What Works for Children's Social Care

Cardiff University
Prifysgol Caerdydd

A RANDOMISED CONTROLLED TRIAL OF SCHWARTZ ROUNDS: AN INTERVENTION TO REDUCE PSYCHOLOGICAL DISTRESS FOR STAFF IN CHILDREN'S SERVICES

September 2021

What Works *for* Children's Social Care

Acknowledgements

We are grateful to all the local authority partners involved in the study (Bath and Northeast Somerset, Derbyshire, Enfield, Hackney, Haringey, Leicester, Liverpool, Nottinghamshire, Swindon, Walsall, Warwickshire, and West Sussex). Without the commitment and hard work of countless senior managers, project leads, team managers, practitioners, and business support officers, the project simply would not have happened.

We are also exceptionally grateful to the Point of Care Foundation, who worked tirelessly with these local authorities and with CASCADE to ensure that Schwartz Rounds could be delivered and evaluated within children's services. Their willingness and enthusiasm to expose Schwartz Rounds to the rigours of a randomised controlled trial does them great credit.

Finally, there were many other researchers and professional support staff from CASCADE who helped in various ways, big and small, throughout the trial, beyond those listed as authors to this report. We are particularly grateful to Aimee Cummings and Asmaa El-Banna.

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About What Works for Children's Social Care

What Works for Children's Social Care seeks better outcomes for children, young people and families by bringing the best available evidence to practitioners and other decision makers across the children's social care sector. We generate, collate and make accessible the best evidence for practitioners, policy makers and practice leaders to improve children's social care and the outcomes it generates for children and families.

About CASCADE

CASCADE is concerned with all aspects of community responses to social need in children and families, including family support services, children in need services, child protection, looked after children and adoption. It is the only centre of its kind in Wales and has strong links with policy and practice.

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EXECUTIVE SUMMARY

What are Schwartz Rounds?

Schwartz Rounds (SRs) provide a way for staff to meet and share stories about the emotional and social aspects of their work. Within children's services, this means enabling staff to explore and reflect on the challenges and rewards involved in providing services for vulnerable children and families. SRs are open to everyone who works within the organisation, including social workers, family support workers, managers and business support officers. Each SR involves a small panel of staff members sharing stories based on their experiences and linked to a common theme - for example, *a child or family I will never forget*. Afterwards, the audience are invited to reflect on these stories together and share their own experiences. In this study, SRs were provided either in-person (before the Covid-19 pandemic) or virtually (during the Covid-19 pandemic).

Study design

We used a randomised controlled trial (RCT) design. Staff members in participating authorities were randomly assigned to an intervention group (invited to attend SRs) or a control group (asked not to attend SRs during the trial period). We used an online survey to collect T1 baseline data from both groups prior to the first SR and to collect T2 outcome data after the final SR within the trial period. The aim was for each LA (local authority) to provide six SRs, although in practice some LAs provided only three, four or five. The General Health Questionnaire (GHQ-12) was the primary outcome measure. The GHQ-12 is a widely used and validated measure of psychological distress. At T2, we also asked staff to self-report the number of days they were off work due to ill-health in the previous six months. After each SR, staff were asked to complete a feedback form, and throughout the study we conducted key informant interviews, focus groups with staff, and observed at least one SR in each authority. We also collected feedback from the Point of Care Foundation, who license and provide training for the intervention.

Sample

We initially recruited twelve local authorities. Staff from ten of these took part, while two of them withdrew (one because of difficulties organising SRs, and one because they preferred to wait and provide in-person, rather than virtual, SRs). Six of the LAs provided in-person SRs (we call this part of the trial *phase one*), and four provided virtual SRs, using Microsoft Teams or Google Meet (we call this part of the trial *phase two*). In total, 5,072 members of staff were randomised to the intervention group (n=2,534) or the control group (n=2,538). Of these, 776 were recruited to the study via their completion of the T1 survey. 267 completed the T2 survey, and 172 completed both surveys.

Results

The qualitative feedback from staff was almost universally positive in phase one and two. At T2, staff in the intervention group had lower average GHQ-12 scores (Figure 1), and a smaller proportion had elevated GHQ-12 scores (Figure 2) compared with staff in the control group. Staff in the intervention group reported a slightly lower number of sickness-related absences in the previous six months compared with the control group (Figure 3). None of these differences reached the level of statistical significance ($p < 0.05$). The intervention was relatively low-cost to deliver, with initial set-up costs ranging from £5,204.75 and £6,505.14, and running costs per SR ranging from £288.24 to £2,711.60 (the majority of which was the indirect cost of staff time for those who attended).

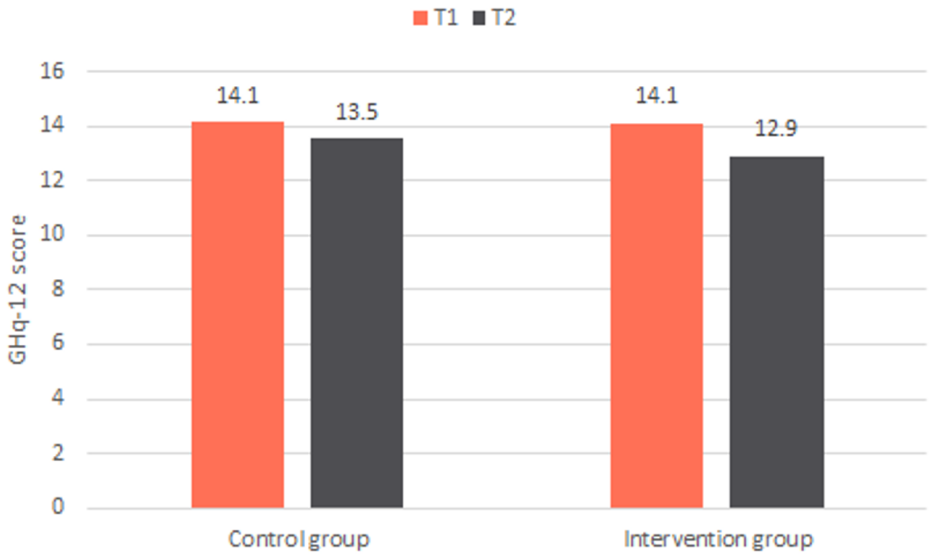


Figure 1: GHQ-12 scores by time point and group | *(T1 n=776, T2 n=267)*

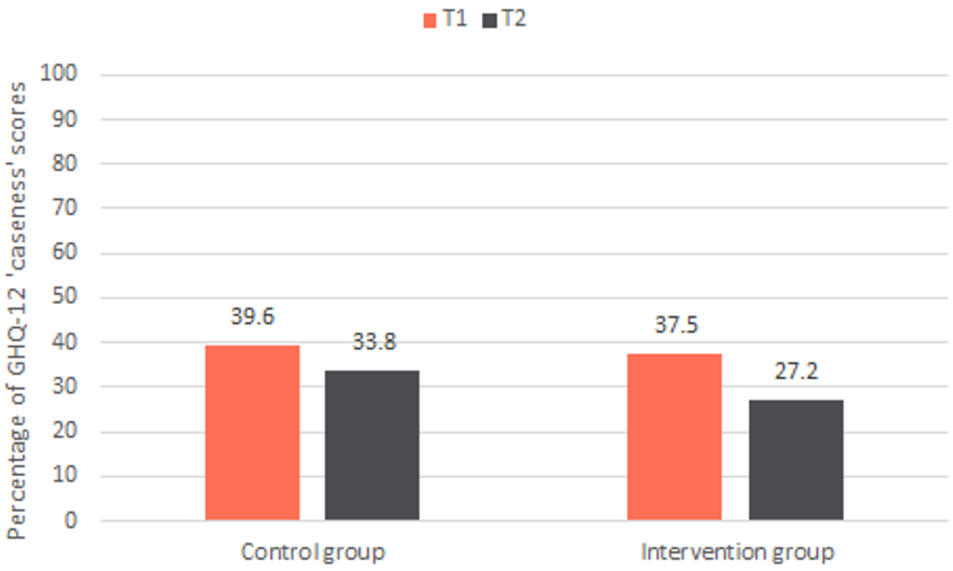


Figure 2: The proportion of elevated GHQ-12 scores by time point and group | *(T1 n=776, T2 n=267)*

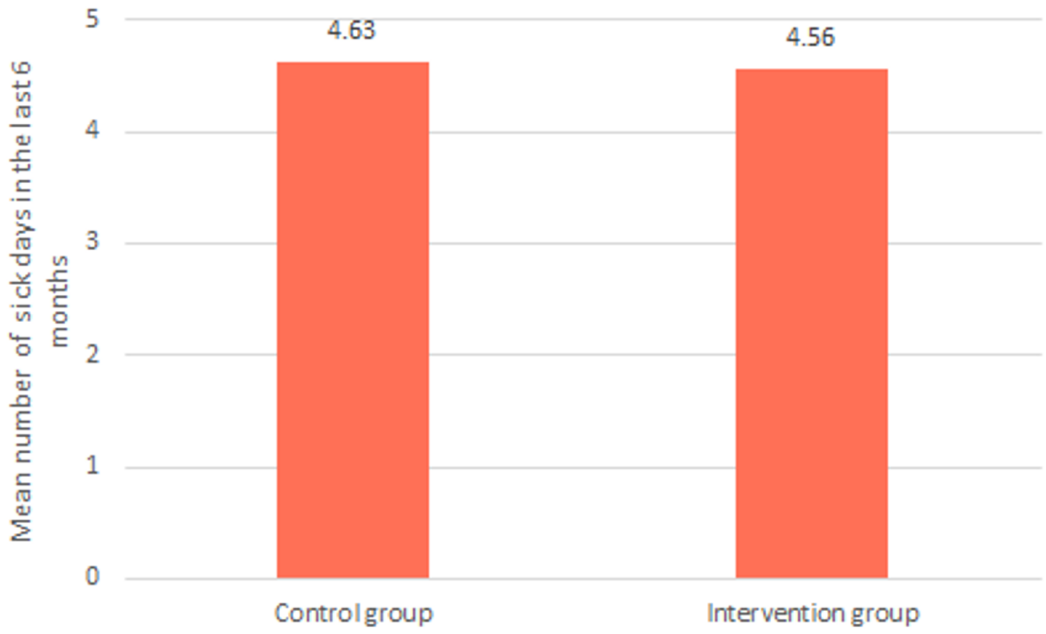


Figure 3: Sick days per group at T2 | *(n=236)*

Implications

It is feasible to implement SRs within children's services. The vast majority of staff who attended found them to be a positive experience, reporting a mixture of benefits in relation to personal wellbeing, collegiate relationships, and their direct work with families. A small minority of staff did not find them helpful, and some of these found them to be upsetting and chose not to attend any more. We found clear signs of promise that regular attendance at SRs in children's services may be associated with decreased levels of psychological distress and fewer sickness-related absences from work, with some large effect sizes, although the differences between the intervention and control group were non-significant ($p < 0.05$). Considering the findings holistically, we recommend that LAs consider providing SRs (or continuing to provide SRs) as part of their efforts to support staff wellbeing.

INTRODUCTION

This report presents the findings from a randomised controlled trial of Schwartz Rounds (SRs) in England. Beginning in May 2019, six local authorities (Haringey, Liverpool, Nottinghamshire, Walsall, Warwickshire, and West Sussex) signed-up to deliver monthly SRs, with the aim of supporting the psychological well-being of social care staff. From January 2020 onwards, an additional six local authorities (Bath and Northeast Somerset, Derbyshire, Enfield, Hackney, Leicester, and Swindon) were recruited to increase the sample size. Due to the Covid-19 pandemic, this second phase of the trial was placed on hold between March and September 2020. When phase two restarted, due to social distancing and work-from-home requirements, SRs were delivered virtually, rather than in-person. To maintain their anonymity in relation to the results, each of the participating LAs has been allocated a random number from 1 to 12.

Background and rationale

Working in children's services can be rewarding but also very challenging. Workers typically report high levels of stress relative to the general population, which may contribute to elevated rates of psychological distress and sickness-related absence (Antonopoulou, Killian, & Forrester, 2017; Ravalier, 2019). These difficulties can be exacerbated by limited resources, high workloads and insufficient organisational support (McFadden, Campbell, & Taylor, 2015).

Previous evaluations of SRs in healthcare settings have shown signs of promise in relation to staff wellbeing (Allen et al., 2020; George, 2016). In this trial, we evaluated the use of SRs within children's services to see what effect they had on levels of psychological distress and sickness-related absence from work for social care staff.

What are Schwartz Rounds?

A recent evaluation of SRs in healthcare described the intervention as follows:

> *"Schwartz Rounds provide a regular open forum for staff to come together [and] reflect on, explore and tell stories about the difficult, challenging and rewarding experiences they face when delivering care. Rounds last for 1 hour and are often held during lunch periods (with food provided). The focus is on psychosocial, ethical and emotional issues [with] attendees encouraged to be open and honest, and reflect, discuss and explore their experiences, thoughts and feelings"* **(Maben et al., 2018, p. 14)**

Maben at al. suggest that SRs function by offering staff a space in which they can share their personal experiences of work. They help staff to recognise their commonality and enable deeper connections between colleagues. This results in greater trust and empathy within the organisation. This in turn supports better psychological well-being. As a result, people who use the service experience a more compassionate form of care.

In the UK, training and support to deliver SRs is provided by the Point of Care Foundation (PoCF), a registered charity in England and Wales (no 1151628). SRs are a licensed intervention and should not be provided without the support of the PoCF. In practical terms, providing SRs involves a small project team, consisting of:

- **A clinical or practice lead**, with overall responsibility for SRs
- **An additional one or two people trained as facilitators**, to help run the SRs
- **An administrator** to assist with minute taking, room bookings, staff invites and communication
- **A steering group**, with 8 to 12 members from across the organisation (Table 1).

Table 1: A brief description of key roles when delivering SR

Role	Brief description
Clinical / practice lead	A respected senior member of staff, responsible for representing the importance of SRs to the organisation, championing SRs, working closely with facilitators, helping to find panellists, attending steering groups and running SR meetings.
Facilitator	Staff with good communication skills, helping to find and prepare panellists, attending steering group meetings and running SR meetings.
The steering group	A diverse group of staff with shared responsibility for delivering SRs. Members help to raise the profile of SRs, share ownership of the intervention within the organisation, help to find panellists, offer debriefs for clinical / practice leads and facilitators. Steering group meetings should happen once a month.
Administrator	To help collate feedback from staff, book rooms and lunches, help with communication to staff, co-ordinate steering group meetings and take minutes.

Facilitators and clinical or practice leads are required to attend initial training sessions and are also offered ongoing mentoring support from PoCF. The initial training consists of two days. Day one includes an introduction to SRs, topic generation, panel preparation, facilitation skills and the demonstration of a live SR. Day two, which takes place several months after the first, to allow for the delivery of at least three SRs, focuses on ideas for sustainability, advanced facilitation skills, and further panel preparation skills.

What is the existing evidence that Schwartz Rounds are effective?

Taylor et al. (2018) undertook a systematic review of SR studies, based mainly in healthcare settings. Most evaluative studies were said to be characterised by weak research designs. Nonetheless, many staff members who attend report positive benefits for themselves, colleagues, and for the wider organisation. In a recent realist-informed mixed-methods study in healthcare settings, poor psychological well-being, measured using the General Health Questionnaire-12, reduced significantly ($p<0.05$) for staff who attended SRs regularly compared to those who did not (Maben et al., 2018).

METHODS

This study was an individually randomised controlled trial (RCT) with two arms (an intervention group and a control group). The overall aim of the study was to evaluate whether SRs could improve the psychological well-being of social care staff.

The *primary hypothesis* was that at T2, GHQ-12 scores in the intervention group would be on average lower than in the control group. We used an intention-to-treat analysis, whereby all staff in the intervention group were included in this analysis, irrespective of whether they actually attended SRs or not. The GHQ-12 offers a valid and reliable way of measuring psychological well-being and is generally considered suitable for use in various populations (Hardy, Shapiro, Haynes, & Rick, 1999; Kalliath, O'Driscoll, & Brough, 2004; Ozdemir & Rezaki, 2007). Lower scores on the GHQ-12 indicate greater wellbeing. In Maben et al's (2018) study, the GHQ-12 was the only instrument to identify a significant difference between staff who attended SRs and those who did not.

The *secondary hypotheses* were:

a. At T2, the proportion of GHQ-12 scores above an elevated 'caseness' threshold (of 4) would be lower in the intervention group than in the control group.

b. At T2, the number of days of sickness-related absence from work during the trial period would be lower in the intervention group than in the control group.

c. Regular attendance (three or more SRs) would be associated with lower GHQ-12 scores when compared to irregular (one to two SRs) and non-attendance (zero SRs).[1]

d. Schwartz Rounds would be considered acceptable by the staff who attend.

Analyses for the primary hypothesis and the secondary hypotheses *a*, *b* and *c* were two-sided.

Sample

Each LA provided a list of staff members. All members of staff working within children's services were eligible for inclusion (including managers, social workers, family support workers, business support staff and so on). Half of the names on each of these lists were randomly allocated to the intervention group and half to the control group (using the Microsoft Excel RAND function). LAs had the option of including

1 These categories for regular, irregular and non-attendance are based on those used in Maben et al's (2018) major study of SRs in healthcare.

their entire children's services staff group, or to include only those working in certain departments or geographical areas (tables 2 and 3). They were asked not to include or exclude specific individuals or teams, other than those actively working on the project (who could not be in the control group). This took place before the administration of the T1 survey, in an approach often described as pre-randomisation, before the respondent has consented to take part in the study (Zelen, 1979). We used this approach so as to avoid a delay between recruitment and informing respondents which group they were in, which some LAs felt would be too cumbersome to allow them to implement SRs within the trial time-frame. The process of randomisation was completed by a researcher not otherwise involved with the trial, and staff were not informed of which group they were in until after T1 data collection.

Staff were then individually recruited into the trial via their completion of the T1 survey, which included an information sheet and consent form. In other words, respondents who were pre-randomised into the intervention group and completed the T1 survey were invited to attend SRs. Sample size calculations can be found in the trial protocol. Our target sample size, without drop-out adjustment, was 238 in each group (n=476 in total). Based on the data collected at T2, we achieved between 36.1% (based on matched T1 and T2 responses) and 56.0% (total T2 responses) of this target.

Table 2: How each LA identified staff to take part

LA	Approach to randomisation
1	Staff invited to take part and then randomised into two groups.
2	Randomised entire children's services department.
3	Randomised entire children's services department.
4	Randomised entire children's services department.
5	Randomised all staff within one geographic area of the authority.
6	Staff in two geographic areas randomised separately, SRs provided independently in each one.
7	Randomised entire children's services department.
8	Randomised entire children's services department.
9	Randomised entire children's services department.
10	Planned to randomise one geographic area of the authority.
11	Randomised all staff within four selected teams.
12	Randomised entire children's services department.

Note. LA 1 chose not to follow the randomisation protocol and instead asked for volunteers to take part, who were then allocated at random to either the intervention or control group. LA 10 exited the trial before randomisation could be completed and did not provide any data.

Table 3: An overview of the staff lists and the randomisation outcome per LA

LA	Total N	Intervention group	Control group
1	41	20	21
2	598	299	299
3	716	358	358
4	603	301	302
5	69	35	34
6	705	352	353
7	418	210	208
8	780	388	392
9	306	153	153
10	516	258	258
11	76	38	38
12	244	122	122
Total	**5,072**	**2,534**	**2,538**

Note. These figures do not indicate the number of staff recruited into the study via their completion of the T1 survey. Those figures are provided below in Figure 6 (flow diagram).

Data collection

Our primary outcome measure was the GHQ-12, administered at T1, prior to the first SR, and at T2, after the final SR in each LA within the trial period. We also asked respondents at T2 to report the number of days they were absent from work due to ill-health in the previous six months. We arranged for the distribution of feedback forms after each SR[2], held interviews with key informants, ran focus groups with staff, and observed at least one SR in each LA. The key informants were members of LA staff involved in delivering SRs, for example project leads and facilitators. Their involvement in delivery of the intervention meant that it was reasonable to assume they could provide key data about the implementation of SRs in children's services, as well as being well-informed about the staff experience of attending. We also collected economic data relating to the cost of providing SRs throughout the study.

The GHQ-12 is a standardised instrument designed to measure psychiatric morbidity in the general population and in community settings. It has been used widely in studies

2 We administered an amended version of the standard feedback form used routinely by the Point of Care Foundation in healthcare and other settings. The only significant change we made was to the list of job roles, to ensure they were suitable for children's social care staff.

of public sector workers, including social workers (Antonopoulou, Killian, & Forrester, 2017). We used two widely used methods to analyse these data. First, we calculated a total score, with each item marked either 0, 1, 2 or 3. The maximum score using this method is 36. This scoring method was applied for the primary hypothesis. Second, we calculated whether each respondent had an elevated score, meaning they would likely benefit from some form of defined psychological intervention (in GHQ-12 vernacular, whether they were a 'case' or not). For this method, we marked each item either 0, 0, 1 or 1, with a score of 4 or more being categorised as elevated (Hankins, 2008). This approach is widely recommended for calculating 'caseness' (or elevated) scores (James, Yates, & Ferguson, 2013). This scoring method was applied for the secondary hypothesis a.

In the T1 survey, respondents were also asked about their demographic and professional characteristics and the other forms of support available to them at work. The T2 survey repeated the GHQ-12 measure and asked for details of any sickness-related absences in the previous six-months, the number of SRs attended and qualitative feedback about the intervention. For respondents in phase two, we also asked about their attendance at in-person or virtual SRs, as some of these authorities (LAs 7, 8 and 9) held one in-person SR in either February or March 2020, before the trial was paused due to the pandemic.

The feedback forms asked respondents about their experience of attending the individual SR, using a mixture of Likert scales and free-text boxes.

In the key informant interviews (with practice leads and facilitators), we asked questions about how SRs were implemented, barriers and facilitators, how they worked in practice and about adaptations either made or recommended.

We also sought to observe at least one SR in each LA. These observations were based on Maben et al's (2018) study, in which they identified nine key features of the intervention. We looked for signs that these key features were present in the SR and to what extent. More details about the observations and the key features are provided below. We also obtained feedback from the PoCF about their own observations of SRs in each LA, although in practice they were not able to do this for every site.

Finally, we asked LAs to complete a set of economic evaluation forms in relation to the cost of SRs:

1. **Point of Care contact form:** to record LA interactions with PoCF, including travel costs and staff time for training.
2. **SR direct cost form:** including room booking, catering and other setup costs, as well as time spent in preparation and follow-up activities.
3. **Panel preparation form:** including staff time and other costs.
4. **Steering group form:** including staff time and other costs.

Table 4: An overview of data collection

Method	N (phase one)	N (phase two)	N (total)
T1 survey	613	163	776
Feedback forms	502	133	635
T2 survey	225	42	267
T2 survey responses matched to T1	154	18	172
Interviews with key informants	13	18	31
Focus groups	13 groups, 39 attendees	3 groups, 21 attendees	16 groups, 60 attendees
Researcher observations	6	5	11
Economic analysis forms: Contact with PoCF	17	11	28
Economic analysis forms: Steering group	29	0	29
Economic analysis forms: Panel preparation	53	25	78
Economic analysis forms: Cost per Round	35	18	53

Data analysis

Details of the primary and secondary analysis were provided in the trial protocol. The quantitative data were analysed using SPSS (version 25), with specific methods described below as part of the findings section. The qualitative data were analysed using Nvivo (version 12) and Excel. For this, we used recursive abstraction (Polkinghorne & Arnold, 2014), which involves a sequential process in which transcript data are organised by question and respondent, before being coded to identify key themes (Figure 4).

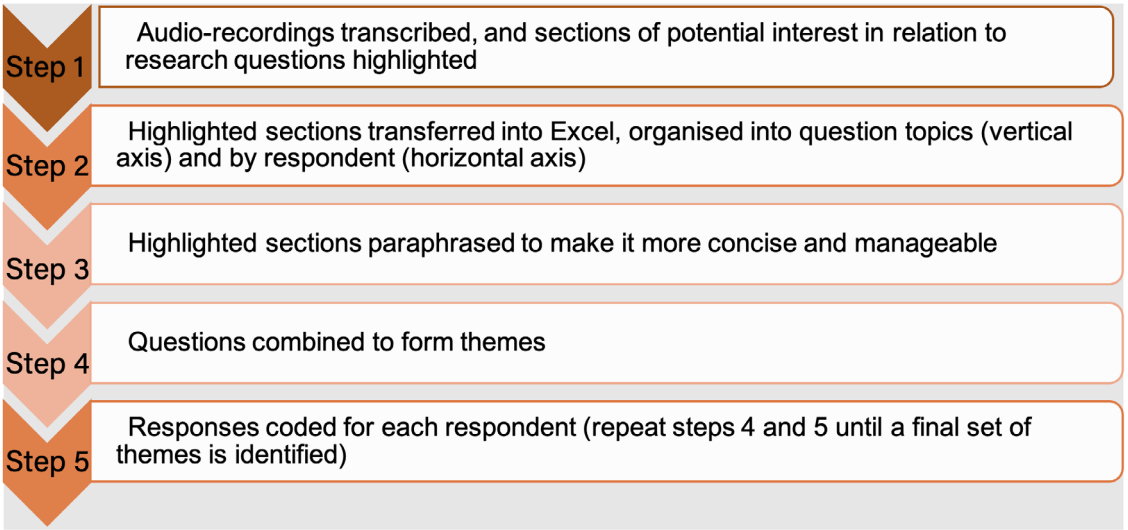


Figure 4: The recursive abstraction process used for qualitative data analysis

Timeline

The first six LAs (phase one) were recruited between February and March 2019, having responded to an invitation to take part from the Department for Education. Training was provided for these authorities by the PoCF between April and June of the same year. Each LA selected their own practice leads and facilitators. We advised that, along with the PoCF, practice leads should be senior managers, for example Principal Child and Family Social Workers. Facilitators could be from any part of the organisation, as long as the individual had the relevant baseline skills (for example, being able to manage meetings and speak in front of large groups of people). The phase one LAs began to deliver SRs from May 2019, and data collection was concluded in January 2020.

In August 2019, additional funding was provided by the Department for Education to expand the trial by recruiting an additional six LAs (phase two). This funding was provided because of a lower-than-expected response rate to the T1 survey in phase one authorities. The phase two authorities, apart from LA 12, were recruited in September and October 2019. The initial intention was for phase two authorities to deliver SRs in the same way as phase one. Training was provided by the PoCF in November and December 2019, with delivery of SRs starting in spring 2020. Three of the LAs (7, 8 and 9) delivered one in-person SR in either February or March 2020.

In March 2020, following the UK government's order to 'stay at home', the trial was placed on hold. In discussion with What Works for Children's Social Care[3], the PoCF, and the phase two LAs, we agreed to review the situation in summer 2020. It was further agreed that the trial would restart in autumn 2020, with SRs being delivered virtually (via Microsoft Teams or Google Meet). Additional training was provided by the PoCF between September and November 2020, and delivery of virtual SRs began between October 2020 and January 2021 (figures 5 and 6).

3 By this point in the trial, What Works for Children's Social Care had been established, and they took over as funder from the Department for Education.

During this time, two of the phase two LAs (10 and 11) withdrew from the study, and one additional authority (LA 12) was recruited in their place (in January 2021). LA 10 withdrew because they no longer had capacity to deliver SRs, the project lead having left the LA on long-term leave. LA 11 withdrew as they preferred to wait until they could deliver in-person SRs. We explored the rationale for this decision as part of our key informant interviews, the findings of which are presented below.

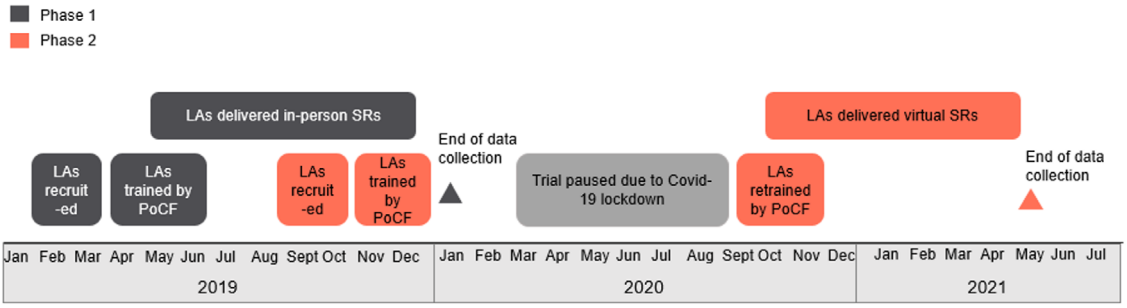


Figure 5: An overview of the trial timeline

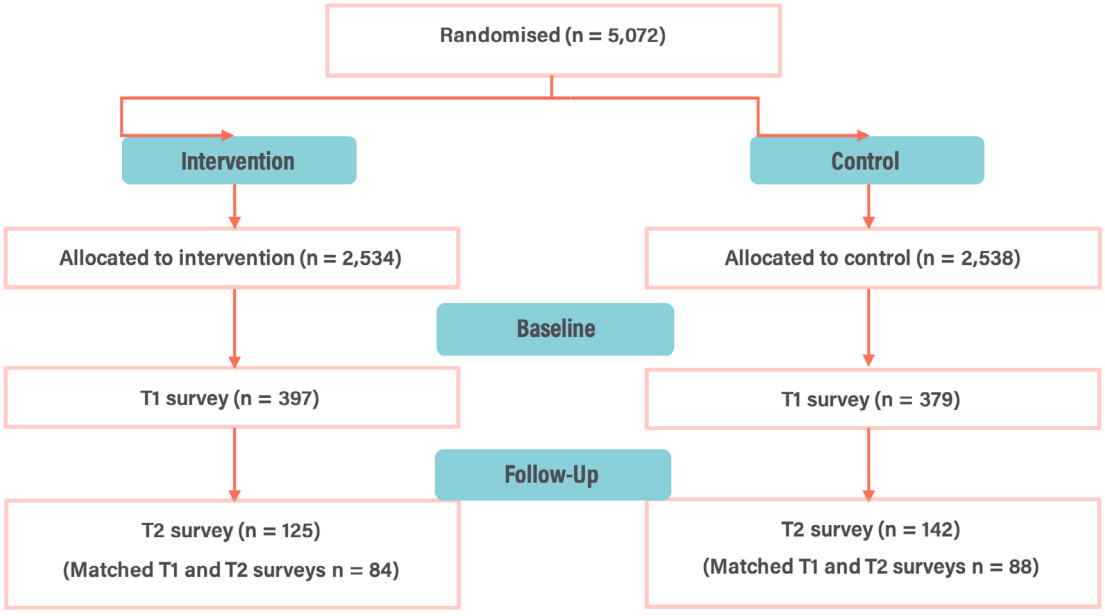


Figure 6: A flow-diagram overview of the sample throughout the study

FINDINGS

In this section, we start by reporting sample demographics and descriptive statistics. We also present the results of our primary and secondary analyses, exploratory analysis, contextual factor analysis, implementation and process evaluation and economic analysis.

Sample demographics

The sample was constituted primarily of White British female social workers and family support workers, aged between 35 and 54. To prevent possible jigsaw identification we have combined all other ethnicity categories, apart from White British, and consolidated many of the less common job roles (Table 5).

Descriptive statistics

In this section, we report descriptive statistics, based on as large a sample as possible, and without matching respondents from T1 and T2. If any respondent provided the relevant data, they are included, even if other data were missing. This is not the case in the primary and secondary analysis, where we used more specific methods of inclusion or exclusion.

Figures 7 and 8 show the overall results for the control and intervention groups at T1 and T2 in relation to GHQ-12 scores and the proportion of elevated scores. Figure 9 shows the number of sick days in the previous six-months reported by staff in each group at T2. None of the differences between the groups reached the level of statistical significance ($p < 0.05$).

Next, we present descriptive statistics based on self-reported attendance, measured via the T2 survey. We categorised respondents as regular, irregular or non-attenders, depending on how many SRs they attended. Regular attenders attended 3 or more SRs, irregular attenders 1 or 2, and non-attenders attended zero. These categories are based on those used in Maben at al's (2018) study of SRs in healthcare settings, who defined regular attendance as 50% out of six SRs. We initially anticipated that every LA would provide six SRs within the trial period, but as discussed in more detail below, this was not the case.

Figures 10 and 11 show these results at T1 and T2 in relation to GHQ-12 scores and the proportion of elevated scores. Figure 12 shows the number of sick days in the previous six-months reported by staff at T2. None of the differences between the groups reached the level of statistical significance ($p < 0.05$).

It is important to be cautious when interpreting these results, as they are based to some extent on a self-selecting sample (albeit not entirely so, as staff members in the control group were actively discouraged from attending).

Table 5: Personal and professional characteristics of the sample | *(n=172)*

	Control group	Intervention group	Total
Sex			
Male	8% (n=7)	17.9% (n=15)	12.7% (n=22)
Female	92% (n=81)	78.6% (n=66)	85.5% (n=147)
Age			
18-34	19.3% (n=17)	16.7% (n=14)	18.5% (n=32)
35-54	62,5% (n=55)	66.7% (n=56)	64.2% (n=111)
55+	18.2% (n=16)	13.1% (n=11)	15.6% (n=27)
Ethnicity			
White British	80.7% (n=71)	65.7% (n=72)	82.7% (n=143)
Other	19.3% (n=17)	13.1% (n=11)	16.8% (n=29)
Role			
Administrative / business support	13.6% (n=12)	4.8% (n=4)	9.3% (n=16)
Non-social work qualified role	31.8% (n=28)	28.6% (n=24)	30.2% (n=52)
Manager	20.5% (n=18)	21.4% (n=18)	20.9% (n=36)
Social worker / senior social worker	27.3% (n=24)	36.9% (n=31)	32.0% (n=55)
Other	6.8% (n=6)	8.3% (n=7)	7.5% (n=13)

Note. These figures are based on the survey respondents matched from T1 to T2. As not every respondent answered every survey question, the n for two of the categories (sex and age) is lower than the total.

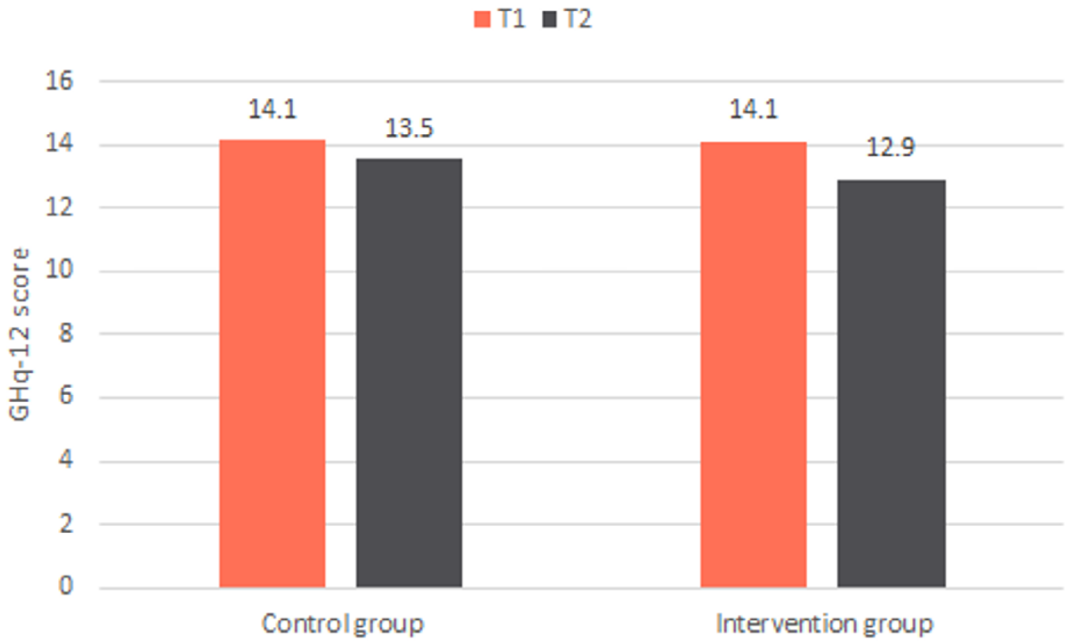


Figure 7: GHQ-12 scores by time point and group | *(T1 n=776, T2 n=267)*

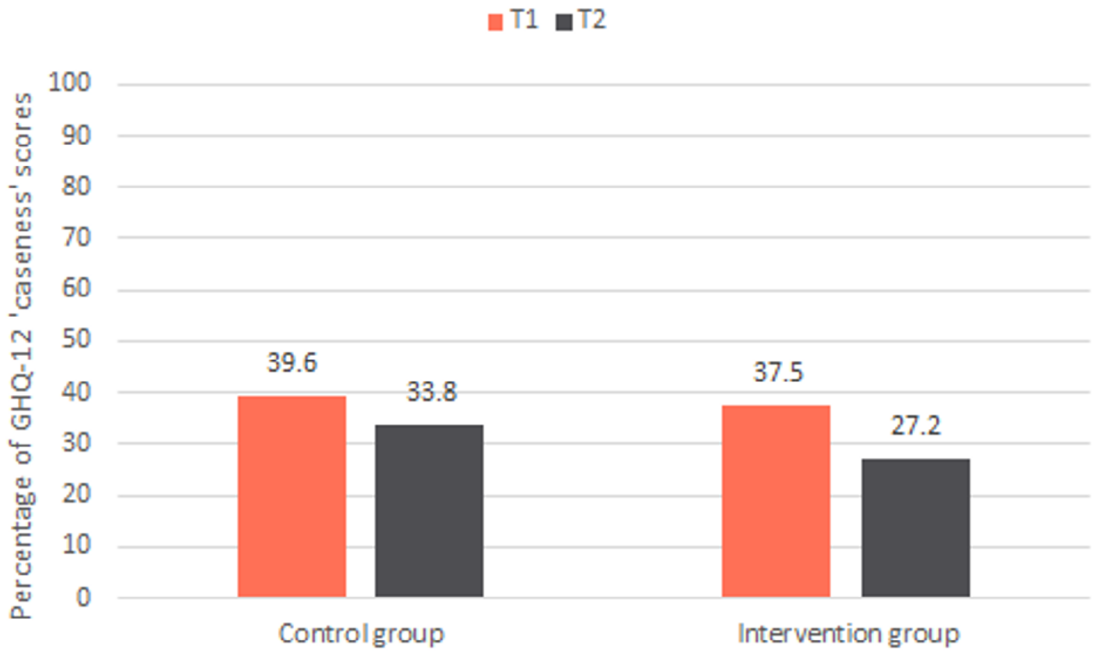


Figure 8: The proportion of elevated GHQ-12 scores by time point and group | *(T1 n=776, T2 n=267)*

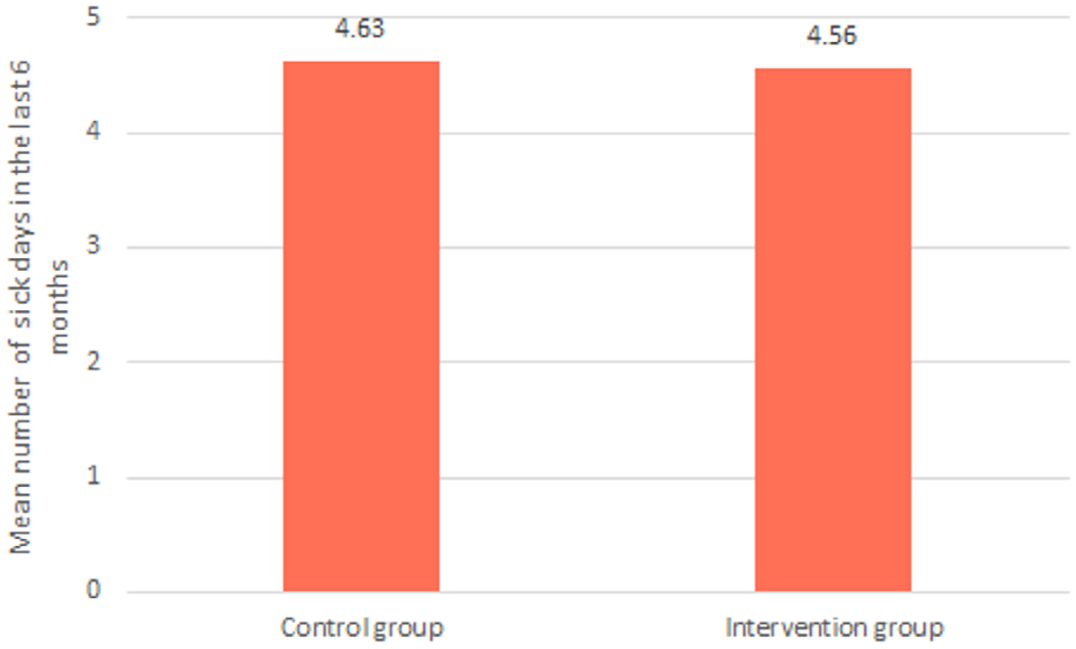


Figure 9: Sick days per group at T2 | *(n=236)*

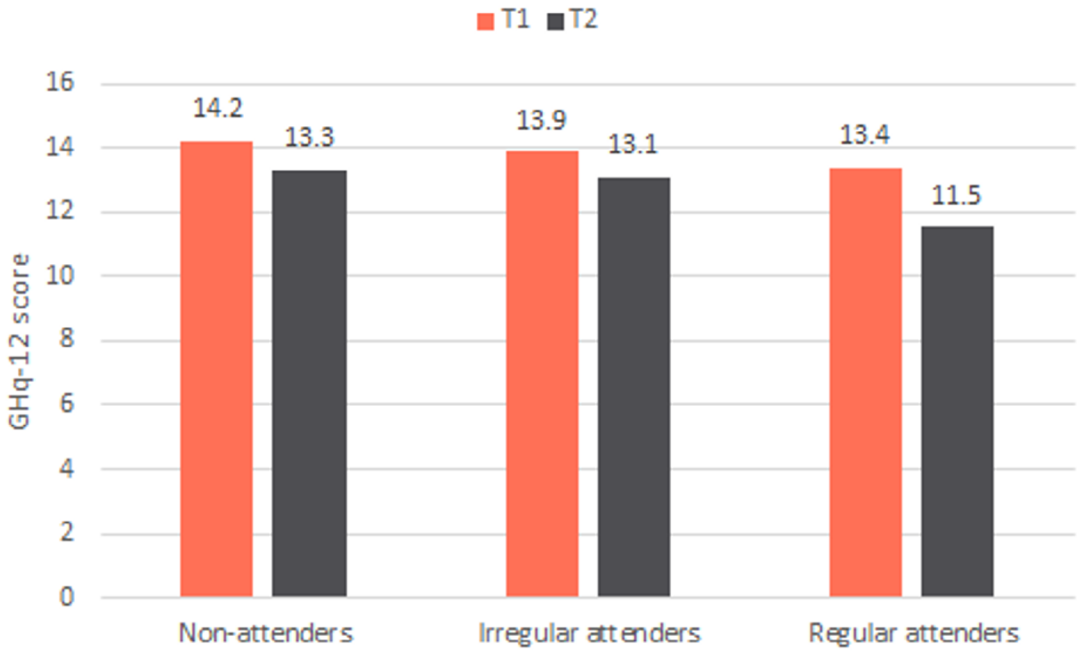


Figure 10: GHQ-12 scores by time point and attendance | *(T1 n=153, T2 n=299)*

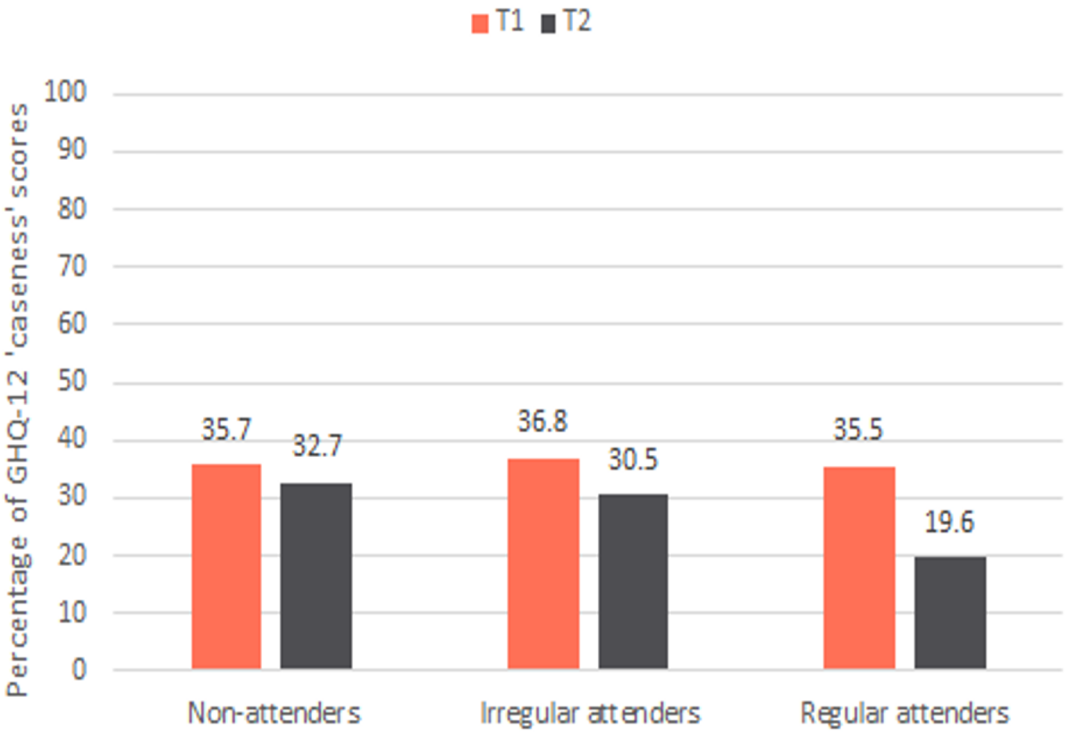


Figure 11: The proportion of elevated GHQ-12 scores by time point and attendance | *(T1 n=153, T2 n=299)*

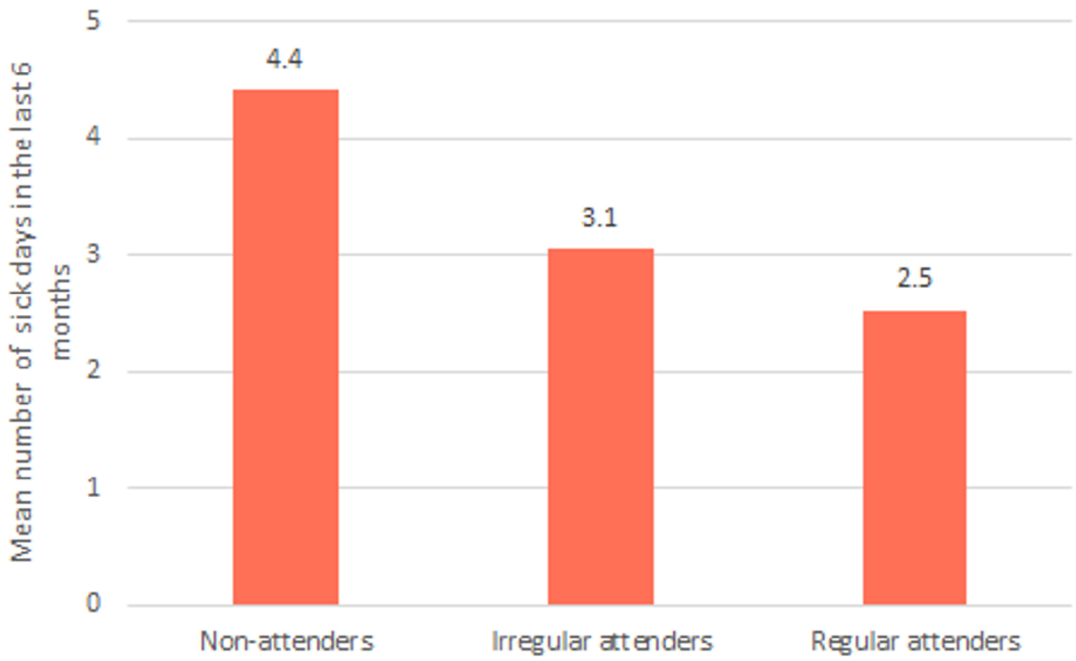


Figure 12: Sick days at T2 by level of attendance | *(n=288)*

Primary analysis

The primary hypothesis for the study was that mean GHQ-12 scores would be lower at T2 in the intervention group than in the control group, irrespective of whether these data were collected in phase one or phase two.

The intervention group did have a lower mean GHQ-12 score at T2, compared with the control group (figure 7, above). However, a linear regression analysis showed that group allocation was not a significant predictor of GHQ-12 scores at T2 when controlling for baseline GHQ-12 score and respondent characteristics (p=0.338, table 6). This analysis was based on the 267 respondents for whom we had a T2 GHQ-12 score, and a known group allocation.

Table 6: Results of a linear regression analysis comparing GHQ-12 scores between groups

	β	SE	95% CI		p-value
Group allocation[a]	-0.72	0.75	-2.19	0.75	0.338
Phase of trial	1.02	1.05	-1.04	3.08	0.330
Sex[b]	-0.81	1.38	-3.53	1.90	0.555
Missing sex[c]	3.61	34.26	-63.87	71.08	0.911
Age[d]	0.31	0.74	-1.15	1.78	0.673
Missing age[c]	-3.04	34.34	-70.66	64.59	0.925
Ethnicity[e]	-1.26	1.12	-3.47	0.96	0.265
Missing ethnicity[c]	-3.62	3.78	-11.07	3.84	0.340
T1 GHQ-12 total score	0.37	0.97	0.18	0.56	0.002*
Missing T1 GHQ-12[c]	4.87	1.63	1.66	8.07	0.003*
Model R^2	0.06				
n	267				

Note. [a] control or intervention; [b] male or female; [c] not missing or missing; [d] 16-34, 35-54 or 55+ years; [e]Other or White British. SE = standard error; CI = confidence interval; * p < 0.05.

We then sought to match respondents between control and treatment arms, according to sex, age, ethnicity and coarsened T1 GHQ-12 score. Any respondents with missing data for these four variables were excluded. These exclusions did not make a significant difference to the overall demographic characteristics of the sample, as when any one of these variables were missing, they all tended to be. Non-matched participants were also excluded from the dataset. A weighted linear regression was conducted (using the MatchIt package in R, with the coarsened exact matching method). This matched exclusion analysis does not show group allocation to be a significant predictor of GHQ-12 scores at T2 when controlling for baseline score and participant characteristics. In this model, age was found to be a significant predictor of GHQ-12 score at T2 (table 7). Using this analysis inevitably resulted in a smaller sample size compared with the table 6 above (n=133 vs n=267). The intention was to potentially strengthen confidence in any significant findings from the primary analysis, however as this was not the case, this analysis does not provide any further relevant information about the intervention (we include it in order to ensure we are complying with the analytical tests outlined in the trial protocol).

Table 7: Results of a linear regression analysis comparing GHQ-12 scores between groups following matched exclusion

	β	SE	95% CI		p-value
Group allocation[a]	-0.04	0.95	-1.84	1.75	0.965
Sex[b]	0.51	1.92	-2.68	3.70	0.791
Age[c]	-2.59	1.23	-4.41	-0.76	0.038*
Ethnicity[d]	-0.06	1.66	-4.45	4.32	0.970
T1 GHQ-12 total score	0.18	0.09	0.00	0.36	0.057
Model R^2	0.09				
n	133				

Note. [a] control or intervention; [b] male or female; [c] 16-34, 35-54 or 55+ years; [d] Other or White British. SE = standard error; CI = confidence interval; * $p < 0.05$.

Secondary analysis

The secondary hypotheses for the study were as follows:

a. At T2, the proportion of GHQ-12 scores above the 'caseness' threshold (of 4) will be lower in the intervention group than in the control group.

b. At T2, the number of days of sickness-related absence during the trial period will be lower in the intervention group than in the control group.

c. Regular attendance (three or more SRs) will be associated with lower GHQ-12 scores when compared to irregular (one to two SRs) and non-attendance (zero SRs).

d. SRs will be considered acceptable by the staff who attend.

Data related to the first three of these hypotheses are presented in this section. Qualitative feedback from staff about the acceptability of the intervention are presented below.

Before conducting these analyses, we first tested whether the mode of delivery (in phase one or phase two) had a significant influence on the outcome measures. Data were clustered according to the mode of delivery for the intervention; in-person (phase one) and virtual (phase two). The T2 GHQ-12 scores varied more within a cluster than between clusters (variance of 34.16 and 1.45 for phase one and two respectively). The intra-cluster correlation coefficient was small (0.04), and not significant (95% CI: -0.02 to 0.99). Hence, the effect of clustering on the outcome measure was considered negligible, and all subsequent analyses were conducted without clustering of the treatment arm.

Secondary hypothesis (a)

The intervention group had a lower proportion of elevated GHQ-12 scores at T2, compared with the control group (figure 8, above). However, a logistic regression analysis showed that group allocation was not a significant predictor of elevated GHQ-12 scores at T2, when controlling for baseline GHQ-12 score and respondent characteristics (p=0.061, table 8). This analysis was based on the 169 respondents for whom we had both T1 and T2 GHQ-12 score, a known group allocation and complete demographic information.

Secondary hypothesis (b)

There was only a very slight difference in the number of days absent from work due to ill-health between the intervention and control groups (figure 9, above). A negative binominal regression, used instead of a linear regression because the data were not normally distributed, showed that group allocation did not predict the number of sickness-related days taken (p=0.091, table 9). However, phase of the trial was a significant predictor, with staff in phase two reporting fewer days of sickness-related absence (M=1.07, SD=2.26) compared with those in phase one (M=4.06, SD=9.68).

Age and ethnicity were also significant predictors, with respondents aged between 18 and 34 (M=4.93, SD=10.01) and White British respondents (M=4.02, SD=9.96) reporting more days of sickness-related absence compared to older colleagues (35-54 years M=3.34, SD=9.11; 55+ years M=3.30, SD=8.06), and non-White British respondents (M=2.10, SD=3.05) respectively. This analysis was based on the 220 respondents for whom we had T2 GHQ-12 scores, complete demographic data and sickness-related absence data.

Table 8: Results of a logistic regression model predicting GHQ-12 elevated scores at T2

	OR	95% CI of ORs		SE	p-value
Intervention group	0.50	0.24	1.03	0.37	0.061
Phase 2	0.87	0.28	2.77	0.59	0.819
Female	0.45	0.16	1.24	0.52	0.124
Age (ref: 18- 34 years)					
35-54 years	1.11	0.44	2.75	0.46	0.828
55+ years	1.36	0.43	4.33	0.59	0.605
White British	1.72	0.62	4.76	0.52	0.295
Elevated GHQ-12 score at T1	4.58	2.22	9.42	0.37	0.000*
Nagelkerke R^2			0.18		
n			169		

Note. OR = odds ratio; SE = Standard error; CI = confidence interval; * p < 0.05.

Table 9: Results of a negative binominal regression predicting sickness related absence

	OR	95% CI of ORs		SE	p-value
Intervention group	0.76	0.55	1.04	0.16	0.091
Phase 2	0.22	0.13	0.39	0.28	0.000*
Female	0.90	0.59	1.38	0.22	0.622
Age (ref: 18-34 years)					
35-54 years	0.57	0.39	0.85	0.20	0.006*
55+ years	0.52	0.31	0.85	0.25	0.009*
White British	1.92	1.26	2.93	0.21	0.002*
n			220		

Note. OR = odds ratio; SE = Standard error; CI = confidence interval; * p < 0.05.

Secondary hypothesis (c)

Staff who attended regularly (three or more SRs) had lower GHQ-12 scores at T2 compared with those who attended irregularly (one or two SRs), who in turn had lower GHQ-12 scores than staff who did not attend at all (zero SRs). We also found a lower proportion of elevated GHQ-12 scores for regular attendees, and a lower rate of sickness-related absence (figures 10, 11 and 12, above). However, these differences were not statistically significant (table 10). This analysis was based on the 196 respondents for whom we had T2 GHQ-12 scores, complete demographic data and attendance data.

The analysis here relies on the assumption that there is a linear relationship between intervention receipt and treatment effect. As a sensitivity analysis, the model was refitted with two different binary definitions of intervention adherence. The most extreme definition (at least three SRs vs. fewer than three SRs) yielded the largest between group difference and the least extreme (at least one SR vs. zero SRs), yielded the smallest (table 11). Nevertheless, as in the initial CACE (Complier Average Causal Effect) model, neither of these results was statistically significant.

Table 10: Two-stage least squares regression model predicting GHQ-12 scores at T2

	β	SE	95% CI		p-value
Attendance[a]	-4.38	4.43	-13.47	4.71	0.324
Sex[b]	-0.82	1.41	-3.12	1.48	0.560
Age[c]	-0.17	0.81	-1.60	1.25	0.833
Ethnicity[d]	-1.12	1.14	-3.48	1.24	0.327
T1 GHQ-12 likert score	0.28	0.11	0.10	0.46	0.008*
Missing T1 GHQ-12[e]	3.46	1.90	0.09	6.82	0.071
Model R^2	0.07				
n	196				

Table 11: Efficacy analyses with binary definitions of adherence (for sensitivity)

	Adjusted between-group mean difference in GHQ-12 scores (T2)	95% CI		p-value
Efficacy with binary definition of adherence (at least three SRs vs fewer than three SRs)	-3.59	-11.06	3.89	0.330
Efficacy with binary definition of adherence (at least one SR vs no SRs)	-1.49	-4.60	1.61	0.323

Note. CI = confidence interval.

Exploratory analysis

We then explored the data to see whether there were any differences between GHQ-12 scores in relation to LA, sex, age, ethnicity, job role, or length of time in post. We also considered whether GHQ-12 scores differed between phases one and two of the trial. As the study was not powered to detect significant differences in these associations, we have not presented p-values (which a series of ANOVAs revealed were all non-significant in any case).

First, we compared GHQ-12 scores between LAs by looking for changes between T1 and T2 (figure 13). A negative score indicates a lower level of psychological distress at T2 compared with T1. Staff in seven of the authorities reported lower GHQ-12 scores at T2, while in two LAs scores were higher, and in one there was no difference. It should be emphasised that some of these figures are based on small numbers of respondents matched at T1 and T2, and that the LAs provided different numbers of SRs during the trial.

In addition, we looked at differences in GHQ-12 scores between T1 and T2 in relation to the personal characteristics of sex, age and ethnicity (figure 14). These results show that psychological distress was lower at T2 across all these categories, apart from male respondents.

Differences in GHQ-12 scores between T1 and T2 were also explored in relation to the professional characteristics of job role and length of time in post (figure 15). This showed that levels of psychological distress were lower at T2 across all these groups, apart from managers, who showed a very slight increase.

Finally, we compared GHQ-12 scores in relation to phase one and two of the trial (figure 16). These results show greater differences in psychological distress during phase two than during phase one. As for most of these categories, we found lower GHQ-12 scores at T2 compared with T1, although clearly we are not suggesting that this is due entirely, or perhaps even significantly, to SRs. More likely these differences are the result of a constellation of factors, which for some people may have included their attendance at SRs.

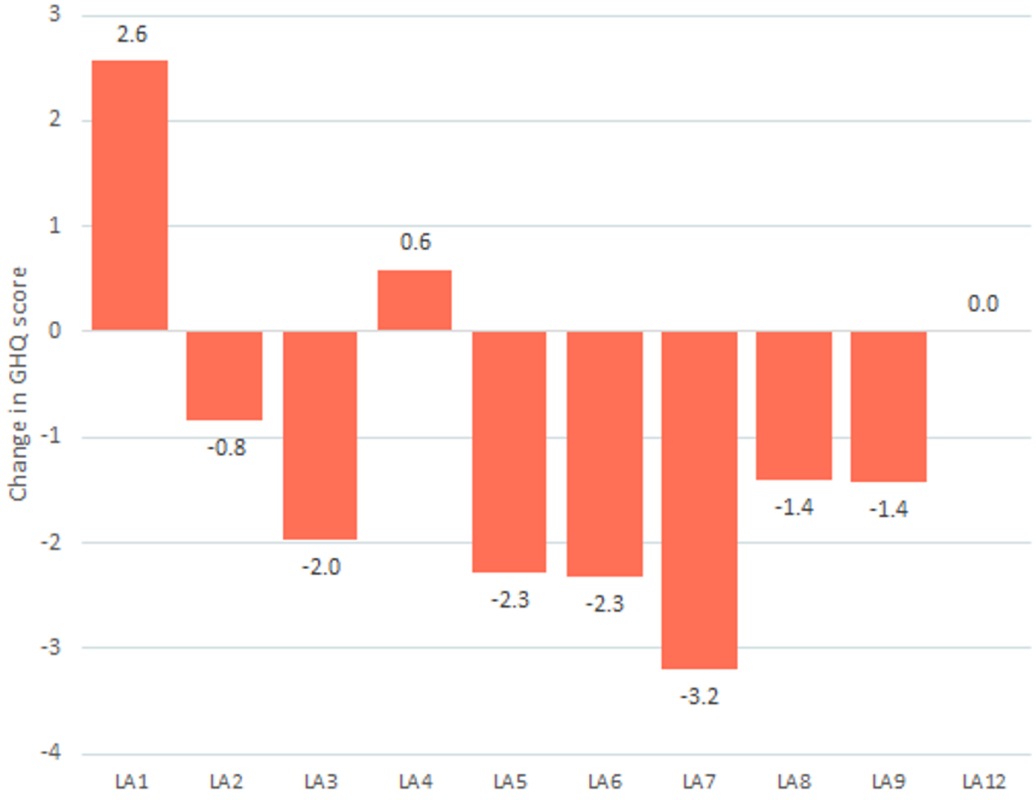


Figure 13: Differences in average GHQ-12 scores between T1 and T2 within each local authority | *(n=173)*

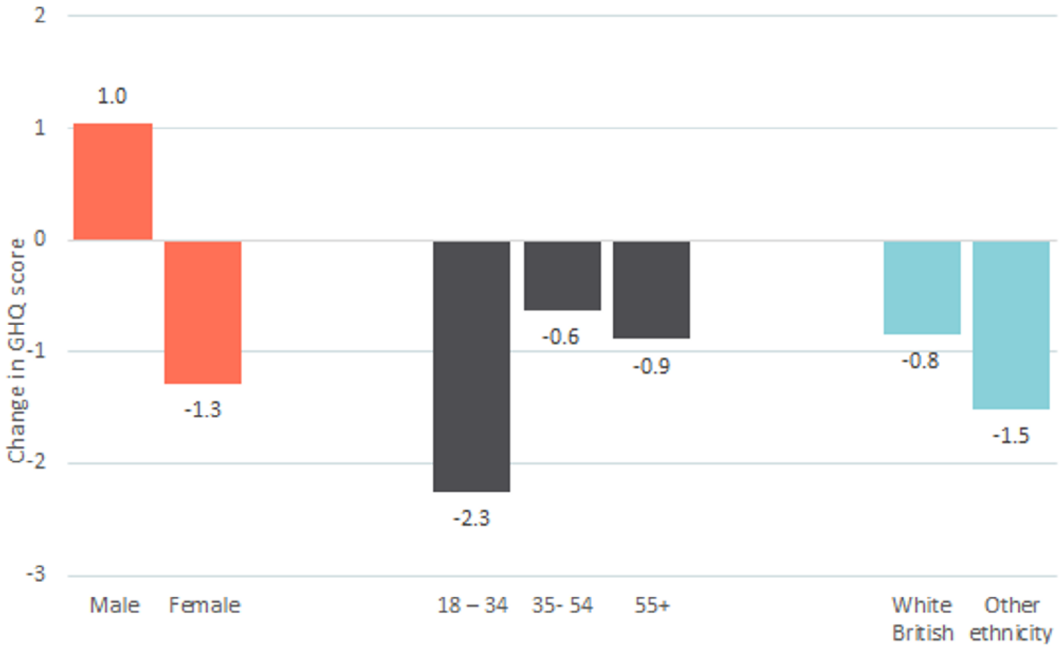


Figure 14: Differences in GHQ-12 scores between T1 and T2 in relation to personal characteristics | *(sex n=170, age n=170, ethnicity n=172)*

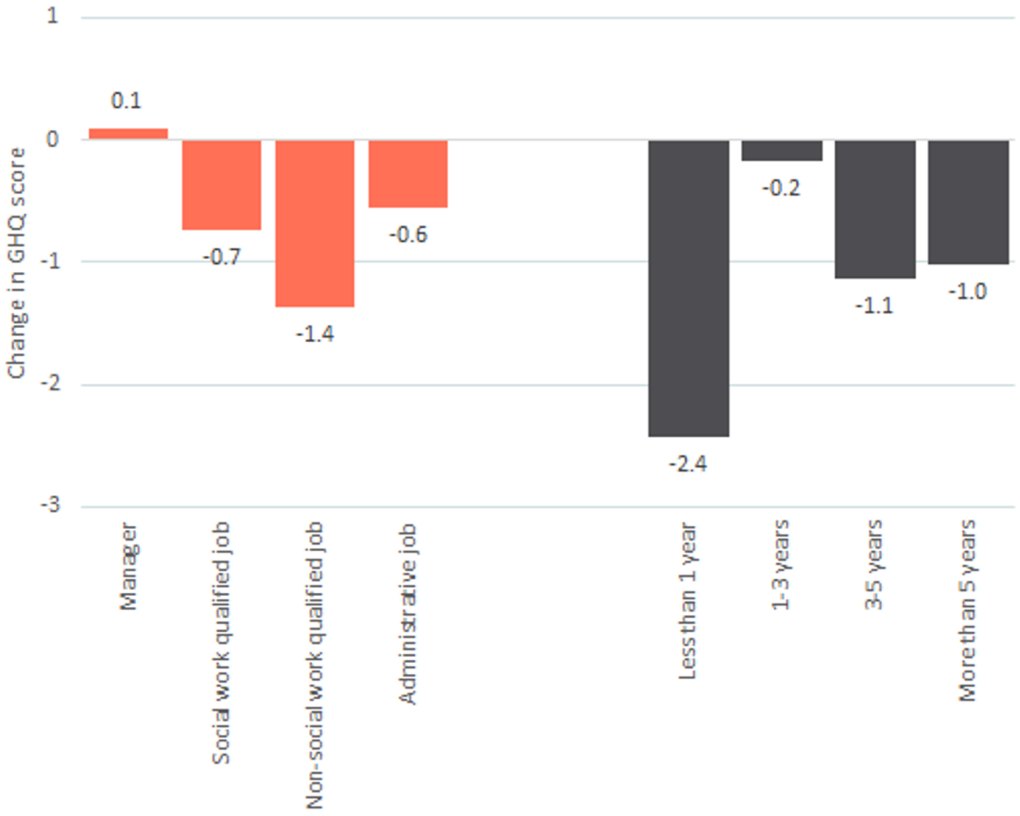


Figure 15: Differences in GHQ-12 scores between T1 and T2 in relation to professional characteristics | *(role n=160, length of time in post n=173)*

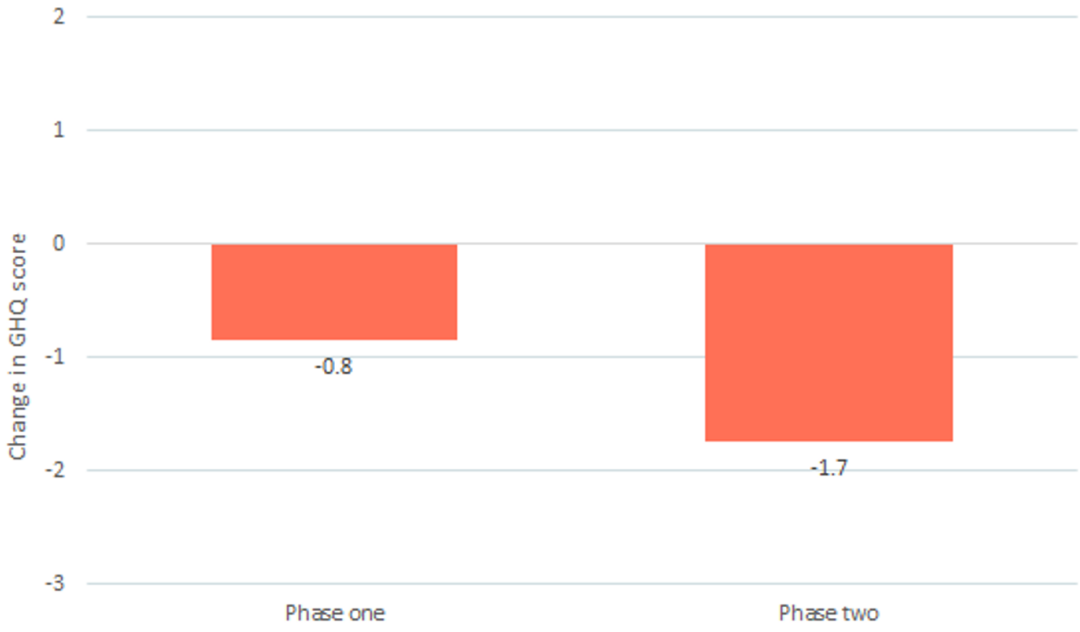


Figure 16: Differences in GHQ-12 scores between phase one and two phase | *(n=173)*

Contextual Factor Analysis

Although each LA was offered similar levels of training and support from the PoCF, we anticipated that there would be differences between the sites in their delivery of the intervention. Via interviews and focus groups, we sought to explore such contextual differences. The most notable finding to emerge however was a general lack of reference to the local context. One key informant (LA 1) spoke about service pressures, including budget cuts, organisational restructurings, high caseloads, and high levels of staff sickness. They noted how these things made it difficult to introduce new ways of working – even when the intention was to help ameliorate some of these problems. For LA 1, these pressures helped explain why they had difficulty in recruiting staff to attend SRs. Respondents from two other LAs (3 and 5), also referred to some teams having particular difficulties during the trial, related to high workloads and staff sickness, and how this affected attendance.

Beyond this, several key informants mentioned the impact of unexpected factors that influenced the delivery and implementation of SRs. The most obvious of these was the global Covid-19 pandemic – not only because it prevented the delivery of in-person SRs in phase two, but also because it led to increased caseloads, services being under (even) more pressure, and the rapid introduction of remote ways of working. One key informant (LA 8) described 'relentless' workload pressures, while several described how the pandemic accentuated the need to provide social and emotional support for staff.

Two of the LAs underwent Ofsted inspections during the trial. Key informants said this prevented them from focusing on the SR project, and reduced the availability of staff to attend. This would not be the first time that Ofsted inspections have diverted LAs from their attempts to improve services (Bostock et al., 2017).

Thus, the overall message is - unsurprisingly - that staff in children's services are often exceptionally busy and may not have time to attend SRs (or engage in other forms of social and emotional support). While SRs are intended to support staff experiencing psychological distress, they are not a panacea and cannot be introduced effectively unless staff have the time and emotional space to attend.

Implementation and Process Evaluation

The implementation and process evaluation sought to address questions about the feasibility and fidelity of delivering SRs in children's services, and the subjective experience and impact of attending. It is based on survey data, observations of SRs, interviews with key informants, focus groups with staff and SR feedback forms.

Is it feasible to implement SRs in children's services, and with what degree of fidelity?

All the phase one LAs provided SRs during the trial, as did four LAs in phase two. Despite the generally positive views of most key informants about the feasibility of providing SRs within children's services, the figures in table 12 show that in-person SRs were more easily delivered than virtual SRs (although it must be noted that the virtual SRs were being organised during the Covid-19 pandemic, and it would no doubt have been easier to organise them without this backdrop). Four of the phase one LAs and all of the phase two LAs indicated their intention to provide further SRs after

the end of the trial. Despite some issues with fluctuating attendance, key informants were generally positive about levels of staff engagement. In addition, two of the phase one LAs (4 and 6) switched to providing virtual SRs during the Covid-19 pandemic, and found it reasonably straight-forward to do so, having already established the credibility of in-person SRs.

Two of the most significant barriers to the implementation of SRs were resource related. First, the workload and time commitment for facilitators and project leads was generally greater than expected and several key informants highlighted the importance of having sufficient administrative support, for example to help with room bookings and catering arrangements (for in-person SRs), and in organising communication to staff. Second, several in phase one also described finding it hard to justify (in their own minds) the cost of providing food as part of in-person SRs, because it involved spending public funds. LAs 1 and 5 experimented with lower cost alternatives (such as coffee and biscuits or breakfast, instead of lunch). LA 8, when they were initially planning before the pandemic to provide in-person SRs, found it hard to negotiate their own local procurement rules, which prevented paying for staff catering. In several LAs (2, 4, 6, 7), steering groups for the project were found to be relatively ineffective in supporting the early development of SRs, which some key informants attributed to their approach of nominating people to take part, rather than asking for volunteers. In phase two, most LAs did not have steering groups. One of the authorities in phase two (LA 9) implemented SRs with only one facilitator, and no administrative support at all. This decision was driven by a lack of capacity to support the set-up of the intervention, rather than a deliberate adaptation, and resulted in a high degree of stress and workload for the individual concerned.

Questions were raised by some key informants about the feasibility of translating the SR model from what they perceived to be single-site healthcare settings to multi-site LAs. Some LAs (LA 1 and 5) described the challenge of adapting their provision of SRs after the trial period to cover a wider geographical area. During phase two, some key informants and staff noted that the use of flexible working meant that it was not always possible to organise SRs at a convenient time for all members of staff.

In relation to the mode of delivery, there were few reported logistical or technological problems in relation to virtual SRs. One key informant (LA 9) attributed this to staff's enforced familiarity with remote working during the pandemic. Having virtual SRs also made it easier to invite people via email, providing a direct link to the session, rather than relying on more traditional forms of LA communication, such as putting up posters in offices, or visiting team meetings. Another practical advantage of virtual SRs included the lack of travel time, and the potential for this to make SRs more inclusive. On the other hand, facilitators were initially more anxious about conducting SRs online, although this reduced over time. Having staff members join the SRs late or leave early caused some disruption, and virtual delivery made it harder to 'read the room', by judging facial expressions and body language. Some staff spoke about their reluctance to share personal experiences in a virtual setting, when it was not always possible to know and see who else was 'in the room'.

There were some mixed views about the fit between SRs and existing practice models. Key informants and staff from one LA debated whether SRs were compatible with their restorative model of practice (Williams, 2019). Some saw congruence between the two, while others saw disparity, for example in relation to the language used in restorative approaches and that used in SRs. On the other hand, key informants in two LAs described how the introduction of SRs complemented their use of Signs of Safety (Turnell & Edwards, 1997, 1999).

For the ten authorities that provided regular or semi-regular SRs during the trial, fidelity was assessed by the observation of at least one session by the research team. Several SRs were also observed by mentors from the PoCF. These mentor-led observations included in-person SRs (in LAs 4, 5 and 6) and virtual SRs (in LAs 4 and 7). For the researcher-led observations, our analysis was based on Maben et al.'s (2018) nine context-mechanism-outcomes (CMO). Each CMO is a proposed hypothesis about how SRs work, for whom and in what circumstances (table 13). The PoCF made their observations in relation to five key aspects of the intervention (table 14).

The observation notes completed by researchers were combined, qualitatively and on the judgement of the research team, and subjected to recursive abstraction analysis, identifying four indicators of fidelity or non-fidelity (table 15).

Table 16 shows how each LA scored in relation to the PoCF's observation schedule, with higher scores indicating greater fidelity (note, the PoCF did not observe SRs in every LA).

Combining the findings represented in tables 14 and 15, based on the judgement of the research team, we rated each LA as demonstrating high, moderate, or low fidelity (table 17). Where the PoCF did not observe the LA, these ratings are based only on the researcher observations. Those rated high tended to score highly according to the PoCF and also demonstrated all of the signs of fidelity shown in table 14. Those rated moderate tended to show a mixture of signs of fidelity and non-fidelity, while those rated low showed primarily signs of non-fidelity.

Table 12: The number of SRs held in each LA during the trial period

LA	In-person SRs	Virtual SRs
1	6	0
2	6	0
3	6	0
4	6	0
5	6	0
6	11 (6 in one part of the LA, 5 in another)	0
7	1	2
8	1	6
9	1	3
10	0	0
11	0	1
12	0	3

Table 13: Nine context-mechanism-outcome configurations for SRs (Maben et al, 2018)

CMO	Description
Trust, safety and containment	Safety in Rounds means a space where panellists and audience members feel accepted, respected and valued. Containment refers to the facilitator's ability to help those in Rounds to manage, explore and understand their difficult feelings.
Group interaction	The importance of sharing stories and reflecting as a group activity.
Countercultural/third space for staff	First and second spaces are two places where people interact e.g., home and work. Third spaces are in-between spaces that provide a different culture and respite from the challenges in the second space (work).
Self-disclosure	The process of sharing information about yourself with another person (or people).
Storytelling	Crafting and telling a powerful story that resonates with others.

Role-modelling vulnerability	Sharing examples of vulnerability and revealing their humanity.
Contextualising families and staff	Stories that allow staff 'to put themselves in family's shoes' or get a 'glimpse into the everyday world of that individual staff member.'
Shining a spotlight on hidden stories and roles	Understanding what different people's roles involve.
Reflection and resonance	Stories can resonate with others and provide opportunity for reflection on their own experiences.

Table 14: A summary of the Point of Care Foundation's observation schedule

Area	Component
The Session	Was open to the site's entire staff group
	Had facilitators with coordinated roles
	Introduction covered purpose of SRs
	Introduction covered ground rules (mobile phones, etc.)
	Confidentiality of service user info and caregivers both stressed
	Food provided was appropriate and sufficient
	Room suitable for SR discussion
	Evaluation forms were distributed and collected
	Began and ended on time
The Panel	Had 2-4 panellists representing different disciplines
	Started with a brief summary of the case or issue
	Focused on social/emotional/communication aspects of practice
	Took a max of 20 minutes before including attendees in discussion

The Facilitators	Fostered participation by attendees
	Managed discussion and kept it aligned with topic and purpose of SRs
	Encouraged sharing of perspectives from varied disciplines or different points of view
	Provided an appropriate closing (e.g., a summary of key take-home messages.)
	Gave a final reminder to fill out evaluation forms.
	Gave the panel the opportunity to have the last word by handing back to them at the end
The Attendees	Represented multiple disciplines
	Seemed engaged
	Seemed comfortable talking from the heart
The Site	Is staffed with an organisational leader, administrative site co coordinator and facilitator
	Has an interdisciplinary planning committee
	Holds SRs at a time and place to maximise attendance
	Regularly reviews evaluation forms and takes into account for future
	Holds a dress rehearsal or otherwise prepares panel prior to event
	Holds a minimum of 6 sessions per year
	Were there any signs that SR discussions were a trigger for changing policies or practices?
	Has co-ordinated systems for advertising SRs

Table 15: Signs of fidelity and non-fidelity in the provision of SRs

Theme	Fidelity	Non-fidelity
Diversity	A mixture of panellists, with different roles and at different levels of seniority, and a mixed audience, with stories and comments shared from a variety of perspectives.	Members of the panel and / or members of the audience are all from similar roles and with similar levels of experience and seniority. Stories and comments shared by the audience present a single or limited set of perspectives.

Quality of storytelling	The stories shared by panellists have a clear structure and focus on a particular person (the storyteller) or a specific time or event at work.	Panellists are not confident, and their stories lack structure and / or a clear link with the topic. The stories may be too general, without a specific focus.
Audience participation	Audience members volunteer comments and share their own stories. This includes talking about emotions, both work and non-work-related issues, and making disclosures about sensitive issues. Audience members are attentive and actively listening. Members of the audience address each other and the panellists directly. Equally, audience members are comfortable with silences. Facilitators need to do less of the talking than other people in the room.	There are few contributions made from the audience, and those that are lack depth. The discussion is relatively superficial, with no sharing of personal or sensitive information. Audience members may be seen checking their mobile phones or laptops. Facilitators and panellists do most of the talking.
Focus on purpose and topic	Most comments are made in relation to the topic and contain a mixture of positively framed and negatively framed stories and experiences.	Most comments are general, and unrelated to the topic. The discussion is characterised by negatively framed stories and comments.

Table 16: Point of Care Foundation ratings of fidelity

	LA 4 (in-person)	LA 4 (virtual)	LA 5 (in-person)	LA 6 (in-person)	LA 7 (virtual)
Session	7/9	8/9	7/9	6/9	8/9
Panel	4/4	2/4	4/4	4/4	3/4
Facilitators	6/6	6/6	6/6	6/6	5/6
Attendees	3/3	3/3	3/3	2/3	3/3
Site	5/8	8/8	8/8	5/8	4/8
Overall	25/30	27/30	28/30	23/30	23/30

Table 17: Overall fidelity-ratings for the LAs

Fidelity rating	LAs
High	4, 5, 8, 12
Moderate	2, 3, 6, 7
Low	1, 9
Not applicable (did not provide regular SRs)	10, 11

What adaptations, if any, are made to the intervention as it is implemented in children's services?

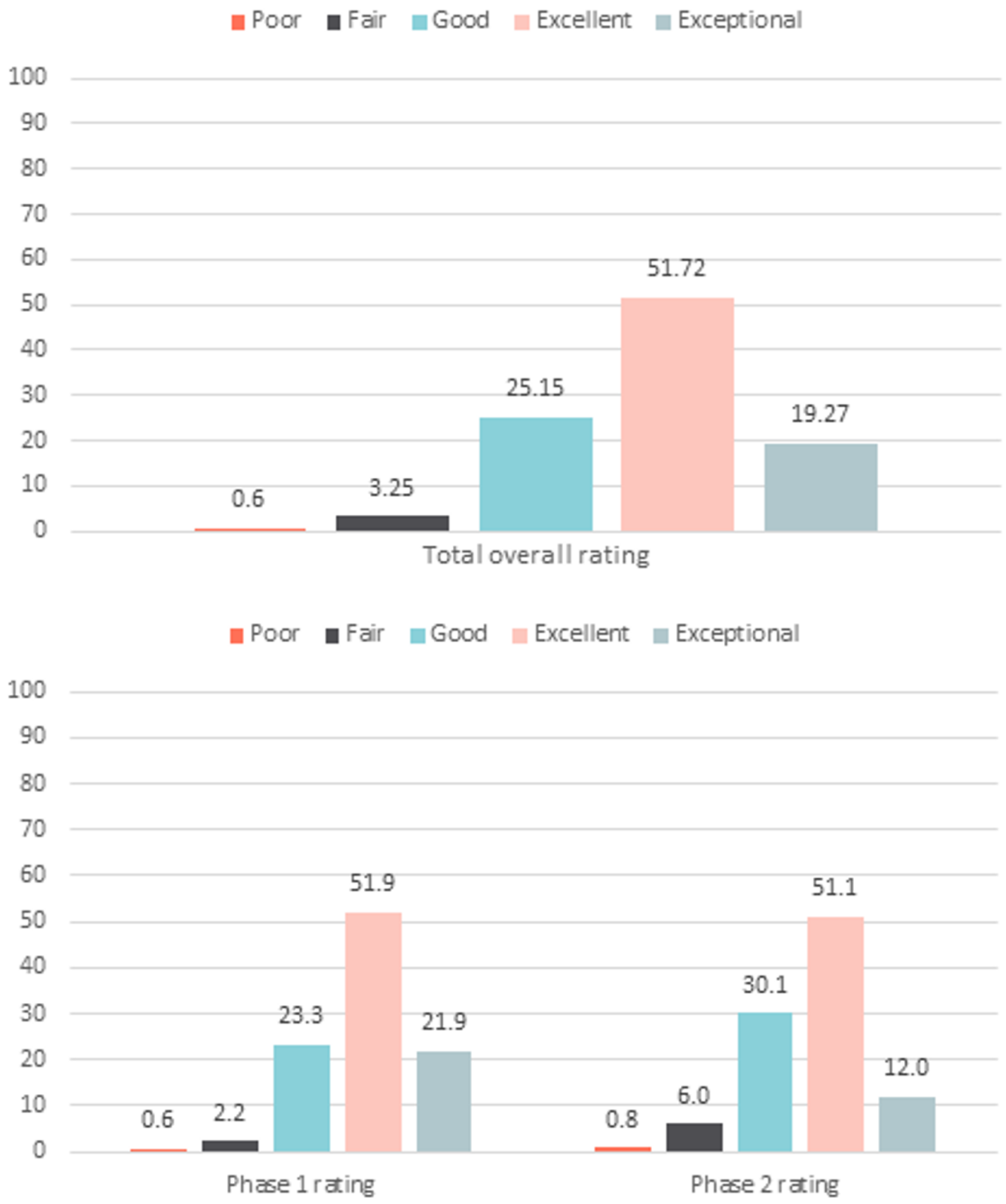
From key informant interviews and observations, it was clear that adaptations made in the delivery of SRs were relatively minor and mostly related to logistics. Project leads and facilitators mostly aimed to remain true to the 'spirit' of the model, while making small adjustments as needed. The most common changes were (i) altering the configuration of the room to allow staff members to make eye contact with one another, for example by using a horseshoe layout rather than rows of chairs, (ii) reducing the cost by providing cheaper alternatives to a full lunch, and (iii) experimenting with the timing and location of SRs to allow a broader range of staff to attend. From feedback forms completed by staff, the only adaptation requested was for the layout of the room to be changed, to avoid using rows of chairs.

A more significant adaptation was the decision by LA 4 to limit the number of staff who could attend each session. They did this based on staff feedback that the group was too large. Key informants from other LAs (3, 5, 7 and 12) said they were considering something similar but had not yet implemented it. If sustained, this would be a significant change to the model as delivered in healthcare, where audiences can number in the hundreds. The rationale for doing so was to provide a more contained space, in which staff who already worked together could feel comfortable in talking about their social and emotional difficulties. Several key informants (LAs 3, 6, 7 and 8) also mentioned the idea of having a debrief session after each SR, available for any staff who found the experience particularly upsetting. One project lead (LA 7) said they had decided to circulate an email after each SR, with information about other support services available to staff.

One key informant noted that no explicit thought seemed to have been given to ensure SRs were inclusive for disabled people, although they also said this was not unusual for LA meetings more generally. Reasonable adjustments that this key informant said would have been helpful included ensuring printed materials were designed for people with visual impairments, that the room layout or technology (e.g., hearing loops) were organised to support those with hearing impairments, and that sufficient time were provided to ensure people with speech impediments can contribute.

How do key informants and staff members within children's services view the intervention?

Overall, the feedback provided by staff was exceptionally positive. Based on feedback forms collected at the end of each SR, the vast majority (96.2%) gave an overall rating of good (25.2%), excellent (51.7%) or exceptional (19.3%). A small minority rated SRs as fair (3.3%) or poor (0.6%). The overall ratings were similar between phases one and two of the trial (figures 17 and 18). Several respondents expressed surprise at how well virtual SRs had worked.



Figures 17 and 18: Staff feedback on SRs | *(n=493)*

In addition, 91.3% of respondents said they intended to attend SRs again in the future and 90.8% said they would recommend SRs to their colleagues. The majority also said that the panel stories were relevant to them (94.8% agreement) and that the audience discussions had been well facilitated (96.2% agreement).

From interviews and focus groups, it was apparent that many staff considered SRs to be a 'safe space' in which they could share their personal experiences without judgement. SRs were said to help foster empathy and connection between colleagues. One respondent said:

> "*There is almost a kind of intimacy created because whether you're a storyteller or in an audience, the audience are participating as well [...] sometimes not even verbally but it's quite powerful [...] just that chance to sit in silence and think and reflect. And you feel you've shared something quite special with people, at the end of it [...] and that's really powerful.* **(LA 4)**

SRs were said to provide the chance for a break, including a rare opportunity to be 'nurtured' by their organisations (especially at in-person SRs). Respondents also welcomed the opportunity to reflect on their practice and on the social and emotional impact of working in children's services. Most respondents (but not all) described the experience as enjoyable and beneficial, even if these benefits were sometimes difficult to articulate precisely. A relatively small number of respondents said they were unsure what to expect from SRs, or that they were not what they hoped for.

A minority of respondents (mostly managers) expressed their concern that some members of staff might be left feeling too upset to continue with their work afterwards (it is important to note that these concerns were being expressed hypothetically, not because of any specific examples). One facilitator explained:

> "*I think the challenge is whether you're leaving people in a safe space to then carry on with their day jobs [...] if people are talking about their emotive experiences, then they go away, whilst we have a conversation about you know, looking after yourself and wellbeing and those sorts of things I'm just always a little bit anxious about whether it makes people more vulnerable.* **(LA 5)**

In both phase one and two, there were a small number of respondents who said they were left feeling distressed following a SR. One member of staff questioned whether she wanted to continue working in children's services. Within the context of the positive feedback overall, it is even more important to recognise the potentially negative consequences that SRs can have for some. In phase two, this was compounded by people having to work from home, without the immediate availability and support of their colleagues in the office.

Several factors influenced how comfortable staff members in the audience felt in making a verbal contribution. The main ones were the size and composition of the audience, and the style of facilitation. Several respondents said they felt anxious at the prospect of speaking in front of a large group of people and so chose not to. The extent to which participants felt comfortable in virtual SRs seemed largely a matter of personal preference, though several noted the importance of careful and 'contained' facilitation (LA 9 and 12) and there was a general preference for conducting SRs in-person. For some, being unsure who

else was 'present' during virtual SRs inhibited their desire to contribute, whereas others felt that virtual meetings were less intimidating than facing an in-person audience.

A key area of debate in the focus groups was whether audiences should be mixed (comprising managers, business support, and frontline staff) or not. There was no clear consensus on this. Some emphasised that the emotional impact of working within children's services took its toll on all staff, including those in managerial and business support roles. One respondent described how her experience as a non-frontline practitioner was highly relevant to SRs:

> *"I do all the notetaking within the child protection conferences, so I listen on a daily basis to a lot of very sensitive and distressful information. That stays with me. And that's multiple times a week, every week, week in, week out. There are things built within our team to have a chat, but there's nothing formally based.* **(LA 7)**

However, others felt that SRs were not relevant for business support staff; some described feeling like an 'intruder' (LA 7) or a 'fraud' (LA 5) when attending. Some felt SRs were not just for social workers, but specifically for child protection social workers who were commonly perceived as having higher levels of stress than staff in other roles. Yet some business support staff described for themselves how positive it had been to attend and to feel part of the wider organisation:

> *"Because I'm not doing front line work I thought maybe that it doesn't really apply to me, 'cause I don't have a direct contact with all these people, so it was very helpful [to] understand how other people feel and […] in a way we were all very similar, even though we do so many different things […] so it was a really good exercise for me to realise that maybe I'm not that unimportant to the system.* **(LA 3)**

In relation to the mixing of managers and frontline workers, there were also some differences of opinion. Two managers (LA 5) said they could not openly share how they were feeling in the presence of their supervisees. This stood in sharp contrast to most of the social workers involved, who valued hearing about the experiences (and struggles) of their managers, as it helped to validate their own. Respondents from LA 12 said they appreciated the opportunity to share a platform with senior managers. Yet some other respondents from the same LA also said that managers found it hard not to engage in problem-solving discussions, and this was not-in-keeping with the spirit of SRs.

Via feedback forms, respondents also provided additional and more immediate comments about the experience of attending. Several noted how being at the SR helped remind them of the purpose of children's services, and how important their work is for vulnerable children and families. One staff member (LA 4) commented that SRs helped her gain "*a better understanding of the humanity of social work*". Another (LA 12) said, "*It was incredibly moving actually to hear colleagues speak about their personal experiences with families and colleagues, [it] really helped me reflect on the true impact of the very difficult work we do*". One of the key informants (LA 6) expressed a similar view, saying that SRs helped her reconnect with the reasons why she came into social care.

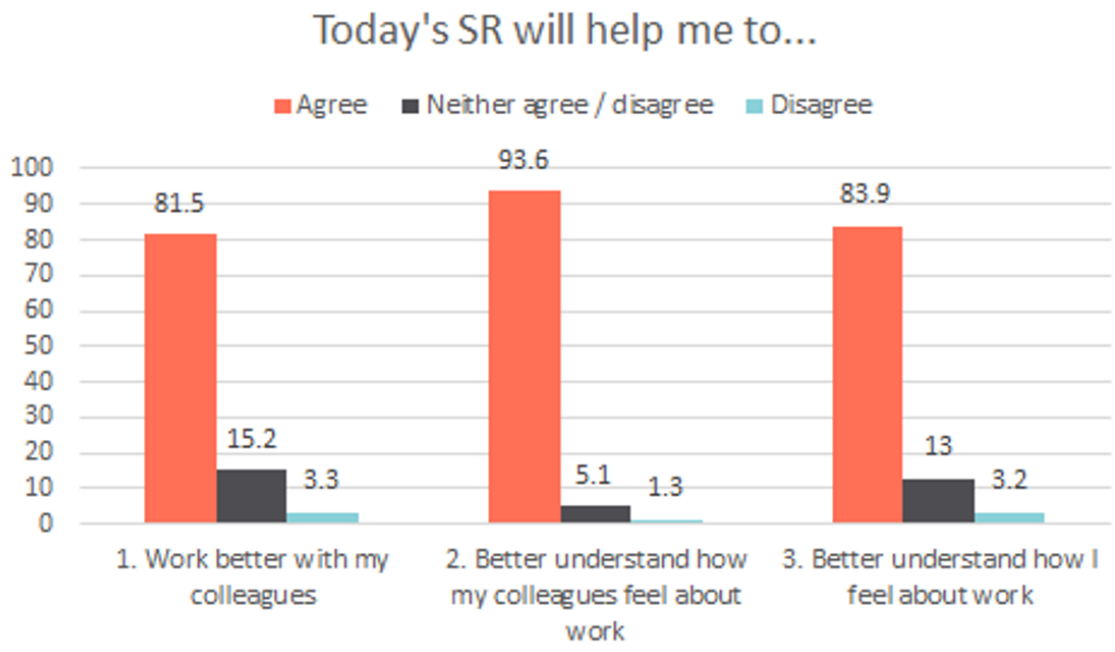
Finally, several key informants (LAs 7 and 12) spoke about the importance of finding the 'right people' to serve as panellists. This included ensuring that people were not asked to be on the panel more than once, and that panellists were enthusiastic about SRs. Another key informant (LA 9) talked about the value of having panellists from a variety of teams and roles, to ensure SRs felt inclusive and were representative of the organisation. Key informants also talked generally about the need to prepare panellists thoroughly beforehand, and having back-up panellists in mind, in case of any last-minute dropouts.

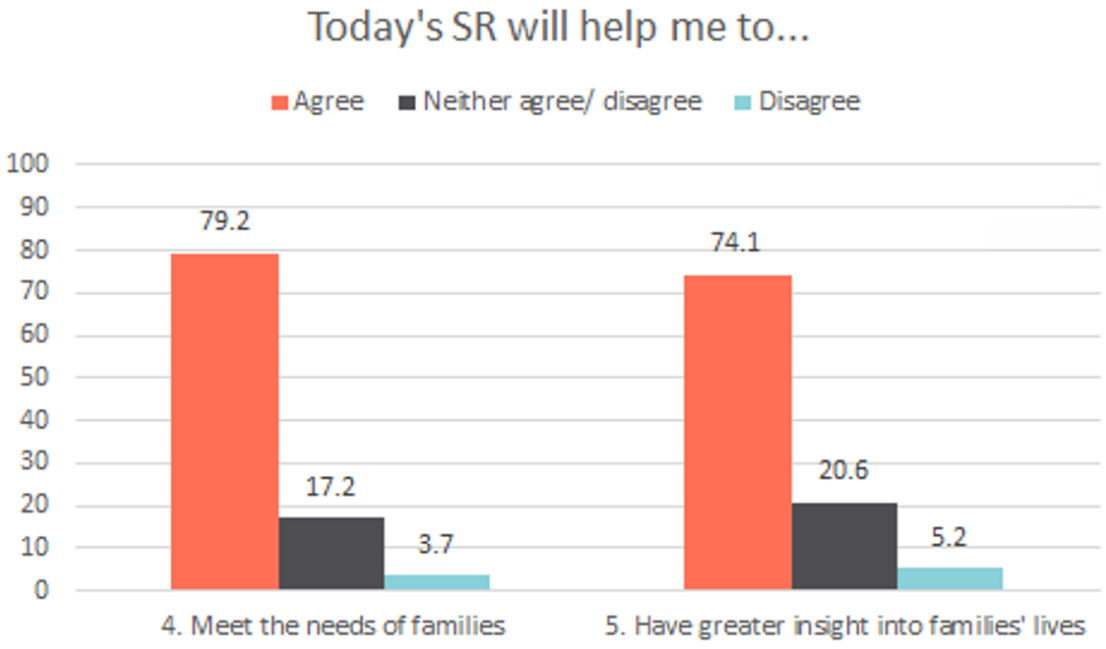
How do staff view the experience of attending SRs and what impact do they have on i) personal wellbeing, ii) relationships with colleagues and iii) work with children and families?

From feedback forms, it was evident that staff who attended SRs were able to identify a range of positive benefits. Most said they helped them understand more about the emotional impact of their work, and to work more effectively with colleagues (figure 19). Most also agreed that SRs provided them with greater insight into families' lives and helped them meet the needs of families more effectively (figure 20). There was little difference in relation to these findings between phases one and two (figures 21 and 22).

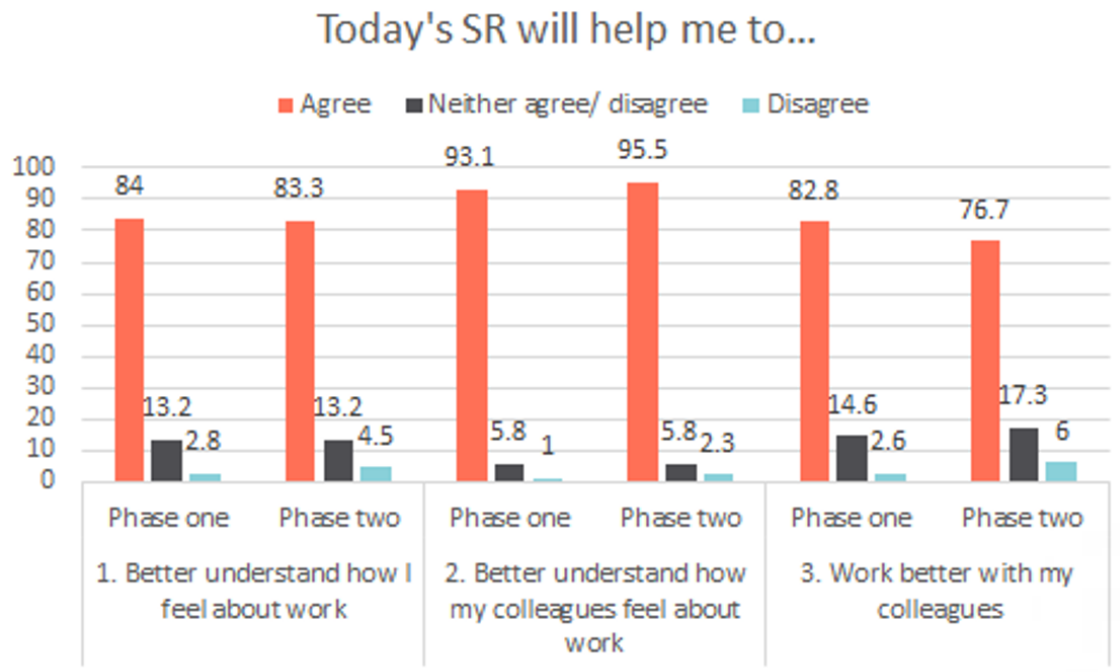
Staff were also asked about the impact of SRs as part of the T2 survey. This provides feedback about the overall experience of attending SRs in general, rather than about any specific SR. This feedback was also very positive (figures 23 and 24).

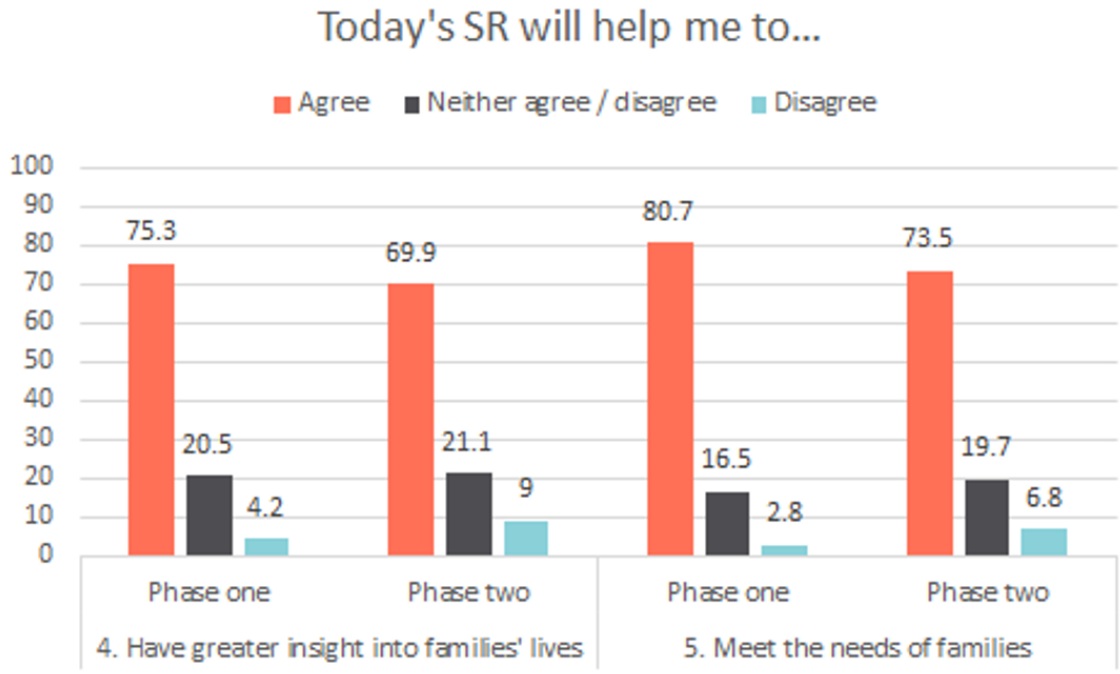
The final question on the feedback form asked, "What has attending the Round meant for you today?", with responses collected via a free-text box. There were 130 examples of respondents providing a detailed response to this question. Using recursive abstraction, five themes were identified in relation to the impact of SRs on personal well-being and relationships with colleagues (Table 18). We discuss these comments below, alongside data from interviews and focus groups.



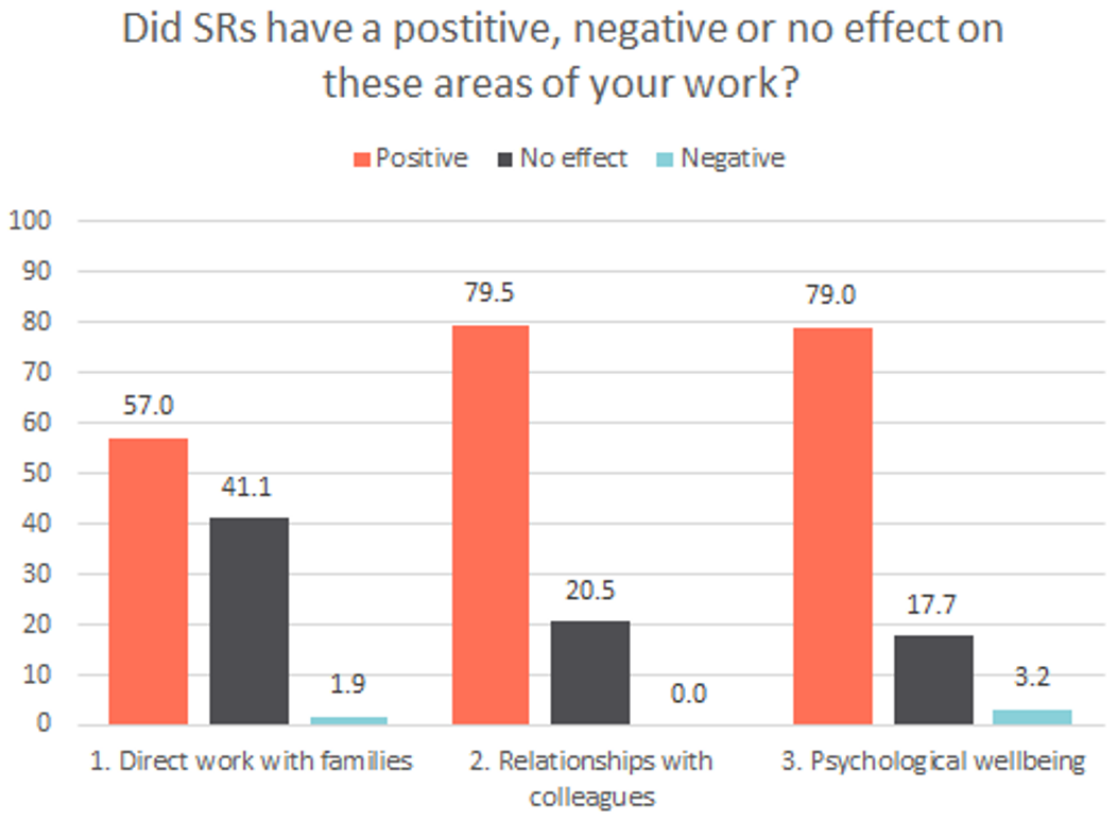


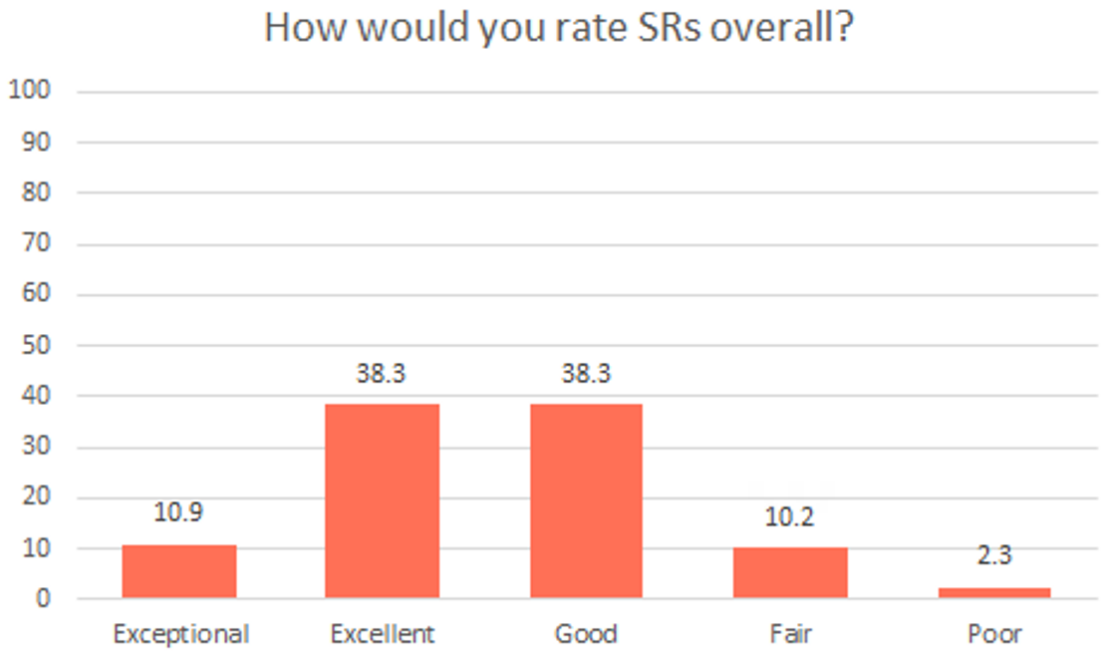
Figures 19 and 20: Overall staff feedback on the impact of SRs | *(n1=633, n2=629, n3=632, n4=628, n5=630)*





Figures 21 and 22: Staff feedback on the impact of SRs in phase one and phase two | *(n1=633, n2=629, n3=632, n4=628, n5=630)*





Figures 23 and 24: Staff feedback on the effectiveness and overall rating of SRs | *(n1=107, n2=129, n3=124, overall n=128)*

Table 18: Themes identified from staff feedback forms

Theme	Sub-themes
Impact on personal well-being	1. Normalising difficult emotional responses 2. Feeling worse than before
Impact on relationships with colleagues	1. Greater awareness of different roles 2. Prompting more supportive behaviour outside of SRs 3. Organisational recognition

Impact on wellbeing

In the interviews and focus groups, respondents spoke about a range of benefits in relation to their own wellbeing. Many frontline workers referred to the validating effect of hearing senior managers describe the personal impact of their work. This "*made it feel that it's ok to discuss the emotional impact of the work*" (LA 6). Several participants said this helped staff to be more open about their own mental health difficulties:

> "*People have seen that their managers have the same struggles that they do. I think before it was very much like you discuss with your own peer group how you may be feeling, but now people are talking about it, spanning different areas of the hierarchy.* **(LA 6)**

> "*We had [a senior manager] talking about a time when she was struggling really badly with her own sort of wellbeing and mental health and I think for her to put herself in a position like that kind of gave a lot of staff, who work underneath her like a lot of strength to sort of be quite honest with their own sort of mental health and wellbeing.* **(LA 3)**

Identifying shared experiences with colleagues was also commonly seen as having an impact on personal wellbeing, as it developed empathy between people, helped staff feel supported and reduced feelings of isolation and shame. One respondent described how, having shared her story at an SR, she felt less guilty about struggling to balance her work and home life commitments:

> *"I think [it's] just an insight into people that I work with or talk to, understanding that I'm not alone, things happen in everyday life, family life and you're trying to juggle everything. I know everybody's going through that, sometimes to have somebody sit there and share it with you it's quite a comfort to go oh, actually, I'm not the only one struggling and you don't feel like you're struggling then.* **(LA 1)**

This normalisation of difficult feelings was also demonstrated in feedback forms. Other influences on mental health and wellbeing included the opportunity to offload and process emotions and gaining an increased sense of emotional awareness. One respondent gave an example of how attending an SR helped her recognise and deal with her emotions:

> *"I was quite cross that morning and I just felt like I had the space to deal with that internally and process it a little bit deeper, a little bit longer, erm, whereas if I'd gone into a full-on day of meetings and telephone calls and … I probably would've ignored that and just suppressed it, but I was aware how I came in that morning and how I went out. That was really valuable.* **(LA 4)**

Despite these positive responses, it is important to note that a minority of feedback forms described how some staff were left coping with negative emotions after the SR. Some described feeling upset, while others were disappointed to learn that not everyone felt as well-supported as they did.

Others felt that some people at the SR presented an unrealistically positive image of their work, which felt out of kilter with their own more negative experiences. Some said they chose not to share how bad they were feeling in case it had a negative impact on those around them. One respondent said, "*today's round left me feeling worse than before...we are in a particularly stressful and pressured time, [and] I didn't feel able to be honest about my experience for fear that I would bring others down with me*" (LA 8). In focus groups as well, there were a small number of respondents who spoke about knowing of people who felt distressed because of attending. One said that while they felt well-prepared as a panellist, not everyone in the audience seemed to know much about SRs or what to expect.

Impact on collegiate relationships

Respondents also described the impact of SRs on the wider organisation and their relationships with colleagues. On an interpersonal level, SRs offered networking opportunities in which staff could learn about each other's roles and develop relationships across different teams. Via feedback forms, many respondents said they had learnt more about other people's work, and now recognised shared experiences between people in different roles. Some said they found it helpful to learn how other teams worked, and the similar challenges they were facing. Many respondents described the equalising function of SRs and how they brought people together from different levels of the organisation. One respondent said, "*it's humbling, it's equalising, and people have to leave their hierarchical hat out of [it]*" (LA 3).

At the organisational level, many respondents described how SRs had a positive impact on morale and provided a tangible way of supporting staff. Another respondent said that holding SRs "*showed that our organisation recognises the significance of emotional needs*" (LA 3).

Another from the same LA described SRs as being the first ever example, in her experience, of the organisation showing active concern about the impact on staff of working with vulnerable families. Finally, managers from several LAs (2, 6, 8 and 12) described how they used SRs to get feedback from staff about the challenges they were facing and helped them think about different ways of helping:

> *"Some of the things people have talked about being really difficult for them to cope with are things within our gift to do something about [..] it can be about some of the internal systems and processes we have and navigating your way through that, and people can feel quite disillusioned by having to go through various hurdles to do things."* **(LA 6)**

These managers said they now intended to provide more reflective supervision, and introduce more social activities for their teams, such as shared lunches.

Impact on direct work

Respondents in interviews and focus groups described three ways in which SRs had a positive impact on their direct work with families - developing emotional awareness, incorporating elements of SRs into other work, and having more empathy for families. Some workers described becoming more aware of their own emotions when working with families and learning how to process them. One explained that attending SRs had served as a reminder of "*what I am bringing into relationships with families and children*" (LA 4). Others described incorporating the principles of SRs into their direct work by talking more openly about emotions with families. This was also true for one manager who said that SRs had changed the way she approached supervision, with the aim of talking more about emotions with her supervisees. Several respondents talked about their own emotional vulnerability within SRs, and how this helped them empathise more with families, reminding them of how powerful it can be simply to listen to someone:

> *"We're often speaking to families, and we're asking them lots of questions, and they're making themselves really vulnerable and opening up...and I think it's really helpful to kind of be in that position yourself either when you're presenting or when you're sharing an emotion yourself and making yourself vulnerable. So I think it has made me think before, you know, the amount of emotion that went into it...we're, essentially asking that of families on a daily basis, and I think that has affected how I kind of perceive [those] situations... it's that reminder of how much we expect of families* **(LA 8)**

> *"I think we're all fixers in our day jobs... because we believe that people can change but it's just nice to be able to think, [sometimes] they just want somebody...to listen to what they're saying, and I think that helps you in your day job as well. It helps you open your eyes and open your ears and listen.* **(LA 3)**

For many however, the impact of SRs on their direct work with families was less tangible or even non-existent, although several did say that SRs had prompted them to be more reflective in general. One respondent said that because SRs are focused on personal experiences at work, their ability to impact directly on practice is limited (LA 5). Several respondents said that widescale changes in practice were unlikely,

because only a small proportion of staff attended SRs.

What reasons do staff give for attending or not attending SRs?

When asked about their reasons for attending, respondents identified three main drivers. Some went because they thought it would be beneficial or enjoyable. Others, mainly in managerial roles, went because they wanted to support and motivate others to attend. A final group went because they had been told to by their managers.

The most common reason for not attending was due to high workloads, both in terms of sheer volume, and the unpredictable nature of children's services. One respondent (LA 4) said her work was '*crisis led*', which meant often having to visit families or appear in court at short notice. This made it difficult to plan for attending SRs. A minority of respondents attended one SR and deliberately went to no more, because they found it unhelpful or unenjoyable.

Finally, LA 11 held one virtual SR and then decided not to provide any more. During interviews with two key informants from this LA, we asked about what happened. Both key informants were positive about the potential for SRs in children's services, particularly in relation to managing secondary trauma. Indeed, their positivity was the main reason why they discontinued with the provision of virtual SRs, because they felt they just did not work as well as in-person SRs would. At the one virtual SR they organised, attendance was poor, and the panellists' stories did not resonate with the audience. The feedback forms indicated that staff did not understand the purpose of SRs, and some were left feeling worse than before. This informed their decision not to provide further virtual SRs, but to wait until it was possible to meet again in-person.

The aim was to ensure that when staff did attend, they had a positive experience, and to protect the longer-term potential for the use of SRs in the LA.

Economic evaluation

Evidence for the direct cost of implementing SRs was derived from the economic forms completed in both phases of the trial. For set-up costs, the PoCF charged each site £5,000 for initial training (and two years of ongoing mentoring support), half of which was reimbursed to the LAs via the Department for Education (in phase one) or What Works for Children's Social Care (in phase two). When calculating costs, we have used the higher figure, as the reimbursement is not available to other LAs in future. We also calculated the indirect costs of attending training, including staff time and travel costs. Mileage was costed at a rate of £0.45 per mile. The mean cost of the initial training (including ongoing mentoring support for two years) was £5,854.57, with a range from £5,204.75 to £6,505.14 (table 19).

We then looked at the cost of providing SRs, the majority of which was for staff time to attend. To calculate the cost of staff time, in phase one and two, respondents were asked to provide their job title as part of the T1 survey. In phase two, respondents were also asked for details about their annual salary and / or pay scales. In addition to this, details of annual salaries were obtained from a variety of other sources, including the Personal Social Services Research Unit (PSSRU), local government pay scale sheets, and online job adverts (appendix 1). Where respondents did not provide information about their annual salaries, or pay grade, the title of their job role was matched to several job adverts, in their own LAs and nationally, and an average yearly salary derived.

To estimate the cost of SRs, hourly staff unit costs were applied to the duration of each SR meeting. Other costs including travel, catering and administrator time were included where applicable (not all LAs provided catering, as discussed above). We also looked at the cost (primarily in staff time) of panel preparation and steering group meetings. LAs 2, 10 and 11 did not provide enough data to be included in this analysis.

The mean cost of providing a SR was £1,238.08, with a range from £288.24 to £2,711.60. The upper end of this range largely represents better staff attendance. The mean cost of providing an in-person SR was £1,885.17, with a range from £1,145.96 to £2,711.60. The mean cost of providing a virtual SR was £429.21, with a range from £288.24 to £702.21 (table 20). Assuming the provision of one SR per month, this would equate to a yearly mean cost of £22,622.04 for in-person SRs and £5,150.52 for virtual SRs (with these costs consisting primarily of staff time for preparation and attendance). As an approximation, based on 502 feedback forms received during phase one and 133 in phase two, this would equate to a per-person per-SR cost of £22.53 for in-person SRs and £19.36 for virtual SRs.[4]

To calculate cost-savings that might be associated with SRs, we started by allocating an annual salary for each respondent, either based on their own self-report in the T2 survey or by matching their job title with the figures in appendix 1. Using these annual figures, we calculated an estimated hourly cost per respondent. Via the T2 survey, we asked each respondent to estimate the number of days they had taken as sick-leave in the previous six months. We then converted the number of days into hours, and multiplied the two figures together (hourly cost per respondent x number of hours taken as sick-leave in the previous six months). Finally, the total cost of sickness-related absence was calculated for staff in the intervention and control groups, and for the two phases. Table 21 provides a breakdown of these costs, as well as estimates of the potential cost-saving benefits of SRs. These data must be interpreted with caution, as we did not collect economic data from all of the LAs, and sickness-related costs are based on self-report data. With those caveats in mind, we have estimated that SRs during this trial provided very small cost-savings for LAs in relation to sickness-related absence from work.

4 These figures are based on the assumption that we collected the feedback forms over a six-month period in each LA, and that the total number of feedback forms equates to the number of attendees. In practice, we collected the feedback forms in several LAs over a shorter period of time, because they held only three, four or five SRs during the trial, and we are reasonably confident that some staff members attended SRs without completing a feedback form. Therefore, while these per-person figures are certainly no more than a crude approximation, they are at least conservative crude approximations.

Table 19: Cost (£) for initial training from Point of Care Foundation per LA

SR component	LA (mean cost (£))				
	Phase 1				
	LA1	LA3	LA4	LA5	LA6
Direct cost	5,000.00	5,000.00	5,000.00	5,000.00	5,000.00
Indirect costs (staff time and travel costs)	848.74	951.92	1,505.14	1,119.90	1,399.62
Total	5,848.74	5,951.92	6,505.14	6,119.9	6,399.62
Phase 2					
	LA7	LA8	LA12		
Direct cost	5,000.00	5,000.00	5,000.00		
Indirect costs (staff time and travel costs)	238.27	568.25	204.75		
Total	5,238.27	5,568.25	5,204.75		

Note: The LAs not listed in this table did not provide sufficient data to be included.

Table 20: Mean cost (£) per SR per LA

SR component	LA (mean cost (£))				
	Phase 1				
	LA1	LA3	LA4	LA5	LA6
Panel meeting	166.12	238.12	266.71	1,102.64	202.86
SR	741.61	728.05	1,454.73	1,102.64	805.89
Steering group	238.23	539.35	349.74	506.32	982.86
Total	1,145.96	1,505.52	2,071.18	2,711.60	1,991.61
Phase 2					
	LA7	LA8	LA9	LA12	
Panel meeting	156.78	199.89	193.65	546.05	
SR	183.80	185.39	94.59	156.69	
Steering group	n/a	n/a	n/a	n/a	
Total	340.58	385.28	288.24	702.74	

Note: LA 7 used their existing Senior Management Team group as a Steering Group and did not provide separate costings; LAs 8, 9 and 12 did not have a Steering Group.

Table 21: Average costs and estimated cost-savings of SRs (£)

Phase	Average cost of an SR			Staff sickness costs		Estimated cost saving
	In-person	Virtual	Overall	Intervention group	Control group	
One	2,330.16	n/a	2,330.16	1,862.84	2,129.55	266.71
Two	2,266.72	493.99	646.04	1,247.40	1,331.78	84.38
Combined	2,298.44	493.99	1488.10	1,555.12	1,730.67	175.55

LIMITATIONS

The primary limitation of the study was the smaller-than-anticipated sample size. While we were reasonably successful at recruiting respondents in phase one, we were unable to replicate this in phase two. We also had a significant drop-out between T1 and T2 in both phases. For the phase two LAs, this was magnified by the need to pause and re-start the trial, which necessitated repeating the T1 survey. In effect, this meant we asked staff from those sites to complete three surveys, which may have contributed to a declining response rate. Where respondents did complete the surveys, there were numerous returns which contained at least some missing data (hence why there are various Ns reported in the figures and findings above). That we did not recruit the number of respondents needed means that additional caution should be taken when interpreting the findings.

We also experienced difficulties in relation to contamination between the intervention and control groups. While most respondents did not complete a feedback form, indicating their attendance at a specific SR, we know that a number of respondents from the control group did. None of the LAs deliberately invited staff from the control group to attend but perhaps inevitably staff in the control group came to know about the project, from team meetings, from seeing posters around their buildings, from reading staff newsletters or by speaking to their colleagues. Some key informants felt it was unfair to deny SRs to those in the control group, especially if they were experiencing psychological distress at work. Almost no staff in the LAs were familiar with the design of a randomised controlled trial or had any experience of one being undertaken in children's services. As pointed out by the PoCF, the spirit of SRs is based on them being open to everyone – yet the trial design meant this was only true for one in every two members of staff.

We did remind respondents via the T1 survey, and as part of the information sheet and consent form, that they should not attend unless they were in the intervention group. Beyond this, we had no means of actively preventing someone from the control group joining a SR. We have attempted to account for this by presenting both the primary intention-to-treat analysis and an analysis based on actual attendance, but this cross-over inevitably makes it more difficult to compare properly between the intervention and control groups. Of the 635 feedback forms we collected in total, 13% (n=83) were completed by respondents who we know were allocated to the control group. Despite this, it is important to be clear that even when control group respondents did attend SRs, we still counted them as being part of the control group for

the primary intention-to-treat analysis. This means, in practice, that differences between the groups were diluted, and the chances of finding a statistically significant difference reduced.

We also set absolute categories in relation to whether respondents would be categorised as regular, irregular or non-attendees, based on the assumption that all of the LAs would offer six SRs during the trial period. In Maben et al's (2018) evaluation, they used a proportional measure (attending 50% of available SRs qualified as being regular attendance), and we could have done the same. As some LAs only provided three or four SRs in the trial period, their staff had less opportunity to be counted as a regular attendee compared with LAs who offered five or six.

The feedback forms, designed by the PoCF to gather ongoing feedback about SRs, and not for use in research studies, use a Likert-scale that may skew responses in a positive direction (the 'overall rating for today's SR' scale is as follows – Exceptional, Excellent, Good, Fair and Poor). Having said this, we did gather lots of other data via interviews, focus groups and the T2 survey to triangulate and substantiate the positive results from the feedback forms.

For data on sickness-related absence we relied on self-report, having initially hoped to gather this information directly from LA HR departments. It may have been difficult for participants to accurately report the exact number of days missed over a previous six-month period, and so these data need to be interpreted cautiously. It is also important to acknowledge that for some LAs, particularly in phase two, six-months was longer than the trial period during which SRs were provided. To maintain consistency between the two phases, we asked all respondents about their sickness-related absence over the past six months, rather than tailoring the question for each LA. We should also have asked about a wider range of personal and professional characteristics in the T1 and T2 surveys, most notably in relation to disability.

Finally, a major implication of the Covid-19 pandemic was the decision to transition from in-person to virtual SRs. In consultation with the funder for the study, we decided for the primary analysis to simply combine the data from both phases. Yet the extent to which the experience and effect of an in-person SR is comparable with a virtual SR is hard to quantify. Certainly, the qualitative feedback from both phases was positive, but nonetheless this is a limitation worth noting. We also faced a challenge in phase two of retaining LAs, with two dropping out of the trial for different reasons. While it would be overly simplistic to suggest these limitations resulted entirely from the Covid-19 pandemic, its impact on the trial, and on the LAs involved, cannot be dismissed.

CONCLUSION AND RECOMMENDATIONS

This trial demonstrates that SRs can be successfully implemented within children's services, and the qualitative feedback from almost all staff was very positive in relation to the experience of attending. SRs were also said by many to have a positive effect on their personal well-being and on their relationships with colleagues. We also found that staff in the intervention group had lower GHQ-12 scores at T2, compared with staff in the control group, and a smaller proportion of staff in the intervention group had elevated GHQ-12 scores. Staff who attended regularly (three or more SRs) also had lower GHQ-12 scores, were less likely to have elevated GHQ-12 scores and had fewer sickness-related absences from work at T2 compared with staff who did not attend or attended irregularly.

Nonetheless, it is important to emphasise that none of these differences achieved a conventional level of statistical significance ($p<0.05$). This means we cannot rule out the null hypothesis that SRs make no difference to levels of psychological distress. It is also worth noting that these differences cannot in any case be solely attributed to SRs. Yet this does not mean that SRs do not 'work', and neither does it invalidate the positive experiences of staff who attended and found them helpful.

In conclusion, considering the findings holistically, we found clear signs of promise in relation to the use of SRs in children's services, especially for regular attendees. The cost analysis found that the provision of SRs may be cost-neutral in relation to time saved from sickness-related absences from work. Even if this were not the case, the intervention is nonetheless relatively inexpensive. We recommend that LAs can consider providing SRs (or continue to provide SRs) as part of their efforts to support staff wellbeing. If so, regular attendees may experience tangible benefits, including lower psychological distress and fewer sickness-related absences from work, and intangible benefits, including improved subjective wellbeing and relationships with colleagues.

To assist LAs who might consider introducing SRs, we make the following ten recommendations (although as noted in the introduction, the first course of action would be to contact the Point of Care Foundation in order to obtain the proper license and training for doing so):

1. Establish a steering group to oversee the delivery of the intervention, with a voluntary and committed membership. Ensure there are enough people trained as facilitators so that responsibility for providing SRs can be shared between a group of staff.

2. Consider how SRs fit with any existing models of practice and with the broader organisational culture. Staff may need help to understand how discussions facilitated within SRs relate to ways of working with families, and with colleagues generally.

3. SRs cannot be delivered without proper support, including administrators or business support officers, and active support from senior managers.

4. While SRs can be provided virtually, on balance the introduction of SRs seems to work better when initiated via in-person meetings. Virtual SRs can be introduced later once the intervention has been properly established.

5. Attendance at SRs should be optional, and open to all staff, including (but not limited to) managers, social workers, support workers, and business support officers.

6. Reasonable adjustments must be made to ensure SRs are open and inclusive for all members of staff, including disabled people and people from ethnic minority groups. For example, providing large-print materials for people with visual impairments, and ensuring that panellists are representative of the wider staff group and of the communities being served.

7. Staff should be made aware in advance what to expect from SRs, so that everyone can make an informed decision for themselves about whether to attend.

8. Staff feedback should be collected after each SR, using feedback forms provided by the PoCF. This can be used to inform the development of future SRs. For example, about the topics that staff want to be discussed, and whether they find the presence of managers to be helpful or inhibiting.

9. Some staff will find the experience of attending to be upsetting. Sufficient time should be provided at the end of each SR for those that need it to process what has been discussed. This is more difficult for virtual SRs. Follow-up support should be available for staff who find themselves to be particularly affected.

10. While the SR model itself is adaptable within reason, care should be taken to ensure ongoing compatibility with the fundamental principles of the model. The contents of tables 11, 12 and 13 can be used to help judge fidelity.

REFERENCES

Allen, Deborah, Spencer, Graham, McEwan, Kirsten, Catarino, Francisca, Evans, Rachael, Crooks, Sarah, & Gilbert, Paul. (2020). The Schwartz Centre Rounds: Supporting mental health workers with the emotional impact of their work. *International journal of mental health nursing, 29*(5), 942-952.

Antonopoulou, P, Killian, Mike, & Forrester, Donald. (2017). Levels of stress and anxiety in child and family social work: Workers' perceptions of organizational structure, professional support and workplace opportunities in Children's Services in the UK. *Children and Youth Services Review, 76*, 42-50.

Bostock, Lisa, Forrester, Donald, Patrizo, Louis, Godfrey, Tessa, Zounouzi, Maryam, Antonopoulou, Vivi, . . . Tinarwo, Moreblessing. (2017). Scaling and deepening the Reclaiming Social Work model.

George, Melanie S. (2016). Stress in NHS staff triggers defensive inward-focussing and an associated loss of connection with colleagues: this is reversed by Schwartz Rounds. *Journal of Compassionate Health Care, 3*(1), 1-17.

Hankins, Matthew. (2008). The reliability of the twelve-item general health questionnaire (GHQ-12) under realistic assumptions. *BMC public health, 8*(1), 1-7.

Hardy, Gillian E, Shapiro, David A, Haynes, Clare E, & Rick, Jo E. (1999). Validation of the General Health Questionnaire-12: Using a sample of employees from England's health care services. *Psychological Assessment, 11*(2), 159.

James, David, Yates, Janet, & Ferguson, Eamonn. (2013). Can the 12-item general health questionnaire be used to identify medical students who might 'struggle'on the medical course? A prospective study on two cohorts. *BMC medical education, 13*(1), 1-8.

Kalliath, Thomas J, O'Driscoll, Michael P, & Brough, Paula. (2004). A confirmatory factor analysis of the General Health Questionnaire-12. *Stress and Health: Journal of the International Society for the Investigation of Stress, 20*(1), 11-20.

Maben, Jill, Taylor, Cath, Dawson, Jeremy, Leamy, Mary, McCarthy, Imelda, Reynolds, Ellie, . . . Foot, Catherine. (2018). A realist informed mixed-methods evaluation of Schwartz Center Rounds® in England. *Health Services and Delivery Research, 6*(37), 1-260.

McFadden, Paula, Campbell, Anne, & Taylor, Brian. (2015). Resilience and burnout in child protection social work: Individual and organisational themes from a systematic literature review. *The British Journal of Social Work, 45*(5), 1546-1563.

Ozdemir, Hatice, & Rezaki, Murat. (2007). General Health Questionnaire-12 for the detection of depression. *Turk Psikiyatri Dergisi, 18*(1), 13.

Polkinghorne, Martyn, & Arnold, Amy. (2014). *A six step guide to using recursive abstraction applied to the qualitative analysis of interview data*: Bournemouth University.

Ravalier, Jermaine M. (2019). Psycho-social working conditions and stress in UK social workers. *The British Journal of Social Work, 49*(2), 371-390.

REFERENCES

Taylor, Cath, Xyrichis, Andreas, Leamy, Mary C, Reynolds, Ellie, & Maben, Jill. (2018). Can Schwartz Center Rounds support healthcare staff with emotional challenges at work, and how do they compare with other interventions aimed at providing similar support? A systematic review and scoping reviews. *BMJ open, 8*(10), e024254.

Turnell, Andrew, & Edwards, Steve. (1997). Aspiring to Partnership. The Signs of Safety approach to child protection. *Child Abuse Review: Journal of the British Association for the Study and Prevention of Child Abuse and Neglect, 6*(3), 179-190.

Turnell, Andrew, & Edwards, Steve. (1999). Signs of safety. *A solution oriented approach to child protection casework*.

Williams, Annie. (2019). Family support services delivered using a restorative approach: A framework for relationship and strengths-based whole-family practice. *Child & family social work, 24*(4), 555-564.

Zelen, Marvin. (1979). A new design for randomised controlled trials. *New England Medical Journal, 300*, 1242-1245.

APPENDIX 1

Staff unit costs (£, 2019)

Role	Salary midpoint (£/annum)	Salary on costs[1]	Overhead costs[2]	Unit cost (£/hour)[3]
Administration role/business support officer	£22,371.50	£5,724.71	£15,834.30	£29.04
Advanced practitioner	£38,735.50	£10,764.83	£25,466.15	£49.55
Assistant head of service	£71,259.00	£20,782.06	£44,609.48	£90.32
Assistant manager	£29,656.50	£7,968.49	£20,122.25	£38.17
Assistant team manager	£37,516.50	£10,389.37	£24,748.64	£48.02
Autism practitioner	£21,337.50	£5,406.24	£15,225.68	£27.74
Business support coordinator	£30,867.50	£8,341.48	£20,835.04	£39.69
Case manager	£31,937.50	£8,671.04	£21,464.84	£41.03
Case/child/family/key worker	£25,271.00	£6,617.76	£17,540.94	£32.67
Child protection coordinator/ independent reviewing officer	£40,283.00	£11,241.46	£26,377.00	£51.49
Clinical supervisor	£53,653.50	£15,359.57	£34,246.88	£68.25
Consultant social worker	£48,727.50	£13,842.36	£31,347.44	£62.07
Contact service/support worker	£20,816.50	£5,245.77	£14,919.02	£27.09
Crime prevention worker	£28,131.00	£7,498.64	£19,224.34	£36.26
Early help inclusion officer	£28,131.00	£7,498.64	£19,224.34	£36.26
Early years practitioner	£23,131.00	£5,958.64	£16,281.34	£29.99
Family support practitioner (SEN)	£28,131.00	£7,498.64	£19,224.34	£36.26
Family support worker	£30,000.00	£8,074.29	£20,324.43	£38.60
FGC coordinator	£24,000.00	£6,226.29	£16,792.83	£31.08
Group manager	£57,845.00	£16,650.55	£36,714.00	£73.50
Head of service	£65,434.50	£18,988.12	£41,181.18	£83.02

Lead	£52,058.50	£14,868.31	£33,308.06	£66.25
Operations manager	£39,308.50	£10,941.31	£25,803.41	£50.27
Organisational development consultant	£38,804.50	£10,786.08	£25,506.76	£49.63
Parenting coordinator	£35,818.06	£9,866.25	£23,748.94	£45.89
Personal advisor	£26,268.50	£6,924.99	£18,128.07	£33.92
Practice development manager	£53,653.50	£15,359.57	£34,246.88	£68.25
Practice manager	£42,941.00	£12,060.12	£27,941.50	£54.82
Principal social worker	£45,713.00	£12,913.90	£29,573.10	£58.29
Professional practice L & D officer	£37,373.50	£10,345.33	£24,664.47	£47.84
Project manager	£38,001.50	£10,538.75	£25,034.11	£48.63
Quality assurance manager	£33,373.50	£9,113.33	£22,310.07	£42.83
Residential worker	£24,124.50	£6,264.64	£16,866.11	£31.23
Senior HR advisor	£35,013.50	£9,618.45	£23,275.38	£44.88
Senior manager	£58,500.00	£16,852.29	£37,099.53	£74.32
Senior practice educator	£25,863.00	£6,800.10	£17,889.39	£33.41
Senior practitioner	£35,198.00	£9,675.28	£23,383.97	£45.11
Senior social worker	£39,784.50	£11,087.92	£26,083.59	£50.86
Sensory advisory teacher	£35,877.50	£9,884.56	£23,783.93	£45.97
Service manager	£51,233.50	£14,614.21	£32,822.47	£65.21
Social work assistant	£25,238.00	£6,607.60	£17,521.52	£32.63
Social worker	£34,748.00	£9,536.68	£23,119.10	£44.55
Specialist support teacher	£32,431.50	£8,823.19	£21,755.61	£41.65
Systemic family therapist	£40,177.00	£11,208.81	£26,314.61	£51.36
Team manager	£48,628.50	£13,811.87	£31,289.17	£61.95
Trainee educational psychologist	£27,973.00	£7,449.98	£19,131.34	£36.06
Workforce manager	£43,663.12	£12,282.53	£28,366.54	£55.73
Youth advocate	£19,363.50	£4,798.25	£14,063.79	£25.26

Notes: 1. Sum of employer's national insurance contributions (secondary threshold at £162/week and rate of 13.8%) and employer's contribution to superannuation at 17% of salary (PSSRU, 2019). 2. Total of direct overheads (29%), indirect overheads (16%) and capital overheads (£3,1919) (PSSRU, 2019). 3. Unit costs based on 1,513 hours per year (PSSRU, 2019).

What Works *for* Children's Social Care

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