



Department
for Education

Adolescent service change and the edge of care

Children's Social Care
Innovation Programme

Thematic Report 2

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Executive summary

This report presents an overview of nine projects funded through the Children's Social Care Innovation Programme, which explicitly targeted adolescents at the 'edge of care', but is informed by findings drawn from across the wider Innovation Programme. The projects took differing approaches to interrupt the journey of adolescents towards care. These included short term residential provision for young people, and sometimes their families (4 projects) and a variety of multi-professional teams (5 projects). One project bridged the two groups as it included a residential provision around which the multi-professional team was based. Several of the multi-professional projects extended their approach beyond Children's Services to include police and health services while one of the residential projects was operated by a school. A feature of several projects was the use of non-social work professionals to work directly with young people and their families using non-traditional methods to build positive working relationships.

Despite the short period available for evaluation, all of the evaluations presented some evidence of impact, even if it was only in relation to staff training and their capacity to undertake new models of practice in the future. Multi-disciplinary teams were demonstrated to have had a positive effect on outcomes in four projects. In two of these there were measurable cost benefits suggesting they could, over a longer period, yield significant savings while further improving outcomes. One of the residential project evaluations looked only at the process of developing a joint provision by a group of neighbouring local authorities, but the other three were all subject to impact evaluations. In each of those, however, the lead time for the creation of the residential spaces &/or the staffing body limited the size of the cohorts subject to the interventions. This meant few robust conclusions could be drawn about their impact. However, in each case there was valuable learning on the organisation and development of the approaches described. Common elements of the most successful projects included strong and consistent leadership and management, effective multi-professional staff development, and a focus on building positive relationships with clients and within client families.

Recommendations

The analysis suggests a number of avenues that should be considered by services looking to reduce the numbers of adolescents entering care and improving the outcomes of those young people for whom care is the best option. Services are encouraged to self-audit against these recommendations, using the tool provided in Appendix 2:

- Project developers should define what they mean by 'edge of care' by placing their proposed intervention on the child's journey into and through care (see Figure 1) to ensure transparent understanding of the expectations of a project that would strengthen accountability as it is implemented.

- Longitudinal studies should be encouraged to explore if the more preventative interventions deployed in most of these projects can delay entry into care indefinitely, or simply delay it, compared to interventions targeting the point at which adolescents are imminently at risk of entry to care.
- Those children and young people closest to the edge of care remain the hardest to engage, so where interventions focus on them, regular monitoring of information and strong leadership and management on the ground are essential to avoid 'mission creep' to less complex cases.
- Though innovations are often designed to meet need, once implemented managers must ensure there is sufficient flexibility in the service offer to enable referrals to be needs-led rather than service-led.
- The Department for Education, Department of Health, and the Home Office, with support from the Information Commissioner's Office should facilitate the development and dissemination of appropriate models for data sharing agreements that would reassure local partners currently reluctant to make such commitments.
- Multi-professional co-location should be encouraged as it leads to genuine multi-professional decision-making, rather than multi-agency inputs into a system, and provides a single channel of communication likely to increase engagement of the young person and family, and better outcomes.
- Multi-professional working that includes qualified social workers is more likely to increase the confidence of non-social work professionals who are managing safeguarding risks.
- Short-term residential placements can be effective in helping young people to engage. However, the provider needs to resist pressures to reduce the unit cost by filling places from outside the target cohort; empty beds may sometimes be an appropriate opportunity cost. They should also consider the holistic needs of the child and ensure there is sufficient robust education (and health and well-being) provision available alongside any innovative residential care intervention.
- Training should be multi-professional (and extend to carers where appropriate) as it is more likely to raise managers' confidence that it is making a difference irrespective of professional background, while also bolstering worker confidence.

Introduction

Evaluation of the Children's Social Care Innovation Programme

The first Wave 2014-2016 of the Children's Social Care Innovation Programme received a major investment of £100m in 57¹ projects and their evaluations. The evaluations were undertaken by 22 evaluation teams and the reports of these evaluations can be found on the [DfE Publications website](#). [Two-page summaries](#) of these reports designed to engage the interest of a wider community can be found on the Spring website².

Most projects were funded in late 2014 so implementation started in early 2015 - evaluations in Wave 1 therefore ran for 10-18 months typically, making the focus of the evaluations mainly but not exclusively on process, with much less on outcomes. Several projects have commissioned evaluations that extend beyond this window, but they sit outside the scope of this report.

The Rees Centre as Evaluation Coordinators had responsibility for the standards of evaluation in the first Wave of the Innovation Programme. The Evaluation Coordinator was also responsible for the over-arching evaluation. Five issues were identified that merited cross-cutting thematic reports drawing on findings from across the projects:

1. What have we learned about good social work systems and practice?
2. Adolescent service change and the edge of care
3. Child sexual exploitation and mental health
4. Systemic conditions for innovation in children's social care
5. Informing better decisions in children's social care

The purpose of the thematic reports is to provide a summary of evidence that emerged from across projects about innovation in children's social care, thus demonstrating the added value of a Programme of projects rather than 57 unconnected innovations. The evaluation teams evaluating projects in specific areas – e.g. adolescence, children's social work, shared their findings and identified issues across projects. Furthermore, the Evaluation Coordinator synthesised messages from across evaluation reports in each of these areas. The thematic reports of these messages are designed to support future

¹ Elsewhere, Wave 1 of the Innovation Programme is referred to as 53 projects because the 5 National Implementation Service projects are treated as one. As they are separate interventions individually evaluated, we treat them as 5 projects.

innovation in children's social care in local authorities and other providers, by promoting learning across the sector.

Adolescent service change and the edge of care

Local authorities face considerable service pressure given that 62% of children looked after were aged 10 years and over in [2016 compared with 56% in 2012](#), and late arrivals into care often bring with them more complex needs. Many of the Innovation Programme projects planned to safely reduce the care population by working more effectively with those on the edge of care.

This thematic report brings together messages from the evaluations of the 9 projects listed below, funded through the Children's Social Care Innovation Programme, which explicitly targeted adolescents on the 'edge of care' but is informed by findings drawn from across the wider programme. The projects' aims are briefly summarised in Appendix 1, but the reader is referred to the individual published [evaluation reports](#). Recommendations are drawn out and services are encouraged to self-audit against these recommendations, using the tool provided in Appendix 2.

Individual Projects

Achievement for Children (AfC) – Better by Design (BBD) – building the skills and capabilities of young people in care, or on the edge of care

Gloucestershire County Council – to develop a multi-agency, LA-wide service for the most vulnerable young people aged 10–25

London Borough of Ealing, Brighter Futures Intensive Engagement Model – to set-up two edge of care and one in care multi-disciplinary teams

London Borough of Enfield, Family Support Hub (FASH) – to set up 3 multi-disciplinary teams focussed on re-unification; edge of care; and CSE

London Borough of Hackney, Family Learning Intervention Project (FLIP) – to set-up a residential based, whole-family, intervention aimed at children at the edge of care

North London Children's Efficiency Programme (NLCEP) – to create a shared (across LAs) residential provision for children at the edge of care and their families

North Yorkshire County Council, No Wrong Door - create multi-disciplinary hubs to support children to remain safely within birth families

Sefton Council, Community Adolescent Service (CAS) - create a multi-agency/multi-disciplinary service to address the needs of vulnerable 12-25 year-olds

Tri-borough Alternative Provision (TBAP) – to create an off-site, residential education, provision for edge of care

Where is the 'edge of care'?

There is a risk that the phrase 'edge of care' is used to describe too broad a group. Different practitioners will have diverse views on what constitutes the edge of care and the term may be used inconsistently by local authorities, or even within different services in the same authority. Edge of care tends to refer to that group of families where entry into care is being actively considered as a likely option to meet that young person's needs. Children and young people on the edge of care are often described as the most challenging, or those with the most complex needs, though this is rarely explicitly defined.

The Evaluation Coordinator worked with colleagues at the DfE to offer a definition of 'Edge of Care'. This aimed to increase the comparability of evaluations of the impact of projects, and of their value for money. It was suggested that children and young people are on the edge of care who:

- a senior social worker believes will need to enter care within days or weeks as current levels of support are insufficient to safeguard them, while needs are escalating and/or family relationships or other issues are worsening
- are in the early stages of court proceedings, and where social workers are having to make decisions on whether sufficient change is possible to allow the child to safely remain at home
- a senior social care manager has agreed should be accommodated if an alternative intervention or support package is not swiftly put in place including those provided with respite care, or those who have been accommodated in an emergency but where the aim is for them to be reunited with their family quickly with appropriate support
- cease to be looked after and return to their parents or wider family network, but require further support to ensure they are safeguarded and do not re-enter care.

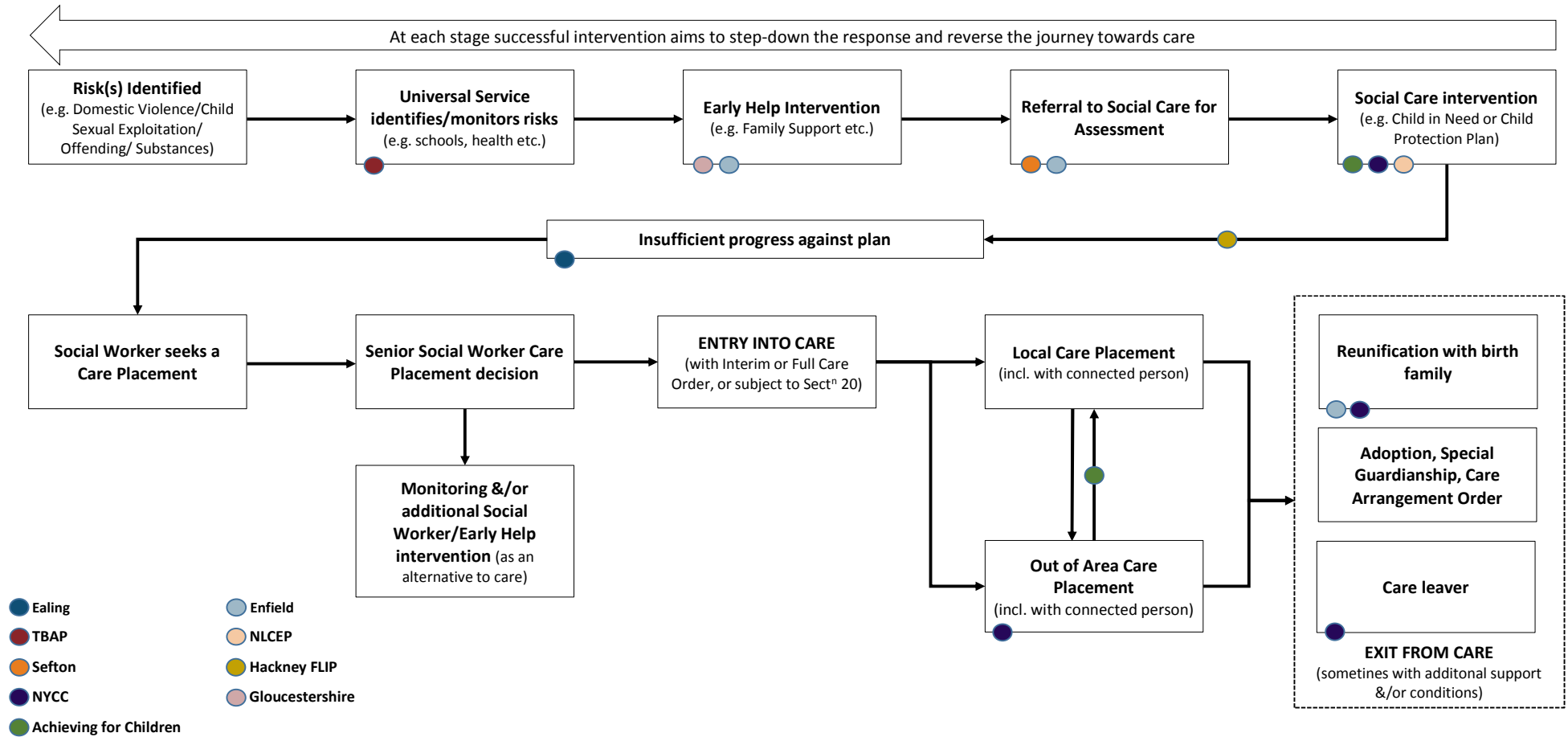
What were the needs of the young people defined as edge of care?

All the projects considered in this report planned to work with children and young people on the edge of care when they applied to join the Innovation Programme. However, the evaluations have revealed that most worked with a broader range of adolescents than the definition given here of 'edge of care' suggested. This is illustrated in Figure 1, which shows where the principal cohort that each project addressed sits on a generic 'journey into, and through, care'.

In most cases, inclusion in the intervention cohort seems to have been based on a professional judgement of need, and despite the definition above, local judgement of whether a child was at the edge of care. There is some evidence that where this was expressed relatively early in the journey into care, there was senior social worker filtering or moderation of referral decisions into the innovative intervention or service. However, the interpretation of the edge of care has not been consistent across projects.

Figure 1 suggests that most of the projects, when implemented, were focussed on preventing cases escalating to the point where care was necessary, rather than diversion from care at the point the decision was imminent (i.e. before the senior social worker care decision was made). Projects have most often intervened with children and young people who could be described as 'edging towards care' rather than being on the precipitous 'edge of care' defined above.

Figure 1: Points at which projects intervened in the stages in the adolescent's journey into and through care



Source: Evaluation teams and reports

In the Sefton evaluation, a screening tool was described (Table 1). It was used to identify young people for referral to the Community Adolescent Service (CAS) intervention. The tool lists many of the vulnerabilities professionals would recognise as significant contributory risk factors in the journey towards care, as well as ‘edge of care/risk of accommodation’ criterion.

Table 1: Eligibility criteria for the Sefton Community Adolescent Service (CAS)

Screening tool for referral to CAS	
Group A vulnerabilities	Group B vulnerabilities
<ul style="list-style-type: none"> • Sexual exploitation (risk of, or involved in police investigation) • Missing (risk identified) • Sefton young person, homeless 16 & 17 years old • Gun and gang – youth at risk • Edge of care/Risk of local authority accommodation 	<ul style="list-style-type: none"> • NEET³ • Domestic Violence (DV) • Neglect • Persistent absence from education • Substance misuse • Self-harm by the young person • Significant contact/referral history • Crime and ASB⁴ • Parental mental health • Young person mental health

While the screening tool in Sefton allowed the evaluation to look at cohort selection and how it changed, a similar approach is less explicitly suggested in some other evaluation reports. They suggest that the target cohort had to be appropriate to the model of intervention and the capacity of the intervention teams created. In nearly all projects, while there is evidence of deploying specific pieces of work to support the individual needs of children and young people, initial selection for an intervention proved to be largely service-led, rather than needs-led.

While project theories of change had begun with needs and devised models of intervention to meet them, in practice, once the interventions and teams had been put in place, the cohorts were selected to a greater or lesser degree to match the interventions. For instance, while TBAP considered some of the children benefiting from time at their residential education provision to be ‘edge of care’ (and 10 of the 15 participants were subject to either a CIN or CP plan) there is no direct evidence from social workers to support that assertion, or of their role in referring them into the provision. There is, however, evidence of education professionals, who may have known the children and families well, using the likelihood of the young person fitting into the Residence cohort,

³ Not in Education, Employment or Training

⁴ Anti-Social Behaviour

and the willingness of parents to agree, as important criterion for inclusion. Parental agreement was also a factor in referral to the Hackney FLIP intervention.

Case study – Sefton’s screening tool

The initial threshold for referral to CAS required at least two criteria from Group A and two from Group B in Table 1, so that the cohort of cases reaching the CAS were both complex and requiring very intensive work. They were also young people subject to significant safeguarding risks; described by one CAS worker as ‘last chance’ cases, where the local authority had tried everything it could and CAS was what was left.

Quantitative evidence from the evaluation supports this view as approximately:

- 75% of the 329 young people referred to CAS had prior involvement with the social care system: 127 were previously subject to Child in Need (CIN) plans; 87 were previously subject to Child Protection (CP) plans, and 33 were previously Looked After Children (LAC) subject to Care Plans.
- 53 (nearly 40%) of those referred under the ‘edge of care’ criterion had a previous CIN plan (of whom 47 had 1 previous plan, 5 had 2 previous plans, and 1 had 3 previous plans).
- 31 had a previous CP plan (of whom 27 had 1 previous plan and 4 had 2 previous plans).
- 16 had a previous CLA plan (of whom 13 had 1 previous plan, 2 had 2 previous plans, and 1 had 3 previous plans).

After ‘edge of care’ the next highest vulnerability among cases referred was ‘domestic violence’ (74 cases), then ‘substance misuse’ (60), and ‘self-harm’ (55 cases). The screening tool successfully identified young people with a complex mix of significant needs that placed them squarely within the definitions of ‘edge of care’ as those imminently at risk of requiring accommodation, described above.

However, this needy and challenging cohort stretched the CAS, which was not staffed by qualified social workers, beyond what had been expected and left it holding risks which were considered beyond its capacity to manage safely. As a result, the tool’s use was modified so referral required only one vulnerability, plus a cross-cutting ‘edge of care’ risk. This changed the cohort being referred to include less complex cases where the preventative support offered by CAS had a greater chance of changing behaviours while managing a more limited range and severity of risks.

It is possible that given a longer timescale for implementation, projects might have been enabled to manage the more complex, multiply vulnerable, and imminently at risk of care cohort targeted by the programme. This might also have allowed a more flexible and

needs-led response. However, several projects had just begun to refine their models of support with a less critically at risk cohort, when the evaluation period came to an end. Where projects are continuing, the cohort may shift more consistently towards those critically at risk – as their original project proposals indicated. Where evaluations demonstrate decreases in the numbers entering care this seems most likely due to effective earlier intervention than diversion at the point of a care decision. For instance, In Enfield, of 121 FASH cases, 92 left with no concerns, and of the 9 who were in care at the start, only 4 were by the end and 2 more became in need. In Sefton, of 329 young people ‘on the edge of care’, only 16 went into care by the end of the evaluation and in North Yorkshire’s NWD, 86% of the 290 young people involved remained out of care.

In Sefton, CAS has increased its co-working with social workers since the end of the Wave 1 evaluation so its confidence and capacity to manage more critical levels of risk will be strengthened. The Ealing evaluation makes a similar point that a ‘team around the worker’ with shared responsibility for cases is an improvement over lone workers holding risk and relying on multidisciplinary input. TBAP have also recognised the absence of social worker views in referrals and the evaluation report commented that they are now establishing closer links with social care in response to feedback from their evaluation.

How did the projects meet these needs?

The initial theories of change produced by projects, together with their evaluation plans, identified clear links between the needs of the target cohort, the approaches likely to meet those needs, and the measures that might indicate if those approaches were effective. There were some common approaches across this set of projects.

Relationships with children and families

By age 14, only 42% of entries to care are due to abuse or neglect, while 45% are accounted for by a mixture of acute family stress, family dysfunction and socially unacceptable behaviour. Alongside this, many young people face challenges with their mental and emotional health (64%), special educational needs (38%) and substance misuse (32%)^{5 6}. The building of effective working relationships with young people and their families, and shoring up strained relationships within families is, therefore, a significant challenge to those working with adolescents.

The use of social network analysis in the evaluation of the Ealing project clearly demonstrates the reduction in the number of, often confusing, parallel approaches to families and children, under business as usual. Multi-professional working simplified relationships with young people and families who, in all these projects, uniformly appreciated a single channel of communication, even if they are subsequently supported by specialists. Some young people found the difference in approach a refreshing change from what they felt were stale 'social work' relationships. There is good evidence that youth work approaches were valued by young people and families and delivered positive outcomes. Even where a youth worker was not the lead professional there was evidence in Ealing that they bridged the gap between young people and the worker who was the lead, and therefore supported young people's engagement.

Families were sometimes much more open to developing a relationship with someone other than a social worker as they felt less threatened by the statutory weight of the social work system. However, in the most effective projects, close working with social workers ensured that the statutory framework remained available where risks were not being managed. Simultaneously, professionals other than social workers were reassured

⁵Green, J. M., Biehal, N., Roberts, C., Dixon, J., Kay, C., Parry, E., ... & Sinclair, I. (2014). Multidimensional Treatment Foster Care for Adolescents in English care: randomised trial and observational cohort evaluation. *The British Journal of Psychiatry*, 204(3), 214-221.

⁶Farmer, E., Moyers, S., & Lipscombe, J. (2004). *Fostering adolescents*. London: Jessica Kingsley Publishers.

that they could manage quite high levels of risk safely when social work advice was close at hand.

‘Short-term’ residential responses to need

The Hackney FLIP project targeted whole families with its residential intervention, while the TBAP Residence targeted children and young people. Both suggested that taking the participants out of their typical environment would enable more intensive and impactful interventions. NLCEP and Achieving for Children (AfC), in contrast, sought to create residential provisions that would provide a bridge back into local foster care for young people previously placed in out-of-borough residential provision, as well as young people on the edge of care who might be safely re-united with their families. While the North Yorkshire project reflected a similar aim, its implementation was more multi-professionally based; the team was based in a residential provision. In Sefton, the project piloted the provision of two short break beds within an existing residential provision, as part of the ‘whole adolescent’ service.

This range of models makes the identification of generalisable findings a challenge. This is compounded by FLIP’s planning difficulties which means the evaluation is of an interim model utilising out-of-borough residential placement for families in activity centres. Similarly, the termly evolution of TBAP Residence model makes the definition of clear benefits more difficult. Finally, the NLCEP project had not moved beyond the planning stage, so there was no evidence of what difference it might make. It is clear that the creation of a residential provision takes longer than the creation of a multi-professional team and this should be considered by those setting them up.

Despite the interim nature of the FLIP model and the small sample of cases it worked with, there was evidence that some families benefitted from the experience of supported respite that mixed a range of positive activities with more focussed and intensive work to develop family relationships and resilience.

The TBAP provision separated young people from their family and there is some evidence that families valued the respite provided. Initially conceived as a fixed period intervention where young people would remain at the Residence full-time, a variety of pressures led to young people going home at weekends. There is evidence that some young people, particularly younger adolescents, demonstrated improved engagement with learning after their residential experience but some of the most interesting findings relate to their feelings about the experience. They, and their residential workers, describe the benefits of the family-type relationships that developed, particularly at shared meal-times which presented an opportunity to relate differently to one another than during either structured activities or learning.

NYCC bravely placed a 'no heads on beds' principle at the centre of their No Wrong Door approach and this was effective in freeing managers to resist filling beds from outside the target cohort. Where this was not the case, such as Sefton, the pilot respite provision was abandoned. All these 'residential' evaluations, though, recognise the pressure to fill beds irrespective of need at a time of budget squeeze and increased demand, as unit costs are much higher when the provision is not at capacity.

AfC recognised that re-integration into local care provision would also require robust education provision. Identifying the difficulty previous returnees had had in moving straight into fulltime education they added an education capacity to their residential hub. Unfortunately, finding qualified teachers able to work effectively with the target cohort proved difficult. Any education provision attached to a residential provision must be robust; the linking of TBAP teaching staff to the Residence is a successful example of this approach.

Though not strictly a 'residential' response it is worth noting that an area of need specific to the older adolescent group was risk of, or actual, homelessness. Though homelessness is often a proxy for a range of more complex needs, shaping the interventions offered to enable swift and easy access to a tenancy or similar does seem to have had benefits to those projects that identified this need and responded. Enfield included a 'Homelessness Team' within its innovation and this avoided the need to accommodate some older teens through the care pathway with a consequent reduction in numbers entering care.

Case-holding, management, and planning

While none of the projects sought an exception to the statutory requirement for children with a plan to have a qualified social worker, many projects did expect all members of the team to act as lead professional, irrespective of their discipline, where necessary. Ealing are considering whether the unit cost of a clinical psychologist makes it cost effective for them to act as lead professionals going forward but everywhere else, the sharing of the lead key worker role has proved effective. Evidence (e.g. Ealing) suggests that multi-disciplinary working, has encouraged the expertise of different professionals to be shared and integrated into the formulation of more effective single support plans.

Professional development

This set of projects made significant use of staff other than qualified social workers who were seen as more cost-effective for the intensive family and young-person centred work envisaged, but also as a way of injecting different skill-sets into the innovations. As described above, close working relationships with social workers strengthened the confidence of these workers in dealing with higher levels of safeguarding risk. This was

also supported by well-constructed professional development and all the projects recognised that where they were creating new teams, or expecting new models of working to be adopted by existing teams, there was a need for training. In some cases, workers without a social work qualification asked for more training on Children in Need, Child Protection, and Children Looked After processes so they had a similar grasp of the context of the families they were working with, as their qualified social worker colleagues.

Workers responded well to training in common models of practice, or which supplemented existing models being implemented, such as Signs of Safety. Where training was not offered consistently across teams, there was strong feedback to suggest it should be, as there was a synergy when co-located multi-professional working was paired with a common training programme. It inducted professionals, who might not previously have worked together, into a team, but also gave them a clear set of models within which to work. While it is difficult to demonstrate the impact of a particular model for practice, such as 'Signs of Safety' in Sefton, 'Better by Design' in the Achieving for Children project, or the 'BASE' model in Gloucestershire, there is clear and positive feedback from professionals in Ealing, for instance, who felt supported by the scaffolding such systems provided. They, and others across the projects, universally valued the training offered.

Where training was in a multi-professional, co-located, context it was also much easier for managers to be confident that it was making a difference irrespective of professional background. Foster carers in Ealing recommended that they should have training in Dyadic Developmental Psychotherapy (DDP) prior to placements and respite care should be provided by DDP trained carers.

There were positive comments in the Sefton evaluation (from interviews with centre staff, CAS practitioners and young people) on the value this added particularly as residential and CAS staff undertook joint training with the community-based CAS team to ensure that the respite option featured within the single plan.

The full range of professional development offered across this set of projects was very impressive and likely to have benefits beyond the specific measures included in evaluation plans as it built broader system-wide capacity and expertise. It included social pedagogy and restorative practice training in Sefton, and very well received training in DDP, adolescent mentalisation-based integrative treatment (AMBIT), and the Helping Families Programme (HFP) in Ealing.

Leadership and partnership

There is no doubt that the most successful projects benefitted from strong strategic vision and leadership. Where this was less 'present', or not sustained due to leadership

changes, implementation stuttered. The process evaluation of the NLCEP project presents an example of shared strategic leadership. Even though the boroughs concerned had a history of close and effective partnership, the evaluation suggests that each new initiative still requires effort to deliver. It illustrates the cost to progress of inconsistent attendance at strategic board meetings as decisions were re-examined, for instance.

Multi-professional working

Multi-professional working encompassed models that brought professionals from different disciplines together into a formal team structure that dissolved previous barriers between services. It goes beyond multi-agency working where strategic agreements to operate 'virtual' teams around the child are not reflected at the frontline. In this context, it has required co-location; multi-professional working without co-location being subject to the limits of 'virtual' teams.

Multi-professional working was a response to the identified needs of the cohort adopted by Enfield, Ealing, North Yorkshire and Sefton, and underpins the plans yet to be implemented fully in Gloucestershire. It was premised on the view that 'business as usual' slowed the response to need while bringing together professionals with different expertise would make swift and easy referral a reality. Projects had different ways of describing the members of teams but Ealing's approach included the widest explicit breadth of expertise, including clinical psychologists, family support, youth justice and education workers, as well as a Connexions specialist, and social workers. Sefton and North Yorkshire included a police officer while Enfield included CSE workers.

The impact of the Sefton CAS project suffered from separate lines of management from social care, initially, and this may have led to some confusion over its role and some inappropriate referrals. Deploying an interim manager to lead the Enfield project slowed the integration of the service offers into the broader Enfield context. It is important, therefore, that any innovation is appropriately integrated into existing services and provision

As detailed earlier and in Thematic Report 5, multi-agency data sharing proved much more difficult to establish than multi-professional working; the former too often limiting the impact of the latter.

Co-location was a real strength where it was adopted, as it developed greater understanding between disciplines and provided informal professional development to all. It also helped the development and adoption of a shared vocabulary across the multi-professional team that provided families with more consistent clarity. The ambitious aim to provide support to clients when they needed it, in Sefton and Enfield, was facilitated by

co-location. While not risking the dissolution of individual professional expertise, the sharing of professional expertise and case knowledge in regular team meetings enabled any member of the team to take on the role of lead professional, referring to other team members as necessary, if the client's key worker wasn't available. Even the absence of agency-to-agency data sharing agreements does not seem to have interfered with the helpful sharing of case-level advice.

Value for Money

Judgements on the value for money of interventions need a measure of the costs of 'business as usual', sufficient sample size for analysis, and clear outcome data. Relatively few projects have been able to provide evaluators with the data they needed for a robust cost benefit analysis. All evaluation plans included clear proposals to assess value for money. Projects that embraced economic evaluation from the start, reported on value for money (e.g. Enfield, North Yorkshire, and to a lesser extent Ealing). These projects all reported significant savings. In Enfield for example, for every £1 invested in support for each family in FASH, there was a return of £3 in potential savings to the local authority, which dropped to £1.84 when all associated costs of the service provision were taken into account. The evaluation team had worked closely with the project to ensure that the data needed was collected and available to them from the start. Similarly, in North Yorkshire, estimated cost savings associated with cases being assessed within NWD rather than being referred to CAMHS, was in the region of £160,000 per annum. Furthermore, costs avoided to the police, were in the region of £200,000, during the first year which encouraged the Police to commit to future support.

Evaluation in the adolescent service change projects

Nature of the evaluations

Most evaluations in the adolescent area adopted a mixed-methods approach that combined quantitative analysis of administrative data collected by the local authorities, exploration of case records, and agreed measures of impact, with qualitative evidence from interviews with service clients (including young people and their families or carers), professionals delivering or managing the project intervention, and other stakeholders as appropriate. Some evaluation teams supported the development of capacity for longer-term evaluation in the projects. For example, the 'longitudinal tracker', developed as part of the NWD innovation is being continued (as a revised and adapted version) beyond the lifetime of the formal evaluation. It might be that if the specification of social care databases included greater capacity for longitudinal tracking of impact, then such a separate system might not be needed and more social care services would embark on their own longitudinal analysis of impact.

Facilitators of, and limits to, evaluation

Embedded researchers

A particular strength of some evaluations (e.g. Enfield) in which there was effective evaluation management, was the deployment of embedded researchers. Seven projects in the broader Innovation Programme engaged embedded researchers who were one of two kinds. The first were research-experienced practitioners, part of whose role was allocated to collecting data within the service and regularly feeding back findings. In Enfield, the researcher was sourced from the evaluation team not the LA, and was an experienced practitioner. They were located in the LA team, developed familiarity with the contextual working of the LA, collected data on behalf of the evaluation team and fed this back to the project team. The second type of embedded researcher was seconded into the service from a university or the evaluation team itself (as in Stockport, one of the social work projects), in order to undertake a similar role. (Their roles are more fully discussed in the final report of the evaluation and Thematic Report 4 on the use of data). A variation on this was the ethnographic approach adopted for example in the North Yorkshire evaluation where researchers worked among the project workers without being 'embedded' in the service.

These researchers in the adolescent projects had an opportunity to understand the intervention model first hand and address evaluation issues as they arose. This ability to respond quickly to local issues reduced delays in data capture and delivery to the evaluation teams. Where they were not in place in the adolescent projects, evaluation

teams were less agile in responding to local circumstances, relying on meetings with project leads at longer, often fixed, intervals. They were also able to respond to the flow of work through an intervention team or 'catching them being good' in ways that more formal data collection or interview sweeps were less likely to do. There is also some evidence that having researchers working closely with the project teams will leave a legacy of increased understanding of robust evaluation techniques and tools that will enhance the capacity of local authorities and their partners to undertake routine evaluation of their own work.

Sharing of data

The acute family stress identified above as a driver towards care is often attributable to the young person putting themselves at risk of criminal activity, substance misuse, CSE and homelessness. There are, therefore, a variety of services and agencies likely to be involved with the young person and their family prior to a care decision being made. Several projects, notably Sefton and North Yorkshire, sought to leverage more effective interventions from those partner agencies through improved sharing of data and intelligence.

While Sefton was unable to obtain the necessary data sharing agreements with the police or health, NYCC and North Yorkshire Police have worked closely together having reached an agreement on data sharing. The No Wrong Door (NWD) project has stimulated them to develop the Risk Analysis Intervention Solution and Evaluation (RAISE) process. It aims to facilitate the sharing of intelligence and information between all partner agencies, all of whom have ownership and shared accountability. However, the RAISE process was not operationalised until 12 months into the implementation of the NWD model because various protocols had to be put in place before young person specific data could be shared between agencies. Since it has become operational, there are emerging findings that suggest the sharing of real time intelligence is supporting the safeguarding of young people, particularly in relation to risks within the community in which they live.

The gathering of intelligence data and information sharing between North Yorkshire Police and NYCC has been central to the positive outcomes achieved by the NWD programme. This has been achieved by the inclusion of a police analyst alongside their children's services opposite number as part of the NWD central support team.

The broader issues and recommendations regarding data and intelligence sharing are detailed in Thematic Report 5.

Conclusions and recommendations

- Project developers should define what they mean by 'edge of care' by placing their proposed intervention on the child's journey into and through care (see Figure 1) to ensure transparent understanding of the expectations of a project that would strengthen accountability as it is implemented.
- Longitudinal studies should be encouraged to explore if the more preventative interventions deployed in most of these projects can delay entry into care indefinitely, or simply delay it, compared to interventions targeting the point at which adolescents are imminently at risk of entry to care.
- Those children and young people closest to the edge of care remain the hardest to engage, so where interventions focus on them, regular monitoring of information and strong leadership and management on the ground are essential to avoid 'mission creep' to less complex cases.
- Though innovations are often designed to meet need, once implemented managers must ensure there is sufficient flexibility in the service offer to enable referrals to be needs-led rather than service-led.
- The Department for Education, Department of Health, and the Home Office, with support from the Information Commissioner's Office should facilitate the development and dissemination of appropriate models for data sharing agreements that would reassure local partners currently reluctant to make such commitments.
- Multi-professional co-location should be encouraged as it leads to genuine multi-professional decision-making, rather than multi-agency inputs into a system, and provides a single channel of communication likely to increase engagement of the young person and family, and better outcomes.
- Multi-professional working that includes qualified social workers is more likely to increase the confidence of non-social work professionals who are managing safeguarding risks.
- Short-term residential placements can be effective in helping young people to engage. However, the provider needs to resist pressures to reduce the unit cost by filling places from outside the target cohort; empty beds may sometimes be an appropriate opportunity cost. They should also consider the holistic needs of the child and ensure there is sufficient robust education (and health and well-being) provision available alongside any innovative residential care intervention.
- Training should be multi-professional (and extend to carers where appropriate) as it is more likely to raise managers' confidence that it is making a difference irrespective of professional background, while also bolstering worker confidence.

Appendix 1 – Aims of individual projects

Project	In summary, the project intended to ...
Achievement for Children (AfC) – Better by Design (BBD)	... trial BBD (developed by AfC & the Univ. of Birmingham) which would combine social learning principles with collaborative problem solving approaches aimed at building the skills and capabilities of young people in care, or on the edge of care
Gloucestershire County Council Innovation Project	... develop a multi-agency, LA-wide service for the most vulnerable young people aged 10–25 (and their families) and test a new practice model that would integrate attachment theory and restorative practice
London Borough of Ealing – Brighter Futures Intensive Engagement Model	... set-up two edge of care and one in care multi-disciplinary teams (which included a ‘9-to-5’ lead professional chosen by the young person) and link this development to the upskilling of fostering teams and carers
London Borough of Enfield – Family Support Hub (FASH)	... set up 3 multi-disciplinary teams focussed on re-unification; edge of care; and CSE
London Borough of Hackney – Family Learning Intervention Project (FLIP)	... set-up a residential based, whole-family, intervention aimed at those families with a child at the edge of care and strengthening resilience, raising aspiration, and empowering/enabling parents to parent effectively
North London Children’s Efficiency Programme (NLCEP) – Residential Innovation Project	... create a shared residential provision for children at the edge of care and their families, which would focus on building family capacity to continue to parent the child safely at home
North Yorkshire County Council – No Wrong Door	... create multi-disciplinary hubs to support children to remain safely within birth families and reunite those who were already in care with those birth families
Sefton Council – Community Adolescent Service (CAS)	... create a multi-agency/multi-disciplinary service to address the needs of vulnerable 12-25 year-olds which might otherwise have led to them entering care
The Tri-borough Alternative Provision (TBAP) Multi-Academy Trust – The TBAP Residence	... create an off-site, residential education, provision for edge of care and other vulnerable young people on the roll of a TBAP academy

Appendix 2 – Audit of adolescent services

Service descriptor	What happens now in your service?	What needs to happen?	How will you progress this?
Triggers bringing adolescents into care are well understood			
These triggers are used to define the needs of the target cohort			
Planned interventions target need (e.g. Table 1) and fit into guidance framing broader service provision			
There is a shared local understanding of what 'edge of care' means (e.g. Figure 1)			
Referrals into interventions are needs-led, rather than service-led			
Multi-professional working is supported by formal team structure and co-location so any worker can be the key worker			
Training is multi-professional, and thoroughly evaluated for sustained impact			
Empty beds in residential provision designed to meet specific needs, or a strategic imperative, are tolerated as a worthwhile opportunity cost			
Care interventions are planned with health and education in mind			
Robust data sharing agreements across services are established and make a difference			

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