



Department
for Education

Extended HOPE Service

Evaluation report

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**Ana Calderón, Julian Edbrooke-Childs,
Louise Chapman, Chloe Edridge,
Marjolein Maas and Miranda Wolpert –
Anna Freud National Centre for
Children and Families**

**John Rodger and Matthew Cutmore –
York Consulting**

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Executive summary

Summary of the project and evaluation

The aim of Extended HOPE was to build upon the success of the HOPE Day service through the addition of an out-of-hours Assessment and Support Service and through the integration of a Residential Service (such as HOPE House) for young people facing mental health crisis out of hours. HOPE Day service works at a preventative level with children and young people in the early stages of emotional and mental health difficulties, and is a joint partnership between health, children's services and education. The service is for 11 to 18 year olds and it is open Monday to Friday from 09:00 to 17:00. The primary outcome of Extended HOPE was that young people's out-of-hours mental health needs were met by appropriate services.

The Assessment and Support Service was established on October 2015, and by April 2016 was operating 7 days a week (between 17:00 and 23:00). This service is mostly over the phone and consists of advice and referral assessments to help young people in mental health crisis and/or their families and carers outside of normal office opening hours. The Assessment and Support Service also undertakes mental health and risk assessments of young people out of hours, and supports young people using the respite beds. The Assessment and Support Service was reached by 121 young people facing mental health crisis out of hours, or their parents (in 749 face-to-face or telephone contacts) between October 2015 and July 2016.

HOPE House was established in May 2016 with the aim of providing respite beds for young people who are experiencing a mental health crisis and need intensive support, but whose mental health does not require them to be admitted to a psychiatric ward, or to become a looked after child. At the time this report was written, HOPE House was not fully operational and, at times, it needed to be closed during the weekends due to staffing. The maximum length of stay for young people in the respite unit is 10 days per episode. Since May 2016, HOPE House has been used by 13 young people in 18 visits.

Methodology of the evaluation

A multi-level, mixed methods, Realistic Evaluation framework (Pawson & Tilley, 1997) was used to consider contexts, mechanism and outcomes (CMO) regarding the implementation of Extended HOPE. It comprised the following strands:

- Extended HOPE service data (749 contacts from 121 cases from October 2015 until July 2016 for the Assessment and Support Service and 18 visits from 13 young people to HOPE House) and routinely collected clinical data (125 for face-to-face visits made by Assessment and Support Service to young people's houses, and 18 for the 13 young people who used HOPE House)
- patient experience data gathered by Extended HOPE staff after telephone and face-to-face contacts ($n=234$ and $n=41$, respectively) and by researchers after interviews ($n=3$ young people and $n=8$ parents or carers)
- qualitative data consisting of interviews with young people ($n=6$) and parents or carers ($n=8$), and focus groups with professionals ($n=4$ with 14 Extended HOPE and HOPE House staff) involved in the Support and Assessment Service and HOPE House
- participant observation tools ($n=15$) completed by Extended HOPE staff
- document analysis.

Key findings

Through the implementation of the Assessment and Support Service and HOPE House, the primary outcome was achieved, as evidence suggests that young people's out-of-hours mental health needs were met more appropriately by this service. Between October 2015 and July 2016, two-thirds (66%) of the Assessment and Support Service's telephone support prevented¹ events: 126 contacts (23%) prevented Tier 4 admissions; 92 (17%) Accidents & Emergency (A&E) presentations; 88 (16%) placement breakdowns; and 53 (10%) paediatric ward stays. On the other hand, three-quarters (76%) of face-to-face contacts in the Assessment and Support Service prevented events: 34 (27%) prevented Tier 4 admissions; 33 (26%) prevented A&E presentations; 12 (10%) prevented placement breakdowns; 11 (9%) prevented paediatric ward stay; and 5 (3%) other events (see Table 3).

The secondary outcomes of Extended HOPE were:

- that families and young people are more resilient by being empowered in relation to both their own mental health, and the services that support them
- that young people and families report a better experience of services

¹ Prevention data was extracted from the contact log; hence, criteria for recording a prevented event were defined by Extended HOPE staff completing the contact log.

- a system change that results in mental health services which are tailored to the needs of young people
- better emotional wellbeing and mental health for young people in, and on the edge of, care

Regarding the first secondary outcome, young people and parents felt empowered by having someone to talk to and someone who listened to their needs. A small team meant that service users were familiar with Extended HOPE clinicians. In terms of implication and recommendation for this secondary outcome, wider dissemination of information about Extended HOPE would help the innovation to be embedded and to reach a greater number of young people and carers. Funding for this should not present a challenge, since the service has secured funding for at least 2.5 years. However, it would be important to maintain the familiarity that parents and young people feel with Extended HOPE's staff, even with larger numbers of service users, as this emerged as crucial for young people and parents. Both parents and young people reported high levels of satisfaction with Extended HOPE. Parents appeared to report a more positive experience of the service than young people, which may suggest that Extended HOPE is more appropriate for parents when their child is in crisis. Regarding implications and recommendations for the experience of service, the results of this evaluation suggest that service users experienced Extended HOPE as meeting parents' needs more fully than young people's needs. Considerations for meeting young people's needs more fully – as suggested by young people – included implementing a direct line for contacting Extended HOPE and increasing the number of home visits.

Regarding the system change, staff reported how the integration of health and social care services was integral to achieving tailored care for young people as the multidisciplinary team (MDT) was able to support families comprehensively and to share skills. Building on the success of the cross-sector working and the multidisciplinary team, cross-sector training would be recommended to further integrate staff across both health and social care.

Finally, in terms of young people's emotional wellbeing and mental health, significant changes in mental health symptoms and overall functioning were not observed. This may be because the effects of the intervention might have not been visible at the second time point, or might be because of small sample sizes in the outcome data. Service users use Extended HOPE on a short-term basis, meaning there is little time for mental health outcomes to change. A longer follow-up period of those accessing Extended HOPE may be necessary in order to capture changes that might take longer to materialise. In addition, our confidence in quantitative results will increase once a bigger sample is collected. New outcome measures could be used, given the

length of time that young people usually stay at HOPE House, such as the Clinical Global Impression Scale (Busner & Targum, 2007).

How can Extended HOPE be embedded in existing social care provision and sustained in the long-term?

Staff in the focus groups mentioned 3 main issues regarding embedding Extended HOPE in existing social care provision and the innovation sustainability in the long-term:

- grow Extended HOPE and HOPE House services to being all night and all weekend
- additional beds in HOPE House
- high levels of communication and working closely with the Emergency Duty Team

Results from the cost-benefit analysis (CBA) conducted by an independent party (York Consulting) showed a positive Fiscal Return on Investment (FROI) of 3.0. This means a saving of approximately £3 for every £1 invested. CBA also showed that even under the most pessimistic scenario of 50% outcome sustainability, the FROI remains positive at 1.5. Constraints of this analysis, however, have to be taken into account, and York Consulting recommended the following to improve CBA analysis in the future:

- the Extended HOPE project needs to calculate the staff time associated with different types of interventions and fine tune the costs
- the project needs to record outcomes against every young person supported on an annual basis to improve the robustness of estimated benefits
- the project needs to track young people 12 months after support to check the sustainability of outcomes
- the project should repeat this CBA exercise, based on the information generated above, in 12 months' time to test and improve CBA estimates

From a sustainability perspective, the next 2 years of Extended HOPE are covered. The team has secured a further 2.5 years of funding from the Clinical Commissioning Group Transformation funding and is in discussion with the Police about them buying into the service. In addition, Surrey and Borders Partnership funding of salaries for health staff has been secured for a further 4 years and discussions with Surrey County Council about budget were underway when this report was written.

What were the facilitators to implementing and sustaining Extended HOPE?

Some of the facilitators to implementing and sustaining Extended HOPE were a strong implementation team who meets regularly, the recruitment of good operational staff, and receiving funding to make up for staffing shortfalls. In addition, the MDT was described as a key facilitator to implementing and sustaining Extended HOPE, as it allowed staff to share information and expertise, leading to enhanced inter-collegial support for staff and better support for children, young people and families.

Young people and parents identified knowing Extended HOPE and HOPE House staff, and staff knowing them, as a facilitator. For young people this was important because it was less intimidating to call the service, and for parents this was relevant because it allowed them to receive support faster, as they did not have to tell the whole story to someone new: they just reported what was happening in that moment of crisis.

It is recommended that clear operational procedures which allow fluid communication between members of staff, so that, in instances where a young person's call is received by a staff member who is not familiar with the case, he or she can rapidly redirect the call to someone in the team who is. Even though this is something that is current practice in Extended HOPE, maintaining it when the service receives a larger volume of contacts may result in another level of complexity and new challenges.

What were the barriers to implementing and sustaining Extended HOPE?

The implementation of Extended HOPE was not without challenges. Delays in the implementation of HOPE House due to building issues and Office for Standards in Education, Children's Services and Skills' (Ofsted) requirements meant that, for a few months, staff did not have appropriate facilities, which created some tensions over sharing working space with the Emergency Duty Team (EDT). Staff also experienced frustration because children, young people and families who would have benefitted from accessing HOPE House were unable to do so.

Another important barrier was recruitment of suitable staff. Challenges in recruiting nurses willing to work out of hours was described as an issue that limited the capacity of the service to run through the night for several months.

Young people reported a lack of information about both Extended HOPE and HOPE House as a barrier to accessing the services. Parents, on the other hand, described accessing Extended HOPE through the EDT as frustrating and as preventing the service from being as productive as it could be.

It is recommended that a direct line of contact for parents, carers and young people is implemented, as opposed to accessing Extended HOPE via the EDT. This may allow a more immediate response from Extended HOPE, which could particularly benefit young people because, as reported by parents, delays in response sometimes deter young people from opening up. Therefore, a direct line might be a step closer to young people feeling that Extended HOPE could be as helpful for them as they think it is for their parents.

Implications and recommendations for policy and practice

In Surrey there is a need for Extended HOPE to provide appropriate care for young people and families in crisis, as indicated by the findings of this evaluation. In particular, parents reported needing the out-of-hours support when facing their young people's emotional or behavioural crises, and staff reported high levels of need from parents and young people. Young people, on the other hand, reported that the service covered their parents' needs better than their needs, and that more home visits would be needed for them. More resources would make this possible, as well as keeping HOPE House running for 7 days a week.

Wider dissemination of information about Extended HOPE would help the innovation to be embedded and to reach a greater number of young people and parents. However, dissemination would also mean that more young people and families would access Extended HOPE and HOPE House, and hence more resources would be needed in order to cope with future staffing and demand. In addition, it was crucial for parents and young people to feel that Extended HOPE staff knew them and that they knew staff; hence, if a larger number of young people, parents and carers accessed Extended HOPE it would be pivotal to implement clear operational procedures that will allow fluid communication between members of staff, so that in instances where a young person's call was received by a staff member who is not familiar with the case, he or she could rapidly redirect the call to someone in the team who is. Even though this is something that is current practice in Extended HOPE, maintaining it when the service receives a larger volume of contacts may result in another level of complexity and new challenges.

Overview of the project

The aim of Extended HOPE was to build upon the success of HOPE Day service through the addition of an out-of-hours Assessment and Support Service that includes both telephone contact and home visits, and through the integration of a Residential Service (such as HOPE House). HOPE Day service works at a preventative level with children and young people in the early stages of emotional and mental health difficulties, and is a joint partnership between health, children's services and education. The service is for 11 to 18 year olds and it is open Monday to Friday from 09:00 to 17:00.

What the project was intending to achieve

The primary outcome of Extended HOPE was that young people's out-of-hours mental health needs were met by appropriate services.

The secondary outcomes of Extended HOPE were:

- that families and young people were more resilient by being empowered in relation to both their own mental health and the services that supported them
- that young people and families reported a better experience of services
- a system change which resulted in mental health services that were tailored to the needs of young people
- better emotional wellbeing and mental health for young people in, and on the edge of, care

What the project was intending to do to achieve these outcomes

Extended HOPE intended to achieve these outcomes in 2 ways. Firstly, the Assessment and Support Service was established on October 2015. It started operating Thursdays and Fridays from 17:00 to 23:00, and Saturdays and Sundays from 09:00 to 17:00, but was extended in April 2016 to 7 days a week between 17:00 and 23:00. This service is mostly over the phone and consists of advice and referral assessments to help young people in mental health crisis and/or their families and carers outside normal office opening hours. The Assessment and Support Service also undertakes mental health and risk assessments of young people out of hours and supports young people using the respite beds.

Secondly, HOPE House was established in May 2016 with the aim of providing respite beds for young people who were experiencing a mental health crisis and need intensive support, but whose mental health did not require them to be admitted to a psychiatric ward, or to become a looked after child. From May until August 2016 HOPE House opened only during weekdays as there was a shortage of staff during weekends. Currently, HOPE House is not fully operational and at times it needs to be closed during the weekends due to staffing. Following refurbishment work, HOPE House contains 2 bedrooms for young people, a bedroom or office for staff, a lounge and kitchen area, and a bathroom. The respite unit is staffed by one Residential Worker, one senior practitioner, and one Senior Residential Worker with experience in working with young people who have mental health needs. The Community Psychiatric Nurse from the Assessment and Support Service is also based within the respite unit and assists with supporting the young people in the unit when not undertaking visits to other young people off site. The maximum length of stay for young people in the respite unit is 10 days per episode.

Relevant existing research relating to this innovation

As described in the initial project proposal, it is nationally recognised that half of those with lifetime mental health problems first experience symptoms by the age of 14, rising to three quarters by their mid twenties (NHS England, 2013). Moreover, one in 10 young people suffer from a diagnosable mental health disorder. Supporting young people with mental health issues is therefore essential to improving lifetime health and wellbeing, and preventing intergenerational inequality cycles; and could also reduce costs incurred by a range of agencies, such as health, the police and social care. Support for looked after children, of whom 45% were assessed as having a mental health need, rising to 72% for those in residential care (Ford, Vostanis, Meltzer & Goodman, 2007), is of particular importance. This is important to prevent placement breakdowns and out of county placements, which are known to detrimentally affect young people's outcomes (Institute of Public Care, 2006).

A gap in services out of hours

When the initial project proposal was presented, services for young people experiencing a mental health crisis out of office hours were very limited. Evidence provided to the Health Select Committee highlighted that "the very limited CAMHS available outside of office hours steers young people towards A&E and access to out-of-hours, crisis or home treatment services for young people are not widely established..." (House of Commons, 2014). This evidence is also supported by data from the Association of Chief Police Officers, which highlight that 45% of under 18s detained under section 136 (Healthwatch Suffolk, 2015) were assessed in police

cells². Moreover, there is a national shortage of designated places of safety³ in England and 35% of those in existence do not accept young people under the age of 16 (Campbell, 2014).

A recent report by Mind (2011) identified that people wanted responsive care to prevent further deterioration or escalation of mental health crisis. One friend or relative of someone with a mental health condition stated that people in crisis needed “to know there was help readily available without having to jump through hoops. People in crisis do not have the capacity to make appointments, phone calls, take long journeys or communicate what they need.” (p. 14). A recent Health Select Committee report argued that “intensive services provided in the community can act as a bridge between inpatient services and community services, with the aim of preventing the need for an admission, or facilitating more swift discharge back to the community.” In response, the Health Select Committee has suggested that such bridging services may be a more useful focus of investment than inpatient services.” (House of Commons, 2014).

Changes to the project’s intended outcomes

There have not been any major changes to the intended outcomes or activities as funded by the Social Innovation Fund. However, implementation took more time than initially planned because:

- the opening of HOPE House was delayed because of issues with information from the builders, the building itself, and Office for Standards in Education, Children’s Services and Skills (Ofsted) requirements
- recruitment of staff was more difficult than originally planned because posts were advertised in a lower pay band than professionals were willing to earn for the commitment the job required. Hence, for example, the nurse positions were re-organised in order to increase the salary band and decrease the number of nurses needed (for instance, instead of 3 band 6 nurses as advertised for a year, Extended HOPE recruited 2 band 7 nurses and one part-time band 6 nurse). In addition, contracts were temporary and some positions were filled with seconded staff from HOPE

² The police can use section 136 of the Mental Health Act to take people from a public place to a place of safety if they believe that person has a mental illness and is in need of care.

³ A “place of safety” is defined in section 135(6) of the Mental Health Act 1983 as: ‘residential accommodation provided by a local social services authority under part III of the National Assistance Act 1948; a hospital as defined by [the Mental Health Act 1983]; a police station; an independent hospital or care home for mentally disordered persons; or any other suitable place the occupier of which is willing temporarily to receive the patient’.

It is worth also mentioning that everything was newly set up for this service, such as referral pathways; what clinical outcome measures to use, and what other routine measures to record. Therefore, the implementation of Extended HOPE required a great effort from many different people involved in the project.

Context within which this innovation has been taking place

Surrey County Council (SCC) is composed of eleven local government districts: Elmbridge, Epsom and Ewell, Guildford, Mole Valley, Reigate and Banstead, Rungby, Spelthorne, Surrey Heath, Tandridge, Waverley, and Woking. Its estimated mid-2015 population was 1,168,809 people, of which 24.227% (283,099) were estimated to be under 19 years of age (ONS, 2016). Regarding the gender of people under 19, 48.7% were female.

SCC was ranked 150th most deprived LA out of 152 LAs in England in 2015 (1st being most deprived), with 8% of pupils in primary school and 6.7% of pupils in secondary school eligible for free school meals (compared to 15.6% and 13.9% in England, respectively) (GOV.UK, 2016). Out of young people aged 16-18 years, SCC had 1.6% not in education, employment or training in 2015, compared to 4.2% in England.

In 2016, SCC had 190,244 pupils in 501 schools, 93 academies and 70 Sure Start Children Centres; 12.7% primary pupils, and 10.1% secondary pupils' first language was other than English (compared to 20.1% and 15.7% in England, respectively).

The rate of looked after children (LAC) per 10,000 children aged under 18 in 2015 was 31 (and in England was 60), whilst the rate of children in need per 10,000 in 2015 was 225.3 and in England was 337.3 (GOV.UK, 2016).

Lack of appropriate out-of-hours provision

As described in the original bid, Surrey operates an Emergency Duty Team (EDT) between 17:00 and 09:00 across weekday evenings and 24 hours a day at weekends and Bank Holidays, but does not have the expertise or capacity to deliver the level of mental health support needed for young people out of hours. The Team provides emergency social work for those urgent situations outside office hours which cannot be left, with an appropriate degree of safety, until the next normal working day. Between 30 November 2013 and 1 December 2014 the Team received over 400 calls relating to young people who had mental health concerns. The majority of calls received during the evening were between 17:00 and 23:00, identifying a need for support for young people with mental health concerns and their families during this time.

Young people in mental health crisis end up in inappropriate settings

When the proposal for the innovation programme was submitted, young people in crisis out of hours could end up in a range of inappropriate settings, as demonstrated below:

- young people experiencing mental health crisis out of hours often first present at A&E and will then be admitted to a paediatric ward for assessment, as per NICE guidelines. Between February and November 2014 approximately 270 young people in Surrey were admitted to a paediatric ward due to deliberate self harm. While at times there may be physical medical reasons why this is necessary, this is not always the case, and paediatric wards are not often equipped to treat severe emotional and mental ill health
- in the year April 2013-2014, 9 young people were admitted to an adult psychiatric ward due to a lack of appropriate adolescent provision, representing safeguarding concerns. Anecdotal feedback from practitioners has highlighted that this is often a wholly inappropriate place for a young person to stay, but due to a lack of alternative provision this was the safest option
- between January and July 2014 28 adolescents not detainable under the Mental Health Act remained in a police cell overnight because they could not be bailed due to a suspected mental health need
- for many adolescents social care is often the last port of call once partners have exhausted other avenues, resulting in adolescents becoming looked after children and often placed out of county, as local provision is not always available to meet their needs. This, too, is a completely inappropriate response to a young person with mental health needs, which results from a lack of alternative provision in the county to support them in Surrey during their crisis

Overview of the evaluation

Evaluation questions

The aim of the evaluation was to answer the question: under what circumstances, by what means and in what ways can Extended HOPE help meet the needs of young people in crisis, improve their outcomes, and enhance their experience of care?

The primary research question was: Does Extended HOPE reduce inappropriate out-of-hours service utilisation for young people in crisis?

The secondary research questions were:

- how does appropriate out-of-hours crisis care (for example, Extended HOPE) increase child and parent empowerment to manage emotional and behavioural difficulties?
- how does Extended HOPE and/or HOPE House enhance young people's, parents' or carers' experience of care?
- what aspects of the different contexts (for example, the Assessment and Support Service vs. HOPE House) do young people, parents and clinicians view as most and least empowering?
- how can Extended HOPE be embedded in existing service social care provision and sustained in the long-term?
- what are the barriers and facilitators to implementing Extended HOPE in different contexts?
- what is the impact of Extended HOPE and HOPE House on young people's mental health?
- are case complexity factors (for example, looked after children) associated with different experiences or outcomes of Extended HOPE?

Methodology used to address these questions

A multi-level, mixed methods, Realistic Evaluation framework (Pawson & Tilley, 1997) was used to consider contexts, mechanism and outcomes (CMO) regarding the implementation of Extended HOPE. The evaluation has been designed to maximise use of existing data and data collection procedures to minimise burden on young people, parents and staff.

The evaluation comprised the following strands:

- Extended HOPE service data (749 contacts from 121 cases from October 2015 until July 2016 for the Assessment and Support Service, and 18 visits from 13 young people to HOPE House) and routinely collected clinical data (125 for face-to-face visits made by the Assessment and Support Service to young people's houses, and 18 for the 13 young people who used HOPE House) were collected and analysed to describe the service provided to parents and young people, and to explore how appropriately young people's mental health needs were met by the out-of-hours service
- patient experience data gathered by Extended HOPE staff after telephone and face-to-face contacts ($n=234$ and $n=41$, respectively) and by researchers after interviews ($n=3$ young people and $n=8$ parents or carers) were analysed to understand the impact of these services on young people's, parents' and carers' experience of care
- qualitative data consisting of interviews with young people ($n=6$) and parents or carers ($n=8$), and focus groups with professionals ($n=4$ with 14 Extended HOPE and HOPE House staff) involved in the Support and Assessment Service and HOPE House were conducted and analysed to further explore their experience with the service and how service users' and providers' needs were met
- participant observation tools ($n=15$) were also used to collect data by professionals in Extended HOPE to gain detailed understanding of the experience of these services
- document analysis was conducted to understand the wider context of communication and decision-making regarding out-of-hours care provision
- York Consulting led the cost-benefit analysis (CBA)

Focus groups with staff and interviews with parents or carers and young people

All Extended HOPE staff were invited to participate in focus groups. Before carrying them out, researchers explained the aims of the focus groups, provided information sheets to participants, and answered their questions. Staff gave consent for focus groups to be recorded and transcribed.

A total of 4 focus groups were conducted with Extended HOPE and HOPE House staff. The first 3 were conducted during February 2016 and the fourth in July 2016 because HOPE House was not opened until May 2016, and hence staff that were going to work at HOPE House, who participated in the focus group in February, could not give an account of the experience of the service. The first 3 focus groups included 11 staff (5 managers, 3 residential workers, 2 nurses, and one senior

practitioner), and the fourth focus group included 3 staff who had participated in previous focus groups (2 residential workers and one nurse), and 3 new staff (one senior residential worker, one residential worker, and one nurse). Out of the 14 staff, 4 were male and the rest were female. The mean age of participants was 39 years (ranging from 31 to 55 years). In terms of ethnicity, 10 participants were White, 2 were Asian, one was Black and one self-identified their ethnicity as 'other'. Only one participant worked part-time. The average years of experience working with a similar population was 10 years (ranging from 5 months to 25 years).

Parents, carers and young people were invited to participate in interviews by Extended HOPE staff, who provided an information sheet explaining the study. If parents of young people were interested in participating, they completed the Expression of Interest form, which was then sent to researchers at the Anna Freud National Centre for Children and Families (AFNCCF). Researchers then contacted potential participants and agreed on a specific date and place for the interviews. A full explanation of the research was provided to parents and young people before the beginning of the interviews. Interviewees gave their informed consent to be interviewed, and for the researcher to record and transcribe the interview.

A total of 8 parents and carers of 6 young people were interviewed; 7 were parents and one was a carer. The average age of parents was 45 (SD=3.69), and ranged between 41 and 50 years. Regarding gender, 6 parents were female and 2 were male. Five parents reported being white, one was Asian, and 2 did not answer the question. In terms of education, 3 had college education, 2 had an undergraduate degree at a university, one had teacher training, and 2 did not answer the question. In terms of marital status, 4 were married, one was divorced and 3 did not answer the question. Regarding occupation, 2 worked in the public sector, 2 in marketing and/or sales, one in business and 3 had missing data.

Five young people were interviewed. Demographic information was recorded for only 4 of them. Ages ranged between 14 and 16 (average age=16, SD=1.6); 2 of them were female, one was male and one preferred not to say. Regarding ethnicity, 3 were white and one preferred not to say. In terms of education, 2 young people were at Year 9, one at Year 11, and one at Year 13.

Changes to evaluation methodology from the original design

There were no substantive changes to the evaluation methodology from the original design. However, some minor changes were made as follows:

- due to the extension of Extended HOPE and the deadline for this report, data collection was also extended until end of July 2016
- less data than expected was collected before the implementation of Extended HOPE. Regarding routinely collected clinical data, no data for before the implementation was received by the evaluation team, as, after discussions with the implementation team, it was conjointly decided that existing data on HOPE service could not be used as a comparator group, as several of the young people accessing Extended HOPE were also part of the HOPE Day service. Instead, it was planned to use contextual data for before Extended HOPE was implemented, keeping in mind the limitations of using local authority level data to explore the impact of one specific program. Unfortunately, contextual data for Surrey County Council (such as the number of young people entering care at Surrey) was not made available to the research team due to capacity issues in the council team with other pressing deadlines
- the number of young people and parents interviewed was smaller than planned, given the challenges of recruitment. In the case of young people, for example, the evaluation team received 'expression of interest forms' but when calling to book the interview, the young person was no longer interested in taking part. In other cases, even when interviews were booked, researchers arrived and the young person was no longer interested in taking part
- as the implementation of HOPE House was delayed, its evaluation was only partial and hence all results presented here should be taken as preliminary
- one of the original questions could not be answered through the data collected by Extended HOPE (such as 'Are case complexity factors (for example, LAC) associated with different experiences or outcomes of Extended HOPE?') as the contact log did not include demographic information. Other indicators of LAC (for example, placement breakdown) were explored in contextual data and in actions prevented in the contact log.
- the original economic evaluation partner did not have the capacity to carry out this aspect of the evaluation, due to unexpected lack of staffing. Therefore, York Consulting conducted the economic evaluation. We were only expecting to be able to examine the feasibility of collecting data for the CBA and as there was more data available, a summary of the results of the CBA analysis are presented below (and in full in the Appendices)

Key findings

This section presents a summary of all the results obtained for Extended HOPE and HOPE House. For complementary results please refer to the Appendices. The qualitative analysis of the parents' and young people's interviews, the qualitative analysis of the focus groups, and the document analysis, are available on request.

Characteristics of the service provided by Extended HOPE and HOPE House

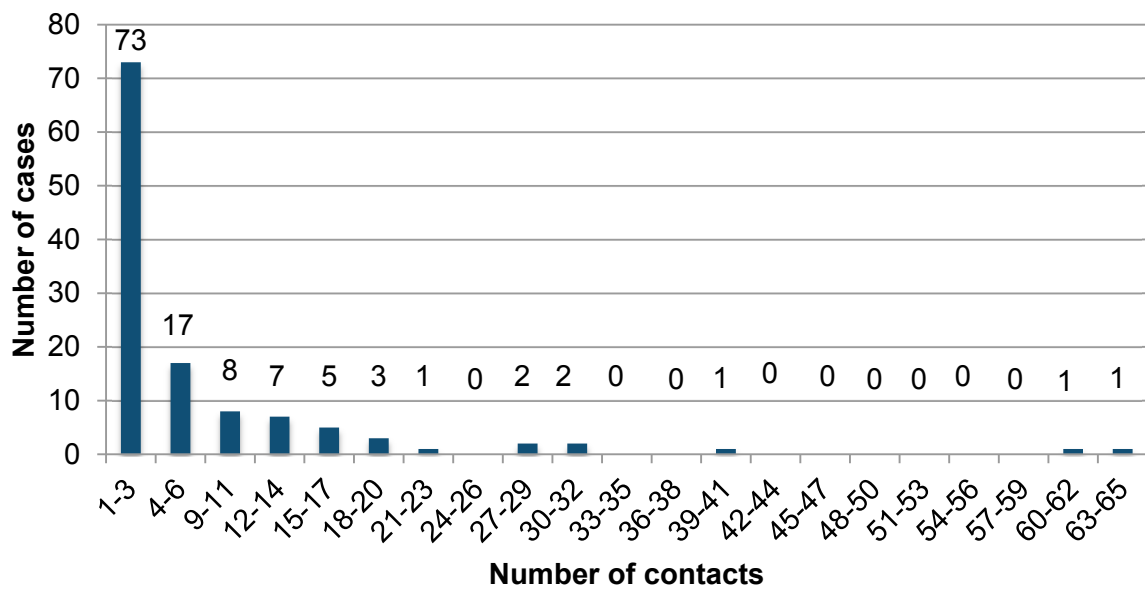
Contact log

Between October 2015 and July 2016 a total of 749 contacts from 121 cases were recorded. Out of the 749 contacts in the log, 624 (83%) were telephone contacts⁴ and 125 (17%) were face-to-face contacts. Out of the telephone contacts, 12% (72/624) were calls made by a member of the Assessment and Support Service to a young person or a parent or carer that were not answered (for example, a request from HOPE to call a young person over the weekend, to a recently discharged young person from a paediatric ward, follow-up, and so on).

The mean number of logged contacts per case was 6.19 (SD=9.87) and their distribution can be found in Figure 1 below.

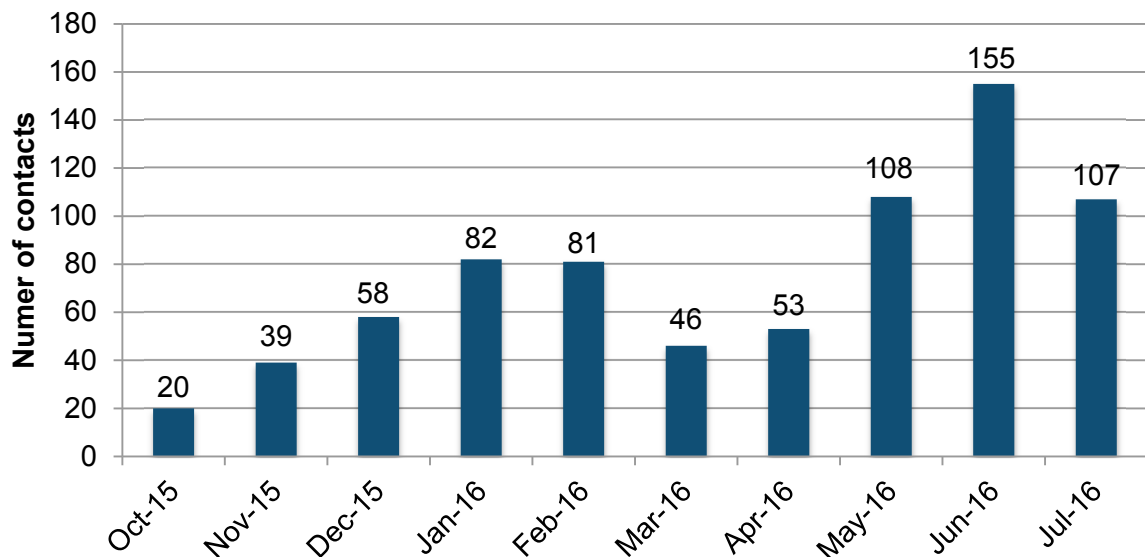
⁴ In Extended HOPE all telephone contacts from young people and parents are made through the Emergency Duty Team; hence, professionals in the Assessment and Support Service return the call to the young person, parent or carer that made the contact.

Figure 1: Frequency distribution of logged contacts per case (n=121)



The number of logged contacts per month can be found in Figure 2 below. The increase in the number of contacts is likely to be due to an increased awareness of the service, combined with an increased capacity of the service itself after May 2016.

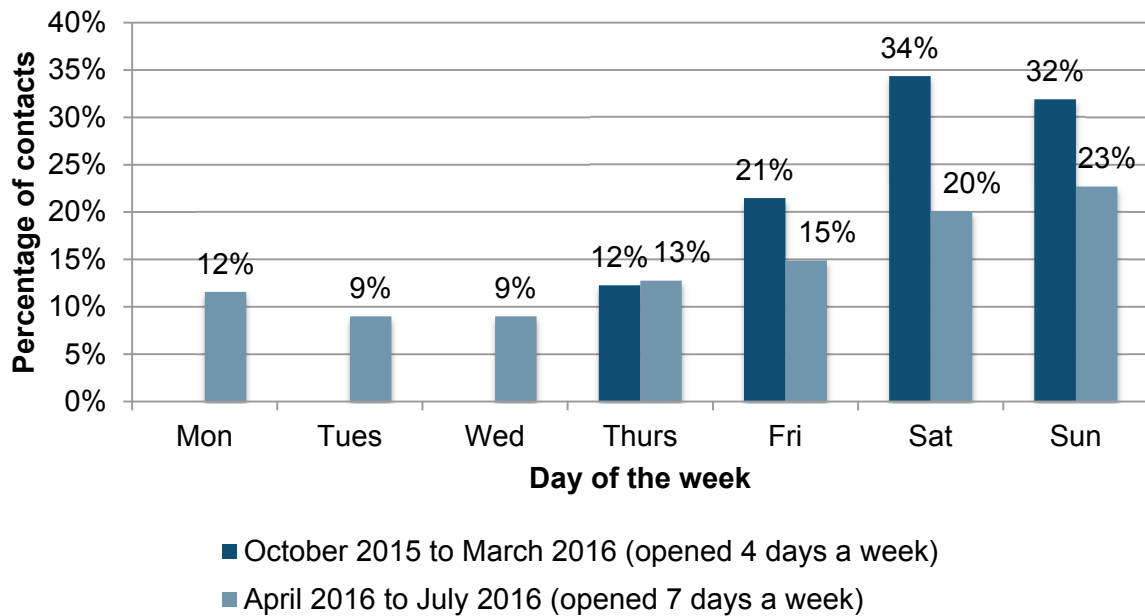
Figure 2: Number of contacts logged per month



In terms of the number of contacts made by day of the week, both when the Assessment and Support service was working from Thursday until Sunday and when the service was working from Monday to Sunday, most of the contacts were logged during the weekend (see Figure 3). Triangulating with the qualitative data obtained in interviews with parent, carers and young people, and in focus groups with staff, where both staff and service users reported that Extended HOPE was filling a gap

felt by other services, the higher use of the service during the weekends might be due to unavailability of other services.

Figure 3: Percentage of contacts per day of the week, for the period when Extended HOPE was open 4 days a week (October 2015 to March 2016) and when it opened 7 days a week (April 2016 to July 2016)



Regarding referral, more than half of the logged contacts in the Assessment and Support Service (405, 54%) were referred by HOPE, followed by 160 (21%) who were referred by parents, and 89 (12%) who were young people who self-referred.

The reasons logged for the contacts with the Assessment and Support Services were varied, and were grouped into 13 categories (see Table 1).

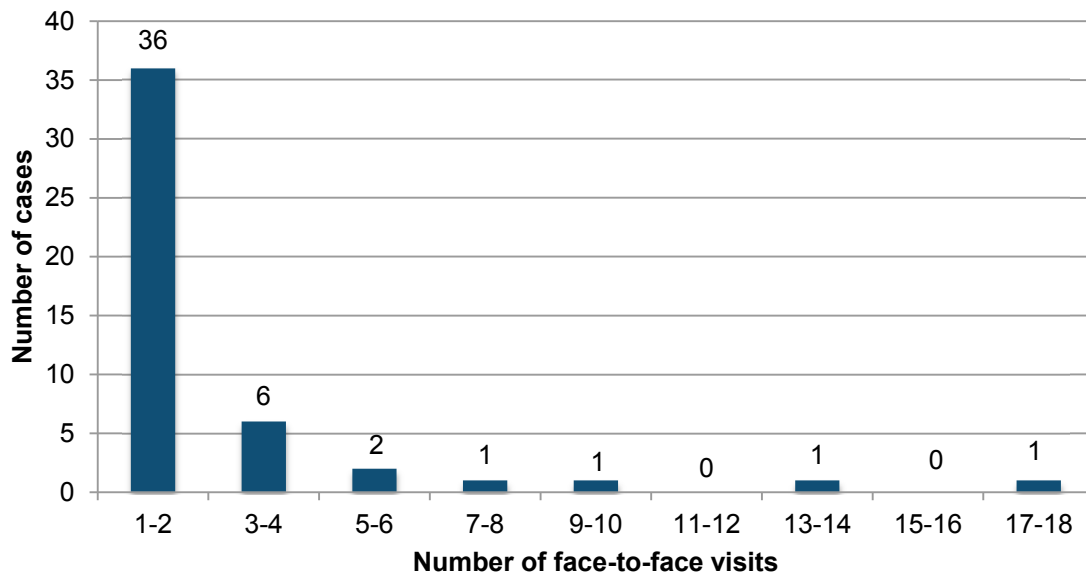
Table 1: Presenting problem for contacts logged per month

Presenting problem	Total
Admissions/discharges/leave from hospital	197 (26%)
Low mood/distress/ concerns about state of mind	143 (19%)
Other support (for example, "Request from coordinator to provide telephone support over the weekend", "Request from HOPE to contact young person over the weekend", "Young person telephoned after drinking alcohol, wanting support")	140 (19%)
Self-harm/suicidal thoughts/attempts	87 (12%)
Family/home support needed	62 (8%)
Behaviour concerns	51 (7%)
Crisis/risk response	30 (4%)
Psychotic episode/ symptoms	27 (4%)
Medication	5 (1%)
Placement concerns	3 (0.4%)
Crisis visit	1 (0.1%)
Missing young person	1 (0.1%)
Referral to other service	1 (0.1%)
Grand Total	748

Out of the 552 logged telephone contacts that were answered, the majority (504, 91%) received support and/or advice, followed by 32 (6%) who had a mental health or risk assessment. On the other hand, the majority of face-to-face contacts (98, 78%) were for mental health risk assessment, followed by 10 (8%) who received support or advice.

The 125 face-to-face contacts were provided to 48 cases, with a mean of 2.6 visits per case and maximum of 17 visits per case. As shown in Figure 4, most of the cases (36, 75%) had 1 or 2 home visits from Extended HOPE staff.

Figure 4: Distribution of face-to-face visits per case (n=48)



The time of contact was recorded in 545 instances (99%) out of the 552 telephone contacts that were successful. Most of those (207, 38%) occurred between 19:00 and 21:00, followed by 175 (32%) that happened between 17:00 and 19:00. On the other hand, the time of contact was recorded in 122 instances (98%) out of the 125 face-to-face contacts. The same pattern was found: most of them (48, 39%) happened between 19:00 and 21:00, followed by 46 (38%) between 17:00 and 19:00.

The Children's Global Assessment Scale (CGAS) was completed in all 125 face-to-face contacts in Extended HOPE (which corresponded to 48 cases). The maximum number of CGAS per case was 17, and the minimum 1. Most of the 48 families (25, 52%) had one CGAS score, followed by 11 (23%) families that had 2 CGAS scores. CGAS scores were generally low (ranging from 1 to 61), with the following distribution:

Table 2 Frequency and percentage of CGAS scores

CGAS score	N (%)	Description
1	1 (1%)	Extremely impaired
11	11 (9%)	Very severely impaired
31	50 (40%)	Serious problems
41	41 (33%)	Obvious problems
51	17 (14%)	Some noticeable problems (in more than one area)
61	5 (4%)	Some problems (in one area only)
Total	125 (100%)	

Regarding HOPE House, the length of stay varied between 0 and 5 days, with a mean of 3 days (SD=1.38, n=18). Most of the young people (7, 39%) stayed for 4 days. A total of 13 young people in 18 separate visits accessed HOPE House from May 2016 to the end of July 2016. Most of the young people (9, 69%) stayed at HOPE House only once, with 3 young people staying 2 times, and one young person staying 3 times.

Does Extended HOPE reduce inappropriate out-of-hours service utilisation for young people in crisis?

Summary

- evidence from the document analysis suggested that, in the first 4 months the Assessment and Support Service prevented one young person from presenting at Accidents and Emergency (A&E) and one from absconding from police
- evidence from contact log suggested that, according to Extended HOPE staff who completed the contact log, two-thirds (66%) of telephone contacts and three-quarters of face-to-face contacts prevented events: most frequent prevention was Tier 4 admissions (23% of telephone contacts and 27% of face-to-face contacts)
- staff reported reducing or minimising crisis, and preventing placement breakdown by intervening early, and providing, not only respite services, but also skills to help young people and families better manage emotional and behavioural difficulties at home
- young people expressed mixed opinions. On the one side, some young people reported that Extended HOPE was preventing them from feelings and behaviour (such as self-harm) that would end up with them using other out-of-hours services (such as A&E). On the other hand, some young people reported that Extended HOPE has not had an impact on them
- parents gave examples of how Extended HOPE reduced inappropriate out-of-hours service utilization, and some of them viewed Extended HOPE as a sticking plaster, a service which could be used in the interim whilst waiting for a level 4 bed or until the next time there was a situation
- in future service evaluations, it is expected that as Extended HOPE scales up and reaches more comprehensively across the population of Surrey, we might observe changes in local authority data, such as reductions in the number of children in care. For example, local authority data indicated that on average 51 out of 10,000 children in Surrey were in care from October 2014 until September 2015, and that this figure increased to an average of 56 out of 10,000 children in Surrey from October 2015 until February 2016

Document analysis

Document analysis was conducted during January and February 2016. It showed that, during the first 4 months, the Assessment and Support service was running

there were positive outcomes. It was described in minutes of a meeting between Extended HOPE and evaluators that the Assessment and Support Service prevented one young person from presenting at A&E. In meeting minutes of the Extended HOPE programme board it was reported that Extended HOPE prevented one young person from absconding from police. The Assessment and Support Service has been working closely with the EDT who has commented on the usefulness of Assessment and Support Service in reducing their workload.

Contact log

Between October 2015 and July 2016, two-thirds (66%) of telephone support and three-quarters (76%) of face-to-face contacts prevented⁵ events (see Table 3 below).

Table 3: Events prevented by type of support provided by Extended HOPE

	Telephone	Face-to-face
Tier 4 admission	126 (23%)	34 (27%)
A&E presentation	92 (17%)	33 (26%)
Placement breakdown	88 (16%)	12 (10%)
Paediatric ward stay	53 (10%)	11 (9%)
Police detention	3 (0.54%)	0 (0%)
Detained under s136 MH act	3 (0.54%)	4 (3%)
A&E Admission	1 (0.2%)	0 (0%)
Out of county placement	0 (0%)	1 (1%)
No prevention	185 (34%)	30 (24%)
n/a	1 (0.18%)	
Total	552	125

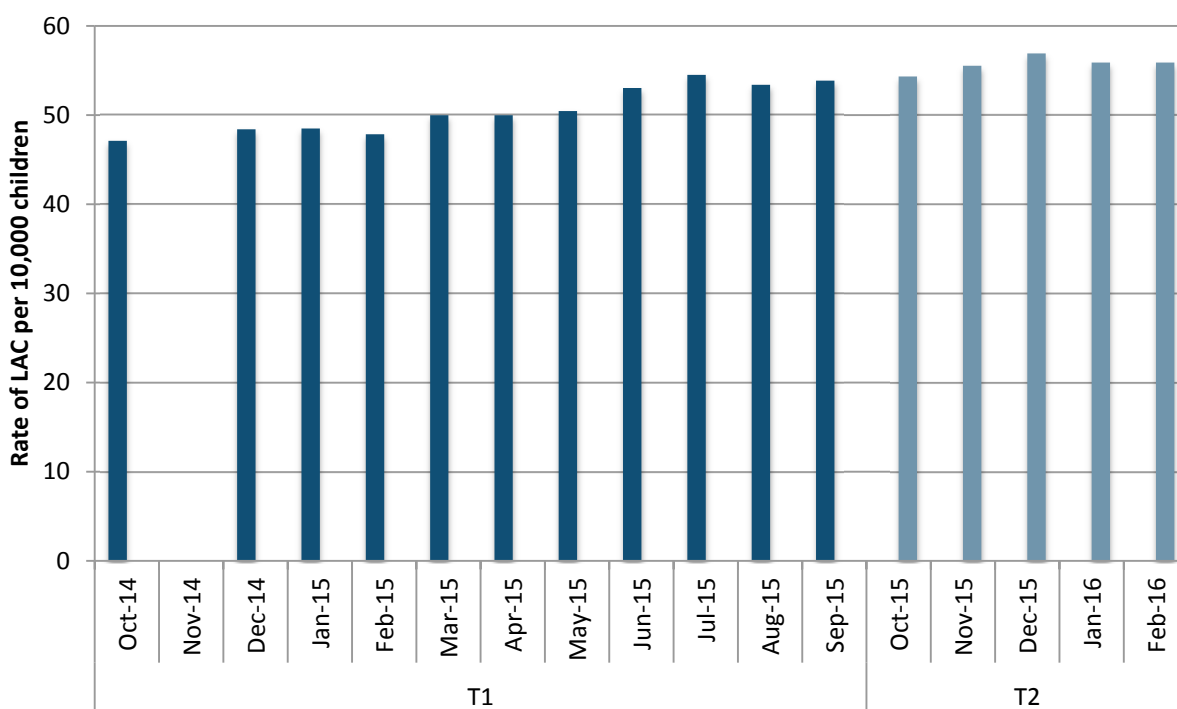
Contextual data

At local authority level, Figure 5 shows that there was an increase in the rate of young people aged 10 to 17 per 10,000 children who were in care after the implementation of Extended HOPE (mean T1=50.6, range = 47.1 – 54.5; mean T2=55.7, range = 54.3 – 56.9). This indicates that on average 51 out of 10,000 children in Surrey were in care from October 2014 until September 2015, and that this figure increased to an average of 56 out of 10,000 children in Surrey from October 2015 until February 2016.

⁵ Prevention data was extracted from the contact log; hence, criteria for recording a prevented event were defined by Extended HOPE staff completing contact log.

When interpreting these results, it is important to keep in mind that causality should not be inferred, as contextual data includes a larger group of children and young people than the ones accessing Extended HOPE or HOPE House, and other factors than HOPE services might be influencing changes and/or fluctuations in numbers in contextual data. This is why a longer time-frame and a bigger cohort of young people would be needed to observe changes in LAC rates associated with Extended HOPE at local authority level. Nonetheless, these are useful indications of what Extended HOPE can be doing in the future to evaluate their services.

Figure 5: Rate of Looked After Children per 10,000 in Surrey (10 to 17 year olds)



Source: Surrey Council

Focus groups

The Assessment and Support Service and, in time, HOPE House were discussed as reducing or minimising crisis, and preventing placement breakdown by intervening early; and providing respite services and skills to help young people and families better manage emotional and behavioural difficulties at home. Staff provided examples of cases demonstrating enhanced care for children, young people and families, including quicker access to inpatient beds during a crisis, swifter and more supported discharge, and crisis management. Correspondingly, participants noted that this should result in cost savings, as fewer agencies would need to be involved since the severity of a young person’s situation should be prevented from deteriorating.

Young people⁶

In the interviews, young people expressed mixed opinions. On the one hand, only one interviewee said that Extended HOPE had had an impact on his wellbeing and mental state, as he now calls Extended HOPE before doing something “stupid”:

“they've got me used to ringing up, and asking for help when I do feel bad. Because I never used to, I just used to go and do something stupid. But, I've rung them, even if I am going to do something stupid, I'll ring them first to try to see if they can help before.” (Young Person 2)

Another young person mentioned he now knows that calling Extended HOPE is an option but sometimes prefers to self-harm:

“So sometimes it is literally like, cutting myself and going into hospital is going to be easier and less fatal than calling up (...) I cut because I know it helps. And I don't really see an issue with that, because I look after it, I go to the hospital. But it's always another option. Like, I know that [calling Extended HOPE] it's an option now. So that has kind of changed it.” (Young Person 1)

They both also mentioned a positive impact of Extended HOPE in that they are better now at reaching out and asking for help when feeling down.

On the other hand, 3 young people said Extended HOPE has not had an impact on them because the way they manage their symptoms and emotions has not changed:

“I usually get upset, let it get all out, and then I stop, and calm down, and then do something.” (Young Person 5)

“after the calls I usually self-harm still or I just feel really bad.” (Young Person 3)

However, one of them did mention that Extended HOPE has helped in prevent him doing things he might regret later:

“it's like saved me from doing a lot of things I might regret, but it hasn't changed like me. I'm still the same.” (Young Person 3)

⁶ Interviewed parents and young people sometimes had difficulties differentiating which staff belonged to which HOPE service (Extended HOPE, HOPE and HOPE House) or other services (such as CAMHS). In some instances, parents and young people might have been referring to all HOPE services, including the HOPE Day Service which was not part of this evaluation.

Parents

Interviewed parents gave examples of how Extended HOPE reduced inappropriate out-of-hours service utilisation. For example, 2 parents felt that, since using Extended HOPE, they were less likely to go to the Emergency department:

“She’s anorexic, she’s in and out of hospital constantly, had severe self-harm ... it was really about having that extended one-to-one time whilst in hospital, which we were trying to break so we’d had conversations with HOPE around that.” (Parent 2)

“...before the Extended HOPE came about, I would call my out-call doctor. He would then refer you to someone who would then ring you back, and then you'd have this wait. And because they don't know the case, they will tell you to go to casualty.” (Parent 4)

For 2 parents Extended HOPE was seen as a sticking plaster, a service which could be used in the interim whilst waiting for a level 4 bed or until the next time there was a situation:

“Extended [HOPE] is very much a, it's almost like a sticky plaster to get you through to the next week. Or to get you through to the next session. So, everything is very day-to-day when you've got someone in this state, so having someone that can say 'Right, it's okay, you need to do this.', I think you need someone that you can talk to, whatever time it is.” (Parent 5)

How does appropriate out-of-hours crisis care increase child and parent empowerment to manage emotional and behavioural difficulties?

Summary

- young people found Extended HOPE more helpful than other services they had used in the past; for example, one young person commented on the importance of receiving help before being in a crisis
- parents reported on the importance for them of Extended HOPE’s reduced waiting time and timely intervention
- staff reported that Extended HOPE was effective at providing children, young people, and families with the skills, knowledge and confidence to be able to better manage emotional and behavioural difficulties independently without accessing services

Young people

All the 5 young people interviewed had had previous experience with another service (for example., Surrey Young Carers, Mencap, Child Line, Samaritans, and CAMHS [Child and Adolescent Mental Health Services]), and found them not helpful:

“the amount of numbers I got given, that's [Extended HOPE] the only one that helps.” (Young Person 2)

“Like when I rang up Child Line sometimes they were just horrible. And these people are alright.” (Young Person 3)

One young person highlighted that with Extended HOPE he does not have to be in a crisis to receive support, and hence, he felt that it is easier to get back on track when his mood gets low:

“With the crisis line, I always had to wait until it was literally a crisis, whereas with Extended HOPE, if I feel it going down, I can call them up at that point and they can pick me up, whereas with crisis it would have to go all the way down, and then it would be a lot harder to bring it back up.” (Young Person 1)

Parents

Some of the interviewed parents reported that Extended HOPE increased their overall optimism and confidence of the situation, and helped them to understand risk assessment better (for example, when to go to hospital or not) and facilitating connections to other services such as CAMHS:

“it's really breaking that down and empowering them to take it forward because that's the bit about Extended HOPE is it's an input but to strengthen everything around the young person not just the young person.” (Parent 1)

All of the parents had experiences of other service use with the young person, with the most discussed being hospital emergency services and CAMHS. As opposed to Extended HOPE, parents often reported that hospital emergency services were not the right setting for the young person to be in, and that, in CAMHS, there was a big issue with the time they had to wait for the service when in hospital, the time on waiting lists to receive therapy and the times the service was open:

“I think with the hospital there's nothing they can do. They just have to wait until the following day for CAMHS to come around.....You're waiting for CAMHS and CAMHS can take hours and hours and hours so it's just really unsettling.” (Parent 7)

“Very useful [Extended HOPE] because CAMHS is the service that is working with [young person] the most. But they're not always there. And things don't happen between 9 and 5 generally!” (Parent 5)

“HOPE has been pretty regular, whereas the eating disorder service has been ad hoc and pretty much not something which has worked out in this case.” (Parent 8)

In addition, one interviewed parent mentioned that staff in Extended HOPE were trained or equipped to deal with mental health issues, which resulted in staff understanding the impact that the young person's difficulties have on the family:

“...as much as paramedics and hospital staff and emergency staff are all amazing, their understanding specifically of mental health issues in young people, I think there's a level of insensitivity sometimes, which then exacerbates how the young person's feeling (...) You've got a 16 or 17-year-old in crisis, you're not going to get that piece of glass off of them and if they're going to harm themselves or others you have to get someone in. So it's that understanding of the impact on carers of young people with mental health issues as well so that's where it is obviously unique.” (Parent 1)

However, CAMHS for some was the gateway to Extended HOPE and there were some positive references to the service relating to staff and consistency:

“CAMHS reasonably regular in terms of appointments, either with the consultant psychiatrist or with one of the counselling staff members... think the young person's been under fairly close watch from CAMHS.” (Parent 8)

Focus groups

Most staff described a key mechanism by which Extended HOPE was effective as providing children, young people, and families with the skills, knowledge and confidence to be able to better manage emotional and behavioural difficulties independently without accessing services, thereby reducing the need for crisis intervention and promoting better long-term outcomes.

Additionally, staff described Extended HOPE as filling an important gap in existing services, by not only providing out-of-hours crisis care, but providing a service children, young people and families could access directly out of hours before crisis was reached. Staff described conversations with children, young people, and families about discharge as being, at times, challenging as they may be reluctant to leave the service even though discharge planning is discussed from the outset.

A few participants noted how the service model had been developed based on feedback from children, young people and families, staff, clinical experience, and also theory. This resulted in Extended HOPE, not only filling an important gap and meeting children, young people and families' needs, but also having a coherent structure, further facilitating its implementation. As a new service, staff described how important it was to reflect on early implementation and have a space for frequent meetings in which to collectively reflect. Even if staff had not been involved in decision-making, they reported being continuously updated about progress of the service.

How does Extended HOPE enhance young people's and parents' or carers' experience of care?

Summary

- young people liked that staff went to their houses in moments of crisis. However, they reported mixed experiences of Extended HOPE care
- parents reported positive experiences of Extended HOPE and described personal characteristics of the staff they felt had facilitated a positive experience of the service, for example, "kind", "caring", "helpful", "devoted", "non-judgemental" and "understanding"
- overall, parents and young people who used Extended HOPE reported high levels of satisfaction with the telephone and face-to-face services

Young people

Interviewed young people mentioned that it was especially helpful when staff went to their houses in moments of crisis:

"They've come out a couple of times and that was good. They've come out and seen me and that helped." (Young Person 3)

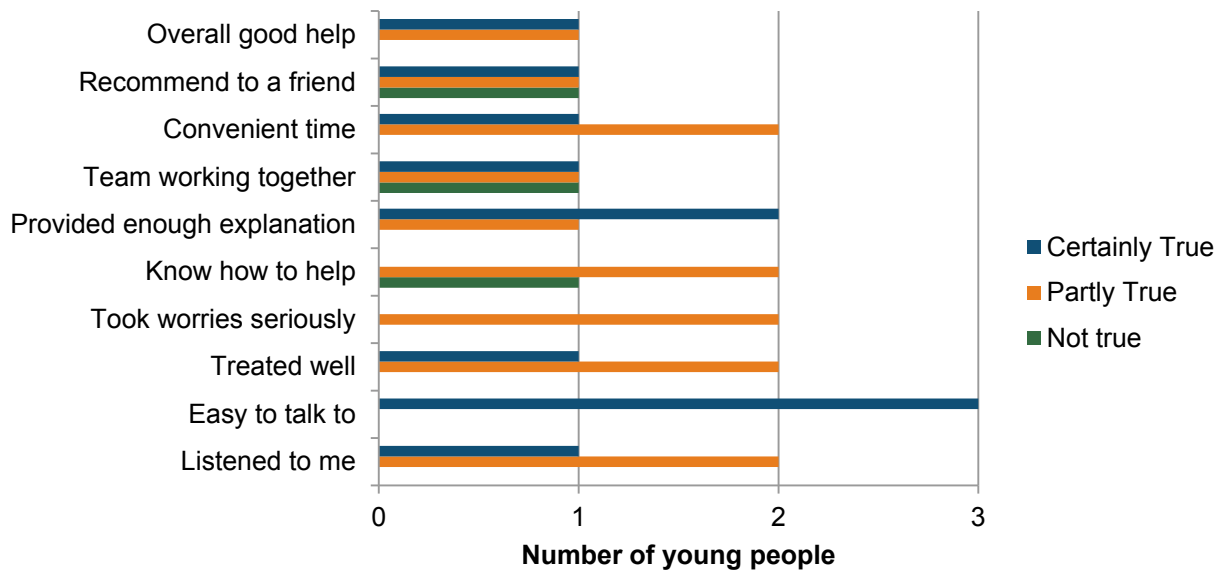
Hence, when asked about what could be improved at Extended HOPE, interviewees mentioned that it would be helpful if staff would go the young people's houses more often:

"... obviously they can't do that all the time. But that's the only thing that helps, when they come out and see me." (Young Person 3)

In addition, 2 of the interviewed young people mentioned that they were close to turning 18 and were worried that, after that they would not be able to get this support.

Three of the 5 young people who were interviewed completed the Experience of Service Questionnaire (CHI-ESQ). As can be seen in Figure 6 below, the 3 young people agreed that it was easy to talk to Extended HOPE staff. The rest of the questions presented mixed answers, with one young person stating that the help received was good but it was partly true that he would recommend the service to a friend, and another saying that it was partly true that the help received was good but that he would recommend the service to a friend.

Figure 6: Frequency of answers given by interviewed young people to CHI-ESQ questions (n=3)



Parents

Overall, parents had a positive experience of the Extended HOPE service, with it being described as “unique” “extremely helpful” and that it should be continued. Parents were extremely positive about Extended HOPE’s staff, referring to them as “absolutely brilliant” or “fantastic characters”. They often described personal characteristics of the staff who they felt had facilitated a positive experience of the service. These included “kind”, “caring”, “helpful” and “devoted”. Communication style was also a key aspect, with parents feeling listened to and considered with personalised conversations. The staff were described as “non-judgemental” and “understanding”, seeing things from the parents’ perspective. Parents reported that they did not feel “intimidated” by them and that staff did not use “jargon” to relay information. Parents viewed the staff as knowledgeable, capable and intelligent which instilled confidence in the advice and guidance they provided.

Parents mentioned that having the facility to speak to someone on the phone, or have them come round when there was a crisis, was comforting:

“If they ring when he's still having his episode, or he's still quite bad, because they can hear it, and then they can really feel what you're going through. And then that's, you feel more listened to, it's a bit like the story I was telling you earlier, you feel more listened to when people have actually seen or heard.”
(Parent 4)

However, some parents also mentioned improvements to the Extended HOPE service that would make their experience better. One of those improvements was extending opening hours beyond 11pm:

“...timings because obviously it’s still eleven so it just is that extension and actually maybe if it’s twelve, one o’clock.” (Parent 1)

“the thing is his mental health doesn’t stop at the weekend. It needs to be a 24/7 service.” (Parent 7)

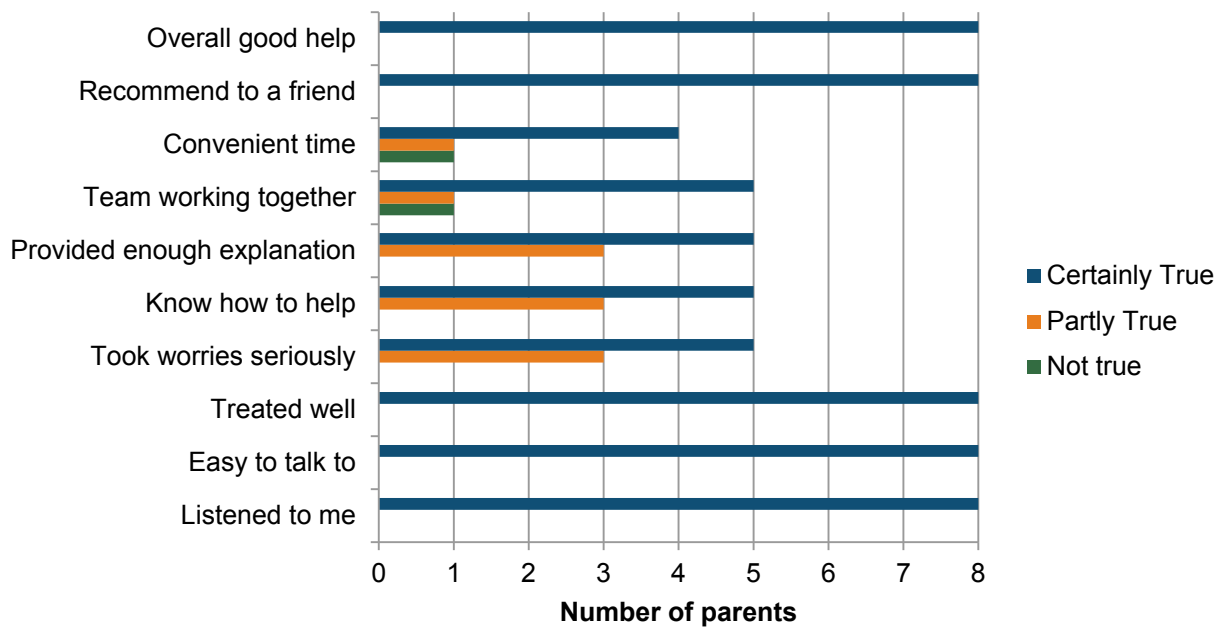
Another parent mentioned that he does not feel the service is running as smoothly as it should be:

“[Extended HOPE] doesn’t feel fully like a really well oil machine where all the pieces are really well in place and everybody knows exactly what they’re doing and communicating and they’ve got a, “Yeah, okay, we know how to deal with this. We’re just going to go and we’re going to do this, this and this (...) it’s probably a combination of resource, I’m sure it’s mainly driven by resource, but also possibly planning and structure. So I think they’re doing their best and we are making progress, but I wouldn’t say that overall I feel this is a top-class mental service provision, and this is not in any way a commentary on any of the people involved, who are great, but it feels a little bit as if it’s under-resourced and they’re making the best of what they have.” (Parent 6)

However, during the interviews most of the parents viewed HOPE, Extended HOPE and HOPE House as one service operated by the same group of staff, which could be interpreted as a result of fluid communication between HOPE services. In addition, as this was a new service, time was needed for the team to settle in, for staff to be trained and for sorting out operational processes and procedures.

Satisfaction with the service was also measured using the Experience of Service Questionnaire (CHI-ESQ). It was completed by all 8 parents who participated in the interviews. As can be seen in Figure 7 below, all parents were, overall, happy with the help received and would recommend the service to a friend. However, a few parents thought that they weren’t provided with enough explanation; staff did not always know how to help; and sometimes staff did not take worries seriously.

Figure 7: Frequency of answers given by interviewed parents to CHI-ESQ questions (n=8)



Document analysis

Document analysis showed that the service had been communicated with young people and families in a limited capacity through flyers, web pages and news articles. As discussed in the focus groups, this was mainly because staff were mindful that Extended HOPE had only been funded for a limited period and did not want to strongly advertise a service that may not exist in a year's time. The Assessment and Support Service has been communicated to relevant partners and young people using the HOPE service.

The launch of HOPE House was attended by approximately 30 people, and one article was published in Surrey's intranet about HOPE House's opening. By June 2016, the aim was to publish the existence of HOPE House in the national media and then organise a Corporate Launch event.

Contact log

Before ending the telephone contact or finishing the face-to-face visit, staff in Extended HOPE asked about young people and parents' satisfaction with the service provided; 234 (42%) out of 552 contacts over the telephone, and 41 (33%) out of 125 face-to-face contacts rated the service received from 0 to 10. The average satisfaction with the telephone support was 9.18 (ranging from 7 to 10), whilst the average satisfaction with the face-to-face service was 9.12 (ranging from 7 to 10).

In addition, 235 (43%) out of 552 contacts over the phone and 41 (33%) out of 125 face-to-face contacts were asked if they would recommend Extended HOPE to family or friends in a similar situation. All replied that they would. The high percentage of missing data adds uncertainty; however, at the same time, most of the cases (64%, 77/121) contacted Extended HOPE more than once which seems to indicate that they thought it was a helpful service.

When asked about further comments to add, more than half of the contacts (117/223, 52%) said that the service had been supportive or helpful, 75 (34%) commented that they had a positive experience of staff, and 27 (12%) mentioned that it was “amazing” or “enormously helpful” to have someone who could provide advice or support. On the other hand, 2 contacts (1%) mentioned that HOPE service needs to provide better information of what Extended HOPE could offer, and further 2 (1%) contacts said that it had been difficult to get a staff from Extended HOPE to go to his or her house to assess young person.

Observation tools

Fifteen observations tools were completed between December 2015 and March 2016. In all the observation tools, staff reported that they agreed that, during their work with other staff, there were opportunities to identify risks and discuss concrete plans to mitigate these risks, and that everyone had the opportunity to contribute during discussions which respected all points of view.

In addition, 13 out of 15 times, staff reported that, during their shift, service users had had the opportunity to talk about what they wanted to talk about, their views were listened to and respected, and they had the opportunities to ask questions. Furthermore, 12 out of 15, times staff agreed that they felt as if service users understood what was talked about.

As an additional comment, staff highlighted that parents felt relieved and reassured after contact with Extended HOPE.

What aspects of the different contexts do young people, parents and clinicians view as most and least empowering?

Summary

- young people said that knowing the staff, and that, in turn, staff knowing them, was an important aspect of their experience with Extended HOPE
- some young people reported that Extended HOPE was more helpful for the parents than for young people, which coincided with the opinion of some of the parents
- HOPE House was described by one young person as a very nice place with a welcoming environment and nice staff, but without any therapeutic provision
- parents described that they used Extended HOPE for “tips”, “advice”, clarity on what was best to do in a situation, and reassurance
- some parents mentioned that they would like tools and skills that they could use when the crisis was over
- despite some raising challenges of out-of-hours working, the majority of staff discussed the importance of this aspect of care

Young people

In the interviews young people expressed mixed experiences of Extended HOPE. On the one hand, some young people reported positive experiences and highlighted the importance of knowing Extended HOPE staff and that, in turn, staff knew them:

“I think it's just the people know you, the people that I speak to know me, and they know how to deal with me when I get bad, whereas strangers don't, necessarily.” (Young Person 2)

On the other hand, a few young people were less positive about their experience with Extended HOPE, with one mentioning that it was helpful for his mother:

“Probably for her [mum], but not for me, I don't think.” Young Person 5

Another said that it was not helpful when he was visited in hospital because he did not understand what was happening:

“Not... not really in the sense... you know, because I didn’t know what was going on. I didn’t know what the hell they were talking about.” (Young Person 4).

Regarding HOPE House, 2 of the interviewees had stayed there. One young person thought his experience of HOPE House was positive:

“It was good. It was very comforting. Welcoming environment. Nice staff there. (...) they made you do some basic things as well. You’ve got to set up the table and help doing this, help doing that, but I was fine with that. Don’t really push your buttons, though. And, you know, it was really about socialising. You know? Watching TV. A little bit of TV. Board games. Card games. They really wanted to encourage us to do that sort of stuff. It was very homely environment. And I really liked it.” (Young Person 4)

At the same time, the young person saw it more as a place where he (and his parents) could get a short break rather than a therapeutic place:

“They don’t help with the mental health state. They... they’re just there to contain for a short while to give them a break, to give their parents. There’s no... there’s no treatment there. You know? There’s no therapy.” (Young Person 4)

Parents

On the positive side, all interviewed parents acknowledged how beneficial it was having an out-of-hours service which was easy to access and responded within a few hours. However, they generally referred to the service as being used more by themselves than by the young person:

“...he wants to get better, he doesn’t want to talk about getting better.” (Parent 5)

Parents reported that they use Extended HOPE for “tips”, “advice”, clarity on what was best to do in a situation, and reassurance:

“...it's the despair that things aren't getting better. And it's having someone say 'Yes, it will get better.'” (Parent 5)

On the other hand, one parent mentioned that he would like Extended HOPE to provide him with tools and skills that he could use when the crisis is over:

“It’s not, “Help, I’m a parent, what do I do?” that’s not really, that’s the crisis (...) but it doesn’t feel like somewhere you’d sit and say, “Can you coach me on how to manage my mentally ill child?” (Parent 6)

Focus groups

The majority of staff commented that Extended HOPE had resulted in the provision of enhanced care for children, young people and families, including management of difficulties at home; better and safer crisis provision; developing effective therapeutic relationships with children, young people and families; reduced placement breakdowns; reduced utilisation of inappropriate crisis care, including out of county placement; and suicide prevention. In addition, despite some raising challenges of out-of-hours working, the majority of staff discussed the importance of this aspect of care.

Staff described high levels of job satisfaction from working with children, young people and families and providing a new, innovative, needed service. However, a few mentioned that the large workload involved in implementing a new service, and the shift pattern providing out-of-hours services, was a challenge.

How can Extended HOPE be embedded in existing social care provision and sustained in the long-term?

Summary

- grow the out-of-hours service to being all night and all weekend
- additional beds in HOPE House
- high levels of communication and working closely with the EDT

Focus groups

The majority of staff highlighted the ambition for the out-of-hours service to extend to being all night as opposed to ending at 11pm, and all weekend (which was tied to the lack of staff) as filling an important gap in existing services. Similarly, some staff also highlighted that additional beds to the 2 currently in place in HOPE House would probably be needed. The opening of HOPE House was mentioned as providing an opportunity for Extended HOPE to provide more intensive work with children, young people and families and, hopefully, more effectively prevent crises.

High levels of communication and working closely with the EDT were described as beneficial in terms of drawing on the EDT's experience and relationships within the community. In addition, respondents described the service as being very sustainable given the high levels of need for it, and the lack of comparable services in the community. There was less certainty over the availability of future funding for the service.

What are the barriers and facilitators to implementing Extended HOPE in different contexts?

Summary

- barriers: recruitment of staff to work out of hours and during weekends (especially nurses), HOPE House's building issues and Ofsted regulations
- barriers: lack of information, according to young people, and access to Extended HOPE through EDT, according to parents
- facilitators: strong implementation team which meets regularly, and a multidisciplinary team
- facilitators: for both parents and young people an important facilitator was knowing the staff and that in turn staff knew them and, hence, did not have to spend precious time recounting the young person's history

Barriers

Document analysis

Document analysis showed that there have been many barriers to implementing Extended HOPE. The main ones have been recruiting suitable staff, building issues, lack of funding and Office for Standards in Education, Children's Services and Skills (Ofsted) requirements.

Focus groups

Staff mentioned the delays to the opening of HOPE House as a barrier, because staff had to be temporarily based in the Emergency Duty Team (EDT), as opposed to working out of the residential service. On the one hand, this was described as facilitating multidisciplinary work and giving staff the opportunity to learn from, and shadow, existing staff from the HOPE and Extended HOPE services. On the other hand, this appeared to cause challenges for staff as they did not have appropriate facilities and as there were some tensions over sharing working space with the EDT.

Staff reported working with children, young people and families who would have benefitted from accessing HOPE House, but who were unable to, as the premises were not available. Nevertheless, staff also praised being able to implement some of the Extended HOPE service before HOPE House had been completed.

In addition, challenges in recruiting nurses willing to work out of hours was described as an issue that limited the capacity of the service to run through the night for several months.

Young people

In the interviews with young people, lack of information regarding Extended HOPE and HOPE House was mentioned as a barrier to access the service:

“In terms of the phone service, when they brought that out, we got given information, but I'm still not entirely sure what HOPE house it is” (Young Person 1)

“Not so much at the beginning, no, I felt like I didn't know, I just felt like I got given the number (...) and I was like 'Well, I don't know anyone.' But since I've been coming here [HOPE House] I know people and I've been ringing more.” (Young Person 2)

Furthermore, 2 of the young people interviewed coincided in saying that they did not feel understood by staff at Extended HOPE at first, but that changed afterwards when they got to know the staff.

Parents

Although the interviewed parents were generally positive regarding Extended HOPE, the prominent barrier to accessing the service was around the initial contact made with Extended HOPE that did not have a direct line but went through the EDT. Parents expressed frustration at the delay in follow-up calls or visits and one parent said that the delay in being able to speak to someone deterred the young person from opening up:

“...the only time when we've been slightly frustrated is when [young person] actually wanted to talk to someone. And when he wants to talk to someone, he needs to talk to someone really quickly. And it took about 2.5 hours for someone to ring back, by which time he's not interested in talking to anyone. So we then talked to them, but we had no clue what he wanted to talk about.” (Parent 5)

On the same lines, another parent felt this prevented the service from being as productive, as “his tantrums come on so quickly (Parent 7)” and therefore the parent could not receive help at the height of them.

A third parent reported that the initial contact with the EDT was a bad experience for his young person, but that Extended HOPE later called back and helped:

“The first time she called there, she did it, I think, on her own upstairs. It was after hours and she got through to somebody who didn’t really speak very good English and couldn’t really deal with it, so that wasn’t helpful and [young person] was very confused by that. (...) somebody did then call her back and I think they had a good chat and it was kind of helpful.” (Parent 6)

Facilitators

Document analysis

Document analysis showed that there were several factors that facilitated the implementation, including a strong implementation team who met regularly; the recruitment of good operational staff, and receiving funding to make up for staffing shortfalls.

Focus groups

Building Extended HOPE on the existing HOPE service was described as a facilitator to innovation by many participants as staff, processes, patients and professional relationships (particularly across disciplines) had already been established, meaning there was already a reputation for high quality care and support from stakeholders and senior management. In addition, establishment of the multidisciplinary team was described as a key facilitator to the effectiveness of Extended HOPE, as staff with different areas of expertise were able to share skills and support each other.

Young people

Some young people interviewed mentioned that it was easier to contact Extended HOPE than other mental health services, because staff knew them and they knew staff working there:

“you know who you're calling. It's quite small. You can call up, and if I said 'I want to speak to [staff],' they can say 'Oh, she's out at the moment. But she can call you back.', and you know that they actually will call you. (...) it's a lot more personal, and less intimidating.” (Young Person 1)

Parents

An important facilitator to parents accessing Extended HOPE was the fact that everything was logged when they called, and that staff generally knew the young people who were using the service, saving parents time from recounting the young person's history:

“It's very helpful if they have access to notes, because I think I've had, again, it wasn't with your service; actually, it was another service who said “Oh, I don't know, I don't know him.” It was like 'Read his notes then.' Because I know you can all access the notes. So generally speaking, the people I've spoken to at extended hours do know the situation, which I think is good. Because you don't want to have to sit there for half an hour explaining the history. So that's helpful” (Parent 5).

What is the impact of Extended HOPE and HOPE House on young person's mental health?

Summary

- in the Assessment and Support service, out of the 11 young people who had paired CGAS scores, 4 improved, 4 did not change and one deteriorated
- in HOPE House, CGAS scores did not change from admission to discharge, and the YP-CORE showed that level of symptomatology of most of the young people was at clinical level at admission and discharge
- confidence in the findings is very likely to change when a bigger sample is obtained

Routinely collected data was used in order to make the evaluation sustainable beyond the end of the evaluation. As opposed to a randomised controlled trial (RCT) where random allocation of participants ensures homogeneity of groups at baseline, this evaluation methodology entails challenges when identifying a comparator group that is actually comparable (for example, 2 groups without systematic differences at baseline). An approach that could be used to overcome this limitation is the use of synthetic controls, which was the original intention of this evaluation when trying to obtain pre-implementation data and contextual data. In future evaluations, a synthetic control group could be used, using propensity score matching on routine clinical data from other similar services or wider local authorities to try and make groups similar and more comparable. Despite this limitation, routinely collected data

was collected and analysed in order to explore how young people were (or were not) changing after using Extended HOPE and HOPE House.

Routinely collected data

Out of 11 young people who had paired CGAS scores, 9 had paired scores in different months. For those 9 young people the difference between the first and the last CGAS was calculated: 4 presented the same score, 4 improved by 10 points (one category), and one deteriorated by 30 points (3 categories). The period of time between measurements varied between 1 and 9 months, with an average of 5 months.

In HOPE House, the 13 young people in the 18 visits had paired CGAS scores. These did not vary between admission and discharge, or within young people between visits to HOPE House (for T1 and T2, M=41.56, SD=9.38, range=31 to 61). AFNCCF recommended this measure to the team because of its clinical usefulness. However, as young people stayed in HOPE House for less than 2 weeks (which is the time frame clinicians are asked to consider when completing the CGAS), scores could not reflect the changes that might have happened during young people's stay at Hope House. Thus, new outcome measures such as the Clinical Global Impression Scale (Busner & Targum, 2007) that do not require 14 days between measurement points, could be used.

Out of the 18 visits to HOPE House, 15 had information regarding YP-CORE at admission (T1) and 13 at discharge (T2). In terms of severity of symptoms, 14 (93%) were in the clinical range at admission and 12 (92%) were still in the clinical range at discharge. Most of the young people (9, 69%) who had paired YP-CORE and were in the clinical range at T1 did not reliably improve nor recover.

It is important to highlight that the results presented in this section are descriptive and our confidence in the findings is very likely to change when a bigger sample is obtained.

What are the results of Extended HOPE's cost-benefit analysis?

A cost-benefits analysis (CBA) for Extended HOPE was conducted by an independent party (York Consulting). The following is the report prepared by John Rodger and Matthew Cutmore.

CBA Constraints

- it has not been possible to directly analyse primary cost or outcome data for the Extended HOPE project
- the Extended HOPE project does not have a monitoring system in place to directly calculate support costs and outcomes
- it has not been possible to establish a historical comparator group from existing HOPE records
- there is no direct evidence regarding the sustainability of outcomes achieved by the Extended HOPE project

Approach to costing

- the costs take account of the total steady-state costs associated with providing support to young people. The table below details the different support scenarios offered by the Extended HOPE service

Table 4: Types of Extended HOPE contacts

	Nature of contact	Duration
Type 1	Telephone contact only	45 mins
Type 2	Telephone and face-to-face	3 hours
Type 3	Telephone and face-to-face and HOPE Stay	8 days
Type 4	Telephone and face-to-face and HOPE Stay and Day programme	10 days

- typically, we would have sought to analyse the costs and benefits by type of contact and young person. Unfortunately, data at this level was unavailable. Our analysis is therefore limited by the use of whole programme costs
- data relating to other services (for example, social care) supporting the young person around the same time as Extended HOPE was also unavailable

Estimated costs

- total Innovation programme costs for the Extended HOPE project were calculated to be £729,000
- the project estimated the steady-state annual running cost to be £658,000 (this has been selected as the CBA cost line)
- the project conducted a detailed analysis of 4 months of Extended HOPE activities and concluded that there were 423 support contacts corresponding to 68 young people
- annually this translates to 1269 contacts and 204 young people.
- the average cost per contact is £519 and the cost per young person supported £3,225

Classification of support by type of intervention

Type 1. Telephone contact only: 71%

Type 2. Telephone and face-to-face: 12%

Type 3. Telephone and face-to-face and HOPE Stay: 8.5%

Type 4. Telephone and face-to-face and HOPE Stay and Day programme: 8.5%

- it has not been possible to separately cost each of the cost delivery routes

The benefits: removal of adverse outcomes

- benefits or cost avoidance were calculated for the 12 months immediately after the young person exited support. Outcomes data for all cases was provided by the HOPE team. We provided advice about key outcomes, including the level of change required to claim each outcome. This was then translated into financial benefits by applying proxy values associated with these outcomes
- we cannot accurately predict what will happen to these young people in the future – there are too many variables. Although we recognise that the work of HOPE (and other support services) may benefit young people well in to their adult lives, to keep the model robust, we only capture benefits that are immediate and can be tracked
- when monetising outcomes into benefits, we have used only robust financial proxies

Calculating the outcomes:

- the Extended HOPE project analysed cases for 4 months and identified 82 measurable outcomes, which corresponded to 68 young people and 1.2 outcomes per young person.
- assuming the 4 months to be typical of all support, this was annualised to 246 outcomes and 204 young people.
- a cost per outcome of £2,675.

Table 5: Monetised adverse outcomes avoided

Adverse outcome avoided	Proxy description	Proxy value	No. of outcomes (annually)	Benefit
A&E presentation	The average cost per incident of a trip to A & E. We assume one trip only as after the first visit professionals could identify underlying issues and administer appropriate treatment and/or make a referral to other services.	£117	75	£8,775
Placement breakdown	In the event of a placement breakdown, we assume the young person was in foster care (a typical placement setting) and one week of temporary residential care was provided whilst an alternate placement was found.	£3,089	45	£139,005
T4 admissions	Mental health inpatients, hospital attendance – average cost for children and adolescents over 6 weeks	£28,392	48	£1,362,816
Short stay Paediatrics ward	In relation to inpatient treatment, we adopt the NHS methodology of costing per finished consultant episodes (FCE). We use the average cost of a non-elective inpatient short stay.	£1,542	27	£41,634
Police involvement	The average cost to the police service of an incident of crime/ASB. It is assumed appropriate action to prevent repeat crime is taken following the initial incident.	£663	12	£7,956
Police Custody	Average cost to the police service to detain an individual for 24 hours.	£769	6	£4,614

Adverse outcome avoided	Proxy description	Proxy value	No. of outcomes (annually)	Benefit
Out of county placement	Average cost of LAC where 50% of cases are high-cost placement scenario for a young person with complex behavioural and/or emotional needs (such as a residential home) and 50% foster care. We assume the placement has a view for eventual reunification or kinship care and therefore only cost for 3 months.	£30,718	6	£184,308
LAC	Average cost associated with placing a young person in a typical foster care setting. We assume the placement has a view for eventual reunification or kinship care and therefore only cost for 3 months.	£8,055	27	£217,485
Total			246	£1,966,593

Fiscal return on investment (FROI)

- the fiscal return on investment (FROI) shows the benefit or cost ratio for the Extended HOPE service
- total benefits, understood as adverse outcomes avoided, were calculated to be £1,966,593
- total annual steady-state costs were calculated to be £658,000
- based on the above, the Fiscal Return on Investment is shown to be 3.0
- this demonstrates a very positive cost benefit outcome equating to a saving of £3 for every £1 invested in the Extended HOPE project

Sustainability

- in order to take into account the sustainability of outcomes we have calculated the Fiscal Return on Investment under 3 scenarios
- optimistic: all outcomes sustained for 12 months = FROI 3.0
- base: 75% of all outcomes sustained for 12 months = FROI 2.4
- pessimistic: 50% of all outcomes sustained for 12 months = FROI 1.5

Conclusions

- due to data limitations, it has been necessary to make a number of constraining assumptions to conduct the cost benefit analysis
- based on annual costs of £658,000 and estimated annual benefits of £1,966,593, the programme reveals a very positive FROI of 3.0: a saving of approximately £3 for every £1 invested
- even under the most pessimistic scenario of 50% outcome sustainability, the FROI remains positive at 1.5

Recommendations

- the Extended HOPE project needs to calculate the staff time associated with different types of interventions and fine tune the costs
- the project needs to record outcomes against every young person supported on an annual basis to improve the robustness of estimated benefits
- the project needs to track young people 12 months after support to check the sustainability of outcomes
- the project should repeat this CBA exercised based on the information generated above in 12 months' time to test and improve CBA estimates

Limitations of this evaluation and plans for the future

Limitations of this evaluation

- as the implementation and the evaluation of the programme started at the same time, delays in implementation entailed delays in the evaluation and the available timeframe made only a partial evaluation of HOPE House possible. In addition, this also meant that some of the interviews with young people or parents were conducted when the young person was still experiencing high levels of emotional and behavioural difficulties, which introduced higher levels of uncertainty to the outcome that parents and young people thought Extended HOPE and HOPE House could achieve. This was also linked to the number of young people who agreed to be interviewed, as sometimes young people wanted to participate but felt anxious or fragile and preferred not to do the interview
- the fact that implementation and evaluation started at the same time also added an extra layer of complexity to the implementation of the project, because, when the team was organising processes and procedures, they also had to recruit young people and parents for the interviews
- interviewed parents and young people sometimes had difficulties differentiating which staff belonged to which HOPE service (Extended HOPE, HOPE and HOPE House) or other services (such as CAMHS). Even though this was seen by researchers as evidence of HOPE services' coordination and fluid communication: it meant that, in some instances, parents and young people might have been referring to all HOPE services, including the HOPE Day Service which was not part of this evaluation
- data at local authority level was used to compare indicators before and after Extended HOPE's implementation. However, causality should not be inferred because Extended HOPE is currently reaching only a small percentage of the children and young people who could benefit from such a programme, and also because factors other than Extended HOPE are likely to be influencing changes and/or fluctuations in numbers in the contextual data
- due to capacity issues, Surrey Council was only able to provide one indicator at local authority level, which was the total number of children in care. For the purposes of evaluating the impact of Extended HOPE in the future, it is recommended that the number of children entering care per month is used
- additional social care data, such as consultation with children's services, would be useful to reflect combined with data on impact on health services
- a limitation of the data collected in Extended HOPE was that contact logs did not include:

- a record of who was calling (for example, young person, parent, or foster carer), and hence data could not be analysed by those groups in order to identify differences in, for example, support received
- demographic information. As the evaluation is reliant on the data provided by the service, and the service did not provide demographic information, we could not explore which complexity factors were associated with different experiences or outcomes of Extended HOPE.
- even though efforts were made to have a comparator group for exploring the impact of Extended HOPE and HOPE House on young people's mental health, it was not possible to obtain routinely collected data for a comparable group of young people
- sample size of outcome data: in the Assessment and Support Service only 9 young people had paired CGAS scores in different months (out of the 48 families that had a face-to-face visit) and, because HOPE House had been running for only a few months, the sample size of outcome data was small (specifically, 13 young people in 18 visits). Hence, results presented were mostly descriptive and our confidence in the findings is very likely to change when a bigger sample is obtained. However, when analyses include larger sample, they should take into account the time elapsed between measurement points, as for example with the CGAS in the Assessment and Support Service this varied between 1 and 9 months
- as data was routinely collected, there may be variations in how data was collected and recorded. This is especially important for the information recorded in the contact log under the "prevention" heading, as whether certain events, such as Tier 4 admission or A&E admission, were prevented depended on the criteria of the team completing the contact log. At the time this report was written there was no protocol available for this, so staff entered the actions prevented and then the log was looked at by the Team Managers who checked the individual cases and looked to see whether, over the period of time, an action like Tier 4 admission had been prevented). The implementation team reported that staff had been able to accurately record preventions, such as A&E presentation, paediatric ward stay, and police detention as it is an immediate prevention. However, they also reported that they have found that actions such as Tier 4 admission entailed larger speculation from staff, as they were not immediate and took a period of support to prevent

Appropriateness of the evaluative approach

Bearing in mind the above limitations, the strengths of the evaluation were that:

- it addressed most of the central questions from different perspectives (staff, young people, and parents), using a number of data sources
- it included triangulation of data, which may result in more reliable findings
- the evaluation drawing on quantitative data can be sustained by Extended HOPE and HOPE House after the end of our evaluation. It would be useful to continue to capture qualitative data from service users. However this would be more sustainable if open-ended responses to questionnaires (such as on the CHI ESQ) were used, as opposed to interviews or focus groups

Capacity built for future evaluation and the sustainability of the evaluation

We will work with the implementation team to feed back findings from the evaluation to ensure lessons learnt regarding barriers and facilitators to implementation are considered when sustaining Extended HOPE and HOPE House after the end of the project. We will be particularly focused on advising how best to sustain ongoing treatment and service evaluation. This may include, for instance, the recommendations outlined in the next section, embedding the use of the participant observation tool as a tool for self-reflection and evaluation, or developing templates for the implementation team to update analyses when new data, such as run charts of routine clinical data, is collected. The exit strategy will involve the implementation team reviewing the evaluation report and providing feedback, and a handover period where the implementation team can ask evaluation questions post-exit. The exit strategy will be particularly focused on ensuring the implementation team is left with the skills, understanding and planning to collect, analyse, interpret and disseminate outcomes in accordance with the medium- and long-term aims.

Recommendations for future evaluation

In addition to the above, the following recommendations are made:

- revise the measures used for HOPE House. Even though CGAS was recommended by AFNCCF, a possible addition to HOPE House outcome measures could be the Clinical Global Impression Scale (Busner & Targum, 2007), which is completed by clinicians and consists of 2 questions answered in a 7-point scale. The first question measures the severity of psychopathology and the second question measures the change from the initiation of the treatment. This is due to the length of time young people usually stay at HOPE House, which is a maximum of 10 days but most frequently 4 days
- regarding Extended HOPE data, it is recommended that the recipient of support (young person, parent, or foster carer) and his or her demographic information (for

example, age, gender, and, in the case of the young person, whether he or she is LAC) is recorded in the contact log

- continuing the evaluation for a longer time period and for a larger number of young people is also recommended. Outcome results presented in this report were mostly descriptive and our confidence in the findings is very likely to change when a bigger sample is obtained

Implications and recommendations for policy and practice

Capacity and sustainability of the innovation

From a sustainability perspective, the next 2 years of Extended HOPE are covered. The team has secured a further 2.5 years of funding from the Clinical Commissioning Group Transformation funding and are in discussion with the Police about them buying into the service. In addition, Surrey and Borders Partnership funding of salaries for health staff has been secured for a further 4 years and discussions with Surrey County Council around budget were underway when this report was written.

In addition, as stated above, the CBA report from York Consulting stipulated that, in order to take into account sustainability of outcomes we have calculated the Fiscal Return on Investment (FROI) under 3 scenarios:

- optimistic: (all outcomes sustained for 12 months) = FROI 3.0
- base: (75% of all outcomes sustained for 12 months) = FROI 2.4
- pessimistic: (50% of all outcomes sustained for 12 months) = FROI 1.5

This implies that Extended HOPE is sustainable even in a pessimistic scenario, in which a saving of approximately £1.5 for every £1 invested is projected.

Conditions necessary for this innovation to be embedded

In Surrey there is a need for Extended HOPE to provide appropriate care for young people and families in crisis, as indicated by the findings of this evaluation. In particular, parents reported needing the out-of-hours support when facing their young people's emotional or behavioural crises, and staff reported high levels of need from parents and young people. Young people, on the other hand, reported that the service covered their parents' needs better than their needs, and that more home visits would be needed for them. More resources would make this possible, as well as keeping HOPE House running for 7 days a week.

Wider dissemination of information about Extended HOPE would help the innovation to be embedded and to reach a greater number of young people and parents. However, dissemination would also mean that more young people and families would access Extended HOPE and HOPE House, and hence more resources would be needed in order to cope with future staffing and demand. In addition, it was crucial for parents and young people to feel that Extended HOPE staff knew them and that they knew staff; hence, if a larger number of young people and parents or carers accessed Extended

HOPE it would be pivotal to implement clear operational procedures that would allow fluid communication between members of staff, so that, in instances where a young person's call was received by a staff member who was not familiar with the case, he or she could rapidly redirect the call to someone in the team who was. Even though this is current practice in Extended HOPE, maintaining it when the service receives a larger volume of contacts may result in another level of complexity and new challenges.

Consideration of future development of the innovation and wider application

Future developments of Extended HOPE as identified in the evaluation include the following:

- wider dissemination of information about Extended HOPE would help the innovation to be embedded and to reach a greater number of young people and carers. Funding for this should not present a challenge, since the service has secured funding for at least 2.5 years. However, it would be important to maintain the familiarity that parents and young people feel with Extended HOPE's staff, even with larger numbers of service users, as this emerged as crucial for young people and parents
- the results of this evaluation suggested that service users experienced Extended HOPE as meeting parents' needs more fully than young people's needs. Considerations for meeting young people's needs more fully – as suggested by young people – included implementing a direct line for contacting Extended HOPE and increasing the number of home visits
- building on the success of the cross-sector working and the multidisciplinary team, cross-sector training would be recommended to further integrate staff across both health and social care, in addition to clear operational procedures that allowed fluid communication between members of staff
- service users use Extended HOPE on a short-term basis, meaning there is little time for mental health outcomes to change. A longer follow-up period of those accessing Extended HOPE may be necessary in order to capture changes that might take longer to materialise. In addition, our confidence in quantitative results will increase once a bigger sample is collected. New outcome measures, such as the Clinical Global Impression Scale (Busner & Targum, 2007), could be used, given the length of time that young people usually stay at HOPE House.
- it is recommended that a direct line of contact for parents and carers or young people is implemented, as opposed to accessing Extended HOPE via the EDT. This may allow a more immediate response from Extended HOPE, which could particularly benefit young people because, as reported by parents, delays in

response sometimes deter young people from opening up. Therefore, a direct line might be a step closer to young people feeling that Extended HOPE could be as helpful for them as they think it is for their parents

References

Busner, J., & Targum, S. D. (2007). The clinical global impressions scale: applying a research tool in clinical practice. *Psychiatry* (Edgmont). 4 (7), 28.

Campbell, D. ['Scandal of putting mentally ill children in police cells must end, says MP'](#). *Guardian* 17 August 2014 (viewed on 5 July 2016)

Department for Education. ['Local authority interaction tool \(LAIT\)'](#) 2016 (viewed on 5 July 2016)

Ford T., Vostanis P., Meltzer H. & Goodman R. (2007). Psychiatric disorder among British children looked after by local authorities: comparison with children living in private households. *British Journal of Psychiatry*. 190, 319– 325.

Healthwatch Suffolk. ['CQC map highlights worrying restrictions in access to health-based places of safety for young people experiencing a mental health crisis'](#) 2015 (viewed on 5 July 2016)

House of Commons. ['Children's and adolescents' mental health and CAMHS – Health Committee Contents'](#) 2014 (viewed on 5 July 2016)

Institute of Public Care. ['What works in promoting good outcomes for Looked After children and young people?'](#) 2006 (viewed on 5 July 2016)

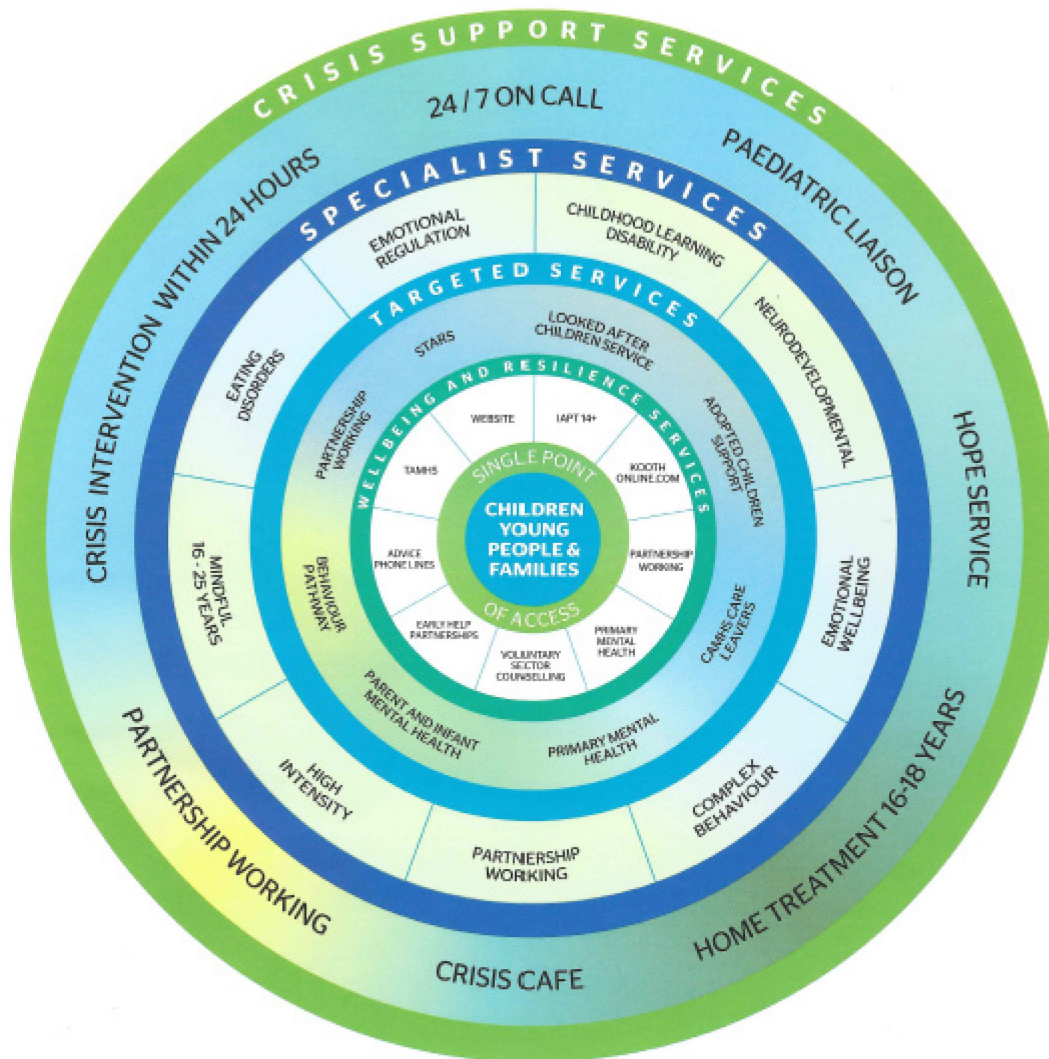
Mind. ['Listening to experience: An independent inquiry into acute and crisis mental healthcare'](#) 2011 (viewed on 5 July 2016)

NHS England. ['The NHS Belongs to the People: A Call to Action'](#) 2013 (viewed on 5 July 2016)

Office for National Statistics (ONS). ['Population Estimates Analysis Tool'](#) 2016 (viewed on 5 July 2016)

Appendices

Appendix A: Service model in Surrey



Appendix B: Analysis of Contact Logs, Extended HOPE (Oct 2015 to July 2016)

Table 6: Number of contacts logged per month and day of the week

Days	Oct -15	Nov -15	Dec -15	Jan -16	Feb -16	Mar-16	Sub-total (Oct -15 to Mar-15)	Apr -16	May -16	Jun-16	Jul-16	Sub-total (April -16 to Jul-16)	Total
Mon								1	18	12	18	49	49
Tues								3	11	15	9	38	38
Wed								1	7	18	12	38	38
Thurs	2	5	6	8	12	7	40	7	13	22	12	54	94
Fri	5	5	11	16	20	13	70	10	20	24	9	63	133
Sat	8	13	22	30	26	13	112	24	16	25	20	85	197
Sun	5	16	19	28	23	13	104	7	23	39	27	96	200
Total	20	39	58	82	81	46	326	53	108	155	107	423	749

Table 7: Referral source for contacts logged per month

Referral source	Oct-15	Nov -15	Dec -15	Jan-16	Feb -16	Mar -16	Apr-16	May -16	Jun -16	Jul-16	Total
HOPE	8	14	34	40	50	30	29	71	85	44	405
Parent /Carer	7	7	10	29	5	3	6	22	39	32	160
YP	2	8	4	7	22	8	5	6	15	12	89
CAMHS			3	3		1	9		10	7	33
Other		8		1				7	3	7	26
EIIP			2	1		4	2				9
Police	1		1	1			1		2	3	9
A&E			1				1		1	1	4
Emergency Duty Team	1	1			1						3
Paediatric Ward	1	1	1								3
CJLDS					2						2
Hospital								2			2
Wayside			2								2
AMHP					1						1
HTT										1	1
Grand Total	20	39	58	82	81	46	53	108	155	107	749

Table 8: Presenting problem for contacts logged per month

Presenting problem	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Total
Admissions/ discharges/ leave from hospital	7	18	21	18	28	13	3	19	37	33	197
Low mood/distress/ concerns about state of mind		4	4	18	25	17	15	20	28	12	143
Other support	3	1	4	16	7	3	7	26	51	22	140
Self harm/suicidal thoughts/attempts	2	11	4	4	11	1	19	10	10	15	87
Family/home support needed	2	2	15	8	1	3	1	14	9	7	62
Behaviour concerns	6		2	7	1	1	5	6	13	10	51
Crisis/risk response		3	1	5	8			3	4	6	30
Psychotic episode/ symptoms			2	2		8	3	9	2	1	27
Medication			2	1				1	1		5
Placement concerns				3							3
Crisis visit			1								1
Missing young person			1								1
Referral to other service			1								1
Grand Total	20	39	58	82	81	46	53	108	155	106	748

Table 9: Clinical outcomes for telephone support and face-to-face contacts per month

Type support / clinical outcome	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Total
Telephone support	16	26	45	70	63	39	42	74	105	72	552
Support/advice given	15	19	35	70	55	36	37	71	97	69	504
MH/risk assessment		7	8		7	3	3		4		32
Sent to A&E			1		1		2	2	2	1	9
No change								1	2	2	5
Admit to psychiatric ward	1		1								2
Face-to-face	4	11	11	6	9	6	5	23	21	29	125
MH/risk assessment	4	10	8	6	8	5	5	19	12	21	98
Support/advice given			2					3	4	1	10
Admit to HOPE House								1	4	3	8
Sent to A&E									1	2	3
Discharge from A&E			1			1					2
Discharge from S136					1					1	2
Admit to psych ward										1	1
Discharge from paediatric ward		1									1
Total	20	37	56	76	72	45	47	97	126	101	677

Table 10: Number and percentage of telephone and face-to-face contacts that occurred in intervals of time of 2 hours

Time	Telephone	Face-to-face
Before 17:00	25 (5%)	10 (8%)
Between 17:00 and 19:00	175 (32%)	46 (38%)
Between 19:00 and 21:00	207 (38%)	48 (39%)
Between 21:00 and 23:00	138 (25%)	18 (15%)
Total	545	122

Table 11: Actions prevented with telephone and face-to-face contacts per month

Prevented actions	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Total
Telephone support	16	26	45	70	63	39	42	74	105	72	552
No prevention	7	6	13	32	18	11	11	20	43	24	185
Tier 4 admission	4	6	16		12	11	13	23	27	14	126
A&E presentation	1	6	2	14	12	8	3	11	24	11	92
Placement breakdown		6	8	13	10	4	7	15	11	14	88
Paediatric ward stay	4	2	4	10	8	5	7	5		8	53
Police detention					2		1				3
Detained under S136 MH act			2	1							3
A&E Admission										1	1
n/a					1						1
Face-to-face	4	11	11	6	9	6	5	23	21	29	125
No prevention		3	4	4	5	1	1	4	4	4	30
Tier 4 admission					1	4	3	16	1	9	34
A&E presentation	1	3	1	2	3			1	11	11	33
Placement breakdown		2	2			1	1	1	4	1	12
Paediatric ward stay	3	2	2					1	1	2	11
Detained under S136 MH act		1	2							1	4
Out of county placement										1	1
Total	20	37	56	76	72	45	47	97	126	101	677

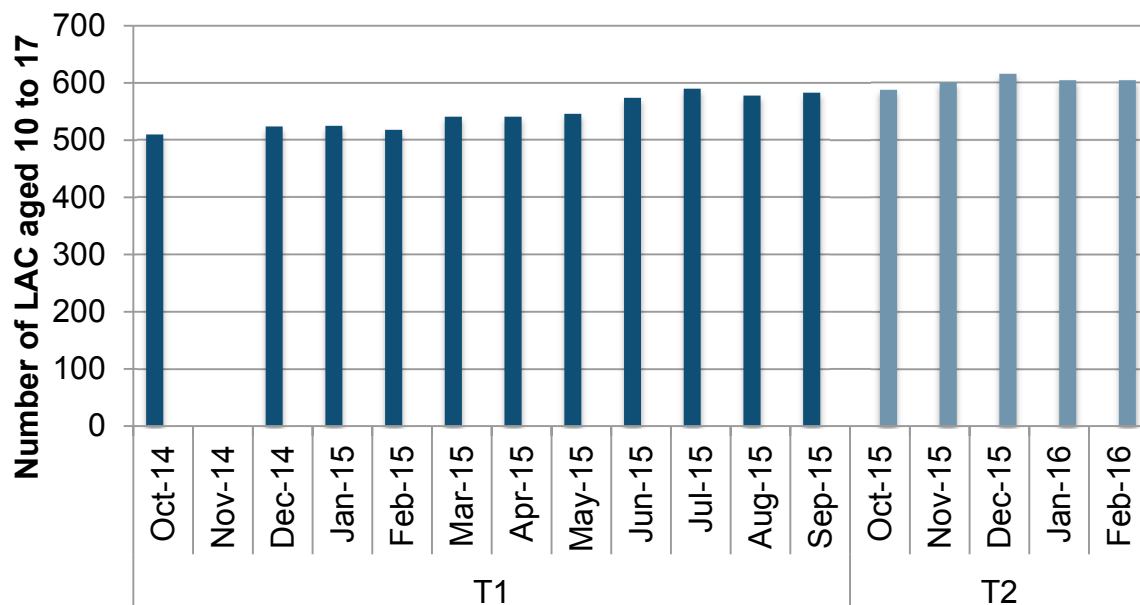
Appendix C: Contextual data (October 2014 to February 2016)

Number of children in care

Table 12: Number of children in care by age groups and months

Month	Aged under 10 (0 to 9)	Aged 10 plus (10 to 17)	Total (0 to 17)
Oct-14	247	510	757
Nov-14	-	-	767
Dec-14	254	524	778
Jan-15	254	525	779
Feb-15	253	518	771
Mar-15	243	541	784
Apr-15	249	541	790
May-15	245	546	791
Jun-15	257	574	831
Jul-15	262	590	852
Aug-15	268	578	846
Sep-15	268	583	851
Oct-15	265	588	853
Nov-15	274	601	875
Dec-15	268	616	884
Jan-16	264	605	869
Feb-16	269	605	874

Figure 8: Number of young people aged 10 to 17 years who were in care by month (from October 2014 until February 2016)



Rate of LAC per 10,000 children

Table 13: Rate of children in care per 10,000 children by age groups and months

Month	Rate aged under 10	Rate aged 10 plus	Overall rate
Oct-14	16.9	47.1	21.9
Nov-14	-	-	30.1
Dec-14	17.4	48.4	22.5
Jan-15	17.4	48.5	22.5
Feb-15	17.3	47.9	22.2
Mar-15	16.6	50.0	23.2
Apr-15	17.0	50.0	23.2
May-15	16.7	50.4	23.4
Jun-15	17.6	53.0	24.6
Jul-15	17.9	54.5	25.3
Aug-15	18.3	53.4	24.8
Sep-15	18.3	53.9	25.0
Oct-15	18.1	54.3	25.2
Nov-15	18.7	55.5	25.8
Dec-15	18.3	56.9	26.4
Jan-16	18.0	55.9	26.0
Feb-16	18.4	55.9	26.0



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Any enquiries regarding this publication should be sent to us at:

richard.white@education.gov.uk or www.education.gov.uk/contactus

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