Interim Evaluation of the National Trauma Training Programme Local Delivery Trials

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Executive Summary

Background

Since 2018, the Scottish Government (SG) has committed over £1.5 million to design and deliver a National Trauma Training Programme (NTTP), led by NHS Education for Scotland (NES), which aims to develop and support a consistent, highly skilled, trauma-informed workforce across all frontline services.

Three local Delivery Trials Sites were established in Argyll and Bute, Glasgow and Midlothian during summer 2019, to test a range of approaches to implementing the delivery of high quality and sustainable trauma training in differing contexts. These trials are one of many elements of the NTTP.

This **interim report** presents learning from a process **evaluation** of the Delivery Trials Sites which aimed to explore contextual issues that contributed to successful implementation and to inform the roll out of the NTTP. The evaluation used a Theories of Change approach.

Delivery Trial Site Outputs

Each site built on previous trauma related work such as Adverse Childhood Experiences. Substantial work was undertaken across the sites to: establish multi-agency steering groups; conduct needs assessments; tailor training content; raise awareness; establish skilled internal trainers or commission training providers; agree plans to embed and sustain training; identify opportunities for participation from people with lived experience and agree monitoring and evaluation processes.

A number of barriers delayed full implementation of both the trials and the evaluation, including limited time-frames and local staffing and workload challenges. The COVID-19 pandemic prevented the delivery of all frontline workforce training and the subsequent monitoring and analysis of the impact of that training within and across sites.

Scottish Trauma Informed Leadership Training (STILT) was delivered in two sites and local roadshow sessions in three sites. These short face to face sessions were aimed at local leaders to raise awareness and achieve a shared understanding of Trauma Improved Practice (TIP) and its impact. STILT sessions aimed to highlight the benefits of culture change to embed TIP principles and secure support for frontline staff training. STILT training was positively received. Catering for varying knowledge levels from different services was challenging as was identifying the appropriate levels of leaders to target in different sites. The most senior partnership and political leaders were targeted in the second waves of training where that had not been achieved in the first wave.

Differences in approach influenced by context

Contextual issues such as geography, quality of existing partnerships and prior involvement in TIP influenced the different approaches progressed. The main variations in approaches were in relation to whether sites targeted all agencies within their Health and Social Care Partnerships (HSCPs)/Local Authority or focused on specific sectors or geographical localities. One site intended to saturate frontline services across their partnership, one targeted change in CYP's Services and one throughout services in a specific locality within a much larger partnership.

Partnerships and third sector engagement

All areas established multi-agency implementation groups to lead the work. Faster progress was made in areas with consistent project lead officers, stable multi-agency groups and where project managers had dedicated time allocated to their role.

Third sector agencies were involved in the implementation groups in two sites. In one site some third sector partnership staff participated in the train the trainer programme and were part of an 'in house' training team. One site 'commissioned' the tailoring of content and delivery of their level 2 and 3 training from a consortium of national third sector agencies that were experienced providers of services for looked after CYP. An unanticipated issue that arose in this process was the need for consideration of, and negotiated solutions to, ownership and management of intellectual property with regard to training content, tools and approaches within the public and third sector consortium.

Leadership and culture change

Emphasising that staff value training and benefit in terms of their own experiences and responses to trauma encouraged commitment from leadership. Delivery of STILT and awareness raising led to interest and demand for input and training from other services within partnerships and/or an increased interest from, and opportunities to engage with, strategic leaders (e.g. CEOs and Elected members) to scale and spread training and TIP. Early work also raised awareness of the wider NTTP and associated tools.

Published TIP literature suggests that culture change requires additional focus beyond training and must include staff health and wellbeing actions that ensure appropriate staff support, supervision and self-care as well as policy and practice alignment. The initial prioritisation of training in the three sites meant these other elements were not as yet developed beyond what was existing practice in the trial localities.

One site suggested that services with more rigid service user rules (e.g. housing, finance, police) struggled more with aspects of culture change associated with TIP. However, these services were also 'coming on board' even within the short time frame of the trials.

Engagement of people with lived experience of trauma

Whilst all sites had intended that people with lived experience would be involved at a strategic level within their implementation groups the reality of achieving this was challenging. Such strategic involvement may not be the most attractive role for people with lived experience. Roles such as co-production of training content and delivery and/or supporting peer evaluation may prove more attractive and fulfilling.

One site planned to co-produce bespoke training for and with foster/kinship carers and adoptive parents. Once complete the resulting content and process should be informative for the NTTP roll out. In the other sites the most fulfilling roles for people with lived experience were still being identified and participants engaged.

Key Learning

Participation as a Delivery Trial Site brought additional work to partnerships and services that were already experiencing substantial work pressures. The progress achieved took substantial time and effort. Evidence suggests that achieving such organisational change takes upwards of 2 years. Embedding TIP across multiple organisations with varying purposes (e.g. health, care, education, leisure, etc.) as was the case in all three sites may take even longer.

The support via the NTTP from NES was viewed positively and STILT and e-learning resources and tools valued. Timing of the release of new content and tools when local agreements on these had already been made and ensuring that e-learning did not reduce attendance at face to face training were two areas for potential improvement.

Partnership contexts result in the need for tailored rather than overly centralised approaches.

Changes in practice and services that may have resulted post training could not be monitored given the postponement of frontline training. Relevant literature however suggests that evaluation should be integrated at the planning stage and be pragmatic and proportionate to the scale of programmes and resources. There are many existing tools and scales that can be used to enhance planning and evaluation locally and nationally. Where resources allow, further validation of these scales is needed to inform more consistent use across interventions and allow more robust analysis. This, in turn, will help inform issues such as optimum length of training course and necessary packages of interventions to maximise positive impacts on individuals, teams, partnerships, systems and people with lived experience.

The early learning from the process evaluation reinforces the conclusion from a recent systematic realist informed review which stated that:

“Five factors were instrumental in implementing trauma informed care across a spectrum of initiatives: senior leadership commitment, sufficient staff support, amplifying the voices of patients and families [people with lived experience],

aligning policy and programming with trauma informed principles, and using data to help motivate change".

The National Trauma Training Programme

Since June 2018, the Scottish Government (SG) has committed over £1.5 million to design and deliver a National Trauma Training Programme[1] (NTTP), coordinated by NHS Education for Scotland (NES). The NTTP is comprised of the following core elements:

- a range of online resources (e-modules, webinars and animations)
- Scottish Trauma Informed Leaders Training (STILT) – a short face to face programme aimed at senior leaders
- Train the Trainers approach for future facilitators
- three Delivery Trial Sites testing the implementation of trauma training for priority public sector frontline workers in three local authority areas (Argyll and Bute, Glasgow and Midlothian) from Summer 2019.
- local training, supervision and coordination of Service Level Agreements or delivery (now in place within all 14 Health Boards to provide dedicated, locally based posts leading activity on a cross-sector basis).
- support for tailored training projects (e.g. within the Judicial Institute, the Joint Investigative Interview Team, Forensic Medical Examiners, Maternity Services, Services for CYP who are in /or at risk of being in the care system and high-volume delivery in the health and social care sector) and testing of routine enquiry approaches.

The NTTP builds on the NES "*Transforming Psychological Trauma: A Knowledge and Skills Framework for the Scottish Workforce*"[2] (KSF) published in 2017 and a Trauma Training Plan for Scotland[3] published in 2019. These documents and the NTTP provide guidance on trauma training to support all sectors of the workforce and outline the steps that can be undertaken within services to develop, commission and embed the use of high-quality trauma training to develop their workers' trauma related knowledge and skills. The overall long-term aim of the NTTP is to develop and support a consistent, highly skilled, trauma-informed workforce across all frontline services.

To be trauma informed, workforces need to be aware of the impact of trauma, recognise those who are (or have been) exposed to trauma and perceive and reduce barriers to service engagement for people who are trauma experienced. In addition, a trauma informed workforce should be trained to provide support appropriate to their roles and tailored to those in need of their services. The NTTP[1,2] identified four progressively specialised levels of Trauma Informed Practice (TIP). These are illustrated in Figure 1.

[1] National Trauma Training Programme

[2] National Trauma Training Progamme Knowledge and Skills Framework

[3] National Trauma Training Programme Trauma Training Plan

Figure 1: Four levels of trauma training

People with lived experience report that the most important factor impacting upon their capacity to seek and receive care, support or interventions is having a trusting relationship with a worker[1]. A trauma informed organisation is one that has embedded an understanding of the impact of trauma into all aspects of its service delivery, and one whose culture reflects each of the values of safety, choice, trust, collaboration, empowerment in each contact, physical setting, relationship and activity. This culture should also be evidenced in the treatment and experiences of the organisation's staff[1].

Delivery Trial Sites

The three Delivery Trials Sites in Argyll and Bute, Glasgow and Midlothian were established in Summer 2019 to test out a range of approaches to implementing the delivery of high quality and sustainable trauma training in differing contexts. They were to last a period of 6-12 months and were to receive support from NES including delivery of local roadshows (high volume awareness and delivery events), STILT and advice on needs assessment and evaluation. The Delivery Trial Sites shared £120K funding and were encouraged to work with/include third sector training delivery partnerships where possible. The Delivery Trial Sites were expected to build on existing local approaches for trauma informed practice and identify where there were gaps in trauma informed service provision. Sites were to ensure that appropriate coaching and supervision structures were in place for staff beyond the initial trial period. In addition, they were expected (with support from the externally commissioned process evaluation) to embed monitoring and evaluation processes in their plans and consider quality improvement (QI) activities that would inform scaling-up training provision. Finally, they were also required to develop communication and dissemination processes so that learning could inform any future roll out of the NTTP.

The Process Evaluation

This **interim report** focuses on the progress of the NTTP Delivery Trial Sites[4] and learning from the independent **process evaluation**. The process evaluation was commissioned in October 2019 and ended in March 2020. The process evaluation aimed to provide learning for future expansion/roll out of the NTTP with regard to practical and effective approaches to partnership working to deliver and embed trauma training. It was to explore contextual elements within the three sites which contributed to enhanced trauma awareness and facilitated successful implementation. The more detailed aims and objectives are listed in Appendix 1.

Intended methodology

To address the evaluation aims and objectives a Theories of Change (ToC)[5], approach was used. ToC is a participative approach that supports the articulation of an intervention's programme theory. ToC models were developed to illustrate what sites intended to do and how and why their activities would lead to their intended outcomes. The approach sought to understand the contexts and assumptions on which activities were based. A ToC should be plausible, doable and testable and provides a framework for strengthening planning and delivery and for informing monitoring and evaluation[6]. The planned process evaluation methods included:

- the development of a strategic ToC model for the overall Delivery Trial Sites programme (set within the wider NTTP)
- the facilitation of local ToC models at each site
- accompanying narratives and descriptors of context at each site
- support for the prioritisation of outcomes and development of a high-level data collection/monitoring and evaluation plans
- participative reflections on progress and learning at two time points
- analysis and triangulation of learning
- reporting on learning for future roll out by March 2020.

Delivery Trial Site ToCs were informed by the local funding applications and aligned to a nationally agreed template model for the overall Delivery Trial Site programme. The above activities collectively were intended to provide a means of framing local data and learning within and across sites when these became available.
There were a number of barriers that prevented the delivery of several of the above methods across the Delivery Trial Sites. Barriers included limited time-frames and staffing and workload challenges that hampered implementation in local areas. More is said about these issues in the findings/learning section below. The barriers and delays prevented full engagement with the process evaluation activities and in

[4] Scottish Government news release on local delivery trials

[5] Better Evaluation

[6] Theories of Change and Realistic Evaluation

turn impacted on the resulting analysis and learning**. Most significantly the Coronavirus (COVID-19) pandemic prevented the delivery of the planned frontline training and internal monitoring, evaluation and subsequent analysis of the impact of that training within and across sites.** Table 1 shows the progress achieved against the intended process evaluation methods.

Table 1: Progress against intended process evaluation methods by March 2020

	Methods completed			
Intended Methods/ Site	**National Delivery Trial Site Programme**	**Site1**	**Site 2**	**Site 3**
1. Strategic ToC for overall Delivery Trial Site programme	√	N/A		
2. Local ToCs	N/A	√	√	√
3. Capture contextual issues	N/A	√	√	√
4. Prioritise outcomes and refine monitoring and evaluation plan	N/A			√
5. Reflective learning - focus groups /interviews	N/A			√
6.Triangulate Learning	√			
7.Report Learning	√			

As a result of the barriers and delays the independent evaluator was unable to conduct activities 4 and 5 in Delivery Trial Sites 1 and 2 as illustrated in Table 1. This meant that for Delivery Trial Sites 1 and 2 monitoring and evaluation plans were not discussed in detail nor supported as part of the process evaluation. It also meant that follow-up reflective sessions to seek learning on barriers and facilitators to success were also not conducted in these sites. One reflective interview was conducted with a third sector organisation representative who coordinated a consortium to deliver aspects of training in one area. In Delivery Trial Site 3 one reflective focus group was conducted with key members of the implementation group (including the appointed Project Manager) and a further interview was undertaken with the initial Lead Officer who submitted Site 3's Delivery Trial Site funding bid.

Outputs from the process evaluation

Theories of Change

A range of ToC models were produced from stage 1 and 2 of the process evaluation. A strategic ToC for the overall Delivery Trial Site programme which included assumptions that underpinned the overall programme theory is in Appendix 2. The ToCs for each individual Delivery Trial Site are in Appendix 3.

The delays and postponements across all sites as a result of Coronavirus (COVID-19) meant that the only training that was delivered was that targeted at senior managers and leaders - STILT training delivered by NES and associated awareness raising roadshows delivered by NES and/or local teams. This evaluation cannot therefore report back on the reach and short-term outcomes or impact of frontline staff training. All that can be reported is learning from the planning phases and delivery of STILT and associated awareness training for senior managers.

Progress in achieving planned activities

Substantial work was undertaken across the sites to progress the activities listed in their ToCs during the 6/7 months they were operational. This included:

- the establishment of the interagency steering/ implementation groups
- conducting needs assessments or workforce mapping of the specific settings and workforce
- considering appropriate roles and methods for engaging and recruiting people with lived experience of trauma
- agreeing content of training courses and any specific tailoring needed to the content recommended by NES for the various levels of training and ensuring this aligned with the results of needs assessment and previous training delivered within the specific contexts
- agreeing communication plans to raise awareness and recruit targeted participants for training
- identifying the best mode of training delivery (in house and/or externally commissioned)
- the delivery of training and agreed support and supervision (delayed in part due to Coronavirus pandemic)
- identifying processes to embed and sustain training in ongoing workforce planning
- considering monitoring and evaluation processes.

Similarities and differences in planned activities across sites

The key contextual and intervention differences across the three sites are illustrated in the figures in Appendix 4. Appendix 5 provides further explanation of similarities and differences in each of the specific activities progressed across the sites.

Learning

The NTTP highlights a number of expectations and principles for local implementation structures intending to develop trauma informed workforces and organisations. These processes and outcomes where change was anticipated include:

1. Provide local oversight, governance and planning of sustainable local training delivery and implementation - **Leadership**

2. Committing to trauma-informed principles and values – **Culture change**

3. Use available local evidence and take local needs and priorities into account, including access and equity of access to support, care and interventions, service, organisational needs and cost effectiveness – **Needs Assessment**

4. Committing to training and translation of training into practice and promote trauma-informed practice (TIP) - **Training, TIP and service change**

5. Promote cross-sector, partnership working and third sector involvement - **Partnership Working**

6. Develop staff support, coaching and supervision systems – **Staff Support, supervision and self-care**

7. Ensure involvement of people with lived experience in local training initiatives and developments - **Involvement of people with lived experience and co-production**

8. **Monitor and evaluate** outcomes

Many of these processes and outcomes align with domains within implementation and audit tools in the wider TIP literature[7,8]. An example of this alignment is highlighted in Table 2, which compares the above NTTP expectations with domains from Trauma-Informed Care and Practice Organisational Toolkit (TICTOP)[5] revised in 2018 and currently used to support the roll-out of TIP across Australia's public services.

[7] Trauma Informed Care and Practice Organisational Toolkit (TICPOT)

[8] Creating Cultures of Trauma Informed Care

Table 2: Alignment of NTTP and Trauma-Informed Care and Practice Organisational Toolkit (TICTOP) domains

TICTOP ORGANISATIONAL AUDIT DOMAINS					
DOMAIN A	**DOMAIN B**	**DOMAIN C**	**DOMAIN D**	**DOMAIN E**	**DOMAIN F**
Governance, management and Leadership	Organisational Structure and Policy	Consumer and Family Participation and Peer Work	Direct Services to Consumers and Families	Healthy and Effective Workforce	Outcomes and Evaluation
NTTP EXPECTATIONS AND PRINCIPLES					
1 & 5	**2**	**7**	**4**	**4 & 6**	**3 & 8**
Leadership and Partnership Working	Culture Change	People with lived experience & Co-production	TIP and Service Change	Staff Training Support, Supervision and Self-Care	Needs assessment and Monitoring and Evaluation

Given the consistency of these process and outcome areas with those in the wider TIP literature they are used below to structure the feedback on progress and learning from the Delivery Trial Sites. It should be reiterated that significant challenges including pre-existing workloads and pressures, staff absences, and the outbreak of Coronavirus (COVID-19) combined to limit implementation progress. These barriers also prevented access to participants and data to address the process evaluation objectives. The findings and lessons below are therefore based only on the limited information and data accessed from those research activities achieved - illustrated in Table 1. As such, the findings should be treated with caution and seen as early feedback that should be further informed/refined

Leadership and Partnership Working

Engaging leaders

The main tool used in the Delivery Trial Sites to engage and enthuse leaders was awareness raising roadshows and STILT training. Two of the three sites delivered both their awareness raising and STILT sessions to a range of senior and operational leaders and managers in their areas. A STILT session had been requested for Senior Board members at a third site but had not as yet been delivered. Additional sessions were also planned with elected members in two sites. The STILT and roadshow sessions were intended to raise awareness and achieve a shared understanding of TIP and its impact as well as the benefits of culture change to embed the principles of TIP.

STILT training was positively received although session vibrancy varied slightly depending on the range and mix of attendees. Catering for varying knowledge levels was challenging for leadership/manager awareness training provided by the

site teams (rather than NES). Some services, such as criminal justice, were already vary aware of, and working on, trauma whereas other services were less so. Where delivered, these sessions helped secure support for frontline staff training.

There were some challenges encountered in identifying the appropriate levels of leaders to attend STILT and this varied across sites. NES describes STILT as training for **senior leaders** within partnerships but in fact many who attended were senior operational managers. In the site focusing on a locality, rather than a whole HSPC area, local lead officers were initially not targeted for STILT yet had roles and responsibilities for population groups as large, complex and perhaps more socio and economically deprived as those 'more senior' leaders targeted within other sites. Delivery Trial Sites were however all intending to include the most senior partnership and political leaders (e.g. HSCP Board members and elected members) in second waves of leadership training.

Engaging partners

Participation as a Delivery Trial Site brought additional work to partnerships and services that were already experiencing substantial work pressures. One area reported that insecurity of staff contracts and staff turnover added to challenges of progressing the project. In another site staff illness and absence impacted substantially on overall progress. All areas established multi-agency implementation/steering groups to lead the work. This process was at an earlier stage and less stable in Site 2 due to staff sickness absence and/or as a result of the locality focus - given different agencies may have had non-aligned boundaries and roles.

Unsurprisingly, faster progress seemed to be made in areas with consistent project leaders, an established /stable multi-agency implementation group and where project managers were identified with dedicated time allocated to their role.

Engaging third sector partners

Contextual issues such as geography, quality of existing partnerships and prior involvement in TIP influenced the varied approaches to engagement of third sector partners.

In Sites 2 and 3 third sector agencies were involved in the implementation/steering groups. In Site 2 such third sector participation was from an agency with recent experience of the roll-out of a training programme for those working with the sensory impaired. In Site 3 a cohort of third sector partnership staff had participated in the train the trainer programme and were part of 'in house' training team for Level 2 input.

Site 1, a more rural area with training capacity issues took a unique approach which saw them 'commission' the tailoring of content and delivery of level 2 and 3 training from a consortium of national third sector agencies that were experienced providers of services for CYP with significant experience of trauma (e.g. residential child care providers). Table 3 highlights key aspects of, and learning from, this approach.

An unanticipated issue that arose in this process related to the need for consideration of and negotiated solutions to ownership and management of intellectual property with regard to training content, tools and approaches in joint developments between statutory services and national and local third sector agencies -who brought their own content, experience and expertise to the task, partnership and consortia.

Table 3: Trial Site 1 -Third Sector Training Consortium

Membership
The coalition was brought together through Care Coalition Providers Scotland (CCPS). It included the Scottish Throughcare and Aftercare Forum (STAF), Kibble, Barnardo's, and Aberlour. The consortium was led and overseen by STAF.

Remits
In partnership with Site 1's implementation team the consortium was to collate, adapt and tailor content for level 2 (skilled) and level 3 (enhanced) TIP training for CYP's Services and to provide trainers for the delivery of the agreed package. The training content was to be used going forward by Site 1 to ensure sustainability of training. The Delivery Trial Site implementation team were to coordinate the participant recruitment, timing and venues for training.

Training content and delivery
NES training content was blended with material from the consortium agencies' existing whole systems TIP change programmes that are delivered within their own organisations and in some instances to other partnerships. A substantial proportion of the content came from consortium members and this was blended with content from Site 1's implementation partners (NHS and Local Authority) that was specific to their local and service contexts, systems, needs and levels of demand. For example, content took account of the GIRFEC structures and processes locally and service user numbers and access routes for CYP's Services in rural and remote areas. The content had not, at the time of reporting, been fully signed off.

Training delivery was not progressed due to COVID and associated lockdowns. Delivery was to be face to face. The anticipated throughput was that each of the 4 localities would have 1 skilled (level 1) and 2 enhanced (level 2) courses with level one being delivered over 2 days and level 2 being delivered over 3 days. Attendance was anticipated as circa 20-25 at each course and with the likely need for an additional mop-up session. The key focus was to be on social workers, residential, education and health staff delivering CYP's Services. The training was intentionally developed as a workshop model where knowledge on TIP would be refreshed and reinforced but where there would be space to reflect on current and future practice and work in multi-disciplinary groups on how to challenge practice, system and cultural issues relating to TIP. The consortium was keen to ensure a focus beyond individual and team practice to issues of leadership, organisation and partner systems, structures and culture to effect change.

Challenges and learning
There appeared to be an initial lack of clarity over whether SG/NES guidance was encouraging third sector engagement in this site as a partner and co-deliverer relationship (where input might have been contracted via SG/NES) or, unfolded, a more traditional commissioner and contractor arrangement. The collaborative and administrative processes in setting up the coalition and delivery arrangements were more complex and time consuming than anticipated in part because of this confusion.

Consortium members contributed aspects of their agencies' existing training content and experience into the development of the adapted and tailored localised Site 1 materials. In addition, members spent time accessing free and publicly available content and material from other organisation and providers. Site 1, as the 'commissioners' requested ongoing access to and 'ownership/copyright' of these outputs and materials as part of the contractual arrangement. This contractual arrangement was seen as unusual by and raised challenges for consortium members

with regard to existing legal arrangements covering their specific content and indeed the Intellectual Property rights around the contract outputs. Challenges around IP for training content and materials and therefore the immediate and longer-term commercial value of the consortium's input were not fully resolved pre COVID-19. Key lesson to unfold from this process should inform future sensitivities and issues around contract specification, commercialisation of outputs and appropriate costing of such partnership contributions.

The balance of the consortium's role between content development for and delivery of training and any potential wider support and influence for structural and culture change as part of the agreement was discussed with the implementation team. The former, more transactional rather than collaborative, relationship was prioritised at least initially and in part due to short timeframes and resource restrictions.

Existing training content that was used to contribute to the specific and tailored outputs had previously included co-produced contributions and oversight from people with lived experience of trauma. Whilst the consortium was keen to have further co-production and involvement of people with lived experience, limited timescales and resources may have challenged or curtailed this in practice.

Evaluation materials for the training had been developed but the overall monitoring and evaluation of the training and other aspect of the contract were still to be finalised.

This type of consortium approach as a mechanism to fully involve third sector partners was unique to Site 1. Whilst it encountered several challenges, the resulting learning if taken on board may have much to offer in terms of collectively addressing TIP challenges and fully utilising the extensive knowledge and expertise of third sector partners. Informing such potential collaborative gains was a key intention of funding the Delivery Trials as part of the NTTP.

Organisations versus multi-agency partnerships

Despite TIP work having started prior to the establishment of the Delivery Trials it was evident in all sites that gaining leadership approval across partnership services, mobilising multi-agency participation and agreeing training content, schedules and roles and responsibilities still took substantial time and effort. This finding concurs with the wider literature which emphasises the long-term nature of the endeavor to influence and change trauma improved practice and culture within organisations[6,9]. The CCTIC framework[7] for example, developed to support such culture change in an organisation, suggests it requires between 2-5 years to achieve, embed and sustain such change.

Much of the literature on TIP is informed by research that focuses on driving practice and culture change through single (even if large-scale) health and or care organisations. All three NTTP Delivery Trial Sites were trying to progress TIP across partnerships rather than simply organisations. It is likely that driving such change across multiple organisations with varying purposes (e.g. health, care, education, leisure, etc.) is even more challenging and time consuming.

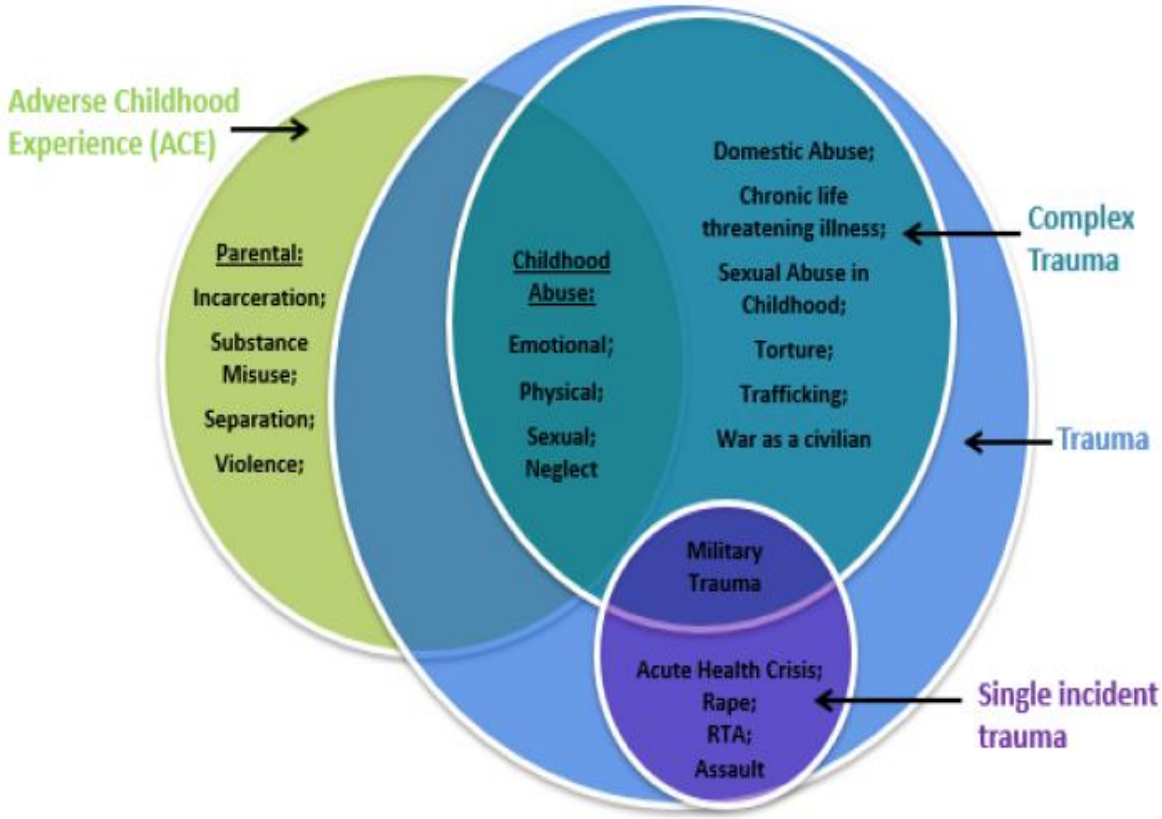
Culture Change

In each locality implementation built on previous trauma related work. All areas, for example, had previously completed work on Adverse Childhood Experiences

[9] Centre of Health Care Strategies

(ACES) as part of the SG's 2017/18 Programme for Government which committed to preventing ACES, helping to reduce the negative impacts of ACES where they occur and supporting the resilience of CYP, families and adults in overcoming adversity. Figure 2 illustrates the relationships between ACES and other aspects of trauma. Delivery Trial Sites used their experiences of ACES to inform their TIP plans and activities.

Figure 2: The intersections and overlap with the ACES agenda.

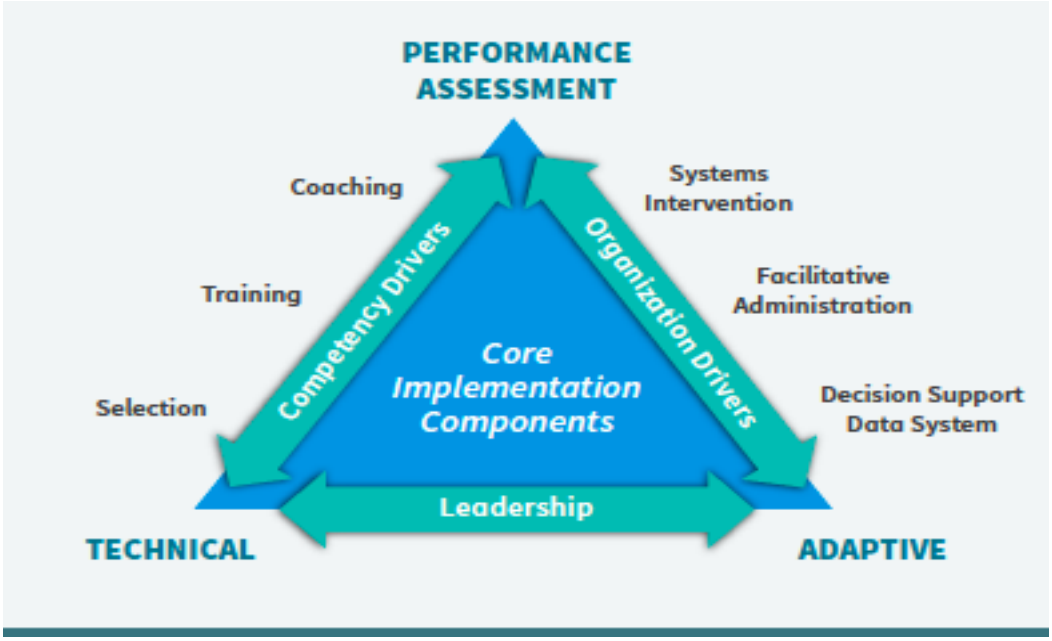


Esaki 2019[10] suggests that trauma informed leadership is key to achieving a trauma responsive culture. Leadership is also highlighted as a key driver within the KSF[2] as illustrated in Figure 3[11].

Figure 3: Implementation Science Drivers for Change

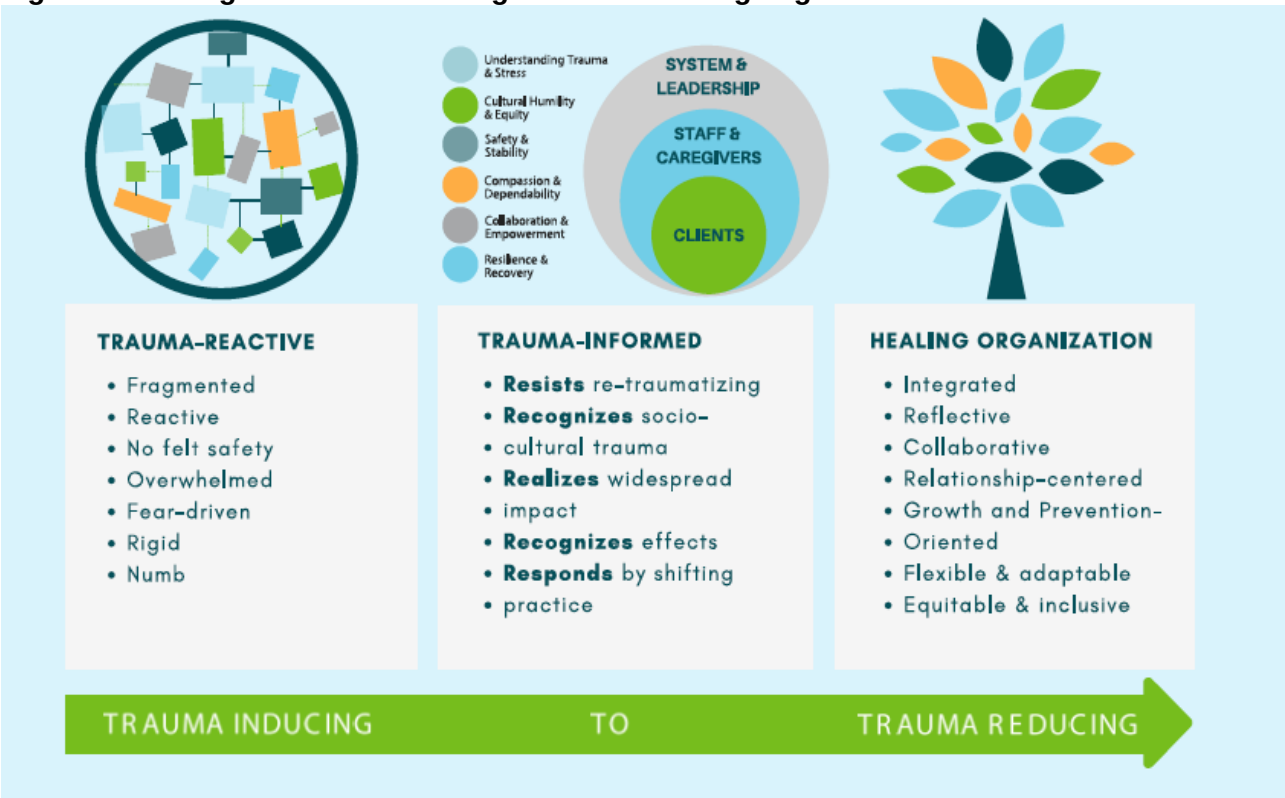
[10] Trauma-responsive Organisational Cultures: How safe and supported do employees feel?

[11] Taken from KSF - from slide used at Implementation Masterclass, Dublin Mat 2011 by Karen Blasé and Dean Fisher



Much of the ACES work completed previously in sites would likely have initiated changes in practice, staff support and culture within their partnerships and organisations. Figure 4 shows the many changes needed within organisations as they become increasingly trauma transformed.

Figure 4: Moving from a Trauma Organised to Healing Organisation [12]



[12] Trauma Transformed

Due to implementation delays only one Delivery Trial Site participated in the reflective feedback sessions (see Table 1). There were therefore as yet limited data to inform lessons with regards to influencing culture beyond the STILT/leadership training and co-production of carers training in Site 1 discussed above.

One site suggested that partnership services and agencies with more rigid rules that service users must abide by (e.g. housing, finance, police) sometimes struggled more with aspects of culture change associated with TIP. However, with time, these services were also 'coming on board' even within the short time frame of the trials.

Site 3 suggested that to secure agency participation TIP training needed to be sold as a win-win situation. Emphasising that staff will value and enjoy training and benefit from the training in terms of their own experiences and responses to trauma encourages leadership commitment. Further learning about progressing culture change may result from the process of delivering training and as services try to translate training into practice and service change.

German et al[8] like Esaki[9] highlights that culture change requires additional focus beyond training and must include staff health and wellbeing actions that ensure appropriate staff support, supervision and self-care as well as policy and practice alignment.

The Delivery Trial Sites (like the wider NTTP) acknowledged the need for these additional cultural elements related to staff supervision, care and wellbeing and involvement of people with lived experience within their plans. Progress towards these are discussed below.

Involvement of People with Lived Experience[13]

Exposure to adversity and trauma in Scotland and elsewhere is common and can substantially impact upon short and long-term life chances, wellbeing and quality of life[3,14.] Within some services there are often particularly high rates of people who have lived through trauma: 75% of women and men attending substance misuse services, for instance, report abuse and trauma in their lives[15]. Among people in prison, studies have found 94% of people report a history of trauma[16] and in inpatient mental health services 60% of women and 50% of men report being

[13] When using the term people with lived experience in this report we are we are referring to people who are explicitly identifying themselves as trauma experienced and who share their experience/expertise as a result of this.

[14] National Strategy to address Domestic Abuse in Scotland. Scottish Partnership on Domestic Abuse (2000)

[15] World Health Organisation (WHO) (2002) World Report on Violence and Health WHO Geneva

[16] Komarovskaya, I.R., Booker-Loper, A., Warren, A. & Jackson, S. (2011) Exploring gender differences in trauma exposure and emergence of symptoms of PTSD among incarcerated men and women Journal of Forensic Psychiatry and Psychology 22(3), 395-410

sexually or physically abused in childhood[17]. Research suggests that many people experience events described as traumatic – rapes, assaults, traffic accidents for example – at some point in their lives[18]. Given these prevalence figures many people working within public services will also have lived experience of trauma and may be able to use that to influence their own practice, services and organisations.

Whilst Trial Sites had set out in their applications that people with lived experience would be involved at a strategic level within implementation/steering groups the reality of achieving this seemed more challenging. Some participants highlighted that people with lived experience may prefer to be involved in other less strategic ways such as co-training, peer evaluation etc.

Site 1 had plans for involvement of people with lived experience in a specific and bounded area of their programme. They focused on co-production of bespoke training for foster/kinship carers and adoptive parents. Once complete this element of their programme should provide both a useful training product and learning on the co-production process for this important target group for the NTTP.

In Site 2 the HSCP Board was reported to have representation from people with lived experience but the trial site implementation group was not yet stable and it did not as yet have formalised involvement from people with lived experience.

In Site 3 involvement of people with lived experience at a strategic level was sought via a Local Authority wide Advocacy Group but was not yet secured. The project team recognised the need for involvement of people with lived experience who were engaged with more local services but they had not as yet investigated the extent to which those using their service Hub might wish to participate or the type of involvement that would be desired or appropriate for those who might volunteer/contribute.

Trauma Improved Practice and Service Change

Given that the Delivery Trial Sites were at an early stage and had not yet conducted their frontline training nothing can be said about changes in practice and services that may have resulted post training.

Two of the three sites reported that early activity had led to interest and demand for input and training from other services within their partnerships and/or an increased interest from, and opportunities to engage with, strategic leaders (e.g. CEOs and Elected members) to scale and spread TIP and training. Their early work had also raised awareness of the wider NTTP and associated tools as well as local activity.

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[17] Read, J., Goodman, L. & Morrison, A et al (2005) Childhood trauma, psychosis and schizophrenia: A literature review with theoretical and clinical implications *Acta Psychiatrica Scandinavica* 112, 330-350

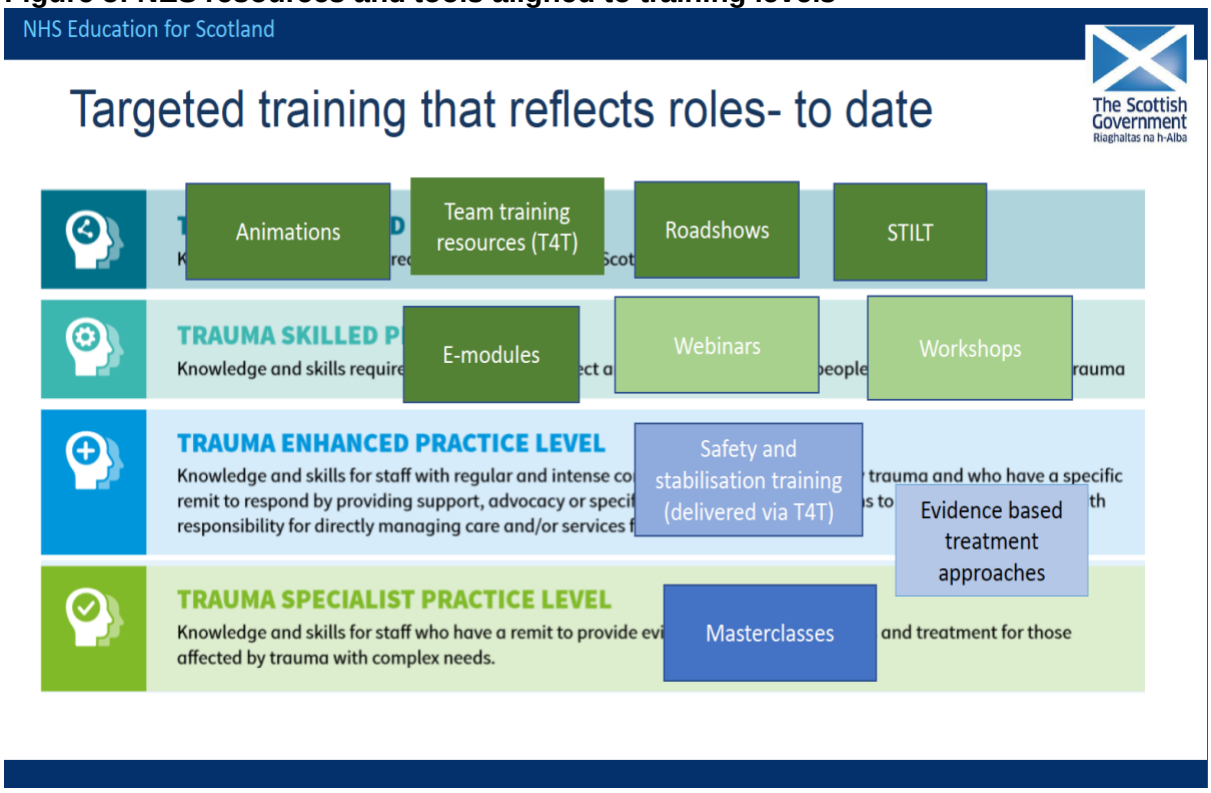
[18] Kirkpatrick et al (2013) National estimate of exposure to traumatic events and PTSD prevalence using DSM-IV and DSM-V criteria Journal of Traumatic Stress 26(5) 537-547

Staff Training, Support, Supervision and Self-care

Staff Training Content

The NTTP outlined potential content to be covered and tools available for different levels of training. Figure 5 shows the intended alignment of NES animations, existing training content and e-learning tools to the various levels of training.

Figure 5: NES resources and tools aligned to training levels



The resources provided by NES were generally well received. The NTTP and the KSF were used to inform training content and overall site training plans. The KSF booklets were reported as very useful for collaborating with third sector colleagues. The animations were also seen as informative and useful to integrate with training and have resulted in very positive feedback.

Whilst guidance on content and supportive tools from NES were seen as beneficial the fact that resources continued to be developed during the trial period required constant review of already agreed content in local areas. There was also some concern that the recent availability of the e-learning resources for level 2 might dissuade staff from attending face to face training and reduce collective learning and potential links for future collaboration as a result.

Staff Training, Targeting and Delivery Teams

The wider literature such as the CICI framework[19] highlights how the effectiveness of complex interventions, as well as their success in reaching targeted populations, is influenced by various interrelated aspects of context. They identify three dimensions in their framework, each with multiple elements - context (e.g. geography and socio-economic conditions), implementation (e.g. strategies and delivery agents) and physical settings (e.g. organisations and networks). Many of these elements such as size, geography, workforce stability and previous local experience influenced decisions about training focus and delivery with the Delivery Trial Sites.

Site 1, due to rural geography and associated challenges in terms of recruitment and capacity, choose to focus on a particular sector (CYP) as an initial priority. This site planned to deliver level 1 training 'in house' which necessitated agreeing the appropriate mix of e- learning resources and face to face contact and deciding how best to ensure group training opportunities and interaction across a rural area even when using e-learning resources. Site 1 also chose to outsource the delivery of level 2 and level 3 training due to limited training capacity (See Table 3). The content for these sessions was jointly developed and the training was to be delivered by a third sector consortium (containing national third sector providers of residential care for young people) as detailed above. Content was agreed but delivery had not taken place prior to the outbreak of Coronavirus (COVID-19).

Site 2, where services and populations were less geographically spread intended to use in-house trainers although they may have encountered capacity challenges given existing workloads. Challenges for this site included population size, levels of socio-economic deprivation and resultant high incidence of issues such as substance abuse and poor mental health. Given similar funding was available for each site, Site 2 was unable to take a whole HSPC approach and so focused on a single locality within the partnership.

Site 2 and 3 had similar reach target numbers for level 1 training, but the latter had lower targets for level 2. Site 2 could not saturate the whole HSCP and chose to prioritise training for staff in services with clients who experienced high levels of trauma within one locality. The implications of this was that almost the totality of their targeted group required level 1 *and also* level 2 training.

Site 3 was geographically smaller and less deprived, so the intent was to saturate services across the whole of the partnership. Training was to be provided face to face with e-learning resources being integrated and or used for later cohorts/top-ups. Delivery challenges were fewer in Site 3 due to size and to the presence of a cohort of existing trainers who had gone through the NTTP train the trainers programme. Several of these trainers were from CYP's Services -previously involved through ACES training - despite CYP not being a specific focus as part of

[19] Making sense of complexity in context and implementation: the Context and Implementation of Complex Interventions (CICI) framework

the trial for this site. Even within this smaller locality ensuring consistent contacts with some participating agencies was still challenging.

Due to the Coronavirus (COVID-19) pandemic and the postponement of level 1, 2 and 3 training delivery there is no evidence to confirm whether local recruitment strategies would have been fully integrated with their intended programme theory. For example, it cannot be known whether training uptake would have achieved the intended thresholds and fully addressed the gaps and needs identified. Initial invites were open for self-referral in at least one site - so training places may perhaps have been taken up by the most motivated or usual early adopters rather than necessarily those intended or most in need of training. Whilst this may have been an intentional strategy to seek early adopters this was not made explicit. Similarly, it remains unknown whether chosen recruitment strategies would lead to sufficient numbers of staff trained within specific sectors, services or teams to create a 'tipping point' in these key contexts that would accelerate practice changes.

Various aspect of context have undoubtedly influenced decisions about focus and delivery methods within the sites and will likely influence the success and impact of both training and other actions to enhance trauma informed cultures. Tools such as the CICI framework [19] and learning from reviews[20] conducted in Scotland concerning how factors that facilitate and hinder progress and effectiveness of similar QI interventions may be useful for NTTP roll-out given they highlight the many contextual issues that should be considered in both planning and evaluating complex intervention such as training and improvement programmes within HSCPs.

Staff Support, Supervision and Self-Care

The applications and plans for the Delivery Trial Sites included contributing to understanding the impact of trauma on staff, the risks of vicarious trauma and how to prevent and decrease its effects. As training (other than STILT) was not yet delivered in any of the sites changes to staff support and supervision and how these changes would further contribute to staff health were not yet well specified.

Plans across sites generally implied that staff support would follow existing supervision processes within services targeted at individuals more exposed to trauma (such as Social Work or Community Mental Health Services). Whilst the trial implementation teams acknowledged that more needed to be done to secure appropriate levels of supervision and prevention of vicarious trauma these areas were not prioritised in advance of training content and delivery. There had therefore been limited progress on these staff health and welfare issues or wider cultural change at the time of writing.

[20] The influence of contextual factors on healthcare quality improvement initiatives: a realist review

Needs Assessment and Monitoring and Evaluation

Needs Assessment

Varied approaches to assessing needs were used across the three sites and again these were influenced by the contextual factors discussed above [14,15]. Site 1 used learning from the roll-out of their ACES training and from inspection reports for care services and schools for their needs assessment. In addition, Site 1 conducted a bespoke staff survey informed by intended training outcomes agreed locally and prioritised from the national KSF[1].

Site 2 commissioned an external and wide-ranging needs assessment well in advance of their bid for inclusion as a Delivery Trial Site[21]. This needs assessment highlighted key barriers to TIP that included service designs and environments, buy-in from leaders and managers to culture change, in addition to staff capabilities.

Site 3 used learning from their recent co-location of services for those highly likely to have experienced trauma (e.g. substance misuse, mental health and domestic violence services). The Project Lead also conducted further mapping of needs within this Hub to further their understanding of level 2 and 3 training demand.

As sites have not yet delivered their frontline training it is difficult to know which of these approaches most accurately predicted gaps and needs. Learning from needs assessments along with contextual issues seemed, in the main, to be used to identify the sectors or services to prioritise for initial training delivery. It was less evident that recruitment for training at the level of the individual staff member was influenced by the output from needs assessment processes. For example, recruitment of individuals for level 1 training in at least one site was by open invitation rather than targeted at individuals with expressed need. However, this area was seeking saturation across partnership services. In terms of training at levels 2 and 3, further mapping of skills within more specialist services was still being undertaken in at least two sites.

Figure 6, taken from the NTTP[2] illustrates the complexity and multiple steps that should be undertaken to comprehensively prioritise the focus and level of training for services, professional roles, teams and individuals. Identifying needs and gaps in training at service, team and individual level is a time consuming and iterative task. In the complex context of service reconfiguration and health and social care integration in Scotland the task should be closely aligned with and embedded in existing workforce planning and recruitment. All sites acknowledged the need for this alignment.

[21] Trauma informed practice training needs assessment

Figure 6: How to deliver the NTTP

Monitoring and Evaluation

Each Delivery Trial Site had integrated aspects of monitoring and evaluation at the initial planning stages. In the main this involved intentions to monitor the reach/numbers of attendees completing training at all levels. All sites followed a Kirkpatrick Training Evaluation Model approach looking for changes at Kirkpatrick levels 1-3[22] of the four-level model. Kirkpatrick's model describes evaluating training outcomes at the following levels:

- *Level 1 - Reaction* (the degree to which participants found training favourable, engaging and relevant);
- *Level 2 - Learning* (the degree to which participants acquired the intended awareness, knowledge, skills, confidence
- *Level 3 - Behaviour* (the degree to which participants changed their own behaviour and practice)
- *Level 4- Results* (the degree to which participants influenced the wider service and organisations)

The sites intended to use the NES post-training evaluation questionnaires to assess these outcomes for the relevant levels of training. Site 1 agreed priority local learning outcomes that tied into the KSF and sector specific needs for CYP and were considering using a repeat of their initial needs assessment survey to gauge

[22] Kirkpatrick, D l. Evaluation. In R.L. Craig, & L.R. Bittel (Eds.) Training & Development Handbook. *American Society for Training and Development 1996*, New York: McGraw-Hill Book Co

changes in outcomes post training. Detailed monitoring and evaluation plans in Site 2 were still being developed.

Site 3 added further tailored follow-up questions to the level 1 and 2 NES training evaluation sheets for use immediately after and at 3 and 6 months post training. Site 3 was also investigating using coded responses to allow following up individual change pre and post training rather than only reporting changes in awareness, knowledge, confidence or practice at a group level. There were however concerns expressed over ensuring confidentiality as part of this process. This site also identified more nuanced potential evaluation questions about levels of exposure to training within services and across the whole partnerships to achieve a tipping point in practice and culture changes. Plans to address these were not furthered at the point that training delivery was paused.

There was discussion in all sites about the value of investing in monitoring and evaluating at level 1 training given this was 'light touch' and involved only short (circa 2 hour) input aimed mainly at awareness raising. The likelihood of achieving practice change via level 1 training alone was questionable given this limited exposure. As substantial time and effort was being expended on level 1 training some feedback on changes in awareness and knowledge would inform whether this investment was of value.

Greater changes in knowledge, confidence and subsequent practice were more likely to result from level 2 and 3 training. Plans for monitoring such changes were again based on developing existing NES evaluation sheets and tools. The Trial Delivery Sites faced similar challenges to other professional training focused programmes (including those promoting quality improvement in healthcare) where it is more difficult to gather evidence of impact at team, service, culture and system level[23,24]. Two sites were explicitly considering QI methods such as small test of change or case study approaches to address these issues within teams and services showing early evidence of practice or service adaptations.

A recent systematic review[25] of TIP interventions involving training showed positive changes in staff attitudes, knowledge and behavior post training but could not confirm if these outcomes would have been achieved by training alone (rather than the wider organisational aspect of the interventions reviewed). The review also identified the need to:

- identify minimum durations for effective training courses
- provide more detail on content and implementation processes
- understand the extent to which tailoring of training for specific sectors or organisations is needed to ensure achievements of outcomes

[23]Mery G, Dobrow MJ, Baker GR*, et al* Evaluating investment in quality improvement capacity building: a systematic review.*BMJ Open* 2017;7: e012431.
[24] Tamkin, P, Yarnall, J & Kerrin, M, Kirkpatrick and beyond-a review of training evaluation

[25] Systematic review of evaluations of trauma informed organisational interventions that include staff training

- further test and validate existing outcome measures and scales and seek consistency of measures across interventions
- measure outcomes at least 1 month post training and report on survey completion rates (and characteristics of non-completers)
- understand what level of change in outcomes is important to lead on to further impact in people with lived experience and what mechanisms lead to such improvements
- conduct more sophisticated analysis of training outcomes (e.g. aggregate means, multivariate analysis and report rates in service use/uptake rather than counts)
- use more robust and sophisticated evaluation designs with (randomisation or) matched control/comparative designs.

Sites had limited resources and timeframes to embed sophisticated evaluation processes into local implementation. Many of the issues raised in the above systematic review should be consider by NES and the SG if commissioning a wider outcome evaluation of the NTTP programme as a whole.

Conclusions

By March 2020 the three NES/SG funded Delivery Trial Sites had made progress in many areas including:

- establishing multi-partner steering/ implementation groups
- conducting needs assessments and workforce mapping
- designing training content
- progressing leadership training - STILT and roadshows (high volume awareness raising events)
- identifying inhouse and/or commissioning trainers to deliver at level 1, 2 and 3
- progressing monitoring and evaluation plans.

The main variations in approaches between sites were in relation to whether they targeted all agencies within their HSCP/Local Authority or focused on specific target groups or geographical localities. Other variations existed in terms of their approaches to project management and involvement of people with lived experience and third sector partners. These variations and outputs such as the carers' training module may lead to useful learning once delivery is complete and outcomes measured.

Training for senior leaders and managers was delivered in 2 out of 3 sites. Unfortunately due to the Coronavirus pandemic training of frontline staff was

organised and advertised but unable to proceed. Given this, the process evaluation was unable to report on the reach and early outcomes from frontline training.

The support via the NTTP from NES was viewed positively and STILT training and e-learning resources and tools were valued. More specific guidance from NES/SG on ways in which third sector agencies and people with lived experience could/should be engaged in co-production and delivery were suggested improvements. An additional suggested improvement was further consideration on the timing of the release of new content and tools when local agreements on these had already been made. A final issue was ensuring that e-learning did not reduce attendance at face to face training where this was available.

The learning and feedback gathered from the process evaluation is limited as it focused only on early planning for the role out of training – only one aspect of the plans. Lessons from the wider literature suggest there are a number of necessary conditions which when aligned with training will create a sufficient package of interventions to achieve TIP. A recent realist informed systematic review of trauma informed care in youth inpatient psychiatric treatment settings [26] highlights this by concluding that:

> *"Five factors were instrumental in implementing trauma informed care across a spectrum of initiatives: senior leadership commitment, sufficient staff support, amplifying the voices of patients and families [*people with lived experience*], aligning policy and programming with trauma informed principles, and using data to help motivate change"*

Further lessons from the process review and literature that may be important for future roll out of the NTTP are that:

- developing a Trauma informed *organisation* needs long-term action. The timeframe needed when working across *partnerships* such as integrated HSCPs which contain many agencies and organisations may therefore take even longer than for single organisations
- no one size fits all solutions exist and the varied partnership contexts will need tailored approaches. Recent literature [13,14] and learning from the process evaluation indicate that many contextual factors will impact on implementation such as geography, socio-economic, political, organisational, local networks etc.[13,14]
- numerous mechanisms (e.g. trusting relationships, open communication, effective staff supervision and support, empowerment of and coproduction with staff and people with lived experience, choice and collaboration) are all likely necessary for practice and service changes to occur and for subsequent impact to be achieved[8,9]

[26] What are effective strategies for implementing trauma informed care in youth patient psychiatric and residential treatment settings?

- monitoring and evaluation should be integrated at the planning stage and needs to be pragmatic and proportionate to the scale of programmes and resources. There are many existing audit tools and measurement scales used in TIP worldwide[6,7,8,18]. These can be used to enhance future planning and evaluation within the local and national roll out of the NTTP. Where resources allow, further validation of these tools and measure is needed to inform more consistent use across interventions and allow more robust analysis. This in turn will help inform issues such as optimum length of training course, and necessary packages of intervention to maximise positive impacts on individuals, partnership and people with lived experience.

Appendix 1:

Process Evaluation Aims and Objectives

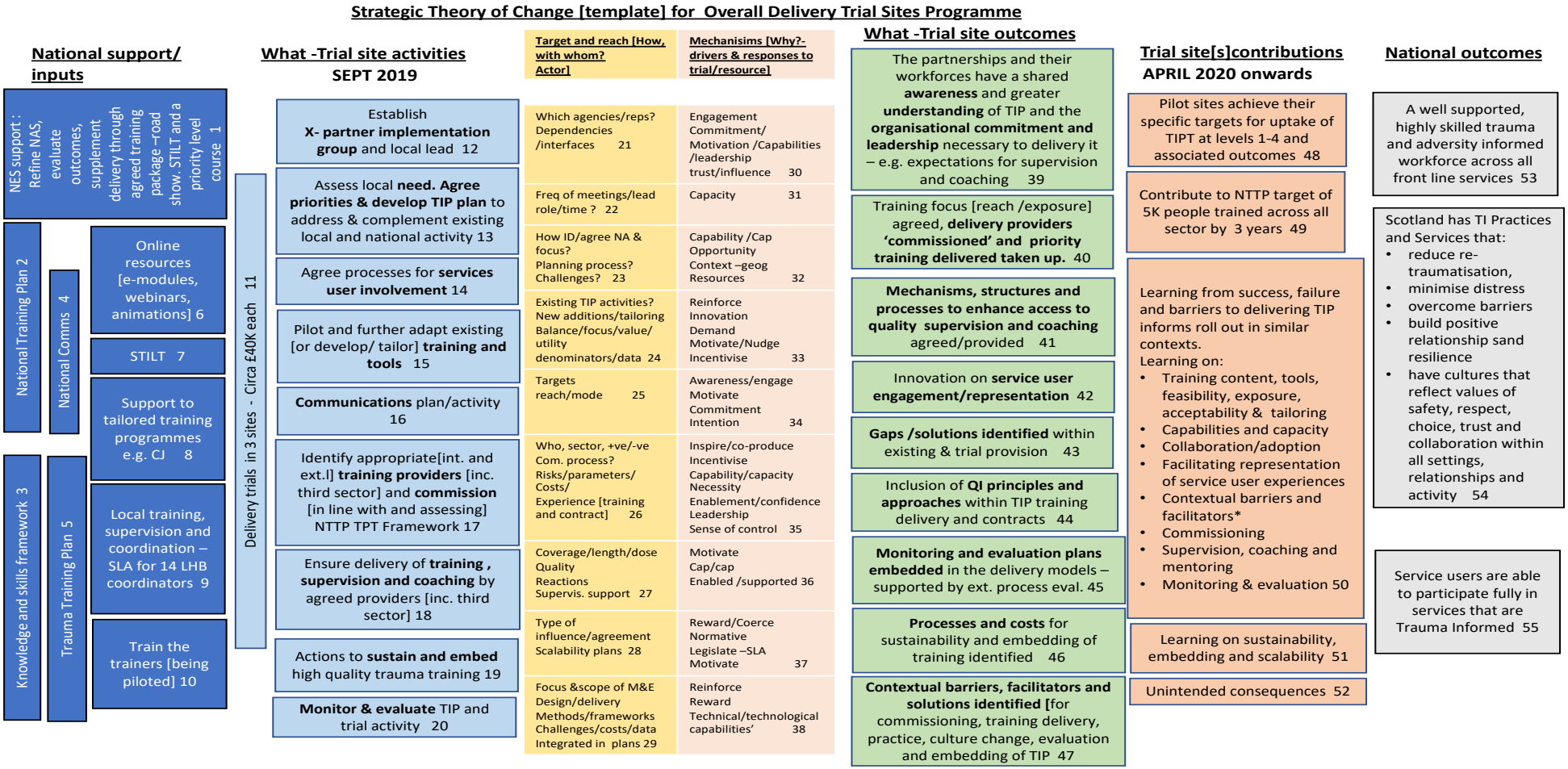
The aims of the process evaluation were to:

- provide learning to inform the future roll out of the NTTP including effective and practical approaches to working with local partners in delivering and embedding training
- provide an exploration of the key elements within the local contexts of the three delivery trials which were shown to influence success in improving trauma awareness

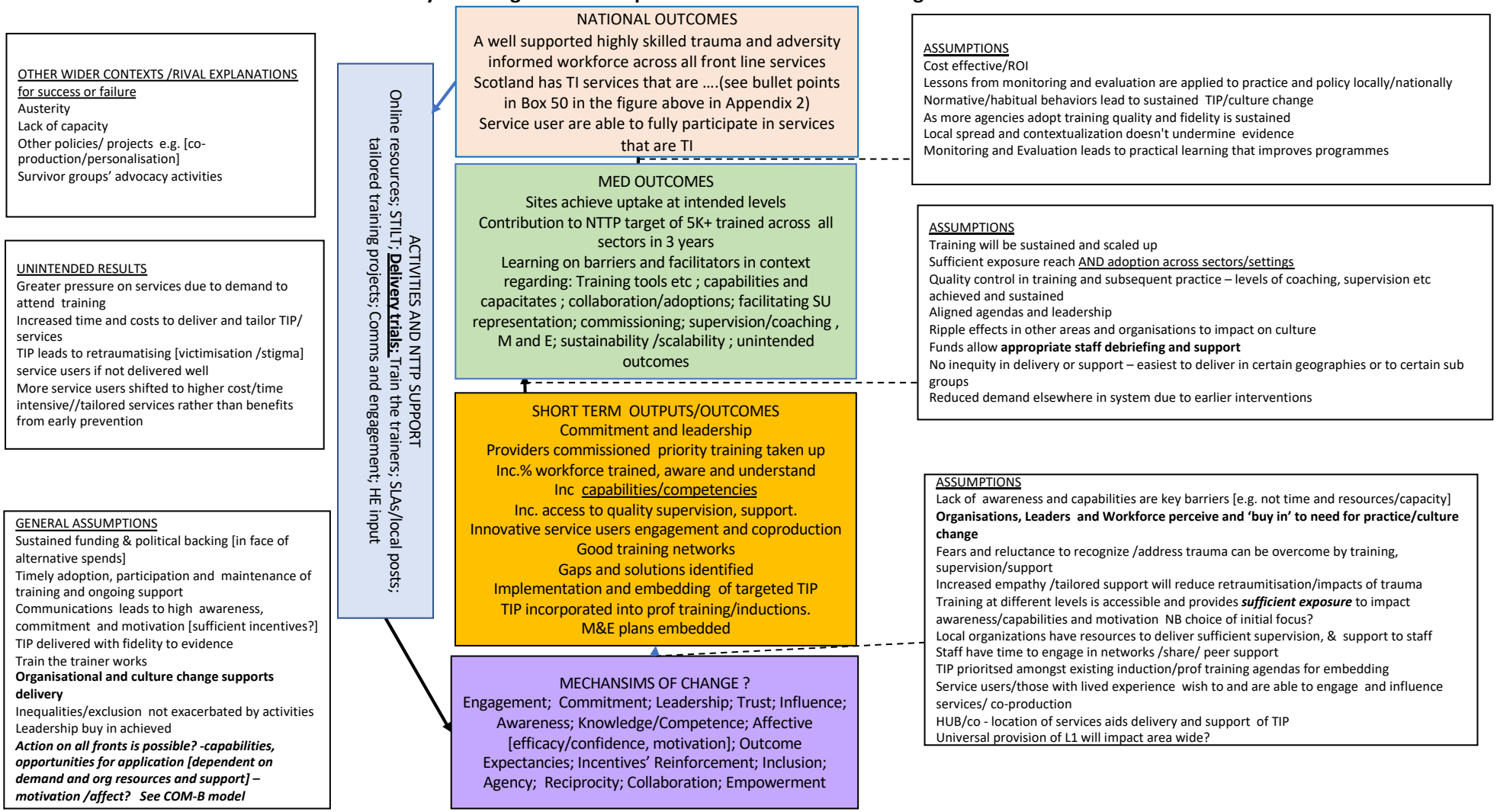
The specific process evaluation objectives were to:

- explore what worked well/less well in each site in terms of delivering on agreed trial delivery plan objectives
- explore contextual issues in each site (e.g. leadership, local structures, sectors/agencies and partnerships and their approaches, culture, existing training resources and stakeholder engagement) and their role in facilitating successful implementation
- explore the extent to which stakeholders had shared understandings of trauma informed services
- explore unintended outcomes (positive and negative)
- understand what went well /less well in terms of governance and support from NES and the SG
- explore the extent to which long-term outcome and impact evaluation plans have been integrated with planning
- support formative learning and programme improvement as part of the process evaluation.

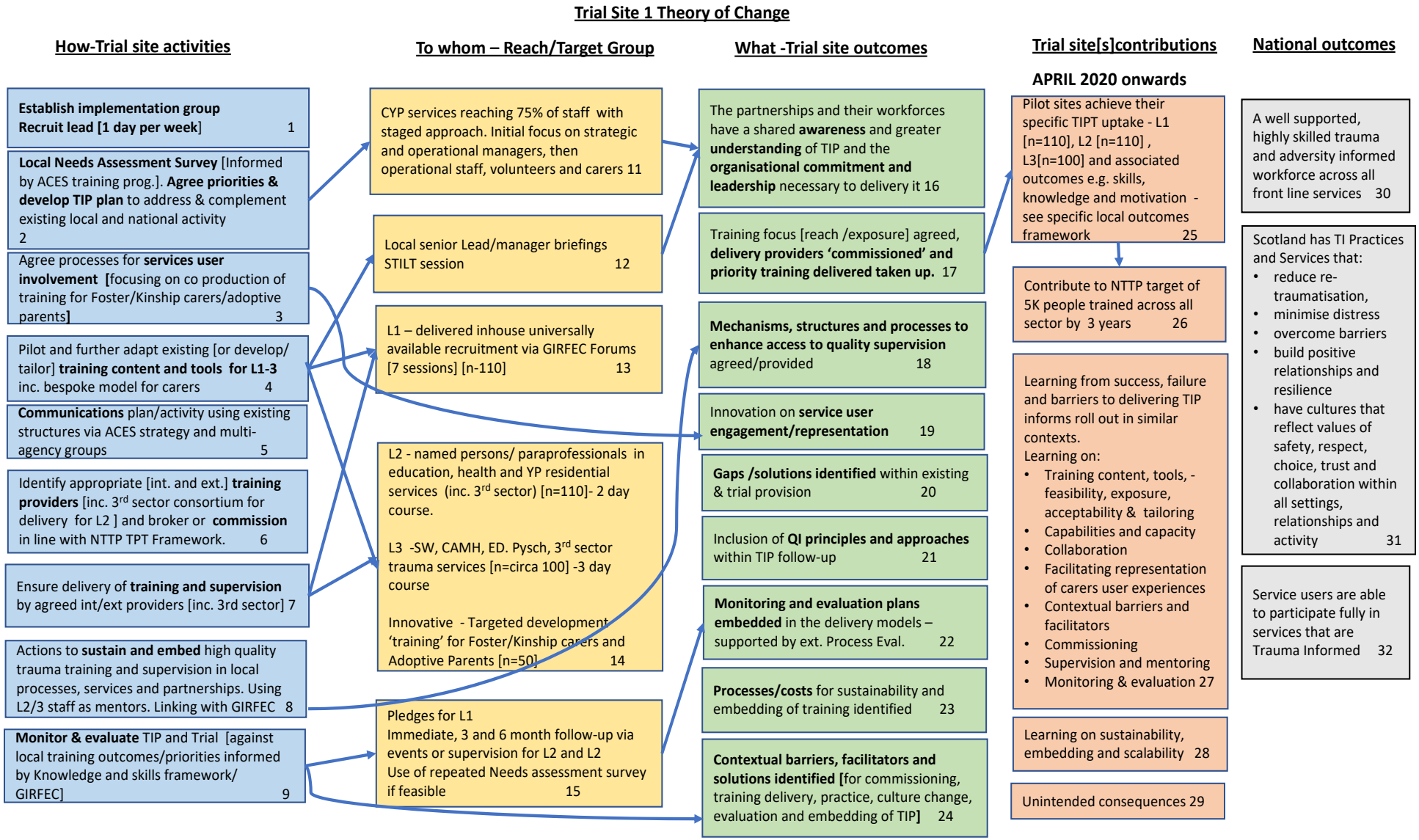
Appendix 2: Strategic ToC for the Delivery Trial Site programme



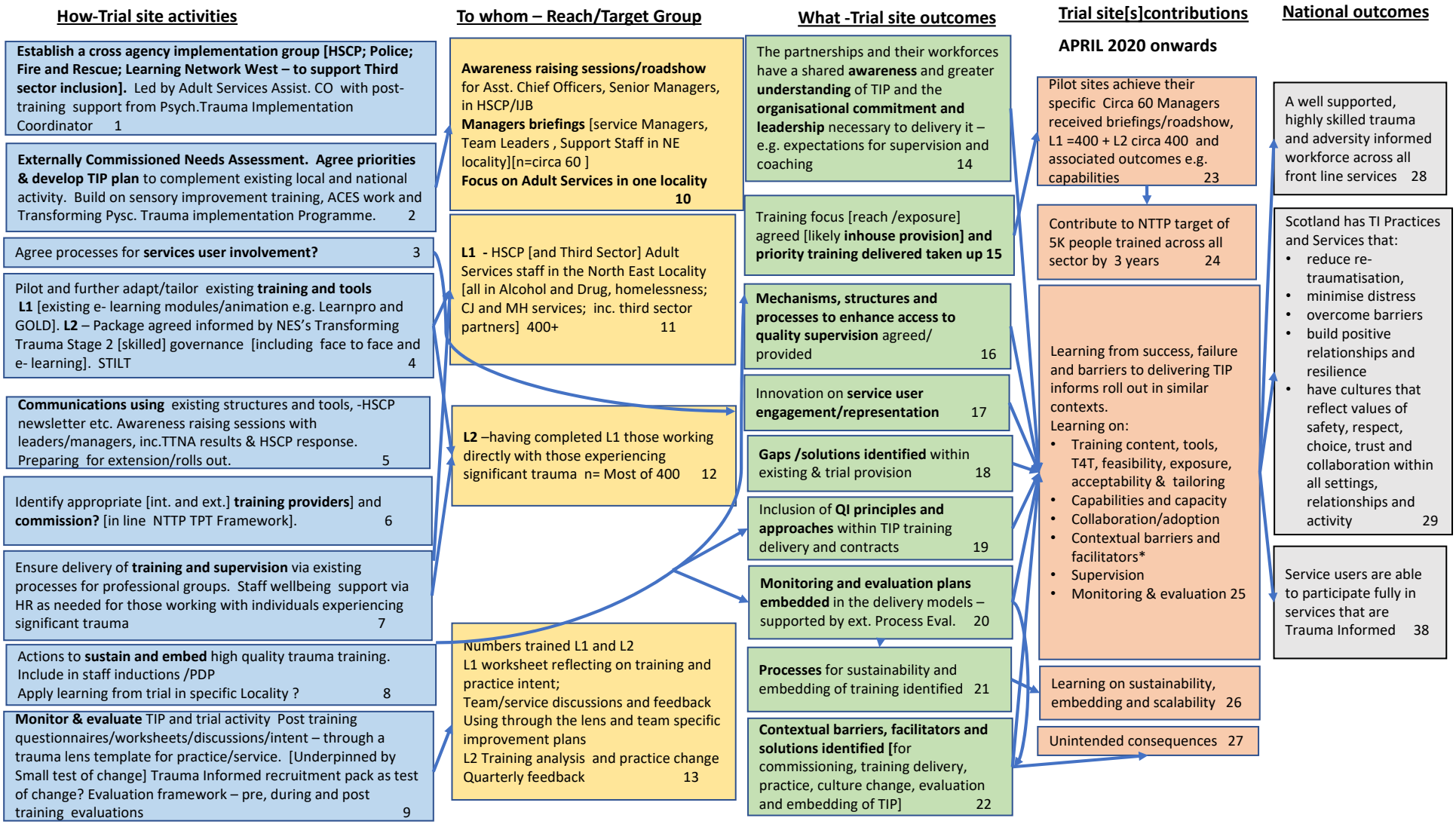
Theory of Change and assumptions for Overall Trial Site Programme



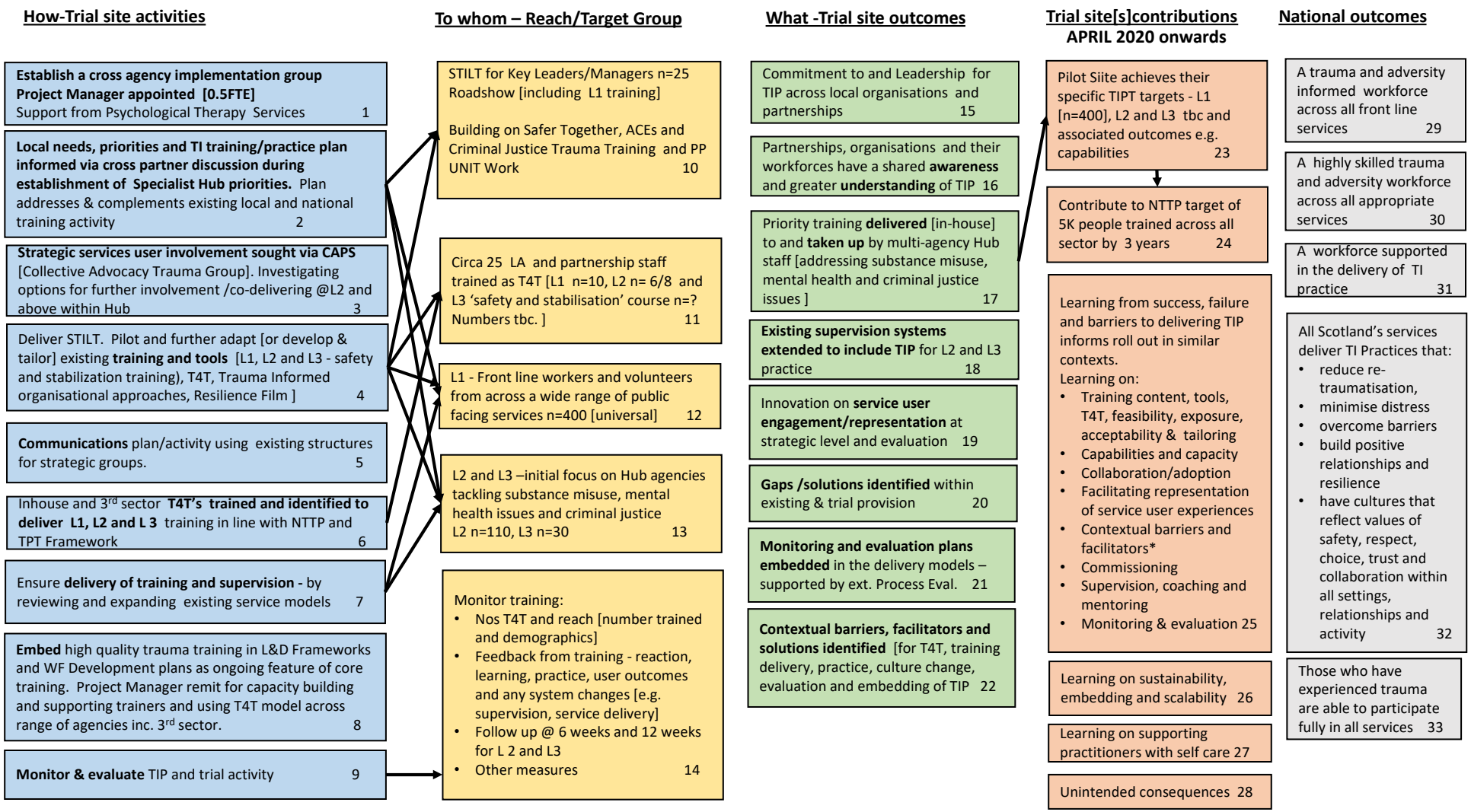
Appendix 3: Local Delivery Trial Site ToCs



Trial Site 2 Theory of Change

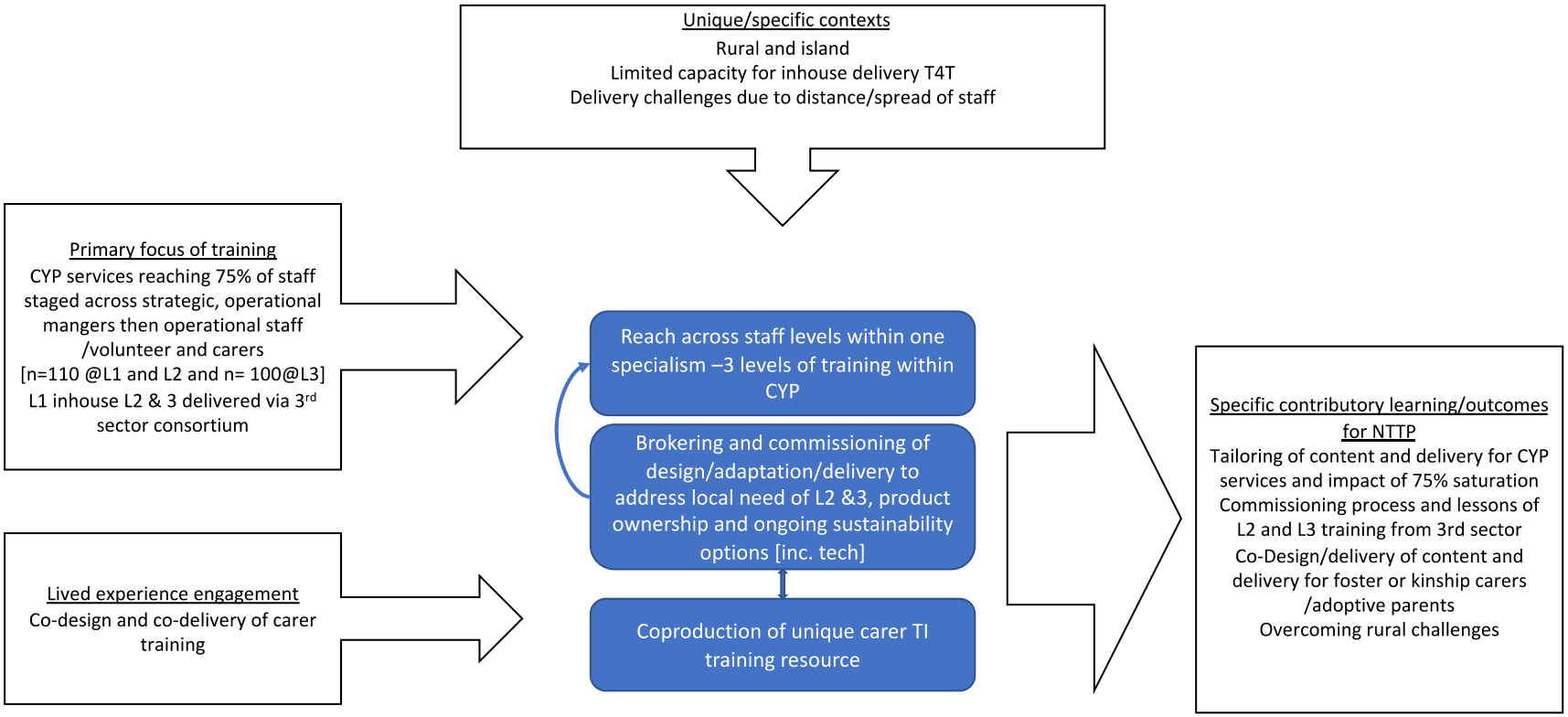


Trial Site 3 Theory of Change

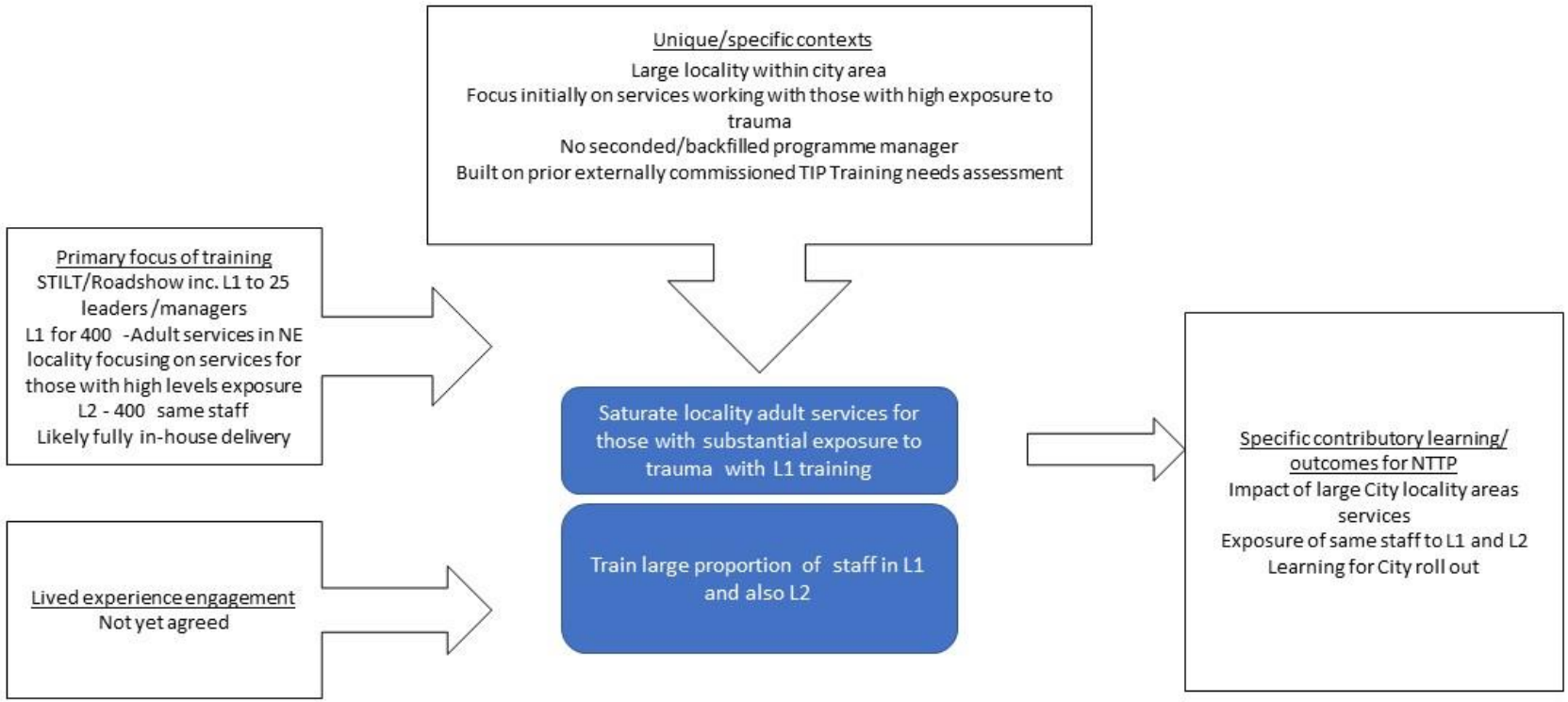


Appendix 4: Key contextual and intervention differences sites

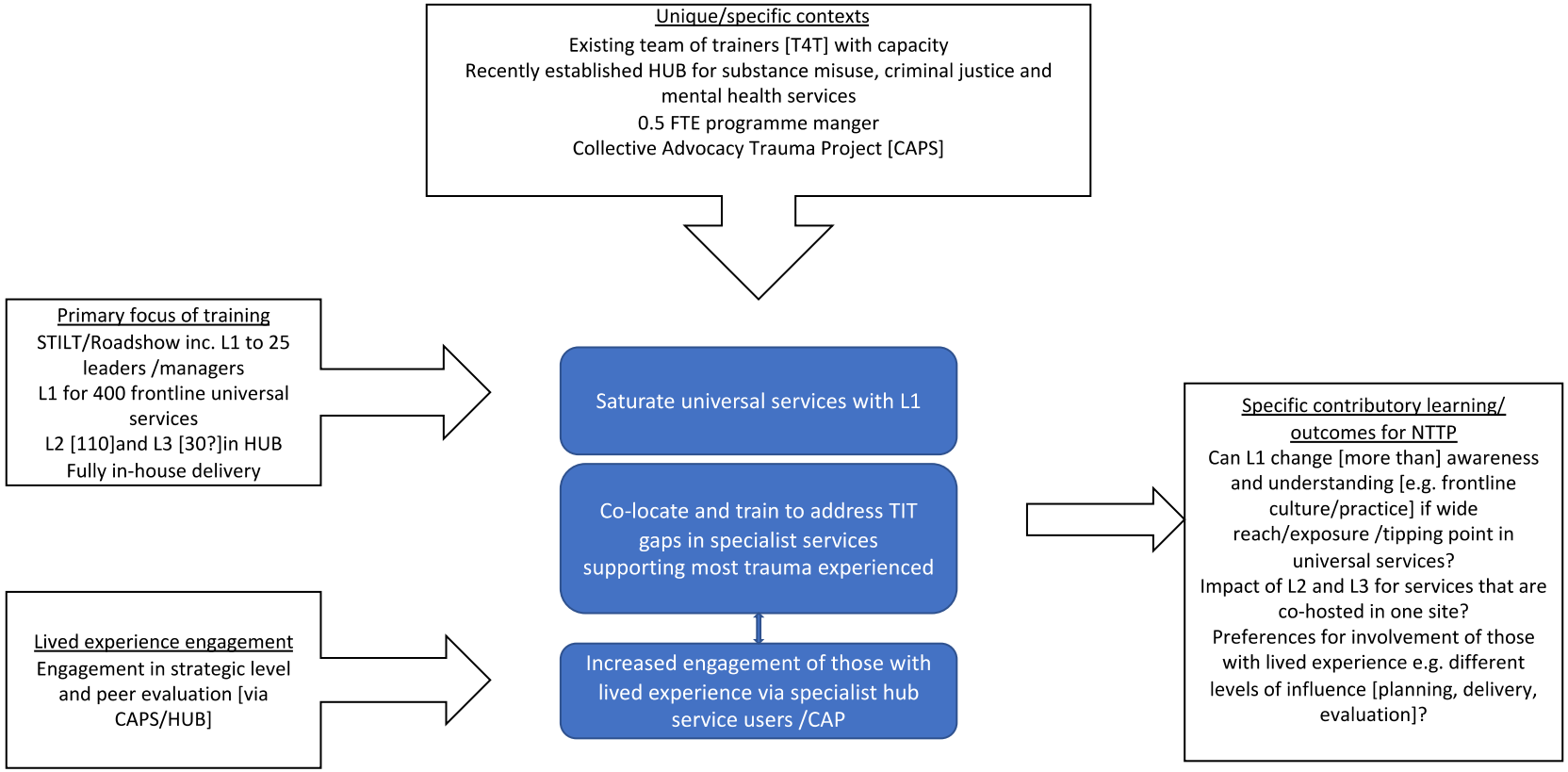
Unique aspects of Site 1



Unique aspects of Site 2



Unique aspects of Site 3



Appendix 5: Differences in specific activities across sites.

ToC Box	Activity	Site 1	Site 2	Site 3
1	Establish implementation group	Participation from: ACES group; Education; Social Work; CAMHS; and Educational Psychology. Oversight by ACES strategic group. Led by the Locality Manager for CYP's services with a local coordinator released from existing duties circa 1 day per week to assist.	Involvement (sought) from: HSCP; Police; Fire and Rescue; Learning Network West; Mental Health Services; Criminal Justice; Adult Services; and Third Sector. Led by Assistant Chief Officer for Adult Services and support provided post training from Applied Psychological Trauma Implementation Coordinator. No specifically appointed/freed-up project officer.	Membership of cross agency group included: Mental Health Services; Substance Misuse; Criminal Justice; CYP's and Adult Services; and sought involvement from Advocacy Trauma Group. Initial bid led by Integration Manager. 0.5 FTE project coordinator then subsequently appointed. Support also provided via Psychological Therapy Services
2	Needs assessment	Needs assessment built on: learning from significant work undertaken for ACES training in 2019; inspection reports; self-evaluations; input from Lead Officers in various CYP services; and counselling work within 'Building Mentally Healthy Schools'. A bespoke survey was also developed to gauge staff skills/confidence.	Comprehensive trauma needs assessment commissioned and published in 2018 for whole of NHS Board area (rather than specific Locality) prior to trial site bid. Focusing on specific Locality due to staff numbers /size of NHS Board. Plans complement existing activity and builds on recent experience of roll-out of sensory impairment training.	No 'formal' needs assessment carried out however approach informed by recent mapping work for co-location of key services within a specialist hub. Trial approach is based on bringing additional value to existing training/workforce development activity across whole of partnership services in Local Authority.
3	Involvement of service users/ people with lived experience.)	Involvement of people with lived experience focused on co-production of bespoke training for foster/kinship carers and adoptive parents. Co-production of content and approach to bespoke training due to start in March 2020	No agreed process was yet established for formal involvement of people with lived experience. Keen when feasible to reflect on appropriate role and capacities of volunteers. People with lived experience. had representation in HSCP strategically but not on Trial Site	Involvement of TWLE was sought via but not yet secured. Investigating options for involvement of those with lived experience /co-delivering or co-evaluating at level 2 training and above within specialist Hub and associated service users.

			implementation group. Third sector engagement was through Third Sector Learning Network -who were involved in the roll-out of training for the sensory impaired.	
4	Agreeing/adapting training content	Existing NES and local content at levels 1, 2 and 3 will be further developed /tailored. Levels 2 and 3 will be tailored with and for delivery by 3rd sector. Existing e-modules/online training tools will be used to supplement face to face [or web meetings] for those with rurality /islands access challenges. These individuals will ideally still receive group delivery /experience even where web based.	Trial Lead attended STILT. Wider STILT not initially undertaken due to large numbers of top senior leaders in Site 2 and capacity for NES. Session subsequently agreed but not yet delivered due to COVID -19 pandemic. In place of STILT there are awareness raising roadshows for HSCP CEOs/managers [starting late March 2020] and awareness sessions for locality area [Heads of Service and Team Leads [starting April 2020. Level 1 [existing e- learning modules/ animation e.g. Learnpro and GOLD]. Level 2 – Package informed by NES's Transforming Trauma Stage 2 [likely including face to face and e- learning].	STILT is being delivered via NES and Site partnership staff to ensure Senior Leader/Manager buy-in to staff training and support. NES roadshow(s) delivered. Existing e-modules/media training tools will be used where appropriate [level 1, T4T, STILT, TI organizational approaches, Resilience Film]. Existing module content from local NHS Board used for level 2. Level 3 based on strength and stability training. Pilot and further adapt [or develop/ tailor] above content where necessary.
5	Communication plans	Through existing approaches and methods. Recruitment through GIRFEC forums given focus on CYP. Specific web site for TIP being launched in addition to usual communication channels	Use of existing communication channels through strategic groups and agencies. HSCP newsletter, Needs Assessment results shared with Senior Managers and also HSCP response to external report.	Use existing communication channels through strategic groups and agencies. Possibly develop own twitter account
6	Identify/commission training providers	Level 1 to be delivered in house but third sector consortium 'commissioned' to tailor and deliver content for level 2 and level 3. Training for Trainers (T4T) not viable due to low staff	Plans to deliver training in house e.g. via Health Improvement Training Network. Content in line with NTTP & KSF. Not intending using T4T as proved challenging previously to ensure delivery capacity within existing roles.	All delivery in house with partnership from a cohort of trainers who had gone through T4T process. Cohort identified to deliver level 1, 2 and 3 training in line with NTTP and TPT Framework. T4T cohort included

		numbers/capacity, rural geography and staff turnover.		some Third Sector staff within partnership
7	Deliver training and supervision	STILT and roadshows delivered to senior staff/leaders with support from NES (see Table 2 on reach above). Levels 2 and 3 delivered via third sector consortium. Supervision provided using existing systems.	Delivery of agreed training supervision based on existing processes in organisations. Wellbeing support available via Human Resources if needed. No further detail on changes to supervision.	STILT and roadshows delivered to senior staff/leaders. Training slots advertised for level 1 and 163 of planned 400 booked. Oversight of delivery of agreed training via Programme Manager. TIP Supervision is specified and integrated into existing supervision processes in SW/Education services. Supervision not necessarily delivered 1:1. Coaching unlikely to be relevant outside some education services. Whilst supervision for TIP focuses on levels 2 and 3 reflective practice approaches should be encouraged through all services.
8	Embed and sustain training	Embed TIP in strategic planning and workforce development programmes (WFD) across agencies. Use extensively experienced levels 2 and 3 trained staff (e.g. from ACES work) to be future mentors. Link and embed with GIRFEC leadership, improvement journey and self-evaluation agenda programme locally	Embed high quality trauma training in L&D Frameworks and WFD plans and via on-line platform if appropriate as an ongoing feature of core training. Use learning from roll-out and embedding of sensory impairment training as a model.	Embed high quality trauma training in L&D Frameworks and WFD plans as ongoing feature of core training. Align training with other training packages such as; Safer together, safety inequalities and GIRFEC. Offer level 1 to wider range of staff later in process through local WFD platform. Project Manager has remit for capacity building and supporting trainers and using T4T model across range of agencies including Third Sector
9	Monitor and evaluate	Key staff local outcomes adapted form National KSF. May redistribute staff survey used as	Post training worksheets/discussions/identifying future intent – using 'through a trauma	Numbers of T4T and reach [number trained and demographics]. Feedback from training - reaction,

		part of needs assessment. No recall/follow up at L1 but using Opening Doors questions. Post training evaluations for levels 2 and 3 immediately and follow up at 3 and 6 months (possibly via rerun survey and/or reflection sessions) to capture individual change based on local outcomes framework. Smalls tests of change and practice to be used. inquiry/reflection in key services	lens' template for practice/service. Trauma informed recruitment pack may be used as a as test of change. Evaluation framework to include – pre, during and post training evaluations.	learning, practice, user outcomes and any system changes [e.g. supervision, service delivery] Follow up at 6 weeks and 12 weeks for levels 2 and 3. Considering follow up at level 1. Possible longer-term methods to include: client stories and potential involvement of peer volunteers/those with lived experience in monitoring and evaluation. Mental Health QI coach may be used as an advisor with regard to use approaches that strengthen infrastructure /systems

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