



Department
for Education

Evaluation of the Gloucestershire Innovation Project

Research report

July 2017

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Executive summary

In September 2015, Ecorys (UK) was appointed by Gloucestershire County Council (GCC) to provide an independent evaluation of the local Children's Social Care Innovation Project. The ambitious project was divided into 2 parts with distinct aims:

- to develop a unified authority-wide service for the most vulnerable young people and their families (aged 10 to 25 years), combining expertise from targeted youth support, children's social care and some elements of NHS Child and Adolescent Mental Health Services (CAMHS)
- to test a new practice approach – branded as the BASE model, and integrating attachment theory and restorative practice within a competency framework

By the final quarter of 2016, GCC and partners had set in place the building blocks for the new practice model, following a tightly controlled pilot phase within a multi-agency team, and wider roll-out to practitioners working across the service team in Gloucestershire had commenced. At the time of writing, over 150 practitioners and managers had completed the training and were being supported in supervision to adopt the new practice model with a selection of their current cases.

This report aims to present the key findings and emerging evidence from the progress to date for this project. A full summative assessment of outcomes and impact will be reported in a final report to GCC, who have extended the evaluation until November 2017 to cover the full roll-out of the new practice model countywide.

Evaluation Activities

The original evaluation plan set out to assess the effectiveness, outcomes and value for money of the project, using a mixed methods approach. However, the project timeline meant that it was too early to make a full assessment during the initial period for the evaluation. This report is based primarily on qualitative research with stakeholders and practitioners involved in designing and implementing the project, with limited feedback from a very small sample of service users who participated in the new practice model.

This report includes reflections on implementing the unified structures and developing the practice model, the lessons learnt following the roll-out of workforce training; and some indicative evidence of outcomes and the cost savings from the project.

Appendix 2 provides a further overview of the key phases in the development of the project, including outputs and milestones, and the corresponding evaluation tasks.

Key Findings

The organisational model – ‘a single, unified service’

- Overall, it took longer than anticipated to progress the 2 main elements of the project – the organisational model, and the practice model with delays in establishing the unified service. The time taken largely reflects the ambition of the project to engage a range of partners in the service, and the complexity in agreeing integrated governance arrangements to support the proposed unified arrangements
- While the ultimate aim was to develop a single unified partnership, incorporating all key stakeholders involved in supporting vulnerable adolescents, the initial phase was primarily managed between children’s social care and targeted youth support. This bilateral partnership was broadly thought to be strong and well suited to the new model. The level of direct engagement of health partners was less visible during the first year and was recognised as an area for improvement
- The governance arrangements for the project were influenced by wider restructuring and re-commissioning processes within the authority. Gloucestershire had recently moved to a single delivery model for the 11+ Looked After Children (LAC) cohort, with statutory responsibilities for Child In Need (CIN) and Child Protection (CP); Section 47 and Section 17 of the Children’s Act 1989 held jointly by children’s social care and targeted youth support. It was necessary for the project to align with these new arrangements

Piloting and implementing the new practice model

- Having a common and clear definition of the practice model meant that practitioners were better able to involve other agencies and to communicate progress using common reference points and language. There was some evidence that this reduced the propensity for practitioners to hand off cases where external support was required, with better continuity in the key worker assigned to individual cases
- There was evidence that the mixed professional groups of social workers and youth workers testing the BASE model had provided an opportunity to engage in critical self-reflection. Service managers and practitioners alike considered that the team was operating at a higher level of confidence and that the Learning Circles proved to be an effective mechanism for embedding the new competency framework
- Initial service-user feedback from a very small number of young people involved in the initial piloting of the BASE model (n=18) indicates that vulnerable young people and parents were generally responsive, and compared the model favourably to traditional social work methodologies. Practitioners largely attributed this to the

extended initial engagement and observation process, and the emphasis on young people's participation in defining and reviewing their goals. Young people reported valuing the practitioners' efforts to afford sufficient time to develop a trusting relationship, and ensuring that their views were heard and taken into account

- The small number of practitioners involved in the piloting considered that the assessment model and participatory formulation meetings helped provide a deeper understanding of presenting behaviours, resulting in more targeted interventions

Areas for further development

- There was some variability in how the BASE model was implemented by individual practitioners – especially so during the early stages of the piloting. Examples were identified where practitioners had skipped stages of the model, and case recording practices were reported to have been of varying quality and completeness. There was an acknowledged need to step-up self-evaluation and supervisory feedback, to provide more rapid feedback loops and to ensure fidelity to the model
- A tendency was observed for practitioners to revert back to more familiar methods and professional boundaries, when they were presented with cases involving a higher level of risk, and where there was greater pressure to act quickly and under scrutiny. The learning circles proved to be effective in moderating judgements about levels of acceptable risk and providing reassurance. Even so, the piloting shows a need to further refine the model at the acute end of the spectrum. It also showed that unlearning of unhelpful practices was an important part of practitioners adapting to a new approach
- Practitioners sometimes reported greater challenges in implementing the BASE model in cases where there was a statutory order of some kind. Examples included Youth Offending Team (YOT) cases involving court decisions, but sometimes also related to the statutory elements of the CIN and CP plans. The piloting showed a tension between the voluntary and participatory ethos of BASE, and the need for enforcement. These tensions were not thought to be irreconcilable, however, and there were positive signs of adapting to achieve a balance during the piloting
- Following the start of the project, GCC and the partners had identified gaps in service provision for the highest need and most vulnerable adolescents within the authority. At the time of writing, the partners were planning to extend the remit for the new service to include LAC young people with unstable placements, young people with significant mental health or emotional issues, and young people who were remanded to the care of the local authority, among others. This work is set to be further developed during the full roll-out phase in 2017

Cost-effectiveness and service-user outcomes

- A small-scale comparison between a sample of 5 cases worked under the new model and 5 from the traditional one revealed potential cost savings. Principally, fewer cases escalated from CIN to CP under the new arrangements. The intensity of engagement and improved diagnostic capacity were identified as key factors leading to more rapid step-down from CIN plans, and in reducing the number of hand-offs between agencies. It should be acknowledged that the scale of this analysis (10 cases in total) means that there are limitations to the generalisability of the promising findings and insufficient data to monetise these benefits in full
- Despite the small-scale evidence of positive engagement and self-reported outcomes by families and practitioners, stakeholders were aware of a shortfall in hard outcomes data, as well as limited evidence to date that the service is being delivered more efficiently or at a reduced cost. Challenges with setting up the Performance Monitoring Outcomes Framework and case-management system resulted in limited centralised outcomes data for the project during the first year. This, along with the size of the small-scale piloting in November 2015 to February 2016, meant that there was limited potential for assessing progress against the original Key Performance Indicators (KPIs). A fuller assessment is planned following the 2017 roll-out, reporting in November 2017

Next Steps

GCC has retained Ecorys to complete a final summative evaluation of the full roll-out phase. This work will be carried out within the scope of the original evaluation budget, with the data collection and analysis back-weighted to 2017 to better reflect the timescales for the full roll-out of the BASE practice model across Gloucestershire. This will entail carrying over the resources that were originally allocated for the administrative data analysis in 2016, and adding a further wave of in-depth qualitative fieldwork with young people, families and practitioners in place of the 2016 survey work. The work programme will also include a follow-up to the baseline practitioner survey (at +30 months) and a final top-down cost-benefit analysis at an overall project or service level. A final report to GCC is scheduled for November 2017.

Introduction

In September 2015, Ecorys (UK) was appointed by GCC to undertake an independent evaluation of the Gloucestershire Children's Social Care Innovation Project. This report presents the summative findings from the evaluation, based on work carried out between September 2015 and November 2016. The outcomes from the full implementation fall beyond the timescales for the current reporting period. GCC has therefore chosen to extend the evaluation, and a final summative account of the project impact and outcomes will be reported in November 2017

Overview of the project

The aim of Gloucestershire's Social Care Innovation Project was to bring about a step change in services for vulnerable children and young people aged 10 to 25 and their families, through wholesale local systems reform. The project included a programme of workforce development, underpinned by a unified theory of adolescent risk and resilience, to determine the most suitable organisational and commissioning model.

The main elements of the new approach, as set out in the original bid, included:

- a completely redesigned and reshaped safeguarding hub, with multi-professional assessment, formulation service planning and interventions
- a new model of service delivery, with multi-professional teams providing a mix of specialists, and replacing functions that were covered between children's social care, targeted youth support, and some elements of NHS CAMHS¹
- a unified theoretical approach and model of practice, based on the principles of attachment theory, resilience theory (Research in Practice, 2014), and restorative practice², and informed by local testing
- a commitment to adopting alternative delivery arrangements, including delegated statutory social care functions for adolescents, building on experiences of similar arrangements for youth offending, and for care leavers aged 16+

The pilot project also set out to implement the following:

¹ Branded in Gloucestershire as the Children and Young People's Service (CYPS), part of the 2Gether NHS Foundation Trust.

² Restorative Approach is defined as an ethos: "It's a way to be, not a thing to do." The synthesis of Restorative Approach with BASE is that the new practice approach will prioritise 'Working With', rather than 'Doing To', or 'For'; one with high expectations, high support and high challenge, that motivates and engages people, wherever possible, on a voluntary basis.

- redefinition of the known difficulties for adolescents and their families within the cohort, to provide a common classification that was understood by all
- a unified model of assessment, risk management and intervention
- commissioning of new programmes and interventions, where these were needed based on the mapping and assessment of already-available interventions
- a strengthened Quality Assurance framework, to regulate processes, practices and risk and safeguarding
- a programme of workforce reform, to review existing lines of professional accountability, and to re-model according to the revamped model

The final reconfigured service will span approximately 300 professionals, organised into around 20 teams across Gloucestershire. The combined service functions will cover a potential cohort of 2,500 to 3,000 vulnerable children and young people and their families.

The logic model developed by GCC and the partners (Appendix 2) sets out the key issues to be addressed and the proposed inputs, activities, outputs and outcomes. As we go on to discuss further below, a number of adjustments were made to the original design. The project was sub-divided into 2 separate pilots to develop the organisational model and practice model respectively, with piloting of the latter taking place on a controlled scale within an established multi-agency hub (the Gloucester Pod). The rationale for this separation was to ensure that the practice dimensions were agreed independently of any commercial considerations regarding the re-commissioning of contracts. The evaluation focused principally on the practice model.

Overview of the evaluation

The evaluation aimed to provide an assessment of the effectiveness, outcomes and value for money of the pilot project. A mixed methods approach was used, incorporating qualitative and quantitative data collection and analysis, triangulation of the evidence, baseline, interim and final reporting. An analytical framework can be found in Appendix 2, outlining the key research questions and the corresponding research methods³

This report is based on evidence from the following:

- participatory methods: the evaluators worked with the participation team at GCC to recruit a group of 10 young people to an advisory panel. The young people were

³ Ecorys also provided a separate baseline report to Gloucestershire County Council, with a more detailed account of the findings from the baseline practitioner survey and qualitative interviews, and a report of the work conducted with the young people's panel. These outputs are not included within this report.

aged between 15 and 21 years old, and all had interacted with the service in different ways, ranging from early intervention to social care support. Half of the young people were Young Ambassadors for the GCC participation team, and the remainder were recruited via local services. The panel convened in September 2015 and March 2016, contributing to the design of the primary research tools. Two of the young people joined the April 2016 site visit, where they were supported by the Ecorys research team to conduct interviews with project staff at the Gloucester Pod ($n = 5$)

- survey research: an online baseline survey of practitioners was designed, piloted and rolled out in October 2015 ($n = 156$). The survey aimed to establish the views of managers and practitioners working with the adolescent cohort regarding their working environment, professional effectiveness, and satisfaction with services for vulnerable adolescents and their families, with the aim of repeating the survey post-implementation to allow for a pre/post comparison. Just over two-thirds (67%) of respondents were from youth support, and one-third (33%) from children's social care and other local authority teams. The survey data was used to provide baseline descriptive statistics, and cross-tabulations were applied to explore patterns of results by grade and occupation. A full account was provided to GCC in a separate baseline report
- qualitative research: 3 waves of qualitative fieldwork were completed, in May 2015 ($n = 4$), April 2016 ($n = 5$) and October 2016 ($n = 5$). Each wave included semi-structured interviews with senior managers from children's social care, youth support and NHS CAMHS, and practitioners involved in the small-scale piloting of the BASE Practice model in the Gloucester Pod. The interviews were written up within structured grids, mirroring the key themes for the evaluation. Thematic analysis was used to explore similarities and differences in perspective according to respondent role and organisation
- cost-effectiveness analysis: a bottom-up analysis was undertaken, using a bespoke cost-capture tool to establish the nature and extent of potential time and cost savings arising from the new model. This work involved sampling 5 cases out of 18, which were worked using the new model in the pilot phase of the project. The subsequent analysis involved identifying the key processes and activities that took place during a 12-month period, and estimating the associated staff time and costs. Local unit cost estimates developed by GCC, following the approach set out by

Loughborough University⁴, for a range of children's social care processes informed the assessment

Two further online surveys were designed, scripted and piloted for children and young people, and parents and carers respectively. These surveys were discontinued, owing to the high turnover of young people within the services covered by the evaluation, and concerns about the administrative burden placed on practitioners. The equivalent evaluation resources re-allocated, following consultations with GCC, to include an additional wave of qualitative interviews with young people and their families in spring/summer of 2017 after the full roll-out of the model.

Limitations of the evaluation, and future evaluation

The following data limitations and caveats should be taken into account when considering the evidence presented within this report:

- the report gives an account of the initial work undertaken by GCC and partners to scope and test the practice and organisational models for the new service, and piloting in one geographical location with an established multi-agency team (the Gloucester Pod). As the project ultimately aims to achieve wholesale systems change for the entire workforce working with adolescents within GCC, the full roll-out of the model falls beyond the current reporting point, and therefore it is not possible to conclude on the effectiveness of the implementation of this second phase. The evidence at this stage therefore focuses on the effectiveness of the new practice model, lessons learnt from testing, and early signs of the types of outcomes that might be anticipated when the model is rolled out at scale
- the evaluators had fairly limited access to administrative and programme data during the development and piloting phase of the new practice approach. This is mainly because the model was still under development, and GCC and the partners were not in a position to share finalised data. The description of the pilot project is therefore largely based on qualitative interviews, background documentation underpinning the BASE model, and redacted data for a small sample of cases. A more complete analysis of administrative data is scheduled for November 2017
- the planned cost-effectiveness analysis included both top-down and bottom-up approaches, with the former based on an analysis of the total actual expenditure in both situations coupled with an analysis of the aggregate benefits (outcomes) for the young people involved. As monitoring systems were still in development, and the full roll-out of the model had not taken place, it was not possible to complete the

⁴ This approach attempts to cost individual activities by recording the time inputs of relevant staff and applying appropriate rates.

top-down cost–benefit analysis. This work will be revisited in autumn 2017. As such, the findings at this stage do not provide estimates of the likely total projected cost savings resulting from positive outcomes achieved and negative outcomes avoided

- the baseline workforce survey conducted for the evaluation achieved a response from 156 managers and practitioners⁵ across the Gloucestershire adolescent workforce providing their views on the effectiveness of services under business as usual, their aspirations for the project and insights to professional knowledge and confidence, self-efficacy, workforce morale and team working. This data provides a strong base for follow-up in autumn 2017

In summary, the evaluation methodology mirrors the timescales for the pilot, and the data collection and analysis is back-weighted to a significant extent. At this point in the evaluation, it is not possible to make an assessment of impact or value for money on the new practice model. Instead, the main focus of the report is on:

- the processes involved in implementing the unified structures and developing the practice model
- the lessons learnt following the roll-out of workforce training
- some indicative evidence of the cost savings from the innovative model

GCC has retained Ecorys to complete a summative evaluation of the full roll-out phase. The autumn 2017 fieldwork will allow for larger-scale interviewing with young people and their families who have received support under the rolled out model; a follow-up to the baseline survey to capture self-reported outcomes and service satisfaction data from the workforce; analysis of administrative data-sets, and a full top-down cost-effectiveness analysis. A final report to GCC is scheduled for November 2017.

⁵ 436 practitioners were in the eligible population for the survey (36% response rate).

Key findings

The Gloucestershire context – the rationale for change

As a county, Gloucestershire has comparatively low levels of deprivation, being ranked in the least deprived quintile among upper-tier local authorities in England in 2015, at 124 out of 152 (HM Government, 2015), and most young people achieve positive outcomes. The county has pockets of deprivation, however, and a recent analysis estimated the total number of young people living in poverty in Gloucestershire at 18,300, with 392 receiving Youth Offending Interventions, 400 on Child Protection Plans and 650 LAC.

Designing the innovation project

In their original proposal, Gloucestershire sought to significantly develop their service offer to the most vulnerable young people and their families (aged 10 to 25). This was in response to a number of issues in the existing services, including a high number of re-referrals to services, duplication in key processes within and across different agencies, and an insufficient focus on the journey and experience of the young person through intervention (further detail is provided in Appendix 3, under 'where we are now' in the logic model). These issues combined to restrict the experiences and outcomes of young people engaging with the services, and incurred a cost to GCC.

Research carried out by Research in Practice (2015), to support GCC's application to the Innovation Fund, reviewed 39 cases to explore the range of needs presented by young people and their families receiving support from targeted services. The report confirmed that, across all services, a high number of parents and children presented with mental health needs, as well as a high number of children with learning and communication difficulties. This report also indicated that young people accessing services usually presented with multiple, complex and co-dependent problems.

Another finding in the RIP report was that, frequently, families did not understand the support they were receiving, and their motivations were not aligned with the goals of the agencies trying to work with them. The report recommended that a common language of identification and intervention to help professionals from different agencies work together should include families to ensure that they had a strong voice within the system and build their capacity to effect change. A priority was identified to develop a shared understanding of risk and resilience between professionals and families.

The baseline workforce survey with frontline practitioners identified a number of barriers within adolescent services at GCC. The main themes to emerge from an open-ended question relating to limitations of the current services included:

- the lack of time available for practitioners to build trusting relationships with young people and families

- high levels of administration associated with cases
- a lack of consistency and shared understanding between different teams/agencies, with regard to the most effective methods of engagement and working with vulnerable adolescents
- an overemphasis on targets (through key performance indicators), which was perceived by some to have been detrimental to the quality of support offered to young people

During the qualitative interviews, service managers reflected that, too often, cases were closed because the young person would not take part in the core assessment. However, attempts to sustain their engagement had not always been successful. GCC's own monitoring data pointed towards relatively high turnover rates, with young people disengaging and re-presenting, and low efficacy within some interventions. In addition, referrals between individual agencies were assessed to be too frequent and not always sufficiently coordinated. These challenges were viewed as potentially costly, inefficient and detrimental to service users, as well as undermining staff morale: especially against a backdrop of funding uncertainty and service restructuring.

The baseline workforce survey indicated that the main challenge, as perceived by practitioners at baseline, related to service capacity. Overall, the governance, quality and effectiveness of services were rated quite highly by frontline practitioners (Figure 1).

Figure 1: Frontline practitioner ratings of service provision for vulnerable adolescents and their families

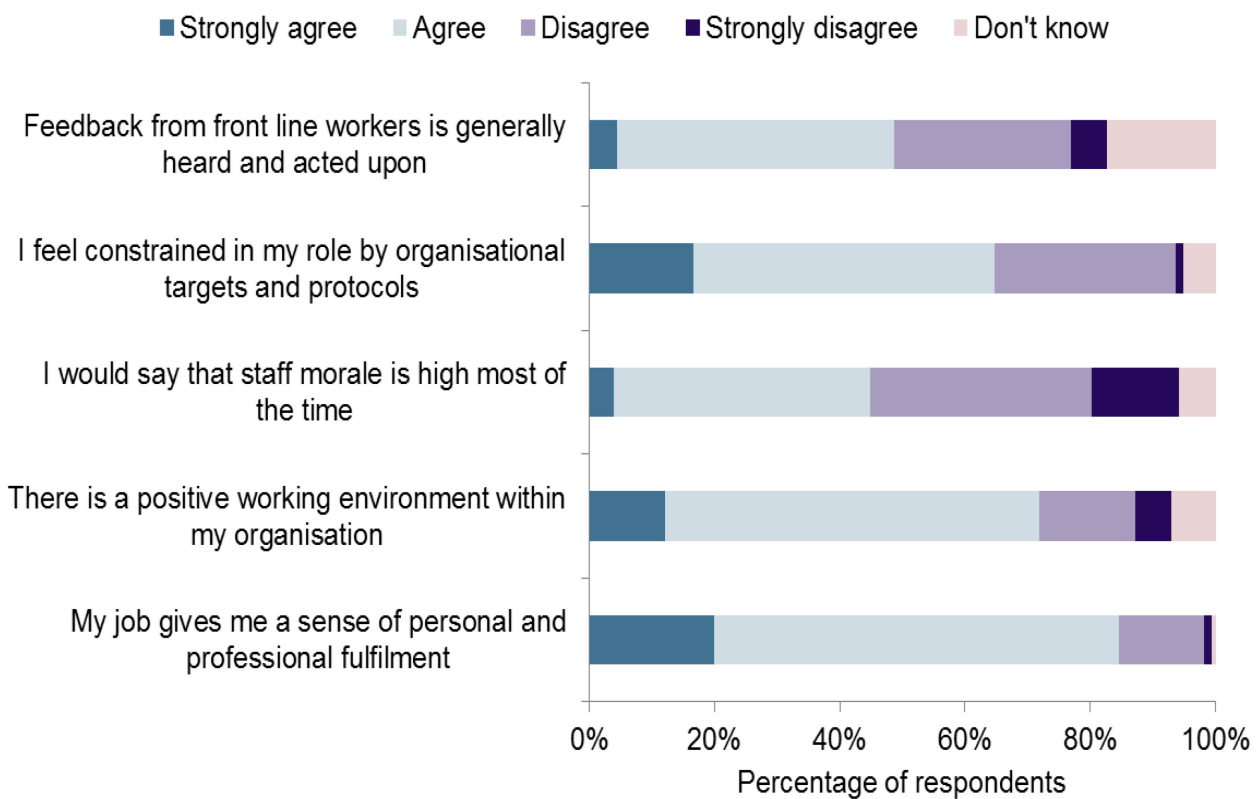


Source: Ecorys Baseline workforce survey (n = 156)

The qualitative interviews also showed that partnership working between children’s social care and targeted youth support was generally considered to have been strong, and that this had created a solid foundation for trialling and testing innovation. Service managers took pride in the flexibility of this partnership to respond appropriately to emerging needs within Gloucestershire. One senior manager reflected that, owing to a culture of continuous adaptation and improvement for services for vulnerable adolescents across the county, the Innovation Project benefited from a rolling start of local collaborative working.

There was also evidence in the baseline survey that there were high levels (85%) of personal and professional fulfilment among the workforce at GCC (Figure 2). Almost three-quarters of respondents (72%) agreed or strongly agreed that there was a positive working environment in their organisation. Opinions were more divided about levels of staff morale, although almost one in 5 (17%) strongly agreed that morale was generally high. There was also a sense of frustration among the workforce with regard to organisational targets and protocols.

Figure 2: Frontline practitioner perceptions of workforce and working environment



Source: Ecorys Baseline workforce survey (*n* = 156)

It was against this backdrop that the Innovation Project set out to achieve a real step change in how services work with vulnerable adolescents in the county, as well as to examine how best to build on the strengths of the existing organisational framework and to develop a more integrated organisational model to meet young people's needs. Essentially, stakeholders perceived the Innovation Project as an opportunity to rethink the current working arrangements and develop a systematic and evidence-based model.

Project design and development

The project aspired to implement an approach that was more appropriate to the risk and resilience attributes of adolescent service users, and which provided a focal point for bringing together children's social care, youth offending and NHS CAMHS. This aspiration was based on the evidence from a key research paper by RIP (Hanson and Holmes, 2015), which highlighted the limitations of the current child protection system for adolescents, as well as the specific needs and response to adolescent risk.

The concept of a single unified partnership, incorporating all key stakeholders involved in supporting vulnerable adolescents, was central to the project. A multi-agency Innovation Project Board was established, reporting directly to the Vulnerable Children's Board, within which the key partners from mental health, targeted youth support and social care

were represented. The longstanding nature of the partnership between GCC and the contractor overseeing the provision of targeted youth support within the authority was thought to have helped to build consensus around the concept, and to provide the combination of social care expertise with knowledge of effective methods for the engagement of vulnerable adolescents. This core partnership ensured that the project was built on trusted communication channels, providing appropriate support and challenge as the model was worked through during the initial stages.

Developing the practice model: ‘a secure base’

The new practice model, BASE, was developed through consultation with colleagues from children’s social care, targeted youth support, and Children and Young People’s Services (CYPS), and NHS CAMHS in Gloucestershire, who were brought together to find a common way to work across the system to better meet the needs of the most vulnerable young people. GCC organised a series of events with young people, families, practitioners and managers from across the sector to understand what an innovative and effective service for young people might look like. Appendix 4 provides a full description of the new practice model that was developed and refined through this consultation process.

As well as developing a conceptual practice framework to overarch the different disciplines within the unified service, the following supporting documents have been developed to support the implementation of the practice model:

- a competency framework
- new Assessment, Planning and Risk (APR) paperwork (being implemented in non-statutory parts of the system at present)
- an outcomes framework
- an Evaluation (QA) tool and approach that spans social care, youth justice and early help
- formulation meetings guidance and resource packs
- documentation to support Learning Circles, 2:1 meetings, and Practice Leaders clusters
- a range of tools to support the practice model, including versions of The Cycle of Change intended for young people, an Engagement Wheel, a Working Relationships Tool, an evidence-based Resilience Factors checklist and an interactive method for applying this in practice

The organisational model – ‘a single, unified service’

The project aspired to create a unified service that appropriately brought together professionals from different disciplines (social care, targeted youth support and youth

offending). This required a further work stream to identify the most suitable organisational model. The evaluation found some progress, although further decisions were pending regarding the structure of the service, in the context of wider restructuring to children's social care within the authority. Gloucestershire had recently opted to move towards a single delivery model for children over 11 in care, overseen by a commissioned provider. Responsibilities for CIN and CP were still under shared arrangements with GCC.

Target groups – (re)focusing on young people at the edge of care

The original target group that GCC was aiming to better support was defined as 'edge of care'.⁶ At the time when the evaluation fieldwork took place in November 2016, GCC and the partners were considering an extended remit for the service to cover the target groups below as part of the unified service offer to adolescents:

- who were in care with unstable placements, significant mental health/emotional difficulties and young people who are difficult to place with mainstream carers
- who were in need of mental health and/or Mental Health Act assessment and a safe place to be (for both NHS and social care cohorts)
- who were in crisis, severe emotional distress and at risk of significant self-harm/suicide
- who had significant mental health needs stepping down from inpatient psychiatric care or as an alternative to an inpatient admission
- who had behaviour (or emerging personality) disorder indicating a high risk of family breakdown
- who were held in police cells and should be transferred to Local Authority Accommodation, remanded to the care of the local authority

This shift acknowledged that young people at a higher level of need often engaged with multiple services; the lack of sufficiency for appropriate placements; and the resulting poor value for money for GCC and other local services. Service managers acknowledged that this re-focusing had brought new challenges: in particular, focusing on direct support

⁶ 'Edge of care' includes young people in the following situations: 1) before entering care, where the young person has been identified as being at risk of needing care – this is not an easily definable point, a range of problems and factors may have a cumulative effect resulting in a crisis where the young person comes into care; 2) in care before a long-term decision has been made about the future of where the young person will live (usually at the latest by 12 weeks after a young person has come into care); 3) when a young person is leaving care by going home or to live with a relative (sometimes called reunification); and 4) receiving support from a youth offending team, where they may commit an offence that risks remand or custody (as they are then automatically a child in care).

for health and mental health issues had implications for the role of the NHS Foundation Trust, and the regulatory requirements were under review.

Overall, the first 18 months of the Innovation Project in Gloucestershire gave stakeholders an opportunity to make progress towards restructuring the 11+ workforce in a way that supported professionals from multiple disciplines working together within a unified service. This will continue to be the focus for the remainder of the project, as the Council decides the most appropriate and cost-effective way to define the unified service framework, as well as the specific needs that the unified service should be targeting.

Lessons learnt from the new practice model

Piloting the new practice model

The new practice element – branded as ‘BASE’ – was piloted on a small scale within an existing multi-agency co-located team in Gloucester (Pod 7 in the Gloucester Pods). As part of a separate pilot project since 2013, the Gloucester social care team was divided into 7 smaller teams (or Pods) serving the 7 districts in Gloucester. Pod 7 was chosen to pilot the practice model, as the team received the highest demand and most complex cases. It was also the only Pod to include a multi-agency team, including representation from substance misuse, domestic violence and mental health services.

One stakeholder described the Pod 7 as an ‘excellent test bed’ for the new practice approach, as it was an opportunity to test and demonstrate how it worked in a controlled but realistic environment. Another stakeholder emphasised that it was important to choose a challenging environment to test the new approach, to ensure that the principles and practices were robust enough to support all cases referred to social care. The partners designed a prototype for case management under the new model, including assessment and measures to analyse outcomes. This was developed by social worker and youth support workers to combine strengths from both practices.

Originally, it was planned that 2 keyworkers would deliver the new practice approach in Pod 7, but this did not prove possible owing to extended leave. The single keyworker involved in the pilot was able to apply the new practice model to 18 cases with vulnerable young people over 4 months (November 2015 to February 2016). However, stakeholders reflected that the smaller than planned scale of the pilot initially made it hard to raise the profile of the approach within the team while also being quite isolating for the worker using the new practice, as their approach was different from that of their co-workers. Furthermore, it was difficult to assert whether any improved engagement and outcomes from the pilot were attributable to the new approach or to the worker. This added to the impetus to roll the model out more widely and train more of the workforce.

Wider workforce training

Following the initial pilot of the practice model, a 2-day training programme was delivered to the case-holding workforce across services for adolescents, as well as some partners from probation, police, health, mental health, and speech and language therapy. The first day focused on the Restorative Approach, and the second day focused on the BASE model. Following the training, staff joined a learning circle, which they attended once a month to allow them to consolidate their skills and to continue to embed the approach.

Staff also attended ongoing supervision sessions with trained managers, or '2 to 1s', for more direct support on their developing practice towards greater fidelity. During these sessions, the practitioners had the opportunity to review the competencies framework, developed for the Restorative Approach and BASE model, and to provide feedback.

Training phases

The workforce training was staged over to 2 phases, to maintain the control over the model and ensure that any feedback could be used to refine the model accordingly (see Table 1 for more details). At the time of writing, over 160 professionals had attended the training, and there were 11 learning circles in operation to help practitioners consolidate their skills. With this progress, stakeholders were confident that a critical mass for the new model was building across the adolescents' service, and the next steps were to monitor the approach in practice and to embed this new way of working.

Table 1: Professionals included in the roll-out of the workforce training (February to December 2016)

Phase	Pilot	Implementation phase 1 February to September 2016	Implementation phase 2 September to December 2018
N = total number of professionals	2*	16 (18 cumulative)	150 (168 cumulative)
Breakdown of professionals	2 practitioners**	5 managers 11 practitioners***	11 senior managers 17 managers 110 practitioners 12 partners****
Breakdown of teams trained	Gloucester Pod 7	<ul style="list-style-type: none"> • Health team • Cheltenham District • Forest of Dean District • Community Integrated Care (CIC) Wraparound • Gloucester North • Gloucester District Team • Gloucester Pods • Child Sexual Exploitation Team 	<ul style="list-style-type: none"> • Integrated district teams (youth justice, early help, NEET, youth work) • 11+ CIC and Care Leavers • Multi-disciplinary health team (CAMHS, speech and language, physical health, substance misuse, sexual health and pregnancy) • FastTrack team • Administrative staff

* One practitioner took extended leave following the training and did not participate in implementation.

** Both practitioners were Case Responsible Officers.

*** Practitioner roles included: senior practitioners, generic case responsible officers, youth justice case responsible officers, housing worker, care leaving worker, Child Sexual Exploitation engagement workers.

**** Partners included: probation, police, health, mental health, and speech and language therapy.

In the qualitative interviews, the practitioners reported that the training was a promising way of bringing together professionals from different disciplines, including social workers and youth support workers, to support the transition to multi-agency working within a single, unified service. Practitioners commented on how having the mixed professional groups often presented an opportunity to engage collectively with the new model and to encourage critical self-reflection.

While practitioners reported some differences in outlook according to their professional background, the Innovation Project was perceived to have helped in moving towards a more consistent set of practices using BASE. Practitioners who attended the training were generally receptive to the new way of working and found that the principles were aligned with their current professional practices regarding risk and resilience in young people. Practitioners valued the peer discussions about the model and the core competencies, and the opportunity to test and reflect on its application with more complex cases:

“There was lots of discussion as to how the model could be adapted to suit all types of young people. There was [*sic*] scenarios that came up and being like, ‘Oh well, in this situation you couldn’t do restorative approach because it wouldn’t work’, but the facilitators were always, ‘Well, yes it would because you could do this, this and this’, so that was really handy in showing that it can be applied to every scenario that you’re in as long as you can be flexible enough with it.”

(Generic case responsible officer, Youth Support Team (YST))

Service managers reflected that it was challenging to convey the complexity and application of the principles in practice. Some practitioners had found it hard to see the difference from their current way of working, as the core principles, such as engagement and motivation, were phrased in familiar terms. One stakeholder observed that there was an important period of unlearning of current understanding and then re-learning in the context of the approach, particularly when applying the model to more complex cases:

“People have particular views on what is meant by engagement, and so some of this is about unlearning ... although it seems very obvious and very simple, it’s quite challenging in a very complex, pressurised, risky work environment where people need to move quickly through processes and procedures ... it’s a particular discipline to be able to calm oneself to go back to basics rather than to just be in the moment and be driven by some of the pressures, either within a young person’s life within a family or in one’s organisation.”

(Service manager, YST)

Practitioners in the qualitative interviews identified that the learning circles had proven to be an effective mechanism for quality assurance, and to embed competencies in a peer-to-peer format. The rationale was that the newly trained staff would be unlikely to retain all of the new knowledge and with the additional support practitioners are more likely to work with fidelity to the new approach. Practitioners saw the learning circles as a reflection of the high support within a new practice approach and a further opportunity to work in groups to fully understand the competencies and principles of the model. Supervision was perceived as a more focused opportunity to review with a line manager the practitioner’s experience of working in the different way with specific cases.

The first team to receive the workforce training in February and March 2016 subsequently went on to hold the first caseloads of young people as part of the unified adolescents’ service. Service managers and practitioners reported that the team was operating at a perceptibly higher level of confidence and that there were signs of improved engagement and progress among young people.

A number of the practitioners who were trained earlier concurred that their skills and confidence had developed over time. While a number of the social workers within the team had initially voiced reservations about compatibility with statutory social care processes, many of these concerns had been resolved by the third wave of fieldwork. This was largely as a result of having undergone testing and refinement with more acute cases. The application of the BASE principles in formulation meetings was cited as an example of how the model had started to inform statutory work.

Early outcomes from the new practice model

As part of the roll-out, the practitioners who had received training in the BASE model each trialled it with between 2 and 3 cases in the first instance. The rationale was to ensure fidelity, prior to rolling out on a larger scale across entire caseloads.

The qualitative interviews with practitioners showed that this approach was generally welcomed, as it allowed for reflection on what was different about the new model, and to compare with established working practices. The service managers, however, commented that this model of roll-out was difficult to monitor and quality assure centrally as there was some variation in how practitioners chose to implement the training. This resulted in some cases where BASE was only partially implemented and others where it was adopted for a much higher number of cases than was originally intended.

From practitioners' perspectives, the additional time afforded to manage the initial engagement process was often considered to have helped gain a deeper understanding of presenting behaviours than under previous models of contact with families:

“We’ve been able to really drill down on lots of areas of a young person ... to really concentrate on that engagement, really concentrate on what risky behaviours, and look at their resilience, because actually young people go through lots of stuff.”

(Generic case responsible officer, YST)

“It is always young people who have kind of reached a situation where there is risk involved, they are experiencing quite a lot of problems, so yes, very much so... within the client group that I’ve got, it definitely works.”

(Substance abuse case responsible officer, YST)

Practitioners reported that they often approached cases differently when taking the model's perspective that services users are their own expert on what they need and can achieve, thereby prioritising their relationship with the young person and helping them to articulate what they need from the professional support. This non-judgemental approach was often reported to have received positive feedback from families:

“The success comes from spending time with families, and listening to their views and working on what their strengths are ... bringing it back to actually what's the focal point here and what works for them is what helps, rather than it being directive or people feeling judged.”

(Generic case responsible officer, YST)

The quality of this initial engagement with the service user was often on the basis of the young person's greater subsequent willingness to share their views on what needed to change, and to identify more realistic timescales. Practitioners commonly found that the process of identifying risk and protective factors helped to check and challenge any misconceptions they had as to the key factors influencing the young person's life. This was important information when determining the focus and content of the intervention:

“When we did it [BASE assessment] in that meeting ... something that came out was mum said that the young person didn't have contact with her biological father, and I instantly went down to write that as a vulnerability factor and then I thought no, hang on, that could be either/or, so I asked mum. She said, 'It's actually a positive

one', so I think we need to be a bit more open-minded as to how we see those factors ... depending on the family rather than just depending on what we feel is right."

(Generic case responsible officer, YST)

Another important application of the new way of working was through the formulation meetings. Service managers and practitioners reported that families were often able to engage and share in the meeting's process. In particular, the meetings created opportunities to unpick challenges in more complex cases and look more closely into a range of risky behaviours with the young person:

"I appreciated the fact that the meeting looked at lots of risks. Not just the obvious ones, such as those related to school attendance ... a broad picture, which enabled us to not get stuck just with one risk. Also, the meeting provided a better understanding of the impact of the likelihood of [it] happening again."

(Social worker, Children's Social Care)

Beyond the reported benefits to the service user, having a common and clear definition of the practice model meant that practitioners were often better able to communicate progress to other agencies using common reference points and language. There was some evidence that this had reduced the propensity for social workers or youth workers to hand-off a case where additional external support was required.

"I thought, early days, it was like, this is going to really clash against functional family therapy, but ... I've found that, no, we can complement each other and we can still do this together ... I'd say that the other services that are around just working with young people have also come on board with it as well, which is really good."

(Generic case responsible officer, YST)

Overall, therefore, practitioners reported promising, and mutually reinforcing benefits, from the relationship building, engagement and careful analysis of the different factors in young people's lives using the BASE model. This in turn was thought to have improved levels of diagnostic awareness and a better understanding of the appropriateness of the available interventions.

Practitioners spoke with candour about the likelihood of any vulnerable young person reaching a crisis point again in the future – a feature that had characterised the interventions with many of the young people who were well known to social care teams and for whom casework had been a revolving door of social work. The extent to which the BASE model achieves measurable improvements in this regard will be determined at the final analysis stage, using a comparison of the available administrative data.

Areas for development

While the early piloting largely pointed towards positive developments in the service, the evaluation highlighted a number of areas for further development, to ensure that the model is successfully implemented. These can be summarised as follows:

- in the early stages of implementing the new model, stakeholders found that some practitioners had a tendency to rush or skip stages in the BASE model, while the relative strengths and experiences of individual practitioners were apparent within case recording. There was some consensus that the main future priority was to step up self-evaluation and supervisory feedback, to provide more rapid feedback loops and ensure the fidelity of the model
- practitioners often reported a tendency to revert back to more familiar practices when presented with cases involving a higher level of risk, where there was greater pressure to act quickly and under a higher level of scrutiny. There were some tensions with the more open-ended approach towards user-led assessment within BASE. The peer-review process facilitated by the learning circles was found to have helped to a considerable extent in seeking feedback on cases and moderating practitioners' judgements about levels of acceptable risk. Even so, this remains an aspect of the model that will need to be further tested, as GCC looks to consolidate a service for some of the most vulnerable young people in the authority
- related to the above, the flexible and user-led approach sometimes proved less straightforward to implement where cases involved a statutory order. However, practitioners from youth support who were interviewed commented on how they had seen social work colleagues start to openly adopt the risk assessment approach and other elements of the BASE model, where initially they reported some discomfort at doing so while also meeting the requirements of the CIN or CP Plan. There were still some concerns about using the approach with YOT cases involving court decisions. Practitioners thought it may be harder to be flexible with the engagement and timing of support from the service because the judge's decision was final, and there were unambiguous consequences of non-engagement
- a final challenge facing the early implementation of the new practice model relates to the monitoring requirements. While the stakeholders have developed an evaluation tool to assess the quality of the work, the mechanisms for capturing service outcomes remained less clearly defined at the time when the evaluation fieldwork took place. Developing a Performance Monitoring and Outcomes Framework for the service has proven to be challenging because of the limited scope to adjust or extend the parameters of the established IT-based social work case management system. This issue had been acknowledged by senior managers, and GCC and the partners were looking to set more robust arrangements in place within an estimated timescale of 18 months. This work has taken place in tandem with efforts to set in place information-sharing agreements between the key partner agencies, to facilitate better access to multi-agency data

Project outcomes and cost-effectiveness

Service-user outcomes

As part of the 5 costed case studies included in this evaluation⁷, service-user feedback was collected from 5 young people who were supported as part of the pilot phase of the new practice model. The data from these cases are useful to the evaluation to provide an insight into the experiences of young people, particularly as it was not possible to monitor their experience via a survey. The report also includes service feedback from professionals and parents involved in each of the cases, as a way to add different perspectives to the young person's viewpoint.

Overall, the 5 young people in question consistently rated engagement with the practitioner positively (Figure 4), reporting that they were good, or very good, at explaining the services to them, as well as making an effort to listen to their views and to develop a trusting relationship to them. Several of the young people specifically made a reference to how the practitioner had helped them to pursue a particular education or employment goal, which they had achieved, or were working towards, and they now felt more confident as a result:

“When I started working with [youth support worker] I was shy and wouldn't talk much but that changed because [youth support worker] gave me confidence. [Youth support worker] is easy to talk to and helps me understand how to relate to people. [Youth support worker] doesn't make me feel uncomfortable, creates a good space where I can trust him and myself.”

(Young person, female, 14)

“Having a normal life, a job – I'm doing this now with or without [youth support worker]. I know they can't be involved all the time but I feel I can do this on my own now.”

(Young person, male, 16)

The aspect of the support that the young person was more likely to rate as only 'OK' (rating 3 out of 5) related to understanding of the complexities in their life, including the young person's strengths, vulnerabilities and risks, as well as the practitioner's ability to do everything they said. However, young people often explained their rating with a comment that acknowledged that the practitioner was 'trying their best' and that it was their responsibility to be motivated and achieve their goals as well:

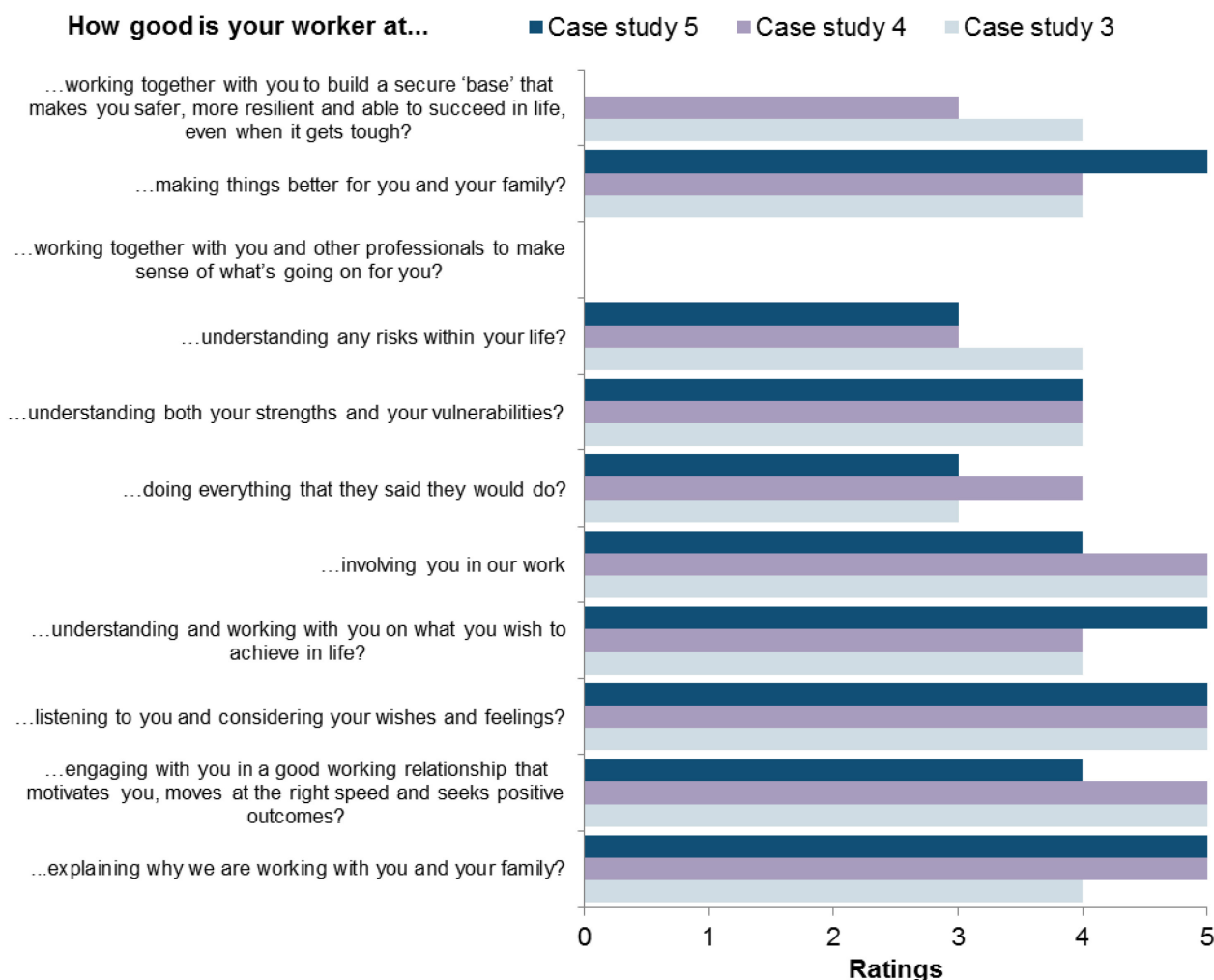
⁷ The 5 cases were drawn from the cases from the same keyworker working within the pilot of the new practice model. The cases were the same 5 new cases included as the costed case studies in the evaluation.

“Sometimes it’s not happening exactly when agreed but I could say the same about myself. I also could be better at this – it’s not just for [youth support worker] to do.”

(Young person, male, 16)

Young people were least aware of how professionals worked together to support them, as they were unable to provide a rating for this aspect of the support.

Figure 3: Service-user experience from 5 case studies: young person ratings



Data source: case study evidence collected by GCC. Rating scale from 1 very poor to 5 very good. No data was collected from the young person for case study 1 or 2. The data can be triangulated with the ratings from parents (Figure 5), social workers (Figure 6) and 5 costed case studies (Appendix 3).

Parental feedback

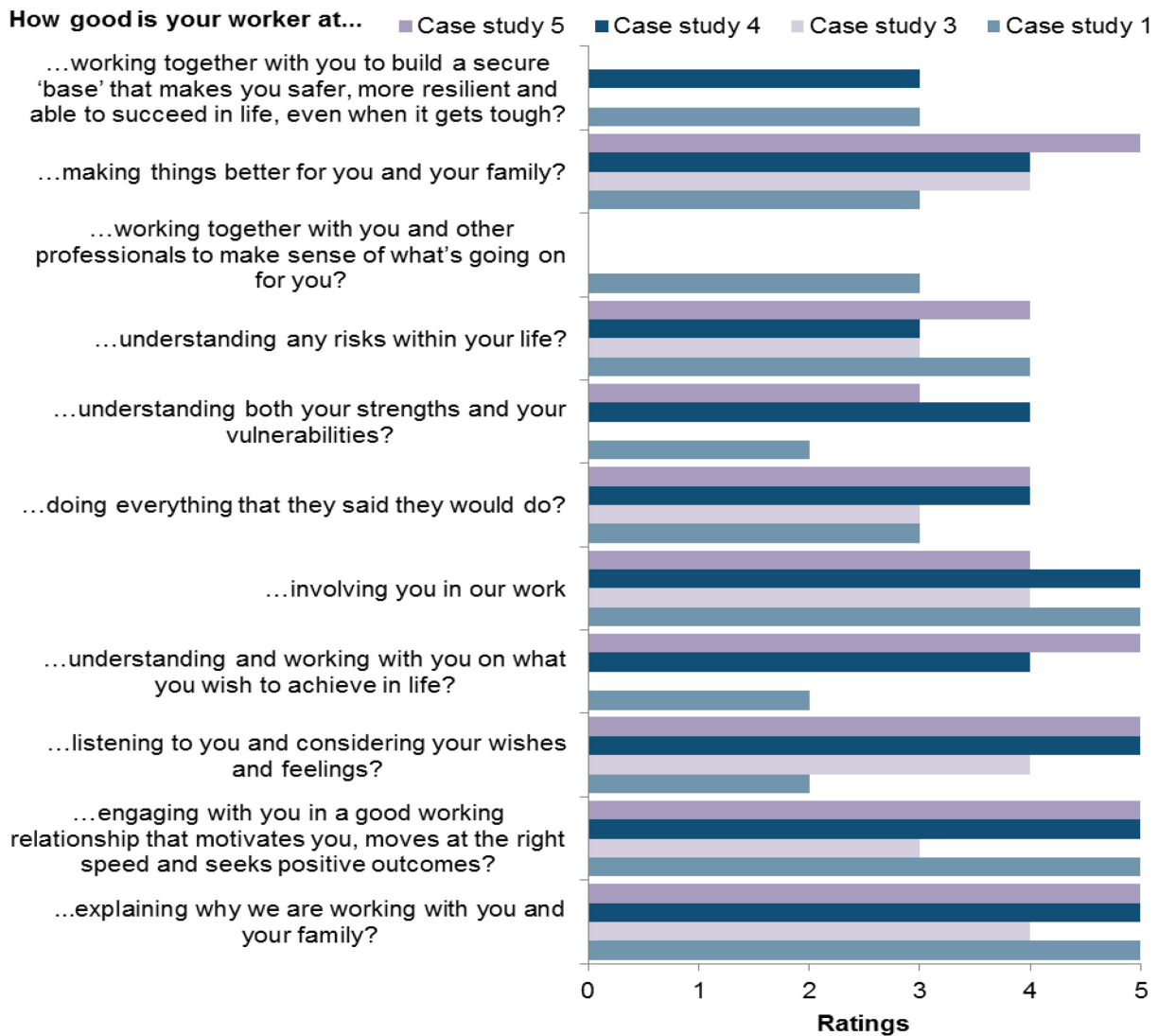
Parents who provided feedback as part of the case-study reviews confirmed the positive experience of the support offered by the youth support worker (Figure 5)⁸. In describing their experience, parents frequently made comparisons with previous engagements with social workers, where they reported that they had more negative experiences, including more judgement from the professional about their situation and lack of understanding about the purpose of the support they were receiving:

⁸ Some of the low variable ratings in case study 1 are because the parent is rating the support offered to her by the service, rather than her perception of the support towards the young person.

“...with the social workers before, I didn’t understand why my situation was risky, I didn’t understand why they thought like they did. I didn’t understand the risks”.

(Parent)

Figure 4: Service-user experience from 5 case studies: parent ratings



Data source: case-study evidence collected by GCC. Rating scale from 1 very poor to 5 very good. No data was collected from the parent for case study 2. The data can be triangulated with the ratings from young people (Figure 4), social workers (Figure 6) and the 5 costed case studies (Appendix 3).

Professional feedback

Overall, the ratings by social workers for the 5 cases were still largely positive, but there were cases where the ratings were low or more variable (Figure 6). Here, the social worker explained that, despite a high level of contact time with practitioners, there had been less progress with the young person or their family.

In other cases, social workers reflected that the youth support worker had been more effective in achieving positive outcomes, compared with the interventions by social care, and to reflect this they gave 2 ratings in their assessment. Some explained that the difference between the 2 disciplines was because the role of the social worker was to assess and support the whole family, rather than offer targeted support to just the young person:

“I feel no real change has happened in the last 2 years, mainly due to father’s lack of motivation and engagement The [youth support worker] really helped in mediating with school and working with [young person]. I felt [youth support worker] understood our expectation in terms of education.”

(Social worker, Children’s Social Care)

“For social care – not so successful – we had numerous meetings and attempts to engage the father and to try and move things forward but not very successful. I think the family had the opportunity but they didn’t engage ... For [youth support worker] work with [young person] – this is more successful hence a 4.”

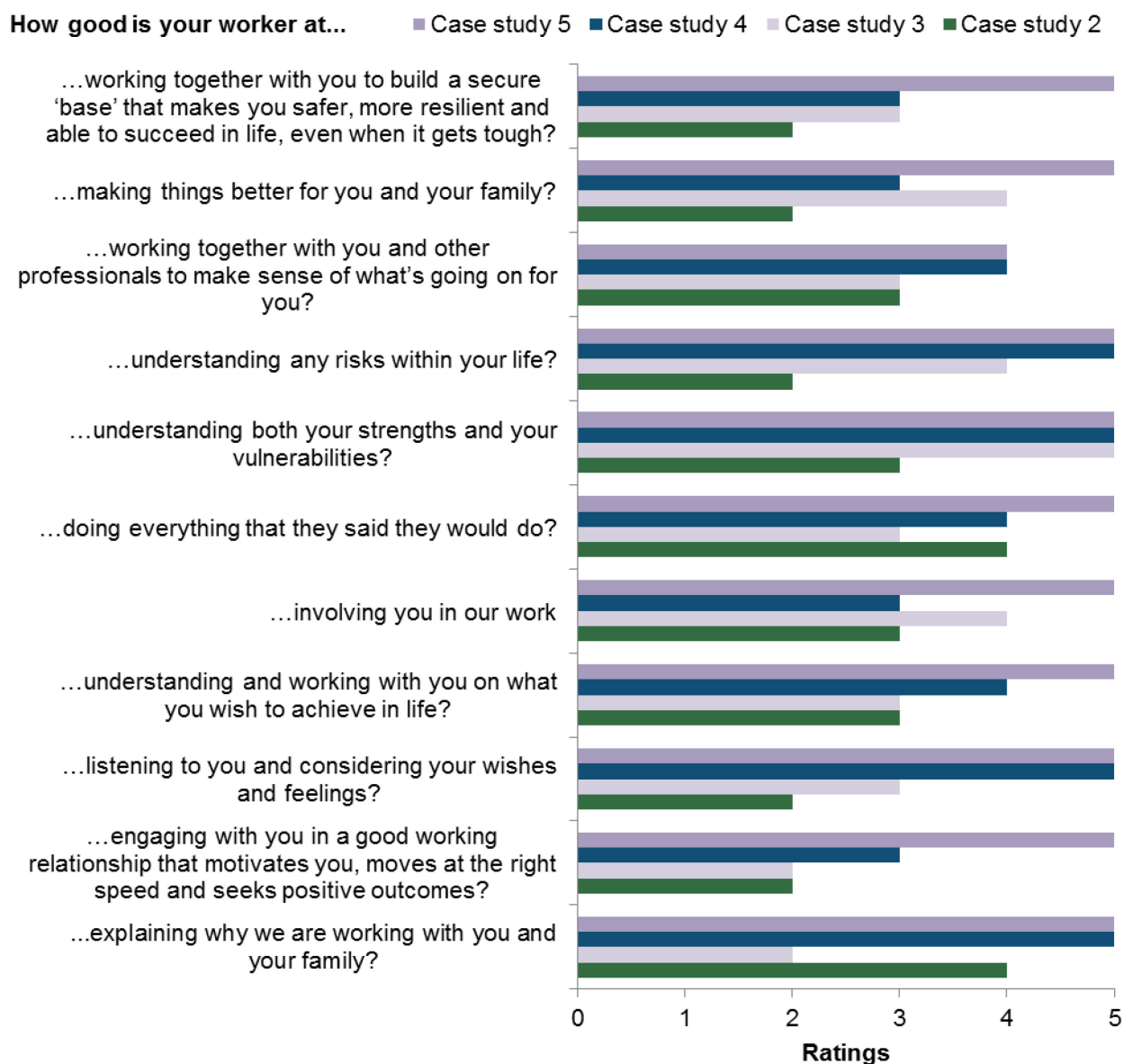
(Social worker, Children’s Social Care)

Overall, however, the evidence indicates that social workers recognised the benefits of the intensive and personal support. As well as enabling positive outcomes for the young person, social workers valued the opportunities afforded by the BASE model to spend additional time to observe and understand the presenting issues within the family:

“It was very helpful that [youth support worker] took the time to understand [young person’s] needs and family’s issues ... they followed up outstanding actions and kept things on track. This also freed me up to focus on the other aspects of the case. Consistency and persistency are important ... the [youth support worker] had to cancel some appointments, but this was mainly because of their caseload. All in all, [youth support worker]’s approach was very beneficial.”

(Social worker, Children’s Social Care)

Figure 5: Professional perspective from 5 case studies: social worker ratings



Data source: case-study evidence collected by GCC. Rating scale from 1 very poor to 5 very good. No data was collected from the social worker for case study 1. The data can be triangulated with the ratings from young people (Figure 5), parents (Figure 6) and the 5 costed case studies (Appendix 3).

Further evidence of service user experience

Beyond these 5 case studies, there is less direct evidence of the outcomes for young people. The stakeholders interviewed as part of the third wave of qualitative research in the study reflected that it was difficult to report conclusively on service outcomes at the initial implementation stage, in the absence of routinely collected monitoring data. This is an obvious limitation of the evaluation currently and will be a future priority to ensure that there is a thorough consideration of the service-user outcomes in order to make an assessment of impact of the new way of working.

It is, however, promising that the small sample of practitioners interviewed in the third wave of the evaluation, who had been supporting young people through the BASE approach, reported very tentative positive outcomes for young people they had supported, which reflect similar themes from the 5 case studies described above.

In particular, practitioners reported that the approach was effective in supporting young people on the edge of care and engaging in risky behaviour, where previously intervention by other services had not been successful. They attributed this to the specific principles of the new approach – namely, the focused work on engagement; holistic support related to strengths and vulnerabilities; and the careful analysis of needs informing action planning, which helped the young person to feel motivated to achieve change and to feel more effective than the previous way of working. However, it is important to exercise caution around extrapolating this as evidence of an impact on outcomes for the young person, as the sample of practitioners was again small. The themes highlighted by practitioners should also be further explored in the later stages of the evaluation.

Cost-effectiveness outcomes

At the time when the evaluation fieldwork took place, GCC and the partners were in the process of compiling data to better understand the costs of implementing the new model, and the areas where savings might be accrued. While this work was still at an early stage, there was a sense that inefficiencies in the system were being addressed:

“Within the children in care there’s been some efficiencies ... partly around management and also around a better grip on cost ... there wasn’t consistency in how things were being paid, what policies were in place, how to make certain decisions about payments for young people or their parents or their carers, and I think that’s much clearer now from our service in terms of the cost saving.”

(Service manager, Children’s Social Care)

To provide a more detailed insight, Ecorys undertook a review of 5 cases sampled from the new model. It should be noted that all new model cases have been co-worked with social care. Therefore, social workers will continue to undertake assessments, reviews and visits in line with established processes (such as setting up, supporting and reviewing CIN plans). Therefore, to some extent, the inputs of the youth support team can be seen as additional to the existing model. However, the intention is that this additional input results in better engagement and more targeted support, which allows cases to be stepped down and closed to social care more quickly than would otherwise have been the case, helping to free up social worker time, potentially reducing costs in other areas (such as placements) and producing better outcomes for the young people and their families. After being closed by social care, cases remain open to the youth support team to allow continued engagement and monitoring (building upon the relationship that has been developed).⁹

Table 2 summarises the estimated time input of the YST during the review period based on information extracted from case files. The cost of this input was then estimated based on the salary costs of the YST case responsible officer. The final column indicates the savings to social care that would be expected to have resulted from any change in circumstances during the review period (full summaries of the case-study reviews for the new model can be found in Appendix 3).

⁹ The dual working between social workers and youth support workers was because the social care staff in Pod 7 have not yet been trained in BASE, so this was a precautionary element of the pilot to ensure safe and compliant practice. Should these social workers also be trained and apply the model, this duplication would ease with commensurate efficiencies and savings.

Table 2: Summary of review of new model cases

Case	YST inputs	Cost	Potential savings
No. 1	75 hours	£1,730	Support for CIN plan no longer required (estimated at £393 per month, or £4,714 for 12 months)
No. 2	45 hours	£1,050	Support for CIN plan no longer required (estimated at £393 per month, or £4,714 for 12 months)
No. 3	105 hours	£2,680	Prevention of escalation to CP plan (cost of developing a CP plan estimated at £2,200 plus £1,147 per month for ongoing support, or £13,769 for 12 months of ongoing support)
No. 4	80 hours	£1,800	Not applicable (although evidence of improved engagement)
No. 5	70 hours	£1,615	Support for CIN plan no longer required (estimated at £393 per month, or £4,714 for 12 months))

Data source: Ecorys review of GCC cases. Note that cases were co-worked with social care, so YST inputs should be seen as an additional cost compared with the existing approach

The review of the outcomes from cases worked under the new model indicates some success in securing and maintaining engagement with young people (and their families) and also in identifying and addressing their issues. Three out of the 5 cases reviewed were closed to social care during the review period (with these individuals no longer classified as CIN), which would be expected to result in savings to social care, as there was no longer a need to support CIN plans. In a fourth case, escalation to a CP plan was avoided as a result of the progress made by the YST, which again would result in significant savings to social care in formulating and supporting a CP plan. These savings would be expected to offset or outweigh the costs of involvement by the YST. The final case (no. 4) showed less progress in that no change in status was recorded; however, it was agreed that significant progress had been made in terms of engagement, which would be expected to facilitate positive outcomes over time.

Conclusions and recommendations for future policy and practice

This report has presented the findings from the independent evaluation of the Gloucestershire Children's Social Care Innovation Project, based on work carried out between September 2015 and November 2016. In this final section, we draw together, and reflect upon, the key messages from the evaluation, and we set out the next steps for the evaluation in the remaining period up to November 2017.

Concluding thoughts

Overall, the picture to emerge from the Innovation Project in Gloucestershire on conclusion of the piloting stage is encouraging, from the worker's perspective. There is also small-scale, emerging positive evidence regarding young people's views.

At the time of writing, GCC and the partners have set in place the building blocks of the new practice model, and commenced the wider roll-out, with training completed for over 160 practitioners and managers. The pilot benefited from drawing upon the diverse range of professional backgrounds and experience of stakeholders who are engaged with the adolescent cohort, blending practices from targeted youth support and social care, with well-established evidence-based approaches.

There was evidence that the training and learning circle approach was proving effective as a means of supporting practitioners to gain confidence and competence in the principles of the new practice approach. The mixing of professional disciplines in the training was another supportive factor in implementing a unified service.

The new practice model designed as part of the Innovation Project includes a number of strong elements, including:

- the joint infrastructure for integrated multi-professional teams
- the platform of joint training and restorative practice, underpinned by a competencies-based framework
- the commitment to ensuring that the model is tailored towards the specific developmental needs of adolescents – both in engagement and in terms of identifying and appraising risk and resilient factors for the young person

The feedback from a small sample of families and young people provides some indication of the value of the relationship-based support that was developed, often where services would previously have referred onwards and/or closed the case. Further, a small-scale analysis of cases shows the potential cost savings to be accrued from a step-down from CIN plans, and preventing individual cases from escalating to CP proceedings.

The pilot highlighted the importance of testing the new model in the context of the statutory guidelines for young people involved with social care. While there is an acknowledgement that the model must hold true for higher- as well as lower- risk cases: this is an area that practitioners, particularly practitioners who do not have a social work background, have found challenging to put into practice. There is a clear need to continue to monitor the effectiveness of the new model in this more challenging context, to ensure the safety of the young person and their family, and to evidence the outcomes.

It was an aspiration of the project to provide a unified service for young people that combined support from targeted youth support, social care and children, and some elements of NHS CAMHS (CYPS) for the adolescent cohort. The development of the model to date has been primarily managed in partnership between children's social care and targeted youth support. Although stakeholders reflected that this had been largely owing to the need of a more staggered approach to rolling out the model, the level of direct engagement of partners from the health sector was less visible, and involving health partners more concretely in developing the service would seem to be a priority in the medium term – especially so, given the prevalence of mental health issues within the cohort that was identified within the RIP report (2015).

Progress over the past last 18 months indicates that the original timescales for the project were too ambitious to develop and test a new practice model spanning the range of professions working with vulnerable young people in the adolescent cohort, and to establish a multi-professional competency framework. There was an understandable degree of caution to ensure that the testing phase was concluded robustly, prior to wider roll-out. Nevertheless, the evaluation found that the project was hindered by a lack of practitioner capacity during the initial stages. Specifically, the initial piloting within the Gloucester Pod relied on the judgements of a small number of practitioners, and it is only through the subsequent phased roll-out that it will be possible to fully triangulate the evidence about the experience of the practice model.

With the challenges in creating a new workforce structure, senior managers were cautious in how they communicated to staff about the project, to avoid creating unease at further restructuring. There was some concern about the retention of social workers, but also because the project came at a time when fiscal constraints on services were being felt locally as well as nationally. These 2 factors created a fragile environment to implement change and required a careful approach to disseminating the project during the first year, and it is only in recent months that the model has become more visible across the authority.

In the short to medium term, there is a real priority to robustly monitor the implementation of the BASE model and to capture a suitable range of service outcomes. The challenges around implementing the Performance Monitoring Outcomes Framework, coupled with delays to establishing a case management system, meant that there were very limited centralised outcomes data for the new service. This in turn has restricted the potential for

measuring changes over time using an appropriate set of indicators. This data might prove difficult to collect retrospectively, and therefore there should be an impetus to put the process in place to collect data as the model is rolled out more widely.

Strengths and areas for development

Reflecting upon the findings from this report, the main achievements of the Innovation Project during the initial phases of design and implementation include the following:

- there was much consensus among all stakeholder groups that the new practice model trialled through the Innovation Project stands to provide a common approach and common principles that can be applied to a diverse range of disciplines, starting with youth support and social care
- the work to develop a competencies-based framework is particularly significant in this respect. The ability to benchmark using common criteria will be essential to preserve the fidelity of the model: both the stakeholder interviews and the workforce survey indicated that practitioners' views of their professional competences are not always consistent with externally validated measures
- the training in this new approach and restorative practice would seem to have been largely well received by social care and youth support professionals who have participated in the small-scale trial within the Gloucester Pod, where it has further cemented the multi-professional approaches that started under a previous pilot
- learning circles are proving to be an effective way to develop staff beyond training, which is important, given the initial variations in practitioners delivering the model and has real potential for achieving the intended scale that would be necessary to achieve systems change
- there is evidence that the learning from the pilot has an application beyond the Innovation Project and that the partners have aligned the DfE funding effectively with wider restructuring for children's services countywide. There is a strong common thread in the application of restorative practice
- there are promising signs that this new approach has secured the engagement of young people and their families. Anecdotally, young people recognised and experienced the engagement model as being something new and different, and particularly valued the sense that their views were being heard and acted upon

Nonetheless, the service faces a number of ongoing challenges:

- the structural changes in the workforce have been generally perceived as an unsettling time for the practitioners. The potential for negative impact has been mitigated by careful communication around the changes, but going forward, more support may be needed to avoid staff turnover and anxiety

- although the baseline survey showed a widespread recognition of the need for a stronger multi-professional approach towards working with vulnerable young people in Gloucestershire, there were residual concerns about the concept of a single integrated service, and many staff expressed some anxieties as to what this might mean for their professional role and employment status. This would suggest a need for further reassurances and greater transparency as the model is scoped out, so that practitioners are fully on board with the transformation process and understand what it will mean for them
- the baseline survey flagged a number of further areas for attention. These include some concerns among frontline practitioners that their feedback is not always heard and acted upon by managers, suggesting that it might be useful to review lines of communication to ensure that they are fit for purpose. Some concerns were also apparent from the survey regarding capacity and workload, and the pressure from targets, although these findings are far from being unique to Gloucestershire
- from the piloting exercise in the Gloucester Pod, it is clear that levels of confidence have generally been lower where practitioners have applied the new model with higher need or risk cases. Further work is likely to be needed to build the confidence and competence of practitioners to preserve the fidelity of the model and not to revert to familiar ways of working when faced with more challenging behaviours
- further time is needed to establish what the offer for adolescents will look like at scale when there are fully formed multi-professional teams working with larger caseloads; and what the longer-term arrangements will look like for supervision and professional development within the integrated teams
- the phased implementation has entailed that the model remains firmly grounded in partnership working between children's social care and targeted youth support, Whilst this has clearly been a strong partnership, the success of the model is likely to be influenced by the timing and scope of engagement of other key agencies working with the adolescent cohort. The original plans to develop the model with strong involvement from NHS CAMHS were not taken forward during the first 18 months, and the working arrangements that emerge during the next phase will be critical to positioning the new service as genuinely multi-professional – especially so with regard to working with young people and families where there is a greater risk and complexity
- despite small-scale evidence of positive engagement and self-reported outcomes by families and practitioners, stakeholders are aware that there is still a shortfall in hard outcomes data as well as limited evidence to date that the service is being delivered more efficiently or at a reduced cost. The next stage of the independent evaluation will complement these 2 areas of work over the next 6 months

Next steps for the evaluation

This evaluation report has presented the evidence from the set-up and early implementation of the Social Care Innovation Project in Gloucestershire. Wider roll-out was under way at the time of writing, with plans for a renewed focus on higher-risk young people, having established the building blocks of the delivery model. GCC and partners were also looking towards extending the training to provide BASE to the LAC young people, and therefore to close the loop with the restorative practice dimensions of the model by supporting young people through reunification.

GCC has retained Ecorys to complete a final summative evaluation of the full roll-out phase. This work will be carried out within the scope of the original evaluation budget, with the data collection and analysis back-weighted to 2017 to better reflect the timescales for the full roll-out of the BASE practice model across Gloucestershire. This will entail carrying over the resources that were originally allocated for the administrative data analysis in 2016, and by adding a further wave of in-depth qualitative fieldwork with young people, families and practitioners in place of the 2016 survey work. The work programme will also include a follow-up to the baseline practitioner survey (at +30 months) and a final top-down cost–benefit analysis at an overall project/service level. A final report to GCC is scheduled for November 2017.

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Appendix 1: Key phases in the project and the independent evaluation

Table 3: Phasing of the Innovation Project

Criteria	Development May to October 2015	Pilot November 2015 to February 2016	Implementation 1 February to April 2016	Implementation 2 April to December 2016
Social Care Innovation Project implementation	The initial phase of the project aimed to develop the framework of the new practice model (BASE). This phase involved consultations with professionals in Children's Social Care, Youth Support and CYPS (CAMHS), and consultations with young people receiving support from services.	A small and tightly controlled pilot involving youth support workers within the multi-disciplinary Gloucester social care pods*.	The tightly controlled phase involved training a small number of professionals working in youth justice, substance misuse, social care, education training and employment and child sexual exploitation. The training was delivered by leads at Prospects.	The second phase of implementation involved training the remainder of the YST, starting with the senior management team, and moving across the rest of the service. This phase was also delivered by leads at Prospects. Following the training, practitioners selected 2 or 3 current cases to apply the model.
Total number of practitioners trained	n/a	2 practitioners	5 managers 11 practitioners	11 senior managers 17 managers 110 practitioners 12 partners
Total number of young people cases	n/a	18	~32 ^{***}	~300 ^{***}
Evaluation stages	Background scoping and research design. Introductory sessions with Ecorys young people's panel to inform the research design processes. Qualitative research with strategic stakeholders ($n = 4$).	Baseline survey with practitioners ($n = 156$) ^{**} .	Qualitative research with strategic and operational stakeholders ($n = 4$). Qualitative research with stakeholders (with Ecorys's young people's panel) ($n = 5$). Interim report for GCC.	Qualitative research with strategic and operational stakeholders ($n = 5$). Qualitative research with practitioners delivering the BASE model ($n = 6$). Case studies comparing Business As Usual (BAU) with the new practice model (BASE) ($n = 10$). Final report for DfE.

*GSC team has been divided into 7 smaller teams (or Pods) that serve the 7 districts in Gloucester. This has been part of a separate pilot since 2013.

**Surveys with young people and parents were also piloted at this baseline stage, but both were discontinued owing to challenges in implementation the process with the cohort.

***This is an estimated figure provided by GCC based on the stipulation that, following training, practitioners were supposed to select 2 or 3 cases within their caseload to adopt the new approach. Gloucestershire did not monitor the application of this rule closely, as it proved to be quite resource-intensive. Their experience was that practitioners were more flexible in how they applied their model and often decided to implement the new approach with all their cases or switched the selection part way through.

Appendix 2: Analytical framework

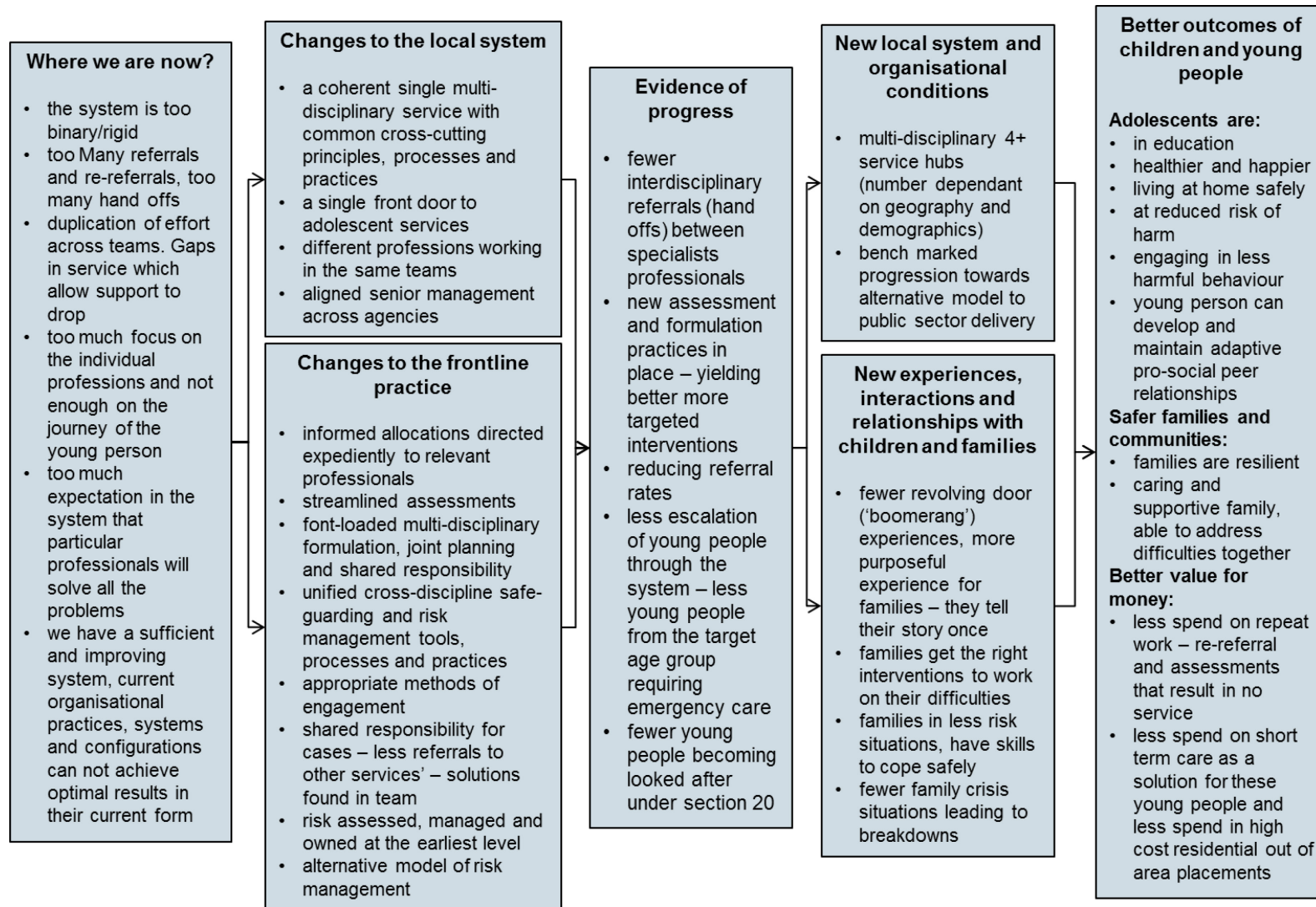
Table 4: Analytical framework

Research questions	Scoping desk research	Qualitative interviews with managers and practitioners	Qualitative interviews with children, YP and families	Surveys of managers and practitioners	Participatory workshops with professionals and children and YP	Analysis of social care case data	Financial modelling and cost-effectiveness assessment
Process evaluation							
a. What steps are involved in transferring to the new integrated system? What are the main barriers and enablers?	X	X		X	X	X	X
b. What do the optimum governance, leadership and management and supervisory structures look like?	X	X		X		X	
c. How far has the intended delegation of statutory responsibilities been achieved?		X			X	X	
d. What are the advantages/limitations of a delegated model, and what lessons have been learnt?	X	X	X	X		X	X
e. To what extent is the project's theoretical model of risk-resilience reflected in practice?	X	X	X	X	X	X	
f. How consistently has the model been implemented within different areas of professional expertise? What are the main challenges and opportunities?		X	X	X	X	X	
g. How do young people and their families experience interactions under the new system? What is different?			X	X	X	X	
h. How effective is the local model in driving services and systems reform? Is further redesign needed?	X	X	X	X	X	X	X

Research questions	Scoping desk research	Qualitative interviews with managers and practitioners	Qualitative interviews with children, YP and families	Surveys of managers and practitioners	Participatory workshops with professionals and children and YP	Analysis of social care case data	Financial modelling and cost-effectiveness assessment
Outcomes and impact evaluation							
a. What outcomes are achieved for young people and their families? Are these as expected?	x	x	x	x	x	x	x
b. How do these outcomes compare with business as usual?	x	x	x	x	x	x	x
c. How is 'resilience' understood and measured?	x	x	x		x	x	
d. Has the service reduced numbers of re-referrals, and hit the other priority KPIs?	x	x		x	x	x	x
e. Has the new model prevented the unnecessary escalation of risks? What effect has this had on the stock and flow of young people within the system?	x	x			x	x	x
f. What contribution has the Innovation Project made to bringing about systems change? What were the likely scenarios in the event that this had not gone ahead?	x	x	x	x	x	x	x
Economic evaluation							
a. How cost-effective is the new model?	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	x
c. How do costs and benefits compare with business as usual?	x				x	x	x
d. Has the service resulted in fiscal savings, and if so to what extent are these cashable (and for whom)?	x	x		x	x	x	x

Appendix 3: Theory of Change logic model

Figure 6: Theory of change



Appendix 4: The practice model – ‘a secure base’

The BASE model forms the main practice dimension. BASE draws upon the evidence-based principles from attachment theory and resilience theory to guide the practitioner to work holistically with the young person and their family, working on strengths and vulnerabilities in their life to develop a secure base. The BASE model was combined with the principles of restorative practice (Wachtel, 2015), which was identified as an approach that aligned with the values, principles and priorities emerging from other consultations in Gloucestershire, such as Future in Mind (Department of Health, 2015) and also with the partnership approach which GCC and partners are developing their relationship with the public and each other. The principles were introduced as part of improvement plans to all services for families in Gloucestershire and embedded as part of the Innovation Project to ensure consistency.

The BASE model is an ‘organising approach’ with 5 stages (Figure 7). The principles of the approach are based on a series of best practice frameworks drawn together from different disciplines and practices. By combining the best evidence-based approaches from multiple disciplines, the model aims to ensure that each case is managed in a way that achieves the best outcomes for the child, young person or family.

Figure 7: The principles of the BASE model¹⁰



The first stage in the BASE model is based on the principle that, before any intervention or action plan can be implemented with a service user, the practitioner needs to establish their engagement; to agree on their expectations and aspirations (objectives); and to ascertain their motivation and capacity to change. The priority in this stage is to build an effective working relationship with the service user and gain their authentic co-operation. This approach highlights the differences in working with teenagers, who are more autonomous in their decisions and should be involved in planning their intervention or strategy. Through engagement, the approach aims for the service user to become a co-producer in their support and care. As a stakeholder described:

¹⁰ Image from presentation by Gloucestershire County Council on the Base model.

“Where you've got an 11/12-year-old who's living within domestic abuse or mental health issues, or alcohol misuse with an adult, then the plan has really got to focus on the motivation and the capacity of the adult to change and not just the young person ... there's got to be balance in the system.”

(Service manager)

The assessment stages in the BASE model places resilience and risk as core components to the process. All of the factors included in the assessment were developed by reviewing evidence-based resilience criteria and consultations with young people. These are described in appropriate language in the model. The assessment of resilience aims to understand the strengths (positive factors) in the service-user's life and the vulnerabilities (vulnerability factors). This dual approach is intended to avoid any potential blind spots of an assessment conducted solely with either a strength or deficit focus. This balanced approach has been well received by young people, who understand the concept as tipping scales in their lives.

The assessment of risk within the BASE model aims to identify risk factors or hazards in a young person's life. This element does not aim to increase the focus on risks over strengths but ensures that the young person's safety is assessed, and that any risk is considered for its likelihood, imminence and impact. Moreover, the resilience factors are explored to understand the extent to which they mitigate the risk. Fundamental to this assessment is the premise that there is a level of tolerable adversity that is healthy for teenagers, and, if managed properly, risk can be part of a young person's development.

To develop better action or care plans, and to offset a tendency within this sector to leap from information to action, the practitioner undertakes an analysis of the available information. This is a multi-disciplinary process, which encourages professionals to test different theories and challenge their conclusions. Analysis can take 3 forms:

- individually by the practitioner
- collectively with the young person, family and multi-disciplinary team
- within formal, facilitated formulation meetings (for high-risk, complex and/or stuck cases)

The formulation meetings in particular present an opportunity for practitioners to review the progress on a case and identify any barriers to engagement. Following the analysis, the final stage is to develop actionable steps for a plan, which are pragmatic and scaled towards higher-level outcomes for the service user, with the overall aim of building a secure base for the young person and their family.

Key to each stage in BASE is collaborative working between the professional and the service user. Although the process is sequenced as described, the information from each stage informs the overall process, and the different stages are reviewed again as more

information is known, to ensure that the developments are always aligned with the service user's own needs and aspirations.

A competency-based framework was developed to underpin the key skills needed to support the new practice model. The intention was that practitioners use the framework to review their cases during supervision sessions, where they are using the new approach, and describe their level of competence as 'Basic', 'Competent' or 'Advanced'. The feedback is then used to inform the training and support to help practitioners to become fully competent and confident in the new way of working.

Restorative practice

The rationale for including training on restorative practice techniques within the project was to bring services together to work in a reflective and unified way, as well as to promote the key skills required for the BASE model. Restorative practice aims to help practitioners develop skills to reflect and think about the needs of the family, and then to reflect on how to challenge and support the service user through their intervention. The processes are perceived as reciprocal, as young people, and their family, are encouraged to feel that they can challenge the practitioner, as well as being challenged themselves. Encouraging professionals to reflect on their decisions also supports appropriate practice decisions the first time, which subsequently reduces the number of cases escalating to crises and improves the appropriateness of referrals to specialist services.

Restorative practice also provides a common ethos, language and support mechanism to bring together professionals from different disciplines, and builds up collective responsibility across service providers. This is central to the unified service approach, which aims to align practices of professionals working with vulnerable young people, particularly for those presenting with multiple needs.

Appendix 5: Cost-effectiveness analysis – case examples

The cost-effectiveness analysis was based on a review of a sample of 5 cases that were worked using the new model, using a bespoke cost-capture tool. The subsequent analysis involved identifying the key processes and activities that took place during the review period and estimating the associated staff time (and therefore costs).

The review of the new model cases confirmed the systematic steps taken by the youth support team, as follows:

- direct work sessions with the young person and their family: these generally involved a home visit taking place several times a month (often more frequently towards the start of the engagement). However, it is clear that not all of these visits were productive, with some cancelled or not attended by the young person
- early intervention and prevention assessment: this took place over a period of up to 6 weeks and included scoring of outcomes and triangulation of the views of the young person, their parent(s) and the practitioner. The assessment was informed by a number of visits (i.e. the direct work sessions specified above)
- formulation meetings: for the cases reviewed, these were generally informal meetings, led by the case responsible officer (although as the model developed, these became formal meetings chaired by a third party). For the cases reviewed, one or 2 such meetings were held and provided an opportunity to think about progress and to identify any barriers to engagement
- risk assessment and risk-management plan: if needed, an assessment of risk was undertaken, informed by the direct work session (visits) and other evidence
- reviews: as required, the early intervention and prevention assessment was reviewed to assess progress (achievement of outcomes) and to inform changes in focus/activities to be provided. The risk assessment was also reviewed
- attendance at professional meetings: the case responsible officer attended and contributed to relevant meetings led by other agencies (such as CIN meetings led by social care or meetings to discuss placements or education provision)
- practical support: where needed, practical support was provided to the young person, such as taking them to appointments (for example medical appointments or other activities). The frequency of this intervention was based on need

The following boxes set out details of the reviewed cases, highlighting the type and frequency of contact by the youth support team and the resource implications, as well as the outcomes achieved (based on case notes).

Table 5: New model case no. 1

Summary
<p>Profile: 12 year old male, living at home with parents and siblings CIN status Persistent non-attendance at school and difficult behaviour at home Situation escalating</p>
<p>Activity by youth support team:</p> <p>Direct work sessions 11 sessions that were attended by the young person/their family 11 sessions (calls/visits) that were not attended</p> <p>Early intervention and prevention assessment This work was informed by visits (direct work sessions) specified above</p> <p>Formulation meeting An initial informal formulation meeting A formal formulation meeting led by the YST service manager</p> <p>YST risk assessment and risk-management plan This work was informed by visits (direct work sessions) specified above This work was also informed by attendance at the CIN meeting specified below</p> <p>Reviews Early intervention and prevention assessment (including review of outcomes) Risk assessment</p> <p>Meetings Attendance and contribution to 2 CIN meetings Attendance and contribution to 2 meetings with education providers</p> <p>Overall, it is estimated that the YST spent a total of 75 hours of the above activities. Based on the estimated hourly rate of the case responsible officer, this equates to a cost of £1,730.</p>
<p>Outcomes: At the outset of the review period, the young person had CIN status. By the end of the review period, this case was closed to social care, and the CIN status was no longer applied. The case remained open to the YST, and it was intended that there would be a continuation of work under the new model in order to address the remaining risks (particularly in relation to involvement in education). Case files revealed that, in closing their involvement with the case, social care felt that they had limited ability to effect change going forward and that the YST was best placed to continue to build on the progress made.</p> <p>The closure of the case to social care represents a saving in terms of the need to support a CIN plan. Work undertaken by GCC estimated the cost of supporting a CIN plan at £393 per month. Although it is not possible to say if/when the case would have been closed if worked solely by social care, it is thought that the involvement of the YST accelerated this outcome, and the potential savings to social care would be expected to offset the cost of YST involvement.</p>

Table 6: New model case no. 2

Summary
<p>Profile:</p> <p>16 year old male, living at home with parents and siblings CIN status Poor school attendance, anxiety, social isolation and low motivation Case of inefficient processes leading to lack of engagement and root causes not being addressed</p>
<p>Activity by YST:</p> <p>Direct work sessions 3 sessions (visits) that were attended by the young person/their family 9 sessions (calls/visits) that were not attended</p> <p>Early intervention and prevention assessment This work was informed by visits (direct work sessions) specified above</p> <p>Formulation meeting An informal formulation meeting</p> <p>YST risk assessment and risk management plan This work was informed by visits (direct work sessions) specified above This work was also informed by attendance at the CIN meeting specified below</p> <p>Reviews 2 reviews of the early intervention and prevention assessment (one formal and one informal)</p> <p>Meetings Attendance and contribution to one CIN meeting</p> <p>Overall, it is estimated that the YST spent a total of 45 hours on the above activities. Based on the estimated hourly rate of the case responsible officer, this equates to a cost of £1,050.</p>
<p>Outcomes:</p> <p>At the outset of the review period, the young person had CIN status. Around 4 months into the review period, the case was closed to social care, and CIN status therefore no longer applied. The case remained open to the YST, and it was intended that there would be a continuation of work under the new model. However, there were difficulties in establishing consistent engagement, and issues remained unaddressed as a result.</p> <p>Case files revealed that, in closing their involvement with the case, social care felt that they had limited ability to effect change going forward and that the YST was best placed to continue to build on the engagement to date.</p> <p>It was also noted that the young person had made progress in achieving personal outcomes, such as leaving the house more often, behaviour, personal hygiene and general attitude towards life. The mother had also agreed to continue to support the individual. These outcomes would be expected to support improved future life opportunities, particularly with regards to moving into employment.</p> <p>The closure of the case to social care represents a saving in terms of the need to support a CIN plan. Work undertaken by GCC estimated the cost of supporting a CIN plan at £393 per month. Although it is not possible to say if or when the case would have been closed if worked solely by social care, it is expected that the involvement of the YST accelerated this outcome, and the potential savings to social care would be expected to offset the cost of YST involvement.</p>

Table 7: New model case no. 3

New model case no. 3
<p>Profile:</p> <p>14 year old female, living at home with parent and siblings CIN status Poor attendance and behavioural issues at school; episodes of self-harming, low self-esteem, poor eating habits and vulnerable to sexual exploitation and alcohol misuse Case of inefficient processes leading to significant issues not being addressed</p>
<p>Activity by YST:</p> <p>Direct work sessions 14 sessions that were attended by the young person/their family 9 sessions (calls/visits) that were not attended</p> <p>Early intervention and prevention assessment This work was informed by visits (direct work sessions) specified above</p> <p>Formulation meeting An informal formulation meeting</p> <p>YST risk assessment and risk management plan This work was informed by visits (direct work sessions) specified above This work was also informed by attendance at the CIN meeting specified below</p> <p>Reviews Early intervention and prevention assessment (including review of outcomes) Emerging and changing plan (a more informal review which led to a CIN meeting with social care)</p> <p>Meetings Attendance and contribution to 6 CIN meetings, case direction meeting (strategy discussion) and initial CP conference</p> <p>Practical support Support to attend 4 appointments with mental health team Meeting with alternative education provision Attending an intensive group programme (delivered by YST) Support during work placement</p> <p>Overall, it is estimated that the YST spent almost 105 hours on the above activities. Based on the estimated hourly rate of the case responsible officer, this equates to a cost of £2,680.</p>
<p>Outcomes:</p> <p>At the outset of the review period, the young person had CIN status, and this remained in place at the end, although she was considered to be in a stable situation. The case also remained open to the YST. This was due to the need to consolidate improvements and address issues around school attendance and resilience.</p> <p>However, it is acknowledged that progress has been made by the YST. Although there were a number of failed attempts at engagement, the YST was more successful than social care in achieving engagement, and acknowledged that the involvement of a consistent YST practitioner helped to move things forward.</p> <p>It is also important to note that social care escalated the case during the review period and recommended a CP plan. However, owing to the intensive work of the YST, the unanimous decision of the initial child protection conference was to not escalate to a CP plan (although the case of the younger sibling was escalated). Prevention of such an escalation has resulted in a saving in the cost of developing and supporting a CP plan (estimated by GCC at £2,200 for set-up and £1,147 per month for ongoing support). It is expected that the avoidance of this cost would more than outweigh the costs of YST involvement.</p>

Table 8: New model case no. 4

New model case no. 4
<p>Profile: 14 year old male, living with grandmother (Residence Order) CP status Poor school attendance, risk of offending and missing episodes, emotional difficulties resulting in disruptive behaviour Case of ineffective processes and escalation</p>
<p>Activity by YST:</p> <p>Direct work sessions 16 sessions that were attended by the young person/their family 4 sessions (calls/visits) that were not attended</p> <p>Early intervention and prevention assessment This work was informed by visits (direct work sessions) specified above</p> <p>Formulation meeting An informal formulation meeting</p> <p>YST risk assessment and risk management plan This work was informed by visits (direct work sessions) specified above This work was also informed by attendance at meetings formed by part of the CP process and meetings with education providers specified below</p> <p>Reviews 5 reviews of the early intervention and prevention assessment (including review of outcomes)</p> <p>Meetings Attendance and contribution to 4 core group meetings (part of CP process) Attendance and contribution to 2 combined CP review conferences and CIC reviews Attendance and contribution to 2 personal education plan meetings</p> <p>Practical support 5 meetings to review school attendance and progress 5 outreach sessions in the community</p> <p>Overall, it is estimated that the YST spent almost 80 hours on the above activities. Based on the estimated hourly rate of the case responsible officer, this equates to a cost of £1,800.</p>
<p>Outcomes:</p> <p>The young person remained on a CP plan for the duration of the review and also became a child in care; therefore, the case is still subject to social care involvement (as permanency plans are still being consolidated and agreed) as well as the YST. The future role of YST will be to consolidate their engagement with the individual and develop aspects such as emotional resilience and social interaction).</p> <p>Staff felt that it was positive that significant engagement had taken place with the YST, despite the volatility of the situation during the period (including the breakdown of living arrangements/placements). It was noted that the individual had missed fewer sessions than many of the other young people working with the YST.</p> <p>It is difficult to point to any specific cost savings at this stage, although there are signs that YST involvement has had a positive effect on levels of engagement and has been a vital source of emotional support, which would be expected to contribute to improved outcomes in the longer-term.</p>

Table 9: New model case no. 5

New model case no. 5
<p>Profile:</p> <p>16 year old male, living with mother and some siblings CIN status NEET; declining mental health and issues of social anxiety; poor communication skills Case of escalation of issues that have persisted for many years</p>
<p>Activity by YST:</p> <p>Direct work sessions 10 sessions that were attended by the young person/their family 3 sessions (calls/visits) that were not attended</p> <p>Early intervention and prevention assessment This work was informed by visits (direct work sessions) specified above</p> <p>Formulation meeting A formal formulation meeting led by the YST service manager</p> <p>Reviews 4 reviews of early intervention and prevention assessment (including review of outcomes) 4 reviews with training provider</p> <p>Practical support 16 sessions of support to attend appointments (dentist and optician), support to start and attend training, support to mother with benefits</p> <p>Overall, it is estimated that the YST spent a total of 70 hours on the above activities. Based on the estimated hourly rate of the case responsible officer, this equates to a cost of £1,615.</p>
<p>Outcomes:</p> <p>At the start of the review, the young person had CIN status, but after 4 months, this was removed, and the case was closed to social care in recognition of the significant progress that had been made by the YST practitioner. The case remains open to the YST, but since the end of the review period, contact has become less frequent or intensive with a focus on working on longer-term aspirations.</p> <p>The relationship-based, non-judgemental approach coupled with a clear understanding of aspirations and barriers, was considered to be very important in achieving a successful outcome in this case. Case files show that the young person has experienced a range of personal outcomes, such as increased resilience and connections (evidenced by increases in leaving the house, travelling independently and taking responsibility). These improvements would be expected to contribute to the achievement of improved life opportunities and outcomes in the future.</p> <p>The closure of the case to social care represents a saving in terms of the need to support a CIN plan. Work undertaken by GCC estimated the cost of supporting a CIN plan at £393 per month. Although it is not possible to say if or when the case would have been closed if worked solely by social care, it is expected that the involvement of the YST accelerated this outcome, and the potential savings to social care would be expected to offset the cost of YST involvement.</p>



Department
for Education

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Reference: DFE-RR585

ISBN: 978-1-78105-646-2

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