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Evaluation of the clinical support provided to Islington's Bright Futures team

April 2023

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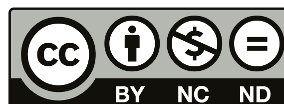

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Executive summary

This report presents findings from a feasibility and pilot study evaluation conducted by the Early Intervention Foundation (EIF), now merging with What Works for Children's Social Care (WWCSC) and operating under the working name of What Works for Early Intervention and Children's Social Care (WWEICSC). The evaluation explores the clinical support provided by two clinical teams to Islington's Bright Futures team.

Approach being evaluated

Bright Futures, a family support and outreach service which is part of Islington's Supporting Families Early Help programme for families with children aged 5–19, supports many families who have complex mental health issues or children with behavioural difficulties. The Parental Mental Health Team – part of a wider Psychologically Informed Consultation and Training (PICT) service – and Children, Adolescent Mental Health Services (CAMHS) are commissioned to provide ongoing support as an integrated clinical team to Bright Futures practitioners. The clinical support offer has been running since the Bright Futures team was set up in July 2020, although some elements of the offer were available to the team in its previous form before that.

The clinical support offer was designed to offer a range of activities, including workforce training and workshops, monthly facilitated group case consultation and reflective practice space, targeted individual consultation sessions with clinicians and support in family sessions. Its aim is to provide practitioners within the team with psychologically informed support to help them to deliver better care to the increasing number of families in Islington presenting with complex mental health needs. The offer also aims to help practitioners to feel more supported, have improved wellbeing and be less likely to suffer from burnout.

Research questions

The key research questions were:

1. Evidence of Feasibility: Is the clinical support offer operating as intended; and what are the barriers and enablers to delivering the offer?
2. Evidence of promise: What are the potential benefits of the offer for families, practitioners and the wider service; and are there any unintended consequences?
3. Evaluation feasibility: What is the most feasible way to assess the implementation and impact of the clinical offer; and which outcomes are critical to measuring impact?

Methods

The evaluation combined exploratory qualitative research with descriptive statistics of administrative data and survey data on practitioners. The qualitative research involved 12 interviews with clinicians, team managers and practitioners, combined with observation of seven activities delivered by the team. Interviews and observations of training workshops

and group sessions were carried out in April and May 2022. Quantitative data were analysed descriptively. The findings from the different data collection methods were triangulated to draw conclusions.

Findings

Evidence of feasibility

The evaluation provided evidence of how the clinical offer is operating as intended (as specified in the theory of change), suggesting a clear, shared vision for what the clinical support offer comprises.

While overall, the offer appears to be delivered as planned, there have been two notable adaptations made to help the offer better meet the needs of practitioners: running separate reflective practice sessions for practitioners and team/deputy team managers, and a flexible approach to case consultation sessions with less focus on specific cases in some instances. There was general consensus among the interview participants that running the group sessions online as necessitated by Covid restrictions had not been a positive move and had resulted in them being less engaging and effective as in-person.

Management data suggested that reflective practice sessions were happening about once a month but that case consultation sessions expected to run monthly were happening less frequently. However, no data on attendance was available. Training had been delivered a lot less frequently with only two training sessions run so far. Practitioners' engagement with the clinical support offer was found to be variable.

No specific quality standards were set for the clinical support offer, but interview participants highlighted three key ingredients: clinicians being readily available and having the capacity to engage; clinicians having the right skills and experience; and the clinical offer being evidence-based.

Support from the PICT and CAMHS clinicians was not unique to Bright Futures; however, they are the only team to embed the support and to have the PICT and CAMHS teams working together in this way to provide this specific range of activities.

Barriers and enablers

Enablers to delivery included:

- **Clinicians' skills and experience,** as well as strong facilitation skills and experience or knowledge of the populations that practitioners work with.
- **Clinicians' availability** and that availability being embedded into the Bright Futures teams was seen as fundamental to delivery.
- **The nature of clinicians' relationships,** including between PICT and CAMHS, between clinicians and their managers and with external teams and services.
- **Having a structured approach** and having clear expectations.

Barriers to delivery included:

- **Practitioner engagement** was found to be variable. Factors influencing engagement were: practitioner capacity and workload, the nature of practitioners' roles (and relevance of the offer to them), previous experience of using psychologically informed approaches, concerns about feeling exposed, not liking the expectation to attend, the recent service restructures and session dynamics.

- **Remote delivery:** impacting on the group dynamic and the quality of relationships.
- **Staff turnover of clinicians.**
- **Resources within the wider system,** including low funding of services coupled with increased demand.

Evidence of promise

The evaluation suggests that there are signs that some of the clinical support offer's aims are being met in some cases. Evidence from interviews and staff surveys point to practitioners approaching their work differently as a result of the support they are receiving and, in some cases, practitioners are taking a more psychologically informed approach to their work with families. There is also some evidence that the support is impacting on practitioners' knowledge, skills and confidence around working with families with more complex needs. There was also broad consensus that the support is considered to have a positive influence on practitioners' general resilience and wellbeing.

While the evaluation was not designed to detect causal impact, there was emerging evidence that the offer is having an effect on the service provided to families. In some cases, practitioners feel better able to support families or to signpost families to the right services. It was also felt that practitioners' relationships with families are improving, in some cases. The influence of the offer on the wider service and system is less clear, although there were suggestions that the offer is helping to bring the team together.

Conclusions and recommendations for the clinical support offer

The Bright Futures clinical support offer, with notable adaptions, appeared to be being delivered as intended. The offer was designed to support practitioners to deliver better care to the increasing number of families presenting with complex mental health needs, help them feel more supported, and improve their wellbeing. The evaluation suggests that there are signs that some of these aims are being met in some cases but that more needed to be done to improve engagement by practitioners.

Recommendations on delivering the approach

Evidence from this evaluation points to a number of recommendations that the Bright Futures team could consider. These include:

- **Training and guidance,** considering providing regular short training sessions on what a psychologically informed approach is aiming to do and why it is relevant, as well as identifying other areas for training and roll them out.
- **Delivery of the offer,** considering whether there is the resource and opportunity to provide outreach workers with a separate forum during team case consultation sessions.
- **Recruitment,** considering referencing the support offer to support practitioner recruitment.

Recommendations on evaluating the approach

Evaluating the impact of the approach is an important part of understanding how effective it is in achieving its intended outcomes. Part of the evaluation was to assess the feasibility of conducting a future impact study on the clinical support provided to the Bright Futures team. The evaluation team were unable to identify or construct a sufficient counterfactual (ie a control group) which would support a future impact study by the team. The evaluation team would therefore recommend that Islington continues to assess the implementation and builds towards evaluating the impact of the offer.

In terms of evaluating implementation, this could include improving management data collection on the key components of the approach including the frequency and participation in key components of the offer. We recommend this is supplemented with qualitative data collection of practitioners' and families' views to understand perceptions of this approach.

In terms of evaluating impact, while it may be challenging to carry out a full impact evaluation of the clinical support offer, we recommend that the Bright Futures team measures the key outcomes that are articulated in the theory of change through administrative data collection and the collection of validated outcome measures that are feasible and practical. This would give strong evidence of promise which could potentially be used to undertake impact analysis in the future.

1. Introduction

Project background

The Supporting Families Programme, funded by the Department for Levelling Up, Housing and Communities (DLUHC), aims to help thousands of families across England to get the help they need to address multiple disadvantages through a whole-family approach, delivered by keyworkers, working for local authorities and their partners.[1] A national impact evaluation demonstrated that the programme has impact on certain outcomes, but local approaches vary substantially with little current understanding of what is effective within early help more broadly.[2] Local areas also face challenges in evaluating their local early help services and therefore struggle to know whether they are delivering effective practice to support families in early help.[3]

WWEICSC, formerly EIF, has been funded by the Supporting Families Programme to work with a number of local areas to carry out feasibility and pilot studies on promising approaches to supporting families with multiple disadvantages. Building on this work, DLUHC has committed to commissioning a large fund to administer impact studies to produce evidence on effective approach for areas nationally.

Approaches to test through feasibility and pilot studies were selected based on an initial assessment of the evidence where DLUHC prioritised three topics with potential. The focus of this feasibility study was **psychologically informed keyworker practice built around an evidence-based practice model**. Some of the root causes of poor outcomes for vulnerable families are driven by a complex interaction of different needs. The hypothesis is that providing support to key workers from clinicians via training, supervision and psychological tools, to build supporting relationships and help families identify strengths at the child, family, service/school and community level can support families with complex needs to develop strategies specific to their situation. It is hoped that this will strengthen family relationships and make positive change.

The feasibility and pilot studies aim to:

- Test fidelity to the approach as well as reach, participant views, and factors affecting implementation (feasibility study element)
- Assess the approach's evidence of promise and readiness for trial (pilot study element).

After a joint EIF and Department for Levelling Up, Housing and Communities call-out to local authorities (LAs) and initial scoping, EIF identified four LAs, one LA with a data pilot linking housing providers to early help data, two with clinicians supporting key workers, and one with a psychologically informed Edge of Care team.

This evaluation report focuses on the current implementation of the clinical support provided to Islington's Bright Futures (Early Help) team.

1 Department for Levelling Up, Housing and Communities. (2021). *Supporting families*. https://www.gov.uk/government/collections/supporting-families

2 Ministry of Housing, Communities & Local Government. (2019). *National evaluation of the Troubled Families Programme 2015 to 2020: Findings*. https://www.gov.uk/government/publications/national-evaluation-of-the-troubled-families-programme-2015-to-2020-findings

3 Taylor, S., Drayton, E., & McBride, T. (2019). *Evaluating early help: A guide to evaluation of complex local early help systems*. Early Intervention Foundation. https://www.eif.org.uk/resource/evaluating-early-help-a-guide-to-evaluation-of-complex-local-early-help-systems

Local context

Islington is a London borough that experiences high levels of deprivation and there are a considerable number of children, young people and their families with multiple and often complex needs.

Bright Futures is part of Islington's Early Help offer and provides family support and outreach to families with school-aged children up to 19 years old with whole-family support including parenting, employment, family relationships, home finances and getting to school support. The team collaborates with a range of organisations across Islington as part of their Fairer Together way of working. The Bright Futures team supports many families who have complex mental health issues or need support with child behaviour. In 2019 the Children's Commissioner estimated that 7,714 0–17-year-olds in Islington were in households where a parent suffered from severe mental health problems. This equated to 183 children or young people per 1,000 and was the 99th highest percentile out of 100 nationally.[4]

In initial scoping interviews with the Bright Futures team, it was reported that the mental health needs of families have increased in recent years, with an increase in neurodevelopmental challenges including Autism Spectrum Condition (ASC). However, Islington like many other local authorities, has significant waiting lists for CAMHS and adult mental health assessment and services. Consequently, the Bright Futures team estimates that about 90% of cases can have mental health needs. Practitioners also indicated that since the pandemic, they were taking on cases needing a lot more intensive care. All of this means that practitioners are working within a constantly changing and increasingly complex set of circumstances.

Approach being evaluated

In line with best practice, we have used the template for intervention description and replication (TIDieR) checklist to set out the approach being evaluated.[5] Information included in the description below was gathered in an initial scoping phase through interviews with the heads of the Bright Futures team along with the clinical leads overseeing the clinical support offer, a theory of change workshop as well as data provided by Islington and evidence gathered on identified activities or approaches.

Brief name

The clinical support offer provided to the Islington Bright Futures team.

Why

Practitioners working in Islington's Bright Futures (Early Help) team are seeing increasing numbers of children and families with complex mental health needs while mental health services themselves are hugely stretched and have significant waiting lists. The aim of the clinical support offer is to provide practitioners with clinical support while working with these families so that families receive better care and practitioners are better supported and less likely to suffer from burnout.

4 Children's Commissioner Office. (n.d.). Local vulnerability profiles. https://www.childrenscommissioner.gov.uk/vulnerable-children/local-vulnerability-profiles/

5 Hoffmann, T. C., Glasziou, P. P., Boutron, I., Milne, R., Perera, R., Moher, D., … & Michie, S. (2014). Better reporting of interventions: template for intervention description and replication (TIDieR) checklist and guide. *BMJ*, 348, g1687. https://doi.org/10.1136/bmj.g1687

What

The clinical support offer was designed to offer a range of activities each of which are outlined below:

- **Workforce training and workshops:** The idea behind this training was that it is generally available to the whole of Bright Futures but more targeted training to specific workers is available when needed.
- **Monthly group case consultation:** These monthly sessions are run for each of the Bright Futures' three teams. The idea is for practitioners to bring difficult cases and use the 'case reflection' approach to talk through practitioner skills and understanding of parents, children and young people, as well as strategies and formulation.
- **Monthly group reflective practice space:** These sessions, facilitated by clinicians, are less functional and structured, focusing on practitioners having a reflective space to share their experiences and reflections and discuss issues which they as a group decide upon.
- **Targeted Individual Consultation session:** These are one-to-one sessions between practitioners and clinicians which practitioners can request when needed when they want to discuss a difficult case directly with a clinician.
- **Clinicians support in family sessions:** The majority of the clinicians' work is with practitioners rather than families and they are therefore non case holding. However, there may be instances where practitioners may identify that it is helpful for a clinician to join a specific session with a family to support the practitioner.

In addition to these specific activities, the clinicians are also co-located with each of the three Bright Futures Teams for a set amount of time each week to support on an ad hoc basis.

The clinical support is offered to the Bright Futures service. The service works on a locality model with three teams within the borough. Each has a team manager, deputy manager and about five family support workers who have a case load of around 12–15 families each and typically work with a family for six to nine months. Every team also has a senior practitioner who manages three outreach workers (including an education link worker, a community outreach practitioner applying youth outreach practice and an employment lead), who are more community based and provide rapid response with support not usually lasting more than six weeks.

Who provided

The clinical support offer is delivered by a group of clinicians from two teams within Islington: the Islington Parental Mental Health Team known as PICT (Psychologically Informed Consultation and Training) and the local Child and Adolescent Mental Health Service (CAMHS). Each of the two teams has a lead clinician and then at least one other clinician who helps to deliver the support offer to the Bright Futures team. The clinicians come from a range of backgrounds and have a broad skill set. Some are trained clinical psychologists, while others have a background in social work.

How

The clinical support offer was designed to be delivered face to face either in groups or as one-to-ones depending on the activity. However, during the Covid pandemic, the majority of the activities have been delivered online. As the study was being carried out in spring/summer 2022, these activities were starting to return to in-person delivery.

Where

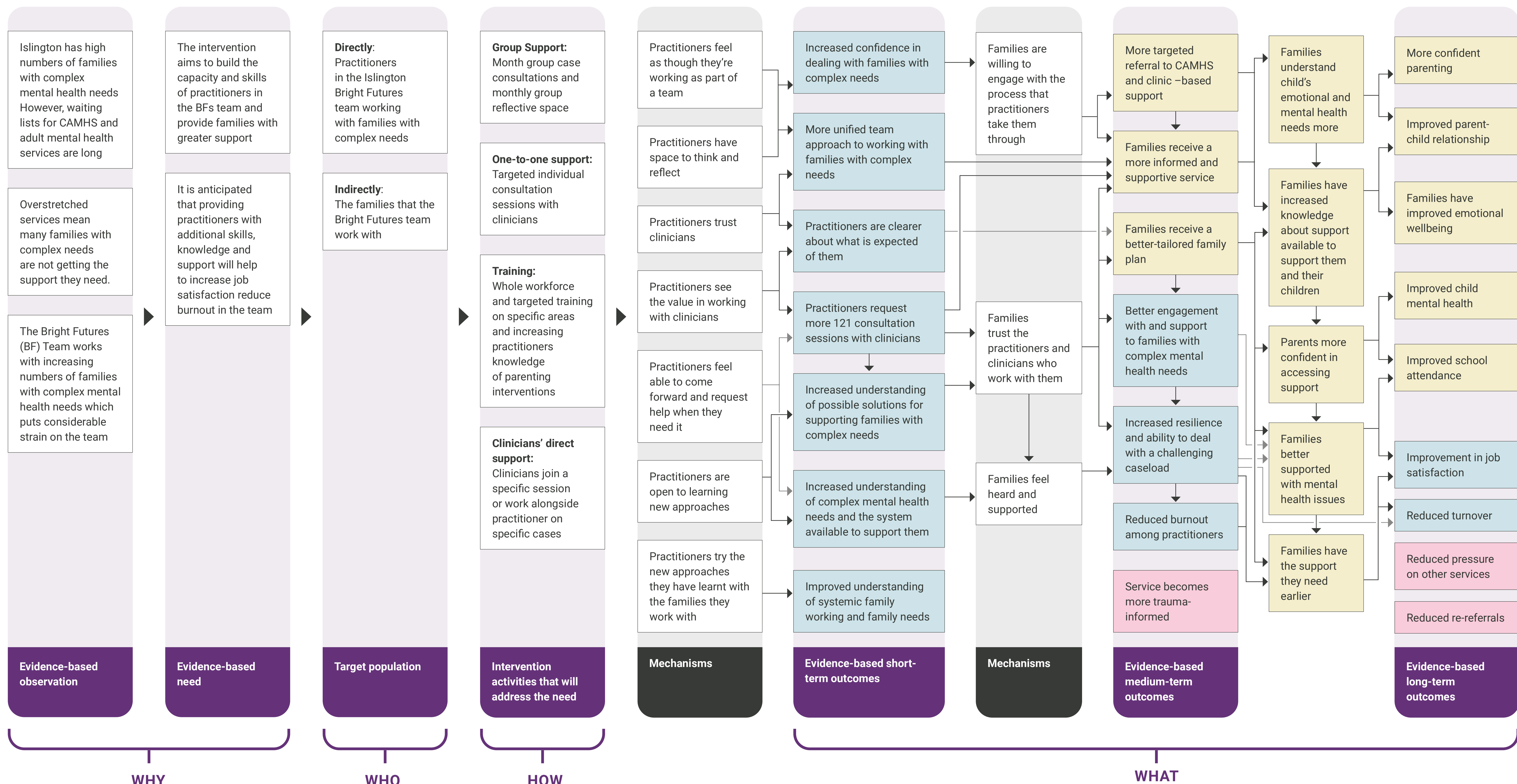
The clinical support offer is made available to each of the three teams that comprise the Islington Bright Futures team.

When and how much

The clinical support offer has been running since the Bright Futures team was set up in July 2020, although some elements of the offer were available to the team in its previous form before that. Group case consultation sessions and reflective practice sessions are held monthly and last an hour and 15 minutes and an hour, respectively. One-to-one case consultations take place on an ad hoc basis as decided by both the practitioner and clinician. The training offer currently has no fixed schedule.

Theory of change

Below is the high-level theory of change diagram which was developed as part of the initial phase of the evaluation with the Bright Futures team.[6]



Enablers: Easier access to a range of professionals because of online working driven by Covid
Barriers: Hard to get families to engage online; online working makes it hard to generate the informality that is needed within the team; high caseloads make it hard for the BF team to engage with the offer

Unintended consequences
The increase in skills and support in the BF team may unwittingly signal to other services/partners that they are not needed which could place extra burden on the team

6 A more detailed, narrative theory of change was also developed and is available on request.

2. Methods

This section sets out the aims, research questions and methods of the feasibility and pilot study in Islington.

Evaluation aims and research questions

Aims

The purpose of the evaluation work is to explore the current implementation of the clinical support offer provided to Islington's Bright Futures (Early Help) team via a feasibility study and the feasibility of conducting an impact evaluation on the approach via an initial pilot study.

Research questions

The research design employed both quantitative and qualitative methods to address the feasibility and pilot study research questions. Below is a high-level summary of the research questions that were answered in the evaluation. A full list is available in Annex C.

1. **Evidence of feasibility**
   - **Fidelity:** Is the clinical offer being delivered as intended?
   - **Adaptation:** Does the delivery of the offer vary across the Bright Futures teams?
   - **Dosage:** How much of the clinical offer is being delivered?
   - **Reach:** Does the clinical offer reach the intended practitioners and as a result the target families in need?
   - **Quality:** Is the clinical offer being delivered to a high quality?
   - **Participant responsiveness:** To what extent do practitioners engage with the clinical offer?
   - **Intervention differentiation:** What is the value added of the approach and how does it differ to business as usual?
   - **Enablers and barriers:** What are the enablers and barriers to successful delivery of the clinical offer?
2. **Evidence of promise**
   - **Potential benefits:** What are the potential benefits of the approach for families, practitioners and the wider service?
   - **Unintended consequences:** What are the actual or potential unintended consequences for families, practitioners and the wider service?
   - Is there evidence to support or extend the theory of change?
3. **Evaluation feasibility**
   - What is the most feasible approach to assess the implementation and impact of the clinical offer?
   - Which outcomes are critical to measuring impact and how?

Data collection

The research design draws mainly on qualitative methods and administrative data analysis. The components are discussed in turn below.

Quantitative research

Administrative data

We analysed administrative data already routinely collected by Bright Futures. This data included management data (ie data collected about staff and implementation of the service) and aggregated family-level data (ie data collected about families being supported by the service). The data was anonymised and shared securely with the evaluation team.

Bright Futures survey data

We have included data from two surveys that were conducted by the PICT team as part of their own internal evaluation of their offer to the Bright Futures team:

- Evaluation of group case consultation and reflective practice sessions: Every six months, attendees of these sessions are asked to complete a series of measures related to how they have found these groups. The survey is administered online and includes questions on the sessions as well as the Professional Quality of Life (ProQoL) Scale.
- Evaluation of the Emotionally Based School Avoidance (EBSA) training offer: A short online survey issued after the EBSA training to gather practitioners' views including whether it is relevant to practitioners' work, whether it will have a positive impact on work, and how the training could be improved.

Qualitative research

Observations

The evaluation team undertook observations of some of the core components of the clinical support offer in order to explore fidelity, quality, the extent to which practitioners engage with the various components (participant responsiveness), and unintended consequences. The team observed three training workshops (one with each of the three Bright Futures teams), three group case consultations (one with each of the three Bright Futures teams), and one group reflective practice session with team managers and deputy managers from across the three teams. Participants in the sessions were made aware that an EIF researcher would be present beforehand and gave their consent to the observations. No recording was made but researchers noted their observations of the sessions in a pre-agreed template. The evaluation team asked to observe practitioner reflective practice sessions and a team manager's meeting, but it was felt by the Bright Futures team that this would be too invasive and may affect how staff used the sessions. No one-to-one sessions were observed for similar reasons. All observations took place in April and May 2022.

Interviews

The evaluation team carried out a total of 12 depth interviews with members of the Bright Futures team: three interviews with clinicians, three with team managers (one with each of the three teams) and six with practitioners (two from each team with a mix of family support workers and outreach practitioners). Participants were recruited with the aim of achieving diversity in terms of gender, level of experience and role; however, the approach was also pragmatic and guided by the availability of participants. All interviews took place online or by phone and lasted between 40 minutes and an hour. The interviews were guided by a pre-agreed topic guide (which can be found in Annex H, I and J) and were audio recorded with participants' consent. Interviews took place in May 2022.

Analysis

Quantitative analysis

Quantitative data was provided by the Bright Futures team, reported yearly, from April 2017 to April 2022. As Bright Futures was formally established in July 2020, the analysis of the quantitative data focused on the data reported for the years 2020/21 and 2021/22. No statistical analyses were performed on the data, rather data was summarised and compared across the two reporting years and, where relevant, between other services for which data was provided, namely Bright Start and Early Help. Data was provided and summarised for demographic information, number of referrals, consent and assessments, number and reasons for case closures, and finally, progress as measured by the Family Outcomes Star Assessment. Quantitative data was also captured through two surveys, one evaluating the Emotionally Based School Avoidance (EBSA) training offered to practitioners and one evaluating the Bright Futures Group Spaces. This data was analysed and presented using frequency counts of different categorical responses.

Qualitative analysis

All depth interviews were audio recorded (with participants' permission). Observation notes were written into a pre-agreed observation template. A framework approach was taken to analysing the qualitative data. This involves summarising the data from each research interview into a thematic framework. Columns represent themes and each participant's data is summarised (charted) across a row. The strength of this approach is that it enables systematic and comprehensive analysis of the complete dataset in a manageable way. Analysis can be done both thematically and individually. The analysis sought patterns, consistencies and inconsistencies in data collected from different participants to help answer the research questions. To illuminate the descriptive and explanatory data presented, anonymised verbatim quotes from the depth interviews with clinicians, practitioners and team managers are integrated throughout the report. Quotes are labelled with their unique identifier only and do not indicate which group of participants they came from in order to preserve anonymity.

Study limitations

Qualitative research

There are a number of limitations that affect the quality of the qualitative evaluation data. First, the qualitative sample was not as diverse as hoped. The sample did not include any deputy team managers or CAMHS clinicians as none were available to interview. Likewise, it should be noted that practitioners were identified by Team Managers and so it is possible that there is an element of selection bias in the sample. However, given the practitioners' heavy workloads, the tight research timescale and the need to use team managers as gatekeepers for recruitment, it was felt that this was the most effective route for recruiting the sample. The observations of reflective practice sessions were also limited because of concerns about research presence affecting the quality of the exchanges between staff.

It also should be noted that the 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 that the research was able to capture. If it had taken place over a longer period of time for example, it may have captured different types of training activities or changing dynamics within the group sessions. It should be noted that at the point that the evaluation

activities were carried out, all the clinical support activities were being carried out online because of Covid concerns. However, shortly after the evaluation fieldwork concluded, some in person activities resumed, meaning that these were not captured by the evaluation. The shorter timescale also impacted on the level of analysis that was possible and for this reason, the report draws out high-level thematic analysis rather than anything more granular.

Despite these limitations, there was still considerable diversity in the qualitative sample and a good level of saturation in the themes emerging from the data, so we can be reasonably confident that we have captured a large number of the views and experiences of Bright Futures staff.

Finally, the original intention had been to carry out some qualitative work with families using the Bright Futures service. However, this did not go ahead for two key reasons. First, the timescales did not allow for families to be contacted. Second, it was felt that while families would have views on the quality of the service and the impact it had or had not had on them, they would have limited knowledge of the clinical support offer and so the relevance of the data could be limited and may not justify the potential burden that the research could put on families taking part. Therefore, any views on the impact of the offer on families is from the point of view of the practitioners.

Quantitative research

The quantitative data also has a number of limitations. While the data can provide useful insight into the reach of the Bright Futures offer, it is not possible to quantify how the Bright Futures offer compares to other services due to the varying nature of support provided across different services, as well as the difference in number of children and families that are supported. The data is also at a high level making it challenging to quantify which distinct aspects of the Bright Futures offer may be more beneficial than others, although the qualitative data can and does provide depth to mitigate this shortcoming. The data also does not capture information about families who do not access Bright Futures services making comparisons impossible.

In addition, much of this data is captured by Bright Futures staff and we thus have no ability to verify the accuracy or validity of the data. As well as this, the Bright Futures team relies on the Family Outcomes Star measure as a way of recording outcomes across a range of different domains. While these have been shown to facilitate dialogue with users and supporting the co-creation of goals, EIF has previously cautioned against using them as robust tools for assessing impact in a research evaluation.[7]

Ethics

The evaluation has followed EIF's ethical guidelines which were set out in the evaluation protocol. To ensure all participants in the qualitative research were able to give informed consent, we provided participants with a clear and accessible information sheet (see Annex D and E). 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 Annex F). Care was taken to ensure participants understood that they did not have to participate in research activities and could withdraw at any time. To reduce burden on research participants, the research team ensured that the qualitative interviews and surveys were kept short. To ensure

7 Ghiara, V. (2020). A place for everything and everything in its place: Using the Outcomes Stars in combination with validated measures of impact. Early Intervention Foundation blog. https://www.eif.org.uk/blog/a-place-for-everything-and-everything-in-its-place-using-the-outcomes-stars-in-combination-with-validated-measures-of-impact

inclusion in research, we selected appropriate methodologies 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

EIF complies with the General Data Protection Regulation (GDPR) when handling and storing data. The legal basis for data sharing for this evaluation is 'legitimate interest' and 'informed consent'. Participants received a link to **EIF's Privacy Policy** available on the EIF website which provides further information on how we collect data, what their rights are as research participants and how they can withdraw their data if they wish. Although the evaluation activities included the observation of training and case reflection and management sessions, the evaluation team did not see or record any family data.

This report and other publications arising from this research will not identify any individual practitioner, family or child. Islington's Bright Futures service shared case management information and administrative data on the running of the service, including data on training, consultation sessions, practitioner demographics. The service removed any identifying information from the data so that names and other identifying information not necessary for the evaluation was removed or replaced with a code. Therefore, all data was pseudonymised or fully anonymised.

3. Findings

This section provides findings of the evaluation. It assesses the implementation and delivery of the clinical support offer for the Bright Futures team, sets out a number of identified enablers and barriers to delivery and views on what was working well and what could be improved. It then goes on to explore the evidence gathered on the impact of the clinical offer for practitioners, families and the wider system.

Evidence of feasibility

Clinical support offer

The Bright Futures service went through a restructure in 2019/20 which included joining up the previously separate clinical offer by the Parental Mental Health team (part of a wider Psychologically Informed Consultation & Training – PICT) and Children and Adolescent Mental Health Service (CAMHS) team. The clinical support offer has been running since the Bright Futures team was set up in July 2020, although some elements of the offer were available to the team in its previous form before that.

The aim of Islington's clinical support offer is to deliver a suite of activities that would provide practitioners within the Bright Futures team with support, advice and access to clinicians to support their work with families. **The evaluation data suggests that there is a clear, shared vision for what the support offer looks like. Practitioners, team managers and clinicians all have clear understanding of what is meant by the support offer and there is broad agreement among the team that the offer comprises**:

- Group case consultations
- Individual case consultations
- Training
- Group reflective practice
- The option for clinicians to engage directly with families in specific cases
- Co-location of clinicians in Bright Futures' teams.

It should be noted that delivery of the offer had moved online as a result of Covid restrictions. This meant that some components of the offer were slightly different to what had been envisaged. However, there was general consensus among the interview participants that running the group sessions online, for example, had not been a positive move and had resulted in them being less engaging and effective than had been hoped.

Group case consultation sessions

Monthly group case consultation sessions are run for each of the Bright Futures' three teams where practitioners bring cases that they are finding challenging or are 'stuck' with (for example, going back and forth to children's services) to the group space (see cast study 1, below). They present their case to the group, ideally without interruption, and then take clarification questions before listening to colleagues' reflections without speaking again themselves until the end of the session when they are invited to reflect on what they have

heard from colleagues and how they might take the case forward. The session is facilitated by one or two clinicians who draw in the practitioners and ensure that the conversation remains focused and constructive. Clinicians hope that the group format offers an opportunity to all staff (including those who are not requesting individual sessions) to be exposed to the clinical thinking, ideas and perspectives within the group and which could be relevant to families that practitioners are working with. During the 12 months prior to the evaluation, eight sessions were offered per team. There is an expectation set that practitioners will prioritise both group case consultation and group reflective practice sessions. Consequently, these sessions were said to have a good turnout. However, no data was provided on the number of practitioners who attended each session.

CASE STUDY 1

An 'original-style' case consultation

The case consultation session is held online, with nine members of one of the three Bright Futures teams and two clinicians in attendance. One of the clinicians leads the session while the other co-facilitates. The lead clinician begins the session by asking whether any of the practitioners has a case that they want to bring to the group. Immediately a practitioner comes forward and indicates that they need advice on how to close a particular case. They give details of the case while colleagues listen. Practitioners are then encouraged to ask questions about the case and reflect a little on what they have heard and where they see the challenges as being. The lead facilitator ensures that there is a lot of time between contributions to allow others to come in and respond to a point. Practitioners are then encouraged by the lead facilitator to move on from questions to thoughts and suggestions. They offer gentle suggestions about possible approaches to take. The topics discussed include how to end a case, how the practitioner can engage with a parent who isn't willing to engage, the way that the parent has responded to the practitioner, the parent's ability to 'mentalise' or hold their child in their mind and what might have influenced this, how the parent's response has impacted the practitioner and recognition of what the practitioner has achieved on the case. Throughout this, the practitioner who presented the case is silent and simply listens to the reflections and suggestions from their colleagues. In the last ten minutes of the session, they are invited to respond to what has been said and they reflect on how what they have heard has resonated with them. The facilitator then brings the session to a close.

Source: Observation of a group case consultation with a Bright Futures team.

In the staff survey administered by PICT in 2022, staff were asked how much the group case consultations had met their hopes/goals. Of those that responded (18 out of a possible 40 practitioners), 61% indicated that the groups had met their expectations 'mostly' or 'very much'. This was an increase of 17% since the same survey was administered in October 2021, where 28 out of a possible 40 practitioners responded. However, we were unable to assess whether this was a statistically significant change.

The evaluation evidence suggests that **the group case consultation format is being followed in some but not all of the case consultation sessions**. In some cases, there has been a reluctance among practitioners to bring cases to the sessions due to concerns about feeling exposed or critiqued. This reluctance resulted in clinicians changing the format of the case consultation sessions in some instances. Instead of encouraging practitioners to present a specific case, some sessions are now structured around a theme and practitioners are encouraged to contribute examples of that theme from their caseload, to develop the discussion and provide an evidence base.

Clinicians who were interviewed spoke about how they had taken to using polling software to gauge which topics practitioners might find most interesting to cover and then running the sessions based around those specific themes rather than cases. However, this adaptation to the case consultation sessions is not being delivered in the same way across the three teams. The evaluation evidence suggests that each of the teams has a different culture and that some are more willing to engage in the original classic case consultation format than others. The clinicians have therefore been highly responsive to the specific needs of each team and are delivering a slightly different version of the offer to each.

In a case consultation session observed by the evaluators for example, the theme of child to parent aggression was introduced and practitioners were invited to share examples they had come across where a child had been aggressive towards their family. This discussion was then supplemented with the clinician inputting evidence on the subject that they had come across through their wider reading.

While there is evidence of some adaptation, interviews with practitioners suggest that this has not gone far enough for some. The difference in roles between family practitioners and outreach practitioners was flagged as a real challenge, with some outreach practitioners indicating that they felt overlooked in the sessions and that more could be done to adapt the sessions to accommodate these differences.

Group reflective practice sessions

The group reflective practice sessions are designed to be less structured than the case consultations, focusing on giving practitioners and managers a reflective space to share their experiences and views and discuss issues which they decide upon as a group. This might include systemic practice, work culture and topical issues (eg Black Lives Matter). Group reflective sessions are facilitated by clinicians and are held monthly, lasting an hour. Data from Islington reported that during the 10 months preceding the evaluation, nine sessions were offered per team. From interviews it was understood that sessions are scheduled into diaries and practitioners are encouraged to prioritise them and so reportedly there is generally good attendance. However, no data was provided on the number of practitioners who attended sessions.

In general, **group reflective practice sessions are being delivered as intended, as facilitator-led, semi-structured sessions during which participants are given the space and time to reflect on how they are feeling and how this is influencing their work**.

CASE STUDY 2

Group reflective practice session

This is a small group session with four participants and one clinician who facilitates, that takes place online lasting for one hour. The facilitator acknowledges that the group is usually larger and starts the session by asking participants to provide a brief update on how they are feeling. This provokes mixed responses with some indicating that they are doing well, and others saying that they are feeling a little uncontained. The facilitator opens the discussion up and asks if there is anything that anyone would like to discuss. The subject of vicarious trauma is raised, and the facilitator opens it up to the group to share their thoughts and experiences of this. There are subsequent discussions about the importance of containment when managing others, about the importance of supervision and about strategies to overcome challenges experienced by managers. Throughout, the facilitator summarises what participants have said before asking others whether they agree with the points made.

Source: Observation of group reflective practice.

Initially the sessions were run by the team with team managers and deputy team managers attending alongside practitioners. However, there was a sense across the team that this was not working well as both the team/deputy managers and practitioners were less comfortable opening-up with the others there. Instead, these are now run as separate sessions and there was broad agreement amongst both team managers and practitioners that the new format worked better and meant that both practitioners and managers had a space in which they felt more comfortable and were able to support each other as peers.

Individual case consultations and co-location

In addition to regular group case consultation sessions, the clinical support offer provides practitioners with the opportunity to contact the team of PICT and CAMHS clinicians as they need, to arrange a one-to-one session to discuss a particular case they are working on. The idea was that because the clinicians would be co-located with the three teams for part of the week, the practitioners would get to know the clinicians and feel comfortable about approaching them.

Covid restrictions have meant that co-location has not happened in the way that was envisaged. At the point that the evaluation took place, the three Bright Futures teams were just in the process of returning to the office and some physical co-location with clinicians was starting to happen again. However, for the previous two years there had been limited physical contact between clinicians and practitioners. Despite this, clinicians reported that the individual sessions had been happening and that practitioners had been getting in touch to talk through specific issues and cases. Management data collected by PICT shows that 53 one-to-one consultations were delivered by PICT in the ten months from October 2021 to August 2022 and 58 individual consultations were delivered by CAHMS clinicians between July 2021 and August 2022.

Clinicians send out reminder emails to all staff to let them know that they are available for individual consultations to discuss cases if needed, and team/deputy team managers will sometimes suggest that a practitioner contacts a clinician if they raise a case in supervision that the manager thinks could benefit from a clinician’s perspective. Some clinicians felt that they would have liked to have seen more contact from practitioners and there was a sense across the interview participants that there wasn’t an even spread of practitioners requesting individual sessions, with some practitioners requesting repeat sessions and others not making use of the opportunity at all. However, no data was provided on who attended the case consultations, to understand its reach across the Bright Futures teams.

Data from the interviews suggests that reasons for not taking up the offer of one-to-one sessions include workload being too high and practitioners not always seeing the benefit. In some cases, clinicians felt that the practitioners who were not coming forward were often those they felt could benefit most from the support and indicated that they would ideally like this element of the offer to be used more.

> *“And so there’s a bit of a dilemma, sometimes you feel like maybe the people that might benefit from it the most, are the least likely to request it.”*
> – Brighter Futures Staff Member 01

Alongside the more structured individual sessions, the aspiration was that the co-location would present opportunities for more informal interactions between practitioners and clinicians, presenting practitioners with the chance to ask a quick question or get a view on something without committing to a scheduled meeting. Covid restrictions have prevented this from happening in the way that was hoped, but as the evaluation was taking place and physical co-location was starting to return, there were early signs that this element of the offer would also start to gather momentum.

Training

The aspiration for the training element of the offer was for the clinicians to run regular training on issues that practitioners might come across regularly in order to support them in their practice. While no desired frequency for the training sessions was articulated, interview participants were united in expressing a desire for it to happen more often than it had done to date and there was a sense that the training element of the offer had taken a little while to get off the ground. The only core training that had been provided as part of the clinical offer was on Emotionally Based School Avoidance (EBSA). This training was service-wide and delivered by CAMHS and Islington's Educational Psychologist service. Each of the three Bright Futures Teams received their own training sessions. This was delivered in two parts; an overview training session followed by a workshop style session which focused on introducing a tool for understanding EBSA that practitioners could use with families. This two-part approach to delivering the training is in line with what was articulated for the offer. During the training sessions observed by the evaluation team, there was a good turnout. However, levels of engagement were mixed. Some practitioners were very engaged, asked lots of questions and enthused about the usefulness of the training during break out groups; others, however, kept their cameras off for most of the session and contributed very little.

Clinicians' support to practitioners working with families

Alongside the core elements of the clinical support offer, PICT and CAMHS clinicians also gave practitioners the opportunity to bring them in to meet with a parent and/or family for a session about a specific issue. For PICT this tended to be limited to one session only, whereas CAMHS clinicians could meet up to three times. The idea was that this allowed the clinician to support the practitioner more intensively as they were able to gain first-hand experience of the issues that the parent or family were experiencing and in some cases were able to model approaches that the practitioner can then follow up with. The expectation was that this element of the offer would be used sparingly and only when there was a clear need.

The evaluation evidence suggests that this was the case: clinicians' direct engagement with the families was happening but only occasionally when the practitioner was able to put forward a convincing case for it; both PICT and CAHMS clinicians reported wanting to meet with the practitioner first to understand the aims for the clinician getting involved in more detail. Data from the Bright Futures team indicates that there were three meetings between families, practitioners and a CAMHS clinician in the year to August 2022 and seven with PICT clinicians over a slightly longer time period (April 2021 to September 2022).

In the examples of direct support that were given during the interviews, practitioners spoke about how they had requested for a clinician to meet with a family that they were 'stuck' with in order to get another opinion on the family's support needs. The practitioners that had accessed this support spoke about how it was helpful to have a clinician's viewpoint, but also to see how they interacted with the family.

> *"I think it's really nice to see a clinician working with a client and kind of how they are ... I think that's really lovely, I really enjoy watching that, like what they say."*
> – Brighter Futures Staff Member 09

However, it was clear that not all practitioners knew exactly what the criteria for accessing this type of support was. One practitioner interviewed mentioned that they had been told that they were the only person in their team accessing the individual support on a regular basis, but there was an aspiration that this will improve as the team moves back to face-to-face working and there are more opportunities for practitioners to get to know clinicians and engage with them more informally.

Reach of Bright Futures team support for families

A core aspiration of the clinical offer, as set out in the theory of change, is that it will provide Bright Futures practitioners with additional skills and support so that they are more resilient, better looked after and in a stronger position to address the mental health needs of the families they work with.

Administrative data provided by Islington gives insights into the demand on the Bright Futures team and the needs of the families they supported. In the 2021/22 year, the Bright Futures team worked with 837 families (1,520 children and young people), up from 573 families (1,030 children and young people) in the 2020/21 year.[8] Thirty-six per cent (263 out of 727 cases closed) of families were supported for a month or less, with 27% (198 out of 727) being supported for six months or more.

Looking at the need of the families, the majority of referrals in 2021/22 came from schools (28%), followed by health (16%) mainly from GPs and hospitals, the Police (15%), children's social care (8%) and mental health (7%, split 6% CAMHS and 1% adult mental health). In addition to 13% of self-referrals and 9% from a relative or carer.

The primary reason for referrals included parenting capacity difficulties (22%), children whose needs do not meet the statutory threshold for children's social care (13%), domestic abuse (9%), children and young people with disabilities/additional needs/SEND (7%). Only 5% of referrals indicated parental mental health as a primary reason and 3% indicated child mental health.

Data from Bright Future's Family Outcomes Star assessment of children and young people's areas of greatest needs also provides insight into the needs of the families that Bright Futures supports. The assessment is carried out at the beginning of a practitioner's work with a family and comprises of 10 domains, looking at distinct areas of parenting and family life. Each is scored from 0–10 with the family. Table 3.1 shows the proportion of children and young people where the score for the relative domain is either four or lower. This score indicates that although the family may be aware of the problem, the family and the practitioner believe they have not yet found ways to address them. Scores above five indicate that the family and practitioner believe parents are trying and implementing new parenting strategies which they believe to be effective, and scores above nine indicate a belief that their parenting is effective. The domains with the highest proportion of children who scored four or lower were the child or young person's wellbeing, progress to work and social networks. The domains with the lowest proportion scoring four or lower were being safe, family routines and physical health.

TABLE 3.1.

Family Stars assessment of children and young people's areas of greatest need

Domain of need	Proportion of children and young people with a score of 4 or lower out of 10
Your wellbeing	26%
Progress to work	22%
Social networks	21%
Home and money	20%
Education and learning	19%
Boundaries and behaviour	19%

Table continued on next page >

8 Figures count each family member once, regardless of the number of episodes in the period.

< Table continued from previous page

Domain of need	Proportion of children and young people with a score of 4 or lower out of 10
Meeting emotional needs	16%
Physical health	11%
Family routines	9%
Keeping children safe	7%

Note: Data is from live or closed cases in 2021/22.

Intervention differentiation

The Islington Bright Futures team was established in July 2020. Elements of the clinical support offer were in place before the team was restructured but the offer as it stands had only been running for around two years at the point of the evaluation. The clinicians, team managers and practitioners we spoke to reflected on how the offer compared to other teams and local authorities they had worked in. While some practitioners referenced psychologically informed approaches that other teams had used, the suite of support and activities that the Bright Futures team provides was regarded as unique. Some practitioners spoke about how in roles in other local authorities, there had been very little support for practitioners and no space for reflection which they felt had a detrimental effect on the ability to deliver the role.

> *"It wasn't a priority for [another local authority] to do that, the priority was more family containment. What I realised ... was that for families to be contained, workers have to feel contained at times and also have to feel supported and that was what was lacking, and it was evident; there was a high turnover and so on."*
> – Brighter Futures Staff Member 12

It was suggested that not having regular access to clinicians resulted in a worse service for families as practitioners had to seek the expertise elsewhere which could take time and add to their already heavy workload. One practitioner suggested that the difference between Islington and their previous local authority was about focus; their previous team had focused on the child, whereas they saw the Bright Futures team as being focused on the whole family, something that is supported by the close working relationship between the PICT and CAMHS teams. Clinicians also spoke about how they had discussed the offer with peers and the general consensus had been that it was an innovative approach. It should be noted that Bright Futures is not the only Islington team to draw on support from the PICT and CAMHS clinicians; however, they are the only team to embed the support in this way and to promote a close working relationship between PICT and CAHMS clinicians with the aspiration of creating a whole-family focus.

Enablers and barriers affecting delivery of the clinical offer

Practitioners, managers and clinicians identified the following enablers and barriers to delivery of the clinical support offer to the Bright Futures team.

Enablers

Enablers fell into four broad categories: clinicians' skills and experience; their availability; the nature of their relationships; and the structure of the offer.

Clinicians' skills and experience

It was felt that the clinicians' skills and experience were fundamental to the offer being delivered effectively. For the various activities to work well, it was thought that the clinicians need to be excellent facilitators to be able to support the discussions during case consultations and group reflective practice sessions, bring practitioners in when needed, coax solutions and build confidence. Some practitioners felt that it was important for the clinicians to be thoughtful and understanding of what the practitioners' roles involve. Practitioners also spoke about the ability of the clinicians to shift discussions in an organic way and how they found it helpful when clinicians brought clarity to something a colleague had said by reframing it. They also felt it was important that the clinicians were able to hold the space well and to manage silences and interject at the right time. Data from the Bright Futures team indicates that, at the point that the evaluation took place, the PICT clinicians included a Clinical Psychologist and a Social Worker who had worked in a range of child, family and mental health settings. The CAMHS clinician was a Clinical Nurse specialist so there was a good range of experience and qualifications on the team.

Some practitioners also felt that the clinicians supporting the team had good relevant experience of the populations that practitioners are working with within Islington and felt that their understanding of the demographics, challenges and experiences of those communities was really helpful when it came to supporting practitioners with their work. Clinicians' ability to consider culture, ethnicity and inequality in discussions was also seen as important to enable the activities to work effectively.

Clinicians also spoke about the importance of keeping their own professional development up to date so that they were in the best position to provide relevant support. Additionally, some interview participants felt that it was important for the offer to be evidence-based and backed with clear research about psychologically informed approaches and what works to support practitioners and families. However, no specific detail was given about what this evidence should look like.

Clinicians' availability

Clinicians' availability and having the capacity to engage with practitioners through a range of mediums (in person, online and by phone) was seen as crucial to enabling successful delivery of the offer. The fact that the clinicians are available for managers and practitioners to contact across the week was seen as incredibly helpful.

> *"I think what's working well is that practitioners and managers have access to clinicians. I can't stress how much of a privilege that is. They're there Monday to Friday nine to five and that enables practitioners to build confidence and enables the practitioner to carry out a very purposeful intervention with the families, but it could also be getting the family the right mental health support."*
> – Brighter Futures Staff Member 03

Some practitioners and managers also reflected on how it was not just the clinicians' capacity that was important, but the fact that their capacity was embedded into the Bright Futures team because the clinicians had specific time dedicated to working with the practitioners and were, in theory, co-located with the teams, making it easier for practitioners to access them. The consistent availability of clinicians was also credited with allowing them to embed learning into the team over time and develop practitioners' skills and approach, and a change of culture to the team overall.

Nature of clinicians' relationships

The nature of clinicians' relationships was also regarded as an important enabler. Clinicians spoke about the importance of the relationships between PICT and CAMHS which were described as being really strong, and the two teams were felt to complement each other well. It was suggested that this strong relationship enabled the clinicians and practitioners to take a more systemic approach to their work and think about adults and children holistically rather than separately.

> *"It enables there to be much more of a kind of a systemic and whole-family view, I think. And we can think much more about the links between parental mental health and child mental health, and, what's going on for the parent that might be impacting on the child or the wider family, or ... you know, I think it enhances and brings a richness that we wouldn't have if it was just PICT or just CAHMS. There's something quite unique and special about that."*
> – Brighter Futures Staff Member 02

Relationships outside of the Bright Futures team were flagged as equally important, and clinicians spoke about the need to have good links with a range of teams (but were not specific about which ones) across different services so that they had good knowledge of changes to services and could relay these effectively to practitioners. Clinicians also mentioned relationships with their managers and the guidance they received from them. Clinicians receive their own support and have weekly group meetings which include peer supervision. These are either peer led or run by an external consultant and the nature of these sessions was seen as fundamental in supporting the work that the clinicians deliver. They described how this helped them to feel contained and enabled them to provide a better service to practitioners.

> *"We as practitioners feel well supported, and just try to kind of reach out to the people that we are supporting and hopefully provide that same level of containment that I think we need to do this job effectively, to be in touch with the reality of our experience."*
> – Brighter Futures Staff Member 01

Structured approach

It was also felt that the structured approach that the Bright Futures team takes to the clinical support offer helps with its effective delivery. Practitioners and team managers reflected on how it was helpful to have clear expectations around the various sessions. Practitioners are expected to prioritise group case consultation and reflective practice sessions in their diaries and some interview participants felt that this was helpful as the space was protected and it meant that there was a good turnout to each session.

> *"So, I think it was really good that the expectation was there from the beginning – this is a sacred space that we are able to provide for you and is unusual maybe to be able to have that but would be beneficial and that was really, you know, encouraged by our managers."*
> – Brighter Futures Staff Member 09)

Barriers

Four key barriers, or challenges, to delivery of the clinical offer were also identified through the evaluation: practitioner engagement; remote delivery; staff turnover; and resources within the wider system.

Practitioner engagement

It was clear from the observations and interviews that practitioners' engagement with the clinical support offer is variable. While there is a general expectation that practitioners attend the group sessions whenever possible, not all practitioners are engaging with these sessions in the same way. A range of factors appeared to influence practitioners' engagement.

Capacity was highlighted as a barrier for some practitioners. While interviews suggest that many of the practitioners value the clinical support offer, the nature of the practitioner role means that their capacity is already stretched. Practitioners spoke about the challenge of juggling the group sessions with their heavy caseload. When practitioners do join the sessions, their heavy or challenging workload can make it hard for them to focus. For example, one practitioner mentioned that they will often do other work while the online session is happening in an attempt to stay on top of everything.

While the structure to the sessions and the **expectation to attend** was regarded as a benefit by some practitioners, there were some who felt that they would benefit more from the support offered if they had more autonomy about when they attended. They reflected on the fact that if you need a case consultation then it's great; but if you don't, then the compulsory element can feel a bit challenging.

> *"It is already good as it is, so if I had the full autonomy and I'm consulted about if I need it or want it, I think I would appreciate it a lot more. I appreciate it, but I think I would appreciate it a lot more if I had autonomy about when and how I could use it."*
> – Brighter Futures Staff Member 11

Practitioners' roles also influenced the extent to which they felt able to engage with the clinical offer. In some cases, outreach workers felt as though case consultation sessions were not as relevant for them as they do not case hold in the same way that family practitioners do. While this was not the case with all the outreach practitioners, it was clearly an issue that was very live for the Bright Futures team as it was also mentioned as a factor by both team managers and clinicians too.

Practitioners' previous experience of using psychologically informed approaches appeared to have an impact on engagement. Some practitioners spoke about how they had worked in other jobs where a case consultation or reflective practice model was used, and this meant that they had seen the benefits already and felt that this made them more likely to engage with the offer than some of their peers.

Engagement with the group case consultation sessions was also felt to be affected by practitioners' concerns about feeling exposed. It was suggested that some practitioners may feel reticent to present a case as this would put them under the spotlight and that their approach to a case and their work more generally might be scrutinised.

> *"I think there's a sense that people feel that they'll be put on the spot, and they might have maybe flaws in their work highlighted and that it might be looked upon negatively if they haven't thought about something that somebody else suggests or if they haven't fixed a problem that came in when the referral was received."*
> – Brighter Futures Staff Member 07

Recent Bright Futures service restructure had taken place in July 2020 and there was a sense that this had left some concerns among some practitioners about how they were perceived by managers within the Bright Futures team. Some participants indicated that this impacted on practitioners' willingness to engage in the clinical offer and suggested that in some cases, practitioners were using sessions to air grievances about the new direction of the service and other issues within the team rather than for the purpose they were designed for.

The specific **dynamics within the sessions** also appeared to have a bearing on the extent to which practitioners were able to engage. Even with the practitioners, deputy team managers and team managers having separate sessions, challenges to the dynamics remain. There are only three team managers, for example, so there was quite an intensive focus in the managers' group reflective practice sessions on them as opposed to the larger practitioner sessions.

Remote delivery

Another key barrier was the remote delivery model that was necessitated by the Covid pandemic. Clinicians, managers and practitioners all discussed how delivering the sessions online made them challenging as it was more difficult to manage the dynamic, and much harder to build the effective relationships needed to make everyone involved feel as though the sessions were a safe space. Operating remotely was also identified as creating a barrier to practitioners forming strong and trusting relationships with the clinicians, and it was suggested that this was one of the reasons that practitioners may not be approaching clinicians for one-to-one sessions more frequently.

Staff turnover

Levels of staff turnover were also considered to be a barrier in some cases. Interview participants spoke about how there was a high turnover among the clinicians since the Bright Futures team had been established which was driven by clinicians either leaving or taking periods of leave. While the reasons for this were understood, it was felt that the constant changes had made it hard for a good group dynamic to be established in the sessions and for practitioners to build trusting relationships with the clinicians.

> *"You have to be familiar ... in order to be in a position to open up and kind of truly speak what's on your mind. When a lot of the disruptions were happening, I do think it was a bit disruptive for people and our ability to engage as much."*
> – Brighter Futures Staff Member 12

Resources within the wider system

Finally, the resources within the wider system were also considered to prevent effective delivery of the offer in some cases. Low funding of services coupled with increased demand has made it hard to work systemically and to ensure that families are being referred to the right places. Clinicians reflected on how even with the support they offered, practitioners can often reach the point of closing a case feeling as though they haven't helped a family as much as they could have if the right services had been available.

Views on what was working well and what could be improved

Team managers, practitioners and clinicians were asked to reflect on how they felt the clinical support offer was working and the extent to which they felt that the offer was of high quality. For ease, these have been grouped below under the elements that were felt to be working well and those elements that could benefit from improvement.

Views on what was perceived to be working well

While many elements of the support offer were identified as working well, there were four key components that were singled out as being particularly successful. First, it was felt that the way the support offer **gives practitioners space to reflect and think differently** is working well. Practitioners, team managers and clinicians all identified the value that comes from sharing a reflective space with colleagues. All supervisions within the Bright Futures team have an element of reflection, but having a wider group of colleagues to share thoughts with was seen as adding an extra element of perspective and as allowing practitioners to feel heard. It was also suggested that the space the activities create allows practitioners to think more deeply about cases than they might otherwise have done. Managers spoke about how they saw practitioners stop and consider cases differently, think about how a families' circumstances, culture or ethnicity might be impacting on their experience, and consider colleagues' views on how best to approach challenging cases.

Second, in some cases, the **clinicians' balanced approach to facilitation** was considered to work well. Practitioners and managers spoke about how the clinicians were generally skilled facilitators who take a trauma-informed and empathetic approach. The clinicians were seen to strike a good balance between being friendly without being over familiar and at drawing people into the discussions without picking on individuals. Some practitioners also felt that the clinicians were very boundaried in their approach and this was appreciated as it helped practitioners to feel contained, safe and heard in the group discussions.

> *"There's been lots of anxiety and challenges for the team, and I think that the clinical offer, particularly I guess the reflective practice has been really containing and that's not an easy thing to facilitate."*
> – Brighter Futures Staff Member 05

Practitioners discussed how the clinicians never came across as being superior and how they felt able to disagree with the clinicians because they were so professional in their approach. The very focused approach that clinicians take was also appreciated, and practitioners reflected on how they felt that clinicians were fully present during sessions and how this made them feel listened to. While skilled facilitation was identified as a success, it's important to note that it was not seen as universal, and some less successful facilitation was also identified. This is explored below.

Third, the **training element of the support offer** was generally felt to be working well. Despite there being less training than was originally envisaged, there was a general consensus that the training that had been delivered was useful. It was felt that the topic of the training was very relevant, as EBSA is a huge issue for families, especially in the wake of the pandemic, and the team is getting a high volume of referrals where children are not attending school. The majority of practitioners (16 out of 21) who responded to a survey about the training evaluation agreed or strongly agreed that the training was relevant to their work. Practitioners felt that the clinicians had really considered what was needed and targeted the training based on that, with the majority of practitioners who responded to the survey either agreeing or strongly agreeing that the training was engaging (15 out of 21), that the training had given

them ideas on how to develop their work (15 out of 21), and that the training will have a positive impact on their work (15 out of 21).

> *"It was a real gap that was identified and addressed."*
> – Brighter Futures Staff Member 07

Interview participants also valued the fact that the training helped to challenge practitioners' thinking and language around school avoidance and that it had a practical element in the form of introducing them to a tool that they could use with families. Even more experienced practitioners who had knowledge in the area of EBSA valued having the refresher and found the tool helpful as something they could share with the schools they work with.

Finally, it was felt that the **access to expertise and data** was a crucial element of the offer. Practitioners not only benefit from the input of clinicians that have a range of skills and knowledge, but the clinicians are also able to access databases (such as GP records) that tell them which services a family has or hasn't accessed before, and this was felt to be a hugely helpful benefit to the partnership.

Views on what could be improved

While there was a broadly positive response to the clinical support offer, practitioners, team managers and clinicians did identify areas that they felt could benefit from improvement. These fall into four areas.

First, it was felt that although there was generally a good structure around the support activities, this could be tightened in places to improve **the clarity of purpose and expectations around the support offer**. Some practitioners found it frustrating that colleagues were allowed to turn up late to sessions or leave early, and felt that for the sessions to run effectively they needed to be run tightly with the space being well held and considered important by everyone involved.

> *"If we're going to take this seriously as an offer to actually enhance our practice and support us, then we have to commit to it and there has to be a following up if we're not."*
> – Brighter Futures Staff Member 07

The structure of the sessions was seen as equally important. It was suggested by some practitioners that the sessions needed to remain the same across the board with the same guidelines, for example the expectation that no one should interrupt a practitioner when they are presenting a case. Some interview participants indicated that the clinicians did not always follow this pattern or did not facilitate strongly enough to manage interruptions. Likewise, there was some frustration among practitioners that clinicians did not push more strongly for colleagues to present cases. They felt that the case consultation sessions where people didn't present were not as helpful and could be hijacked by practitioners airing grievances or not being constructive.

Second, linked to this was a view among some practitioners that **facilitation could be inconsistent**. While clinicians' balanced facilitation was identified as a highlight of the support offer, some practitioners indicated that it was not delivered consistently and that it was very dependent on the individual clinician. When groups were not facilitated tightly enough, it was felt that this could result in the focus, and therefore the value, of the session being lost. Some practitioners suggested that facilitators could sometimes do more to move discussions on when they digressed or when they strayed into colleagues letting off steam rather than talking more constructively.

It was also proposed that the group sessions could be ended in a more considered way. Partly as a result of the sessions being online, it was felt by some that the sessions could end quite abruptly, and it was suggested that this could leave some practitioners feeling a

little abandoned. It was suggested that it would be helpful for more thought to be given to how the sessions end and for clinicians to ensure that there was time left at the end of them to do this well.

Third, while practitioners valued the space that the sessions provided, there was a sense among some of them that the combination of having regular case consultation sessions alongside reflective practice and supervision could result in them feeling as though they did **too much talking**. This was not a universal view, but there were those who felt that although reflection was helpful it had limited value, and that sometimes it would help for the focus to shift away from what has happened for a family to what could be done for them in the future.

> *"Sometimes I think we go trauma, back trauma. We're talking about the trauma, the history, sometimes hypothesising, and although I think it's helpful to put things in context, we're not therapists, we're here to move things forward, so we can understand it and know that but how's it actually going to help us move the work and the family forward?"*
> – Brighter Futures Staff Member 09

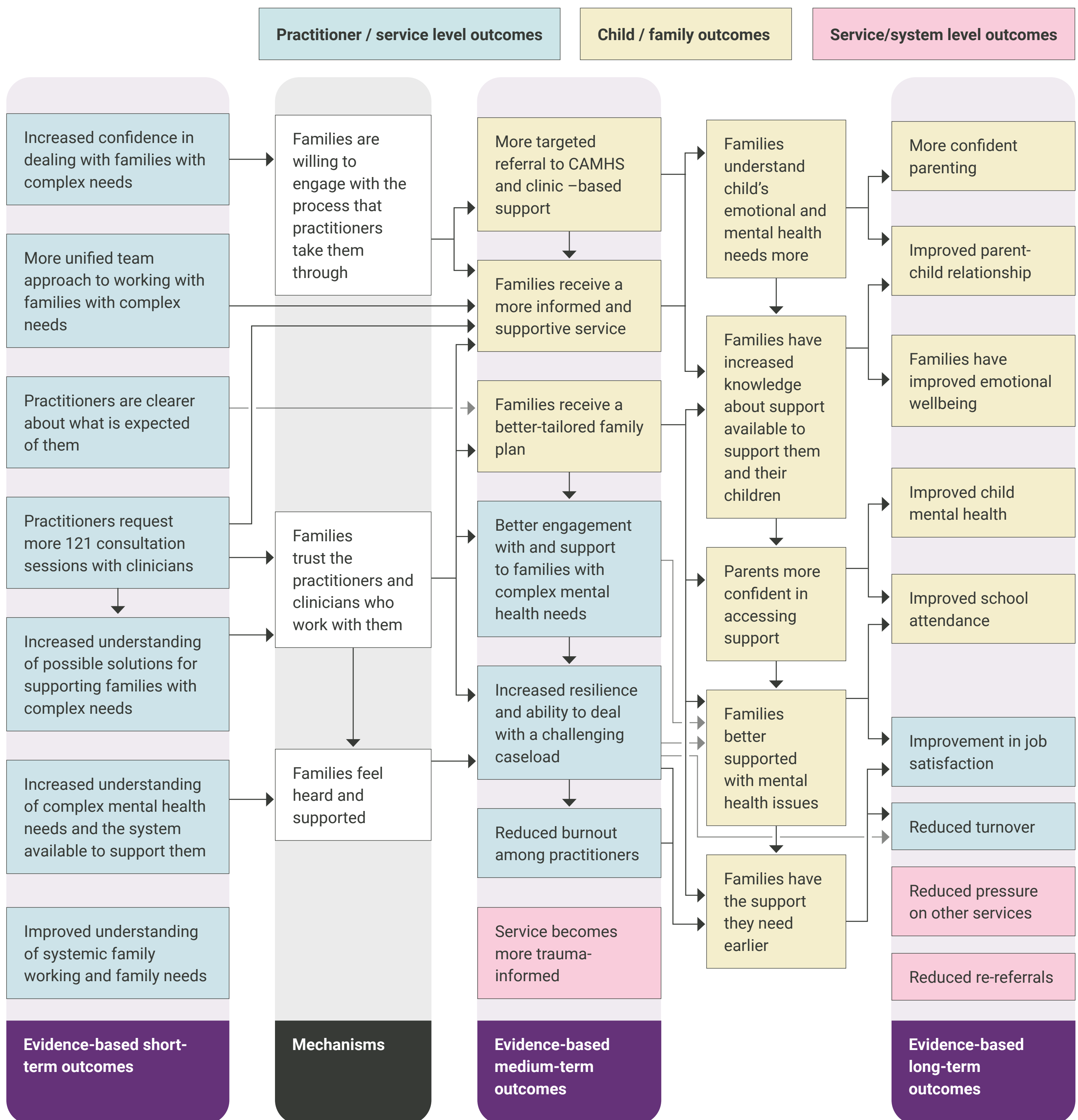
Finally, while efforts have been made to tailor the support offer to different roles, there is still a sense among some practitioners that it **isn't tailored enough**. Some practitioners suggested that the case consultation sessions are not working for outreach practitioners since they don't hold cases that they could bring to the sessions.

> *"Let's prioritise [sessions] for family practitioners and outreach can join them, but it is never directed to outreach at all."*
> – Brighter Futures Staff Member 10

While this was identified by some outreach practitioners, it was also flagged by some family practitioners who indicated that they had noticed some discontent about the sessions from some of their outreach colleagues. It was suggested that, in an ideal world, there would be a separate session for outreach workers that was theme- rather than case-based. It was also mooted that better communication across different teams would help so that outreach practitioners could hear more about what happens to a family that they refer on to a family practitioner.

Impact of the clinical offer

This section reports on the perceived and reported outcomes of the clinical offer based on the outcomes identified in the theory of change (see below) developed before the evaluation's fieldwork. This evaluation was not able to measure the causal impact of the offer as no counterfactual was identified for families or practitioners. Instead, this section draws on data provided by Islington and qualitative interviews with clinicians, managers and practitioners. This section looks first at outcomes according to the theory of change for practitioners, and then for families and the wider service that Bright Futures sits within.



Outcomes for practitioners

Clinicians, team managers and practitioners were all asked to reflect on the impact of the clinical support offer on practitioners during the interviews. Overall, there was a general consensus that the support offer is making a difference to practitioners, though there were differing views on the extent and nature of these outcomes. Data collected from the Bright Futures staff survey provides supporting evidence from practitioners for some of this.

Increased knowledge, skills and confidence in working with families

As set out in the theory of change, key expected outcomes of the clinical offer were increasing knowledge, skills and confidence in mental health issues, and working with families with complex needs. Some practitioners felt that the clinical support offer was having an impact on their knowledge, skills and confidence. In a staff survey issued by the PICT team in March 2022, when asked to what extent group case consultations had helped them learn new skills to address issues: one-third of practitioners who responded to the survey (18 out of a possible 40) reported 'very much' or 'moderately' (33%), almost two-thirds reported 'a little' or 'to some extent' (61%) and 6% 'not at all'. This was an increase on when practitioners were asked the same question in October 2021 (when 16 out of 40 practitioners responded). However, given the aggregated data provided, we could not assess whether this was a statistically significant change.

During interviews, practitioners who believed the support offer had increased their skills and knowledge spoke about how their interactions with clinicians had **developed their knowledge around mental health generally** as well as around the specific areas covered by the training sessions such as Emotionally Based School Avoidance (EBSA). It was felt that the support **helped practitioners with learning to have more boundaries and realistic expectations around what they could deliver for families**. Practitioners also mentioned having more respect for families with mental health difficulties as a result of the support; the knowledge they had gained meant that they felt better able to understand and interact with parents with mental health challenges.

There was also a clear theme around the support helping to develop practitioners' confidence. Part of this was felt to come from the fact that the support offer helps to validate practitioners' experiences which makes them feel less alone in their work. It was suggested that the role can sometimes be quite isolating or cause practitioners to doubt themselves, but the support offer was helping them to get some perspective, recognise their limitations and question themselves less.

> *"Because I think that this role can often make them think they're not good enough or 'what am I doing wrong' but actually when they discuss cases, it's the case that actually, it's not about me, I'm doing ok. Or it makes them realise how they need to approach the case differently or recognise that they're being defensive."*
> – Brighter Futures Staff Member 05

Practitioners spoke about how having the **support from clinicians was giving them the confidence to work with families that they would previously have found overwhelming**. One practitioner for example, spoke about how valuable it was to work one-to-one with a clinician while they had a particularly challenging case. The practitioner felt that had the support not been available, they would have found it more difficult and had less capacity to respond to the family's emotional states as the case was overwhelming. Team managers echoed this and suggested that practitioners were now better equipped to work with a parent who is presenting as suicidal, or who has very challenging mental health issues, as they have PICT on hand to support them with the diagnosis and give them the confidence that they have spoken with a real expert. In turn, the training they have had as managers means that they are also now more confident in picking up signs of secondary trauma in the practitioners they supervise, intervening if necessary and instigating strategies to support them.

Specifically on the outcome from the theory of change of increased understanding of possible solutions for dealing with families with complex needs, practitioners indicated that they had **better knowledge of where to refer families to and were more confident in suggesting to families that they could seek this support**. In some cases, practitioners reflected on how the clinicians were not only good at helping to develop new knowledge and skills but at supporting practitioners to trust the knowledge they already have. It was suggested that the support sessions are focused on helping them to realise what they were achieving, and that clinicians will often guide them to answer their own questions and so empower them to recognise their own skill base.

> *"Sometimes, I think it's just useful for you to think you already have the skills and the knowledge you need, it's just that you may not necessarily be utilising it."*
> – Brighter Futures Staff Member 12

While there were clear benefits to some practitioners' skills and confidence, others had a more mixed experience. In one instance, a practitioner reflected on how they had initially found the support to be helpful when they were newer to the role and unsure about which approach to take as it allowed them to develop their skill set and learn from others. However, they now found the sessions to be quite repetitive and did not always feel that they were getting any new benefits from them.

Understanding of systemic family working and family needs

Other key expected outcomes were on improved understanding of systemic family working and family needs and a more unified team approach to working with families with complex needs. From interviews, it was felt that the clinical support is having an impact on the way practitioners approach their work. It was felt that **some practitioners are considering their cases in a different, more psychologically informed way**, thinking about how they interact with families, about the language they use with them and how they can best support them. For example, team managers mentioned that partly as a result of the EBSA training, practitioners are using different language in their assessments and their family plans or in their interactions with schools and other partner organisations. It was suggested that this was having an impact on the team around the family.

Some practitioners indicated that taking a more psychologically informed approach had become engrained in what they did. One spoke about how they found themselves mirroring the behaviours and demeanour of one of the clinicians, for example; while another detailed how whenever they got a new referral, they now instinctively started unpicking it in a reflective way. Clinicians echoed this and felt that the consistent focus on being reflective and taking a more trauma-informed approach was helping practitioners to think about families in a more flexible way and that the support helps practitioners to foster more thoughtfulness, compassion and flexibility.

The staff survey issued by PICT in March 2022 providing feedback on the group reflective practice sessions indicates that the support offer is influencing how reflective practitioners are in their work. Just under three-quarters of respondents who answered the survey (18 out of a possible 40) indicated that they 'very often' or 'almost always' think about how things went with clients after interactions (72%). Around two-thirds of respondents indicated that they 'very often' or almost always' consider how their own thoughts and feelings (61%), as well as the thoughts and feelings of clients (61%) influence the interaction. In addition, the survey also found that 4 in 10 practitioners reported that the group sessions have given them a new understanding or changed their way of thinking to help them address issues experienced by families either 'very much' or 'moderately' (39%).

While there were largely positive perceptions about the impact that the support offer is having on the way practitioners work, it is important to note that some practitioners felt that it wasn't as beneficial as it could be. One practitioner felt that the offer was useful but that it

was hard to make use of it in the context of a heavy caseload when there was little time to think about the issues raised in reflective practice spaces, and that until the other reasons that practitioners' burnout were addressed, the full potential of the support offer would not be realised.

In terms of a more unified team approach to working with families with complex needs, it was felt that the clinical support offer is a good way to bring the team together and for them to feel as though they are working as a unit through sharing experiences and hearing reflections from colleagues. However, limited detail on how this was achieved was given by those interviewed.

Improved relationship with, and outcomes for, families

A key expected outcome was to improve the relationship and support to families, for example better engagement with and support to families with complex mental health needs. In the March 2022 staff survey, 39% reported that group case consultations had 'very much' or 'moderately' improved their relationship with children/parents and their colleagues, with 56% reporting 'a little' or 'to some extent' (61%) and 6% 'not at all'. This was an increase from the previous survey in October 2021 (where 16 out of a possible 40 responded) in which 13% reported 'not at all' – however, we were not able to assess whether this was a statistically significant decrease.

In the qualitative interviews, practitioners and team managers spoke about how the support they received encouraged them to **think about cases in new ways**. One practitioner spoke about how they had been stuck on a case and went to PICT for support; the clinician encouraged them to really strip it all back and remember the basics which gave them the confidence to try new things with families. Team managers echoed this and felt that having the clinicians to call on gave the team a new perspective that they could use constructively with the families they worked with.

> *"Just having those clinicians at hand, allows us to think about things in a different way, and can sometimes really help get a parent and/or a child access to that right help."*
> – Brighter Futures Staff Member 03

Linked to this was practitioners' perception that the clinical support offer allowed practitioners to empathise with families more and to take a more trauma-informed approach to working with them. It was suggested that when practitioners work with families in this way, the family is less likely to feel judged and so engages more freely, which can ultimately lead to better outcomes.

In the same staff survey issued in March 2022, 39% of practitioners believed 'very much' or 'moderately' that the group case consultations had enabled positive outcomes or effects for children, parents or colleagues they work with – with half (50%) believing 'a little' or 'to some extent' and 11% 'not at all'. This was an improvement on scores from October 2021, but again – we were not able to assess whether this was a statistically significant change.

Improved resilience, wellbeing and job satisfaction

A core expected outcome of the clinical offer was increased resilience and ability to deal with a challenging caseload, reduced burnout, improved job satisfaction and lower staff turnover. There were indications that the offer is providing practitioners with the space to take a more balanced approach and manage their wellbeing. Some practitioners spoke about how they have felt less anxious since the support offer has been in place and it was suggested that when practitioners are less stressed, they're able to give families more focus and professionalism.

The group sessions were seen to play a key role in this as they provide practitioners with a protected time away from their screen and present a chance to hear from peers and share

reflections. Practitioners spoke about how it was helpful to have space to think in the context of a challenging workload and felt that even just being able to listen and observe could be restorative.

> *"There are definitely times when I've reached the end of a group like that and felt kind of more ... like a kind of weight's been lifted. You know you take a moment away from the screen and from your cases and from working in a little silo and you get to hear about what other people are up to and other ideas and somebody from a different discipline and I think that offers quite a lot of relief to have that there."*
> – Brighter Futures Staff Member 07

Practitioners also appreciated the opportunity to share the specifics of a difficult case in the group sessions and some spoke about how doing so helped them to feel that they were no longer alone as everyone else in the session was also thinking about the case. They felt they came away with the load being shared more as well as with ideas of new routes to take to support that family. In line with the qualitative findings, evidence gathered from the staff survey issued in March 2022 indicated that a third of respondents (33%) reported the group case management sessions had helped to ease stress about work-related issues/improve confidence either 'moderately' or 'very much', with 61% stating 'a little' or 'to some extent' and 6% 'not at all'. This is in contrast to the staff survey in October 2021 where 43% reported it had helped either 'moderately' or 'very much' but a quarter (25%) felt it had 'not at all'. Again, we were not able to assess whether this was a statistically significant change.

The same survey used a validated outcome measure of self-reported work-related secondary traumatic stress which was found to be in the 'low' range among staff who answered the survey (18 out of a possible 40). This was similar to scores reported in October 2021 and March 2021. This could support the hypothesis that the clinical offer has an impact on reducing work-related secondary traumatic stress. However, the same survey also found that burnout was in the 'moderate' range.[9] This was higher than in previous surveys administered in October 2021 and March 2021, but again we could not assess whether this was a statistically significant change. These survey results taken together suggest that the clinical offer could be supporting practitioners with burnout; however, it is possible that the impact of the pandemic on both families and practitioners may have limited the effect of the support offer resulting in a higher burnout score than might otherwise have been expected. Since it is impossible to disentangle the various factors at play within these figures, they should be treated with caution.

From the interviews there were also mixed views on the impact the offer had on practitioners' workloads and general burnout. Some practitioners felt that it resulted in a slight reduction in their workload as they were signposted to the correct professionals to speak to; however, others felt that attending case consultations or reflective practice sessions could result in practitioners being given ideas that resulted in them coming away with a heavier workload.

> *"It's all really nice that you're giving us this space and time to think managers, thank you, cos I would hate for it not to be there, I think it's very invaluable; but at the end of the day it can sometimes feel like it's given you more to do."*
> – Brighter Futures Staff Member 09

It was also suggested that the support was having an impact on some of those in management roles within the team as they were now better equipped to spot early signs of burnout in their colleagues and to approach these instances in a more trauma-informed way. The counterfactual was also discussed in relation to practitioners' wellbeing. Those who had held previous roles where no support was available spoke about how challenging it was to have nowhere to go with concerns or to think reflectively. Some suggested that without the

9 Burnout score= 27.7 in March 2022. A score of 22 or less is 'low', between 23 to 41 is 'moderate' and 42 or more is 'high'.

offer in place there would be higher stress levels and lots more staff sickness and there was a sense of gratitude among practitioners that the support and the space it provided them was available within the team. Clinicians echoed this and suggested that one of the benefits of the support was that practitioners learnt how to manage their boundaries with clients better, which impacted on both their wellbeing and their resilience.

While there was general agreement that the support had a positive impact on practitioners' wellbeing, there were some who felt that the support offer did not go far enough. There were examples given of times when practitioners felt isolated and overwhelmed by their workload. This was seen to be particularly challenging when there were high levels of sickness absence in the team which could place greater pressure on the remaining practitioners.

Outcomes for families (parents and children/young people)

Better support from practitioners

Key outcomes from the theory of change for families were that they would receive a more supportive and informed service, be better supported with mental health issues, have better-tailored family plans and receive the support they need earlier.

Clinicians reflected on how, if practitioners are given opportunities to manage their own stress, then they are less likely to be unboundaried in their approach or to do something unhelpful such as closing the case abruptly. Giving practitioners the space and support to manage themselves means that they are better equipped to provide families with more targeted and considered support.

> *"It gives the families an experience of maybe more emotionally, psychologically resilient practitioners who can then engage with the needs and the present challenges of the family in a more thoughtful way."*
> – Brighter Futures Staff Member 06

Practitioners agreed with this sentiment and felt that when they were supported, this led to better outcomes for the families they worked with. Some practitioners also pointed to the counterfactual and indicated that had they not been so well supported, they could have experienced higher levels of stress or lower wellbeing, meaning that they could be less well positioned to provide families with the support they needed.

While there was no quantitative data to directly support this, Islington does hold data on re-referrals. This indicates that 13% of cases in 2021/22 (12% in 2020/21) were re-referrals.[10] While this is not attributable to the clinical offer, it suggests that, overall, Bright Futures was meeting the needs of families resulting in a low re-referral rate.

Better access to the right services

Key outcomes identified in the theory of change focused on better access including, corresponding to the short-term outcomes of an increased number of referrals to clinic-based support and more targeted referral to CAMHS, parents being more confident in accessing support and increased knowledge about resources available to support them and their child.

Adult and child mental health services can be very difficult to navigate and interview participants spoke about how the support offer was helping practitioners to get the right knowledge and networks to understand the system and what is available, and to pass that knowledge on to families.

10 Defined as within 12 months of recent referral, allocated to the same team.

> *'If the staff member feels more supported, and we have more access to resources or knowledge, or whatever it may be, I feel like, as a practitioner we then go to share that with the family. Whether we share exactly what's said or we've taken on the advice we've been given, and we may slightly change the way we're engaging with a family member."*
> – Brighter Futures Staff Member 12

However, further evidence to support this, such as the number of referrals to clinic-based support or CAMHS, and evidence to support outcomes such as whether families have better understanding of child's emotional and mental health needs, was not able to be gathered. In addition, limited evidence was provided on longer-term outcomes set out in the theory of change, such as improved parent–child relationship, parenting, emotional wellbeing, school attendance and child mental health.

Outcomes for wider services and systems

Key outcomes from the theory of change that were expected for wider services and systems included reduced re-referrals and pressure on other services, as well as services becoming more systemic and psychologically informed.

On re-referrals and pressure on other services, data from Bright Futures shows that the proportion of re-referrals has remained relatively low since the offer has been introduced, with just over 1 in 10 families re-referred within 12 months of recent referral – 12% in 2020/21 and 13% in 2021/22.

In terms of services becoming more systemic and psychologically informed, interviews with Bright Futures staff yielded less information. However, it was felt that the training on Emotionally Based School Avoidance (EBSA) was having benefits both for and beyond the team. The training has given the team new language to use around EBSA, for example not using the term 'school avoider'. This language and approach is now being used with schools and other partners, meaning that they will have the opportunity to understand more about a psychologically informed approach to school avoidance, and this could lead to a ripple effect from the training.

Unintended consequences

Clinicians, team managers and practitioners were asked to reflect on the potential or actual unintended consequences of the clinical support offer. The main unintended consequence identified was that **the support activities can leave practitioners feeling more stressed or overwhelmed**. As an example of this, team managers spoke about how the group case consultation sessions can sometimes be very draining. They described how some practitioners in their team found it hard to go straight back to their case load after the more intensive sessions and to make the switch from a very reflective and emotive space, to focusing on their own at their desk. The online delivery of these sessions was thought to exacerbate this challenge, in some cases it was also felt that the online group sessions could end too abruptly, leaving practitioners feeling a little abandoned. It was suggested that more thought could be put into how sessions were ended but also that when sessions are face to face again, they may be less emotionally draining for practitioners.

Another example of feeling overwhelmed was given by a practitioner who had brought a clinician in to work with their family directly for one session. Having previously worked hard to put a boundary around what they were able to deliver, when the clinician joined a session lots of the family's history came up again and the practitioner found it hard to reset the boundaries again afterwards and was left feeling paralysed about the case.

Linked to this was the observation that it can be very stressful for practitioners to hear about families who have so much unmet need and for them to only be able to address a small part of that as many of the families face challenges that are far bigger than the practitioners' remit.

> *"It can be very stressful hearing about the high level of need and feeling that you know ideally what should happen sometimes, and you know that it's not possible. This is extremely stressful I think for the workers and for us maybe less so because we're one degree removed."*
> – Brighter Futures Staff Member 06

Similarly, it was recognised that some of what is discussed in the sessions can be triggering for practitioners if it links with any trauma that they have experienced in their personal lives. Clinicians reflected on how this can happen anyway in the work that practitioners do directly with families but that it is important to make sure that the spaces feel safe, because case consultation sessions bring up more challenging cases by definition and it's impossible for clinicians to know all the practitioners' personal histories and how discussing these cases might impact on them. Where staff are experiencing higher stress levels, clinicians were cautious about the potential for managers to simply refer their staff to PICT and stressed the need for staff to have their own emotional support that did not come from the co-located clinicians. While staff referrals to PICT were not thought to be happening regularly within the team, clinicians indicated that there were hints of it and thought it important that their role was kept boundaried and focused on the practitioners' professional challenges.

However, there was no evidence found to support the possible unintended consequence identified in the theory of change that the increase in skills and support in Bright Futures may unwittingly signal to other services/partners that they are not needed, which could place extra burden on the team.

4. Discussion

Discussion of findings

This section sets out the findings in relation to the key research questions.

Evidence of promise

Fidelity

- **Is the clinical offer being delivered as intended?**

The evaluation data suggests that there is a clear, shared vision for what the clinical support offer looks like. Practitioners, team managers and clinicians all have a clear understanding of what is meant by the support offer; there is broad agreement among the team that the offer comprises group case consultations and reflective practice sessions, individual case consultations, training, and direct support by clinicians to support practitioners with specific cases, along with co-location of clinicians in Bright Futures teams.

Adaptation

- **Does the delivery of the offer vary across the Bright Futures teams?**

While overall, the offer appears to be delivered as planned, there have been two notable adaptations made to help the offer better meet the needs of practitioners:

- » The change in format of the reflective practice sessions so that they are run separately for practitioners and team/deputy team managers.
- » A flexible approach to case consultation sessions to accommodate both outreach practitioners and those who are more reluctant to bring a case to the sessions to be reviewed. However, this adaptation to the case consultation sessions is not being delivered in the same way across the three teams.

Additionally, most of the offer had moved online as a result of Covid restrictions rather than practitioner request or need. There was general consensus among the interview participants that running the group sessions online had not been a positive move and had resulted in them being less engaging and effective than had been hoped.

Dosage

- **How much of the clinical offer is being delivered?**

Group case consultations and reflective practice sessions were meant to be run monthly. Alongside this, each team also usually has one other session which could be training or could be something else. Data from the evaluation showed that reflective practice sessions were happening about once a month (there had been nine sessions offered per team in the past 10 months). However, case consultation sessions appeared to be happening less frequently as eight sessions had been offered per team in the past 12 months.

In addition, the formal training sessions are not being delivered as frequently as was originally planned (although no specific parameters were set for this), and so far, only two rounds of training – both on Emotionally Based School Avoidance – have been delivered. In the 10 months from October 2021 to August 2022, 53 one-to-one consultations were

delivered by PICT, and 58 individual consultations were delivered by CAHMS clinicians between July 2021 and August 2022. Clinicians indicated that they are keen for this number to increase.

Reach

- **Does the clinical offer reach the intended practitioners and as a result the target families in need?**

The Bright Futures team took a decision to make attendance at the group case consultations and reflective practice sessions compulsory which means that those sessions are generally well attended. However, no data was provided on the attendance rate. The individual consultations are less well used with an average of around 10 sessions per month across PICT and CAMHS. There is no data on which types of practitioners are using these or how many practitioners these sessions represent, so no estimates about whether they are reaching their intended audience could be made.

Quality

- **Is the clinical offer being delivered to a high quality?**

Since no specific quality standards were set for the clinical support offer, interview participants were asked to reflect on what they felt quality looked like within this offer. Three key ingredients were identified: **clinicians being readily available** and having the capacity to engage with practitioners through a range of mediums (in person, online and by phone); **clinicians' skills and experience** and this being used to ensure that the sessions are all well and tightly facilitated and for the **offer to be evidence-based** and backed with clear research about psychologically informed approaches and what works to support practitioners and families.

Participant responsiveness (engagement)

- **To what extent do practitioners engage with the clinical offer?**

Practitioners' engagement with the clinical support offer was found to be variable. While there was a general expectation that practitioners attend the group sessions whenever possible, not all practitioners are engaging with these sessions in the same way. The factors influencing practitioner engagement were: their **capacity** and workload; the **expectation to attend**, which encouraged some practitioners to engage; **practitioners' roles**, with outreach workers sometimes feeling as though the case consultation sessions were less relevant to them; **practitioners' previous experience of using psychologically informed approaches**; the **team restructure** which had created some concerns for some practitioners; and the **dynamics within the sessions** themselves also had a bearing on the way and extent to which practitioners felt able to engage.

Intervention differentiation

- **What is the value added of the approach and how does it differ to business as usual?**

The Bright Futures team is not the only Islington team to draw on support from the PICT and CAMHS clinicians; however, they are the only team to embed the support and provide this particular range of activities which was seen as unique and innovative. Some practitioners spoke about how in roles in other local authorities, there had been very little support for practitioners and no space for reflection, which they felt had had a detrimental effect on the ability to deliver the role.

Factors affecting delivery of the clinical offer

- **What are the enablers and barriers to successful delivery of the clinical offer?**

The enablers to successful delivery fall into four categories:

- **Clinicians' skills and experience:** The evidence suggests that the clinicians not only need the right qualifications and experience, but also need strong facilitation skills and experience or knowledge of the populations that practitioners work with.
- **Nature of clinicians' relationships:** This includes the relationships between PICT and CAMHS, relationships between clinicians and their managers, and the relationships that clinicians have with a range of external teams and services.
- **Clinicians' availability:** Both clinicians' availability and that availability being embedded into the Bright Futures teams was seen as fundamental to delivery.
- **Structured approach:** Having clear expectations about prioritising the group sessions was seen as useful.

Barriers to successful delivery also fall into four categories:

- **Practitioner engagement:** The evidence suggests that practitioner engagement is variable and that this is influenced by a range of factors, including: capacity; the nature of practitioners' roles; practitioners' previous experiences of psychologically informed approaches; concerns about feeling exposed; not liking the expectation to attend; the recent restructure within the team; and the dynamics within the group sessions.
- **Remote delivery:** This was felt to have an impact on the group dynamic and the quality of relationships that colleagues could form.
- **Staff turnover:** High turnover among clinicians was felt to impact on the group dynamic and practitioners' relationships with clinicians.
- **Resources within the wider system:** Low funding of services coupled with increased demand were perceived to create a barrier to successful delivery.

Evidence of promise

- What are the potential benefits of the clinical offer?
- Do there appear to be any unintended consequences or negative effects of the offer?
- Is there evidence to support or extend the theory of change?

There is emerging evidence that the clinical offer in the Bright Futures team has benefits for practitioners and families.

The key outcomes for practitioners included:

- Some practitioners felt that the offer is having an impact on their **knowledge, skills and confidence** in working with families.
- There was a sense that the support is helping practitioners with their **knowledge around mental health** and helping them to have **more boundaries and realistic expectations** about what they can deliver for families.
- In some cases, the support is giving practitioners the **confidence to work with families that they might previously have found overwhelming**.
- Some practitioners also reported **better knowledge of where to refer families to**.
- There is also some evidence that practitioners have a more systemic understanding of family working and family needs and that they are **considering cases in a more psychologically informed way**.
- There was evidence that the offer is providing practitioners with the space to **take a more balanced approach to their practice and manage their wellbeing**. However, there are also signs that, in some cases, workload and burnout remain high.

The key outcomes for families included:

- Some practitioners felt that they were **better equipped to provide families with more targeted and considered support**.
- It was also felt that the support is providing practitioners with the ability to **understand the system and available services and pass knowledge on to families**.
- Evaluation data also suggests that **referrals have remained relatively low** while the offer has been delivered, although this cannot be directly attributed to the offer itself.

The study yielded very little information on the outcomes for wider services and systems:

- As noted above referrals have remained relatively low since the offer has been introduced.
- There was also the suggestion that the training on Emotionally Based School Avoidance was giving some practitioners new language to use around school avoidance, and that this language and approach is being used with schools which could in turn increase their understanding of the issues, although this was not tested.

The study has identified some unintended consequences of the clinical support offer. These include:

- The support activities can leave practitioners feeling **more stressed or overwhelmed**, something that was thought to be exacerbated by the online delivery of the activities that was taking place while the evaluation was under way.
- Some of what is discussed in group sessions can also be **triggering for practitioners**.

Overall, this study provides a good body of evidence to support the theory of change. Many of the outcomes identified in the theory of change are supported by the evaluation. However, it would be worthwhile reviewing the theory of change against the evidence from this evaluation and updating it in line with the findings. For example, there was no evidence to support the unintended consequences identified in the theory of change, but other unintended consequences emerged from the findings.

Conclusions and recommendations for the clinical support offer

The Bright Futures clinical support offer is designed to provide practitioners within the team with psychologically informed support to help them to deliver better care to the increasing number of families in Islington presenting with complex mental health needs. The offer also aims to help practitioners to feel more supported, have improved wellbeing and be less likely to suffer from burnout. This evaluation suggests that there are signs that some of these aims are being met in some cases.

Evidence from interviews and staff surveys point to practitioners approaching their work differently as a result of the support they are receiving and, in some cases, practitioners are taking a more psychologically informed approach to their work with families. There is also some evidence that the support is impacting on practitioners' knowledge, skills and confidence around working with families with more complex needs.

There was also broad consensus that the support is considered to have a more positive impact on practitioners' general resilience and wellbeing with some practitioners reporting feeling less anxious and more supported in their work. However, there were practitioners who also felt that the support offer did not go far enough and indicated that there were times that they felt very overwhelmed by the job. And while some practitioners reported that the offer had helped them feel that their workload was more manageable, others reported the reverse.

There is also emerging evidence that the offer is having an impact on the service provided to families. In some cases, practitioners feel better able to support families or to signpost families to the right services; while others are finding that they are able to approach cases differently, and there is evidence that practitioners' relationships with families are improving, in some cases.

The evidence of the impact of the offer on the wider service and system is less clear, although there were suggestions that the offer is both helping to bring the team together more and giving teams the right language around mental health, which is now being shared with schools and other partners. Data from Islington also indicates that re-referrals have remained relatively low since the offer was introduced.

Where the offer has been successful, this is attributed to a range of factors including the clinicians' skills and experience, as well as the structured approach to delivering the offer and the relationships that clinicians' hold. Unsurprisingly, there have been challenges to delivering the offer during the Covid pandemic and the online delivery of group sessions has made it harder to deliver the support effectively. Other barriers include high levels of staff turnover, particularly among the clinicians and variable levels of engagement from practitioners.

While elements of the offer have received a mixed review, overall, there is a high level of support for the offer among the Bright Futures teams, and practitioners value the opportunities, learning, guidance and space that the support provides.

If the Bright Futures team wishes to continue with the offer, the evidence from this evaluation points to a number of recommendations that the team could consider. These include:

Training and guidance

- While there is a clear shared understanding of what the clinical support offer comprises and what it aims to achieve, there is also evidence that those who have previous experience of psychologically informed approached appreciate the offer more. There are also some practitioners who question the usefulness of reflective approaches. Therefore, it may be worth the Bright Futures team considering **providing regular short training sessions on what a psychologically informed approach is aiming to do** and why this approach is relevant to practitioners' work (perhaps using one of the existing group spaces). This would ensure that all practitioners understand where the possible value could be for them and help them to get the most out of the offer.
- The training delivered as part of the offer to date has been well received and largely considered to be effective. However, it has been very limited. **The Bright Futures Team could identify other areas for training and roll them out over the coming year**. Since practitioners valued the EBSA training because it was relevant and specific to their role, future training should aim to fulfil the same brief and focus on challenging aspects of practitioners' roles or tools that could be used with families.

Delivery of the offer

The evaluation evidence suggests that while the offer is broadly working well for practitioners, there are challenges for outreach practitioners with taking part in group case consultations since their role is not case holding. This is not a new issue, but one that may be worth revisiting, and **Bright Futures managers may want to consider whether there is the resource and opportunity to provide outreach workers with a separate forum** during team case consultation sessions.

Recruitment

While practitioners value hugely the skills and expertise that clinicians bring to their practice, their facilitation skills and knowledge of the context in which practitioners are working were seen as equally valuable. **Bright Futures managers may therefore want to consider including these attributes in the clinicians' job description** (if this is not already the case) and considering these attributes during recruitment processes.

- There is evidence that practitioners really value the support offer and those who have worked for other local authorities without this support appreciate what it brings to their role. Therefore, **there may be merit in referencing the support offer during practitioner recruitment**. This would not only provide additional incentive for high-calibre candidates but set expectations about the importance of the offer to the team and ensure that new practitioners understand its role from the outset.

Finally, the evaluation team suggest that these findings are shared with the Bright Futures and PICT/CAMHS teams, even if in a summary form.

Recommendations for future evaluation

- What is the most feasible approach to assess the implementation and impact of the clinical offer?
- Which outcomes are critical to measuring impact and how?

Evaluating the impact of the clinical offer is an important part of understanding how effective it is in achieving its intended outcomes. Part of the evaluation was to assess the feasibility of conducting a future impact study on approach. The evaluation team were unable to identify or construct a sufficient counterfactual (ie a control group of either practitioners or of families with similar characteristics who had not been supported by the Bright Futures team, either from Islington or from other comparison areas) which would support a future impact study by the team.

As a result, the evaluation team recommend that Islington builds on this evaluation and continues to assess the implementation and works towards assessing the impact of the offer on practitioners and ultimately families. Below we provide a range of options for how this could be achieved. The evaluation team suggest that the Islington team reviews these options and considers which ones it could successfully embed into its practice and use consistently without affecting the relationships it has with the families it works with.

Implementation of the clinical offer

We recommend the Bright Futures team and the PICT/CAMHS team work closely together to continue to enhance their assessment of the delivery of the offer to ensure that key components are being delivered as intended.

The evaluation team recommend **continuing and improving management data collection on the key components of the approach**. We recommend that the frequency of key components of the offer including group case consultations and reflective practice sessions, individual case consultations, and training continues to be collected. However, no data was provided on the direct support by clinicians to support practitioners with specific cases. We would recommend that the frequency, and the type of support provided is collected, along with the duration – that is, whether the support was one-off or for a period of time.

No data was provided on who participated in the key components of the clinical offer; for example, the number of practitioners who attended and what teams they were from. If attendance data was collected, it would give a better understanding of the dosage and reach

of the clinical offer. If this was linked to data on staff, such as what team they were from, what type of role they had or how long they had worked in the Bright Futures team, this would allow analysis on whether these factors were influencing engagement.

The evaluation team recommend that data on practitioner views of the Group Space (group case consultations and reflective practice sessions) offer continue to be collected via surveys undertaken every six to 12 months.[11] We would also recommend continuing to collect survey feedback on every training session. In addition, we recommend that practitioner views on the other key components also be collected, including individual case consultations and direct support by clinicians to practitioners working with specific cases. This could be achieved by expanding the scope of the survey on the Group Space sessions to cover all components of the offer including individual support by clinicians and training generally.

We also suggest **that more in depth detail on the practitioners' views of the clinical offer is collected**. As part of the evaluation, we interviewed a number of practitioners, managers and clinicians. Undertaking a similar exercise, every year for example, could help explore perceptions of the offer and provide useful recommendations. Topic guides used in this evaluation could be used as templates. If these take place, we recommend that personnel skilled in interviewing and independent of the CAMHS/PICT and Bright Futures teams be chosen to undertake these.

Another avenue to explore would be to **make use of practice weeks**, which are understood to be a time when cases are audited and teams reflect on a specific issue, asking for feedback from families they have worked with. We think these could be useful avenues to explore implementation and perceived impact of the clinical offer on practitioners and families. However, we did not collect enough information on the structure and process of these to offer concrete recommendations.

It was not believed to be appropriate for the evaluation to gather views from families given the clinical offer is primarily aimed at practitioners, and therefore families would have had limited insight into the offer. However, as part of a wider evaluation of Bright Futures (and not just the clinical offer) we suggest considering **conducting interviews with families to understand their perceptions of all the support they received from Bright Futures**. This could include, for example views on perceived impact they think the practitioner has had on their needs, including social and emotional needs and mental health, as well as specific needs such as school attendance.

Impact of the clinical offer

We recommend that Islington continues to investigate the impact of the offer on practitioners as well as on children and families through robust quantitative methods. We do not feel that there is currently robust enough data on the offer or its impacts to do this. We therefore suggest agreeing a number of key outcomes on which to measure impact, ideally by reviewing the theory of change, and then making concerted efforts to collect these either by using administrative data and/or validated outcome measures that are feasible and practical. This would give strong evidence of promise which could be built on for more robust impact analysis in the future.

Below, we suggest a number of key outcomes we believe could be robustly assessed. However, Islington may potentially need to decide which ones to prioritise and consider which ones are most feasible and practical.

11 A small improvement in the reporting of survey findings could be achieved by not collapsing the scores, allowing for a better understanding of the distribution of answers.

Impact on practitioners

We recommend the use of outcome measures to explore how the clinical offer, including its different key components, impact on practitioner outcomes as articulated in the theory of change. We suggest continuing and expanding the collection of data on validated outcome measures, such as those collected as part of the survey on Group Space undertaken twice a year, including the Professional Quality of Life Measure (ProQOL). As above, we recommend that the survey is expanded to cover all aspects of the clinical offer, with responses given for each of the components.

We would also suggest gathering data on other aspects of the theory of change, including increased confidence in dealing with families with complex mental health needs and improved understanding of mental health issues. This could be done by adding questions to the surveys of practitioners on their knowledge and confidence on mental health needs.

A key long-term practitioner outcome is reduced turnover of practitioners. We were unable to obtain data on staff turnover; however, we recommend this is collected and looked at in relation to previous years. No causal claims would be possible, but it could be useful to benchmark the turnover rate of the Bright Futures team with previous turnover rates as well as turnover rates of other similar teams in Islington and other London boroughs to get a sense of whether the offer could be helping to reduce turnover.

Impact on families

The evaluation was unable to collect data on the causal impact the clinical offer was having on families, both children and young people and their parents/carers. This is partly due to the indirect nature of the clinical offer, which is mainly focused on supporting practitioners, as well as the difficulties in identifying causal impact on outcomes which have multiple interdependencies. We would, however, still recommend that attempts be made to evaluate the impact of the offer on families using accurate administrative data.

A key outcome set out in the theory of change was better access to the right services, including more targeted referral to CAMHS and clinic–based support. We suggest that administrative data be collected on better access to services which could include the number (and outcomes) of the CAMHS and adult mental health service assessments and referrals Bright Futures supports. If this data is available but not currently analysed, it could be useful to look back to see longitudinal trend data to compare to before the clinical offer was introduced.

We also recommend considering the collection of additional outcome measures which cannot be collected by administrative data through appropriate and feasible validated outcome measures. We would, however, emphasise that the collection of outcome data by practitioners would need to be piloted and include adequate training and capacity to collect the data. It therefore needs to be proportionate to the time spent with families and easily integrated into the practice approach in Bright Futures so that it could be implemented consistently across teams. As a starting point, in the box below we offer some high-level considerations when using, analysing and monitoring the use of outcome measures.

Considerations when using, analysing and monitoring use outcome measures

Using validated outcome measures

Data should be collected from families **both before and immediately after they have received support**. We would also recommend **collecting follow-up data** to see whether changes are sustained, for instance, 6 months and 12–18 months after support has ended.

Data should be collected from practitioners routinely to track outcomes over time. For instance, a practitioner survey might be conducted twice yearly.

Analysing outcome measures

Data should be analysed using **statistical testing** (eg a paired sample t-test) on whether differences between the 'before' and 'after' data is significant, or if it is likely to have been due to chance.[1]

Monitoring use of outcome measures

We recommended that the **implementation of the outcome measures is monitored** through regular feedback both formally (via surveys for example) and informally (in practice meetings or supervision for example). Refresher training at regular intervals could also be useful to ensure high-quality administration. In addition, feedback from families could be gathered on the use of outcome measures. Again, we would recommend formal and informal feedback be obtained.

1 Further guidance on how to complete this type of data analysis is provided in appendix D of *10 steps for evaluation success*: https://www.eif.org.uk/resource/10-steps-for-evaluation-success

Key outcomes set out in the theory of change focused on better support from practitioners including receiving a more supportive and informed service, being better supported with mental health issues, having better-tailored family plans and receiving the support they need earlier. There are limited ways to directly measure these outcomes, but many rely on an improved therapeutic/working relationship between the family and the practitioner. This could be a useful outcome to be included in the theory of change and could be measured. One known tool to capture this is the Working Alliance Inventory-Short Revised (WAI-SR).[12] It measures 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. This measure could be completed by both the practitioner and the family receiving support.

Another key outcome articulated in the theory of change included improvements in wellbeing and mental health. There are two tools that may support the measurement of these outcomes. First, the Warwick-Edinburgh Mental Wellbeing Scale (WEMWS), a scale widely used throughout health and family support services to report on individual wellbeing. Second, the Revised Child Anxiety and Depression Scale (RCADS) a youth self-report questionnaire for young people aged 8–18 which has a parent version that could be used to assess a young person's anxiety and depression.

In sum, the evaluation team would recommend that Islington continues to investigate the impact of the clinical offer on practitioners as well as on children and families through robust quantitative methods. However, we advise that Islington identifies a few key outcomes to collect quality data on based on what is both feasible and practical for the service.

12 For more information on this measure, see: https://wai.profhorvath.com/sites/default/files/upload/WAI%20Ts%20k.pdf