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Evaluation of Rotherham's systemically informed Edge of Care team

April 2023

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

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

To find out more, visit our websites at: https://www.eif.org.uk and https://whatworks-csc.org.uk.

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WHAT WORKS FOR EARLY INTERVENTION AND CHILDREN'S SOCIAL CARE IS PROUD TO BE A MEMBER OFTHE WHAT WORKS NETWORK

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This report was first published in April 2023.

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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 systemically informed approach of the Edge of Care team in Rotherham.

Approach being evaluated

The Edge of Care team was created as part of the transformation of Children's Services and the launch of an Early Help Offer. It was set up as a response to high numbers of children entering the care system whose families had multiple and complex needs and were not engaging in support or statutory services. The Edge of Care team was intended to support very complex and vulnerable children (on the 'edge of care') to remain safely in their home environment or be reunited within their family/kinship networks. It was underpinned by evidence about the significant emotional distress and poor outcomes that can result from taking a child into care and the positive impact that systemic practice can have on supporting these children.

The Edge of Care team is a small multidisciplinary team, made up of eight practitioners with complementary skills and experience who have been operating since 2017. The key elements of their systemically informed approach include:

- training in systemic theory and practice: including supervision and reflective practice sessions
- family intervention offer: a dedicated family intervention worker (FIW) using systemic practice with families, including formulation meeting and an action plan co-created with families
- therapeutic clinic: a manager and clinical psychologist provide mental health and relationship support
- evidence-based interventions: families are offered a range of Triple P Parenting programmes and Non-Violent Resistance programme (NVR) run by a parenting practitioner
- visits to an outdoor education centre: used to inform assessments and support families.

Research questions

The research questions were:

1. Evidence of feasibility: Is the systemically informed Edge of Care team operating as intended; and what are the barriers and enablers to delivering a systemically informed approach?
2. Evidence of promise: What are the potential benefits of the approach for families, practitioners and the wider service; and are there any unintended consequences?

3. Exploratory research: How could the systemically informed Edge of Care approach be adapted to work for families supported by Early Help?
4. Evaluation feasibility: What is the most feasible way to evaluate the Edge of Care approach; and which outcomes are critical to measuring impact?

Methods

The evaluation combined exploratory qualitative research with quantitative analysis of administrative data collected by the Edge of Care team. The study also piloted three validated outcome measures, which were administered by the Edge of Care team. The qualitative research involved 15 interviews with both the Edge of Care team and their key stakeholders from across social care and Early Help, combined with observation of five activities delivered by the team. Interviews and observations were carried out between March and July 2022. Quantitative data was analysed descriptively. The findings from the different data collection methods were triangulated to draw conclusions.

Key findings

Evidence of feasibility

The evaluation provided evidence of how the Edge of Care team was operating as intended (as specified in the theory of change), working systemically with very complex and vulnerable families and children who are on the edge of care.

Limited adaptation was identified among those delivering the approach; however, the systemically informed approach was premised on the need to tailor and adapt their work to the different levels of need of families. The pandemic had affected the delivery of elements of their work, such as the therapeutic clinic, and limited the training and supervision opportunities, but did not appear to have affected the core functioning of the service.

When the team was created, their systemic training and monthly reflective practice sessions were delivered by external systemic practitioners. However, the budget was cut in 2019 and these sessions were delivered less frequently by the team manager with support from the clinical psychologist.

Assessing the quality of the approach was difficult as no validated assessments were completed. However, interviews and observations of training and practice found that members of the Edge of Care team were very engaged and positive about the systemic approach. Children's Services, including the service, were judged as 'good' by Ofsted in August 2022.

Families were not interviewed as part of the study, making it difficult to assess their engagement. However, the low level of families who disengaged with the service and the sustained time with which the team worked with families was a good indication of their engagement. In circumstances where families were not engaged, it was felt to be due to families not being in the 'right place' for systemic intervention.

Data and interviews suggested the team were reaching children who were most at risk of coming into care, or where there was a placement at risk of breaking down, or where they were being reunified back home.

The team was viewed as adding value to the range of services already in place by introducing a new systemically informed approach. This provided freedom to tailor their approach based

on their assessment of a family's needs in contrast to set assessments and processes in other services such as social care and early help. The service also had more time to work with families more intensively and for longer.

Enablers and barriers

Enablers to delivery included:

- practitioners being able to tailor and adapt their approach to the presenting needs of individual families, supported by a strong foundation of systemic practice
- appropriate foundation-level systemic training combined with group monthly reflective practice and individual supervision facilitated by an experienced systemic practitioner to embed and apply learning
- an effective referral pathway via the Edge of Care Panel process that ensured adequate referrals
- weekly formulation meetings, providing a reflective space for all professionals involved with a family
- being part of a small, supportive multidisciplinary team with a strong whole-team culture made up of practitioners with complementary skills and experience, with practitioners having the appropriate mindset and interpersonal skills
- low caseloads and good capacity ensured time to slow work down and explore the family dynamic and history, to work intensively and get to the roots of underlying issues
- a range of systemic tools used flexibly to support practice, including the Sessional Rating Scale (SRS) and Outcome Rating Scale (ORS) and the SCORE-15
- strong partnership working, especially with their social care counterparts.

Barriers to delivery included:

- capacity of the team and financial pressures of other services
- working alongside partners who lacked understanding or faith in a systemic approach
- child protection procedures and regulations dictating the timescales of their work with families
- working remotely during the pandemic, limiting the scope and depth of their therapeutic work
- how receptive and open families were to working with the team. Barriers included being the wrong time for families to work with the service, a lack of trust in services and a reluctance to work in a systemic, restorative and trauma-informed way
- the recommendations from interviews for Edge of Care revolved around expanding their service to work with more families, developing an emergency/crisis out-of-hours response and developing an Edge of Care consultancy offer for social care and early help. It was also suggested that they could share advice and training with other local authorities and support a national peer network of relevant services.

Evidence of promise

The evaluation was not designed to assess the causal impact of the approach. However, based on outcomes data collected by the service and the perceptions of the Edge of Care team and stakeholders, the service was viewed as having made a difference to key outcomes for families, children, practitioners and the wider system identified in the theory of change.

For children and families, a key outcome was children being safe and creating a sustained change in their lives. As of September 2022, the team had supported 399 children, where 63.7% had stepped down from Edge of Care, 19.8% of children had seen no change and 16.5% of children had been stepped up. Evidence was also found to show that many families had seen improved family relationships and improved parents' confidence in their parenting skills.

For practitioners in the team, the approach was perceived to be making a difference through systemic training, reflective practice, supervision sessions and formulation meetings, which supported the development of the Edge of Care team's systemic skills and practice and supported their wellbeing.

For the wider system, the approach was said to have made a difference to social workers and other teams, including learning how to be more systemic and reflective about families, which helped them to work more effectively with families and was said to have improved the quality of child protection plans.

There were a number of reported unintended consequences, including that working systemically and restoratively could be emotionally intense for family members and there was a risk of dependency given the intense nature of support. For the Edge of Care team, systemic work with families who have complex and complicated issues could be very fatiguing and cause burnout. At a system level, the Edge of Care team's low caseloads and the time afforded to them to work with families could be hard for other frontline professionals to observe.

The recommendations for developing the approach from interviews included expanding the service to work with more families, developing an out-of-hours crisis response and developing an Edge of Care consultancy offer for social care and early help. It was also suggested that they could share advice and training with other local authorities and support a national peer network of relevant services.

Exploratory research to adapt the approach to Early Help

Given that the Edge of Care team were separate from the Early Help service, additional research was conducted to understand how their systemically informed approach could be adapted to Early Help. This included:

- delivering training in systemic practice
- rolling out reflective practice supervision groups, formulation meetings, systemic tools and an NVR parenting programme
- embedding the Edge of Care team in Early Help as part of a co-located team sharing their expertise and learning and having protected caseloads
- setting up a Centre for Systemic Children's Work within the local authority as an evidence-based hub which would operate as a centre for training and ongoing professional development and supporting practice.

Starting with a pilot of basic training and use of systemic tools was suggested to start the process. However, the evaluation team would caution implementing only specific elements (such as certain tools or light-touch training) with a wider workforce without considering how this could dilute the critical features of the team's systemic approach. Thought would need to be given to how the critical elements such as low caseloads, a small team and a specific culture (which may not be able to be rolled out) could affect its impact elsewhere.

Conclusion and recommendations

The systemically informed Edge of Care offer to families, including intensive support from a family intervention worker with a small caseload, therapeutic clinics, parenting programmes and use of their Outdoor Education Centre all appeared to be working as intended. The team appear to have been important in Rotherham's improvement journey progress, keeping children safe and creating sustained change in their lives for families with very complex and often entrenched issues leading to them being on the edge of care.

Recommendations on delivering the approach

The evaluation team recommend that core components of the approach, including a package of systemic training supported by group reflective practice sessions, systemically informed supervision and formulation meetings, are sustained and built on. Cuts to training budgets and the pandemic appeared to impact training, reflective practice sessions and face-to-face delivery. Most of these were beginning to be restored when fieldwork took place. We would recommend that these are fully implemented.

The use of the Sessional Rating Scale, Outcome Rating Scale and SCORE-15 seemed to be working well in a small pilot as part of the evaluation and we would recommend consistent use of the tools by all members of the team for all families supported.

Multi-agency partnership working was a core component of the approach and appeared to be working well, especially with social care, where there were clear processes through the Edge of Care Panel and the formulation meetings. We would recommend these are developed – for example, the planned additional joint supervision days with the Looked After Therapeutic team. The evaluation team also recommend the team support the use of systemic practice throughout the local authority, particularly Early Help, possibly in a pilot of systemic training and tools in a number of Early Help teams.

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 Edge of Care systemically informed approach. The evaluation team was unable to identify or construct a sufficient counterfactual (that is, a control group) which would support a future impact study by the team. The evaluation team would therefore recommend that efforts be made to conduct a small-scale impact evaluation on the piloting of systemic training and tools in Early Help teams to inform future impact studies on similar approaches in other areas.

The evaluation team would also recommend that Rotherham continues to assess both the implementation and the impact of the Edge of Care systemically informed approach.

In terms of evaluating implementation, this could include:

- improving management data collection on the key components of the approach, such as frequency, participation and engagement by practitioners and families
- regularly collecting feedback on the approach, including what is working well and could be improved, from practitioners and key stakeholders
- considering collecting the views of families to understand their perceptions of the support they receive.
- In terms of evaluating impact, the evaluation team recommend collecting data on key outcomes identified in the theory of change in order to measure change over time and begin to assess the impact of the Edge of Care service. This could include:

- enhancing the data already collected on whether children have been stepped up or down in children's services by linking it to other administrative datasets. For example, involvement in crime and antisocial behaviour, school absences–exclusions or educational attainment
- continuing to administer validated outcome measures for all families who are referred into the service, such as the SCORE-15, and considering using additional validated outcome measures on mental health and wellbeing. These measures could also be administered at set timepoints after the closure of support. In addition, validated outcome measures could be selected and administered before and after specific interventions such as Triple P, NVR or the therapeutic clinic
- collecting comprehensive data on practitioner outcomes such as increased skills and confidence in systemic practice, as well as their wellbeing and burnout through validated outcome measures such as the Professional Quality of Life Scale.

1. Introduction

Project context

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 an 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. Feasibility and pilot studies aimed 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).

Promising approaches were selected based on an initial assessment of the evidence, in which the Department for Levelling Up, Housing and Communities prioritised topics with potential. One area 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 needs. It is hoped that this will strengthen family relationships and make positive change.

After a joint EIF and Department for Levelling Up, Housing and Communities call-out to local authorities (LAs) and initial scoping, EIF identified three areas with promising approaches on this topic.

This report focuses on one of them: Rotherham's systemically informed approach in their Edge of Care team.

1 Department for Levelling Up, Housing and Communities. 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

Rotherham Metropolitan Borough Council was recently recognised by the *Local Government Chronicle* as the most improved council[4] in the country. This was in recognition of its improvement journey since being placed in intervention from February 2015 to the restoration of powers in March 2019. Children's Services were judged as 'good' by Ofsted in August 2022. Rotherham's Edge of Care service sits within the Early Help and Family Engagement Service in the Children, Young People and Families Directorate and was established in 2017.

Before the Edge of Care team was set up in 2017 there had been a consistent upward trend in the numbers of looked-after children to 488 at the end of December 2016 – a 9% increase over the course of 2016 alone. While this trend was reflected across many local authorities in the Yorkshire and Humber region, at a rate of 86.5 per 10,000 children (December figures) this was significantly above the statistical neighbour average of 64 looked-after children per 10,000 of population (as of 31 March 2016).[5]

Rotherham's Looked After Children Strategy 2017–20[6] set out that 'by investing in the recruitment and development of a dedicated team of practitioners [Edge of Care] offering a range of services to support children to remain living safely with their immediate or extended families they will be given the best chance to thrive without long-term reliance on services. This provision is projected to achieve a net reduction of 69 LAC [looked-after children] over the 3-year period of this Strategy'.

As a result, the Edge of Care service was created to work systemically with very complex and vulnerable families and children who are on the edge of care. They were set up to support families to remain safely in their home environment or be reunited within their family/kinship networks where it was safe to do so. Where it was not considered safe for this to happen, their role was to support families to have the best form of family life or contact with their child/young person.

While the number of children in care and on child protection plans has decreased since the Edge of Care team was created, there were still high levels of children within children's services. According to 2019 data from the Children's Commissioners,[7] there were 500 children who had an open child protection plan in Rotherham (8.7 children in every 1,000, which was the 97th highest percentile out of 100 nationally) and 642 children who were in care in Rotherham (11.2 children in every 1,000, which was the 90th highest percentile out of 100 nationally). In addition, when looking at child in need (CIN) episodes (excluding looked-after children) Rotherham had some of the highest rates nationally where domestic abuse, mental health issues or substance misuse was identified in the household.

The Edge of Care team was originally set up within the wider Early Help service to work with very complex vulnerable families on the edge of care. It then moved into the looked-after children's service and was closely aligned with children's social care before moving back as a small multidisciplinary team in Early Help in 2021.

4 Rotherham MBC. News. Local government awards – Rotherham is 'most improved council'. https://www.rotherham.gov.uk/news/article/586/local-government-awards-rotherham-is-most-improved-council-#:~:text=Rotherham%20Council%20has%20been%20named,London%20on%2020%20July%202022

5 Rotherham MBC. (2016). Rotherham Looked After Children and Care Leaver's Strategy 2017–20. p. 16. https://isabelsvoice.azurewebsites.net/content/upload/1/root/rotherham-looked-after-children-strategy-3.pdf

6 Ibid.

7 Taken from the 2021 Children's Commissioner's local vulnerability profiles. https://www.childrenscommissioner.gov.uk/vulnerable-children/local-vulnerability-profiles

Approach being evaluated

In line with best practice, we use the template for intervention description and replication (TIDieR) checklist to set out the approach being evaluated.[8] Information included in the description below was gathered in an initial scoping phase through interviews with the team manager of the Edge of Care team and clinical psychologist, a theory of change workshop as well as data provided by Rotherham and evidence gathered on identified activities or approaches.

Brief name

Rotherham's systemically informed approach within their Edge of Care team.

Why

The Edge of Care team was established as a response to high numbers of children entering the care system whose families had multiple and complex needs and were not engaging in support or statutory services.

The team was created as part of the transformation of Children's Services and the launch of an Early Help Offer in 2016 in response to Rotherham's improvement journey needs. It was set up to provide intensive support for very complex and vulnerable children (on the 'edge of care') to support them to remain safely in their home environment or be reunited within their family/kinship networks. It was underpinned by evidence about the traumatic experience, the significant emotional distress and poor outcomes that can result from taking a child into care and the positive impact the use of systemically informed practice can have on supporting families with children on the edge of care.

What

The approach is rooted in systemic principles and practice where the team receive training and attend reflective systemic practice sessions, individual and group supervision and case consultation.

There are a range of core activities that make up the systemically informed support offer for families who receive a mix of these core activities based on their needs.

- **Family intervention offer.** A family intervention worker (FIW) works as a key worker applying a systemic methodology which includes a systemic formulation meeting with associated professionals, and an action plan co-created with families. Tailored practical and emotional support is offered by the FIW to the family through parenting advice and guidance, talking therapeutic work and support to access specialist services such as Child and Adolescent Mental Health Services (CAMHS), adult mental health and substance misuse.
- **Interventions.** Families have access to two parenting interventions delivered by the team: (i) a range of Triple P Parenting programmes and (ii) Non-Violent Resistance programme (NVR).
- **Therapeutic clinic.** The work is systemic in focus and tailored to the needs of the family member/s.

8 Hoffmann T. C., Glasziou, P. P., Boutron, I., Milne, R., Perera, R., Moher, D., et al. (2014). Better reporting of interventions: Template for intervention description and replication (TIDieR) checklist and guide. *BMJ*; 348 : g1687. doi: https://doi.org/10.1136/bmj.g1687

- **Outdoor Education Centre.** Used to inform assessments, observe family dynamics, work on and strengthen family relationships and functioning, and develop parenting skills to support the reunification of children.

To support the team in delivering these core activities, they used systemic tools such as genograms, SCORE-15, Sessional and Outcome Rating Scales.

Who provided

The Edge of Care team is a multidisciplinary team made up of practitioners with complementary skills including a team manager and deputy, a clinical psychologist (who undertakes systemic practice sessions, training, individual and group supervision and case consultation), senior parenting practitioner, three FIWs and an administrator.

Where

The Edge of Care team operates out of one location working across the whole of Rotherham, but uses various locations when working with families, such as the Outdoor Education Centre or therapeutic clinics.

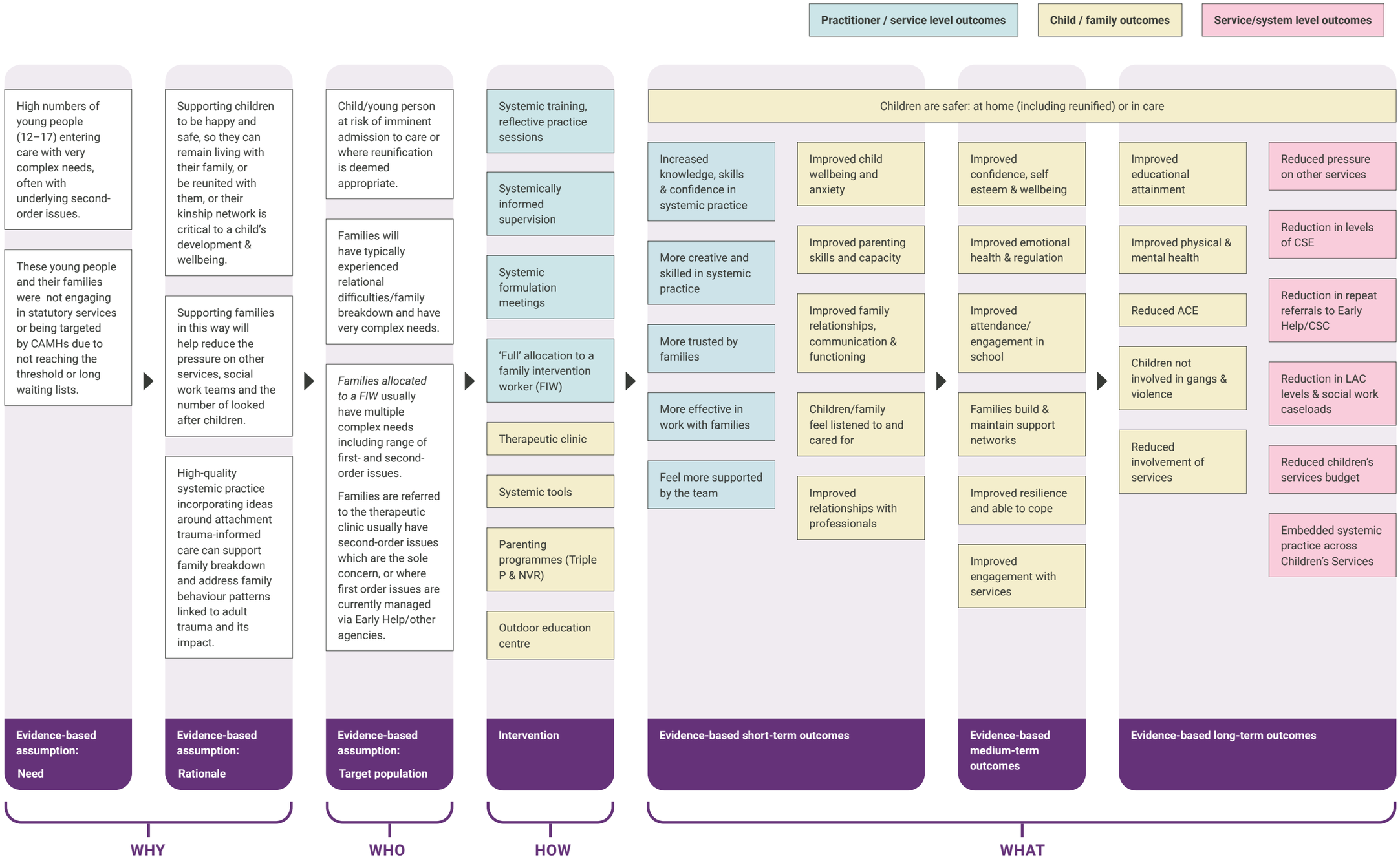
When and how much

Systemic training tailored to the needs of the team was previously delivered by two external systemic practitioners four times a year but, since budget cuts and the pandemic, it has been delivered on a more ad hoc basis. Monthly reflective practice sessions, previously facilitated by one of the external systemic practitioners, are facilitated by the manager, supported by a clinical psychologist. Individual supervision takes place on a monthly basis.

The systemically informed offer is provided to families once a case has been through the Edge of Care Panel. The length of time the Edge of Care team worked with a family was typically determined by where a family as on the safeguarding continuum and their level of risk. In practice, average durations were reported as being between six months (for families with less complex needs) and a year (for families with more complex needs) and could be extended for longer.

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 Edge of Care team.[9]



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

2. Methods

Evaluation aims and research questions

This section sets out the aims and research questions of the feasibility and pilot study in Rotherham.

Evaluation aims

The purpose of the evaluation was to:

- carry out a feasibility study to explore whether the systemically informed Edge of Care team was operating as intended
- explore the feasibility of conducting an impact evaluation of the Edge of Care team via an initial pilot study
- carry out exploratory research to consider how to adapt and scale up the systemically informed Edge of Care team approach to work with families with different and lower levels of need in early help.

Research questions

The evaluation design involved a combination of quantitative and qualitative methods to address the feasibility study and pilot study research questions. The full set of questions can be found in Annex C; below are the main research questions.

1. **Evidence of feasibility**
    - **Fidelity:** Is the systemically informed Edge of Care team operating as intended?
    - **Adaptation:** How does the team's delivery of the systemically informed core activities vary across the team?
    - **Dosage:** How many children/young people and parents/carers are being worked with?
    - **Reach:** Does the team reach the target families in need?
    - **Quality:** Is the systemically informed approach being delivered to a high quality?
    - **Participant responsiveness:** To what extent do families and practitioners engage with the systemically informed approach?
    - **Intervention differentiation:** What is the added value of the approach and how does it differ from business as usual?
    - **Enablers and barriers:** What are the enablers and barriers to successful delivery of the practice approach?
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. **Exploratory research**
   - How would the systemically informed approach need to be adapted to work with families in Early Help?
4. **Evaluation feasibility**
   - What is the most feasible approach to assess the implementation and impact of the Edge of Care approach?
   - Which outcomes are critical to measuring impact and how?

Data collection

The evaluation combined exploratory qualitative research with quantitative analysis of data collected by the Edge of Care team to address the feasibility and pilot study research questions.

Quantitative research

Edge of Care administrative data

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

Pilot of validated family outcome measures

To understand the potential benefits of the Edge of Care's systemic practice approach, the following validated family outcome measures were piloted.

- **Systemic Clinical Outcome and Routine Evaluation (SCORE-15)**[10] was completed by children and young people over the age of 11 and adult family members.
- **Session Rating Scale (SRS) and Outcomes Rating Scale (ORS)** were completed during all face-to-face interventions with families, with all individuals present if it was suitable at the time and the family provided consent.

The measures were administered by the practitioner currently working with the child and family. At the end of the pilot, we asked practitioners to complete a short 25-minute survey of their experiences of using the outcome measures. Findings are reported in the 'Outcomes' section and Annex M 'Piloting regular use of the SCORE-15, ORS and SRS'.

Qualitative research

The qualitative research involved carrying out seven interviews with the Edge of Care team, eight interviews with their key stakeholders from across social care and Early Help and observation of five meetings and sessions delivered by the team. The interviews and observations were carried out between March and July 2022.

Interviews with Edge of Care team staff

A total of seven interviews were carried out online via Microsoft Teams with all but one member of the Edge of Care team. They explored in depth how the systemically informed key worker model, therapeutic clinic and parenting interventions were operating in practice with

10 Child Outcomes Research Consortium. Systemic Clinical Outcome and Routine Evaluation (SCORE-15). https://www.corc.uk.net/outcome-experience-measures/systemic-clinical-outcome-and-routine-evaluation-score-15

young people and parents/carers. The content of each interview was based on a topic guide which outlined the main topics to be addressed during interviews, but they were tailored to the role and experience of each participant (the topic guide is included in Annex H). Interviews typically lasted about 90 minutes, but ranged from 45 minutes to four hours. They were digitally recorded with the participants' informed consent.

Interviews with key stakeholders

To complement our understanding of whether the systemically informed Edge of Care approach was operating as intended we carried out eight interviews with a range of their key stakeholders. These interviews were carried out online via Teams with six managers from a range of teams within social care and two members of Early Help.

The content of each interview was based on a topic guide which outlined the main topics to be addressed during interviews but were tailored to the role and experience of each participant (an example of a topic guide is included in Annex H). Interviews typically lasted up to an hour and were digitally recorded with the participants' informed consent.

Observation of key Edge of Care team meetings and training

Observations of the key Edge of Care team activities were carried out to provide valuable additional learning about how the systemically informed approach operated in practice. Observations were carried out of a training session, formulation meeting, supervision meeting, an Edge of Care Panel meeting and an NVR parenting session.

We used our observational template[11] and adapted it to this context to support the collection of observational data. We did not record any of the observation sessions or note any identifiable or personal family data. Observations were carried out online, via Teams.

Analysis

Quantitative research

Administrative data

Summarised administrative family data was provided by the Edge of Care service, reported yearly from the establishment of the team in 2017 to 2022. No statistical analysis was performed on the data but descriptive statistics are provided in the report from the summarised data, such as the number of individuals referred to and supported by the service.

Piloting validated family outcome measures practitioner survey

Quantitative survey data was collected from practitioners, using Microsoft Forms, regarding their experience using three outcome measurement tools as part of the pilot: the SCORE-15, and the SRS and ORS. Data was collected from the period 3 to 23 August 2022 and three practitioners responded to the survey, with a response rate of 42.9%. Quantitative data was supplemented with free-text qualitative data collected in the survey where relevant. More information can be found in Annex M 'Piloting regular use of the SCORE-15, ORS and SRS'.

Qualitative data

The interviews were recorded, transcribed and then analysed using a framework approach. This involved summarising and synthesising each interview into a framework which was organised around the key questions the evaluation was addressing (for example, the

11 Early Intervention Foundation. (2020). Reducing parental conflict: A practical evaluation guide for local areas. Observation guide template. https://www.eif.org.uk/files/resources/rpc-eval-observation-guide-template.docx

systemically informed delivery model, enablers and barriers to systemic practice, views of Edge of Care, perceived outcomes). There was a separate Excel worksheet for each question with columns representing the key themes that the research question addressed and the rows contained the summarised (charted) data from each participant. This allowed for the full range of views and experiences to be compared and contrasted in a systemic and comprehensive way. It also ensured that the findings can be traced back to the accounts of participants. Observation notes were written up as detailed notes within the observation framework.

Anonymised quotes from the in-depth interviews with the Edge of Care team and stakeholders have been used to illustrate the findings throughout the report.

Study limitations

There are a number of study limitations that should be noted.

Overall, the evaluation activities were carried out over a short period of time. Compressing the timescales limited the extent of the qualitative and quantitative fieldwork.

Qualitative data

The original intention had been to carry out some qualitative work with families being supported by the Edge of Care team. However, this did not go ahead for two key reasons. First, the timescales would have meant contacting families without proper due diligence being undertaken to ensure families were not adversely affected by talking about the support they received, which could have brought up difficult experiences. 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 systemically informed practice. This meant the relevance of the data would have been limited and may not have justified the potential burden that the research could put on families taking part in qualitative research.

With more time, it would also have been possible to observe an Edge of Care clinic day and a reflective practice session and to interview a wider range of stakeholders from across Early Help and social care to explore their reflections on working alongside the Edge of Care team. Fieldwork was conducted shortly after the easing of most restrictions as a result of Covid-19 and the service was in a period of transition as a result. This impacted on the team's practice and the support they provided to families, which we observed and received data on.

All participants were very generous with their time and reflections and fully engaged with the evaluation. It should, however, be noted that participants may have felt reticent about reflecting on the practice of colleagues who they worked closely with, either in the Edge of Care team or in social care or early help.

Despite the limitations set out, we believe we have been able to carry out a very comprehensive evaluation and addressed our key evaluation questions. The sample included all but one member of the Edge of Care team and a good representation of the leads from the different social care teams. This has hopefully ensured we have a good understanding of how the Edge of Care team were operating in practice. In addition, we were able to draw on data: from qualitative observations as well as management, administrative and outcomes data. This level of triangulation provides more assurance to the findings we have provided.

Quantitative data

Administrative data

There were a number of limitations with the administrative data that should be acknowledged. The data was aggregated and with no comparison group it is difficult to

attribute impact. For example, attributing of the step-up or step-down of families from children's services to the support received from the Edge of Care team.

Ethics

The evaluation has followed EIF's ethical guidelines, which were set out in the evaluation protocol. To ensure all participants were able to give informed consent we provided participants with a clear and accessible information sheet (see Annex E). To gather consent for taking part, we issued participants with a consent form which includes explicit statements about what taking part would involve and how data collected would 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 they did not have to participate in research activities and could withdraw at any time. To reduce the research burden, we minimised the burden placed on participants by ensuring qualitative interviews and surveys were kept short and that outcome measures were short and easy to complete. To ensure inclusion in research, we selected appropriate methodology to ensure no group was unreasonably excluded from the research. When conducting the research, we were aware of and sensitive to cultural, religious, gender, health and other issues in the research population, always acting in a non-discriminatory way.

Data protection

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 on the EIF website, https://whatworks-csc.org.uk/privacy-policy, 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. Rotherham's Edge of Care service shared case management information and administrative data on the running of the service, including data on training, consultation sessions and practitioner demographics. The service removed any identifying information from the data so that names and other identifying information not necessary for the evaluation were removed or replaced with a code. Therefore, all data was pseudonymised or fully anonymised.

3. Findings

This section reports on the findings of the evaluation of Rotherham's systemically informed approach within their Edge of Care team. It assesses the implementation and delivery of the systemically informed approach, the identified enablers and barriers to delivery and evidence gathered on the impact of the approach in addition to recommendations made by participants for further development.

Implementation and delivery of the systemically informed approach

The following section assesses how the systemically informed Edge of Care team's core elements are currently being delivered. This includes a package of systemic training supported by supervision and reflective practice and systemic formulation meetings, as well as systemic therapeutic support offers to families and tools to support these. Partnership working with other services is also detailed, as is the reach of the service and how it is different from other services in Rotherham.

The Edge of Care team

The Edge of Care team is set up as a multidisciplinary team, made up of practitioners with complementary skills and experience. At the time of fieldwork, there were eight permanent members of the Edge of Care team[12] and a clinical psychologist student; the permanent team included:

- a team manager who leads and manages the team. They provide clinical guidance, training and supervision for team members. They also run a therapeutic clinic one day a week for up to five individuals/families and deliver and supervise advanced non-violent resistance (NVR) training
- a deputy team manager, a qualified social worker, who assesses risk and ensures they are working within child protection legislation. They lead on the reunification pilot pathway, deliver and supervise advanced NVR training, hold a caseload of between five and eight families and supervise team members
- a clinical psychologist who works two days in the team – one day is spent creating clinical formulations, providing clinical supervision and guidance. The second day is spent running a therapeutic clinic typically seeing up to five families/individuals
- a senior parenting practitioner who is trained to Level 5 in Triple P complex family work and advanced NVR. They lead on the parenting assessments and deliver advanced NVR and Triple P Parenting interventions. They also supervise team members and hold a caseload of between 10 and 12 families

12 Four of the founder members of the team were still in post: the team manager, deputy team manager, clinical psychologist and senior practitioner and parenting lead.

- three family intervention workers (FIWs) who each hold a caseload of around five families and deliver advanced NVR and Triple P Parenting interventions. One of the family intervention workers is an NVR supervisor and carries out trauma stabilisation work with families. The current team members joined during 2019 and 2021. They have backgrounds in counselling, youth work, teaching and family support in a pupil referral unit (PRU), Early Help in Rotherham
- a practice support worker who supports the team coordinating referrals and organising formulation meetings, the Edge of Care Panel and NVR courses. They are also trained in advanced level NVR.

In addition, the team often have clinical psychology students for long placements contributing to education and wider team work, adding capacity for the team.

Annex L provides a diagram of the team structure. Since carrying out the interviews in spring 2022 the clinical psychologist has left and been replaced with another clinical psychologist,[13] and the senior practitioner was on a six-month placement as part of their training to become a social worker. Apart from the practice support worker, the core members of the team hold a caseload of families.

Edge of Care's systemically informed approach

The systemically informed Edge of Care model is premised on the need to tailor and adapt the approach to the presenting needs of individual families. There is no specific blueprint to follow but instead a systemic philosophy which provides a systemic framework, a set of ideas, key principles (see below) and tools which are adjusted to the family make-up and dynamic, their family history, their experiences and relationships, their needs, their age, any previous experience of trauma and the preferred learning style of family members.

The systemic framework was described as providing a focus and structure to guide the way the team formulated and planned their work and ordered their thoughts. The systemic philosophy was described as being like an umbrella with a set of ideas and concepts which were adapted to the people they were working with. The team explained that they aimed to embed systemic thinking in everything they did to bolster the quality of their practice, so it became almost intuitive.

> *'I wouldn't sit there and think, oh, I did that systemically. I'd be like, I've done it and it's worked. It's really, really good. And then afterwards I'll sit back and go, alright? Actually I didn't realise I did that.'*
>
> **Edge of Care team member 3**

All the team members reflected on how they tailored and adapted their systemic approach and use of the tools to each individual family and their different levels of need. They were constantly adjusting their focus, reassessing their approach, drawing on different techniques as they responded to the presenting concerns of family members.

> *'We have a referral form that tells us what people would like us to do. And we… obviously we have targets and goals and we do an action plan for how we get there. It's very much based on an individual…agreement, review and analysis of that particular family. It's not taken out the Triple P…book…and…going to do this step by step, and we're going to cover the first chapter before the 2nd; that's not gonna work.'*
>
> **Edge of Care team member 3**

13 They work three days a week with the team and work in the local Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) Child and Adolescent Mental Health Service CAMHS for their additional two days.

CASE STUDY 1

Systemic principles rooted in the Edge of Care team approach

- Ensuring the voice of the child is central, with the child considered and made present even when working with just the parents/carers.
- Non-expert, neutral, curious.
- Being aware of how the family processes operate and being able to make these apparent to the family.
- Being able to work systemically with children in relation to their parents and vice versa.
- Being able to work with families to understand and productively use the influence of their family history and traditions.
- Helping to enable family members to recognise options they have not been making use of through both conversation and action.
- Collaborative exploration of strengths and resources of family members that they can bring to bear to support each other.

Members of the team who had also been trained in trauma-informed approaches reflected on the importance of being able to view a family's problems through a 'systemic and trauma-informed lens'. Combining both approaches enabled them to support and address some of the deep-rooted issues that might be impacting on parenting or a child's emotional health.

In the sections below we present the evidence for how each of the core elements of the systemic approach appeared to be being implemented by the Edge of Care team as intended.

Developing systemic skills: training and reflective practice

The founder members[14] of the team all received training in systemic theory and practice to a level that was commensurate with foundational level systemic training. The training programme was tailored to the needs of the Edge of Care team and delivered by two experienced systemic practitioners four times a year. The training covered an understanding of systemic theory and practice along with the core tools to support practice, which included: interventive interviewing (that is, lineal, circular strategic or reflexive questions), sculpting, scaling, internalised other interviewing, externalising questions, narrative ideas and relational genograms. These were underpinned by the principles of neutrality and curiosity.

Alongside the formal training, one of the trainers who was a qualified systemic supervisor facilitated monthly reflective practice sessions with the team where they learned more about applying systemic theory to their practice.

The budget for the external training and reflective practice sessions was cut in 2019. From this point the training and reflective practice sessions were delivered, less frequently, by the team manager with the support of the clinical psychologist. Subsequently, all formal training and reflective practice sessions were paused during the pandemic, which affected the FIWs who joined the team during this time. Their induction to the team consisted of two days with the team manager delivered on Teams and in person. This was complemented with what they described as equally important '*learning on the job*', shadowing team members, attending formulation meetings and working closely with the team manager who supported their development and observed their practice.

14 The team manager, the deputy manager, the clinical psychologist and the senior practitioner and parenting lead.

> *'I learn so much every day from everyone around me. So like formulations…You learn the knowledge side of things, but also the way that people phrase things or the way that they might ask a certain question and the style. So it's been really helpful shadowing people and attending formulations and things like that. I've found that to be really, really useful.'*
>
> **Edge of Care team member 6**

Since the end of the pandemic the team had reinstated their ongoing learning and practice development days run by the team manager and the clinical psychologist. The first of these was held in May 2022 and provided a brief overview of systemic theory, practice and tools. It also covered the use of the outcome rating tools Outcome Rating Scale (ORS) and Sessional Rating Scale (SRS), as well as the SCORE-15 (see Systemic tools below).

As part of their ongoing continuous professional development (CPD) all staff also attended training on safeguarding, trauma and attachment. In addition, each member of the team was also encouraged to take on a specific area of systemic practice to study and develop expertise on which could be shared across the team.

From interviews and observation of the training in May 2022, while there had been changes to training and CPD in terms of who delivered them and their frequency – which appeared to be partly due to budget cuts and the pandemic – **it appeared to be taking place as intended**. For example, a team member reflected on how the training helped to provide the ideas and tools for how to work systemically with families, which they were then encouraged to apply and adapt to the needs of each family.

It also appeared that the ***reflective practice sessiozns*** **were being delivered as intended**. Team members brought a case they wanted to discuss and may have been struggling with which was used as a basis to try out the different techniques they had learned in training sessions. They would work as a group discussing and thinking together and engaging in role play. These sessions were described as a safe place to get things wrong and to learn how to work systemically. As a result of this shared learning experience the founder members reported feeling closer and stronger as a team.

It was, however, acknowledged that the Edge of Care team had lost some of its focus as a result of the pandemic, the recent staff changes and not having access to regular external training and reflective practice sessions. At the time of the evaluation the team were planning to reinstate their monthly reflective practice sessions facilitated by the clinical psychologist as well as regular external training.

Supervision

Individual supervision was provided monthly for all members of the team. Like reflective practice sessions, supervision was viewed as being critical for helping to apply the learning about how to use systemic techniques. Supervision meetings provided time for an individual to discuss any cases they were struggling with, to share good practice, to have their achievements celebrated and to reflect on their wellbeing.

> *'So it's a way of sort of checking everything. So checks your wellbeing, checking your safety, checking your actual work and your progress, and then giving you sort of ideas [for] moving forward as well. So yeah, really beneficial.'*
>
> **Edge of Care team member 6**

It appeared that the supervision sessions were being run as intended as they were reported by the team members as providing a safe place to reflect on their feelings and the impact their cases were having on them and to explore their own 'triggers', which in turn helped them understand how this might be affecting their work with families. Moving forward the team were going to have additional joint supervision days with the Looked After Therapeutic team.

The supervision provided by the Edge of Care service with their core systemic focus was also favourably contrasted with previous supervision experiences in other services. These were described as feeling more like a 'tick box' exercise where managers would follow a process but did not have the experience to be able to support an individual's practice effectively.

Edge of Care core activities with families

As set out in the section 'Approach being evaluated', there were a range of core activities that made up the support offer provided to families once families had been referred to the service and gone through an Edge of Care Panel. Families received a mix of these core activities based on their needs. Annex L provides a diagram of the team structure and core activities with families.

Referrals – Edge of Care Panel

The main referral pathway to the Edge of Care service was via the Edge of Care Panel. The team received 57 referrals in 2021/22, a decline on previous years, believed to be mainly due to a better understanding of the range of families the service supported by those referring into the team.

The Edge of Care Panel was held every week and chaired by the head of safeguarding. Before the panel meeting, a social care assessment will have been completed by the social worker involved with the family. The lead social worker will also present the case to the panel, outlining the type of support they believe the family require and their reasons for this.

The panel considered a range of options including full allocation to Edge of Care, or the therapeutic clinic, or one of the NVR or Triple P programmes (see below for details on each). Cases that were not felt to be appropriate for the Edge of Care team could be offered a formulation meeting to help reflect in more depth about a family or referred to Early Help or another service. Otherwise, referrals were made for NVR via the reunification pathway or, more informally, by contacting the Edge of Care team manager for NVR, Triple P or ad hoc consultation from the team.

Based on our observation of the **referral panel, it appeared to be operating as intended having developed an efficient and effective approach for discussing cases**. It was clear that participants were well prepared for the meeting. The chair had a clear understanding of the families who were most appropriate for the Edge of Care team, which helped to streamline the discussion and decision-making about cases. The Edge of Care team reflected that the families they worked most effectively with were:

- families who would benefit from an intensive systemic approach but were not meeting criteria for accessing support from CAMHS
- families where children have become looked-after, but parents have shown capacity to/or progress towards a point where reunification may be possible
- the most complex families who are either complex 'legacy' families or those where there are significant levels of complexity.

The stakeholders interviewed in social care and early help **all appeared to have a clear sense of the eligibility criteria for the Edge of Care service and were aware that these were strictly enforced because of the Edge of Care team's capacity levels**. The most appropriate referrals to the panel were described as those where the families have experienced quite significant trauma and where social workers had a clear idea of what they needed from Edge of Care. It also helped if families had already worked with Early Help to address any first-order and parenting issues. Conversely, an Edge of Care team member said professionals who lacked an understanding about Edge of Care could result in making inappropriate referrals.

Being a small team, Edge of Care lacked capacity to work with all the families that were referred to them and this resulted in some families being placed on a waiting list for between four and eight weeks. This limited the '*window of opportunity*' that Edge of Care had to work with families on statutory timescales. There was also the risk that any delay for a family could result in their problems becoming too entrenched or acute for Edge of Care to work with. This situation was also described as occurring when social workers made a referral too late.

> *'We may refer a case through to Edge of Care for some support, but the backdrop to that is, that child and their carers may have been experiencing some difficulties for the last 12, 24 months before we become involved and actually, at that point, that we refer to Edge of Care, they may be already experiencing that blocked care…And we are already dealing with parents that have already had too much or…they have just had enough and they're just saying I don't want any intervention and obviously E of C is voluntary as well. So if you haven't got parents signing up to that that's also very difficult in a point of crisis. So I don't think there's anything that could be changed to prevent it other than the capacity issue and the earlier allocation of a worker could remedy some of that.'*
>
> **Stakeholder 6**

Views were divided about when was the best time to work with families and how easy it was to ensure that a referral happened at that moment. Being at a crisis point was often not believed to be the best time to work in a meaningful way with families, because their emotions were heightened and that made it harder for them to engage in any support. It was said that families in crisis typically needed trauma stabilisation support before they were felt to be ready for an intervention. Conversely, it was also acknowledged that some families needed to reach crisis point before they were ready to engage.

On balance, there was agreement that it would be helpful if referrals could be made at an earlier stage as long as the team had sufficient capacity to manage this and those referring were able to identify whether any trauma had been experienced.

Family intervention offer

For families on 'full allocation' a FIW worked as a key worker (along with other Edge of Care staff where appropriate) applying a systemic methodology. Figure 2, below, provides an overview of how a FIW worked with families. They aimed to make contact with a family within seven days of the referral. While stakeholders reported that some families were put on a waiting list for between four and eight weeks, the proportion of families contacted within three working days on full allocation had steadily increased since the team was established, with just under two-thirds of families having been contacted within three working days between April 2021 and March 2022 according to data provided by Rotherham.

During the initial phase a FIW built their systemic hypotheses which they explored with family members. **Systemic formulation meetings** (see Figure 3 below) were held during the first stages of working with a family but the exact timing depended on the amount and type of preliminary work that needed to be completed with each family.

From observations of the meetings and interviews it appeared that the systemic **formulation meetings were working as intended**. The Edge of Care team described the systemic formulation meetings as the 'golden thread' as they encouraged all who attended to reflect, explore and be curious about a family. They were viewed as a critical part of the systemic therapeutic process but were also offered sometimes to support social workers as a '*tool*' or '*intervention*' when they were '*stuck*' with a family.

CASE STUDY 2

How a family intervention worker (FIW) works with families – the intervention process

Once a FIW was allocated a case they discussed the referral with their manager, read the background information and contacted any other professionals who had been working with the family.

They might initially phone the family to introduce themselves before making a joint visit with the social worker. During the first visit they explored whether the family were emotionally ready to work with them and any concerns parents had about the service. They introduced the assessment tools and routine outcome measures (SRS, ORS and SCORE-15) and explained how they would be used to track progress.

They worked in a collaborative and non-judgemental way – working 'with' rather than 'doing to' the family.

The initial phase of systemic formulation involved trying to build a therapeutic alliance with the parents. They worked together on the action plan, ensuring it captured the nature of the family relationships, their family history and their strengths. Throughout these discussions they were building systemic hypotheses about the family and checking their assumptions with them. The child was always at the centre of their approach, but they often needed to support the parents first and address their emotional needs, relationship and parenting issues. Depending on the circumstances and the other professionals involved, they may decide it is not appropriate to work directly with a child/ren. They held a systemic formulation meeting (see Figure 3) at some point during this stage.

During these introductory conversations the FIW spent time listening to a family, slowly exploring their previous experience of services, being open and curious with them. They used circular and reflexive questioning which helped to draw out the family history and to reflect on parenting styles and influences on these. They also listened out for any experience of trauma. Family relationships were explored through the relational genogram and the therapeutic timeline was used to encourage a parent to tell their story and to understand their behaviour patterns. FIWs also relied on their 'gut senses' and 'honest feelings' about a family, which they discussed in supervision and formulation meetings.

The FIW worked as intensively as was needed with the families, which ranged from contacting families up to three times a week and every day when in crisis. They tailored their approach and support to meet the goals and needs of a family. This included providing parenting advice and guidance, practical and emotional support, accessing specialist interventions such as CAMHS, adult mental health or substance misuse. They also acted as advocate for the family with other professionals.

The FIW co-worked the family with the social worker who was the lead practitioner, attending core group meetings, and child protection conferences as needed. They also worked alongside other professionals such as mental health teams, CAMHS and schools professionals.

They managed and facilitated the closure process with options for closing without any follow-up contact; closing with follow-up contact initiated by the Edge of Care team within two months; and closing with the offer of a 'bank' of three contacts for families to use when they need.

Formulation meetings were widely praised and valued by stakeholders as a key component of the service Edge of Care provided. Bringing together busy professionals and encouraging them to take a step back, to slow down their thinking, to be open to different ideas and perspectives, was identified as being 'really effective' and helped to win the 'hearts and minds' of busy professionals. During this time period, they also co-created an action plan which was rooted in the Signs of Safety operating model, allowing FIWs and families to reflect and respond to three core questions which asked about what was working well, what they were worried about and what needed to happen. This was shared with the family and other professionals and used to track and review their progress.

The time taken to contact families, hold a formulation meeting and co-create a customised action plan appeared to be based primarily on when a FIW perceived a family to be ready to engage with the process. More recently the Edge of Care team have agreed timescales for the completion of key documents to bring the team more in line with Early Help and to encourage a more dynamic approach.

The typical caseload for a **FIW was set at around five families but could increase to eight families depending on the size of the family, the complexity of their needs and the intensity of work required**. As far as was feasible managers aimed to ensure FIWs had a balanced caseload of families who were at different stages of their intervention.

FIWs reported that they carried out around two to three contacts/visits with a family per week in the early stages of their work. From then they stated it fluctuated between once a week to two to three visits a week depending on how well the family were coping, and could increase to every day for families who were in crisis. **A distinction, however, was drawn between the intensity of their work and the frequency of contacts.** They emphasised that even when they visited families less frequently than once a week they were nevertheless working very intensively with them. They regularly reviewed their approach in supervision to ensure that they were not becoming too embedded in a family's life. A manager explained that to avoid families becoming too dependent it was important to encourage FIWs and other professionals to periodically take a step back to see how the family managed on their own.

The duration of time the Edge of Care team worked with a family was typically determined by where a family were on the safeguarding continuum and their level of risk. If their plan closed, or their level of risk reduced sufficiently, then it was assumed that the Edge of Care team would close. In reunification cases this occurred when a young person returned home, and the family were viewed as being able to cope on their own. They sometimes agreed to continue working with families in situations where social care wanted to close a case before the Edge of Care team had completed their therapeutic work.

In practice the average duration they worked with families was between six months for a family with less complex needs and nine to 12 months for a family with more complex needs, and could be extended for longer where necessary. Some families had been worked with for between one and a half and two years. Irrespective of the duration of time, the team said they were always working to 'an end stage' and managing the expectations of families and other professionals about this.

The user data collected by the Edge of Care team provides further insight into the length of their intervention. The average duration of case closures across all reported years was 296 days. There has been a steady increase in the average duration of cases closed in each reporting year, rising from 210 days in the 2018/19 year, through to 295, 328 and 372 days in the subsequent reporting years up to the 2021/22 year. Although the average length of intervention is below 12 months, there was a proportion of families who received support beyond this period. Views from the Edge of Care team suggested that this was due to an increase in appropriate screening through the panel and reflected the complexity of the

CASE STUDY 3

Systemic formulation meetings

Systemic formulation meetings were described as a reflective space for all professionals involved with a family to discuss a case. The meetings were typically organised early on in their work with families, but could be held at any point during their work with a family. The meetings were held on a weekly basis, lasting up to three hours to ensure there was time to slow down their work and discuss and reflect on a family. Since the pandemic they have been carried out online.

The formulation meetings were facilitated by the Edge of Care team manager or the clinical psychologist. They steered the meeting and created a safe and supportive space to engage all who attended in 'honest reflection' about the way they had been working with a family. Participants were invited to reflect on what appeared to have worked, or not, with a family and anything that may have influenced this. They punctuated the start and end of the meeting by encouraging those who attended to share some personal reflections. This was viewed as important for helping to set the context for how participants worked during the meeting and ensured they ended the meeting in a positive and constructive way. At the start of the meeting, participants were invited to reflect on how they were feeling and, at the end, about what they learned and found helpful from the discussion.

During the first half of the meeting the professionals who had been working with the family (such as a FIW worker from Edge of Care, a social worker, family support worker from early help, a CAMHS practitioner and so on) provided a detailed summary of the family and their involvement with services and reflected on the impact this has had on their problems. The professionals (typically the lead social worker and the FIW) who were working with the family collectively provided a profile of family members and any other key people in their family network, drawing on tools such as the relational genogram to illustrate this. They also used a timeline to describe the family history.

At the end of the summary, participants were invited to reflect back on what they heard, to ask questions and to be curious about the family, raising any hunches or hypotheses they had. They then spent the rest of the meeting reflecting on their thoughts and hypotheses, making suggestions about possible causes of the problems and ways to address these, trying out different ideas and suggestions. They may use role play to help act out their thinking, to reflect on the family and to test out some ideas, solutions and ways of working.

families they were working with. It was suggested that Covid-19 may also have had an impact on the duration of time they were working with families for. At year end the total number of cases open that had been open longer than 12 months was 16 in 2019, 23 in 2020, 21 in 2021 and 15 in 2022.

Therapeutic clinic

The Edge of Care team offer a therapeutic clinic where the manager and the clinical psychologist work systemically with family members (children and/or adults) either in their homes or at their office. Families referred to the therapeutic clinic may also be jointly worked with by a FIW. It was estimated that the team had run over 290 therapeutic clinics since the team became operational.

CASE STUDY 4

The therapeutic process

The systemic therapeutic process was described as providing a framework for ordering the team's thoughts and actions as they formulate and think and plan with a family member during sessions. Once a case was allocated, the Edge of Care manager or clinical psychologist prepared for the session by reading the case notes and speaking to any professionals who had been working the family. They described feeling some fear and uncertainty at this stage.

The first step of the therapeutic process involved working hard to engage the individual/family, who may not have proactively sought help from the team and could be feeling anxious about having 'therapy'. During this stage the manager or clinical psychologist worked hard to build their trust by being open about the service and tentatively seeking their permission to work with them. This was described as trying to even out the power imbalance in the relationship by checking with family members whether, for example, it 'would it be all right if I ask you a question' or 'do you mind if I give you a call tomorrow or would a different time be better?' They tried to be as transparent as possible about the therapeutic process by, for example, explaining what they would be doing during sessions and the information that would be shared. They also tried to talk through their approach and reasoning, to avoid the family wondering or worrying about what they were thinking.

The next step involved working with the family to explore their views of the problem and its causes and then comparing their reflections with that of the professionals. They then agreed a plan for addressing the problem. This was described as a systemic recursive process, as working out ways to address a problem also helped to inform understanding about its causes. Similarly, talking about why something was happening could influence the views and behaviour of family members. At all times the manager or clinical psychologist would be observing, noticing and reflecting on any changes that occurred during sessions. They described the formulating process, the most time-consuming part of the work, as happening live in the room and being co-created with the family.

> *'The wondering and creating understanding and ideas is co-created with the family in the room, and that's almost like the theatre that change can kind of happen in and the idea is that change then continues…outside the room in between sessions. And you come back and revisit that in the next session. So I think a lot of it's done live.'*
>
> **Edge of Care team member 2**

The manager or clinical psychologist planned each session based on previous conversations, building on the systemic formulation and the goals that were set at the outset. They may also set some homework for the individual/family to work on between sessions. They drew on a range of systemic tools (see below) which they used as appropriate to support their work and tailored their approach to each individual family and their different levels of need. They used the ORS, SRS and SCORE-15 to help guide the focus of each session and to track their progress.

During a therapeutic clinic the manager and the clinical psychologist will see up to five families/individuals either on a weekly or two-weekly basis. **They typically worked with families for between six months and a year, with the option to extend for longer where necessary.** A description of the therapeutic process can be seen in Figure 4.

From interviews, **it appeared that the therapeutic clinic was operating as intended, with the approach tailored to the specific needs of the family member/s often focusing on low mood, anxiety, a relational difficulty or family breakdown**.

Alongside the clinic, the clinical psychologist and psychologist student provided consultations to predominantly social workers to help support their work with family members with a complex mental health issue. The manager and deputy manager also provided ad hoc consultation, advice, support or case formulation for team managers or social workers in relation to trauma, relational difficulties and the disruptions in the family/ professional system.

Systemic tools

The team drew on a range of systemic tools that played an important role in supporting their practice. The primary systemic tools the team reported using to support their practice were as follows.

- **The relational genogram and ecomap** were reported to have helped to explore the family, their history and relationships, any challenges, difficulties and trauma experienced and the origin of this.
- **Chronologies: The family timeline** was used to explore and understand the family history. By reflecting on aspects of their lives which were positive or showed they were loved, it was also used to help family members to reframe their life journey in a more positive way.
- **Questioning styles such as interviewing the internalised other, circular questioning and reframing** were used to help parents to see their lives differently and build their confidence as they reframed their self-image and encouraged aspirations.
- **Therapeutic letters** were used to share formulation ideas with families in an accessible way. They also helped to convey to a family that the practitioner had listened and understood their perspective. A therapeutic letter was also used to play back some of the ideas that had been shared in a therapeutic session and to leave a family with some questions to reflect on. They had been used, for example, as a tool at the end of therapeutic work with a family, or to punctuate different points in the process. The therapist said they read their letter aloud and then asked the family to reflect on what they heard.
- **ORS/SRS** were used to track feedback on the session (SRS) and outcomes (ORS). They were also valued for helping to lead and guide sessions as they provided an instant snapshot or 'temperature' check of what was going on for a family. Team members reflected on how the ORS feedback at the start of a session could be very helpful for helping to tailor the focus of the session and to respond to whatever might be concerning a family. Similarly, the use of the SRS at the end of the session could help to gauge whether their approach was meeting a family's needs. Acting on the feedback provided in the SRS was also felt to have helped to build trust with a family. More information on the data collected from these tools can be found in the 'Impact of the systemically informed approach' section and Annex M 'Piloting regular use of the SCORE-15, ORS and SRS'.
- **The SCORE-15** was used to provide an overall view of the family dynamics and the nature of any conflict among family members. Team members acknowledged that occasionally families refused to complete the SCORE-15 or they got 'fed up' of completing it at every session. More information on the data collected from these tools can be found in the 'Impact of the systemically informed approach' section and Annex M 'Piloting regular use of the SCORE-15, ORS and SRS'.

Additional tools sometimes used by the team included the following.

- **Cycle of change** was used to understand the stage a family were at and how receptive they might be to a particular therapeutic approach.
- **Live modelling statues** was used to act out and visually reflect how different family members were feeling.
- **Dan Seigel's Window of Tolerance and the hand model of the brain** were used to help work with trauma and understand stress.
- **Gibbs' reflective cycle model of evaluation** helped to evaluate their approach with families and adapt and change as appropriate.
- While not a systemic tool as such, they used **role play** in a range of settings. It was used during reflective conversations with family members, in formulation meetings with other partners and in reflective practice, supervision and training sessions.
- From the evidence collected as part of the evaluation, including the pilot of the SCORE-15 and SRS and ORS, the **tools appeared to be being used as intended**. Team members appeared to be using them **flexibly to help explore and understand a family's history, their relationships, their needs and the support and interventions that had worked or not in the past**. A team member reflected that the tools supported them to help families reframe their story in a positive way, highlighting their strengths, as they often lacked confidence and felt they had failed.

  > *'And so it's not always about going in and saying you need to do this, you need to do that, to use this technique, use that technique. It's about hearing their story and building on strengths and bringing some new knowledge into that kind of system for them to feel empowered to do that. And normally when you give somebody that kind of power, they grow with that.'*
  >
  > **Edge of Care team member 4**

The tools were also used to help identify the issues that needed addressing, how to approach and guide sessions as well as to track progress.

Parenting offers

Families (whether on full allocation or not) could access two main parenting interventions – non-violent resistance (NVR) groups, and Triple P – as well as bespoke individual parenting support led by the parenting lead.

The **Triple P** programme is designed to give parents, who have children living with them, simple and practical strategies to help them build strong, healthy relationships and confidently manage their children's behaviour. The Edge of Care team delivered the Triple P Parenting Group. In addition, as the Edge of Care team were typically working with parents of looked-after children, whose limited contact with their children happened at a contact centre, they also adapted the original Triple P programme to support them in these circumstances. For this Edge of Care Triple P programme, they contracted the programme from eight to four weeks, as three of the weeks in the original programme were based on sessions that were completed at home with their children. They also adapted their Triple P strategies to focus on managing behaviour during a contact setting in a way that encouraged positive family time. At the end of the four-week course, parents were offered two follow-up weekly drop-in sessions where they could discuss their experiences of trying out what they learned on the course. In terms of the content, they encouraged parents to focus on how they used to parent when their children were living with them and to compare this with their parenting experiences during contact sessions. They also invited parents to reflect on how their children ended up in care and to consider how their parenting may have contributed to this. This gave parents a chance to talk about their feelings and to reflect as a group on

the triggers to their different parenting styles. There are around four Edge of Care parenting courses a year, with between eight and 10 parents on each. Using data from 2021 provided by Rotherham, the Edge of Care parenting practitioner has delivered six face-to-face and one virtual 'Edge of Care' Triple P Parenting interventions to the wider 'locality'.

The Edge of Care team has led Rotherham's **Non-Violent Resistance (NVR)** offer, a systemic approach that has increasingly been recognised as effective in managing behaviours including aggression and violence, running away, truanting, stealing, drug-taking and criminal involvement. It was believed to be helpful when responding to the behaviour of children who have experienced trauma and have poor attachments. The Edge of Care team delivered NVR on a one-to-one and group basis. They developed a 10-week group parenting programme which covered the eight strategies that were part of the standard NVR approach combined with some trauma stabilisation reflection work at the beginning and at the end of the course. To be eligible for their NVR group offer, parents had to be open to social care and to have an identified worker (ether a social worker or a family support worker from Early Help) who could support them through the programme. The team run between five and six NVR courses a year, both during the day and in the evening to allow parity of access. Using data from 2021 provided by Rotherham, NVR has been delivered to 77 family groups, most of whom are outside Edge of Care's 'caseload' and referred from Early Help/Locality Social Care.

From interviews and an observation of an NVR session, both the Triple P and NVR programmes had been adapted to fit the needs of the families they worked with. **In their adapted form, they appeared to be working as intended, supporting families to manage challenging behaviours.**

Bespoke parenting advice was also available for parents/carers of looked-after children on reunification, and any parent/carer worked with by the team where it was deemed appropriate. Additionally, the senior practitioner and parenting lead ran an Edge of Care parenting course through the Evidence-Based Hub Parenting pathway, for parents who do not have children in their care.

Outdoor Education Centre

Before the pandemic, the Edge of Care team also offered families a day trip to their Outdoor Education Centre in Crowden, which had supported around 25 families in recent years. The centre was jointly run by the senior parenting practitioner and the Rotherham outdoor education centre team. The families who consented engaged in various outdoor activities such as climbing, zip lining, canoeing and water sports.

The offer appeared to be delivered as intended. It was used at different stages of the team's work with families, during the warmer months, to meet their clinical need. It was usually used near the start of their work with families to **help inform assessments, observe family dynamics, work on and strengthen family relationships and functioning and develop parenting skills to support the reunification of children**. It was also valued for helping to provide a true insight into the family dynamics as family members tended to forget they were working with professionals when engaging in activities such as building a raft, climbing or zip lining. Once families overcame any initial reservations about going to the Outdoor Education Centre they were reported to be overwhelmingly positive about the experience.

Joint working with other services

The Edge of Care systemically informed approach depended on working closely with Rotherham's Locality Social Work and Looked After Children Service. They co-worked with families, attended child protection meetings and joint supervision meetings and involved their social care partners in formulation meetings. They also jointly set up the reunification pilot with the Looked After Children Service. Joint supervision meetings were singled out for

providing a safe space for professionals to explore differences of opinion and to agree a way forward.

Aside from social care, Edge of Care worked with a range of other professionals, including in schools, colleges and with CAMHs workers. Despite being based in Early Help they rarely worked with family support workers as there was a clear delineation between their respective roles and a need to avoid any duplication. Typically, the families that the Edge of Care team worked with had already been supported by Early Help. When a family were allocated to a FIW in Edge of Care, Early Help would bring their work to a close. However, they sometimes remained involved to support a family who were just accessing the therapeutic clinic or a parenting intervention. This ensured that the Edge of Care therapist or parenting practitioner could focus on their specific work and the family support worker could support the family with their other issues.

Reach and value-added of the systemically informed approach

While the Edge of Care team work with only a proportion of families in Rotherham, since becoming operational in September 2017 they have worked with 358 children and were currently working with 41 children, totalling 399 children. Of these children, data suggested that the service was working with the families they intended to work with: that is, very complex and vulnerable families and children who are on the edge of care. For example, as of September 2022, 254 or 63.7% had been step-down and therefore closed to social care.

The Edge of Care team and stakeholders believed they are reaching children who are most at risk of coming into care, or where there is a placement at risk of breaking down, or where they are being reunified back home. Stakeholders emphasised that they worked with a specific and small cohort of families within the edge of care sector who had a long history of social care involvement of at least a year or more.

There were a number of ways in which the systemically informed Edge of Care team was viewed by the team members and their stakeholders as adding value to the range of services that were already in place to support families and children in Rotherham.

It introduced a **new systemically informed approach that was described as empowering and working 'with' rather than dictating 'to' families**.[15] A stakeholder described this approach as providing the time to consider and unpick ingrained generational issues; to recognise the complexity of humans, to break down the barriers and assumptions about the way families were viewed; and to put the '*humanity*' back into their work. This was viewed as being a '*privileged position*', **because of their low caseloads, which afforded them time and space to work with families more deeply, more intensively and for longer**. This, it was argued, enabled them to explore the family history and dynamics, to be genuinely curious and interested about the whole-family system and to get to the roots of problems more effectively.

> *'If you only mend one bit You're not gonna get…the longevity of it because you've got every other element still going on. So it's about trying to make everything in the family better…if you've…got a mum that's suffering really badly with depression or something like that, and the child's obviously displaying behaviours for whatever reason…you can't just help that child. You've got to help the whole system. Because they're living in that system.'*
>
> **Edge of Care team member 5**

Another perceived difference was **more freedom to tailor their approach based on their assessment of a family's needs**. In contrast with other services, it was said they were not tasked with having to deliver a specific or time-limited intervention relating to a particular

15 Rotherham has also introduced their Family Approach, which is in place across Early Help and social care and adopts a similar style of working with families.

issue. Instead, they were described as working with all the different parts of the system around a child and being the 'gel' that kept them together and steered the work in partnership with the family. Linked to this, the team's **therapeutic interventions, and specifically their focus on trauma and attachment**, were viewed as helping to explore the more deep-rooted issues that might be impacting on parenting, or a child's emotional health or regulation.

> *'I think the difference for me [in E of C] is…embedding what I know, whether it's work around trauma, trauma stabilisation. But it's having the time and space to embed that, and that gives a solid foundation and underpins other work…that previously would have probably been a sticking plaster.'*
>
> **Edge of Care team member 1**

A therapeutic approach was also viewed as enabling family members to reflect on their own behaviours which, it was argued, helped to bring about change more easily.

> *'I guess the other thing that is different is they work maybe more intensively than what a traditional offer of maybe early help and they offer one-to-one and family therapy. And I know they try and work in sort of this systemic model where they're thinking about all the different systems that might be affecting a family unit and the circumstances there.'*
>
> **Stakeholder 8**

While relationship-based practice was applied across children's services, the Edge of Care team's systemic approach was valued for **helping family members to unlock and understand their feelings and to build their relationships with each other**.

> *'I think relationship-based practice is important for all of us in any aspect of children's services. But I think there's probably maybe a real emphasis on taking time to build those relationships given the nature of the sort of the issues they're often managing with families or exploring with families. So I guess there's some, maybe more time…to build those relationships.'*
>
> **Stakeholder 8**

Enablers and barriers of the systemically informed approach

Edge of care team members identified the following barriers and enablers to delivering the systemically informed approach.

Tailored approach

The ability to tailor and adapt their systemic approach to the needs of families was a core enabler to the successful delivery of their work with families. The systemic philosophy provided a framework with a set of ideas, principles and practice which were adjusted to the family make-up and dynamic, their family history, their experiences and relationships, their needs, their age, any previous experience of trauma and the preferred learning style of family members. Accompanying the philosophy was a range of systemic tools that were used flexibly to help explore and understand a family's history, their relationships, the roots of their needs and their reflections on previous support they have received.

Appropriate and high-quality systemic training

The appropriate high-quality training, reflective practice and supervision were all viewed as being fundamental to enabling the team to work systemically and achieve successful outcomes with families. **Foundation-level systemic training or equivalent was identified as a critical prerequisite for practitioners to be able to work systemically.** This, it was argued, ensured that practitioners had a good understanding of the different theories, tools and ways of working to support them to tailor their approach to the families they were working with. In addition, the combination of training in both systemic and trauma-informed approaches was also seen as a key enabler to supporting and addressing some of the deep-rooted issues that might be impacting on parenting or a child's emotional health.

The quality of the training delivered to Edge of Care was also seen as being extremely important to enabling effective systemic practice. Quality came from the following three core elements:

- the **extensive knowledge and experience of the trainer/s**, both as experienced systemic practitioners as well as effective trainers
- **the committed and supportive way in which the training was delivered** and the empathetic way they helped them to apply the learning in reflective practice sessions
- the **content of the training**, which was specifically tailored by the Edge of Care manager for the team.

Reflective practice and supervision

Appropriate and high-quality systemic training needed to be combined with **reflective practice and supervision facilitated by an experienced systemic therapist**. This ensured that practitioners could embed and apply the learning from the training in a way that 'calls you back to your principles', gently challenging and encouraging further exploration of new ideas and approaches.

> *'I think…to use systemic ideas effectively in a social care context with families that are struggling or at the edge of care, or even not, you need a context that uses those ideas. And if you don't it will be a bit like when all of us go on training courses and the ideas slip and we're not using them anymore. And if you're forgetting the philosophy…you're forgetting to reflect on what you're doing. Then all of a sudden you're not being systemic anymore.'*
>
> **Edge of Care team member 2**

The founder team members who worked with the external systemic supervisor stated that their reflective practice sessions supported them to learn on a deeper level about the way they were working with families. It gave them the permission to let go of being the expert and gave them the confidence to test out their ideas and hypotheses in a safe way. A team member explained that, because systemic philosophy is different from the way humans naturally think, supervision and reflective practice play an important role bringing people together who know about systemic approaches. This helped them to keep checking in with systemic philosophy, ideas and techniques and to enable them to line up their practice and approach with these.

Practitioner characteristics

Alongside the training and reflective practice, it was equally acknowledged that working systemically depended on **practitioners having the appropriate 'mindset' and interpersonal skills**. This required a person to be able to be comfortable discussing their feelings or internalising, having strong interpersonal skills and 'a healthy dose of emotional intelligence

and reflective thinking'. These different elements were viewed as having a 'recursive' or interconnected relationship as they each fed into the other. The 'magic fairy dust' of systemic practice was described as the ability to support families practically with whatever they were dealing with while at the same time being able to think and reflect systemically with them.

The **strong interpersonal skills** enabled a practitioner to build a trusting therapeutic relationship with a family and to get to the 'grass roots' of their issues. These and other skills like being respectful, empathetic, open-minded, understanding and non-judgemental were also reported as having helped to engage families who were reluctant.

The **wide background and skills mix of the team** (from early help, social work, youth work, education, CAMHS, substance misuse) was also seen as a key enabler of the team to work systemically – drawing on a range of professional and personal experiences.

Supporting team culture and physical space

Being part of a whole-team culture was another pivotal factor that supported and enabled practitioners to work systemically, providing a supportive environment. The importance of **operating in an environment where people are thinking systemically and embodying systemic practice** was highlighted as enabling them to each mutually reflect on the theory and share and talk about their practice. The team manager worked hard to create this culture and ethos.

> *"I think you…start to think really differently when you've done systemic training and also when you're around people that are a systemically trained, just the way that they talk and the way they phrase things.'*
>
> **Edge of Care team member 6**

All Edge of Care team members described a very supportive team culture that seemed to be a critical element of their model, even if they did not actually identify it as such. This appeared to be a consequence of working systemically and **being so relationship-focused, which applied as much to the way they worked as a team and partners, as it did with the families**.

There was a mutual trust and respect for each other which could be seen in the way they made time to reflect together, to train together and work together with families. They all appeared to be very generous with their time, knowledge and practice. Being a small 'hand-picked' team from a range of different backgrounds who each brought different skills and experience to share made it easier for individuals to get to know each other, to build relationships and to be supportive.

This also happened organically, as was evident from the very tight bond that was created among the founder members during their reflective practice sessions.

This was also observed in the way they made time to care for and support each other – for example, during their Teams 'check-in' and 'check-out' slots at the start and end of every day during the pandemic.

'I think it's absolutely essential because it's not easy work that we do; we deal with a lot of difficult situations…. You never feel like you're dealing with that on your own, and they are really sort of mindful of…who you're going to see or what's been happening and has that affected…you, on a personal level…And really mindful as well that we've got families at home too. And sometimes things come up and sometimes you're not always in the best place so the support of the team is phenomenal and I think that is why we are successful as a team. It's because of the way that everyone just supports each other…we have our check-ins in the morning and check-ins at the end of the day as well, just to make sure everybody's OK.'

Edge of Care team worker 6

'If there is something you don't know there's no fear around asking – it's a lovely team to be part of.'

Edge of Care team member 6

The supportive environment also applied more widely across children's services and was evident from the interviews with stakeholders who demonstrated the way senior managers and external partners were committed to the team and viewed it as an integral part of children's services.

A supportive environment also applied to the **importance of the physical space where team members met with families**. The team worked hard to ensure that they met families in private spaces which were as trauma-informed as possible. It also helped that they were co-located with some of the other specialist services and were not based in a social care building. The manager also reflected that it was important that their building was centrally based and easily accessible and well networked to transport links.

In contrast, **remote working** was viewed as a significant challenge for the team, both in relation to how they adapted their systemic practice with families and in relation to training and reflective practice for the team. As has been mentioned, the face-to-face training and reflective practice sessions were paused during the pandemic, which affected the whole team, but was more of a challenge for the FIWs who joined the team during this time. Apart from formulation meetings, there were limited options for the team to come together and refresh their practice. They also missed having top-up training days or refresher sessions on areas of practice and taking time out to deepen their practice, or to explore new ideas or techniques.

While there were some advantages to delivering the therapeutic clinic and parenting programmes online, as families could access the service more quickly and easily, there were also a number of challenges. The main challenge was that it was not appropriate to carry out the deeper more trauma-focused therapeutic work on Teams in the location where relationships were struggling, or where the trauma happened. There was the added risk that the therapist ultimately had no control over the environment and who was present in the room during sessions, despite providing guidance about this. There were also concerns that the family members might become distressed during or at the end of a session and they would be left to cope with their trauma, or that sessions might be interrupted by children or other family members. As a result of all these challenges they focused the therapy on lighter, more solution-focused work such as considering how families could support themselves to feel better.

Low caseload capacity

Low caseloads and, as a result, having **the time to invest in working with families was identified as another critical feature for enabling effective systemic practice**. The importance of time was recurrently mentioned by team members and stakeholders. It helped practitioners to slow the work down to the pace of each family. It enabled them to reflect and explore the family dynamic and history, to work intensively and get to the roots of underlying issues. Having sufficient time also helped the team to build a trusting therapeutic relationship with families and to be there for them when needed.

However, time and capacity were also a key challenge. First, the Edge of Care team was **a relatively limited resource** for the borough, meaning they had limited capacity to work with the large cohort of children on the edge of care. This resulted in additional burden placed on locality social care and early help teams if there was no other suitable alternative service to work with these families.

Second, the Edge of Care team sometimes had **limited time to work with the families that they did support**. This occurred, for example, when child protection procedures and regulations unhelpfully dictate the timescales for the work they are doing. The duration of time Edge of Care worked with families was typically determined by where a family were on the safeguarding continuum and the statutory timescales. The time pressures were acknowledged by the Edge of Care team and their stakeholders to have limited their ability to build a therapeutic alliance and to enable change to happen. They also resulted in abruptly curtailing their work in some circumstances, such as occurred when a child was taken into care while they were still working with them.

Family engagement

A key enabler also included **how receptive and open families were to working with them and to accepting systemic ideas**. The team worked hard to engage families and to build a relationship with them. They were t**ransparent, open and honest with families about their service and how they would work with them**. They were also honest with families about what they had been told by other professionals. Their approach involved listening and being respectful, non-judgemental, understanding, empathetic and appreciating that family members were struggling and might be feeling defensive about their situation and the reason they were referred.

The **team stressed to families that their focus was on working with them and tailoring their approach to their needs**. They encouraged parents to see themselves as the experts on their lives. They also described the importance of sometimes sharing something personal with a family to help develop a connection with them.

> *'We expect them to open up and tell us absolutely everything and they are not going to do that to a complete stranger.'*
>
> **Edge of care team member 6**

While it was not feasible to interview families as part of the evaluation, it was possible to learn from the Edge of Care team members and their stakeholders about their approach to engaging families. There were three main types of challenges reported to engaging families in a systemic way.

The first was being **the wrong time for families**, either because they were in crisis or experiencing significant trauma, or because their mental health or substance misuse problems prevented them engaging systemically or undermined the success of their systemic approach.

The second was **a lack of trust and a reluctance to consent and then engage with the offer**. This was often due to previous experience of services and being engaged in a legal process where they were told they were poor parents and had failed to keep their children safe. The name of the service was also viewed as unhelpful for engaging families as it could contribute to parents' reluctance if they were worried their children might be taken into care.

The final barrier was the hardest of all to work with, and specifically for reunification work, and that was where the **parent did not want to be reunited with their children or to have them in their care**.

Partnership working

A key enabler of the systemic approach was having close and effective partnership working with children's services and early help, which has been described above. The team worked with both the Looked After Children Service and the Locality Social Work service. They co-worked with families who had a social worker, attending core group Looked After Child Review meetings with independent reviewing officers meetings, child protection meetings and joint supervision meetings as well as Edge of Care formulation meetings.

Social care stakeholders reflected positively on how embedded the team were within social care and the critical role they played in supporting social care case work in Rotherham. They described having good relationships and working well together. They found the Edge of Care team **approachable, flexible and willing to adapt and fit in with the requirements of families and the pressures on social care teams**. They highlighted the benefit of Edge of Care team members having a background in social work and early help as this enabled them to understand how children's social care and early help operated and the pressures facing them.

> *'It's some of that availability and that flexibility…that's for me key…We'll go out we'll do a joint visit we'll kind of check it out a little bit with the family, we'll talk about our service. We'll, you know, we'll give them time to…have a think and then we'll kind of go out again or we'll follow with a phone call. So I think it is some of that flexibility in terms of understanding that locality services are very busy, you know, in terms of care of the day-to-day running of cases and families…And I think they offer a consultation service which brings social workers and other agencies alongside them.'*
>
> **Stakeholder 4**

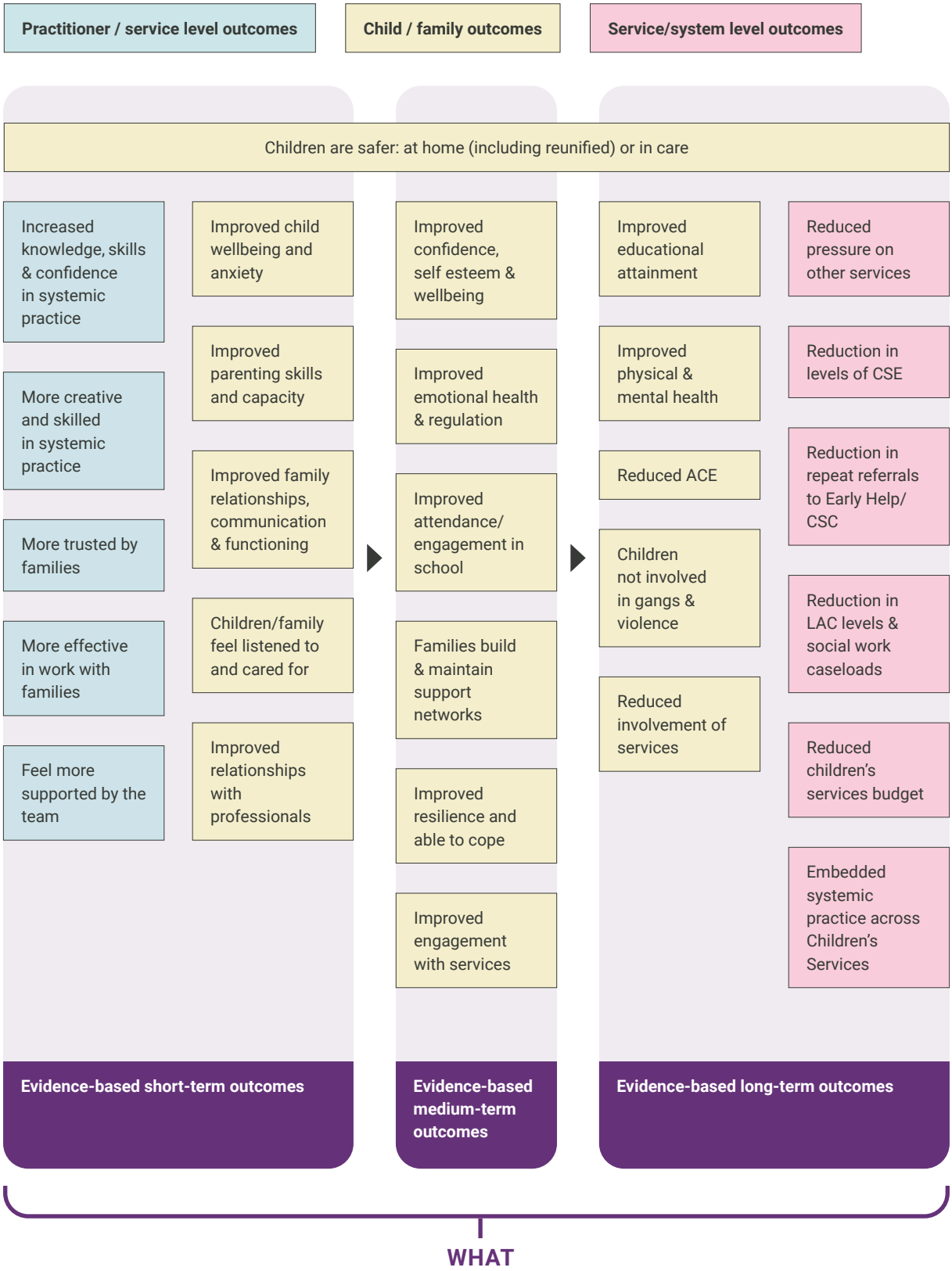
Social care stakeholders also valued the Edge of Care team skills in supporting the emotional needs of family members. **The ability to listen and respect each other while also being willing to challenge and to have brave or 'courageous' conversations**, was mutually viewed as an indicator of the strength of the relationship between social care teams and the Edge of Care service.

The challenge of working with or alongside **partners who lacked understanding or faith in a systemic approach** had undermined their work and been disempowering for families. In these circumstances partners were reported to have quite 'negative' and firm views about how they should work with families and were unable to view their problems through a systemic or trauma-informed lens, or to believe that a child or family member could change. This was also referred to as systemic discrimination as other professionals would not acknowledge or engage with their systemic approach, or allow the time needed to work systemically with a family.

It was also acknowledged that the **financial pressure on other services** who were working with families could also interfere with the therapeutic process, as it resulted in partners retracting to 'silo' working and lacking a capacity to work in partnership.

Impact of the systemically informed approach

This section reports on the perceived and reported outcomes of the Edge of Care team based on the outcomes identified in the theory of change (see below) developed before the evaluation fieldwork. This section draws on the qualitative interviews with the Edge of Care team and stakeholders as well as data provided by Rotherham or collected through the evaluation. The section reports on outcomes for families (parents and children/young people), before looking at outcomes for practitioners and then the wider system that the Edge of Care team operates within.



Outcomes for families (parents and children/young people)

Children are safer and reunified with their parents/carers

As set out in the theory of change, a key expected outcome of the approach was that children would be safer and (those that could be) reunified with their parents/carers. Using case management data provided by Rotherham, as of September 2022, 399 children have been supported by the Edge of Care team. Table 1 below details the number and proportion of children who stepped up, stepped down or displayed no change in their 'Level of Need' since the Edge of Care team became operational in September 2017.

It shows that 254 children (63.7% of those that have been supported) have moved down the child protection continuum, suggesting long-term sustained change, with 79 children (19.8%) seeing no change, which was seen by the team as a positive stabilisation of a child's situation in many instances.

The table also shows that 66 children (16.5% of all those supported) moved up the child protection continuum. This was a reflection of the team's core aim of helping families to stay together or reunite where it is safe to do so, and therefore keeping children safe from harm. The team reflected that sometimes this means there is an escalation of concerns where children's needs were too acute or the safeguarding risks too high not to escalate support into social care. Data also showed that 27 children (34% of all children who were in care) have been reunified since September 2017.

TABLE 1

Change in social care status for children worked with across the project lifecycle, from September 2017 to September 2022

Outcome	Number of children	% children
No change	79	19.8%
Step down*	254	63.7%
Step up	66	16.5%

*** Step-ups and step-downs are calculated using the child status at the start of involvement compared with the period end. A step-up can, for example, signify Early Help (EH) to CIN, CIN to child protection (CP) or CP to LAC, while a step-down can, for example, indicate CP to CIN or CIN to EH.**

Improved family relationships and functioning

Another core expected outcome was improved family relationships and functioning. Since September 2017, the Edge of Care team have collected data using SCORE-15. Results from the SCORE-15 measure showed that, since September 2017, for cases that have been closed, the **average distance travelled for the SCORE-15 was minus four, indicating an overall improvement in family functioning**.[16]

As part of the evaluation, a pilot was run to explore regular use of the validated measures: the SCORE-15, Outcomes Rating Scale (ORS) and Session Rating Scale (SRS) over a three-month period. The team underwent refresher training and were encouraged throughout the pilot to regularly administer the measures (see Annex M 'Piloting regular use of the SCORE-15, ORS and SRS' for further details on the use and acceptability of the measures by the team). However, at the time of writing the data from the tools had not been provided.

However, interviews with the Edge of Care team and stakeholders reported that parents who were previously unable to have a relationship with their children or to care for them had healthier relationships with their children and with other family members as a result of

16 A decrease in score indicates an improvement in family functioning.

the team's work. In some cases, it was reported that parents had come to understand that their situation had not resulted from a failing on their part, but the trauma they experienced, impacting their relationships with their children. The way in which Edge of Care had **enabled parents to reflect on themselves was described as being key to helping them view their relationships differently and apply new meanings to why things had happened**.

> *'I always think if you can get people to hold another person's point of view, better or differently, that is where change happens, and a lot of our support workers, therapists can be around helping people come to new meanings like that.'*
>
> **Edge of Care Team member 2**

Stakeholders cited examples of **parents reflecting it was the first time they had felt listened to and believed in and this helped them make changes in their life**. Similarly, young people were described as having reported that it was the first time they had been able to open up and to speak to someone who understood them.

Improved parenting skills and capacity

While we were not able to measure improved parenting skills and capacity, it was noted from interviews that the team had been instrumental in improving the confidence of parents' and carers' parenting skills. **By coming to terms with their own trauma, parents were reported to have been able to overcome the stigma stemming from the feeling they were 'defective' parents.** This in turn resulted in improvements in children's behaviour. For example, NVR was seen to be helping parents whose children were displaying violence and aggression. We observed participants during their last session expressing how their relationship improved with their children and that this had improved their behaviour and reduced their verbal and physical aggression towards them.

There were a number of other family outcomes highlighted in the theory of change which we were unable to collect evidence on. These included: improved child wellbeing and anxiety; children/family feeling listened to and cared for; improved relationships with professionals. Other outcomes included: improved confidence, self-esteem and wellbeing; improved emotional health and regulation; improved attendance/engagement in school; families building and maintaining support networks; improved resilience and ability to cope; and improved engagement with services.

Outcomes for practitioners and the wider system

There were three main ways the Edge of Care service was perceived to have made a difference to practitioners in the Edge of Care and social care teams and the wider system from the qualitative interviews. However, no quantitative data was collected to support these findings.

Developed individual practice and supported wellbeing

Edge of Care team members reflected how the systemic training, reflective practice, supervision sessions and formulation meetings supported the development of their systemic skills and practice. They helped them to **learn how to slow their thinking down and be curious without 'marrying ideas' or making judgements about family members**. These sessions also provided important reassurance and confirmation about the way they were working with a family. A team member described leaving a supervision session feeling safe and supported as well as having some clear actions to follow.

Supported social work practice

Stakeholders recurrently reported that working alongside Edge of Care had enabled them to learn new approaches and how to think and work systemically. It was the experience

of working with Edge of Care that had helped them to understand how they could work differently and how they could take elements of the practice into other work they were doing.

> *'Everywhere they go, they are able to share their learning or their way of working and everybody who comes away, you know, quite passionate about, "oh, I'm gonna try this because Edge of Care tried it. I feel brave or I can use that tool." So I think that's the real benefit as well.'*
>
> **Stakeholder 1**

> *'Everybody they touch is absolutely influenced in a positive way about how they worked with E of C.'*
>
> **Stakeholder 1**

Formulation meetings were identified as a key catalyst for helping stakeholders to think differently, to adopt different approaches, to be more reflective and understanding and to learn how to reframe their views of families, as one Edge of Care team member explained:

> *'They come in from a high-pace, high-intensity world and are invited into a slow, reflective space where they leave able to continue that train of thought and to other places.'*
>
> **Edge of Care team member 7**

A stakeholder reflected how they left formulation meetings feeling more enthusiastic, more challenged and more equipped to make changes.

Locality social work teams described how they adopted a peer and reflective supervision model and a particular style of questioning as a result of working with Edge of Care. This involved one of the team bringing a case to reflect and discuss in a peer supervision meeting. While they reflected that they were not able to replicate Edge of Care's model, due to their caseload size and the timescales they were working to, they were encouraging teams to dedicate time to reflect on a complex case as and when they could.

The social workers involved in the reunification pilot also reflected how the **formulation approach enabled them to develop their own approach for assessing when reunification was appropriate, and when working with young people who were in crisis**. There were also examples of useful techniques and resources that Edge of Care had taught them on their NVR training.

Quality of child protection plans

Social work stakeholders reflected that working with Edge of Care had also resulted in improving the quality of child protection plans as professionals were encouraged to think differently about a family and to consider new areas to explore. This was reported to have helped to progress their work, to unblock cases they were 'stuck' with and to bring about change. Stakeholders described individual experiences of where they had changed their views or tried a new approach and were working more effectively with a family as a result of discussing a family with the Edge of Care team.

Unintended consequences

The Edge of Care team and stakeholders were asked to reflect on the potential or actual unintended consequences of the team's systemically informed approach for families, the team and the wider system.

Families

The Edge of Care team highlighted some unintended consequences for families, including the fact that the way they worked with families, including working systemically and

restoratively, **could be draining and emotionally intense for all family members involved**. In addition, talking therapies come with a risk of making problems worse by being intrusive and by opening up traumatic situations to get to the root cause.

Another unintended but recognised consequence was the **risk of dependency and the difficulties of ending the relationship with the families**. Often the team worked with families that had a history of working with, and in some respects, dependency on, support services. This can be difficult for families to recognise and break. The team spoke about the positives and negatives for not having a timescale when working with families. Timescales could be unique to the family, but could also raise the risk of creating dependency. They aimed to empower families so that they were confident in taking agency in their own lives and spoke about the need to discuss and manage ending the relationship with families from the outset.

In rarer cases, there could also be the unintended consequence that the service can result in a **child being taken into care**, if that is believed to be in their best interests, even if it is not the outcome that either the child or the parents/carers desire.

Edge of Care team

For the Edge of Care practitioners, one unintended consequence was that **systemic work, especially with families who have complex and complicated issues, can be very fatiguing and cause burnout**. However, it was felt that the supportive whole-team culture along with training, reflective practice and supervision within the team were critical to helping mitigate these impacts and reduce burnout.

The wider system

The one unintended consequence identified by stakeholders related to the team having a different set-up and configuration. For example, low caseloads and a flexible approach to the frequency, intensity and type of support the Edge of Care could devote to families. This could be frustrating for staff working in other services such as early help and social services, who have higher caseloads and a more performance-driven approach due to their statutory status or national guidelines.

Recommendations from Edge of Care and stakeholders

We end the findings section with recommendations for its future development made by the Edge of Care team and their stakeholders. These revolved around recommendations for developing Edge of Care's service and recommendations for rolling out elements of Edge of Care's systemically informed practice across early help and social care.

It should be noted that these are not the recommendations of the evaluation team, but of those interviewed.

Recommendations for developing Edge of Care

Recommendations for improving and developing Edge of Care were primarily focused on expanding their service in different ways to work with more families. There were also some specific suggestions for improving procedures, activities and raising awareness.

A common recommendation made was for **expanding and scaling up the Edge of Care team so they would be able to work with more families**. These suggestions centred on creating pathways for both Locality Social Work teams and Early Help teams. Underpinning this suggestion was the desire to shift the focus of Edge of Care to earlier intervention and to work with families before they reach crisis levels.

Expansion of the team also included **developing an emergency or crisis out-of-hours** response with the aim of containing families or bringing a child into temporary accommodation and supporting them to avert the crisis. It was suggested that this would adopt a solution-focused approach. There were different suggestions made for how this could be staffed, including social workers joining on secondment for a period of time.

To create additional capacity in the team to support more families, the other key suggestion made **was to develop an Edge of Care consultancy offer for early help and social care teams in Rotherham**. This would provide a range of options including clinical consultation, bespoke systemic supervision, reflective practice sessions and formulation meetings facilitated by Edge of Care team members for families that Edge of Care are not working with. It was suggested that the consultancy service could be run one day a week.

Other specific suggestions included the following.

- Expanding the offer within the team to include a therapeutic outward-bound instructor to support children and young people on the edge of care, or on an emergency care admission, or young people who have recently been reunified.
- Recruiting a systemic family therapist trained to supervisor level, to work five days a week alongside the clinical psychologist. This person would be a co-commissioned therapist with the Clinical Commissioning Group and would facilitate reflective supervision for the Edge of Care team.
- Adopting the Children and Young People – Improving Access to Psychological Therapies (CYP-IAPT) two-year training programme with additional training to apply the course to the context practitioners operate in, including, for example, developing a therapeutic alliance, mental health and social care risk management, attachment theory and strategies and substance misuse.
- Promotion and awareness-raising sessions of Edge of Care for new staff that have joined early help and social care to support partnership working as well as raise awareness about the referral process and criteria and include in the referral form a checklist of eligibility requirements.
- Producing a written plan of the options discussed at Edge of Care Panel for cases that are not allocated to Edge of Care.
- Producing a written plan for cases discussed at a formulation meeting which would be reviewed at four-weekly intervals.
- A mid-way report and final exit report for families being jointly worked with by Edge of Care and social care.
- Reunification pilot to ensure that cases referred to Edge of Care are those that have a realistic prospect of reunification and will happen within a foreseeable timeframe.

A final suggestion made was for Edge of Care to offer to provide advice and training to other local authorities. In addition, it was proposed that they could also help the Department for Education and DLUHC set up a national peer network of Edge of Care services organising conferences, sharing ideas and organising away days, practice development and manager forums.

Recommendations for rolling out elements of Edge of Care's systemically informed approach across early help and social care

A wide range of suggestions were made for how to roll out and apply systemic principles and practice to early help and social care. The suggestions included the following.

Training in systemic practice. This ranged from rolling out systemic practice training across the whole workforce to more bespoke options for training on specific systemic ideas and tools, activities and elements of systemic practice. These suggestions included delivering training four times a year at whole-service events, providing practice briefings, offering 'top tips' on key areas of practice such as trauma-informed work, or family therapy or NVR.

Rolling out systemic tools such as the ORS/SRS and SCORE-15. These would be used to complement the suite of validated tools that were already used to measure distance travelled in Early Help (for example, Daily Hassle Scale, the Warwick–Edinburgh Mental Wellbeing Scale and Strengths and Difficulties Questionnaire).

Rolling out NVR across Early Help and social care, with Edge of Care providing both the training and the supervision for staff.

Rolling out reflective practice supervision groups to support families that would benefit from them thinking differently and applying more of a systemic approach.

> *'Those really sort of stuck families, the ones that we really struggling with, it probably would be really helpful to have somebody more independent coming in and reviewing that and asking different questions because I think often when a family gets stuck, that's because we're stuck as well normally and then it's really hard on your own if you've been involved in that case and invested in it for a long time to be able to maybe see wood for the trees. Sometimes you need somebody to help you do that.'*
>
> **Stakeholder 8**

Develop a formulation meeting model to support busy team managers and frontline social workers with their thinking and to be available for working with more children and families across children's social care, coordinated by a systemically trained individual.

Embedding the Edge of Care team in Early Help as part of a co-located team sharing their expertise and learning and having protected caseloads. An alternative delivery model involved training a small number of family support workers in each of the early help teams in systemic practice, providing monthly supervision and reflective practice groups and opportunities for them to meet as a group to formulate and talk about systemic ideas and practice. These people would carry out the more complex relational orientated work in Early Help and also be champions of those ideas among the other parts of the workforce. These individuals would need to have their caseloads protected and time to work with families.

A final specific suggestion for rolling out systemic practice involved setting up a **Centre for Systemic Children's Work** within the local authority. It would be an evidence-based hub which would be the centre for training and ongoing professional development and supporting practice. The hub would provide a space to train the whole of children's services (at all levels) in some foundational systemic ideas to ensure they can permeate throughout the whole workforce. They would then apply the learning to practice through systemic supervision. There would be a team who were trained in systemic supervision who could work alongside Early Help and social work managers to inform and support their case-holding conversations.

The hub would be a base for Early Help and social work teams who were in need of support for supervision groups, therapeutic and reflective spaces. There would be a clinical psychologist as part of the hub who would offer consultation and a link with CAMHs. They could also have an NVR café located at the evidence hub where parents who have been on the programme can come and meet other parents and get involved in supporting hub staff with running groups.

Specialist systemic practitioners would be based within all the localities offering therapeutic support coordinated by the centrally hub-based learning and development team.

The training would cover fundamental systemic ideas including:

- **core training on** systemic theory and practice, the Social GRACES, ways of being, ideas of control, curiosity, neutrality and being a self-reflective practitioner alongside their safeguarding role
- **elements of practice:** use of cultural genograms, ecomaps, timelines, narrative ideas, solution-focused ideas, externalising problems and talking about families, circular questions, linear questions and questioning
- **use of evidence-based tools** to complement systemic practice such as the use of the SRS and ORS as well as SCORE-15.

4. Discussion

Discussion of findings

This section sets out the findings in relation to the key research questions on feasibility of the approach.

Implementation and delivery of the systemically informed approach

Fidelity

- **Is the systemically informed Edge of Care team operating as intended?**

The Edge of Care service was set up to work systemically with very complex and vulnerable families and children who are on the edge of care. The evaluation provided evidence of how the Edge of Care team were operating as intended. They were supporting families to remain safely in their home environment or be reunited within their family/kinship networks where it was safe to do so. Where it was not considered safe for this to happen, their role was to support families to have the best form of family life or contact with their child/young person.

The systemic framework was described as providing a focus and structure to guide the way the team formulated and planned their work. The core elements of their systemically informed approach included a package of systemic training supported by supervision and reflective practice, systemic formulation meetings, systemic therapeutic support offers and tools to support these. The evaluation highlighted the importance of the following elements as being critical to the successful delivery of their core offers.

- A small closely connected multidisciplinary team made up of practitioners with complementary skills and experience.
- Being trained by experienced systemic practitioners in systemic theory and practice to a level that was commensurate with foundational level systemic training.
- Applying the learning from the formal training to practice during monthly reflective practice sessions facilitated by an external qualified systemic supervisor.
- Individual supervision provided by a systemic practitioner to discuss cases, develop systemic practice and support personal development.
- The use of weekly formulation meetings to provide a reflective space for all professionals involved with a family, to discuss their needs, be curious and hypothesise about the possible causes of their problems and ways to address them.
- Referrals to the team were efficiently managed by the Edge of Care Panel process. The expertise of the chair helped to steer the discussion of cases and ensure that referrals were appropriately allocated.
- A therapeutic clinic which worked systemically with family members (children and or adults) focusing on low mood, anxiety, relational difficulties, trauma or family breakdown.
- Delivery of Triple P and the systemic non-violent resistance parenting interventions. These evidence-based programmes needed to be tailored and adapted to work with parents of looked-after children.

- Access to a range of systemic tools that can be used flexibly to help explore and understand a family's history, their relationships, the roots of their needs and their reflections on previous support they have received. It appeared that the primary tools used by team members were the relational genogram, the timeline and questioning styles such as interviewing the internalised other, circular questioning and reframing. In addition, therapeutic letters were being used to help punctuate different stages of the therapeutic process for families attending the therapeutic clinic.
- While ORS/SRS were used to track outcomes they appeared to be valued more for helping to lead and guide sessions as they provided an instant snapshot of what was going on for a family. The SCORE-15 was used to provide an overall view of family dynamics and the nature of any conflict among family members.
- Before the pandemic, the Outdoor Education Centre in Crowden was being used to help inform assessments, observe family dynamics, work on and strengthen family relationships and functioning and to support parenting skills.

Adaptation

- **How does the team's delivery of the systemically informed core activities vary across the team?**

Limited adaptation of the offer was identified. However, the systemically informed approach was premised on the need to **tailor and adapt their work to the needs of families and different levels of need**. For example, implementation of the Triple P programme for parents who did not currently live with their child(ren).

The **pandemic had affected the delivery of elements of their work, such as the therapeutic clinic, and limited the training and supervision opportunities**. While this did not appear to have affected the core functioning of the service, for some families they adapted their focus from exploring the deeper relationship difficulties and trauma to more of a solution-focused work approach.

Dosage

- **How many children/young people and parents/carers are being worked with?**

When the team was created, their systemic training, which took place four times a year, and monthly reflective practice sessions were delivered by external systemic practitioners. However, the budget for the external training and reflective practice sessions was cut in 2019, which meant they were delivered less frequently by the team manager and the support of the clinical psychologist. Training was paused over the pandemic but has now resumed. Individual supervision takes place on a monthly basis.

As of September 2022 the team had supported 358 children. Currently, there are an additional 41 children being supported, equalling a total of 399 since the team became operational in September 2017.

The number of contacts for a FIW was adapted to the needs of a family and the phase of their work, fluctuating between **once a week and two to three times a week or every day**. A distinction, however, was drawn between the **intensity** of their work and the **frequency** of contacts. The number of therapeutic clinics were over 250 since the team became operational. There are around four Edge of Care parenting courses a year with between eight and 10 parents on each, and between five and six NVR courses a year. Around 25 families had attended the Crowden Outdoor Education Centre in recent years. The duration of time the Edge of Care team worked with a family was typically determined by where a family were on the safeguarding continuum and their level of risk. In practice, average durations were reported as being between **six months (for families with less complex needs) and a year (for families with more complex needs)** and could be extended for longer.

Reach

- **Does the team reach the target families in need?**

Data suggested that the service was working with the families they intended to work with: that is, very complex and vulnerable families and children who are on the edge of care. The Edge of Care team and stakeholders believed they were reaching children who were most at risk of coming into care, or where there was a placement at risk of breaking down, or where they were being reunified back home.

Quality

- **Is the systemically informed approach being delivered to a high quality?**

Assessing quality of the approach was difficult as no validated assessments were completed and families were not interviewed as part of the study. However, stakeholders' assessments of the quality of the systemically informed approach that the team offered were based on observing the knowledgeable and skilful way in which team members worked with families, the relationship and trust they built with a family, and the degree to which they were able to put a good plan in place demonstrating their understanding of the family, their history and needs. They also acknowledged that quality should not be solely judged on the basis of a successful outcome as they were working with very complex families and this might not reflect the actual quality of the team's practice.

The confidence with which team members worked systemically with families and used the systemic tools was observed as a key indicator of quality practice as well as how practitioners talked and reflected about their practice in supervision, in formulation meetings or in the way they recorded their case notes.

Judgements about the quality of the training and systemic practice were made on the basis of the skills and experience of the team, their commitment, the relationships they built, the combined systemic and trauma-informed approach and the time they had to spend with families.

Participant responsiveness

- **To what extent do families and practitioners engage with the systemically informed approach?**

From interviews and observations of training and practice it was clear that members of the Edge of Care team were very engaged and positive about the systemic approach.

Families were not interviewed as part of the study, making it difficult to assess their engagement. However, the low level of families who disengaged with the service and the sustained time with which the team worked with families was a good indication of their engagement. In interviews with the team and stakeholders it appeared that families were highly engaged. In circumstances where families were not engaged, it was felt to be due to families not being in the 'right place' for systemic intervention. Enablers to engagement are discussed in the main report.

Intervention differentiation

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

The Edge of Care service introduced a new systemically informed approach to Rotherham that worked 'with' rather than dictated 'to' families. It had more freedom than other services to tailor the approach to individual families' needs. Their low caseloads enabled them to work with families more deeply, more intensively and for longer than either Early Help or social care were able to do. Their therapeutic interventions, and specifically their focus on trauma and attachment, enabled them to explore the more deep-rooted issues that

might be impacting on families and encourage families to reflect on their own behaviours, relationships and history.

Factors affecting delivery of the systemically informed approach

- **What are the enablers and barriers to successful delivery of the practice approach?**

A number of core enablers to the Edge of Care team's systemic practice included:

  - a tailored and adaptable approach to the presenting needs of individual families with effective referral, panel and support pathways to ensure families received the most appropriate support
  - the appropriate training, reflective practice and supervision facilitated by an experienced systemic practitioner
  - a small, supportive multidisciplinary team with a strong whole-team culture made up of practitioners with complementary skills and experience, with practitioners having the appropriate 'mind set' and interpersonal skills
  - low caseloads ensured practitioners had time to slow the work down and explore the family dynamic and history, to work intensively and get to the roots of underlying issues
  - strong partnership working.

The main challenges to delivery related to:

  - capacity of the team and the specific cohort of families within the edge of care sector they could work with
  - working alongside partners who lacked understanding or faith in a systemic approach
  - child protection procedures and regulations unhelpfully dictating the timescales for the work they were doing
  - financial pressures of other services
  - working remotely during the pandemic, limiting the scope and depth of their therapeutic work.

Impact of the approach

- What are the potential benefits of the approach for families, practitioners and the wider service?
- 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?

Based on the outcomes data collected by the service and the perceptions of the Edge of Care team and their stakeholders, the service was viewed as having made a difference to the lives of families and children, practitioners and the wider system.

For families, the Edge of Care team was reported to have **created sustainable change for the children and families they worked with**. Families were reported to have improved family relationships and improved parental confidence in their parenting skills.

For practitioners in the team, the approach was perceived to be making a difference through systemic training, reflective practice, supervision sessions and formulation meetings which supported the **development of the Edge of Care team's systemic skills and practice and supported their wellbeing**.

For the wider system, the approach was said to help social workers and other teams, including **learning how to be more understanding and reflective about families, which**

helped them to work more effectively with families and to improve the quality of their child protection plans.

There were a number of reported unintended consequences. These included how working systemically and restoratively could be draining and emotionally intense for all family members involved and the risk of dependency. For the Edge of Care team themselves, systemic work, especially with families who have complex and complicated issues, can be very fatiguing and cause burnout. At a system level, the Edge of Care team's low caseloads, and the time and opportunities afforded to them to work with families, could be hard to enable for other frontline professionals.

Exploratory research

The recommendations for Edge of Care centred around expanding their service to work with more families, developing an emergency/crisis out-of-hours response and developing an Edge of Care consultancy offer for social care and early help. It was also suggested that they could share advice and training with other local authorities and support a national peer network containing relevant services.

- **How would the systemically informed approach need to be adapted to work with families in Early Help?**

A wide range of suggestions were made for how to roll out and apply systemic principles and practice to early help and social care. These included delivering training in systemic practice; rolling out reflective practice supervision groups, formulation meetings, systemic tools, such as the ORS/SRS and SCORE-15, and NVR parenting programme across Early Help and social care; or embedding the Edge of Care team in Early Help as part of a co-located team sharing their expertise and learning and having protected caseloads. A final specific suggestion for rolling out systemic practice involves setting up a Centre for Systemic Children's Work within the local authority. This would be an evidence-based hub which would operate as a centre for training and ongoing professional development and supporting practice.

Conclusions and recommendations for the systemically informed approach

This section sets out conclusions and recommendations from the evaluation for the systemically informed Edge of Care team and for future evaluation.

The systemically informed Edge of Care team appear to have been important in Rotherham's improvement journey, supporting the population of families with very complex and often entrenched issues leading to them being on the edge of care.

While causal claims on the impact of the systemic approach on family outcomes could not be made, it appeared from data that there had been sustained change for children and their families as the majority had not seen a step-up to social care after working with the team. In addition, outcome data appeared to show improvements in family functioning and interviews with practitioners suggested the approach was creating substantial positive change in the lives of children and their families. It also appeared that the approach was having an impact on practitioners' individual practice and wellbeing, as well as system-level impacts on reduced pressure on social care and the embedding of systemic practice across social services. We recommend that further evaluation, as outlined in this report, is undertaken to support the evidence of promise.

Core components of the approach, which appeared to be key to the systemically informed approach, included a package of systemic training supported by group reflective practice sessions, systemically informed supervision and formulation meetings. We would

recommend that these core components are sustained and built on. Cuts to training budgets and the pandemic appeared to impact the delivery of certain elements including training, reflective practice sessions and face-to-face delivery. Most of these were beginning to be restored when fieldwork took place and we would recommend that these are fully implemented – for example, monthly reflective practice sessions facilitated by the clinical psychologist as well as regular training by an external systemic expert. We would also recommend consideration of what was learned from delivery within the pandemic, such as online formulation meetings to support partnership working, as well as the added value of interventions which were paused over the pandemic such as the Outdoor Education Centre.

The systemic therapeutic support offered to families, including intensive support from family intervention workers with small caseloads, therapeutic clinics, the provision of parenting programmes and the use of an Outdoor Education Centre all appeared to be working as intended.

There were a host of systemic tools which were used by the team. The use of the ORS/SRS and SCORE-15 seemed to be working well in a small pilot as part of the evaluation and we would recommend consistent use of the tools by all members of the team for all families supported.

Multi-agency partnership working was a core component of the approach and appeared to be working well, especially with social care, where there were clear processes through the Edge of Care Panel and the formulation meetings. We would recommend that the team continue to sustain and develop these further (for example, the planned additional joint supervision days with the Looked After Therapeutic team). This should be done alongside continuing to expand support of systemic practice throughout the rest of the local authority.

Our exploratory research provided views on how the systemic model could be delivered in early help. The pilot using systemic tools in Early Help teams could be the start of this process. However, we would caution implementing only specific elements (such as certain tools or light-touch training) to a wider workforce without considering how this could dilute critical features of the team's systemic approach. Thought needs to be given to how critical elements such as low caseloads, a small team and a specific culture may struggle to be rolled out elsewhere.

Recommendations for future evaluation

- **What is the most feasible approach to assessing the implementation and impact of the Edge of Care approach?**
- **Which outcomes are critical to measuring impact and how?**

Evaluating the impact of the psychologically informed Edge of Care approach is an important part of understanding how effective it has been in achieving its intended outcomes and providing evidence to improve delivery going forward.

Part of the evaluation was to assess the feasibility of conducting a future impact study on approach. The evaluation team was unable to identify or construct a sufficient counterfactual (that is, a control group of either practitioners or of families with similar characteristics who had not been supported by the Edge of Care team, either from Rotherham or from other comparison areas) which would support a future impact study by the team.

The evaluation team would therefore recommend that efforts be made to conduct a small-scale impact evaluation on the piloting of systemic training and tools in Early Help teams with a control group (that is, practitioners who do not attend systemic training or use tools) to inform future impact studies on similar approaches in other areas.

However, the evaluation team would recommend Rotherham continue to assess both the implementation and the outcomes of the approach, building on the findings from this evaluation. Below we provide specific advice for how this could be achieved. We would also recommend that any differences between the theory of change and findings from this evaluation (or further evaluation) be reflected in a revised theory of change.

Implementation of the approach

The evaluation team recommend the Edge of Care team continue with, and enhance, their assessment of the delivery of the psychologically informed approach to ensure that key components are being delivered as intended.

We recommend **continuing and improving management data collection on the key components of the approach**. We recommend that the frequency and who takes part in key components of the approach is collected, including components which are practitioner-facing, such as systemic training, individual supervision and group reflective practice sessions; as well as family-facing components such as support from FIWs, therapeutic clinics, evidence-based interventions, visits to the Outdoor Education Centre and the use of systemic tools. Gathering comprehensive data on these, linked to which practitioner undertook these and which child/family was supported, would help analysis looking at factors which could influence engagement.

The evaluation team recommend that **views on the approach by team members be collected regularly** (perhaps every six months). This could be through surveys which ask for feedback on how they feel each core component is being implemented, including what is working well and what could be improved. A good example of this was the short survey administered as part of the pilot of the SRS/ORS and SCORE-15 (see Annex J for more details).

In addition, the evaluation team recommend that more detail on the views of team members is collected. As part of the evaluation, we interviewed most of the team. Undertaking a similar exercise, every year for example, could help explore perceptions of the approach and provide useful recommendations. Key stakeholders could also be included. 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 Edge of Care service be chosen to undertake them.

Given the short timeframe, it was not possible to gather views from families of the psychologically informed approach. However, we suggest considering **conducting interviews with families to understand their perceptions of the support they received**. During interviews, we would recommend that families are encouraged to discuss their experience of each of the core components they received. For example, the support provided by FIW, the therapeutic clinic, the Outdoor Education Centre, parenting programmes and so on. We would also suggest that feedback is obtained on how they found using the systemic tools, such as genograms, the SRS/ORS and SCORE-15, building on the pilot conducted as part of this evaluation.

Impact of the Edge of Care approach

The evaluation team recommend that Rotherham continue to investigate the impact of the offer on practitioners as well as on children and families through robust quantitative methods. We would emphasise measuring the key outcomes that are articulated in the theory of change.

Impact on families

The evaluation team recommend emphasis be placed on collecting data on outcomes identified in the theory of change in order to measure change over time and begin to assess the impact of the Edge of Care service.

Children are safer. The central aim of the Edge of Care service is to keep children safe, and reunifying children with their families when appropriate. As reported on in this report, data is collected on this for all those that have been supported by the service.

We recommend further work be undertaken to look at the characteristics and multiple issues that these children and their families face to build up a comprehensive picture of their need and the impact that the team's support has. This could include their involvement with children's services and early help, as well as police, school and healthcare, such as involvement in crime and antisocial behaviour, or school absences–exclusions, as well as education attainment, for example. If their involvement could be charted over time it could provide a more holistic understand of the Edge of Care's long-term impact. One way to do this could be to look at whether the families are found within Rotherham's Supporting Families dataset.

Family functioning and therapeutic change. The evaluation team recommend continuing to administer validated outcome measures for all families who are referred into the service. The small outcome measure pilot which included the SCORE-15, SRS and ORS showed that practitioners were comfortably able to use the measures and saw the benefit both in supporting their systemic practice with families and in tracking outcomes and sessional feedback; see Annex M 'Piloting regular use of the SCORE-15, ORS and SRS'.

Based on the pilot and our fieldwork we recommend that these measures continue to be used with all families. In particular:

- For **SRS/ORS** we would recommend that these continue to be used at all sessions with families where appropriate. However, it should be noted that while these measures are a good marker of individuals' perceptions of the session (SRS) and wellbeing and distress (ORS), caution is needed when using them to track change.
- For **SCORE-15** we recommend that the measure is used with every family at specific timepoints. For instance, when they are referred to the Edge of Care Panel, when an action plan is complete, at appropriate timepoints throughout their support (every two to three months, for example) and at exit from the service. Thought could also be given to whether it is possible to collect data on families at set timepoints after support has ended. This could include a short qualitative interview and/or the administration of a short survey with a number of validated outcome measures such as the SCORE-15 and other measures noted below such as the Revised Child Anxiety and Depression Scale (RCADS) and Warwick–Edinburgh Mental Wellbeing Scale (WEMWS). These could be administered, for example, at six, 12 or 24 months after exit from the service.

The evaluation team would recommend that this data be linked to other data on the families supported, such as presenting needs, family characteristics and service involvement. This could support a richer and more holistic understanding of families, and what might be the most effective means of support.

In addition, we would recommend that some of the specific interventions delivered to families as part of Edge of Care be evaluated with pre- and post-outcome measures to look at change in outcomes for families. Candidates for this would be the Triple P Parenting programme and NVR. Measures of child outcomes such as the Child Behaviour Checklist or Strengths and Difficulties Questionnaire could be used, alongside measures of parent outcomes including Parenting Scale and Parenting Sense of Competence Scale. Piloting the use of these measures before and after the courses could then be built on for other specific interventions such as the Outdoor Education Centre.

Collection of additional outcome data. There were a number of other children and family outcomes highlighted in the theory of change which the evaluation was unable to collect evidence on, as previously discussed.

Further work could be undertaken to pilot the collection of valid and reliable measures for many of these outcomes. As a starting point, we would recommend (as stated above) that data already collected on families in Rotherham be linked to those families supported by the Edge of Care team. This could include, for example, police data such as involvement in gangs and violence, schools data such as attendance/engagement and educational attainment at school. This could be shared in addition to data on use and therefore engagement in other services.

Other measures found in the theory of change would probably involve the collection of validated outcome measures, such as improved child wellbeing and anxiety. A starting point could be the piloting of the RCADS, which we heard in the evaluation had been used by some practitioners, but not used comprehensively. The RCADS is a youth self-report questionnaire for young people aged 8 to 18 and has a parent version which can be used to assess parental views on the young person's anxiety and depression. In addition, the WEMWS, which is used by other practitioners such as Rotherham's Early Help teams, could also be used by the team – as suggested above, at set timepoints when working with families and after support has ended alongside the SCORE-15.

Impact on practitioners

While the evaluation findings from interviews with practitioners and stakeholders were critical in understanding their perceptions of the impact the systemically informed key worker approach had on practitioners and the wider system, no robust impact data was collected.

A key part of the theory of change is that practitioners have the knowledge and confidence to take a systemic therapeutic approach and are more creative and skilled in their practice. Looking at how the quality assurance of practice could be inbuilt into continued evaluation is recommended.

While not part of the theory of change, practitioner wellbeing was identified as an important element to effective practice. Measuring this through validated outcome measures could greatly enhance continued evaluation of the team. This could include administering validated measures such as the Professional Quality of Life Scale (ProQOL), looking at work-related secondary trauma, burnout and compassionate job satisfaction, which could take place once or twice a year.

In addition, we would recommend that formal training, such as the one we observed, be evaluated to understand satisfaction with the training as well as its impact on practice. We would also recommend that future evaluation work observe more direct practice, such as general systemic work FIWs undertake with families, reflective practice sessions, therapeutic clinics, Triple P courses and trips to the Outdoor Education Centre.

Impact on the wider system

For impact on the wider system, little quantitative data was obtained in the evaluation other than the impact on children escalating up to social care or down into early help services. As suggested above, the evaluation team would recommend this data be linked to other data sources such as the police, schools and health data to understand wider-system impact and trajectories of service involvement for families supported by Edge of Care.

In addition, an outcome of the theory of change is the embedded systemic practice across children's services. Further thought should be given to what measures could be administered, potentially in staff surveys and after practice trainings provided by the team to the wider services to understand if and how system practice is being embedded. We hope that the

current pilot in Early Help where systemic tools are used to support practice will provide recommendations on how to measure this in Rotherham.