ROCKET SCIENCE

Adversity, Trauma and Resilience Programme Evaluation

Final Report for West Yorkshire Combined Authority Violence Reduction Unit

March 2022

Contents

1. Executive summary

This report outlines the evaluation of the first stage of the Adversity, Trauma and Resilience (ATR) programme conducted by Rocket Science between December 2021 and March 2022.

It is clear that the programme focus on creating the culture and conditions for change has been instrumental in convening and maintaining a strong network of commissioners and providers across West Yorkshire, and that this has mirrored the values and approach of trauma informed practice. This provides a strong base from which to affect change in the future stages of the strategy. Despite the relatively early stages in the wider strategy to 2030, the programme is having impact within systems and organisations and there are early indications of changes that will impact upon people accessing the services delivered. Stakeholders across the network attribute a number of these changes to the ATR. Although it is too early to robustly determine value for money, the network clearly benefits from the energy and enthusiasm it generates, despite there being very little dedicated resource to the work.

The report makes a number of recommendations for the next stages of the programme. There is a clear desire across the network to begin to crystalise the aims, objectives, and outcomes that the ATR is seeking to influence. We suggest that there are opportunities to do this through the ATR supporting a number of 'test and learn' approaches across shared priorities, across systems, sectors, and services. There is also a need to review the network membership and engagement to identify any gaps in influence and consider the communications strategy of the programme.

2. Introduction

In December 2021, Rocket Science were commissioned to be the independent evaluation partner for the programme being delivered by the West Yorkshire Combined Authority Violence Reduction Unit (VRU). Delivered in conjunction with the West Yorkshire Health and Care Partnership, the ATR programme has been formed to increase knowledge and practice in relation to trauma informed practice and enhance partnership working to deliver this. The ATR programme started in June 2020 and has ten-year workplan to influence system change across the combined authority area and an underpinning strategy to deliver this change will be co-developed by the partnership in April 2022.

2.1 The evaluation methodology

This report presents findings from the evaluation of the initial phase of the ATR programme. The evaluation was commissioned with four specific aims:

- Evaluate the implementation and delivery of the ATR programme to date, identifying changes and innovations in systems and practice which are emerging as a result of the programme
- Identify direct and indirect impacts of the programme
- Determine where causal attribution of impacts can be attributed to the ATR programme
- Establish value for money of the programme.

In order to achieve these outcomes the evaluation used a mixed methodological approach combining:

- 25 in-depth qualitative interviews with a range of stakeholders across West Yorkshire
- Four focus group discussions utilising existing ATR network meetings attended by over 60 people
- An online survey which received 30 responses
- A detailed literature review.

Given the stage of the programme within its overall life span it may not be expected that changes made as a result of the ATR programme will necessarily have impacted upon care or support for those accessing services. Whilst our research looks for these, the focus of this evaluation is understanding the learning from the implementation of the programme, and the implications of this for future developments.

It is worth noting that in total the ATR programme has a network of over 300 members, of which this evaluation has only been able to engage around 10% of the membership despite a number of

attempts to broaden engagement. Whilst this is likely reflective of resource and time challenges that individuals and organisations face this may also reflect differences between membership and engagement. Both of these are themes explored in this report.

3. Literature review

Summary

Defining successful systems change

- There is a wide range of definitions of systems change and its key factors, with the exact definition dependent on local context, needs and challenges
- Successful systems change improves outcomes for the intended beneficiaries of the system, addresses the root causes problems and underlying structures through involvement of people with lived experience, and is sustainable in the long term.

Measuring and evaluating systems change

- Theories of Change for systems change initiatives tend to include a range of multiple and connected pathways which relate to a broad set of outcomes, with a greater focus on learning and adaptation than a traditional programme level Theory of Change
- The Theory of Change can be treated as the best collective hypothesis of how change happens, which is flexible and can be updated as it is tested
- The Centre for Evaluation Innovation proposes an approach to measuring and evaluating systems change which is based on the structure of a straight-forward programme evaluation combined with a developmental evaluation approach, where the evaluator takes the role of a 'learning partner'. This approach focusses on three key evaluation targets within a system pathway, institutional structures (context) and collaboration
- Systems change evaluation should take a collaborative approach which includes the perspectives of the agents of system change, such as organisational leaders, practitioners, and beneficiaries
- Beneficiaries should be involved at all stages of the systems change evaluation, including understanding what 'success' looks like from the beneficiaries' perspective when creating a picture of the challenges the systems change seeks to overcome

- Measuring systems change on the beneficiary level is challenging however by not being able to attribute positive or negative outcomes for the beneficiaries to the systems change.

Whilst this evaluation, until the end of March 2022, is a summative evaluation of the ATR implementation to date, it is also important to consider the future formative evaluation of the programme. To support this, we have conducted a literature review relating to the evaluation and monitoring of system change. Whilst there is little evidence in relation specifically to trauma informed system change it is helpful to consider how system change in other areas has been conducted, to inform the evaluation from April 2022 onwards. As will be seen, below, a significant amount of evidence is held within the Fulfilling Lives programmes which shared some common principles with the ATR programme.

3.1 Defining successful systems change

There is not one definition of systems change in the literature or public sector, but rather a wide range of definitions, theories, frameworks, and methods.[1] The exact definition of systems change and what this entails is different for each system and depending on local context, needs and challenges. Definitions from systems change do highlight a number of key factors which contribute to the success of systems change, and define when systems change is 'completed':

- The University of Sheffield and CFE Research defined systems change as the opposite of the 'status quo': *"Any change to a system which improves outcomes for the intended beneficiaries of a system, is sustainable in the long-term, and is transformational."*2. This type of change is different to tokenistic changes, changes that rely on the work of individuals rather than services, and one-off developments.[3]

- The Lankelly Chase Foundation and New Philanthropy Capital's guide on *Systems Change: A guide to what it is and how to do it* highlighted systems change as an intentional process which requires buy-in from involved stakeholders and beneficiaries: *"Systems change [is] an intentional process designed to alter the status quo by shifting the function or structure of an identified system*

[1] Hargreaves, M. (2010). Evaluating System Change: A Planning Guide. Princeton, NJ: Mathematica Policy Research.
[2] Cordis Bright (2020). Evaluating Systems Change: Literature Review. Available at: https://www.cordisbright.co.uk/admin/resources/evaluating-systems-change.pdf Accessed 28th January 2022
[3] Ibid. (Cordis B)

with purposeful interventions. It is a journey which can require radical change in people's attitudes as well as in the ways people work. Systems change aims to bring about lasting change by altering underlying structures and supporting mechanisms which make the system operate in a particular way."[4] *Systems* change may also occur as an unintentional process, through shifts in one part of the system which have repercussions on another part, whether positive or negative.

- To understand the journey of systems change and its' 'completion' requires an understanding of the characteristics of complex systems, which are *"comprised of multiple diverse interacting actors, and non-linear and non-proportional interactions between them."*[5] Systems do not operate as siloes, but rather have **fluid boundaries** which shift and adjust as the system changes. Defining the change in a system therefore requires **a thorough understanding and mapping of what the system looks like**, which boundaries are used and subsequently who is included in the system and who is not.[6]

- A final key factor of successful and sustainable systems change is **the inclusion of experts**, being **people with lived experience.** As systems change often ultimately results in a change or improvement to how people with lived experience are supported, these people need to be able to directly influence the design and delivery of systems change: *"Experts provide a powerful and authentic voice and unique insights that can challenge assumptions, motivate organisations to do things differently and pinpoint areas for change."* [7]

In summary, successful systems change involves two key characteristics:

- System change improves outcomes for the intended beneficiaries of the system, addressing the root causes of the problems and underlying structures in the system through key involvement of people with lived experience.
- System change is transformational and sustainable in the long-term and is not overdependent on a number of individuals of services or the political will to support the system change.

[4] Abercrombie, Harries, and Wharton (2015). Systems Change: A guide to what it is and how to do it. Available at: https://www.thinknpc.org/resource-hub/systems-change-a-guide-to-what-it-is-and-how-to-do-it/ Accessed 28th January 2022
[5] Cordis B (2020).
[6] Abercrombie, Harries, and Wharton (2015).
[7] Cordis Bright (2020).

A whole systems approach to changing health and social care systems – Health and Social Care Devolution in Greater Manchester

A 2015 study by Greater Manchester Combined Authority and NHS Greater Manchester outlined a strategic approach to enact radical change in how health and social care is provided to the people in Greater Manchester, with a focus on people and place, rather than organisations. The key objectives of the strategic plan were empowering people and communities to manage their own health and wellbeing and shifting care to predominantly take place in the community through joining up care across primary, secondary, acute and community settings. Collaboration will be key to this approach, with an agreement between people, staff, and organisations on how care is arranged.[8]

Further information on the Health and Social Care systems change in Greater Manchester can be found here.

3.2 Measuring and evaluating systems change

Theory of change and systems change

Systems change evaluations begin with the underlying logic of the systems change, which can be expressed through a logic model or Theory of Change.[9] The Theory of Change is the starting point for the evaluation – the hypothesised changes to a system, and the associated outcomes, that an initiative seeks to affect.

While an individual service is typically structured around a Theory of Change which makes simple causal links between inputs, activities, outputs, and outcomes on a range of time scales, theories of change for systems change initiatives tend to include a range of multiple, coordinated pathways, which relate to a broader set of outcomes[10] and have a greater focus on learning and adapting as part of the Theory of Change.[11]

New Philanthropy Capital puts forward 5 'rules of thumb' for developing Theories of Change for systems change:

[8] Greater Manchester Combined Authority (2015). Taking charge of our Health and Social Care in Greater Manchester. Available at: https://www.gmhsc.org.uk/wp-content/uploads/2018/05/Taking-Charge-summary.pdf Accessed 28th January 2022.
[9] Cordis Bright 2020).
[10] Ibid.
[11] Abercrombie, Boswell and Thomasoo. (2018) Thinking Big: How to use Theory of Change for Systems Change. New Philanthropy Capital and Lankelly Chase. Available at: https://www.thinknpc.org/resource-hub/thinking-big-how-to-use-theory-of-change-for-systems-change/?platform=hootsuite Accessed 28th January 2022.

1. Understand context – including policy, the behaviour of institutions, the evidence base, and the needs and perceptions of beneficiaries.
2. Know yourself – agents of change must have opportunities for self-reflection, considering assets, motivations, strengths, and weaknesses.
3. Think systemically – consider the forces supporting and preventing change, and how the context influences the system.
4. Learn and adapt – treat the Theory of Change as the best collective hypothesis of how change happens, which is flexible and can be tested and updated as new information is received.
5. Recognise change is personal – theories of change need to reflect that change is about people and relationships. Lived experience can play a central role in the development of the Theory of Change.[12]

Using a Theory of Change to create systems change hypothesis

The Fulfilling Lives programme aims to change lives, change systems, and involve beneficiaries.[13] Blackpool Fulfilling Lives (BFL) sought to improve the stability, confidence, and capability of people with multiple and complex needs through creating sustainable changes to the way services work together to provide care and support. As part of the initial stage of the evaluation of this initiative, a Theory of Change was developed to outline the proposed logical connections between the intended systems changes, the coordinated pathways involved in BFL and the outcomes for people who are supported by services. This Theory of Change had a strong focus on learning and adapting, the institutional structures and other contextual factors influencing people moving through the service, and the interconnected nature of the pathways within the BFL service landscape, in line with the 5 rules of thumb developed by NPC.[14]

A full report of the Blackpool Fulfilling Lives evaluation can be found here.

[12] Abercrombie, Boswell and Thomasoo. (2018)
[13] Harris, Hutton, Boxford et al. (2017) Blackpool Fulfilling Lives. Year Two Evaluation Report: Value for Money Analysis. Cordis Bright, Blackpool Fulfilling Lives, Addaction. Available at: https://ssir.org/articles/entry/systems_change_should_lift_up_beneficiary_voices. Accessed 28th January 2022.
[14] Abercrombie, Boswell and Thomasoo (2018)

A guide to evaluating systems change

The Centre for Evaluation Innovation and Learning for Action provides a toolkit in their guide to evaluating systems change[15], which is summarised in this section. This guide focuses on one type of system as an example: a *human services delivery system* - this is defined as any system that delivers services to people with the primary goal of improving outcomes for the beneficiaries of the system, such as a health system or education. Taking a practical approach to systems change evaluation, the report suggests using the structure of a more straight-forward programme evaluation and translating this into a sequence of steps for systems change evaluation:

"Although systems are complex, we can actually consider a system to be just like any other object of evaluation, in the sense that we want to know what it is like at different time-points, describe how it has changed over time, and explain what has contributed to this change. In this way, an evaluation of systems change is not so different from standard programme evaluation."

A summary of this approach to evaluating systems change, and the steps involved in the evaluation, is provided in Table 1.

When evaluating systems change, baseline and follow-up data is collected at multiple time-points, taking an evaluative approach which borrows from both a traditional evaluation approach and the developmental evaluation (DE) approach, which acknowledges the complexity and dynamic properties of systems. Under this approach, the evaluator takes a more active role as a 'learning partner' who is embedded in the system and can provide ongoing insights which can be incorporated into strategy and inform decisions. The evaluator works in close partnership with initiative stakeholders, collecting and providing data throughout the process rather than at a discrete set of time points. This approach has the potential to guide the system towards deeper and more sustainable change, effectively contributing to the systems change itself,[16] and include strategic decision makers in the learning and reflection process.

The DE approach can be employed to assess three key evaluation targets in the system:

- Pathways and pathway effectiveness. Pathways are organisational and inter-organisational arrangements which are set up to deliver programmes and services. In these pathways, system

[15] Latham, N. (2014). A practical guide to evaluating systems change in a human services system context. Center for Evaluation Innovation and Learning for Action. Available at: https://www.evaluationinnovation.org/wp-content/uploads/2014/07/Systems-Change-Evaluation-Toolkit_FINAL.pdf Accessed 28th January 2022.
[16] Carter, P., & Blanch, A. (2019). A Trauma Lens for Systems Change. Stanford Social Innovation Review, 17(3), 48–54. https://doi.org/10.48558/ESG7-3823

parts are the pathway steps, and links between and among steps are (inter)organisational connections which support people to move from one step to another. In effective pathways, people enter the pathway, move along it continuously and smoothly, and exit the pathway with improved outcomes. Systems evaluations can consider whether and how there has been a shift to more effective pathways within a system. This could for instance be evidenced by increased capacity (ability to support more people) and/or increased connectivity (smoother transitions for people between the steps of a pathway)

- Institutional structures. Institutional structures form the context within which pathways function. External forces, such as policy, strategic direction, and funding flows, have a profound impact on the functioning and structure of pathways. These structures shape the behaviour of pathways in different ways depending on whether structures provide incentives, opportunities, or constraints on pathways
- Collaboration and collaborative effectiveness. People who design and implement systems change initiatives are the agents of system change, and they almost always work in collaboration. Effective collaboration is required for systems change initiatives to be implemented. Factors such as governance structures, accountability frameworks and member engagement all contribute to the effectiveness of a collaborative approach, the effectiveness of which must be assessed when measuring and understanding systems change. This will be further discussed in section 2.2.3.

The Centre for Evaluation Innovation argues in their guide that by assessing these three core elements of the system and their effectiveness over time, it is possible to measure and evaluate systems change.[17]

Contextualising the approach

In a health services system, there will be a range of pathways an individual might take through that system, within and between different services. Institutional structures and changes in these structures, such as lack of parity of esteem between mental and physical health, or increased funding for children and adolescents' mental health services, will influence the experience of someone navigating these pathways. People who design and implement the health services system work in collaboration via governance structures and accountability frameworks to affect systems change, against the backdrop of these institutional structures.

[17] Latham (2014).

Practical evaluation steps

Evaluating systems change is comprised of a number of evaluation phases which put the developmental evaluation approach into practice. These steps focus on key questions evaluation practitioners need to ask throughout the systems change evaluation on what change is needed, why it is needed and what might be the unintended consequences[18] Table 2 below outlines the approach to evaluating systems change suggested by the Centre for Evaluation Innovation, including a detailed breakdown of actions at each evaluation step.

Table 1 – Evaluation phases for systems change evaluation [Source: A Practical Guide to Evaluating Systems Change in a Human Services System Context (2014)]

Evaluation phases for systems change evaluation	
Orientation	Understand the goals of the system change initiative, and who is implementing the changes. Understand the pathways people take through the system
Evaluation planning	Define priorities, research questions and data collection plan
Develop data collection instruments	Develop tools for collecting baseline and follow-up data
Collect baseline data	Collect baseline data on pathway effectiveness, institutional structure, collaborative effectiveness
Collect follow-up data	Collect follow-up data on pathway effectiveness, institutional structure, collaborative effectiveness Ask key stakeholders about perceived changes in collaboration and in the system since baseline.
Describe change between baseline and follow-up	Compare baseline and follow-up, analysing changes in structures and pathways within the system and the perceived changes stakeholders note
Analyse how the intervention contributed to the change between baseline and follow-up	This stage involves understanding the attribution of the changes described at the previous stage to the systems change intervention. This may include: • Assessing how the initiative influenced structural barriers and enablers • Assessing how structural change contributed to increased pathway capacity and/or improved pathway connections

[18] Abercrombie, Harries, and Wharton (2015).

	• Assess the extent to which changes in collaborative functioning within the system contributed to the system change
Develop recommendations	• Identify ways that pathways can continue to improve • Identify structural changes that might facilitate pathway improvements • Identify how collaborative structures and processes could improve to facilitate implementation of the systems change initiative.

Collaborative approaches to measuring and evaluating systems change

As discussed above, collaboration and the involvement of people with lived experience should be central to systems change and is a key evaluation target to measure the degree systems change has been successful. Because systems change is an approach to social change, evaluation needs to ask questions about **what change is needed, why it is needed and what might be the unintended consequences on a rolling basis.**[19] The evaluation of a systems change needs to be based on a collaborative approach which includes the perspectives of those involved in the systems change and those will be affected by the systems change, which will also contribute to the extent to which an evaluation is trauma informed.[20] Measuring systems change at the level of the beneficiary, staff and wider partner organisations will provide valuable complementary perspectives of systems change from those grounded in practice (such as practitioners), to those grounded in theory (such as stakeholders).[21]

Evaluating systems change at the level of beneficiaries

The inclusion of beneficiaries in creating and evaluating systems change is a powerful method to ensure systems change is designed, delivered, and adjusted with the perspective of people with lived experiences in mind. To engage beneficiaries in evaluating systems change requires:

- Involving them at all stages of design, evaluation, and implementation with measures to address power imbalances.[22] This ensures that successful systems change is defined from the perspective of beneficiaries, not just evaluators and leaders.[23]

[19] Abercrombie, Harries, and Wharton (2015).
[20] Carter & Blanch, (2019).
[21] Abercrombie, Harries, and Wharton (2015).
[22] Here to there consulting (2019). What we know so far about sets of principles for evaluating systems change efforts. Available at: https://here2there.ca/wp-content/uploads/2019/01/WhatWeKnowSoFar-Systems-Change-Evaluation_Principles.pdf Accessed 28th January 2022.
[23] Long, P. (2015). Systems change should lift up beneficiary voices. Available at: https://ssir.org/articles/entry/systems_change_should_lift_up_beneficiary_voices Accessed 28th January 2022.

- Being aware of the potential negative impacts for people with lived experience to collaborate in the evaluation, such as the triggering of certain memories.[24]
- Ensure people with lived experience are informed of the findings of the evaluation throughout the evaluation process, as a lack of knowledge on how their contribution has impacted the evaluation and systems change may be demotivating.[25]

While it is important to include beneficiaries in every part of the evaluation, it may be challenging to measure systems change at the level of the beneficiary due to the unknown degree of attribution of the systems change on the outcomes for beneficiaries. We were not able to find practical guidelines on measuring systems change at the beneficiary level for this literature review, which highlights a gap in existing evidence on how this measurement may be accomplished. Here to There Consulting does address attribution as a challenge to measuring outcomes in systems change, but rather proposes alternatively to "focus on estimating social innovators' contribution – rather than attribution – to outcomes." [26]This could be an alternative to measure systems change on the beneficiary level.

Working with people with lived experience to understand and evaluate barriers and enablers of system change – Fulfilling Lives Manchester

A 2020 study aimed to understand whether Fulfilling Lives partnerships in Manchester have overcome systemic barriers which stop people with 'Multiple and Complex Needs' from getting the help and treatment they need. Key to the study was understanding the main barriers preventing people from accessing services and getting the support they need, and to what extent those barriers had been addressed through system change. Engagement with beneficiaries was at the core of this evaluation. This included working with 26 service beneficiaries to develop detailed case studies, which were analysed as part of a journey mapping exercise to understand barriers and enablers within systems which help or hinder people as they move through mental health services. The evaluation then looked at how the work of Fulfilling lives partnerships had made an impact on this journey. Workshops with experts by experience were also held to further explore the impact of FL on the system.[27]

[24] Cordis Bright (2020).
[25] Cordis Bright (2020).
[26] Here to There Consulting (2019).
[27] CFE Research and the University of Sheffield, with the Systems Change Action, Network (2020). Improving access to mental health support for people experiencing multiple disadvantage. Evaluation of fulfilling lives: supporting people with multiple needs. Available at: https://www.fulfillinglivesevaluation.org/wp-admin/admin-ajax.php?juwpfisadmin=false&action=wpfd&task=file.download&wpfd_category_id=324&wpfd_file_id=6604&token=fbb1c0b62552c3d3a56227a9322d4862&preview=1 Accessed 28th January 2022.

A full report of the Manchester Fulfilling Lives evaluation can be found here.

Evaluating systems change at the level of the staff and other stakeholders in the system

Similar to the involvement of beneficiaries, involving staff and other stakeholders in systems change transformation and evaluation is key to ensuring a collaborative approach to the evaluation. Engaging staff and stakeholders in evaluating systems also encourages staff to think systemically, rather than working in a siloed way focussed on their organisations and services alone. Systemic thinking also helps to create an environment which empowers and engages service users (Leadership for Local Government, 2014).

The Centre for Evaluation Innovation's Practical Guide to Systems Evaluation provides examples of research tools, including suggested questions for staff and other stakeholders, which can be used in baseline and follow-up data collection to measure system change through interviews with staff and other stakeholders at different levels of the system.[28] Questions focus on the elements of the system outlined in section 2.2.2, namely pathways, institutional structures (context) and collaboration. A sample of evaluation themes and associated questions is provided below:

- Theme: changes to pathway scale and capacity, eg: *In the last stakeholder assessment we collected data about program supply and access. We heard from stakeholders that [at X step] the number of program slots available wasn't enough to meet the need of [the focal population], and/or that clients have challenge with accessing services. Can you tell me about the progress that has been made on scale since then?*
- Theme: changes to pathway linkage, eg: *In the last stakeholder assessment we did about challenges that clients' face in making these transitions from [X part of the system] to [Y part of the system] Do you feel that there have been improvements here? If yes, what are they?*
- Theme: collaborative effectiveness, eg: *In general within the collaborative, do you feel that there could be some improvement in aligning the goals of the member organizations with those of the systems change initiative? [If yes,] To what extent do you feel that lack of goal alignment is challenging for the initiative? Do you have any suggestions for how to create greater goal alignment?*

[28] Latham (2014)

Protocols or topic guides for evaluating systems change among staff and stakeholders should be flexible, with the potential for new questions or foci as the evaluation develops and new information about the system is collected and analysed.[29]

The challenges of evaluating systems change

While system change evaluation can be built on a framework of traditional programme evaluation, systems change evaluation presents additional challenges which merit a modified approach. These challenges include:

- Systems change can take a long time – the length of time is dependent on factors such as the context the system is operating within and the scale of the system.[30] Ultimate outcomes might take years to change. Therefore, system change evaluations which use baseline and follow-up assessment are likely to require longitudinal evaluations which take place over a number of years
- Systems are dynamic, with new patterns of interactions and relationships created over time. This property of systems therefore requires the developmental evolution approach described in section 2.2.2.
- As discussed in Section 2.2.4. outcomes for beneficiaries cannot be fully attributed to the outcomes of systems change, limiting measuring the success of system change initiatives on the beneficiary level.

Trauma informed system change

Whilst there is a great deal published about trauma informed care and practice there is little current literature around trauma informed system change across services and systems. Whilst some models such as the *Trauma Informed System Change Instrument*[31] provide validated tools for the implementation of trauma informed practice within child welfare systems[32] others such as the *Missouri Model: A developmental framework for trauma informed approaches* [33]specifically warn against the use of "fidelity checklists" (p.1) due to such an approaches inability to captures changes in learning, attitude, knowledge, and culture the trauma informed approaches require. There are some

[29] Latham (2014).
[30] Ashoka (2020) Embracing complexity – Towards a shared understanding of funding systems change. Available at: https://www.ashoka.org/en/files/embracing-complexityexecutive-summaryfinalpdf-0 Accessed 28th January 2022.
[31] Trauma-Informed-System-Change-Instrument-Scoring-Guide-and-Psychometrics.pdf (traumainformedoregon.org)
[32] Development of the Trauma Informed System Change Instrument: Evaluation of Factorial Validity and Implications for Use (wmich.edu)
[33] The Missouri Model: A Developmental Framework for Trauma-Informed Approaches | dmh.mo.gov

examples of similar approaches across the UK from which learning relevant to the ATR programme could be used:

- Dr Angela Kennedy has been leading trauma informed system change for Tees, Esk and Wear Valley (TEWV) NHS Trust with a scope of both introducing trauma informed practice as well as implementing governance changes across the trust[34].
- Bristol, North Somerset, and South Gloucestershire have developed a knowledge and skills framework[35] which outlines knowledge, skills and behaviour required by staff from support to strategic leads to implement trauma informed care.

Implications for future formative evaluation

The literature offers two different, although complimentary approaches to the evaluation of system change. A traditional evaluative approach in which baseline information is gathered and monitored to provide evidence of impact and in which the evaluator may seek (although not always successfully) to use counterfactual or qualitative approaches to determine attribution for change. The second approach is one of a learning partner in which the evaluator is embedded within the system and can itself be an agent of change. Through this approach capturing learning of the experiences of change and the barriers and enablers it is possible to identify 'how' change is being achieved and share this across the system. Combining these approaches is becoming increasingly common with the Health Foundation, National Lottery Community Fund and The Robertson Trust, to name a few, all seeking to use learning partner approaches which support capacity building within system partners to monitor and evaluate outcome information whilst also capturing learning from implementation. Whilst these approaches are complimentary, tensions do exist and particularly in developing a theory of change, underlying logic models and outcome frameworks and the ability of these tools to monitor, manage and communicate changes across complex and adaptive systems. The literature suggests tackling this through a broad theory of change which outlines a series of flexible hypotheses, but which is underpinned by pathway mapping, logic models and outcome frameworks. Given this, it may be beneficial to review the ATR theory of change (figure 1) unpacking it in relation to identifying working hypotheses, what are the underlying logic models and how can these be used to inform a system wide outcome framework. Appendix 1 provides an examples of a possible evaluation framework that could be used as a basis for co-producing a system wide approach.

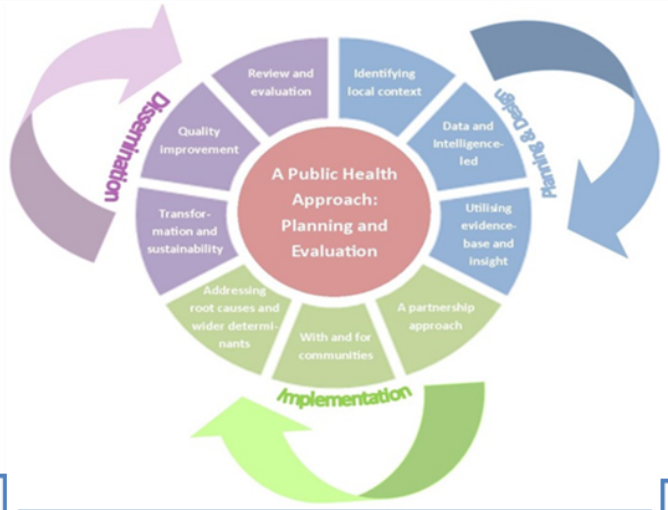
[34] CPN16-trauma.pptx (live.com)
[35] Trauma-Informed System (bristolsafeguarding.org)

Across West Yorkshire (WY), we will work together to establish a sustainable WY Adversity, Trauma and Resilience Training Collaborative, to support the success of our ambition for;

West Yorkshire to be a Trauma Informed and Responsive system by 2030 and develop a whole system approach to responding to multiple disadvantage

Outcomes

1. West Yorkshire will establish a sustainable multi agency Training Collaborative for Adversity, Trauma and Resilience.
2. West Yorkshire will have a skilled and knowledgeable workforce to support the system around serious violence, exploitation and will be trauma informed
3. The WY workforce are prepared and able to respond to children and young people who may have experienced or are currently experiencing adversity & trauma
4. The WY workforce will respond early to prevent and address any potential harms and risks relating to children and young people's involvement in serious violence and crime
5. Multidisciplinary peer support network for WY Adversity, Trauma and Resilience



Outputs

Bespoke and coproduced Adversity, Trauma and Resilience training which enables WY workforce to:

1. Better understand underlying trauma
2. Address the drivers behind immediate threats and harm
3. Understand the impact of trauma
4. Avoid practices that may inadvertently retraumatise
5. Increase understanding of how young women and girls present trauma

Continuously refreshed interactive online and in-person training packages

Repository of training resources

Developing the evidence for 'what works' and best practice

Dedicated Training Collaborative Project Officer

Sector based training needs assessment

Annual training report with published outcomes

Community and engagement plan

Local evaluation framework and dashboard aligned to Theory of Change

Inputs

Funding - VRU Funding 30k contribution
Bid for £700k from YEF

Capacity - Central VRU staffing,
WY&H ICS Staffing
Additional capacity to be recruited

Products - Training Packages & Knowledge Events
Knowledge and Skills Framework
Training Matrix
Training Needs Assessments
Engagement Reports
Case Studies
Evaluation

Partnerships - Statutory partners
Existing multi agency partnerships
Third sector and community networks

Delivery - Existing interventions programme

Support - Experts in trauma, resilience and adversity
Trainers
Public Health registrar

Activities

Developing the WY multi agency Training Collaborative for adversity, trauma and resilience, supported by trauma informed experts and trained professionals

Develop and deliver trauma informed training programmes to increase understanding of trauma, awareness of trauma symptoms & how experiences of trauma may influence children's and young people's behaviour and relationships

Commissioning of specific training pages in response to the needs assessment

Identify collaborative and match funding to support sustainability

Continuous gap analysis

Supporting local initiatives and priorities through partnership working

Intelligence and information sharing, collection and analysis – to support VRU products

Evaluation of trauma informed training to increase understanding of trauma

Young People and Community involvement, engagement, and coproduction

Development of a communications and engagement plan

Impact

Systemwide increased capability and understanding of what being trauma informed and responsive means – including consistent use of language:

1. Reduction of the root causes of adversity and trauma
2. Early recognition and prevention of adversity and trauma
3. Reduction of adversity and trauma
4. Prevent systemic retraumatisation
5. Victims who feel supported
6. Personalised and continuity of care
7. Reduction in health inequalities
8. Reduction in serious violence and exploitation
9. Reduction in violence towards women & girls
10. Reduction of children & young people in the criminal justice system
11. Increase in educational attendance and attainment
12. Empowered, engaged communities
13. Safe, healthy and thriving communities

Responsive workforces who will provide a trauma informed approach to support young people at risk of involvement/involved in serious violence and crime

Additional capability and capacity to deliver training across West Yorkshire which will be sustainable

West Yorkshire will be a trauma informed and responsive system by 2030

4. Findings from stakeholder interviews

25 interviews have been conducted with stakeholders identified as a priority for engagement. These have included representatives from NHS trusts, local authority teams, public health, and the West Yorkshire Combined Authority. A full list of organisations is in Appendix 2.

Thematic analysis was completed from interview transcripts, and the emerging themes are presented below.

4.1 Developing and implementation of the ATR programme

Establishing the programme

It was noted by the majority of those interviewed that the enthusiasm, drive and *"dynamic approach"* to building the ATR programme by those convening it was a critical factor to its success. This was described by one interviewee as the ability to *"generate energy and harness interest"* whilst another reported feeling *"nourished"* through their involvement. Another person described the *"strong leadership on culture"* that was evident through the programme. This modelling of a trauma informed approach to programme development, across systems which are not always trauma informed, is important and is very likely integral to the ATR programme's success in securing and maintaining engagement. That this momentum has been achieved in the context of the pandemic was often noted as being remarkable with one person interviewed suggesting that the programme's approach of bringing people together at a time of increasing isolation is also a factor for its success.

The networks organic development was seen as both a strength for the initial set up but also a potential weakness for future delivery. The organic nature to date is seen as attracting the involvement of those who prioritise, and can see the value of, trauma informed approaches.

"The first year has been all about building relationships and that is core to what we are trying to achieve"

This approach has also enabled the ATR programme to respond flexibly to the wider context of progress towards trauma informed practice across West Yorkshire prior to the programme. Examples include the WY-FI project which the ATR programme was described "dovetailing" well with as this project came to an end, and Bradford's ACES, trauma and resilience strategy which was launched ahead of the ATR programme.

Programme membership and engagement

There were mixed views as to whether the composition of the membership is right. Even with organic growth it is felt by some that membership at an organisational level was strong, the inclusion of anchor institutions and strong representation from the VCSE as well as health, education and criminal justice was highlighted. It was also reflected that generally strategic involvement, particularly across the ICS was an asset and that there is the right level of senior leadership buy-in to affect change and that the programme effectively connected organisations and systems across the combined authority/integrated care system. As one person stated, *"if a Chief Executive of a Local Authority is giving time, then this emphasises it is worthwhile"*. Several people also acknowledged the importance of the horizontal structure that had been created within the ATR programme structure in enabling everyone to equally contribute whilst mirroring the co-productive approach of trauma informed practice.

> *"Trauma informed approach needs to be reflected in parallel processes – everyone cares for one another, cultural way of being with each other from senior management down".*

However others interviewed were not as sure and questioned whether the right people (in relation to role, seniority, and ability to leverage change) were attending meetings *"[I'm] not sure that the right people are being involved in the right places"*. One person speculated that there is *"a core of 20 people come* [to meetings] *how representative is the network of systems across the places?*". The right membership was of particular concern for colleagues in one local authority who identified that their area was *"far behind"* but having learnt of the ATR programme by chance, said they don't *"have the right capacity and the right time, you don't usually allocate capacity by chance"*. Whilst our observations are that the core is substantially greater than 20 it might be useful for the network to undertake a gap analysis and identify who else, if anyone, can be engaged. Given the organic growth of the network some interviewees also believed that efficiencies could be found as it was their observation that often multiple people attending from the same organisation. However, as discussed further below, this is possible an internal communication issue within organisations.

The active membership was seen as a strength of the programme and that the approach of attracting members who were interested or already working in this space was seen as important in creating a culture which was often described as *"passionate"*, *"enthusiastic"* and *"driven"*. This culture, driven by the programme coordinators, was recognised by nearly all interviewees as the foundation for the ATR's successes to date. However for some recruitment by attraction needed to be considered on

the context of the overall membership, one interviewee reflected on how to balance passionate interest with being accessible for a wider audience.

> *"It feels that people's involvement in ATR is interest driven* – [you] *need to have a passionate interest in it as it is very much a culture shift in the way we work.* [But the approach] *requires a level of introspection so if people haven't been on that journey, then they wouldn't get much out of it".*

Similarly a number of interviewees also expressed concerns of *"preaching to the converted"* and therefore questioned whether the programme was reaching those who were not engaged or were sceptical about the role of trauma informed practice. As alluded to in the introduction to this report our experience has been of a small number of people who have been very engaged and supportive of the evaluation, often participating in several elements. This is also observed in those who attend several of the network meetings. A network mapping exercise, determining which organisations are represented, by whom, and their levels of involvement in the programme would be beneficial to understand any gaps in influence and the potential difference between programme membership and programme engagement.

Communication

Internal communication within the network is seen as strong with the 'horizontal' culture creating an environment in which everyone is able to contribute. That the programme has convened the network and provided opportunities for sharing of learning (see below) is seen by stakeholders as valuable and important. It was commonly acknowledged that the programme team's ability to do this with limited resources was a real strength.

As described above there is some confusion as to the membership of the ATR regionally, locally and within organisations. Given that there are few explicit strategies in organisations and systems to become trauma informed there is not necessarily relevant communication or governance structures through which people can identify as being involved in the ATR programme. For this reason a published membership directory may be useful to facilitate both internal and local communication and coordination.

Communication was also raised by several other interviewees and those that had missed meetings reported struggling to keep abreast of developments. E-bulletins or similar resources were

commonly identified as a need and one person reported difficulties in attending all of the meetings but catching up from colleagues who also attend, whilst another stated:

> *"If there was a structured approach [to communication] they could share that in Wakefield and give people more hooks in to it…but I don't know if as a member of the board I could articulate it and share it back".*

That network meetings continue to be held virtually was a significant benefit for many and increased the programmes accessibility although it was acknowledged that this reduced opportunities to network and have 'side conversations' which would further enhance networking.

4.2 Outcomes, impact, and attribution

A number of outcomes and impacts were identified by people we spoke to, although it was commonly acknowledged that this was still very early in a long-term strategy.

Developments in practice

Whilst it is widely understood that the changes being implemented as a result of the ATR programme are not yet impacting upon people accessing services, a number of examples of how the programme has influenced individual practice were given.

For some, this was in relation to personal development and practice whilst others were seeing changes being made in the way appointments were managed and physical environments such as waiting rooms were considered. For one person there was also emerging evidence of impact at the service delivery level including greater use of outreach and flexibility in delivery of services:

> *"[there is] already evidence of changed practice, for example flexibility of services for people with experience of trauma. Instead of giving them a 20 minute appointment then not seeing them if they are late services are being more flexible"*

Another example of impact included one public health team changing their approach to identifying hot spots.

The provision of training was often cited as a positive outcome for organisations and particularly for those sectors and professions that were considered harder to reach or with little previous experience

of trauma informed practice (eg GPs and the police). This presents clear opportunities to follow up with delegates to understand if/how the training has influence their practice.

Sharing of learning

A number of examples of impact at a system level were given, relating to accelerating learning and development through the sharing of resources and knowledge amongst the network *"Networking is really important, to be efficient and get further faster"*, the workstream involving schools was particularly identified as being accelerated due to the ATR programme although a school which was specifically operating in a trauma informed way felt that there were more opportunities for them to share their experience across the region.

The openness within the programme was also attributed to generating a generousness across the network and *"taking away preciousness"* about work or 'intellectual property'.

Impact on existing workstreams

For a number of organisations and individuals involved in the programme the journey to becoming trauma informed pre-dates the ATR programme. However for many this has not lessened the impact of the programme and for some it has validated how they have felt about either change that is needed or that they are working towards

> *"Trauma gave a language to what I knew was wrong with the system [but couldn't articulate]".*

> *[The ATR programme has] "been a really great platform to start working within health and care partnership, been a great place to meet people and network and feels like everyone has a voice in this work as it's not mainstream, can be very isolating that you're the only one in your department thinking this way, so good to have contact with other people who think the same way."*

The continuity that the ATR has provided in sustaining elements of, and particularly the learning gathered through, the West Yorkshire Finding Independence (WY-FI) project was noted as being valuable for the region. It was highlighted that the ATR programme's convening role for statutory and VCSE organisations was particularly valuable since the end of WY-FI and that whilst it *"would have been easy to go back to own little boxes after WY-FI"*

the ATR programme instead continues to provide connectivity and opportunities for exchanging knowledge.

Given the different stages of organisations, places and individuals and the work of programmes such as WY-FI before, it is perhaps unsurprising that attribution of impact to the ATR programme is mixed amongst those we interviewed. For one interviewee the ATR programme was instrumental in instigating trauma informed policing *"ATR came first, then this led to fitting it in to policing, it forced the conversation"*. However for those who had developed a strategy before the ATR programme, attribution of cause is a little less clear *"at the moment we are going ahead with what we are doing…and hoping that fits in with the whole programme"*.

Co-production

As well as mirroring a co-productive process within the network, specific examples of how this has cascaded to service development were also given. The co-production framework is seen as particularly valuable and has resulted in tangible outcomes including the involvement of survivors in a Violence Against Women and Girls (VAWG) strategy in one local authority,

4.3 Costs, value for money and sustainability

All of the stakeholders we spoke to reported that support for the programme was in-kind although the resource allocated was clearly determined by the presence or absence of a place-based trauma informed strategy. Those local authorities where this is present indicated that they had dedicated people who could also attend the ATR networks and contribute learning. Where a clear trauma informed strategy was absent, resource required was additional to usual duties and one interviewee questioned whether the ATR programme could support capacity building. None of the stakeholders we spoke to were accounting for the time put in to the programme although one estimated this to be between 12 and 20 hours per month across the team, it was also recognised that those attending got a lot back from participation. None of the stakeholders we spoke to reported that this was a significant challenge, although it was apparent from a number of people, we spoke to that engaging with the ATR programme was often difficult and had to be balanced with other priorities.

In addition to saving time and accelerated learning as described above, opportunities for cost savings were particularly identified in relation to training and being able to provide 'in house' training across West Yorkshire would lead to considerable savings. Some stakeholders also saw opportunities to

maximise economies of scale across the network, for example through sharing licences, or contributing to an evaluation fund to coordinate impact evaluation across West Yorkshire.

It was commonly acknowledged that the programme required more resource to be delivered, and that significant time was spent applying for funds that could be better used supporting change. There was one suggestion for ensuring financial sustainability which was each of the five local authority areas 'top slicing' ICS funding for the delivery of trauma informed practice.

4.4 Future programme direction and priority outcomes

Interviewees were asked what they saw as the priorities for the next phase of the ATR, and a number of clear themes emerged.

Standards and standardisation

A substantial number of people we spoke to identify a need for a mechanism to ensure standards and quality of practice across the network. The development of a 'kite mark' was commonly cited as a piece of work that would clearly define trauma informed practice as a recognised way of working and is clearly attractive to a number of stakeholders. One person we spoke to felt that *"culture change has to be about standards"* and, as such, a series of standards or a self-assessment tool would be particularly useful for reviewing how trauma informed practice is consistent throughout organisations, from management approaches to delivery of services.

Structure and governance

Opportunities to introduce more structure were identified in other areas too, and for two stakeholders moving away from evolution to principles of design and seeing things through is key for the programme to realise its full potential. This is perhaps particularly relevant given the scale of the task, that many acknowledged as significant and the different stages each local authority area and service is at.

One stakeholder described difficulty in explaining the ambitions and the potential outcomes of the ATR programme and that this was impacting upon their ability to draw in resource for the work

required. Another highlighted a need to ensure a focus on where programme can have the most impact with a focus on initiatives that can span multiple places:

> *"[There needs to be a] clear delineation of that is delivered across the system and what is better done at place…At the moment its [ATR] a discussion forum and ideas generator but the doing is happening at place."*

A number of suggestions were made as to how to simplify the task ahead and to ensure progress was tangible and achievable within a limited, but realistic, number of areas.

> *"Really need to do justice to a couple of things rather than trying to do everything at once…have a realism to this"*

Recommendations included reviewing the role and membership of the steering group to ensure that each sector was represented but also taking responsibility for common action plans across each of the workstreams. The development of measurable outcomes was also seen as necessary to ensure clarity of purpose and direction. That the ATR programme workstreams were not aligned to local authorities existing strategies, which adopt a 'life course' approach, was a challenge and it was questioned whether the workstreams were the correct ones although it was acknowledged that the programme cannot keep going back to the drawing board. This is clearly a challenge for the programme in having multiple workstreams across multiple stakeholders with differing remits and agendas but is to be expected when taking a systems level approach.

Building the evidence base

Structure in relation to clear objectives, outcomes and an evaluation framework was commonly identified by the majority of people interviewed as fundamental to providing direction *"what gets measured gets done"* as well as supporting communicating the programmes objectives to key stakeholders. One highlighted the role in this in relation to getting more understanding from strategic leaders (eg CEO's, councillors, and those on scrutiny panels).

Generating evidence and demonstrating value were also key for a number of people in sustaining involvement either due to allocation of resource *"[we] can't afford to be doing pieces of work without value"* and due to the requirement to deliver evidence based practice, particularly in relation to public health. It was also acknowledged that a clear evidence base and rationale as to why a trauma informed approach adds value is required to make a case for investment.

A number of organisations whose trauma informed work pre-dates the ATR programme identified outcomes and impacts as a result of their work. The development of an evaluation workstream would be useful in communicating a call for evidence held within organisations but not published. Whilst useful in developing a common data framework these would also be beneficial for wider communications work and expanding support for the programme.

Those we spoke to saw a number of opportunities to measure the outcomes and impact of the programme, and as reported above this is seen as critical to the future success of the programme.

Suggestions for evaluation varied across both system and service levels and ranged from developing proxy measures of cultural change (such as the impact on the wellbeing of staff), trauma informed commissioning processes and improved information sharing, to specific intermediate and long-term outcomes including workforce training, enrolment of schools on the programme, trauma informed assessment processes. There was a common acknowledgement that outcome and impact measures cannot solely be quantified, and that stories and rich qualitative accounts of impact and insight are also required.

Workforce development

As highlighted above the training provision has been consistently identified as a positive outcome for the network members but a number of opportunities were identified to develop this further, considering wider workforce development. This included how trauma informed practice could create more inclusive, attractive, and psychologically safe environments, that would subsequently positively impact upon staff recruitment and retention. Consideration of how this approach could also influence organisational learning cultures to further develop co-production was also raised. Given the challenges that the many sectors face in relation to staff recruitment and retention, prioritising workforce development, and evidencing impact in this area, may be an attractive proposition for network partners.

5. Findings from focus groups

In total four focus group discussion were held with existing network members. These were conducted within existing meetings to maximise attendance of, and efficiency for, network colleagues. Members of the Training Collaborative, Community Action Collective and the programme steering group were asked to discuss three questions:

- What changes and innovations have they seen as a result, or with the support, of the ATR programme?
- What have been the impacts of the ATR programme to date?
- What are the priority areas for future outcomes?

Following a brief presentation of the interim findings to the ATR strategy board, the board members were asked to consider two questions:

- What do you see the role of the board in the next stages of the ATR programme?
- What are the priority outcomes of the ATR programme?

All four focus groups were facilitated virtually using a Google Jamboard and last between 20 minutes and one hour. The remainder of this chapter reports on themes emerging across the groups in relation to these questions. Themes have been identified when the same topic has been raised across multiple forums.

5.1 Changes and innovations

Specific examples of change identified through the focus groups included:

- Training, with GP and Police training being particularly highlighted as achievements
- Increasing membership of the programme
- Routine offers of choice of gender of worker being offered to people accessing services
- Reviews of reception areas for services.

However the groups also identified fewer tangible changes in the culture and approach. Increased whole system working and providing a joined up approach across West Yorkshire was identified in each of the focus groups as a change that has resulted from the ATR programme. This improved system coherence and was identified as an opportunity to share good practice, learn across the network and bring together *"like-minded people"*. The cultural dynamics of the network was also frequently raised, with the passion and enthusiasm of network members commonly highlighted *"there*

is a true partnership working, we feel like one big team". For some this also fostered a sense of optimism and hope that system change is possible through the accumulation of small changes across systems and places.

It was also identified that the approach was also a motivator in some areas/sectors as system partners *"don't want to be left behind"* as the programme developed. As well as supporting a joined up approach across systems and places, the ATR programme was also cited as driving consistency within them. One stakeholder attributed the raising of the profile of trauma informed practice outside of children and young people's services (where the strategy sits) as being an impact of the programme. As a result the strategy is now being reviewed to encompass adult services.

This increased connectivity was also linked to raising the profile of adversity and trauma, particularly amongst senior leaders. Whilst some networks members acknowledged that there was still work to do with senior leaders it was felt that there was a greater understanding and enabled *"us to push on open doors with senior management to train and embed trauma informed work*".

A final theme in relation to change and innovation was around access to expertise and resources as a result of the ATR programme. It was noted that as well as the network having access to subject matter experts, the training, and consistency of this was also highly valued. Access to resources has enabled locally relevant material to be developed, this included the infographic produced by Bradford Council after the knowledge exchange. Changes to and a sensitivity to the importance of language was also identified, as well as the importance of staff support and a trauma informed approach to supporting staff.

5.2 Impact to date

Building on the changes described above and reflecting where the programme is in relation to its 10 year strategy, impacts were largely seen by the groups as being in relation to effecting the cultural changes, joining systems up, increasing capability and raising awareness and the profile of trauma as described above. For some network members this had resulted in changes to their own practice and understanding *"it really challenged my own practice of co-production"*. Whilst others saw more discussion and a raising of the profile and priority of trauma informed practice in their roles. This increased awareness subsequently influenced awareness of the impacts of adversity and trauma and decision making in a range of forums, including safeguarding.

The groups also identified an increase in awareness of trauma amongst staff and the need for greater staff support as a result of the ATR programme.

A consistent theme of facilitating a more joined up approach across systems and within individual organisations also emerged. One group member identified a *"rare"* joining up of adult and children's services whilst another reported being *"more aware of what colleagues in my area are doing"*. Another reported how trauma informed worked had previously been siloed in the departments which were responsible for its development, however the ATR programme had managed to raise wider awareness indicating the value of an external influence on strategic development. This more coherent approach was seen as beneficial for stronger partnership working and a common base from which the VCSE and statutory sectors can collaborate.

Again access to resources, training and development were also commonly identified as having positive impacts in increasing capability both within services and across the system. The provision of training to workforces who were often hard to engage due to multiple competing demands, such as GP's, was particularly highlighted as being significant, whilst sharing resources were also seen as an opportunity to efficiently develop locally relevant materials as well as enabling *"doing things once – together"*.

This *"culture of open sharing and co-learning"* was also reportedly having impacts wider than the network members with some group members also seeing this reflect in practice and particularly in relation to greater co-production and *"professionals listening to lived experience"*.

5.3 Priority areas for future outcomes

Section 4.2, above, highlights how currently the distinction between change, innovation and impact is not clearly delineated and, as such, how the programme may benefit from a clearly defined set of intermediate outcomes and longer-term outcomes. Themes which emerged from discussions around priority outcome areas were:

Development of guidance to becoming trauma informed

There was a clear theme in relation to the development of *"more resources for organisations to become trauma informed"* and a *"step by step guide to key priorities when trying to become more trauma informed"*. One suggestion was the development of a *"kite mark for what being trauma informed looks like"* and such a definition would be required to achieve *"all services to be trauma informed"*. Standardisation in

co-production was also identified as a need. The need for such guidance or standards was often tempered in discussion by network member's reflections that trauma informed practice not being something that is 'achieved' but a continuous process of development and learning. This reflects a wider tension that exists within in highly regulated systems which require adherence to standards from regulators which are not necessarily trauma informed and the responsive approach of trauma informed practice. However it was a clear desire of the strategy board to develop KPI's which reflect the importance of the work being done by the programme and enable its effectiveness to be clearly communicated.

Changes in governance, policies, and procedures

A second clear theme which emerged was the need to affect internal changes within organisations ensuring that processes and governance are consistent with, and support, operational delivery of trauma informed practice. Changing policies and procedures, and particularly in relation to HR and staff support, were commonly identified. One group member stated a need for *"Organisational leadership [to join up with] operational good practice"*.

Changes in service delivery

Whilst changes to service delivery was a consistent theme, all focus groups suggested outcomes in relation to this which varied significantly. These ranged from priority organisations/sectors such as the DWP and the criminal justice system to more *"drop in type support services"*, *"buddying systems for young people"* and initiatives to tackle digital and cyber related trauma. The need to prioritise youth services and how this can support a preventative agenda was often raised, as was creating less complicated referral routes and pathways for people was identified whilst ensuring a consistency of approach across pathway providers.

Underpinning these, and a clear theme across the groups, was the need for trauma informed commissioning that included meaningful co-production and not *"just as a tick box"* as well as simplified referral pathways *"making it an easier for service users"*.

There was a clear direction from the strategy board in relation to the ATR programme supporting piloting projects and services in the future and this lends itself well to service development and commissioning practices.

Continued training

Understandably given the positive reception of the training to date, continued and further training was also often identified in the focus groups. This was particularly in relation to ensuring a consistent approach across pathways, particularly in relation to the standards of care and support that people experience as they move through the system. Training the VCSE sector to ensure that the whole system has an equal understanding was identified, as was mandatory training at key junctures in people's job roles such as at point of recruitment and at points of promotion or progression.

Developing the evidence base

As in stakeholder interviews the need to establish a clear evidence base for the impact of the programme was consistently raised in all of the focus groups and is a clear priority of the strategy board. *"Create a baseline – where are we starting from – what are we trying to achieve".*

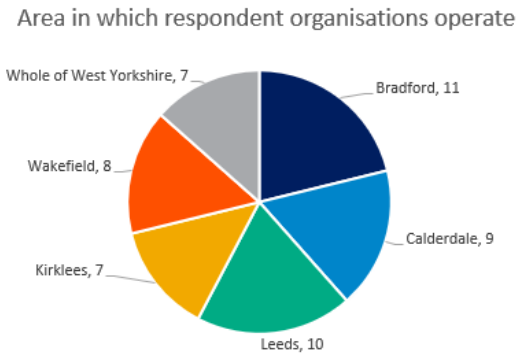
For some however this was also a way to share learning across the network and further accelerate change and a repository of such information was also identified as being useful.

> *"Shared case studies from organisations, elements of their implementation, challenges and overcoming them. Processes they went through to help others think about what they could do"*

6. Findings from the stakeholder survey

An online survey was circulated via email and via meetings to network members. The survey was designed to collect both changes and impact as a result of the ATR programme as well as gauge network partners perceptions of the programmes approach to partnership working. The survey structure is included in appendix 2. In total 30 responses were received representing 8.5% of the total network membership.

Figure 1, below, details the places in which respondents operate whilst figure 2 details which sectors respondents operate in. Both questions allowed for multiple responses. As can be seen respondents were distributed relatively equally over West Yorkshire and were mostly working in Health or Other Public Sector jobs. We received only four responses from members working in the criminal justice sector or related positions.



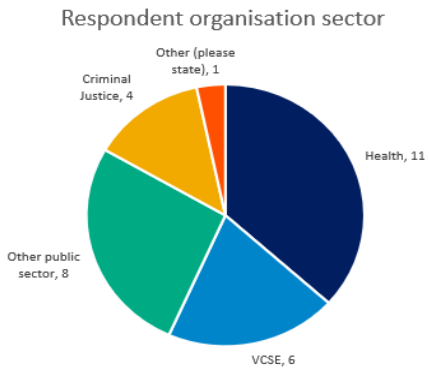


Figure 1, Local Authority Area. Source: Rocket Science survey Figure 2, Organisation sector Source: Rocket Science survey

Within these sectors, respondents were asked to select the field they operate in within their sector. This question was optional and not everyone provided this sector breakdown information. Figure 3 outlines the field of those that did fill out the question. As can be seen the majority of respondents work in secondary healthcare and local authority roles, and no respondents working in the criminal justice sector provided further information on their sector area.

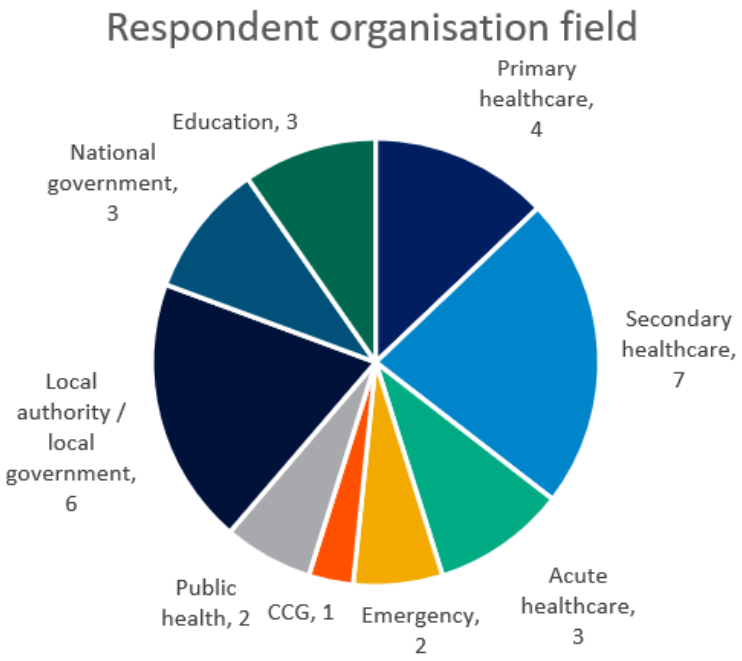


Figure 3. Local Authority Area. Source: RS survey

As can be seen in figure 4, below, 57% of survey respondents reported already working towards being trauma informed prior to the ATR programme being established. 20% (6 organisations) stated that they had started making changes as a result of their involvement in the programme. Whilst, as highlighted, the survey is a small sample of the network, and this may indicate a need to identify and proactively engage with key organisations which are not yet in the process of becoming trauma informed.

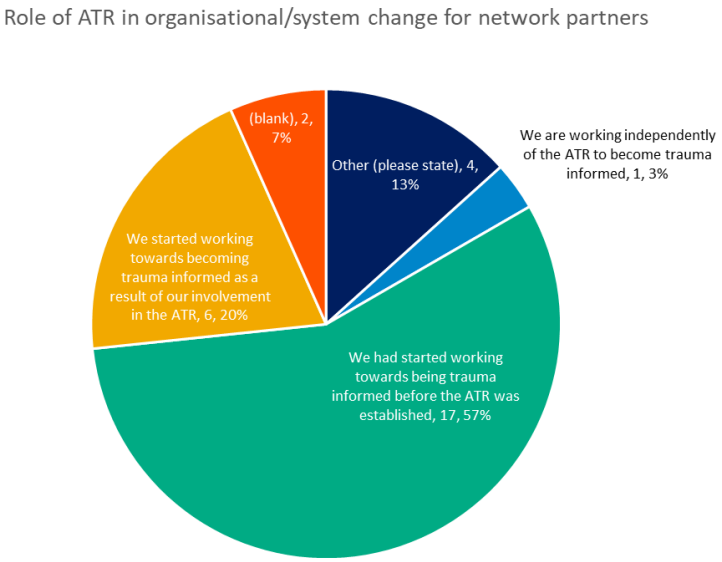


Figure 4. Role of ATR in organisational change towards becoming trauma and adversity informed. Source: Rocket Science survey

Respondents were asked to rate ease of accessibility to the ATR programme on a scale of 1 (not at all easy) to 5 (very easy). The average score was 3.7 and as can be seen in figure 5 no-one reported experiencing the programme as very difficult to access.

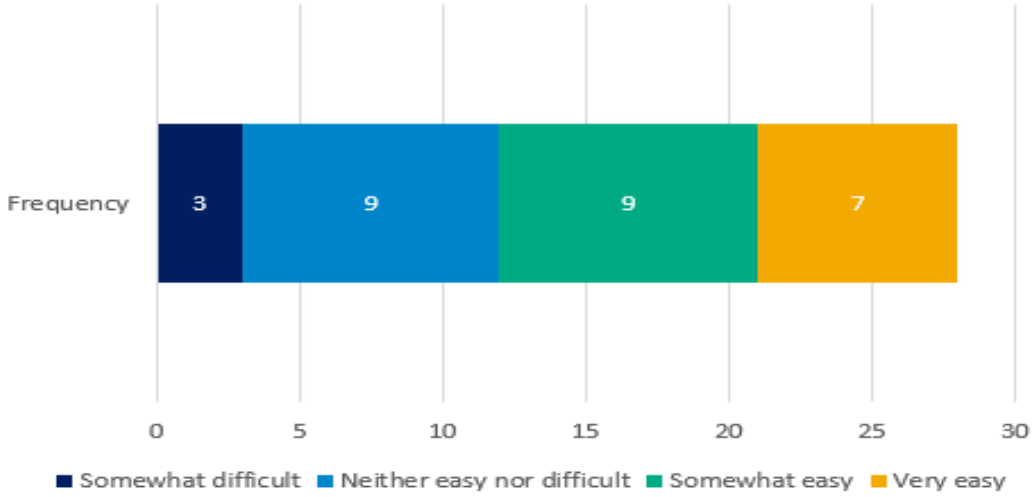


Figure 5. Ease of engagement with ATR. Source: RS survey

Respondents were asked to explain their rating. Reasons for difficulty in engagement included time commitments and clashes with competing priorities although one respondent from the VCSE sector highlighted the impact of the pandemic for them.

"We have little knowledge ourselves, so we're on a steep learning curve and then we have to cascade this out to a sector that has been significantly hit by the pandemic... Many groups are focused on re-establishing their activities and volunteer programmes"

Two respondents reporting experiencing a disconnect between network members with one person describing their experience as the programme being dominated by NHS leads whilst another has concerns around motivation to engage *"not all people singing from the same hymn sheet, some see it as the 'buzz' of the moment"*. Not all respondents answered the question.

Despite the ease of access the most common barrier/obstacle to engaging was time (n=19, 63%) and resources (n=9, 30%). Just one organisation identified organisation support or buy in as a barrier, although a second did identify organisational governance and another identified that the getting the organisational membership right was key:

"I feel that we need our organisational development team to be involved, there are very wide systemic issues that need to be changed for us to become A&T informed - ie how we respond as an organisation to missed appointments / engagement into services being" Rocket Science *survey* respondent

Organisational support and buy in was identified by respondents as being the most significant enabler of involvement (n=18, 60%). Just five (17%) of organisations reporting having dedicated time and resource to becoming trauma informed. Other enablers identified included the use of virtual meetings, buy-in from health partners and the relational approach across the network.

Survey respondents were also asked which of the available elements of the programme they were engaged with. The training collaborative was the most accessed resource with 21 of the 30 respondents being a part of this. Table 2 breakdowns which resources had been used.

Table 1. Accessed ATR resources among survey respondents

ATR resource	Number of respondents accessing
Knowledge exchange	20
Trauma informed resources	11
Training	9
Training Collaborative	21
Community Action Collective	17
Staff peer support	5
Other	3[36]

11 of the 23 respondents identified as attending both the training collaborative and the community action collective. Four respondents reported utilising/attending all of the elements of the ATR programme.

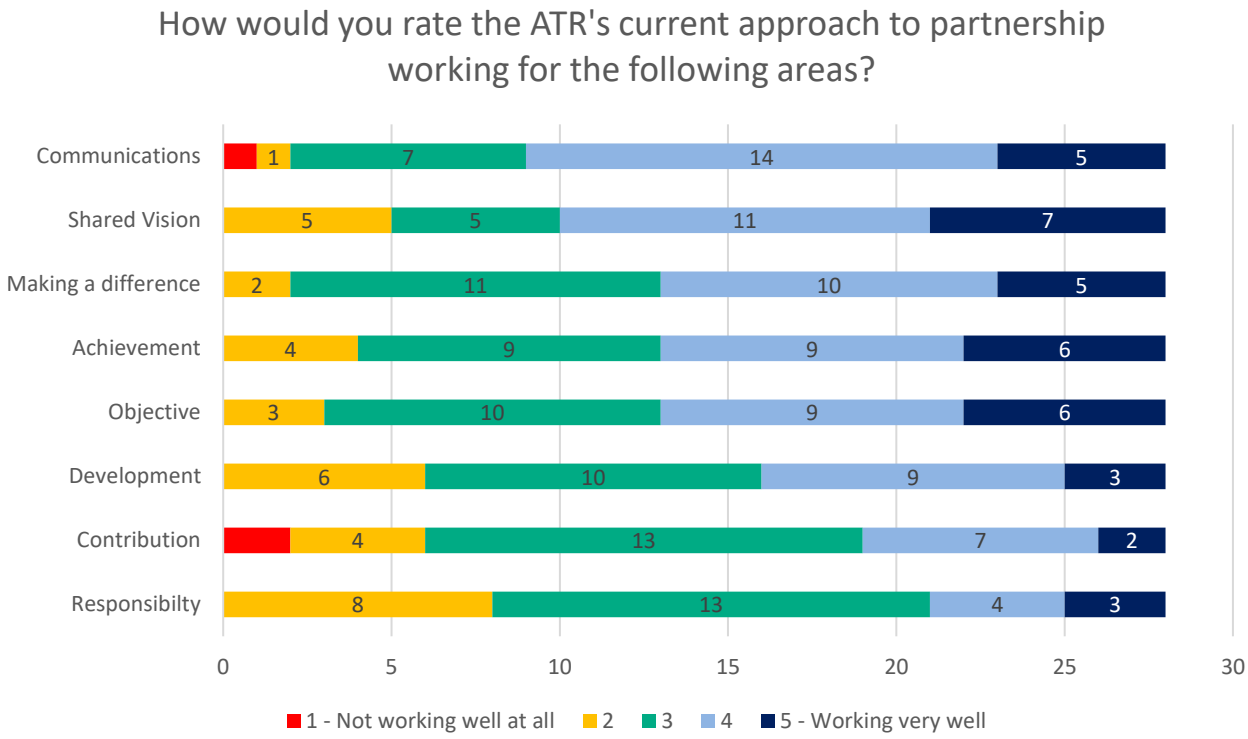
Partnership approach

We asked survey respondents to rate the ATR programme's current approach to partnership working on a scale of 1-5 (1 – not working well at all to 5 – working very well) on eight elements of partnership working. Respondents considered communications, shared vision, and ability to make a difference to be the most successful partnership elements of the ATR programme, whereas

[36] Other responses included education workstream, "large meetings not sure of the jargon describing them" and "meetings with Carrie and Emm"

contribution and responsibility were rated the least successful and possibly relates to comments in interviews in relation to clear direction and focus on change in clearly defined areas.

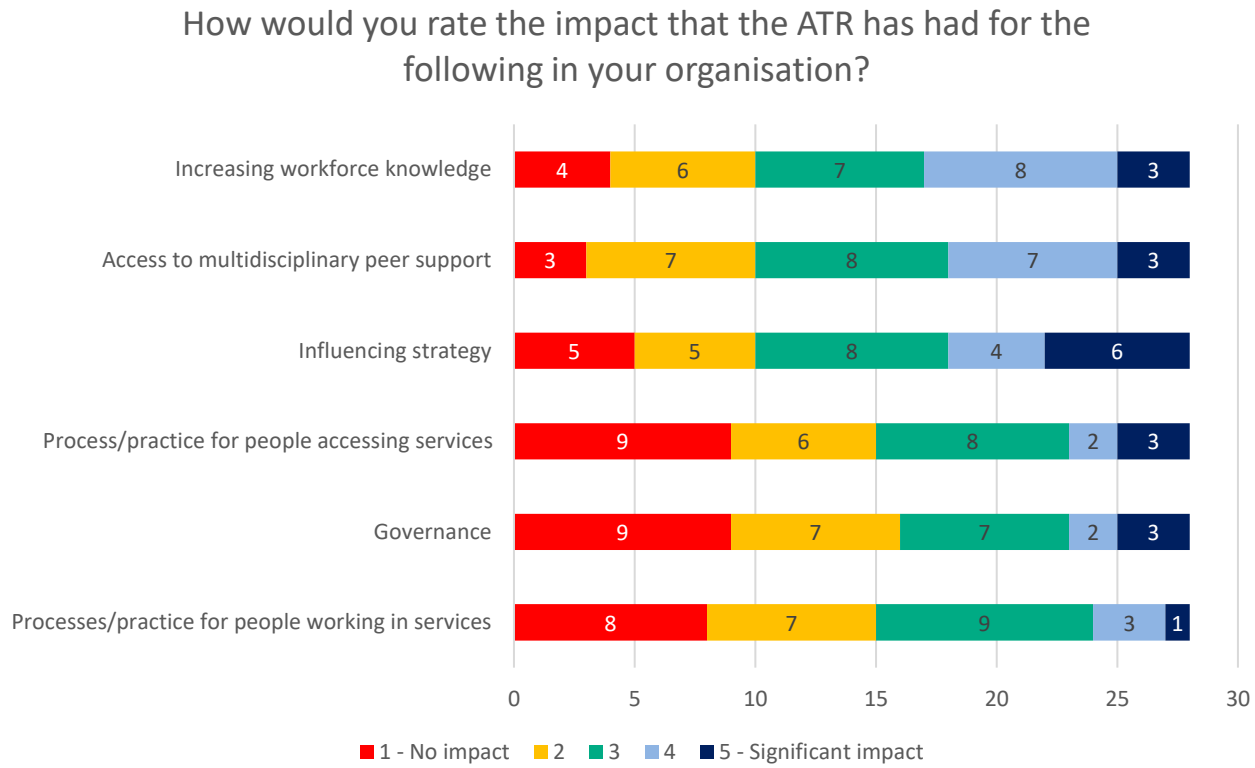
Figure 6. Partnership scorecard. Source: Rocket Science survey



Impact

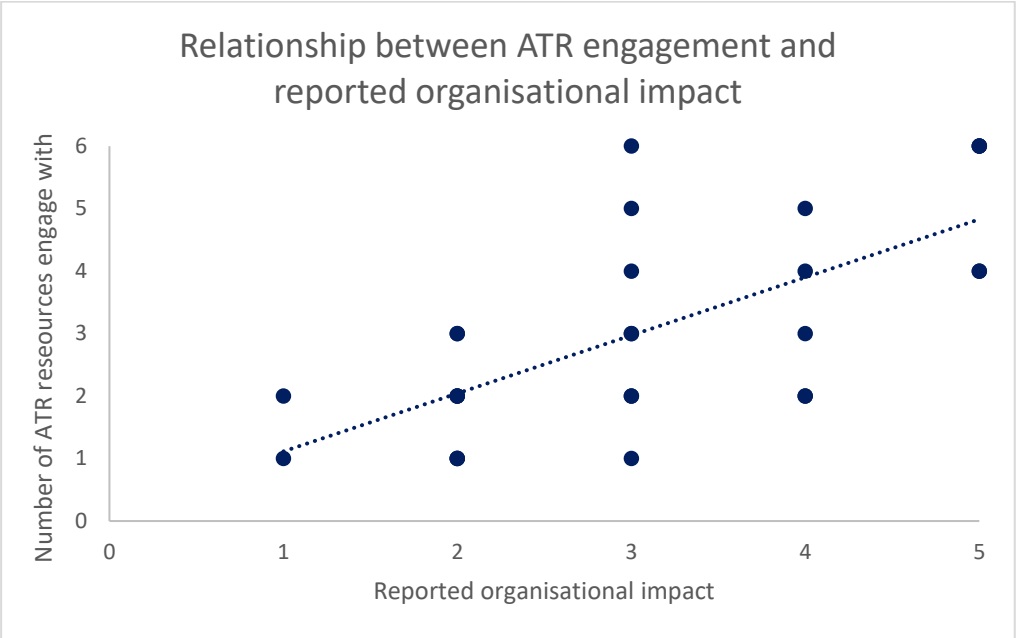
Respondents were asked to rate the impact of the ATR programme for their organisational development on a scale of 1 (no impact) to 5 (significant impact). As can be seen in figure 7 below the most significant impacts have been in influencing organisational strategy, access to multidisciplinary support and increasing workforce knowledge. Again, as may be expected given the stage of the ATR programme, the least impact is seen in processes and practice for people accessing or delivering services. The lower impact in governance is also notable and suggests that despite strategic influence this has not yet crystalised into organisational change.

Figure 7. Organisational impact of ATR. Source: Rocket Science survey



When considering programme engagement and perceived impact there is a positive correlation between the number of elements of the ATR engaged with and reported impact of the programme. This is illustrated in figure 8 below. Whilst this does not infer causality it suggests that promoting and communicating the other elements of the programme may be beneficial for supporting organisational change. On average those organisations who had already started a process of becoming trauma informed rated the impact of the ATR programme as 2.8 out of 5 (range 1-5). This compares with an average rating of 4.2 (range 3-5) for those organised who have started to make changes as a result of their involvement with the programme and identifies that targeting those 'harder to help' organisations in the future will be of benefit.

Figure 8. Relationship between ATR utilisation and self-reported impact. Source: RS survey



"Meetings are currently attended by people with a passion for this area, but who may have limited decision making influence. It would be interesting to think about who within an organisation (especially a large one such as mine) needs to be included in the thinking. Sometimes it can feel that in the meetings, everyone present is of a similar mindset - the challenge we will face is winning over the hearts/minds of others within our organisations - organisational change process" RS survey respondent

Respondents were also asked to reflect on changes they had observed in the wider system as a result of the ATR programme. 24 (80%) of survey respondents reported having seen some wider impact. Awareness raising and adversity and trauma having a higher profile and priority across systems, the impact of the training and multi-agency and cross sector working were three emerging themes.

"The buy-in from professionals from all backgrounds and the unity this has created which powers the ability for positive change. The ATR completing steps in training with the Police and understanding the impact this will…It is also through this network that [name of organisation] *has become involved with a research project into post-traumatic growth, the*

findings of which will be far reaching inside and outside our organisation." RS survey respondent

A number of survey respondents identified a need to ensure that the programme has clear and concrete objectives as well as definition of trauma informed practice that can result in measurable change. A number of respondents identified the need for "*Clarity as to where the ATR adds value to local delivery…clear objectives"* whilst another commented:

"This is a bit like a murmuration of starlings. there's a lot of diversity in a general forward movement. There is good and shared understanding within the group with some key decision-makers present and access to some resources. However there are varying levels of constraint on services to make changes (some internal, some external) so not everyone is moving at the same pace. Some organisations are focussing on being joined up with each other, other organisations are focussed on implementing a TIA internally before "coming out". Trauma Informed Approaches are contextual and ultimately client-led/ co-produced. A system-wide set of standards and model works against the efficacy of TIAs." Rocket Science survey respondent

7. Conclusions and recommendations

"Culture eats strategy for breakfast" Peter Drucker

It is clear that the initial focus of the programme in creating a collaborative, inclusive and co-productive culture, that mirrors the principals of trauma informed practice, has been instrumental in the programme's development, sustainment, and achievements to date. That this has been the focus of this initial stage of the programme has clearly been the correct approach and, given the pressures that the key network partners face as a result of the last two years of the pandemic, the size and engagement of the network is a considerable success and lays the foundation for enabling change as the programme moves to its next phase. Despite being in the early stages in the overall strategy, impact of the programme is being seen, particularly in relation to workforce training, convening across systems and ensuring an on-going prioritisation of the adversity and trauma agenda.

Stakeholders who are experiencing these outcomes and impacts do attribute them to the ATR programme. Even those organisations which had already begun the process of becoming trauma informed reported benefitting from being involved in the network. There are also early indicators of changes in service delivery that, in time, are likely to result in outcomes and impacts for people accessing and working in services.

Whilst continuing this approach and being sensitive to emergent need and strategy is required, it is clear from the network that there is also a need for a more crystalised, intentional, strategy in which a clear direction and coherent ambition is defined and communicated. Whilst there are mixed views as whether all the required stakeholders are engaged by the programme network, a mapping exercise which considers the extent to which members are active and engaged with the programme would be beneficial to determine this, as well as to identify any system partners who are not currently engaged.

Time and dedicated resource are the most commonly cited barriers for engagement with the ATR programme and, given the current social, economic and health environments it is apparent that pressure on resources to fulfil statutory duties will continue to be challenging for the foreseeable future.

We are aware that a strategy is currently in development but see an opportunity for the ATR programme to explicitly prioritise supporting the challenges that both the statutory and VCSE sectors will commonly face over the next few years. We would suggest that these are:

- Poverty and widening health inequality. The cost of living crisis and poverty will be traumatic for those disproportionately affected by it and. The increase in economic inactivity, particularly for those 50+[37] are likely to increase health inequalities at a point when the health system is still stretched by the pandemic and waiting lists are increasing. The often punitive approaches to benefit sanctions and default on debts is likely to exacerbate need. Identifying how the ATR programme can support efficiencies in the health system through reduced re-presentation and more efficient pathways would likely to be attractive. Similarly support for DWP to appropriately respond to need in a preventative manner would be of significant benefit in preventing or escalating financial crisis.

  The role of trauma informed practice in schools in raising aspirations and supporting children with experiences of trauma may have socio-economic, as well as individual, benefits for the region. Rocket Science's other research commissioned by WYCA highlights the region is also impacted by low aspiration, attainment and social mobility in children and young people. Consideration as to how the ATR programme can support the objectives of work in this area should be considered.

- Staffing. Staff recruitment and retention continues to be a significant issue for the health and social care sector with over 210,000 unfilled vacancies in March 2022[38]. Exploring how the ATR programme can support workforce development and the creation of safe and attractive environments for workers is likely to be of strategic importance for the sector. Enhancing the regional response to workforce trauma may also impact productivity through reduced absence, quicker returns to work and improved staff wellbeing.

- Governance (quality and safety). Given the anticipated increases in demand and fewer resources with which to meet, this maintaining the safety and quality of services will be challenging. There is a potential risk of trauma informed practice as being seen as a 'nice to do' as organisations and systems focus on what they 'must do' with a particular focus on

[37] Movements out of work for those aged over 50 years since the start of the coronavirus pandemic - Office for National Statistics (ons.gov.uk)
[38] VACS02: Vacancies by industry - Office for National Statistics (ons.gov.uk)

regulatory requirements. The workforce changes described must be supported by governance changes, not just in relation to human resources, but processes such as serious untoward incident reviews, management and leadership practice and co-production and involvement. A prioritisation in this area would also support the development of clear guidance and standards which is consistently seen as needed by the network. There are examples of how regulated activities within education and health in the region have become trauma informed and have been inspected, which can be learned from. Again ATR programme support for how quality and safety obligations can be met through a trauma informed approach are likely to be appealing to stakeholders whilst also working towards resolving the tension between regulators who may not be trauma informed and services/systems which aim to be.

The strategy board clearly stated a preference for the programme supporting testing and learning approaches in the future and these are areas which lend themselves well to discrete testing and evaluation. This could be done discretely within services, through a pathway approach bringing services and sectors together or even across systems on a larger scale. Such a test and learn approach would also ensure that 'bottom up' and 'top down' change are coordinated and are of equal pace to avoid potential imbalance which may result in either organisational environments and cultures which do not support trauma informed approaches or in which trauma informed practice is perceived as a top down initiative without operational staff buy-in. Finally it would also enable the development of a clear and focussed evaluation framework which can start to measure outcomes, impact, and value for money at system, programme, and project/service level.

In addition we would also make the following recommendations of, potentially, quicker wins for the programme:

Review governance and network structures

- Reviewing network groups membership will identify any gaps in relation to key stakeholders whilst also identifying opportunities for efficiencies in the network partners.
- Consider the role of the steering group and strategy board in driving and holding the network responsible for change. This should also include reviewing how workstreams operate and how action plans are aggregated and owned.
- Providing regular communications of programme aims, progress and outputs would be beneficial for stakeholders not regularly attending meetings or in securing buy-in from local decision

makers. The Greater Manchester Health and Social Care Partnership Taking Charge campaign provide a potentially useful model for this.

Evaluation and monitoring

- Consideration should be given to establishing an evaluation workstream to develop and maintain a common data framework across all of the stakeholders. Mapping existing data collection and outcomes would support in ensuring future evaluation is using existing structures and ensuring efficiency, where this is possible.
- Whilst there are some opportunities for a framework to follow a traditional baseline-follow up approach, the literature suggests primarily taking a learning partner approach to evaluation and consideration should be given as to how to establish this across the network over the remainder of the implementation period.

Appendix 1: Proposed evaluation framework

A number of those interviewed to date have acknowledgement the need to evaluate the ATR programme on an ongoing basis and there is a clear willingness to be involved. The table below presents a draft of what a system wide formative evaluation framework could look like, for the evaluation of the programme in future. This is included as an example or starting point, and it would be expected that this would be co-produced with stakeholders.

System level	Indicator of change/impact	Measure of change/impact
ATR partnership at a system level	Partners have a shared understanding of vision, goals, and potential outcomes of the ATR programme	Partnership scorecard (survey)
		Strategy for intentional change created and agreed with partners
	Partners have shared understanding of pathways across systems and how these can be better trauma informed	System and pathway mapping exercise completed at agreed intervals
	Learning captured and shared on an ongoing basis	Use of a learning partner approach to change
		Evaluation plan is developed and agreed across the partnership, with a common data framework and data collection methods agreed
	Transitions along the pathway are 'smoother'	Reduced repetition on assessment process/unitary assessment approach – measurement to be agreed
		Transition between services is quicker – measurement to be agreed
		Increased capacity for support – measurement to be agreed

		Information sharing across partners is systematic – measurement to be agreed
	Funding can be agile and responsive to need	Shared pathways by multiple service providers – measurement to be agreed
		Specific funding provision 'top sliced' from across systems
Service provider level (Governance)	System partners have a commitment to contribute to system change	Sign up/commitment to ATR strategy by partner organisations
	Governance is trauma informed	Development of trauma informed policies at organisational level, and where possible, system level
		Contribution of lived experience at board / decision making levels at organisational level
Service provider level (staff)	Learning and development	Training of staff trauma awareness/trauma informed practice - measurement to be agreed
		Introduction of reflective practice for frontline staff – measurement to be agreed
	Staff wellbeing	Trauma responsive approaches to critical incidents at - measurement to be agreed
		Staff wellbeing surveys - measurement to be agreed
		Impact upon staff presenteeism - Absence records
	Inclusion of lived experience in service design, evaluation, and delivery	Case studies/insight reports developed and shared

Service provider level (delivery)	Trauma informed assessment and planning processes developed and in place	Routine screening for trauma including specific tools as appropriate - measurement to be agreed
		Unitary assessment process across services – implementation to be agreed
	Lived experience valued in service delivery	Inclusion of peer support/mutual aid models - measurement to be agreed
	Trauma specific advice and guidance is routinely available	Educational material about trauma and impacts is available to those accessing the service – impact measured through satisfaction surveys
		Staff provide brief intervention around distress tolerance
Person (people accessing services)	Increased access/reduced barriers	Pathway 'flow' (eg timeliness) - measurement to be agreed People's experience of transition between services- measurement to be agreed
	Personal experience is valued within services	Payment/expenses for contributions implemented
		Feedback on involvement in planning and risk processes implemented
	People are educated about effects of trauma and equipped to manage symptoms of trauma	Educational material available and accessible – impact measurement to be agreed
		Brief wellbeing interventions are available- measurement to be agreed
	Improved outcomes for people	Measurement to be agreed

Appendix 2: Organisations engaged with the evaluation

Interview participants

Barnardo's
Bradford Council
Bradford University
Calderdale & Huddersfield NHS Trust
Calderdale Council
Inspire UK
Kirklees Council
Leeds City Council
Locala
National Lottery Community Fund
New Beginnings Peer Support
NHS Calderdale
NHS Leeds
NHS Wakefield CCG
South and West Yorkshire Resettlement Service
Spen Valley High School
South West Yorkshire NHS Foundation Trust
Wakefield Council
Warren Larkin Associates
West Yorkshire & Harrogate Health and Care Partnership
West Yorkshire Violence Reduction Unit
WYCA

Survey respondents

Bradford Liaison and Diversion
Bradford District NHS Foundation Trust
Calderdale CCG
City of Bradford Metropolitan District Council
Department Work and Pension
Humankind
Inspire North
Kirklees Council
Leeds City Council
Leeds Community Healthcare NHS Trust
Leeds Virtual School
Locala CIC
Luminate Education Group
New Beginnings Peer Support
South and West Yorkshire Resettlement Consortium
South West Yorkshire NHS Partnership Foundation Trust
Spectrum Community Health CIC
The University of Bradford
Touchstone
Violence reduction board
VSI Alliance
Wakefield Integrated Care Partnership
Wakefield District Housing
West Yorkshire and Harrogate Health Care Partnership
Young Lives Leeds

Cherri Blissett, Director

James Ward, Principal Consultant

Jessica Shields, Principal Consultant

Jenny Paisley, Lead Consultant

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