Evaluation of the ‘**Me** first’ training on children & young people centred conversations about Child Sexual Exploitation (CSE) & safeguarding concerns

Report to NHS England

Carin Eisenstein

Alison Ford

Child Outcomes Research Consortium (CORC)

corc@annafreud.org

December 2017

Contents

1 Executive Summary ... 3
2 Introduction ... 4
2.1 About the Me first CSE & safeguarding concerns training ... 4
2.2 Me first Safeguarding Communication Framework ... 4
3 Evaluation Design ... 5
3.1 Evaluation Overview ... 5
3.2 Methodology ... 5
3.2.1 Measures captured pre- and post-training ... 5
3.2.2 Measures captured post-training only ... 6
3.3 Analytical Approach ... 6
4 Sample ... 7
5 Results ... 7
5.1 Knowledge ... 7
5.2 Confidence ... 8
5.2.1 Setting the scene ... 8
5.2.2 Exploring ... 9
5.2.3 Listening ... 9
5.2.4 Responding ... 11
5.3 Self-Report Change in Confidence ... 12
5.4 Feedback – Quantitative Items ... 12
5.5 Feedback – Qualitative Items ... 13
5.5.1 What was done especially well during the training? ... 13
5.5.2 What could have been done better to improve the training? ... 14
6 Discussion ... 15
7 Conclusion ... 16
8 References ... 17
Appendix A: Me first Safeguarding Communication Framework ... 18
Appendix B: Measures ... 19
Appendix C: Knowledge and Confidence Subscales ... 20
Appendix D: Training Sites ... 21
Appendix E: Demographic Tables ... 22
Appendix F: Item-level Breakdowns ... 24
Appendix G: Feedback on Multiple Choice Questions ... 27
Appendix H: Open-Ended Feedback ... 31

1 EXECUTIVE SUMMARY

The '**Me** first' training on children and young people centred conversations about Child Sexual Exploitation (CSE) and safeguarding concerns ('the training') is funded by NHS England. The training aims to improve health and social care professionals' knowledge of the signs and risk factors for CSE and other safeguarding concerns, and their confidence communicating with children, young people and colleagues around these concerns.

The half-day training was delivered to 15 sites across England between June and October 2017, reaching over 240 health and social care professionals who work with children and young people in a range of settings and professional capacities. Common Room commissioned the Child Outcomes Research Consortium (CORC) to conduct an evaluation of the training, which is presented in the following report.

The evaluation assessed the impact of the training on two key outcomes agreed with the training developers:

1) *improved knowledge and identification of signs and risk factors for CSE and other safeguarding concerns*
2) *improved confidence communicating with children, young people and colleagues around concerns about a child or young person's wellbeing, safety and relationships*.

Further feedback from trainees was also collected to understand the training's relevance, accessibility, presentation quality, expected impact, and perceived strengths and areas for improvement.

Results from the evaluation indicate the training had a positive impact on trainees, with the following key findings:

- Prior to training, a high proportion of trainees reported feeling knowledgeable about signs and risk factors for CSE and abuse, and confident engaging and communicating with children and young people around concerns about their wellbeing, safety and relationships.
- There was a statistically significant ($p<0.01$) shift towards a higher level of knowledge and improved confidence across all subscales.
- 87% of trainees 'agreed' or 'strongly agreed' that the training improved their confidence to open up space for a difficult conversation with a young person about any concerns.
- 62% of trainees felt the training was 'entirely relevant' to their work, and 26% felt it was 'mostly relevant'.
- 58% expected the training to make a 'significant difference' to the way they do their job, and 39% expected it to make a 'moderate difference'.
- 98% trainees felt trainers were competent and knowledgeable.
- 78% would 'completely recommend' the training to colleagues and 20% would recommend it 'for the most part'.

Very positive feedback from trainees on the format and content of the training, the quality of its presentation and facilitation, and the usefulness of the **Me** first safeguarding communication framework and other tools and resources further supports these findings.

Based on staff feedback, elements to consider when delivering future trainings include using additional case scenarios, incorporating more of the young person perspective, and providing more pre-training communication around logistics and what to expect on the training day.

2 INTRODUCTION

2.1 ABOUT THE ME FIRST CSE & SAFEGUARDING CONCERNS TRAINING

'Me first' is an education and training resource funded by Health Education England (HEE) and developed by Great Ormond Street Hospital and Common Room Consulting. It aims to improve health outcomes for children and young people by enhancing healthcare professionals' knowledge, skills and confidence communicating with children and young people.

The '**Me** first' training on children and young people centred conversations about Child Sexual Exploitation (CSE) and safeguarding concerns was funded by NHS England. The training was created within the **Me** first programme to address a lack of confidence among frontline professionals around how to engage children and young people when they are concerned about their wellbeing, safety and relationships, which means many cases of CSE or other safeguarding concerns go missed.[1] [2] The training was delivered by Kate Martin, Duncan Law and Amy Feltham.

The training targets healthcare professionals who work with children and young people in a range of settings (e.g. A&E departments and paediatric wards, community health, general practice, mental health services, sexual health services) and professional capacities (e.g. nurses, medics, healthcare assistants, social care workers, etc.). The objective of the training is to enhance health and social care professionals' awareness of the signs and risk factors for CSE and other safeguarding concerns, and to build their confidence communicating with children, young people and colleagues around these concerns.

The half-day (4 hour) sessions:

- Explore the common situations professionals experience with young people where they have concerns,
- Explore what professionals see or notice that gives them a hunch something is not right,
- Explore professionals' worries/concerns about opening up conversations,
- Introduce a communication framework for difficult conversations, and
- Support professionals to develop the skills and confidence to put the framework into practice.

2.2 ME FIRST SAFEGUARDING COMMUNICATION FRAMEWORK

The **Me** first safeguarding communication framework is a set of steps professionals can take when they have concerns about a child or young person's wellbeing, safety or relationships. These steps include:

---

[1] Berelowitz, S., Clifton, J., Firimin MBE, C., Gulyurtlu, S. & Edwards, G. (2013). "If only someone had listened," Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups – Final Report.

[2] Child Exploitation and Online Protection Centre (CEOP) (2011). "Out of Mind, Out of Sight: Breaking down the barriers to understanding child sexual exploitation". London: CEOP.

- Setting the scene, preparing and reflecting before opening a conversation,
- Exploring and being curious about a child or young person's wellbeing, safety and relationships,
- Letting the child or young person know about any concerns and encouraging them to feel able to talk,
- Listening and validating children and young people's feelings,
- Developing and putting into place a shared plan,
- Looking after oneself as a professional, and
- Reaching out to appropriate colleagues and professionals (See Appendix A for the framework in more detail).

3 Evaluation Design

3.1 Evaluation Overview

Common Room commissioned the Child Outcomes Research Consortium (CORC) to conduct an evaluation of the '**Me** first' training on children and young people centred conversations about Child Sexual Exploitation (CSE) and safeguarding concerns to assess its impact on trainees' knowledge and confidence of how to respond to concerns about a child or young person. This report presents results from the evaluation of fifteen trainings delivered around England between June and October 2017.

The training was evaluated using a mixed-methods approach to assess if completion of the training is associated with 1) *improved knowledge and identification of signs and risk factors for CSE and other safeguarding concerns*, and 2) *improved confidence communicating with children, young people and colleagues around concerns about a child or young person's wellbeing, safety and relationships*. Further feedback from trainees was also collected to understand the training's relevance, accessibility, presentation quality, expected impact, and perceived strengths and areas for improvement.

3.2 Methodology

The evaluation used pre- and post-training questionnaires consisting of multiple choice and open-text questions, completed on paper immediately before the session began, and again on its completion. The pre- and post-questionnaires were numbered to anonymously link participants' responses.

3.2.1 Measures captured pre- and post-training

Knowledge: A bespoke measure of healthcare professionals' knowledge of signs and risk factors for CSE and other safeguarding concerns was created in the absence of an existing measure appropriate to the audience and objectives of the training. The knowledge measure (see Appendix B) consists of five items assessed on a 5-point Likert scale ('Strongly Disagree' to 'Strongly Agree'). A Cronbach's alpha[3] of 0.89 (0.87 – 0.91 95% CI) indicates good/excellent correlation among these items, suggesting sufficient reliability to be assessed together in this subscale.

[3] Cronbach, L. J. (1951). Coefficient alpha and the internal structure of tests. *Psychometrika*, 16(3), 297-334.

Confidence: The measure of confidence was adapted from a previous questionnaire used to measure physicians' communication skills around difficult topics[4]. The adapted measure (see Appendix B) consists of 14 items assessed on a 4-point scale ('Not confident at all' to 'Completely confident').

Four subscales mapping to broad categories in the **Me** first safeguarding communication framework were identified (see Appendix C for items in each subscale). These subscales relate to professionals' confidence to:

- Set the scene to open up conversations with a child or young person,
- Explore and be curious about their wellbeing, safety and relationships,
- Listen and validate their feelings, and
- Respond professionally.

Cronbach's alphas for these subscales show fair to good internal consistency for the subscales *setting the scene* (0.82, 0.78 - 0.86 95% CI), *exploring* (0.83, 0.79 - 0.86 95% CI), and *listening* (0.81, 0.77 - 0.85 95% CI), indicating sufficient reliability to assess these items together. A Cronbach's alpha on the subscale *responding* (0.70, 0.63 - 0.76 95% CI) indicates fair internal consistency though the confidence intervals indicate some uncertainty (less than the commonly recommended alpha of 0.70 or higher). Interpreting results for this subscale should therefore be made with caution, and change at the item-level is also considered in the results.

3.2.2 Measures captured post-training only

Confidence opening up space for difficult conversations: The post-training questionnaire included a single question asking trainees to what extent they agree with the statement, "Overall I feel this training improved my confidence to open up space for a difficult conversation with a young person about concerns I might have about them" (assessed on a 5-point Likert Scale, from 'Strongly Disagree' to 'Strongly Agree'), since this was identified as a key outcome of the training.

Feedback (Close-ended): Post-training questionnaires included multiple choice questions asking trainees about the relevance, accessibility and expected impact of the training, the competency of presenters, the suitability of venues, and whether they would recommend the training to colleagues.

Feedback (Open-ended): Trainees were asked two open-ended questions about what they felt the training's strengths and areas for improvement were ("What did you feel was done especially well during this training?"; "What could have been done better to improve this training").

3.3 Analytical Approach

The training was evaluated using a combination of quantitative and qualitative methods.

The distribution of responses on the knowledge and confidence subscales at pre- and post-training are shown in Sections 5.1 and 5.2 to assess for any change in responses between the two time points. For analysing the significance of any change, responses were compared using Wilcoxon

[4] Baile, W. F., Kudelka, A. P., Beale, E. A., Glober, G. A., Myers, E. G., Greisinger, A. J., ... & Lenzi, R. (1999). Communication skills training in oncology. *Cancer*, *86*(5), 887-897.

Signed Rank tests[5], a non-parametric test appropriate for use with ordinal data. A Bonferroni adjusted[6] p-value ($p<0.01$) was applied to all pre-post significance testing to adjust for multiple tests.

The distribution of responses to multiple-choice feedback questions collected post-training are presented in Sections 5.3 and 5.4 and in more detail in Appendix E.

Qualitative feedback on the training was collated and categorised according to key themes, which are presented in Section 5.5.

4 SAMPLE

246 trainees from across 15 trainings participated in the evaluation. The number of trainees completing questionnaires at each event ranged from 5 to 33 (mean of 16), reflecting variation in the number of trainees across sessions. A high proportion of trainees (98%, 242/246) completed both pre- and post-training questionnaires.

Trainees with paired questionnaires ranged in age, with the most number of trainees (33%, 79/242) between the ages of 45 to 54 years. Most trainees were female (92%, 223/242) and white (87%, 211/242). A majority of trainees (57%, 139/242) were registered nurses or midwives and the remaining were medics, allied health and social care professionals, nursing and healthcare assistants, and general managers. A minority of trainees (9%, 21/242) were students. Over half (55%, 134/242) had 10 or more years of experience working with children and young people. The number of weekly sessions worked and hours of contact with children and young people varied. The majority (66%, 158/242) of trainees work nine or more sessions in a week (See Appendix E for a full breakdown of demographic and professional characteristics).

5 RESULTS

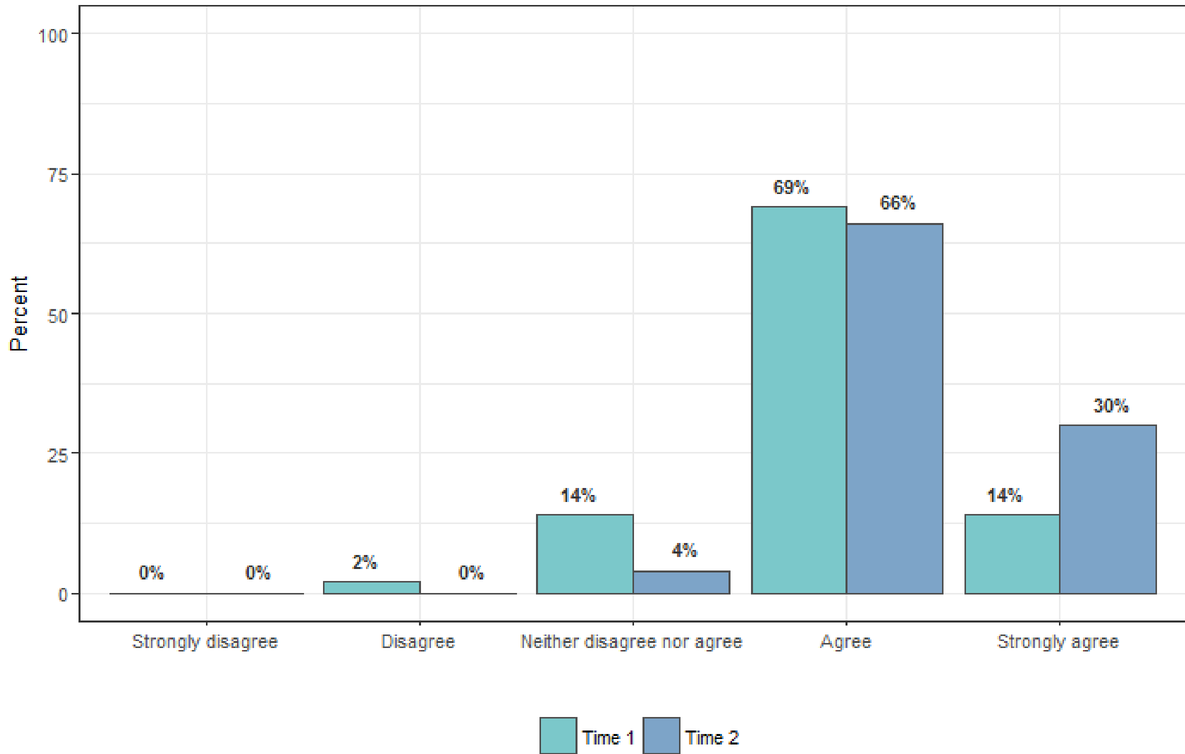
5.1 KNOWLEDGE

The pre-training distribution of responses on the *knowledge* subscale indicates most trainees 'agreed' or 'strongly agreed' that they had knowledge of and were able to identify signs and risk factors for CSE and abuse before training (see Figure 5.1.1). Only 2% of responses on this subscale were 'disagree' and none 'strongly disagree' prior to the training. The most common response on knowledge items was 'agree' at both pre- and post-training.

The distribution of pre- and post-training responses indicates movement towards a higher level of knowledge: 30% of responses were 'strongly agree' after training, compared to 14% before. The shift towards a higher level of knowledge from pre- to post-training was statistically significant ($p<0.01$). For breakdowns of pre- and post-training responses for each knowledge item, see Appendix F).

[5] Hollander, M., & Wolfe, D.A. (1999). *Nonparametric Statistical Methods, 2nd Edition*. New York: John Wiley & Sons.

[6] Bland, J.M., & Altman, D.G. (1995). Multiple significance tests: the Bonferroni method. *British Medical Journal*. 310, 170.

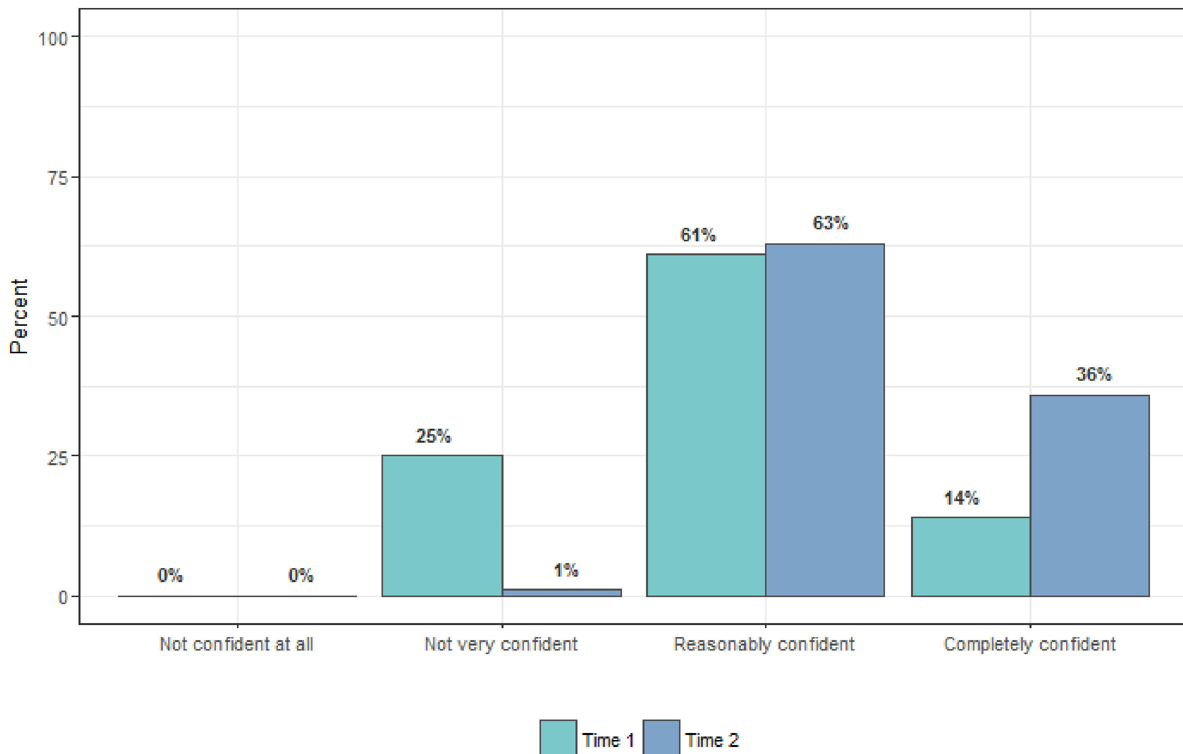


5.2 Confidence

Changes in confidence were assessed on four subscales: *setting the scene* (creating a comfortable setting, opening up space for difficult conversations, and encouraging a child or young person to feel comfortable to talk); *exploring* (talking with a child or young person about their safety, relationships and activities, and sexual activity, and explaining about any concerns); *listening* (checking in and reflecting back with the child or young, validating their feelings, showing empathy, and supporting them when they do not want to talk); *responding* (managing one's own response to a young person's distress, developing a shared plan with the young person, and discussing concerns with appropriate professionals). Breakdowns of item-level responses are shown in Appendix F.

5.2.1 Setting the scene

The most common response on the subscale *confidence setting the scene* was 'reasonably confident', both prior to training (61% of responses) and after training (63% of responses, see Figure 5.2.1). One in four (25%) of responses pre-training were 'not very confident', compared to 1% post-training. The distribution of responses before and after training indicates a shift towards an overall higher level of confidence, with 36% of responses 'completely confident' post-training, compared to 14% pre-training and nearly all (99%) of responses indicating at least 'reasonable confidence' after training. The change in responses on this subscale is statistically significant ($p<0.01$).



5.2.2 Exploring

The most common response on the subscale *confidence exploring* was 'reasonably confident' both before and after training (63% of pre-training responses, and 58% of post-training responses; see Figure 5.2.2). Around one in five (18%) of responses were 'not very confident' on this subscale before training, compared to 3% after training. There was an overall increased level of confidence exploring concerns with children and young people among trainees from pre- to post-training, with 39% of responses 'completely confident' post-training, compared to 18% pre-training. The change in responses on this subscale is statistically significant ($p<0.01$).

5.2.3 Listening

'Reasonably confident' was also the most common response on the subscale *confidence listening*, both pre- and post-training (65% and 60%, respectively; see Figure 5.2.3). 17% of responses were 'not very confident' on this subscale before training, compared to 1% after training. The distribution of responses from pre-to post training indicates a shift towards a higher level of confidence listening to children and young people, with 39% of responses 'completely confident' post-training, compared to 18% pre-training. The change in responses on this subscale is statistically significant ($p<0.01$).

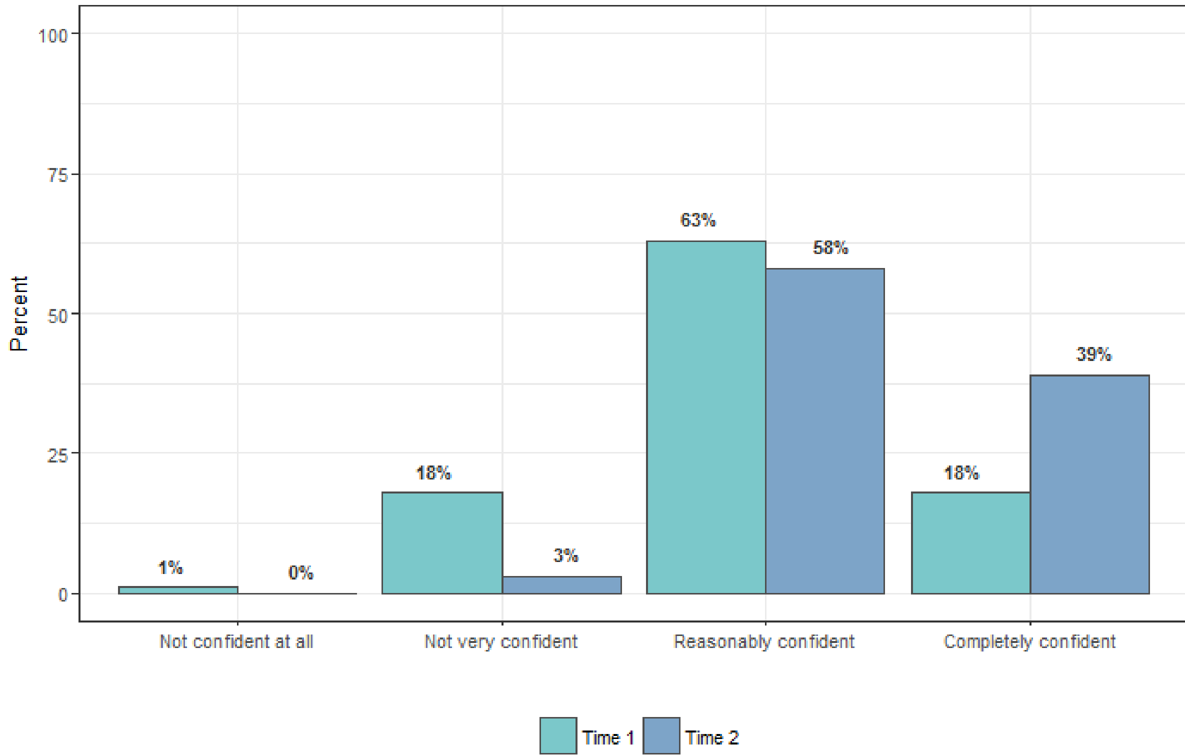


Figure 5.2.2 Distribution of Responses to Confidence - Exploring Items
Includes only responses from trainees with all subscale items complete pre and post training, n=226 (93%)
Percent
100
75
50
25
0
1%
0%
18%
3%
63%
58%
18%
39%
Not confident at all
Not very confident
Reasonably confident
Completely confident
Time 1
Time 2

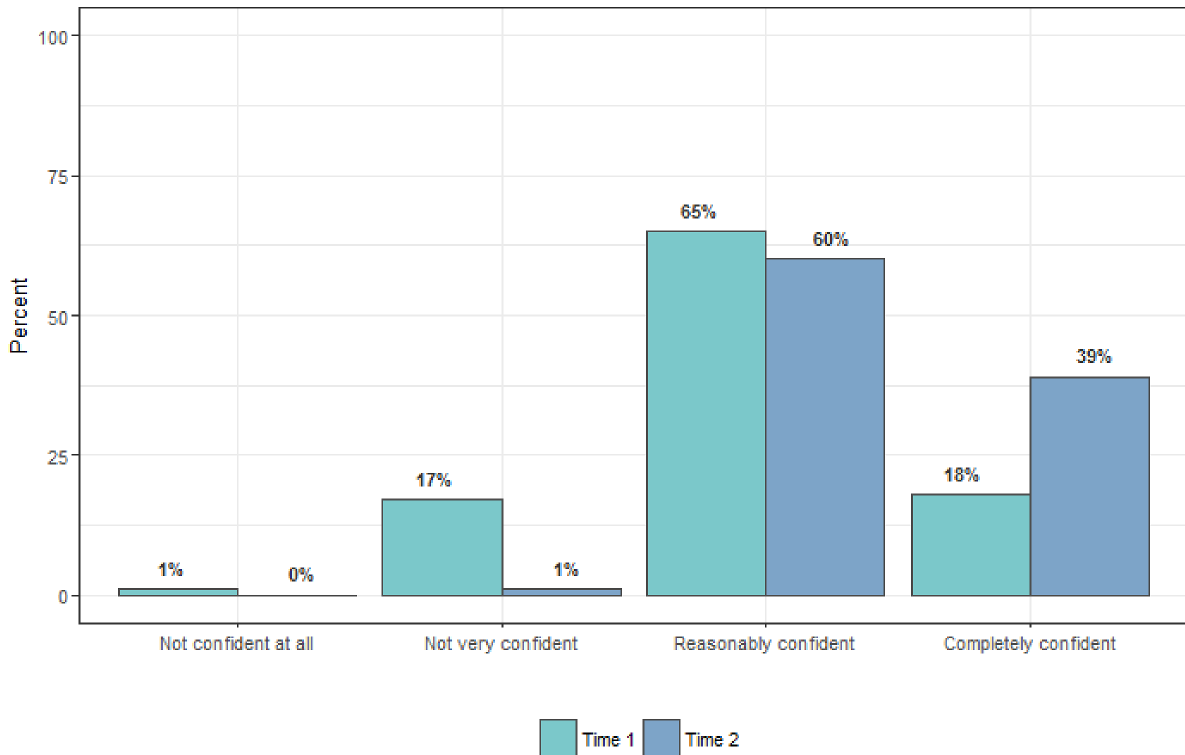
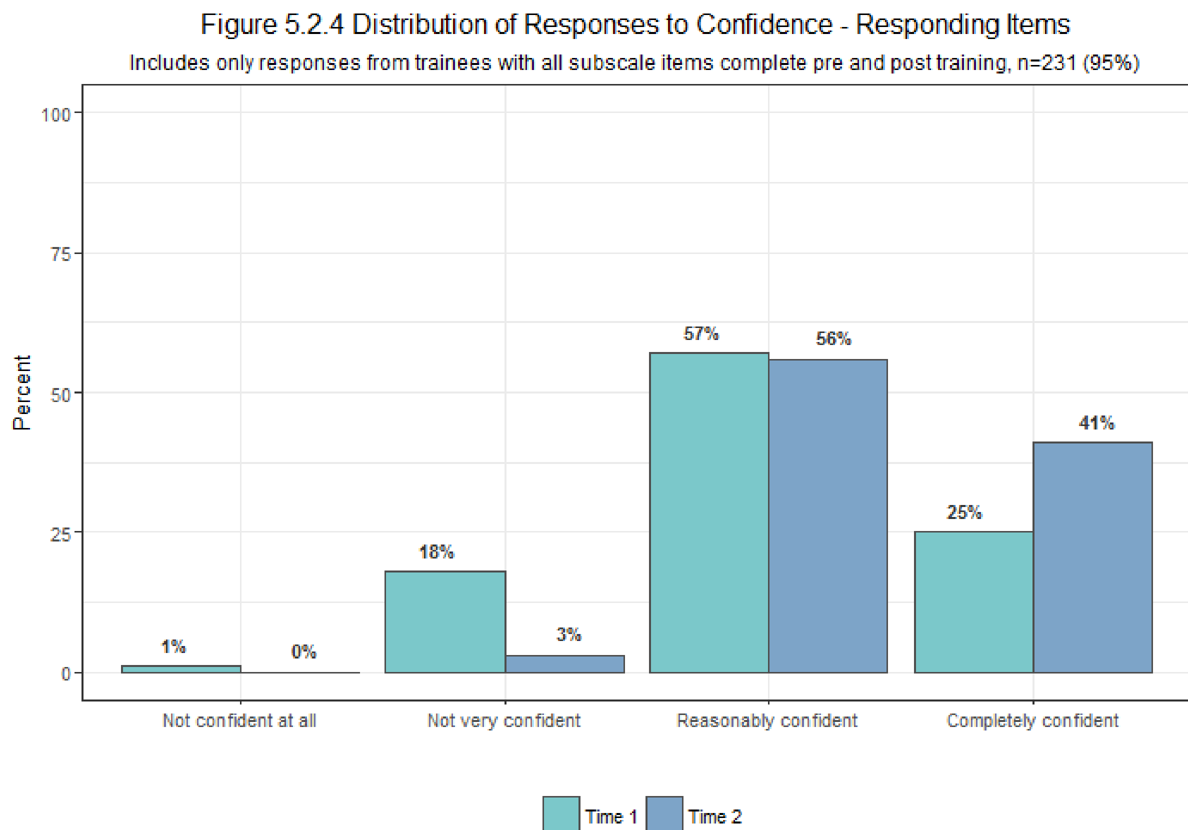


Figure 5.2.3 Distribution of Responses to Confidence - Listening Items
Includes only responses from trainees with all subscale items complete pre and post training, n=226 (93%)
Percent
100
75
50
25
0
1%
0%
17%
1%
65%
60%
18%
39%
Not confident at all
Not very confident
Reasonably confident
Completely confident
Time 1
Time 2

5.2.4 Responding

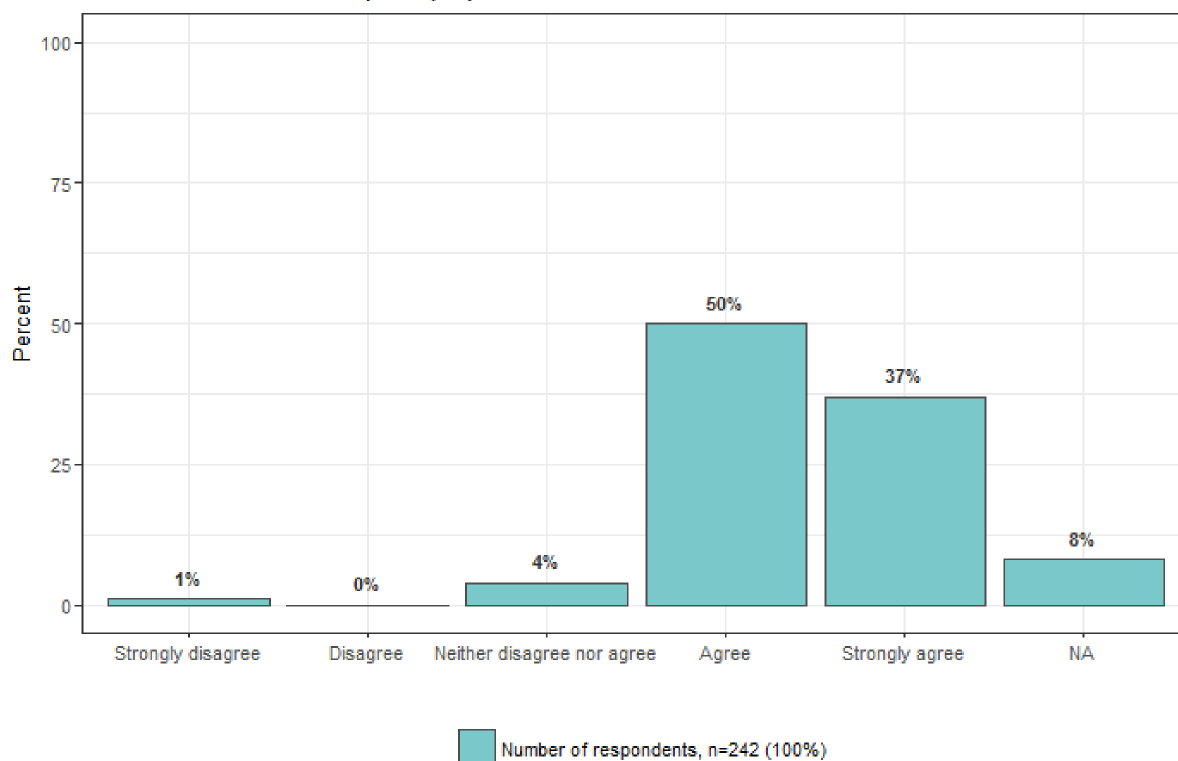
The most common response on the subscale *confidence responding* was 'reasonably confident', both pre- and post-training (57% and 56%, respectively; see Figure 5.2.4). 18% of responses were 'not very confident' on this subscale before training, compared to 3% after training. The distribution of responses from pre-to post training indicates a shift towards a higher level of confidence responding, with 41% of responses 'completely confident' post-training, compared to 25% pre-training. The change in responses on this subscale is statistically significant ($p<0.01$).

Due to uncertainty around the internal consistency for this subscale, change on individual items was also assessed. Generally, the shift towards a higher level of confidence was evident across all three items, however, on the item "Discussing concerns with appropriate professionals", there was an overall higher level of confidence before and after training: 41% of responses pre-training and 51% post-training were 'completely confident' (see Appendix F, Table F.5).



5.3 SELF-REPORT CHANGE IN CONFIDENCE

Trainees were asked to what extent they agree with the statement, “Overall I feel this training improved my confidence to open up space for a difficult conversation with a young person about concerns I might have about them”. A high proportion of trainees (87%, 210/242) ‘agreed’ or ‘strongly agreed’ that the training improved their confidence in this area. A minority (4%, 10/242) ‘neither agreed nor disagreed’, and a small number ‘strongly disagreed’.[7] [8]



5.4 FEEDBACK – QUANTITATIVE ITEMS

Most trainees (62%) felt the training was ‘entirely relevant’ to their work, and one in four (26%) felt it was ‘mostly relevant’ (Appendix G, Graph G.1). Most (88%) trainees felt topics were ‘easy to follow’, 10% felt they were ‘mostly easy to follow’ and none felt they were ‘not easy to follow’ (Appendix G, Graph G.2). More than half (58%) expected the training to make a ‘significant difference’ to the way they do their job, and 39% expected it to make a ‘moderate difference’ (Appendix G, Graph G.3). A high proportion (78%) would ‘completely recommend’ the training to colleagues and 20% would recommend it ‘for the most part’ (Appendix G, Graph G.4). Almost all (98%) trainees felt trainers were competent and knowledgeable (Appendix G, Graph G.5).

[7] Responses of ‘Strongly Disagree’ to the feedback question ‘Overall, I feel this training improved my confidence to open up space for a difficult conversation…’ were coded to missing where trainees (n=14) responded positively on all other multiple-choice feedback questions and gave no negative feedback on open-text questions. It is thought that respondents in these cases chose ‘Strongly Disagree’ as it was the first response option.

[8] This figure includes trainees with missing responses on this item, including the 14 cases coded to ‘missing’ as described above. Of those with valid responses on this item, 95% responded ‘Agree’ or ‘Strongly Agree’.

5.5 Feedback – Qualitative Items

Overall, responses to the two open-text feedback questions were very positive and trainees had many laudatory comments about the training. For example, trainees wrote:

> *"Fantastic trainers and presentation. Thank you. Really made me think about my practice. The framework is a great tool. Will use this and share with my team."* (Registered Nurse)

> *"Everything was right: balance of group work and presentation was brilliant, role play conversation helped me a lot to have a thoughtful productive conversation."* (Social Care Professional)

> *"Came with very little knowledge how to open conversation so am feeling much more confident and able to think of a way to improve."* (Healthcare Assistant)

> *"For me as a student school nurse, it helped me to feel less daunted and overwhelmed stepping into the safeguarding arena. Its message was simple, "we are human and "I'll walk through this with you."* (Student Nurse)

Trainees' responses were categorised into themes and sub-themes (see Appendix H), relating to the aspects of the training that trainees felt went well and the aspects that they felt could have been improved. Results are specific to this sample, and will not necessarily transfer to other groups.

5.5.1 What was done especially well during the training?

222 trainees (90% of the 246 respondents) gave feedback on this question. Their comments on this question fall within the following categories:

Skilled and engaging facilitation (n=88): Trainees were very positive about the quality of trainings, particularly their facilitation. Trainees wrote that presenters "*made the day interesting and fun*" (Registered Nurse), were *"extremely knowledgeable about subject"* (Registered Nurse) and had an *"easy inclusive manner – good presentation skills"* (Registered Nurse). Presenters were described as *"discussion generating"* (Registered Nurse) and *"very engaging"* (Project co-ordinator).

Inclusive learning environment (n=23): Trainees described the trainings as inclusive, safe, comfortable and conducive to learning. For example, one person wrote that presenters *"created a comfortable and safe space"* (Registered Nurse). Another felt their presenter was *"knowledgeable, diplomatic and helped people think about and articulate their thoughts on difficult issues"* (Medic).

Interactive activities (role play and group discussions) (n=101): Many people highlighted the interactive nature of the training as a strength, particularly the role play and group discussions. The role play was described as *"brilliant", "well-delivered"* and *"a practical way to put in action"* (Professional working in sexual health services) that *"didn't put people on the spot"* (Allied Health professional). One trainee wrote that role plays are *"usually a dreadful experience however done as a group was unstressful and informative"* (Registered Nurse).

Opportunities to reflect and share ideas (n=47): Many highlighted the reflective nature of the training. Two people described the training as an opportunity to *"reflect on your own practice"* (Allied Health professional and Registered Nurse). Another found the training to be "time for personal reflection" (Registered Nurse). Group discussions and interactions also provided opportunity to reflect, for example, one trainee felt the training allowed the group to *"collectively share ideas and thoughts about addressing difficult conversations with young [people]"* (Healthcare

Assistant) and another felt it was a *“great opportunity to share ideas with different professionals.”* (Allied Health professional). Having professionals from different backgrounds in the training was also deemed helpful; for instance, to hear *“how they phrase questions or interact with children and what works well for them”* (Medic), or “to get different view point that you may not have previously considered” (Allied Health Professional).

Tools for practice (n=29): Trainees also found the communication framework and handouts (e.g. the tips sheet and flow chart on conversations about safeguarding concerns) to be accessible and relevant to their practice. One person found the framework *“very clear, concise and easy to use”* (Registered Nurse) and another felt it was useful *“discussing through the framework and how this fits with the views shared of the young people”* (Registered Nurse).

Young person input (n=18): Trainees appreciated hearing about the thoughts and experiences of young people. One person wrote that it was *“really helpful to hear young people’s own views about how they would like/not like professionals to interact with them”* (Registered Nurse).

Relevance and accessibility (n=20): Many trainees commented on the relevance of the training to their practice with children and young people, and the accessibility of the content covered. One person wrote that the training *“covered my needs and gave me valuable information to cascade/use in practice”* (Registered Nurse). Another felt it was *“pitched at the right level”* (Registered Nurse).

5.5.2 What could have been done better to improve the training?

98 trainees (40% of the 246 respondents) did not respond to this question and 48 (20% of the 246 respondents) commented but said there was nothing to add or gave positive feedback. 100 trainees (41% of the 246 respondents) gave suggestions for areas of improvement. Their comments on this question fall within the following categories:

Format (n=27): Several trainees (n=14) felt the training could be longer, with some suggesting an all-day workshop (however, 92% felt the length of training was “just about right” in the quantitative feedback). Seven trainees felt that there could have been more time spent on the role play and scenarios, to have time to explore different scenarios. However, four people felt there could have been less time spent on group work and the role play. Two people suggested to do the role play in smaller groups.

Materials (n=10): Two people suggested materials would be more accessible by using larger font and bigger slides on handouts. One person felt there was too much paper, and that it would also work to *“signpost to online resources”* (Student). Two trainees would have liked *“scripts of open ‘helpful’ questions”* (Assistant Psychologist) and *“more specific ‘stock’ phrases”* (Medic) and one trainee would have liked “more resources and tools to use to help support the young person” (Social care worker). Four trainees suggested using more visual aids, like videos to show scenarios and examples of how to respond, or actors to *“[help] bring situations to life”* (Social Care professional).

Additional content (n=20): Trainees highlighted additional content they felt the training could cover or go into more depth with, including how to communicate with young people with communication needs or difficulties; more information on signs and symptoms of CSE; more content around children and young people who have difficulty engaging or refuse to engage; more clinical practice examples and specific scenarios; more discussion of how to respond and escalate; link to other safeguarding topics; discuss how to talk about social work referrals or the police.

More input from young people (n=10): Some trainees felt more young people examples, feedback and involvement would have been beneficial, ideally as co-presenters.

Pre-training information and logistics (n=12): Some trainees requested more pre-training information about venue logistics (e.g. parking, location and directions) and more clear information about the training beforehand. Three trainees (two Registered Nurses and one Healthcare Assistant) felt there could have been more descriptive information about the course at registration (e.g. who the targeted audience was and what the content would cover, as the training was not what they expected).

Venue (n=9): Some trainees noted that the venue could have been more accommodating (e.g. with parking; larger rooms; temperature control).

6 Discussion

Results indicate the training is associated with increased knowledge around signs and risk factors for CSE and abuse, and increased confidence in how to respond when concerned about a child or young person's wellbeing, safety and relationships. The shift towards a higher level of confidence was similar across all subscales (setting the scene, exploring, listening, and responding) and the change in scores from pre- to -post training was statistically significant for all measures. This indicates that overall, the training is associated with the desired impact across all aspects covered in the **Me** first safeguarding communication framework.

However, pre-training responses suggest most trainees were knowledgeable and confident around CSE and other safeguarding concerns before attending training, possibly reflecting self-selected participation and more extensive experience working with children and young people among trainees (the majority of participants had 10 or more years of experience). Future roll-out of the training could target healthcare professionals with less awareness of and confidence around CSE and other safeguarding concerns to reach those who may especially benefit.

Self-reported feedback from the post-questionnaire further supports findings of a positive impact on trainees' confidence and future practice. Most trainees (98%) felt the training would make a moderate or significant impact on their practice and a high proportion (87%) agreed or strongly agreed that the training improved their confidence to open up space for difficult conversations with a child or young person.

Qualitative feedback from trainees was also very positive, and reflected the finding that most trainees (98%) would recommend the training to a colleague (78% 'completely' and 20% 'for the most part'). Staff highlighted the skilled and engaging presenters, interactive activities (particularly the role play), safe and inclusive learning environment, and practical framework relevant to their work with children and young people as the training's key strengths.

Suggestions for future trainings included having longer sessions to provide more opportunity for role play and discussions, making materials more accessible (e.g. with larger text), and exploring other formats for delivering content (e.g. videos of interactions between professionals and young people). While most people enjoyed the role play, there were some trainees (n=4) who felt there was too much time spent on it, and a few (n=2) who felt it may have been more helpful to do in small groups. Many trainees (n=18) felt the input of young people in the design of the training and the incorporation of the young person perspective was a strength of the training, though some (n=10)

felt there could have been more involvement from young people during the training and ideally as co-presenters if possible.

Limitations of the evaluation: The main limitation of this evaluation is that it is not possible to make direct inferences of causality due to the study design, since there is no 'counter-factual', i.e. it is not known how trainees' responses would have changed had they not participated in the programme. This evaluation also was not able to assess for any variation in how the training was delivered across sessions, which may have influenced how people experienced the training, and may be reflected particularly in the qualitative feedback. Finally, since the evaluation does not include a follow-up with trainees, it is not possible to comment on whether any improvements in knowledge or confidence will translate into changes being embedded in practice.

7 CONCLUSION

The evaluation of the '**Me** first' training on children and young people centred conversations about Child Sexual Exploitation (CSE) and safeguarding concerns indicates it had a positive impact on trainees, with results suggesting a significant shift towards increased knowledge of signs and risk factors for CSE and abuse, and improved confidence communicating with children and young people around concerns about their wellbeing, safety and relationships.

Very positive feedback from trainees on the format and content of the training, the quality of its presentation and facilitation, and the usefulness of the **Me** first safeguarding communication framework and other tools and resources provided further supports these findings.

Based on staff feedback, elements to consider when delivering future trainings include using additional case scenarios, incorporating more of the young person perspective, and providing more pre-training communication around logistics and what to expect on the training day.

8 REFERENCES

Baile, W. F., Kudelka, A. P., Beale, E. A., Glober, G. A., Myers, E. G., Greisinger, A. J., ... & Lenzi, R. (1999). Communication skills training in oncology. *Cancer*, *86*(5), 887-897

Berelowitz, S., Clifton, J., Firimin MBE, C., Gulyurtlu, S. & Edwards, G. (2013). “If only someone had listened,” Office of the Children’s Commissioner’s Inquiry into Child Sexual Exploitation in Gangs and Groups – Final Report.

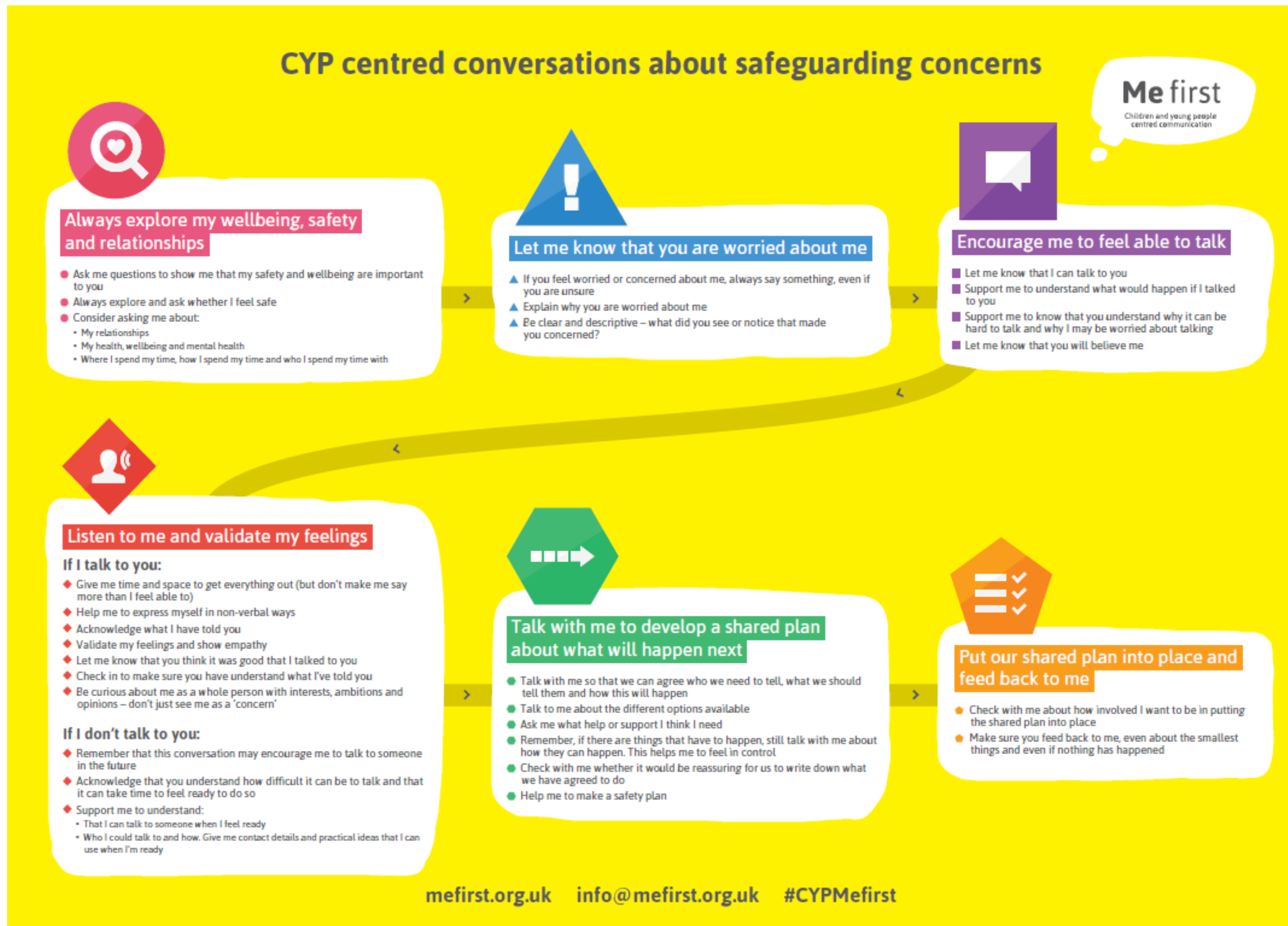
Bland, J.M., & Altman, D.G. (1995). Multiple significance tests: the Bonferroni method. *British Medical Journal*. 310, 170.

Child Exploitation and Online Protection Centre (CEOP) (2011). “Out of Mind, Out of Sight: Breaking down the barriers to understanding child sexual exploitation”. London: CEOP.

Cronbach, L. J. (1951). Coefficient alpha and the internal structure of tests. *Psychometrika*, 16(3), 297-334.

Hollander, M., & Wolfe, D.A. (1999). *Nonparametric Statistical Methods, 2nd Edition*. New York: John Wiley & Sons

APPENDIX A: ME FIRST SAFEGUARDING COMMUNICATION FRAMEWORK



APPENDIX B: MEASURES

Table B.1 Knowledge Items *To what extent do you agree with the following statements?*

	Strongly Disagree	Disagree	Neither Disagree nor Agree	Agree	Strongly Agree
I know the signs to look out for when a child or young person is being sexually exploited.					
I know the signs to look out for when a child or young person is experiencing abuse.					
I know the factors that increase a child or young person's risk of being sexually exploited.					
I can identify possible signs of sexual exploitation in a child or young person.					
I can identify possible signs of abuse in a child or young person.					

Table B.2 Confidence Items *Thinking specifically about young people for whom you have concerns about their wellbeing, safety and relationships, to what extent do you feel confident…*

	Not confident at all	Not very confident	Reasonably confident	Completely confident
Creating a comfortable setting to discuss your concerns with a child or young person?				
Talking to a child or young person about whether they feel safe?				
Opening up space for a difficult conversation with a child or young person about concerns you might have about them?				
Talking to a child or young person about their relationships and activities?				
Talking to a child or young person about their sexual activity?				
Checking in and reflecting back to a child or young person to ensure you have understood them?				
Validating a child or young person's feelings and showing empathy?				
Responding to a child or young person's emotional reactions?				
Managing your own response to a child or young person's distress?				
Explaining to a child or young person about why you are worried about them?				
Encouraging a child or young person to feel comfortable to talk?				

Supporting a child or young person when they don’t want to talk?				
Developing a shared plan with a child or young person about what will happen next?				
Discussing concerns with appropriate professionals?				

Appendix C: Knowledge and Confidence Subscales

Table C.1 Knowledge
I know the signs to look out for when a child or young person is being sexually exploited.
I know the signs to look out for when a child or young person is experiencing abuse.
I know the factors that increase a child or young person's risk of being sexually exploited.
I can identify possible signs of sexual exploitation in a child or young person.
I can identify possible signs of abuse in a child or young person.

Table C.2 Confidence – Setting Scene
Creating a comfortable setting to discuss your concerns with a child or young person?
Opening up space for a difficult conversation with a child or young person about concerns you might have about them?
Encouraging a child or young person to feel comfortable to talk?

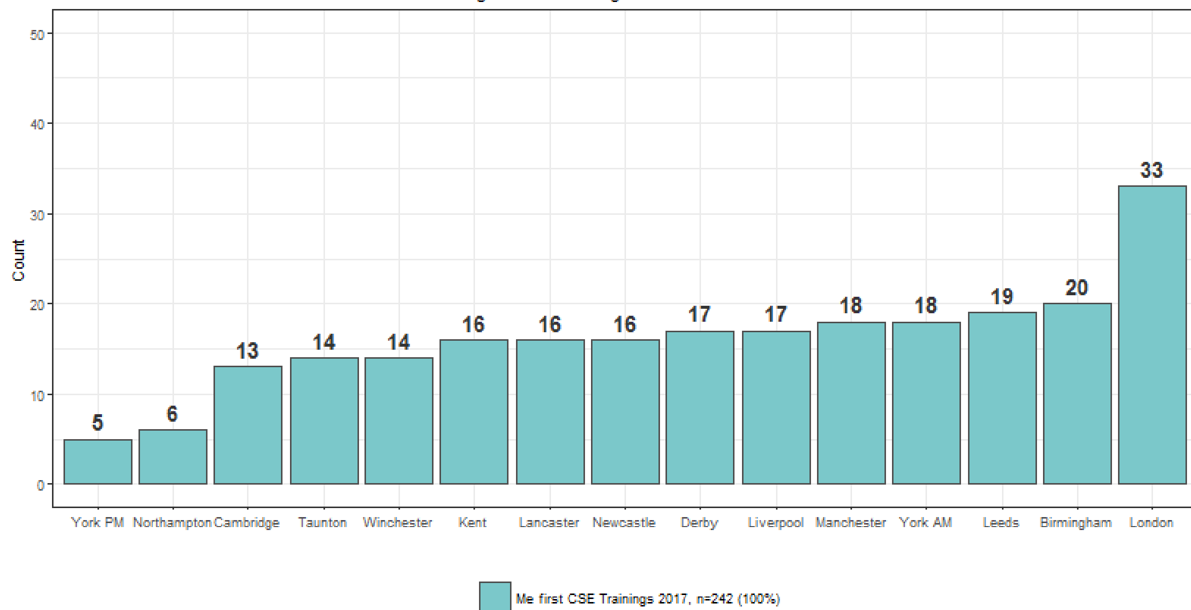
Table C.3 Confidence – Exploring
Talking to a child or young person about whether they feel safe?
Talking to a child or young person about their relationships and activities?
Talking to a child or young person about their sexual activity?
Explaining to a child or young person about why you are worried about them?

Table C.4 Confidence – Listening
Checking in and reflecting back to a child or young person to ensure you have understood them?
Validating a child or young person's feelings and showing empathy?
Responding to a child or young person's emotional reactions?
Supporting a child or young person when they don't want to talk?

Table C.5 Confidence – Responding
Managing your own response to a child or young person's distress?
Developing a shared plan with a child or young person about what will happen next?
Discussing concerns with appropriate professionals?

APPENDIX D: TRAINING SITES

Table D.1 Number of respondents per Training Site	
Training Site	**Count**
Birmingham	20
Cambridge	13
Derby	17
Kent	16
Lancaster	16
Leeds	19
Liverpool	17
London	33
Manchester	18
Newcastle	16
Northampton	6
Taunton	14
Winchester	14
York AM	18
York PM	5



APPENDIX E: DEMOGRAPHIC TABLES

Table E.1 Demographics	
Variable	**Count (%)**
Age Bands	
18 to 24	8 (3%)
25 to 34	57 (24%)
35 to 44	61 (25%)
45 to 54	79 (33%)
55 to 64	36 (15%)
Missing	<3
Gender	
Female (including trans woman)	223 (92%)
Male (including trans man)	17 (7%)
Non-binary	<3
Missing	<3
Ethnicity	
Asian or Asian British	16 (7%)
Black or Black British	9 (4%)
Mixed	3 (1%)
Other Ethnic Groups	<3
White	211 (87%)
Missing	<3
Service Type	
A&E Department	14 (6%)
Community Health	102 (42%)
General Practice	9 (4%)
Mental Health Service	31 (13%)
Other	84 (35%)
Paediatric Ward	21 (9%)
Sexual Health Service	19 (8%)
Walk in Centre	<3
Number of Sessions (per week)	
No sessions	2 (1%)
1 or 2 sessions	3 (1%)
3 or 4 sessions	9 (4%)
5 or 6 sessions	30 (12%)
7 or 8 sessions	40 (17%)
9 or 10 sessions	125 (52%)
11 or 12 sessions	4 (2%)
13 or 14 sessions	21 (9%)
Missing	8 (3%)
Hours of Contact with CYP (per week)	
None	23 (10%)
1 to 5	52 (21%)
6 to 10	46 (19%)

11 to 15	35 (14%)
16 to 20	24 (10%)
21 to 25	21 (9%)
26 to 30	11 (5%)
31 to 35	12 (5%)
36 or more	10 (4%)
Missing	8 (3%)
Experience working with CYP	
Less than 12 months	21 (9%)
1 to 4 years	38 (16%)
5 to 9 years	43 (18%)
10 or more years	134 (55%)
Missing	6 (2%)
Profession	
Allied Health	20 (8%)
Medical	23 (10%)
Registered Nurse or Midwife	139 (57%)
Nursing or HCA	19 (8%)
Social Care	6 (2%)
General Management	6 (2%)
Other	27 (11%)
Missing	<3
Student	
Not a Student	217 (90%)
Student	21 (9%)
Missing	4 (2%)

APPENDIX F: ITEM-LEVEL BREAKDOWNS

Table F.1 Knowledge Items		
Categories	**Time 1 (% of total, n = 242)**	**Time 2 (% of total, n = 242)**
I know the signs to look out for when a child or young person is being sexually exploited.		
Strongly disagree	0	0
Disagree	3	0
Neither disagree nor agree	19	5
Agree	65	64
Strongly agree	12	28
Missing	0	3
I know the signs to look out for when a child or young person is experiencing abuse.		
Strongly disagree	0	0
Disagree	1	0
Neither disagree nor agree	10	2
Agree	73	64
Strongly agree	15	30
Missing	0	3
I know the factors that increase a child or young person's risk of being sexually exploited.		
Strongly disagree	0	0
Disagree	2	0
Neither disagree nor agree	10	5
Agree	69	61
Strongly agree	19	31
Missing	0	3
I can identify possible signs of sexual exploitation in a child or young person.		
Strongly disagree	0	0
Disagree	5	0
Neither disagree nor agree	19	4
Agree	64	65
Strongly agree	10	27
Missing	1	4
I can identify possible signs of abuse in a child or young person.		
Strongly disagree	0	0
Disagree	1	0
Neither disagree nor agree	12	1
Agree	72	64
Strongly agree	13	31
Missing	1	4

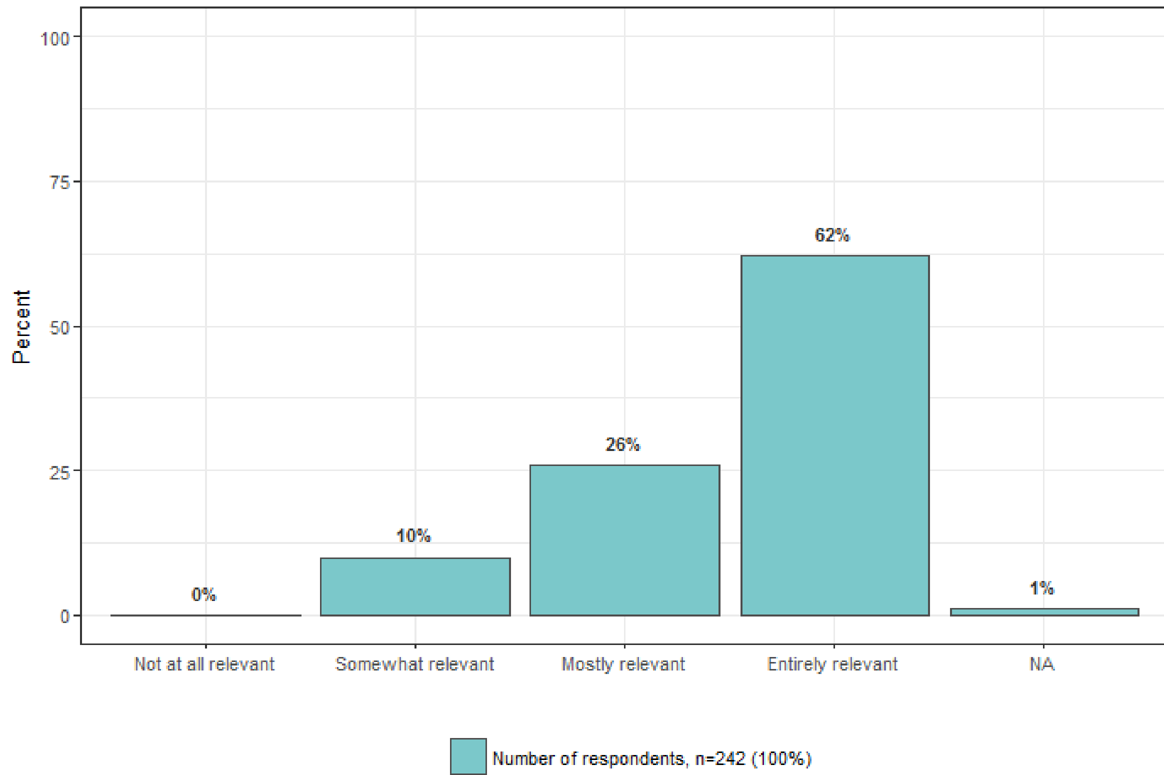
Table F.2 Confidence – Setting Scene Items *To what extent do you feel confident…*		
Categories	**Time 1 (% of total, n = 242)**	**Time 2 (% of total, n = 242)**
Creating a comfortable setting to discuss your concerns with a child or young person?		
Not confident at all	0	0
Not very confident	18	1
Reasonably confident	66	59
Completely confident	15	38
Missing	0	2
Opening up space for a difficult conversation with a CYP about concerns you might have about them?		
Not confident at all	0	0
Not very confident	38	1
Reasonably confident	53	65
Completely confident	8	31
Missing	1	3
Encouraging a child or young person to feel comfortable to talk?		
Not confident at all	0	0
Not very confident	19	1
Reasonably confident	64	61
Completely confident	17	36
Missing	1	2

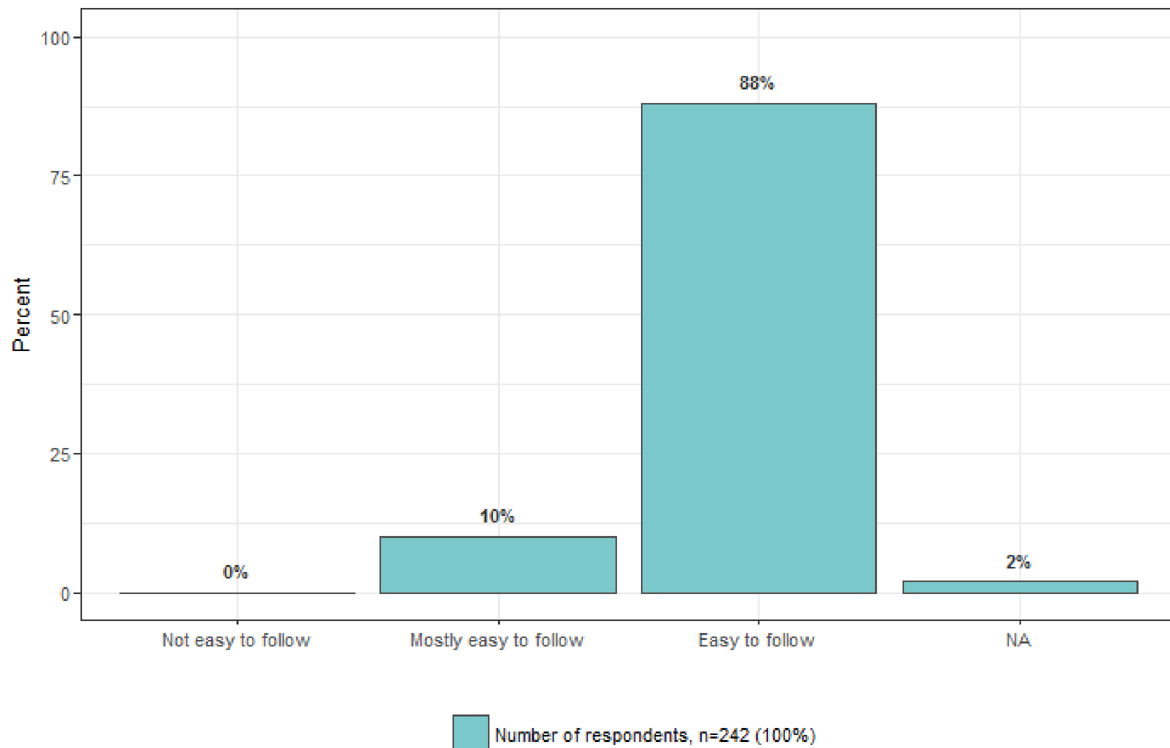
Table F.3 Confidence – Exploring Items *To what extent do you feel confident…*		
Categories	**Time 1 (% of total, n = 242)**	**Time 2 (% of total, n = 242)**
Talking to a child or young person about whether they feel safe?		
Not confident at all	0	0
Not very confident	19	0
Reasonably confident	65	59
Completely confident	15	38
Missing	1	3
Talking to a child or young person about their relationships and activities?		
Not confident at all	0	0
Not very confident	1	1
Reasonably confident	55	55
Completely confident	41	41
Missing	2	2
Talking to a child or young person about their sexual activity?		
Not confident at all	4	0
Not very confident	24	9
Reasonably confident	56	55
Completely confident	15	31
Missing	1	4
Explaining to a child or young person about why you are worried about them?		
Not confident at all	0	0
Not very confident	17	1
Reasonably confident	63	54
Completely confident	19	41
Missing	1	3

Table F.4 Confidence – Listening Items To what extent do you feel confident…		
Categories	**Time 1 (% of total, n = 242)**	**Time 2 (% of total, n = 242)**
Checking in and reflecting back to a child or young person to ensure you have understood them?		
Not confident at all	0	0
Not very confident	10	1
Reasonably confident	71	54
Completely confident	17	42
Missing	1	3
Validating a child or young person's feelings and showing empathy?		
Not confident at all	0	0
Not very confident	5	0
Reasonably confident	72	55
Completely confident	22	42
Missing	0	3
Responding to a child or young person's emotional reactions?		
Not confident at all	0	0
Not very confident	12	1
Reasonably confident	70	61
Completely confident	17	36
Missing	1	2
Supporting a child or young person when they don't want to talk?		
Not confident at all	2	0
Not very confident	38	3
Reasonably confident	45	61
Completely confident	14	32
Missing	1	4

Table F.5 Confidence – Responding Items *To what extent do you feel confident…*		
Categories	**Time 1 (% of total, n = 242)**	**Time 2 (% of total, n = 242)**
Managing your own response to a child or young person's distress?		
Not confident at all	1	0
Not very confident	15	2
Reasonably confident	68	63
Completely confident	15	32
Missing	1	3
Developing a shared plan with a child or young person about what will happen next?		
Not confident at all	2	0
Not very confident	30	5
Reasonably confident	50	55
Completely confident	17	37
Missing	1	3
Discussing concerns with appropriate professionals?		
Not confident at all	0	0
Not very confident	6	2
Reasonably confident	53	45
Completely confident	41	51
Missing	0	2

Appendix G: Feedback on Multiple Choice Questions





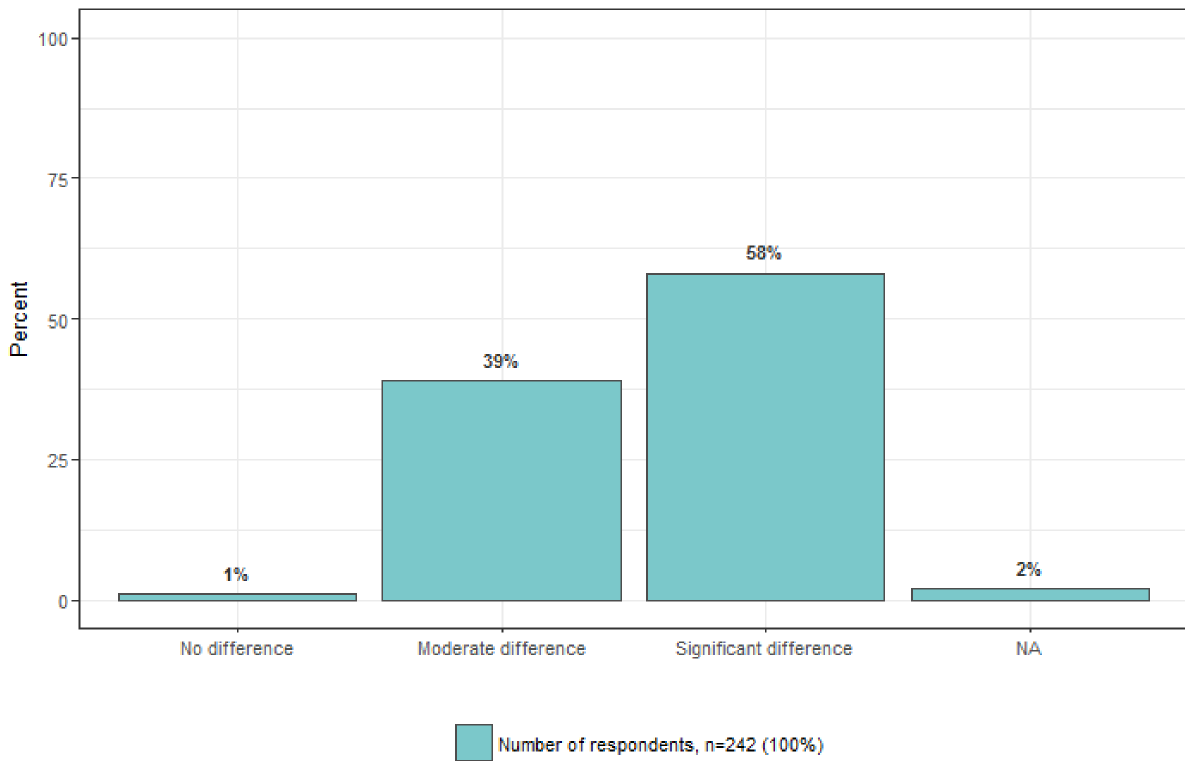


Figure G.3 Responses to the item,
'To what extent do you expect this training to make a difference in the way you do your job?'
100
75
50
25
0
Percent
58%
39%
1%
2%
No difference
Moderate difference
Significant difference
NA
Number of respondents, n=242 (100%)

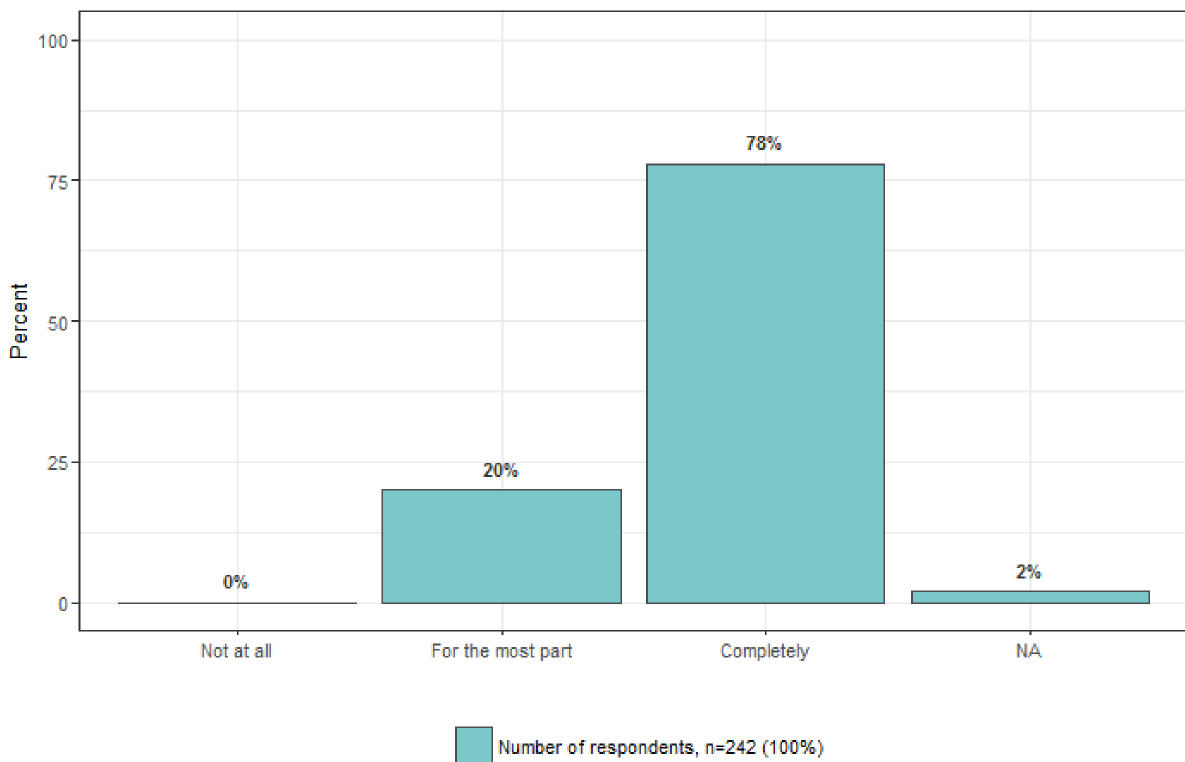


Figure G.4 Responses to the item,
'Would you recommend this training to colleagues?'
100
75
50
25
0
Percent
78%
20%
0%
2%
Not at all
For the most part
Completely
NA
Number of respondents, n=242 (100%)

Figure G.5 Responses to the item, 'Were presenter(s) competent and knowledgeable?'

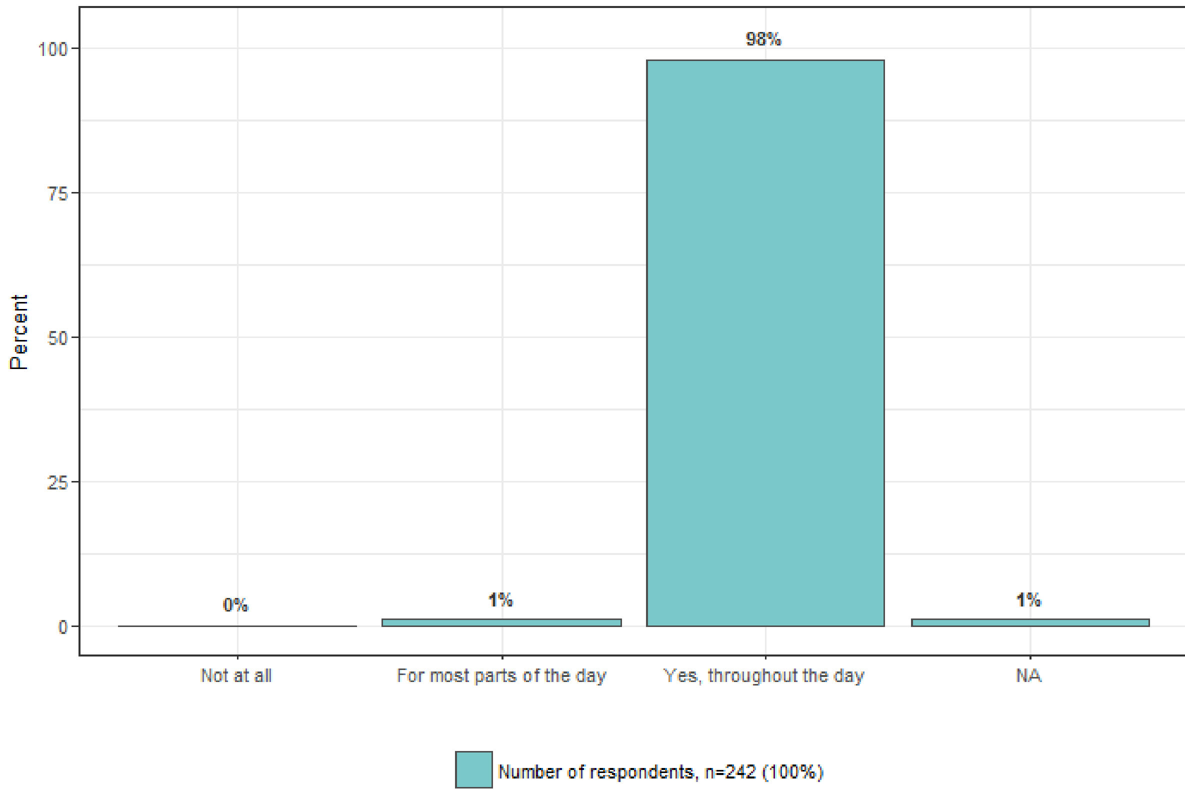
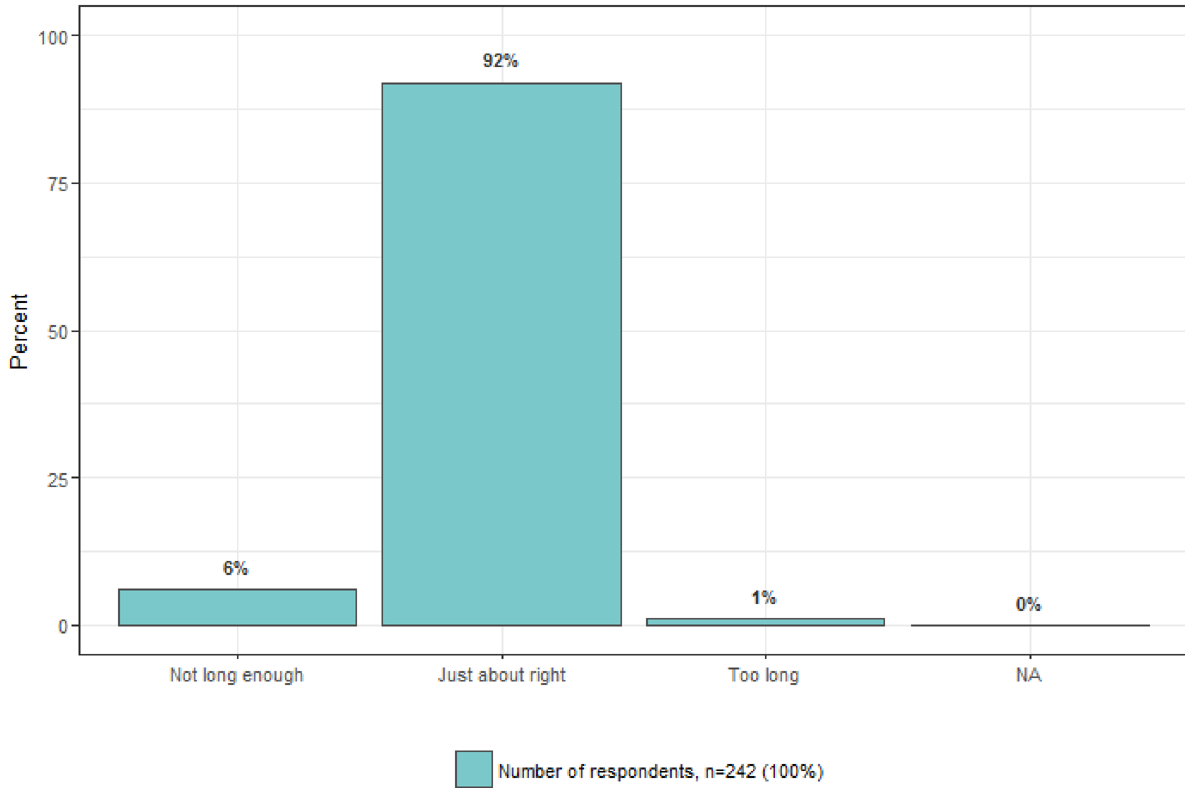


Figure G.6 Responses to the item, 'Thinking about the length of the training, was it:'



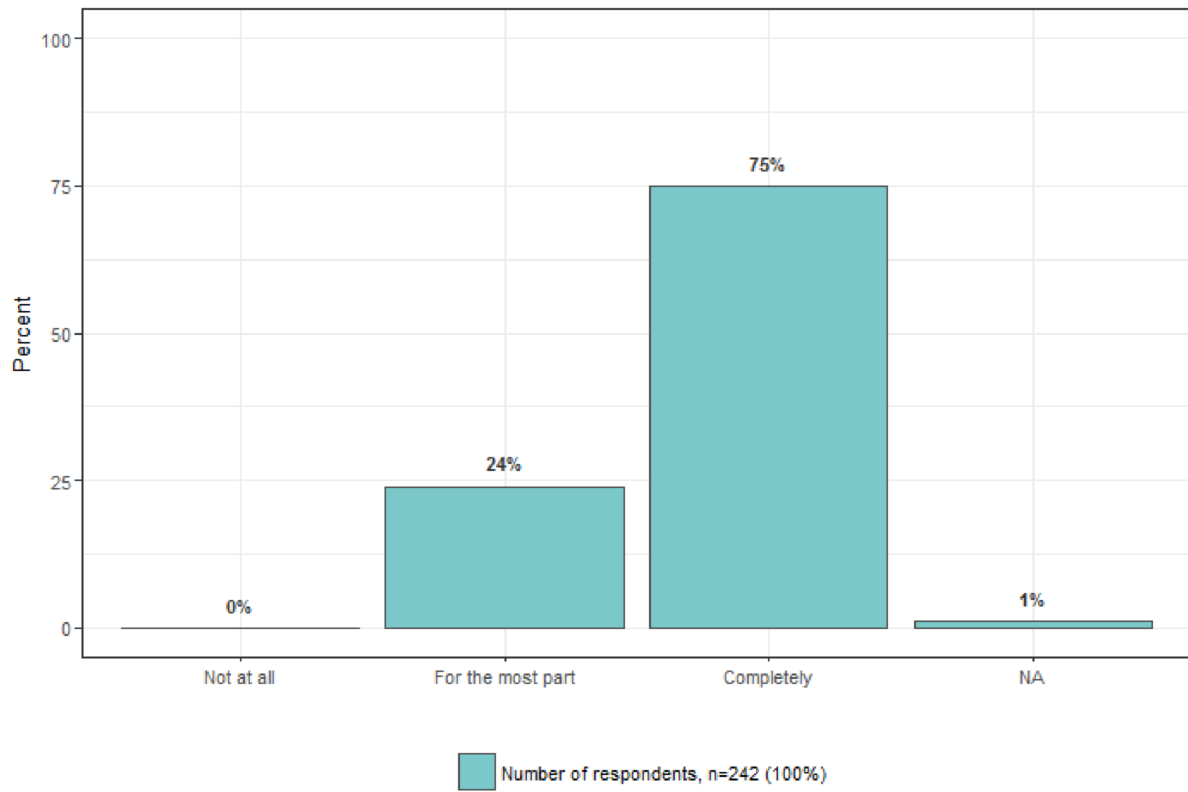


Figure G.7 Responses to the item, 'Was the venue suitable to your needs?'
Percent
100
75
50
25
0
75%
24%
0%
1%
Not at all
For the most part
Completely
NA
Number of respondents, n=242 (100%)

APPENDIX H: OPEN-ENDED FEEDBACK

Table H.1 Categories and Sub-Categories in Open-Ended Responses	
1. What was done especially well during the training?	**Number endorsing (% of total 246 respondents)**
1.1 Skilled and engaging facilitation	88 (36%)
1.2 Inclusive learning environment	23 (9%)
1.3 Interactive activities (role play and group discussions)	101 (41%)
1.4 Opportunities to reflect	47 (19%)
1.5 Tools for practice	29 (12%)
1.6 Young person input	18 (7%)
1.7 Relevance and accessibility	20 (8%)
2. What could have been better?	
2.1 Format	27 (11%)
2.1.1 Longer day of training	14 (6%)
2.1.2 More time spent on role plays / more scenarios	7 (3%)
2.1.3 Less time spent on role plays	4 (<1%)
2.1.4 Role play in small groups	2 (<1%)
2.2 Materials	10 (4%)
2.2.1 Material format & accessibility	3 (1%)
2.2.2 Visual aids	4 (2%)
2.2.3 More resources/tools/ scripts/stock phrases	3 (1%)
2.3 Additional content	20 (8%)
2.5 More input from young people	10 (4%
2.6 Pre-training information and logistics	12 (5%)
2.7 Venue	9 (4%)
2.8 Nothing	48 (20%)