Department for Education

Systemic practice pilot trial

Research protocols

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Coram, Ecorys

Government Social Research

Contents

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Summary

This protocol summarises plans for a pilot randomised controlled trial (RCT) and process and implementation evaluation of a pilot to embed systemic practice in keyworker teams as part of the Department for Education's Supporting Families Programme. The aims of the pilot trial are to:

1. Provide indicative evidence of the impact and efficacy that the model delivers on family outcomes compared to models that have not embedded systemic practice in their keyworker teams, and;

2. Establish the feasibility of delivering a full trial of the model in a larger number of local authorities.

A consortium led by Coram and the Institute of Family Therapy (IFT) will deliver the pilot. Twelve local authorities submitted Expressions of Interest (EOIs) and entered the randomisation process, six were randomised into the intervention group and six into the control group. Unfortunately, two local authorities in the control group dropped out of the pilot due to capacity and internal transformation projects taking place. The pilot RCT therefore comprises ten local authorities, six in the intervention group and four in the control group.

The pilot began in October 2024 and will end in May 2026. The evaluation is being led by Coram, partnering with Ecorys.

The six intervention group local authorities have begun embedding of systemic practice. This has included training in systemic practice to keyworkers by IFT, the hiring of systemic practitioner by local authorities and on-going support via a virtual systemic practice hub run by IFT and IFT's Systemic Psychotherapist Delivery Lead. The four control group local authorities not embedding systemic practice in the pilot period are being provided with technical support to collect data throughout the pilot and will receive training in systemic practice at the end of the trial period.

Findings will inform the development of the Families First Partnership programme delivery and wider children's social care policy, including the Government's reform of children's social care.

Background and previous evidence

The Government's Supporting Families Programme[1] (formerly the Troubled Families Programme) supported families facing multiple disadvantages to make significant and sustained improvements in their lives between April 2012 until March 2025. The programme operated a 'keyworker model' where keyworkers supported the whole family around a single agreed plan and coordinate local support services. The programme was delivered by local authorities and partners across England. The Families First for Children Pathfinder and the Families First Partnership Programme are building on the learning from Supporting Families and the Independent Review of Children's Social Care to test a new model of Family Help.

What is systemic practice?

Systemic practice has its roots in systemic therapy which holds that people make sense out of their lives and derive meaning through relationships. Relationships are all important in the construction and dissolution of problems and therefore, systemic practice focuses on group relationships or networks, such as family and friends, rather than solely on an individual's thoughts and feelings.

Systemic therapy is undertaken by trained clinicians and psychotherapists. Systemic practice is an evidence based therapeutic approach, which includes a range of psychological interventions for individuals, couples and families based on systemic concepts and theory by those with some level of training but not qualified to a clinical level.[2]

A systemic approach focuses on problems being treated in the context in which they arose, building on the strengths and resources of an individual's network of relationships to make lasting change. Systemic interventions are designed to help people make changes in their thinking, behaviour and understandings to relieve distress, improve the quality of significant relationships and make positive changes in their lives: this gives the systemic approach a particularly good fit with the aims of intervention in children's social work.[3]

[1] Supporting Families Programme: https://www.gov.uk/government/collections/supporting-families
[2] For more information on training in systemic practice and routes to becoming a qualified family and systemic psychotherapist see: https://www.aft.org.uk/page/routestoqualification
[3] Cameron, C., Elliott, H., Iqbal, H., Munro, E., & Owen, C. (2016). Focus on practice in three London boroughs: An evaluation. Department for Education.

Current evidence base

There is strong evidence to support the effectiveness, acceptability and cost effectiveness of systemic therapy primarily in clinical settings, with some evidence to suggest the benefits of systemic practice in health as well as children's social care.[4] However, there is currently limited evidence for the effectiveness of systemic practice in earlier intervention services including early help and family help. Several feasibility studies and additional research were previously commissioned by the Supporting Families Programme which this pilot trial is building on.[5]

Previous research

Previous and recent meta-analyses and systematic reviews provide a strong evidence base for the effectiveness of systemic therapy, specifically for child-focussed problems.[6] Systemic family therapy has become a widely used approach in clinical settings for families of young people with common mental and physical health problems including recovery from child abuse and neglect, externalising and internalising problems, substance abuse and mental health problems such as depression, eating, anxiety and mood disorders, as well as psychosis.

Systemic practice has also been adopted in health and social care settings. The NHS England initiative Children and Young Persons Increased Access to Psychological Therapies (CYP-IAPT) chose Systemic Family Practice as one of the evidence-based interventions within CAMHS (Child and Adolescent Mental Health Services).[7]

While not as strong as the evidence base for systemic therapy or systemic practice in clinical settings, there is a growing evidence demonstrating the benefits of systemic practice in children's social care.[8] In a review of the Department for Education (DfE) Children's Social Care Innovation Programme, systemic social work practice was identified as a key approach that encouraged: "high quality case discussion that [are] family focused and strengths-based to build families and/or young people's capacity to address their own problems more effectively". [9] Systemic practice formed a large part of the Reclaiming Social Work (RSW) Model[10] which included in-depth training in systemic practice, group systemic case discussions and clinician support for social workers which

[4] Stratton, P. (2016). The evidence base of family therapy and systemic practice. Association for Family Therapy and Systemic Practice UK.
[5] These can be found here (and are detailed in the next section): https://www.eif.org.uk/report/supporting-families-feasibility-reports and https://www.eif.org.uk/report/evaluating-systemic-practice-within-the-supporting-families-programme
[6] Carr, A. (2024) Family therapy and systemic interventions for child-focussed problems: The evidence base. Journal of Family Therapy. https://doi.org/10.1111/1467-6427.12476
[7] Association for Family Therapy and Systemic Practice (2023) CYP IAPT. https://www.aft.org.uk/page/cypiapt
[8] Bostock, L., Patrizio, L., Godfrey, T., & Forrester, D. (2022). Why does systemic supervision support practitioners' practice more effectively with children and families? Children and Youth Services Review, 142, 106652. https://doi.org/10.1016/j.childyouth.2022.106652
[9] Sebba, J., Luke, N., McNeish. D., Rees, A. (2017). Children's Social Care Innovation Programme: Final evaluation report. Oxford: Rees Centre, University of Oxford.
[10] https://www.gov.uk/government/publications/scaling-and-deepening-the-reclaiming-social-work-model

found evidence of high quality, family focused and strengths-based practice that built families' and young people's capacity to address their own issues more effectively.[11]

The next sections set out more detail on the current evidence base on systemic training, clinician support and case discussions which were found to be important in embedding systemic practice within the DfE's Children's Social Care Innovation Programme.

Systemic training

The previous Supporting Families guidance and now the Families First Partnership Programme does not have requirements for practitioners to hold certain qualifications, nor did it provide a skills, knowledge or competency framework for practitioners. However, comprehensive training was found to be important for developing Supporting Family Programme practitioner skills to help provide the support needed to families they worked with and ensured consistency in support across keyworkers.[12]

UK and international evidence in children's social care suggests that foundation-level training[13] in systemic practice is an important element of embedding use of systemic theory and ways of working with families which are systemic.[14, 15,16,17] A mixed-methods evaluation exploring the introduction of systemic practice found training to not only be welcomed by social work staff, but also critical for implementing a systemically informed approach.[18] However, the study also found that high staff turnover diluted practice. Other studies on implementation of systemic practice looked to address this issue by running refresher training and providing practical guidance to ensure new and previous staff are well versed in systemic practice.[19]

A comparative study exploring the implementation of systemic practice in five local authorities showed that training in systemic practice was significantly associated with greater worker skill and high-quality practice.[20] Foundation's pilot study of training in

[11] Bostock, L., et al. (2017). Scaling and deepening the Reclaiming Social Work model.
[12] 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
[13] Foundation-level training is the first level of systemic training, followed by Intermediate and Qualifying. The Association of Family Therapy details the training standards for family and systemic psychotherapy courses: https://cdn.ymaws.com/www.aft.org.uk/resource/resmgr/resources/policies_&amp__guidance_docs/cred_&amp__training/aftbluebook_4th_ed_final_pdf.pdf. AFT sets clear expectations on the training standards for family and systemic psychotherapy courses (AFT, 2015). For this reason, the content delivered for Foundation-level courses is vastly similar across different providers.
[14] Forrester, D., et al. (2013) Reclaiming Social Work? An Evaluation of Systemic Units as an Approach to Delivering Children's Services.
[15] Cameron, C., Elliott, H., Iqbal, H., Munro, E., & Owen, C. (2016). *Focus on practice in three London boroughs: An evaluation*. Department for Education. https://dera.ioe.ac.uk/26763/1/Triborough_focus_on_practice_ July_2016.pdf
[16] Bostock, L., Forrester, D., Patrizo, L., Godfrey, T., Zounouzi, M., Antonopoulou, V., ... & Tinarwo, M. (2017). *Scaling and deepening the Reclaiming Social Work model*. Department for Education. https://assets.publishing.service.gov.uk/media/5fa41353d3bf7f03afd7b5ba/Reclaiming_Social_Work_-_Bedfordshire.pdf
[17] Isokuortti, N., & Aaltio, E. (2020). Fidelity and influencing factors in the Systemic Practice Model of children's social care in Finland. *Children and Youth Services Review, 119*, 105647. https://doi.org/10.1016/j. childyouth.2020.105647
[18] Cameron, C., Elliott, H., Iqbal, H., Munro, E., & Owen, C. (2016). *Focus on practice in three London boroughs: An evaluation*. Department for Education. https://dera.ioe.ac.uk/26763/1/Triborough_focus_on_practice_ July_2016.pdf
[19] Owen, J., Patridge, K., & Dugmore, P. (2019). *The Camden model of social work*. https://tavistockandportman.nhs. uk/about-us/news/stories/camden-model-social-work-and-our-tips-support-whole-system-change/
[20] Bostock, L., Forrester, D., Patrizo, L., Godfrey, T., Zounouzi, M., Antonopoulou, V., ... & Tinarwo, M. (2017). *Scaling and deepening the Reclaiming Social Work model*. Department for Education.

systemic tools suggested that the training was linked to increased resilience and reduced burnout.[21]

Systemic practice support from clinicians

Evidence from studies of children's social care the UK and Finland suggest that support from qualified clinicians and psychotherapists alongside training is crucial to embedding systemic practice. [22,23] In a comparative study exploring the implementation of systemic practice in five local authorities, there was a strong relationship between the presence of a clinician in systemic case discussions and quality of practice.[24] A study looking at the quality of social work group supervision suggested that the presence of clinicians in supervision can improve the quality of supervision as clinicians helped to support practitioners by reframing elements of practice and helping practitioners to 'pitch' questions to families that would enable trusting relationships to develop. This helped ensure systemic concepts were fully incorporated into practice and as a result improved the quality of practitioner work with families.[25,26]

Systemic group supervision

Systemic group supervision and consultation provides a space for practitioners together to reflect on systemic principles learnt in training, discuss how to use systemic ideas with families and role play systemic ideas with colleagues in a safe space.[27] The comparative study exploring the implementation of systemic practice in five local authorities highlighted above also found a strong significant relationship between the quality of systemic case discussion and the quality of practice. [28] Staff believed that systemic practice helped ensure a child's needs were at the centre of their practice and improve child safety as practitioners drew on the perspectives of others to confirm or challenge

https://assets.publishing.service.gov.uk/media/5a82c569e5274a2e87dc2e5e/Scaling_and_deepening_the_Reclaiming_Social_Work_model.pdf

[21] Burridge, H., Nolan, J., & Stanford, M. (2023) Piloting the implementation of systemic training and feedback tools in Rotherham's Early Help & Family Engagement Service: Evaluation report. https://www.eif.org.uk/files/pdf/piloting-implementation-systemic-training-feedback-tools-rotherham-early-help-family-engagement.pdf

[22] Cameron, C., Elliott, H., Iqbal, H., Munro, E., & Owen, C. (2016). *Focus on practice in three London boroughs: An evaluation*. Department for Education. https://dera.ioe.ac.uk/26763/1/Triborough_focus_on_practice_ July_2016.pdf

[23] Isokuortti, N., & Aaltio, E. (2020). Fidelity and influencing factors in the Systemic Practice Model of children's social care in Finland. *Children and Youth Services Review, 119*, 105647. https://doi.org/10.1016/j. childyouth.2020.105647

[24] Bostock, L., Forrester, D., Patrizo, L., Godfrey, T., Zounouzi, M., Antonopoulou, V., ... & Tinarwo, M. (2017). *Scaling and deepening the Reclaiming Social Work model*. Department for Education. https://assets.publishing.service.gov.uk/media/5a82c569e5274a2e87dc2e5e/Scaling_and_deepening_the_Reclaiming_Social_Work_model.pdf

[25] Bostock, L., Patrizo, L., Godfrey, T., Munro, E., & Forrester, D. (2019). How do we assess the quality of group supervision? Developing a coding framework. *Children and Youth Services Review, 100*, 515–524. https://doi.org/10.1016/j.childyouth.2019.03.027

[26] Bostock, L., Patrizio, L., Godfrey, T., & Forrester, D. (2022). Why does systemic supervision support practitioners' practice more effectively with children and families? *Children and Youth Services Review, 142*, 106652. https://doi.org/10.1016/j.childyouth.2022.106652

[27] Bostock, L., Patrizio, L., Godfrey, T., & Forrester, D. (2022). Why does systemic supervision support practitioners' practice more effectively with children and families? *Children and Youth Services Review, 142*, 106652. https://doi.org/10.1016/j.childyouth.2022.106652

[28] Bostock, L., Forrester, D., Patrizo, L., Godfrey, T., Zounouzi, M., Antonopoulou, V., ... & Tinarwo, M. (2017). *Scaling and deepening the Reclaiming Social Work model*. Department for Education.

their thinking helping to create a shared sense of responsibility of risk and identify how best to support families.

Systemic tools

A key part of professional practice is the use of tools to support practitioners to engage, understand and support with families. Systemic practice often uses a number of tools including genograms, ecomaps and family trees. These give a pictorial representation of a family system including information about relationships and interactions between family members, past and present. They are created in collaboration with families and can be used to identify patterns of relationships, historical influences and stressors on the family, and to consider how these may impact on the difficulties experienced by family members. They are not only used to gather information but can also form part of the therapeutic process: helping family members consider each other's viewpoints and actions as well as explore strengths and resources within the family and wider network.[29,30,31]

The use of genograms during group supervision can help other team members to understand a family's context and offer more informed support and advice to fellow practitioners.[32,33]

The 'Good Practice Pyramid'

Evidence from a number of studies looking at the successful implementation of systemic practice in children's social care have emphasized the combination of the components detailed above (systemic training, clinical support and systemic case discussion) as critical. A study exploring the implementation of systemic practice in three local authorities concluded that that while training social workers was important, it was more effective when implemented alongside support from family therapists and clinical psychologists qualified in systemic supervision.[34] A longitudinal follow-up exploring the scaling and deepening of the Reclaiming Social Work Model found that systemically trained consultant social workers shared thinking and decision-making around cases via systemic group supervision, and the use of embedded clinicians and dedicated administrative support, were vital in ensuring good systemic practice developed.[35] This

[29] Joseph, B., Dickenson, S., McCall, A., & Roga, E. (2023). Exploring the therapeutic effectiveness of genograms in family therapy: A literature review. *The Family Journal, 31* (1), 21–30. https://doi. org/10.1177/10664807221104133
[30] Rivett, M., & Street, E. (2009). *Family therapy: 100 Key points and techniques*. Routledge.
[31] Forrester, D., Westlake, D., McCann, M., Thurnham, A., Shefer, G., Glynn, G., & Killian, M. (2013). *Reclaiming social work? An evaluation of systemic units as an approach to delivering children's services*. University of Bedfordshire.
[32] Burridge, H., Mulcahy, J., & Stanford, M. (2023) Evaluation of Greenwich's Family and Adolescent Support Service (FaASS) practice approach https://www.eif.org.uk/files/pdf/greenwich-evaluation-family-and-adolescent-support-service-practice-approach.pdf
[33] Burridge, H., Mulcahy, J., Stanford, M., & White, C., (2023) Evaluation of Rotherham's Systemically informed Edge of Care team. https://www.eif.org.uk/files/pdf/rotherham-evaluation-of-systematically-informed-edge-of-care-team.pdf
[34] Cameron, C., Elliott, H., Iqbal, H., Munro, E., & Owen, C. (2016). *Focus on practice in three London boroughs: An evaluation*. Department for Education. https://dera.ioe.ac.uk/26763/1/Triborough_focus_on_practice_July_2016.pdf
[35] Bostock, L., & Newlands, F., (2020). Scaling and deepening the *Reclaiming Social Work model: Longitudinal follow up: Evaluation report*. Department for Education.

termed the ‘good practice pyramid’ as shown in *Figure 1 - Reclaiming Social Work - Good Practice Pyramid*.

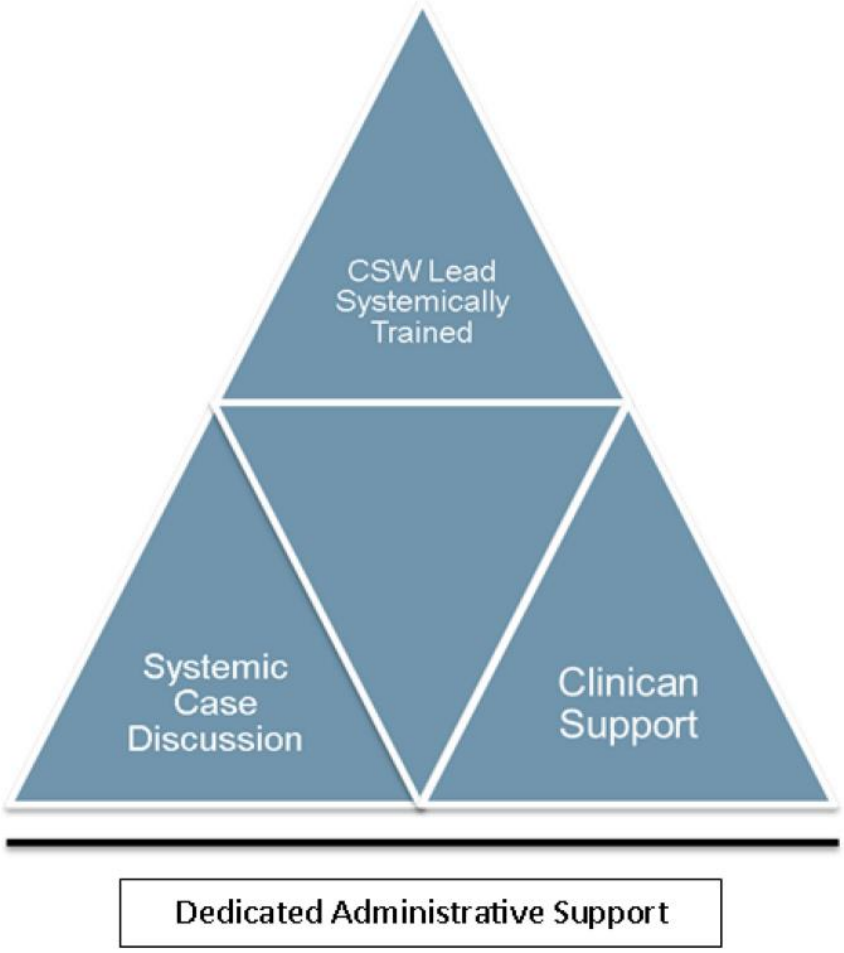

Figure 1 - Reclaiming Social Work - Good Practice Pyramid

Systemic Practice and the Supporting Families Programme

The National Evaluation of the Troubled Families Programme from 2015-2020 found that the programme delivered positive impacts for families.[36] This included reductions in the proportion of children being taken into care, juvenile sentencing outcomes and adult sentencing outcomes. However, the evaluation found substantial variation in practice amongst local areas and was not able to identify what aspects of the programme or keyworker practices were leading to positive outcomes. In addition, local areas faced

[36] 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

challenges in evaluating their local supporting families programme and early help services more generally, making it difficult for them to identify local effective practice.[37]

Building on the national evaluation, a 'what works' approach[38] has been taken to identify and understand effective practice in local authority early help services that could support positive outcomes for families. In a rapid evidence review conducted by the Early Intervention Foundation for the Supporting Families Programme, a number of areas of promising practice were identified, including approaches informed by psychotherapy.[39]

Working with the Supporting Families Programme, Early Intervention Foundation (which became Foundations – the What Works Centre for Children and Families) undertook four feasibility studies to develop the evidence on effective approaches within the Supporting Families Programme. [40] Three of these looked at approaches which used clinical or systemic practices in keyworker teams:

- **Evaluation of clinical support provided to Islington's Bright Futures team**. This study evaluated the clinical support provided to Islington's early help team (Bright Futures) by the Parental Mental Health Team and the Children, Adolescent Mental Health Services (CAMHS). This included workforce training and workshops, monthly facilitated group case consultation and reflective practice space, targeted individual consultation sessions with clinicians, and support in family sessions. It aimed to provide practitioners with psychologically informed support to help them to deliver better care to the increasing number of families presenting with complex mental health needs as well as help practitioners to feel more supported, have improved wellbeing and be less likely to suffer from burnout. The evaluation found some evidence that practitioners felt supported but there was a need for improved engagement by practitioners and limited evidence for the impact the support was having on families.

- **Evaluation of Greenwich's Family and Adolescent Support Service (FaASS) practice approach**. Based on the Reclaiming Social Work Model,[41] this approach included mandatory workforce training, In-house training workshops, weekly practice meetings, case consultations between clinicians and keyworkers, clinician support in family sessions, and use of multi-model systemic tools (such as genograms). The evaluation found evidence of high engagement and satisfaction from children, families and practitioners with promising evidence on improving

[37] 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
[38] Cabinet Office (2023) What Works Network Strategy. Evaluation Task Force. https://assets.publishing.service.gov.uk/media/6565ed1462180b0012ce8318/What_Works_Network_Strategy_November_2023.pdf
[39] Stanford, M. (2023) The Supporting Families Programme: A rapid evidence review. Early Intervention Foundation. https://www.eif.org.uk/report/the-supporting-families-programme-a-rapid-evidence-review
[40] The host of reports can be found from these links: https://www.eif.org.uk/report/supporting-families-feasibility-reports
[41] Forrester, D., Westlake, D., McCann, M., Thurnham, A., Shefer, G., Glynn, G., and Killian, M. (2013) Reclaiming Social Work? An Evaluation of Systemic Units as an Approach to Delivering Children's Services: Final report of a comparative study of practice and the factors shaping it in three local authorities https://basw.co.uk/sites/default/files/resources/basw_11812-8_0.pdf

outcomes for children and families by intervening in a timely way and creating change that is sustainable.

- **Evaluation of Rotherham's systemically informed Edge of Care team**. Key elements of their systemically informed approach included training in systemic theory and practice, supervision and reflective practice sessions with a systemic clinician, a therapeutic clinic providing mental health and relationship support from the systemic clinician, and use of systemic tools such as genograms by family intervention workers in their work with families. The evaluation showed that the majority of families subsequently stepped down from Edge of Care with improvements in family relationships and parents' confidence in their parenting skills.

Two of these feasibility studies identified that embedding systemic practice in keyworker teams showed signs of promise, positively supporting keyworkers and the families they worked with. Further research by Foundations for the Supporting Families Programme was then undertaken to inform future work.[42] This included:

- **Piloting systemic training and feedback tools in a number of Rotherham's Early Help and Family Engagement Service teams**. Teams were randomised to either be trained in systemic practice tools or not. This provided insight into training and implementation of systemic tools and practices as well as collecting outcome measures on practitioners. While positively received by practitioners, limited change was found in pre-post- measures of professional wellbeing.

- **Scoping the core components of a systemically informed key worker model**. This was undertaken through a desk-based review which provided detail on the core components of a systemically informed key worker model that could be trialled.

- **Scoping the use of systemic practice components in Early Help services in English local authorities**. This was based on a survey distributed to all local authorities in England. Of the 70 local authorities that responded, half reported the use of systemic training and a third employed a qualified clinician to support their Early Help team. This illustrated that there was scope to conduct a trial in areas that had not implemented systemic practice.

- **A lessons learned report which summarised insights from conducting evaluations of the Supporting Families Programme in Early Help settings**. The report highlighted the importance of establishing a working relationship with senior leadership and Early Help managers to get their buy-in and support for the evaluation. The report also showed that barriers to delivering a new approach

[42] The host of reports can be found from these links: https://www.eif.org.uk/report/evaluating-systemic-practice-within-the-supporting-families-programme ;https://www.eif.org.uk/report/the-supporting-families-programme-a-rapid-evidence-review

include initial apprehension from staff and issues prioritising the new approach above other work.

Study aims

Using the previous evidence, the Supporting Families Programme identified several components which were previously found to be important in embedding systemic practice in social work and keyworker teams. These included:

- High-quality accredited training for keyworkers in systemic practice with consistent refresher training.
- Embedding systemically trained clinicians or practitioners to provide support and case guidance to support keyworkers' use of systemic practice and use of tools. This included group reflective practice sessions with keyworkers.
- Use of systemic tools such as genograms, goal-based outcomes and sessional rating scales to support keyworkers to work systemically with families.

In order to test the effectiveness of these components in the embedding of systemic practice and subsequently in improving keyworker practice and ultimately improving outcomes for families, the Supporting Families Programme commissioned this pilot study.

The pilot study has two primary aims to:

1. Provide indicative evidence of the **impact** and **efficacy** that the model delivers on family outcomes compared to models that have not embedded systemic practice in their keyworker teams, and;
2. Establish the **feasibility** of delivering a full trial of the model in a larger number of local authorities.

In order to achieve these aims the study employs a pilot randomised control trial (RCT) design integrated with a mixed methods implementation and process evaluation (IPE) to provide high-quality, timely evidence of the impact of the delivery model alongside evidence on its implementation, while assessing the feasibility of delivering a full scale efficacy trial of the model.

Systemic practice pilot

The systemic practice pilot study aims to test the feasibility of embedding systemic practice in keyworker teams through a number of components. These include:

- Funding and support to local authorities to hire a local **systemic practitioner** qualified to an intermediate level in systemic practice for the duration of the pilot to work within keyworker teams to embed systemic practice. This will include providing monthly group reflective practice sessions, ad hoc targeted training and one-to-one consultation for keyworkers. Within the pilot, hired systemic practitioners will be offered masters equivalent training to become a qualified systemic psychotherapist by IFT.

- Providing **systemic training** by accredited IFT systemic tutors supported by local authority systemic practitioners. This will include:

    - A 'leader's introductory day' of training in systemic practice for senior leaders and managers in early help.

    - Five days of in-person and hybrid continuous professional development certified systemic practice training for all keyworkers, taking place over 10 weeks.

    - Additional 10 days of training resulting in an equivalent of a 15 day foundation course in systemic practice for a proportion of approximately 10-20 percent of keyworkers per local authority to become 'Systemic Champions'. Their role will be to support the embedding of systemic practice across keyworker teams working with the local authority systemic practitioner.

- A **systemic practice virtual hub** which will host the training materials and additional resources and guidance. The hub will also include a forum for each local authorities' keyworkers and a separate forum for the systemic practitioners. The hub will be curated by IFT and overseen by the Systemic Psychotherapist Delivery Lead.

- Support by an IFT **systemic psychotherapist delivery lead** to work across the intervention local authorities to embed systemic practice including coordinating systemic training, supervising and supporting local authority hired systemic practitioners, and moderating the systemic practice virtual hub.

For this pilot, **keyworkers** are defined as the lead practitioner for a family within early help/family help services within a local authority. They will not be social workers working in children's social care teams such as Child Protection or Children Looked After. They

will be the family's main point of contact, including overall case management and family engagement. However, we recognise that local authorities have very different workforce and service delivery structures which will be considered in the pilot.

Theory of change

Below is a logic model outlining the programme theory of change which sets out the identified need, the pilot's components as well as the anticipated outcomes, both for keyworkers and families in the immediate and long-term. The general hypothesis is that some of the root causes of poor outcomes for families within early help and family help are driven by relationships within the family and the array of different needs of individuals within the family. Embedding systemic practice is hypothesized to support keyworkers in their ability to support families including in identifying the families' needs and family dynamics as well as work collaboratively with families build a positive therapeutic alliance with the family. In addition to helping families identify strengths within the family and their support network which can help them overcome presenting and underlying issues. This is expected to be achieved via training and guidance, reflective group supervision and day to day support to embed systemic principles and use of systemic tools, improving keyworker confidence and skills to work systemically and therefore improve the quality of their practice to ultimately support families to strengthen family relationships and make positive change.

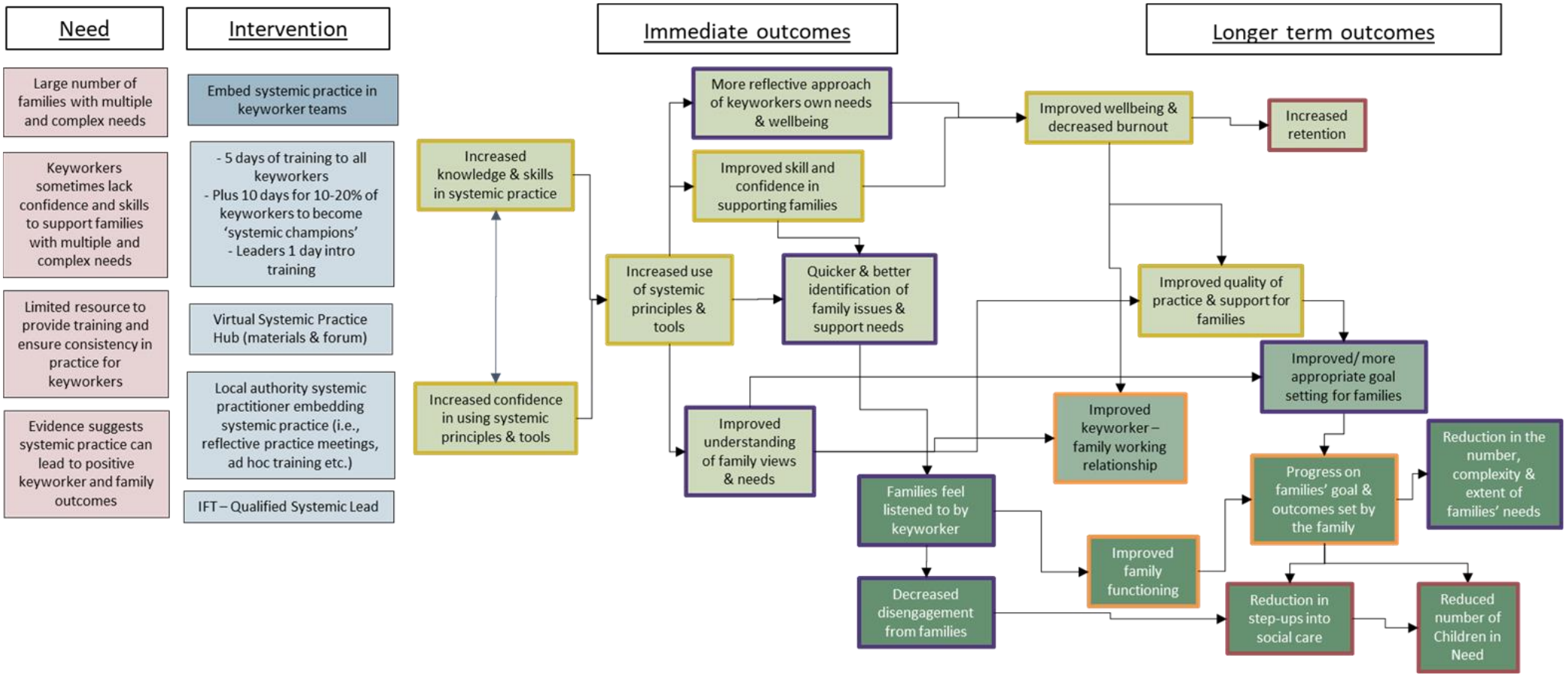

Figure 2 -Systemic practice trial logic model

Local authority systemic practitioners

While evidence from previous studies in social care as well as Foundation's feasibility studies suggests use of a fully qualified psychotherapist is important to embedding systemic practice, Foundation's scoping reports and feedback from the pilot delivery partner, IFT, highlighted the challenges in recruiting qualified clinicians.

As a result, local authorities will be encouraged to recruit systemic practitioners who are Intermediate Level trained in Systemic Practice[43] (who have at least 2 years of training: Foundation year 1, Intermediate year 2,) and offer them the qualifying level Masters training in Family and Systemic Psychotherapy, rather than recruiting practitioners qualified at that level. It is hoped that this will increase the pool of potential applicants, the chances that those recruited will have backgrounds in early help and support recruitment, retention, and sustainability. This has been a successful model used in several areas where IFT has delivered training. IFT and Coram will advise local authorities on job descriptions, key responsibilities, and professional standards to ensure good practice is consistently used across local authorities.

In each intervention local authority systemic practitioners will work with keyworker teams to embed systemic practice alongside keyworker Systemic Champions. The Systemic Practitioners will attend and support IFT training to local authorities, in addition to providing their own informal learning sessions with keyworkers on specific topics of interest after the five days of formal training. For example, how systemic practice can support school-based avoidance, or use of circular questioning and reflectivity to increase quality practice and engagement with families. Systemic practitioners will facilitate monthly group reflective practice sessions, provide 121 consultations to key workers, support the use of systemic tools (such as genograms and family trees) and outcome measures, as well as keyworker engagement and use of the virtual hub.

Systemic practitioners will be line managed with local authorities but have monthly clinical supervision with IFT's Systemic Psychotherapist Delivery Lead. Systemic practitioners will also come together as a group for their own monthly reflective practice meeting run by IFT's Systemic Psychotherapist Delivery Lead to discuss barriers and enablers to the ongoing embedding of systemic practice as well as consistency and fidelity across areas.

Systemic Psychotherapist Delivery Lead

The Systemic Psychotherapist Delivery Lead hired by IFT will take a leading role in the delivery of training in local authorities and supporting local authority systemic practitioners to embed systemic practice working to ensure fidelity and consistency

[43] AFT. Training route for family and systemic psychotherapy and development of systemic. Available at: practicehttps://www.aft.org.uk/page/routestoqualification

across local authorities including overseeing the systemic practice virtual hub. They will provide clinical supervision to local authority systemic practitioners.

Systemic training to keyworker teams

A core component of embedding of systemic practice will be the delivery of high-quality systemic training to local authorities. Training will be mandatory for keyworkers and will be led by IFT's Systemic Psychotherapist Delivery Lead and a number of qualified IFT tutors to ensure consistency. Local authority systemic practitioners will attend and support the training. The training will include:

5 days of CPD certified systemic training course mandatory for all keyworkers. It is envisaged that training will take place fortnightly for 10 weeks to ensure practitioners are not overloaded, allowing them time to reflect and test learning in everyday practice, and take this back to subsequent training to accumulate knowledge.

Based on evidence from training and implementation of systemic practice, many local authorities have struggled to ensure all staff undertake the full 15 days of foundation level training. This is due to limited capacity across keyworker teams, and differing levels of skills, academic aptitude and motivation from practitioners leading to high dropout rates. Instead, the full 15 days of foundation level training will be offer to a smaller group of keyworkers ('systemic champions' as set out below).

The aims of the 5 days of training will be to:

- Introduce underlying theories, principles and evidence base for systemic practice.
- Provide an overview and framework of different approaches and models of systemic family therapy.
- Introduce systemic tools and measures for keyworkers to develop their practice.
- Introduce ways for keyworkers to develop their own self-reflective practice.

An overview of the course themes and learning objectives are set out below.

- Theme 1: Overview of Systemic Ideas
    - Understand basic systemic theories.
    - To gain an understanding of the relational, systemic approach to family and other relationships
- Theme 2: Engaging and developing effective partnership working with children and families alongside culturally sensitive practice & GRAACEES
    - Understand personal and professional influence

    - To develop further systemic awareness of the impact of the wider social context especially in respect of race, class, religion, culture, gender, sexual orientation, age and disability.
    - To identify prejudice and disadvantage whilst continuing to promote the needs of children
- Theme 3: Relationship mapping
    - To gain an understanding of the relational, systemic approach to family and other relationships
- Theme 4: Introduction to The Milan Systemic Interview, hypothesising circularity and neutrality, and exploring the use of systemic questions
    - To develop a range of questions that can be used in practice contexts and to have an opportunity to explore their use.
    - Understanding of key tasks when engaging families in therapeutic work
    - To understand a systemic commitment to anti-discriminatory practice.
    - Systemic analysis and models of risk assessment and ethical postures
- Theme 5: Working with reluctance and relational risk taking, and exploring issues in working in contexts of risk, uncertainty and abuse
    - To develop the problem-solving capacities of clients.
    - To understand reflexivity and to be able to articulate the distinctions between reflection and reflexivity.
    - To promote reflexive abilities to review and reflect on work and decision-making

Additional 10-day follow-on training resulting in a foundation level certificate in Systemic Practice. This will be provided to 10-20 percent of keyworkers in each local authority chosen based on their willingness, ability and motivation through self-nomination and selection by team leads. These keyworkers receiving the full 15 days of foundation level training will become ‘Systemic Champions’ who will support the systemic practitioner to embed systemic practice in keyworker teams. Training will take place once a month ensure capacity of the keyworkers.

Leader’s introductory day bringing together senior leaders and managers in keyworker services across all intervention local authorities. The day will provide an overview of systemic practice, the key components of the practice model being implemented, and core aspects of the evaluation. It will help to establish a shared understanding of the pilot’s aims and be an opportunity to discuss opportunities and potential challenges to embedding systemic practice. Evidence from Foundation’s feasibility studies and DfE

Social Innovation Programme evaluations suggest that for services to successfully adopt a systemic model, leaders need to understand the fundamentals of systemic practice, its benefits and how it will be implemented. This will support buy-in and ownership as well as a network of advocates in leadership roles for sustainability of the practice model.

All training will have four core components, being evidence-based and practice informed; reflective; inclusive and participatory and encourage use in everyday practice.

Key aspects of the evaluation, including the administration of family level outcome measures for the pilot RCT, will form part of the training. A degree of adaptation will be needed to ensure training is contextualised to the needs of each local authority, including mapping onto current local workforce priorities and standards such as professional capabilities frameworks, and knowledge and skill statements.

Systemic Practice Virtual Hub

The systemic practice virtual hub will be hosted on the IFT's website to support training, implementation and embedding of the systemic practice model across intervention local authorities. It will be curated and overseen by IFT's Systemic Psychotherapist Delivery Lead and will provide an online resource centre and forum for all keyworkers (including Systemic Champions) and embedded Systemic Practitioners. The resource centre will draw on IFT's reference library built up over 40 years and include an extensive online resource centre including training syllabus and materials, videos and voice notes of teaching and actual practice, as well as guidance on use and completion of systemic tools and outcome measures for families administered by keyworkers within the evaluation.

The hub will also include dedicated forums which will include a main forum for all those within the pilot for general Q&A and networking between the intervention local authorities. It will also include forums for each local authorities' keyworkers, in addition to a private forum for the six hired Systemic Practitioners to communicate across the intervention local authorities.

Local authority Systemic Champions

Evidence suggests that practitioners acting as systemic champions or advocates who can promote and model best practice can play a key part in embedding systemic practice in local authorities.[44] Around a 10-20 percent of keyworkers per local authority will be chosen to be 'systemic champions' and receive an additional 10 days of training over the course of the pilot (above the 5 days of systemic training for all keyworkers). This will

[44] Sebba, J., Luke, N., McNeish. D., Rees, A. (2017). Children's Social Care Innovation Programme: Final evaluation report. Oxford: Rees Centre, University of Oxford.

provide an equivalent of a Foundation Course in Systemic Practice.[45] They will support local authority systemic practitioners to embed practice throughout keyworker teams with the aim of having at least one systemic champion within each keyworker team or locality. They will help with trouble shooting, identifying barriers and supporting enabling factors. It is envisaged that systemic champions could have a specific theme within systemic practice in each local authority that they focus on (such as working with difference across cultures, self-reflexivity, life-cycle development). It is hoped they will be a critical factor in the sustainability of systemic work after the pilot.

Systemic group reflective practice

Group systemic reflective practice is a core part of systemic practice. Studies show that it provides a space for practitioners to reflect on and embed systemic principles into their everyday practice with children and families.[46] A key principle is that practitioners, managers or clinicians do not hold all the answers about how best to progress work with a family. Instead, solutions develop when working collaboratively. It is different from one-to-one supervision that might occur between a practitioner and manager because the focus is on generating multiple perspectives to consider the family system in a group reflective space. Sessions can involve case presentations, group discussions, role-play, and testing of different tools and techniques learned in training. The frequency and make-up of the sessions (for example being in whole teams or smaller groups) can vary.

An example of how group-based reflective sessions take place in one local authority is set out below.

Practice meetings are held weekly and are chaired by a Unit Leader or in their absence, a designated senior-level practitioner. All members of the Unit are expected to be present at every meeting. Families are discussed at least once within a four-week cycle. All attendees are expected to prepare for Practice Meetings by thinking about the cases for discussion and noting the information they will bring. For new cases, attendees are expected to read key documents. During practice meetings, discussions about each case cover:

- A review and update of family or individual plans
- Sharing information about needs of children and family dynamics
- Risk management

[45] AFT. Training route for family and systemic psychotherapy and development of systemic. Available at: practicehttps://www.aft.org.uk/page/routestoqualification
[46] Bostock, L., Patrizio, L., Godfrey, T., & Forrester, D. (2022). Why does systemic supervision support practitioners' practice more effectively with children and families? Children and Youth Services Review, 142, 106652. https://doi.org/10.1016/j.childyouth.2022.106652

- Problem-solving and generation of creative solutions
- Sharing information about unit performance.

Source: Royal Borough of Greenwich's Early Help Operating Guidance

Systemic practitioners will lead the sessions as evidence suggests that having a qualified practitioner trained in systemic practice attend is important to ensure the full incorporation of systemic concepts and practice in the supervision.[47]

Systemic tools

Systemic tools such as genograms, ecomaps and family trees are an important part of systemic practice. They give a pictorial representation of a family system including ages, relationships, life events etc. [48] and although often led by a practitioner, are meant to be developed in collaboration with the family. They can be used to identify patterns of relationship, historical influences and stressors on the family, and to consider how these may impact on the problem/difficulty being experienced by the individual or family.

They can be used at any stage of a family's interaction with practitioners and revisited and updated but are often created during initial visits and in the assessments phase. They can be utilised for the practical purposes of information gathering on families, but also as part of the therapeutic process.[49]

These systemic tools form a central part of systemic supervision and genograms were one of eight features described for a unit meeting to be considered systemic in a study comparing systemic practice to service as usual.[50]

Another systemic tool is the SCORE-15, a measure used to assess family functioning and will be both a secondary outcome measure (see below) and used as part of the therapeutic process as a tool to understand the family and develop a therapeutic alliance, as well as provide avenues for the family to explore their own relationships and dynamics.

[47] Bostock, L., Forrester, D., Patrizo, L., Godfrey, T., Zounouzi, M., Antonopoulou, V., ... & Tinarwo, M. (2017). *Scaling and deepening the Reclaiming Social Work model*. Department for Education. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625227/Scaling_and_deepening_the_Reclaiming_Social_Work_model.pdf

[48] Research in Practice (2019). *Drawing a genogram*. https://practice-supervisors.rip.org.uk/wp-content/ uploads/2019/11/Drawing-a-genogram.pdf

[49] Research in Practice (2021). *Using genograms in practice*. https://www.researchinpractice.org.uk/media/4962/ cf_pt_using-genograms-in-practice_final.pdf

[50] Bostock, L., Forrester, D., Patrizo, L., Godfrey, T., Zounouzi, M., Antonopoulou, V., ... & Tinarwo, M. (2017). *Scaling and deepening the Reclaiming Social Work model*. Department for Education. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625227/Scaling_and_deepening_the_Reclaiming_Social_Work_model.pdf

Incentives for control local authorities

To ensure recruitment and retention of control local authorities throughout, online introductory sessions for key workers, senior leaders and managers will be provided at the start of the pilot, providing an overview of what it means to be in the control group, including training in administering family outcome measures and an explanation of the training they will receive after the pilot delivery. Control group local authorities will also be given a financial grant to support data collection, along with ongoing support from the evaluation team to troubleshoot queries, concerns or issues.

As a further incentive, at the end of pilot delivery, IFT will deliver CPD certified 2 days' training to keyworkers to provide an overview of systemic practice, including ways to embed it within practice using tools and techniques supported by worked examples, observations and reflection sessions.

Impact evaluation

Research questions

As highlighted above, the pilot study has two primary aims: (i) to provide indicative evidence of the impact and efficacy the model delivers on family outcomes compared to models that do not use this specific approach, and; (ii) to establish the feasibility of delivering a full trial of the model.

The impact evaluation has one primary research question:

1. Do families who have a keyworker have **improved progress towards personal goals** in line with the Supporting Families Outcomes in local authorities that have implemented systemic practice compared to local authorities that have not?

This is supplemented by six secondary research questions:

1. Do families who have a keyworker have **increased levels of family functioning** in local authorities that have implemented the systemic practice model compared to local authorities that have not?

2. Do families who have a keyworker have a **better therapeutic alliance with their keyworker** in local authorities that have implemented systemic practice compared to local authorities that have not?

3. Are there **reductions in step-up to statutory support** for families with a keyworker in local authorities that have implemented systemic practice compared to local authorities that have not?

4. Are there **more case closures with positive progress** made by families who have a keyworker in local authorities that have implemented systemic practice compared to local authorities that have not?

5. Do keyworkers in local authorities that have implemented systemic practice have **increased levels of professional wellbeing** compared to keyworkers in local authorities that have not?

6. Do keyworkers in local authorities that have implemented systemic practice have **improved practice quality** compared to keyworkers in local authorities that have not?

Design

The study will use a parallel 1:1 randomised controlled trial design to compare business-as-usual to business-as-usual plus embedded systemic practice. The local authorities in the sample have in common the fact that they currently, or in the last three years, have not implemented systemic practice throughout their keyworker teams. Business-as-usual will be the standard approach to early help/family help as set out in the Supporting Families Programme guidance.[51]

Table 1: Systemic practice trial design

Trial design, including number of arms	**Parallel non-blinded trial 1:1 randomisation**
Unit of randomisation	Local authority
Stratification variables (if applicable)	Local authority structure
Primary outcome	**Variable**: Progress towards personal goals within the Supporting Families Outcome Framework **Measure(s) (instrument, scale, source):** Goal Based Outcomes (GBO)

[51] Department for Education and Department for Levelling Up, Housing and Communities. Supporting Families Programme guidance 2022 to 2025: Guidance. https://www.gov.uk/government/publications/supporting-families-programme-guidance-2022-to-2025

Secondary outcome(s)	**Variable(s):** 1. Family functioning 2. Therapeutic alliance 3. Step-up to children's social care 4. Positive progress made by families 5. Professional wellbeing 6. Quality of practice **Measure(s) (instrument, scale, source):** 1. SCORE-15 Index of Family Functioning and Change 2. The Consultation and Relational Empathy (CARE) measure 3. Outcome at closure – Early Help dataset 4. Outcome at closure – Early Help dataset 5. An adapted measure of professional wellbeing 6. An adapted measure of systemic practice quality
Baseline for primary outcome	**Variable**: Progress towards personal goals **Measure(s) (instrument, scale, source):** Goal Based Outcomes (GBO)
Baseline for secondary outcome	**Variable(s):** 1. Family functioning 2. Therapeutic alliance 3. [None] 4. [None] 5. Professional wellbeing 6. Quality of practice **Measure(s) (instrument, scale, source):** 1. SCORE-15 Index of Family Functioning and Change 2. The Consultation and Relational Empathy (CARE) measure 3. [None] 4. [None] 5. An adapted measure of professional wellbeing 6. An adapted measure of systemic practice quality

Randomisation and blinding

The unit of randomisation is at the local authority level. We have randomised at a local authority level for two main reasons:

- Contagion effects at a keyworker, or family level. The practice model is a whole service approach which would be difficult to implement if randomisation took place either at a team, keyworker, or family level. This was a key concern in Foundation's Rotherham pilot study which could have contributed to its limited effects.[52]

- Ethical considerations. Having received initial advice from Coram's Research Ethics Committee, ethical issues were identified in a trial that provided psychologically informed keyworker practice to some families and not others within the same service as the support families would receive could be very different. There may also be a tendency to prioritise families receiving support from systemically trained keyworkers.

As is typical of trials in the field of social policy, the trial is unblinded. Keyworkers and families will know they are part of a pilot study. Keyworkers will be notified when undertaking training as part of the pilot. Families will be told when they are asked to consent to taking part in the pilot study. This lack of blinding is a necessity of the trial design. However, we have selected standardised self-reported outcomes and routinely collected early help data for family outcomes to avoid observer bias that may be introduced if outcomes were to be assessed by unblinded keyworkers for example.

In early discussions, local authority structure, size of Free School Meals population, and rate of Children in Need were identified as some of the possible variables that could be used to stratify and randomise the local authorities signing up to the Supporting Families trial. All three of these alternatives were examined to establish what approach might work best to provide an equitable distribution of families and key workers supporting across the two trial arms. Based on this randomisation will be stratified by local authority structure.

The randomisation procedure by LA structure was be carried out using a combination of random allocation rules to ensure equal arm allocation (control = 0, intervention = 1). The random allocation rules were generated in the statistical package R for each local authority and were combined in Excel to carry out the randomisation. To make the distribution more equitable, a special allocation procedure was used for local authority

[52] Burridge, H., Nolan, J., & Stanford, M. (2023) Piloting the implementation of systemic training and feedback tools in Rotherham's Early Help & Family Engagement Service: Evaluation report. https://www.eif.org.uk/files/pdf/piloting-implementation-systemic-training-feedback-tools-rotherham-early-help-family-engagement.pdf

structures with uneven numbers, utilising the number of families supported as set out in local authority expressions of interest for the pilot. This included:

- Randomly allocate County Councils to each trial arm.
- The arm being allocated with the County Council serving more families (compared to the other County Council) was allocated the Metropolitan Council serving fewer families (compared to the other Metropolitan Council), and the trial arm with the County Council serving fewer families was allocated the Metropolitan Council serving more families compared to the other Metropolitan Council.
- The arm being allocated with the County Council serving more families was allocated the London Borough serving most families, as well as the Unitary authority serving the least families. The other two London boroughs were allocated to the other trial arm.
- The remaining Unitary authorities were allocated randomly across trial arms.

While this process was not completely random, it did guarantee a more equitable split of the sample across the two trial arms. For comparison, we simulated three processes completely at random, to see how the allocations vary across trial arms. To test the performance of the approaches, 100 simulations of each randomisation were conducted to compare the variation of the gap between arm allocations. As was expected, the more deterministic approaches have a smaller gap in the number of families between trial arms, while the more random approaches have bigger gaps. While the minimum gaps are smaller in the more random approaches, they occur with very low probabilities (~ 5%), with the overall approach having a larger variation.

The approach set out above was used to ensure an equitable distribution of families. This approach also ensured a more equitable distribution of the keyworker sample across arms. To strengthen the validity of the approach further, baseline equivalence testing[53] of possible allocations across trial arms was carried out against relevant covariates[54] to examine any possible bias emerging within trial arms. There was no significant difference between the covariates across the two arms in any of the scenarios (alpha = 0.05).

In addition, those undertaking the trial analysis will be blinded to randomisation. We will prepare the main analytical dataset so that trial arm is indicated by numbers and there is no data about participation in the pilot trial (i.e. the data analyst cannot infer which

[53] A two-tailed t-test between the means of two independent samples with unequal variances was conducted for each of the covariates across trial arms, with standard assumptions (alpha = 0.05). The Wilcox Test was also used for a portion of the cases to verify these results.

[54] The covariates examined at Local Authority Level were: Proportion of Child Population (0-18) (2022 Mid-Year Estimates); Share of Population known to be eligible for Free School Meals (2022-23); Proportion of Children in Need (2023); Proportion of School Children Requiring SEN Support (2022-23); Proportion of Children Looked After (2023); Proportion of Children in Low Income Families (2022-23). For Westmorland and Furness, the data for Cumbria (the LA that contained it previously before it split on 01 April 2023) was used.

participants received the intervention and which did not). This, in addition to the a priori data analysis plan, will prevent bias being introduced during data analysis.

Participants

The trial aimed to recruit twelve local authorities to take part in the pilot, six intervention local authorities embedding systemic practice in keyworker teams, and six local authorities not embedding systemic practice.

Keyworkers will be practitioners working in local authorities' family support or early help services (including those in the Supporting Families Programme) providing support to a caseload of families within the timeframe of the pilot.

Participants will be families (parents/carers and their children/young people aged 8 and over) that meet the following criteria:

- A parent/carer who has a keyworker within the trial period. This will mainly include 'new' families; those that are referred and then supported by a keyworker within the pilot period. Keyworkers will have to work with a family for at least 10 weeks within the pilot period, as we want to evaluate families with ongoing contact with this service that would be expected to be influenced by the treatment.
- Parent/carer has one or more children aged 0-17 they have legal responsibility for at the point of referral.
- Child or young person 8 years old and over as outcome measures have not been adapt for children younger than 8 years old.

Exclusion criteria

Local authorities were not eligible for the pilot if they:

- Currently, or in the last three years, have implemented systemic practice in their keyworker teams. This includes systematic training in systemic practice for keyworker or the hiring/commissioning of Psychotherapists or Clinicians to support keyworkers.
- Were initial Families First for Children DfE pathfinder local authority; or
- Currently, or in the last two years, have an inadequate Children's Services Ofsted rating.

Recruitment

Local authorities were recruited via an Expression of Interest (EOI) hosted on Coram's website. The EOI was advertised through a number of routes including a press release from Coram, IFT and Ecorys, several sector press articles as well as a number of notices including by ADCS and in the DfE DCS newsletter. In addition, the then Supporting Families Programme hosted a webinar and posted repeatedly on their weekly newsletter. The Programme also advertised it through their local authority development team and via DfE's social care regional programme advisors.

Coram assessed the EOIs and then undertook randomisation of 12 local authorities. Since randomisation occurred, two local authorities in the control arm have dropped out of the trial, resulting in a total sample of ten local authorities, six in the intervention arm and four in the control arm.

Reasons for dropout included limited capacity for additional data collection and decisions to implement systemic practice and training in the local authority in the pilot period. One of the local authorities was embarking on a new framework and practice standards which included systemic principles alongside a wider change programme within the local authority which limited their capacity to implement new approaches to outcome collection with families. The other local authority also wished to implement systemic practice within the pilot period. They also noted that the required additional data collection would be too burdensome on staff and family time and require additional resources to oversee and quality assure the processes, particularly as they would have fell outside their current established measurement system already in place.

Within the pilot local authorities, all keyworkers in both control and intervention local authorities will take part in the study.

Recruitment of families into the pilot study has the advantage of being determined by eligibility for support by keyworkers. As a result, all families supported by a keyworker within the trial period will be eligible to be included within the trial if they consent to take part when completing the Family Outcome Questionnaire. Keyworkers in both control and intervention local authorities will receive training and detailed guidance in administering the Family Outcome Questionnaire. They will also receive ongoing support from Coram as well as from their local authority systemic practitioner including refresher training and drop-in sessions for troubleshooting.

Sample size calculations

When using a mixture of initial and revised numbers of families supported by local authorities that expressed an interest in the pilot, we decided to consider only 75% of the reported figures in our calculations. Our reasoning behind this was that whilst local

authorities provided their caseloads, we want to be cautious when taking these numbers into our estimates, as the caseload numbers may contain errors or old data, may include inactive or ineligible cases, and may include cases that are inaccessible as part of an evaluation owing to practicalities such as families relocating.

We hence conservatively estimate that the systemic practice trained keyworkers would potentially be dealing with 7,766 families, of which 1,165 families would participate in our programme data collection at baseline. Based on our assumptions on trial attrition in the CONSORT, this would amount to an analysable sample of 560 families, which was used to estimate an MDES of 0.446. While the dropout has led to a potential imbalance between treatment and control (65%:35%), this has been accounted for in our power calculations. We feel that this MDES is sufficient to detect a significant change using the GBO, with studies showing effect sizes[55,56,57,58,59]

Table 2: Sample size calculations

Parameter	Value
Minimum Detectable Effect Size (MDES)	0.446
Pre-test/ post-test correlations	Level 1 (participant): 0.6 Level 2 (family): 0.6 Level 3 (LA): 0.6
Intracluster correlations (ICCs)	Level 2 (family): 0.3 Level 3 (LA): 0.1
Alpha	0.05

[55] Duncan, C., Cooper, M., & Saxon, D. (2022). Test–retest stability, convergent validity, and sensitivity to change for the Goal-Based Outcome tool for adolescents: Analysis of data from a randomized controlled trial. *Journal of Clinical Psychology*. Advance online publication. https://doi.org/10.1002/jclp.23422

[56] The Wellbeing Practitioners for children and young people (CWPs) and the Education Mental Health Practitioner (EMHP) Programme trained cohorts of CWPs/EMHPs to deliver brief, evidence-based interventions based on cognitive behavioural therapy (CBT) for common mental health problems, with the intervention ranging from 6-8 sessions with either with the parent/carer or the child /young person or both. Unpublished summary reports shared by our project steering group (generated through the collaboration of UCL, KCL and Anna Freud) show that for both programmes, there was a high effect size related to the average increase in first stated young person or parent goal in the GBO over the course of the intervention. The ES was 1.73 for the CWP programme (n = 3391 cases), reported in 2019 covering data from the preceding 2 year period; and 1.37 for the EHMP programme (n = 1682) reported in 2021 covering data from the preceding 2 year period. Notably, the latter programme was established just before COVID and a majority of the interventions were delivered online.

[57] Edbrooke et al. reported that for a sample of 137 CYP that were CAMHS attenders, the effect size for their progress towards goals (averaged across the three goals stated in the GBO) between the initial assessment and about 4-6 months after was reported as 2.37. Edbrooke-Childs, J; Jacob, J; Law, D; Deighton, J; Wolpert, MR; (2015) Interpreting standardized and idiographic outcome measures in CAMHS: What does change mean and how does it relate to functioning and experience? Child and Adolescent Mental Health , 20 (3) pp. 142148. 10.1111/camh.12107.

[58] Turnbull et al. (2023) reported a large effect size of 1.33 for young people receiving support from CAMHS.

[59] Porter et al. (2022) reported a large effect size of 1.39 for young people receiving digital cognitive behavioural therapy.

Parameter	Value
Power	0.8
One-sided or two-sided?	Two-sided
Average cluster size (if clustered)	Individuals in families: 1.5 Families in local authorities (LAs): 56 Local authority count: 10
Number of families[60]	Intervention: 361 Control: 199 **Total:** 560
Number of participants	Intervention: 369 adults, 193 children Control: 203 adults, 101 children **Total:** 572 adults, 294 children

[60] Final numbers reported (post attrition) that we will be analysing, rather than in the entire sample.

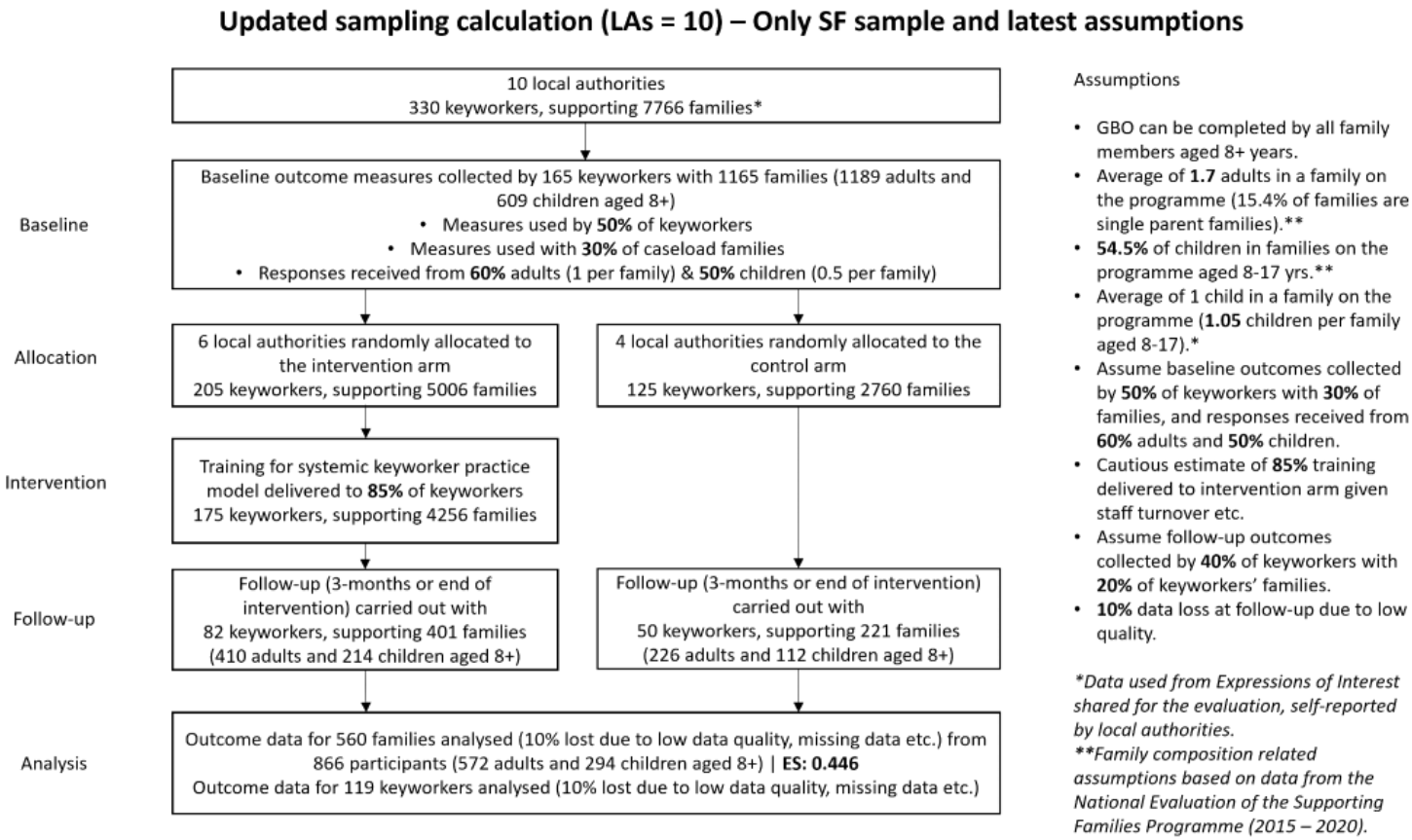

Figure 3 – Sampling calculations

SF Sample Size Calculation Table

MDES		0.446
Alpha Level (α)		0.05
Two-tailed or One-tailed Test?		Two-tailed
Power (1-β)		0.8
Baseline/Endline correlations	Individuals	0.6
	Families	0.6
	Local authorities	0.6
Average cluster size	Individuals in families	1.5
	Families in local authorities	56
	Number of local authorities	10
Intraclass cluster correlation	Families	0.3
	Local authorities	0.1

Assumptions

- 3 level clustering – individual in family in local authority
- Assumed a low ICC for families in terms of family functioning (expect different views)
- Assumed a very low ICC for local authorities in terms of family functioning (some clustering of scores based on shared factors, but not strong)
- Assumed baseline/ endline correlations of 0.6 at all levels (unknown)

Figure 4 – SF Sample size calculation table

Outcome measures

Table 3: Primary outcome measures

Variable	**Progress towards personal goals**
Measure	Goal Based Outcomes (GBO)[61]
Sample	Parents/carers and children/young people aged 8 and over. The GBO will be administered as part of the Family Outcome Questionnaire at an individual level by keyworkers. There will be an adult version (for use with adults and young people aged over 12) and a child-friendly version (for use with children aged 8 to 12). Total GBO scores will be reported, as well as themed scores. We anticipate theming goals using existing taxonomies from psychotherapy research[62,63] and using inductive analysis owing to the novel context for use of the GBO.
Time point	Baseline: within the assessment period of the first six weeks of the keyworker working with a family. Midline: at a review point when working with the family. Typically, this is between two to five months of working with the family. Endline: At closure when the keyworker stops working with a family.

Secondary outcome measures for families:

Table 4: Secondary outcome for families 1

Variable	Family functioning
Measure	SCORE-15 Index of Family Functioning and Change[64]

[61] Bradley, J., Murphy, S., Fugard, A. J., Nolas, S. M., & Law, D. (2013). What kind of goals do children and young people set for themselves in therapy? Developing a goals framework using CORC data. Child and Family Clinical Psychology Review, 1(1), 8-18.; Law,D.,& Bradley,J.(2015).Goals and Goal Based Outcomes(GBOs): Some Useful Information.(3rd ed.) London: CAMHS Press.
[62] Mok, W. C., Vainieri, I., & Jacob, J. (2024). Exploring goal taxonomies using the goal-based outcome tool in children and young people's mental health settings. Counselling and Psychotherapy Research, 24(2), 472-490.
[63] Banwell, E., Salhi, L., Hanley, T., & Facey-Campbell, N. (2023). The use of goal-based outcome measures in digital therapy with adults: What goals are set, and are they achieved?. Counselling and Psychotherapy Research, 23(3), 770-780.

Sample	Families – Score-15 is administered at an individual level with the child/young person referred to the keyworkers and at least one parent/carer. Scores are then combined into a composite score for the family.
Time point	Baseline: within the assessment period of the first six weeks of the keyworker working with a family. Midline: at a review point when working with the family. Typically this is between two to five months of working with the family. Endline: At closure when the keyworker stops working with a family.

Table 5: Secondary outcome for families 2

Variable	Therapeutic alliance – relationship between the family and keyworker
Measure	The Consultation and Relational Empathy (CARE) measure[65]
Sample	Children/young people and parents/carers. The CARE measure will be administered at an individual level, for parents/carers and young people ages 11 and older, and a version for children aged 8-11. Scores will not be combined but reported separately Families - 10 questions on the relationship between the family and the keyworker.
Time point	Baseline: within the assessment period of the first six weeks of the keyworker working with a family. Midline: at a review point when working with the family. Typically this is between two to five months of working with the family. Endline: At closure when the keyworker stops working with a family.

Table 6: Secondary outcome for families 3

Variable	Step-up to children's social care

Measure	Reasons for closure (local authority closure assessment) “Step up/escalated to statutory children’s services” [binary yes/no].
Sample	Families where keyworker support is ending.
Time point	Endline: At closure when the keyworker stops working with a family

Table 7: Secondary outcome for families 4

Variable	Positive progress made by families at closure
Measure	Reasons for closure (local authority closure assessment) “End of casework, positive progress made against all issues”
Sample	Families where keyworker support is ending.
Time point	Endline: At closure when the keyworker stops working with a family.

Table 8: Secondary outcome for keyworkers 1

Variable	Professional Wellbeing
Measure	Adapted measure of professional wellbeing using Professional Wellbeing Self-Assessment Tool[66] and The Social Work Organisational Resilience Diagnostic (SWORD) Tool[67]
Sample	Keyworkers who are in the pilot
Time point	Baseline: at the start of the pilot. For intervention local authorities this will be before the training begins. For control local authorities this will be after they have been trained in use of the family level outcome measures at the start of the pilot. Endline: At the end of the pilot.

Table 9: Secondary outcome for keyworkers 2

Variable	Practice Quality
Measure	Adapted measure of practice using the Systemic Therapy Inventory of Change (STIC) and the Systemic Practice Competency Scale (SPCS)
Sample	Keyworkers who are in the pilot
Time point	Baseline: at the start of the pilot. For intervention local authorities this will be before the training begins. For control local authorities this will be after they have been trained in use of the family level outcome measures at the start of the pilot. Endline: At the end of the pilot.

Primary outcome measure

In line with the pilot's theory of change of creating systemic practice supporting families to make meaningful progress towards personal goals, the Goal-Based Outcome (GBO) has been chosen in consultation with the expert working group.[64] The GBO tool is a way of evaluating progress towards goals in work with children, young people, and their parents and carers. The GBO assesses how far an individual feels they have moved towards reaching a goal that they have set for themselves at the beginning of their support, on a scale between 0 and 10. The measure suggests setting three goals. GBOs are also a tool to facilitate shared decision making and enable more personalised support.[65] The Family Outcome Questionnaire which includes the GBO questions are included in Annex B.

As the GBO tool is an idiographic outcome measure, the approach to testing psychometric properties differs from traditional measures. An assessment of the GBO's psychometric properties is as follows:

- **Internal consistency** (the degree to which similar items within a scale correlate with each other): There are mixed views on whether internal consistency of goal measures is relevant, given that the goals set may be focussed on the different

[64] For more information please see: The Goal-Based Outcome (GBO) Tool Guidance PDF and the dedicated website: https://www.goals-in-therapy.com/the-gbo-tool

[65] Law, D., & Jacob, J. (2015). Goals and Goal Based Outcomes (GBOs): Some useful information. Third Edition. London, UK: CAMHS Press)

areas of change. However, Edbrooke-Childs et al., found evidence of good internal consistency for parent rated goals.[66]

- **Test-retest reliability** (the degree to which the same respondents have the same score after a period of time when goals shouldn't have changed): Acceptable stability over a 6 to 24 week period has been found.[67]
- **Concurrent validity** (the correlation of the measure with others measuring the same concept): Parent and young person reported goals have been found to be significantly moderately correlated with measures of functioning and satisfaction. Using multilevel analysis techniques, moderate convergent validity has been found with measures of wellbeing, self-esteem and depression.
- **Discriminant validity** (the Lack of correlation with opposite concepts): No significant correlations have been found between parent or young person reported GBO and other measures of symptoms. [68] [69] This suggests that goals may capture areas of change not explored by these symptom measures.[70]

The suggested 'meaningful change' level for GBO, based on the principles of the reliable change index, is reported to be 2.45 in a 1-10 scale.[71] As noted earlier, studies using the GBO show large effect sizes ranging from 1.33 to 2.37 (see section on power calculations for references). As this is the first time (to our knowledge) that the GBO is being used in the context of children's social care, this is relatively exploratory, but we hope to see similar effect sizes to this range to demonstrate evidence of promise. We intend to report overall GBO scores across all goals, as well as for themed goals. Goals will be themed using existing taxonomies from psychotherapy research[72,73]. However, given that this is the first time, to our knowledge, that the GBO is being used in a study of Early Help, we will also generate our own themes inductively from the data. The measure is licensed under creative commons (CC) and therefore, free to use for the delivery and improvement of health and/or social care. It is also currently available in 9 different languages.

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[66] Edbrooke-Childs, J., Jacob, J., Law, D., Deighton, J., & Wolpert, M. (2015). Interpreting standardized and idiographic outcome measures in CAMHS: what does change mean and how does it relate to functioning and experience?. *Child and Adolescent Mental Health*. 20(3), 142-148. https://doi.org/10.1111/camh.12107

[67] Duncan, C., Cooper, M., & Saxon, D. (2022). Test–retest stability, convergent validity, and sensitivity to change for the Goal-Based Outcome tool for adolescents: Analysis of data from a randomized controlled trial. Journal of Clinical Psychology. https://doi.org/10.1002/jclp.23422

[68] Edbrooke-Childs, J., Jacob, J., Law, D., Deighton, J., & Wolpert, M. (2015). Interpreting standardized and idiographic outcome measures in CAMHS: what does change mean and how does it relate to functioning and experience?. *Child and Adolescent Mental Health*. 20(3), 142-148. https://doi.org/10.1111/camh.12107

[69] Krause, K. R., Edbrooke-Childs, J., Singleton, R., & Wolpert, M. (2022). Are we comparing apples with oranges? Assessing improvement across symptoms, functioning, and goal progress for adolescent anxiety and depression. Child Psychiatry & Human Development, 53(4), 737-753. https://doi.org/10.1007/s10578-021-01149-y

[70] Jacob, J., De Francesco, D., Deighton, J., Law, D., Wolpert, M., & Edbrooke-Childs, J. (2017). Goal formulation and tracking in child mental health settings: when is it more likely and is it associated with satisfaction with care?. European child & adolescent psychiatry, 1-12. https://doi.org/10.1007/s00787-016-0938-y

[71] Edbrooke-Childs, J., Jacob, J., Law, D., Deighton, J., & Wolpert, M. (2015). Interpreting standardized and idiographic outcome measures in CAMHS: what does change mean and how does it relate to functioning and experience?. *Child and Adolescent Mental Health*. 20(3), 142-148. https://doi.org/10.1111/camh.12107

[72] Mok, W. C., Vainieri, I., & Jacob, J. (2024). Exploring goal taxonomies using the goal-based outcome tool in children and young people's mental health settings. Counselling and Psychotherapy Research, 24(2), 472-490.

[73] Banwell, E., Salhi, L., Hanley, T., & Facey-Campbell, N. (2023). The use of goal-based outcome measures in digital therapy with adults: What goals are set, and are they achieved?. Counselling and Psychotherapy Research, 23(3), 770-780.

Secondary outcome measures (families)

SCORE-15

The Systemic Clinical Outcome and Routine Evaluation-15 (SCORE-15) Index of Family Functioning and Change is a short, validated, self-reported measure of family functioning used in clinical and non-clinical practice.[74] Most measures used in therapeutic work are designed for administration to individuals. However, the focus of systemic work is the family's relationships, context and functioning as relevant to the referral problems and /or to the effectiveness of support. Therefore, the SCORE was specifically designed for use with families. It is designed to enable family members to report on aspects of their interactions which have clinical significance and are likely to be relevant to therapeutic processes.

It is able to track progress and outcomes, and is helpful to the support process when used interactively with the family. The SCORE-15 has 15 Likert scale items and six separate indicators, three of them qualitative. It is appropriate for use with individuals, couples and full families when relationships within the family is relevant to the support being given. It is relevant when working systemically with an individual, in relation to their significant relationships, when working with members of more than one family (multi-family work), and in sessions involving family member(s) and professionals. It records perceptions of the family from each member over the age of 11 years. There is also a version for children aged 8 to 11 years which will be used in the pilot.[75]

In the original development of the measure, extensive consultations with therapists, service users and researchers were undertaken to obtain simple and unambiguous items hat would be meaningful to families from a wide variety of cultural, ethnic and socioeconomic backgrounds.[76]

It has been shown to be reliable and valid both as an indicator of the quality of interactions within the family and as a measure of therapeutic progress early in family and couples therapy.[77] The measure had been found to have good internal reliability with alpha coefficients for overall scales and subscales above 0.7. Cronbach alphas for the SCORE-15 and SCORE-28 totals were 0.90 and 0.93, respectively. The SCORE-15 has also been found to have good test-retest reliability and good criterion validity, discriminating between clinical and non-clinical cases. [78]

[74] Stratton, P, Bland, J., Janes, E & Lask, J. (2010) Developing a practicable outcome measure for systemic family therapy: The SCORE. Journal of Family Therapy. 32, 232-258 https://doi.org/10.1111/j.1467-6427.2010.00507.x
[75] Jewell, T., Carr, A., Stratton, P., Lask, J., & Eisler, I. (2013). Development of a Children's Version of the SCORE Index of Family Function and Change. Family Process, 52 (4), 673-684.
[76] https://www.corc.uk.net/media/1249/score_userguide.pdf
[77] Stratton, P., Lask, J., Bland, J., Nowotny, E., Evans, C., Singh, R., Janes, E. and Peppiatt, A. (2014), Validation of the SCORE-15 index. J. Fam. Ther., 36: 3-19. https://doi.org/10.1111/1467-6427.12022
[78] Hamilton, E., Carr, A., Cahill, P., Cassells, C., & Hartnett, D. (2015). Psychometric Properties and Responsiveness to Change of 15- and 28-Item Versions of the SCORE: A Family Assessment Questionnaire. Family Process, 54 (3), 454-463.

It can be administered in less than 10 minutes, is free to use, and has a variety of clinical and non-clinical uses as well as being usable for research and audit. SCORE-15 has been translated into a range of other languages by practitioners.[79] It was also used successfully in the Foundations feasibility studies in Rotherham and Greenwich.

Consultation and Relational Empathy (CARE)

The Consultation and Relational Empathy (CARE) Measure is a person-centred measure that looks at empathy in the context of the relationship between a practitioner and a beneficiary.[80]

The Consultation and Relational Empathy (CARE) Measure is a patient-rated experience measure of the interpersonal quality of healthcare encounters. Empathic person-centred care is central to high quality support from practitioners. Research has linked empathic care to higher levels of patient satisfaction, enablement and improved health outcomes.[81]

Originally developed and rigorously tested for use by doctors, it is now widely used in GP settings, and it has since been successfully used by other professionals.[82] It has been found to have high face and construct validity, high internal consistency (Cronbach's alpha coefficient = 0.97) and acceptable inter-rater reliability (G = 0.6 with 60 patients ratings per nurse). In addition, factor analysis has found that the CARE Measure items load highly onto a single factor and scores were not affected by patients' age, gender, self-perceived overall health, living arrangements, employment status or language spoken at home. [83]

Its ten items ask beneficiaries' perception of the practitioner's 'relational empathy', defined as the practitioner's ability to:

- understand the beneficiary's situation, perspective and feelings (and their attached meanings);
- communicate that understanding and check its accuracy, and
- act on that understanding with the beneficiary in a helpful (therapeutic) way.

[79] https://www.aft.org.uk/page/scoretranslations
[80] Mercer SW, Maxwell M, Heaney D, Watt GC. The consultation and relational empathy (CARE) measure: development and preliminary validation and reliability of an empathy-based consultation process measure. Fam Pract. 2004 Dec;21(6):699-705. doi: 10.1093/fampra/cmh621. Epub 2004 Nov 4. PMID: 15528286.
[81] Bikker, A.P., Fitzpatrick, B., Murphy, D. et al. Measuring empathic, person-centred communication in primary care nurses: validity and reliability of the Consultation and Relational Empathy (CARE) Measure. BMC Fam Pract 16, 149 (2015). https://doi.org/10.1186/s12875-015-0374-y
[82] Bikker AP, Fitzpatrick B, Murphy D, Forster L, Mercer SW. Assessing the Consultation and Relational Empathy (CARE) Measure in sexual health nurses' consultations. BMC Nurs. 2017 Nov 25;16:71. doi: 10.1186/s12912-017-0265-8. PMID: 29204104; PMCID: PMC5702142.
[83] Bikker, A.P., Fitzpatrick, B., Murphy, D. et al. Measuring empathic, person-centred communication in primary care nurses: validity and reliability of the Consultation and Relational Empathy (CARE) Measure. BMC Fam Pract 16, 149 (2015). https://doi.org/10.1186/s12875-015-0374-y

The measure has been translated into a number of different languages.[84]

Secondary outcome measures (keyworkers)

Adapted measure for Professional Wellbeing

The evaluation originally planned to use the Professional Quality of Life Scale (ProQOL)[85,86] a 30 item self-report questionnaire designed to measure compassion fatigue, work satisfaction, and burnout in helping professionals. The measure was used in the pilot of systemic training and feedback tools in Rotherham's Early Help service, but substantial ceiling effects were found.[87] When reviewing the tool for this trial, the measure was not aligned to the theory of change and instead identified as a general measure of practitioner wellbeing, specifically for health practitioners that did not look at factors which might affect practitioner wellbeing in family support and social care.

As a result, the Professional Wellbeing Self-Assessment Tool[88] and the Social Work Organisational Resilience Diagnostic (SWORD) Tool[89] were both identified as tools which included topics and questions which more closely aligned to the outcomes identified in the theory of change including practice competency, wellbeing, and professional development.

The Professional Wellbeing Self-assessment tool was developed for the DfE by Vicki Hirst and Rosemary Nash with Research in Practice. It looks at professional wellbeing in a social care context and assesses holistic professional wellbeing by looking at professional's own perspective, self-management, meaningfulness, self-care, practice competency, and professional development. While the tool has not been used as an outcome measure in a research study, it has been piloted with a wide range of social work professionals with a mix of culture, age, gender, social work experience, fields of practice, and work environment.

The Social Work Organisational Resilience Diagnostic (SWORD) Tool was developed by Research in Practice and Dr Louise Grant, University of Bedfordshire, and Professor Gail Kinman, Birkbeck University of London, was developed to improve organisational resilience in child and family social work. It is used as a diagnostic tool to explore respondents' experiences of wellbeing and resilience within five domains and has been used by several local authorities for a number of years. As with the Professional Wellbeing Self-Assessment Tool, SWORD tool has not been created for, or used in, a

[84] https://caremeasure.stir.ac.uk/CARE%20other%20languages.htm
[85] https://img1.wsimg.com/blobby/go/dfc1e1a0-a1db-4456-9391-18746725179b/downloads/ProQOL_5_English.pdf?ver=1657301051771
[86] https://novopsych.com.au/assessments/clinician-self-assessment/the-professional-quality-of-life-scale-5-proqol/
[87] Burridge, H., Nolan, J., & Stanford, M. (2023) Piloting the implementation of systemic training and feedback tools in Rotherham's Early Help & Family Engagement Service: Evaluation report. https://www.eif.org.uk/files/pdf/piloting-implementation-systemic-training-feedback-tools-rotherham-early-help-family-engagement.pdf
[88] https://practice-supervisors.rip.org.uk/wp-content/uploads/2024/05/PT-The-Professional-Wellbeing-Self-assessment-Tool_05.24FINAL.pdf
[89] https://sword.researchinpractice.org.uk/about/

research study to assess outcomes. As a result, adaptations were made to develop a bespoke set of questions to assess professional wellbeing in the context of the pilot study.

Adapted measure for Practice quality

A review of outcome measures assessing the quality of keyworker practice generally, and of systemic practice specifically, was undertaken as part of this project. Unfortunately, no validated measure of either was identified. As a result, a set of questions were created to assess systemic practice quality based on the Systemic Therapy Inventory of Change (STIC), and the Systemic Practice Competency Scale (SPCS).

The Systemic Therapy Inventory of Change (STIC) is a multisystemic and multidimensional feedback system that provides therapists feedback about systemic domains of client change in individual, couple, and family therapy over time.

The Systemic Practice Competency Scale (SPCS) provides a structure for the assessment of Systemic Family Practice (SFP) skills to evaluate family therapy sessions as well as training and supervision. It covers 12 areas of systemic family practice: Interpersonal Effectiveness and Development of Therapeutic Alliance; Convening and managing the session; Collaboration; Conveying a Systemic View; Conceptual Integration; Use of Questioning; Feedback; Intervening in Process; Working with Power and difference; Exploring and managing emotions in sessions; Use of change techniques; and incorporating the outside World.

Data collection

Family Outcome Questionnaire

Data for the primary outcome measure (the Goal Based Outcome) and the first two secondary outcome measures (SCORE-15 and CARE measure) will be collected directly from families via an online Family Outcome Questionnaire administered by their keyworker in control and intervention local authorities. All families who are referred to keyworker teams for family support or early help within the timeframe of the pilot will be asked to complete the questionnaire by their keyworker. The questionnaire will form part of the standard assessment, review and closure process with families that keyworkers go through. Families and they will be supported to complete the questionnaire by their keyworker.

Baseline scores will be collected in the assessment period (first six weeks) when the keyworker starts working with a family. Midline scores (at least one) will be collected at a review point. Typically this is between two to five months of working with the family. Endline scores will be collected at closure when the keyworker stops working with a

family, or when the trial ends. Keyworkers will need to work with a family for a minimum of 10 weeks to be included in the trial analysis.

As a minimum, at least one parent/carer and the child will need to complete the questionnaire at least two timepoints: baseline and at mid or endline. Ideally, all family members (including other carers and children) working with the keyworker will also complete the questionnaire. Keyworkers judgement will be used when deciding whether the child or young person is capable of completing the questionnaire. Versions of each measure have been developed for children aged 8 and over.

The questionnaire will be available online using a link provided to keyworkers, as well as paper versions for practitioners or administrators to upload. All families in the trial will be provided with an easy-read sheet on the outcome measures as part of their privacy notices and online consent form within the outcome questionnaire.

Training, guidance and support will be provided to keyworkers and those supporting data collection in the local authorities. Refresher training and ongoing support will be provided by Coram and the local systemic practitioner. The Family Outcome Questionnaire is included in Annex B.

Supporting Families Data collection

Data for two secondary outcome measures (whether a family has been stepped-up into statutory support and whether a family has been closed with positive progress as part of the Supporting Families Programme) will be collected indirectly from families through data local authorities collect as part of their early help data collection as part of the Supporting Families Programme. Families will consent to this data being provided via their consent forms and local authorities will provide this data as part of the Data Sharing Agreement agreed with each local authority.

To minimise the burden on families and keyworkers and to maximise the analysis that can be undertaken, local authorities will also be asked to provide additional data on the families already collect this data as part of their case management systems provided via DfE's early help dataset.

This additional data is currently being collected at two time points by local authorities:

1) In the assessment period when the keyworker first starts to work with a family usually within the first six weeks of working with a family.

2) At closure when the keyworker stops working with a family.

Baseline data will include demographic information on:

- Child Date of Birth

- Parent/carers Date of Birth
- Relationship of the parent/carer to the child
- Sex of the child
- Sex of the parent/carers
- Ethnicity of the child
- Ethnicity of the parent/carers
- Whether the child has a Special Educational Needs (a SEN statement or Education Health and Care Plan)
- Whether the parent/carers have a disability
- The work status of the parent/carers
- Whether the child has English is an Additional Language
- Whether the parent/carers has English is an Additional Language
- The work status of the parent/carers
- Whether the child is eligible for Free School Meals.

Assessment data will also include information collected as part of DfE's early help dataset:

- Family ID
- Date assessment started
- Whether the case is a re-referral
- Whether the case is eligible for the Supporting Families Programme
- Family Need identified from items with the Supporting Families Outcome Framework[90]

Closure data will include information collected as part of DfE's early help dataset:

- Family ID
- Reasons for closure
- Outcome at closure using items with the Supporting Families Outcome Framework[91]

Keyworker outcome measures

Data for the final two outcome measure (changes in professional wellbeing and changes in systemic practice) will be collected from all keyworkers in the study local authorities via an online survey emailed to them at the start of the trial and at the end of the study.

90 https://assets.publishing.service.gov.uk/media/62471c2be90e075f08be4248/Annex_A_National_Supporting_Families_Outcome_Framework.pdf

91 https://assets.publishing.service.gov.uk/media/62471c2be90e075f08be4248/Annex_A_National_Supporting_Families_Outcome_Framework.pdf

Keyworkers in the intervention group will also be asked questions on these measures in a post-training survey.

Compliance and fidelity

Steps will be taken to monitor compliance and identify risks to contamination. The local authority level randomisation design has the advantage of making risks to contamination low as the model to embed systemic practice will only be implemented in intervention local authorities. In addition, local authorities in the trial are not geographical neighbours, meaning it is unlikely that families will move from one to another.

Eligibility for the pilot study also has the advantage of being determined by eligibility for support by keyworkers meaning that all families supported by a keyworker will be eligible to be included within the trial, if they consent to take part when completing the Family Outcomes Questionnaire. For families that do not consent to take part in the trial, we will request aggregate level anonymous data about these families from local authority case management administrative data. This will allow us to compare the characteristics of those who do and do not consent to the trial. This will include potential biases across characteristics such as type of need at referral, whether they are being re-referred as well as demographic characteristics such as, sex, race and ethnicity, and disability.

Coram was responsible for randomisation and undertook internal quality assurance checks to minimise any biases.

Coram will also explore the influence of trial arm allocation compliance using Complier Average Causal Effect Analysis (meaning whether families or keyworkers in the intervention arm receive the intervention), by including intervention receipt in an instrumental variable analysis. Keyworkers in the intervention arm that attend at least 80% percent (four out of five days) of the initial five-day systemic practice training for all keyworkers will be deemed compliant. This threshold of 80% was recommended by IFT based on their extensive experience of keyworkers being able to use and embed systemic training in their practice. IFT and the local authorities will record attendance of keyworker training which will be included in the administrative data collected.

Quality assurance of the Family Outcome Questionnaire data will be undertaken frequently, and any missing, anomalous or any potential biases in the data will be queried with the respective local authority. If any consistent issues are identified, additional guidance and targeted training for keyworkers and additional guidance within the questionnaire for families will be provided to help ensure compliance.

Implementation fidelity will be measured according to the core components of the systemic practice pilot. This is set out in the table below.

Table 10: Implementation fidelity measures for intervention local authorities

Component of fidelity	Measure	Source
Training in systemic practice	• Leaders introductory day attended by the majority of early help senior staff. • At least 90% of keyworkers attend at least 3 out of the 5 days of systemic training. • At least 80% of keyworkers attend at least 4 out of the 5 days of systemic training. • At least 60% of keyworkers attend all 5 days of systemic training. • At least 50% of the 10-20% of keyworkers chosen as 'systemic champions' complete the 15 days of Foundation level training.	Data collected from IFT on attendance to training
Systemic practitioner	• A systemic practitioner trained to level two in systemic practice is employed for at least 12 out of the 15 months of the trial. • Systemic reflective practice sessions held at least monthly for at least 12 out of the 15 months of the trial with at least 60% of keyworkers attending each session across teams.	Data collected from local authorities on hiring a practitioner and number of reflective practice sessions
Virtual Practice Hub	• At least 75% of keyworkers who attend IFT training access the virtual practice hub for one or more of the following types of support: i) training material from the 5 day course ii) additional training material and guidance not part of the 5 day course iii) Q&A and networking forms.	Data collected from IFT

Fidelity will also be explored in the implementation and process evaluation. This will include interviews and focus groups with keyworkers, systemic practitioners and senior staff and observations of training, group reflective practice sessions, team meetings, and (if feasible) keyworker sessions with families. As well as Participatory Action Research (PAR) by embedded Systemic Practitioners and interviews with parent/carers and (if feasible) children and young people. They will be used to explore whether systemic practice was embedded in keyworker teams and whether systemic approaches were used with families in the intervention group.

These actions will help monitor fidelity and compliance as well as identify risks to contamination.

Analysis

A final Statistical Analysis Plan will be produced prior to any analysis detailing the analysis strategy in full.

Analysis will include a baseline description of the trial participants using baseline outcomes data and additional data provided by local authorities (see data collection above) and additional monitoring data from local authorities and IFT on fidelity as set out above. Descriptive statistics (means and standard deviations for continuous variables, percentages and counts for categorical variables) for each variable will be set out.

Outcomes analysis for the pilot study will include all randomised participants who provide outcome data across the pilot. Reporting will include participant flow throughout the trial, including completion rates of outcomes in a CONSORT diagram.

All outcomes will be analysed on an **intention-to-treat** basis meaning that all participants will be analysed according to the trial arm to which they were assigned, as opposed to whether the intervention was received.

We will calculate and report descriptive statistics, including the characteristics of the intervention and control groups on each key variable collected. We will carry out balance checks to report on how balanced the characteristics of respondents are across treatment and control groups. These characteristics will include the child/young person and parent/carers sex, age, ethnicity, English as an additional language, in addition to the child SEND status, child social care status, parent/carer disability, and parent/carer employment status.

Using this data, balance checks will be carried out to report on how balanced the characteristics of respondents are across treatment and control arms. For continuous variables (e.g. age), test balance will be undertaken using two sample t-tests with unequal variances. Balance in proportions (e.g. sex, ethnicity) will be tested using a chi-square test.

If any characteristics are significantly unbalanced between trial arms, these will be adjusted in the outcomes analysis. Analysis will report on full baseline characteristics of the sample including baseline outcome scores, the characteristics of those lost to follow-up, and the characteristics of the analysable sample. This will include the extent and pattern of missing data and explore this using regression modelling if required.

Missing data will be assessed to explore whether the data is:

1) *missing completely at random* (data is randomly distributed across the variable and unrelated to other variables),

2) *missing at random* (data is not randomly distributed but they are accounted for by other observed variables), or

3) *missing not at random* (data systematically differs from the observed values) and adjust our approach to analysis based on this assessment.

Where data is missing completely at random, no imputation will be carried out and only available cases will be analysed. Where data is missing at random it will considered whether multiple imputation is required. Where data is missing not at random it will be considered which sensitivity analyses are required to produce estimates that adjust for missingness.

We anticipate all variables will be analysed using a three-level multilevel modelling approach for family-based outcomes, and two-level multilevel modelling approach for keyworker outcomes to estimate the average effect of the treatment allocation using a Huber-White (HW) robust error procedure to account for heteroscedasticity. We anticipate including fixed effects for delivery site and time from randomisation (to account for ongoing referral throughout the pilot). We will also adjust for stratification factors used at randomisation and report ICCs for clustering. The coefficient will be an estimate of the size and direction of the treatment effect and its significance will be tested with a two-tailed 5% Type I error threshold.

The analysis explore the influence of trial arm allocation compliance using Complier Average Causal Effect Analysis, by including intervention receipt in an instrumental variable analysis. The analysis will also include an exploratory analysis with sub-groups or other exploratory analysis including analysis of harms.

All analysis will adhere to good spreadsheet design principles and document the sequence of steps used to get from raw data to findings to enable review. All data cleaning and analysis will be undertaken in R statistical software. All code and analysis will be quality assured by a second member of staff and includes both the logic and the arithmetic of analysis. Full records of code will be shared with the DfE and published to enable replication.

Implementation and process evaluation

The aim of the Implementation and process evaluation (IPE) will be to address key questions of implementation and delivery including fidelity, dosage and quality, reach and responsiveness, acceptability as well as mechanisms of change, barriers and enablers to implementation and capacity and capability to implement.

Fidelity & Adaptation

Main Question:
To what extent are intervention local authorities adhering to the intended systemic practice pilot model?

Methods

Intervention group:

- Keyworker survey
- Family interviews
- Keyworker interviews and focus groups
- Systemic practitioner analysis of case files
- Observations of training and practice
- Keyworker and systemic practitioner case studies and learning log
- Administrative data on families and keyworkers

Dosage & Quality

Main Questions:

- How much of the systemic practice pilot model has been delivered?
- How well are different components delivered in each local authority?

Methods

Intervention group:

- Keyworker survey
- Family interviews
- Keyworker interviews and focus groups
- Systemic practitioner analysis of case files
- Observations of training and practice
- Keyworker and systemic practitioner case studies and learning log
- Administrative data on families and keyworkers

Reach & Responsiveness

Main Questions:

- What is the rate of participation by practitioners in the training?
- What is the extent of practitioners' engagement in the systemic practice model?
- What is the extent of engagement from families' keyworkers?

Methods

Intervention group:

- Keyworker survey
- Family interviews
- Keyworker interviews and focus groups
- Systemic practitioner analysis of case files
- Observations of training and practice
- Keyworker and systemic practitioner case studies and learning log
- Administrative data on families and keyworkers

Acceptability

Main Question:
Is the systemic practice pilot model acceptable to practitioners and families?

Methods

Intervention group:

- Keyworker survey
- Family interviews
- Keyworker interviews and focus groups
- Systemic practitioner analysis of case files
- Observations of training and practice
- Keyworker and systemic practitioner case studies and learning log

Programme Differentiation

Main Question:
To what extent is the systemic practice pilot model different from existing practices?

Methods

Intervention group:

- Keyworker survey
- Family interviews

- Keyworker interviews and focus groups
- Systemic practitioner analysis of case files
- Observations of training and practice
- Keyworker and systemic practitioner case studies and learning log
- Administrative data on families and keyworkers

Control group:

- Keyworker survey
- Administrative data on families and keyworkers

Mechanisms

Main Question:
What appears to be the mechanisms of change and perceived outcomes of the systemic practice pilot model for practitioners and families?

Methods

Intervention group:

- Keyworker survey
- Family interviews
- Keyworker interviews and focus groups
- Systemic practitioner analysis of case files
- Observations of training and practice
- Keyworker and systemic practitioner case studies and learning log
- Administrative data on families and keyworkers

Barriers, Facilitators & Unintended Consequences

Main Question:
What are the challenges and enablers as well as unintended consequences to implementing the systemic practice pilot model?

Methods

Intervention group:

- Keyworker survey
- Family interviews
- Keyworker interviews and focus groups
- Systemic practitioner analysis of case files
- Observations of training and practice
- Keyworker and systemic practitioner case studies and learning log

- Administrative data on families and keyworkers

Capacity and Capability

Main Question:
What is the capability and capacity of local authorities to implement the systemic practice pilot model?

Methods

Intervention group:
- Keyworker survey
- Family interviews
- Keyworker interviews and focus groups
- Systemic practitioner analysis of case files
- Observations of training and practice
- Keyworker and systemic practitioner case studies and learning log
- Administrative data on families and keyworkers

Control group:
- Keyworker survey
- Administrative data on families and keyworkers

Unintended Outcomes

Main Question:
Are there any unintended outcomes as a result of implementation of systemic practice in keyworker teams?

Methods

Intervention group:
- Family interviews
- Keyworker interviews and focus groups
- Systemic practitioner analysis of case files
- Observations of training and practice
- Keyworker and systemic practitioner case studies and learning log
- Administrative data on families and keyworkers

IPE research methods

The IPE will include an extensive mixed-methods design, building on Foundation's feasibility and pilot studies and other studies looking at the implementation of systemic practice, including evaluations of the Reclaiming Social Work model.

In intervention local authorities the IPE will include:

1. Survey of keyworkers before training, post training and at the end of the pilot.
2. Focus groups and interviews with keyworkers (including systemic champions), the local authority systemic practitioners and senior staff (service leads and team managers).
3. Interviews with families receiving early help support
4. Administrative data collection from IFT and local authorities looking at training, implementation of systemic practice and support to families.
5. Observations of training, group reflective practice sessions, and (if feasible) keyworker sessions with families. Action learning research through analysis of keyworker and systemic practitioner case studies and learning logs.
6. If feasible, analysis of keyworker casefiles by embedded local authority Systemic Practitioners

In control local authorities the IPE will include:

1. Surveys of keyworkers at the start of the pilot and at the end.
2. Focus groups with keyworkers and interviews with senior staff (service leads and team managers)
3. Administrative data collection about business as usual implementation of key worker practice.

Practitioner surveys

For both the impact and IPE evaluation design a short online surveys of keyworkers will be administered to the intervention and control group keyworkers (as shown in the table below) led by Ecorys. The survey will be used in intervention areas to understand keyworker perspectives on implementation and fidelity to the systemic practice pilot. This will include training, use of the systemic practice virtual hub, support from the local authority systemic practice lead and systemic champions as well as the use of systemic practices (such as group reflective supervision) and tools (such as genograms). In addition to the perceived impact of the pilot on keyworkers and on families. In the control

arm the survey will be used to understand business-as-usual including standard practice and training. The survey will also be used to capture practitioner information such as roles and qualification levels as well as practitioners outcome measures for the pilot RCT.

Table 11: Survey timings

	Baseline survey Administered before training session 1	**Post-training survey** Administered at the final training session	**Endline survey** At the end of the pilot
Intervention LA	X	X	X
Control LA	X	-	X

The survey will take a census approach where keyworkers will be sent a direct link and promoted by keyworker managers. The online surveys will be created using Ecory's bespoke survey platform and tested in-house, with Coram and IFT as well as with local authorities before going live. The control group baseline and endline surveys will be designed to last no more than 10 minutes, and the intervention group baseline, post-training and endline survey will be designed to last no more than 15 minutes.

To maximise survey response rate, keyworkers will be sent links directly to their email addresses by Ecorys. The survey will also be promoted through multiple routes. For keyworkers in the intervention arm, keyworkers will be asked to complete the pre-survey and post-survey as part of the training sessions. Time for completion will be built into the introductory day and final training sessions. For keyworkers in the control, it will be mandatory for keyworkers to complete the survey as part of their online training on outcome measures for families.

In control and intervention local authorities, the endline survey will be promoted by the systemic practitioner and keyworker managers. Baseline, midline (for intervention) and endline surveys will be matched via keyworker emails. A targeted reminder strategy using their emails will be implemented using behavioural insights to design attractive materials, and targeted telephone reminders will be used if certain teams have a low response rate. It is hoped that a high response rate will be achieved given Foundation's pilot evaluation in Rotherham received a 96% response rate at baseline and 85% at

endline.[92] However, the number of keyworkers will be much higher and therefore the response rate will likely be lower than in the Rotherham study.

Keyworker focus groups and interviews

As part of the IPE, semi-structured focus groups and interviews will take place with keyworkers (including systemic champions) in both intervention and control local authorities. Interviews will also be conducted with embedded systemic practitioners and senior staff, such as service leads and team managers. Interviews and focus groups will focus on key aspects of implementation, delivery, and perceived impact.

In intervention local authorities, interviews with systemic practitioners and senior staff in local authorities will take place half way through the study and will be repeated towards the end of the study, in order to explore how their experiences and views have changed over the course of the trial. In control local authorities, senior staff will be interviewed once towards the end of the study.

With keyworkers, we will aim for 2 focus groups (with approximately 6 participants) in each of the 6 intervention local authorities, allowing us to reach around 12 practitioners in each local authority (a total of 72 practitioners across the intervention arm). These will take place approximately half way through the study. Towards the end of the study, we will also conduct 2-3 follow-up interviews with keyworkers in each local authority to explore how their experiences of embedding systemic practice have evolved over time. In control local authorities, we will conduct 1 focus group in each of the 4 control authorities (with approximately 6 participants in each).

To ensure a suitable mix in the focus groups, the sample will include keyworkers with a range of experience and roles to ensure the fieldwork explores key barriers and facilitators.

Focus groups and interviews will take place online, but in some instances may take place in-person if requested and feasible within the trial timeline and budget.

All interviews and focus groups will be digitally recorded and transcribed, with participants' consent.

Interviews with families

A key part of the IPE will be understanding families' perspectives in intervention local authorities on how keyworkers are embedding systemic practice in their support to families. This will include families' perspectives on the therapeutic relationship with keyworkers, how systemic keyworker practice was with families, their experiences of

[92] Burridge, H., Nolan, J. & Stanford, M. (2023) Piloting the implementation of systemic training and feedback tools in Rotherham's Early Help & Family Engagement Service: Evaluation report. Early Intervention Foundation.

systemic tools such as genograms, and their views on the impact of the keyworkers support on family outcomes.

We plan to sample families based on those that completed baseline outcome questionnaires along with input from local authority systemic practitioners and team managers. To ensure a suitable mix the sample will include families with a range of demographics including age of the child, ethnicity, SEND and social care status known via the additional data local authorities provide as part of the evaluation. We will aim to over-represent families from marginalised groups where possible.

We will aim for 3 family interviews in each of the of the 6 intervention local authorities, allowing us to reach 18 families overall. Interviews will be conducted online and a £25 voucher will be given to each family as a thank you for participation.

Observations

We will observe 3 training sessions run by IFT for keyworkers (the 5 day training programme) and 3 sessions for systemic champions (the additional 10 day training programme). We will also observe one keyworker reflective-practice session in each of the 6 intervention local authorities.

If feasible, we will also observe 3 keyworker sessions with families in each of the 6 intervention local authorities, resulting in 18 observations of families in total.

Observation data collection tools will be adapted from in Foundation's feasibility and pilot studies as well as previous observational tools. This includes a systemic practice coding tool used in the evaluation of systemic practice in social work[93] which has been developed over the course of 15 years to reliably code the quality of practice. The tool codes practice under the domains of: evocation, collaboration, autonomy, empathy, purposefulness, clarity about concerns, and child focus. This will be used as a robust and comprehensive method for observing improvements in keyworker practice. The tool will be adapted and tested with the expert working group, which includes those who developed the tool, as well as local authorities who have implemented systemic practice.

Action Learning Research

In order to enrich the learning from the evaluation, the IPE will include action learning research from analysis of keyworker and systemic practitioner case studies and learning log.

A short practitioner feedback form will be provided across all 6 intervention local authorities. This will be a non-mandatory form which practitioners can use to provide

[93] Bostock, L., et al. (2017). Scaling and deepening the Reclaiming Social Work model. Evaluation Report. Department for Education: Children's Social Care Innovation Programme Evaluation Report 45.

feedback and case studies on the impact of embedding systemic practice for themselves and the families they work with. We will ask for practitioners to anonymise any information given and data will be further anonymised by the Coram evaluation team before analysis. The form will provide open text to allow for practitioners to provide case studies of when they have used systemic practice principles with a family and the impact it had. It will also ask a short number of Likert scale questions on their confidence and use of systemic practice. The form will also ask if practitioners are happy for their responses to be linked to their keyworker survey responses.

In addition, as part of IFT's additional 10 days of systemic training systemic champions will be asked to complete learning logs and written case study assignments on how they have implemented and embedding systemic practice in their work with families as part of their practical implementation of systemic and reflective practice. This will include reflections on their evolving experiences and behaviours relating to systemic practice.

These case studies and learning logs will then be thematically coded and used to understand the use and embedding of systemic practice, including changes to practice and perceived impact on families. It is hoped some anonymised case studies will be used within the published outputs as illustrative examples.

Analysis of keyworker casefiles

A key part of the IPE will be understanding whether practice has changes as a result of the training and support. Observing practice through analysis of keyworker casefiles could be a way of assessing change. We will assess the feasibility of analysing keyworker case files to assess the implementation, use and quality of systemic practice by keyworkers. We will work with intervention area systemic practitioners and team managers to assess whether it is feasible in terms of capacity and capability of. We will develop a short assessment criteria to assess the use and quality of systemic practice drawing on the Systemic Therapy Inventory of Change (STIC) and the Systemic Practice Competency Scale (SPCS). We request each intervention area provide three randomly selected cases from families who closed to the service just before the pilot began and three files from cases who closed in the latter stages of the pilot (estimated between December 2025 and February 2026). These cases will be anonymised and only information pertaining to practice and processes provided. The evaluation team will then use the assessment criteria to code and analyse case files to understand if there has been changes to practice in terms of systemic practice principles, terms or tools used

Monitoring and administrative data

Administrative data from intervention and control local authorities will be collected to understand contextual service and team factors alongside implementation and fidelity of the practice model. As set out in *Compliance and Fidelity* above, this will include data on:

- Training attendance (from IFT and local authorities);
- Implementation of systemic practice such as number of systemic practice group reflective sessions and genograms created (from intervention local authorities);
- Keyworker caseloads, number of family assessments and closure forms; and
- Children and young people and parents/carers keyworker support (see impact evaluation data collection for more information).
- Usage of the Virtual Systemic Practice Hub such number and type of resources used and use of the Q&A and other forums

Analysis

Our analytical approach will involve a structured and robust process of data collation, sorting, coding and tagging (data preparation) and thematic investigation against the evaluation questions (data analysis). An overview of the methods can be found in below.

Practitioner Survey

- Data Collection Methods: Online pre-, post-, and end-line survey
- Participants / Data Sources: Practitioners from all 6 treatment and 4 control local authorities
- Data Analysis Methods: Quantitative analysis
- Research Questions Addressed:
    - Do keyworkers have increased levels of practice quality and professional wellbeing compared to practitioners in local authorities that have not implemented the model?

Interviews and Focus Groups

- Data Collection Methods: In-person or virtual interviews, recorded or notes taken
- Participants / Data Sources:
    - Focus groups with keyworkers in intervention local authorities (approximately 72 participants in total)
    - Focus groups with keyworkers in control local authorities (approximately 24 participants in total)

    - Interviews with senior staff (team managers and heads of service) in intervention and control local authorities (10–20 participants in total)
    - Interviews with systemic practitioners in intervention local authorities (6 participants in total)

- Data Analysis Methods: Qualitative thematic analysis
- Research Questions Addressed:
    - Do families have a better therapeutic alliance with their keyworker in local authorities that have implemented the systemic practice model compared to local authorities that have not?
    - Do keyworkers have increased levels of practice quality and professional wellbeing compared to practitioners in local authorities that have not implemented the model?
    - Are there any unintended outcomes as a result of implementation of the systemic practice model?

Observations

- Data Collection Methods: In-person observation of a training session, keyworker practice sessions, and sessions with families if feasible; note-taking
- Participants / Data Sources: Training sessions with keyworkers, reflective practice sessions with keyworkers, support sessions with families
- Data Analysis Methods: Qualitative analysis of observation notes
- Research Questions Addressed**:**
    - Do families have a better therapeutic alliance with their keyworker in local authorities that have implemented the systemic practice model compared to local authorities that have not?
    - Do keyworkers have increased levels of practice quality and professional wellbeing compared to practitioners in local authorities that have not implemented the model?

Casefile Analysis

- Data Collection Methods: Requesting a sample of keyworker casefiles
- Participants / Data Sources: Keyworkers and families
- Data Analysis Methods: Casefile analysis
- Research Questions Addressed:

- Do keyworkers have increased levels of practice quality and professional wellbeing compared to practitioners in local authorities that have not implemented the model?
- Do families with a keyworker have increased levels of family functioning in local authorities that have implemented the systemic practice model compared to local authorities that have not?
- Do families have a better therapeutic alliance with their keyworker in local authorities that have implemented the systemic practice model compared to local authorities that have not?
- Do parent/carers and children with a keyworker have increased levels of mental wellbeing in local authorities that have implemented the systemic practice model compared to local authorities that have not?

Action Learning Research

- Data Collection Methods: Practitioner feedback survey, case studies, and learning logs/case study assignments from 10-day training
- Participants / Data Sources: Keyworkers
- Data Analysis Methods: Qualitative analysis
- Research Questions Addressed:
  - Do keyworkers have increased levels of practice quality and professional wellbeing compared to practitioners in local authorities that have not implemented the model?
  - Do families with a keyworker have increased levels of family functioning in local authorities that have implemented the systemic practice model compared to local authorities that have not?
  - Do families have a better therapeutic alliance with their keyworker in local authorities that have implemented the systemic practice model compared to local authorities that have not?
  - Do parent/carers and children with a keyworker have increased levels of mental wellbeing in local authorities that have implemented the systemic practice model compared to local authorities that have not?

Administrative Data

- Data Collection Methods: Information request
- Participants / Data Sources: All 12 treatment and control local authorities
- Data Analysis Methods: Quantitative analysis
- Research Questions Addressed:

- Are there reductions in re-referrals and step-up to statutory support in local authorities that have implemented the systemic practice model compared to local authorities that have not?
- Do different sub-groups of families or keyworkers have different outcomes?

Table 12: IPE methods overview

Research methods	Data collection methods	Participants/ data sources (type, number)	Data analysis methods	Research questions addressed
Practitioner survey	Online pre, post and end line survey	Practitioners from all 6 treatment and 4 control local authority practitioners	Quantitative analysis	Do keyworkers have increased levels of practice quality and professional wellbeing compared to practitioners in local authorities that have not implemented the model?

Research methods	Data collection methods	Participants/ data sources (type, number)	Data analysis methods	Research questions addressed
Interviews and focus groups	In person or virtual interview, recorded or notes taken	Focus groups with keyworkers in intervention local authorities (approximately 72 participants in total.) Focus groups with keyworkers in control local authorities, (approximately 24 participants in total). Interviews with senior staff (team managers and heads of service) in intervention and control local authorities (10-20 participants in total) Interviews with systemic practitioners in intervention local authorities (6 participants in total)	Qualitative thematic analysis	Do families have a better therapeutic alliance with their keyworker in local authorities that have implemented the systemic practice model compared to local authorities that have not? Do keyworkers have increased levels of practice quality and professional wellbeing compared to practitioners in local authorities that have not implemented the model? Are there any unintended outcomes as a result of implementation of the systemic practice model?

Research methods	Data collection methods	Participants/ data sources (type, number)	Data analysis methods	Research questions addressed
Observations	In person observation of a training session, keyworker practice sessions, and session with families if feasible, note taking	Training sessions with keyworker, reflective practice sessions with keyworkers, support sessions with families	Qualitative analysis of observation notes	Do families have a better therapeutic alliance with their keyworker in local authorities that have implemented the systemic practice model compared to local authorities that have not? Do keyworkers have increased levels of practice quality and professional wellbeing compared to practitioners in local authorities that have not implemented the model?
Casefile analysis	Requesting a sample of keyworker casefiles	Keyworkers and families	Casefile analysis	Do keyworkers have increased levels of practice quality and professional wellbeing compared to practitioners in local authorities that have not implemented the model? Do families with a keyworker have increased levels of family functioning in local authorities that have implemented the systemic practice model compared to local authorities that have not? Do families have a better therapeutic alliance with their keyworker in local authorities that have implemented the systemic practice model compared to local authorities that have not? Do parent/carers and children with a keyworker have increased levels of mental wellbeing in local authorities that have implemented the systemic practice model compared to local authorities that have not?

Research methods	Data collection methods	Participants/ data sources (type, number)	Data analysis methods	Research questions addressed
Action Learning Research	Practitioner feedback survey case studies and learning logs/case study assignments from 10 day training	Keyworkers	Qualitative analysis	Do keyworkers have increased levels of practice quality and professional wellbeing compared to practitioners in local authorities that have not implemented the model? Do families with a keyworker have increased levels of family functioning in local authorities that have implemented the systemic practice model compared to local authorities that have not? Do families have a better therapeutic alliance with their keyworker in local authorities that have implemented the systemic practice model compared to local authorities that have not? Do parent/carers and children with a keyworker have increased levels of mental wellbeing in local authorities that have implemented the systemic practice model compared to local authorities that have not?
Administrative data	Information request	All 12 treatment and control local authorities	Quantitative analysis	Are there reductions in re-referrals and step-up to statutory support in local authorities that have implemented the systemic practice model compared to local authorities that have not? Do different sub-groups of families or keyworkers have different outcomes?

Qualitative data analysis (interviews/focus groups, observations, Action Learning Research and case file analysis) will be guided by Braun and Clarke's 6-stage process of

reflexive thematic analysis.[94] NVivo software will be used to facilitate the analysis due to its scale (number of data points, i.e. interviews, observations etc.) and scope (participant groups, timelines and local authorities) to help develop our analytical themes. We use thematic analysis of qualitative data collected and an inductive approach so that findings are grounded in what participants have said and there is a clear link between themes and the data. These findings triangulated and analysis will involve detailed thematic investigation based on the evaluation questions and themes identified in the analysis framework.

Our quantitative analysis (from the surveys, administrative data etc.) will provide a detailed descriptive picture of the implementation of the practice model. It will explore trends and variations in the key IPE evaluation questions. This analysis will provide:

- *Frequency* tables of key variables/survey questions in the workforce and family experience surveys.
- *Cross tabulations* of a selected variables/survey questions, and where possible with significance tests.
- *Indication of significant differences where applicable* (the robustness and precision of subgroup comparisons will largely depend on the size of each group).

All data will be checked and cleaned thoroughly before analysis. Analysis will be undertaken using R (and/or similar tools as appropriate), moving from descriptive to inferential analysis.

In practice, the analysis will:

- Involve *familiarisation* with all data, to describe and interpret the findings across the main research aims and questions, by participant type. We will also identify any *unexpected themes* in terms of participant experiences or perceived outcomes/impacts.
- Assess *commonalities and differences* participant groups, local authorities, or data sources, unpicking the reasons for these. We will conduct within (e.g., local authorities) and between case analyses (e.g., across local authorities), triangulating the views of the different groups.
- Triangulate qualitative and quantitative data to help explain the impact findings.

All analysis will be fully documented, ensuring the evidence claims are auditable and can be traced back to the original data source.

[94] Braun, V. and Clarke, V. 2019. Thematic Analysis: a practical guide. SAGE: London

Cost data collection and reporting

The aim of collecting cost data will be to estimate the systemic practice pilot costs. Cost estimation is about placing a monetary value on all the resources used in the delivery of an activity, in this case – the activities to embed systemic practice in local authority keyworker teams. This will be guided by the HM Treasury Green Book,[95] the National Audit Office's '4Es' framework,[96] and the Youth Endowment Fund's Cost Reporting Guidance.[97]

Cost estimation is a valuable evaluation tool used to understand the resources needed to deliver an intervention and to compare the cost of different services. Cost estimation is an important first step in understanding whether an intervention offers value for money.

The general principles of the cost data collection and reporting in the reporting will follow YEF guidance and include:

- Estimates will be of the costs of delivery only.
- Cost estimates will use a 'bottom-up' approach.
- Cost estimates will be from the perspective of all organisations, Coram, IFT and the local authorities within the trial.
- Estimates should capture the nature of resources used, the quantity and monetary value in delivering the intervention.

The main cost categories will include the costs of delivering the model of embedding systemic practice. To do this we will define the role of each organisation in the delivery of the programme and then assess what costs are incurred for them individually and combined. We will work with each organisation to understand the costs of the pilot but estimate it will include all costs related to IFT's delivery of the pilot such as: training to keyworkers, IFT's systemic practice lead, the virtual practice hub set up and maintenance, and general support to local authorities. As well as costs to local authorities in the intervention arm, including the costs to hire and employ a systemic practitioner, training venue hire/use and time taken by keyworkers to take part in training and systemic practice reflective meetings. In addition to costs incurred to Coram for support to IFT and local authorities. Costs relating to the evaluation and programme development from Coram and IFT will be excluded. Labour costs will be calculated directly from staff costs provided by IFT, Coram and intervention arm local authorities. This will include salary and on-costs of staff.

[95] www.gov.uk/government/publications/the-green-book-appraisal-and-evaluation-in-central-governent
[96] www.nao.org.uk/successful-commissioning/general-principles/value-for-money/assessing-value-for-money
[97] https://youthendowmentfund.org.uk/wp-content/uploads/2022/01/21.-YEF-Cost-reporting-guidance.pdf

All costs will be adjusted to constant prices using GDP deflators. The base year used should be the year in which delivery begins. Cost estimates will be generated assuming full compliance (i.e. keyworkers attend all sessions). Costs will be separated into prerequisite, set-up and recurring. Recurring costs will be calculated for one financial year (i.e. one round of delivery) of ongoing delivery. For example, the cost of the local authorities' systemic practice lead, ongoing training, maintenance of the virtual practice hub. Total costs will be presented for one financial year for an average cohort of keyworkers as well as for families receiving keyworker support. We will also attempt to calculate costs per participant figures (keyworker and families) should be presented for set-up, recurring and total costs.

Costs will be presented as a full list and description of the items included in the cost; and, a detailed breakdown of cost estimates by item and each organisation.

Feasibility for a full-scale trial

Trial feasibility will be answered using findings from both IPE and pilot RCT via the following questions:

1. Is there a clear description of the systemic practice model that would allow it to be implemented and evaluated in other local authorities? Are any changes needed to before further rollout?

2. Does the systemic practice model show enough promise of impact to take to a full trial?

3. What is the recommended approach for further evaluation?

4. What are the implications for family help and early help as well as wider policy and practice?

From this the evaluation will provide critical learning about recruitment, capacity of local authorities to implement systemic practice, fidelity, dosage, feasibility of data collection and appropriateness of measures, sample size for statistical power, expected effect size, follow-up sequencing, and identify any unintended consequences.

To assess the feasibility for a full scale trial the following progression criteria using pre-determined thresholds has been developed in line with standard evaluation practice[98] and with the pilot's expert working group. A set of criteria, RAG rated for 'stop,' 'amend' and 'go' is set out in the table below.

As a guide:

- If at least 10 out of the 12 'proceed' criteria are met, we will recommend proceeding to a full trial

- If there are at least 10 'review' criteria met, we will recommend reviewing before moving to a full trial

- If there are more than 6 'stop' criteria met, we will recommend not proceeding to a full trial

[98] Avery K., et al (2017) Informing efficient randomised controlled trials: exploration of challenges in developing progression criteria for internal pilot studies. BMJ Open. doi: 10.1136/bmjopen-2016-013537.

Table 13: Criteria for full-scale trial

Criteria	Green (proceed)	Amber (review)	Red (stop)
1. Adequate recruitment of local authorities into the trial	≥10 local authorities recruited	≥8 local authorities recruited	<5 local authorities recruited
2. Adequate retention of local authorities within the trial (an indicator of acceptability of randomisation)	No local authorities drop out of the trial	1-3 local authorities drop out of the trial	≥4 local authorities drop out of the trial
3. Adequate recruitment rate of families into the trial and completion of baseline Family Outcome Questionnaire	80-100% (n=932-1165) families complete baseline measures	60-79% (n=699-931) families complete baseline measures	0-59% (n=0-698) families complete baseline measures
4. Adequate response/attrition rate to the trial	50-100% families complete endline measures	35-49% families complete endline measures	0-34% families complete endline measures
5. Adequate follow-up data from the keyworker survey	≥200 keyworker follow-up measures completed	≥175 keyworker follow-up measures completed	<150 keyworker follow-up measures completed
6. Minimal Family Outcome Questionnaire data loss/unusable due to poor quality data	10% of outcome data lost to poor quality data	15% of outcome data lost to poor quality data	20% of outcome data lost to poor quality data

Criteria	Green (proceed)	Amber (review)	Red (stop)
7. Sufficient administrative data on families collected from local authorities to allow for analysis	Low rates of missing administrative data (>75% of family cases complete)	Some missing data (>60% of cases complete)	High rates of missing data (<50% of cases complete)
8. Evidence of promise according to the primary outcome of progression towards goals	The MDES of the study is ≤ 0.50	The MDES of the study is between 0.51-1	The MDES of the study is > 1
9. Sufficient fidelity to trial protocol	Low rates of deviation from the trial protocol, as measured by incidents of trial arm contamination (80-100% of cases)	Moderate rates of deviation from the trial protocol, as measured by incidents of trial arm contamination (70-79% of cases)	High rates of deviation from the trial protocol, as measured by incidents of trial arm contamination (0-69% of cases)
10. Sufficient fidelity to systemic practice intervention	Low rates of deviation from the intervention theory of change according to the fidelity checklist	Moderate rates of deviation from the intervention theory of change according to the fidelity checklist	Low rates of deviation from the intervention theory of change according to the fidelity checklist

Further considerations beyond these progression criteria would also support assessing the feasibility of a full trial. We suggest these should include:

- An assessment of how many local authorities in England would be provisionally eligible for a full trial to enable adequate recruitment, in that they i) currently, or in the last three years, have not implemented systemic practice in their keyworker teams; and ii) currently, or in the last two years, have not had an inadequate Children's Services Ofsted rating

A consideration of barriers, enablers, and unintended consequences as identified in the implementation and process evaluation. Key mechanisms for change identified in this

evaluation should be reviewed and considered as part of the practice model before progressing to a full trial.

Ethics

We will use Coram's well-established research ethics standards to ensure ethical rigour. These standards are based on guidelines from the Economic and Social Research Council, the Social Research Association, and the UK Research Integrity Office.

The evaluation will go through a full ethics application via our Research Ethics Committee (REC) chaired by Professor Jonathan Portes. An ethics application will be submitted to the REC and discussed at appropriate REC quarterly meetings. A minimum of two members of the REC will review the application. Possible outcomes of the review are favourable, conditionally favourable or unfavourable. A favourable decision means the project and evaluation can go ahead as proposed. If a conditionally favourable decision is made, the project and evaluation can only go ahead once certain conditions are met. If an unfavourable decision is made, the project and evaluation will need to be revised and then reconsidered by the REC.

The project and evaluation will not start until Coram's REC and DfE's ethics board have provided ethical approval.

A RCT design raises ethical questions about the control local authorities being denied systemic practice. However, as systemic practice is not part of usual support offered to families as part of the Supporting Families Programme, those in the control group are not being denied a service that they would have otherwise received. In addition, as there have been no previous impact studies of systemic practice in early help, it is unclear if it is effective in supporting keyworkers to help families achieve better outcomes for themselves. A well-planned and executed pilot RCT would be more likely to provide causal evidence of impact than other forms of evaluation such as a quasi-experimental design (QED).

To minimise ethical issues (and as is typical of trials in family support), the RCT will be unblinded. Local authorities, keyworkers and families will know or be able to find out that they are in a pilot RCT and that they are in the control or intervention group.

We do not anticipate either families or keyworkers will experience harm as a result of participation, but we would gather information through regular communication with local authorities and IFT about any emerging risks and harms. If evidence emerged of serious and substantial harms being caused to families in either the control or intervention group, we would consult Coram's REC. Ethically, we feel it is important that the evaluation is co-designed with CYP. Therefore, we will work with our peer researcher young advisors in throughout the evaluation to ensure our design, data collection, analysis and dissemination is informed by them.

Confidentiality would only be broken if there was a risk of harm. Participants will be anonymous in all outputs. Any safeguarding issues that arise will be escalated in

accordance with our safeguarding policies. Appropriate signposting and referral mechanisms will be in place for if children/young people or parents/carers disclose anything where there is a legal obligation to act on. It will be made clear in data privacy notices and any information shared with participants what may happen if they do disclose anything that would warrant a safeguarding consent.

We will ensure participants receive good quality, accessible information about our research to support informed consent, making it clear that participation is voluntary. We will provide and support the use of accessible evaluation materials such as information sheets, FAQs, and consent forms, using plain, simple language and pictures where appropriate. We will seek consent to take part in the evaluation, surveys and interviews from children/young people and from parents/carers.

For primary data collection (i.e. interviews) we will make it clear to participants that they will not have to answer questions they do not want to, and that they could stop the interview at any time. We will also have a list of resources for support to hand to participants if we feel it appropriate.

Registration of the trial will be undertaken by the Department for Education via the Cabinet Office's evaluation taskforce registry.

Equity, diversity and inclusion

We are committed to creating equitable and inclusive research. We have strict ethical protocols and processes in place, and Coram's research ethics framework requires us to do our research in an accessible and inclusive way. Our policies go beyond legal requirements, aiming to involve people from underrepresented communities. We are upfront about the drawbacks of being a predominantly White team in our research, and recognise this will inevitably affect our work (and take action to address this in our recruitment practices).

We understand the power imbalance that research with vulnerable children/young people and their families can bring. We will apply reflexivity to our research to understand how we may influence and interpret findings and report this honestly. We will consider racial diversity and inclusion prominently in our evaluation plans and ongoing work with local authorities as well as DfE and within the pilot such as IFT and Ecorys.

Throughout the pilot, we will focus on encouraging inclusivity and meaningful participation by:

- minimising the burden on research participants by ensuring questionnaires and interview discussions are focussed on the most pertinent questions
- working flexibly to meet the varied needs and preferences of different participants and to reduce barriers to participation, including carrying out interviews at times to suit participants, and using creative, child-friendly, easy-read and/or translated tools and methods where appropriate
- using accessible information sheets and consent forms and checking for informed consent throughout
- confirming with participants prior to any interviews whether they have any support or access needs (e.g. being accompanied by a trusted person, having the interview over two shorter sessions, easy read formats, interpreters etc.)
- research activities will take place in safe, culturally-appropriate, accessible settings
- signposting to additional support if needed.

Data protection

Maintaining data security is a key risk mitigation for the pilot and we will work closely with local authorities to ensure data is collected, shared, analysed and stored appropriately.

Coram and Ecorys holds a Cyber Essentials Plus certificate. All Coram and Ecorys staff receive data security and GDPR training.

Coram and DfE both completed a Data Protection Impact Assessment (DPIA) for the pilot. In line with these DPIAs, data for the purposes of this research study will be collected under these lawful bases:

- **Personal data** will be processed under the basis of **Public Task** under UK General Data Protection Regulation Article 6.1(e).
- **Special category personal data** being processed for research purposes is under GDPR Article 9.2(j) and DPA18 Schedule 1 Part 1.4(a), (b)&(c) for special category data including data considered to be a protected characteristic under the UK Equality Act 2010.

For ethical reasons Coram and Ecorys will actively request consent from those providing data as part of the evaluation (for example, Family Outcome Questionnaire, keyworker survey and interviews).

The pilot will also be informed by the Department for Education's Personal information charter.[99]

Coram and each of the local authorities will be the **joint controllers** of personal data throughout the pilot. Coram and the local authorities will make decisions together about what data will be collected and how they will be processed for the evaluation.

Clear guidance and data privacy notices on handling, collecting and processing personal data have been developed for both practitioners and families.[100] This focus on communicating participants' rights or change the data we hold on them, or to have it deleted within a given timeframe.

Data collected by Coram as part of the evaluation from families and keyworkers will be stored securely on Coram's internal server, only accessible by the Coram study team members. Data collected by Ecorys (from the keyworker surveys) will be sent to Coram securely via a secure folder on SharePoint, only accessible by named users. Data

[99] See: https://www.gov.uk/government/organisations/department-for-education/about/personal-information-charter
[100] For practitioners see: https://www.coram.org.uk/wp-content/uploads/2024/10/Systemic-Practice-DPN-for-practitioners-v1.2.pdf and for families: https://www.coram.org.uk/wp-content/uploads/2024/11/Systemic-Practice-DPN-parents-carers-and-children-FINAL.pdf

transferred from local authorities will be via a secure folder on SharePoint, only accessible by named users.

Interviews will only be recorded with informed consent. Interview recordings will be securely deleted after finalisation of the final report and other data anonymised and archived. We will not use identifying information when reporting and disseminating findings.

Risks and mitigations

Table 14: Risks and mitigations

Risk	Risk category	Likelihood/ Impact	Mitigation strategy
One or more local authorities drop out	Delivery	Medium / High	A clear MOU will set out the roles and responsibilities for local authorities to ensure they understand participation in the project. We will also provide extensive support via administrative and contract support through our dedicated Business Support Manager. We have also costed for £10,000 to each local authority in the control group local authorities (£5,000 at the start and £5,000 at the end) to support administration and data collection. In addition, control local authorities will receive incentive training after the pilot. In addition, we have constructed conservative sample size assumptions to ensure sample power even with local authority drop outs. Finally, as this is a pilot, having the required power for the RCT is less a priority than understanding whether a full-scale efficacy trial is feasible.
Poor understanding of the practice model which is not informed by evidence, practice or lived experience	Delivery	Low / High	The delivery and evaluation team have extensive knowledge of the practice model. In addition to the previous work undertaken. A comprehensive co-design period with an expert working group to produce detailed practice model and use journey maps which include key elements of the intervention.

Risk	Risk category	Likelihood/ Impact	Mitigation strategy
Limited understanding of local authority needs and context	Delivery	Medium / High	Work closely with local authorities in the co-design stage to collect contextual information and use initial IPE fieldwork to collect this information.
Low recruitment and/or retention and/or low participation rates keyworkers	Delivery	Medium / High	Ensure training and the model is focused on the needs of keyworkers and contextualised. Comprehensive co-design period with expert working group. Rapidly feed in findings from early stage IPE on identified barriers and possible solutions to delivery of training and embedding the model etc.
Low fidelity and consistency in delivery across local authorities	Delivery	Medium / High	Develop a standardised systemic practice model in the co-design stage with expert working group. Explore inconsistencies in the IPE rapidly feedback to IFT and local authorities. Evaluation design will spread fieldwork effort across sites to enable variation to be explored and a fidelity checklist will be developed.
Temporary or permanent loss of IFT & Coram delivery team	Delivery & Evaluation	Medium / Low	The full team would be kept up-to-date through internal catch ups so would be able to 'pick up' tasks at any stage; good record keeping; ability to draw on extensive capacity at IFT to draw on qualified trainers and teachers.
Specific areas of work demand more time / resource than expected.	Delivery & Evaluation	Medium / Low	Careful project/budget management and open/close communication between key partners. We have robust project management processes with monthly completion of timesheets, monthly project planning to review days on project budgets, weekly staff meetings to identify priorities for the week and regular communications around project

Risk	Risk category	Likelihood/ Impact	Mitigation strategy
			deliverables. This will identify any potential for project overspend well in advance, and put in course correction measures before this happens. We will ensure regular communication with Thrive at Five team as well for timely identification of any issues where deadlines are not being met (and developing updated timelines where necessary).
Low recruitment and/or participation rates of keyworkers (including high turnover) in the evaluation	Evaluation	Medium / High	Develop a thorough and comprehensive plan for involving practitioners which recognises the challenges and builds in appropriate time and resources from the outset. This will be underpinned by a rigorous approach to research ethics and stakeholder participation. Ensuring that our project plans, recruitment and findings recognise intersecting needs and diverse experiences of participants. refine recruitment and approach as necessary before efficacy study; avoid overburdening delivery staff and children/young people and families with excessive data demands; a flexible approach to data collection (e.g. flexibility in interview times and locations); reminders. Ensure research instruments are appropriate.
Unavailable or poor quality administrative data. **Difficulties obtaining existing administrative**	Evaluation	Medium / High	We will begin as early as possible creating robust and compliant data sharing agreements with key partners; co-design phase to involve data mapping including what format this takes, and quality considerations. This will allow greater specificity of the data requests to help ensure we obtain what is needed and necessary for the evaluation. Both

Risk	Risk category	Likelihood/ Impact	Mitigation strategy
data (e.g. lengthily delays, inappropriate format, missing categories).			Coram and Ecorys have robust data security processes in place to meet standards necessary for accessing data held by public systems. Supply a template of required fields; advance warning of data requests; reminders and support; thorough quality assurance such as cleaning and checking; time allowed for querying data with partners.
Temporary or permanent loss of evaluation team members	Evaluation	Medium / Low	Coram and Ecorys are both agile organisations comfortable with managing multiple demands and have a skilled, multi-disciplinary staff team with regular oversight of workload to redeploy in the event of staff absence or significant change in the work. Coram and Ecorys also have a robust associate network who may be drawn upon to provide freelance support if there are long-term absences within the core project team. The full team would be kept up-to-date through internal catch ups so would be able to 'pick up' tasks at any stage; good record keeping; ability to draw on extensive capacity at Ecorys and Coram.
Communication / dissemination of findings with public and scope for misinterpretation	Dissemination	Low / Medium	Early discussion and testing of dissemination plan, incorporation of dissemination questions during engagement with key stakeholders. Testing of initial communications with relevant audiences.

Annex A – High-level timeline

Systemic practice pilot timeline

August 2024

- MOU and DSA signed — *Coram*

September 2024

- Ethical approval given — *Coram*

October 2024 – April 2025

- Pilot starts: IFT training (1-day intro for all staff and 5 days training for all keyworkers) — *IFT / Local Authorities*

November 2024 – April 2025

- Pre-training survey of keyworkers — *Ecorys / Coram*

January 2025

- Start of outcome data collection with families by keyworkers — *Local Authorities*
- Drop-in sessions for keyworkers and LA staff working on the Pilot begin — *Coram*
- IPE and qualitative data collection (interviews, observations) begins — *Coram*

April – June 2025

- Post-training survey of keyworkers — *Ecorys / Coram*

April – October 2025

- Additional 10 days training for identified ‘systemic champion’ keyworkers — *IFT*

February 2026

- End of baseline outcome data collection with families by keyworkers — *Local Authorities*

End April 2026

- End of midline and endline outcome data collection with families by keyworkers — *Local Authorities*

April – May 2026

- Post-pilot survey of keyworkers — *Ecorys / Coram*

May 2026

- Outcome data matching with LA data on families — *Local Authorities / Coram*
- Control group local authorities receive training — *IFT*

End May 2026

- Final administrative data to Coram — *Local Authorities / IFT*

June 2026

- Coram data clean and QA — *Coram*

August 2026

- IPE and outcome data analysis — *Coram*

Autumn 2026

- Draft final report to DfE — *Coram*
- Final published report — *DfE*

Annex B – Family outcomes questionnaires

Systemic Practice Pilot Family Outcomes Questionnaire

ADULT QUESTIONNAIRE – PAPER VERSION

This is a paper copy of the Family Outcomes Questionnaire for **adult** family members as part of the Systemic Practice Pilot Study. We are using this questionnaire to support the evaluation of the pilot.

Please also take a paper copy of the privacy notice to give to parent/carers and children **before** they consent to completing the questionnaire: https://www.coram.org.uk/wp-content/uploads/2024/11/Systemic-Practice-DPN-parents-carers-and-children-FINAL.pdf

Information collected on this paper version should be uploaded via the link: https://www.smartsurvey.co.uk/s/FamilyOutcomeQuestionnaire/

Administrative information for the Keyworker to complete

Please write the local authority ID number for the adult completing the questionnaire. The ID will be the one you use in your service for the adult or family.

Providing this is very important as it will allow us to use the questionnaire data in the pilot.

Adult/family ID ☐

1. Please tick the box to indicate who is completing this questionnaire.

☐ Mother

☐ Father

☐ Other carer/guardian

(for example, step parent)

☐ Other adults in the household/family

(e.g. grandparent, older sibling etc.)

2. Has this family member completed the questionnaire before?

☐ No, this is their first time completing the questionnaire

☐ Yes, they have completed the questionnaire before, and today they are completing it as part of a review of their progress

☐ Yes, they have completed the questionnaire before, and they are completing it as part of ending our support (case closure)

3. Please state roughly how long you have worked with the family. If the family have been re-referred, please state how long you have been working with them since the rereferral.

☐ Less than a week
☐ 1 to 2 weeks
☐ 3 to 4 weeks
☐ 5 to 8 weeks
☐ 9 to 12 weeks
☐ 3 to 6 months
☐ 7 to 12 months
☐ Over 12 months

Questionnaire information and Consent

Welcome to the Family Outcome Questionnaire as part of the Systemic Practice Pilot.

We are using this questionnaire to understand how training and support to keyworkers can improve the support they give to families like yours.

The questionnaire will take around 15 minutes to complete and will ask questions about your goals for working with the keyworker service, your family relationships and your relationship with your keyworker.

Please read the pilot's Data Privacy Notice here, before deciding whether to take part in the pilot and completing the Family Outcomes Questionnaire.

5. Please tick the box to indicate that you consent to taking part in this evaluation.
Please note that whether you consent or not will in no way affect the support provided to you by the service.

☐ I consent to taking part in this questionnaire and for my data to be used in the evaluation as set out in the Data Privacy Notice

Introduction

Thank you for agreeing to complete the Family Outcomes Questionnaire.

The questionnaire will ask a series of questions divided into three sections. They will cover:

- **Your family** – 15 questions about how you see your family at the moment.
- **Your goals** – goals (up to three) you want to achieve for your family through this service. It also asks your views on your current progress towards these goals.
- **Your keyworker** –10 questions about your relationship with your keyworker.

If you have any questions when completing the questionnaire **please ask your keyworker and they will be able to help you**.

Section 1: Your Family

In this section we would like you to tell us about how you see your family at the moment. **So we are asking for <u>your</u> view of your family.** When people say 'your family' they often mean the people who live in your house. **But we want you to choose who you want to count as the family you are going to describe.**

There are 15 short questions. Please tick whether the statement describes your family very well through to not well at all. For example, if a statement was "We are always fighting each other" and you felt this was not especially true of your family, you would tick the box that says "Describes us: not well".

Very Well	Well/	Partly	Not very well	Not at all
			X	

Do not think for too long about any question, but do try to tick one of the boxes for each question.

For each line, would you say **<u>this describes our family</u>:** Very well / Well / Partly / Not very well / Not at all / Do not want to answer

1. In my family we talk to each other about things which matter to us
2. People often don't tell each other the truth in my family
3. Each of us gets listened to in our family
4. It feels risky to disagree in our family
5. We find it hard to deal with everyday problems
6. We trust each other
7. It feels miserable in our family
8. When people in my family get angry they ignore each other on purpose
9. We seem to go from one crisis to another in my family
10. When one of us is upset they get looked after within the family
11. Things always seem to go wrong for my family

12. People in the family are nasty to each other
13. People in my family interfere too much in each other's lives
14. In my family we blame each other when things go wrong
15. We are good at finding new ways to deal with things that are difficult

Section 2: Your Goals

In this section we want to know the most important **goals** to you that you want to achieve for your family in coming to this service.

We will ask you to list up to **three** of your goals. After each goal we will ask how close you feel you are currently in progress to reaching that goal on a scale from zero to ten. A score of zero means no progress has been made towards a goal, a score of ten means a goal has been reached fully, and a score of five is exactly half way between the two.

Your first goal is:

How close do you feel to reaching your first goal?

1 – Goal not at all met
2
3
4
5 – Half way to reaching goal
6
7
8
9
10 – Goal reached

Your second goal is:

How close do you feel to reaching your second goal?

1 – Goal not at all met
2
3
4
5 – Half way to reaching goal
6
7
8
9
10 – Goal reached

Your third goal is:

How close do you feel to reaching your third goal?

1 – Goal not at all met
2
3
4
5 – Half way to reaching goal
6
7
8
9
10 – Goal reached

Section 3: Your Keyworker

This section asks 10 questions about working with your keyworker present here today.

For this section, you **do not need to discuss** your answers with your keyworker. Instead, please give your honest opinion on the support you have been given. Please note, answers given here or anywhere in this questionnaire **will not affect the support you receive from this service** in any way.

For each line, would you say **this describes your relationship with your keyworker:** Poor / Fair / Good / Very good / Excellent / Does not apply / Do not want to answer

1. **Making you feel at ease** *(introducing him/herself, explaining his/her position, being friendly and war towards you, treating you with respect, not cold or abrupt)*
2. **Letting you tell your "story"** *(giving you time to fully describe your condition in your own words; not interrupting, rushing, or diverting you)*
3. **Really listening** *(paying close attention to what you were saying; not looking at the notes or computer as you were talking)*
4. **Being interested in you as a whole person** *(asking/knowing relevant details about your life or your situation; not treating you as 'just a number')*
5. **Fully understanding your concerns** *(communicating that he/she had accurately understood your concerns and anxieties; not overlooking or dismissing anything)*
6. **Showing care and compassion** *(seeming genuinely concerned, connecting with you on a human level; not being indifferent or 'detached')*
7. **Being positive** *(having a positive approach and a positive attitude; being honest but not negative about your problems)*

8. **Explaining things clearly** *(fully answering your questions, explaining clearly, giving you adequate information; not being vague)*
9. **Helping you to take control** *(exploring with you about what you can do to improve your health yourself; encouraging rather than 'lecturing' you)*
10. **Making a plan of action with you** *(discussing the options, involving you in decisions as much as you want to be involved; not ignoring your views)*

Thank you for completing this questionnaire, it is an important part of the pilot.

For further information on how this information will be used, please see the **Date Privacy Notice**: https://www.coram.org.uk/wp-content/uploads/2024/11/Systemic-Practice-DPN-parents-carers-and-children-FINAL.pdf

Systemic Practice Pilot Family Outcomes Questionnaire

CHILD (8-17 years old) QUESTIONNAIRE – PAPER VERSION

This is a paper copy of the Family Outcomes Questionnaire for **child (aged 8 and over)** family members as part of the Systemic Practice Pilot Study. We are using this questionnaire to support the evaluation of the pilot.

Please also take a paper copy of the privacy notice to give to parent/carers and children **before** they consent to completing the questionnaire: https://www.coram.org.uk/wp-content/uploads/2024/11/Systemic-Practice-DPN-parents-carers-and-children-FINAL.pdf

Information collected on this paper version should be uploaded via the link: https://www.smartsurvey.co.uk/s/FamilyOutcomeQuestionnaire/

Administrative information for the Keyworker to complete

1. **Please write the local authority ID number for the child completing the questionnaire. The ID will be the one you use in your service for the child.**

Providing this is very important as it will allow us to use the questionnaire data in the pilot.

2. **Child ID**

Has this child completed the questionnaire before?

☐ No, this is their first time completing the questionnaire

☐ Yes, they have completed the questionnaire before, and today they are completing it as part of a review of their progress

☐ Yes, they have completed the questionnaire before, and they are completing it as part of ending our support (case closure)

3. Please state <u>roughly</u> how long you have worked with the child. If the child have been re-referred, please state how long you have been working with them since the rereferral.

☐ Less than a week

☐ 1 to 2 weeks

☐ 3 to 4 weeks

☐ 5 to 8 weeks

☐ 9 to 12 weeks

☐ 3 to 6 months

☐ 7 to 12 months

☐ Over 12 months

4. Questionnaire information and Consent

We are a charity called Coram. We support families and children. We want to find out whether the keyworker training is working well and whether it could be better.

We are asking you to take part because your family has a keyworker. You do not have to take part. You will still get the same support from your keyworker if you do not want to answer these questions.

We are asking you to answer some questions about your family, goals, and keyworker in this questionnaire. It will take about 15 minutes to answer these questions.

Please read the pilot's Data Privacy Notice here, before deciding whether to take part in the pilot and completing the Family Outcomes Questionnaire.

4. **Please tick the box to indicate that you consent to taking part in the evaluation.**

Please note that whether you consent or not will in no way affect the support provided to you by the service.

☐ I consent to taking part in this questionnaire and for my data to be used in the evaluation as set out in the Data Privacy Notice

5. **As the parent/carer, please tick the box to indicate that you consent to your child taking part in the evaluation.**

Please note that whether you consent or not will in no way affect the support provided to you by the service.

☐ I consent to my child taking part in this questionnaire and for my data to be used in the evaluation as set out in the Data Privacy Notice

Introduction

Thank you for agreeing to fill in this questionnaire.

The questions will cover:

- **Your family** –15 questions about how you see your family at the moment.
- **Your goals** –goals (up to three) you want to achieve for your family through this service. It also asks about your progress towards these goals.
- **Your keyworker** –10 questions about your relationship with your keyworker.

If you have any questions when completing the questionnaire **please ask your keyworker and they will be able to help you**.

Section 1: Your Family

In this section we would like you to tell us about how you see your family at the moment. **So we are asking for your view of your family.** When people say 'your family' they often mean the people who live in your house. **But we want you to choose who you want to count as the family you are going to describe.**

There are 15 short questions. Please tick whether the statement describes your family very well through to not well at all. For example, if a statement was "We are always

fighting each other" and you felt this was not especially true of your family, you would tick the box that says "Describes us: not well".

Very Well / Well/ / Partly / Not very well / Not at all

X

Do not think for too long about any question, but do try to tick one of the boxes for each question.

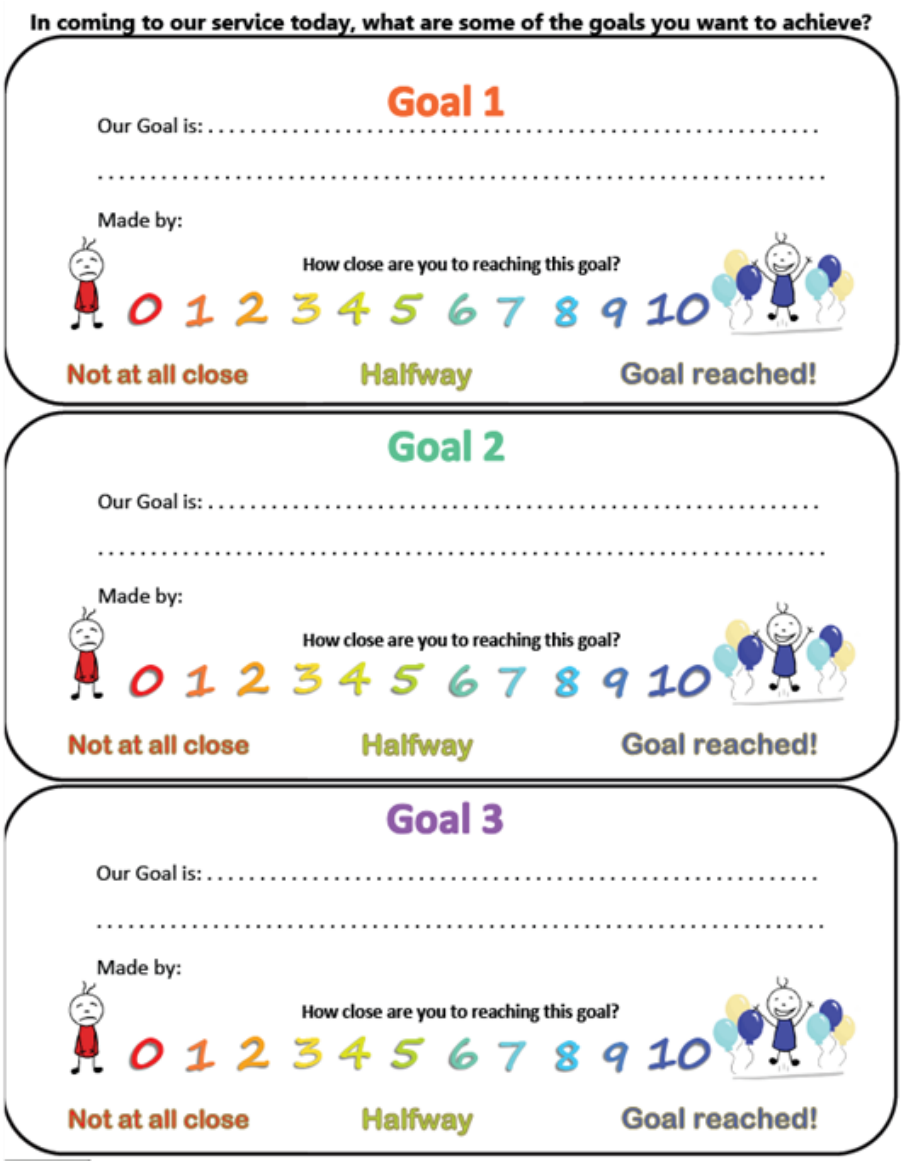
For each line, would you say **this describes our family:** Very well / Well / Partly / Not very well / Not at all / Do not want to answer

1. In my family we talk to each other about things which matter to us
2. People often don't tell each other the truth in my family
3. Each of us gets listened to in our family
4. It feels risky to disagree in our family
5. We find it hard to deal with everyday problems
6. We trust each other
7. It feels miserable in our family
8. When people in my family get angry they ignore each other on purpose
9. We seem to go from one crisis to another in my family
10. When one of us is upset they get looked after within the family
11. Things always seem to go wrong for my family
12. People in the family are nasty to each other
13. People in my family interfere too much in each other's lives
14. In my family we blame each other when things go wrong
15. We are good at finding new ways to deal with things that are difficult

Section 2: Your Goals

In this section we want to know the most important **goals** to you that you want to achieve for your family in coming to this service.

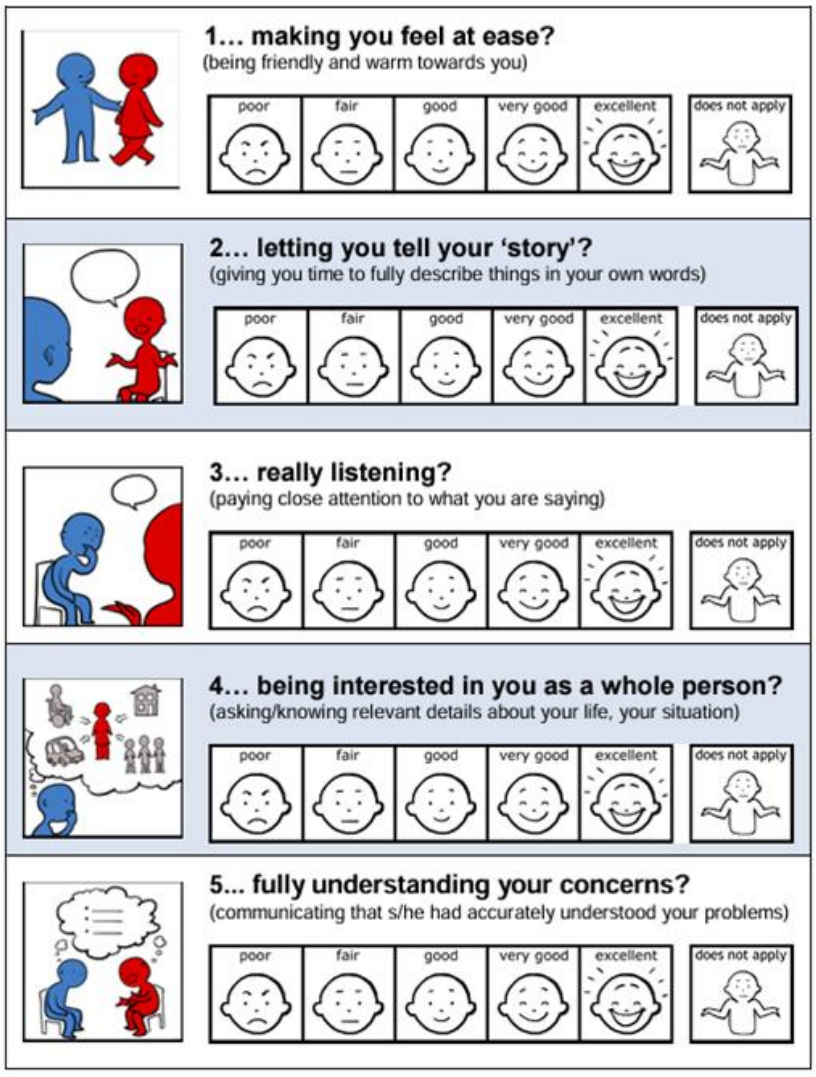
We will ask you to list up to **three** of your goals. After each goal we will ask how close you feel you are currently in progress to reaching that goal on a scale from zero to ten. A score of zero means no progress has been made towards a goal, a score of ten means a goal has been reached fully, and a score of five is exactly half way between the two.

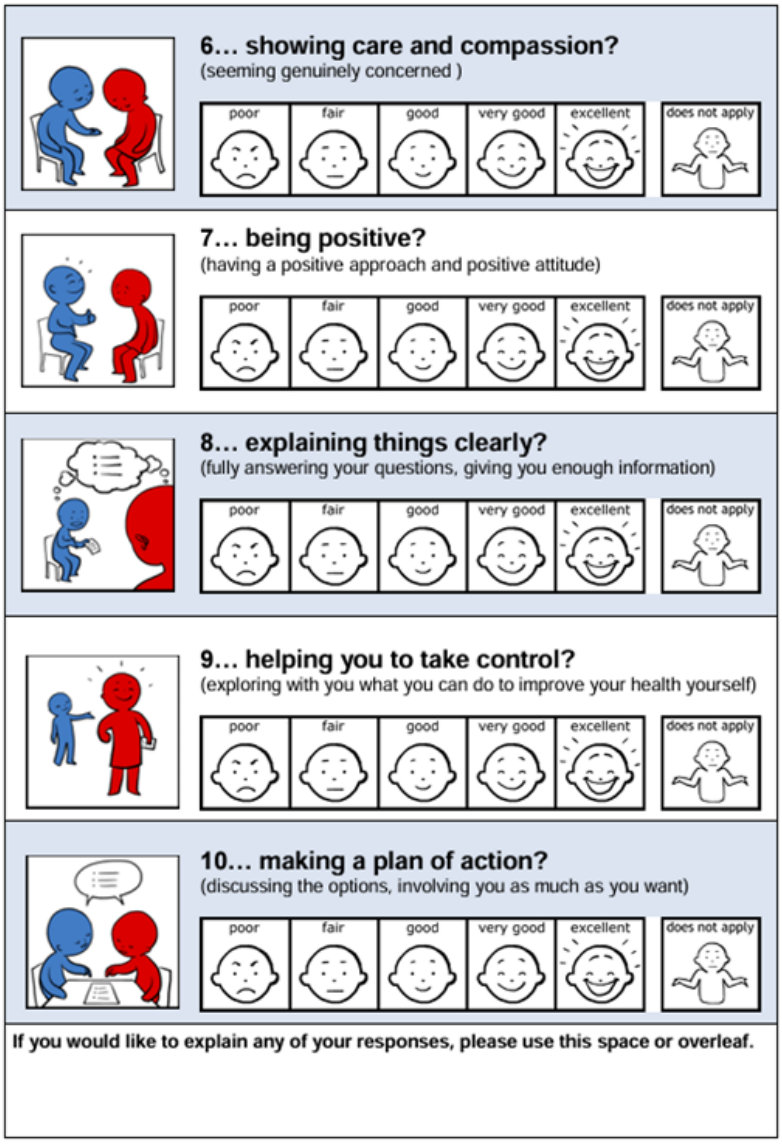


Section 3: Your Keyworker

This section asks 10 questions about working with your keyworker present here today.

For this section, you **do not need to discuss** your answers with your keyworker. Instead, please give your honest opinion on the support you have been given. Please note, answers given here or anywhere in this questionnaire **will not affect the support you receive from this service** in any way.





Thank you for completing this questionnaire, it is an important part of the pilot.

For further information on how this information will be used, please see the **Date Privacy Notice**: https://www.coram.org.uk/wp-content/uploads/2024/11/Systemic-Practice-DPN-parents-carers-and-children-FINAL.pdf

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