Leicester's Edge of Care Strategy 2025-2027

Foreword

We know that it is in a child's best interest to remain at home where it is safe for them to do so.

To support this ambition, we have developed our first Edge of Care Strategy which is aspirational in its approach to seek opportunities to grow and shape services to support children to remain safely at home or to safely return home.

I am excited to launch our strategy, which I hope will enable colleagues and partners to:

1) get insight into the essence of the Edge of Care work undertaken within the local authority and across the partnership and,
2) understand the impact the nationally and internationally recognised Edge of Care therapeutic programmes have for Leicester's children and families.

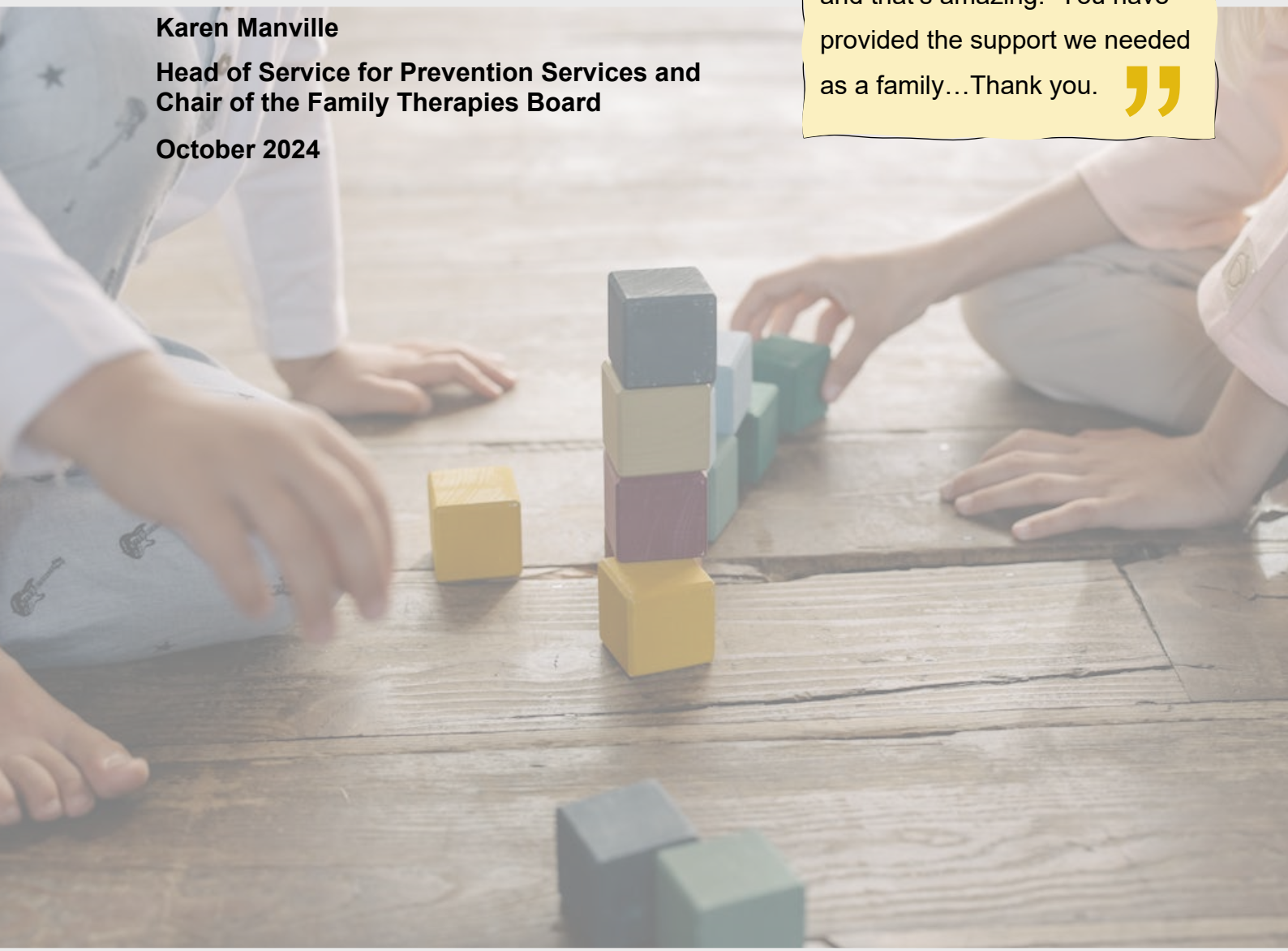
We are proud of our Edge of Care work and can see tangible evidence of the benefit that our services have on the lives of children and families.

> "You may think it's just a job, but you are changing lives and that's amazing. You have provided the support we needed as a family…Thank you."

Karen Manville

Head of Service for Prevention Services and Chair of the Family Therapies Board

October 2024

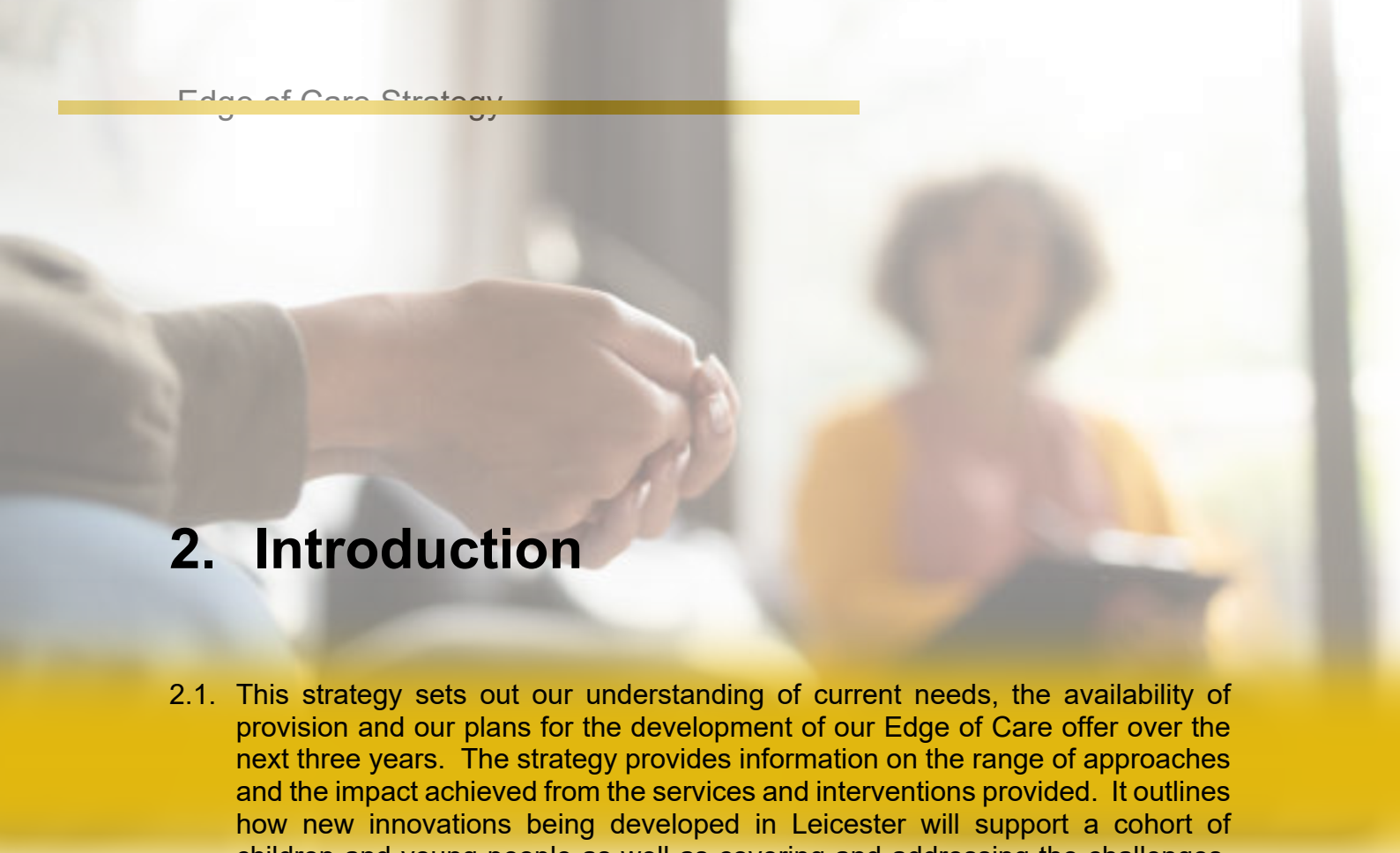


1. Rationale

1.1. Within the children's social care system, the priority is to keep families together. We know that children who are looked after are at risk of having poor educational experiences, of leaving school with fewer qualifications, of having an increased risk of offending and of becoming a teenage parent. We also know these children often become adults who are out of work. This is why addressing concerns to keep children at home, when it is possible and safe to do so, is so important.

1.2. As well as impacting on children's outcomes, looked after children placements put huge financial pressure on local authorities. The cost of these placements can reach £2,125 per day, with an average cost of £230.07 per day, per child. 19% of children in care in Leicester are in the highest cost placements (based on cost >=£1,000 per day).

1.3. Leicester City Council is fully committed to supporting a child's right to family life and to support children and young on the edge of care and protect them from harm, a range of services and interventions are provided in Leicester. This reduces the likelihood of someone becoming looked after.



2. Introduction

2.1. This strategy sets out our understanding of current needs, the availability of provision and our plans for the development of our Edge of Care offer over the next three years. The strategy provides information on the range of approaches and the impact achieved from the services and interventions provided. It outlines how new innovations being developed in Leicester will support a cohort of children and young people as well as covering and addressing the challenges, evidence of impact and value for money.

2.2. Following recommendations from a series of reviews published in 2022, the government is investing £200 million to set the path for longer term reform. This funding is on top of:

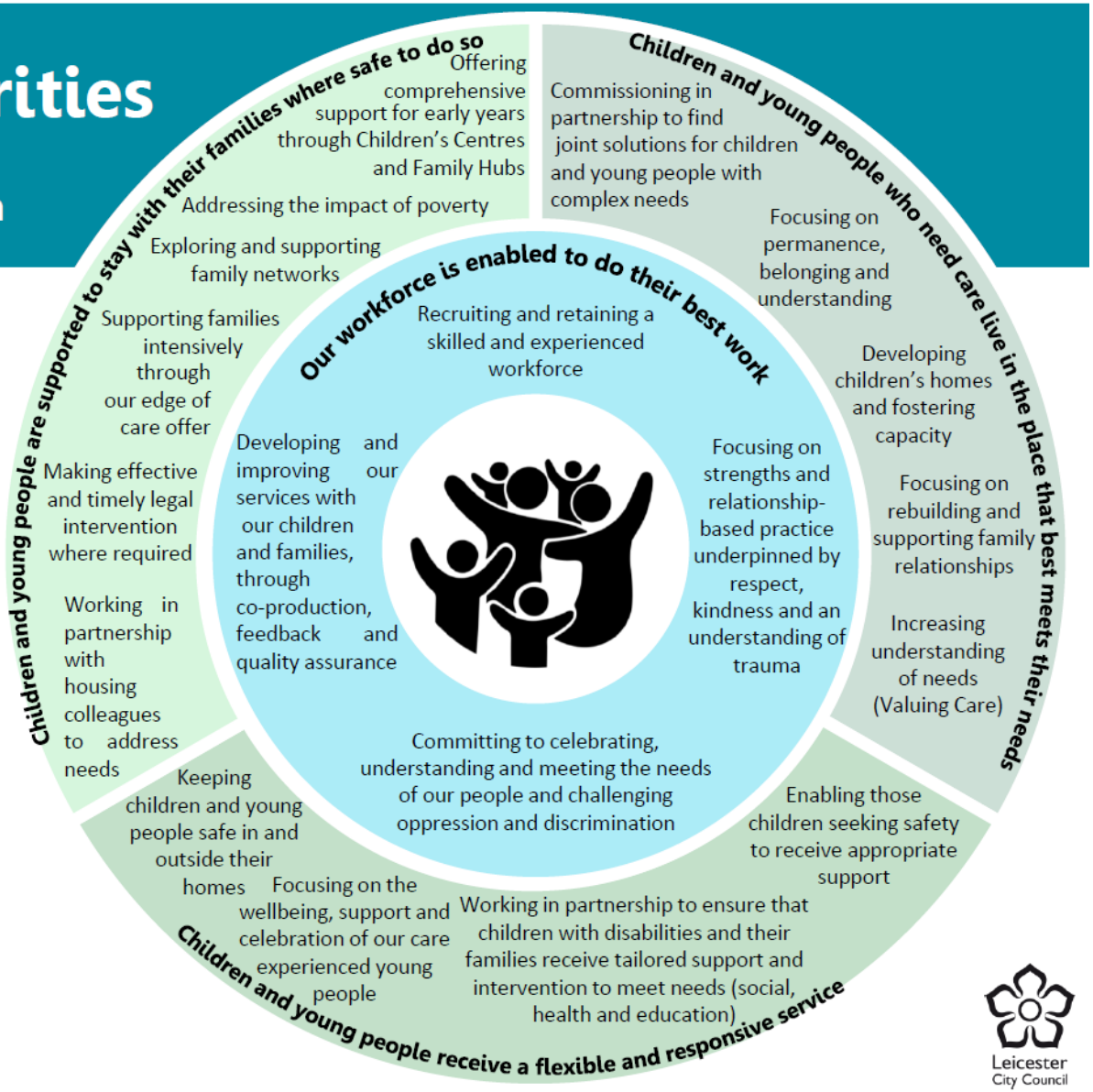
- £142 million to be invested by 2024 to 2025 to take forward reforms to unregulated provision in children's social care.
- £160 million to be invested over the next 3 years to deliver our Adoption Strategy.
- £259 million over this Spending Review period to be invested to maintain capacity and expand provision in secure and open residential children's homes.
- £230 million to be invested over this Spending Review period to support young people leaving care.

2.3. The strategy reflects how we will test some of the most complex reforms to assess the impact of new measures and learn from our approach to inform future decision making at all levels. We will be learning through co-design through our Families First for Children and Regional Care Cooperative Pathfinder programmes. We will achieve this while ensuring practice aligns to our divisional priorities and align with the implementation of a Family Help model.

Divisional Priorities

Children's Social Care, Early Help and Prevention

We are committed to supporting children, young people, adults, and families to live their best life, so they can be safe, be independent and be ambitious for themselves



SCE Social Care & Education

Leicester City Council

3. Our legal duties

3.1. There is no recognised or official definition of what constitutes 'edge of care'. Consequently, the cohort of children and young people on the edge of care is not generally well tracked or understood. However, in Leicester we have a well-established history of offering edge of care services. Therefore, not only are these at-risk children visible, but for the last twelve years they have also been discussed and understood, with their needs carefully considered and actively responded to.

3.2. The characteristics of the children who meet the edge of care threshold vary significantly: including both in terms of age and where they are on their journey. To address this, the offer has grown to accommodate services which can be responsive to differing needs. When the threshold for the edge of care is met, robust processes are in place as part of the Children Act, 1989, to secure intervention and permanence for children at the 'edge of care' within the local authority area.

3.3. Where children are living in an environment where their safety is compromised to an extent that the child protection plan is no longer sufficient, it is incumbent upon the social worker and team manager to request a legal planning meeting. At this meeting there are various options, including referrals to the following edge of care services:

- Family Decision making
- Multi-Systemic Therapy (MST)
- Multi Systemic Therapy for Building Stronger Families (MST-BSF)
- Functional Family Therapy
- Other prevention services within the Youth Support Offer
- Partnership offers

3.4. The legal planning meeting is chaired by a service manager who is advised by a legal representative. Additional options may include both not to engage in pre-proceedings or to escalate with and issue care proceedings. Following the meeting, the decision is made with social care as to what service can best meet the child's need. Managers from the Family Therapies service provide a critical role is supporting this assessment as teams have particular strengths in different areas.

4.1. It takes a village to raise a child. Similarly, it takes a dedicated network to make a difference to the lives of children and young people who are open to children's social care. Family therapies offer therapeutic support to meet the identified issues while bringing families together to ensure robust and ongoing support away from statutory intervention.

4.2. The edge of care services specifically referenced within this strategy are:

- **Multi Systemic Therapy (MST),** a 3 – 5-month programme targeting children
  - aged 11 -17 at risk of custody or care due to behavioural issues.

- **MST Building Stronger Families (MST-BSF),** a 6 – 9-month programme targeting families with at least one child aged 6 – 17at risk of care following one or more episodes of physical abuse and/or neglect.

- **Functional Family Therapy for Child Welfare (FFT-CW**), a programme of approximately six months duration for any child aged 0 – 7 where there is a risk of care due to ongoing child welfare needs (except active sexual abuse) where the family isn't eligible for an MST intervention.

- **Family Decision Making (FDM)** specialist independent service coordinating a personalised community response to prevent family breakdown

4.3. The aim of these programmes is to provide a targeted response to those children most at risk of coming into care with a view to:

- reducing looked after episodes
- reducing the financial cost of these
- improving outcomes for children, young people and their families, including:
  - keeping families together
  - offering assurance that children are safe
  - reducing adult and child substance abuse
  - reducing offending
  - securing and increasing child attendance in education, employment and training
  - reducing mental health difficulties
  - increasing natural social supports

Multi Systemic Therapy (MST)

4.4 MST is an intensive family- and community-based intervention for children and young people aged 11-17 who are on the edge of care. It is targeted at high-risk families where the young person's behaviour across several systems (home, school, community) is unmanageable within the current capacity of the family and supports parents to develop new strategies to keep their young person safe.

Therapists carry low caseloads to support intensive contact and work with families for up to 20 weeks.

4.5 MST is firmly embedded within the edge of care offer with referrals screened and approved at a weekly panel. The MST Supervisor attends the Edge of Care Panel every week and on average the service accepts around 6 new referrals a month for suitability screening.

4.6 MST focuses on family strengths which has numerous advantages, such as building on strategies the family already know how to use, building feelings of hope, identifying protective factors, decreasing frustration by emphasising problem solving and enhancing parents or carers' confidence.

4.7 There is strong evidence to suggest that MST has had a positive and sustained effect on changing participant's behaviour, reducing demands on public services and providing an overall saving on investment.

Multi-Systemic Therapy for Building Stronger Families (MST-BSF)

4.8 MST-BSF is an adaptation of MST and designed for families with serious clinical needs who have come to the attention of children's services due to physical abuse and/or neglect. MST-BSF clinicians work on a team of three therapists, a crisis caseworker, a part-time psychiatrist who can treat children and adults, and a full-time supervisor. Each therapist carries a maximum caseload of four families.

4.9 Treatment is provided to all adults and children in the family. Services are provided in the family's home or other convenient places. Extensive safety protocols are geared towards preventing re-abuse and placement of children and the team works to foster a close working relationship between children's services and the family.

4.10 When needed, the following empirically based treatments are used: functional analysis of the use of force, family communication and problem solving, Cognitive-Behavioural Therapy (CBT) for anger management and post-traumatic stress disorder (PTSD), clarification of the abuse or neglect and Reinforcement Based Therapy (RBT) for adult substance abuse.

4.11 MST BSF offer Reinforcement-Based Treatment (RBT) for drugs and alcohol. It is a therapy approach that helps people reduce substance use by rewarding positive steps like staying sober or attending therapy sessions. When individuals show progress or make healthy choices, they receive incentives or rewards, which encourages them to keep up those behaviours. This method motivates and supports lasting change by focusing on positive reinforcement rather than punishment.

Functional Family Therapy – Child Welfare (FFT-CW®)

4.12 Functional Family Therapy – Child Welfare (FFT-CW®) is an adaptation of Functional Family Therapy (FFT) designed to serve families with children aged 18 or younger. FFT-CW aims to improve child and family outcomes and keep families together by offering a continuum of services tailored to individual family needs. Families receive one of two levels of services based on a preliminary risk assessment. Families can move between levels of services if later assessments indicate that risk factors have changed.

4.13 Families assessed as high-risk receive a developmentally adapted FFT intervention with enhanced behavioural and mental health targets delivered in five phases by a trained clinical therapist. The first three phases focus on increasing engagement, building motivation for change, and understanding relational patterns. The next phase focuses on behaviour change and identifying and addressing family needs. The final phase helps families generalise these behaviour changes to their everyday lives and to contexts outside the immediate family.

4.14 For families with younger children, programme content is more parent-driven, focusing on building skills for creating a family context in which children can flourish. For families with adolescents, programme content focuses on how problem behaviours can motivate families to engage in change.

4.15 Across both levels of services, families are supported by a treatment team that includes the interventionist or therapist as well as a clinical supervisor who provides ongoing supervision and training. Other team members can include recruitment/intake workers and family resource specialists to help with referrals. The treatment team for the high-risk intervention should have plans to access a clinical psychiatrist who can provide as-needed psychiatric assessments, treatment planning, medication management, referrals, and therapy services.

Contingency Management Policy and Protocol

4.16 The FFT service have now received training in Contingency management (CM), which is a highly effective therapeutic intervention for people with problematic drug and alcohol use, which utilises theories of conditioning to reinforce or reward' positive behavioural changes with the aim of achieving abstinence. CM is purely a behavioural intervention but may work alongside external prescribing services.

4.17 Contingency management has been introduced to the FFT CW team in Leicester, in response to a growing awareness that over 80% of cases which resulted in a child being removed from parental care featured drug or alcohol use. It will be employed as an addition to the already successful FFT work and be fully integrated into the behaviour change plan.

4.18 Abstinence from problematic drug and alcohol use will always be the goal of any CM intervention, however it needs to be recognised that this achieving consistent abstinence may take some time and there may be lapses or relapses during this process. It is particularly important that no-one advises someone who has become physically dependent on alcohol to stop drinking suddenly, as this can lead to serious withdrawal symptoms, which can in some cases be fatal. Where an individual is assessed to have a healthy relationship with alcohol or cannabis, and its use is not deemed to be posing safeguarding concerns, these substances will not be addressed by the CM intervention.

Identification of appropriate cases

4.20 Cases where CM will be offered will be identified by the allocated therapist during the initial FFT phase of Motivation. CM may be offered to a anyone in the immediate household of a family who have been referred to FFT CW, where drug and/or alcohol use is assessed to be a contributing factor to the child protection concerns; this can include U18 years olds.

4.21 Whilst Social Workers or Independent Chairs can suggest that a therapist considers offering CM, it is the decision of the therapist and the family whether to proceed with this. This decision will be made based on assessment of motivation and likelihood of compliance.

Family Decision Making (FDM)

4.22 A Family Decision Making Conference is a process led by family members to plan and make decisions for a child who is identified as being at risk. It is a voluntary process that starts with the promise that all relevant family and friends are invited to take part, especially the child or young person, as long as it is safe to do so. Children and young people are normally involved in their own FGC, although sometimes with support from an advocate.

4.23 The aim of the FGC is recognition that often a child's best, most loving and consistent support comes from within their own family. We recognise that families can be transitory, they may not have spoken in some time or may have had disagreements and fall outs, but that when it comes for the best interests of the child, most families will put aside these differences. This is fundamental action to supporting families 'where they are at' in line with Family Help.

4.24 The philosophy underpinning Family Decision Making Conferencing is that:

- Children and young people are paramount to the FGC process
- The family network is central to the FGC process
- FGC is family led decision making in partnership with formal systems
- FGC is a safe, respectful and effective environment for all participants

- Private family time is a vital element to FGC process

Families have the right to be involved in decisions that affect their children and that as long as the plan is safe for the child(ren) it should be fully resourced.

> I say this as honestly as I can because at first I was very sceptical of how talking to someone everyday could really help me… I didn't make it an easy job for them at times yet she never felt gave up on me. She saw in me what sometimes I felt hard to see in myself, and a lot of the time I didn't even notice how I was being therapised until on reflection later on and I would be like 'ok, I see what she did there'. Of course, there were more tougher subjects and obstacles to overcome, and it took a little longer than we may have first thought - but we got there. If anything, it was a little hard to let go of this amazing woman, who will always be such a poignant person in my life and the team behind her who collectively had actually and no doubtingly SAVED MY LIFE, but it was time to go it alone! There is barely a day that goes by that I don't use the skills I learned and hear her voice in my head or ask myself what she would say or do to make me see things clearly but I know the answers now and most of the time I get it right but hey nobody's perfect we make little mistakes and 'we moove'! If you have the opportunity to work with MST give it all you have got and TRUST THE PROCESS. Happy birthday MST may u continue to transform lives from one happy mother and 2 happy children who no longer have any services involved yet still benefit daily from are time working with you!♡

5 Governance and accountability

5.1 All family therapy interventions are governed by the Edge of Care Interventions Board. The key aims of the board are to ensure the programmes operate within the purpose and structure for which they were designed and to ensure a collaborative approach towards reducing the number of children who are looked after. The Board, which is independently chaired and made up of senior members of key stakeholders, serves to hold all interventions and their management to account. It meets four times annually, with briefing papers presented quarterly. The board is chaired by the Head of Service for the Prevention Service and is well represented by a range of partners including Social Care, Health, Police and Education.

5.2 There is strict oversight of the team's performance and what we refer to as adherence. Adherence includes a range of factors, including the therapist's ability to work across the whole of the child's ecology, the ability to collaborate in a strength-based manner and the ability to create sustainable change for our families.

5.3 As the service grows to incorporate the expansion of the FFT model to accommodate children being returned from care, the exiting Edge of Care panel will also house eligible children who can be considered for a return from care to their carers. Such decisions are not taken lightly, recognising the impact of potential trauma and risk of further harm. As such, only children and families who have show clear dedication to persistent contact and close working with the local authority will be considered. The decision to progress with the therapeutic work, timescales and agreement for placement with parents (thus not revoking the care order but allowing the child to share parental responsibility with the local authority while being at home) can be ratified by Head of Service.

Quality Assurance

5.4 Adherence (or client satisfaction) is captured across all five teams via a monthly anonymous interview with family members, generating an adherence score for each therapist. These scores are based on questions designed to ensure that the therapist is being complaint to the relevant model, e.g.: promoting responsibility, strength focused, onus on sustainably. MST and MST BSF teams use a Therapist Adherence Measure (TAM-R) to measure adherence, and FFT-CW use a Family Self-Report (FSR). Leicester continues to be highlighted nationally as a highly adherent service, with a strong reputation for keeping children safely at home.

5.5 In 2023/24, 113 TAM-R interviews were conducted across MST and MST BSF teams. The average adherence score across the therapists remains consistent at .81 (adherence is a target of .61), continuing to be above the national average.

5.6 87% of all families open to MST and MST BSF were interviewed every month, demonstrating the full range of families working across the service providing feedback, despite levels of engagement in the programme.

5.7 The Family Self-Report (FSR) is a 7-item inventory completed by every family member a minimum of six times throughout FFT. Each family member completes a feedback form, including every child living within the home. Families score confidence at each of the 5 phases in treatment. It is expected that as treatment progresses there will be an increase in score by at least 1 point per phase. Families score 1 (very bad) to 7 (very good) to the questions. 29 FSR interviews have been conducted, with an average of +2.25 across the quarter. This is above the target of +1 range.

5.8 In the year of 2023/24, 29 FSR interviews were conducted, with an average of +2.25 across the quarter. This is above target of +1 range.

5.9 In respect of auditing and quality assurance (QA) activity, Family Therapies are included in Local authority audit processes and use a ratified Ofsted framework for assessment. On a monthly basis, managers use an Ofsted-aligned case file audit which is then moderated by a different manager. Any files which are graded as ‘Requiring Improvement’ or ‘Inadequate’ are also reviewed by the Head of Service. There is a clear focus on closing the gap between actions from audits and improvements seen.

> “Emily has changed my life, if it would not have been for Emily, I would have lost everything. Today I am drug free and it’s all because of MST Programme and the work of the team. They are brilliant. I would recommend MST programme to all those families who are suffering like me.”

6 Value for money

6.1 Evidence increasingly demonstrates that interventions at an early stage are more likely to lead to improved outcomes for children and their families and reduce demand across the whole "children's system". This is essential for cost effectiveness but also recognises the inherent difficulties in repairing trauma in later years.

6.2 Different types of interventions in families are often age related with specific early years or adolescent focused interventions. All should focus on securing of permanency and this has been our approach along with ensuring cost avoidance (where safe and appropriate) with savings arising from young people not entering care. The sustainability in the longer term of outcomes requires more research and generally longer interventions are more suited to a chronic type of persistent neglect.

6.3 The cost of Edge of Care interventions varies significantly and should not be compared to one another as they are different approaches for children at different stages. If MST-FFT-FGC is identified as needed, due to the evidence base and ecology of the model, this becomes priority and all other edge of care interventions supporting the family cease. Family Decision Making Conferencing used at any stage when risk of family network is identified as breaking down. It can be used at any stage as an alternative to MST, MST BSF. FFT and MST BSF should only take cases where a decision has been made that they meet the threshold for removal into care.

Intervention	Annual cost	Comments
MST/MST-BSF/FFT	£2.1m	The gross savings of this to the Local Authority are £7.5m 245% of the £3,083k full year target.
Family Decision Making	£160k	£100k funded by Supported Families reserves, ends Mar 25

6.4 While the cost of MST-FFT is significantly higher than other edge of care interventions, this service is subject to rigorous adherence and evaluation, evidencing that placement costs avoided are in excess of the cost of the service. Owing to the nature of more specialised placements utilised, Family Therapies

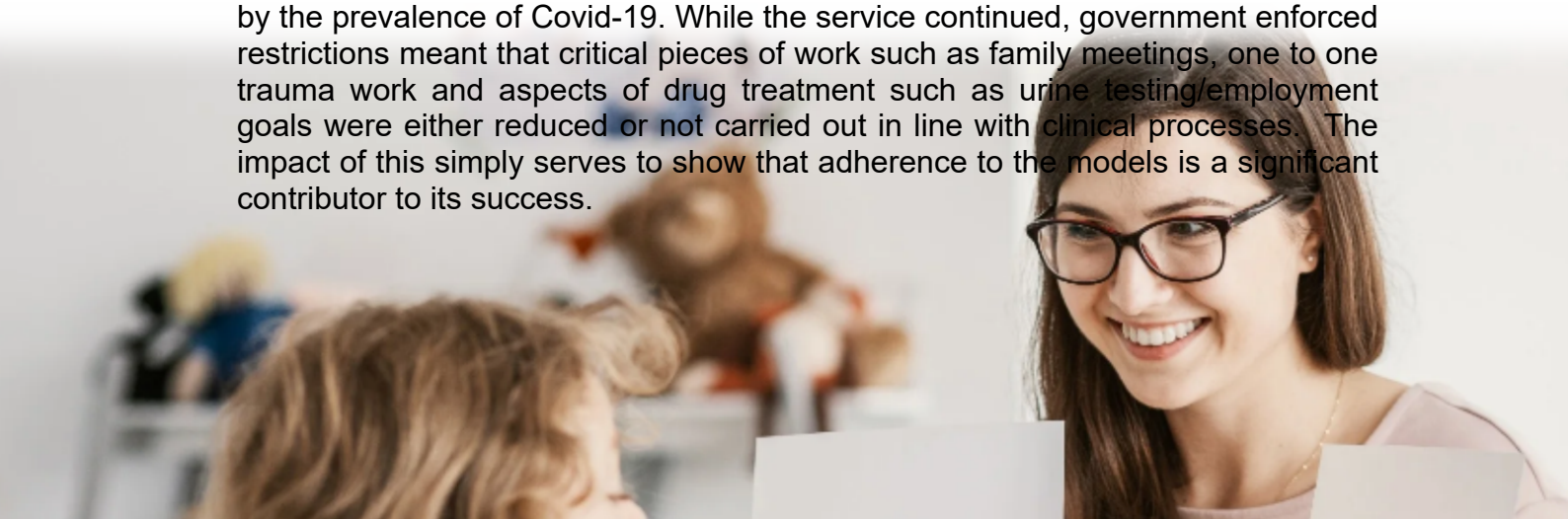
meet with finance regularly to calculate a projected placement (avoided) based on several factors: the risks the child/ren poses or are posed, their behaviours and needs, and placement availability on the day the child/ren is referred. This data is frequently cross checked with social workers and the placement team for accuracy. The average annual placement cost avoided is £84k.

6.5 For other programmes such as FGC, these approaches are encouraged by the Department for Education, with the national consensus that programmes such as these reduce the number of children who come into care.

6.6 The below represents year on care diversion against target goals and associated savings.

Year	Success to date	Gross Savings from success
2020/21	67%	£3,380k
2020/22	76%	£2,071k
2020/23	80%	£4,642k
2020/24	90%	£7,515k

6.7 The graph detailed shows ongoing and consistent savings. While there is a drop in 2020/22, savings were still made above our investment. This period was impacted by the prevalence of Covid-19. While the service continued, government enforced restrictions meant that critical pieces of work such as family meetings, one to one trauma work and aspects of drug treatment such as urine testing/employment goals were either reduced or not carried out in line with clinical processes. The impact of this simply serves to show that adherence to the models is a significant contributor to its success.



7 Impact

7.1 In the past financial year (2023/4), 393 families or 734 children were served with an overall success rate of 90% meaning children were able to stay safely at home.

7.2 Since the start of the financial year 2024, the number of children diverted from care is 199 which is 106% of the annual target. This represents annualised gross savings (from new families opened in the year) of £7.5m, 245% of the full year saving target of £3.1m.

Stability

7.3 Across the full year (2023/4) teams have worked with 393 families and 734 children within these families. Of all 136 families starting in the year, 90% are still together.

7.4 Each child is allocated a projected placement cost avoided figure based on several factors: the risks the child/ren poses or are posed, their behaviours and needs, and placement availability on the day the child/ren is referred. This data is frequently cross checked with social workers and the placement team for accuracy. The average annual placement cost avoided is £84k.

7.5 The average time between referral and treatment starting for quarter 4 2024, as an example, was 14 days, which is above target of <10. The 14 days average between referral and start includes a ‘sign up and consent’ visit before treatment start, so families are contacted and meet the team at least once between referral and start.

7.6 In respect of auditing and quality assurance (QA) activity, over the most recent quarter 4, as an example, 613 file audits took place. There were 34 direct

observations of practice. In addition, 85 cases had additional 'deep dive' analysis exploring practice successes and difficulties, these have taken place outside of the usual QA activity. Finally, the teams completed 4 audits against the Ofsted framework, with 1 scoring outstanding and 3 scoring good. This is a tested and robust process, with every case file being independently moderated by a different manager before concluding on a grade. All QAs are graded before and after the 'loop is closed' with actions for completion checked and signed off as achieved before the QA is completed.

8. Growth and plans for reunification

8.1 The decisions to place any children in care are made following significant assessments or events so worrying that there will have been no other choice. For many children in these circumstances, care is the safest place for them to grow up and achieve their life goals. For others however, whilst this may have been the right decision at that time, it needs to be acknowledged that people and their circumstances can change. For these cases it is appropriate to consider reunifying children into the care of their family. In addition to improving outcomes for children and families, the process of reunification would free up desperately needed care placements.

8.2 Based on analysis of cases to identify potential for reunification, a proposal was made to utilise FFT as a Reunification Programme named **Safe Steps Home**, working with an initial cohort of eight children.

8.3 The FFT reunification pilot has now formally concluded. The programme has entered its next phase, progressing with reunification work beyond the pilot period. This approach continues to support children aged 9–15 in complex and high-cost placements, with the aim of safely returning them to family care, where appropriate.

8.4 Reunification, when safe and supported, improves life chances and alleviates pressure on the care system. The early results of the pilot were positive. However, the transition into delivery at scale brings challenges. These include increased assessment demands, new decision-making processes, and the continued need for close collaboration across care homes, education, and Independent Reviewing Officers.

8.5 Despite the current staffing pressures particularly the absence of two key posts that are now in recruitment the FFT team is effectively managing the increased workload. This commitment and adaptability are ensuring that reunification work remains safely on track.

Key recommendations from the pilot have and are continuing to be implemented, including:

- Targeting high-cost, complex placements
- Strengthening early identification of reunification opportunities;
- Enhancing multi-agency coordination; expanding therapeutic capacity in a phased manner
- Recruitment of 2 new posts to meet demand

''I don't know what happened that meant we ended up working together, she was my guardian angel'l

8 Joint working

8.1 Family therapies have clear protocols which underpin strong working relationships with identified partners. This ensures that the therapeutic offer can be met without compromise or difficulty.

8.2 Good practice expects that multi agency decision making provides best outcomes for children and families and as such, it is expected that therapeutic staff are involved in all relevant decision making that could have impact on the long-term outcomes. It means ensuring that the various stakeholders involved with any given family are coordinating care, as needed.

8.3 Most, if not all referral families to MST, MST BSF and FFT are open to children's social care. While social care has statutory responsibility for visits, family therapies lead delivery for intervention and should have clinical leadership. This leadership role is not intended to replace or remove the responsibilities of statutory social work. It does however provide the framework for the inclusion of therapists in all relevant decision making that could have impact on the long-term client outcomes. It means ensuring that the various stakeholders involved with any given open family are coordinating care, as needed.

Substance misuse

8.4 Where substance misuse is identified, it is expected that the MST/FFT-CW teams should have clinical leadership. This leadership role is not intended to replace or remove the responsibilities of statutory agencies or other key workers, in particular

criminal justice work and managing prescribing. It does however provide the framework for the inclusion of MST/FFT-CW in all relevant decision making that could have impact on the long-term client outcomes. It means ensuring that the various stakeholders involved with any given family open to one of the teams are coordinating care, as needed. MST/FFT-CW are governed internally by the Local Authority and externally by MST and FFT Services and the DfE on a weekly, monthly and biannual basis following evidence-based scrutiny processes.

Children and Young People's Justice Service (CYPJS)

8.5 Where young people referred are open to Children and Young People Justice Service (CYJPS) MST BSF take referrals where they meet the eligibility criteria. There is no referral form to complete but the team require a rationale for referral and the most recent assessment and report. Once the referral is received, the team will contact the referrer within 48 hours, to advise on eligibility, space and allocation timeframes. If a case is not accepted for treatment, a rationale will be provided, and alternative suggested interventions will be made.

Education welfare

8.6 In cases where families where school attendance is a concern, there will be an introductory meeting with the therapist, Education Welfare Officer and key school staff involved with the child/young person (Special Education Needs Co-Ordinator, staff from alternative provider, learning mentor etc). All relevant professionals will be asked for their desired goals for treatment to ensure the programme is working towards all key agency remits. Regular reviews to take place 4-6 weekly with all professionals and the family, monitoring progress towards goals.

8.7 Any safeguarding concerns will be discussed with the Social Worker, the Education Welfare Officer, and the school, or Duty and Advice Service immediately and records of discussions will be logged onto Liquid Logic within 24 hours.

Police

8.8 The MST Supervisor will inform the Safeguarding Partnership Manager of cases open to the MST programme when consent is given by the family to share. The Safeguarding Partnership Manager will also be informed when each family is closed to MST. There will be up to 40 families with specialist markers, highlighting MST involvement on the police system at any given time.

8.9 MST operates a 24/7 on-call system to provide support to families when crisis occurs. When a family open to MST calls the police, the call taker will be made aware from the specialist marker that the family are open to MST.

8.10 Prior to dispatch, police will inform the on-call therapist of the nature of the incident, where a joint decision will be made on the need for immediate police attendance depending on the nature of the incident. The on-call therapist will contact the family and review the incident resulting in the police callout with an attempt to de-escalate with the family over the phone. At each stage, the on-call

therapist will remain in contact with the police officer allocated to the call and will make a joint decision on whether police attendance with or without on-call therapist is still required.

8.10 Family Therapy services will be available to the community and will be available for discussion, support and referral in community centres in line with Family Help.

> *"I was not ready to stop heroin, and I wasn't ready for therapy. I was so scared about what was going to happen, and then all that stuff happened when my son was born and I thought I was going to lose him. Jacquie pushed me, but not forced, and in the right direction. She was absolutely amazing, and didn't feel like therapy. She worked me hard I know, but I trusted her and I'll never forget what she did for me.. She is amazing."*

9 Summary

9.10 Leicester has an excellent edge of care offer available to support children and young people. Since 2012 the service has been extended to include a comprehensive offer meeting the many and varied needs of children who are at risk of coming into care. The robust nature of our local legal planning and edge of care panels has enabled interventions to be utilised at an earlier point for some children and young people where there is a clear pathway of escalation.

9.11 Following referral to any of our services, managers conduct detailed ecological assessments under a well-managed using a robust assessment framework. All teams are well integrated into social care and early help teams; visible and ready to provide support and guidance, even if a referral is not being considered allowing skills and knowledge to be shared across services.

9.12 Teams are respected by professionals, the courts, and families alike with teams and therapists receiving excellent feedback as well as praise and recognition in a national scale for their efforts and tenacity.

9.13 Outcomes are monitored not just at the end of treatment, but on-going at both 6, 12 and 18 months to ensure that our interventions 'hold'. We are proud of these results, with our sustainability holding at a 90% longitudinal success rate post treatment.

9.14 We will expand our edge of care offer with the development of innovations and ensure children and their families are appropriately supported in their communities. There remains volatility in relation to admissions into care and our edge of care offer needs to be flexible and responsive to achieve good outcomes for children and young people, there is some recent evidence to suggest increasing minimisation of this volatility.

9.15 Our investments in a good edge of care offer is a moral and financial imperative and current edge of care services are demonstrating value for money and supporting the achievement of safe, happy, healthy and successful outcomes.