Department for Education

Evaluation of the Belhaven Service

Research report

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The original proposal for this project was named ‘Avoiding Admission to Child and Adolescent Mental Health Services (CAMHS) Inpatient Services for Children in, or on the Edge of, Care’. The project has piloted a new type of residential home. This residential home is known as Belhaven. Belhaven uses an approach that spans 2 regulatory regimes. It aimed to provide a blueprint for similar homes that would provide mental health treatment in a local care home setting to reduce the risk of referral to mental health inpatient services and breakdown of educational and care arrangements for young people. The project aimed to achieve this by establishing a local children’s home setting which integrated health, care and education delivery, to provide residential support to young people in, or on the edge of, care, with high levels of mental ill health that would otherwise be likely to lead to a CAMHS inpatient admission

The original proposal to the DfE from the Belhaven project team described the service as a new model for the delivery of specialist mental health services for the most vulnerable children, that meets their health and care needs and protects the educational, social and care systems that have been developed to support them. The innovations outlined in the original proposal included the scale and location of the services; the integration of health, care and educational service delivery; the partnership approach; and the holistic, child centred service model. Due to the local nature of the service, young people were able to continue working with the same professionals as before admission, helping to ensure continuity of care.

The project model was designed by the Priory Group and Suffolk County Council. The context to the model is that rates of mental ill health amongst looked after children are 4 to 5 times higher than matching age groups in the general population. These young people have less success in the education system than their peers, and are far less likely to go on to further education and employment. In this context, this innovation aims to break the cycle of repeat admissions to CAMHS inpatient services, reduce first-time admissions to CAMHS inpatient services, and reduce the likelihood of entering care following admission to CAMHS inpatient services.

Referrals to the service come from Suffolk County Council, directly from young people’s social workers. The service at Belhaven then works alongside a range of agencies involved with the young person, including social services, CAMHS and education, to carry out an impact risk assessment process which determines the potential impact of the service and the existing residents on this young person, and vice versa, before a decision is made regarding whether to admit them.

This summary provides detail of progress against intended impacts and outcomes. Due to the small numbers of young people, 5 in total, who have accessed Belhaven during the evaluation period, it is still too early to reach any firm conclusions regarding the effectiveness of the innovation. However, the report that follows provides evidence to date about the impact of the service at Belhaven, as well as its progress concerning implementation.

The evaluation is based on a review of documentation; monitoring and finance data; impact assessment tools conducted at 2 points in time with young people receiving the new service (on entry to, and on exit from the service); and in-depth qualitative interviews with 5 young people, and 2 parents or carers; 15 interviews with key project stakeholders undertaken at 2 points in time; and with 3 wider professionals with specific knowledge and experience relating to an individual young person who received the service.

Key findings

How has the innovation been implemented?

The service at Belhaven has been established and has been operating at full capacity for the majority of the evaluation period. The evidence shows that the following challenges to implementation have been faced:

- there were delays of approximately one month in establishing the service due to delays with Ofsted registration caused by the novelty of the model
- it was reported that getting all partners involved and committed to the service was a challenge initially. However, all stakeholders agreed that all partners are now fully committed to the service, and it was suggested that effective communication regarding the aims and objectives of the service achieved this
- the service was originally intended to receive referrals of young people in order to prevent an episode of hospitalisation, that is from a family or care setting, as opposed to referrals of young people already in a tier 4 inpatient service. However, impact tool data and qualitative interview data suggests that, of the 5 young people who have accessed Belhaven, 2 were referred directly from a secure hospital unit
- there are ongoing concerns amongst stakeholders and wider professionals that there is a lack of appropriate local long-term placements for the young people attending the service, leading to delays in discharging young people from Belhaven. This has been a contributing factor to the lower numbers of young people being discharged from the service during the evaluation period than

originally anticipated. It was reported that there was a need for long-term placement options with specific support for young people with mental health issues, and that this was not currently available in Suffolk. Specifically, it was suggested there is a need for more specialist foster carers with relevant mental health training, and for supported housing services with mental health support

How far has the innovation achieved its intended outcomes?

Assessing the impact of the service at Belhaven on its intended outcomes was challenging because a lower than expected number of young people passed through the service during the evaluation period: only 5 young people received support from Belhaven in comparison to the 20 or so originally envisaged during the evaluation period. Therefore, it is challenging to make generalisable judgements regarding the success of the innovation against intended outcomes due to the small number of children that have received support.

The evidence collected by this evaluation suggests a complex picture regarding the innovation's impact on the outcomes it was aiming to achieve.

For young people there is evidence that:

- the service has led to fewer episodes of hospitalisation for 3 young people, and to avoidance of admission to CAMHS inpatient service in at least one case
- there have been positive outcomes regarding sustainability of educational placement; lack of breakdown of educational placement and improved educational attainment following admission to the service
- for some young people, the innovation has resulted in improved relationships with family and friends. However, there is no evidence regarding impact on the likelihood of young people being discharged into the family setting, as just one young person out of the 5 was discharged during the evaluation period
- there have been positive improvements in mental and emotional health and wellbeing during young people's time at Belhaven

For families and communities, there was some evidence that, in cases where young people were engaging with parents or carers, there were improvements in relationships. However, data was only available for 2 young people.

There is limited data available regarding the value for money offered by the service. Data suggests that, based on intended lengths of stay, the service may offer value for money in comparison with the CAMHS tier 4 services in some cases. However, this is

reliant on the service achieving shorter lengths of stays for young people than observed during the evaluation period.

Innovations like Belhaven take time to be implemented and embedded into the wider health and care system. Further evaluation would be required to demonstrate the impact that Belhaven was having on young people's outcomes over a longer time period than has been available in this evaluation timescale.

To demonstrate impact, future evaluation would also benefit from using a comparator or control group to provide confidence that any change in outcomes for young people receiving support at Belhaven (or similar services) could be attributed to the service over and above other factors. Whilst it was originally intended to include a comparator group in this evaluation, this approach was amended to take a more qualitative approach, due to a combination of difficulties in securing access to comparator group data, and the low number of young people accessing the service at Belhaven during the evaluation period. This made it difficult to draw comparisons with a comparator group of a similar small size, meaning any findings would not have been statistically significant between 2 groups of 4 or 5 young people.

Implications and recommendations for policy and practice

Based on the findings of this evaluation, the following recommendations have been made to be taken into consideration for the future development of the innovation:

- ensure strong communication regarding the length of stay and establishment of provisional discharge dates at the point of admission. The primary limitations of the service to date have been extended lengths of stay, and issues surrounding ensuring appropriate discharges for the young people admitted to the service. It is recommended that staff ensure that the service effectively communicates a specified length of stay to those social workers and other professionals who may be referring young people. Once a young person is to be admitted, it is recommended that a provisional discharge date, based on this specified length of stay, is established so that all professionals involved can work together to put in place appropriate discharge plans for the young person

- continue to focus on receiving referrals of young people from a family or foster carer setting. The original service model intended to work mostly with young people before they required hospitalisation, receiving referrals from a family or foster carer setting. However, 2 of the young people admitted to the service arrived directly from hospital inpatient services. Whilst it was always intended that the service would accept admissions from young people being discharged from hospital, this, perhaps, represented a higher proportion of total referrals than

anticipated. As a result, their levels of need were higher than the service had originally intended to work with, and therefore the young people were not suitable to be discharged into a family setting. One of these young people required re-admission to a tier 4 inpatient service, whilst the other was assessed to have a higher level of need than appropriate for a specialist foster care placement, and their discharge was delayed whilst a suitable alternative discharge setting could be identified and secured

- secure a dedicated family therapist to work with young people, both at Belhaven, and as an outreach service. Whilst the original service model included provision for a family therapist, this role has not yet been filled. It is recommended that a family therapist be secured for the service, in order to offer direct support to young people at Belhaven, and also to support outreach work with families

- explore possibilities for the establishment of a family therapy outreach service. As outlined above, it is recommended that possibilities for the establishment of a family therapy outreach service be explored. This would offer support both to the families of young people admitted to Belhaven, and to families with children deemed on the edge of care where the young person has mental ill health. It is suggested that this may improve family relationships for those admitted to the service, reducing the likelihood of need for a potentially more costly care placement following discharge, and also reduce the chance of care breakdowns for young people with mental ill health who have not been admitted to Belhaven, thus potentially avoiding both a CAMHS inpatient admission and admission to the residential service at Belhaven

- ensure staffing levels are sufficient to allow for appropriate levels of observation at all times, including when individual young people require particularly high levels of one-to-one observation. It was reported by one young person that, at times, when an individual young person required one-to-one observation, the other young people at the service felt there was insufficient supervision for remaining residents. Whilst there is no suggestion that supervision or observation has been inappropriately or unsafely staffed, it is recommended that, at times when staffing demand may be higher due to elevated observation needs of an individual, additional staffing be secured in order to ensure peace of mind for the remaining young people

- steps be taken to increase the provision of appropriate discharge destinations. Whilst the lack of sufficient appropriate discharge destinations offering residential care with an element of specialist mental health support was out of the direct control of the service at Belhaven, it is suggested that the evidence gathered by this evaluation, and elsewhere in the service, is used to make the case for an increase in provision of such placements in the Suffolk area

- embed ongoing evaluation to demonstrate impacts and sustainability. Due to the various limitations of this evaluation, as outlined in the limitations of the evaluation section, it has not been possible to make solid conclusions regarding the impact of the innovation or to assess the sustainability of any impacts on outcomes. As a result, it is recommended that the service embed ongoing evaluation activities to demonstrate impacts and sustainability over time. It is recommended that this could be done using comparable impact measurement tools (such as those designed for this evaluation) on entry to the service, on exit from the service, and at a point 3 months following exit from the service. If possible, consideration should be given to developing a comparator group of young people elsewhere in the country, who have similar characteristics and symptoms to those who are supported by Belhaven, to act as a comparator or control group. By doing this, the service at Belhaven will be able to build-up evidence of the impact it is having on young people's outcomes which can be compared against a comparator or control group. Over time, this should help show whether Belhaven is achieving its desired impact in comparison to more traditional service models

Overview of project

The original proposal for this project was named 'Avoiding Admission to Child and Adolescent Mental Health Services (CAMHS) Inpatient Services for Children in, or on the Edge of Care'. The service that was developed to pilot this proposal is known as Belhaven. The service is described as "a new model for the delivery of specialist mental health services for the most vulnerable children that meets their health and care needs, and protects the educational, social and care systems that have been painstakingly developed to support them." The innovations are "the scale and location of the services; the integration of health, care and educational service delivery; the partnership approach; and the holistic, child centred service model"[1].

The project has piloted a new type of residential home (an approach that spans 2 regulatory regimes). It intended to provide a blueprint for similar homes, that would provide mental health treatment in a local care home setting to reduce the risk of referral to mental health inpatient services and breakdown of educational and care arrangements for young people.

What was the project intending to achieve (outcomes)?

The key outcome of the project was outlined as: "that the child feels that we have invested in them as a valued person and not sent them away as a problem to be dealt with elsewhere"[1].

The project's theory of change is detailed in Appendix 3: Theory of change, with intended outcomes outlined on the right-hand-side.

What was it intending to do to achieve these outcomes?

As outlined in the theory of change in Appendix 3: Theory of change, the project intended to achieve these outcomes by establishing a local children's home setting which integrated health, care and education delivery, to provide residential support to young people in, or on the edge of, care with high levels of mental ill health that would otherwise be likely to lead to a CAMHS inpatient admission.

The setting was established as a 5 bed facility. However, it should be noted that only 4 of these beds were funded by the DfE Social Innovation Fund, with the fifth funded by the West Suffolk and Ipswich & East Suffolk Clinical Commissioning Groups (CCGs). Whilst

[1] Source: The Priory Group and Suffolk County Council's original proposal to the DfE Social Innovation Fund.

all young people accessing the service at Belhaven received the same level of service, regardless of funding source, following guidance from the Priory Group and Suffolk County Council, this evaluation is based only on those young people who have accessed the DfE funded beds. The young person whose placement was funded by the CCGs was identified by Belhaven staff, and not included in any evaluation activity, including interviews and the completion of impact tools.

Referrals to the service came from Suffolk County Council, directly from young people's social workers. The service at Belhaven then worked alongside a range of agencies involved with the young person, including social services, CAMHS and education, to carry out an impact risk assessment which determined the potential impact of the service, and existing residents on this young person, and vice versa, before a decision was made regarding whether to admit the young person.

Following admission, the young person had no contact with their previous carers for the first 2 to 4 weeks, to enable them to fully settle in to the new environment. The 5 young people who were admitted to Belhaven had previously been cared for by extended family, local authority foster carers, or in a secure unit.

During their time at Belhaven, the young people were supported to continue attending their current school where applicable. They were also supported in accessing a range of services appropriate to their needs, including CAMHS, Suffolk Connect (a specialist service for young people up to 18 years old who are adopted, looked after, or in Special Guardianship, Child Arrangement or Kinship Care); psychologists, and counselling services. Due to the local nature of the service, young people were able to continue working with the same professionals as before admission, helping to ensure continuity of care.

Where appropriate, young people were also supported in maintaining contact with family members, including visits to the family home, and having family members visit Belhaven. The young people could also access a range of recreational activities both on- and off-site. These were arranged in collaboration with the young people, in line with their wishes and their assessed levels of risk and need.

Changes to the project's intended outcomes or activities

The project was intended to provide a wide range of therapeutic services within the children's home setting, including counselling, family therapy, and sessions with a clinical psychologist with medical oversight from a clinical psychiatrist. However, over the course of the evaluation, the project had not been able to recruit appropriate staff for the delivery of in-house family therapy services. It is hoped that this can be remedied by the end of 2016.

The original proposal for the service stated that the service would work mostly with young people "before they need hospitalisation"[2], as by doing so it aimed to reduce the risk of breakdowns in the young person's local care and educational arrangements, family and social network. However, of the 5 young people admitted to Belhaven, 2 were admitted from a hospital inpatient unit. Whilst it was always intended that the service would accept admissions from young people being discharged from hospital, this perhaps represented a higher proportion of total referrals than originally anticipated.

The project also initially intended to provide services for young people for an average stay of 3 months[2], which was later refined to anticipated placement lengths of between 10 and 26 weeks, depending on the needs of the young person[3]. However, between the service becoming operational in October 2015, and September 2016, a total of 5 young people had been admitted to the 4 beds being evaluated, with lengths of stay exceeding original expectations in all but the most recent admission, when the young person in question left the service after one month and moved to a CAMHS inpatient service, having higher levels of need than were suited for the service. Reasons for this are explored in the Key Findings section of this evaluation report.

The context within which this innovation has been taking place

The innovation was jointly proposed by the Priory Group of Companies (Priory) and Suffolk County Council. The Priory Group provides a range of health, care and education services to young people with mental ill health, special educational needs and behavioural, emotional and social difficulties. It provides approximately 15% of NHS funded CAMHS inpatient beds and operates 30 Ofsted registered, 52-week children's homes in the UK[2]. As a result, Priory has experience of working with partners from the public, commercial and voluntary sectors to provide services for the full range of national and local health and care commissioners, in environments regulated by the Care Quality Commission (CQC) and Ofsted.

Prior to the innovation, Suffolk County Council commissioned a range of services from Priory, including residential care placements and specialist education for children. It was through this working relationship that the Priory and Suffolk County Council identified a specific need related to meeting the acute mental health needs of children and young people in, or on the edge of care. It is this need which the innovation seeks to address.

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[2] Source: The Priory Group and Suffolk County Council's original proposal to the DfE Social Innovation Fund. The original source of these statements is not clear from this document.
[3] Source: Belhaven Statement of Purpose, July 2015.

The Priory Group and Suffolk County Council's original proposal to the DfE Social Innovation Fund outlined their perceived context and need for the innovative service model[2]. This is presented below, alongside external research:

- rates of emotional and mental health problems amongst looked after children are around 60%, rising to 72% of those in residential care. This compares to one in 10 children aged between 5 and 16 years in the general population with a clinically diagnosable mental health problem[4]

- many of these young people will go on to suffer from severe mental ill health, with looked after children comprising 12% of the children and adolescents in tier 4 inpatient services in England and Wales; 9% of the general youth population who are using CAMHS, and 0.5% of the general population[5]

- poor mental health is also associated with poor educational attainment, a greater risk of experiencing homelessness, and poor employment outcomes[6]

In this context, this innovation aimed to break the cycle of repeat admissions to CAMHS inpatient services; reduce first-time admissions to CAMHS inpatient services, and reduce the likelihood of the young person entering care following admission to CAMHS inpatient services.

Existing research relating to this innovation

Research into alternatives to inpatient mental health services for children and young people in the UK[7] found that existing alternatives to inpatient admission, such as multi-systemic therapy (MST) at home - a specialist outpatient service, intensive home treatment and intensive home-based crisis intervention - showed little notable improvement in patient and service user outcomes as a result of these service interventions. Whilst those receiving MST showed some improvements in terms of externalising symptoms and educational attendance, these were not sustained, and, in randomised controlled trials, the other services showed no differences.

This suggests that existing CAMHS services which can present alternatives to inpatient admission are not effective in improving outcomes for young people, and so are unlikely

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[4] Children and Young People's Health Outcomes Forum (2012). *Report of the Children and Young People's Health Outcomes Forum – Mental Health Sub-group.*
[5] Richardson, J. (2002). The Mental Health of Looked-After Children. *The Mental Health Foundation.*
[6] Bazalgette, L., Rahilly, T., & Trevelyan, G. (2015). Achieving emotional wellbeing for looked after children: A whole system approach. *NSPCC.*
[7] Shepperd, S., Doll, H., Gowers, S., James, A., Fazel, M., Fitzpatrick, R., & Pollock, J. (2009). Alternatives to inpatient mental health care for children and young people. *The Cochrane Library*.

to prevent admission or re-admission to inpatient services. However, this innovation differs from these existing alternatives as it offers a residential setting, allowing for intensive therapeutic support in a safe and controlled environment, whilst allowing young people to continue contact with family, peers and wider professionals as appropriate.

There is evidence to suggest that young people with complex behaviours - including mental health needs, challenging behaviours, drug and alcohol use and poor educational achievement - benefit from settings which provide 24/7 care, with the stability offered by this, and the relationships formed between professionals and young people, being the key agents of change[8]. It is this stability which the service at Belhaven aimed to foster through enabling young people to maintain existing local relationships, whilst also providing a constant and stable setting within which they were able to receive care and support.

[8] Snodgrass, C. & Preston, J. (2015). 'Psychological Practice in Secure Settings'. In Rogers, A., Harvey, J. & Law, H. (eds.) (2015). Young People in Forensic Mental Health Settings. *Palgrave Macmillan.*

Overview of the evaluation

Evaluation questions

The evaluation questions included:

- what impact is the new service having on service user outcomes?
- what impact is the new service having on service user outcomes, over and above similar service approaches?
- what is the most appropriate approach to demonstrating impact and value for money in the medium and long term, meaning after this evaluation is complete?
- the views of young people and families or carers concerning the following questions:
    - what is the quality of the new service compared to existing or similar services?
    - how could the new service be improved in the future?
- the views of project stakeholders concerning the following questions:
    - what has been the impact of the new service on the wider system?
    - have the aims and objectives of the service been achieved?
    - what have been the challenges to setting the service up and how have these been overcome?
    - what has been the impact of the service on young people and families or carers?
    - how could the service improve and develop in the future?

Methodology

The methodology for this evaluation was agreed in advance with the Priory Group, Suffolk County Council, the Rees Centre at the University of Oxford and the Department for Education. All research tools were agreed with the Priory Group in advance of use in the field. The following methodologies were used to conduct the evaluation of the service at Belhaven:

- review of documentation, monitoring and finance data. This included reviewing the original proposal, strategic documentation, operational information,

organisational structures, meeting notes, and finance data for the project

- conducting an impact assessment tool questionnaires at 2 points in time with young people receiving the new service. Impact tool questionnaires were administered to young people receiving the new service, and practitioners working with these young people. Questionnaire tools were administered at T1 (on entry to the service at Belhaven) and T2 (on exit from the service at Belhaven). It was originally intended to complete T3 tools 3 months following exit from the service. However, due to the timescales of young people leaving Belhaven, meaning that no T3 tools could be administered as part of this evaluation. Young people who had not exited the service by October 2016 also completed a T2 tool to allow for examination of any change over their time at the service. Only one young person exited Belhaven during the period of the evaluation. Table 1 provides a timeline of impact tool completion across the evaluation period. The lengths of stay for those who completed, or partially completed, a T2 tool ranged from 32 weeks to 50 weeks. These tools included both bespoke and validated measures in relation to the intended impact and outcomes of the innovation. Details of the number of impact tools completed can be found in Appendix 1: impact tool case studies. As well as being developed to provide evidence for the independent evaluation, these tools were designed so that they could continue to be administered by Priory staff to monitor the effectiveness of the innovation on an ongoing basis. Details of the young people receiving the service are presented in Figure 1 below

Figure 1: Profile of young people

Characteristic	Details of the young people
Age at point of admission	Mean: 15 years old. Range: 13 to 16 years old.
Length of stay[9]	Mean: 33 weeks. Range: 2 weeks to 50 weeks.
Gender	All female
Total number of young people	**5**

[9] For those young people who had not exited the service during the evaluation period, length of stay refers to the time from their entry to the service to their completion of a T2 impact tool.

Table 1: Timeline of impact tool completion

Young person	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
A				T1							T2		
B				T1									T2
C	T1												T2
D	T1												T2
E											T1		

- in-depth, retrospective interviews with young people receiving the new service. Qualitative data was collected through retrospective face-to-face interviews with young people who received the new service at Belhaven. Young people who had not exited the service by August 2016 also participated in face-to-face interviews. As a result, a total of 5 young people participated in retrospective interviews, that is all the young people who had been supported by Belhaven during the pilot

- in-depth retrospective interviews with family members or carers. Additional qualitative data was collected through retrospective interviews with family members or carers of the young people who received the new service. In total, interviews were conducted with a family member or carer for 2 young people. Interviews with family members or carers were not conducted for the remaining young people who received the service, as Belhaven colleagues reported to us that that it was deemed inappropriate, due to the young people being subject to full care orders

- in-depth interviews with key project stakeholders at 2 points in time. Telephone interviews were conducted with key project stakeholders in February 2016, and August and September 2016. This was due to changes in the original methodology, outlined below. A total of 14 stakeholders were identified for interview by Priory Group colleagues, and their details provided to us. Stakeholders included Belhaven managers and practitioners, and strategic managers and senior clinicians from the Priory Group, Suffolk County Council, and Norfolk and Suffolk NHS Foundation Trust. Email invitations and reminder emails were sent out, and reminder telephone calls were made. In February 2016, 6

stakeholders were interviewed. In August and September 2016, these same 6 stakeholders were interviewed a second time, along with 3 additional stakeholders. In total, 15 telephone interviews were conducted across the 2 points in time. An overview of these participants is given in Table 2 below

Table 2: Profile of stakeholder interviewees

Organisation	Interviewees – Feb 2016	Interviewees – Aug/Sept 2016
Priory Group	4	7
Suffolk County Council	1	1
Norfolk & Suffolk Partnership NHS Foundation Trust	1	1
Total	**6**	**9**

- in-depth interviews with wider professionals. Telephone interviews were conducted in September 2016 with wider professionals with specific knowledge and experience relating to an individual young person who received the service. These included social workers, independent reviewing officers, registered mental health nurses and care coordinators. Five wider professionals were identified for interview by the Priory – one for each young person who received the service – and their details provided to us. In total, 3 telephone interviews were conducted with an independent reviewing officer, a registered mental health nurse and a care coordinator. The remaining 2 wider professionals declined to take part in the interviews as they were unavailable during the evaluation period.

Changes to the methodology

Due to longer than anticipated lengths of stay, fewer young people passed through the service at Belhaven than the 20 that were first estimated. As a result, it was agreed that the evaluation timescale would be extended to ensure that the evaluation could include some young people who had left the service. Because of these delays, it was not possible to complete T3 impact tools as intended for any of the young people, as by October 2016 less than 3 months had passed since the first young person had left the service.

As a result of this extension, and the lower than expected number of young people involved with the service, evaluation capacity was used to conduct further interviews with key project stakeholders at a second point in time. As well as allowing us to include a greater number of stakeholders' views in the evaluation, this also enabled the evaluation to assess any change by comparing interview responses between the 2 points in time.

In addition, in order to supplement the data from impact tools and interviews with young people and family members, it was agreed that, for each young person who had accessed the service at Belhaven, an interview would be conducted with a professional not directly involved with the service, but with specific knowledge and experience relating to the individual young person. Five wider stakeholders were contacted, and in total 3 interviews were conducted.

The original evaluation methodology also included provision for a comparator group, consisting of young people with similar characteristics to those accessing the service at Belhaven, drawn from the Priory Group's other services across England. However, it was decided during May 2016 not to proceed with this comparator group, because of difficulties in accessing data for a comparator group, and the realisation that only a small number of young people were going to receive support from Belhaven during the evaluation period – meaning that findings would not be statistically significant due to the small numbers involved. It was decided that the evaluation should take a more qualitative approach and seek to engage with more project stakeholders and wider professionals working with each of the young people instead (see paragraphs above). However, taking a longitudinal evaluation approach which includes a comparator or control group is something that should be considered as part of the evaluation of Belhaven (and similar services) in the future.

Key findings

This section provides key findings of the process evaluation of the implementation of the innovation, as well as an evaluation of the impact it is having on outcomes to date. The following findings should be taken as an initial indication of progress against intended impacts and outcomes, and further evaluation should take place to continue to develop the evidence base for the innovation. In addition, the small number of young people who have accessed the service (5) mean that changes cannot be statistically tested for significance and as such findings are not generalisable. Also, not having a comparator group means that it is challenging to attribute any changes in outcomes directly to the innovation over and above any other factors which may be responsible for changes.

How has the innovation been implemented?

In addition to its impact, the evaluation also explored the process of the innovation's implementation. The following findings are based on evidence from interviews with key project stakeholders, wider professionals, young people, and parents and carers, and our review of strategic documentation relating to the programme and its implementation.

Rationale, aims and need for the service

Stakeholders were clear that the service is aiming to both improve outcomes for young people with mental health needs, and also to reduce pressure on existing services through a reduction in future admissions to health and social care and/or CAMHS services. There was a consensus that there is a significant need for the service being offered, as at present tier 4 CAMHS services (where these young people would otherwise be being admitted to) are too geographically spread out and the intensity of the support they provide are not appropriate for young people with the level of need being targeted by the service at Belhaven.

Target audience of the service

The service was originally intended to receive referrals of young people in order to prevent an episode of hospitalisation, that is from a family or care setting, as opposed to referrals of young people already in a tier 4 inpatient service. However, impact tool data and qualitative interview data suggests that of the 5 young people who have accessed Belhaven, 2 have been referred directly from a secure hospital unit. This has implications in terms of the fidelity of the model in terms of delivering its intended outcomes, that is, if Belhaven is not working with its original intended target audience, what are the implications in terms of how realistically it can deliver against its intended outcomes?

Challenges faced in establishing the service

It was reported that getting all partners involved and committed to the service was a challenge initially, and it was suggested that this initial reluctance was due to anxieties regarding the purpose of the service: clinical partners were reported to be concerned that the service would be used as a care resource, whilst care partners were concerned that the clinical elements of the service would lead to the service being used to support young people who would be better suited to a more intensive tier 4 service in a hospital setting. However, all stakeholders agreed that all partners are now fully committed to the service, and it was suggested that effective communication regarding the aims and objectives of the service achieved this.

The service is dual registered, and the opening of the service was delayed because of the time taken by Ofsted to register the service partly due to the innovative nature of the model in contrast to the Care Quality Commission, where there was no delay to registration. This delayed the start of the service by approximately one month.

Challenges regarding the recruitment of appropriate staff to posts at Belhaven were also reported. However, it was suggested that this was mainly due to wider issues with the nursing employment market.

Operation of the service

Stakeholders were clear that the operation of the service differed from that of existing CAMHS services in the level of therapeutic support being provided outside of a hospital setting. However, there were clear issues in relation to discharging young people from the service, and between October 2015, when the service became operational, and September 2016, only one young person had been discharged.

Stakeholders reported that the main reasons for the increased length of stay were a lack of appropriate discharge destinations, and a lack of joint working between professionals in the discharge planning process.

It was reported that the discharge planning process had become better integrated into the ongoing assessment processes in place at Belhaven as the service has developed, and stakeholders are now confident that, in future, young people who are admitted will have fewer delays in discharge and a shorter length of stay.

However, there are ongoing concerns amongst stakeholders and wider professionals that there is a lack of appropriate local long-term placements for the young people attending the service. It was reported that this was leading to delays in discharging young people from Belhaven. In particular, it was reported that there was a need for long-term placement options with specific support for young people with mental health issues, and that these were not currently available in Suffolk. Specifically, it was suggested there was

a need for more specialist foster care placements with relevant mental health training, and for supported housing services with mental health support.

How far has the innovation achieved its intended outcomes?

We address each of the evaluation questions below:

What impact is the new service having on service user outcomes?

Fewer episodes of hospitalisation

Stakeholders were confident that the service led to fewer episodes of hospitalisation for the young people: for example, one stated that "it has reduced tier 4 admissions without a doubt". Stakeholders also reported anecdotal evidence of several situations where the service appears to have avoided a hospital admission: for example, in the case of a young person who had recently had 2 emergency hospital admissions prior to arriving at Belhaven, and who, since admission to the service, has had no further admissions. In another case, a stakeholder reported that an acute hospital admission had been avoided when a young person was taken to A&E following an episode of self-harm, and the A&E team advised that they were happy to discharge the child to Belhaven, specifically because there were nurses on duty in the care team at the service.

There was also evidence from stakeholder interviews that in one case a young person's admission to Belhaven prevented an otherwise inappropriate admission to a CAMHS inpatient service. However, in another case, a young person was admitted to a CAMHS inpatient service 2 weeks following admission to Belhaven. Stakeholders reported that, in this case, the young person's needs were not appropriate to the level of care provided at Belhaven, meaning the young person required a higher level of support than Belhaven could provide[10].

Less risk of breakdown of care

Stakeholders reported that, based on their knowledge of the individual young people, their needs, and any ongoing discharge planning that may already have taken place, young people accessing the service are likely to be discharged into a range of care placements and living arrangements, including specialist foster care placements, and supported housing services. However, at the time of the evaluation only one young person had been discharged, moving on to a semi-independent supported housing

[10] Impact tool data relating to episodes of hospitalisation was limited, with T1 and T2 data only available for 2 young people due to incomplete impact tools. This showed that, in one case, a young person had experienced one episode of hospitalisation in the 12 months prior to admission, and none following admission. In the other case for which data was available, no episodes were reported at either T1 or T2.

setting. Therefore, it is not possible to assess the impact of the innovation on the risk of a breakdown of care arrangements for a young person.

Impact tool data showed that in one case the young person moved from living with extended family at T1 to living in a semi-independent unit at T2, which the practitioner described as a positive step, giving the young person a chance to make choices for themselves. Three of the other young people remained at Belhaven at the time of evaluation, whilst another young person was admitted to an inpatient ward one month following their arrival at Belhaven.

Less risk of breakdown of educational placements

Qualitative data from interviews with young people, family members, stakeholders and wider professionals suggests that the innovation had a positive impact on reducing young people's risk of breakdown of educational placements in some cases. For example, one professional interviewed reported that admission to Belhaven meant that a young person "was still able to go to school and do GCSEs", whilst in another case a young person was effectively supported in continuing to attend the same school, with the service arranging for transport.

Qualitative feedback provided by practitioners for 3 cases revealed positive outcomes regarding sustained educational placements at T2. In one case, the young person had missed large parts of their education before Belhaven, but, whilst at Belhaven, they had returned to registered school part-time, taken their GCSEs, and, following this, had started college.

Less risk of breakdown of family and social support

Three young people interviewed reported positive improvements in relationships with family and friends. For example, one young person reported that they had been able to maintain friendships at school because Belhaven supported them in continuing to attend the same school. In another case, a young person reported that being able to have frequent contact with family was "a big benefit of Belhaven".

Qualitative data from interviews with stakeholders echoed this, with several stakeholders reporting that the service was having a positive impact on family relationships. For example, one stakeholder reported that the service "gives families a better insight into their child's needs" by allowing frequent contact, compared to more traditional tier 4 CAMHS services. However, this does not necessarily lead to the young person being more likely to remain being cared for in the family setting upon discharge, highlighting that family members "get to think things through differently, recognising that perhaps the family can't meet their child's needs on their own".

Impact tool data relating to child-parent relationships shows emerging positive evidence of improved closeness and reduction in conflicts in the 2 cases where data was available.

Improved health outcomes

Young people supported at Belhaven reported positive improvements in mental and emotional health and wellbeing during their time at Belhaven. One young person reported that they had made some progress in improving their mental health, and that this was "better than I would have made in hospital". Another young person reported positive impacts in terms of their mental health and wellbeing:

> *"*Over a long period of time, I've started to feel safe, started to trust, not feel scared, not feel threatened, feel protected here [at Belhaven]"

These positive impacts were also reflected in interviews with stakeholders, family members and wider professionals. Furthermore, data collected by the service using the Child Global Assessment Scale (CGAS)[11] showed continuing improvement in mental health measures for all of the 4 young people for whom data was available. However, it should also be noted that stakeholders report that in one case, the young person showed no improvement in mental health and wellbeing, and was subsequently admitted to a tier 4 CAMHS service within one month of arriving at Belhaven. It was reported that this was due to inaccurate records and risk assessment being provided to the service in the referral from the local authority, and that once the young person arrived at the service, they were reassessed and it was identified that they were unsuitable for Belhaven. A request for readmission to a tier 4 service was then made.

In addition to positive mental health and wellbeing outcomes, one young person reported stopping substance misuse following admission to the service. A stakeholder also reported that one young person had significantly fewer episodes of self-harm following admission to the service.

The self-reported Strengths and Difficulties Questionnaire (SDQ) was used to assess changes in total difficulties (including emotional problems, conduct problems, hyperactivity and peer problems) and prosocial scores. There was little, or negative, change for the 2 cases where data was available for total difficulties, and 3 cases where data was available for prosocial scores data. These results may differ from those of the CGAS as the SDQ is self-reported by the young people, whereas the CGAS is completed by mental health practitioners.

However, qualitative feedback from a practitioner showed that, in one case, the young person was able to manage their low mood in a positive manner whilst at Belhaven,

[11] This data is displayed in Appendix 2: Child Global Assessment Scale (CGAS) data.

through mindfulness sessions and talking through issues with staff on a daily basis. Furthermore, despite initial concerns from the young person regarding reducing their medication, their dosage was reported to have reduced by almost 75% following admission to Belhaven. There was also positive evidence from the Ohio Brief Resilience Scale (BRS) (which formed part of the impact tool questionnaire), of increased long-term resilience in the 2 cases out of 5 for which T1 and T2 data was available.

Improved outcomes for families and communities

Parents/carers of 2 young people reported improved relationships between them and their children. However, it is important to note that this data only represents 2 of the 5 young people who had accessed the service. Family member interviews were deemed by Priory Group colleagues not to be appropriate for the parents or carers of the other 3 young people.

Value for money for the taxpayer

Reduced cost of CAMHS, inpatient and care placements

As outlined above, there is some evidence to suggest that the service at Belhaven was contributing to reducing inpatient admissions for young people. For example, in one case, a young person was admitted to Belhaven directly from a tier 4 CAMHS inpatient ward, and their discharge from the inpatient ward would not have been possible without the service.

shows programme data relating to the cost per young person per day of the service at Belhaven, compared with that of a CAMHS tier 4 service. This has been calculated using the total cost of the service for the first 12 months of operation excluding NHS funded activity (£986,651), and dividing this total cost across the 4 beds, to give a cost per person.

It shows that, based on the original length of stay (LoS) of 90 days that had been anticipated by the innovation, the cost of the service represented a potential £11,176 saving, compared to the cost of a CAMHS tier 4 admission, based on the average length of stay of 112 days.

However, when the innovation's revised LoS of between 10 and 26 weeks was applied to these costs, a range of potential cost implications emerged, ranging from a £24,696 saving to a £51,016 additional cost for the service at Belhaven when compared to the average CAMHS tier 4 service admission.

This suggests that the service at Belhaven will only prove to be less costly than a CAMHS tier 4 admission when the LoS is a maximum of 106 days, or 15 weeks.

In addition, Table 3 shows basic unit costs of Belhaven's cost per person per day based on full occupancy, and on the occupancy observed during the evaluation period. These have been calculated by applying the total cost of the service for the first 12 months of operation to the number of occupied bed days, based both on full occupancy and on occupancy observed during the evaluation period.

Table 3: Placement cost data for the service at Belhaven and CAMHS tier 4 service

Service at Belhaven	Cost	CAMHS tier 4 service	Cost
Cost per person per day – assuming full occupancy	£676	Cost per person per day	£643
Cost per person per day – based on occupancy during evaluation period	£849	-	-
Cost per placement – planned LoS of 90 days	£60,840	Cost per placement – average of LoS 112	£72,016
Cost per placement – revised LoS of 70 - 182 days	£47,320 - £123,032	-	-

Source: Data provided to the evaluation team by the Priory Group

However, this calculation does not take into account any potential wider savings that may be made by the service at Belhaven - for example, by reducing the chance of further hospital admissions - and improving educational attendance and attainment. In addition, the calculated cost per day of the service is based on the running costs of the pilot, which may not be representative of the running cost of the mature service. The scale of the pilot (4 beds over a period of 12 months) was based on the funding and operational constraints of the pilot, and it was reported by stakeholders that the optimal size of the service is 5 to 6 places, which is what the service is developing towards.

Therefore, it is important that further evaluation be conducted to assess the impact of the service following discharge from Belhaven - for example, at 3 and 12 months following discharge - in order to assess whether cost savings in these areas may have been made.

Reduced waste from failed placements

Stakeholders reported that one of the biggest strengths of the service at Belhaven was that it provided a safe environment where young people experiencing a mental health crisis could be assessed, and appropriate support and placements identified. As a result of this, several stakeholders suggested that the service was increasing the appropriateness of placements following discharge.

However, as only one young person was discharged during the course of the evaluation, no evidence is available on whether the innovation was reducing waste from failed placements.

What impact is the service having compared to similar services?

Qualitative data from interviews with young people, parents and carers, stakeholders and other professionals has been used to assess what the impact of the service was compared to similar CAMHS services.

The views of young people and families or carers concerning the quality of the new service compared to existing or similar services

Young people and parents or carers reported that they viewed the quality of the service at Belhaven as higher than that of existing CAMHS services which they previously had experienced. One young person reported that "Belhaven is great in comparison [with their experience of other mental health services], it's not stressful, it's a homely environment", whilst another reported that Belhaven "helps my recovery all day every day, not just through meds and treatment sessions". In addition, one parent/carer reported that Belhaven was "really good, much better than other CAMHS", and another parent/carer stated that Belhaven was "at least 100 times better than other services". However, this is based on the views of parents or carers of 2 young people, and so it is not possible to draw generalisable conclusions from this.

The views of project stakeholders concerning the impact of the new service on the wider system

The majority of stakeholders reported that it was too early in the life of the service and that too few young people had been through the service to assess its impact on the wider system. However, some stakeholders did suggest that the service was likely to have reduced demand on CAMHS tier 4 services, as well as reducing Accident and Emergency attendance due to reducing incidents of self-harm.

The views of project stakeholders concerning the impact of the new service on young people, and families and carers

Project stakeholders perceived the service as having a positive impact on the young people at Belhaven, in terms of improved mental health and wellbeing; improved education attendance, and, in some cases, improved family relationships.

However, it is important to note that these impacts were not in evidence for all young people, with one young person being admitted to a CAMHS inpatient unit following a one month stay at Belhaven, and stakeholders reporting no improvements in family relationships between young people and their parents or carers in 2 other cases.

Lessons learned about the barriers to this innovation

Key barriers to the establishment and effectiveness of the innovation identified by the evaluation were:

- delays in establishing the service due to delays with Ofsted registration, due to the novelty of the model

- high reported levels of social worker turnover within the local authority, leading to delays in discharge planning processes. It was reported by stakeholders that this resulted in frequently having to establish new relationships between the service at Belhaven and young people's social workers, and additional time being needed for new social workers to develop an understanding of the needs of the young people

- receiving more referrals of young people in tier 4 inpatient settings, meaning not from family settings as initially planned. This has resulted in young people at Belhaven having higher levels of support needs than initially planned, and as a result requiring specialist discharge destinations as opposed to being discharged back to their original family or care setting

- a lack of sufficient, appropriate discharge destinations for young people with mental health needs in Suffolk

- a lack of joint working in the discharge planning process, and failure to begin the discharge planning process as soon as a young person is referred. Stakeholders reported that the process of identifying and securing appropriate placements for young people following discharge from Belhaven did not begin until several weeks after a young person arrived at Belhaven. Due to the lack of sufficient, appropriate discharge destinations for young people with the level of mental health needs experienced by young people in Belhaven in Suffolk, more time was needed to identify and secure appropriate placements, and as a result it was suggested that the discharge planning process start as soon as a young person is referred, as opposed to waiting until after they have arrived at Belhaven

Lessons learned about the facilitators to this innovation

Despite the barriers outlined above, the innovation was able to be established as an operational model. This was facilitated by:

- a strong, competent, multi-disciplinary staff team, including experienced care staff and mental health nurses working alongside each other to deliver the service. Whilst some initial frictions were reported, in terms of differing working practices, qualitative data shows stakeholders reported positive working relationships have developed with shared learning between different professionals

- strong communication with families, including regular contact from the service's registered manager. This was reported by both parents or carers interviewed as a strong element of the service, and an improvement on the communication offered

by existing CAMHS services that they had experienced

Suggestions for improvement

Overall, qualitative interview data suggests that young people, and parents and carers were satisfied with the service. However, one young person suggested that staff could do more to ensure that all young people are being observed by a member of staff at all times, reporting that, for example, when a young person is being observed during the night it can appear that the other young people are not receiving the same level of support and observation. Whilst there is no suggestion that supervision or observation was inappropriately or unsafely staffed, it was reported that, at times when staffing demand may be higher due to elevated observation needs of an individual, additional staffing may be of benefit in order to ensure peace of mind for the remaining young people.

Several stakeholders and other professionals suggested that a possible improvement to the service would be to offer outreach family therapy support, both to the families of young people admitted to Belhaven, but also to families with children deemed on the edge of care where the young person has mental ill health. It was suggested that this may improve family relationships for those admitted to the service, reducing the likelihood of need for a potentially more costly care placement following discharge, and also reduce the chance of care breakdowns for young people with mental ill health who have not been admitted to Belhaven, potentially avoiding both a CAMHS inpatient admission and admission to the residential service at Belhaven.

Limitations of the evaluation and future evaluation

Limitations of the evaluation and key findings

The original methodology for this evaluation was designed on the basis of approximately 20 young people passing through the service at Belhaven over the 12 month evaluation period. However, as detailed above, due to the delays in discharging young people from the service, over the course of the evaluation period only 5 young people were admitted to the service at Belhaven, 2 of whom were discharged. As a result, the evaluation is based on limited data.

Additionally, whilst the evaluation had initially intended to capture evidence relating to sustainability of any impacts through a T3 impact tool completed 3 months following discharge from the service, this was not possible due to these delays, and so no evidence is available regarding the sustainability of the innovation's impacts.

Furthermore, the original service model included provision for a family therapist. However, this role has not yet been filled. It is possible that the service, when operating as fully intended, that is, with a family therapist, may have different impacts to those identified by this evaluation.

The original evaluation methodology also included provision for a comparator group, which would have enabled comparison between young people accessing the service at Belhaven and young people with similar characteristics elsewhere in England. This was intended to enable greater attribution of any impacts to the service at Belhaven as opposed to other services or factors. However, as discussed earlier in this report, it was decided not to involve a comparator group, and, as a result, the evaluation is limited in its ability to attribute impact to the service.

Completed practitioner and young person impact tools were expected for all 5 young people at T1 and T2. However, whilst all young person impact tools were received at T1, only 3 completed practitioner tools were received for this period. Whilst the reasons for this are not known, it may be that practitioners were not fully engaged with the evaluation activity at the start of the service. At T2, 4 young person and 4 practitioner impact tools were received. However, in most cases some answers were left incomplete or multiple answers were provided, meaning that impact and outcome measures could not accurately be used. This suggests that the impact tools and evaluation approach are still in the process of being embedded within the service, which has limited the data available for this evaluation.

Capacity and plans for future evaluation and the sustainability of the evaluation

The innovation is likely to be sustained, and it was suggested by senior stakeholders that evaluation of the innovation will be ongoing, utilising data that is already being collected by the service relating to the young people, such as the Child Global Assessment Scale and the Adolescent Wellbeing Tool. During the evaluation period, some impact tools were either not completed, or only partially completed. Accordingly, it is recommended that Belhaven staff be made aware of the importance of evaluation activity and the role they play in gathering data; and for the completion of this data to be embedded in the admission and discharge processes for young people.

However, it is recommended that in addition to evaluation of young people's outcomes during their time at Belhaven, follow-up evaluation work should be conducted in order to examine the sustainability of any impacts the service may be having. It is recommended that this could be done using comparable impact measurement tools - such as those designed for this evaluation - on entry to the service, on exit from the service, and at points 3 and 12 months following exit from the service. This will ensure that the innovation is able to evidence any lasting impacts on the young people accessing the service.

Implications and Recommendations for Policy and Practice

Evaluative evidence for capacity and sustainability of the innovation

Qualitative data shows evidence that the innovation is likely to be sustained, with Suffolk County Council likely to spot-purchase beds in the service when required, and vacancies being offered to other local authorities as well. In order to ensure young people are able to benefit from the advantages of continuity of existing relationships with services, it is likely that local authorities neighbouring Suffolk would most benefit from this.

Conditions necessary for this innovation to be embedded

It was reported by stakeholders that in order for the innovation to become embedded within the health and social care system in Suffolk, it must continue to work towards ensuring discharge planning processes are commenced on a young person's arrival at Belhaven, and that staff and wider professionals work closely to ensure that planned discharge dates are adhered to.

In order for this to happen, it is recommended that the service at Belhaven ensures social workers are engaged from before a young person's admission to the service, and are clear regarding the expected length of stay, with a provisional discharge date be put in place at the point of admission.

It will also be necessary for the service to continue evaluation in order to ensure it is able to evidence any impacts it may be achieving, and that it does so in a way which assesses the sustainability of these impacts.

Consideration of future development of the innovation

Based on the findings of this evaluation, the following recommendations have been made, to be taken into consideration for the future development of the innovation:

- ensure strong communication regarding length of stay and establishment of provisional discharge dates at the point of admission. The primary limitations of the service to date have been extended lengths of stay, and issues surrounding ensuring appropriate discharges for the young people admitted to the service. It is recommended that staff ensure that the service effectively communicates a specified length of stay to social workers and other professionals who may be referring young people. Once a young person is to be admitted, it is

recommended that a provisional discharge date, based on this specified length of stay, is established so that all professionals involved can work together to put in place appropriate discharge plans for the young person

- continue to focus on receiving referrals of young people from a family or foster carer setting. The original service model intended to work with young people before they required hospitalisation, receiving referrals from a family or foster carer setting. However, 2 of the young people admitted to the service have arrived directly from hospital inpatient services. Whilst it was always intended that the service would accept admissions from young people being discharged from hospital, this has perhaps represented a higher proportion of total referrals than originally anticipated. As a result, their levels of need were higher than the service had originally intended to work with, and therefore the young people have not been suitable to be discharged into a family setting. One of these young people required re-admission to a tier 4 inpatient service, whilst the other was assessed to have a higher level of need than appropriate for a specialist foster care placement, and their discharge has been delayed whilst a suitable alternative discharge setting is identified and secured

- secure a dedicated family therapist to work with young people both at Belhaven, and also as an outreach service. Whilst the original service model included provision for a family therapist, this role has not yet been filled. It is recommended that a family therapist be secured for the service, in order to offer direct support to young people at Belhaven, and also to support outreach work with families

- explore possibilities for the establishment of a family therapy outreach service. As outlined above, it is recommended that possibilities for the establishment of a family therapy outreach service be explored. This would offer support both to the families of young people admitted to Belhaven, and also to families with children deemed on the edge of care, where the young person has mental ill health. It is suggested that this may improve family relationships for those admitted to the service, reducing the likelihood of need for a potentially more costly care placement following discharge, and also reduce the chance of care breakdowns for young people with mental ill health who have not been admitted to Belhaven, potentially avoiding both a CAMHS impatient admission and admission to the residential service

- ensure staffing levels are sufficient to allow for appropriate levels of observation at all times, including when individual young people require particularly high levels of one-to-one observation. It was reported by one young person that, at times, due to an individual young person requiring one-to-one observation, the other young people at the service may feel there is insufficient supervision for the remaining residents. Whilst there is no suggestion that supervision or observation has been

inappropriately or unsafely staffed, it is recommended that, at times when staffing demand may be higher due to the elevated observation needs of an individual, additional staffing be secured in order to ensure peace of mind for the remaining young people

- steps be taken to increase the provision of appropriate discharge destinations. Whilst the lack of sufficient appropriate discharge destinations offering residential care with an element of specialist mental health support is out of the direct control of the service at Belhaven, it is suggested that the evidence gathered by this evaluation, and elsewhere in the service, is used to make the case for an increase in provision of such placements in the Suffolk area

- embed ongoing evaluation to demonstrate impacts and sustainability. Due to the various limitations of this evaluation, as outlined in the limitation of the evaluation section, it has not been possible to draw solid conclusions regarding the impact of the innovation or to assess the sustainability of any impacts. As a result, it is recommended that the service embed ongoing evaluation activities to demonstrate impacts and sustainability over time. It is recommended that this could be done using comparable impact measurement tools, such as those designed for this evaluation, on entry to the service, on exit from the service, and at a point in time 3 months following exit from the service

It is important to note that the Belhaven service has continued to operate in accordance with the pilot model following the end of the pilot. NHS and Local Authority commissioners in Suffolk continue to place children on an individual placement basis, and the pilot project steering committee, comprising Priory, Local Authority and NHS stakeholders, continues to oversee the service, with particular reference to further developing the assessment and referral process, and improving discharge planning.

Appendix 1: impact tool case studies

The following table outlines the symbols used to indicate whether there has been a change in situation and outcomes for the young people between time periods where data is available.

Symbol	Meaning
✓	There is evidence of improvement in the situation or outcomes between time periods available.
•	There is evidence that the situation or outcomes has remained the same between time periods available.
X	There is evidence of worsening in the situation or outcomes between time periods available.

Table 4 gives details of each outcome measure included in the impact tools:

Table 4: Description of impact and outcome measures

Impact and outcome measures	Details
SDQ scores	**Strengths and Difficulties Questionnaire scores**. This validated scale returns scores for Total difficulties, Emotional problems, Conduct problems, Hyperactivity, Peer problems and Prosocial. Each score is categorised as Normal, Borderline or Abnormal, with higher scores indicating less positive outcomes (except in the case of the Prosocial score, where a higher score indicates a more positive outcome). These bandings are based on a population-based UK survey, attempting to choose cut off points such that 80% of adolescents scored Normal, 10% scored Borderline and 10% Abnormal.
BRS scores	**Brief Resilience Scale scores**. This validated scale returns a score between 1 and 6, with higher scores indicating higher levels of resilience.
C-PRS scores	**Child-Parent Relationship Scale** scores. This modified scale returns 2 scores, Conflict and Closeness. Conflict score ranges from 3 to 15, with higher scores indicating a less positive outcome; and the Closeness score ranges from 9 to 45, with higher scores indicating a more positive outcome.
Care status	The impact tools collected data from practitioners relating to the care status of the young person at the time of completion at T1, and on exit from the project (T2).
Living arrangements	The impact tools collected data on the living arrangements of the young person prior to their admission at Belhaven (T1) and on exit from the project (T2).
Episodes of hospitalisation	The impact tools collected data from practitioners regarding whether the young person had any episodes of hospitalisation in the 12 months preceding T1, and over the course of their residential stay (T2).
Self-harm	The impact tools collected data from practitioners regarding whether the young person had any self-harm issues in the 12 months preceding T1, and over the course of their residential stay (T2).

Impact and outcome measures	Details
Mental health	The impact tools collected data from practitioners regarding whether the young person had any mental health diagnoses in the previous 12 months to T1.
Substance misuse	The impact tools collected data from practitioners regarding whether the young person had any substance misuse issues in the previous 12 months to T1, and had any episodes of substance misuse over course of residential stay (T2).
NEET	The impact tools collected data from practitioners regarding whether the young person had not been in education, employment or training (NEET) in the 12 months preceding T1, and over the course of their residential stay (T2).
Criminal offences	The impact tools collected data from practitioners regarding the whether the young person had been convicted of committing a criminal offence in the 12 months preceding T1, and over the course of their residential stay (T2).

The case studies below relate to the 5 young people who received the new service.

Table 5: Case Study A

Impact and outcome measure	Data available	Change	Details
Child/YP impact tool data			
SDQ scores	T1, T2 (incomplete)	-	Incomplete data at T2 for total difficulties. However, where data was available emotional problems improved from Abnormal to Normal.
	T1, T2	X	Prosocial scores worsened from Normal to Borderline level.
BRS scores	T1, T2 (incomplete)	-	Incomplete data at T2. However, score at T1 was very low (1.5 out of 5).
C-PRS scores	T1, T2	✓	Closeness score increased from 16 to 20 (out of 35).
	T1, T2	✓	Conflicts score decreased from 13 to 10 (out of 15).
Practitioner impact tool data			
Care status	T1, T2	●	Cared for by LA (section 20) at both T1 and T2.

Impact and outcome measure	Data available	Change	Details
Living arrangements	T1, T2	-	Went from living with extended family at T1[12], to living in a residential care home at T2[13].
Episodes of hospitalisation	T1, T2	✓	One episode at T1, and none at T2.
Self-harm	T1, T2	•	Self-harm issues reported at T1 and T2[14].
Mental health	T1	-	No mental health diagnoses reported.
Substance misuse	T1, T2	✓	Had reported 2 episodes of substance misuse at T1, but not at T2.
NEET	T1, T2	X	Was not reported as NEET at T1, but was at T2[15].
Criminal offences	T1, T2	•	Had not been convicted of committing a criminal offence at T1 or T2.

[12] And had not had any episodes in residential care in the previous 12 months.
[13] At T2, practitioner reported in section regarding relevant information that young person had moved to semi-independent unit.
[14] However, in following comment box, severe self-harm issues were reported at T1, and it was reported that self-harm issues had reduced at T2.
[15] However, in following comment box at T, a practitioner commented that the child or young person had missed large parts of education before going to Belhaven, and at T2 highlighted that, whilst at Belhaven, it was arranged that they would go part-time and then went on to take their GCSE exams.

Table 6: Case Study B

Impact and outcome measure	Data available	Change	Details
Child/YP impact tool data			
SDQ scores	T1, T2	X	Total difficulties score saw a large increase from a Normal level at T1 to Abnormal level at T2.
	T1, T2	•	Prosocial score remained at Normal level.
BRS scores	T1, T2 (incomplete)	-	Score of 3.0 at T1, but incomplete data at T2.
C-PRS scores	T1, T2 (incomplete)	-	Incomplete data for Closeness score at T2, however score was high at T1 (33 out of 35).
	T1, T2	✓	Conflicts score decreased slightly from 13 to 11 (out of 15).
Practitioner impact tool data			
Care status	T1, T2	✓	Cared for by LA (Section 20) at T1, and cared for by birth/adoptive parents at T2.
Living arrangements	T1, T2	•	Was living with LA foster carers at T1, and living with LA foster carers and in residential care home at T2.
Episodes of hospitalisation	T1, T2	•	None at either time period.
Self-harm	T1, T2	•	Self-harm reported at T1 and T2.
Mental health	T1	-	Mental health diagnoses reported at T1.
Substance misuse	T1, T2	•	None reported at T1 or T2.
NEET	T1, T2	•	No episodes of NEET at T1 or T2.
Criminal offences	T1, T2	✓	Reported assault at T1, but no convictions reported at T2.

Table 7: Case Study C

Impact and outcome measure	Data available	Change	Details
Child/YP impact tool data			
SDQ scores	T1, T2 (incomplete)	-	Incomplete data at T1 and T2 for total difficulties score.
	T1, T2	X	Decrease in prosocial score from Normal to Abnormal level.
BRS scores	T1, T2	✓	Increase in brief resilience score from 2.3 to 3.0.
C-PRS scores	T1, T2	•	Little change in closeness score.
	T1, T2	•	Little change in conflict score.
Practitioner impact data			
Care status	T2	-	Cared for by local authority (Section 20).
Living arrangements	T2	-	Was living in residential care home.
Episodes of hospitalisation	T2	-	None reported.
Self-harm	T2	✓	A large reduction in harming behaviour was reported.
Mental health	No data available	-	-
Substance misuse	T2	-	None reported.
NEET	T2	-	Reported period of NEET at T2, due to being unwell.
Criminal offences	T2	-	None reported.

Table 8: Case Study D

Impact and outcome measure	Data available	Change	Details
Child/YP impact tool data			
SDQ scores	T1, T2	●	Small decrease in total difficulties score, but remained at Abnormal level. However, emotional problems, conduct problems and hyperactivity scale scores all improved.
	T1, T2	●	Small increase in prosocial score, but remained at Normal level.
BRS scores	T1, T2	✓	Resilience score increased from 2.5 to 3.3 (out of 5).
C-PRS scores	T1, T2	✓	Closeness score increased from 25 to 33 (out of 35).
	T1, T2	●	Conflicts score showed little change, remaining high.
Practitioner impact data			
Care status	T2	-	Cared for by birth/adoptive parents
Living arrangements	T2	-	Was living with LA foster carers and living in residential care home
Episodes of hospitalisation	No data available	-	-
Self-harm	T2	-	Reported self-harming behaviours
Mental health	No data available	-	-
Substance misuse	T2	-	Reported substance misuse issues.
NEET	T2	-	Reported as NEET.
Criminal offences	T2	-	None reported.

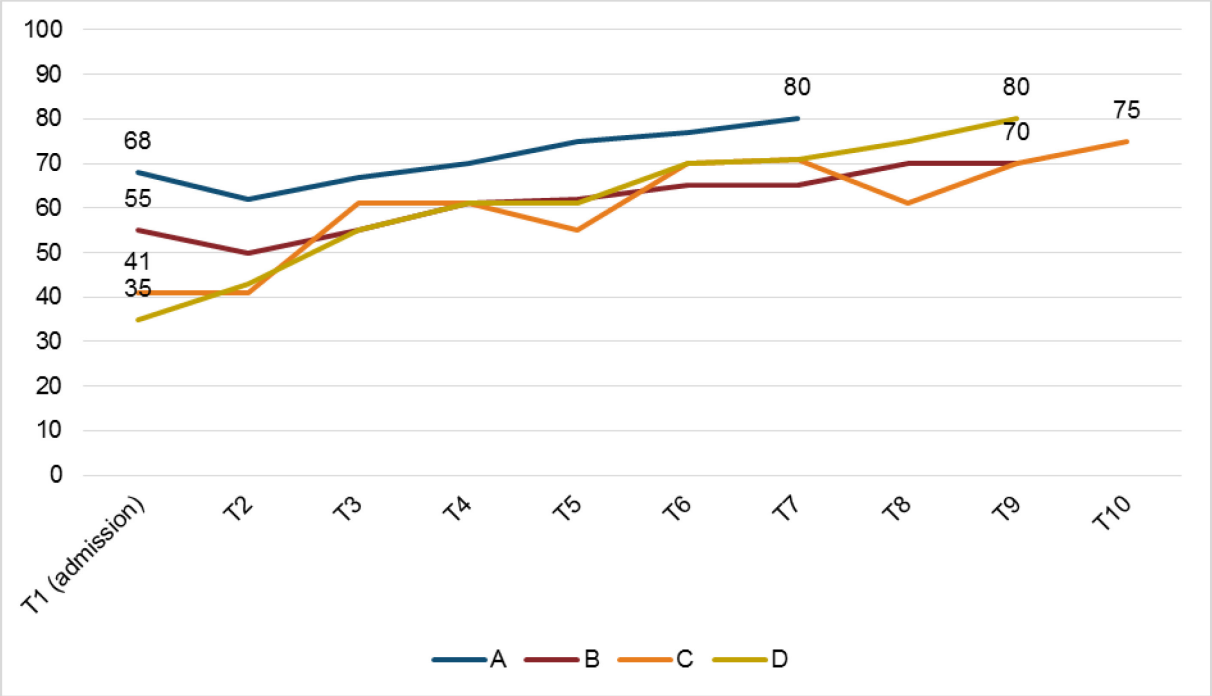
Table 9: Case Study E

Impact and outcome measure	Data available	Change	Details
Child/YP impact tool data			
SDQ scores	T1	-	Incomplete data so unable to calculate total difficulties. However, emotional, conduct and peer problems scores all at Abnormal level.
	T1	-	Prosocial score at Normal level.
BRS scores	T1	-	Brief resilience scale score of 2.3 (out of 5).
C-PRS scores	T1	-	Closeness score of 27 (out of 35).
	T1	-	Conflicts score of 8 (out of 15).
Practitioner impact tool data			
Care status	T1	-	Cared for by LA (Section 20).
Living arrangements	T1	-	Was living in a secure unit.
Episodes of hospitalisation	T1	-	Has been hospitalised full-time under Section 3.
Self-harm	T1	-	Self-harm reported.
Mental health	T1	-	Mental health diagnoses reported.
Substance misuse	T1	-	None reported.
NEET	T1	-	None reported.
Criminal offences	T1	-	None reported.

Appendix 2: Child Global Assessment Scale (CGAS) data

Data collected monthly from the point of admission by the service at Belhaven using the Child Global Assessment Scale (CGAS)[16] is presented in Figure 2, Figure 3, Figure 4 and Figure 5 below.

Figure 2: CGAS data - At home with family



[16] CGAS is completed by Belhaven staff to rate the general function of the young people accessing the service on a month basis from the point of admission in 4 areas; at home with family, at school, with friends and during leisure time. The scale runs from 1 to 100, with higher scores representing better functioning. More information is available from the Royal College of Psychiatrists at rcpsych.ac.uk.

Figure 3: CGAS data - At school

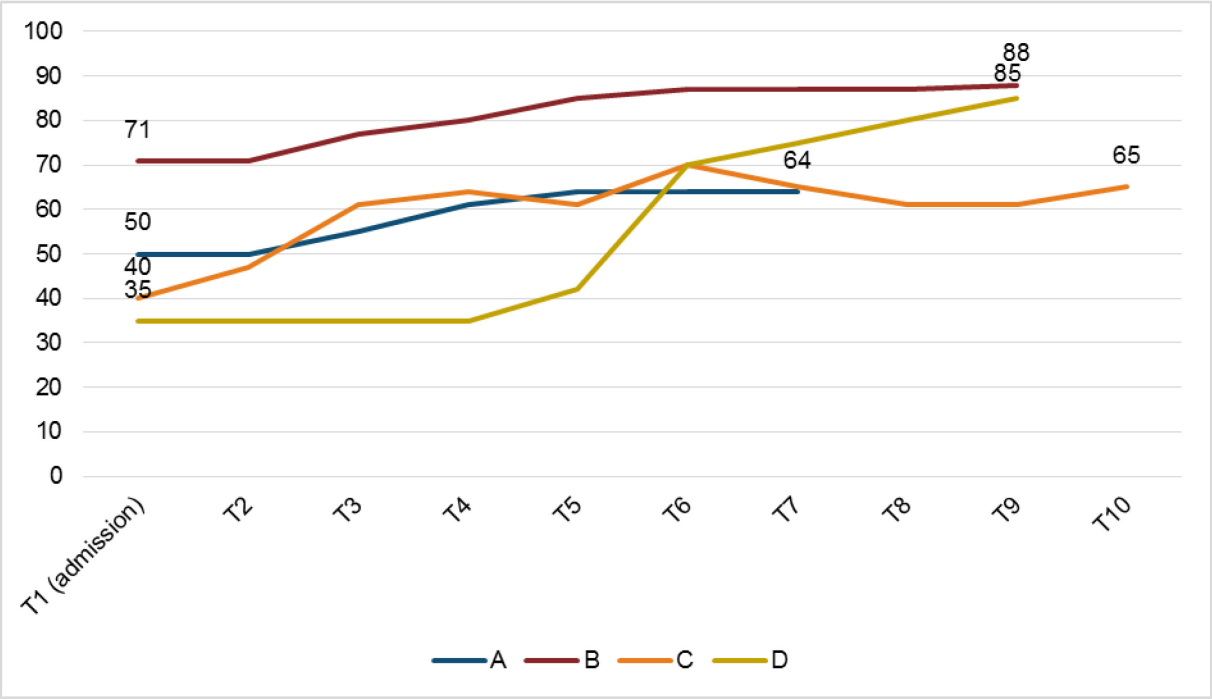


Figure 4: CGAS data - With friends

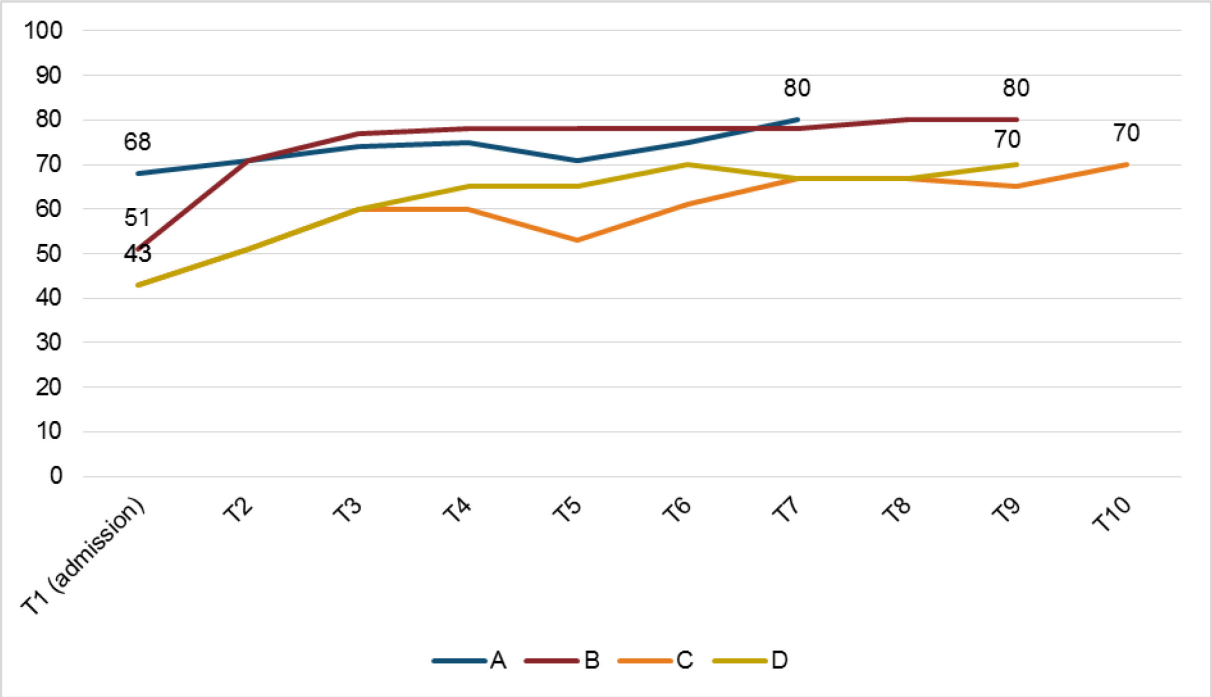
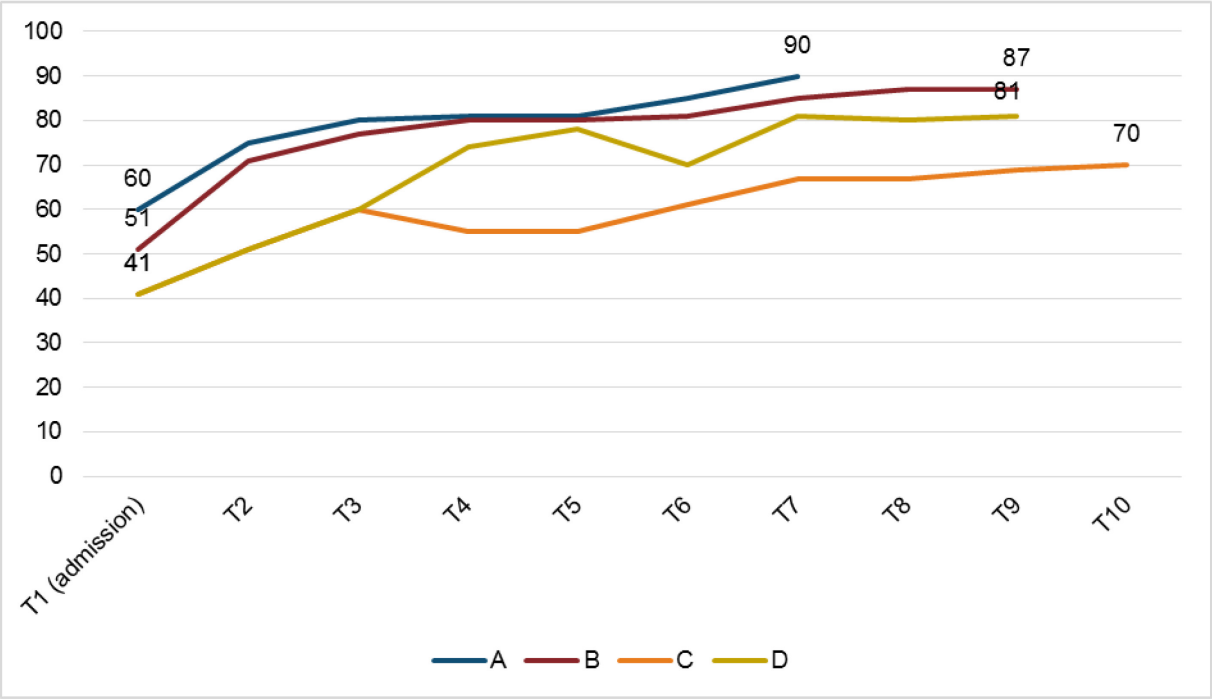
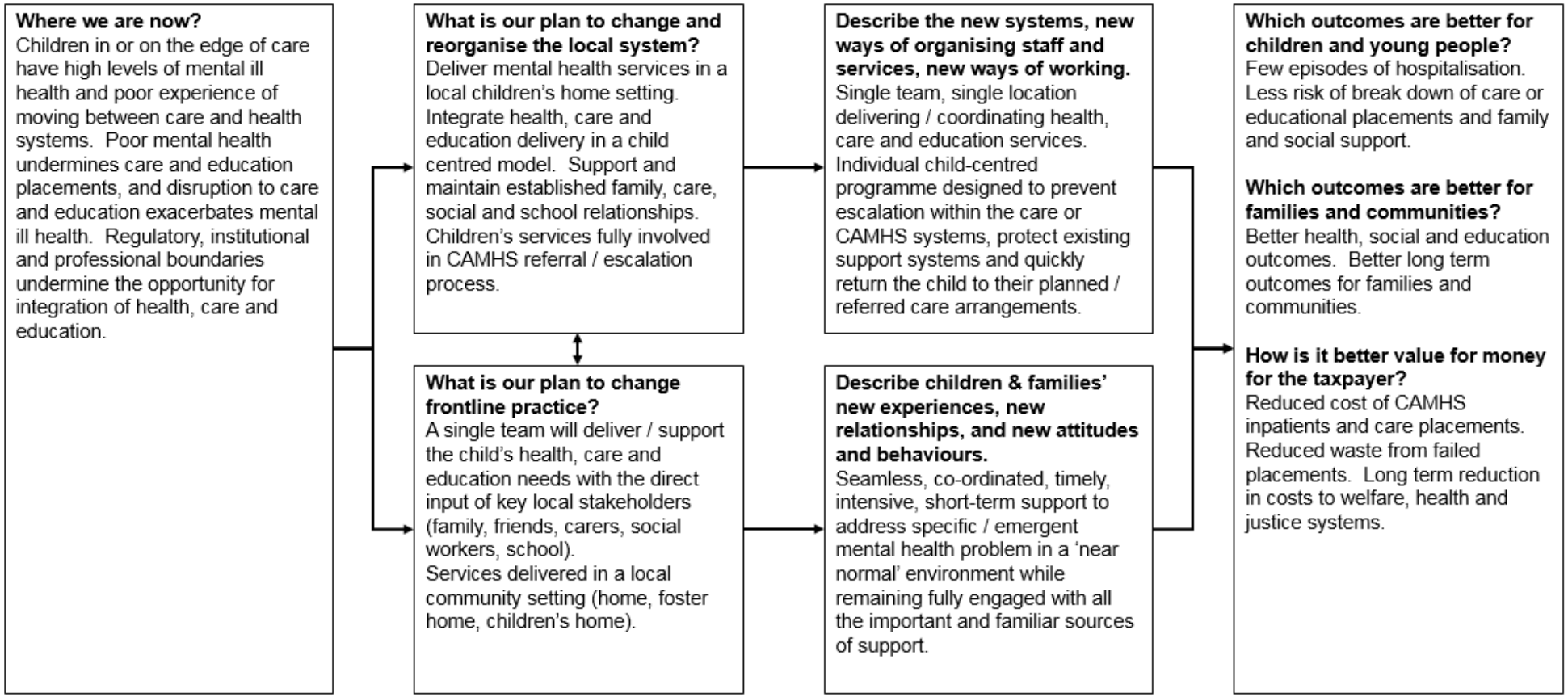


Figure 5: CGAS data - During leisure time



Appendix 3: Theory of change

Figure 6: Theory of change



Source: The Priory Group and Suffolk County Council's original proposal to the DfE Social Innovation Fund

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