EARLY INTERVENTION FOUNDATION

What Works for Children's Social Care

Coming together as What Works for Early Intervention & Children's Social Care

Lessons learned from conducting evaluations of the Supporting Families Programme in Early Help settings

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Acknowledgments

We would like to thank Early Help leads, managers and practitioners in Greenwich, Islington, Rotherham and Somerset for their collaboration on our evaluations conducted 2021–2023. Without their support the evaluations would not have been possible, and their openness to work with us has benefited the evaluations greatly.

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

What Works for Children's Social Care (WWCSC) and the Early Intervention Foundation (EIF) are merging. The newly 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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Department for Levelling Up, Housing & Communities

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

What Works Network

This report was first published in May 2023.

The aim of this report is to support policymakers, practitioners and commissioners to make informed choices. We have reviewed data from authoritative sources but this analysis must be seen as a supplement to, rather than a substitute for, professional judgment. The What Works Network is not responsible for, and cannot guarantee the accuracy of, any analysis produced or cited herein.

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This document is available to download as a free PDF at: www.eif.org.uk/report/evaluating-systemic-practice-within-the-supporting-families-programme

Contents

Overview

The purpose of the report is to share knowledge WWEICSC has gathered from conducting the four evaluations of psychologically informed key worker practice within the Supporting Families Programme. In this report the findings of the evaluations are not explored; these can be found in the evaluation reports. Instead, this report explores the practicalities of undertaking evaluation and generating evidence in local Early Help and Children's Services. This learning is valuable for design of future evaluation, including pilot and efficacy/ effectiveness impact evaluations.

Lessons learned

Recruitment and set-up

Buy-in from the senior leadership in Early Help was critical during recruitment and set-up for the evaluation as they provided sign-off for taking part in evaluation activities. Senior leadership were also able to introduce staff members who would be able to assist in the evaluation, such as data leads and managers. Developing a working relationship with senior leadership helped the evaluation team begin to understand the approach that was being tested and the local context in which it was being delivered.

Once buy-in from senior leadership had been secured, it proved valuable to meet with managers to explain their own and their staff members' role in evaluation, including explaining the rationale for evaluation and getting their buy-in to the evaluation. It was also important to articulate what the evaluation was trying to achieve and dispel any fears that we were assessing individual performance. Managers were satisfied with the information they received from us throughout the evaluation process:

> *'I think it's very well organised... It's very clear because you send the information before and about what to expect ... I've got the confidence that what you're doing is a good piece of work.'*
>
> **Early Help Manager**

Delivery of approaches

Three of the evaluations involved studying an approach that was already being used. The fourth evaluation in Rotherham's Early Help service involved introducing new elements to the approach already in place: systemic training and the use of two outcome tools. This provided important learning about enablers and barriers to delivery of new elements in the Early Help context.

Interviews with Early Help staff in Rotherham revealed their thoughts about taking part in the pilot. Initially, practitioners were apprehensive about adopting a new way of working and felt they 'already had enough on', especially as the team was overstretched due to capacity. Managers also cautioned that staff already used a range of different tools and strategies in their practice approach. The training was mandatory, however, so staff were not able to opt out of the training. The compulsory element appeared to be an important facilitator because they were more positive after attending the training and saw use in the new way of working:

> *'I feel very grateful that I've been given the chance to do it because, at the end of the day, it's improved my practice and even my own wellbeing and confidence.'*
>
> **Early Help Practitioner**

Nearly all practitioners who attended the training began using the tools in their practice. Factors which made it easier for practitioners to use the measures were related to a fit with their overarching practice framework and easy integration into their current ways of working. For instance, practitioners uploaded scores onto Liquid Logic which is a platform

they were already familiar with. Feedback from practitioners indicated that they would have valued more check-ins from their managers to support them to implement the tools and to receive refresher training to discuss any issues with using the tools and learn from other practitioners. This highlights the importance of practitioners receiving ongoing support to implement a new approach.

Another barrier to delivery raised by managers was having other things to focus on, so while they felt the new approach being introduced was valuable, they were not able to prioritise it above other things.

Research design

Feasibility and pilot evaluation

Three of the evaluations involved exploring approaches that were already being implemented by local areas. These evaluations involved a feasibility study to explore implementation and a pilot study to explore the feasibility of conducting an impact evaluation on the approach. The research involved quantitative and qualitative methods to address the research questions. 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 approach, either from the local area being evaluated or from other comparison areas) which would support a future impact study. The studies provided evidence that the psychologically informed key worker model was feasible to implement and provided detail on how the model could be implemented.

Pilot randomised control trial

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

Collecting implementation data

Theory of change workshops

Theory of change workshops were scheduled as the first data collection activity as part of the evaluation. They provided an opportunity for the research team to build a relationship with those taking part in the evaluation, including senior members of staff as well as practitioners. Staff members valued meeting the evaluation team and having the opportunity to ask questions and voice any concerns about taking part.

More detailed learning about the running of theory of change workshops was published in a blog and a quick reference guide for facilitators.[1]

Observations

Observations were a useful way to view the operations of an activity while they were occurring to understand how they were being implemented without having to depend on practitioners' willingness or ability to participate in a survey, interview or focus group. Observations were used to gather information on how training and practice meetings were implemented. Observations took place in person and online depending on the mode of delivery.

Participants were willing to participate in observations. Some behaviour changes occurred due to the observation taking place which may have compromised the validity of findings. For example, to comply with data protection, practitioners changed names of children and families being discussed. However, despite this, discussions appeared to flow naturally with little disruption to the content that was discussed.

In one local area, some concerns were raised with the evaluation team attending more observations than necessary for the evaluation. The clinical psychologist did not want a reflective practice meeting to be observed for a second time. This is because the spaces are intended to be a secure and closed space to allow practitioners to feel comfortable and share personal reflections about the impact of their work.

Semi-structured interviews

Semi-structured interviews were used to explore implementation and perceived effects for the perspectives of practitioners, managers and/or clinicians. Interviews were typically scheduled for one hour and took place online via Microsoft Teams. There were no issues with recruiting for interviews; practitioners reported they were able to and willing to take part in an interview.

Practitioners were positive about their experiences of taking part in the interviews. They valued opportunities to share their views about their job role and have the time to reflect. Several practitioners from different local authorities commented that the interviews had encouraged them to self-reflect on their practice. They enjoyed sharing their views about their job and welcomed the opportunity to take part in the interviews.

Surveys

Surveys were used to explore implementation and outcomes, and they collected information in a standardised and systematic way from a wide group of respondents.

The administration of online surveys via Microsoft Forms worked well. Managers and senior leadership were important in encouraging practitioners to take part and secure a high response rate. Practitioners commented that they were happy to take part in the surveys and did not think they were burdensome. This likely contributed to a high response rate, with nearly all eligible practitioners taking part.

Measuring impact using administrative data

Using administrative data already collected by local areas was a practical option to explore reach and impact of the approaches in each local area. Using existing data sets minimised

1 See: **https://www.eif.org.uk/blog/using-workshops-to-develop-a-theory-of-change-experiences-and-examples-from-our-work-with-four-local-early-help-teams**; and **https://www.eif.org.uk/resource/running-a-theory-of-change-workshop-a-quick-reference-for-workshop-facilitators**

the time and burden required to obtain primary data. However, as the data had been collected for other purposes, we found it did not contain the range of information required to answer all research questions. We engaged with the performance/data analysis team in each local area to establish what data they were able to provide and then submitted a formal data request. It was important to engage with the data team early and leave enough lead-in time for the data team to prepare the data.

Usefully, quantitative data was available across a number of years which enabled us to explore changes over time. However, as the data is captured by local areas, we had no ability to verify the accuracy or validity of the data. There were some instances where data was missing or local areas were unable to explain the meaning behind the data (such as how re-referral rates were calculated).

Measuring impact using outcome measures

The feasibility evaluations provided an opportunity to explore the possibility of measuring impact using validated child, family and practitioner outcome measures. See **appendix A and B** for further detail on the measures used in the evaluations.

Due to the limited timescale of the evaluations, the time between baseline and endline was short (between six to eight weeks in Greenwich; three months in Rotherham's Edge of Care team; four months in Rotherham's Early Help team) which may have affected our ability to detect statistically significant changes in the outcome measures. However, we were able to assess the feasibility of using outcome measures which is useful learning for future trials with regards to measurement selection and administration.

Practitioners attended training which was essential to introduce the child and family measures, explain how to use them, and outline their responsibilities for data collection during the pilot. A two-hour training in Greenwich was viewed by practitioners as sufficient and practitioners were comfortably able to use the outcome measures.

Practitioners administered the measures to the children and families they were currently supporting. Measures were administered in person using paper forms which were uploaded by practitioners online after sessions. Practitioner outcome measures were administered as part of the practitioner surveys.

As indicated in practitioner surveys, overall practitioners found the outcome measures suitable and useful for their practice and there is an appetite among both local areas to continue using outcome measures beyond the evaluation. Practitioners and managers saw the benefit both in supporting their systemic practice with families as well as in tracking outcomes.

A 'ceiling effect' in responses was found for both practitioner measures (Working Alliance Inventory-Short Revised and ProQOL Compassion Satisfaction), with many respondents selecting 'Always' in their responses. This could help explain the small and non-significant changes, in that practitioners' already high compassion satisfaction and therapeutic alliance at baseline limited the scope for improvement at follow-up. Although it was emphasised to practitioners that the evaluation was not to assess their performance, social desirability bias may explain the ceiling effect within the sample. Therefore, we recommend further work to identify suitable measures to use in future evaluations.

Participant burden and participation

Across evaluations, we engaged participants in a range of evaluation activities (described above). The number and time required varied among practitioners. Participants reported no issues with the time commitments needed to take part in

evaluation activities, including practitioners who took part in the highest number of activities (three surveys and an interview).

Low staffing, caused by long-term sickness and issues with staff recruitment, made it difficult for individual practitioners and certain teams to take part in evaluation activities. It will be crucial in future evaluations that staff have adequate time and capacity to take part in data collection.

Summary

This report outlines learning WWEICSC has gathered during the four evaluations of psychologically informed key worker practice within the Supporting Families Programme. Here is a summary of the key learning points:

- It is important to establish a working relationship with senior leadership and Early Help managers from the outset to get their buy-in and support for the evaluation.
- Barriers to delivering a new approach include initial apprehension from staff and issues prioritising the new approach above other work.
- It is feasible to collect data from practitioners using a mixed-methods approach. Practitioners were able to and willing to take part in theory of change workshops, surveys, observations and interviews.
- Administrative data was a practical option to explore reach and impact of the approaches, but there were some issues with the quality of the data provided. It is important to engage with the data lead early to ensure there is enough time for them to prepare the data.
- Outcome measures were piloted successfully in three local areas. Practitioners found the child and family outcome measures useful and wanted to continue to use them. There was a ceiling effect for the practitioner outcome measures which limited the ability to detect changes. Further work should be done to identify suitable practitioner outcome measures.
- Research participants reported no issues with taking part in research activities, although staff sickness and absence made it difficult for certain teams to be involved in the evaluation.

Appendices

Appendix A: Outcome measures used in local area evaluations

Respondent	Outcome measures	Greenwich Early Help	Rotherham Edge of Care	Rotherham Early Help
Child	Me and My Feelings			
Family	SCORE-15			
	Outcome Rating Scale (ORS)			
	Session Rating Scale (SRS)			
Practitioner	Working Alliance Inventory-Short Revised (WAI-SR)			
	ProQOL Compassion Satisfaction			

Appendix B: Validated outcome measures used in the local area evaluations

Measure	Outcomes assessed	Scales and subscales	Reflections	Further information
Child outcome measures				
Me and My Feelings	Child mental health	Total score and two subscales: emotional difficulties and behavioural difficulties.	The majority of practitioners reported finding the tool useful in supporting families in their practice, and many would like to continue using the tool beyond the pilot.	**https://www.corc.uk.net/outcome-experience-measures/me-and-my-feelings-mmf/**
Family outcome measures				
Systemic Clinical Outcome and Routine Evaluation-15 (SCORE-15)	Family functioning	Total score and three subscales: strength and adaptabilities, overwhelmed by difficulties and disrupted communication.	Families responded positively to the use of the tool. Practitioners agreed that the tool was useful in their practice and said they would like to continue using the tool in their future practice.	**https://www.corc.uk.net/outcome-experience-measures/systemic-clinical-outcome-and-routine-evaluation-score-15/**
Outcome Rating Scale (ORS)	Areas of life functioning	Total score and four subscales: individual wellbeing, relationships, satisfaction with work/school and overall wellbeing.	Practitioners found the measure useful to gather perspectives of families and wanted to continue to use it.	**https://www.corc.uk.net/outcome-experience-measures/outcome-rating-scale-ors-child-outcome-rating-scale-cors/**
Session Rating Scale (SRS)	Dimensions of an effective therapeutic relationship	Total score and four subscales: Respect and understanding, relevance of goals and topics, client-practitioner fit and overall alliance.	Practitioners found the measure useful to gather feedback on their practice and wanted to continue to use it.	**https://www.corc.uk.net/outcome-experience-measures/session-rating-scale-srs/**
Practitioner outcome measures				
Working Alliance Inventory-Short Revised (WAI-SR)	Therapeutic alliance	Three subscales: agreement on the tasks of therapy; agreement on the goals of therapy; and development of an affective bond.	The measure was adapted to ask about families in general rather than specific families. However, some practitioners found it difficult to answer about families in general as there is variation in their relationships with different families. A ceiling effect was observed for this measure.	Munder, T., Wilmers, F., Leonhart, R., Linster, H. W., & Barth, J. (2010). Working Alliance Inventory-Short Revised (WAI-SR): Psychometric properties in outpatients and inpatients. Clinical *Psychology & Psychotherapy: An International Journal of Theory & Practice, 17*(3), 231–239. **https://doi.org/10.1002/cpp.658**
ProQOL Compassion Satisfaction	Pleasure a practitioner derives from being able to do their work well.	Compassion satisfaction is a subscale taken from the full ProQOL measure.	A ceiling effect was observed for this measure.	Stamm, B. (2010). The concise manual for the professional quality of life scale. Eastwoods. **bit.ly/3BeEnUM**