# Tri-borough Innovation Programme Bid

Tri-borough local authorities and the Spring Consortium

July 2014

# The case for change

- In the context of having to make 25% cuts in 2015-18, we have no choice but to do things differently.
- The model of social work practice developed over 20 years has seen the domination of case manager role in preference to direct and effective intervention. There is too much watching, waiting and referring out to other agencies to do the work with the family.
- We see front line practitioners who are not confident in their expertise, or given enough time or the means to develop trusted relationships with families. There is a stemming of practice expertise at a low level in the hierarchy, the only promotion route is a management route.
- Families have not got the support they have needed. Child outcomes have not therefore been as good as they could have been.
- There are too many repeat referrals, assessments, child protection plans and interventions which do not result in significant change, and which drive unnecessary costs. We need to get it right first time.
- There has been a growth in 'add on' projects and initiatives to test out models of practice, but little whole system change.

# The proposed model of practice

- The three key elements of the new model are to create **time** for practitioners to work with families, to develop their knowledge, confidence and **expertise** in order that they are more effective in creating change, and lastly but importantly, to change the **system conditions** which reinforce and steer practice.
- Practitioners will work intensively with families to solve problems and change behaviours, rather than referring out to others.
- By use of evidence based interventions and a more engaging approach, practitioners will develop relationships with families that enable them to build on their strengths. To enable this to happen, there will be delivery of training, clinical supervision, and management and technology consistent with the new approach.
- The workforce will move from one which is dominated by micro management and process accountability to one where practice, not management, is the highest status, and is actively undertaken at all levels in the hierarchy.
- There will be built in learning mechanisms within the organisation, specifically, with the support of Professor Donald Forrester and his team, a framework of observation, feedback and coaching to change practitioner behaviour and consolidate training.
- We will work more proactively with families, identifying those who would benefit from sustained help at key stages, for example, secondary school transfer, in order to reduce the number of teenage entrants to care.
- At all stages we will continue our existing good practice in managing risk and keeping children and young people safe from harm.

# Testing hypotheses for the Wider System

We propose to deliver this practice change at scale and pace across our 3 boroughs, and in doing so to create and share learning that is highly relevant to colleagues elsewhere. By not only making the change, but reflecting on and learning from HOW to make the change, we will develop our ability to serve as an equivalent to a 'teaching authority ' beyond the end of the programme.

| | |
|---|---|
| **We can change the behaviour and skills of the workforce, sustainably** | What makes training effective and leads to impact on practice & outcomes? Coaching, consolidation? How important is the practitioner's starting point? What % of practitioners can really make the jump to being at least good or better under the new expectations? Evaluation team under Prof. Forrester will measure baselines, & monitor attitudes & practice in almost real time, providing short feedback loops to drive continual reflection allowing us to iterate on and flex the model |
| **Intervention is most effective when the SW practitioner delivers everything themselves** | What specialist skills do we want and need social workers (and wider teams) to have? What referrals might be needed and when? Is there a 'best' option for the working relationship between SW teams and the wider system (DV, D&A, MH etc). Is embedding clinicians the best way of influencing practice to be more systemic? |
| **We can change how families view SW teams, create much more positive forms of engagement** | Is it possible to change the expectations of families? How can this be done?<br>Is it realistic to expect all practitioners on SW teams to have the relational skills necessary to do this? |
| **There is an ideal timeframe for intervention** | How much time is needed to change behaviour irreversibly? Do defined periods of intervention help (ie putting a limit on how long the intervention relationships should be)? How important is clarity of expectation?<br>What about wider issues (eg housing, poverty, worklessness)? How do we ensure we don't build dependency? |
| **We can describe and deliver effective step-down support for families** | What offers work best, and enable families to avail themselves of what is on offer in the wider system, including Early Help? What role might there be for community or peer support?<br>Do families who have experienced a positive engagement with our new SW teams engage better with the wider system too as a result? |
| **Attending to system conditions is critical for success.** | It has to be easier for practitioners to do the new thing than continue old practices which are familiar and comfortable: change will only be achieved and sustained if supported at every stage by permitting circumstances. What does this look like, in terms of leadership? Management? Technology? Administrative flexibility? Accountability? Culture? Incentives and rewards? Underpinning corporate systems (eg HR)? |

# Theory of Change

The following slides show a simplified version of our Theory of Change. A complex web of activity will be required to bring about the final outcomes we are looking to achieve:

- Children make improvements in progress measures
- Fewer children come into care
- Cost savings

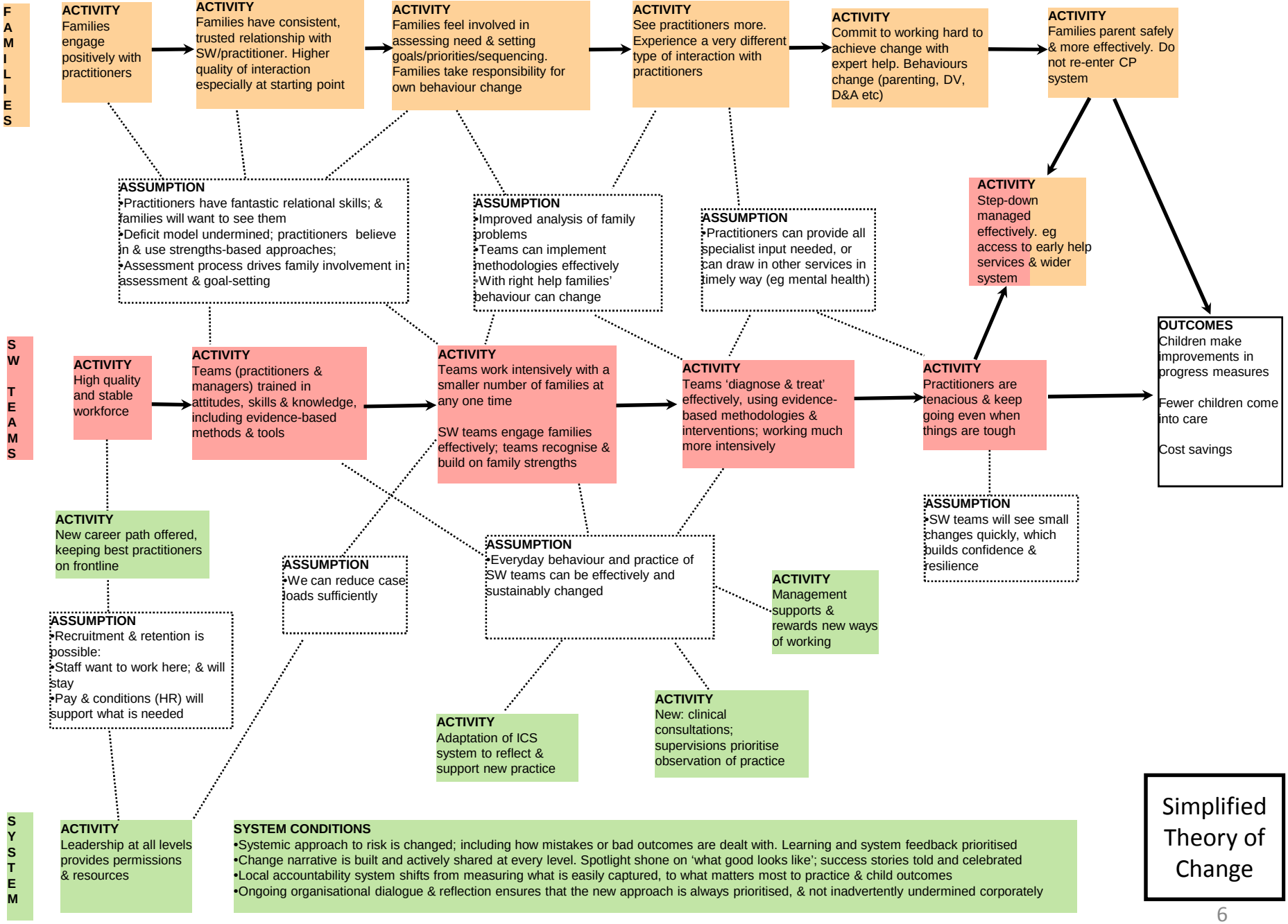
This Theory of Change defines the key building blocks we believe will be required to bring about the longterm outcomes, and makes explicit the underpinning assumptions behind the causal links between the steps in the change pathway. We have identified the changes we need to bring about:

**Changes in Families**

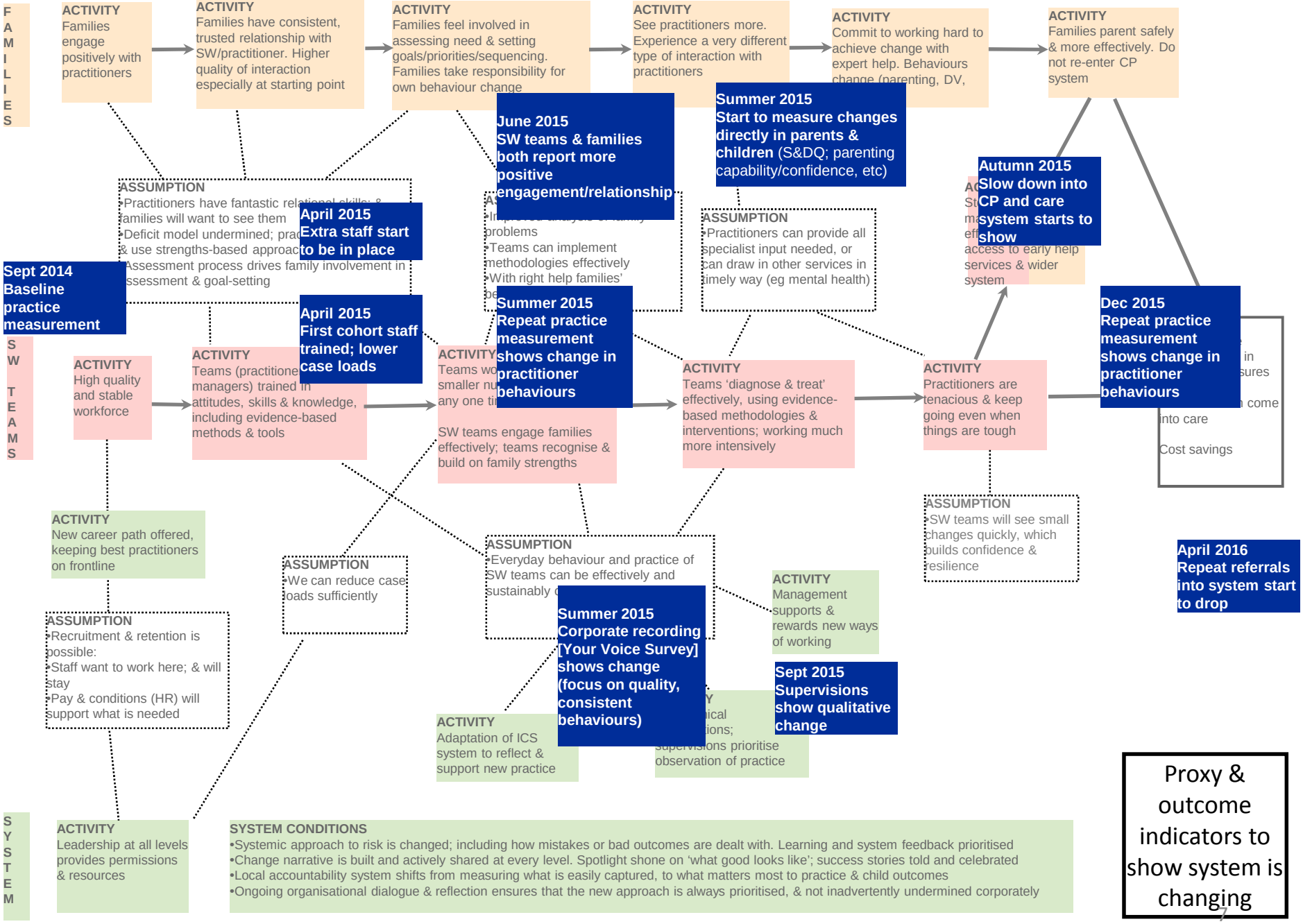
**Changes in SW Teams**

**Changes in the under-pinning system**

The second slide identifies indicators that will show that the system is changing in the way that it needs to, and the dates when we expect to be able to start measurements. We are particularly keen to have proxy measures that will give us confidence that change is happening (for example in families' experiences, in practitioner behaviour), long before outcomes for children and referral numbers start to shift.




Simplified Theory of Change

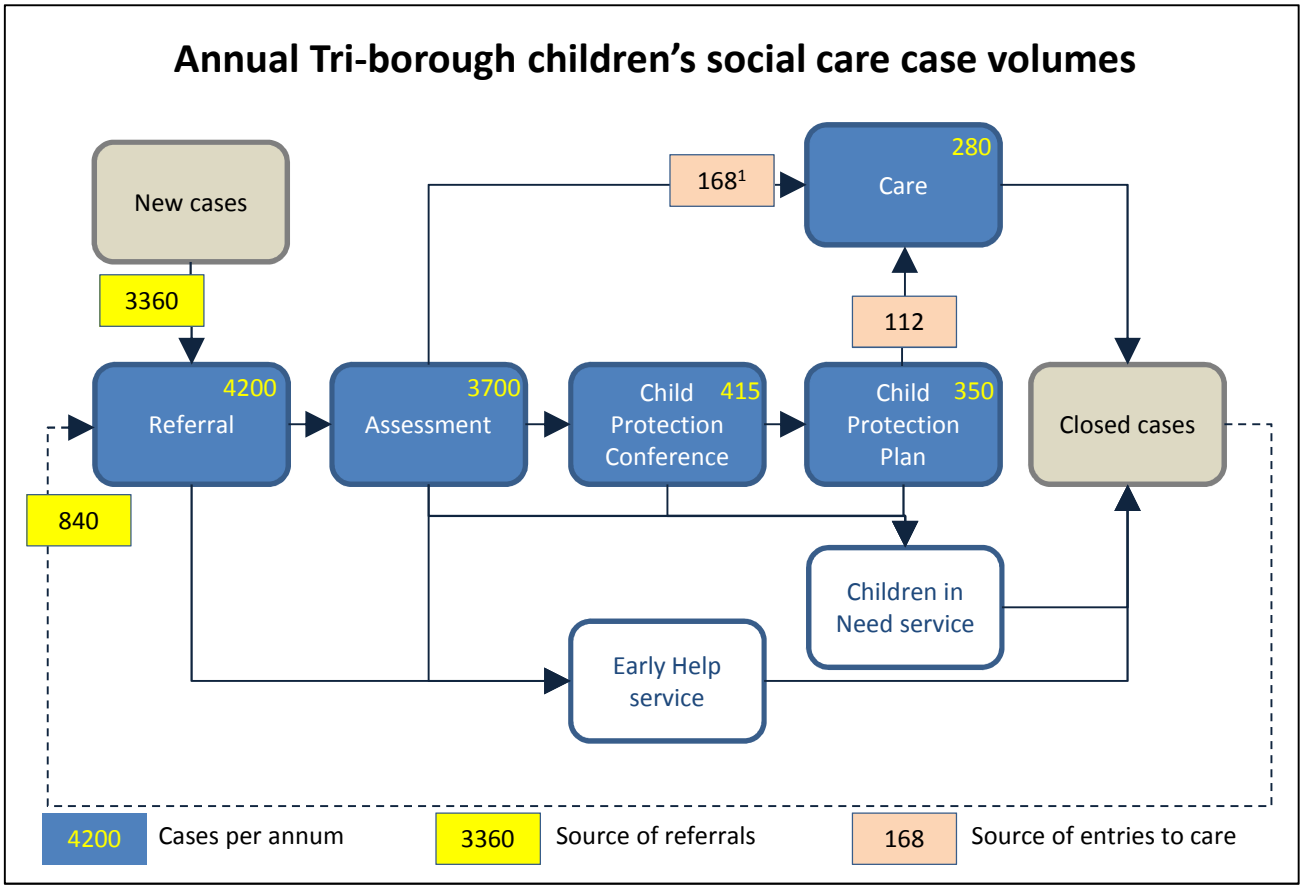

FAMILIES
ACTIVITY
Families engage positively with practitioners
ACTIVITY
Families have consistent, trusted relationship with SW/practitioner. Higher quality of interaction especially at starting point
ACTIVITY
Families feel involved in assessing need & setting goals/priorities/sequencing. Families take responsibility for own behaviour change
ACTIVITY
See practitioners more. Experience a very different type of interaction with practitioners
ACTIVITY
Commit to working hard to achieve change with expert help. Behaviours change (parenting, DV,
ACTIVITY
Families parent safely & more effectively. Do not re-enter CP system
June 2015
SW teams & families both report more positive engagement/relationship
Summer 2015
Start to measure changes directly in parents & children (S&DQ; parenting capability/confidence, etc)
Autumn 2015
Slow down into CP and care system starts to show
ASSUMPTION
•Practitioners have fantastic rela
families will want to see them
•Deficit model undermined; prac
& use strengths-based approac
Assessment process drives family involvement in
ssessment & goal-setting
April 2015
Extra staff start to be in place
problems
•Teams can implement methodologies effectively
•With right help families'
ASSUMPTION
•Practitioners can provide all specialist input needed, or can draw in other services in timely way (eg mental health)
access to early help services & wider system
Sept 2014
Baseline practice measurement
SW TEAMS
ACTIVITY
High quality and stable workforce
ACTIVITY
Teams (practitione
managers) trained in
attitudes, skills & knowledge, including evidence-based methods & tools
April 2015
First cohort staff trained; lower case loads
ACTIVITY
Teams wo
smaller nu
any one ti
SW teams engage families effectively; teams recognise & build on family strengths
Summer 2015
Repeat practice measurement shows change in practitioner behaviours
ACTIVITY
Teams 'diagnose & treat' effectively, using evidence-based methodologies & interventions; working much more intensively
ACTIVITY
Practitioners are tenacious & keep going even when things are tough
Dec 2015
Repeat practice measurement shows change in practitioner behaviours
in
sures
come
into care
Cost savings
ASSUMPTION
•SW teams will see small changes quickly, which builds confidence & resilience
April 2016
Repeat referrals into system start to drop
ACTIVITY
New career path offered, keeping best practitioners on frontline
ASSUMPTION
•We can reduce case loads sufficiently
ASSUMPTION
Everyday behaviour and practice of SW teams can be effectively and sustainably
Summer 2015
Corporate recording [Your Voice Survey] shows change (focus on quality, consistent behaviours)
ACTIVITY
Management supports & rewards new ways of working
Sept 2015
Supervisions show qualitative change
ACTIVITY
Adaptation of ICS system to reflect & support new practice
ical
ions;
visions prioritise observation of practice
ASSUMPTION
•Recruitment & retention is possible:
•Staff want to work here; & will stay
•Pay & conditions (HR) will support what is needed
SYSTEM
ACTIVITY
Leadership at all levels provides permissions & resources
SYSTEM CONDITIONS
•Systemic approach to risk is changed; including how mistakes or bad outcomes are dealt with. Learning and system feedback prioritised
•Change narrative is built and actively shared at every level. Spotlight shone on 'what good looks like'; success stories told and celebrated
•Local accountability system shifts from measuring what is easily captured, to what matters most to practice & child outcomes
•Ongoing organisational dialogue & reflection ensures that the new approach is always prioritised, & not inadvertently undermined corporately
Proxy & outcome indicators to show system is changing

# Current flow of children through the Tri-borough social care system

The diagram below provides a simplified model of the children's social care system and is used in the slides that follow to illustrate the impact of the Tri-borough's proposed children's social care changes. All figures displayed represent numbers of children.

Key features of the Tri-borough's current children's social care volumes include:

- 4200 annual referrals to children's social care, of which 20% are repeat referrals related to families who have previously received children's social care support in the previous 12 months[2].
- 3700 annual statutory care assessments, resulting in 415 Child Protection Conferences , following which 350 families receive a Child Protection Plan.
- 280 annual entries into care, of which 112 involve children who have previously received a Child Protection Plan but for whom the planned interventions were ineffective in preventing the need for the child to be taken into care (32% of all Child Protection Plans).




The Tri-borough system also features step-down (and occasionally step-up) Children in Need and Early Help services, provided by a combination of internal social care work staff and external services commissioned by the Tri-borough from other providers.

[1] For simplicity these 168 entries to care are shown in the diagram as being made from the assessment stage. In reality some of these cases are made directly at the referral stage, and some others are made from the Children in Need service.

[2] In addition, there are also many children and families referred to social care who have received social care more than 12 months previously. Data on the number of such cases is not available. In the diagram, these cases will be included in the 3360 "new" cases.

# Changes to flow of children through the Tri-borough social care system

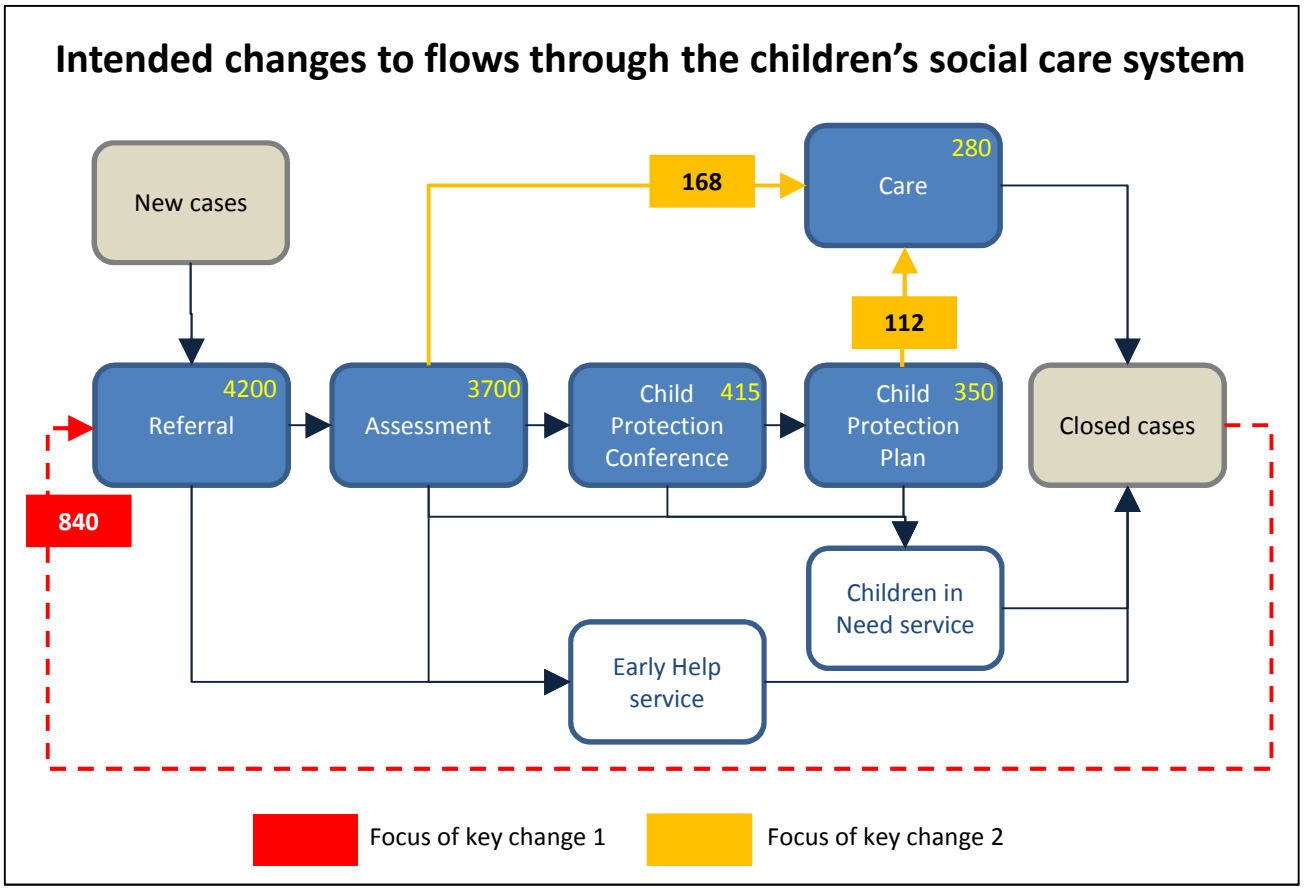
The proposed new Tri-borough children's social care services model will result in two key changes to the flows of children around the system. These are described below, with the assumed magnitude of the change also outlined.

**Key change 1:** Stronger and more intensive relationships between social workers and families, and use of more effective interventions in all parts of the system (including Early Help and Children in Need services) will reduce the number of repeat referrals.

***Assumed size of change:*** Reduction in the referral rate from 20% to 10% of all closed cases.

**Key change 2:** More effective interventions at the assessment, Child Protection Plan (CPP) and Children in Need stages will reduce the percentage of children being taken into care

***Assumed size of change:***
(i) A 10% reduction (from 4.8% to 4.3% of assessments) in the percentage of children entering care without a CPP.
(ii) A 25% reduction (from 32% to 24% of CPPs) in the percentage of children with CPPs subsequently entering care.



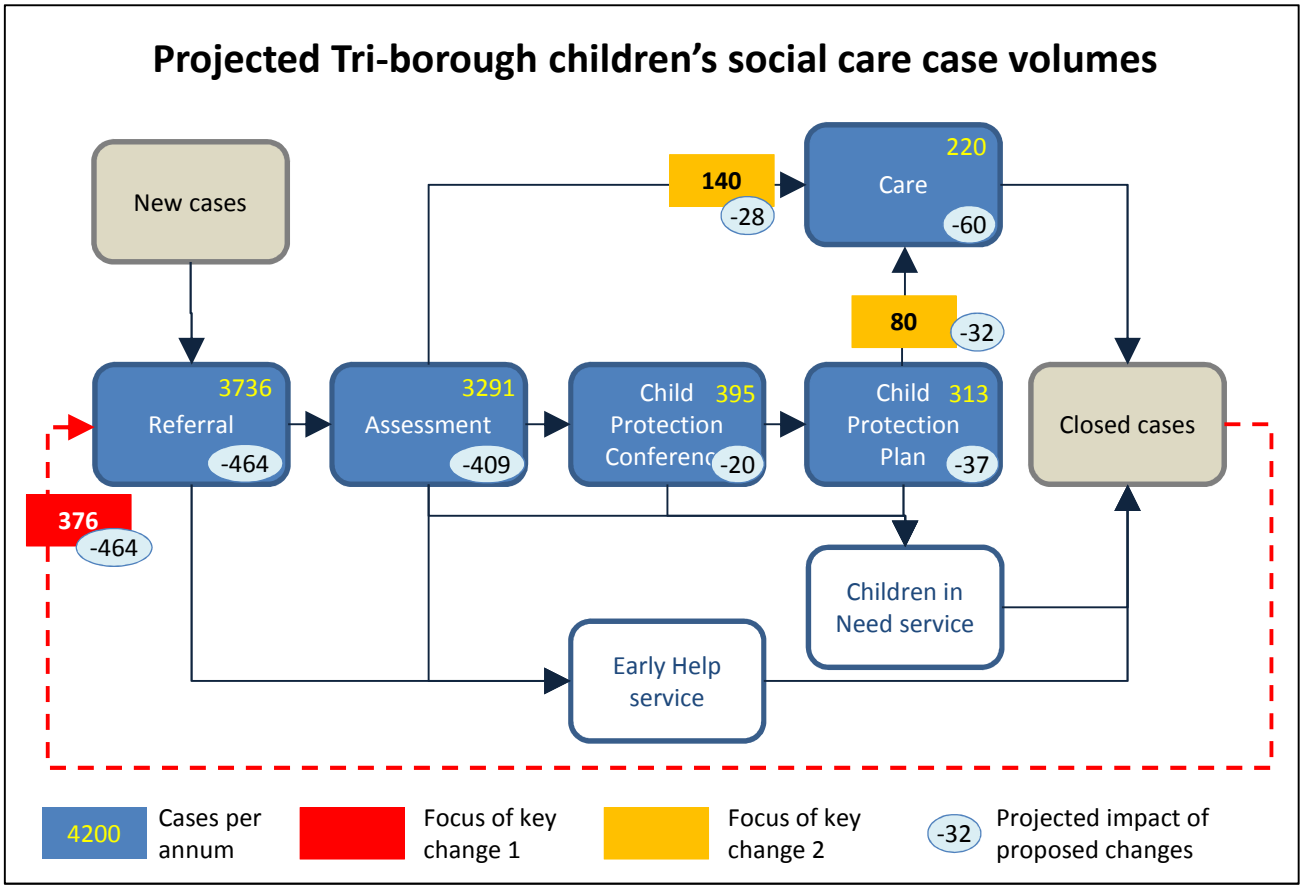

The following page examines the impact of these changes in more detail , and Annex 2 examines sensitivity to the assumptions outlined in the paragraphs above.

# Future flow of children through the Tri-borough social care system

The diagram below highlights the projected changes to flows through the Tri-borough children's social care system, based on the key changes detailed on the previous page and the outlined assumptions associated with each.

The main impacts on flows are:

- A reduction in re-referrals of 464 per annum, with a knock-on effect of fewer assessments, fewer Child Protection Conferences, fewer Child Protection Plans, and reduced demand on the Early Help and Children in Need services.
- A reduction in the number of children entering care of 60 per annum (with a small increase in volumes of Child Protection Conferences and Child Protection Plans as an alternative to direct entry to care from the assessment stage).




The size of impacts highlighted above are dependent on the assumptions associated with the changes to the system . Annex 2 examines sensitivity to those assumptions.

# Innovation Programme financial support

We are requesting £1.4m in 2014/15 and £3.5m in 2015/16 to fund the additional expenditure that is not covered by the use of existing resources. This financial support will enable us to:

- Implement the model in a much shorter timeframe than we would otherwise be able to do ourselves with existing financial constraints.
- Demonstrate the impact of our proposed model at a system level and share lessons learned with other Local Authorities embarking on similar changes

The table opposite gives a breakdown of the funding request. Each item in that table is explained in more detail on the following page, with outline implications of not receiving funding for each item.

**Variances to our previous proposal**

In developing our proposal further we have made the following changes to the financial support being requested:

1. Reduced amounts for new posts in 2014/15 for two reasons:
   - People will be in new posts for a shorter portion of 2014/15 than we previously planned due to a later start date
   - A staggered recruitment to the family therapist and transitional social worker posts is planned, with three major rounds of recruitment over a period of 6 months
2. An increase in training costs to reflect more detailed analysis of training needs that we have now undertaken (we noted in the previous proposal the figure at that time was a rough estimate)
3. Addition of £50k cost of external researchers to observe and rate the quality of engagement with families before, and after training.
4. A more accurate estimate for the tracking programme team costs
5. A reduction in some 2015/16 amounts where these will be able to be part-funded from existing Tri-borough budgets

The table opposite summarises these variances. Annex 3 provides more detail.

## Financial support request

| | 2014/15 | 2015/16 |
|---|---|---|
| Project management | £41k | £70k |
| Training | £200k | £460k |
| External observation on quality of engagement and impact of training | £20k | £30k |
| Heads of Clinical Practice (3 posts) | £81k | £210k |
| Family therapists or psychologists (24 posts) | £400k | £1,080k |
| Tracking programme team (15 posts) | £309k | £530k |
| Career pathway for social workers | £100k | £200k |
| Transitional social work staff (24 posts) | £267k | £960k |
| **Total funding request** | **£1,418k** | **£3,540k** |

Tri-borough will itself fully fund backfill of training, management input to the project, changes to IT system and training programme development.

## Variances to previous proposal

| | 2014/15 | 2015/16 |
|---|---|---|
| Previous proposal | £1,800k | £3,460k |
| Revised 2014/15 recruitment profile | (£621k) | - |
| Revised training estimate | £100k | £400k |
| External observation on quality of engagement and impact of training | £20k | £30k |
| Revised tracking programme team costs | £119k | £150k |
| Amounts part-funded by Tri-borough | - | (£500k) |
| **Revised funding request** | **£1,418k** | **£3,540k** |

# Innovation Programme financial support

The table below describes the expenditure for which funding is requested , and outlines the likely alternative course of action that the Tri-borough will take if each item is not funded by the Innovation Programme

| | Description | Funding request | Alternative to Innovation Programme funding |
|---|---|---|---|
| Project management | The project management job profile would include teaching and coaching of staff | £111k | Without project management capacity, senior managers would manage the project on top of day jobs. The change programme would be considerably slower. |
| Training | Training of staff in evidence based interventions and systemic approaches | £660k | Some training would take place but at a much smaller scale and would inevitably lead to pockets of training rather than whole system change |
| External researchers | External researchers to regularly observe and rate the quality of engagement with families before, during and after practitioners have engaged in training. | £50k | Consolidation of learning is crucial in embedding skill and knowledge development of staff. Without this element of the programme there is a risk that the training would be less effective and that staff would revert to previous practice. |
| Heads of Clinical Practice (3 posts) | K&C have appointed to this post and the first year of costs are covered in one borough | £291k | Without additional capacity and expertise provided by lead clinical practice posts, systemic practice would be adopted at a superficial level and only partly embedded. |
| Family therapists or psychologists (24 posts) | Joint funding arrangements with health commissioners may reduce this amount. We would want to employ a number of these staff permanently and will work with our CAMHS colleagues to re-commission existing contracts | £1,480k | In a similar vein to the point above, without the expertise provided by family therapists, the change in practice, would still be positive, but the difference would be less radical and systemic practice much harder to embed as a routine way of working with families. |
| Tracking programme team (15 posts) | Case tracking practitioners will proactively identify and follow targeted cohorts of children and provide ongoing analysis | £839k | Without the funding for this team, our business analysis team would take on the tracking function but not as their core business. We would model proactive intervention with a small pilot group in one borough. |
| Career pathway for social workers | 10 senior posts per borough at an additional cost of £30k per post. This will taper over three years as current management posts are adapted. | £300k | The career pathway is an essential change to the practice system and we would continue to develop practice posts at a higher level in the hierarchy, but at a much slower pace and in a more piecemeal way, possibly one or two posts per year over a five year period. |
| Transitional social work staff (24 posts) | An additional 10 social workers in H&F, 8 in Westminster and 6 in K&C to enable a gradual reduction in caseloads over a three year period | £1,227k | The transitional staff are a key element to provide capacity and reduce risk during the change programme. They are also a key component in reducing caseloads. Without transitional capacity we would continue to reduce caseloads but at a much slower rate, and in response to reduced demand after three years. |
| **Total** | | **£4,958k** | |

# Financial sustainability

The sustainability of the new model depends on it directly contributing to (or enabling) 25% cost reductions that Tri-borough must make over that timeframe. In that context, Tri-borough's proposal for Innovation Programme support projected annual recurring cost savings of £4.2m (2018/19 onwards).

**Projected recurring cost savings (original proposal)**

| | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 |
|---|---|---|---|---|---|
| **Placement cost savings** | £0.68m | £1.35m | £2.03m | £2.70m | £2.70m |
| **Staff cost savings** | - | £0.25m | £0.70m | £1.50m | £1.50m |
| **Total savings** | **£0.68m** | **£1.60m** | **£2.73m** | **£4.20m** | **£4.20m** |

The largest portion of the projected cost saving is lower placement costs resulting from fewer children entering care. The projected savings value is based on up to a 20% reduction in the number entering care. The projections on the previous pages highlight how a reduction of this magnitude might be achieved.

The smaller portion of the projected cost saving is a reduction in staff costs. There are various competing factors that will affect the staff costs required by the new model. These are outlined in the table opposite.

Further work is needed to model these factors and to validate the achievability of the projected staff cost savings and test whether the proposed model is sustainable within the financial envelope within which the Tri-borough will need to operate.

**Factors affecting projected cost savings**

| | | Why might costs increase? | What might enable cost reductions? |
|---|---|---|---|
| **Placement costs** | | | • Fewer children entering care |
| **Staff costs** | Social workers | • More time spent per family<br>• Creation of higher cost senior social worker grade | • Fewer repeat referrals |
| | Other social work staff | • New permanent clinical therapist roles | • More targeted use of edge of care / step down services |
| | Managerial and supervisory staff | • New head of clinical practice role in each borough | • Possible need for fewer supervisors due to staff being higher-skilled (including the new senior social worker grade) |

**Wider benefits**

A more effective children's social care system that results in better and more timely outcomes for children will also have indirect benefits across the wider public sector (edge of care services, school interventions, health services, youth justice, etc).

# What does innovation investment buy?

Rather than running a small-scale 'innovation project', investment will allow us to accelerate significantly the scale (whole system) & pace of change, including:

- Delivery of comprehensive skills and development programme for 600 staff over two years instead of five, significantly accelerating the change in frontline practice that we need to see. The existing training budget will be used to supplement these funds as current learning and development programmes are de-commissioned.
- Use of transitional staff to reduce caseloads quickly, in order that more effective work can be undertaken, reducing repeat referrals and the numbers of families being worked with at any one time. Lower caseloads can be maintained as the number of additional staff tapers in year three.
- Paying for additional costs of practitioners at senior levels. The long term funding for these posts will come from reducing the numbers of posts with management responsibilities, currently 150.
- Employing clinical staff at all levels to develop expertise in systemic practice; as expertise embeds, the need for this will decrease. Expected reduced demand on CAMHS will support negotiations for shared funding of clinical posts (early conversations with commissioners are promising).

Investment will also fund powerful systemic learning:

- The whole model depends on achieving behaviour change in practitioners and managers, but evidence from education in England [CUREE study for Teacher Development Trust] suggests barely 1% of training is transforming classroom practice. We will develop a robust, replicable model for successful practitioner behaviour change. Key to this is the embedding real-time observation of practice and coaching into our programme of change of change, enabling us to assess what is working (how much, and why?) and what is not (why?), and the impact of training on different types of practitioner.
- Driving whole systems rather than piecemeal change will enable us to attend properly to the system conditions and permitting circumstances that are so influential on success (or failure). This will be key if new models of practice are to diffuse and embed successfully nationally.

# Focus on Practice: Risks & Mitigations

| **Risk** | Mitigation |
|---|---|
| Child Death: potential that a child dies in circumstances which bring intense media pressure, and questions about whether Focus On Practice has been a contributory factor. | We are not changing our child protection antennae or system; we are adding quality interventions into the system. Existing framework is unchanged and we will continue to keep children safe from harm. |
| Family Engagement: risk that the frequency with which families engage effectively in our interventions is lower than anticipated. | We will involve families in co-design, to ensure that there is the best possible chance of them choosing to engage positively with the new offer |
| Inconsistencies in the System: risk that some elements of our system do not sign up to or deliver Focus on Practice in full – for example practitioners may be wholly engaged, but impact will be weakened if their supervisors and managers are not, or practitioners find it a struggle to change deeply embedded ways of working | Programme of observation, coaching and consolidation will enable us to find out quickly if and where problems like this might exist, and to mitigate against them. |
| Lack of support: risk that political and/or corporate leaders do not understand or maintain support for the programme, most likely due to pressures for delivery of savings, or as a result of high profile CP case. | We have excellent high level commitment to the change programme, which we will seek actively to maintain through continuation of active dialogue at every stage |
| Recording: risk that we fail to change recording practice and so fail to increase time practitioners spend delivering interventions with families. | Considerable energy already invested in case recording practice, which will be maintained. |
| Proven interventions: risk that our implementation of four key programmes does not have the impact anticipated despite their evidence base. | We know that picking the right models is necessary but not sufficient for success in terms of outcomes. Commitment to fidelity of implementation, clinical supervision, and the observation of practice and coaching will help maximise impact. But we are clear that behaviour change will not be achieved in every case. |
| Assumptions on reduced demand and delivery of savings: risk that projections turn out to be miscalculated such that the planned tapering of additional staff capacity becomes harder to achieve, making model unsustainable. | Detailed further modelling including of staffing, flow, throughput, volumes, workload etc to understand how best the model can work within the viable financial envelope. |

# Conclusion / outcomes for children

- The theory of change and data analysis in the slides above, demonstrate the projected reduction in demand which we would expect to see and which is outlined in the table below.

- By reducing the number of families we work with at any one time, we will manage a gradual reduction in caseloads for practitioners, giving them the time to work intensively and in-depth with families. The additional expertise, use of evidence based methodologies and embedded systemic practice will lead to more effective intervention and improved outcomes for children and their families.

- We believe this whole system change will lead to a radically different relationship between practitioners and the families with whom we work and facilitate change within a risk management context, which will enable more children to grow up safely within their families.

| | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 |
|---|---|---|---|---|---|
| Referrals | 4,200 | 4,200 | 3,990 | 3,759 | 3,736 |
| *Change from 2014/15* | | - | *-210* | *-441* | *-464* |
| Assessments | 3,700 | 3,700 | 3,515 | 3,312 | 3,291 |
| *Change from 2014/15* | | - | *-185* | *-388* | *-409* |
| Child Protection Conferences | 415 | 422 | 414 | 397 | 395 |
| *Change from 2014/15* | | *+7* | *-1* | *-18* | *-20* |
| Child Protection Plans | 350 | 356 | 349 | 335 | 333 |
| *Change from 2014/15* | | *+6* | *-1* | *-15* | *-17* |
| Entered into care | 280 | 261 | 231 | 221 | 220 |
| *Change from 2014/15* | | *-19* | *-49* | *-59* | *-60* |

# ANNEX 1: Next steps (modelling of flows and cost savings)

Further modelling of flows and cost savings will enable Tri-borough to make detailed transition and staffing plans, validate that the proposed changes are sustainable within the future available financial envelope, and establish clear benefits targets. In particular, the Tri-borough would welcome analytical and financial modelling support from the DfE Innovation Programme's delivery partner with two distinct (but related) areas of focus.

## Validation of flow assumptions

The projected impact of Tri-borough's proposed model is dependent on the achievability of the assumed reductions in:

- Repeat referral rate
- Percentage of children at the assessment stage being entered directly into care
- Number of children with a Child Protection Plan subsequently being entered into care

Subject to availability of suitable data, these assumptions can be validated via one or a combination of the following methods:

- Benchmarking across the three boroughs (to identify scale of reductions possible through adoption of local best practices)
- Benchmarking with other Local Authorities (to identify potential scale of reductions through adoption of national best practices)
- Degree of change achieved by other Local Authorities (e.g. Hackney) who have made similar changes to their approach to children's social care
- Dip sampling of historic Triborough cases to identify those where alternative courses of action might be taken under the proposed model

## Staffing, costs and savings modelling

More detailed modelling of future staffing, costs and savings will validate that the proposed model can generate the level of saving necessary for Tri-borough's children's social care services to be able to operate within the future likely available budgets.

The core of this modelling will be a five-year staffing model that will enable analysis and forecasting of:

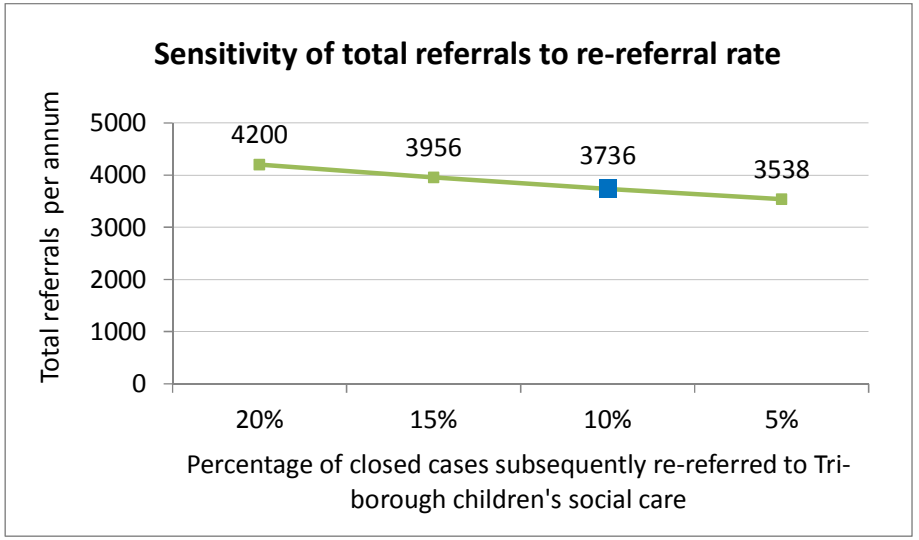
- Social worker staffing levels required to enable smaller caseloads and more intensive relationships with families, whilst taking into account the projected changes in the volumes and flows of children through the system
- Other social care work staffing levels, in particular taking into account new clinical therapists, and the impact of changes in volumes and flows through the system on step-down and edge of care services
- Supervisory staff levels, including the impact of the introduction of a senior social worker role, and career pathway for social workers, and analysis of potential options to increase spans of control and reduce numbers of supervisors

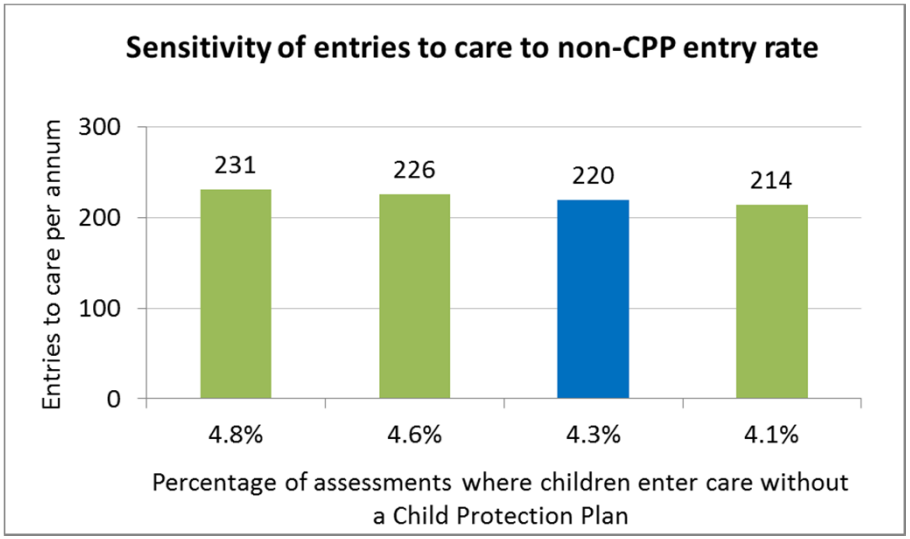
# ANNEX 2: Sensitivity analysis

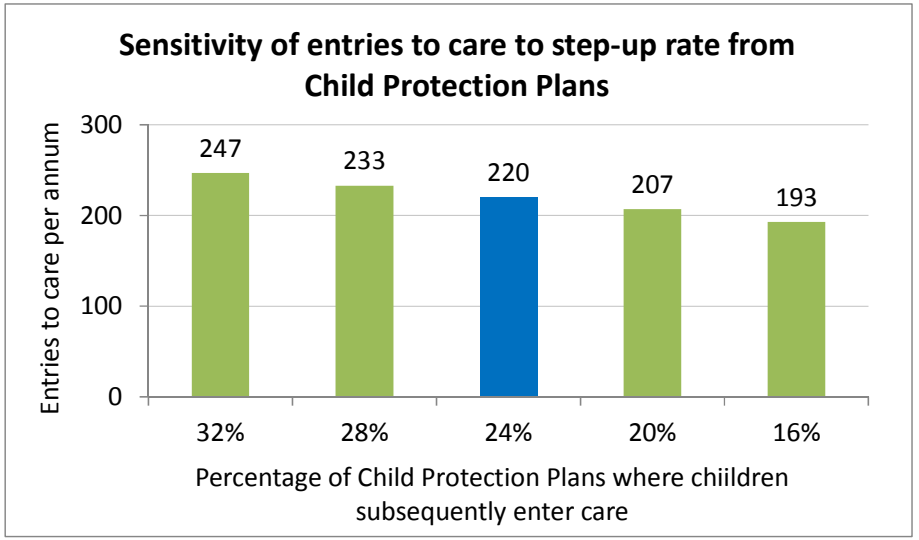
The charts on this page illustrate the sensitivity of volumes and flows of children to three key assumptions with regard to the impact of the proposed changes to Tri-borough's children's social care model:

- A reduction in the re-referral rate from 20% of closed cases to 10% [sensitivity of total referrals illustrated in the upper right graph]
- A reduction in the percentage of times where a child with a Child Protection Plan (CPP) subsequently enters care from 32% of CPPs to 24% [sensitivity of total care entries illustrated in the lower right graph]
- A reduction in the percentage of non-CPP cases where a child is entered into care from 4.8% of assessments to 4.3% [sensitivity of total entries to care illustrated in the lower left graph]

Base case assumptions  Sensitivity test assumptions




N.B. In examining sensitivity to each assumption, the other two key assumptions remained constant at their base case projections (e.g. in the top right graph showing sensitivity to re-referral rate, the assumptions for direct entry from assessment and step-up from CPP are fixed at 4.3% and 24%)

# ANNEX 3: Innovation Programme financial support

| **Previous funding request** | | Add in Tri-borough part funding deducted previously | **Previous cost estimate** | | | Re-profiling of 2014/15 recruitment | Re-estimate from more detailed/ accurate analysis | | **Revised cost estimate** | | Part-funding by Tri-borough | | **Revised funding request** | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *2014/15* | *2015/16* | *2014/15* | *2014/15* | *2015/16* | | *2014/15* | *2014/15* | *2015/16* | *2014/15* | *2015/16* | *2014/15* | *2015/16* | *2014/15* | *2015/16* |
| 70 | 70 | | 70 | 70 | **Project management** | (-29) | - | - | 41 | 70 | - | - | 41 | 70 |
| 100 | 100 | | 100 | 100 | **Training** | - | 100 | 400 | 200 | 500 | - | (-40) | 200 | 460 |
| - | - | | - | - | **External researchers** | - | 20 | 30 | 20 | 30 | - | - | 20 | 30 |
| 140 | 210 | 70 | 210 | 210 | **Heads of Clinical Practice (3 posts)** | (-59) | - | - | 151 | 210 | (-70) | - | 81 | 210 |
| 720 | 1440 | | 720 | 1440 | **Family therapists or psychologists (24 posts)** | (-320) | - | - | 400 | 1440 | - | (-360) | 400 | 1440 |
| 190 | 380 | | 190 | 380 | **Tracking programme team (16 posts)** | - | 119 | 150 | 309 | 530 | - | - | 309 | 530 |
| 100 | 300 | | 100 | 300 | **Career pathway for social workers** | - | - | - | 100 | 300 | - | (-100) | 100 | 300 |
| 480 | 960 | | 480 | 960 | **Transitional social work staff (24 posts)** | (-213) | - | - | 267 | 960 | - | - | 267 | 960 |
| **1,800** | **3,460** | 70 | **1,870** | **3,460** | **Total** | (-621) | 239 | 580 | **1,488** | **4,040** | (-70) | (-500) | **1,418** | **3,540** |
| | | | | | Backfill[1] | | 60 | 100 | | | (-60) | (-100) | | |

*All figures in £000s*

[1] Backfill of training, management input to the project, changes to system pcs and training programme development