First Investment Memorandum

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Pan-London Care Impact Partnership

Project: Five London boroughs are launching a public tender process for an organisation / consortium to bid to deliver high quality family therapy for 3.5 years, to try to help improve outcomes for families who have been referred to children's social care. The therapies they want to jointly commission initially are 'Multi-Systemic Therapy' and 'Family Functional Therapy'.

Opportunity: Our research suggests that these therapies can make a significant difference when offered to the right families, at the right time. However, there are insufficient places available to London authorities from existing therapy teams, and both therapy effectiveness and team utilisation seem to be highly dependent on the quality of implementation of the service into the local systems. This project presents an opportunity to invest into a series of Design Features and Delivery Pilots, intending to improve the consistency and quality of delivery, and also increase the number of appropriate families who are able to benefit from these therapies per new team, during each year of delivery.

Social Impact: Core impact of the therapies, enhanced by delivery innovations:

1. Contribute to improved health, educational, behavioural and family functioning outcomes, by delivery of the highest quality family and systemic therapy to as many appropriate families as possible across Greater London
2. Explore ways to improve consistency and quality of delivery from this suite of therapies, and significantly increase the number of appropriate families who are able to access it. We believe that a ~30% improvement in therapy quality and a ~70% increase in number of families treated are theoretically possible, vs the first 3 years' of family referrals to an 'average' historical implementation.

Cost drivers: Total basic fixed delivery cost for three new London therapy teams over 3.5 years (3 years of referrals, plus up-front mobilisation, and also delivery to final referral cohort) plus standard supervisory and administrative support is estimated at ~£4.5m. Additional design features and delivery pilots to increase therapy quality and/or volume of families treated could cost another £1m+, depending on which are chosen by the management team for implementation.

Revenue drivers: Unlike most normal Government contracts, no payment is offered for recruitment, mobilisation or delivery of the service. Contract payment from London boroughs is made over 2 years, after they have started receiving the therapy, calculated using the ongoing care status of each family. We estimate that this mechanism is likely to result in total payment of around £12k-19k per family who receives the therapy. Our analysis of the first three years of previous comparable implementations suggests that most teams experience turnover of therapists, and uneven referral of families. As such, we estimate that a 'normal' implementation would be likely to result in approximately 225 families receiving therapy, with variable quality of therapy across the teams.

Finance required: We currently estimate that a commitment of around £4-5m working capital will give the project access to up-front funding for basic delivery, investment into comprehensive delivery enhancements, and adequate contingency.

1. Executive Summary

There are nearly 400,000 'Children in Need' across England, of whom approximately 60,000 live in Greater London (~12,000 live in the 5 boroughs who are commissioning this project). Children who have become known to social care teams, and assessed as a 'Child in Need', tend to suffer poorer outcomes in the short and longer term than the wider population, as do their families.

Interventions exist which can make a transformative difference for some of these children, and their families. Potential areas for improvement include health (particularly mental health), educational engagement & attainment, behaviour, substance use & interaction with the criminal justice system, and longer-term employment prospects. Preventative intervention to improve family functioning and reduce risk may also result in a lower level of future interaction with the children's social care system than would have otherwise been the case. Some children's services in England (e.g. Leeds[1]) have deployed such intervention strategies to very positive effect.

In London, however, children's services are divided between 32 individual Borough Councils, each with a total population of just 150,000-350,000 (Leeds has 800,000, for comparison). This tight geographical fragmentation, and other features of the London-wide mental health infrastructure, seem to make it more difficult for individual council children's services departments to justify allocating resources to commission highly specialised family interventions, for fear that the team may subsequently be under-utilised (and therefore prohibitively expensive per family treated).

With support from the Greater London Authority, Social Finance UK, and Tim Gray Consulting, five London Boroughs have come together to establish the 'Pan-London Care Impact Partnership' to jointly commission therapy for families known to social care. The founding boroughs created a partnership agreement and a framework which makes it possible for other London boroughs to join in the future. This is the first partnership of this kind enabling delivery of family therapy at scale. The boroughs have chosen to commission 'Multi-Systemic Therapy' and 'Family Functional Therapy' for a referral period of 3 years. They estimate that there are a least 128 families per year (384 total) in their areas who meet the criteria for these treatments, could benefit significantly from accessing them, and for whom their existing range of service options are insufficient.

Bridges has experience of delivering one of these therapies (MST), and the positive impact reported by the families was profound[2]. We believe that offering these two therapies to appropriate families across London could contribute significantly to improving short- and medium-term outcomes in four main areas: Family functioning and risk; crime/anti-social behaviour; health (particularly mental health); and educational engagement and attainment.

The commissioning councils have chosen a payment mechanism which seems to incentivise: 1/ maximising the number of families who successfully receive a course of therapy; and 2/ minimising the amount of time that children from the treated families spend in local authority care, during the 2-year measurement period following the therapy received.

This payment mechanism is not perfectly aligned with the broad family impact we hope to see, and there may be instances where payment or non-payment is not fully correlated with the outcomes trajectory for some individual families. However, across the cohort of 200-400 families, we believe the payment mechanism aligns adequately with the actions needed to enhance therapy effectiveness, for the maximum number of appropriate families who can benefit from it.

We recommend this opportunity to the committee, and seek feedback on the terms for our bid.

2. Background to Children's Social Care in England

See '*Children's social care services in England*', House of Commons Library Briefing Paper, for a summary of the children's social care system, and *DfE/ONS annual statistics* for annual data. Local areas in England offer a 4-tier service for the children and families living in their area:

[1] The children's regulator inspection of Leeds' children services references these service offerings
[2] http://www.mstuk.org/sites/default/files/mst/resource-files/MST%20Evaluation%20Report_FINAL_July2019.pdf

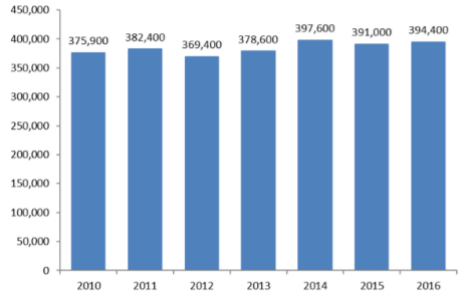
Tier 1: Universal services such as schools, family centres, health visiting etc.
Tier 2: Targeted services for children and families beginning to experience difficulties (or at risk of them); e.g. school counselling, parenting programmes, support for teenage parents.
Tier 3: Specialist services for children and families with multiple needs such as intensive family support, and services for children with disabilities.
Tier 4: Specialist services for children and families with severe and complex needs, including child protection services, and looked after children.

Tiers 3 and 4 overlap with a council's legal duties under the "Children's Social Care Act", as follows:

Referrals. Across England, over 600,000 families are referred to Children's Social Care each year.

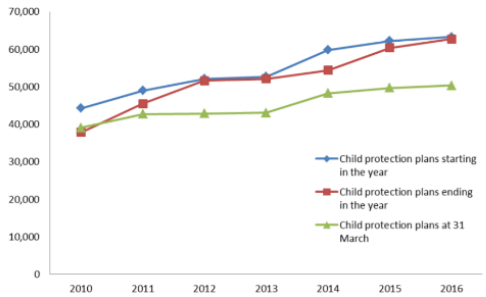
Child in Need (CiN). Following an assessment, if a local authority decides that a referred child "requires further support to reach a reasonable level of health or development", then they will be defined as a "child in need". The number of children in England meeting this criteria is just under 400,000. (This figures includes 'CPP' and 'CLA', see below.) Local Authorities are required to provide all of these children with "a range and level of services appropriate to their needs."

Figure A: Number of children in need at 31st March
England, 2010-2016

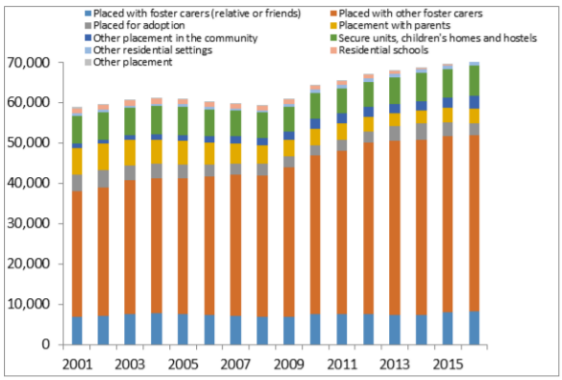


Child Protection Plan (CPP). In cases where there is "reasonable cause to suspect that a child is suffering or likely to suffer significant harm", the local authority can investigate, and may decide to put a "child protection plan" in place. The number of children in England living at home with a Child Protection Plan from their local authority in place is now ~50,000.

Figure B: Number of children who were the subject of a child protection plan starting in the year, ending in the year and at 31st March
England, 2010-2016



Child Looked After (CLA). In "the most severe cases" action will be taken to take a child into the care of the local authority. They will be looked-after by local councils, and usually live with relatives, foster carers, or in residential care settings such as children's homes. There are currently 70,440 Children Looked After in care, of whom 6% (4,200) are unaccompanied asylum seekers. A move towards (involuntary) CLA status is instigated by a social worker commencing a 'Public Law Outline' (PLO) process, to prepare the case for a formal CLA decision by the family court.



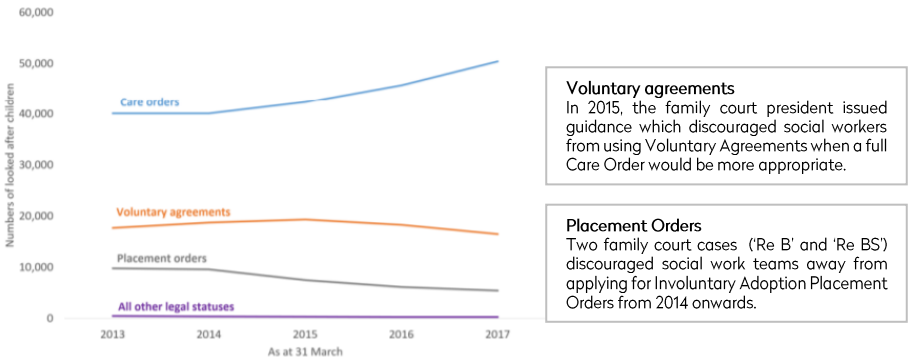
The death of Baby P became public in 2008, leading to some tightening of the 'CLA' thresholds in subsequent years

There are three main types of circumstances under which a child can become Looked After:

Full Care Orders: These are cases where the council has applied to the family courts to take a child into care against the wishes of the family. The proportion of CLA numbers on a Full Care Order rose in recent years following precedents and guidance away from the other two main types.

Voluntary Agreements: These are cases where the parents have agreed for the child to be taken into local authority care. These may include, for example, cases where parents are struggling to cope with the behaviour of a teenager, and the family is at risk of breakdown. Some families move directly to Voluntary Agreements without going through the full CiN, CPP, PLO statuses linearly.

Placement Orders: These are cases where the family court judges that the child will never be able to return to their birth family, and a permanent placement (e.g. adoption) should be sought.



As the child grows older, the level of obligation on the local authority to care for them reduces:
Age 16: The local authority must "give the child a plan" to "help them make the transition from care to independent life". Some children choose to move into independent living at this point, in which case the local authority should help them to locate suitable accommodation.
Age 18: The child is "no longer in care", but the council "must still provide them with some support, including a personal adviser and plan". If living in foster care, the young person can continue living with their foster parent if they choose to (and the council must pay for this).
Age 21: The council is no longer obligated to pay for foster care, but the young person can "continue to get help and advice from the council and a personal adviser until they are 25, if they want to".

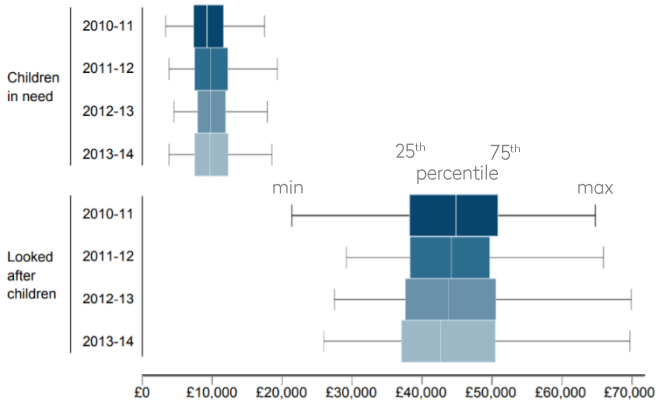
When each child leaves care, the council has an obligation to help them find somewhere to live. Young people who have been in care are entitled to some financial allowances e.g. education bursary, leaving care allowance, etc., and councils must help them to access these. Some local authorities offer additional help, e.g. support to access further education or employment.

Proactive family intervention services
Local authority children's services teams have a duty to investigate referrals, understand risks and take appropriate action if any child in their local area is perceived to be in danger. However they also allocate resources to offer proactive support and help to families who are experiencing difficulties. Many local authorities choose to offer intensive interventions to families known to social care, in the belief that this can improve family functioning and longer term outcomes, and may slow or reverse the trajectory of risk of difficulties. There may also be interventions which can potentially de-escalate difficulties which have already occurred, and/or reunite families after a period in care. "*Children's services: spending and delivery*" by the Early Intervention Foundation summarises how a selection of councils allocated their recent children's services budgets.

Councils across the country employ a wide range of such approaches, sometimes referred to as 'Early Help' or 'Early Intervention'. Prior to 2011, some of the services offered were specified by central government, known as 'Family Intervention Projects and Services'. Annual data summaries were published by the Department for Education. Since 2012, local authorities were given much greater freedom to decide locally how to use the money from central government, now known as the 'Troubled

Families' budget allocated to each council. Councils also allocate some of their wider children's services budget towards proactive family intervention. Councils have full discretion on how much to prioritise spending on proactive interventions for families (and on children services more broadly), and there is wide variation in practice across the country.

The median amount of money spent in 2013-14 for a Child in Need was £10k per annum. The median amount spent in 2013-14 for a Child Looked After was £42k per annum.



Spend per head, per year (2015 prices) for all 139 English local authorities.
"*Children's services: spending and delivery*" Early Intervention Foundation

Educational outcomes for children who become known to the social care system (i.e. all Children in Need, including Children Looked After) are poorer than the wider population, as follows:

- One in ten of all pupils in 2019 have been in need in the previous 6 years. Compared to all pupils, these children are less likely do well at each stage of education, and more likely to be persistently absent.
- Children who were assessed as Child in Need at some stage of their schooling had lower attainment at each Key Stage of schooling than children who never needed a social worker, scoring between 10-16% lower than their peers at the end of primary school and 34-53% lower than their peers at the end of secondary school.[3]
- 35% of all Children in Need in Key Stage 2 achieved the expected level in reading, writing and maths, compared to 65% for all pupils
- The average "Attainment 8" score for all Children in Need in Key Stage 4 was 18.5, compared to 46.7 for all pupils.
- 29% of all Children in Need were persistently absent from school, compared to 11% for all pupils.

Source: ONS/DfE statistics

Longer-term outcomes are also poorer, although here the available data focuses more on the smaller subset of children who actually experienced a period of being Looked After (CLA):

- A quarter of all prisoners have been in care compared to 2% of the population overall;[4]
- One third of previously looked after children are 'NEET' (not in education, employment or training) at age 19.[5]

Intervention services offered by councils are intended to address four main outcome areas: a/ family functioning and risk; b/ crime/anti-social behaviour; c/ health; and d/ education/ employment. Improving "family functioning and risk" may bring the most visible change in terms of impact on the councils' short term children's services budgeting, but all four outcomes are valuable to the family themselves, wider society, and to the longer-term budgets of other government departments (such as justice, welfare, health, etc).

[3] Children in need and children in care: Educational attainment and progress, April 2020, Rees Centre and University of Bristol
[4] Prison Population Statistics, May 2012 – House of Commons Library; Offender Management Statistics Quarterly Bulletin
[5] DfE: Outcomes for Children Looked After by Local Authorities in England, as at 31 March 2010.

Note: Whilst longer-term data focuses on children who have experienced an actual period of being Looked After, this may be because such data is more easy to track. The evidence seems to suggest that it is the broader CiN classification which is correlated with poor outcomes, not the narrower CLA classification. Indeed, some short-term indicators such as education attendance appear to improve for the duration that a child is Looked After. As such, our view is that any intervention must focus on genuine sustainable improvements for the family, rather than the narrow question of whether the child needs to be Looked After for a defined period of time, or not.

3. Multi-Systemic Therapy and Family Functional Therapy

Some children become known to social care, and ultimately placed into local authority care, because they are at immediate risk of violence from parents, or because parents are unable to look after them safely due to serious medical conditions. Others become looked after because they have no family who can, e.g. following death of immediate family members, or in the case of unaccompanied asylum seekers. In each of those cases, the best course of action is for the state to complete the decision and provide the most appropriate, stable care as rapidly as possible.

However, there are many cases where children become known to social care, and ultimately become looked after, as a consequence of the young person's deteriorating behaviour which their family is struggling to manage. In many of these situations, parents could safely continue to look after the child, with the right help and support. It is these situations where a proactive intervention can potentially make a real difference, and re-build family relationships to have a long-term positive impact on the entire household. In cases like these, removing the child into the care system for the remainder of their adolescence rarely improves outcomes for them or their family – and once they graduate from the care system at 18, family may be the only support they have. So regardless of the financial calculations, it makes moral sense to invest into very high quality support for those families who could benefit from it. The potential impact is so great, if it works. These are the cases where local authority children's services teams try to offer 'early intervention', to proactively reverse the worsening family trajectory where it is thought that this is possible. The therapies selected here (MST and FFT), are specialised versions of such 'early interventions'.

Overview of MST and FFT therapy offerings and their suitability for this contract

Young people within the target age group for this project, 11 – 17, often become known to social care because of multiple and complex behaviour problems. Triggered at adolescence, these issues can lead to aggression, antisocial behaviour, parental loss of control, family breakdown, and ultimately an inability or lack of desire to continue living with their families.

Multisystemic Therapy (MST) is a programme that aims to address the wider "systemic" reasons for a young person's serious antisocial behaviour and family difficulties that could lead to family breakdown. MST is most effective when the young people's difficulties are a result of multiple sources of influence - for example, family dysfunction combined with negative peer group influence, low self-esteem, poor school performance, bullying etc. Ideally, the whole family would participate in the therapy, but MST can continue with only the parents if the young person will not participate. An MST therapist works primarily with parents: helping them to understand and address the wider systemic causes of antisocial behaviours; and enabling a common approach across key people in a young person's life. The MST UK website (www.mstuk.org) contains full details of the therapy, including links to research articles and outcomes data from UK implementations, where published.

Functional Family Therapy (FFT) is a programme that focuses primarily on improving the interpersonal relationships within families. Therapy sessions have to include the whole family, including the young person and is most effective when internal family relationships are the major contributing factor in the young person's problem behaviour. By increasing supportiveness and functioning, FFT helps the family unit be a positive influence on a young person, guiding them away from behaviours such as argumentative escalation, aggression, running away, or drug use. The FFT UK website (www.functionalfamilytherapy.org.uk) contains full details of the therapy, including links to research articles and outcomes data from UK implementations, where published.

We believe that MST and FFT represent complementary options. Families experiencing a combination of issues in systems surrounding the child will likely benefit most from MST; where the primary issue is within the family itself, it will likely benefit most from FFT. We would propose to give authority to the Programme Director to assess which therapy is most suitable for each family, on a case by case basis.

Both MST and FFT have clear guidelines, based on substantial sector evidence, regarding which families are appropriate for referral, and only those families which meet the published guidelines are accepted onto the therapies. However, there remains considerable social worker discretion around when to refer appropriate families. The evidence base suggests that the effectiveness and longer-term impact of both of these therapies is greater if families are referred at an earlier stage in their trajectory through social care. But, our experience suggests that some social work teams wait for significant periods of time before referring families, either because they wish to try internal alternative approaches first, or (occasionally) if they believe the family may be able to resolve its difficulties without intervention. This represents a risk to success, see section 7.

4. Costs and potential revenue range of a 'basic' therapy implementation

These therapies seem to cost around £400,000 per year around the UK for a good team of therapists, plus a senior 'supervisor' and appropriate administrative support. (We will potentially need to add ~10% of this to account for higher salaries and living costs in London.) The geographical split will require two therapy 'clusters', one based in east London and one in the west, each with 1.5 therapy teams (likely to be a dedicated MST team in each cluster, with the FFT team split across the two sites). To deliver for 3 years of family referrals, we will need teams in place for at least 3.5 years. Therefore the total (mostly fixed) cost of a 'basic' implementation of three new therapy teams across the two London clusters would likely be ~£4.6m.

Our research suggests that the commissioning councils are not willing to pay any kind of perceived 'risk premium' or 'quality premium' for outsourcing these services using a heavily outcomes-based contracts. Our understanding of the proposed payment mechanism and the councils' expected price implies that a payment range of £12,000 - £19,000 per start is likely (the range depends on ongoing family stability after the therapy is received, we estimate that payment per family increases by approximately 2% from the £12,000 lower bound with each 1% improvement in quality scores vs the 'normal' average). This range of payment is below our understanding of the average cost to government per family of these therapies during the first three years of previous 'normal' implementations, and it is very significantly less than the effective amount paid per family by the Department of Education in the only previous implementation which launched these two therapies together, across London boroughs (see section 6 "Impact Risks").

Data on historic team utilisation is not widely published, but our research suggests that most successful teams average around 25-30 families receiving therapy per year over a finite 3 year referral period (compared to a theoretical maximum capacity of around 45). This means that a 'basic' implementation of 3 new teams would expect to work successfully with around 225-270 families, resulting in potential total revenue of £2.7m-£4.3m.

The Committee should note that there are a small number of examples of sites in England which performed significantly worse than this in their early years, and were closed down. Whilst London has good travel links and relatively small geographies (reducing travel time between family visits for therapists), it appears to be a challenging region to retain high quality therapists and supervisors, because of the wide range of other relevant opportunities available with comparable or higher compensation packages, e.g. senior psychologist positions within London NHS Trusts and other related services. In addition, those sites working with multiple local councils appear to have struggled to create a smooth referral pathway for families, compared to sites which were deeply embedded within one single local authority children's department (see section 6 "Impact Risks").

5. Implementation Science and the potential for delivery innovation

When these therapies were first introduced to England, the implementation was very inconsistent. Dr Tom Jefford, who we worked with on the Essex MST project, introduced the first England MST team 15 years ago, and has detailed the difficulties he and Brigitte Squire, the Clinical Director faced implementing these services across Cambridgeshire. Amongst other problems, the entire team of therapists left the team, and needed to be replaced during the first year of operation, leaving the service dramatically under-staffed and thus serving far fewer families than planned.

Dr Jefford's PHD thesis covers implementation difficulties consistently encountered by a sample of such MST services across England, and in his role as Chair of the UK Implementation Society, he has broad experience of the importance and difficulty of high quality implementation.

The Department of Health created a 'National Implementation Service' to drive improved quality of implementation standards from MST, FFT and a suite of other evidence based interventions across the country. This has refined effective ways to improve implementation quality, and we would propose to work closely with this team to adopt and build on their best practices.

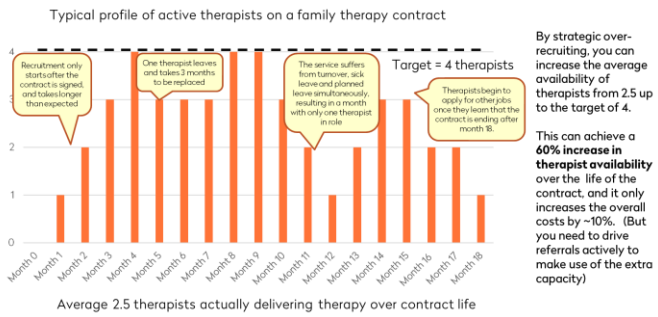
We believe that there is an opportunity in this contract, working closely with the National Implementation Service, to invest into a further series of Design Features and Delivery Pilots which have the potential to significantly improve the quality and consistency of delivery, and the number of families who can be offered these interventions each year.

The main problems causing under-performance vs potential in many such services appear to be:

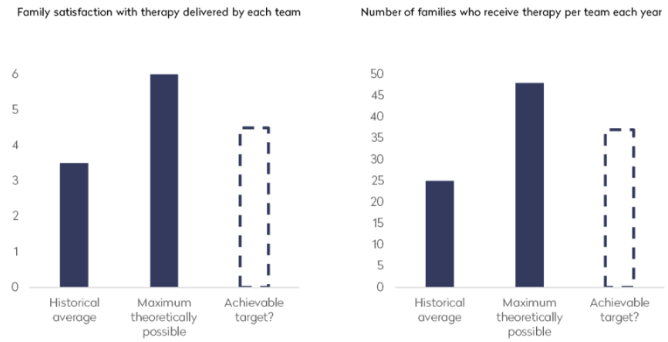
1. **Under-staffing.** Teams become fully staffed later than planned, and experience turnover and absences, leading to periods of under-staffing. This creates multiple periods of time where the actual number of trained, experienced therapists delivering at full caseload is significantly lower than the theoretical number in the therapy staffing model.
2. **Under-utilisation.** Referrals of appropriate families from social work decision panels are inconsistent, leading to periods of under-utilisation of the team's capacity. This is caused by unawareness of the service, differences in interpretation of the referral criteria, and insufficient time for council social workers to devote to planning and referral of families.
3. **Inconsistent quality of therapy.** During periods of understaffing, therapists must take on higher caseloads and do out-of-hours shifts more frequently than planned, which increase stress and burnout, leading to reduced quality of delivery. Under-utilisation because of lower than planned referrals also impacts consistency, because therapists working with fewer families than planned take longer to gain the required experience of the therapies.
4. **Insufficient wider systems integration.** Teams not sufficiently well integrated with council social work teams, education teams, mental health teams & youth justice boards cannot have the full systemic impact they need to work fully effectively with families

To illustrate the first issue (under-staffing), the chart below shows the typical staffing profile of a therapy team throughout an 18-month contract. This example shows an average of only 2.5 therapists actually in place delivering therapy each month, vs an original budget target of 4.

A typical family therapy team is persistently understaffed throughout the contract



We have spoken directly with most of the historical therapy implementations across the country, and every single team reported periods of understaffing compared to their budget target, which directly impacts both the volume of families who can be treated, and level of quality that the therapists are able to deliver (if they have to cover other team caseloads, or repeated weeks 'on 24 hour call' during understaffed periods, this heightens stress and risk of potential burnout).
"Quality" is difficult to measure objectively, as is the "effectiveness" of the therapy against the four target outcomes. Even the outcome with the most easily available data (family functioning and risk, as defined by the official CSC status of each child) is subject to a range of external influences. However, two reasonable proxy measures which we believe have some consistency and validity are the regular family feedback and therapist adherence scores. These measure the extent to which the therapy is being delivered in accordance with best practice, and the family's perception of its effectiveness. Looking at our understanding of the historical data, we believe that there is material room for improvement against the perception of therapy quality and consistency by those families who experience it, and also the volume of families treated per year by each team.



Our belief (from the published evidence base, and from our own experience with these services) is that if all else is equal, investing into enhancements to significantly enhance the quality and consistency of the therapy delivered ***should*** (if these enhancements are successful) lead to visible changes in improved family feedback and therapist adherence scores, and ***should also*** result in real improvements in longer-term family outcomes – and thus ***should*** positively impact the measure used by the councils to calculate payments made per family (periods of being Looked After vs expected the rates for this cohort in these boroughs). Obviously there are material risks inherent in this assumption, and our options to measure the effectiveness of such enhancements on longer-term family outcomes in real time during delivery are limited, and indirect.

The Essex MST service

Our experience of delivering an MST service in Essex showed that heavy investment above the original delivery budget can achieve materially improved performance. Many of the changes made are documented in the evaluation of that service. The investment made into design features and delivery pilots to enhance core delivery totalled nearly £2m. As a result, the service provided therapy to 388 families over 5 years (i.e. an average of ~39 per team per year), the service achieved best in class quality scores and feedback from families, and the assessed risk profile of the cohort reduced significantly after the therapy, against the level that was expected.

Social Care Status	Before therapy	After tracking period	*Expected level after tracking period*
No active social care provision	9%	45%	*Unknown*
Some social care provision (not CIN)	7%	22%	*Unknown*
CiN (inc CPP / CLA)	84%	33%	*Unknown*
- of which: CPP	9%	4%	*Unknown*
- of which: CLA	10%	19%	*68%**

Essex MST evaluation, University of Oxford

** Social Finance UK had worked with Essex Council before the launch of the project to map the historical social care trajectory of a "control" group of children with similar characteristics to those who would be referred to the therapy programme. That study found that 68% of the total cases became CLA during the synthetic 2 year 'monitoring period'.*

An in-depth series of interviews with families was undertaken at the end of the Essex MST service, as part of the evaluation. 48 families (out of 49 interviewed) said they would recommend MST to another

family. The standard mental health measurement tool used by social work teams ('Strengths and Difficulties Questionnaire') showed a 21% average improvement when measured after completion of the therapy. The evaluation concluded that "*the MST service has had a profound impact on the families that we interviewed*" and that "*there was evidence that MST had also had a longer-term impact on social work practice in the Essex area.*"

Delivery Enhancements for this service in London

To address the four core issues described above which typically cause under-performance vs potential, and to catalyse continuous innovation and improvements, we would intend to focus the management teams on designing and implementing incremental changes which can improve quality of therapy and number of families helped, at rates which are disproportionate to their cost.

A list of ideas is given below. However the management team will be responsible for generating ideas, prioritising recommendations and implementing the changes throughout. We expect that the cost of all such delivery enhancements is likely to be >£1m, above the basic £4.6m fixed cost.

Potential Design Feature / Delivery Pilot	Learning from Essex	Approx. cost
Add an extra role of **Programme Director** – a very experienced clinical lead who can improve overall quality, and also liaise directly with social work teams to ensure the families being referred are the most suitable for these two therapies	The introduction of this role was universally recognised to have dramatically improved the service	£100k per year
Improved terms and conditions for therapists to ensure the role is competitive against similar positions within London NHS Trusts and other relevant comparators, and to ensure that therapists can stay and deliver right until the end of the contract.	This was needed to retain therapists in Essex - Chelmsford is only 30 minutes by train to London so easily commutable	~10-20% on top of basic cost, per team per year
Expedited training. MST and FFT only run training courses periodically. Therapists cannot start until after an accredited course. The Essex project flew some therapists to Florida for training to ensure prompt starts and more families able to receive therapy	This approach enabled at least 20 additional families to receive therapy, compared to waiting for England courses to become available	Negligible cost. A return flight to Florida is ~£500. Hotels there are cheaper than in London.
Extra therapists. Proactive recruitment of therapists above the normal budget, in anticipation of future turnover, to ensure that teams do not fall below the minimum number needed to serve families during periods when some therapists are absent.	This proved vital in Essex to ensure that teams were fully staffed, and enabled reduced stress and burnout from therapists compared to other implementations	£100k per year

Two therapies implemented together

A learning from Essex was that MST alone was not the most appropriate service for every family whom the council wished to help. Some aspects of the MST referral criteria, and the focus on wider systemic issues were felt to be restrictive. As such , we believe that implementing MST and FFT side by side will bring benefits, enabling a wider range of families to be helped, and targeting the most appropriate service to the situation of each family. However, managing two therapies simultaneously will obviously create additional complication, and therefore require resourcing.

Multiple referring boroughs

Managing and offering therapy to families referred from 5 boroughs will be more complicated, time consuming and therefore expensive than working with the four referring 'quadrant panels' of social workers access Essex County. Moreover, the service may wish to expand into other boroughs across London – which would bring additional cost and complexity for each new borough joining the service.

These costs will need to be weighed against, and the opportunity to help additional families, and the overall benefits of achieving greater scale.

6. Impact Risks

Previous implementations in London

As outlined in the previous section, many implementations of these therapies have under-performed their theoretical potential.

The only attempt to implement a joint service of MST and FFT in the UK was also into London boroughs – the recent Department for Education Step Change programme. This site was given a grant of £3.3m to deliver MST and FFT to a target of 170 families over two years. The service encountered a range of the problems experienced in previous implementations (as described above), which are described in detail in the evaluation. The service only managed to offer therapy to 95 families during the two years that the grant was spent, with variable staffing (and therefore quality).

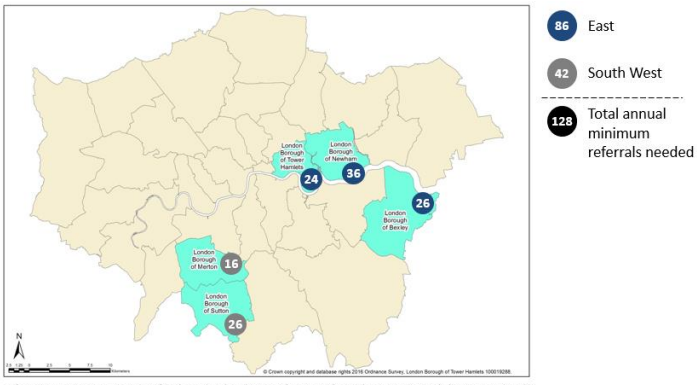
Our view is that the only way to have confidence that the service will reach the optimum levels of quality and consistency of delivery, and offer therapy to at least the targeted number of families, is to invest heavily into the highest quality delivery enhancements. We also believe that investing heavily into the highest quality, highest performing service is the most effective way to drive enthusiasm for the service across local social work teams, who are the source of appropriate family referrals.

Referral criteria and volumes

MST and FFT have fairly well-defined referral criteria. To illustrate, the typical profile of an adolescent / family that will benefit from intensive therapeutic interventions like MST and FFT is as follows:

- Aged 11-17;
- Currently living with family / long term caregivers;
- The young person and / or their family system show signs of highly complex needs / behaviours that need addressing which will otherwise likely lead to family breakdown and the young person being taken into care. These needs can include (but are not limited to) family dysfunction, socially unacceptable behaviour, substance misuse, self-harm; and
- The circumstances allow them to engage with and are suitable for intensive therapeutic interventions like MST and FFT (e.g. both interventions exclude young people with pervasive developmental delays and those who are referred because of serious psychiatric problems, including psychosis, suicide or homicide risk).

Clinical Director and Supervisors have the ability to accept or refuse families, but only if they do not meet the criteria set out in the standard Goals and Guidelines MST and FFT documents.



The contract is open to 26 further London borough councils and 6 county and district councils (subject to agreement between Pan-London commissioners and the Provider)

The 5 boroughs consist of a cluster in the east, and a separate cluster in the west. This geographical separation will require careful logistical organisation. One team of therapists must be located near each cluster, to reduce travel times between cases and make regular visits to families homes possible.

The 5 boroughs commissioning this contract believe they have 128 families per year who are appropriate for these interventions. The competition provides the option for bidders to propose a "penalty rate" if referrals form the boroughs fall below these targeted annual levels. However, the contract is being let by "commissioning teams" in each borough, whereas referral of families is controlled by social work operations teams. Our experience of children's social care services suggests that the only way to ensure that appropriate families are referred is to reach out and form active, productive relationships with the social care teams directly, so they understand and believe in the service. Council commissioning units do not have line management over social work teams, and often have little ability to directly influence the referrals that social care teams actually make each month.

We believe that the safest way to ensure that there are adequate volumes of families able to benefit from the service (assuming that we invest additional amounts to enhance therapist availability) is to offer the improved service to a broader range of boroughs, to widen the pool of families who can benefit from the offer. This will require investment into building those relationships, and will require careful operational management to ensure that additional boroughs are not too far geographically from the team locations, and thus do not place unreasonable pressure on therapist travel times.

The therapy is most effective, and therefore most cost effective for government as a whole in the long run, if it delivered as early as possible during the family's trajectory through the CSC risk categories. However, the delivery consortium will have no influence on the timing when families are referred, and we expect that (as was the case in Essex) many families will be referred after a significant delay, at the point where the therapy is less effective that would have been the case with an earlier referral. There may even be some referrals (as there were in Essex) where the child is already in the PLO/LAC status.

7. Delivery Consortium and Governance to maximise project impact

There are two options for delivery:

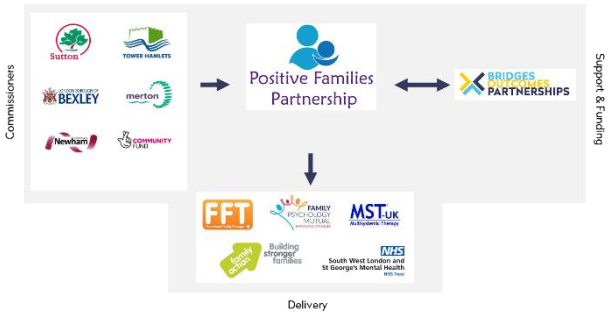
1. Select a large organisation with experience of these therapies, and rely on them to manage the risks and maximise the opportunities for improvement. There are three potential organisations who fit this criteria and are interested in this contract, two of whom we have worked with before on other projects
2. Create a consortium of organisations with a blend of skills, and recruit a dedicated central management team to catalyse continuous improvements across the service. This is a much bigger commitment from us in terms of ongoing time and investment into management and coordination, but may have the potential to achieve better results, if it works.

We have identified three organisations who we believe could form a strong consortium. None of these three organisations would be able to form a strong bid on their own, but with the right coordination, we believe that their combined strengths could be brought together effectively.

	Organisation type	Organisation financial and operational strength	Contains individuals with strong MST/FFT experience?	Existing local presence and relationships with councils	Organisational openness to Implementation Science
Family Action	Large national charity			 (East)	
SWLSTG Trust	NHS Government Entity			 (West)	
Family Psychology Mutual	Start-up social enterprise				

Such a consortium approach would require a very strong central team to coordinate it. We propose to appoint Brigitte Squire as the Programme Director, overseeing all delivery quality.

Brigitte brings extensive experience of leading partnerships in her own right, in addition to her clinical qualifications. She is the clinical lead in the Cambridgeshire County Council early help leadership team and MST Programme Director. She was instrumental in bringing MST adaptations to the UK (MST-CAN, MST-SA, MST-PSB and MST-FIT) and set up these programmes in close partnership with the developers and local authorities. MST-PSB was a partnership agreement between 4 local authorities with Cambridgeshire providing the service which has evolved in managing the spot purchasing of MST-PSB by neighbouring LAs. She has been a National Sector Advisor in the promotion and implementation of Intensive Evidence Based Programmes (including MST and FFT) since August 2011, and assisted in setting up multiple MST sites. She was awarded an 'MBE' honour for outstanding contribution to the Youth Justice Field in 2010.



8. Costs, revenues and investment requirement

We have provided a simplified spreadsheet to enable the committee to test different amounts of investment into delivery enhancements, and the losses or surpluses achieved under a range of scenarios looking at i) number of families treated during the contract; and (ii) the amount paid per family (which we assume to increase for by two percentage points for each percentage point improvement in quality of therapy).