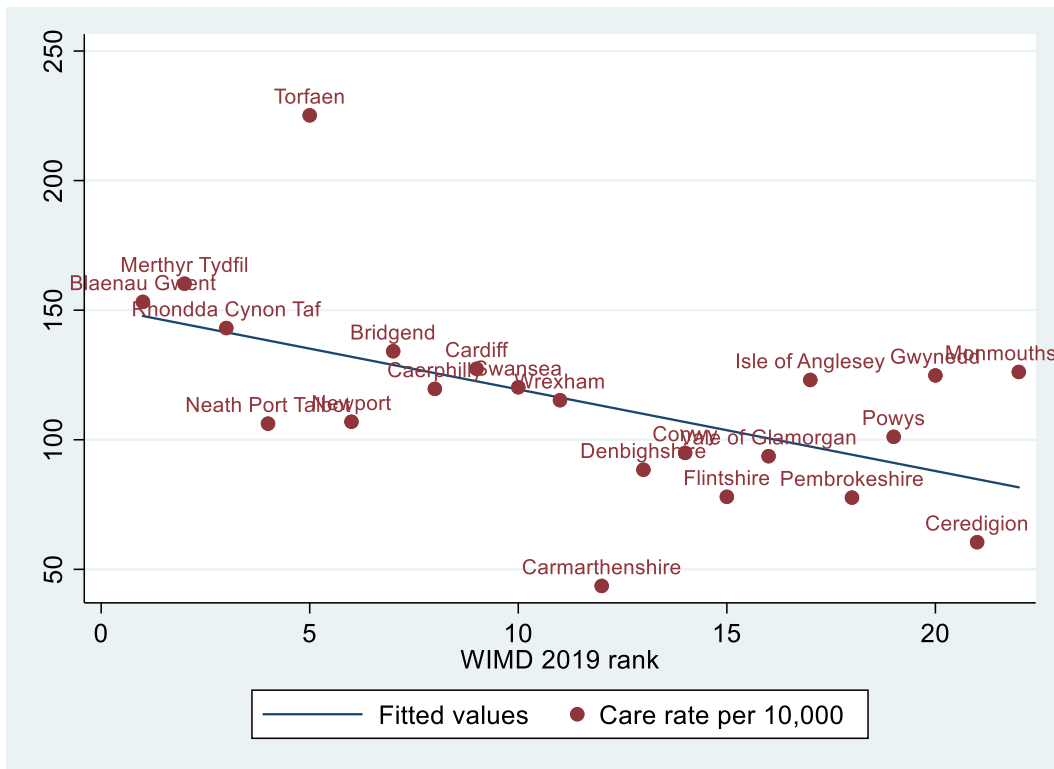
We excluded LAs in the increasing group that had a care rate 15% lower than expected in 2020; likewise, we only included LAs in the decreasing care rate group if their care rate was 15% lower than expected based on deprivation. This was to try to identify the LAs that are doing things differently and to account for deprivation in our analyses. This resulted in one LA being excluded from the increasing care rate group as its predicted rate of care was more than 15% lower than predicted in 2020.

This created two groups: LAs with decreasing care rates and LAs with increasing care rates. There were just two LAs in the decreasing care rate group, but they have a very marked difference in relation to care rates to all other Welsh LAs. The total number of respondents in the decreasing group is 70, and 413 in the increasing group from 10 LAs (see Findings section, Table 3 for selected LAs).

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What are the similarities and differences in the views of leaders and workers about factors influencing care rates?

Approach: We compared the responses of leaders and workers using:

- The seven factors.
- Three values subscales.
- Responses to each case study.
- Demographics: age, whether they are a qualified social worker.

This analysis considers all leaders and all respondents – it does not disaggregate this by LA. (This is not possible, owing to low numbers of leaders in each LA.) Note that some questions to leaders asked both how they would respond and how they thought workers in their LA would respond.

Initial bivariate analysis (t-tests) was carried out followed by a logistic regression.

Are there differences between LAs with higher or lower rates of care than might be expected?

LAs with decreasing care rates were compared to respondents from LAs with increasing care rates for:

- The seven factors.
- Three values subscales.
- Responses to each case study.
  Demographics: age, whether they are a qualified social worker.

Initial bivariate analysis (t-tests) was carried out followed by a logistic regression.

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Appendix D: Respondents' Views Tables

Table D1: Respondents' views about factors influencing care rate in Wales

	Not a factor		A minor factor		A factor		An important factor		A very important factor	
	n	%	n	%	n	%	n	%	N	%
Increased poverty (n=680)	4	0.6	43	6.3	233	34.3	222	32.7	178	26.2
Increased domestic abuse (n=682)	1	0.2	10	1.5	135	19.8	301	44.1	235	34.5
Increased awareness of child sexual exploitation (n=683)	2	0.3	27	4	224	32.8	270	39.5	160	23.4
More drinking or drug taking by parents (n=682)	10	1.5	30	4.4	203	29.8	274	40.2	165	24.2
Cuts in support services for families (n=678)	8	1.2	49	7.2	169	24.9	198	29.2	254	37.5
Cuts in universal services for families (n=679)	9	1.3	49	7.2	168	24.7	221	32.6	232	34.2
Increased focus on risk within social services (n=678)	20	3.0	84	12.4	239	35.3	228	33.6	107	15.8
Cuts within social services (n=681)	34	5.0	96	14.1	177	26	179	26.3	195	28.6

Table D2: Respondents' views about the influence of agencies or groups on care rate in their LA

	Not a factor		A minor factor		A factor		An important factor		A very important factor	
	n	%	n	%	n	%	N	%	n	%
Schools (n=693)	14	2.0	89	12.8	304	43.9	204	29.4	82	11.8
Health visitors (n=693)	11	1.6	65	9.4	295	42.6	240	34.6	82	11.8
Police (n=688)	6	0.9	30	4.4	254	36.9	282	41.0	116	16.9
Judges and the court (n=695)	3	0.4	15	2.2	106	15.3	198	28.5	373	53.7
LA solicitors (n=692)	17	2.5	56	8.1	222	32.1	254	36.7	143	20.7
Social workers and line managers (n=702)	4	0.6	5	0.7	99	14.1	293	41.7	301	42.9
Senior managers in the LA (n=694)	5	0.7	18	2.6	111	16.0	274	39.5	286	41.2

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Table D3: Respondents' views about their LA

In my LA we…	Strongly Agree		Agree		Neither agree nor disagree		Disagree		Strongly Disagree	
	n	%	n	%	n	%	n	%	n	%
Emphasise working to support families (n=683)	399	58.4	246	36.0	26	3.8	7	1.0	5	0.7
Ensure children are kept safe (n=683)	427	62.5	222	32.5	26	3.8	2	0.3	6	0.9
Only take children into care when absolutely necessary (n=682)	340	49.9	243	35.6	68	10.0	24	3.5	7	1.0
Keep the right children at home or in care (n=681)	204	30.0	281	41.3	152	22.3	38	5.6	6	0.9
Work hard to have children return home if they come into care (n=681)	232	34.1	297	43.6	98	14.4	42	6.2	12	1.8

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Table D4: Workers' views about the leaders in their LA

In my LA, the leaders (e.g. head of services/senior managers/ director of services) ...	Strongly Agree		Agree		Neither agree or disagree		Disagree		Strongly Disagree	
	n	%	n	%	n	%	N	%	n	%
Are practitioners first, managers second (n=619)	84	13.6	202	32.6	179	28.9	125	20.2	29	4.7
Have strong, positive values (n=618)	187	30.3	307	49.7	97	15.7	23	3.7	4	0.7
Are mainly interested in budgets and administration (n=620)	37	6.0	111	17.9	275	44.4	175	28.2	22	3.6
Emphasise working with families to keep children at home where possible (n=621)	199	32.1	344	55.4	62	10.0	15	2.4	1	0.2
Emphasise protecting children from harm (n=620)	288	46.5	294	47.4	27	4.4	9	1.5	2	0.3

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	n	%	n	%	n	%	n	%	n	%
Are afraid of negative media coverage or inspections (n=619)	46	7.4	105	17.0	254	41.0	171	27.6	43	7.0
Are focused on what is best for each child (n=618)	202	32.7	303	49.0	84	13.6	26	4.2	3	0.5
Are risk averse (n=616)	33	5.4	128	20.8	227	36.9	190	30.8	38	6.2

Table D5: Respondents' views about their LA practice

My LA has …	Strongly Agree		Agree		Neither agree or disagree		Disagree		Strongly Disagree	
	n	%	n	%	n	%	n	%	n	%
A consistent set of values (n=676)	179	26.5	354	52.4	95	14.1	43	6.4	5	0.7
Training and supervision to support the LA's vision of practice (n=681)	198	29.1	356	52.3	86	12.6	35	5.1	6	0.9
A practice framework(s) we use (n=671)	165	24.6	321	47.8	142	21.2	37	5.5	6	0.9

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Table D6: Standardised factor loadings and Indicator reliability

	Factor loadings (95% CI)*** (n=643)	Indicator reliability[a]
Factor 1		
In my LA we…		
Emphasise working to support families	0.73(0.68-0.77)	53.11
Ensure children are kept safe	0.67(0.62-0.72)	45.32
Only take children into care when absolutely necessary	0.82(0.78-0.85)	66.93
Keep the right children at home or in care	0.75(0.7-0.79)	55.63
Work hard to have children return home if they come into care	0.74(0.69-0.78)	54.33
Factor 2		
In Wales rates of children in care have increased due to…		
Cuts in support services for families	0.92(0.9-0.94)	84.53
Cuts in universal services for families	0.93(0.91-0.95)	86.65
Cuts within social services	0.73(0.69-0.77)	53.27
Factor 3		
My LA has…		
A consistent set of values	0.77(0.72-0.82)	59.33
Training and supervision to support the LA's vision of practice	0.78(0.74-0.83)	61.47

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Has a practice framework(s) we use	0.68(0.63-0.73)	46.21
Factor 4		
Agencies most likely to influence the likelihood of children being in care in your LA…		
Schools	0.86(0.83-0.9)	74.39
Health visitors	0.95(0.92-0.98)	90.33
Police	0.61(0.56-0.66)	37.26

***All factor loadings P≤ 0.001; [a]The amount of the variance in an indicator explained by the latent variable

Table D7: The odds of being a leader vs worker based on survey responses

Variable	Odds ratio (95% CI) n=675	Explanation
Against removal of child at risk from home (Subscale 1)	2.45(1.33-4.51)**	The odds of being a leader increases by 145.0% for every one unit change in subscale 1. In other words, leaders are more against removing a child at risk from home than workers.
Favour reunification (Subscale 3)	2.94 (1.73-4.99)***	The odds of being a leader increases by 193.6% for every one unit change in subscale 3. In other words, leaders are more in favour of reunification than workers.
Cuts to services (Factor 2)	0.70(0.52-0.92)*	The odds of being a leader decreases by 30.4% for every one unit change in factor 2. In other words, leaders are less likely than workers to place emphasis on external cuts to services as factors influencing care rates in Wales.
The influence of the courts & LA solicitors[a]	0.68(0.48-0.95)*	The odds of being a leader decreases by 32.2% for every one unit change in the court factor. In other words, leaders are less likely than workers to believe that the courts and LA solicitors

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influence whether a child goes into care in their LA.

*p ≤ 0.05; ** p ≤0.01; *** p ≤0.001

[a] Leaders were also less likely to place emphasis on community agencies such as police, schools and health services as factors influencing the rate of children in care in their area (factor 4). However, owing to collinearity with the court factor, this variable could not be included in the regression model. When the court factor was replaced with factor 4, the odds ratio was 0.69(95% CI 0.49-0.98) meaning that the odds of being a leader decreases by 31.1% for every one unit change in factor 4.

Table D8: The odds of being a respondent from a LA with increasing vs decreasing care rates over the last 5 years.

Variable	Odds ratio (95% CI) n=429	Explanation
Against removing a child at risk from home (subscale 1)	0.51 (0.30- 0.85)*	The odds of being a respondent from an LA with an increasing care rate decreases by 49.3% for every one unit change in subscale 1. In other words, respondents from LAs with increasing rates of care are less against removing a child at risk from home than LAs with decreasing rates.
Case study 2 risk score	2.08 (1.22- 3.56)*	The odds of being a respondent from an LA with an increasing care rate increases by 108.2% for every one unit change in risk score. In other words, respondents from LAs with increasing rates of care are more risk averse than LAs with decreasing rates.
LA attitude to risk (Factor 1)[a]	0.40 (0.23-0.71)**	The odds of being a respondent from an LA with an increasing care rate decreases by 59.9% for every one unit change in Factor 1. In other words,

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respondents from LAs with increasing rates of care are less confident that their LA keeps children safe and where possible, at home, than LAs with decreasing rates.

*p ≤ 0.05; ** p ≤0.01

[a] Respondents from LAs with increasing rates were also less likely to feel that their LA had the procedures in place to support the LA's vision of practice (factor 3), such as suitable training, however due to collinearity with factor 1, this variable could not be included in the regression model. When factor 1 was replaced with factor 3, the odds ratio was 0.51 (95% CI 0.31-0.84), meaning the odds of being a respondent from an LA with an increasing care rate decreases by 49.2% for every one unit change in Factor 3.

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