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for Education

Evaluation of the Sefton Community Adolescent Service (CAS)

Research report

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Executive summary

In December 2014, Sefton Council was awarded £1.1m from the Department for Education as part of the Children's Social Care Innovation Programme, to establish a new multi-professional service dedicated to vulnerable adolescents aged 12 to 25 years - the Sefton Community Adolescent Service (CAS). The project received a further £3.9m from the Council and local partner organisations, with the aim of bringing about a step change in support for vulnerable young people, and achieving better outcomes.

In March 2015, Ecorys (UK) was appointed to undertake an independent evaluation of the CAS. A mixed methods design was deployed, incorporating desk research, qualitative interviews with key stakeholders within the CAS service and partner organisations; qualitative interviews with young people and their families, and a Cost-Benefit Analysis (CBA). The work took place between summer 2015 and autumn 2016.

Key findings

- overall, the project achieved mixed success. The original plan was overly ambitious, incorporating too many sub-pilots, and the CAS was rolled out while management and supervisory structures were still under development. Nonetheless, a boost to management capacity in early 2016 and a new joint protocol, helped to establish a niche for the CAS, bridging Early Help and Children's Social Care (CSC)
- the CAS was characterised by its organisation into multi-professional co-located team(s), underpinned by social pedagogy and restorative practice, and combining a key worker model with a residential short-term breaks unit. While bearing some resemblance to Multi-Systemic Therapy (MST), the CAS was wider in scope, with less focus on youth justice issues and a greater emphasis on family reunification
- the ability to capture and measure outcomes was hindered by a lack of centralised data held on individual young people referred to the CAS and their families. This situation arose as a result of delays in establishing a fit-for-purpose case recording system, and limited access to data from partner organisations. The changing structure of the CAS, and the shift towards a co-working arrangement with CSC in the later stages of the project, also meant that cases from different periods were not always comparable
- the available management data provides a broadly positive overall picture of the CAS. Approaching two thirds (65 per cent) of CAS cases were closed because the original aims in the family plan were achieved. A smaller proportion of cases were closed due to withdrawal of consent (26 per cent), or moving out of area (9 per cent)
- around 5 per cent of young people who were the subject of a CAS episode went on to become LAC at some point afterwards. The main factors identified by CAS teams

included the complexity of some of these cases, and the young people's long history of involvement in the care system. CAS practitioners considered that some young people were referred too late for the CAS to offer an alternative to becoming LAC

- young people and families consistently self-reported positive changes to their lives through the qualitative interviews. These included improvements to self confidence, family relationships, engagement in education, healthier lifestyles and behaviours, and being able to remain at home safely. The trust in the relationship with the key worker, and participation in setting goals, were particularly valued by young people, although they often had high expectations of the accessibility of their key worker
- a wide range of outcomes were also reported indirectly by practitioners, although the format of the CAS assessment and case management tools meant that these were not always recorded systematically. Practitioners had routinely observed:
 - stronger relationships between family members
 - re-engagement with education
 - reductions in missing episodes
 - reductions in levels of illegal substance misuse¹
 - securing access to temporary accommodation for homeless young people
 - facilitating access to specialist assessments (e.g. SEND, mental health)
- there was some evidence of savings arising from service improvements, including reduced numbers of different professionals involved per individual CAS case, and streamlining of administrative processes. Quantifiable savings also accrued from a reduced incidence of missing episodes, and cases stepped down from CIN or CP plans. These savings were offset by the costs of young people who became LAC

Aims and scope of the project

The target groups were adolescents aged 12 to 25 on the edge of care²; involved in, or at risk of, child sexual exploitation; gang and gun crime; exiting mainstream education; offending; missing from home or care; homeless, or Not in Education, Employment or Training (NEET). Referrals came via one of 3 routes – the Multi-Agency Safeguarding Hub (MASH), as a result of a Children and Family Plan, or as a step-down arrangement from a CIN or CP plan.

The project aimed to reduce numbers of young people entering the care system at age 13+; improve placement stability for LAC young people; reduce the number of children

¹ This was managed through a co-working arrangement with specialist addiction workers.

² Sefton Council did not apply a fixed definition of 'edge of care', but assessed eligibility in terms of multiple vulnerabilities associated with young people with involvement in the care system.

missing from home or care; achieve engagement in Education, Training and Employment (ETE); reduce involvement with the criminal justice system, and with guns and gangs; and reduce the number of young people at risk of Child Sexual Exploitation (CSE).

The model centred on 2 multi-disciplinary hub teams, working with young people and their families using a relationship-based approach and working to a single integrated family plan, with support for younger siblings where appropriate. These teams were supported by a 4 bedded residential children's home, commissioned to offer planned respite provision for young people in stressful family situations as part of the CAS.

Sefton Council also recruited 2 Young Apprentices to support the development of a communications and social media strategy for the CAS, with a view to scaling up young people's participation, and moving towards a Children's Council model.

Lessons learned from implementation

The project was implemented in 3 phases, as follows:

- phase 1 – early development (October 2015) – was characterised by intensive work with caseloads of 8-12 families, under the coordination of a single CAS worker. This proved conducive to the social pedagogy approach, by affording practitioners the time and space to build trusting relationships and to work with family members other than the young person who was the subject of the initial referral
- phase 2 – scaling up (spring 2016) - followed the CAS internal audit in early 2016, which identified concerns over the high proportion of cases requiring statutory work, and costly open-ended cases with weakly defined objectives. The management increased caseload sizes to 15-20 young people, with more active target-setting and review. While many practitioners were uneasy that the reduced contact time and pressure to close cases, conflicted with the social pedagogy model, this change was considered necessary to ensure the longer-term viability of the CAS
- phase 3 - consolidation (summer and autumn 2016) – saw closer integration between CAS and CSC, with a significant increase in the proportion of co-worked cases and a role for CAS in supporting the step-down from CIN plans. While the co-working model was established for a shorter period, the initial signs were promising. It allowed CAS workers to benefit from the additional safeguarding and risk management expertise of the social worker; although the co-working arrangement meant that the CAS intervention was strongly influenced by the quality of the statutory plan, as this formed the basis of decisions relating to the case

The CAS pilot set out to test a number of other distinct elements, alongside the key worker service. These experienced a mixed degree of success (Table 1).

Table 1: Overview of lessons learned from the CAS strands and sub pilots

Strand	Overview
Residential short-term breaks	The 4 bedded short-term breaks unit suffered from under-occupancy. This was a result of communication difficulties with the community CAS teams, and compatibility issues with some of the young people referred for a short break episode. Nonetheless, the respite format showed the potential to add real value. In successful examples, the short breaks provided valuable respite for vulnerable young people and eased the strain on family relationships. The work with younger siblings was particularly promising, and helped to ensure that the CAS retained a preventative focus, alongside working with high need cases.
Social worker exemption	Sefton originally sought an exemption from the requirement for all looked after children (Section 20) to have an allocated social worker, to enable continuity in relationships with the allocated CAS worker, on the basis that statutory requirements would be met. This was not pursued, due to the unnecessary risk posed to young people and professionals at a time when case recording systems were not fully operational. The approach was superseded by the co-working model with CSC.
Specialist residential foster care	The specialist foster carer secondment to the CAS was also halted at a relatively early stage. The piloting found insufficient demand for this dedicated post, and the council's in-house specialist foster care team already held the expertise to place vulnerable young people.
Private residential provider	The CAS included provisions for a residential children's provider to provide stability of placement for LAC up to 16 weeks, supporting rehabilitation, home, or permanency planning ³ . The procurement process was subject to lengthy delays, and the placements had not commenced at the time of writing the final evaluation report.

Recommendations

At the time of writing, Sefton Council had stated a commitment to extend the CAS, located under the Safeguarding Board. The proposed model included many of the hallmarks of the CAS from the pilot, including the integrated plan; the multi-professional teams; and a focus on preventing family breakdown and LAC, while recognising the need for the service to drive down the cost base and to operate in a more targeted way.

³ The residential provider was registered on 23rd September 2016 for residents, (Children's Act, 1989, S.20: Children Looked After). The residential resource provided an intensive assessment service with CAS.

The recommendations from the evaluation included:

- reviewing the eligible age range, and the flexibility to work with younger siblings
- consolidating the position of the CAS as a bridge between CSC and Early Help
- reintroducing flexibility to the residential strand of the service
- strengthening the multi-professional composition of the CAS
- establishing a clear pathway, and clarifying entry and exit routes from the service
- strengthening the evidence base for the CAS by improving data recording systems, and embedding stronger mechanisms to capture and validate outcomes

Methodology

The evaluation was funded between March 2015 and November 2016 to provide an assessment of the effectiveness of the design and implementation of the pilot programme, and the outcomes achieved within the 18-month evaluation timeframe.

A mixed methods approach was used, comprising qualitative interviews with senior managers, practitioners and partner organisations during Phase 1 and Phase 3 of CAS development⁴; qualitative interviews with young people and their parent or carer⁵; a quantitative survey of CAS teams and partner organisations⁶, and an analysis of CAS administrative data, including a Cost-Benefit Analysis⁷. The evaluators also observed a cross-section of strategy board and management group meetings. Further details on sampling, data collection, analysis and reporting are provided in the main report.

The scale and scope of the qualitative strand was sufficient to provide an in-depth set of perspectives on the emerging successes and challenges of the CAS. The CBA was limited by the small number of measures for which individualised data was available at a CAS cohort level (CP, CIN, missing episodes and NEET data), and the restricted access to police, health, youth offending and education (schools) data. It would be necessary to include a wider set of metrics to more fully explore the savings achieved by the service.

⁴ In total, 20 professionals were interviewed at Phase 1, and 25 professionals were interviewed at Phase 2.

⁵ In-depth qualitative interviews were conducted with 20 young people, and 5 parents or carers. A preliminary telephone interview was undertaken with the CAS worker for each case, to establish background context and to review progress.

⁶ A total of 52 responses were elicited across the surveys of CAS team members and partner organisations.

⁷ The CBA entailed an analysis of data on the costs of providing the CAS, and the outcomes (benefits) for a sample of young people supported. The savings were calculated based on the change in incidence of these outcomes, between a fixed period prior to entering the CAS, and a fixed period after exiting.

Introduction

In March 2015, Ecorys (UK) was appointed by Sefton Council to undertake an independent evaluation of the Sefton Community Adolescent Service (CAS). This report presents the findings from the evaluation, based on work carried out between April 2015 and November 2016. In this introductory section, we give an overview of the project aims and how it was structured, and we explain the evaluation aims and methods. We then go on to explain the structure for the remainder of the report.

Overview of the project

Funded with £1.1m from the Department for Education and a further £3.9m from Sefton Council and local partner organisations⁸, the overall vision for the project was to set-up and implement a new multi-professional service dedicated to adolescents aged 12 to 25, on the edge of care, who were involved in, or at risk of, child sexual exploitation, gang and gun crime; exiting mainstream education; offending, missing from home or care, homeless, or NEET. The project aimed to bring about a step change in how these young people were supported, and to achieve better outcomes.

Project aims and objectives

The primary outcome measures included a reduction in numbers of young people entering the care system at age 13+; improved placement stability for young people who were already looked after, fewer children missing from home or care, and to achieve engagement in Education, Training and Employment (ETE); reduced involvement with the criminal justice system; reduced involvement with guns and gangs; and fewer young people at risk of Child Sexual Exploitation (CSE). The logic model developed by Sefton Council and the partners set out how these were to be achieved (Appendix 2).

The original CAS model was guided by 5 core principles:

1. working with young people, their parents and younger siblings from 12-25 and never closing a case, creating the possibility for long term support throughout the transition to adulthood, by avoiding the need for re-referrals
2. creating sustainable professional relationships: a single referral process, key worker and family plan, removing the need for multiple workers and ensuring that parental needs were also identified and addressed to break the cycle of negative outcomes for younger siblings

⁸ See page 16 for a full listing of partner organisations.

3. seeking an exemption from the requirement that all looked after children (Section 20) have a dedicated social worker: permission was sought to provide flexibility for young people to remain with an existing worker, where there was an established relationship, with a delegation of authority
4. a multi-disciplinary service with a shared vision, evidence-based delivery, policies and procedures: instilling organisational culture change through a programme of training and professional development in social pedagogy and restorative practice
5. remaining focussed on the needs of young people: the active participation of young people at all stages of design and implementation, managed via the Children in Care Council and Young Advisers, and through the recruitment of 2 Apprentices to work within the CAS teams

Project structure and key elements

The CAS was based around 2 multi-professional hub teams, linking with the Multi-Agency Safeguarding Hub (MASH), and taking referrals where young people met the eligibility criteria (see also 'Project design and development'). The CAS underwent a number of adjustments, with service delivery falling into 3 main phases:

- phase 1 – early development (October 2015), which was characterised by a lower number of young people supported by the service (at around 80) and caseloads of around 8-12 young people, including a high proportion of more complex cases. This phase corresponded with the piloting of the original referral criteria (Figure 3), and the delivery and embedding of the social pedagogy training within the CAS teams
- phase 2 – scaling up (spring 2016), corresponding with a change of management within the CAS. This was characterised by more assertive marketing of the CAS to partner organisations, and targets to close cases within 6 months. This phase saw typical caseloads increase to around 15-20 young people, shorter interventions on average, and a greater mix of cases as the referral criteria were opened-up.
- phase 3 - consolidation (summer and autumn 2016), with total numbers of young people supported remaining stable (averaging just over 200), corresponding with the implementation of the joint protocol with Children's Social Care. This phase saw an increase in the number and proportion of co-worked cases between the CAS and CSC, and a clearer niche emerging for the CAS sitting between Early Help and CSC, with a focus on supporting family reunification and preventing LAC

Over the previous year of service delivery, between November 2015 and October 2016, the CAS teams had worked with 393 young people of 25 years and under, of whom 3 quarters (n=294) were supported by a CAS practitioner, and one quarter (n=99) were also assigned a co-worker from CSC. Most of the co-worked cases were assigned from the summer of 2016 onwards.

Finally, the project set out to test a number of distinct elements in conjunction with this new service. These included the following:

- exemption to the requirement for all looked after children (Section 20) to have an allocated social worker, to enable continuity in relationships with the CAS worker, on the basis that statutory requirements would be met within the service
- the secondment of a specialist foster carer to test what support might be needed to take on vulnerable young people on the 'edge of care'
- commissioning of a residential provider to provide stability of placement for LAC up to 16 weeks, supporting rehabilitation, home, or permanency planning⁹
- recruitment of 2 Young Apprentices to support the development of a communications and social media strategy for the service

Overview of the evaluation

The evaluation aimed to provide an independent assessment of the effectiveness of the new service; to capture the lessons learned from testing the different elements of the CAS model, and to assess the outcomes and value for money.

Ecorys designed a mixed methods approach, to meet these objectives. This included a combination of desk research, qualitative interviews with key stakeholders within the CAS service and partner organisations, qualitative interviews with young people and their families, surveys of practitioners and young people, and a Cost-Benefit Analysis (CBA).

- the qualitative interviews with professionals were clustered at 2 key points – autumn 2015 and spring 2016, following the initial rollout of the service (n= 20), and again in autumn 2016 following the scaling-up and subsequent consolidation (n= 25). Ecorys also attended and conducted observations at 3 of the Strategy Board meetings, and 1 of the Management Group meetings, and held a meeting with the Children in Care Council (the Making a Difference Group) in autumn 2015
- the qualitative interviews with young people and their families were conducted on a rolling basis during spring and autumn 2016. In-depth qualitative interviews were conducted with 20 young people, and 5 parents or carers. A preliminary telephone interview was undertaken with the CAS worker for each case, to establish background context and to review progress. Prior written parental consent was obtained for all interviews with young people under the age of 16, and participants were offered shopping vouchers in return for their participation

⁹ The residential provider was registered on 23rd September 2016 for residents, Children Looked After S.20 Children's Act 1989. The residential resource provided an intensive assessment service with CAS.

- a pre and post online survey of professionals was also carried out with the CAS hub teams and partner organisations, to supplement the qualitative interview data and to gauge views on progress achieved between baseline (n=52), and follow-up (n=20). The planned young person survey was replaced with qualitative interviews, following concerns about the administrative burden on the 2 CAS teams
- the Cost-Benefit Analysis (CBA) entailed an analysis of data on the costs of providing the CAS, and the outcomes (benefits) for a sample of the young people supported. The savings were calculated based on the change in incidence of these outcomes, between a fixed period prior to entering the CAS, and a fixed period after exiting

The data analysis comprised of manual content analysis of recorded and transcribed interview data, using a framework of themes and codes, and a synthesis of the different data sources, to arrive at summative conclusions. Ecorys also provided a baseline data scoping report in summer 2015 and an interim report and presentation in spring 2016.

Limitations of the evaluation, and future evaluation

The scale and scope of the qualitative strand was sufficient to provide an in-depth set of perspectives on the emerging successes and challenges of the CAS, and appropriate steps were followed for sampling, analysis and reporting. The CBA was limited by the small number of measures for which individualised data was available at a CAS cohort level (CP, CIN, missing episodes and NEET data), and the restricted access to police, health, youth offending and education (schools) data. The original analysis plan was based on the assumption of having access to a much wider range of individualised data, to be collected by Sefton Council and partner organisations using a Performance Outcomes Framework for the CAS¹⁰. The plans for developing this database were discontinued, meaning that it was not possible to undertake a full cost-benefit analysis.

¹⁰ The planned metrics included individual-level data for: LAC; escalation; stability in care placements; involvement in Crime and ASB; gang-related activity; CSE risk; drugs and alcohol; self-harm; DA or DV; mental health; educational participation, and behaviour and attendance.

Report structure

The remainder of this report is structured as follows:

- section 2 presents the key findings from the evaluation, reviewing the lessons learned from project design and development, project implementation, and the emerging evidence of the project outcomes and cost effectiveness
- section 3 draws conclusions from the findings from the evaluation, and offers a series of recommendations for policy and practice based on the findings in this report
- appendix 1 presents an Analytical Framework for the evaluation
- appendix 2 presents the Logic Model for the project, which was developed by Sefton Council and partners in consultation with the Spring Consortium coach
- appendix 3 provides further detail on the CAS staffing structure, enabling a comparison between start and end of project

Key findings

Project design and development

The original structure for the CAS comprised 2 multi-professional teams, located within hubs in the north and south of the authority, and supported by a wider network of partner organisations sitting outside the CAS and providing specialist expertise as needed (Figure 1, overleaf¹¹). The CAS was overseen by a Service Manager, supported by a Quality Assurance Manager. These management arrangements were completed with a CAS Strategic Board¹², with representation from all partner organisations, and a CAS Operational Group, mirroring these arrangements at a service delivery level¹³.

Overall, the strategic management and governance arrangements for the CAS were felt to have been overstretched during the initial stages of the programme. The post of Service Manager straddled the strategic and operational aspects of the service, and took on elements of project management. This over-stretch was perceptible to the partner organisations within the strategic board, with one board member observing that progress had been unnecessarily slow during the first 6 months as a result. The delay in introducing an electronic database until 3 months following pilot implementation was one such example of the operational challenges for the service.

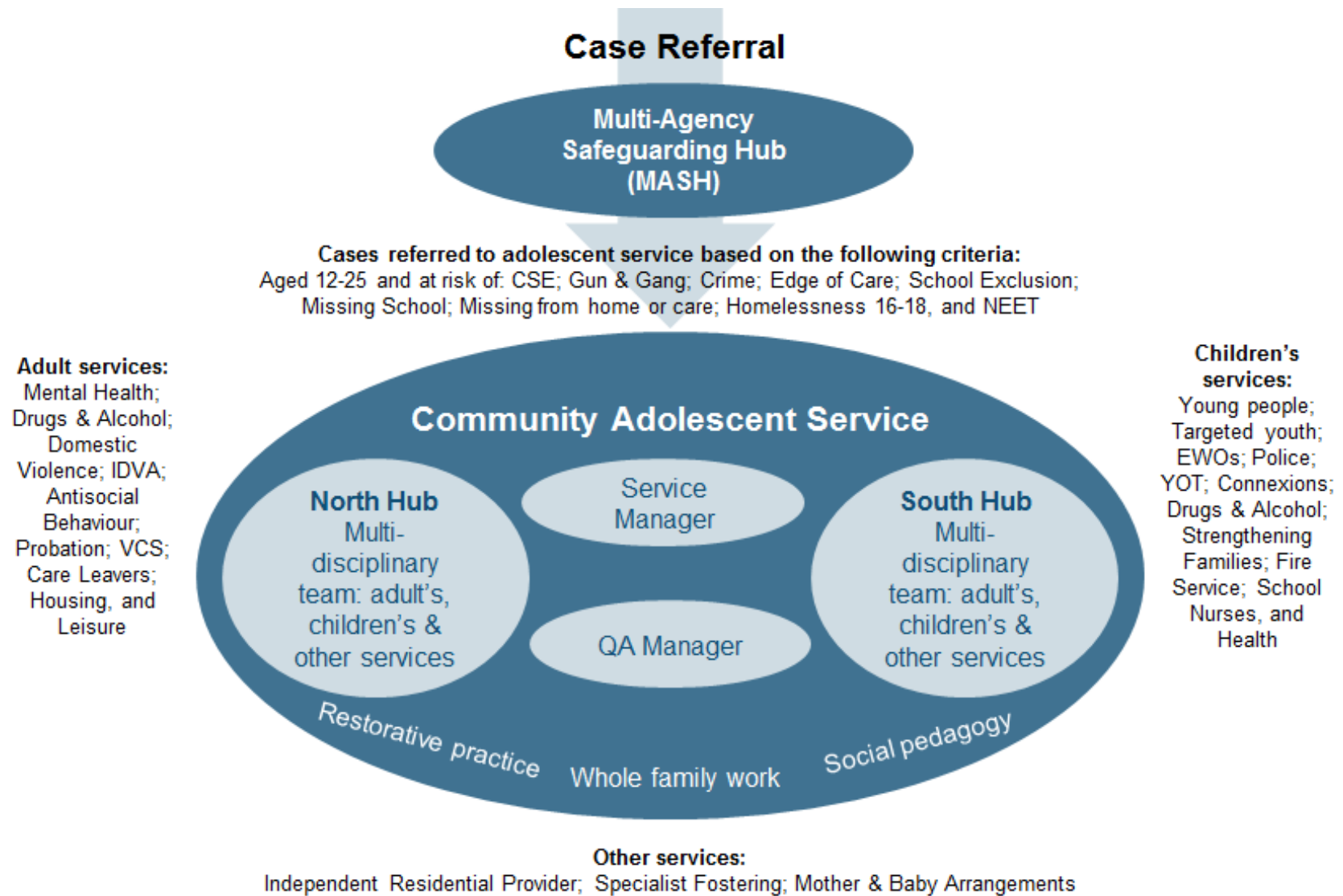
The management capacity issues were compounded by the challenging timescales for the national pilot programme. The vision for the CAS was based on 2 new multi-professional teams with an underpinning programme of training. However, the only viable model for staffing the CAS for a time limited project was through the re-deployment of staff from existing posts. The result was that the service went live while roles and responsibilities were still being mapped out, and protocols and systems were still under development. This resulted in some apprehension amongst staff, and left practitioners with a sense of operating outside of formal structures:

¹¹ More detailed information is provided on team composition and partner organisations at Appendix 3.

¹² The CAS Strategic Board was chaired by the Director of Health and Social Care, with senior level representation from Children's Social Care, Adult Social Care, Communities, Police, Probation Service, Early Help, MASH and Assessment, Safeguarding, Housing, Youth Offending Service (YOS), Council for Voluntary Services (CVS) and the Virtual Head-teacher.

¹³ The CAS Operational Group was chaired by the CAS service manager and included representation from the YOS, Youth Service, CVS, Sefton Children in Care Council (branded locally as the 'Making a Difference Group'), Family Support, Children's Social Care, and Housing.

Figure 1: Structure of the Community Adolescent Service (CAS)



“The first 6 months... we still got on it... we still did everything that we were asked to do and continued to work in the way that we were told we needed to work in, but I think that's a credit to the people that are working here really. They've just managed it, taken it in their stride and just done it, and just got on with it. I think that needs to be recognised.”

(CAS Practitioner)

The appointment of a dedicated strategic and operational lead for the CAS in January 2016 was widely welcomed by strategic and operational stakeholders alike, and was thought to have given a renewed impetus to the work programme, as well as taking important measures to strengthen protocols for management, supervision and joint working with other services. The decision was also taken at this stage to relocate the CAS from its original home within the Corporate Parenting Board, to sit under the Safeguarding Board, bringing the service closer to Children's Social Care (CSC). Nonetheless, significant slippage had occurred by this stage, with blurred lines of accountability for the service.

Multi-professional profile of the CAS teams

The CAS operational teams were staffed from a number of different services, and it was apparent that there were a number of advantages to this multi-professional format. Bringing together practitioners with different professional backgrounds – those who were previously based in Family Intervention Projects (FIPs) and Early Help, for example - helped to encourage self-reflection and to think critically about the key elements of the lead professional role. This created a suitable environment for the social pedagogy training.

Challenges of multi-professional working

These differences in previous roles and experience also presented challenges. In particular, it meant that practitioners had varying experience of case management. Not all of the CAS workers were familiar with undertaking a full range of case-holding and administration tasks within the same role, and this required some adjustment. It also took time to make the shift in mind-set from implementing short-term crisis interventions, to the longer term cases. There was a priority to quickly establish competences within the team, and to back-fill any gaps in knowledge and experience, although the absence of formal protocols and structures made it difficult to do so within the initial 6 months.

At the same time, it was considered important to maintain distinct areas of professional expertise, which were called upon to meet the needs of young people within the cohort. For example, the social care and education expertise of the CAS workers often proved invaluable, whilst having a seconded CAMHS worker significantly boosted the capacity for supporting young people and families with mental health issues. Similarly, colleagues

from the Youth Offending Service (YOS) were rated very highly by the CAS workers for their expert advice on the youth justice system.

One of the challenges encountered by the CAS was that staff turnover and absence eroded the original blend of professional expertise. The hub teams initially benefited from having representation from practitioners with a background in social work and education welfare, but, as individuals left, they were not replaced like-for-like. Moreover, the original secondment from the YOS was discontinued as it became apparent that the CAS was not the most appropriate forum in which to implement statutory youth justice orders, and a secondment was therefore of limited value to the YOS. Furthermore, a number of practitioners from adult mental health, Connexions and CAMHS did not join the CAS as originally planned. This meant that the skill set of the CAS teams drew quite heavily on Early Help and FIPs entering the final stages of the pilot, which was sometimes mismatched with the complexity of the casework:

“Recruitment and retention problems... [have] put additional pressures on the practitioners that are left. If we need a bit of YOT support, or a bit of education support, or a bit of social worker support, the workers that we had allocated aren't there anymore”.

(CAS Practitioner)

Overcoming the challenges of multi-professional working

This over-stretch was compounded by the difficulties encountered with poor communication during the first half of the pilot programme. The CAS teams found that cases were referred inappropriately, due to a misunderstanding of their remit. There was a perception that the CAS offered expertise in working with gun and gangs, for example; with social workers putting forward high risk cases on the basis that the CAS team were best placed to deal with them. It took a combination of measures to raise the profile of the CAS and to improve levels of awareness and understanding before these issues were tackled and the service achieved a stronger identity. Measures included the following:

- the re-branding of the CAS, and the marketing and communications campaign in early 2016, which significantly increased the visibility of the service
- the change agents model – practitioners acting as advocates for the CAS through contact with other services, and raising awareness of the offer in a more consistent way
- refreshed membership for the CAS operational management group, which provided a sharper focus on partner engagement in service delivery
- the completion of revised protocols for joint working between the CAS and CSC, to more clearly define how the service was positioned in relation to statutory work

The interviews identified scope to further strengthen the multi-agency composition of the CAS teams, and the wider tier of partners. Reflecting upon the experiences of the pilot phase, the main areas where additional expertise might be needed included:

- housing support – access supported lodgings for 16+ year olds in particular
- adult mental health - to widen access to therapeutic support within the CAS, and to address levels of unmet need identified among the families of young people
- education and careers advice – to strengthen the capacity of the CAS to offer support around 16-18 education, training and employment
- social work – by the latter stages of the pilot, there was only 1 social work practitioner within the CAS teams, and this gap in social work expertise was flagged as a potential cause for concern by some managers, given the need identified to embed stronger case review and safeguarding practices within the teams within the CAS Performance and Practice Improvement Plan

Other challenges were more operational than this. It transpired that the Police resource was initially under-utilised, and 50 per cent of the role was seconded to the MASH within 4 months of the start of the pilot. It was through the re-invigoration of the CAS strategy board in early 2016 that these issues came to the fore, and could be addressed. CAS teams commented favourably on the adjustment of the Police role, with stronger involvement in casework, including some joint home visits with CAS workers.

More widely, the CAS management identified scope to build on the effective engagement with specific clusters of schools during the pilot, in order to raise awareness of the CAS offer. The level of demand was thought to have been potentially high, although schools often wanted a conversation about the young people who were giving cause for concern, and found the indirect referral arrangement via the MASH frustratingly indirect. The Virtual Head Teacher representation on the CAS strategy board was also identified as a potential mechanism for ensuring that the service engaged with LAC young people.

Co-location and Hub Teams

Having co-located teams within a shared supervisory structure was thought to have helped develop greater consistency in professional practice, and facilitated both formal peer review and informal peer learning and processes. CAS workers noted that there were often connections between individual cases, and that having a core team based within the same building provided rapid access to information about individual families who had come into contact with the service previously.

There were mixed views on the value of having 2 geographically defined hub teams in the north and south of the borough. The CAS practitioners reflected that there were some differences in the profile of cases, reflecting the socio-demographic profile of the north

and south, and that local knowledge could be an asset - especially when identifying options for young people leaving the scheme:

“... you get to know your patch better, you get to know your community resources better, and you develop stronger relationships with schools in your area”.

(CAS Practitioner)

As the CAS started to move more towards a more specialist “edge of care” service during the latter stages of the pilot, however, the benefits of a single centralised team became more apparent, and this proved to be the model selected for the rollout beyond 2017.

Training and professional development

The bid for the CAS pilot identified a commitment to ensure that the service adopted a theory-based approach to working with adolescents. The aim was to develop the service based on the principles of:

- social pedagogy
- restorative practice
- whole family working

The decision was taken at an early stage to invest in a programme of social pedagogy training, which was sourced from an external provider. This training was delivered in 3 blocks of 3 days at a time, starting with the CAS teams (including the workers based at the short breaks unit) and subsequently rolling out to include a wider tier of professionals, including foster carers, third sector, and social workers.

The aspiration for the training was to achieve a common language and ethos for the CAS, and to achieve cohesion between practitioners from a variety of different professional backgrounds who were co-located within the service. There was also an expectation that this would foster a more self-reflective approach and to encourage peer-to-peer support, which would ultimately be reflected in joint planning and review processes to underpin the key worker model within the Hub teams.

Initial implementation of the training programme

There was some consensus that the timing of the initial wave of training was not ideal, coming at a point of upheaval while practitioners were re-locating to the CAS teams, and while there was ongoing uncertainty surrounding roles and terms of employment. It was difficult to relate the training to a professional role that was not yet fully defined, and this meant that there was some anxiety within the groups. Moreover, the gap between the training sessions for the CAS managers and practitioners in autumn 2015, and the development day in April 2016, meant that the external trainers did not see the day-to-day implementation of the social pedagogy techniques. Equally, however, there was

recognition that the training needed to be completed prior to the service going live, and a trade-off was needed between professional development and service continuity:

“There is a fine balance between training, development and service delivery. I think the learning from the implementation... is we could have done better in terms of intensive training. The last thing you want is interruptions because of routine work, business, managing risk. That was something that we had to manage and it was a difficult one in terms of delivering the service and the intensive training.”

(CAS Manager)

Despite these issues, the initial round of training delivery was received very positively by the CAS teams. The principles of social pedagogy resonated with practitioners, and the model was thought to sit well with the CAS ethos of “1 worker, 1 plan”. It was recognised from the outset that delivering social pedagogy training within a multi-professional setting presented challenges, due to practitioners’ varying expertise – especially so with regard to cases involving statutory work, where there was an emphasis on ‘enforcement’. In the main, however, this was not felt to have been problematic, as the context for setting-up the co-located teams had already pushed practitioners to challenge their professional boundaries and the training was just a single element of this.

Benefits of the training programme

Having had an opportunity to put the training into practice, the CAS practitioners generally agreed that the training had a number of tangible practice benefits:

- strengthening working relationships within the CAS teams: it was widely considered that the training had created an open environment within which practitioners felt comfortable to discuss and reflect on their practice among their peers. It also instilled a common language and ethos among the practitioners, along with confidence in what effective models of practice should look like
- supporting and sustaining engagement with young people and families: the social pedagogy approach was thought to be conducive to building families’ trust and confidence in the worker. This was assisted by the relationship-building and non-hierarchical approach. Practitioners often compared this favourably with more traditional social work models of engagement:

“One of the things that’s good for me is being able to reveal a little bit of yourself... and that’s something I’ve always felt I’d like to be able to do, but I’ve always been guarded... I think this is important stuff to build relationships [with families]. It’s part of the process”.

(CAS Practitioner)

- building families’ capacities for decision making, and reducing dependency: practitioners also spoke of the importance of social pedagogy techniques in building

families' confidence and capacities towards the point when an exit was feasible. Rather than creating dependency issues, therefore, the model was used to manage expectations and to avoid a sense that the support was open ended

Challenges of the training programme

Two main challenges emerged from embedding the social pedagogy training within the CAS teams. The first of these related to assessment and case recording. The internal audit of the CAS in spring 2016 found that practitioners were not systematically recording evidence of pedagogical work. The original CAS tool was comprised of a number of different assessments, including those relating to mental health, Youth Offending Services (YOS) and social care¹⁴. Practitioner feedback showed that it was cumbersome to implement. The CAS team streamlined the original tools and incorporated the Diamond Model of participant-led assessment (Eichsteller & Holthoff, 2012), with families rating progress visually on a chart.

The second main challenge related to the lower than anticipated uptake of the social pedagogy training among partner organisations. Only 2 social workers had completed the full 9 days of contact time immediately prior to the last of the 6 cohorts of training in September 2016, while other key partners such as YOS and housing teams, had also struggled to release staff. CSC had recently provided a comprehensive programme of Signs of Safety training for social workers, and there was limited capacity for further training. However, some partners questioned whether the full 9 days was proportionate for organisations sitting outside the CAS, and whether a shorter course of around 3 days might achieve a higher level of take-up. CAS management were exploring a range of options, including the development of a social pedagogy practice network, and a continuation of the 'change agents'.

There were some marked differences in opinion, regarding the future positioning of social pedagogy within the CAS. While many of the practitioners greatly valued this way of working, senior management expressed some concerns that it had obscured a wider set of professional development needs within the CAS teams:

“The skills mix in the CAS means that they have gone down that route and that route alone [social pedagogy]. But you also need crisis work, and you need systems theory. They don't have that repertoire, because they come from an Early Help background”.

(Senior Manager)

¹⁴ The original format incorporated: CAS consent and criteria; Basic details – general; Assessment framework - CAMHS and Mental Health; YOS or Asset; YOS - outcome star, and Signs of Safety (CSC)

Management oversight and supervision were highlighted as areas for improvement within the internal CAS audit in spring 2016, and within the CAS Performance and Practice Improvement Plan. The audit specifically identified the lack of a clear framework and supervisory standards, with formal supervision arrangements found to be too ad hoc. This partly reflected a lack of performance management, safeguarding and social work case management experience within the CAS teams.

Nonetheless, the Signs of Safety model was generally considered to be a good match with the social pedagogy training, and was selected to complement this with a social work practice model for managing risk within families with complex needs. Practitioners also valued the peer-to-peer support, and commented on the value of being able to discuss individual cases in a supportive setting with other practitioners.

Project implementation

This section reviews the key findings from the implementation of the pilot. We start by considering how the target groups were identified and engaged, and the adjustments that were required as the CAS was rolled out. We go on to consider the lessons learned from service delivery, examining each of the different strands of the CAS service in turn.

Identifying and engaging the target groups

All referrals to the CAS routes came via 1 of 3 routes: directly through the Multi-Agency Safeguarding Hub (MASH¹⁵), as a result of a Children and Family Plan; or as a step-down arrangement from a Child in Need (CIN) or Child Protection (CP) plan. A protocol was set in place to ensure consistency in the referral process. This was assisted by the high levels of coordination, including a CAS worker sitting in MASH on a part time basis to attend multi-agency meetings. The involvement of the CSC Assessment Service manager on the CAS strategic board also ensured close links between the 2 approaches.

The eligible target group for the CAS was identified (as follows) at the stage when Sefton Council first developed their funding bid for their innovation project:

“Adolescents aged 12 to 25 on the edge of care who are involved in or at risk of child sexual exploitation, gang and gun crime, exiting mainstream education, offending, missing from home or care, homeless or NEET”.

¹⁵ The MASH brings together a range of agencies into an integrated multi-agency team, where information is shared appropriately and securely on children, families and adults around the child or young person. Phase 1 of MASH involves all contacts pertaining to domestic abuse, CSE, or where the child is deemed to be at risk of significant harm (Child Protection). Sefton’s MASH is an operational model as such the MASH social workers will undertake any Section 47 investigation that is required.

These criteria were based on research evidence for the risk factors associated with entry to the child protection system (Education Select Committee, 2012). A local mapping exercise was conducted prior to the submission of the bid to the Innovation Programme, to estimate the potential size of the CAS cohort using these criteria. This exercise showed that the 141 young people were potentially eligible for support from the CAS, including those already very vulnerable and involved in risky behaviours, and those at an earlier stage of escalating problems.

This initial work was used to develop a light-touch screening tool (Table 2). Young people originally had to meet 2 of the criteria from 2 sets of risk factors (Groups A and B), as a proxy measure for multiple vulnerabilities. There was an aspiration from the outset to work with the younger siblings of vulnerable young people who were eligible. The CAS, as originally conceived, was intended to include a preventative dimension – both in terms of young people who were the subject of the initial referral, and of the work with their siblings.

Table 2: Eligibility Criteria for the Community Adolescent Service

Control Groups	Criteria of risk factors
Group A	<ol style="list-style-type: none">1. Sexual exploitation (risk of, or involved in, police investigation)2. Missing (risk identified)3. Sefton young person, homeless 16 & 17 years old4. Gun and gang – youth at risk5. Edge of care or risk of local authority accommodation
Group B	<ol style="list-style-type: none">1. NEET2. Domestic Violence (DV)3. Neglect4. Persistent absence from education5. Substance misuse6. Self harm by the young person7. Significant contact or referral history8. Crime and ASB9. Parental mental health10. Young person's mental health

The early development of the CAS showed that the risk profile of the young people who were referred was higher than anticipated. There was a greater proportion of acute cases

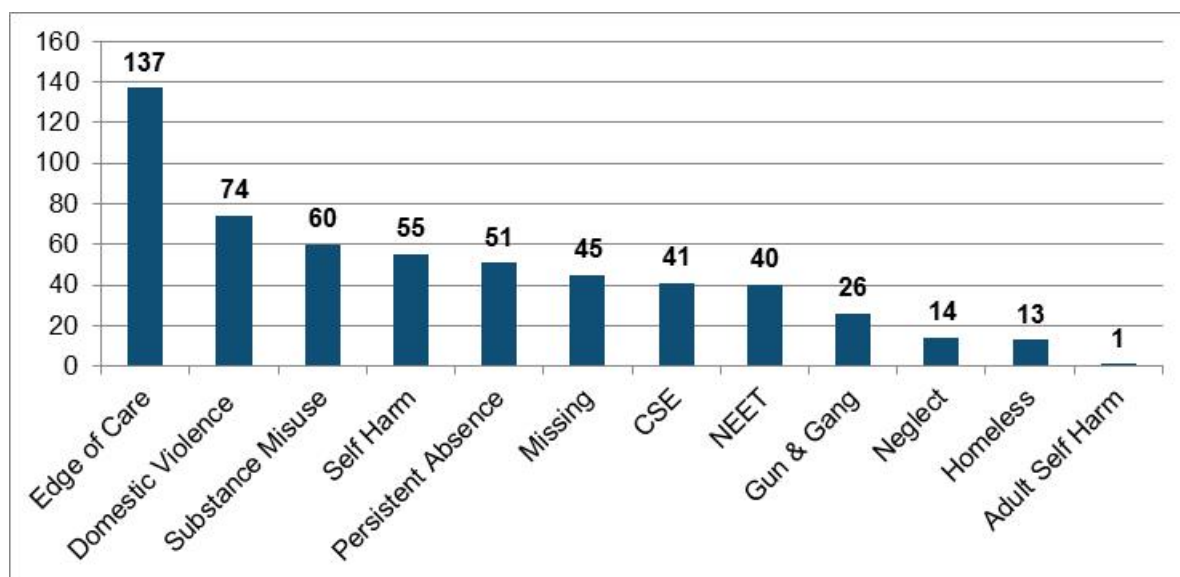
where there were risk factors such as domestic violence, substance misuse, and self-harm, and the intended preventative dimension was less apparent. The interviews suggested that there were 2 main factors involved, as follows:

- the first of these was the original eligibility criteria. The fact that young people had to meet 2 of the criteria from each set of risk factors (Groups A and B) inevitably meant that there was a high level of complexity. The consequence of this model was a skew towards higher levels of need
- the second factor was the profile of cases referred via the MASH, including a high proportion of 15, 16 and 17 year olds who were well known to children's social care. These were described by a worker as last chance cases, where the referral was made as a final effort to avoid a Child Protection Order (CPO). There was also a high proportion of cases involving homelessness, or homelessness risk, which had underlined the scale of local demand for emergency accommodation.

Action was taken to modify the CAS eligibility criteria as a result, so that young people would only need to meet one of the criteria from Group A or B, plus a crosscutting 'edge of care' criterion. This gave greater discretion to the CAS workers to appraise levels of need and scope for issues to be disclosed during the assessment phase, after consent had been obtained. Even so, the teams faced a challenge in moving forward young people with a very long history of intervention, and had already accrued a significant number of more complex cases at the stage when the changes were made to the criteria.

Across the available period for which monitoring data was available, young people qualified for the CAS across the full range of eligibility criteria (Figure 2). Unsurprisingly, the 'edge of care' criterion was the most prevalent within the cohort (n=137). There was a correspondingly high occurrence of social care indicators such as domestic violence, substance misuse, self-harm, CSE and missing children. Educational indicators including persistent absence and NEET, were also prevalent (n=51 and n=40, respectively).

Figure 2: CAS eligibility criteria selected at assessment stage



Source: CAS management data (Jan 2017) Base: n=329 cases

A further analysis of the assessment data shows a fairly high level of prior involvement with the care system, among young people in the cohort. Of those 329 young people of 18 years or younger who were subject to a CAS assessment, 127 were previously subject to CIN plans; 87 were previously subject to CP plans, and 33 were previously subject to LAC plans, indicating a fairly high level of prior involvement with CSC¹⁶. The sub-group of young people meeting the 'edge of care' criterion also had a fairly substantial level of prior involvement with CSC, although not all of them had been subject to a statutory plan prior to starting on the CAS (Sefton Council, 2016)¹⁷.

Working with young people and families

The key worker or casework service was at the core of the CAS model as envisaged in the original bid. The pilot set out to test whether having a single worker, trained in social pedagogy and restorative practice methods, offered a more effective alternative to more traditional models of professional contact with young people and families.

The qualitative interviews with young people and their families who were involved in the research (n=25) provided some important insights. These interviewees were largely

¹⁶ As the management reports do not stipulate dates for previous CIN, CP, or LAC episodes, the timeframes between closure of the plan and the CAS episode are not known. Furthermore, these data exclude any co-worked cases between CAS and CSC, as assessments would be conducted by the social worker as part of the statutory plan and not by the CAS worker in these cases.

¹⁷ By way of further breakdown: 53 of the 137 young people meeting the 'edge of care' criterion had a previous CIN Plan (of whom 47 had 1 previous plan, 5 had 2 previous plans, and 1 had 3 previous plans); 31 had a previous CP Plan (of whom 27 had 1 previous plan and 4 had 2 previous plans), and 16 had a previous CLA Plan (of whom 13 had 1 previous plan, 2 had 2 previous plans, and 1 had 3 previous plans).

positive about their involvement with CAS. Most young people had recognised the need for professional support when it was first offered to them, and had wanted to change their own situation, or that of their family. A few said that they were initially wary of the key worker, but quickly recognised that the support would be beneficial.

Young people often felt that their key worker took a different approach to others who had been involved with them in the past, although they often struggled to recall who these different professionals were. The primary difference noted by young people and families was having 1 worker, and avoiding the need to have contact with multiple different agencies. One parent described how she had previously attended a Team around the Family (TAF) meeting where 17 professionals were present, and she had found this very difficult to deal with. Meanwhile, 1 young person noted “I hated having 12 people involved. None of them talked to each other and nothing really got done.”

For the most part, young people felt that the most important aspect of the service was having someone to talk to. Those who were most positive about the service also felt that their key workers had taken the time to get to know both the young person and the wider family, and from that the key workers really understood their issues and family dynamics. This also seemed to be a factor that distinguished CAS workers from those from other services. One noted that her work with CAMHS had focused on her own feelings and emotions, while CAS explored her whole family, and therefore the key worker understood the family better. As a result, she noted that “I can talk to him about stuff I wouldn’t talk to anyone about before.”

While the quality of the relationship was crucial, young people also placed a heavy emphasis on the importance of having a voice in their interactions. Almost all of those interviewed said that they felt involved in setting targets and actions, and felt that they had a say in what happened, which seems to reinforce the social pedagogy basis of the CAS approach. Comments included that:

“She [key worker] asked the right questions... she asked me how I felt about things instead of just talking to my mum about me... she actually helped me to get what I needed.”

“He knows how to sort situations. He doesn’t just pick a side, he listens to both.”

“I feel like I can tell her everything because... she just listens to me.”

(Young people, CAS beneficiaries)

While the voluntary and consent-based nature of the engagement was not discussed explicitly by young people, 1 noted that they had not engaged well with social services previously because they had felt “forced to comply”.

Young people were also positive about their ability to access support when they felt they needed it. For example, the interviewees often described their key workers as being responsive and easy to contact, with almost all stating that they had their key worker's number and could call them whenever they felt they needed to. However, it was clear that young people's expectations of making contact with their key workers were often very high. It was common for young people to refer to being able to (or wanting to) contact key workers on a weekend or out of hours. A number of young people reported having needed to contact their key workers in the event of an emergency, including where issues had arisen during evenings, when they had needed to call their worker.

The use of therapeutic services provided by, or through, the CAS was quite common, and was viewed in a positive light. One family had been attending family therapy and the young person interviewed could now reflect on how her behaviour (and that of her siblings) impacted on the family dynamic and home environment. Another young person had been supported to live independently and had received help to attend college.

Involvement of the wider family

The impact of parental behaviours on young people was very apparent from the qualitative interviews with young people and families. Young people and their parents or carers commonly talked about a breakdown in family relationships, and expressed concern about the effect on their siblings, reflecting the importance of supporting a wider family rather than focusing solely on the young person at the centre of a referral. Parental mental health issues, alcohol dependency and domestic violence were recurrent themes, perhaps highlighting a need for the involvement of a range of adult services in the provision of CAS, which was not fully apparent during the pilot.

In most instances cases, young people noted that parents or guardians were involved in meetings with the key worker. These generally involved assessing need and setting up action plans. Family members were also regularly described as having been involved in the intervention. Numerous examples were provided of support to other family members as part of the CAS work. In one example, the key worker had supported the family to access an intensive alcohol detox programme, while in a further example the key worker had secured specialist support for a sibling with autism. One young person recalled that:

“There were a couple of disagreements but [the key worker] really helped. It was all about the talking and the way we were talking. She would tell us where we went wrong and would suggest what we needed to do. She is kind... she listens to us.”

(Young person, CAS beneficiary)

In a handful of cases, young people held more negative or ambivalent views about the CAS. One described the involvement of the CAS key worker as causing arguments within the family, and had experienced this involvement as being intrusive. Another reported

having had only limited contact with their key worker and had found this frustrating, with a perception that progress was disappointing as a direct result.

Challenges arising from implementation

Risk management proved to be one of the key challenges for the CAS during its early development in 2015. The timescales for rollout meant that it was necessary to go live with the service whilst management structures and protocols were still being tested and embedded. This resulted in some practitioners feeling overstretched prior to the appointment of the dedicated managers for each CAS hub team, both in terms of their individual decision-making, and in the availability of information to assess levels of risk and to decide when to escalate. The service framework for the CAS was new and untested, and this was coupled with the expectation that practitioners would keep cases open for longer periods of time, requiring ongoing monitoring.

The piloting of the CAS also demonstrated that there were advantages and drawbacks to the consent-based model for the service. On the one hand, there were often benefits in terms of transparency, and gaining families' trust. On the other, it entailed that a voluntary service was overseeing cases that included an Education Supervision Order or a Youth Offending Order. CAS workers found themselves in an enforcement role, which sat uncomfortably with the ethos of the service, and required levels of specialist expertise that were not always readily accessible to the CAS teams. The consent-based approach meant the workers had limited powers to prevent young people or families withdrawing if problems were encountered during the intervention. One CAS manager recalled:

“There's a young person previously known to the YOT, family involved in CAS, who said he didn't want his family to be involved in the management of the YOT order. That's a difficult one to manage because we wanted to get the family - particularly mum - involved in supporting the plan to prevent him from offending. He didn't want mum to be involved, nothing to do with mum; a 17-year old lad, 'I want to withdraw my consent'. These are genuine issues that are thrown up”

(CAS Manager)

Caseload management

The approach taken to caseload management and casework was influenced by the changes to the structure and focus of the CAS during 3 main development phases.

Phase 1 – early development (from October 2015)

The CAS workers typically held caseloads of 8-12 families during the initial stages of the project, although this was subject to considerable variation depending on levels of complexity. The CAS teams encountered some scepticism - or even hostility - from other

services, including a view that the service was over-resourced and that caseload sizes were too small. Social workers might have 20-30 cases each, for example.

Although there was an acknowledgement of the need to increase throughput, a direct comparison in caseload sizes with social care was considered to have been unhelpful. Under a social work model, the specialist inputs are typically commissioned (e.g. single pieces of work by the Youth Offending Service, Drug and Alcohol Team, and so forth). In contrast, the CAS practitioner would assimilate many of these functions within a single role. In this sense the smaller caseload sizes were offset with potential cost avoidance by removing the need for multiple referrals and commissioned pieces of work.

Practitioners had also encountered a misperception amongst external agencies that the CAS service was an entirely 'additional' resource. However, Senior Management confirmed the hub teams were formed by seconding staff from the Strengthening Families service and Family Intervention Project (FIP) staff from Sefton. In the short term, this meant that the new service was compensating for reduced capacity in other teams, and this was felt to have had a knock-on for the referrals to the CAS.

Case-holding arrangements underwent a review in spring 2016, as part of the wider exercise informing the CAS Improvement Plan. From a management perspective, the CAS had suffered as a result of difficulties with the MASH operating at a high threshold, which meant that young people were often at a more acute stage by the time they came to the attention of the CAS, and the hub teams were holding a disproportionate number of 'high risk' young people as a result. This had skewed the profile of the service, which should have been accessible to a much wider cohort, and resulted in a backlog of cases requiring longer-term inputs.

There was also a perception by the incoming management that the CAS teams had been previously led to believe that caseloads would remain low, when this wasn't necessarily realistic or appropriate; and that the resistance among staff to close cases partly arose from a misunderstanding of the arrangements for leaving the service. The concept of dormant cases was intended as a mechanism to ensure that families could be moved on from the service once the objectives in the CAS plan had been met, while maintaining the flexibility for re-engagement if this later proved necessary, without the need to come back via the MASH. Without this safety valve, there was a perceived risk that the CAS would become over-run with a large number of very long-term cases.

"If it's true Early Help then you don't need to be in that family home 5 days a week. As you get to the "edge of care", there is that need for more intensive work for a period... around 6 weeks... but then that should calm down, and if it doesn't then it might not be the right intervention".

(Strategic Manager)

The original bid included an aspiration to keep cases open for as long as necessary, and potentially up to the age of 25. On reflection, both managers and practitioners perceived that this was unviable in the format that was originally intended. However, it was acknowledged that various steps could be taken to stepdown the case, at the point when less intensive intervention was required. The CAS management were exploring ways to ensure young people received a service that was proportionate to their need and risk.

One such option was described in terms of maintaining 'dormant' cases – young people who would remain on the case management database and be tracked, with the scope to re-activate if their needs escalated. The key principle in this respect was that the same worker could re-engage directly with the young person at any point (and vice-versa), rather than requiring a re-referral via the MASH. Several examples were uncovered through the qualitative interviews. For example, one young person had not seen her CAS key worker for 4 months at the point when she was interviewed. However, she felt that her situation was now much more stable, and that she did not feel she needed to see her key worker at the moment. She was confident that she could contact the key worker at any time she needed to.

Phase 2 – scaling-up (from spring 2016)

The change in approach in early 2016 was viewed as something of a watershed by the CAS practitioners. There was a very noticeable increase in caseload sizes, and a sense that the new management approach was drawing much more strongly on a social care model with regard to target-setting and review. This was reflected in the drive to close cases that had been open for more than 6 months, while seeking to open up the service to greater numbers of young people, with a focus on shorter periods of intervention. Some tensions were apparent between the management position that this was a necessary move to ensure the longer-term viability of the CAS as a service, and the concern among many practitioners that the push on closing cases at 6 months, and the greater numbers of cases, risked undermining the social pedagogy model. There was some consensus among practitioners that a certain 'critical mass' of contact time was necessary with families to maintain their engagement:

“Initially it was a very intensive service with a clear approach, and I think the approach itself has changed... it's very much social care, very much numbers, very much processing... and it's changed the work massively in terms of what families are receiving, and what we're able to offer. The shift away from doing the pedagogical work is a shame, because it's a good model”

“The whole thing rested on building a relationship with young people... it may take 3 visits to get to see someone, and if you've got a lot of cases, you're looking then not to be wasting these visits... so then the relationship is not there, and it's harder to do the work with the young person... they won't wait around for you”.

There were also concerns in this respect about the reduced scope for working with the siblings of young people in the CAS, where higher caseloads placed greater limitations on the amount of contact time that was possible beyond the work with the young person who was the subject of the initial referral.

Phase 3 – consolidation (summer and autumn 2016)

The shift towards co-working was one of the most significant changes made to the model, and effectively signalled the start of a 'third phase' of the CAS during the summer and autumn of 2016. This approach was driven by 2 main considerations. First, it represented a strategy for managing what were considered to be unacceptable levels of risk at the point when the service was reviewed in early 2016, with CAS workers holding cases that required social worker expertise. Second, it allowed for a much clearer repositioning of the CAS, to identify joint pathways for young people with CSC and to raise the profile of the service and what it could offer. It was apparent that the CIN case review provided the impetus, while the introduction of the joint protocol for CAS and CSC was an enabling mechanism that formalised the joint working arrangements and provided greater clarity for the remit of CAS workers regarding statutory work.

The case review showed that, while most CIN cases could step across to the CAS, there was a time lag in the completion of statutory social work processes before young people were ready to be stepped down. A co-working arrangement allowed CAS workers to engage earlier, and to provide a managed transition from CIN. The benefit for CSC was to ease capacity and to provide a better quality of input to CIN cases, while for the CAS it meant that there was stronger risk management because social workers retained an element of the risk.

There was a good match with the ethos of the CAS, as this arrangement meant that the CAS workers could take on young people who had been placed with parents to focus on reunification. The main drawback of the co-working arrangement was that the quality of the CAS Intervention was dependent, to a greater extent, on the level of engagement of individual social worker, and the quality of the statutory plan. There were some residual tensions where individual social workers were less willing to engage with the CAS, and where CAS workers were more sceptical of a drift towards a social work practice model. However, the protocol generally proved to be effective in formalising roles and responsibilities, while the co-working provided the ongoing inter-professional contact that was needed to build a better understanding of the CAS within CSC teams:

“The casework needs to be directed by the [statutory] plan, whether it’s coming down from CP to CIN, or from CIN down to the CAS for longer-term support... it needs to be established by social workers, and I don’t think they understood that ... they would just say, ‘you need to build relationships in that family... off you go”

(CAS practitioner)

Other strands of the pilot

The CAS pilot set out to test a number of additional strands, alongside the key worker service. These included the social worker exemption, foster carer sub-pilot, and residential provision, including short breaks. The picture was rather mixed with regard to the success of these different elements, and a number of changes were made.

Exemption from social worker requirement

Sefton Council had originally sought an exemption to the requirement that all looked after children have an allocated social worker, on the basis that there would be social work qualified managers within the CAS, and that every young person would have an allocated worker who would ensure both that the statutory requirements were met in full, and that all looked after children received the full protection of existing legislation.

CSC senior management took the decision not to go ahead with this arrangement. It was recognised that the CAS workers were often dealing with acute and complex cases and that the exemption posed an unnecessary level of additional risk, because not all of the CAS workers were from a social work background, despite the social work expertise within the management teams. The co-working arrangement was ultimately taken forward as an alternative, as this ensured that cases involving a statutory CIN or CP plan benefited from the ongoing involvement of a social worker up to the point when the plan was closed. The CAS worker was then able to continue to work with the young person where necessary, to support any follow-on work around family reunification.

Foster carer pilots

The CAS originally included a specialist foster carer secondment, to develop 2 related strands of work. The first was to develop a ‘kinship care’ model – working with extended family members as if they were foster carers, and the second was to work with existing foster carers to test what support or incentives might be needed for them to take on a vulnerable young person on the “edge of care”. The pilot sought to establish the level of demand for this service, and whether placement with suitably trained extended family members was a more attractive option for caring for young people within the CAS cohort.

The specialist foster care element of the programme was discontinued. This was ultimately because there was insufficient demand to warrant the seconded post. Moreover, it became clear that the council’s in-house specialist foster care team already

held the expertise and capacity to place vulnerable young people and that there was a risk of duplication. The specialist foster carer placement therefore ended.

Residential short breaks for young people

The CAS pilot included the provision of short breaks for young people, to provide respite from volatile family situations. The aim was to integrate the short breaks provision within the CAS to provide a seamless service, underpinned by social pedagogy training. The residential staff mirrored the social pedagogy techniques used by the community-based CAS workers, and the short break was approached as a planned intervention with clear expectations from the outset. Young people were the subject of a short break plan, in accordance with Ofsted guidelines, which typically included building self-sufficiency skills, and activities from the 'Teen Talk' programme, covering anger management, counselling, self-esteem and anti-bullying.

A total of 69 young people accessed the short breaks during the first year, of whom:

- 28 were being supported by a CAS key worker
- 41 were the subject of a co-working arrangement between CAS and CSC, of whom 9 were subject to CP plans, 10 were subject to CIN plans, and 22 were subject to Children and Families assessment

There was mixed success with piloting the respite service as part of the CAS. While the original vision was for a single unified offer, the 'community' and 'residential' CAS teams remained very separate despite the joint training and the shared protocol. This was attributed to a number of factors, including the different regulatory requirements for the residential unit; management differences, and a lack of regular communication during the initial stages of the pilot. In the best examples, the short break plan was nested within the over-arching CAS plan, with regular progress meetings between the community and residential workers, but this was not always the case.

Challenges of delivering the short breaks provision

One of the main challenges related to under-occupancy. This was partly due to compatibility issues: it was necessary to assess young people to determine whether there were potential conflicts with others who were already accessing the provision, and solo placements were necessary for particularly vulnerable young people. Also, the respite provision was under-utilised by the CAS community team during the initial stages, with a tendency for workers to hold young people and only refer at a crisis point.

The registered manager of the short-term break unit conducted weekly drop-in sessions with the CAS team to raise awareness of what they could offer, including more preventative work, and there was some success with this approach, which challenged the perception that the short breaks were exclusively for crisis situations. Numbers did not

increase significantly, however, and there was a perception that the higher caseloads following the spring 2016 service review made it less likely that the CAS workers would see the short breaks as an attractive option, given the additional coordination time.

Where the respite provision was accessed in a joined-up way, however, the feedback from CAS workers and young people was invariably very positive. Those practitioners who had a number of young people on short break plans valued this service highly, with it being noted that it "...fitted hand in hand" with the community-based work. The aspects of the short break provision that proved to be the most successful included:

- additional contact time with young people

A principal benefit of the respite provision was the opportunity for staff to engage with young people in an informal setting, which often provided further insights to their needs and circumstances. Staff cited a number of instances where professional curiosity on the part of the residential workers had identified previously undisclosed issues, including a case where CSE risk was identified during the stay, and was subsequently factored in to the CAS plan. The short break format was felt to have made the difference:

"They're here for a good few hours... so we can have those conversations in a nice, relaxed way. They'll open up a lot to the staff, because they'll build up that relationship and they put their trust in you, because you're looking after them".

(Manager, Short Breaks resource)

- flexible access arrangements

The piloting showed that a planned sleepover was not always the best option, and that some young people benefited the most where they were able to access the unit as a safe environment in which to do shorter pieces of work after school before returning home. One example was given of a 14-year-old who was very protective of her mother, following past issues with domestic violence in the family, and who did not want to spend a night away. The flexibility allowed the team to undertake a valuable intervention with her. In another example, a parent had an unplanned hospital admission and it was possible to make a bed available for the young person for several nights at the provider.

- work with siblings

While the short breaks were quite often provided for the young person who was the main focus of the intervention, and for whom family relationships were the most problematic, it was not uncommon for the short break plan to include respite for siblings. This work added a stronger preventative dimension to the CAS plan. It also helped to provide time and space for families to work through relationship difficulties. Indeed, rather than removing a young person from the situation, the approach was sometimes the opposite – using the respite to support restorative practice, while siblings were given the opportunity

to take a break from a difficult home environment. This work was valued by the CAS workers, who had sometimes utilised the short breaks to good effect:

“The sibling effect has been really good... I’ve had ten-year-old twins and an eleven-year-old that have been affected by the behaviour of a third child, who are now able to access [short breaks provision] ... it’s getting them away from their situation and developing good coping strategies. I think that’s been massive”

(CAS practitioner)

Key learning points from the short breaks provision

Overall, there was some evidence that the respite proved more attractive to younger age groups - 11, 12 or 13 year olds - but was often less appealing to 14, 15 or 16 year olds who generally wanted to be with their peers rather than based at the centre. Some young people also knew of the provider from when it previously operated as a children’s home, so the staff needed to undertake work to counteract the stigma and to provide reassurances that a stay was time-limited and voluntary. The success with “winning over” young people was attributed to a combination of the skill and tenacity of the staff, and the informal and supportive environment. Young people had access to a communal space to socialise and to participate in group activities, and were able to select from a number of themed rooms, which they had helped to decorate.

While the residential beds were originally ring-fenced for planned respite, a shortfall in emergency accommodation across the borough, and a spate of emergency cases involving 16 or 17-year-old homeless young people, left the CAS team with no option but to remove the ring-fencing, and to make the beds available to the Emergency Duty Team. This resulted in the cancellation of some planned short break placements.

Young Apprentices and Children’s Council

The bid for the CAS included provision to recruit and train 2 Apprentices, to work within the CAS Hub teams and to take an active role in the branding, publicity and awareness-raising of the service, as well as acting as advocates to young people within the borough. The Apprentices were selected through an application and interviewing process, and took up their posts in November 2015. They were engaged in developing the website and social media presence for the CAS. Their involvement was set to expand at the time when the fieldwork took place, and the website was due to launch.

Beyond this, the CAS actively engaged with the Children in Care Council (the MAD Group) at the bid development stage, and on an ongoing basis through the operational group. It was reported that the levels of participation in these meetings were relatively consistent, although some senior managers felt that there was potential to achieve a much wider footprint for the participatory work initiated during the CAS. Towards the end

of the evaluation, plans were underway to establish a Children's Council, to be chaired by young people and with broader representation from young people in the borough.

Project outcomes and cost effectiveness

This section of the report considers the evidence for the outcomes achieved to date by the CAS service. First, we examine the outcomes for young people and their families, and early signs of improvements to services and systems for working with vulnerable adolescents across the borough. We then examine the potential for cost savings.

Achievement against the high-level project objectives

The high-level objectives of the CAS were to reduce the number of young people entering the care system at age 13+; to provide greater placement stability for young people who were already LAC, in order to have fewer children missing from home or care, and to achieve positive outcomes relating to Education, Training and Employment (ETE); reduced involvement with the criminal justice system; reduced involvement with guns and gangs; and fewer young people at risk of Child Sexual Exploitation (CSE).

Overall, the ability to robustly measure change was hindered by a lack of centralised data held on individual young people and families referred to the CAS. The original plans to develop a multi-agency Performance Outcomes Monitoring Framework stalled during the early stages of the project. The partner organisations were unable to come to an agreement on a data-sharing protocol, and the integrated database was never built.

These difficulties were mirrored in the efforts to establish a case management system for the CAS. The original aim was to develop a bespoke system, integrating the Early Help Module (EHM). Delays were incurred, however, and it was recognised that the consent requirements - including access to historical data recorded via the Common Assessment Framework (CAF) - would be difficult to administer in the context of the CAS. The decision was therefore taken to align the CAS with the social care integrated case management system (ICS), to align more closely with Children's Social Care. The decision to adopt the ICS was made in October 2016, resulting in gaps in the data held on the initial cohort of young people in the CAS, and requiring a retrospective data cleaning and matching exercise by council analysts. This underlined the extent to which the ICS had not been fit for purpose for the CAS, with gaps in data and issues arising from mis-coding.

Nonetheless, this exercise provides some valuable insights to the CAS cohort. Perhaps most promisingly, the data shows that approaching two thirds (65 per cent) of cases were closed because the original aims in the CAS plan were achieved. Of those cases that closed for other reasons, a smaller number were as a result of parent or young person withdrawing their consent (26 per cent), or the family moving out-of-area (9 per cent).

These figures underline the overall achievements of the service, even though data was not available on the full range of outcomes achieved at an individual case level.

Outcomes for young people and their families

Practitioner and partner testimonials provide a source of evidence for outcomes, including the 'step change' measures for young people and families. The practitioners who were interviewed reflected that the specific outcomes varied considerably on a case-by-case basis; partly reflecting the breadth of the eligibility criteria for the CAS and the complexity of families' circumstances. Some of the areas where practitioners felt they had routinely experienced success included:

- stronger and, or, repaired relationships between family members
- re-engagement with education, and improved attendance and behaviour
- reductions in missing episodes
- reductions in levels of illegal substance misuse, through co-work with specialist substance misuse workers
- securing access to temporary accommodation for homeless young people
- facilitating access to specialist assessments (e.g. for SEN and, or, mental health issues)

The advocacy role was often reported to have been a success factor in achieving a positive outcome. Practitioners recalled how it required the expertise of the CAS key worker, often having consulted with peer professionals within the Hub teams, to secure access to the necessary support for the family. One such example is in cases where housing providers were reluctant to accept homeless young people from the CAS cohort for a semi-independent placement because of their high levels of need.

Young person and family case study 1

Gemma¹⁸ (17) was homeless at the point of referral to the CAS team, following a breakdown in the relationship with her mother. She was NEET at the time, and had recently come to the attention of the Police as a result of involvement in anti-social behaviour. She also had a history of mental health issues.

Following initial engagement, the CAS worker re-established contact with Gemma's mother and acted in a mediating capacity to start the process of rebuilding their relationship. A family assessment and plan were completed, which identified a number of support actions for Gemma, her mother, and her younger brother.

Having applied for income support and registered Gemma with an alternative education provider, the CAS worker was successful in supporting her with an application for a semi-independent placement.

This was initially refused because Gemma's history of mental health issues was considered to be high risk and she was not receiving treatment from NHS CAMHS. The CAS worker was able to demonstrate the support that was being provided by the specialist internally to the CAS team, and outlined the measures that were in place via the family plan. The practitioner commented that:

"I spoke to [housing provider] and they said they'd want to see evidence that she [young person] was getting support. You know, for her mental health issues and she was in education. So, it was showing them that this is how we do it, and this is the evidence. And then they thought... 'I get it now more because we can see what work she has done, and that she's been attending appointments'. They were happy enough with that... It's almost like you're their guarantor."

(CAS Practitioner)

Since moving into the supported accommodation, the CAS worker has continued to work with Gemma to support with her attendance at the education provider. At the time of the interview, there had been no recent reports of antisocial behaviour; Gemma was still engaged in education and training, and was attending her therapy appointments with the CAS team mental health practitioner. The family were taking steps to resolving their differences, and making plans for a safe return home.

¹⁸ Not real name

A number of the partner organisations for the CAS had also captured and recorded positive outcomes for young people following their involvement with the service. There were promising signs of reductions in the incidence of young people absconding from care, as evidenced by local Police statistics. For example, a Police representative cited the example of 2 young people for whom there had been quite significant reductions in missing episodes following the assignment of a CAS worker. Over a period of just 6-9 months, the combined number of episodes for these 2 young people alone reduced from 65 to 22. This was potentially valued at £80k of savings to the Police.

Family dimensions to the outcomes

The importance of the wider family dimensions of the CAS came through strongly in both the practitioner and the family interviews. The CAS typically provided a combination of practical support with routines, getting to appointments, advocacy on behalf of the young person with other agencies, and support for adult family members. From the family's perspective, the interviews generally showed that there was a clear sense of what had been agreed within the single plan, and what progress would look like. This was contrasted favourably in some cases to previous experiences of plans being 'imposed' on the family; although engagement was often hard fought and young people were not always willing to identify with the reason for referral. This was particularly the case where there was a need to address challenging behaviours (see boxed case study 2).

Young person and family case study 2

Mandy¹⁹ (14) was referred to the CAS following disclosure of possible CSE risk following reports of inappropriate sexual behaviour. Mandy was living at home with her mother and younger siblings at the time. The family had been known to children's social care for nearly 10 years, as a result of significant domestic violence between multiple family members, and concerns over unsafe parenting. Mandy also had a long history of absenteeism and school exclusions.

The CAS practitioner worked with the family to set a plan in place, with key goals around Mandy and her siblings remaining in education; family members working together and engaging with services; reducing levels of conflict within the family home, and raising Mandy's awareness of the possible consequences of her risk taking, including issues with negative peer influences.

It took some time to build trust to a point where the family would engage with the CAS worker, and Mandy was resistant to tackling the issues relating to CSE risk. However, at the time when the interview took place, there had been some success with establishing boundaries at home, and all family members were engaging in family meetings to review progress. Mandy had agreed to attend sexual health awareness sessions and was attending a local youth club. There was also some progress with Mandy keeping her mother updated on her whereabouts.

Looking ahead, the CAS practitioner identified a priority for Mandy to re-engage with education, but this was proving more challenging, and a recent attempt had been unsuccessful. The practitioner noted that there were still significant ongoing risks, and that the case highlighted the challenge of working with families where there were long-term, entrenched child protection issues.

Work with siblings also featured to varying extent within the cases that were reviewed for the evaluation. Practitioners described how, sometimes, a referral might be accepted on the basis of the needs of the individual young person, but the subsequent intervention highlighted the risks posed to younger brothers or sisters. In the medium term, the CAS service aimed to achieve earlier and more effective engagement when these younger siblings also reached adolescence, having made contact with the family and established a relationship. For some families, the potential value of this approach was very apparent:

¹⁹ Not real name.

“You get some cases... where they've got say 6 children in the family. You're trying your best to say, put a halt to what the oldest one is doing, and yet you can see the same pattern of behaviour continuing unless you can do something with the second to oldest one. You can see that negative impact on the other siblings.”

(CAS Practitioner)

Outcomes reported directly by young people

Young people were generally clear that having support from CAS had impacted on their lives in positive ways. While some could express more clearly and specifically how things had changed for them, others found it more difficult to do so. One young person noted that they thought “things would have been worse without [the key worker]” but wasn't able to express why that might be. Most spoke positively of having regular progress meetings with their key worker, and valued the opportunities to review their development.

The circumstances of the young people within the interview sample varied considerably, and this was reflected in the outcomes they reported, which ranged from increased self-confidence and living more healthily, to engagement in education and getting on better with family members. Many recalled the empowering approach of the CAS workers, and how this had given them tools to improve their home routines. In turn, this had positively impacted on family relationships:

“He [the key worker] has been helping with home life a bit - making it easier for me, so all the arguments would stop”.

“[Key worker] taught me it was better to be on my family's side. I was ready to give up on them before [the key worker] but not anymore. I love them and want everyone to be close.”

“I didn't expect [the key worker] to have this effect on me. Others haven't pushed me or believed in me as much as they have.”

(Young people, CAS beneficiaries)

Access to the short breaks respite provision was also mentioned by several of the young people in the context of helping to ease family conflict, with a young person commenting that:

“Without that [respite], I would always be at home, which would make me more angry.”

(Young person, CAS beneficiary)

Several of the young people made a more direct association between the support they had received, and their ability to remain at home, or in suitable independent lodgings. One young person noted that they would “probably be in a hostel” without the support,

while another had been able to live independently as a result of the key worker's support with budgeting, finance and time management. This meant they had been removed from a vulnerable position in the family home but without the need for social care intervention.

Providing support for the adults of the household to address alcohol dependency was also referenced by several interviewees. In one case, the young person felt that the key worker was the only person who had been able to get the parent to acknowledge that they had an issue with alcohol. She stated that without the key worker, it is likely that both the interviewee and her sister would both be drinking as well, and she felt that their mother may not even be alive now had CAS not intervened. Another interviewee noted that "She got my Mom into an alcohol thing; she is stopping my Mom from drinking which is a very big thing for us." Furthermore, several young people made reference to reducing, or stopping, self-harming as a result of the support they received.

While emotional support, and support to resolve existing issues, were common to many of the beneficiaries' experiences, some noted that they had also received support to move their lives forward through work and training. One had developed a CV with the help of their key worker, while another had been supported into college and had taken up a course that the key worker found for them. Almost all of those interviewed said that they wanted to keep making improvements, and most were more optimistic about the future.

A few of the young people expressed concerns that some problems might return, without key worker involvement. One noted that without the key worker they would have had to do things for themselves such as managing their finances; while another felt it was likely that their sister would start self-harming again if the key worker disengaged. However, most of the young people who were interviewed had fewer concerns about the support ending and felt well-equipped to move forwards.

Outcomes from more complex cases

Timescales for demonstrating outcomes proved more challenging for some of the more acute and complex cases. The practitioners discussed how young people were often referred to the CAS at the point where substantial groundwork was needed to get them back on track. One of the implications of having more of these cases than anticipated was that there was sometimes a need for a considerable investment of time and support, but with fewer hard outcomes to evidence in the shorter term:

"I think it's important to note that a lot of the cases we get... the options are very limited. You get cases like, last week a lad has been permanently excluded from school. So, you try to re-engage, but that takes time... it could take up to 3 months, 4 months, just to get that person assessed, education psychologist input,

all that type of thing. Then when it goes through to SEN for example, putting an education health care plan in place, that can take up to 6 months.”

“We've got a lot of cases, where [the young person's] routines are like ingrained. They're in a gang. They're doing drug dealing and as you said, they're earning a crust from it. You've got to change that whole outlook. Even though they have had social care intervention there's still been no change”.

(CAS Managers and Practitioners)

In the shorter term, changes in the levels of engagement and attitudes towards receiving support sometimes proved to be a key indicator of capacity to change.

Cost effectiveness of the service

One of the objectives of the evaluation was to explore the value for money provided by the CAS. The CAS service set out to realise tangible savings within 3 years.

Costs

The Department for Education provided a funding allocation of £1,116,000 and financial records suggest that almost all of this amount will be spent by the end of the period (£1,080,000). In addition, the local authority provided match funding of about £1,464,000.

As would be expected, given the intensive support provided by the model, the majority of the available budget (62%) was spent on staff costs, including the costs of bringing in staff from other agencies (the police and the YOT).

The CAS can provide efficiencies compared to the standard social work model as the cost of a CAS team member is lower than that of a social worker (with an hourly rate of £16.67 for a member of staff at the top of Grade H compared to around £17.64 for a social worker in Grade I). However, this saving is offset by the more intensive support provided, albeit over a shorter period (with CAS workers typically spending an average of 5 hours on a case per month over a 6 month period, compared to an estimated 1 hour per case by social workers for a period of up to 18 months).

The ‘one worker’ approach advocated by the CAS key worker model also removes the need for multiple practitioners to be involved in providing support (a staff member noted that typically 3 professionals would be involved in a traditional case), so although CAS workers may spend more hours on a given case, the cost of this additional time would be offset by the reduced need for involvement of other colleagues or agencies. However, it has not been possible to do a detailed comparison of time inputs for the CAS approach with the traditional model. It should also be noted that, more recently, some cases were co-worked with social care and it would be useful to undertake a comparison of inputs (and outcomes) for the 2 approaches to inform future resourcing decisions.

Also included in the budget was the cost of the short-term break unit (£672,750). The unit has capacity for 4 young people to stay each day, totalling up to 1,440 overnight stays a year. However, under-occupancy issues have meant that the total number of young people using the unit has not exceeded 139 since July 2015. The unit costs of this provision were therefore higher than expected during the pilot, with a cost per night of £889²⁰ compared to £467 if operating at full capacity over the year.

However, recognising the learning which has been gained from the operation of short-term break provision as part of the CAS so far, as well as the value which young people have gained from this opportunity, Sefton Council has commissioned a 12-month block contract with the independent residential provider, which was registered in September 2016. The 4-bedded unit is split-funded between Sefton residential agency budget and the Department for Education grant. An important factor in the success of the provision is the stability of the placements (albeit for a short period), which is thought to improve the likelihood of a return home. Analysis of costs has revealed that full occupancy would yield a saving for the authority of up to £2,000 per month as compared to spot purchasing a residential bed. The contract will run until September 2017 and be monitored accordingly.

Benefits

In order to make an assessment of benefits, data was collated for a sample of CAS cases. The cases chosen were those young people who first came into contact with the CAS in the period January to March 2016, which resulted in a sample of 126 individuals²¹. Data was then collected for each individual on a number of metrics (missing episodes, time spent in care, time spent on a child protection plan and whether the cases were stepped down from social care)²². There was then a comparison of the outcomes experienced for a 3-month period before and after CAS involvement²³. This approach implicitly assumes that the patterns of behaviour observed in the 'before' period would have continued in the absence of intervention, and that the CAS formed a significant intervention in the lives of the young people in the sample. A change in outcomes was then valued on the basis of available unit cost figures²⁴. However, it must be

²⁰ This is based on a total of 756 overnight stays.

²¹ This excluded 18 cases opened in this period which had not yet been closed.

²² CSE and NEET data was also analysed. The prevalence of CSE risk assessments and NEET status in the chosen sample was very small and showed no change (for the latter this is assumed to be because most of those in the sample were aged under 16). Attempts were made to collect further data (such as school attendance and involvement in youth offending) but this was not possible due to issues with accessing and linking data from different sources.

²³ This was approximated by looking at the status or frequency of incidents in the period October to December 2015 (that is, before contact with the service) and August to October 2016 (that is, after contact with the service, based on the assumption that the cases had been closed by or during this period).

²⁴ These figures were largely sourced from research undertaken by Loughborough University, uprated to account for inflation using the PSS pay and prices index. The cost of missing episodes was sourced from

acknowledged that this type of analysis can only demonstrate contribution not attribution due to the absence of a control or comparison group. It would also have been preferable to look at data over a longer period, although, due to the timing of the evaluation, this was not possible.

The following table shows that positive progress appears to have been made amongst the sample in relation to missing episodes and the time spent on child protection plans. In addition, a number of these cases were stepped down from children’s social care to CAS which should also be viewed as a positive outcome (and a source of potential cost savings for social care teams).

Table 3: Potential savings

Outcome	Potential saving (in total across the sample)
Missing episodes	£22,040 (linked to investigation of 9 fewer missing episodes across the sample)
Child protection plans	£7,045 (linked to the time taken to support a reduction in CP plans over a total of 26 months ²⁵)
Stepped down from social care	£9,240 (this applied to 28 cases and has been valued on the basis of 3 months of ongoing support for CIN plans per case ²⁶)

Although the primary beneficiary of a reduction in child protection plans and a step down from social care is the local authority (children’s social care team), it is interesting to note that the police are also a significant beneficiary, to the extent that the CAS intervention can impact on the number of missing episodes (with an estimated saving of £22,040 resulting from the sample analysis undertaken as part of this evaluation, see Table 3).

However, comparison of LAC status amongst those in the sample before and after the CAS intervention showed an increase in the time spent in care. Whilst 3 young people had exited care during (or around the start) of their CAS involvement, a further 6 individuals had subsequently become LAC.

work undertaken by the University of Portsmouth (adjusted for inflation as before), which considers the cost to the police of such investigations.

²⁵ This is likely to be a conservative figure, as it relates only to ongoing support for CP plans and does not account for any reviews which might take place.

²⁶ Again this is likely to be a conservative figure, as it relates only to ongoing support for CIN plans and does not account for any review. Also it assumes that cases were stepped down from CIN status.

Table 4: Costs incurred

Outcome	Cost incurred (in total across the sample)
Child looked after	£18,270 (linked to an increase of 16 months spent in care by those in the sample over the period Aug-Oct 16 compared to Oct-Dec 15; valued on the basis of the cost of the process for deciding a child needs to be looked after ²⁷)

On the other hand, 26 young people in the sample made use of the short break provision, amounting to a total of 353 nights. Staff identified that, in some cases, the ability to offer such a short break away from home in volatile family situations where the young person was unable or willing to come home had helped to prevent young people becoming LAC.

Around one-quarter (25%) of the cases in the sample were co-worked with the social care team. Comparison of the outcomes for the 2 sub-samples showed that the co-worked cases had a relatively higher share of the increase in the time spent in care, but also a higher share of the reduction in the time spent on child protection plans. However, it is possible that this reflects the circumstances of the cases selected to be co-worked, rather than providing any conclusions on the relative effectiveness of the 2 models.

Overview

The evaluation has made an initial assessment of the benefits of the CAS. This was limited by current data availability, the timing of the evaluation and also the difficulties of robustly quantifying and monetising the outcomes. However, the framework which has been developed could continue to be updated as further data becomes available, and used to inform decisions about future development of the CAS.

The analysis only considers outcomes in terms of the associated and immediate fiscal costs and savings, although in reality the service would be likely to have contributed to a range of social and economic outcomes, some of which may only fully emerge over a much longer timeframe. Interviews with service users suggest that the CAS has had a wide range of less tangible benefits such as improvements in trust and family relationships, which can be difficult to quantify and value in monetary terms.

The current analysis also does not attempt to capture the benefits of preventing outcomes which had not previously occurred. For example, given that a key criterion for referral to the CAS was that a young person was judged to be on the edge of care (having not previously been looked after) it is possible that, in some of these cases, an episode of care would have taken place, were it not for CAS intervention. By working to

²⁷ This does not account for any associated care planning and review activity, nor does it include the placement costs which are more significant.

prevent children becoming looked after the CAS has potential to generate significant savings in children's social care team inputs as well as the costs of placements. Further, more detailed, exploration of the trajectories of these cases would be necessary to more robustly assess this counterfactual scenario.

Conclusions and recommendations for future policy and practice

This report has presented the findings from an independent evaluation of the Sefton Community Adolescent Service (CAS), drawing upon qualitative and quantitative data collected between April 2015 and November 2016. In this final chapter, we draw together, and draw conclusions from, the evidence, ending with a series of recommendations.

Overall assessment of the project

Sefton Council set out to test a new multi-professional service dedicated to vulnerable adolescents, and to transform the way services are provided to young people aged 12-25 on the 'edge of care' within the borough. Overall, the evaluation provides emerging evidence that the CAS has the potential to address a gap in provision for the intended target group, despite the challenging circumstances during the pilot phase.

It is clear that the project as originally conceived was too broad, with too many disparate elements, and that it suffered from a lack of strategic level buy-in or leadership during the early stages. The pressure to become operational at pace was counterproductive, and the service was cast adrift following the departure of the original strategic lead, falling between Early Help and CSC but without clear lines of accountability. The CAS management and hub teams showed tenacity in making the service operational during this time, and the early piloting provided some valuable lessons that informed the subsequent adjustment of the model. Nonetheless, the service was exposed to what many considered to be unacceptable levels of risk, lacking, as it did, a robust quality assurance framework, supervisory structures, and access to reliable outcomes data.

The CAS benefited considerably from the boost to managerial capacity in January 2016, with the appointment of a designated, strategic and operational lead for the CAS; the establishment of a joint working protocol with CSC; a concerted effort to raise awareness of the service among partner organisations and families, and an overhaul of the case management toolkit. These measures came late in the pilot, however, and there were missed opportunities to establish joint working with CSC at a much earlier stage. Similarly, efforts to capture monitoring data for the CAS cohort proved challenging and it was not possible to assess the full range of potential outcomes from the service.

Effectiveness of the community-based CAS model

The interviews with professionals and young people and their families suggest that certain 'building blocks' of the CAS model stood out from the piloting. These included the relationship-based approach, with CAS practitioners having the time and space to engage with young people and families on their terms, building trust, and facilitating their

active participation in setting and reviewing objectives. Young people and families also consistently valued the single plan, and the role of the CAS worker in streamlining inputs from multiple different professionals, while the practitioners within the hub teams were strong advocates of co-location and multi-professional working, and the team ethos this created. Having access to a breadth of expertise - ranging from family intervention to youth offending, education welfare and mental health - was a core part of the CAS and equipped the teams to support young people in diverse circumstances.

The social pedagogy training resonated with the CAS practitioners, and was thought to have been an excellent match with the CAS model. This was not always consistently valued to the same degree at a management level, however, where there was some nervousness about the time and funding invested in 3 day blocks of training. Concerns were expressed about the risk of endorsing a single theoretical model, when this did not have the necessary buy-in among partner organisations. There was also a feeling that the service required a toolkit of approaches, including an injection of social work case management and supervisory expertise, and that the social pedagogy was not the 'magic bullet' for multi-professional working that some had hoped it might be.

The embedding of the service during the summer and autumn of 2016 provided an opportunity to further test the parameters of the CAS, with larger caseloads, a more clearly defined 'edge of care' remit, and sharper monitoring and feedback mechanisms. This phase revealed some tension between the relationship-based practice model, and the need for the service to demonstrate its worth in meeting acute levels of need within the borough. On the one hand, there was a convincing case that the more open-ended casework was unsustainable beyond the pilot, and that caseloads of 10 to 12 families were achievable for more specialist pieces of work. On the other hand, higher levels of contact time were reported to have been necessary to build families' capacity for self-management, and to avoid dependency. This contact time also proved conducive for engaging with younger siblings, which was not always feasible with larger caseloads, as CAS workers had to prioritise the young person who was the subject of the referral. There were concerns among practitioners of tipping the CAS model too far in the direction of a traditional social care intervention and that these benefits would be lost.

Effectiveness of the additional project elements

Looking beyond the hub teams, the evaluation found that the residential short breaks provision showed promise as a model, despite the under-occupancy issues and the high cost arising from this. The flexibility of the format, along with the ability to diffuse tensions within difficult family situations, and to support reunification, all point to a potential future role within the service. Importantly, the model was not limited to crisis intervention, and the preventative work with younger siblings also showed promise.

The other elements of the project had more limited success. The foster carer pilots ultimately proved unnecessary; as they risked duplicating the work of specialist foster care teams; while the YOS secondment showed that the CAS was not necessarily the most appropriate vehicle for administering statutory youth justice work, despite the strong and productive partnership between the CAS and the YOS. There was also a need to counteract a misconception that the CAS was a specialist service designed for tackling gun and gang violence.

It also became apparent from a fairly early stage that the delegation of social worker authority was an unnecessary risk for a service that already faced a host of safeguarding challenges as a result of the high levels of need among the target group of young people. The co-working arrangement between the CAS and CSC proved to be a more effective alternative, with the dual benefits of pooling expertise within the respective teams, and adding real value to step down CIN cases to provide quality pieces of work focussed on reunification. In turn, relocating the CAS to sit beneath the Safeguarding Board provided the additional safeguarding and risk management assurances that were much needed.

Ultimately, this process of drawing boundary lines proved to be useful in helping to determine where best to position the CAS. While the service shared some characteristics with Multi-Systemic Therapy (MST) - for example, the piloting showed that the focus was different, with a much stronger emphasis on preventing family breakdown; supporting engagement in ETE; and addressing safeguarding risks, such as missing episodes and CSE. The CAS was not specifically targeted at tackling antisocial behaviour and criminogenic risk factors to the same extent as the MST model, although it offered the flexibility to undertake casework with families where these factors were present.

Outcomes and cost effectiveness

The limited available data for the CAS makes it more difficult to draw firm conclusions about the cost effectiveness of the model, and indeed the co-working arrangements with CSC were more recently established, and so longitudinal data was not yet available. There was some quantifiable evidence of cost savings arising from service improvements – a reduction in the number of different professionals involved with individual cases, compared with business as usual, and streamlining of social care planning and

administrative processes. The analysis of a sample of cases also identified savings arising from reductions in the incidence of missing episodes, child protection plans, and cases stepped-down from CSC involvement.

These savings were offset by the costs of a proportion of the young people subsequently becoming LAC, and these negative outcomes would risk cancelling out the net monetary benefits of the CAS. The practitioner interviews showed that there were some difficulties with referrals coming too late, when young people were already at the point of tipping into care, which might be a contributory factor. There is a priority for the CAS management to investigate these trends, to understand whether escalation to LAC was preventable.

Recommendations from the evaluation

Looking ahead, it is possible to identify a number of recommendations for Sefton Council, based on the findings from the evaluation. These are as follows:

Recommendation 1: Ensuring the flexibility to work with younger siblings

The piloting showed that there were often opportunities for CAS workers to engage with younger family members as part of the intervention, and that this work had a strong preventative focus where younger children were exposed to many of the same risk factors as their older siblings who were the subject of the referral. Similarly, feedback from CAS practitioners indicated that many of the presenting issues for the service (missing, CSE, guns and gangs) were starting at age 9 or 10, and that the 12-25 age range was pitched too high to achieve the maximum impact from the CAS. Taking these points into account, Sefton Council might wish to consider the merits of extending the age range for the service, and including work with young people at the cusp of transition from primary to secondary school. This might also require some consideration of the composition of the CAS team, and/or, the external expertise that is accessed by the service, to include the younger age groups.

As a separate, but related point, there would seem to be a priority to engage with the concerns raised by CAS practitioners regarding the reduced time and capacity to undertake work with younger siblings, and to ensure an open and constructive dialogue with management about the relationship between caseload sizes, and the ability to undertake valuable work with siblings and other family members.

Recommendation 2: Consolidating the position of the CAS as a bridge between CSC and Early Help

The evaluation found promising signs that the CAS had become more clearly positioned as a specialist 'edge of care' service. These arrangements were much better defined in relation to CSC, with the shared governance structure. Similarly, the co-working

arrangements had enabled the CAS to improve the quality of the step-down process for young people who were subject to a CIN plan.

There would seem to be a need for further work to position the CAS in relation to Early Help, at the other end of the scale. Having a presence in the MASH was undoubtedly important during the pilot, but the CAS might also benefit from having a clearer role within the Early Help strategy, and more defined arrangements for how and when cases are stepped down from the CAS to Early Help teams (if indeed this is the planned approach). A protocol of some kind might be beneficial, as proved to be the case when redefining the working arrangements with CSC.

Recommendation 3: Reintroducing flexibility to the residential strand of the service

The residential arrangements under the proposed new service are very much focussed on crisis intervention, where there is a risk of family breakdown. This is consistent with the 'edge of care' function of the CAS. However, the evaluation evidence suggests that planned residential short breaks provision might still have a role to play within the service. This work was very different to a purely crisis prevention model, and seemed to complement the community-based work, where it was planned effectively.

Similarly, the Ofsted inspection of the residential provider resulted in positive feedback on the drop-in feel of the communal area, which provided a welcoming environment for young people and enabled the CAS team based at the residential provider to undertake valuable small group work. Sefton Council might therefore wish to consider whether there is scope to plan some element of (preventative) respite provision into the new CAS model.

Recommendation 4: Strengthening the multi-professional composition of the CAS

The piloting showed that the mixed professional teams were a real asset to the service, but this mix was eroded to some extent by staff turnover, and various secondments coming to an end. Managers and practitioners were in agreement that the skills mix within the CAS had a direct bearing on the interventions with young people, and that this mix should be planned as far as possible.

There was some variation in terms of what the optimum skills mix within the CAS teams was considered to be, although, overall, there was a sense that the hub teams drew a little too heavily on Early Help professional expertise during the pilot phase. The interviews suggested that ensuring continued access to mental health expertise, youth work, education and employment and social work would be important. There was also demand for adult mental health expertise, which had arisen as a perceived area of need during the piloting phase. Beyond this, there is a continued role for a wider network of professional expertise, including YOS, Police, Housing, VCS, Drug and Alcohol and Domestic Abuse specialisms.

Recommendation 5: Establishing a clear service pathway

Related to the above, it is not yet clear whether the refocussed CAS will continue to use the 3 existing pathways into the service – referral to MASH, outcome from C&F assessment, or step down from CIN, CP, or CLA plan. The single point of access via the MASH had many advantages during the pilot, but high thresholds also meant that this route tended towards a high proportion of cases that had escalated to crisis point, and gave the CAS teams more limited room to manoeuvre with very complex cases that were at the point of tipping into LAC.

The evaluation also showed that there was a high level of demand from schools to engage with the CAS, within the school clusters where the service was better established. Schools had expressed frustrations during the pilot at needing to refer indirectly via the MASH, and not having a direct line to the CAS team. This would suggest that, even if stopping short of a model where direct referrals were possible, the CAS would benefit from providing some kind of professional advice line. There is clearly untapped demand among schools, and building relationships in this way would be another means of raising the profile of the CAS and extending its impact.

Pathways out of the service are also an area for consideration. This is perhaps the single greatest area of modification since the original project bid was submitted, with the CAS moving from the concept of keeping cases perpetually open, to the ‘dormancy’ arrangement of closing cases with the option of bypassing the MASH in the event that they needed to be re-opened; to a proposed, much shorter, model of 6-12-week intensive work followed by step-up or down. The options for stepping down during the pilot were not clearly defined, as the rationale for closing cases was nearly always related to addressing the objectives in the plan, consent withdrawal, or stepping-up. If a step-down approach is indeed to become more established for the CAS, then attention might be needed to what this follow-on support might look like; how and from whom it is sourced; and how continuity can be assured.

The decisions about which model(s) of training are to be endorsed for the CAS are important in this respect. Whether this is further cascading of the social pedagogy model via the change agents, or an alternative training programme of some kind, a mechanism is needed to ensure the shared language, principles and pedagogical understanding of CAS workers and other professionals working with the service. It seems unlikely that the social pedagogy model could be sustained in the longer-term purely through second-tier training, without compromising the model.

Recommendation 6: Strengthening the evidence base for the CAS

Finally, the evaluation has underlined the critical importance of setting in place a robust performance management system for the CAS. The work undertaken latterly during the pilot, to extract data from the LSC children's record, was commendable and provided insights to case status, progress, and (some) destinations data. Going forwards, however, there is a real priority to establish a system up-front for the CAS that reflects the metrics on the score-card, and allows for the disaggregation of data held on individual young people within the cohort. If the CAS is wider than a social care intervention, then a more effective mechanism is needed to monitor and review the status of young people supported by CAS according to education and employment, health, housing, social care, crime and antisocial behaviour. There might be potential to draw upon the learning from the Troubled Families service in Sefton to help scope a suitable model for the CAS service.

More effective recording of outcomes data within the core assessment toolkit for the CAS would also seem to be warranted. The cost-benefit analysis undertaken by the evaluators found that the assessment and planning data was not a reliable source of outcomes data, and that it would benefit the service to capture this information more systematically within core casework processes. The continued use of the Diamond model would make sense if social pedagogy is to provide the underpinning approach for the service. Alternatively, other validated tools, such as the Strengths and Difficulties Questionnaire (SDQ), or Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) might be considered, to record outcomes relating to social, emotional and behavioural functioning within the CAS cohort.

Sustainability - towards the rollout of the model

At the time of writing, Sefton Council had stated a commitment to extend the CAS service, under the leadership of CSC. The model was still being worked through, but it was anticipated that it would be based on a smaller and more specialised service, including:

- retention of the CAS 'brand' and identity, supported by the website
- smaller teams of practitioners, co-located within a single central unit on the premises of the short breaks provider, replacing the separate hub teams
- a refreshed multi-agency profile, including additional specialisms²⁸
- more flexible working arrangements, including evening and weekend duty teams
- shorter pieces of work, with sharper decision-making about stepping-up to CSC or down to Early Help following the intervention, but retaining the option of keeping 'dormant' cases where the CAS objectives were met
- extended arrangements to support young people's participation in decision-making, including plans for young people to chair the operational group, and momentum for the idea of establishing a Children's Council
- a bespoke CAS website, which would be developed to evolve into an over-arching 'Sefton Youth' website in the medium-term

This overall approach for the CAS is largely supported by the evidence from the independent evaluation, and influenced by the significant budget reductions that are anticipated within Sefton Council over the next 3 years. The proposed model includes many of the hallmarks of the original CAS service from the pilot, including the integrated plan, the multi-professional teams, and a focus on preventing family breakdown and LAC, while recognising the need for the service to reduce the cost base and to operate in a more targeted way.

²⁸ The size and composition of the teams was not in the public domain at the time of writing.

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Appendix 1: Analytical Framework

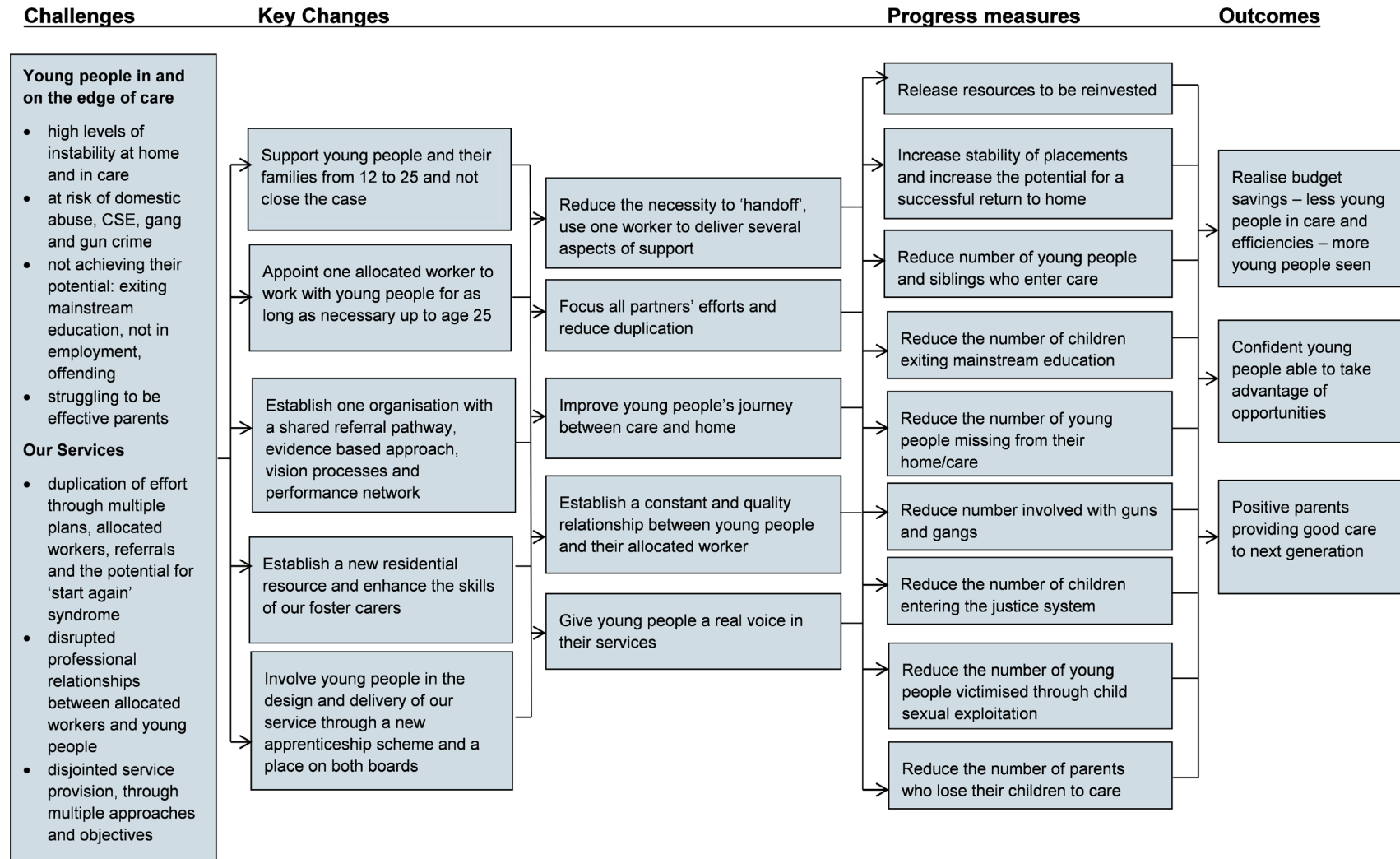
Table 5: Analytical Framework

Research Questions	Scoping desk research	Case study research with stakeholders	Case study research with children and families	Analysis of service data	Financial modelling (CBA)
Process evaluation					
a. How effective is the local model in driving services and systems reform?	x	x	x		x
b. What has been the added value of the social pedagogy and restorative practice basis to the service?		x	x		
c. What are the key success factors for effective identification, referral, assessment and support?	x	x	x	x	
d. How do young people and their families perceive and experience the service?			x		
e. How does the service interact with other providers to avoid duplication?	x	x	x	x	x
f. What does long term planning look like within the CAS, and how is this sustained whilst building independence and avoiding dependency?	x	x	x		
Outcomes and impact evaluation					
a. What outcomes are achieved for young people and their families?	x	x	x	x	x
b. Has the service reduced numbers of new entrants to the care system at 13+ and hit the other priority KPIs?		x	x	x	x
c. Has the programme built families' resilience and reduced the risk of future negative outcomes?		x	x		
d. How do these outcomes compare with business as usual?	x	x	x	x	x
e. Is a quasi-experimental design possible for the CAS, and if so how might this be set-up and implemented?	x	x		x	x

Research Questions	Scoping desk research	Case study research with stakeholders	Case study research with children and families	Analysis of service data	Financial modelling (CBA)
Economic evaluation					
a. How cost effective is the service?	x	x	x	x	x
b. What time and resources have been incurred by the Council and its partners in transferring to the new model?	x	x		x	x
c. How do costs and benefits compare with business as usual?	x	x	x	x	x
d. Has the service resulted in fiscal savings, and if so are these cashable?	x	x		x	x

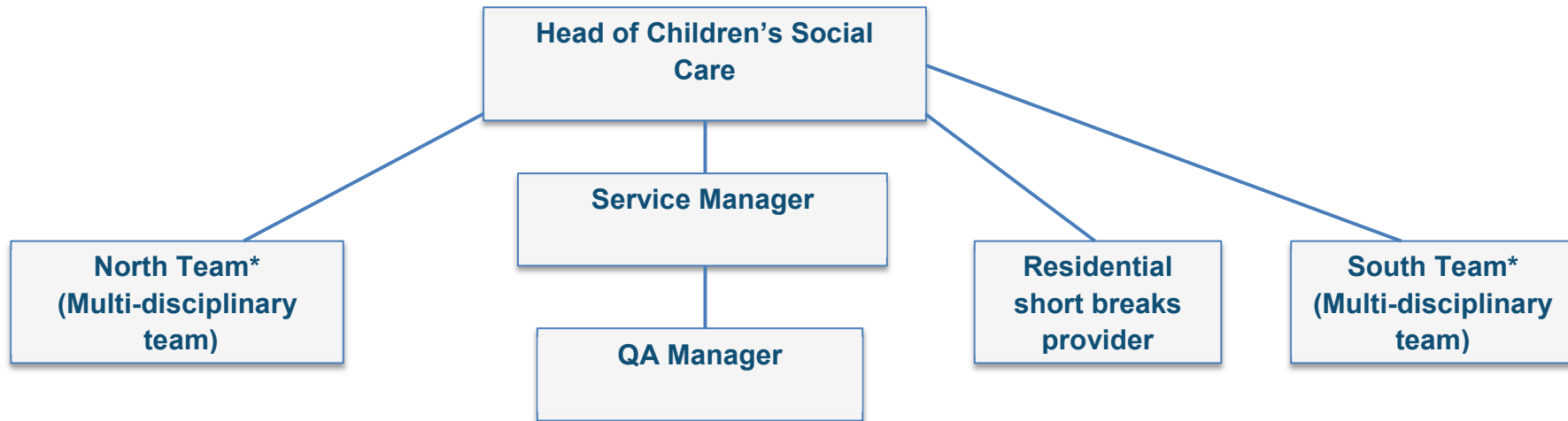
Appendix 2: Theory of Change Logic Model

Figure 3: Theory of Change



Appendix 3: CAS staffing structure – comparison between start and end of project

Figure 4: CAS structure July 2015



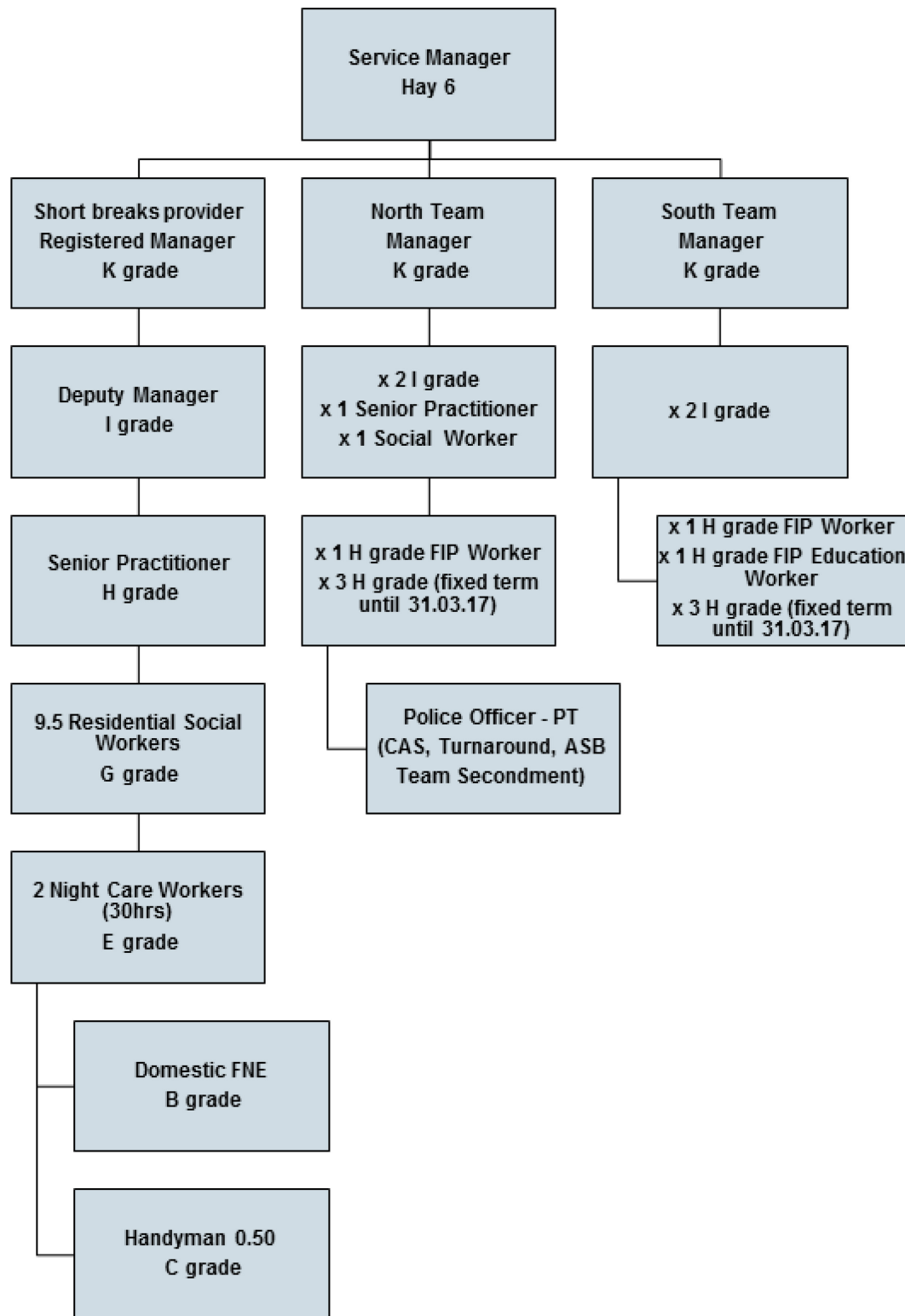
Secondment model to support hub teams:

Sefton Council match: Strengthening Families team = 10 staff; YOT = 2 staff; Attendance & Welfare = 2 staff; FIP = 2 staff; Integrated Youth support = 1; Children's substance misuse = 1; Apprentices = 2

* Multi-agency secondment, Police officer = 1

Other planned multi-agency secondments did not go ahead - Connexions, Housing, Probation, and Adult Mental Health.

Figure 5: CAS structure January 2017





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