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Piloting the implementation of systemic training and feedback tools in Rotherham's Early Help & Family Engagement Service: Evaluation report

May 2023

Helen Burridge, James Nolan & Max Stanford

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About What Works for Early Intervention and Children's Social Care

The evaluation was conducted by the Early Intervention Foundation in 2021–2022. What Works for Children's Social Care (WWCSC) and the Early Intervention Foundation (EIF) are merging. The new merged organisation is operating initially under the working name of What Works for Early Intervention and Children's Social Care (WWEICSC).

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Early Intervention Foundation
Evidence Quarter, Albany House, Petty France, Westminster, London SW1H 9EA

W: www.EIF.org.uk
E: info@wweicsc.org.uk
T: @TheEIFoundation
P: +44 (0)20 3542 2481

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This report was first published in May 2023.

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Summary

Introduction

This document outlines the pilot evaluation of initial training for Early Help practitioners in systemic practice and the implementation of the Outcome Rating Scale (ORS) and Session Rating Scale (SRS) with families in Early Help. Together these form an approach being piloted within Rotherham's Early Help & Family Engagement service.

The evaluation aims to inform a model of practice which could be rolled out by Rotherham's Early Help & Family Engagement service and other services in Rotherham, as well as by other local authorities. This pilot evaluation, led by WWEICSC provides an important opportunity to lay the groundwork for roll-out, scale-up and evaluation of the intervention and systemic practice more generally.

Research questions

This evaluation aimed to evaluate the implementation of initial training for Early Help & Family Engagement practitioners in systemic practice and the implementation of the Outcome Rating Scale (ORS) and Session Rating Scale (SRS) to answer questions framed around the pilot's feasibility, evidence of promise and readiness for trial.

Methods

The pilot evaluation involved five teams in Rotherham's Early Help & Family Engagement service, three of which received the intervention and two which were used as a comparison group and continued with business as usual.

Adopting a mixed-methods approach, this pilot evaluation involved:

- Observations of systemic training
- A baseline, post-training and endline survey
- Admin data from Rotherham
- Qualitative interviews with managers and practitioners.

The findings were triangulated in this report and summarised according to research questions.

Key findings

Evidence of feasibility

Findings suggest that the training and tools are feasible to implement in an Early Help service. Both the training and tools were well received by Early Help practitioners.

Evidence of promise

During interviews and the endline survey, practitioners and managers identified a number of benefits consistent with the short-term outcomes articulated in the theory of change.

Practitioners perceived that the approach had improved outcomes for themselves and for families, as indicated by the qualitative data collected. However, this was not supported by the quantitative data collected from the practitioner outcome measures – perhaps due to limitations with the measures used or the relatively short duration of the pilot.

There appeared to be minimal unintended consequences of the approach.

Readiness for trial

There is a clear description of the approach in the theory of change, and this evaluation identified key barriers and facilitators which should be considered in future roll-out, alongside other refinements identified in this report. We recommend Rotherham continues to evaluate the implementation of the approach and the outcomes using appropriate and feasible methods.

Conclusions

This mixed-method evaluation provides first early evidence on the new approach being implemented. First, our evaluation found the approach to be feasible. Second, our evaluation identified a range of potential benefits for children and families. The findings suggest the approach would benefit from further development work before roll-out to the multi-agency partnership in Rotherham's Early Help system or to other Early Help services.

1. Project background

Rationale

WWEICSC (previously the Early Intervention Foundation) has recently undertaken an evaluation study looking at the systemically informed approach that is implemented by Rotherham's Edge of Care team.[1] This included qualitative work looking at its feasibility (that is, whether it is operating as intended) and analysis of quantitative data to supplement the qualitative evidence to assess evidence of promise. Findings from the evaluation indicated that the approach is feasible to implement and there was evidence that it was making a positive difference to key outcomes for families, children, practitioners and the wider system.

Furthermore, research on systemic practice suggests that the approach is beneficial for children, families and practitioners.[2]

Rotherham's Early Help & Family Engagement service currently uses an operating model based on Restorative Practice, Signs of Safety/Wellbeing and Social Pedagogy. They do not currently use the Outcome Rating Scale (ORS) and Session Rating Scale (SRS). The ORS and SRS are tools which are used to gather feedback from children and families and can encourage practitioners to take a more systemic approach to their practice. It is unclear whether a systemic approach is feasible to implement within the Early Help context and whether it would lead to positive outcomes for families, practitioners and the wider system. Therefore, the aim of the evaluation is to explore the implementation of systemic training and the ORS and SRS using a randomised controlled trial design. This means a comparison group of practitioners not receiving the training and not using the tools will be included. The approach aims to improve therapeutic alliance between practitioners and families and in the longer-term aims to improve family outcomes such as improved family functioning and communication, and improved mental health and wellbeing. The evaluation also aims to generate key learning about conducting evaluation of systemic practice in the Early Help context to inform future evaluation and roll-out.

Local context

Rotherham is in the county of Yorkshire and the Humber and is situated in South Yorkshire. On the Index of Multiple Deprivation 2019[3] Rotherham ranks as the 35th most deprived upper tier local authority in England out of a total of 151 authorities.

The evaluation explored the implementation of systemic training and use of feedback tools in Rotherham's Early Help & Family Engagement service. The training and feedback tools are already used in Rotherham's Edge of Care service. Across Rotherham there are nine Early Help locality teams that cover the north, south and central areas of the town. The Early Help service is a much larger service than the Edge of Care team with a broader remit. The Early

1 See https://www.eif.org.uk/report/supporting-families-feasibility-reports

2 What Works for Early Intervention and Children's Social Care produced the internal report *Brief evidence review on systemic practice* for the Department for Levelling Up, Housing and Communities in January 2023.

3 See https://www.rotherham.gov.uk/data/people/population/2 and https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019

Help service works in a Family Support capacity with approximately 1,500 families (3,000 children) at any given time. Subsequently, the number of children and families per worker in Early Help are significantly higher than in Edge of Care. Early Help practitioners typically support 15–20 families compared to five families within Edge of Care.

The approach in Early Help is underpinned by ensuring that help is offered to families as needs arise and a 'no waiting list' model is firmly embedded to reduce the likelihood of problems escalating and reaching crisis point while waiting for support. Prevention is also a key aspect of the service which aims to intervene early to prevent additional need from arising.

Pilot evaluation overview

The approach being evaluated is based on a few elements of the approach used in the Edge of Care team. The pilot is focused on only a few elements, rather than the full approach, due to differences in cohort, volume, time available to practitioners per family, and reach between the two services, and the relatively short duration of the pilot. The pilot will provide information about the introduction of systemic practice, which could be used to inform future roll-out of additional elements.

Intervention being evaluated

Below is a summary of the intervention being evaluated. A full intervention description is available in the evaluation protocol.[4]

Intervention overview

Systemic training was delivered in person by a Senior member of staff from Rotherham's Children's Services to Senior Family Support Workers, Family Support Workers (FSWs) and Senior Practitioners in three teams. The training was delivered in person across two half-day sessions. The aim of the first session was to introduce foundational systemic ideas. The aim of the second session was to introduce two feedback tools (the ORS and SRS) to practitioners.

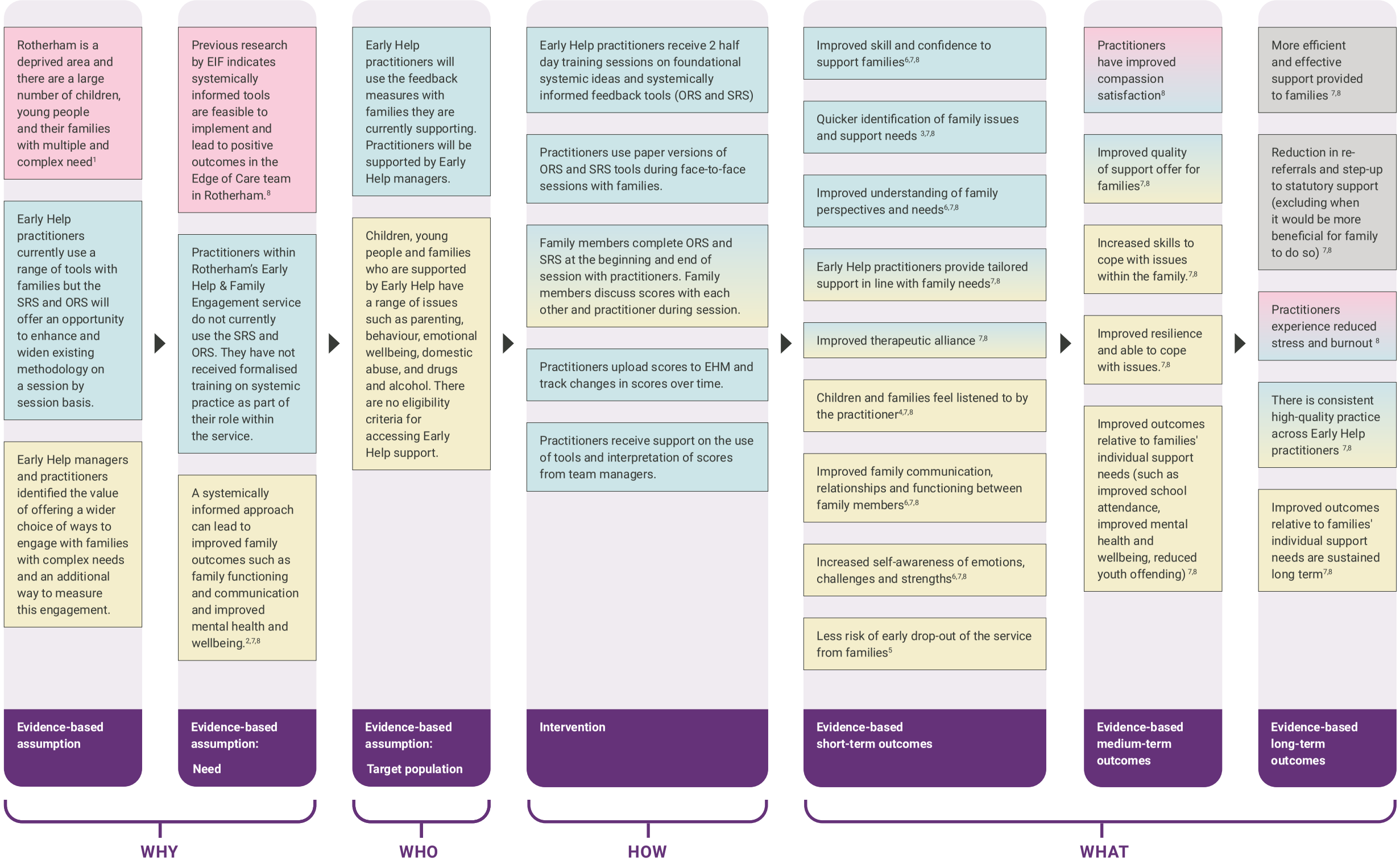
After training, practitioners begun to use the ORS and SRS in the support they provided to families. The ORS was used at the beginning of each session to gather information on how families feel at the beginning of each session and monitor families' feedback on progress over successive sessions. The SRS was used at the end of each session to assess key dimensions of effective therapeutic relationships.

Practitioners uploaded ORS and SRS onto family records in Liquid Logic which is a shared recording and management system used by Rotherham's Early Help & Family Engagement service and Children's Social Care. Liquid Logic displayed a record of scores over time to allow practitioners to identify and track changes in ORS and SRS scores.

4 Piloting the implementation of systemic training and feedback tools in Rotherham's Early Help team: Evaluation protocol (sent to DLUHC in January 2023).

Theory of change

Below is a theory of change which was developed in initial stages of the evaluation. References (footnotes in the diagram) can be found in appendix A.



2. Methods

Research questions

The pilot aims to address the following research questions.

1. Evidence of feasibility

1.1 **Fidelity and adaptation:** How was the approach delivered, was it delivered as intended and what variation was there in delivery across teams?

1.2 **Differentiation:** How is the approach similar to or different from business as usual?

1.3 **Reach:** What is the practitioner and family reach?

1.4 **Barriers and facilitators:** What are the barriers and facilitators to delivery of training and the use of the tools?

1.5 **Participant responsiveness:** Are practitioners engaged during training? Are practitioners and families engaged during the implementation of the tools? What do practitioners and families like and dislike about the approach?

1.6 **Acceptability:** Is the approach acceptable to practitioners and families?

2. Evidence of promise

2.1 What potential impacts of the intervention does implementation of the approach lead to for practitioners and families?

2.2 Do there appear to be any unintended consequences or negative effects?

3. Readiness for trial

3.1 Is there a clear description of the intervention and the contextual facilitators and barriers that would allow it to be implemented and evaluated in other places?

3.2 Is the intervention able to be delivered consistently across teams?

3.3 Are any changes needed to the theory, materials or procedures before roll-out?

3.4 How acceptable is it for practitioners to take part in evaluation activities?

3.5 What are the enablers and barriers to evaluation?

3.6 What is the recommended approach for further evaluation (such as randomisation procedure, outcome measures, and so on).

Methodology

The research design drew on qualitative and quantitative methods. The components are discussed in turn below, and (where relevant) the subsections include details about sampling, data collection methods and timing.

Sample

The evaluation included a sample of five teams in Rotherham's Early Help & Family Engagement service. Given that two teams were located in the same building, share a manager, and are smaller than the others, we grouped these two teams to create a relatively even number of staff across the four teams. We randomly selected two teams to the intervention and two teams to be in the control group. Other teams in Rotherham's Early Help & Family Engagement service were unable to take part in the evaluation due to issues with staffing and were not included in the pilot.

Data collection

Table 2.1 shows an overview of data collection activities by team.

TABLE 2.1.
Data collection activities by team

Randomisation allocation	Team	Oct	Oct/Nov	Nov–Feb	Nov	Feb	Mar
		Baseline survey	Received training	Used tools	Post-training survey	Endline survey	Interview
Intervention	I1	✓	✓	✓	✓	✓	✓
	I2						
	I3						
Comparison	C1	✓	×	×	×	✓	×
	C2						

Practitioner surveys

A baseline and endline survey of all practitioners in the pilot (intervention and comparison groups) gathered information on practitioner characteristics and measured practitioner outcomes (see appendix D). The surveys consisted of the following measures:

- **The Working Alliance Inventory-Short Revised** (WAI-SR) is a measure of the therapeutic alliance that assesses three key aspects of the therapeutic alliance: agreement on the tasks of therapy; agreement on the goals of therapy; and development of an affective bond (Munder et al., 2010). The WAI has adequate reliability and preliminary support for the validity of the measure (Horvath & Greenberg, 1989). An additional study concluded the measure is able to reliably capture information across the range of alliance scores (Hatcher et al., 2020).
- **The ProQOL Compassion Satisfaction** subscale measures the pleasure that practitioners derive from being able to do their work well (Stamm, 2010). There is good construct validity and the ProQOL is stable across time (alpha scale reliability = 0.88) which means the scores across time reflect changes in the person rather than the measure itself (Stamm, 2010).

The baseline survey took most respondents less than 15 minutes to complete.

The endline survey was also used to gather views on participating in evaluation activities (such as surveys, interviews and observations) to understand practitioners' capacity and motivation for taking part from those in the intervention group. The endline survey took most respondents in the comparison group less than 10 minutes and most respondents in the intervention group less than 20 minutes.

A short **post-training survey** of staff who attended the training (that is, the intervention group) was undertaken after the training (see **appendix D**) which took most respondents less than 10 minutes to complete. The survey gathered contextual information about respondents, views on training and perceived learning outcomes. The survey gathered views on the ORS and SRS using the IAM and FIM measures (described below).

The post-training survey gathered views on the ORS and SRS using the following measures:

- **Intervention Appropriateness Measure** (IAM): a five-item scale that measures the perception among implementors that the practice is agreeable and satisfactory
- **Feasibility of Intervention Measure** (FIM): a five-item scale that measures the extent to which implementors believe the practice can be successfully used.

The IAM and FIM have demonstrated strong psychometric properties (Weiner et al., 2017). Both have demonstrated content validity, discriminant content validity, reliability, structural validity, structural invariance, known-groups validity, and responsiveness to change.

The development of three surveys (baseline, endline and post-training) was informed by the observations of the training and through discussions with Rotherham Early Help & Family Engagement service. The baseline survey was administered in September 2022, the post-training survey in October 2022 and the endline survey in February 2023.

TABLE 2.2.

Survey response rate

Group	Team	Surveys		
		Baseline	Post-training	Endline
Intervention	I1	9	5	7
	I2	5	2	4
	I3	13	9	7
	Total	**27**	**16**	**18**
Comparison	C1	7	-	10
	C2	11	-	12
	Total	**18**	**-**	**22**

The baseline and endline surveys collected information about the background characteristics of the practitioners (n = 47). Results indicate that the sample was mixed in terms of the length of time practitioners had worked for the service; however, the most common response was over five years. Similarly, the period of time respondents had practiced as a family support worker or practitioner varied, with the minimum value of 0 years and the maximum of 20 years. The average length of time was just over seven years.

Practitioners had a range of different qualifications, from Level 1 (such as Management for Care) through to Level 7 (such as PGCE Early Childhood Studies and Qualified Teaching Status). The most common qualification was Level 6 which is equivalent to a degree or graduate diploma. A majority of practitioners work full-time, with a minority reporting working fewer than 37 hours per week. On average, practitioners reported that they were currently supporting nine families, with the minimum number being 0 and the maximum number being 17. There were no notable differences in characteristics between the control and intervention groups.

Observation

Observations of training aimed to understand delivery logistics, training content and practitioner responsiveness/engagement. We conducted four observations: two observations of Session 1 and one observation of Session 2. An observation template was developed for consistency of approach and data collection across observations. Training observations took place in September and October 2022.

TABLE 2.3.

Observation sample

Observation type	Facilitators	Attendees
Part 1: Morning	2	11
Part 1: Afternoon	2	2
Part 2: Afternoon	2	7

Interviews and focus groups

Interviews explored practitioners' experiences of the training and the use of the ORS and SRS in their practice. We also gathered practitioners' views on participating in evaluation activities (such as surveys, interviews and observations).

We conducted individual interviews with one Family Support Worker, two Senior Family Support Workers, one Senior Family Support Worker acting as the manager, and one Manager. We sampled participants to ensure diversity in characteristics expected to affect implementation of the ORS and SRS measures (such as experience, team, role, age, level of engagement, and so on). The length of time in the role varied from 18 months up to eight years.

All interviews were conducted online via MS Teams. The discussions were guided by a topic guide and lasted up to one hour. Interviews were digitally recorded with the participant's informed consent.

Admin data

Admin data was collected to understand contextual service and team factors alongside whether training and delivery has been undertaken as planned. Administrative data included:

- number and roles of practitioners who have attended training
- number and roles of practitioners in intervention and comparison groups (five teams in Early Help)
- how many Family Support Workers, Senior Family Support Workers and Senior Practitioners have used the ORS and SRS
- the frequency of how often the ORS and SRS have been used
- the total number of children and adults who have completed the ORS and SRS, as well as the average completion rate for each individual.

Administrative data was anonymised by Rotherham data team and shared in February 2023.

Research questions and methods

Table 3.4 outlines the research questions and the methods used to answer them.

TABLE 3.4.

Research questions and the methods used to answer them

Dimension	Research questions	Method
Evidence of feasibility	1.1. **Fidelity and adaptation:** How was the approach delivered, was it delivered as intended and what variation was there in delivery across teams?	• Observation of training • Interviews with practitioners • Interviews with managers • Admin data • Outcomes data
	1.2. **Differentiation:** How is the approach similar to or different from business as usual?	• Interviews with practitioners • Interviews with managers
	1.3. **Barriers and facilitators:** What are the barriers and facilitators to the delivery of the training and use of the tools?	• Interviews with practitioners • Interviews with managers
	1.4. **Reach:** What is the practitioner and family reach?	• Admin data
	1.5. **Participant responsiveness:** Are practitioners engaged during training? Are practitioners and families engaged during the implementation of the tools? What do practitioners and families like and dislike about the approach?	• Observation of training • Interviews with practitioners • Interviews with managers
	1.6. **Acceptability:** Is the approach acceptable to practitioners and families?	• Interviews with practitioners • Interviews with managers
Evidence of promise	2.1. What potential impacts of the intervention does implementation of the approach lead to for practitioners and families?	• Interviews with practitioners • Interviews with managers • Baseline and endline survey data • Post-training survey • Outcomes data
	2.2. Do there appear to be any unintended consequences or negative effects?	

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Dimension	Research questions	Method
Readiness for trial	3.1. Is there a clear description of the intervention and the contextual facilitators and barriers that would allow it to be implemented and evaluated in other places?	• Observation of training • Interviews with practitioners • Interviews with managers • Admin data • Outcomes data
	3.2. Is the intervention able to be delivered consistently across teams?	• Interviews with practitioners • Interviews with manager • Admin data
	3.3. Are any changes needed to the theory, materials or procedures before roll-out?	• Observation of training • Baseline and endline survey • Post-training survey • Interviews with practitioners • Interviews with managers • Admin data
	3.4. How acceptable is it for practitioners to take part in evaluation activities?	• Interviews with practitioners • Interviews with managers
	3.5. What are the enablers and barriers to evaluation?	• Endline survey
	3.7. What is the recommended approach for further evaluation (such as randomisation procedure, outcome measures, and so on).	• Synthesis of research findings

Analysis

Qualitative data

Detailed notes were taken as part of the observations of training and organised according to key research questions. All interviews were audio-recorded (with participants' permission) and transcribed using Microsoft Forms software. A framework approach was used to manage qualitative data and carry out analysis. The first step was to develop an analytical framework, based on the topic guide and insights from data collection. Then data from each interview/observation was summarised within an analysis matrix (where columns represent the key sub-themes or topics, and the rows represent participants/observations) to order the data systematically. Analysis looked for patterns, consistencies and inconsistencies in data collected from different participants to help answer the research questions.

Quantitative data

Survey data

Quantitative survey data were analysed descriptively. We conducted a paired sample t-test to explore whether the change between baseline and endlines is significant for each survey measure. Qualitative data from open-ended questions was analysed thematically.

We used an intent-to-treat analysis whereby all staff in the intervention group were included irrespective of whether they attended the training or used the ORS and SRS or not.

Administrative data

Administrative data was analysed descriptively to understand contextual service and team factors alongside whether training and delivery has been undertaken as planned.

Data synthesis

We triangulated and synthesised data according to our research questions. This enabled us to provide a comprehensive assessment of implementation, and to report findings against the finalised theory of change.

Evaluation limitations

There are a number of limitations that affect the quality of the evaluation data:

- The **duration of the pilot was relatively short** and practitioners only used the tools for four months. The short timescale may have limited our ability to detect changes in outcomes and it is possible that effects may vary if the pilot were longer in duration.
- Practitioners were **randomised prior to completing the baseline survey**. This is because practitioners needed advance warning to hold the time to attend the training in their diaries. However, the randomisation allocation may have impacted their responses.
- There was a **ceiling effect on both outcome measures** that were used, with practitioners from both the treatment and control groups scoring high at baseline and endline. This significantly reduced the ability to detect differences in outcomes between practitioners in the treatment and control groups.

- **Evaluation activities were carried out at speed and over a very short period of time.** Compressing the evaluation fieldwork may have limited the range of experiences the evaluation was able to capture.
- Although the response rate was high for all three surveys, it should be noted the **sample size was small** which decreased the statistical power to detect statistically significant results.
- We conducted a total **of five interviews with managers and practitioners which is a small sample**. To overcome this limitation, we sought to collect qualitative feedback in the practitioner surveys through the use of open-text questions.
- The qualitative element focused on the views and experiences of practitioners and managers. Although they were asked to reflect on the views of families, it should be remembered that these were staff reflections on perceived impact, and we do not **have qualitative data capturing the views of families or children themselves**.
- Although the evaluation team requested scores from both measures, **the data team was not able to provide the data from ORS and SRS**.

Ethics

Ethical clearance from EIF's ethics committee was sought and granted. The evaluation followed EIF's ethical guidelines which were set out in the evaluation protocol. To ensure all participants were able to give informed consent we provided participants with a clear and accessible information sheet (see appendix B). To gather consent for taking part, we issued participants with a consent form which includes explicit statements about what taking part involves and how data collected will be used, with tick boxes to allow the participant to consent to each statement and, where appropriate, to decide not to take part in certain aspects of the study (see appendix C). Care was taken to ensure that participants understood they did not have to participate in research activities and could withdraw at any time. To reduce research burden, we minimised burden placed on participants by ensuring qualitative interviews and surveys were kept short and that outcome measures were short and easy to complete. To ensure inclusion in research, we selected appropriate methodology to ensure no group was unreasonably excluded from the research. When conducting the research, we were aware of and sensitive to cultural, religious, gender, health and other issues in the research population, always acting in a non-discriminatory way.

Data protection

WWEICSC was the data controller for this study. All data was handled in accordance with GDPR regulations. Data was only to be used for the purpose of the stated research aims and only accessed by members of the research team. Data will be kept for two years after the study has been completed. A copy of the privacy notice can be found in appendix C.

3. Findings

3.1 Evidence of feasibility

This section explores the extent to which the training and the tools were delivered as intended. Evidence of feasibility of the training is explored first, and feasibility of the tools is explored second.

Delivery of systemic training

RQ: 1.1

Fidelity and adaptation: How was the approach delivered, was it delivered as intended and what variation was there in delivery across teams?

The training was delivered in person across two half-day sessions on different days. Two full-day mop-up sessions were delivered for practitioners who could not attend the first and/or the second session. Additional mop-up sessions were held due to practitioners not being able to attend the first two scheduled sessions due to illness, including Covid-19, and absence from work.

The training was facilitated by a Senior Member of Rotherham's Children's Services who is trained to Level 7 in systemic practice and is experienced in delivering systemic training. Facilitation was assisted by another Senior Member of staff who is also trained in systemic practice.

The first session introduced practitioners to foundational systemic ideas. The second session introduced the feedback tools (ORS and SRS) to practitioners. Both sessions were delivered with slides, videos, whole group discussion and roleplay. Due to the interactive nature of the training, and it being partly led by participant need and interest, there were some differences in the content of the training that was provided to each team.

RQ: 1.2

Differentiation: How is the approach similar to or different from business as usual?

Training provision

The provision of training on a topic relevant to practice was perceived to be in line with business as usual. During interviews, managers and practitioners explained that training is provided fairly regularly to staff in the Early Help service throughout the year.

Previous training in systemic practice

A majority of practitioners indicated in the baseline survey that they had not previously received formal training on systemic practice (n = 31, 68.9%). This was reflected in interviews with managers who felt there was a mixture of practitioners who had familiarity with systemic practice and those who did not. Among those that had received training (n = 5, 11.1%), this had either been provided to them during a previous role working for another local authority or as part of a university degree.

Familiarity with the concepts of systemic practice

Although Rotherham's Early Help & Family Engagement service does not formally use a systemic practice approach, it was acknowledged by the training facilitator and Early Help

managers during the training that many of the systemic principles will seem familiar to practitioners even if they have not known the practices by the term 'systemic'. In line with this view, In the post-training survey, a respondent commented that they felt they already had a systemic approach within their work before attending the training, but the training provided structure for how to implement the approach. Views about the novelty of the content were mixed during interviews. One view was that the training covered content that was already familiar while a contrasting view was that the training covered concepts and ideas that practitioners had not already considered.

RQ: 1.3
Reach: What is the practitioner reach?

Three teams in Rotherham's Early Help & Family Engagement service were assigned to the intervention group and received systemic training. In total, 2 Team Managers, 12 Senior Family Support Workers, 9 Family Support Workers and 2 Senior Practitioners attended the training. Four did not receive the training due to absence or illness.

RQ: 1.4
Barriers and facilitators: What are the barriers and facilitators to the delivery of the training?

Data gathered from the evaluation indicated the following facilitators to the delivery of training:

- During interviews, practitioners mentioned the **training facilitator helped them to engage** with the content of the training. Some staff reported that the inclusive nature of the facilitator who directed questions at all trainees in attendance prevented people from disengaging from the content.
- Practitioners valued the **interactive style of delivery**. Practitioners felt that the ice-breaker activities helped them feel more relaxed at the beginning of the training. They felt the roleplays, were a key enabler to engagement and helped them retain information. In line with this view, three-quarters of practitioners (75.0%) reported in the post-training survey that the roleplay was helpful for their learning.
- It was recognised by managers and practitioners during interviews that the service has general capacity issues, so the fact that **attendance was compulsory** meant the training was well attended, whereas this may not have been the case if it were voluntary.

Factors which made the delivery of the training harder were also identified:

- Early Help staff reported that prior to attending the training, there was a sense of reluctance or apprehension to participating as this was considered to be **extra work in an already high performing team with a defined practice approach**. Despite this, once staff started the training, they reported feeling motivated to learn and were open to learning new content as they 'know it makes them better practitioners'.

  > *'I remember the team meeting in summer last year, where they said 'oh, we're going to be part of this new trial'… and my first reaction was 'oh come on, we've got enough on! [laughs]' [Later in the interview]: 'I feel very grateful that I've been given the chance to do it because at the end of the day, it's improved my practice or even my own wellbeing and confidence.'*
  >
  > **– Early Help staff member, interview_01**

- **Staff absences** caused by illness, including Covid-19, led to difficulties with staff attending the training. To overcome this barrier, additional mop-up sessions were held for staff who were unable to attend the original training dates.

RQ: 1.5

Participant responsiveness: Are practitioners engaged during training? What do practitioners like and dislike about the training?

During the training, practitioners were observed to have high engagement with the training content. They asked questions to gain further understanding and willingly offered answers to questions that were asked during the training. Practitioners were keen to offer their views and share experiences with the rest of the group. At the end of the session, attendees reflected that they were 'inspired to try something new' during support they provide to children, young people and their families. In the post-training survey, practitioners were asked the extent to which they would like to know more about systemic principles, ideas and practices. Half of practitioners either completely agreed (18.8%) or agreed (31.3%), with around one-third of practitioners neither agreeing nor disagreeing (31.3%) and a minority disagreeing (18.8%).

During interviews, practitioners and managers were very positive about the training. There was a view that training was useful and insightful and introduced new ideas that they had not explored or heard of before. Practitioners mentioned specific concepts of systemic practice that they enjoyed learning about in the training and felt were useful for their practice. These included practitioners' use of language with families, seeing family members as part of a system rather than as individuals, and being more empathetic.

RQ: 1.6

Acceptability: Is the training acceptable to practitioners?

Practitioners generally reported that the training met their needs and was enjoyable. At the end of the session, attendees reflected that they found the training 'useful and effective'. This view was echoed during interviews and interviewees explained they were motivated to attend future sessions to refresh the content. During interviews, practitioners and managers both commented that they resonated with the content and described systemic practice as a concept that they really believe in.

> *'It was a really good opportunity that we wouldn't have set aside the two days to do some work on systemic practice and it was something that I really believe in, and I think is really valuable.'*
>
> **– Early Help staff member, interview_04**

Findings from the post-training survey revealed that all practitioners (100%) either agreed or strongly agreed the content was delivered at the right pace, there was the right balance of theory and practice, the content was the right level of complexity, the training is relevant to their role, the content of the training was organised well, and the training was of high quality. A majority of practitioners agreed or strongly agreed (81.2%) that they felt comfortable asking questions (figure 3.1).

FIGURE 3.1

Practitioner views on the training

Use of tools

RQ: 1.1

Fidelity and adaptation: How was the approach delivered, was it delivered as intended and what variation was there in delivery across teams?

The training on the ORS and SRS recommended using the tools with every family unless the practitioner decides it is inappropriate because a family had urgent needs or an individual refuses. However, interviews with the Early Help staff showed usage had been inconsistent. This is reflected in the survey data where a majority of practitioners reported using both the ORS and SRS in 'some sessions' (64.7%). The reasons why practitioners did not use measures is explored in the Barriers section below.

TABLE 3.1

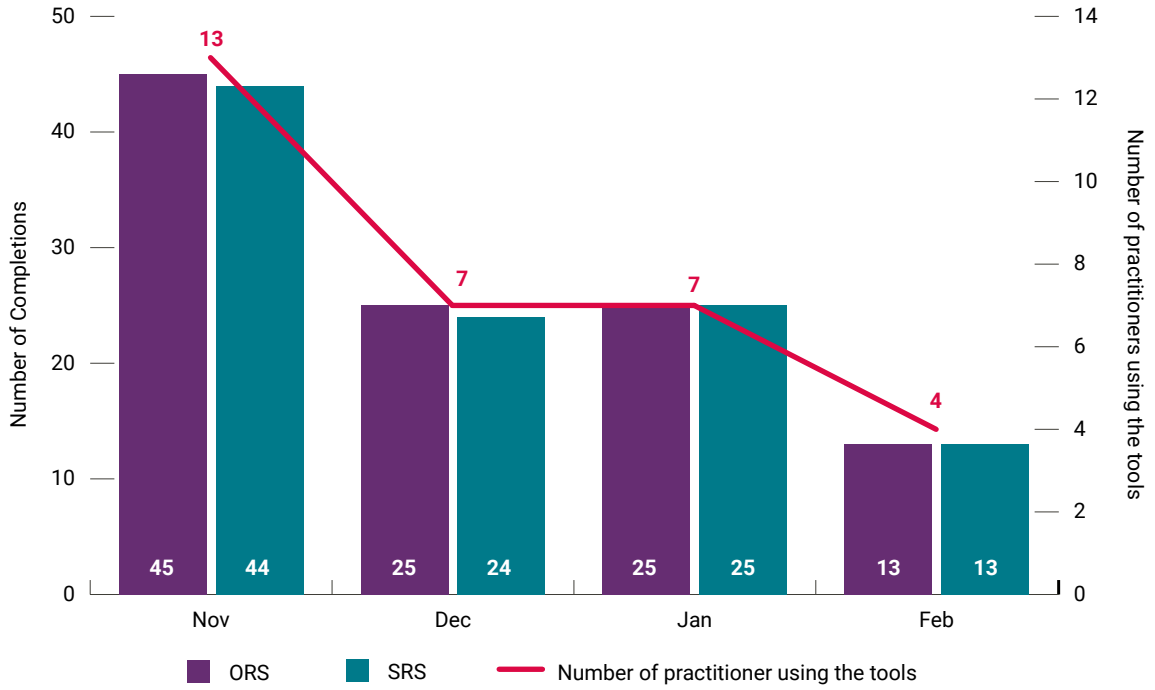
Frequency of use for the ORS and SRS

Frequency of use	Proportion of practitioners (%)	
	ORS	SRS
No sessions	11.8	11.8
Some sessions	64.7	64.7
Most sessions	17.6	17.6
Every session	5.9	5.9

When considering usage over time, the number of completions and the number of practitioners using the tools showed a decreased, with the highest usage in November immediately after the training.

FIGURE 3.2

Use of ORS and SRS by month



From interview data, it was apparent that when practitioners did use the ORS, they typically reported using it at the beginning of a session which was intended. Length of completion was highly variable and could be anywhere from 10 minutes to whole sessions to staying overtime during a home visit for two and a half hours. SRS was used at the end of a session as intended and typically did not take longer than 10 minutes to use.

Among the practitioners that had used the tools, a majority of them (80.0%) had uploaded their scores into the recording and management system (Liquid Logic). The remaining practitioners reported that they had not uploaded their scores due to several reasons explored in the Barriers section.

RQ: 1.2

Differentiation: How is the approach similar to or different from business as usual?

Previous use of the tools

Rotherham's Early Help & Family Engagement service has not previously included SRS or ORS as part of the support offer for families. A majority of practitioners indicated in the baseline survey that they had not previously used the SRS (n = 26, 58%) or ORS (n = 24, 53%) with children or families. Around one-third of practitioners, however, were not sure whether they had used the SRS (n = 13, 29%) or ORS (n = 14, 31%) previously. During interviews, practitioners discussed that while they had not used the tools before, they already use scaling as a technique.

Use of other outcomes measures

Results from the baseline survey indicate Rotherham's Early Help & Family Engagement service do, however, use a range of other outcome measures. This includes Signs of Safety during assessment, support and closure, the Graded Care Profile 2, Closure summary – Family Voice, Strengths and Difficulties Questionnaire (SDQ), and the Warwick-Edinburgh Mental Wellbeing Scale. Other outcome measures mentioned by respondents include Outcome Stars including Recovery Star and Family Star, Signs of Safety Scaling questions and measures to capture the child's voice such as the Children's Wishes and Feelings Review Scaling.

RQ: 1.3

Reach: What is the practitioner and family reach?

Practitioner reach

As outlined in the theory of change, practitioners were expected to use the ORS and SRS in all sessions with families, unless there was a reason not to administer the tools, such as if a family was in distress or needed urgent help. Administrative data showed that nearly all FSWs and Senior Practitioners who attended the training went on to use the tools (table 3.2). The administrative data showed that less than half of the Senior FSWs who attended the training used the tools. However, in the endline survey, all 10 Senior FSWs who responded reported that they had used the tools, which suggests they either had not recorded the scores on Liquid Logic so were not included in the administrative data set, or there was an issue with the administrative data. Practitioners across the three areas used the ORS the same number of times as the SRS.

TABLE 3.2

Number of practitioners who attended training and used the ORS and SRS

Number of practitioners	Senior FSW	FSW	Senior Practitioner	Total
Attended the training	12	9	2	23
Used the ORS and SRS and reported scores on Liquid Logic[1]	5	8	2	15

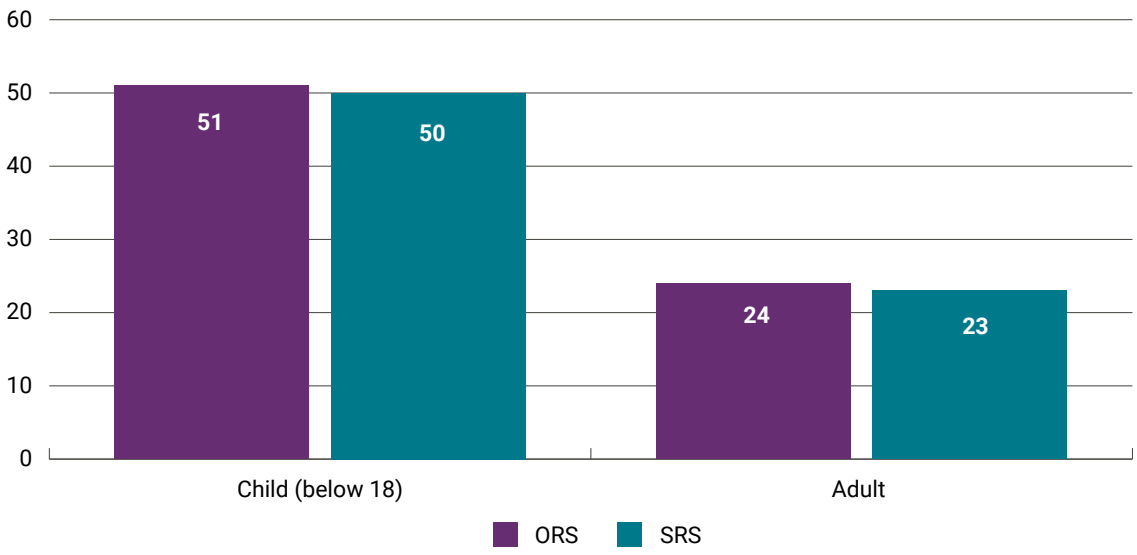
1 Numbers indicated by the administrative data. A higher number of Senior FSWs reported using the tools in the endline survey.

Family reach

In total, the ORS was completed by 51 children and 24 adults. The SRS was completed by 50 children and 23 adults (figure 3.3). Children and adults completed both tools between one and five times with the average number of completions per individual being 1.5 times.

FIGURE 3.3

Number of children and adults who have completed the ORS and SRS



RQ: 1.4

Barriers and facilitators: What are the barriers and facilitators to the use of the tools?

In the endline survey and during interviews, practitioners and managers reported on the following barriers to using the tools:

- A **high workload and tight time constraints** were significant obstacles to using the tools, combined with the fact that practitioners in Rotherham use a variety of other evidence-based tools in their practice. The demands on their time made it difficult for them to prepare for visits and prioritise the tools above their already busy schedules.
- Managers acknowledged that they had **not monitored the use of tools** as much as they had liked due to competing priorities, and they had **not reminded practitioners to use the new tools** which they felt had contributed to lower usage.
- There were some instances where **practitioners failed to engage families**. Families rushed the completion of the tools meaning the scores did not provide useful or accurate data. Other families refused to complete the tools. Reasons why family members may have disliked the tools are discussed in Participant responsiveness below.
- **Finding the balance between using the tool and following pre-planned support activities could be difficult**. It was mentioned in interviews that the ORS specifically could sometimes take sessions 'off-track' from targeted intervention work that practitioners had planned. Additionally, practitioners highlighted that in some instances, the tools were not useful for the type of support they were providing. For example, when providing practical support to find a job.
- Practitioners reflected the **tools were harder to use when they had already been working with a family for a long time** or were approaching the closure of support. Conversely, using the tools with newer families felt easier as a routine was yet to be established.
- Practitioners noted that there were **situations where it would not be appropriate to use the tools due to family needs**. Families in crisis were often more focused on sharing their concerns, making it inappropriate to introduce the tool. Another need included families experiencing mental health difficulties as some families dealing with intense mental health issues found engagement with the tool difficult or have a negative reaction to form filling.
- Practitioners felt **the tools were not always suitable for families with specific communication needs**, such as English as an additional language (EAL), or families with a preference for verbal communication.
- **Attitudinal differences** among practitioners emerged as a barrier to the effective use of tools. While some practitioners expressed a desire to become more proficient in using the tools, others **struggled to adapt to the new way of working**. Managers also cited the difficulty of motivating experienced workers who were set in their ways to engage with the new approach as they were more resistant to change.
- Some practitioners experienced **issues with Liquid Logic**, for example the software displaying results inaccurately, issues with dates, and problems recording data from previous sessions. They also mentioned concerns about the inability to upload data from the scale where children draw their own faces. One practitioner noted that **uploading scales was time-consuming** which is particularly concerning as many practitioners have expressed concerns about their time constraints and heavy workloads.

In the endline survey and interviews, practitioners and managers discussed the following **facilitators** to using the tools:

- The tools were generally perceived as being **easy to use** by managers and practitioners. In the endline survey, over half of practitioners reported they were neither easier nor harder

than the tools they normally use when supporting families (n = 10, 58.8%) and just under one in five reporting they were 'easier' or 'much easier' (n = 3, 17.6%; appendix F). Practitioners commented positively on the layout and scaling of the tools, which they found to be straightforward and user friendly. Practitioners noted that some personal attributes, such as being **receptive to change** and not 'particularly precious' about their current practice approach, made them more willing to use tools with families.

- The **content of the training aligned well with the practice approach already being used by practitioners**. For instance, the systemic training aligned with recent training practitioners had received (such as Dynamic Maturation Model of Attachment Neurodevelopment Psychopathology) and the strength-based approach being used by the service.
- Providing **easy and convenient access to the tools**, for example by printing copies of the tool to have ready in the office, encouraged practitioners to use the tools in their day-to-day practice. This is especially important where practitioners and management have highlighted a lack of time to prepare for visits due to supporting a high number of families and being understaffed.
- When delivering sessions with families, a manager felt that **framing the tools as a routine and mandatory** part of the session was the best way for practitioners to ensure engagement with the tools.

RQ: 1.5

Participant responsiveness: Are practitioners and families engaged during the implementation of the tools?

Results from the endline survey indicated that three-quarters of practitioners (n = 12, 70.6%) reported families were 'somewhat engaged', 'engaged' or 'very engaged' (table 3.3). Among families that were engaged, practitioners reported that they found the tools useful as a means for discussion, were happy to complete them and in some instances, children were excited to use them. Where there were issues with family engagement, practitioners attributed this to families not seeing the value in the tools and instead viewing them as an extra task they needed rather than wanted to do, perhaps due to how the tools were introduced by practitioners. Others highlighted family needs, such as mental health difficulties, contributing to mixed engagement (as mentioned above in Barriers).

TABLE 3.3

How engaged practitioners reported families were when using the ORS and SRS

Engagement	Number of practitioners	Proportion of practitioners (%)
Not engaged	1	5.9
Neither engaged nor not engaged	4	23.5
Somewhat engaged	3	17.6
Engaged	7	41.2
Very engaged	2	11.8

RQ: 1.5

Participant responsiveness: What do practitioners and families like and dislike about the approach?

During interviews and the endline survey, practitioners reflected on the aspects of the tools they liked and disliked. Practitioners and managers who liked the tools and wanted to continue to use them explained that the tools were simple and easy to use, and they believed were leading to positive outcome (see Perceived benefits).

However, other Early Help staff had a more negative view of the tools. They felt the tools were too prescriptive and took too long to complete, leaving little or no time to deliver other support. The tools added to their workload and practitioners could not see the value they added beyond the tools they were already using. Practitioners also commented on the aspects of the tools that the families did not like. This appeared to be down to individual preferences rather than a consistent trend, for example, one family member disliked the tool as they found it too simplistic whereas another found the tool too 'academic' and overwhelming. It was also acknowledged that using the ORS/SRS can sometimes feel burdensome for families as they have many other forms to fill in with practitioners.

RQ: 1.6

Acceptability: Is the approach acceptable to practitioners and families?

Findings from the post-training survey and interviews revealed that practitioners felt the systemic training and tools were relevant to the work the Early Help & Family Engagement service already does (as discussed in *Differentiation*). There was a shared view that the ORS and SRS are a good way to evaluate session and monitor outcomes.

The appropriateness of the ORS and SRS was explored in the post-training survey using the Intervention Appropriateness Measure. The overall mean score for appropriateness for the ORS was 4.20 (SD = 0.65) and SRS was 4.14 (SD = 0.61) out of a maximum score of 5. These are high scores which suggests that practitioners perceived the ORS and SRS to be appropriate.

The feasibility of the intervention was explored using the Feasibility of Intervention Measure. Similar to appropriateness scores, the overall mean score for feasibility for the ORS was 4.00 (SD = 0.78) and for the SRS was 4.00 (SD = 0.80) which indicates a high perceived feasibility for the tools as the maximum score on this measure is 5. The appropriateness and feasibility of the ORS and SRS had similar mean scores, indicating that both tools were equally seen as appropriate and feasible by practitioners.

Despite initial enthusiasm for the tools, in the endline survey, only half of practitioners (n = 9, 55.6%) reported that they would like to continue using the tools in their practice. Practitioners who did want to continue using the tools highlighted that they wanted to use them flexibly, especially as there are certain situations where they would not be useful.

> *'So long as I can use them sometimes as a one-off and there not be an expectation of regularity and frequency.'*
> **– Early Help staff member, endline survey**

Aspects of the tools practitioners liked and disliked as explored above within Participant responsiveness and aspects that made the tools easier or harder to use are explored within *Barriers and facilitators* above.

3.2 Evidence of promise

Perceived benefits

This section reports on the perceived benefits of the approach based on the short-term outcomes identified in the theory of change (see the *Introduction*) developed before the evaluation's fieldwork. We were unable to collect evidence on medium- and long-term outcomes due to the relatively short duration of the pilot.

RQ: 2.1

What potential impacts of the intervention does implementation of the approach lead to for practitioners and families?

Improved skill and confidence to support families

As outlined in the theory of change, the training was intended to improve practitioner skill and confidence to support families using a systemically informed approach. Evidence from the post-training survey indicates that practitioners either agreed or strongly agreed (100%, appendix E) that after the training they understood key systemic principles and ideas (n = 16, 100%), were confident applying systemic principles and ideas to their practice (n = 13, 81.3%), would be able to explain the benefits of using systemically informed practice to a colleague (n = 11, 68.8%), are confident and have the skills to administer the ORS and SRS (n = 13, 81.3%), upload the scores into Liquid Logic (n = 11, 68.8%) and would be able to interpret what the scores mean SRS (n = 13, 81.3%).

> *'[The training] really revolutionised the way I work. It gave me a lot of confidence.'*
> **– Early Help staff member, interview_01**

Practitioners felt that the tools had improved their skill and confidence in talking about sensitive issues with families, particularly during initial visits with families when they may be more apprehensive about what to ask. The tools were viewed as a good starting place to open up conversations.

> *'In those initial visits, I think it is brilliant and it's made me feel a bit more confident as well because … when you don't know a family, you're a bit nervous anyway … I think you've always got those anxieties about what you're going to be faced with but I think you're able to use that a little bit as an approach to say, OK, I'll see you have marked here. Can you explain a bit more about what's happening for you?'*
> **– Early Help staff member, interview_03**

The tools were viewed as a way for practitioners to be more focused and structured in their work, as the tools provide a clear beginning and ending to sessions.

Increased self-reflection and reflective practice

A specific aspect of improved skill that was mentioned across participants was increased self-reflection. This outcome was not specifically articulated in the theory of change, but appeared to be important, and linked to improved skill and confidence among practitioners and improved practice – outcomes that were articulated in the theory of change.

Practitioners felt that the SRS helped them reflect on their own practice which in turn enabled them to provide tailored support in line with family needs. Interviews with Early Help staff supported the view that the training had helped practitioners reflect on their own practice and approach to working with families, including the language that they use and how to create solutions with rather than to families.

'I'm able to reflect on my own practice to see where I can improve. It also shows if I have covered a sensitive subject for the person and if this has made them feel uncomfortable to know how better to approach this next time.'

– Early Help staff member, endline survey

Quicker identification of family issues and support needs

There was agreement from practitioners that the tools give focus to sessions and are basic questions which can lead to more in-depth discussions. This allows practitioners to gather more information – for example one practitioner described using the ORS alone as yielding as much information as a full needs assessment with some families. Practitioners reported on the benefits of using the tools upon first contact with a family which enabled them to quickly identify the support needs of the family.

'When using the scale with families on a first visit when being new to family, [the tools] gave me the ability to gather far more information than I could before.'

– Early Help staff member, endline survey

Improved understanding of family perspectives and needs

During interviews, practitioners mentioned the training had encouraged them to be more empathetic with families. They pointed to the value of the training focusing on how they could get to the root causes of issues and felt this helped understand family perspectives and needs. They mentioned that previously, solutions in their approach were oriented towards individuals and their own capacities and confidence were contributing to issues. Practitioners also spoke about the tools helping them have an increased understanding of the lived experiences of families and seeing things from their perspective. The tools encouraged them to be more curious and listen more.

'I found the tool extremely helpful for gaining a more detailed background not just about what was happening for the family now but what factors might have impacted on them from the past to be experiencing the problems they were having now.'

– Early Help staff member, endline survey

A key benefit identified was the tools helping them understand how a family was feeling at the start of the support session. Overtime, the ORS also allowed the practitioner to identify more systemic issues or patterns in a family members life, for example, generational issues for a father that were reoccurring in his current family. Relating to this, the tools allowed practitioners to pick up on discrepancies in how families were feeling. This helped them to identify where changes could be made.

The SRS also helped practitioners understand how families found the support on offer. Practitioners valued the time to reflect with the families and to ask why they felt a certain way and what they would like to have done differently within the session. Staff described how without the use of the tools, they may have misjudged how a family member found a session and not been able to adjust future sessions accordingly.

Early Help practitioners provide tailored support in line with family needs

The improved understanding of family perspectives and needs has helped practitioners tailor their future sessions to families and provide a more bespoke service. The amount of extra information about a family that practitioners are able to gain through use of the ORS allows future support to be planned around their needs.

'If you're able to get a bigger picture about what's happening within all aspects of their life and … past events as well, that can decide ultimately on your plan moving forward with the family … it's more tailored to them ... it is bespoke to them, to their needs.'

– Early Help staff member, interview_03

Improved relationship with practitioners

As set out in the theory of change, key expected outcomes were children and families feel listened to by the practitioner and improved therapeutic alliance. There were indications that the tools were helping individuals, and particularly young children, express how they were feeling and also how they wanted the sessions to be run.

'[The] young person [I am supporting] finds it mostly easier to express herself and initiate conversation.'

– Early Help staff member, endline survey

Practitioners reflected that they had been more curious in their questioning which means families are given more space to off-load how they are feeling. As a result, practitioners mentioned that some families have felt more listened to and valued by the practitioner.

'With families, you take the time to model that positive communication and are able to show curiosity and empathy, and use that idea of being a detective and not a judge.'

– Early Help staff member, interview_01

Ensuring that families feel listened to by using these tools helps to build a strong and trusting relationship with the family as it allows families to explain what has been happening in their situations. This can help to give families a greater sense of control over the sessions. In turn, this is perceived to add balance to relationships and remove imbalances of power between practitioner and family.

Less risk of early dropout from services

While this pilot did not measure dropout rates directly due to the short time span of the evaluation, practitioners felt the tools represented a different way of working which would successfully engage certain families who previously have had limited engagement.

Improved family communication, relationships and functioning between family members

Practitioners reflected that families are communicating more and are more open with each other about their thoughts and feelings. In part, practitioners feel this is from the positive communication and empathetic conversations they are able to model from their own conversations with families.

'The families are communicating more, they're more open. I know I wouldn't have been able to do that without the ORS, I would say. I certainly wouldn't have been able to do that without the systemic practice training that we had, and having the confidence to go out and do it.'

– Early Help staff member, interview_01

Increased self-awareness of emotions, challenges and strengths

An expected outcome of the tools was families having increased self-awareness of emotions, challenges and strengths. There were indications that the tools were helping families gain a better understanding of issues experienced by the whole family and the underlying cause of the issues. For example, practitioners mentioned that the ORS probed families to think deeper on how things are going for them. This might include generational or historical issues rather than just day-to-day immediate issues. In doing so, this could also help to raise issues that a family member did not previously know they had. One manager

described it as allowing families to reflect in a more 'therapeutic way' to express difficulties they are having now or have had in the past.

> *'[The tools] really do open up those conversations and get families to reflect, reflecting on what's possibly happened in the past.'*
> **– Early Help staff member, interview_03**

Increased self-awareness helped families understand why they were receiving support from Early Help. The measures helped families reflect on their progress and also identify barriers to overcoming difficulties. Improved understanding of support needs also gave families 'permission' to seek additional help, for instance, from their GP.

Evidence of outcomes

Outcomes were captured using two validated outcome measures that were administered at baseline and endline to practitioners in the intervention and control groups.

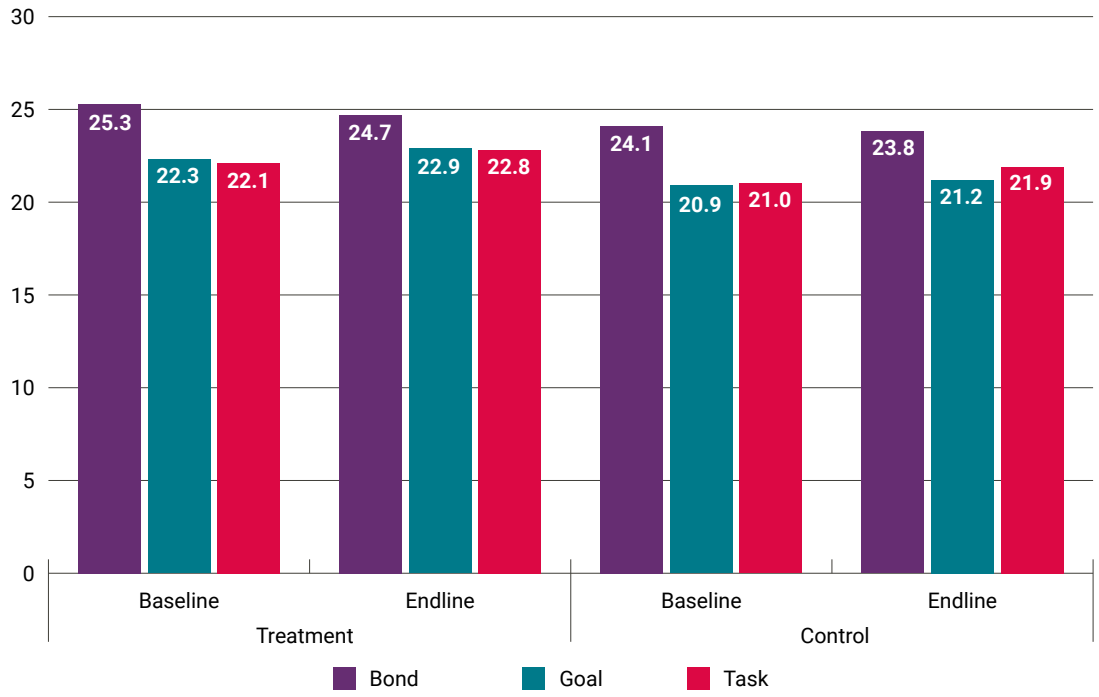
Improved therapeutic alliance

Scores for therapeutic alliance were high for both groups at baseline and endline suggesting a potential ceiling effect of the measure. Scores for the control group at baseline (n = 18, M = 66.3, SD = 7.0) and endline (n = 22, M = 66.9, SD = 4.2) and the treatment group at baseline (n = 27, M = 69.2, SD = 5.1) and endline (n = 17, M = 70.5, SD = 3.9) were high, as the maximum score was 84. Figure 3.4 illustrates the scores for each domain for the treatment and control group at baseline and endline. This shows that scores for each domain were high, with each being above 20 out of a maximum score of 28. Across groups at both time points, 'bond' had the highest score, with goal and task scoring similarly.

A paired sample t-test revealed that neither the treatment (t(16) = 1.22, p =.238) or the control group (t(15)= 0.41, p = 0.684) had a statistically significant change in overall Working Alliance Inventory scores between baseline and endline. The difference between groups was not statistically significant (t(31) = 0.39, p = .697).

FIGURE 3.4

Working Alliance Inventory scores for treatment and control groups at baseline and endline



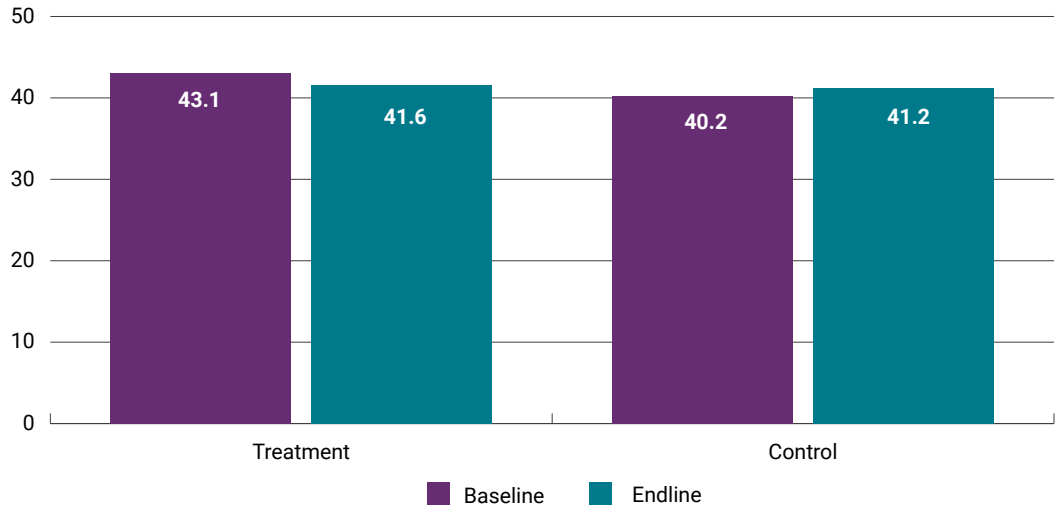
Increased compassion satisfaction

The data on compassion satisfaction indicates that at both baseline (n = 19) and endline (n = 22), the control group had scores between 41 and 42 which is considered an 'average' score and the treatment group had a score at baseline (n = 27) above 42 which is considered 'high' and a score of 41.6 at endline (n = 18) which is considered 'average'.

A paired sample t-test revealed that neither the treatment (t(16) = 1.01, p =.325) for the control group (t(15) = 0.20 p = 0.846) had a statistically significant change in overall compassion satisfaction between baseline and endline. The difference between groups was not statistically significant (t(31) = 0.59, p = .558).

FIGURE 3.5

Compassion satisfaction scores for treatment and control group at baseline and endline



Unintended consequences

RQ: 2.2

Do there appear to be any unintended consequences or negative effects?

Early Help staff were asked to reflect on the potential or actual unintended consequences of the training and use of tools. Overall, very few unintended consequences were identified in the evaluation data.

For practitioners, learning about the plans for the pilot lead to feelings of frustration in some cases that they had something else they needed to do in their already busy workload. However, once they had attended the training, they realised that if used correctly, the tools do not add pressure or take too long to factor in.

Although no unintended consequences were identified by practitioners themselves, a manager reflected that the use of the tools might lead to less-confident practitioners feeling nervous about using the SRS as it can feel like a judgement on their practice.

For families, one consequence was that the SRS could make families feel awkward about sharing how they felt the session had gone with the practitioner or feeling pressured to complete it in a certain way, particularly when the practitioner was in the same room as them. It was noted by one practitioner that this may have been partly down to some confusion in what families believed they were supposed to be rating:

'For me, I don't think they [the families] always fully take in that it's about the session, you're not just looking at me [the practitioner]; it's about, did that session meet your needs? Was it what you wanted? Did you get out of it what you were hoping to? They still see it as they're rating me, rather than the session.'

– Early Help staff member, interview_03

3.3 Readiness for trial

RQ: 3.1

Is there a clear description of the intervention and the contextual facilitators and barriers that would allow it to be implemented and evaluated in other places?

The theory of change developed at the outside of this pilot was largely supported by the findings in this report. We recommend adding 'Increase in reflective practice' as a short-term outcome.

The evaluation identified a number of facilitators and barriers for implementing systemic practice training and the use of two types of practitioner tools. If the approach is implemented and evaluated in other places, we recommend they are given further consideration in the design of the approach.

RQ: 3.2

Is the intervention able to be delivered consistently across teams?

The evaluation included three teams in the intervention group which allowed us to compare implementation across the different teams. Our findings from the evaluation indicated that there was little variation in delivery across the three teams that took part. The facilitators and barriers considered in this report are factors that should be taken into account to ensure consistent delivery.

RQ: 3.3

Are any changes needed to the theory, materials or procedures before roll-out?

Across post-training and endline surveys and during interviews, participants noted various ways delivery of the approach could be improved.

Delivery of training

With regards to training delivery, a majority of practitioners in the survey indicated they would have preferred to have the training delivered over one full day (n = 12, ,75.0%) rather than two half-day sessions. Practitioners mentioned that having a gap between sessions could lead to some information being forgotten; a one-day session would have been better for the purposes of retention.

Refresher and follow-up training

Both practitioners and managers felt they would benefit from future training refresher sessions. This may help to ensure that use of the tools is sustained over time. Having the opportunity to discuss their approach with other practitioners after the initial training was seen as a way for staff to further embed learning from the training into their practice.

'The more times I, sort of, refresh myself on these types of training, the more I seem to pick up every time that I go and then eventually it builds a bigger picture.'

– Early Help staff member, interviews_02

Another suggestion from interviews was that it would be useful to have group feedback sessions with the facilitators of the training from the Edge of Care team to discuss how the tools were being used and generate ideas and new learning. Finally, practitioners may

benefit from regular reminders about using the tools, such as posts on the Service's weekly newsletter, to help embed the tools into their routine practice.

Training content

While some survey respondents felt it was delivered well and nothing needed to be changed, others felt the training could have been delivered at a faster pace. There was a shared preference to have more practical tasks during the training. Staff reported this would help break up the aspects of the presentation that were seen as more theoretical, and help attendees concentrate for longer. Examples of practical tasks that staff requested more of included completing the measures and entering scores into Liquid Logic. Practitioners also wanted to learn more about how to overcome practical barriers such as time constraints, reluctance from families to take part and the logistics of including all the family. Further support may help practitioners develop the way they introduce the tools and adapt their communication style to different needs, which may help overcome difficulties with engaging certain families (as discussed within the Barriers section above).

Support to use tools

To address the challenge of organisation when practitioners have a high workload, it was suggested that better planning and time-management might be necessary to effectively integrate the tool. This could involve small practical changes such as having one staff member responsible for printing out the tools and ensuring there is a fully stocked pile of paper copies in the office which practitioners can take as and when they need before attending home visits. Another way to support higher usage could be to embed discussions about the tools within performance management and supervision.

Although the training mentioned that the tools were available in different languages, practitioners did not use different versions and reported that they experienced barriers using the tools with families with English as an additional language. This suggests practitioners may benefit from further support in how to use the tools in different languages or how to work alongside an interpreter to administer the tools.

Reducing amount tools are used

The tools were intended to be used at the beginning and end of every session, but some practitioners found this too repetitive. There was a view that it would be more appropriate to issue the tools at the beginning and ending of support, rather than during each session.

Fit with usual support

Practitioners mentioned that it would be useful to consider how the tools can complement the support model they are already using to help ensure systemic practice is embedded across teams in Rotherham's Early Help & Family Engagement service. For instance, incorporating the scaling that is done as part of Signs of Safety, and using the tools during supervision and Team Around the Family meetings (meetings to review family plans every four to six weeks).

Improvements to recording in Liquid Logic

Improvements would need to be made to the online system (Liquid Logic) to avoid technical issues which are described earlier. One practitioner mentioned that being able to add notes about families during the upload would be useful.

RQ: 3.4

How acceptable is it for practitioners to take part in evaluation activities?

This section explores acceptability of taking part in data collection activities. Acceptability of taking part in intervention activities is covered within *Evidence of feasibility*.

We randomly selected three teams to be included in the treatment group and two in the control group. It was important to meet with the managers of each team prior to the randomisation process to explain the rationale in more detail and answer any queries they may have. After randomisation, we met with managers again and provided a clear information sheet which explained the randomisation process which could be shared with practitioners in each team. During interviews with managers, we asked for their reflections on the randomisation process. Managers did not report any issues with the randomisation design. Results from the endline survey indicated that there was no contamination to the control group.

We engaged practitioners in a range of evaluation activities, including surveys, interviews and observations. Practitioner reported no issues with the time commitments needed to take part. Evaluation activities including the surveys and interviews were described as something practitioners and managers were willing to make time for:

- Practitioners were willing to participate in **observations** of the training. They found it useful to meet the researcher in person and ask any questions they had about the evaluation. There were no issues recruiting for interviews, and practitioners and managers were able to and willing to take part.
- Practitioners and managers were positive about their experiences of taking part in **interviews**. They valued opportunities to share their views and have the time to reflect.
- The **surveys** gathered practitioners' views on the training and tools and included two outcome measures at baseline and endline. Practitioners commented during interviews they were happy to take part in surveys and did not think they were burdensome. All surveys achieved a high response rate.

> *'I've been happy to [participate] to be honest as without feedback, how do we learn?'*
>
> **– Early Help staff member, interview_03**

RQ: 3.5

What are the enablers and barriers to evaluation?

Enablers

Providing clear information from the outset to all those taking part in the evaluation was crucial for ensuring participants understood the rationale for the evaluation and what their role would be. The evaluation team achieved this by sending clear and accessible information leaflets to managers, who distributed them to the practitioners in their team.

> *'I think it's very well organised. I think that you're real as an organisation. It's very clear because you send the information before and about what to expect. Calm, organised, and I think that it inspires. I've got the confidence that what you're doing is a good piece of work, if that makes sense.'*
>
> **– Early Help staff member, interview_04**

The Early Help managers played a crucial part in the evaluation. They assisted with explaining the evaluation to the practitioners in the team at the beginning of the evaluation. Managers supported data collection by distributing the survey links and reminding practitioners to respond and identifying practitioners to take part in interviews.

Barriers

Initially, the evaluation team set out to conduct the evaluation across all teams in Rotherham's Early Help & Family Engagement service. However, prior to trial commencement it became apparent that certain teams would not be able to take part due to issues with staffing and were therefore excluded from randomisation and evaluation activities. This reduced the size of the sample taking part and may have limited the power to detect statistically significant differences between the control and intervention groups.

As discussed in the Evidence of feasibility section, there were some challenges with delivery. For instance, Early Help managers and practitioners reflected that their limited capacity and having to continue using other mandatory tools meant that they were not able to use the tools as much as was outlined in the training (that is, with every family unless there was a reason not to use the tools). Limited use of the tools may have limited the chance to find a statistically significant result between the treatment and control groups.

RQ: 3.6

What is the recommended approach for further evaluation?

The evaluation team recommends Rotherham continues to monitor the delivery of the approach by investigating whether key components are being delivered as intended using both quantitative and qualitative means.

We recommend continuing administrative data collection to assess implementation of the tools. We would recommend Rotherham continues to collect and monitor attendance data for future training to understand reach, as well as usage data on the tools.

In this evaluation, we collected qualitative data from practitioners and managers to understand their perceptions of the approach. We would recommend continuing and expanding qualitative data collection to understand practitioners' perceptions. Topic guides used in this evaluation could be used as templates. If these take place, we'd recommend personnel skilled in interviewing and independent from Rotherham be chosen to undertake them.

We did not collect data directly from children and families. We'd recommend Rotherham considers gathering qualitative data from children and families to understand their perceptions of the approach. During interviews, we'd recommend that children and families are encouraged to discuss their experiences of support, including the use of the tools, and perceived outcomes they think the support has had on their needs.

The evaluation team also recommends Rotherham continues to investigate the potential for improving child, family and practitioner outcomes. The evaluation attempted to explore two key practitioner outcomes (therapeutic alliance and compassion satisfaction) using two valid and reliable measures. No impact was found, perhaps due to the ceiling effect observed in the measure, and also due to the relatively short duration of the pilot. We'd therefore recommend Rotherham explores the use of other outcome measures to reliably track whether the approach is leading to positive outcomes for children, families and practitioners. This could include using administrative data that is already collected or implementing an appropriate and feasible outcome measure to test key outcomes in the theory of change.

4. Conclusion

Summary of findings

Our evaluation assessed the delivery of the pilot against three key domains:

- evidence of feasibility
- evidence of promise
- readiness for trial.

Evidence of feasibility

Findings suggest that the training and tools are feasible to implement in an Early Help team. Both the training and tools were well received by Early Help staff.

Training was mostly implemented as intended and delivered over two half-day sessions. The compulsory nature of the training meant attendance was high overall and nearly all eligible practitioners received training. Although the service does not formally follow a systemic approach to frontline family work, the ideas taught in training were consistent with the practice model and included content that was familiar to some practitioners. Overall, practitioners liked the training and had high engagement. The interactive delivery of the training helped practitioners understand the content. Prior to training some practitioners were concerned about the extra workload in an already capacity-limited team, but once they had attended, there was agreement that the training had been enjoyable and met their needs.

FSWs, senior FSWs and senior practitioners who attended the training used the tools in their practice with families. When practitioners did use the tools, they used them as planned: the Outcome Rating Scale (ORS) was used at the start of sessions and the Session Rating Scale (SRS) at the end of the sessions. The use of outcome measures was considered to be in line with the service's usual practice approach, although most practitioners had not used the specific tools being piloted. Barriers to usage included high workload and tight time constraints, lack of family engagement, and the tools not being suited to different family support and communication needs. Facilitators included the tools being easy to use, and easy access to the tools. There was mixed engagement from families, and this was usually down to individual support needs and preferences of families. Practitioners who liked the tools found them easy to use and believed they were leading to positive outcomes. They also felt the tools were relevant to their work and were feasible and appropriate. In contrast, there was a group of practitioners who disliked the tools because they found them too prescriptive.

Evidence of promise

During interviews and the endline survey, practitioners and managers identified a number of benefits consistent with the short-term outcomes articulated in the theory of change. The training and use of tools was linked to improved confidence and skill among practitioners which in turn led to them providing better-quality support to children and families. Key outcomes for children and families were that they felt more listened to and developed a better relationship with the practitioners.

While practitioners generally perceived that the approach had improved outcomes for themselves and families, this was not supported by data collected from the outcome measures. The observed ceiling effect, short duration of the pilot and small sample size may have limited our ability to detect statistically significant changes.

There appeared to be minimal unintended consequences of the approach. The few identified included practitioners' initial concerns about the additional workload and some families feeling uncomfortable about providing feedback.

Readiness for trial

There is a clear description of the approach in the theory of change, and this evaluation identified key barriers and facilitators which should be considered in future roll-out. Various refinements to the delivery of training and use of the tools would improve the scalability of the current design, including the provision of refresher training, additional practical support to use the tools, and improvements to recording in Liquid Logic. There were some instances where practitioners did not successfully engage families with the tools and further development should be done to ensure tools can be used with all families receiving support. For instance, practitioners may benefit from further support to enable them to use the tools in different languages. Early Help staff were willing and able to take part in evaluation activities. We recommend Rotherham continues to evaluate the implementation of the approach and the outcomes using appropriate and feasible methods. There were some issues with the outcome measures used in the evaluation which means they may not be suitable for future evaluation. Further work should be done to identify suitable outcome measures.

Conclusions

This mixed-method evaluation provides first early evidence on the new approach being implemented. First, our evaluation found that introducing systemic training and feedback tools in the Early Help context is feasible. Second, our evaluation identified a range of potential benefits for children and families. The findings suggest the approach would benefit from further development work before roll-out to all teams in Rotherham or to other Early Help services.

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Appendices

Appendix A: References for the research which informs the theory of change

Local population data

1. Rotherham.gov.uk. Rotherham Data Hub (accessed 28 March 2023). https://www.rotherham.gov.uk/data/people/population/2

Scientific research

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3. Lambert, M. J., Whipple, J. L., Hawkins, E. J., Vermeersch, D. A., Nielsen, S. L., & Smart, D. W. (2003). Is it time for clinicians to routinely track patient outcome? A meta-analysis. *Clinical Psychology: Science and Practice, 10*(3), 288–301. https://doi.org/10.1093/clipsy.bpg025
4. Kelley, S. D., & Bickman, L. (2009). Beyond outcomes monitoring: Measurement feedback systems in child and adolescent clinical practice. *Current Opinion in Psychiatry, 22*(4), 363–368. https://doi.org/10.1097/YCO.0b013e32832c9162
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Professional knowledge

6. Professional expertise and insight from the Edge of Care manager, Head of Early Help & Family Engagement and Early Help team managers

Evaluation data

7. Observational training evidence from the pilot in Rotherham
8. Wider evidence generation from three feasibility studies conducted by the Early Intervention Foundation (EIF) for the Department of Levelling Up, Housing and Communities (DLUHC) in 2021/2022 to explore feasibility and evidence of promise for using a psychologically informed key-worker approach. See: https://www.eif.org.uk/report/supporting-families-feasibility-reports

◂ *Back to Theory of Change diagram*

Appendix B: Information leaflets

- Practitioner information leaflet (Intervention teams) **[DOWNLOAD]**
- Practitioner information leaflet (Comparison teams) **[DOWNLOAD]**
- Interview information sheet **[DOWNLOAD]**

Appendix C: Privacy notice and consent form

- Data protection notice **[DOWNLOAD]**
- Consent form **[DOWNLOAD]**

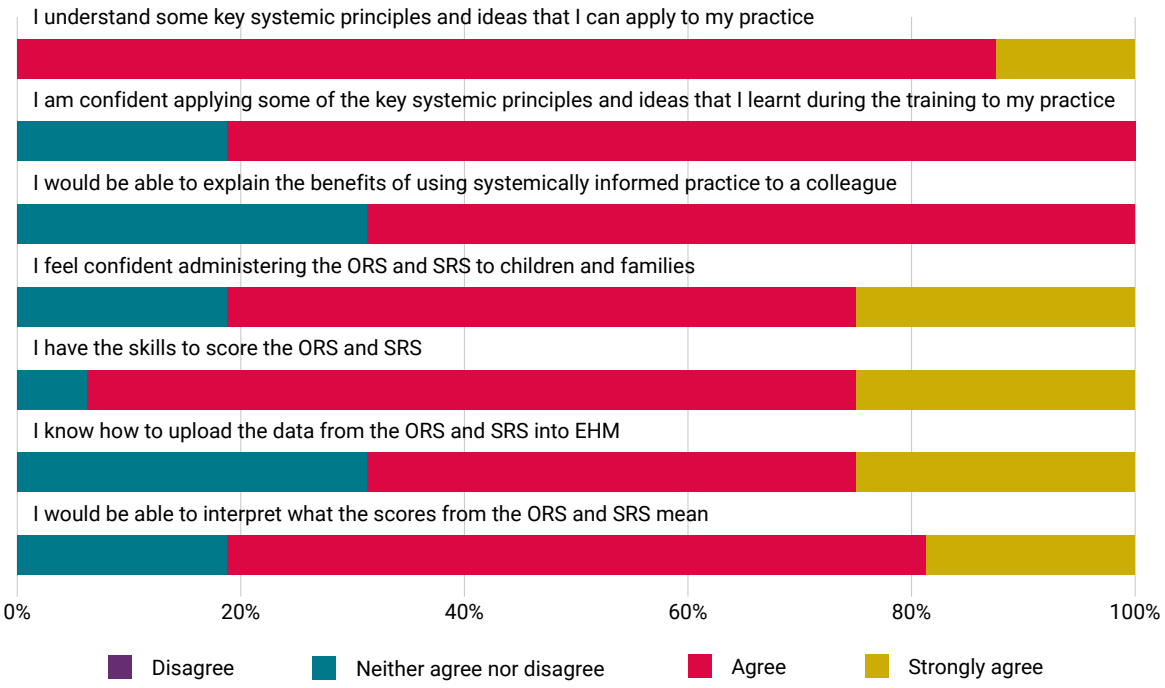
Appendix D: Data collection tools

- Baseline survey **[DOWNLOAD]**
- Post-training survey **[DOWNLOAD]**
- Topic guide **[DOWNLOAD]**
- Endline survey (Intervention teams) **[DOWNLOAD]**
- Endline survey (Comparison teams) **[DOWNLOAD]**

Appendix E: Practitioner views on anticipated outcomes from the training

FIGURE E.1

Practitioner views on anticipated outcomes from the training



Appendix F: Ease of use for ORS and SRS

TABLE F.1

How practitioners found using the ORS and SRS compared to the tools that would normally be used when supporting families

Difficulty compared to tools normally used	Number of practitioners	Proportion of practitioners (%)
Much harder	1	5.9
Harder	3	17.6
Neither easier nor harder	10	58.8
Easier	1	5.9
Much easier	2	11.8