



Department
for Education

An evaluation of the Bradford B Positive Pathways innovation programme

Evaluation report

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Key messages

Bradford's B Positive Pathways (BPP) incorporated 2 innovative practice models (No Wrong Door and Mockingbird) to enhance the service offer available to looked after children, adolescents on the edge of care, and foster families. The evaluation of the BPP innovation derived the following key messages for policy and practice:

- multi-agency teams were found to effectively meet the complex needs of adolescents on the edge of care through provision of intensive, integrated support according to disciplinary expertise and therapeutically-informed practice. This additional support for adolescents on the edge of care was found to have a positive impact in preventing possible entry into care
- collaborative multi-agency working also supported the direct work of residential-outreach practitioners and allowed for the needs of children and young people to be understood and met (sometimes, bypassing the need for lengthy referral process to external services)
- consistency of strategic leadership is imperative when embedding innovation within children's social care services and promoting sustainability of approach. Bradford's experience of turnover in senior leadership and managerial churn within the service forestalled implementation progress. This disruption inhibited the ability to fully embed new practice models and to also demonstrate the impact of BPP within the operational timeframe
- a commitment to quantitative data generation, recording and analysis is required to adequately capture impact and further develop the service where required. This process requires strategic governance to ensure that there are ongoing feedback mechanisms to operational staff as to its importance
- the operation of the residential component is dependent upon the ease of integration of multi-agency specialists from health, policing and education that work alongside BPP homes managers and practitioners. It is essential that the right infrastructure is in place at implementation to facilitate multi-agency working within the social care environment. This would allow the workforce to capitalise on the strength of the model, embed new ways of working and build upon any recognised positive impact
- given the complexities of implementing and operating an innovation, consideration of the perspectives of the workforce and the voice of the child becomes paramount to understanding how new ways of working and service change and development are experienced in practice.

Executive summary

Introduction

Bradford B Positive Pathways (BPP) is a £3.2 million programme funded through Round 2 of the Department for Education's Children's Social Care Innovation Programme (Innovation Programme hereafter). The BPP Innovation Programme adopts and adapts the North Yorkshire County Council (NYCC) No Wrong Door model as a core residential service component to provide enhanced support to children and young people who are within or on the edge of the care system. BPP also included The Mockingbird Family Model (Mockingbird) for its core fostering service component, an approach underpinned by a peer support principle to promote placement stability and enhance carer wellbeing. The evaluation was carried out by a team of researchers from the Rees Centre, University of Oxford, and the University of York.

The project

BPP's residential component provides integrated, multi-agency specialist care (from professionals within health, education, and policing) across 4 of Bradford's residential children's homes (3 long-term specialist homes and 1 emergency short term hub home) to provide enhanced individual support for looked after children and young people with multi-faceted needs. This component also provides access to specialist support through its outreach service, which works with adolescents in their family home, or emergency hub home, to prevent entry into care or support family reunification. The BPP fostering component introduces Mockingbird in the form of 2 satellite constellations of foster families, including 1 constellation for carers who are related persons (family and friends) of involved children and young people and another for mainstream (unrelated) foster families. Satellite carers are supported by an experienced foster carer (the hub home carer) and through access to peer support network of other satellite carers. The 2 service components are consolidated by a common model of care to embed therapeutically-informed practice in each of its service components through training, inter-professional consultation and opportunities for shared learning. The BPP programme aimed to enhance the service for looked after children and adolescents on the edge of care to improve outcomes relating to accommodation stability (placement stability and family reunification), wellbeing and association with risk, and bring immediate and longer-term cost savings to the local authority and partner agencies.

The evaluation

The evaluation of BPP spanned 2 timepoints (baseline and endpoint) and comprised a process strand, assessing the programme's implementation and operational facilitators and inhibitors; an impact strand, assessing the extent to which the programme's intended

outcomes were achieved, and the mechanisms through which this occurred; and, an economic strand, quantifying through a costs benefits analysis any cost savings or costs avoided associated with the programme. A range of primary data collection methods were employed with those involved in each service. The methods and total sample numbers across the 2 timepoints were: interviews with BPP management (21), multi-agency specialists (10), Mockingbird carers (17), and involved children and young people (60); focus groups with multi-agency specialists (9); and, surveys with the residential-outreach practitioners and specialists (97 responses). A data tracker provided measurement of progress of children and young people involved in the residential-outreach service, at a cohort and individual child-level, for key outcome indicators. Additionally, Ofsted Annex A forms data was examined for the BPP residential homes and Bradford's 4 mainstream residential homes. For the fostering component, interview data from the Fostering Network team (6) involved in Mockingbird in Bradford was incorporated into the final reporting.

Key findings

Overall, the process and impact findings demonstrated a degree of progress according to the programme's intended outcomes and highlighted the added value the innovation brought to the workforce and children and young people.

Process

The flexibility associated with having license to adapt existing practice models according to local circumstance and the receptibility of service leads to innovation supported the implementation of the BPP programme. Despite turnover in strategic leadership throughout the operational period, the commitment of service-level management to the programme was found to promote positive staff morale and the level of adaptivity required to deliver innovative practice. Effective relationships were established with multi-agency partners, through shared goals and learning. The introduction of BPP also stimulated further impetus to work flexibly and responsively towards service-level goals, allowing the authority to begin to test new needs-led initiatives.

Impact

The BPP outreach service data demonstrated that most adolescents considered to be on the edge of care (just over 90% of closed cases at evaluation endpoint) were diverted from a care placement. There was evidence of increased accommodation stability provided by data on destinations aligned to care planning following placement in a BPP home (for example return home, step-down into a mainstream non-specialist home, transition to foster care placements, and comparatively lengthier average length of stay providing some indication of stability). Furthermore, results from a standardised measure

of emotional and behaviour traits (the SDQ) provided indication of improved wellbeing in children and young people. Just under two-thirds of the 94 children and young people residing in the BPP homes had improved wellbeing, which was demonstrated through a reduction in 2 of their SDQ scores since being referred to the BPP service. The evidence also indicated improved outcomes in respect to select indicators of risk for the cohort of children and young people supported through the residential component. Across the course of the programme intervention, association to risk along several indicators (such as substance use, self-harm, missing episodes, and other behaviours requiring police intervention, and child sexual exploitation) declined.

The BPP workforce highlighted the added value BPP brought, which provided contextual evidence on the improvements in outcomes recorded. The training according to a common model of care increased skills and confidence in direct work with children and young people. The integration of multi-agency specialists directs tailored and effective support planning, whilst also supporting the direct work of practitioners. Furthermore, integrated specialist support helped break down those barriers in accessing support services or interacting with professionals (such as psychologists, or police) and can mean previously unmet needs are addressed.

Additionally, there was evidence of progress in meeting the outcomes associated with the fostering component. Carers reported that involvement in Mockingbird has enhanced their wellbeing and family stability during difficult periods, as they are able to seek the advice of peers and gain tailored support from an experienced hub home carer. Carers also indicated that confidence in their caring status and skills has increased, particularly given the positive reinforcement received from peers and opportunity for training according to the common model of care.

Economic

The cost benefit analysis focused on 2 monetisable outcomes: diversion from care placement and reductions in police involvement associated with missing episodes and involvement in criminal behaviours. The benefit savings generated by both outcomes equated to circa £1 million but were deflated to take account of existing practice. For example, outreach support was in place before the commencement of BPP and was enhanced by the specialist roles introduced through the residential component. A return on investment calculation was carried out based on low, medium, and high levels of attribution. A ratio greater than 1 was evident at both the medium and high levels: 1.4 for the medium scenario, suggesting that for every £1 invested in the programme there is a potential saving of £1.40.

Lessons and implications

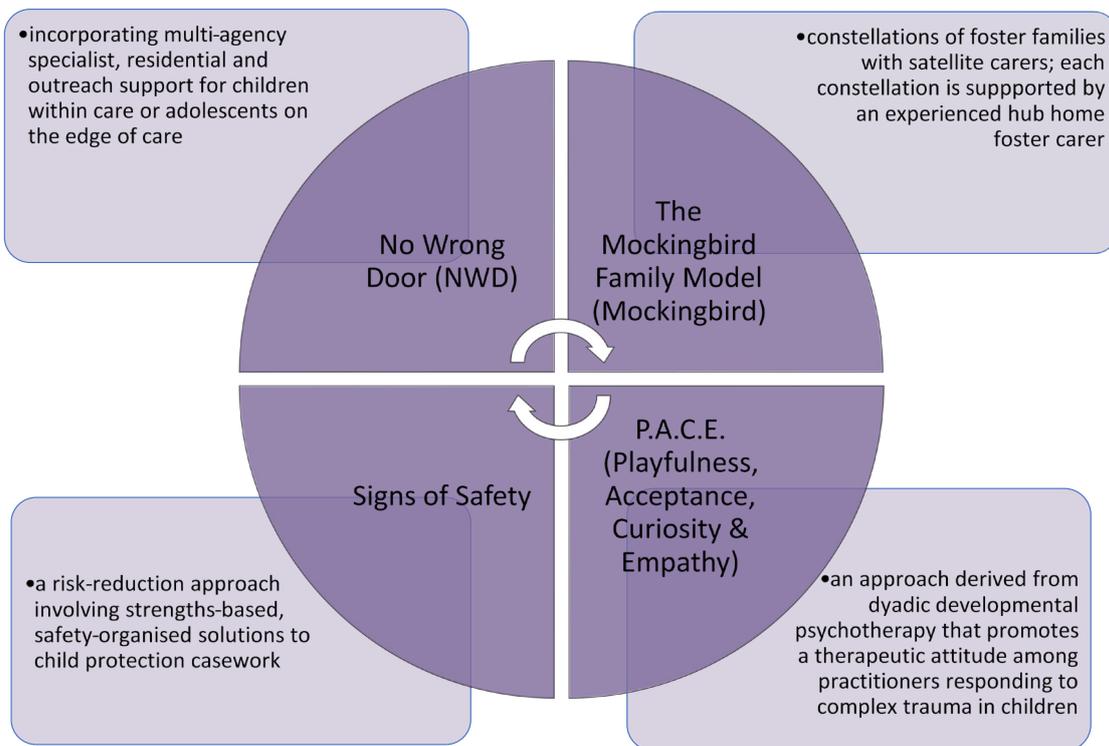
Overall, the evaluation demonstrated that BPP led to enhancement of services that were having a positive impact on children and young people as well as the workforce. The commitment of the workforce has allowed the service to remain operational, in the context of turnover in senior leadership and managerial churn. Closer working between strategic and operational leads is recommended going forward to further embed BPP practice. Ultimately, it is paramount that Bradford strengthens its commitment to data generation, recording and analysis to allow for the robust measurement of impact.

1. Overview of the project

Project context

The City of Bradford's B Positive Pathways (BPP) programme provides an integrated service for looked after children and adolescents on the edge of care. The BPP programme aligns with the broader strategic priorities of Bradford's Children and Young People and Families Plan, 2017-2020 (shown in Appendix 1). BPP incorporates a residential care component (incorporating an adapted version of the No Wrong Door model), a foster care component (utilising the Mockingbird Family Model), and a common model of care (comprising P.A.C.E. and Signs of Safety). The consolidation of these 4 components within a single programme aimed to promote placement stability or family reunification through provision of an integrated service for children and adolescents with complex, multi-faceted needs. The components are presented in Figure 1 below.

Figure 1: Bradford B Positive Pathways programme components



The City of Bradford is a Metropolitan District Council in the county of West Yorkshire. It is the fifth largest local authority in England with a population of 534,800 and has the fourth highest percentage of under-16s of any borough in England (Bradford MDC/ONS, 2018). At 31 March 2019, there were 1159 looked after children in Bradford, constituting a 15% increase (173 children) from commencement of BPP (April 1 2017). The national rate of looked after children per 10,000 children increased between 2015 to 2019, from 60 to 65 per 10,000 children (DfE, 2019). However, Bradford saw a sharper increase in its population of looked after children during the same period - from a rate of 63 to 82 per

10,000 children. The most recent published statistical breakdown of placement type in Bradford shows that between 2017-2018 the majority (70%) of its looked after children were in foster care (DfE, 2018).

BPP's residential component provides integrated care for children and young people with the most complex needs and risk profiles. The residential service centres on an adapted version of No Wrong Door (NWD) model, which aims to support adolescents to prevent entry into the care system and improve their long-term outcomes.¹ The BPP residential service offers integrated outreach support (multi-agency specialists working alongside outreach practitioners) for adolescents deemed to be on the 'edge of care' alongside an emergency, short-term residential placement in the hub home for adolescents as required.² The BPP residential service also provides 3 children's homes with integrated multi-agency specialist support (referred hereafter as the BPP specialist homes) for longer-term placements of looked after children with a particularly complex set of needs (such needs relate to neurodevelopmental, cognitive, psychological, social and behavioural concerns and association with risks). BPP's integrated residential service involves multi-agency specialists working together and alongside residential and outreach practitioners across the 4 homes and outreach service. The Fostering Network's Mockingbird Family Model (Mockingbird) is a foster care model drawing on the concept of an extended family of peers providing support to carers and children.³ The BPP fostering service introduces Mockingbird in the form of 2 satellite constellations of foster carers - 1 for carers who are related persons (family and friends) and another for mainstream (unrelated) foster families. Each constellation is supported by an experienced foster carer (referred to as the hub home carer), who offers stayovers for Mockingbird children and young people for additional support to carers and facilitates peer support within a constellation through informal meetings, shared activities and family get-togethers.

The model of care spans the programme and introduces 2 evidence-based practice approaches, namely P.A.C.E. and Signs of Safety.^{4 5} The programme promotes training in P.A.C.E. techniques, enabling the workforce to respond to children in their care in a therapeutically-informed way. In the residential-outreach setting, training in therapeutically-informed practice was enhanced by knowledge sharing opportunities

¹ No Wrong Door was developed by North Yorkshire County Council as part of the first Round of the Department for Education Children's Social Care Innovation Programme (see [No Wrong Door report](#)).

² Adolescents on the edge of care refers to those at imminent risk of either becoming looked after due to significant child protection concerns or entering long-term placements due to an observed escalation in risk or need(s).

³ For further information on the Mockingbird Family Model, visit [Fostering Network Mockingbird programme](#)

⁴ For further information on this approach visit [Signs of Safety](#)

⁵ Commonly referred to as P.A.C.E., the practice technique of Playfulness, Acceptance, Curiosity and Empathy is central to Dyadic Developmental Psychotherapy; for further information visit [DDP network](#)

between practitioners and specialists through the Team Teach approach.⁶ Central to the residential service is the training of all staff in Signs of Safety, so to encourage restorative and strengths-based responses toward children and young people living in the 4 BPP homes. The overarching aim of incorporating a common model of care is the promotion of a sustained carer-child relationship.

The 4 components shown in Figure 1 were evaluated in Round 1 of the Innovation Programme (McDermid et al., 2016; Baginsky et al., 2017; Luckock et al., 2017; Lushey et al., 2017). Previous evaluations and impact assessments have also been undertaken of Signs of Safety in the UK and internationally (Skrypek et al., 2012; Idzelis Rothe et al., 2013; Sheehan et al., 2018). The Mockingbird model has previously been evaluated in the US prior to introduction in the UK (NICF, 2007) and is presently being evaluated as part of the DfE Innovation Programme national evaluation in 12 areas.⁷

Programme aims and intended outcomes

As set out in the authority's original proposal to the DfE, BPP intended to meet the following outcomes by March 2020:

- reduction in the number of looked after children by a total of 75 over a 2-year period, both preventing entry into care and supporting adolescents to return home
- reduction in the number of out of authority placements by a total of 20 over 2 years
- increased proportion of looked after children in family placements over 2 years, including family reunification where possible
- increased placement stability for children in residential and foster care
- increased educational engagement
- increased transitional support for young people leaving the BPP service (including developing independent and supported accommodation)
- reduction in proportion of looked after children and edge of care adolescents experiencing or developing a multiple set of complex needs that are not identified or addressed
- all children in specialist placements to be supported through psychologically-informed support plans (focussed towards reducing risk taking, placement breakdowns, crises, and self-harming)

⁶ For further information on this approach visit [Team Teach](#)

⁷ Ott, E., Sanders-Ellis, D., Pinto, V., and Trivedi, H. Mockingbird programme: Final evaluation report (forthcoming).

- evidence of improvements in the skills, performance, and job satisfaction of the workforce (including foster carers and residential practitioners)
- significant, cashable savings for the council and its partners as evidenced by the cost benefits analysis.

At programme commencement, the projected split of funding across the 2 different service components was 82% for residential and 18% for fostering. The target number of children and young people for the residential-outreach service was 100 (including home placements of outreach service cases) and 20 for fostering. For the residential-outreach service, the target numbers have been exceeded with 126 involved children and young people in the year ending 2019 (see Appendix 2 for a chart showing residential service use and completion). As of January 2019, the target number of children and young people for fostering was met with 21 children and young people placed in 10 satellite homes across both constellations. At month ending July 2019, there were 26 involved children and young people, with 12 living within 7 satellite homes within the mainstream constellation and 14 living in 7 homes within the related persons' constellation. (The final fostering service numbers provided here preceded the suspension of the related persons' constellation, the reason for which is detailed below.)

Upon implementation, a further intended outcome was incorporated to track the number of residential children going missing from BPP homes and any calls from these homes that sought the assistance of police (referred to as calls for service). This tracking would help establish if the programme contributed to any potential reduction in the number of recorded missing episodes and calls for service. Other major changes came in response to the sustained increase in the number of looked after children across the local authority (as identified above in Project Context).

Project activities

To achieve its intended outcomes, the programme delivered the following activities:

- multi-agency care hubs built around 4 specialist residential care homes and associated outreach support, based on adapting North Yorkshire's NWD model to the Bradford context
- strengthened foster care provision using Mockingbird
- multi-agency, cross-discipline training in P.A.C.E. and Signs of Safety
- a strengthened outreach service for adolescents on the edge of care, one that promotes integrated support and access to therapeutic care, consistent relationships, safety, and better engagement in education and training.

BPP commenced on 1 April 2017, although some elements started later. The recruitment of the 8 BPP specialists (for the residential component) was staggered between March and November 2018. Delays in the recruitment of these specialists meant that children and young people were not receiving the full intervention as the project was not fully operational. Consequently, the evaluation findings refer to any available data that was recorded across different indicators from the period when the programme first became operational (April 2017) until evaluation endpoint (year ending 2019). The BPP residential component was not fully operational until November 2018 upon recruitment of a complete teams of specialists, which had implications for the analysis of the impact of BPP as the tracking of outcomes indicators began at varying starting points across the period of operation (the time period in which each outcome was tracked is stipulated within the findings and any related appendices).

The 2 core service components of BPP (residential and fostering), which are the focus of this evaluation are continuations of Round 1 innovation projects. The multi-agency integrated care hubs that support children and young people within or on the edge of the care system are based on North Yorkshire's NWD model (Lushey et al., 2017) and Mockingbird was introduced in 8 fostering providers as part of Round 1, with the evaluation focusing on early implementation (McDermid et al., 2016). The implementation and operation of the BPP model is being supported by North Yorkshire, as part of their Partners in Practice (PiP) role.

Major changes to planned activities since commencement:

- Bradford experienced a turnover of staff (including senior strategic leads, service management and data analyst) across the operational period, which impacted upon the resilience of the programme beyond implementation (the consequences of such turnover will be detailed in the findings section)
- BPP introduced the specialist education worker role in September 2018. The education specialist is an additional post brought in to work with children and adolescents in the residential component of the project, across the hub home and outreach service. The remit of the education specialist is to identify and address any needs that inhibit educational engagement. An occupational therapist joined the team of health specialists in November 2018 to enhance capacity to deliver interventions across the residential service. The contracts for the 2 police liaison officers expired and, following review of the police partnership, 2 Police, Community and Support Officers (PCSOs) were recruited to the service in August 2019 (with an additional PCSO to be recruited at time of reporting). The PCSO activities will be spread across the 4 BPP homes and 4 LA mainstream homes
- 2 Mockingbird constellations were launched in Bradford in February 2018. By July 2019, the related persons (family and friends) constellation became suspended owing to a failed fidelity check (resulting from the high proportion of children identified as having an elevated need, when constellation diversity is promoted). Further change resulted from the re-organisation of fostering roles within the LA,

with the merger of the liaison worker and supervising social worker role, and Mockingbird carers began to be supported by a different professional. This was followed by the discontinuation of the mainstream constellation resulting from the resignation of the hub home carer. As of February 2020, both original constellations were no longer operating.

The DfE funding for BPP was initially for 2 years, but in November 2018 it was agreed that the money could be re-profiled into a third year. There is a staggered completion date for the 2 years with regards to multi-agency partnerships. The police partnership was reviewed in March 2019 and the health partnership was reviewed in March 2020. In April 2020, it was confirmed that Bradford secured 12 months additional funding from the DfE, meaning the residential component of BPP would continue past the Innovation Programme-funded period. The aim is to continue to collate evidence of demonstrative cost savings to secure the financial commitment of partners during subsequent years. Being able to evidence these savings, and the impact of BPP on the children and young people supported, will help to embed BPP components in the longer-term. The evaluation team will work with colleagues in Bradford during this period of additional funding to support the continuation of data collection and monitoring of outcomes going forward. Discussion between the Fostering Network and Bradford is also underway regarding the re-establishment of Mockingbird, which will draw upon learnings from the first round to achieve future sustainability of the model.

The programme's theory of change can be found in Appendix 3 with a brief narrative on its development, including the review of intended outcomes.

2. Overview of the evaluation

Evaluation questions

The evaluation of BPP comprised 3 main strands – process, impact and economic – that assessed the programme’s implementation, operation and outcomes associated with service development and delivery. Evaluation data was collected across 2 timepoints (baseline and endpoint). The evaluation addressed the following questions:

Process strand (via interviews and surveys with BPP management and the workforce):

- what facilitated or inhibited the implementation and operation of the BPP programme?
- consequently, what enables or limits longer-term sustainability?

Impact strand (via outcomes from child-level data, administrative data, interviews with children and young people, and focus groups and surveys with the BPP workforce):

- to what extent did BPP achieve its intended outcomes?
- what factors facilitated or inhibited the achievement of these intended outcomes?

Economic strand (via a cost benefit analysis of financial, administrative and outcome data):

- what are the cost savings or costs avoided associated with BPP, and are there savings to partner agencies that can also be attributed to the programme?

Evaluation methods

The evaluation of BPP was approved in December 2017 and, following ethics approval by the University of Oxford, commenced in March 2018. The evaluation employed a mixed methods research design and obtained qualitative and quantitative data. The evaluation’s primary focus is on NWD and Mockingbird elements of the programme within Bradford. Bradford has introduced P.A.C.E. and Signs of Safety training across the authority for those practitioners engaged in direct work with children and young people across the residential-outreach service. Subsequently, Bradford’s Mockingbird satellite carers also had access to training in the approaches. The BPP management team indicated at the outset of the project that these training elements would be subject to internal review and, consequently, there will be no need for external evaluation. However, the perceived added value of training in a common model of care was incorporated into this evaluation. The evaluation utilised quantitative longitudinal, child-level data to measure changes in outcomes, which was supplemented by qualitative data to provide an understanding of why change has or has not occurred as expected. Qualitative data

derived the facilitators and inhibitors to BPP's implementation, its operational impact, and degree of programme sustainability from the perspective of the workforce.

Analysis of baseline (time 1) process data was incorporated into interim reporting in March 2019. Interim findings highlighted how the process of implementation was experienced by the workforce and the attributed facilitators and inhibitors to the implementation of the programme. The interim findings also drew on the perspectives of children and young people involved in BPP and provided an indication of the programme's early impact through the intended outcomes observed. This final report will collate the evidence across all stages of the evaluation (process, impact and economic) and will append or finalise those pre-identified implications and lessons for policy and practice. As such, final reporting shall chiefly draw upon data collected at evaluation endpoint (time 2). Appendix 4 and 5 highlight the data collection process and evaluation participation (including sample size) across the timepoints.

Residential component evaluation methods (including sample size):

- structured interviews with Bradford's senior management and residential service management to explore implementation and perceived impact of the innovation (7 interviewed at time 1; 8 interviewed at time 2)
- structured interviews with BPP specialists to explore implementation and perceived impact of the innovation (8 interviewed at time 1; 2 interviewed at time 2)
- online survey with open-ended questions only distributed to health specialists for additional information on their roles and professional interventions (time 2 only, 5 respondents)
- focus groups with BPP specialists to explore nature of direct work and observed impact of specialist integration (time 2 only, 9 participants)
- online survey of BPP residential and outreach managers and practitioners to explore implementation and perceived impact of the innovation (53 respondents at time 1; 39 at time 2)
- semi-structured interviews with children that were current or former residents of BPP hub and specialist homes to explore their experiences and self-reported impact on their lives (16 interviewed at time 1; 13 interviewed at time 2)
- semi-structured interviews with adolescents engaged in the BPP outreach service to explore their experiences and self-reported impact (4 interviewed at time 1; 7 interviewed at time 2)
- child-level data (CLD) for a range of outcome indicators captured via a tracker presenting characteristics and progress of children receiving a service from BPP residential and outreach provision. Data was transferred from the BPP analyst to

the evaluation team between December 2018 and February 2020. Subsequent tracker data transfer and analysis was conducted in April, August, December 2019, with the final transfer and analysis conducted in February 2020 to conclude the analysis. At time 1, preliminary analysis of CLD was carried out for interim reporting to present service use numbers and to understand basic characteristics of the BPP residential cohort to date. At time 2, CLD captured via the tracker informed the impact analysis of the programme along pre-defined outcome indicators pre and post service intervention. The CLD also includes data about a matched comparator group, where this could be accessed from the Bradford Management Information System. There were limitations with CLD and the format of the tracker (the impact on the evaluation is referred to below)

- comparative analysis of data provided by Bradford from their Ofsted Annex A forms for the BPP homes and comparator children's homes in Bradford.

Fostering component evaluation methods (including sample size):

- structured interviews with Bradford's fostering service management to explore implementation and perceived impact of the innovation (3 interviewed at time 1; 3 interviewed at time 2)
- structured interviews with the Fostering Network team (including management and Mockingbird coaches) for their assessment of the implementation and operation of the Mockingbird model within the LA. As part of the national evaluation, data relevant to Bradford is extracted from the analysis for this report (6 interviewed at time 2)
- structured interviews with Mockingbird hub home carers to explore implementation and the perceived impact on involved families (2 interviewed at time 1; 1 interviewed at time 2)
- structured interviews with Mockingbird satellite foster carers to explore the impact of the Mockingbird approach on their caring, family life and children and young people in their care (9 interviewed at time 1; 5 interviewed at time 2)
- semi-structured interviews with children and young people within Mockingbird foster families to explore their experiences and self-reported impact on their lives (10 from across 7 families interviewed at time 1; 10 from across 5 families interviewed at time 2).

Changes to evaluation methods

Throughout the timeframe of the evaluation there were multiple staff changes, which the evaluation team were kept informed of to facilitate the inclusion of exit interviews, where appropriate, with previous interviewees from time 1. For follow-up with BPP specialists,

the intended method of data collection was changed from structured interviews to focus groups. The adapted method of focus groups explored the nature of joined-up specialist direct work with children and young people and how they, alongside residential-outreach practitioners, organise and achieve therapeutically-informed specialist intervention according to their profession. The focus group method was aided by seeking responses to questions on anonymised case study vignettes, reflecting typical cases referred to BPP services, to draw out the intricacies of specialist work.

Limitations of the evaluation

As previously reported, the introduction of the General Data Protection Regulation (GDPR) in May 2018 meant that Data Sharing Agreements (DSAs) were required during the evaluation. This led to a lengthy process of drafting, reviewing, and agreeing data sharing protocols to enable BPP to provide the evaluation team with pseudonymous data. The DSA was signed in December 2018 allowing the child-level data tracker to be transferred to the evaluation team.

The recruitment of the 8 BPP specialists (for the residential component) was staggered between the dates of March and November 2018. Delays in the recruitment of these specialists meant that children and young people were not receiving the full intervention as the programme was not fully operational, having an impact on CLD tracking.

The evaluation was designed to replicate the co-production of a child-level data tracker as occurred in North Yorkshire as part of the initial evaluation of NWD. Although the format of the tracker was replicated, the variable quality of the data was unanticipated, and the multiple changes of senior staff and project leadership resulted in the data not being used internally for operational and strategic purposes in the same way as was achieved in North Yorkshire. As a consequence of key staff leaving the service, the data was not prepared for analysis in the agreed format which consequently limited the quantitative analysis. To mitigate this, the evaluation and BPP project teams worked together to carry out necessary revision to the ways in which data was recorded and analysed (a process supported by North Yorkshire, as a Partner in Practice via the NWD data analyst). Some data gaps remain, and work has been carried out to facilitate ongoing analysis, resulting in the addition of child-level analysis for select indicators where data became available. These data limitations also impacted on the outcomes that could be monetised for inclusion in the CBA.

Any reduction in crisis admissions to emergency care are not presented in this report due to the BPP data analyst not having the permissions in place to access NHS data for involved children and young people. Although previously envisaged, evidenced contribution of the intervention to the number of emergency admissions was not included in the CBA as evidence of cost avoidance.

As a result of the suspension of a Mockingbird constellation, it was not possible to conduct follow-up interviews with all carers and children that were previously interviewed at time 1.

3. Key findings

Within this section we present our key findings, which are organised according to the evaluation's three strands: process evaluation, impact evaluation and cost benefits analysis. The data sources for the findings are detailed within the relevant sub-sections.

Process evaluation: operational facilitators and inhibitors

We include below findings demonstrating the operational facilitators and inhibitors observed across the timespan of the innovation. These process evaluation findings are drawn from interviews at time 2 with senior management that held operational responsibility for BPP and residential and fostering service management (11). The findings will include interview data from the Fostering Network team (6) that supported the introduction of Mockingbird in Bradford. The findings will highlight the benefits innovation funding brought to Bradford's Children's Services and the workforce, whilst also placing emphasis upon the importance of leadership and multi-agency partnerships, particularly when considering the challenges associated with implementing new service models within an authority amid competing service demands.

Adapting the innovation for Bradford

"I think that's been invaluable, to kind of allow us to think about things in a different way and do things that we think will work really well for Bradford; using the ideas and learning from other places to do that" (BPP senior manager).

Bradford adopted evidence-based models for its core components and adapted them to local circumstance. BPP senior management stressed that with their strategy around adopt and adapt of NWD, they had to be realistic around Bradford's demographic profile, the relatively higher rate of looked after children, and the needs of the target group as compared to the North Yorkshire context. An example of adaptation to the NWD model involved the inclusion of a dedicated education specialist. This adaptation aimed to develop the education offer for adolescents supported by its residential-outreach service, one that mirrors the promotion of the educational achievement for Bradford's looked after children achieved through the virtual school head.⁸

In respect to Mockingbird, the programme and service management stipulated the importance of maintaining freedom to consider adaptations to tailor their service to the differing needs of carers pre-identified by fostering staff. Therefore, a decision was made to introduce 2 single-focussed foster family constellations (related persons and

⁸ For detail on responsibilities of local authorities and the virtual school heads to looked after children see the [DfE Statutory Guidance](#)

mainstream). This decision was made despite the Fostering Network team advising that it may be beneficial to have a mix of family types in a constellation. The Fostering Network team based their advice on the emerging evidence base, which highlights that the maintenance of fidelity to the Mockingbird principles of peer-led support can prove difficult in constellations for related persons only. Such carers often experience whole family trauma and complicated dynamics with other family members making it difficult for them to commit time and emotional resource to a community of like carers. On balance, the Fostering Network maintains that families in a mixed constellation overcome any differences associated with carer status and can build a peer network of carers. Furthermore, they underlined the importance of taking an advisory role helping authorities to understand the ramification of their decisions, rather than seeking to determine how they set up their constellations.

The importance of leadership to a culture of innovation

“The management team did lead with a culture of proactive - let’s change, let’s do, let’s discuss, nobody is right on this - innovation. It was a culture that was created” (BPP manager).

During interviews, BPP management highlighted a requirement for confident leadership that does not default to following a rulebook. With this leadership, a strength-based culture is promoted, providing the right conditions and opportunity to think and act differently in a risk adverse, heavily regulated service. The management reflected that during the implementation period BPP had a consistency of leadership that helped rally the workforce behind the programme, despite a degree of apprehension that new projects tend to operate in the short term until another whole or part service change. By evaluation endpoint, the leadership changed owing to significant turnaround in strategic leadership and managerial oversight of the programme. BPP management highlighted that subsequent leads placed less of a priority on the programme as they were pre-focussed on the resilience of the service in the context of budgetary constraints and Ofsted reporting. Uncertainty around the sustainability of the BPP programme also hindered the ability to retain key staff for the lifespan of the project. BPP senior management also highlight that the issue of staff retention is compounded when well-performing staff transfer to other parts of the service or other authorities when demand for their skills and experience arises. These changes and uncertainty left BPP management thinking they were “running on a treadmill to improve services”, an uncertainty that had potential to destabilise programme operation. Whilst BPP welcomed the arrival of a new strategic lead in summer 2019, senior management conceded that commitment to innovation will need to be balanced with competing service demands.

Established relationships with partners for sustainability

“[We] realise that we need to address these things [from] a public service point of view, rather than working individually as organisations” (BPP senior manager).

Senior management indicated that Bradford’s relationships with multi-agency partners, incorporating joint working on integrated care for referred children and young people, may prove to be an important legacy of BPP. This importance was emphasised through looking to North Yorkshire’s maintenance of relationships with partners and securing ongoing commitment, whereby the success of NWD was shared by the authority and partners alike, thus reaffirming collaboration. A BPP programme board met quarterly to steer partnership activity and maintain a common goal. BPP management were derailed during early operation by changes in lead contacts of multi-agency partners, a situation that meant management needed to spend time to re-establish key relationships with partners for continued buy-in and forward funding. This led to a difficult negotiation given the partners’ own competing budgetary priorities relating to austerity, restrictions on resources and high service demand, meaning partners could not easily fulfil their commitments to match-fund police and health practitioners. Senior programme management highlight the benefit of drawing on the continued support from North Yorkshire Council as a Partner in Practice in the development of partnership work to help scale and spread NWD.

In respect to the fostering component, and implementation of the Mockingbird model, senior management highlighted through interview the value of drawing on the support of a Fostering Network coach and attending learning events and activity days, so to build up a network of other Mockingbird authorities and transfer learnings around the model. BPP management and carers alike, each involved in the operation and delivery of Mockingbird, stressed the importance of seeking the support of the coach early on, so to not only develop a robust service delivery plan before its launch but to understand the parameters around model fidelity.

Recourse to consider whole service change and new initiatives

“[There has been] creative space to explore further innovation and new ways of working” (BPP senior manager).

BPP management emphasised through interviews that once the programme became fully operational, they saw the potential of extending the reach of its service offer further and spearheading aligned initiatives. Whilst the service does not have capacity for whole service expansion during the lifespan of the programme, the findings highlight that ideas for new approaches flowed from the innovation. For instance, the outreach service currently works with adolescents on the edge of care and the service has been working to capacity in providing support to all families referred to the service. BPP management therefore recognised a future need to extend the direct work in outreach through

incorporating a younger age range and endorsement of a whole family approach, so to draw on BPP's specialist and practitioner support approach to help alleviate the family difficulties and proliferation of risks that precipitate entry into the care system among adolescents. Furthermore, BPP management are encouraged to develop the 'staying close' offer, drawing on learnings from other innovation projects, and introduce designated residential placements helping young people leaving residential homes to 'stay close' to people they developed connections with.⁹ BPP management are currently drawing from the tenants of the Mockingbird model to test how a service partnership between fostering and residential can materialise. A key example of the stimulation of a new initiative, Friends of BPP, was formed to prepare children and adolescents for fostering placements if appropriate to their care plan. This additional "third service component" would involve bringing in level 4 foster carers into the homes and supporting stayovers in a foster family home (following the hub home concept of Mockingbird), to familiarise children and young people to the foster family life.¹⁰

Workforce receptibility to innovation

"We spent a lot of time building the team. If you don't invest in your team then you're fighting a losing battle" (BPP manager).

BPP senior management highlighted through interviews that morale in the specialist residential homes has been raised, as the workforce witnessed the positive difference the programme had from within the service. Management highlighted that workforce investment increased receptibility to working under a new programme and adopting new ways of working. A specialist home manager, for instance, ensures that residential practitioners assume responsibility for an area of work within the home based on their interests, experiences, or strengths. For example, some practitioners are health and safety leads, criminal exploitation leads, mental health leads. This approach helps keep the staff motivated to work within the programme and gain a sense of being a valued member of the broader BPP team as they are brought into multi-agency meetings depending on their portfolio. It has also been beneficial to allow existing residential or outreach staff the option to focus on residential or outreach work, or combine the roles, so that they have had a sense of ownership at a time when certain adjustments in their ways of working were expected. Moreover, a senior manager highlights a positive response from the workforce to the advertisement to be placed on a rota as a crisis foster carer associated with NWD.

⁹ Further information on the development and key principles of the 'staying close' offer can be found here: [Staying Close: Policy Brief](#)

¹⁰ In Bradford, and many other local authorities in England, level 4 foster carers are typically experienced carers that have received enhanced skills training and have demonstrated competency in supporting children and young people that have a complex set of identified needs.

Service demands can curtail the ability to innovate

“When we start firefighting, opportunities to innovate get reduced, and even our capacity as leaders to think about innovation gets reduced” (BPP senior manager).

Senior management stress a need to recognise that austerity has had a significant impact on Children’s Services in Bradford, with the authority having to manage an associated sharp rise in the numbers of children and young people coming to the attention of Children’s Services. BPP management also alluded to demands that are limiting its capacity to meet the original intentions of adopting an NWD model. Whilst much of the time the hub has placed adolescents that are open outreach cases, where support and care planning processes need to be worked through for family reunification, young people that are not outreach cases may be referred to the hub as an emergency due to placement breakdown. Based on these operational learnings, there is general agreement that greater alignment between the referral panel’s decisions and that of the care planning and support plans initiated through BPP is required. Additionally, wider pressures on the health and social care sector were highlighted as potentially inhibiting the impact of the service. The intensive care provided by specialists in-house helps ease the difficulties that arise from a high take-up of external support services, such as CAMHS, but cannot be a natural replacement given the caseloads of the BPP workforce.¹¹ There has also been suggestion of increased demand for what Mockingbird offers resulting from carers’ need for additional support (such as child stayovers as a form of respite) for children that have a complexity of needs.

In this section of the report we have outlined what facilitated and inhibited the implementation and operation of the BPP programme. We have highlighted the challenges attributed to the multiple changes in the senior leadership team and those found when balancing the freedom to adapt approaches whilst maintaining fidelity of approach. Despite these difficulties, there is indication of innovative practice being provided to support children and young people and evidence of progress being made towards meeting the programme’s intended outcomes.

Impact evaluation: observed programme outcomes

In this section we draw on data from various sources, including interviews with children and young people, the practitioners working with them, as well as the quantitative child-level data, to assess how far the BPP programme achieved its intended outcomes. As previously stated, the numbers of children and young people involved in Mockingbird were reduced by the suspension of one of the Mockingbird constellations. There were 26 children and young people in foster care families across both constellations at the final

¹¹ Child and Adolescent Mental Health Services.

point when Mockingbird was fully operational (July 2019), which was reduced to 16 at year end 2019 (this final figure includes 3 children living in a family within the related persons' constellation that joined the mainstream constellation upon its suspension). As shown in Appendix 5, 10 children and young people were interviewed at time 1, 7 of which were followed-up time 2. Consequently, the impact evaluation cannot fully assess the impact of Mockingbird on children and young people in Bradford. In the latter part of this section, we outline our emerging findings specifically related to Mockingbird.¹² This section will predominantly focus on the impact of the BPP residential-outreach component, delivered through BPP residential homes comprising 3 specialist homes, an emergency hub home, and outreach support. BPP service use data (available up until year ending December 2019), recorded that 26 children and young people were placed across the 3 specialist homes and 60 were placed in the emergency hub home.¹³ In addition, 318 adolescents received outreach support, of which 210 cases remained open at the end of the evaluation.

Prevention of entry into care

Data on the reason for referral of the 210 young people that received BPP outreach support, and whose cases were closed at year end 2019, highlighted that for most family dysfunction (56%) or risks associated with child sexual exploitation (25%) precipitated entry into the service. The average length of an open outreach case was 218 days, and data collected as to the destination of young people upon the closure of their case is presented fully in Appendix 6.¹⁴ Outreach service data highlights that just over 90% (193) of the 210 adolescents previously considered to be on the edge of care did not enter a care placement once their case closed. Of these 210 closed outreach cases, 8% (17) entered care and moved into a mainstream residential home or foster care placement within Bradford or into an out of authority placement. Of the 210 young people who had received outreach support by evaluation endpoint, a total of 172 (82%) remained at their family home at the end of the BPP intervention, whilst 4 (2%) went to live with extended family members. Although we are not able to evidence that these young people may not have entered care in the first instance, data suggest that the service had a positive impact on the target group.

¹² We also direct the reader to the national evaluation of Mockingbird report (Ott et al., forthcoming) for comprehensive, multi-site evidence about the impact of Mockingbird on children and young people.

¹³ BPP residential homes refer to 3 specialist homes (providing multi-agency integrated care within the residential setting to meet multi-faceted needs of looked after children and young people for as long as is required to improve outcomes) and the 1 emergency hub home (providing short-term placements that involve specialist intervention to identify and address needs and formulate associated care plans to prevent long-term entry into the care system or support family reunification).

¹⁴ The length of time each case was open depends on the complexity of the case and whether ongoing specialist intervention was required. Calculations were also subject to how the intervention period and case open-closed status was recorded by workers, meaning any figure is an approximated average.

The young people interviewed at time 2 (7) each expressed how involvement in the outreach service benefitted them. All young people reflected predominately upon the opportunity to build impactful relationships with outreach practitioners:

“They listened to what I had to say; they weren’t like one of those people that it actually felt like you were talking to someone for a random job. I actually felt like I was talking to someone, and they were actually taking notice” (Male, age 14).

[You] need positive support, like not people saying: ‘you need to change your behaviour!’ Speak to us and find the problem” (Female, age 14).

Furthermore, those young people who were assigned a specialist worker as part of their outreach support plan highlighted the value placed on the approach each specialist took to working with them:

“You can’t just come to someone’s house and tell them that you want to speak to them about stuff that they’ve done. You need to take them out, treat them, make them like you first before you start talking to them about it. That’s what he [a BPP police officer] did” (Male, age 15).

“[A BPP health specialist] was my favourite because she was so laid back. She just cares about what you think. [She helped] to control my temper. I thank her for that [and] for getting me into the school because I never thought I would be happy at school” (Male, age 14).

Accommodation stability

An aim of BPP was to increase placement stability for looked after children, including those placed in its 4 residential homes. An aligned aim was to reduce the numbers of children and young people experiencing or developing a complex set of multiple needs, which might lead to instability in the home environment or precipitate another placement move. These aims were to be achieved through the availability of integrated multi-agency specialist intervention and an enhanced individual care plan. According to indicators on destination following placement and average length of stay, there is evidence to suggest that BPP brought accommodation stability to those children and young people placed across the 4 homes. The destinations of the 68 children and young people that left each of the 4 BPP homes over the course of the evaluation are presented fully in Appendix 7. Over the course of the evaluation, 13 young people left the emergency hub and returned home. A further 11 were placed in mainstream (non-BPP) residential homes in Bradford as care plans determined that these young people did not meet the criteria for placement

in a specialist home.¹⁵ The intended outcome to increase the number of children and young people in family placements was met, with 15 transitioning to foster care. It is difficult to evidence whether these children and young people would have transitioned to foster care without BPP support. However, children and young people interviewed that were in foster care by time 2 (3) alluded to the additional support they received through the Friends of BPP initiative:

“[A BPP psychologist asked] some questions of how this home was because I came to visit this house. I met them [foster carers] at the park, [later] I had the night with them, and then I went back to [specialist home 3]” (Female, age 10).

By year ending December 2019 (evaluation endpoint), the average length of stay for all children and young people (aged 9-18) placed across the 3 specialist homes was recorded as 537 days, compared to 273 days recorded for Bradford’s 4 mainstream residential homes. This data highlights that children and young people living in BPP specialist homes spent more days in their placement in a BPP specialist home, thus providing some indication of greater placement stability. Moreover, the data highlighted that the average length of stay for the 57 children and young people placed with the emergency hub home who had subsequently left by year end 2019 was 45 days. This exceeded the initial intended 28-day placement period and is indicative of the length of time that may be needed for intervention with outreach cases proceeding family reunification or the time required to find an alternate placement for those non-outreach young people that have experienced placement breakdown in the authority. A comparison was also drawn between length of stay in BPP homes and that of all children looked after in Bradford (excluding all short-term placements and children and young people within the BPP service) according to number of prior placements of each child. The frequencies are presented in Appendix 8 and in essence indicate that, despite the number of prior placements (an indicator of previous placement stability), children and young people living within BPP residential homes are experiencing greater placement stability in staying within their current placements for a lengthier time period should a return home not be possible.

Of the children and young people placed at a BPP home that participated in follow-up interviews at time 2 (13), most emphasised the centrality of relationships to a sense of stability:

“It was a little bit all over at first; I just thought, ‘oh, I’ll be here for a few months [and] get moved’. [There] were a lot of downs at [specialist home 2] at first; [but]

¹⁵ A young person placed at the BPP emergency hub home is assessed by health specialists and this may determine whether a placement in the specialist home is appropriate given the identified needs. The specific criteria for placement in a BPP specialist home was not available to the evaluation team.

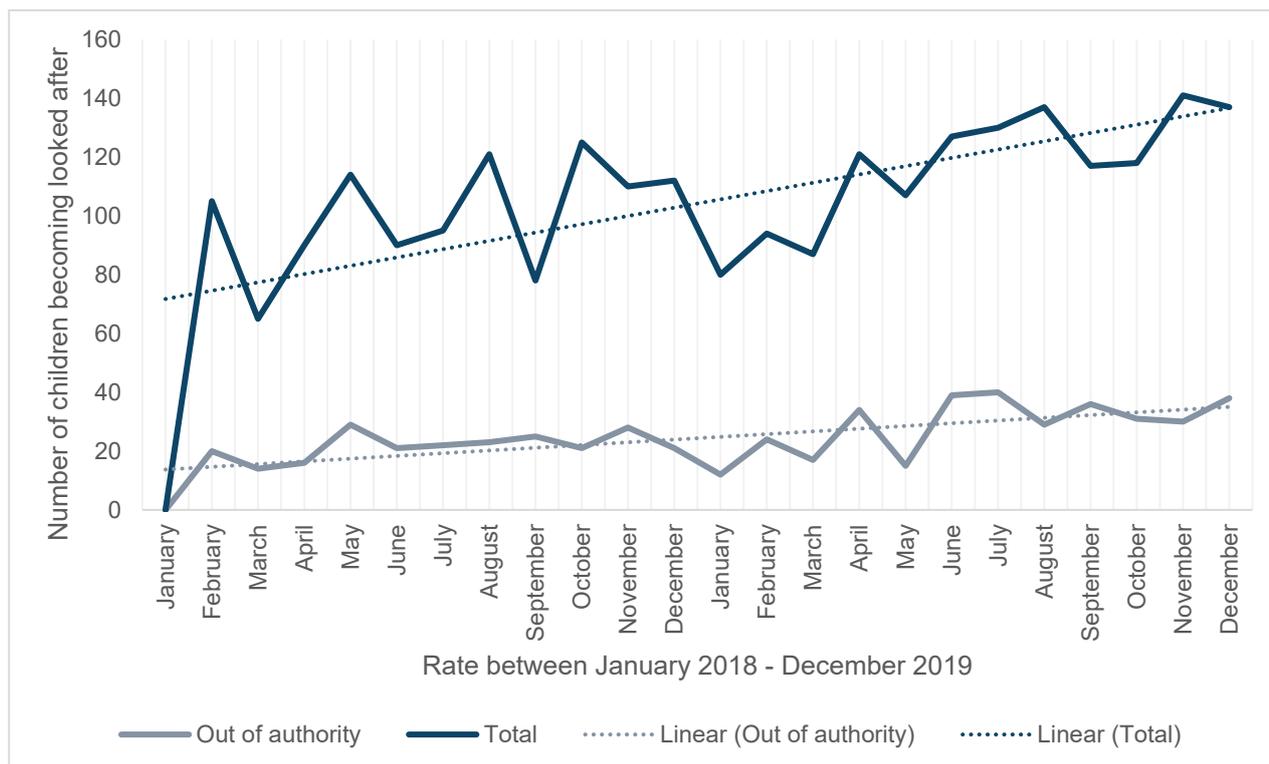
put a kid in there, they're going to go far 'cause the staff there have a heart of gold" (Male, age 16).

"I loved it [at the hub]. I was there for, like, four months or something, I didn't want to leave. [Those] staff were just understanding. You've got to be in the right place. You've got to be with the right people" (Female, age 16).

Out of authority placements

National data show that 41% of all children looked after at 31 March 2019 are placed outside of the council boundary (DfE, 2019). Figure 2 presents monthly data (across 2018 and 2019) showing that, despite the increase in the looked after children population in Bradford during the same time period, the overall rate of new out of authority placements has seen a slight decrease during the operation of BPP. Data shows that 6 out of 68 children and young people were placed outside of the Bradford area when they exited one of the 4 BPP homes, and 3 of the 210 young people formally receiving outreach support were also subsequently in out of authority placements. These figures indicate a degree of progress towards the intended outcome of reducing out of authority figures over the course of the programme's operation. However, there is no complete tracking data providing case-by-case reasons for out of authority placement following BPP involvement (unrecorded information of this kind may be to protect the whereabouts of child or young person, as per national recording of these figures). An interview with a young person placed out of authority after their stay in a BPP home, found that the reason aligned to continued protection against risks that prompted the initial referral to service.

**Figure 2: Number of children in Bradford becoming looked after and number placed out of authority
January 2018 - December 2019**



Source: Bradford Children’s Services management information system

Improvements in wellbeing

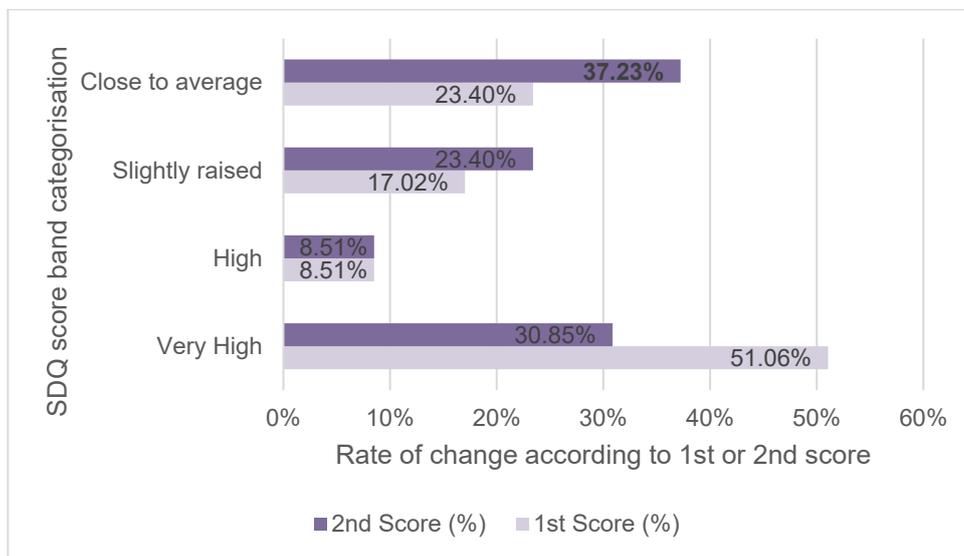
Child-level data provided evidence of programme impact on the wellbeing of involved children and young people via recording of progress according to a standardised measure.¹⁶ SDQs are completed on entry to BPP, then every 3 months or on exit whichever comes first, and responses were calculated using a scoring tool and the results recorded in the CLD tracker for analysis.¹⁷ From programme implementation to year ending 2019, 94 SDQ scores have been returned with a subsequent follow-up score for comparison. For almost two-thirds (61.7%) of these children and young people, there has been a reduction in SDQ scores since being referred to the BPP service, which is indicative of improved wellbeing. Figure 3 below shows the percentile change in SDQ

¹⁶ The strengths and difficulties questionnaire (SDQ) is a tool for children and young people aged 4 to 16 and used to measure for emotional and behavioural traits and related needs. The SDQs are completed by parents, teachers or are self-completed by the children and young people themselves. The SDQ includes questions relating to 25 attributes (both positive and negative) across 5 different areas that make up a total score. These areas include an emotional symptoms subscale, conduct problems subscale, hyperactivity/inattention subscale, peer relationship problem subscale and a prosocial behaviour subscale.

¹⁷ The vast majority of SDQ returns collated by the BPP analyst are self-completed and the scoring aligns to a newer four-band categorisation (0-14 is ‘close to average’; 15-17 is ‘slightly raised’; 18-19 is ‘high’; and, 20-40 is ‘very high’).

scoring according to each of the 4 bands from entry to the service and at the point a follow-up questionnaire occurred.

Figure 3: Rate of change in 1st and 2nd SDQ scores of children and young people placed within BPP homes by 31/12/2019



Source: BPP child-level data tracker

As Figure 3 highlights, 51% of all at entry scores were in the ‘very high’ category compared to 31% when the follow-up was taken. This outcome is positive, as it represents a significant reduction in the ‘very high’ SDQ scores (a signifier of poor wellbeing) from just over half of cases to just under a third across the lifespan of the programme. The most significant changes to date have been for young people residing in specialist home 1 and those placed within the emergency home, which have seen a 41% and 20% reduction respectively. Children and young people placed at specialist home 2 recorded a slight increase in SDQ score rather than a significant improvement, which could be explained by a transition between placements or the complexity of the needs of the young people in this home. For a full presentation of the average in SDQ score categorised according to BPP homes or outreach service, refer to Appendix 9. The continued development of the data tracker and analysis beyond the current Innovation Programme funding round will facilitate a longitudinal, child-level data analysis of the impact of the service on wellbeing and, ultimately, provides an opportunity to initiate service developments to improve the outcomes of the young people.

Time 2 interviews with children and young people who had been placed in a BPP specialist home (9), provides an indication of the positive impact the continued in-house interactions with the health specialists had on wellbeing (allowing for some additional context to the SDQ scores):

“[A BPP psychologist] helps me by talking to me and getting stuff off my mind. [You] need people to be nice and like caring and not get very upset with you all the time” (Female, age 10).

“They helped me control my anger and my feelings. Like before I started seeing [A BPP psychologist and SALT], my anger were like really, really bad. I used to kick off like all the time, and then after I'd seen them it weren't that bad” (Male, age 12).

The changes to risk association attributed to programme involvement

Within this sub-section we examine the evidence related to changes in outcomes relating to risk association that, for most children and young people, form part of the reason for referral to BPP. As outlined earlier in this report, the data for all 5 selected indicators of risk association was initially provided at a cohort level rather than an individual level. Further analysis was conducted at a child level for 3 of the selected indicators, where data became available, and is presented below. Due to the limitations of this data, it remains difficult to attribute changes to BPP given the changing population of children and young people who make up the cohort throughout the evaluation.¹⁸

Substance use and incidence of self-harming

Data highlights an initial spike in the number of recorded substance use (Class A or B) within the 3 specialist homes preceding the time when BPP was fully operational, but this recorded rate of use has plateaued across the lifespan of the programme (as shown in Appendix 10). Further data analysis was conducted at a child level for monthly records of substance use (Class A or B) among 24 children and young people that were in placement across the 3 BPP specialist homes between April 2018 to December 2019. During this timeframe, 25% (6 out of 24) of the cohort had recorded incidents of substance use, with 2 of these cases showing improvement following BPP intervention. These 2 children remained in a BPP specialist homes, with each recording 7 and 12 months of substance use during their placement. Following intervention, each child had no recorded incidences of substance use for 10 and 5 months, respectively. Of the remaining 4 cases, 2 had recorded incidences of substance use in the months preceding a move from a BPP specialist home, 1 had a period of sustained recorded substance use whilst in placement at a specialist home before moving into independent living, whilst the remaining child remained at a specialist home and would be receiving an intervention for substance use that occurred over a period of 5 months.

¹⁸ Data will be produced and analysed at an individual child level over the next 12 months. This includes historical data which has been collected, but not yet collated in a useable format for longitudinal analysis at the individual child level.

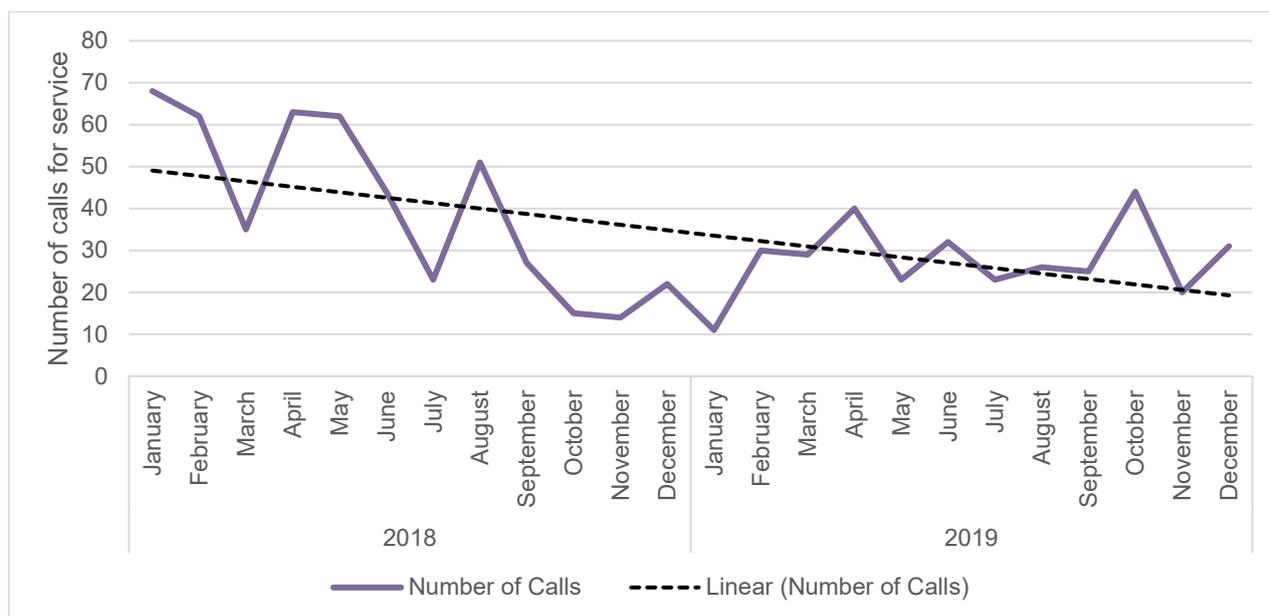
There is evidence to suggest a decline in recorded incidences of self-harming among those experiencing a longer-term placement within the 3 specialist homes during the lifespan of the BPP programme (see Appendix 10). Child-level data analysis was also conducted on monthly records of incidents of self-harm among those 24 children and young people at BPP specialist home between April 2018 to December 2019. During this timeframe, data shows that 9 of the 24 (38%) children and young people had recorded incidents of self-harm. Whereas 1 of the 24 (4%) was recorded as being 'at risk' of self-harm in the month preceding an out of authority placement move, which followed a placement of 11 months at a BPP home with no recorded incidents or identified risk. 7 of the 9 children and young people with recorded incidents of self-harm demonstrated improvement following BPP intervention. Month-by-month analysis of these 7 cases further demonstrate degrees of improvement. 4 of these 7 children and young people remained in a BPP home as of December 2019, each had recorded incidents of self-harm across at least 2 month, or at most 13 month, time periods before showing sustained improvement with no recorded incidents or identified risk of self-harm for periods of between 6 to 17 months. Of those 3 cases remaining, 1 young person was recorded as having incidents of self-harm over a 12-month period during placement at a BPP home, but following a period of intervention recorded no incidents in the 6 months preceding a move into independent living. Another young person had recorded incidents of self-harm across a period 2 months towards the end of 10-month placement; however, the final month showed no recorded incidents following intervention before moving into independent living. Furthermore, a child who remained at a BPP home had recorded incidents of self-harm for a period of 4 months upon entry and, following intervention, had an improved status of 'at risk' of self-harm at end of December 2019.

Overall, however, given the nature of these issues and anonymity in terms of external health-related interventions (for example, rate of admissions to A&E or access to external services), or internal therapeutic interventions, it is difficult to attribute the rate of change recorded above to the programme due to associated data limitations.

Homes' calls for service and missing episodes

The number of calls staff within the BPP specialist and hub homes made that sought the assistance of police ('calls for service') was recorded. Figure 4 below shows that there was a steady decline in the number of calls for service during the operation of BPP. The vast majority of calls for service that sought police intervention in 2018 and 2019 related to missing episodes (71% in 2018; 67% in 2019), whilst the second largest proportion of calls involved criminal activity (15% in 2018; 14% in 2019).

Figure 4: Number of calls for service across BPP homes, January 2018 - December 2019



Source: BPP child-level data tracker

The findings above were corroborated in our analysis of the Annex A Ofsted inspection data for the 4 BPP homes, and 4 Bradford mainstream children’s homes. Our analysis of the number of police call outs, and resultant action (arrests and convictions), indicated higher rates of call outs, and subsequent arrests in the mainstream homes. The Ofsted Annex A data also highlighted that several call outs in the mainstream homes were in response to escalation of behaviours by the children and young people, those that could not be addressed by the staff in the homes. Comparable incidents were not evident in the 4 BPP homes.

A comparison of data was drawn from the 4 BPP homes and Bradford’s 4 mainstream homes according to monthly recorded numbers of missing episodes from January 2018 to December 2019 (see Appendix 11). As shown, the overall rate of missing episodes from all residential homes is declining, however the reduction in the number of recorded missing episodes from the beginning to the end of this recording period is greater in the mainstream homes (a reduction of 17 episodes in comparison with a reduction of 9 in the BPP homes). A breakdown of this data according to BPP homes provides indication of positive change. Notably, the specialist home recorded as having the majority of recorded missing episodes across 2018 and 2019 demonstrated reduced recording of episodes from 2018 to 2019 (aside from 3 months in 2019 where there were increases in recorded episodes by an average of 6). The most recorded missing episodes occurred in April 2018 at 41, in April 2019 this number had reduced to 18. The second highest recorded for the same home was 23 episodes in May 2018, a number reduced to 14 the same month in the following year. Overall, this data does not facilitate an examination of

missing episodes for individual children and this analysis will be included in the work progress associated with the funding extension through to March 2021.

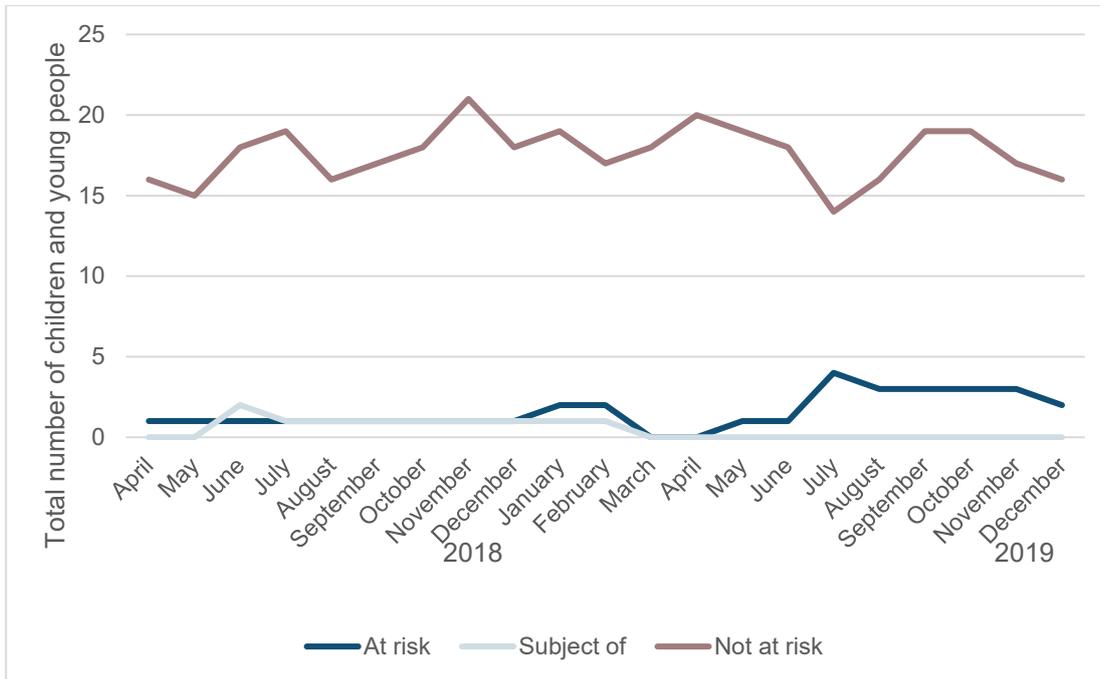
The children and young people placed at the 4 BPP homes that participated in interviews at times 1 and 2 (13) were asked about their interactions with the specialists within the home environment. Some young people reflected on going missing or displaying challenging and potentially criminalising behaviours and highlighted that, over time, they built beneficial relationships with BPP police:

“[A BPP police officer] didn't come in with a uniform [and] would genuinely help you, whether it's online or offline. [He] made me change my complete mindset about coppers” (Male, age 16).

Child sexual exploitation

Child-level data recorded any changes in risks related to child sexual exploitation (CSE) among children and young people across the BPP homes. As Figure 5 shows, during the period in which data was available (April 2018 and December 2019), there was no risk of CSE for most involved children and young people (at its highest, 21 out of 23 during November 2019 showed no association with risk; and, at the lowest, 14 out of 18 during July 2019 had no risk). During the same period, the highest number of children and young people 'subject to' CSE was 2 in June 2018. Subsequently, between July 2018 and February 2019, 1 was subject to CSE. From March to December 2019, no child or young person was recorded as being 'subject to' CSE, explaining the increase in the numbers who were then considered 'at risk' from May to December 2019 (with 1 the lowest number 'at risk' and 4 the highest). However, overall, there was evidence of positive change in the degree of association in CSE risk for children and young people that resided within a BPP home across the stated period.

Figure 5: Number of children and young people placed at BPP homes at risk or subject of CSE April 2018 - December 2019



Source: BPP child-level data tracker

Further child-level data analysis was conducted on monthly records of CSE risk among the 24 children and young people placed at the 3 BPP specialist homes between April 2018 and December 2019. During this timeframe, a third (8) of children and young people were ‘subject to’ or ‘at risk’ of CSE, 6 of which showed improvement following intervention due to reduced association with CSE risk (2 were no longer ‘subject to’ and 4 were no longer ‘at risk’). 5 of the 6 children that showed improvements according to CSE risk remained at a specialist home at end of December 2019, all had sustained periods of time without any association with risk of CSE following intervention (ranging from 5 to 18 months). The remaining child recorded a reduced risk of association with CSE (from ‘at risk’ to ‘medium risk’) before moving into an out of authority placement.

Those children and young people that were placed across the BPP homes that participated in a follow-up interview at time 2 (13) were asked to reflect on the relationships they had developed with residential-outreach practitioners. Some of these participants were referred to the service due to concerns related to CSE, and each highlighted how the relationship they built with a residential-outreach worker who specialised in CSE had helped them to comprehend the risks they encountered:

“There was a risk, because I look older than my age [and] they thought I was at risk of getting groomed. I didn’t realise it, but she used to take me out to try and

get stuff out of me all the time, but it worked, and I told her stuff. I wouldn't even know what grooming and that is, if [she] wasn't there" (Female, age 13).

Education engagement

An integral part of the BPP residential-outreach component is the education specialist to support the education of children and young people referred to the service. Of the 285 children and young people who were referred to the service, for whom data is available, the majority (201: 71%) had an EHC plan in place either at the point of referral, or during the time they were supported by the service.¹⁹ More than half were also regularly attending mainstream school full-time (189: 66%). Although data about school exclusions and attainment were not recorded, data from the Ofsted Annex A indicated that packages of educational support had been put in place for the children and young people placed in the BPP residential homes, when they were not in full-time education.²⁰

Meeting intended outcomes: facilitating and inhibiting factors

This section will further contextualise the evidence provided above from CLD and interviews with children and young people. It will draw upon the perspectives of the BPP team of homes' managers and the practitioners and specialists that provide direct work across the residential-outreach service (incorporating data from interviews, focus groups and surveys that amounts to a participation number of 127; as specified in Appendix 4). The section will highlight the main factors identified by the BPP workforce that brought added value to their direct work and can be aligned to progress towards meeting intended outcomes. The focus of this section is informed by consistent emphasis across the data on the benefits of a common model of care and multi-agency specialist integration in guiding direct work, and the necessity for an environment that enhances capacity for sustained improvements in practice for the most vulnerable children and young people.

Therapeutic intervention according to a common model of care

The BPP workforce emphasised that applying therapeutically-informed direct work (promoted through the common model of care comprising P.A.C.E. and Signs of Safety) has provided a firm foundation for positive and trusting child-carer relationships and helped children and young people to cope with and learn to self-regulate their emotions. Residential-outreach practitioners and homes' assistant managers surveyed at time 2

¹⁹ An education, health, and care plan (EHC plan) denotes the educational, health and social needs and sets out the support required to meet these needs.

²⁰ These education data items (exclusions, engagement, and attainment) were not routinely or systematically recorded by the education specialist. Data is available via the virtual school head, but this was not shared with the BPP analyst, or made available to the evaluation.

(39) highlighted that training according to the model of care, and support offered in applying this to practice, allowed for more targeted therapeutic work and improved ability to manage challenging situations. Of the 34 respondents that stated they had received training in P.A.C.E., most (27) rated training as being useful in their face-to-face interactions with children and young people. In respect to training in Signs of Safety, 29 respondents had received this training and most (27) also rated it highly for its usefulness. Practitioners working across the BPP homes and outreach service highlighted where P.A.C.E. and Signs and Safety training brought added value to their direct work, these are shown in Appendix 12.

Integrated specialist support guiding interventions

The innovative aspect of the residential component rests on the integration of multi-agency specialists from health, policing and education working alongside BPP homes managers and practitioners (see Appendix 13 for summaries of BPP specialist roles and associated activity). The health specialists stressed their overriding aim is to increase understanding on the presenting issues and needs of the young people so to equip practitioners to identify underlying needs and de-escalate more challenging behaviours. A BPP health specialist explains that residential-outreach practitioners are being encouraged to appreciate that effective work with young people is “95% about psychology and 5% about physical interventions”. Additionally, the opportunity for multi-agency specialist integration enables that insight into respective professions:

“I think we’re gaining knowledge about each other’s professions and building professional respect and understanding which is positive in the long term. [We] share good practice” (BPP health specialist).

Interview and survey data of homes management and BPP practitioners highlight integrated multi-agency specialists to be a strength of the model and this multi-agency input enhances and supports their direct work. For instance, residential practitioners highlighted through surveys’ responses that witnessing a specialist’s interactions with young people is a helpful way of modelling their own therapeutically-informed practice. Essentially, specialists can support staff to manage behaviour verbally and calm potentially risky situations rather than defaulting to the standard de-escalation techniques employed in residential care settings that may involve physical restraint. (See Appendix 12 for further perspectives on the added value of specialist integration in practice.)

Breaking down barriers to professional, needs-led support

Children and young people referred to BPP are likely to have experienced difficulties accessing or engaging with support services. The health specialists suggested that these difficulties are likely to either compound existing needs and vulnerabilities or result in underlying needs being unmet. It was also recognised that children and young people

have often experienced a high turnover of professionals involved in their care, and integrated support provides opportunity for a continuity of relationships. The findings highlight that opportunity for relationship building is imperative to enacting therapeutically-informed intervention and thus adherence to the model of care endorsed through BPP. The BPP police specialists placed emphasis on having a presence in the homes, and shared activities with children and young people, which provided an inroad into discussing problematic behaviours whilst also building an understanding on what may trigger certain responses to adults. They highlighted that training in therapeutically-informed techniques underpinned their approach to building those relationships: “P.A.C.E. training was just like a switch being flicked and it turned my way of thinking about young people; [it’s about] connection before correction” (BPP police specialist).

The health specialists highlight that their integration can help overcome the reticence children and young people tend to have when meeting a professional with whom they have had no previous association in a very clinical and unfriendly setting: “It’s a little bit easier for us to build that relationship that young people wouldn’t build if they had just an hour in an artificial situation, called a CAMHS waiting room” (BPP health specialist). As highlighted through interviews with children and young people, there is evidence that specialist integration into the residential-outreach setting fosters relationships with professionals as they are seen to be familiar, friendly, and approachable people who help. Through interviews and focus groups, the specialists themselves recognise the centrality of building relationships with children and young people for effective therapeutic intervention. Specialist integration allows for this approach as familiarity and consistency is built:

“Sometimes, it’s the tiniest things that gets you in [and] you’ve just got to keep that going. You can’t just disappear for 10 days and expect to pick that relationship up with the young person that’s been moved from pillar to post and doesn’t trust people” (BPP health specialist).

The health specialists highlighted that they benefit from being able to assess and work with children and young people in their home environment, so that they can make observations of children and young people and develop a professional understanding of their needs through assessment of “what is going on underneath for that child to behave in [a certain] manner” (BPP health specialist). The regular face-to-face interactions between health specialists and children and young people allows specialists to provide recommendations and introduce responsive and timely interventions according to identified needs. (Appendix 13 provides data on frequency of health specialist-led interactions.) The health specialists were recognised by BPP homes management and residential practitioners (through interviews and survey responses) for creating beneficial therapeutic environments for children and young people to feel comfortable talking to health professionals and other adults about their concerns. Additionally, interview findings highlight that frequent interactions with specialists in the residential or family

home environments can also help break down negative associations with a service. For instance, BPP police specialists emphasised in their interviews that looked after children often experience police intervention during child protection and safeguarding situations, meaning it takes sustained interactions to build familiarity and positive association. Further to this, specialists welcomed the progression that has been made from early operation in terms of having a working environment that supports therapeutic interactions with children and young people in service (including designated child-friendly quiet spaces within each home). Appendix 12 further presents the perspectives of the workforce on the added value of specialist integration to children and young people.

Joined-up support from dedicated health professionals

The BPP health specialists (comprising psychologists, speech and language therapists and an occupational therapist) embrace taking a joined-up approach so that each specialist can take a lead with a young person as appropriate to their primary need to formulate an effective support plan. This joined-up working allows for responsiveness in the formulated support plan, whereby each specialist can either step up or step down their intervention as appropriate to the need and risk profiles of the child or young person and also any significant events that occur. The BPP health and other specialists (from policing and education) meet regularly to discuss young people in residential placements or the outreach service and decide on which health specialist will lead the intervention and devise a support plan accordingly. During this joint consultation between specialists, they will each provide their professional reflections on the case presenting and this will be consolidated into a case formulation summary report and forms a support plan that will be made available to residential-outreach practitioners. Each specialist will also evaluate the impact of any intervention whilst working with young people at their pace and adapting the support plan, as necessary.

The specialists highlighted through interviews that children and young people in placements or engaging in outreach provision present with complex needs, often with some overlap of developmental trauma, language needs, neurological disorder or learning needs. Joined-up working among the integrated health specialists ensures that each presenting need is understood through each disciplinary expertise and that relevant recommendations are integrated into subsequent support plans for the children and young people, carers, families, and practitioners in social care. An anonymised case example highlighted the added value to joined-up working between specialists across the residential-outreach service, and how this led to the development of a support plan in response to these needs. This case study was provided by the health team for evaluation purposes and is shown in Appendix 14.

Additionally, Appendix 14 provides an example of successful joint working between specialists and residential-outreach practitioners. The specialists emphasised (through interviews and focus groups) that existing waiting times for assessments can be detrimental on young peoples' lives and often contribute to their failure in school, involvement in criminal justice, building successful relationships and understanding their

own identity. The specialists therefore developed an 'in house' neurodevelopmental assessment pathway to help identify related conditions to support the number of young people involved in outreach and in placement who were waiting for assessment, or had not been accepted onto assessment waiting lists, or whose needs had not previously been identified. By completing the assessment and providing a more informed picture of the young person's needs their care and education care plans can be better informed and therefore better suited to their needs. The multi-agency specialists also recognised that they had the shared disciplinary expertise, and professional experience with children and young people, to be in the position to complete discrete aspects of the assessment due to their respective close working relationship with the child or young person or the residential-outreach practitioner.

Social care and multi-agency partnership work in practice

The evidence suggested that each home went through a difficult early adjustment period and managers needed to ensure homes' staff and the newly integrated multi-agency professionals were working together cohesively. Forums for knowledge sharing and consultation, bolstered through Team Teach approaches that helps equip teams with strategies to positively manage behaviour without physical intervention, were introduced by evaluation endpoint. A BPP homes manager highlighted that these forums have helped break down inter-professional barriers between social care practitioners and multi-agency workers and brought some previously reticent practitioners around to new thinking and ways of working. The BPP specialists raised a cultural issue within children's services arising from external pressures that lead to a fear of scrutiny, which has had a cascade effect on the residential workforce receptibility to new approaches and the integration of outside professionals. This fear becomes a default position compounded by other pressures on the system, including demand for placements and the statement of purpose of the BPP residential service to place high need children. A BPP specialist highlighted that when a home is in relative crisis it influences the culture of the home, meaning the service becomes locked into a mode of practice focussed around avoiding any negative scrutiny regarding performance. Hence, finding the "brain space for a new professional and some new ideas is difficult" and management and practitioners become pre-focussed on paperwork rather than developing a service informed by evidenced approaches as part of a model of care. As times have progressed, the BPP workforce has recognised the impact of the integrated approach on their direct work and children and young people in their care and, therefore, early challenges were recognised as being largely overcome.

Reassessing programme activities to ensure sustained progress

The added value of the programme was endorsed by the workforce; however, they also stressed the importance of adhering to the BPP ethos and maintaining focus toward intended outcomes of distinct parts of the programme. It is important to keep sight of the

overall aim of the residential component, to prevent placement breakdown, hence a home manager ensures ongoing communication with specialists to understand why they are initiating assessments or support planning so to keep this alignment. Furthermore, some practitioners argued for more clearly distinguishable terms of reference guiding the residential (the emergency hub) and outreach service to direct their work toward improved outcomes. The emphasis on innovation through integrated, specialist support within a fixed setting has created an imbalance between residential and outreach provision – with greater focus on the residential setting as the site and vehicle for this intense support as required. Some outreach practitioners, therefore, argue for both a decoupling of the residential-outreach service and clearer definition of the aims of each service to promote residential placement stability or family reunification.

Through focus groups, the specialists spoke of their frustration that the referral panel does not always base decisions on matching according to the statement of purpose of the hub home, and the requirement of the input of multi-disciplinary team, but on the immediate need to find a placement for a young person. An additional issue recognised that decisions at a referral panel regarding referrals to the emergency home can occur during a time when the homes and specialists are transition planning through a phased-out approach for young people returning home. Whilst the hub home has a statement of purpose to place emergency referrals, the view of the specialist is that the decisions need to take into account existing young people and the statement of purpose of returning a young person home in supportive phased out manner. In light of these issues, specialists suggested that it may prove beneficial to involve them in the referral process as they can advise on placement matching on a case-by-case basis according to the identification of needs. One specialist argued that Bradford can then “take the multi-agency working that we do within the homes to another level, so they get the placements right”. BPP specialists also questioned the very notion of emergency provision and suggest this plank of support requires adaptation. A specialist highlighted that the hub home would benefit from becoming “an assessment home”, providing respite for adolescents whilst responsive and holistic care and support planning can be initiated. This redefinition may provide a firmer foundation to initiate assessment of need and therapeutic work:

“[They] know it’s called an emergency home. Who wants to be in an emergency place [compared with] somewhere where they’re geared up to find out what your needs are?” (BPP health specialist).

The impact of Mockingbird on family stability and wellbeing

The section will also draw upon the findings from time 2 follow-up interviews with a hub home carer and satellite carers (6) and children and young people (7) to understand the added value of the introduction of Mockingbird in the fostering service from the perspectives of involved families. The section will conclude by presenting recommendations drawing from carer experiences to underline what is needed to ensure

success of the model going forward. As previously mentioned, unanticipated difficulties arose that stimulated reflection among the carers within the remaining operational constellation on how Mockingbird could develop in Bradford. Recommendations were suggested as a result, and these are overviewed in Appendix 15 as an adage to the findings presented below.

Peer support concept

The hub home carer recognised that maintaining fidelity to the Mockingbird approach has been straightforward as all carers have embraced the peer support concept: “the fact that everybody’s aware of that concept, everybody works towards the same sort of goal; it’s such an easy formula”. The findings highlighted that planned Mockingbird social activities act as an important foundation to peer support in building familiarity and providing shared experiences for families. These social activities include family get-togethers and meet-ups solely for carers. By time 2, a Mockingbird male foster carers’ group had developed further with more regular meetings. Satellite carers noted in interviews that this group has helped some male carers further identify with the fostering role and has encouraged their participation in related events and training. For some carers, the social activities have proven crucial due to having the status of single carer and, in some instances, needing to withdraw from employment to assume a foster carer role. Other carers are now meeting outside of constellation activities as over time they have forged closer relationships and common bonds with those who have children of a similar age range.

The carers referred to family-like ties having developed with other families in their constellation, and some satellite carers dedicate time to children and young people from other Mockingbird families and taking care of them (for instance, for meals or sleepovers). The forums for carers to meet through Mockingbird has helped the satellite carers form these bonds: “To have that level of support and access to all that experience and information from all those carers, it’s absolutely invaluable” (Mockingbird hub home carer). The hub home carer and other carers referred to a recent incident that tested the closeness of the relationships between involved families. All carers were able to discuss matters openly during a constellation meeting and this helped highlight how much families cared about each other and the best interests of involved children. The children and young people, too, referred to being part of a Mockingbird family: “The carers are like our parents; like a big family” (female, age 11). Others reflect on how it has been beneficial to form close friendships with other looked after children due to commonality of experience and understanding. Children and young people also showed understanding of the peer support underpinnings to Mockingbird and the additional support it provides to their carers.

Promoting family stability

Carers highlight how the Mockingbird approach, centred on a peer network and a hub home concept of accessible support as required, helps alleviate any difficulties that may progress to crisis points (for example, when children and young people are experiencing change in family contact or schooling resulting in instability or have high needs and are demonstrating challenging behaviours). Carers reflected on being less isolated and having an alternate outlet through which to gain support. Interviews with satellite carers emphasised that the hub home carer plays a helpful advisory role to families and has open discussions about potential difficulties she foresees with some children and forms a plan of action relating to sleepovers or activities to ease the situation. The hub home carer emphasises how knowledge of the families has helped her to respond to needs effectively and promote family stability through working alongside them to avert any potential crisis. Some families required more regular sleepovers and support in crises than others, and so the availability of structured and consistent support is beneficial. Satellite carers stated they were able to draw on the support of the hub carer to help alleviate the impact of difficult presenting behaviours of the children and young people in their care. The relationship built with the hub home carer, and sleepovers at the hub home, provide opportunity for children and young people to have time away during difficult periods. Other satellite carers highlighted that as relationships with other constellation families strengthened, the support they provide each other has become invaluable: "If I hadn't have had Mockingbird carers around me I don't think it would have been easy to continue with the placement". Opportunities for training in, and the application of, P.A.C.E techniques was also recognised as being useful to promoting placement stability as carers recognised they have gained a deeper understanding of "the emotions behind how [children] react".

Carer wellbeing and confidence

There is evidence to suggest that involvement in Mockingbird promotes carer wellbeing and confidence in their status. Carers acknowledge that bringing others involved in fostering together within a Mockingbird constellation provides opportunity for sharing of experiences and fostering insights. This community of carers sharing experiences and expressing understanding regarding the nature of the foster carer-child relationship was identified as promoting positive wellbeing among carers. The hub home carer was also recognised for providing emotional and practice support to carers that means they do not have to rely solely on the input of a social worker with demanding caseloads. The hub home carer recognises that satellite carers have become more comfortable with the idea of accessing additional support without the concern it may be interpreted as they are not coping. Moreover, carers acknowledge that, although their families may not have reached a crisis point, it is reassuring that the hub home carer is there to provide additional, immediate support should the need arise. Organising visits to the hub home provide families experiencing difficulties with the necessary breathing space when they

enter intermittent crises. By evaluation endpoint, the hub home carer expressed a greater sense of role purpose and confidence arising from increased responsibility, which meant the role expanded from coordination and family support as required to involvement in decision making as part of the LA Mockingbird team (for instance, around alternate respite placements of involved children and young people).

Evidence of cost savings and monetisable outcomes

The cost benefit analysis (CBA) has been severely constrained by the data limitations discussed earlier in the report (see Limitations of the Evaluation section). In view of this, the results presented here should be regarded as illustrative and indicative. Further details relating to the approach and assumptions are set out in Appendix 16.

Benefits

The benefits relate to the cost savings associated with improved outcomes for young people supported through the BPP residential component. Monetisable information has been identified from project monitoring information for several outcome variables: reduction in looked after children, reduction in police interventions associated with children gone missing and crime, and reduction in 3 other indicators (self-harm, child sexual exploitation, substance abuse).

Details of the benefit savings associated with the 172 young people who remained at home following the BPP outreach support are shown in Table 1. The numbers of young people who would have otherwise gone into each looked after setting were calculated by applying the rate of different placement types in Bradford for 2018-2019 to these 172 young people. This indicates the unit cost saving for each care setting which when aggregated generates a total saving of £8,614,368 over the period of programme operation.

Table 1: Unadjusted reductions in looked after child costs by setting

Setting	Number ²¹	Unit cost	Saving
Foster care	117	£35,620	£4,167,540
Adoption	4	£27,000	£108,000
Other accommodation	11	£10,788	£118,668

²¹ The number of young people in each setting is calculated by applying the rate of different placement types in Bradford according to the government's 2018-2019 annual SSSA903 data return: *Children looked after by local authorities in England*

Local authority residential	16	£254,748	£4,075,968
Placed with parent	24	£6,008	£144,192
Total	172		£8,614,368

Source: York Consulting

Table 2 provides details of the benefit savings linked to the avoidance of 112 police interventions, 87 relating to missing person episodes and 25 to crime. The data for these 2 types of intervention are based on the change (reduction) in calls made by BPP homes relating to missing persons and instances of crime. The total benefit saving reflecting both elements is calculated to be £262,453.

Table 2: Unadjusted reductions in police interventions 2018-2019

Year	Missing persons	Crime	Total
2018	324	74	398
2019	237	49	286
Change	87	25	112
Unit Cost	£2,719	£1,036	
Cost Reduction	£236,553	£25,900	£262,453

Source: York Consulting

Table 3 below provides details of benefit savings linked to reductions according to 3 additional indicators, self-harm, child sexual exploitation (CSE) and substance use. The savings are based on child-level data for each indicator for 24 young people placed or in placement at 3 BPP residential homes between April 2018 and December 2019. Proxy savings have been assumed for any young person who was placed within the period April 2018 and December 2019 and for whom, at that time, an indicator was present but then ceased to be present within the period. For example, 1 young person placed within the period who at that time was using substances stopped doing so while in placement, during this period. Total savings for this small group are £15,897. Full details of the assumptions and proxy savings assigned can be found in Appendix 16.

Table 3: Unadjusted proxy savings for other indicators

Outcome	Number	Proxy saving	Saving
Reduction in self-harm	5	£1,664	£8,320

Reduction in CSE	1	£3,583	£3,583
Reduction in substance abuse	1	£3,994	£3,994
Total			£15,897

Source: York Consulting

The benefit savings need to be deflated to take account of existing practice, for example, outreach support was in place before the commencement of BPP and was enhanced by the specialist roles. As detailed earlier in this report, it took longer than anticipated to have all the specialists in post. In Table 4 below we outline different rates of attribution of the monetisable outcomes to BPP, rather than assuming that BPP could be attributed to all incidences of costs being reduced. Scenarios are included for low (20% of cases), medium (40% of cases) and high (60% of cases). These scenarios allow for what might have happened anyway, in the absence of BPP, by adjusting the benefits to different proportions of the total. For example, the medium attribution of 40% expresses that BPP is responsible for 40% of the observed benefits. The scenarios were informed by the qualitative evaluation findings and are considered to be plausible levels of attribution.

Table 4: Attribution scenarios for cost reductions

Attribution Scenario	Low (20%)	Medium (40%)	High (60%)
Looked after child cost reduction	£1,722,874	£3,445,747	£5,168,621
Police intervention cost reduction	£52,491	£104,981	£157,472
Other indicators cost reduction	£3,179	£6,359	£9,538
Total cost reduction	£1,778,544	£3,557,087	£5,335,631

Source: York Consulting

Costs

The only information available on programme costs is the £3.1 million grant allocation from the Innovation Programme. As the outcomes observed are unrelated to the Mockingbird element of the programme, given the suspension of the hubs, the costs

pertaining to this – 18% of the total £3,144,000 – have been excluded. This generates a base programme cost of £2,578,080.

Return on investment

The return on investment (ROI) is calculated by dividing programme costs by attributed benefits thus producing a benefit cost ratio (BCR). Details of the ratio for each attribution scenario are shown in Table 5.

Table 5: Return on investment by Benefit Attribution Scenario

Attribution scenario	Programme cost on investment	Benefit	Return
Low (20%)	£2,578,080	£1,778,544	0.7
Medium (40%)	£2,578,080	£3,557,087	1.4
High (60%)	£2,578,080	£5,335,631	2.1

Source: York Consulting

The ratios shown above are greater than one for both the medium and the high scenarios indicating a positive return on investment. The medium scenario BCR is 1.4 suggesting that for every £1 invested in the programme there is a potential saving of £1.40. While these results are indicative, they are encouraging and worth revisiting when better data is available. The results will be revisited in early 2021 when better child-level data is made available as part of the scheduled work programme for the extension of BPP until March 2021.

Longer-term sustainability of programme innovation

At the time of writing, Bradford secured funding from the DfE for another 12 months for the residential-outreach component of BPP. In addition, work is underway to re-establish Mockingbird in Bradford, with support from the Fostering Network. As detailed throughout this report, there has been substantial change in leadership and strategic focus in Bradford over the timeframe of the evaluation. Despite these changes, there has been continued operational commitment to the programme that has supported progress and sustainability, not only throughout the evaluation timeframes, but also through the potential for continued positive practice in the longer-term.

The leadership changes, and consequential instabilities, have inhibited and impacted upon the centrality of both evidence generation and evidence-informed practice, which was prioritised at the outset of the programme. The replication of North Yorkshire's tried

and tested framework for data and evidence use (via a data tracker mechanism) has been constrained, with cohort data provided rather than at an individual child level. Consequently, the attribution of impact is less conclusive because it has not been possible to assess the changes in outcomes at an individual level, as was intended. Ongoing communication between the BPP data analyst, the evaluation team, and specialist advice and guidance from North Yorkshire NWD colleagues (as part of their Partners in Practice role) has ensured that evidence generation is integral to sustainability of the programme, and central to BPP over the next 12 months. Much of the necessary data exists, but there were anomalies in the recording of data that came to be identified following a change in data analyst within Bradford. It is essential that this process is supported by the new strategic leaders, to support future sustainability and partnership working with other agencies.

4. Summary of key findings on 7 practice features and 7 outcomes

As reported in the Children's Social Care Innovation Programme Round 1 Final Evaluation Report (2017), evidence from the first round of the Innovation Programme led the DfE to identify 7 features of practice and 7 outcomes to explore further in subsequent rounds.²² Identified below are 2 practice features and 5 outcomes applicable to BPP programme activities and this evaluation alongside a brief summary of relevant findings.²³

BPP promoted workforce-wide access to training in **strengths-based practice frameworks** (namely P.A.C.E. and Signs of Safety) as part of a common model of care. This approach promoted a shared understanding of the tenants of therapeutically-informed direct work, allowing for consistency in how children and young people are responded to and supported. The workforce rated the usefulness of training received and their satisfaction with it, attributing this to their improved skillset.

The findings demonstrated added value of integration of specialists with **multi-disciplinary skill sets** within the residential-outreach setting. The workforce valued access to specialist advice and formal consultation, which helped them to consolidate their training and ultimately enhanced their capacity and confidence in providing intensive and tailored therapeutically-informed support to children and young people. The integration of specialists also provided practitioners with foundational knowledge on presenting behaviours arising from multi-faceted needs and vulnerability to various risks. Joined-up working allowed for appropriate and timely interventions to meet a complexity of needs and steer the formulation of effective support plans. BPP senior management underlined the importance of sustained relationships with multi-agency partners for the continuation of such an approach.

The practice feature of **high intensity and consistency of practitioner** was achieved through integrated, specialist support within the residential component. This integration allowed for ease of access to multi-agency specialist support for involved children and young people in their own environment. There was evidence of positive relationships between specialist workers and children and young people, which is conducive to ongoing therapeutically-informed interactions. The interviews with children and young people highlighted the accessibility of specialist workers and how the professionals

²² Sebba, J., Luke, N., McNeish, D., and Rees, A. (2017) *Children's Social Care Innovation Programme: Final evaluation report*, Department for Education, available [here](#)

²³ The 2 applicable practice features are strengths-based practice frameworks and high intensity and consistency of practitioner. The 5 applicable outcomes concerned reduced risk for children and young people; greater stability for children and young people; increased wellbeing for families, children and young people; reduced days spent in state care; and, generation of better value for money.

helped them when interventions were conducted. Evidence also showed that embedding a common model of care allowed for positive child-carer relationship, providing important foundations for consistency of approach and progress towards meeting intended outcomes. However, the findings also recognise that to sustain this intensity and consistency of practitioner, the specialists require the right working environment and increased continuity between the aims of BPP and how the programme operates in practice to help focus their activity.

There is evidence of **reduced risk for children and young people** involved in the residential-outreach service, with the rates of risk association steadying and decreasing across the lifespan of the programme. However, given the data limitations previously stated, the improved risk profiles observed cannot be conclusively attributed to the programme.

There was evidence of **greater stability for children and young people** through the residential service, as they were experiencing a more settled placement in residential care than those in mainstream homes (as evidenced through the average length of stay). Destination data following placement in a BPP home showed several placements were 'stepped-down' to mainstream homes. Additionally, a proportion of children moved on to fostering arrangement through meeting requirements set out in support plans. Children and young people reflected on the beneficial relationships built with practitioners and specialists over time and the impact this had on their wellbeing and outlook.

The findings suggest that the new service components have brought **increased wellbeing to involved families and children and young people**. For the residential component, the tracking of SDQ scores suggests increased wellbeing for most involved children and young people. Improved SDQ scores were at a positively higher level in 1 specialist home and the emergency hub (an assessment of which was beyond the scope of the returned evaluation data). Mockingbird carers suggested they are building greater resilience to cope with the challenges fostering brings as they feel less isolated and have more outlets to receive advice and support as required. The carers provide examples of how peer support opportunities had a positive impact on their family life and, in some instances, strengthened resolve to continue caring.

The outcome **reducing days spent in state care** was evidenced through the high rate of adolescents involved in the outreach service that were diverted from care and associated rates of family reunification. The interview data placed emphasis on new ways of working (via the common model of care) and specialist integration on the progress evidenced for involved children and young people.

Although data provided for the cost benefit analysis was limited, the potential savings associated with the diversion from care appear to be promising and, therefore, provide some evidence of **generation of value for money**. We hypothesise that evidence pertaining to the value for money associated with the residential-outreach component will

improve as further emphasis is placed on data generation and analysis from the child-level data tracker over the next 12 months.

5. Lessons and implications

Over the timeframe of the implementation of the Bradford BPP programme and the evaluation, there is emerging evidence indicating that the enhancements and changes to practice introduced have had a positive impact on children and young people. As recognised within this report, the necessary conditions associated with effective implementation, such as consistent senior leadership and strategic direction, have been in question throughout. The commitment and oversight of operational leads has helped alleviate associated difficulties and ensured the continuation of BPP. On the basis that Bradford have secured additional funding for another 12 months, we make the following recommendations to build on the progress made and move towards a more robust evidence base:

- closer working between strategic leaders and the operational leads for BPP, not only to ensure that those working to continue and embed BPP practice are adequately supported, but that their perspectives on how well the adapted models operate in practice and suggestions for development are considered going forward
- an aligned commitment to quantitative data generation recognising the necessity of a robust method to track outcomes longitudinally at an individual rather than cohort level, recording and analysis (as planned at the outset). The foundations are in place, but require strategic governance to ensure that there are ongoing feedback mechanisms to operational staff on data monitoring and recorded impact on children and young people
- given the inclusion of a residential-outreach component based on the No Wrong Door (NWD model), it is advisable that any new analyst employed works closely with the community of analysts being set up by the North Yorkshire NWD team
- despite the time commitment involved, it remains important that the voice of the child is given credence to understand how key aspects of the programme impact positively, or otherwise, on their experiences of involvement in children's services and their outcomes.

This evaluation report has focused on 2 areas of practice within Children's Services in Bradford, and the adaptations of models (NWD and Mockingbird) that were first implemented in other local authority areas as part of Round 1 of the DfE Innovation Programme. Despite the less than ideal conditions for innovation, positive outcomes have been achieved.²⁴ As Bradford move into their next 12 months of funding they would benefit from continued alignment to the wider scale and spread activities associated with

²⁴ Additionally, NWD and Mockingbird are continuing to achieve positive outcomes in other areas, as evidenced in the national evaluation of Mockingbird (Ott at al., forthcoming) and the continued evidence generation of the impact of NWD (as part of the DfE Strengthening Families programme).

NWD, as well as ensuring the infrastructure is in place to support the workforce to meet intended outcomes and a renewed focus on quantitative child-level data tracking.

Appendix 1: BPP alignment with Bradford’s strategic priorities

Table 6: BPP alignment with strategic priorities from Children, Young People and Families Plan (CYPPF) 2017- 2020

Strategic priorities identified in Bradford’s CYPPF	Alignment with BPP programme	Anticipated outcome
Ensuring that our children start school ready to learn/ Accelerating education attainment and achievement	Joint working with the specialist school practitioner and the health team to identify any additional needs or requirements to support young people on their educational journey	Child has EHCP plan, any additional issues or needs identified. Better school attendance, improvement in educational attainment
Ensuring children and young people are ready for life and work	Addressing issues early on to ensure that young people can grow and flourish into adulthood without current risks leading to negative outcomes. Providing intervention as and when it is required and on the terms of the young person without waiting lists or appointment-based therapy	Ensuring that young people have the right foundations in their childhood to lead meaningful, positive, and safe futures and to address any areas of trauma for engagement in future opportunities
Safeguarding the most vulnerable and providing early support to families	Remodelling of placement types - introduction of specialist residential placements and new fostering model. Shared therapeutically-minded model of care across placements in favour of crises interventions. Strengthened outreach - children can receive specialist interventions within their family home	Resilience building for families to maintain healthy relationships throughout the generations. Less children coming into care who could have been supported to safely stay within their family home.
Listening to the voice of children, young people and families and working with them to shape services and promote active citizenship	Provide safe environments for young people to be heard, understood and to have their opinions championed. Ensuring that workforce development includes robust training on aspects such as P.A.C.E. to help practitioners and carers explore the view of young people	Through providing Speech and Language Therapy and other services, young people can finally express their viewpoint and needs. This will allow for more successful interventions and strategies and revised ways of working

Source: Bradford Children’s Trust 2017

Appendix 2: BPP service use and completion figures

Table 7: BPP service use and completion figures by year end 2019

BPP service	Timeframe	Number of children and young people currently involved in BPP	Number of children and young people that have exited BPP
Specialist home 1 4-bedded; ages 12-18	At year end 2019	4	1
Specialist home 2 4-bedded; ages 12-18	At year end 2019	4	4
Specialist home 3 7-bedded; ages 5-10	At year end 2019	7	6
Emergency 'Hub' home 4-bedded short stay; ages 11-18	At year end 2019	3	57
Outreach edge of care adolescents	At year end 2019	108	210
Mockingbird children and young people in foster family constellations with satellite carers	At end of July 2019 (when fully operational)	26	10
	Total children and young people	152	280

Source: BPP internal monitoring data

Appendix 3: BPP programme theory of change

A theory of change (ToC) workshop was held by the evaluation team in September 2019 as an opportunity to revisit the original aims and intended outcomes devised pre-implementation. The ToC presented below is the revised version that resulted from consultation between the evaluation team and BPP stakeholders during this workshop. Over the course of the programme lifespan, the number of looked after children in Bradford continued to increase. Such increases were evident not only for the older, adolescent population, but for all age groups. As such, the focus on placement stability and family reunification for adolescents on the edge of care was further underlined. Improved outcomes across education pathways reflected longer-term vision for looked after children (developing from specialist intervention and a consistent care package) and was not, therefore, conceived to be an indicator of interest for the evaluation.

Table 8: BPP programme theory of change

Inputs across BPP components	Activities aligned directly to specific inputs	Outputs arising from all activities	Outcomes anticipated following programme intervention
Residential-outreach service (based on No Wrong Door)	Multi-agency hubs built around specialist residential care homes delivering responsive early intervention care and intensive therapeutic support for looked after children and adolescents on the edge of care.	Indication that all involved children and young people are experiencing stability in care or at home. Children and young people feedback on support received by those around them. Evidence through child-level data tracker and specialist reporting that looked after children and adolescents are having their needs identified and addressed.	1. Increased placement stability. Higher proportion in family placements or family reunification where possible. 2. Improvements in wellbeing alongside reductions in risk association, Improved outcomes across education pathways.
Fostering service (implementation of Mockingbird Family Model)	Constellations of foster families for unrelated and related carers underpinned by peer support concept.	Increased wellbeing as evidenced through improved SDQ scores of looked after children and 'edge of care' adolescents. Increased	3. Reduction in proportion of looked after children or adolescents on the edge of care experiencing or

Inputs across BPP components	Activities aligned directly to specific inputs	Outputs arising from all activities	Outcomes anticipated following programme intervention
<p>Common model of care (P.A.C.E. and Signs of Safety)</p> <p>Governance</p> <p>Management</p>	<p>Workforce access to training and joined-up working aligned to therapeutically-informed integrated care to enhance carer-child relationships.</p> <p>Programme leadership and multi-agency partnerships for specialist integration; programme board overseeing vision and best practice; sign-off of required infrastructure (for example, suitable properties); marketing and recruitment.</p> <p>Dedicated programme manager and data analyst; inter-agency and workforce consultation for risk management and review of support planning; workforce supervision ensuring adherence to ethos; matrix management of specialists</p> <p>Evidencing impact according to progress towards intended outcomes</p>	<p>engagement in education as evidenced through specialist reporting.</p> <p>Deceleration of high-need placements through movement from residential to foster care where appropriate.</p> <p>Evidence of consistent carer-child relationships developed through therapeutically-informed interactions and/or bespoke individual 'fun' activities.</p> <p>Workforce reporting increased confidence to interact positively with children in their care and an ability to identify a child's needs and escalate any issues and access extra support where necessary.</p>	<p>developing complex difficulties and/or dependencies</p> <p>4. Fully-trained workforce competent in therapeutically-informed direct work</p> <p>5. Reduction in demand on public services and evidence of significant cost savings attributable to service change</p> <p>6. Fulfilling targets aligned to Bradford's strategic priorities (for example, Children, Young People and Families Plan; Sufficiency Strategy).</p>

Appendix 4: Sample across evaluation timepoints: BPP workforce

Table 9: Sample across evaluation timepoints - BPP workforce

Role	Evaluation baseline	Evaluation endpoint - second time participants (including number/reason for non-participation at time 2)	Evaluation endpoint - first time participants (including reason)	Evaluation participation totals
BPP senior management	2 interviewed	1 interviewed for follow-up; 1 interviewed on BPP exit (follow-up interview)	-	4 interviews
Residential service management (including service and homes managers)	5 interviewed	2 interviewed for follow-up; 1 interviewed on BPP exit (follow-up interview)	3 interviewed (interim or newly appointed managers)	11 interviews
BPP specialists	8 interviewed	2 interviewed on BPP exit (follow-up interview); 7 participated in focus groups as follow-up; health specialist survey, 5 respondents	2 participated in focus groups (newly appointed specialists)	10 interviews; 5 survey responses; 9 participated in focus groups

Role	Evaluation baseline	Evaluation endpoint - second time participants (including number/reason for non-participation at time 2)	Evaluation endpoint - first time participants (including reason)	Evaluation participation totals
Residential practitioners (including assistant specialist home managers, residential and outreach workers)	53 survey respondents	39 survey respondents	Unknown if responded more than once as anonymised survey	92 survey responses
Fostering service LA management	3 interviewed	2 interviewed for follow-up	1 interviewed (interim or newly appointed manager)	6 interviews
Mockingbird foster carers (including hub and satellite carers)	11 interviewed	6 interviewed for follow-up (5 not interviewed due to constellation suspension before endpoint)	-	17 interviews
			BPP workforce sample size across timepoints	154

Appendix 5: Sample across evaluation timepoints: children and young people

Table 10: Sample across evaluation timepoints – children and young people

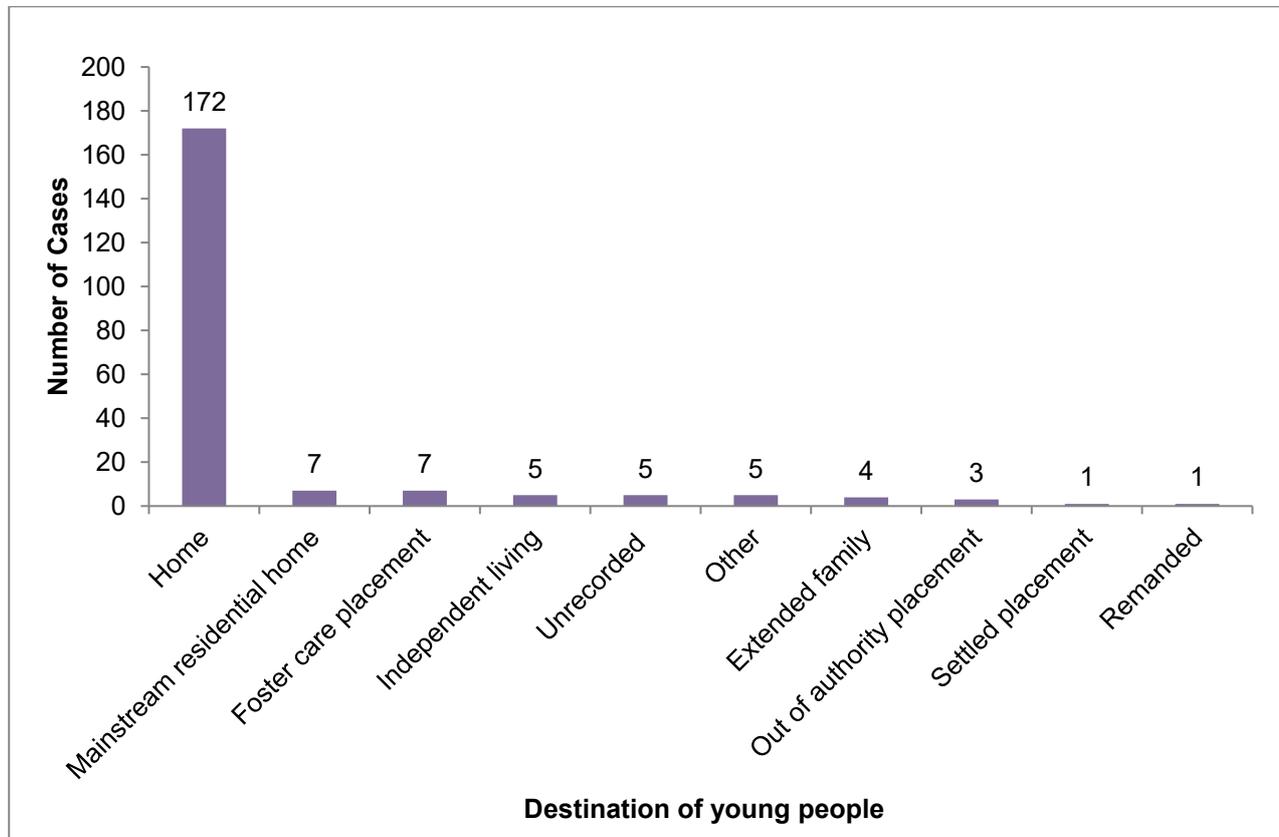
BPP service	Evaluation baseline	Evaluation endpoint - first time participants	Evaluation endpoint - second time 'follow-up' participants (including number/reason for non-participation at time 2)	Destination of children and young people at follow-up	Evaluation participation totals
Specialist home 1	1 interviewed	-	1 interviewed for follow-up	1 post-16 semi-independent accommodation	2 interviews
Specialist home 2	3 interviewed	-	2 interviewed for follow-up (1 left care and uncontactable)	1 remains in BPP specialist home; 1 non-BPP residential home in Bradford	5 interviews
Specialist home 3	7 interviewed	-	6 interviewed for follow-up (1 - evaluation team member agreed with social worker not to approach for interview)	2 remain in BPP specialist home; 1 moved to other BPP specialist home; 3 in foster care	13 interviews
Emergency hub	5 interviewed	-	4 interviewed for follow-up	1 moved to BPP specialist home; 2 non-BPP residential homes in Bradford.	9 interviews

BPP service	Evaluation baseline	Evaluation endpoint - first time participants	Evaluation endpoint - second time 'follow-up' participants (including number/reason for non-participation at time 2)	Destination of children and young people at follow-up	Evaluation participation totals
			(1 not interviewed for follow-up as living with family/uncontactable)	1 residential home out of authority	
Outreach	4 interviewed	5 interviewed	2 interviewed for follow-up (2 not interviewed for follow-up as case closed to Children's Services)	1 living in post-16 semi-independent accommodation. 1 remained at family home	11 interviews
Mockingbird	10 interviewed across 7 families (1 child in family and friends' constellation not interviewed due to age at baseline nor at endpoint as constellation suspended)	3 interviewed from 1 new family that joined the unrelated constellation from the family and friends' constellation	7 interviewed across 4 different families for follow-up (3 children not interviewed for follow-up due to constellation suspension)	All remain in same foster care family	20 interviews

BPP service	Evaluation baseline	Evaluation endpoint - first time participants	Evaluation endpoint - second time 'follow-up' participants (including number/reason for non-participation at time 2)	Destination of children and young people at follow-up	Evaluation participation totals
				Children and young people sample size across timepoints	60

Appendix 6: Destinations of young people following outreach intervention

Figure 6: Destinations of young people following outreach intervention at 31/12/2019



Source: BPP child-level data tracker

Nearly two-thirds of these outreach cases were closed as the desired outcomes attributed to the case were recorded as 'completely achieved' by the allocated practitioner(s), a further fifth of cases were closed having 'partially achieved' outcomes, and 5% saw limited achievement across the intervention. Just 10% of outreach cases were closed as a result of having 'no effect' or due to non-engagement, which, when considered alongside the percentage of adolescents that did not enter care, highlights the positive impact of the outreach service.

Appendix 7: Destinations of children and young people following placement at a BPP home

Table 11: Destinations of young people following placement at a BPP home at 31/12/2019

Destination	Specialist homes	Emergency hub home	Frequency according to destination
Return home	0	13	13
Extended family	0	2	2
Bradford mainstream residential home	3	11	14
Foster care	4	11	15
Out of authority placement	2	4	6
Independent living	1	1	2
Remanded in custody	0	1	1
Other (not recorded/unavailable data)	1	14	15
Total that have left BPP homes			68

Source: BPP child-level data tracker

Appendix 8: Average number of days spent in residential placement in Bradford by 31/12/2019

Table 12: Comparison of average number of days spent in residential placement in Bradford according to number of prior placements by 31/12/2019

Number of prior placements for BPP children and young people	Frequency	Average number of days spent in BPP placement	Number of prior placements for looked after children in Bradford	Frequency	Average number of days spent in placement
1	3	409	1	231	249
2	4	203	2	124	173
3	12	322	3	66	122
4	24	303	4	40	105
5	0	-	5	15	90
6	12	143	6	24	59
7	7	73	7	14	45
8	8	100	8	0	-
9	0	-	9	9	78

Source: Bradford Children's Services management information system

Appendix 9: Rate of change in the SDQ scores of children and young people according to BPP home

Table 13: Rate of change in 1st and 2nd SDQ scores of children and young people according to BPP home by 31/12/2019

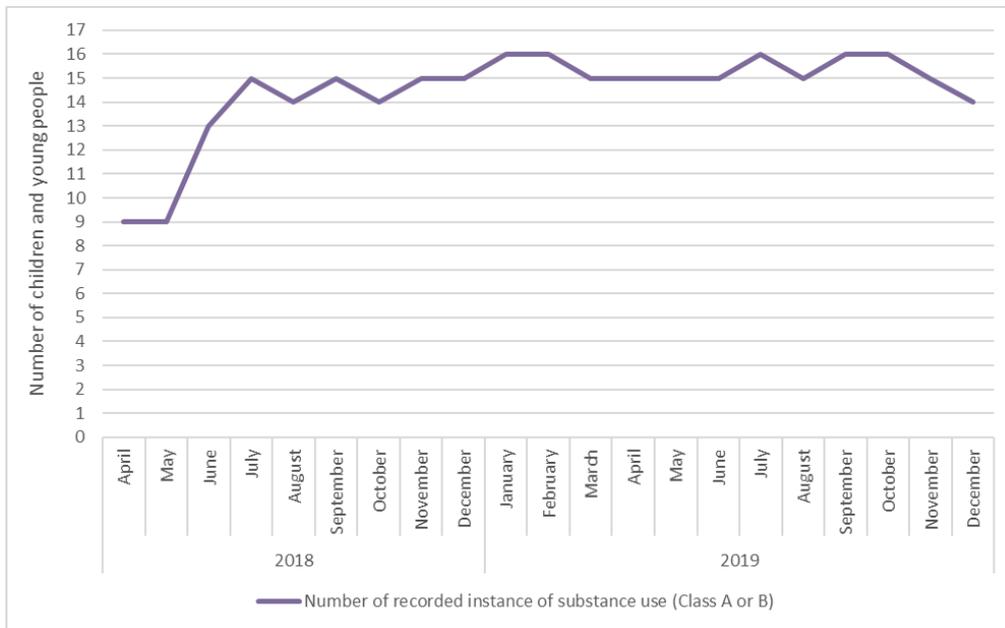
BPP service	Average 1st score (%)	Average 2nd Score (%)	Average percentage decrease
Specialist home 1	20.5	11.8	41.6
Specialist home 2	21.0	21.3	-2.25
Specialist home 3	27.8	23.7	11.34
Emergency hub	24.3	19.5	19.52
Outreach	18.2	15.8	1.82

Source: BPP child-level data tracker

Appendix 10: Recorded instances of substance use and self-harm across BPP specialist homes

Figure 7: Recorded instances of substance use (Class A or B) across BBP specialist homes

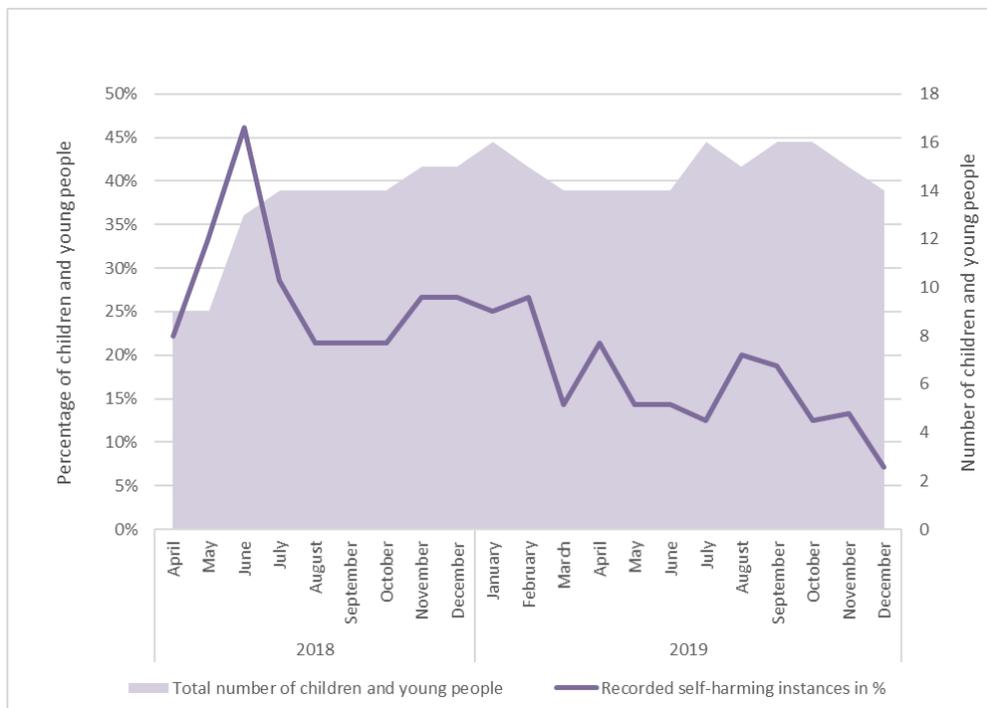
April 2018 - December 2019



Source: BPP child-level data tracker

Figure 8: Recorded instances of self-harm across BBP specialist homes

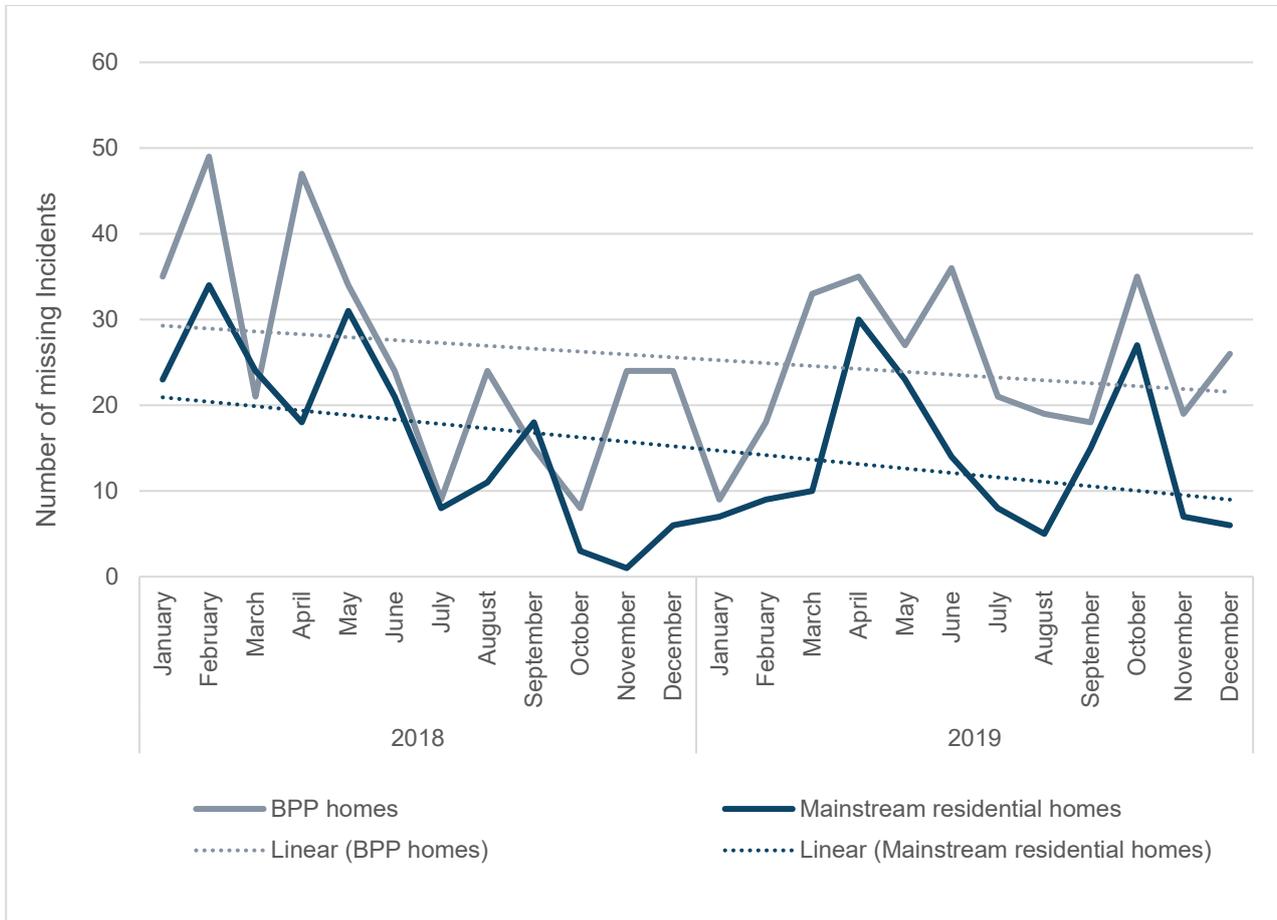
April 2018 - December 2019



Source: BPP child-level data tracker

Appendix 11: Number of recorded missing incidents across BPP homes and mainstream residential homes

Figure 9: Number of recorded missing incidents across BPP homes and mainstream residential homes January 2018 - December 2019



Source: BPP child-level data tracker/ Bradford Children's Services management information system

Appendix 12: Residential-outreach workforce perspectives on added value of BPP

Table 14: Selection of quotes providing residential-outreach workforce perspectives on added value of BPP

BPP role	Added value of P.A.C.E. techniques to direct work with children and young people	Added value of Signs of Safety techniques to direct work with children and young people	Added value of integrated support to children and young people	Added value of specialist integration to practitioners engaging in direct work
Home manager	<p>“P.A.C.E. is based on children feeling safe through boundaries and limits. You’ve always got to have that foundation in a home. If the home isn’t settled, and the children don’t feel safe, I don’t think any interventions are half as effective.”</p>	<p>“Signs of Safety is very much about either assessing risk or assessing worries, or just assessing progress. [I] think that you can very quickly spot risk before it even comes up, and you can address it within Signs of Safety.”</p>	<p>“The work that the BPP police are doing, they’re able to do around knowing the kids at home, when they’re relaxed; [our] kids behave in a completely different way if you just go to an office to see a specialist. [These] specialists know how they behave at home; they know all the pitfalls and their reactions to things. I really enjoyed working with them.”</p>	<p>“I think as a manager, I need to completely buy into that way of working, including Signs of Safety, other ways of assessing risk, and then promoting that within the team, [whilst] making sure that everybody’s acting in a P.A.C.E.-ful way, and understand how to safeguard and protect the children. [Specialist integration] means the staff see the psychology, but in a slightly different way. You always get those people who [are] a bit</p>

BPP role	Added value of P.A.C.E. techniques to direct work with children and young people	Added value of Signs of Safety techniques to direct work with children and young people	Added value of integrated support to children and young people	Added value of specialist integration to practitioners engaging in direct work
				hippyish, it's a little bit nonsense. I think it's the approach of our specialists - [practitioners are] seeing them as sensible people with really good ideas, and they're seeing the processes as things that work."
Home assistant manager	"Working on outreach to support families with placement breakdown."	"[It is useful] when supporting families to create a resilience plan around child sexual exploitation."	"I believe that having BPP to support children is now essential in their continued progress within the service. It can help identify any issues that a child may have, and this can be easily discussed or solved with the therapeutic team we have access to. Children	"Having our specialists on board has saved time when intervention has been needed. It has also helped to be able to talk cases through when needed."

BPP role	Added value of P.A.C.E. techniques to direct work with children and young people	Added value of Signs of Safety techniques to direct work with children and young people	Added value of integrated support to children and young people	Added value of specialist integration to practitioners engaging in direct work
			are more positive when having a familiar face to discuss things with therefore building better and more trusting relationships with professionals.”	
BPP residential practitioner	“Taking the time to empathise with the young person - and applying connection before correction as a daily tool within my work - has helped me to build better stronger relations with young people.”	“I have used Signs of Safety during assessments for families and young people and reports for other professionals.”	“Positive relationships and bridges gaps between looked after children and CAMHS. Direct access to therapy. The input is more specific, individualised and becomes more practical due to being in the house/on shift. Real time responses regarding supporting at the height of crisis -	“The input from all specialists help underpin general practice and supports a deeper understanding of children's needs - in turn, bolstering the care planning processes.”

BPP role	Added value of P.A.C.E. techniques to direct work with children and young people	Added value of Signs of Safety techniques to direct work with children and young people	Added value of integrated support to children and young people	Added value of specialist integration to practitioners engaging in direct work
			better more individualised response.”	
Residential-outreach practitioner	“Working with young person around self-harm issues; having empathy and understanding and good listening skills allowed me to deliver a tailored piece of work with this young person. I have adopted a good relationship with this person and, as a result, she is building resilience within herself to handle underlying emotions.”	“When doing initial assessments, I apply Signs of Safety. This helps to gain an understanding of the situation, highlight any concerns, and direct my work, [thus] enabling further discussion and professional involvement.”	“The young people we support have access to an intensive and broad reaching professional team; appearing more ‘human’ and relatable to the young person.”	“BPP specialists have been beneficial professionals because they are easy to approach, and they all based in one hub. Multi-agency work can take place as there are more opportunities for liaison with different professionals.”
Outreach practitioner	“Young man struggling to regulate in school and home - I went in with empathy and acceptance, gradually via curiosity. I introduced playfulness and got to a position where we could identify his feelings and produced a plan to help him indicate when he was struggling.”	“We often use the phrases what are we worried about, what is working well and what needs to change, with both parents and young people, to give goals to	“Many of my young people have had difficulty engaging in school, so working with the education specialist has been valuable. [She] has accompanied me to meetings in school and	“I feel that the support from the specialist team is invaluable. Lots of our young people have needs which have been missed [and] with the support of our specialists

BPP role	Added value of P.A.C.E. techniques to direct work with children and young people	Added value of Signs of Safety techniques to direct work with children and young people	Added value of integrated support to children and young people	Added value of specialist integration to practitioners engaging in direct work
		work towards and focus on the positives.”	has the knowledge of law and how schools should also play their part. [We have] built up relationships with teachers and support workers, and adaptations have been made. It has had a positive impact on young people helping them engage/reengage.”	these can be identified and supported.”

Appendix 13: BPP specialist role summaries

BPP health specialist: psychologists

Each psychologist will conduct assessments and case-by-case psychological formulations to inform the support plans of children and young people in the residential-outreach service. Each psychologist supports residential-outreach practitioners in their direct work, through drawing on disciplinary expertise on the psychological impact of trauma and resulting emotional and conduct-based difficulties. Each psychologist consults directly with the BPP workforce by providing specialist advice during BPP staff meetings, developing psychological guidance documents, and leading psychological formulation meetings on cases and developing summary reports. The psychologists also commit to knowledge sharing on the psychological development of children and adolescents and practice guidance and evidence. In addition to direct consultation and practice, they help deliver group and individual supervision support to residential and outreach practitioners and provide training in psychologically-informed practice techniques according to the requirement of a practitioner. They also act as members of aligned working groups on behaviour management and, with other health specialists, on a pathway for improved support and identification of neurodevelopmental disorders. They collaborate during weekly multi-agency meetings to discuss any joint working on support plans of young people in emergency placements and any outreach cases requiring multi-agency involvement. Accordingly, they attend external meetings with social care, education, or health to help determine care planning.

Data was collected by the BPP analyst via a monthly return of health specialists' activities and subsequently collated and transferred to the evaluation team by the BPP analyst in June 2019 only. The activity data recorded the direct work the two psychologists conducted each month during the period of August 2018 and June 2019. Such direct work included the total number of face-to-face (F2F) assessment hours, F2F interventions and therapy hours and the informal and casual hours spent F2F to foster therapeutic relationships. The psychologists spent on average 2.8 hours on direct work each child per month and worked with approximately 29 children and young people on average each month across the residential-outreach service.

BPP health specialist: speech and language therapists

The BPP speech and language therapists (SALT) screen for speech, language, and communication needs (SLCN) across the residential-outreach service. The SALT will screen the young people in the specialist homes through observation and assessment of functional communication skills. If a SLCN is identified, a full language assessment is offered to support differential diagnosis. SALTs engage in knowledge sharing and consultation with residential-outreach practitioners to raise awareness of SCLN of young people supported through the BPP service (so they are both able to identify needs and

interact with children and young people in their environment). The workforce is also trained in conducting a preliminary screening tool with young people on the edge of care to identify whether further support from SALT services are required. This disciplinary input also aims to increase understanding of the intent behind a young person's communication. The SALTs may also liaise with external professionals to ensure a package of support for SCLN is available for young people supported through the service. Such support may focus upon enabling the young person to stay in school through guiding the staff to differentiate between negative behaviours and SCLN. External activity may also involve attending meetings with social care practitioners (such as Team Around the Child) to enable a multidisciplinary approach to care planning.

Data was collected by the BPP analyst via a monthly return of health specialists' activities and subsequently collated and transferred to the evaluation team by the BPP analyst in June 2019 only. The activity data recorded the direct work the 2 SALTs conducted each month during the period February to June 2019. Such direct work included the total number of F2F assessment hours, F2F interventions and therapy hours and the informal and casual hours spent F2F to foster therapeutic relationships. The SALTs spent on average 1.8 hours on direct work each child per month, and work with approximately 28 children and young people on average each month across the residential-outreach service.

BPP health specialist: occupational therapist

The BPP occupational therapist (OT) provides professional input across the BPP homes. The OT utilises evidence-based occupational therapy approaches to inform both assessment and intervention. The OT offers assessment and therapeutic interventions primarily with children and young people presenting with functional, gross, and fine motor and sensory processing difficulties. The OT incorporates play-based observational methods to assess psychosocial and functional, motor, and sensory skills. The OT engages in regular case discussions to formulate assessments and intervention plans. The OT also has a prominent role in engaging and educating parents, young peoples' carers, and other professionals on sensory processing difficulties and how the associated challenges experienced by children and young people impact on function and everyday occupations and task demands at home and school.

Data was collected by the BPP analyst via a monthly return of health specialists' activities and subsequently collated and transferred to the evaluation team by the BPP analyst in June 2019 only. The activity data recorded the direct work the OT conducted each month during the period January to June 2019. Such direct work included the total number of F2F assessment hours, F2F interventions and therapy hours and the informal and casual hours spent F2F to foster therapeutic relationships. The OT spends on average 3.4 hours on direct work each young person per month and works with approximately 13 young people on average each month across the residential-outreach service.

BPP police specialists

The BPP police specialists' service remit involves direct work with involved children and young people and supporting the residential-outreach practitioners in respect to any criminal behaviours or activity outside the homes, missing episodes and providing any related necessary intelligence, vulnerability to child criminal exploitation and child sexual exploitation, responding to sexualised behaviours, and challenging dynamics within homes. These activities are largely achieved through monitoring processes and gathering intelligence on any activities that may result in criminal activity, intelligence which is recorded on a system and accessible to the workforce. The BPP police specialists primarily involve building relationships with children and young people to help break down barriers they may have with the police to support them. It may also involve helping children and young people, and sometimes their families, to understand police and court processes. This engagement with children and young people is aligned to fulfil service aims to reduce missing episodes and educate children and young people regarding risk that presents to them (for example, exploitation or violent crime). They also work to prevent the criminalisation of looked after children or adolescents involved in outreach and entry into the criminal justice system. This prevention work is aided through improving policies, procedures, and strategies within the homes. The specialists attend LA meetings when police involvement is required (child safeguarding team, and others) and contribute to internal home and multi-agency meetings to inform support planning.

BPP education specialist

The education specialist role developed to support children and young people referred to the BPP hub home and involved in the outreach service. The role involves working with the BPP outreach team on casework for young people on the edge of care and supporting staff within the hub home by working towards ensuring the young people placed can continue to engage in education provision. The education participation and progress of young people in the hub home is recorded, measured, and celebrated as achievements (engagement in education can include skills for life learning). When emergency placements are made, the specialist will review the looked after child's personal education plan (PEP) so to inform any intervention. The specialist also works as a consultant for the outreach service, involving observations to assess signs of needs that may impact on learning, and construction of a support plan relating to education based on any identified learning disabilities. The specialist is also involved in discussing strategies for intervention with adolescents on the edge of care and formulating support plans alongside other specialist and residential-outreach practitioners. The specialist works jointly with the authority's virtual school and represents children and young people supported through BPP at various looked after child or team around the child meetings to find solutions collectively. The specialist also contributes to ECHP plans. The specialist also liaises with school's senior leadership teams, special educational needs and disabilities co-ordinators, designated safeguarding leads, and mental health champions and counsellors with regards to education needs of involved children and young people.

Appendix 14: Anonymised case studies exemplifying specialist joined-up working across the residential-outreach service

Child A – BPP residential home

A substantial multi-disciplinary meeting was organised to see if a group of specialists could figure out the best way forward. Bringing together professionals with expertise in residential work, social care, education, Team Teach, DDP/evidence-based psychology, speech and language, and occupational therapy, resulted in establishing specific action points.

Following this meeting, substantial and swift advancements have been made to A's neuro-developmental assessment (in collaboration with CAMHS) and establishing what exactly A's 'mental capacity' to understand his difficult behaviours was. Specialist recommendations about residential practice were made and they were subsequently conveyed to the residential practitioners.

A follow-up meeting took place about 4 weeks later. At the meeting it was stated that over the preceding 2 weeks Child A had 100% school attendance, did not go missing, did not physically assault any member of staff, and did not cause any damage in or out of the home. The staff felt more confident to help A express his emotions verbally (as opposed to 'via difficult behaviours'). They were more able to anticipate potential incidents and take appropriate action before an event escalated further.

This multi-disciplinary effort suggested that it is possible for Team Teach, P.A.C.E. (DDP), psychology, speech and language, occupational therapy, education, and residential practice models to work together to help address some complex and multi-dimensional issues.

Source: BPP health specialist for evaluation purposes

Child B – BPP outreach service

A 12-year-old boy (Child B) was referred to the outreach team, he was at risk of placement breakdown and at risk of exclusion from school due to physically violent behaviour and episodes of attempted self-harm. At school, he was placed in isolation for over 2 months. The school felt they could not meet his needs in the mainstream school and were considering a placement for him at a Pupil Referral Unit (PRU).

The BPP educational specialist completed a school observation and felt that the young person appeared to have some motor co-ordination difficulties (dyspraxia) and some traits of Autism Spectrum Disorder (ASD). She discussed the case with me and requested me to assess this young person for motor-coordination difficulties. My assessment highlighted that this young person has dyspraxia and sensory processing difficulties. I also screened him for ASD. I felt he had traits of ASD and recommended a full assessment.

Based on our detailed reports, the school reconsidered their decision and felt that the Pupil Referral Unit was not an appropriate setting for him as underlying causes for his difficulties originated from his special educational needs and possibly due to neurodevelopmental disorder. This young boy was an extremely bright young man and was achieving well academically, but his difficulties with sensory and motor difficulties meant that he was not able to meet the environmental and tasks demands and was getting frustrated and lashing out.

I further discussed this case with my health colleagues, and we decided to do the full ASD assessment. To undertake the autism assessment, I completed the developmental history assessment with parents. Our speech and language therapist (SALT) completed a school observation and, alongside our psychologist, and the SALT completed another assessment called ADOS. Whilst we were completing the specific assessments, our outreach team practitioner was supporting the family and she would bring his case for discussion regularly in our multi-agency meetings for further support and advice.

Recognition of his special needs and putting support in place resulted in cessation of his aggressive and self-harming behaviours at home and school. This young person now has a place at Designated Specialist Educational unit that caters for his specific educational needs and he is engaging well with education. He is no longer at risk of placement breakdown and has been discharged from the BPP outreach team. We managed to complete the autism assessment for him in less than 5 months – he is just awaiting the outcome from a Joint Assessment Clinic.

Source: BPP health specialist for evaluation purposes

Appendix 15: Recommendations for Mockingbird made by involved carers

Recommendations provided by carers from the remaining operational constellation:

- the consolidation of the liaison worker role with that of the supervising social worker (SSW) at time 2 was favoured by carers as it reduces the number of LA practitioners involved in the families. It was also acknowledged that the SSW has a close understanding of the children and young peoples' background and the dynamics of the foster family, meaning it makes sense for this role to be consolidated and for the SSW to be the link person between carers and the LA. Furthermore, carers highlight that it is beneficial as everyone in the constellation has the same SSW and they get to know all families
- the hub carer stresses that constellations do not need to be tailored in respect to age and needs of children, as this does not reflect the natural diversity found in all families. A satellite carer also stressed that the mix of constellations according to status of the carers (related persons or mainstream) is unimportant as Mockingbird centres on the children and young people and not carer status
- it is important not to standardise the degree of support from the hub home carer, or frequency and number of sleepovers at the constellation hub, as this should be proportionate to family need and presenting concerns experienced. It is of further importance to allow children and young people space to determine their own involvement in the constellation, and at their own pace. Some of the older children particularly may become involved in social activities but are resistant to sleepovers. Time and gentle encouragement are helpful in encouraging involvement in all aspects of Mockingbird
- carers indicated that it is important to only include families in a position to embrace the peer support concept and fully benefit from Mockingbird involvement. Some carers pointed towards an imbalance of involvement in peer activity and support. However, there is acceptance that involvement of families can be led by the keenness of children and young people to mix with others in the constellation. Therefore, there was a suggestion that families need to be matched more effectively to maintain the Mockingbird community
- there is a need for assurance on the longevity of Mockingbird in the LA and better communication from the LA to this effect. The uncertainty as to whether the model was to be sustained produced anxiety with some carers as their families were benefiting from involvement in Mockingbird
- finally, some carers recommended that Mockingbird has such positive impact on families that it simply should be mainstreamed and rolled out nationally.

Appendix 16: Approach to Cost Benefit Analysis (CBA)

This appendix outlines the general CBA methodology and sets out how the monetised benefit unit costs were calculated and applied.

Method Overview

The CBA methodology has been severely constrained by the outcome data available from the project monitoring information system and should therefore be regarded as illustrative and indicative. Reflecting these limitations, we have conducted a relatively basic analysis which probably understates actual costs and benefits. The chosen methodology focuses on one-year savings to the local authority and the police over the period April 2017 - March 2020. In this sense it is essentially a Fiscal Return on Investment (FROI).

On the cost side of the equation we have used the total grant allocation for the project from the DfE Innovation programme and weighted it down to exclude the Mockingbird element which does not feature in our observed outcomes.

Benefits are the monetised outcomes of the programme and reflect potential cost savings to key stakeholders. The only outcomes we were able to monetise relate to reductions in looked after children and police interventions and thus apply to the local authority and the police. See Tables 1 and 2 in the main report.

As there was no counterfactual evidence available to us to take account of business as usual, we created arbitrary attribution scenarios of low (20%), medium (40%) and high (60%). These scenarios illustrate what might have happened anyway, in the absence of BPP, accounting for the fact that BPP may not be responsible for all the observed benefits which have been identified. These estimates were chosen in consultation with the evaluation team and reflect their qualitative findings. A medium attribution of 40% would involve deflating total calculated benefits by 60%. In other words, under the medium attribution scenario, BPP is seen to be responsible for 40% of the observed benefits. See Table 4 in the main report.

The return on investment is calculated by dividing benefits by costs and creating a benefit cost ratio (BCR). These were then calculated for each attribution scenario. See Table 4 in the main report. The medium BCR is 1.4 suggesting that the programme has potentially generated a saving of £1.40 for every £1 invested in programme activity. These savings are theoretical and not necessarily cashable by the local authority or the police.

We strongly recommend that the CBA exercise is repeated when better cost and outcome data becomes available.

Benefit Monetisation

The benefits relate to the cost savings associated with improved outcomes for young people supported by the residential component of the B Positive Pathways Programme. Information was identified from project monitoring information for several outcome variables:

- reduction in looked after children
- reduction in police interventions associated with children gone missing and crime
- reduction in 3 other indicators – self-harm, child sexual exploitation and substance use.

Looked after children

To calculate the benefits associated with reductions in looked after children, the numbers of young people who may have otherwise gone into different looked after settings was multiplied by the relevant unit cost for each setting.

This was achieved by extracting programme data showing where young people who had completed outreach had moved on to. The data, as referenced earlier in the report, showed that 172 young people had avoided going into care following support. By applying the rate of different placement types in Bradford for 2018-2019 to these 172 young people, the numbers who may have otherwise gone into each different looked after setting was calculated.²⁵ This enabled a setting by setting benefit savings calculation, the results of which are presented in Table 10 below along with their source. For the most part, costs and their sources were found by referring to the Unit Cost Database V2.0, hosted and updated by the Greater Manchester Combined Authority Research Team, with support from various government departments.²⁶

²⁵ Bradford's placement type rates were sourced from the 2018-2019 annual *Children looked after by local authorities in England data return (SSDA903)*.

²⁶ See [Greater Manchester Combined Authority Unit Cost Database](#)

Table 15: Unit costs for looked after child settings

Setting	Unit cost (annual per young person)	Source
Foster care	£35,620	Average overall cost of local authority foster care, from: unit costs of health and social care (Curtis and Burns, 2018)
Adoption	£27,000	Interagency adoption fee as set by the Consortium of Voluntary Adoption Agencies
Placed with parent	£6,008	Average annual cost of a placement with parents, from: costs and consequences of placing children in care (Ward et al., 2008) and adjusted for inflation
Other accommodation	£10,788	Average cost of semi-independent/semi supported living (includes arrangement cost), from: The Costs of Not Caring: Supporting English Care Leavers into Independence (Brady, 2014), and adjusted for inflation
Local authority residential	£254,748	Average annual cost of local authority residential care per young person, from: unit costs of health and social care (Curtis and Burns, 2018)

Source: As per 'Source' column

Reduction in police interventions

Benefit savings linked to the avoidance of police interventions were calculated with reference to missing persons' investigations and general incidents of crime. Although other categories were present in the BPP data, only these were definable interventions which could be monetised for the purposes of the analysis.

The data for these two types of interventions were compared across 2018 and 2019. The change (reduction) in calls made by BPP homes for each type of intervention was recorded and used to calculate the benefit savings. The monetised benefit unit costs for both a missing person's investigation and incident of crime, along with their sources, are shown below in Table 16.

Table 16: Unit costs for police interventions

Category	Unit cost (per incident)	Source
Missing person investigation	£2,719	Average total cost of a missing persons investigation, from: Establishing the cost of missing persons investigations (Greene and Pakes, 2012)
Crime - Fiscal	£1,036	Average fiscal cost per incident of crime, across all types of crime, from: the economic and social costs of crime, Second Edition (Heeks et al., 2018)

Source: As per 'Source' column

Other indicators

Benefit savings were calculated for 3 additional indicators, self-harm, child sexual exploitation (CSE) and substance abuse. Outcome data for these additional indicators was available at child level for 24 young people placed or in placement in 3 BPP residential homes between April 2018 and December 2019. The data allowed for analysis of when the young person was placed and if each individual indicator was present for that young person (that is, if the young person self-harmed, was subject to CSE, or was abusing substances at the time of their placement to a BPP residential home). Benefits were calculated for any young person placed within the period for whom an indicator was present at the time of placement but stopped being present for them during the period. Those young people for whom indicators were present, but who were placed before the period, were not counted. This is because it is not known whether the issue was present at placement or whether it developed during placement. Proxy savings have been assigned, as can be seen in Table 17 below, along with their sources.

Table 17: Proxy savings for other indicators

Outcome	Proxy change	Proxy saving	Source
Reduction in self harm	The young person self-harms less regularly. It is assumed that one unplanned hospital admission is avoided.	£1,664	Average cost of a non-elective hospital admission. Based on the National Schedule of Reference Costs for NHS trusts and NHS foundation trusts in the financial year 2017-18, and adjusted for inflation
Reduction in CSE	The young person does not require support due to CSE	£3,583	Average cost of providing intensive support to each individual. Based on Pro Bono Economics/Barnardo's 2011 assessment of the potential savings from Barnardo's interventions for young people who have been sexually exploited, and adjusted for inflation
Reduction in substance abuse	The young person reduces or stops substance use and does not require a treatment programme	£3,994	Average annual savings resulting from reductions in drug-related offending and health and social care costs as a result of delivery of a structured, effective treatment programme. Based on Estimating the Crime Reduction Benefits of Drug Treatment and Recovery (NTA, 2012), and adjusted for inflation

Source: as per 'Source' column

References

- Baginsky, M., Moriarty, J., Manthorpe, J., Beecham, J. and Hickman, B. (2017). *Evaluation of Signs of Safety in 10 pilots: Research report* (DFE-RR589) London: Department for Education.
- Bradford Children's Trust (2017). *Bradford Children, Young People and Families Plan 2017 – 2020*. Bradford Metropolitan District Council.
- Bradford Metropolitan District Council (Bradford MDC)/Office for National Statistics (ONS) (2018). *Northern Data Hub: Bradford Population*. Available from: [Data hub – Bradford Council](#) (Accessed: 2nd April 2020).
- Brady, R. (2014). *The costs of not caring: supporting English care leavers into independence*. London: Barnardo's.
- Curtis, L. and Burns, A. (2018). *Unit Costs of Health and Social Care 2018*. Personal Social Services Research Unit, University of Kent.
- Department for Education (DfE) (2018) *National Statistics Children Looked After in England including Adoption: 2017 to 2018*. London: Department for Education.
- Department for Education (DfE) (2019) *National Statistics Children Looked After in England including Adoption: 2018 to 2019*. London: Department for Education.
- Greene, K. S. and Pakes, F. (2012). The cost of missing person investigations: implications for current debates. *Policing* 8(1)27-34.
- Heeks, M., Reed, S., Tafsiiri, M. and Prince, S. (2018). *The economic and social costs of crime, second edition*. Research Report 99, July 2018. London: Home Office.
- Idzelis Rothe, M., Nelson-Dusek, S. and Skrypek, M. (2013). *Innovations in child protection services in Minnesota – Research Chronicle of Carver and Olmsted Counties*. St. Paul, MN: Wilder Research.
- Luckock, B., Sims, L., Whiting, R., Meleyal, L. and Hampden-Thomson, G. (2017). *Cornerstone Adoption Support Programme: evaluation report* (DFE-RR581) London: Department for Education.
- Lushey, C., Hyde-Dryden, G., Holmes, L. and Blackmore, J (2017). *Evaluation of the No Wrong Door Innovation Programme: Research Report* (DFE-RR542) London: Department for Education.
- McDermid, S., Baker, C., Lawson, D. and Holmes, L. (2016). *The evaluation of the Mockingbird Family Model: final evaluation report* (DFE-RR528) London: Department for Education.

National Health Service (NHS) Improvement (2020). *National schedule of reference costs, financial year 2017-2018*. Available from: [Archived Reference Costs](#) (Accessed 17th July 2020). National Health Service Treatment Agency for Substance Misuse (NTA) (2012). *Estimating the crime reduction benefits of drug treatment and recovery*. London: NTA.

Northwest Institute for Children and Families (NICF) (2007). *Mockingbird Family Model Project Evaluation. Year Three Evaluation Report*. Washington: Northwest Institute for Children and Families, University of Washington.

Pro Bono Economics and Barnardo's (2011). *An assessment of the potential savings from Barnardo's interventions for young people who have been sexually exploited*. September 2011. London: Pro Bono Economics/Barnardo's.

Sheehan, L., O'Donnell, C., Brand, S.L., Forrester, D., Addis, S., El-Banna, A., Kemp, A. and Nurmatov, U. (2018). *Signs of Safety: Findings from a mixed-methods systematic review focussed on reducing the need for children to be in care*. London: What Works Centre for Children's Social Care.

Skrypek, M., Idzelis, M. and Pecora, P.J. (2012). *Signs of Safety in Minnesota: parent perceptions of a Signs of Safety child protection experience*. St. Paul, MN: Wilder Research.

Ward, H., Holmes, L. and Soper, J. (2008). *Costs and consequences of placing children in care*. London: Jessica Kingsley.



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