EDGE OF CARE BUSINESS CASE

Project name	Edge of Care	**Project ID**	
Programme Name	Reducing Numbers of Looked After Children		
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SRO			
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Document History

Revision History

Revision date	Summary of Changes (indicate section numbers)	Changes marked
26 June 2017	Further information (including comparative costs/savings) added to support rationale for in house option as opposed to external provider Clarification throughout that this is cost avoidance, not saving	Executive Summary Option Appraisal Executive Summary

Revision History

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This document has been distributed to:-

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Hilary Brooks	Director Children's Services	13 June 2017	1
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1 Executive Summary

This business case proposes the development of an Intensive Family Support Edge of Care service, identified as a key transformation driver in reducing the numbers of children coming into care in the city and reducing the significant cost pressure to the Council. The new service will aim to reduce the need for children and young people to be looked after, by either working with families to keep children safely at home or by keeping care placements short and reuniting children and young people with their families as soon as possible.

It is proposed to develop this service in house as part of the Children's Resource Service and alongside the Building Resilience Service (BRS) and Specialist Assessment Team (incorporating the Family Drug and Alcohol Court (FDAC) and Reunification Team), which have already developed considerable skills and expertise in delivering systemic therapy programmes.

This proposal supersedes a previous proposal to commission an Edge of Care service from an external provider using a Social Impact Bond (SIB) model which was developed as part of the Big Lottery's Commissioning for Better Outcomes Programme. Following a feasibility study, conducted by an external consultant, ATQ, the Council carried out a procurement in December 2016; however this did not yield a bid capable of delivering the service to the quality required. It is understood following further market engagement that the reasons for this were primarily threefold: the lack of a guaranteed level of referrals and income which was deemed to be too high a risk for providers; timescales not being sufficient for a SIB to be established and the Council's standard terms and conditions being seen as too risk adverse for a SIB based contract.

Commissioners and Children's Services officers have therefore taken this opportunity to re-group and reconsider the options for establishing an Edge of Care Service. A paper was presented to the Council's Senior Leadership Team (SLT) in April 2017 setting out two options:

- to return to the market to procure an external provider to deliver the service, learning from the feedback received from providers, ATQ and other Authorities
- to develop an in house Edge of Care Service (acknowledging that the Big Lottery contribution of 17% towards the outcome payments to a commissioned provider would not apply in this scenario)

The options are appraised in more detail at Section 4.

The in house option was preferred by SLT on the basis that it would build on existing in house provision, thereby offering a more cost effective, flexible and integrated solution, which would be embedded in the strengths based restorative practice principles and systemic therapy programmes already being developed in house.

Furthermore, the financial modelling for the in house option demonstrates a much greater cost avoidance saving in subsequent years than would be achieved through the proposed outcome based commissioning model using an external provider, because of the lower cost of provision. The in house provision will cost £173,265 in 2017/18 (6 months only) rising to £397,234 in 2018/19 and £457,867 by 2021/22 (owing to inflationary increases). The proposed outcome payments for the external provider (based on similar SIB models for Edge of Care Services in other parts of the country) were £157,745 for 2017/18, rising to £627,827 in 2018/19 and £986,550 by 2021/22. With the Big Lottery contribution, this would reduce to costs of £130,928, £523,910 and £832,350 respectively but is still much greater than the cost of the in house model after 2017/18. (The costs of the external provider option in 2017/18 would be lower because the payments are based on outcomes and therefore not incurred up front, unlike the in house option).

Further details on the comparative cost avoidance savings of each option can be found at Section 4.

This difference in cost between the two options is partly due to the in house model being built on existing in house services and infrastructure; but it is also due to the external outcome based commissioning model needing to incentivise the provider to take on the risk of non achievement (under an outcome based commissioning model, payment is dependent on achievement of outcomes.)

One of the original arguments for the external provider option was that it minimised risk of paying for non achievement, i.e. if the provider did not achieve the outcome of keeping children out of care, then it would not be paid. However the over-riding consideration should be the effectiveness of an Edge of Care Service to keep children out of care as the potential cost avoidance savings are considerable and so when considering the two options, far greater weight has been given this time to the likelihood of success.

It has also been acknowledged that since the original ATQ report, there has been a steady downward trend in Southampton's children looked after numbers as a result of focussed work on permanency planning, particularly increasing adoptions and use of special guardianship orders.

The SLT paper is attached at Appendix A.

This business case presents the case for the in house option. It shows that, assuming a 50% success rate of keeping children referred out of care (which was the base case scenario used for the ATQ modelling), total net cost avoidance after investment would be in the region of £291k for 2017/18 (assuming an October start date), rising to £1,217k in 2018/19 and £2,079k in 2019/20 . In comparison, the cost avoidance savings for the external outcome based commissioning model are £304,721 for 2017/18 (noting that costs are lower in the first 6 months owing to the outcome payment method), rising to £1,033k in 2018/19 and £1,662k in 2019/20.

Further detail of the financial modelling for 4 years can be found at Section 5.

Approval is being sought to commence implementation.

2 Case for Change

2.1 Current Situation

Southampton City Council has seen a significant increase in the numbers of children coming into care, rising to a high of 637 in the summer of 2015. As at March 2017, the number of children looked after (CLA) was 542 which equates to a rate of 110, against a national average rate of 60 and a local authority comparator average of 76.

The number of children looked after as of the 8 June 2017 is 527. Whilst this is a significant reduction from our previous high this is still significantly higher than would be anticipated for a City of Southampton's size and demographics, and is causing a great financial burden and less than optimising outcomes for children.

In-depth research was undertaken to identify the key factors and reasons for the high numbers of CLA within the City and potential solutions. This identified that, whilst the thresholds for children coming into care were as would be expected, there were insufficient resources in place to prevent children on the edge of care becoming looked after or to support children to return home.

The research recommended the development of an Edge of Care Service linked to the existing preventative and early help services within the City.

Further analysis of the information available on CLA in March 2016 showed that:

- in the year to March 2016, 280 children became looked after;
- Of the 280 children who became looked after, 217 of them did so because of child abuse and neglect. Clearly the circumstances of some of these were such that coming into the care of SCC was the only viable option.

- Of the remainder, SCC estimates that there are between 6 and 12 children a month who might be able to remain at home, or return home more quickly than otherwise, if their families received appropriate intensive and timely support.
- on average children spend around 2.8 years in the care of SCC.

(Since the above data was collected, fewer numbers of children are coming into care however the profile of those children entering and their duration remains consistent. We have therefore modelled the impact on the lower end of 6 children at risk of coming into care each month.)

The above shows that most children are being accommodated in line with thresholds due to safeguarding concerns and that, although there are high numbers of younger children (under 10) coming into care, it is generally the older cohort who are harder to move out of care as they are more difficult to place for adoption. This is also illustrated in the bar charts at Appendix B: the first chart shows numbers of CLA by age group and clearly demonstrates that there are higher numbers in the 9-12 and 13-17 age groups; however the second chart shows the numbers of children subject to child protection which illustrate that there are many more children in the younger age groups subject to child protection and therefore likely to come into care.

Given the above, we are proposing that the edge of care service focuses on older children aged 8+, although it will also have the capability to address the particular needs of younger children.

The client group has been defined as:

- families with children from birth to 18 years (with a focus on those with children aged 8+) subject to child protection planning where the next action would be to take the child (or children) into care; and
- families where children from birth to 18 years (with a focus on those with children aged 8+) have been looked after for a maximum of 6 weeks and whose care plan demonstrates that they could return home with support.

The cohort of children and young people referred to the Service will be those where neglect, substance misuse, behaviour and physical abuse are likely to be the main factors and considered as able to remain or return home with support. This cohort, without the intervention, are very likely to be in care for a number of years and subject to care proceedings.

It is estimated that around 6-12 children per month will fall into this client group. For the purposes of benefits modelling, we have used the conservative figure of 6 a month (72 a year).

2.2 Benefits and capabilities

The primary outcome that will be achieved is that children referred to the Edge of Care Service either remain at home, and do not become looked after by the Council, or are reunited following a limited period of being looked after with their families and return to the family home. Children will be kept safely out of care, via improved parenting and family relationships, improved mental/emotional health and improved educational outcomes.

Outcomes for children will be selected and tracked on an individual basis and this ensures that the needs of individual children and young people within the families will be met. Although referrals may be related to one specific issue, such as a teenager behaving anti-socially it is important that the needs of other children in the household are also recognised and the role of wider family members acknowledged in the role they play in supporting the family. It will be about finding the best solution for each young person to enable them to build resilience, engage effectively with the world around them and improve their relationships.

3 Strategic Case

3.1 Aim & Vision

The aim of the Edge of Care Service is to prevent children coming into care by providing a service to support and develop the skills of families to function effectively. This will be achieved by joint

working arrangements and close partnership with the range of services currently available to families including the integrated Early Help offer, the YOS and Education Welfare Services and universal provision. Motivational Interviewing and Solutions Focused Methods have been identified as the model of intervention, operating on a strengths based approach which compliments our current Strengthening Families Model in Child Protection Conferencing.

3.2 Scope

The Service will support a minimum of 72 families every year with a view to the children remaining or returning home appropriately. The age range is across all ages but with a focus on 8 to 17 years.

Referrals will come from the Edge of Care Panel of children identified as being at high risk of coming into care or who have entered the care system within the last six weeks.

Type of intervention

The ATQ feasibility study highlighted the need for intensive support for parents (and other carers) that might help to prevent any abuse and neglect issue escalating or improve family functioning/parenting skills such that the family could remain together or children could return home as appropriate.

The ATQ report provided a review of a range of programmes as outlined in the table below.

Programme	Target age group	Target cohort and programme length
Multisystemic Therapy (MST)	12 -17	MST is for families of young people who have exhibited serious antisocial and delinquent behaviour. ("wilful defiance"). MST therapists provide the young person and their parents with individual and family therapy over a three to five month period with the aim of doing 'whatever it takes' to improve the family's functioning and the young person's behaviour. Sessions can be held with carers without the young person present as treatment as there is no requirement to engage the young person.
Functional Family Therapy (FFT)	10 -18	FFT is for young people involved in serious antisocial behaviour and/or substance misuse. The young person and his or her parents then attend between eight to 30 weekly sessions over three or four (depending on need) to learn strategies for improving family functioning and addressing the young person's behaviour.
Functional Family Therapy – Child Welfare (FFT – CW)	0 - 18	FFT-CW is an adaptation of FFT that was designed to provide services to children, young people and families in child welfare settings. Services are provided through two tracks: a Low Risk (LR) track on based on Functional Family Probation (FFP) model, and a High Risk (HR) track based on the standard FFT model. Services are linked through a triage process that matches children to appropriate level of services based on level of child and family risk. The intervention lasts four or five months.
Treatment Foster Care Oregon (previously Multi-dimensional Treatment Foster Care – MTFC)	10 - 17	TFCO is an intensive therapeutic foster care alternative to residential placement for adolescents who have problems with chronic anti-social behaviour, emotional disturbance, and delinquency. The child is placed with "treatment foster care" family while they take part in the programme, which lasts about a year. Family therapy is also provided to the biological (or adoptive) family, if the plan is for the child to be reunited with them. Individual therapy is additionally provided to the child during this period.
Option2 – Cardiff Council and Vale of Glamorgan	0 - 16	A crisis intervention service aimed at families where serious child protection concerns are related to parents' use of drugs or alcohol. It uses a combination of Motivational Interviewing, solution focussed and innovative family work to help create positive changes for families and thereby reduce the need for children to enter care.

Following further consideration and how we might build on existing in house provision, we are proposing a model similar to Option2 which has its roots in the American Homebuilders model and was adapted in Cardiff where it was primarily focused on working with parents who had drug and alcohol issues. Wales has now pioneered an intensive family support model (IFSS) building upon this work which is embedded in legislation and delivered in all Local Authorities across Wales. The current model of work utilised within Family Drug and Alcohol Courts is based on similar principles.

The model uses a range of interventions focussed on improving parenting and family relationships, mental and emotional health and educational outcomes. It works with the whole family, combining practical, hands on support with an intensive, highly coordinated and flexible approach to enable change within the family resulting in the child returning or remaining at home. It uses Motivational Interviewing and solution focussed approaches which will compliment the Strengthening Families model already being used in Southampton for Child Protection conferencing.

The principles of MI-style communication lend themselves to a range of challenges when working with the family such as professional conversations around child protection or criminal justice issues. The foundations of MI are essentially those of client-centred, non-directive counselling which takes an empathic, non-judgemental approach that:

- Recognizes and affirms strengths
- Uses open rather than closed questions
- Uses reflections to establish empathic engagement and thus reduce resistance.
- Strategically and skilfully uses summarizing reflections.

Practice has evidenced over recent years that families respond better when workers build effective relationships and there has been a shift away from the concept of sanctions for families to supporting changes in behaviour which appear to be more strongly associated with the building of effective relationships, resulting in the ability for the worker to motivate and influence parental behaviours.

It is proposed that the service will be delivered by Family Engagement Workers (FEWs) working in the Children's Resource Service who will stay involved with families long enough to influence behaviours and bring about change.

Intervention with a family will typically last between 6-12 months but can extend beyond this timeframe, should additional support be required.

There will be two Stages to the intervention: Stage 1 the intensive intervention and Stage 2 maintaining the family plan, as described below:

- **Stage 1** – Stage 1 will last around 6-8 weeks but this is flexible and is determined by the Family Support Team themselves in consultation with the child's social worker. The FEW will work on a 'one to one' basis with the family, helping each family member to identify their problems, establish goals to improve their behaviour, and come to a mutually agreed Family Plan that will document how to achieve those goals. Within Stage 1 the FEW is available to the family flexibly. Although the FEW's will work with the family alone regular group supervision will form part of the team support so that colleagues may be able to offer experience or different solutions if the worker feels stuck
- **Stage 2** – sees the family members having access to a range of services that the FEW can draw upon to help them achieve the goals in the Family Plan. These are known as the 'Family Support Functions', and might include service such as counselling, school mentoring, parenting self-help groups which may be provided by either the statutory partners or voluntary agencies working in partnership. The team may also be able to draw on other departments such as housing or health services to secure a rapid response to the family's issues. While again this period is flexible it would generally be seen as lasting 6- 9 months.

Booster sessions – in some cases families may slip back and require a booster Stage 1

session from the Family Support Team. This may be provided by the original worker.

As part of the Children's Resource Service, the Edge of Care team will be able to call on support from other parts of the service, including the BRS, Specialist Assessment Team and FDAC, as well as other services within Children's Services, including the YOS and integrated Early Help Service. Some of the additional services offered to the family to support the stages identified above may include:

- Evidenced based parenting programmes such as Triple P
- Family Group Conferencing
- Restorative practice
- Brief therapeutic interventions
- Facilitating access to wider services such as substance misuse services, housing services, education, probation services etc. in a timely manner to enable change to be sustained.

A small intervention budget has been built into the proposal to support access to wider resources.

All families receiving support will have an Integrated Family Plan that is subject to regular review. The child's social worker will remain accountable for the case and will remain closely involved in supporting the family.

Outcomes for children will be selected and tracked on an individual basis to ensure that the needs of individual children and young people within the families are met.

Further detail on how the service will operate can be found in the draft Service Specification at Appendix C.

Service Model

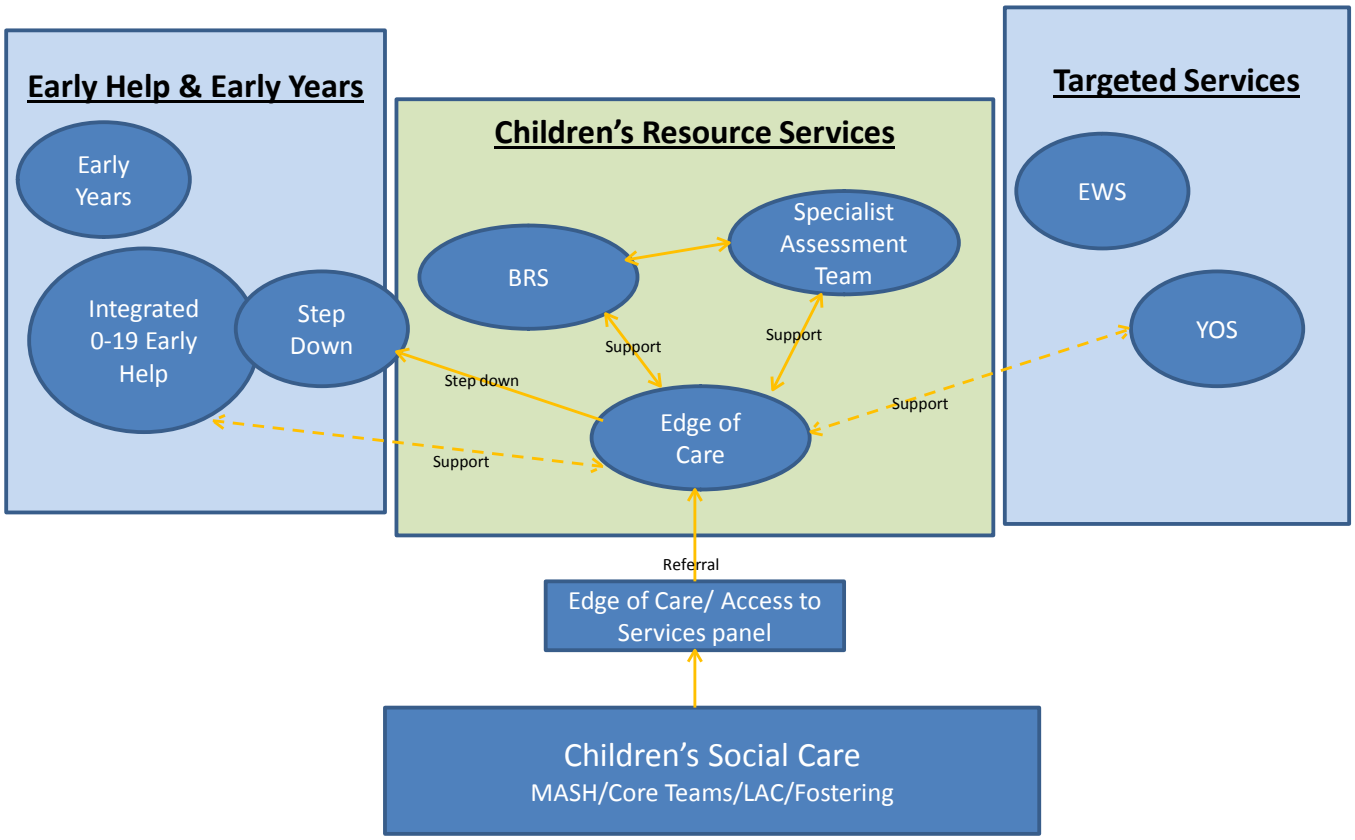
It is proposed to develop this service in house as part of the Children's Resource Service, alongside the BRS, Specialist Assessment Team and the FDAC, with close links to the wider range of services available to families including the YOS, Education Welfare Service and integrated Early Help offer.

Referrals will come from the Edge of Care Panel.

The team will consist of eight Family Engagement Workers (Grade 8) and one case holding Supervisor (Grade 11/12 – pending evaluation). Four of these workers are currently already employed to undertake reunification work with children who are looked after and they will be re-deployed into this new service. It is expected that the remaining staff will be redeployed from other parts of children's service (through Phase 3) or if not, will be recruited. Recruitment is not envisaged to be an issue for this staff group. The team will be based at Civic Centre / or Coxford road with the Children's Resource Service.

Caseloads for the team will be relatively small with each worker holding anywhere between 4-8 families on their caseload at any given time, depending on the number of children in each family and the complexity of the case.

The diagram below presents the links and interdependencies with other parts of children's services:



3.3 Out of scope

The following are out of scope:

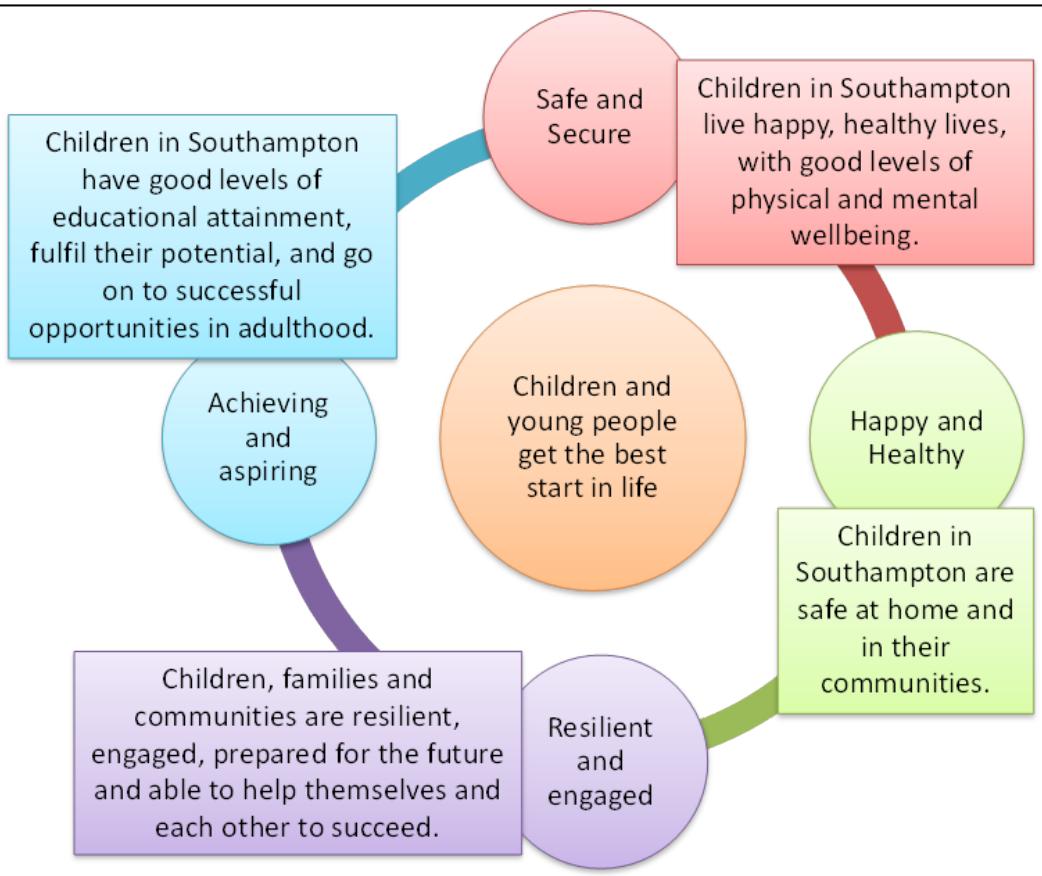
- children whose home situation has been deemed to be unsafe
- children and families who are able to respond successfully to an Early Help service
- children who are subject to child protection planning but not yet deemed to be on the edge of care
- children for whom it is deemed that there is no potential for reunification with their family

3.4 Strategic fit

This proposal is a key element of the Children's Transformation Programme and critical to the delivery of its savings target for reducing the numbers of children looked after.

It is also strongly aligned to the city wide Children and Young People's Strategy Vision which is:
To ensure that children and young people have the best start in life.

The vision identifies 4 key outcomes all of which are strongly supported by this proposal.



3.5 Assumptions

Key assumptions include:

- There will be between 6 and 12 children a month who will meet the criteria for Edge of Care (impact has been modelled at the lower end of this scale, at 6 a month)
- The financial benefits have been based on a minimum of 6 a month, 72 a year with a 50% success rate
- Weekly costs of a child in care have been estimated at £476
- There will be in place a new Step Down team, as part of the integrated Early Help offer which will support the step down of families from Edge of Care
- The numbers of children currently in care will continue to be reduced through strong permanency planning

3.6 Stakeholders

Internal

Stakeholder	Relationship/Dependency	Status
Children's Social Care	Referrer	Represented on project team
Children's Early	Key interdependency - step	Discussions via Children's

Help Services	down and link for interventions e.g. parenting programmes	SLT
Integrated Commissioning Unit	Support/Advice	Represented on project team
Finance	Preparation of Costings	Represented on project team
HR	Advice regarding recruitment to team	Discussions linked to Phase 3

Partner Engagement

Stakeholder	Relationship/Dependency	Status
Southampton City CCG	Co-commissioner, particularly in relation to CAMHS and BRS	Represented on project team
Solent NHS Trust	Integrated provision - BRS and Early Help Services	Represented on project team
Police and courts	Key partner	Communication and engagement plan

Customer and Community Engagement

Stakeholder	Relationship/Dependency	Status
Children and families	Client	
Schools	Key partner	

Member Engagement

Stakeholder	Relationship/Dependency	Status
Cllr Lewzey	Lead member	Discussed at CMBs.

4 Options Appraisal

Further to the unsuccessful procurement of an Edge of Care Service, two options have been considered:

1. a return to the market to procure an external provider to deliver the service, learning from the feedback received from providers, ATQ and other Authorities.
2. develop the service in house

A paper outlining both options and their pros and cons was presented to SLT in April 2017, and is attached at Appendix A. (It should be noted that further work has been done on the financial modelling since this paper went to SLT, in particular to account for an October 2017 as opposed to April 2017 start date).

SLT agreed the preferred option to be Option 2: to develop the service in house.

Below is a summary of each of the options.

4.1 Option 1: a return to the market to procure an external provider to deliver the service, learning from the market feedback

This option was worked up in some detail with officers from the Integrated Commissioning Unit and Capita Southampton Ltd. In order to secure a more positive outcome from a second tender, the following amendments were recommended:

- introduction of a guaranteed level of business. A number of scenarios were modelled and it was proposed to introduce a minimum payment of £3,000 per child for 72 referrals a year for the first 12 months, with a review at month 10 to determine the approach for the second financial year. This would mean that if the provider only received 50 referrals in the first year, then it would automatically receive £3k per child for the 22 referrals it did not receive. For the 50 referrals it did receive, it would receive the outcome payments as defined by the contract, dependent on whether or not it achieved the outcomes.
- a strengthened service specification (highlighting the whole family approach) with additional information on client profile (i.e. age and numbers of children coming into care each month, broken down by reason for coming into care, family size), an outline of current service provision and information on referral and assessment processes.
- an option to mark up the terms and conditions – which would be built into the tender evaluation process. The Council's legal team reviewed the Cabinet Office terms and conditions for SIB contracts and recommended that rather than adopt the SIB contract, providers are asked to mark up any amendments to the existing terms and conditions.

The pros and cons of this option were considered to be:

Pros	Cons
• Enables the Council to take advantage of the Big Lottery grant • External provider takes the majority of the risk, should care cost avoidance savings not be achieved	• More expensive – provider has opportunity to earn payments of up to £986,550 in some years, should they keep 50% of 72 children out of care • More complex set of relationships – i.e.

Pros	Cons
(i.e. no saving = only minimal payment to the provider) • Is in line with original Cabinet decision	how the external provider, commissioners and internal services interface; more complex pathways of care. Danger of duplication and confusion regards what / who has made the difference in keeping a child out of care • Will take longer to mobilise – will need to tender and then build in time for new provider to set up SIB and mobilise new service • Potentially less flexibility to flex service as provider will be working to an agreed specification (albeit this could be varied by agreement) • Potentially the provider may be less willing to work with higher risk families where the success rate (and therefore opportunity for achieving outcome payment) is lower

4.2 Option 2: to develop the service in house.

This is the option described in this business case. The main pros and cons of this option were considered to be:

Pros	Cons
• More cost effective as the in house model builds on existing in house provision • More attuned to Southampton Children's service model of Strengthening families • Greater ability to control and integrate with internal provision • More closely aligned to existing services; more streamlined pathways • Shorter mobilisation period as does not require a tendering exercise • Greater flexibility to flex service to meet wider needs/priorities	• The Council would have to forfeit the Big Lottery grant • Reputational risk with the Big Lottery and other external grant funders • The Council would be taking 100% of risk in investing in an internal provision should the cost avoidance savings not be achieved

The tables below compare the costs and potential cost avoidance savings of both the options, based on a 50% success rate:

In house:

50% Success Rate	2017/18	2018/19	2019/20	2020/21	2021/22
Cost Avoidance	464,649	1,614,984	2,529,264	2,579,900	2,354,401
In house staffing costs	(146,265)	(343,234)	(395,909)	(399,868)	(403,867)
Intervention Budget	(27,000)	(54,000)	(54,000)	(54,000)	(54,000)
Net Cost Avoidance	291,385	1,217,750	2,079,355	2,126,031	1,896,534

External:

50% Success Rate	2017/18	2018/19	2019/20	2020/21	2021/22
Cost Avoidance	464,649	1,614,984	2,529,264	2,579,900	2,354,401
Contracted payments	(157,745)	(627,827)	(963,357)	(986,550)	(986,550)
Project/ Contracts Officer	(29,000)	(58,000)	(58,000)	(58,000)	(58,000)
Big Lottery contribution to payments	26,817	103,917	154,200	154,200	154,200
Net Cost Avoidance	304,721	1,033,073	1,662,106	1,689,550	1,464,051

4.3 Option 3: Do Nothing

This option was not considered to be a viable proposition on the basis that there is an imperative and key financial target to reduce the numbers of CLA and an Edge of Care Service is a key element to achieving this.

4.4 Recommended Option: to develop the service in house

The recommended option is to develop the Edge of Care Service in house. This recommendation is made on the basis that:

- this option is considered to be the more cost effective as it builds on the existing in house provision and infrastructure and is therefore less expensive than the external option
- it enables the service to be integrated into the existing Children's Resource Service (i.e. Specialist Assessment Team, BRS, FDAC) which is already working with complex families and is well positioned to support the interventions required of an Edge of Care Service
- it is considered likely to be more successful in keeping children out of care
- it can be mobilised relatively quickly as some of the staff can be redeployed from within children's services, linking to Phase 3, and it would not require a procurement

5 Benefit Realisation

5.1 Financial Benefits

The following financial model presents the costs and net cost avoidance for the in house Edge of Care Service, based on a 50% success rate.

It should be noted that this scheme is about cost avoidance - preventing children entering care - as opposed to a reduction in current spend.

50% Success Rate	2017/18	2018/19	2019/20	2020/21	2021/22
Cost Avoidance	464,649	1,614,984	2,529,264	2,579,900	2,354,401
In house staffing costs	(146,265)	(343,234)	(395,909)	(399,868)	(403,867)
Intervention Budget	(27,000)	(54,000)	(54,000)	(54,000)	(54,000)
Net Cost Avoidance	291,385	1,217,750	2,079,355	2,126,031	1,896,534

5.2 Non-Financial Benefits

Benefit Area	**Benefit Parameters**
Operational	• Fewer children entering the care system - supports achievement of target of 390 by 2020 • Improvement in school attendance and attainment indicators • Improved behaviour/attitude at school (fewer fixed term exclusions) • Improvement in EET indicators • Reduction in offending behaviour
Customer	• Improved health, emotional wellbeing and resilience • More families stay together

6 Management Case

6.1 Project plan

Under development

6.2 Key Milestones and Dependencies

Key Milestones	**Timescale**	**Dependencies**
Approval to proceed with in house option	15 August 2017	Assumes need to go to Cabinet and earliest Cabinet date.
Recruitment	Aug - Sept 2017	Link to Phase 3 Assumes some

		redeployment of in house staff
Produce detailed standard operating procedure	Aug - Sept 2017	
Establish Edge of Care/Access to Resources Panel	Sept 2017	
Induct and train staff	Sept 2017	Recruitment in place
Commence Service	1 Oct 2017	Establishment of Step Down team

6.3 Risk Analysis

ID	Description	Likelihood	Impact	Mitigation
1	Inability to step down families safely and maintain	Medium	High	Dedicated step down team being developed to align with integrated Early Help service
2.	May take longer than expected to embed model/ways of working	Low	High	Model is based on existing approaches used within the Children's Resource Service. Likelihood that majority of staff will come from within existing children's services. Initial training/induction period being planned.
3.	Lack of capacity in wider system may impact on effectiveness of service	Medium	High	Inclusion of intervention budget within service proposals.
4.	Numbers of children in care could still fail to achieve reduction target (regardless of how successful Edge of Care Service is) should other schemes not enable the current numbers to be reduced	Medium	High	Ensure that there are close links between projects

6.4 Project Organisation

Project Executive: Phil Bullingham/Donna Chapman

Finance Lead: Mark Riley

6.5 Timing

Projected Project Start Date -

mid July 2017

Implementation date / go live -

1 October 2017

Key governance dates (Cabinet, Full Council, TIB)

Children's Transformation Board - 21 June 2017

Children's CMB - June 2017

CMT – W/C 3 July 2017

Forward Plan – by 5 July 2017

Cabinet decision – 15 August 2017