



Department
for Education

Cambridgeshire's Multi-systemic Therapy service's move to a mutual model of delivery

Evaluation report

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Executive summary

Summary of the project and evaluation

As a member of a research consortium headed by the Anna Freud Centre (AFC), the Social Care Institute for Excellence (SCIE), with York Consulting providing economic evaluation, led a process evaluation of the impact of Cambridgeshire's multi-systemic therapy services' (CMST) move from local authority control to a mutual model of delivery, to be called Family Psychology Mutual (FPM). This study was commissioned out of the Department for Education's (DfE) Children's Innovation Programme funding, provided to support CMST's move to the FPM. However, at the time of writing this report, the move to the mutual had not taken place and, therefore, this report presents findings about the preparation for the move to the FPM. Since the move to a mutual has not taken place, we refer to the Cambridgeshire's multisystemic therapy service as CMST throughout the report and the mutual which was being prepared for as the FPM.

The study employed a mixed method, action research process impact evaluation, which used document reviews, a rapid evidence review, an economic evaluation and, to explore change over time, 2 sweeps of qualitative evidence gathering, involving semi-structured interviews and focus groups with CMST staff and interviews with CMST-related stakeholders. The action research element of the study involved supporting CMST to use emerging learning to inform their preparation for the move to the FPM and supporting them to develop a sustainable long-term evaluation strategy.

Summary of key findings

While CMST had yet to make the move to a mutual at the time of writing this report, the experiences of CMST staff and stakeholders have provided an insight into CMST's preparation for their move to a mutual. The following are key findings about what has worked in CMST's preparation for the move to a mutual:

- time was needed to address the complex challenges involved. In the context of the process needed to secure Cambridgeshire County Council (CCC) approval for the move to the FPM, according to interviewees, time has been needed to enable a responsive approach in a shifting process of stakeholder engagement, which, for everyone concerned, proved more complex and time-consuming than anticipated. CMST ultimately gained CCC approval for the move to the FPM in November 2016
- leadership. Having CMST senior managers in place for the whole process who had the vision, determination, ability, experience, network access and technical knowledge to respond to a changing and complex process, while making the case for the move to FPM, has been an important contributing factor

- reliably calculating the cost and the cost advantages of the move to a mutual. A rigorous and reliable statistical approach to proving the cost case was needed and was provided by CMST working with York Consulting. This is needed as early in the preparation process as possible. At an economic level, CMST represents value for money for CCC. The baseline analysis revealed that for every £ 1 spent in CMST, there was a return on investment of £3. Assuming projections regarding the costs and annual caseloads for the FPM with one and 2 teams hold true, there is potential for further savings (in terms of adverse outcomes avoided) for CCC and other local authorities with MST services. The estimated return on investment for the FPM with one team was 3.6 and for two teams 4.1 – for every £1 spent directly supporting young people there could be a return of £4.10
- being able to challenge (what CMST perceived as) simplistic per case cost. This was achieved by emphasising the complex and bespoke MST offer and its long term cost benefits, and the other benefits offered by the move to a mutual, such as, according to CMST, reducing local authority liability associated with running CMST
- consideration of, and response to, the risks associated with becoming an independent business. CMST and stakeholders have worked together to address two key challenges:
 - first, CMST’s financial security and whether the service would survive
 - second, the implications involved in CMST leaving local authority control and accountability to become a commercial business
- consideration of the TUPE process and staff terms and conditions. CMST staff had been employed under a variety of terms and conditions, and CMST learned that it is important that this be addressed at an early stage, because uncertainty about this was a key source for staff concern and a barrier to their buying in to the move until these matters were clarified
- mapping of, and structured engagement with, commissioning and other stakeholders. Constant stakeholder mapping and engagement have been employed by CMST to mitigate CCC staff turnover and shifts in commissioners’ budget thinking and priorities. Engaging also with non-authority stakeholders was important, for instance in relation to pensions
- building new open, informed and transparent stakeholder relationships. The development of relationships has been the result of the process of making the case to commissioners and other stakeholders, resulting in an increased awareness about CMST
- securing the input of experts. Social Finance, Mutual Ventures and Winkworth Sherwood (as part of the Cabinet Office’s Mutual Support Programme) have provided invaluable support to CMST managers

- CMST staff involvement. Staff involvement has been very important. As early in the process as possible, it is important to offer options for staff regarding how they engage with the process. Examples of staff involvement included the CMST FPM project team (that met weekly), staff meetings and staff representation on the board
- secure funding sources and confirmed contracts before the move to a FPM is confirmed. The study emphasised how challenging and important working to secure funding before the move to a mutual is in building a successful mutual
- sharing a common understanding of the rationale for the move is important. In CMST's case this was the preservation of CMST from local cuts. CMST staff appeared united behind the idea that the move was necessary because otherwise, CMST would be at risk due to cuts to council budgets
- considering the processes involved in the transformation and allowing significant time for decision making and approvals. The experience of CMST was marked by delays in developing the business case and securing the approval of the local council
- acknowledging risk. Managers acknowledged the risk in becoming an independent mutual. The business plan acknowledges the possibility that the service may not gain sufficient funding to remain operational
- getting advice from others who have made the transition to a mutual. MST staff said that they would have liked to hear more from others who had completed the transition
- a systematic, responsive, realistic and well-resourced implementation is key to preparation progress

Summary of transferable learning

An MST service is based on a tightly prescribed delivery model and limited case through-put, which means that per case costs are high and this means that smaller, less affluent, local authorities find the costs of establishing and maintaining MST services challenging. Therefore, while the size of county, public purse and demand for MST services are relevant (see Appendix B), caution must be used when making comparisons in terms of transferability of learning. Our research has focused on the process of CMST's move to a mutual model of delivery, hence the factors we have found that have implications for transferability relate to:

- support of officers and funders. Developing and convincing Council officers and elected members is a key part of the process in moving to a mutual, as is time for local authorities to determine how to respond and manage the change process. However, this aspect of the process is subject to unpredictable change, officer

turnover and the election cycle. Our findings indicate that undertaking a similar preparation in local authorities which are themselves undergoing a period of change needs very careful consideration, and that allowing for these types of challenge is important, as is the time to address and mitigate their impact

- staff with experience and belief in the advantages of a mutual. Considerable commitment and drive from leadership is required for the development of a mutual. A key element in attempting a move to a mutual is the presence of staff with the leadership skills, network knowledge, sector experience and who have a passionate belief in their efforts
- using statistical neighbour information to tailor and target the sharing of learning generated by MST services generally, and CMST about their move to a mutual. We suggest selecting authorities that are similar to CCC, who do not currently have an MST service, so that they too are able to consider developing their own. We suggest that, where authorities do have MST services, they may find the learning about attempting a move to a mutual helpful. We would also suggest sharing learning about MST service options, covering regional MST commissioning, spot purchasing and consultancy mentoring, with local authorities who are not in a position to fund their own MST service
- costs and available funding. It would be challenging for Councils with smaller purses than CCC to fund their own MST service. The move to a mutual and planned expansion of CMST means that commissioners in smaller local authorities have the opportunity to contract for a small number of cases and spot purchase should they need more. Commissioners and MST services situated within strategic regional centres may draw useful learning from this approach and consider developing regional MST hubs
- Social Impact Bonds (SIBs). SIBs are relatively new, and the example of their use, provided by CMST's preparation for the move, is a useful one for others
- how to facilitate, achieve and benefit from greater staff involvement in decision making. A staff-led mutual model requires greater staff involvement in decision making, and the learning from this evaluation about how to approach and achieve staff involvement and its benefits is applicable to all public sector workplaces, whether or not they are preparing to move to a mutual model of delivery.

Overview of the project

What the project was intending to achieve

Supported by Social Finance, Mutual Ventures and Winkworth Sherwood (as part of the Cabinet Office's Mutual Support Programme), the Cambridge Multi-Systemic Therapy service (CMST) is attempting to move from local authority control to a staff-led mutual. Once CMST's move to mutual has been approved by Cambridgeshire County Council (CCC), it will be called the Family Psychology Mutual (FPM). CMST is the United Kingdom's longest established Multi-Systemic Therapy (MST) service¹. Building on this foundation, set against the backdrop of austerity, and concern about reductions in local authority spending, the overarching aim of CMST's move to a mutual was to create a staff-led, expanded and commercially sustainable MST service and consultancy business. CMST intend that the FPM will be a Community Interest Company limited by shares, with a not-for-profit structure which will have community benefit described within its articles. The community benefit has been approved by the Community Interest Companies Regulator. The choice of a share ownership structure will allow for the company to raise equity funding should it be necessary to do so. The company cannot be sold commercially nor can it sell more than a single share to any investor; however there may be more than one investor in the company. CMST received funds from the Department for Education's (DfE) Children's Innovation Programme to support its preparation for the move to the FPM and, from these funds, this evaluation was commissioned.

Overview of relevant research

The brief overview that follows is based on the results of a rapid evidence review conducted during the scoping phase of this evaluation in July 2015, which was updated in September 2016. The overview summarises evidence about the cost effectiveness of MST services, how MST impacts and outcomes have been measured, and what current research tells us about moving from public service control into a staff-led mutual model of delivery.

Cost effectiveness and MST

Underpinning the case for MST services is an urgent need for clinically effective and cost-effective methods to manage antisocial and criminal behaviour in adolescents (Fonagy et al., 2013).

¹ Originating in the United States of America, [MST](#) is an intensive family and community-based treatment program. MST uses cognitive behavioural therapy, behaviour management training, family therapies and community psychology.

A cost analysis of MST provision in Washington State Juvenile Courts estimated a per case cost of \$7,076 (Barnoski, 2009). While MST service costs were found to be higher compared to other programmes, the reported benefits of \$23,856 appeared to be substantial and to significantly outweigh the costs, resulting in a benefit-cost ratio equal to 3.7.

Lee et al. (2012) estimate a marginally higher return of \$4.36 for every \$1 invested in MST services, with total benefits per case valued at \$32,121. For the Dartington Social Research Unit (2013) the total benefits per MST participant, resulting from reduced crime and higher earnings, are estimated to be equivalent to £19,893, with a benefit-cost ratio equal to 2.04.

It could be argued that the positive impact reported in a number of US based studies can be ascribed to the lower standard of 'treatment as usual' available in the States. While the evidence outside the USA is more mixed, some UK based studies do also show that MST has scope for cost-savings when compared to other statutory interventions. For example, a study by Cary et al. (2013), which compared MST with usual services provided by two youth offending teams (YOT) found that, at 18-month follow-up, the MST+YOT group cost less than the YOT only group in terms of criminal activity (£9,425 versus £11,715, $p = 0.456$). The net benefits for the MST group at 18-month follow-up were £1,222 per person. Adopting a longer time horizon, an economic modelling analysis comparing MST and treatment as usual in a UK setting estimated that the provision of MST interventions to adolescents with conduct disorder resulted in a net cost, in terms of NHS and personal social services resources, of £3,867 over an 8-year period. However, when a wider perspective was considered to include education and crime costs, the analysis estimated an overall net saving of £7,125 (National Collaborating Centre For Mental Health and Social Care Institute For Excellence, 2013).

Comparing the cost-effectiveness of MST and treatment as usual (TAU) for young people with antisocial problems in the Netherlands, where TAU comprises more elaborate interventions, and is arguably comparable to the UK YOT approaches, Vermeulen et al. (2016) concluded that there were some cost advantages for the individual and his or her family in the MST group, but substantial cost benefits for wider society. They estimated that 'overall costs from a societal perspective were about 50% less for MST compared to TAU.

Evaluating the impact and outcomes of MST

A number of randomised control trials (RCTs) have shown that MST is effective in reducing youth antisocial behaviour. Drawing on a review of the recent literature, Carr (2016) suggests that systemic interventions produce a positive impact in about 2 out of three cases while only one out of three cases shows improvements without systemic therapy.

Terry et al. (2015) find that MST has demonstrated improvements for the following outcomes: reduction in reoffending rates, including among serious and chronic offenders, sex offenders and among UK offenders; improved mental health, although 'MST is yet to show effects in the long-term for young people with serious mental health issues'; improved familial relationships, which in turn may have a positive effect on other outcomes, including reduced reoffending; improved youth behaviour and decrease in aggression; reduced substance misuse, (although the evidence base for this outcome remains limited); preventing institutionalisation (hospitalisation, imprisonment, and going to care); and achieving employment, education or training. In addition, MST participants are less likely to become involved in serious and violent crime and 'significant improvements have also been observed in both self- and parent-reported delinquency' (Young et al., 2016).

While many studies are US-based, RCTs from Norway and Canada have also shown that, at post-treatment, young people randomised to MST demonstrated positive outcomes (Schoenwald et al., 2008).

The literature examines in some detail the enabling factors contributing to positive outcomes. Huey et al. (2000), in particular, have identified 2 key factors that mediate the impact of MST:

- therapist adherence to the model, which is associated with improved family functioning and decreased delinquent peer affiliation, and, in turn, decreased delinquent behaviour
- changes in caregiver discipline practices, and youth association with deviant peers, which is associated with reduced antisocial behaviour

In addition, both clinical and qualitative trials with families have demonstrated that the therapeutic relationship and model of working are key to families' engagement, and, thus, a range of outcomes (Henggeler, 2011; Tighe et al., 2012).

Positive outcomes are seen in a number of national studies, suggesting cross-cultural transferability. While there are examples of international replications that have failed to yield favourable MST results, these have been found to be characterised by low rates of fidelity (Henggeler and Schaeffer, 2016). Indeed, a number of MST trials have provided evidence that fidelity to the programme is a critical enabler of positive outcomes, leading to better results (Henggeler et al 1997). In response, the originators of MST have developed strict treatment protocols and adoption criteria (for example, maintaining rigorous training procedures and a high level of contact including weekly telephone consultations). Fidelity is measured through the use of the MST Therapist Adherence Measure (TAM), a 28-item questionnaire completed by parents at regular intervals during the intervention. MST has since been implemented in the UK, Australia, New Zealand, Canada, Denmark, Ireland, Netherlands, Norway and Sweden.

Developing a mutual

There is increasing interest in moving to a staff-led mutual model to deliver public services. Reynolds et al. (2011) provide a comprehensive overview of the role of both co-operatives and mutuals in the provision of local public services. They suggest that the growing appetite for this type of membership model, based on the principles of mutuality, is driven by:

- the Government's commitment to creating a Shared Society through introducing a greater diversity of public service providers
- a view held by many authorities that mutuals could be a possible way to sustain local public services during a period of unprecedented public spending cuts

Drawing on the evidence and case studies, Reynolds and al. (2011) argue that, for mutuals to contribute positively to public service delivery, key conditions must either be present or absent in specific combinations:

- a contract length of 5 years or longer, which also locks in previous benefits
- buy in from staff and/or citizens
- support, advocacy and expert advice

Other factors found to influence success are membership open to all; an ability to raise finance, concern for social, economic and environmental wellbeing; and a low resource base (Reynolds et al., 2011).

The impact and outcomes have been evaluated in a number of mutual model case studies. An example from Oldham Community Leisure has demonstrated a range of positive effects, including:

- staff developing skills through training and getting involved in the running of the board
- meaningful interaction between stakeholders on the board, comprising staff, service users and representatives of relevant sectors
- clear accountability in the form of a democratic and open process of decision making (Reynolds et al., 2011)

Changes to the project's intended outcomes

There was a change to the intended timetable of the move to the FPM. When the evaluation plan was formulated and agreed in June 2015, CCC's approval for CMST's move to a mutual was anticipated by September 2015. Since then, CMST has anticipated securing CCC approval at several points between September 2015 and October 2016. At the time of writing this report in November 2016, the move to the FPM

had just been approved by CCC. Otherwise, other than the intended addition of a second standard MST team, the intended project outcomes remain unchanged.

The context for the project

According to CMS staff, the key contextual factors lying behind the decision to attempt to move to the FPM, were:

- austerity. CMST's motivation and rationale for the move was driven by the need to protect the service from what was thought to be an impending round of cost saving
- changes in local authority staff and strategic interests or needs. Making the case for the move has required time, mapping and re-mapping, and engagement of stakeholders

CMST service overview

CMST is made up of 2 adaptations of MST: the MST standard service, and the MST problem sexual behaviour service (PSB). The MST (standard) service carries 30 – 25 cases per year. The MST PSB services carries 8.

The annual budget for MST Standard (for CCC) is £ 420,000 and for MST PSB is £212.000.

CMST also provides a spot purchase service: MST standard for CCC (when a referral falls outside the current case limit) and also Peterborough (standard MST) and MST PSB for Bedford Borough Council, Central Bedfordshire Council and Milton Keynes Borough Council.

CMST currently has 13 staff, comprising 4 therapists on the MST standard team, three therapists on the PSB team, 2 supervisors, three senior managers and an administrator. An MST service is based on a tightly prescribed delivery model and limited case through-put, which means that per case costs are high and so smaller, less affluent, local authorities find the costs of establishing and maintaining MST services challenging. Therefore, while the size of county, public purse and demand for MST services are relevant, caution must be used when making comparisons in terms of transferability of learning. Our research has focused on the process of moving to a mutual model of delivery, and the factors we have found that have implications for transferability are presented in the executive summary and sections 6.7 and 8.3. To help readers of this report consider the implications of our learning for them, in context, further information about CCC, including comparisons with other local authorities, can be found in Appendix B.

Overview of the evaluation

The overall aims of the evaluation were to:

- conduct a process evaluation of CMST's adoption and implementation of the mutual model of delivery for their service
- develop and embed an impact evaluation strategy within CMST's work programme

Intended outcomes for the evaluation

The primary outcomes for this evaluation were to:

- use CMST as the focus of an evaluation to identify, describe and explain good practice in the development and adoption of a mutual model of delivery
- use the findings from process research to help improve and develop the mutual model of delivery in CMST
- identify and describe the advantages offered by the adoption of a mutual mode of delivery, including any short-term cost benefits associated with changes in the delivery model
- design and embed a long-term CMST evaluation strategy

The secondary outcomes were to:

- help CMST develop, improve and embed the mutual model of delivery
- as needed, develop the evaluative and research capability and capacity within the CMST
- develop an impact and/or outcome cost-benefit model, so that CMST would be able to evaluate outcomes in the medium and long term

Evaluation questions

The evaluation set out to answer the following questions:

1. How did the mutual model of delivery compare with experiences of delivery prior to the move to a mutual model?
2. What were the processes involved in the move from a public to a mutual mode of delivery?
3. What works in developing a mutual model of delivery in Cambridgeshire, and what are the challenges?

4. What professional development and/or support materials work to help develop a mutual model of delivery?
5. What learning is useful to those outside Cambridgeshire in adopting a mutual model of delivery?
6. How can MST impact and outcomes for both CMST and clients be best evaluated by CMST in the medium and longer term?
7. What opportunities exist for joining up learning and evaluation coming out of other MST programs and projects?

Summary of methods

Employing a mixed method, action research (co-operative enquiry) approach, our process impact evaluation included:

- a review of business plans, including 2 versions of CMST's business plan, a CMST local effectiveness report, CMST's proposal to the DfE Innovation Fund, market analysis materials, stakeholder mapping documents and notes from CMST's FPM preparation workshops
- a rapid evidence review of literature related to the effectiveness of MST, to evaluating MST and evidence about developing mutuals, which was updated in September 2016
- a review of CMST costs and an economic evaluation
- individual semi-structured interviews with CMST staff and local authority stakeholders (summarised in Table 1 below)
- focus groups with CMST staff (summarised in Table 1 below)
- workshops with CMST staff (summarised in Table 1 below)

The evaluation involved 4 strands of work:

- strand one: participant mapping, project document reviews, a rapid best evidence review (reported by PowerPoint), supporting CMST to develop a logic model and develop fieldwork instruments and make preparations for fieldwork and conducting the first sweep of interviews and focus groups with CMST staff and partners in July 2015
- strand 2: a follow-up sweep of individual interviews and focus groups in August 2016 with CMST staff, and telephone interviews with other business stakeholders and commissioners, and 2 development workshops
- strands 3 and 4: evaluation of capacity development, strategy and sustainability. These strands included reviewing evaluation plans, mapping capacity. CMST has provided a cost benefit framework for future use. Time has also been banked so

that a final evaluation strategy can be developed once the move to a mutual has been completed

York Consulting conducted the economic aspects of the evaluation. This involved establishing the costs and benefits of historical CMST cases and exploring how these could be affected through efficiencies brought about by moving to a Mutual delivery model. York Consulting considered the total delivery costs required to support a young person and/or a family to an agreed successful outcome. Economic evaluation findings and conclusions were all sourced from a report, which was provided by York Consulting to CMST and can be accessed [online](#).

Table 1: Interviews and focus groups

Interviewee categories	Number of participants involved in:		
	sweep 1 interviews	focus groups	sweep 2 interviews
CMST administrative staff	1	1	1
CMST therapeutic staff	5	5	6
CMST supervisor staff ²	2	1	2
CMST management staff	3	3	3
CMST stakeholders	4	n/a	2
Totals	15	10	14

All CMST staff were invited to participate in interviews and focus groups. CMST stakeholders were selected for interview as a result of referral from CMST. An information flier was provided to all research participants explaining the evaluation and a full explanation of the research was read out by the researcher at the start of all interviews. Interviewees gave their free, informed consent to be interviewed and to participate in focus groups. Stakeholder interviews were conducted by telephone: all other interviews and focus groups were conducted in person. A disclosure protocol was explained to each interviewee (no disclosures occurred). With the consent of everyone, all interviews were recorded and were fully transcribed. Initially, analysis of document reviews and qualitative data was conducted using a manual approach and then qualitative software packages were used. The evaluation was concerned with understanding the CMST story in its specific context, hence a grounded theory approach for analysis was used, involving a thematic and inductive review of interview and focus group responses. We also used learning from a rapid review about adopting

² Note that one supervisor also had administrative duties. Hence, when later in the report we refer to CMST's 3 administrative staff, this includes the supervisor and another administrator who was not interviewed and left CMST during the evaluation.

a mutual mode of delivery and evaluating an MST service. Therefore, in considering the implications arising from our work, a thematic deductive analysis was also used. Interview and focus group discussion guides can be viewed in Appendices A1 to A5. The interview and focus group coding frame is included in Appendix A6.

Changes to the evaluation

CMST's move to a mutual was delayed and had not taken place at the time of writing this report. SCIE agreed with CMST, AFC and REES that, even if the move to a mutual did not go ahead, the evaluation would continue, so that learning about the preparation for the move could be captured. In this context, the evaluation was unable to:

- conduct the second sweep of fieldwork after the move to a mutual had been completed, even though SCIE had requested and been granted an extension to the final report deadline to accommodate delays
- arrange focus groups for the second round of fieldwork
- complete a post-move cost benefit analysis
- complete the final elements of our improvement and sustainability role, intended to follow the final fieldwork analysis, which means that we have yet to finalise a longer-term evaluation strategy.
- conduct client-based case studies, because no changes to client-facing services as part of the preparation for the FPM were undertaken

However, with the CMST's and AFC's agreement, SCIE have carried over 4 days to be used by May 2017 to:

- present and discuss evaluation findings
- conduct one practice development workshop
- help finalise CMST's evaluation strategy

Preparing for the FPM, key findings

Challenges and what worked

CMST faced the following complex challenges in their preparation for the move to a mutual:

- building the case for, and communicating it to, stakeholders; which included emphasising the cost and other benefits to CCC in moving to a mutual, namely, reducing local authority liability of running CMST, expanding CMST's offer and setting up a second standard MST team
- challenging (what CMST perceived as) simplistic per case cost comparisons between their service and other family intervention services used by CCC, by emphasising the complex and bespoke MST offer and its long term cost benefits
- building new relationships with commissioners and other stakeholders, using preparation for the move to a mutual to convince them of CMST's value, and to invest in, and offer advice to, CMST during their preparations
- addressing concerns from stakeholders and CMST staff related to the implications of moving out of local authority control, in regard to political and service accountability, and in relation to staff terms and conditions
- consistently involving staff and other stakeholders to develop a co-produced approach to the preparation of the move to a mutual, while at the same time developing staff expertise and organisational capacity

Key aspects of what worked

- Time. In the context of the delay in CCC approval for the move to FPM to November 2016, according to interviewees, time has been needed to enable a responsive approach in a shifting process of stakeholder engagement, which, for everyone concerned, proved more complex and time-consuming than anticipated
- Leadership. The genesis and drive behind the idea for the move to a mutual model of delivery, was supplied by a senior manager, in partnership with a senior CMST colleague. These staff have continued to lead the move to a mutual. Interviews showed that this has provided the stability, expertise and consistency needed for stakeholder engagement
- Demonstrating the cost benefits of a comparatively high-cost service. Making the cost benefit case for the move to FPM has been crucial for stakeholder engagement and informing CMST planning around service expansion. Interviewees said that it had been necessary to make the case for an increase in

CMST funding, to take account of the hidden costs of developing a mutual (which, CMST argue, meant that overall, costs would remain the same for FPM)

- Addressing implications associated with service independence. Interviews with staff and stakeholders showed that there were concerns about an independent mode of operation; and particularly the financial security, logistical and political implications of leaving CCC to become a commercial business. It has taken time to address these concerns and for CCC to work through the details of CMST's to move to the FPM, in terms of pensions, procurement, information technology and accommodation
- Staff terms and conditions and the TUPE process. Initially, interviewees were unclear about what a move to the FPM would mean for terms and conditions. Staff told us that they were reassured when clarity had been provided. CMST managers also emphasised that it was a learning process for the pension providers who also had to consider their responses.

Demonstrating the need for CMST

CMST staff strongly asserted that their service produced positive outcomes for families, and that therefore there was a market for it locally. For instance, a manager said:

“... the effectiveness of CMST essentially from outcomes to families to employees and employee's retention and satisfaction of CMST is generally from service users”.

CMST carried out market analysis, a needs assessment and a feasibility study to substantiate their views about the demand for CMST.

The focus on fidelity to the MST model was maintained, as quality was seen as important by CMST staff. Managers said that the act of preparing for the FPM had meant that they were able to take the opportunity to inform stakeholders' perceptions and awareness of CMST. As a manager explained, “I'm definitely going to worry about the bottom line, the pipeline [flow of case referrals], our reputation in the business, ensuring the quality of the services are provided”. The economic evaluation, conducted by York Consulting, has also been used to underpin the case for CMST.

Securing funding for the mutual

CMST is seeking to retain funding from CCC and Bedfordshire County Councils and also secure additional funding streams. At the time of writing CMST were waiting for CCC's agreement to the recruitment of a second standard MST team. Senior managers described the challenges of selling CMST: despite CMST identifying what they believe is a need and demand for their services, senior managers said that many commissioners did not have the resources to commission CMST. In response, CMST

sought to mediate funding issues by considering a social impact bond model and approaching social finance intermediary companies.

“Lots of people are interested in doing things differently but their own circumstances either mitigate against that taking place, or they would love to do it, but they’re so busy making people redundant and having to find this year’s savings target”. (Manager)

“... finding a way of securing CMST moving forward and making sure it has a good basis on which to develop...make it a credible business in terms of financial viability”. (Stakeholder)

CMST managers described the challenges in securing buy-in from the CCC because the cost of running CMST as a mutual would be higher than under CCC control. As a CMST manager explained:

“... where we are currently is CMST costs us X but when we go after the contract it will be Y. It will take a long long time for local authority to understand that the cost of running a service is more than the staff costs and mileage”.

Therapeutic staff, as well as managers, expressed a concern that some unforeseen costs may not be identified before the move, and would pose a financial risk:

“The problem is they are starting to emerge, and coming out of the woodwork and I am just hoping they will come out in time”. (Therapist)

Maintaining fidelity to the model

The rapid review found that fidelity to the MST model was an asset in the development of a mutual, the business plan also reflected this in its job descriptions for therapists and supervisors, as did responses from CMST staff.

“CMST has to be run in a more prescribed way...these services is an evidence based transportable service with a license”. (Supervisor)

“The actual role itself is defined by MST itself so because it is a licensed programme we have to work within that”. (Therapist)

CMST staff reported that the process had not affected the client group up to this point in the process, one therapist said that they were ... confident clients have no idea this is going on”.

Another therapist agreed that clients should not be affected:

“Client group - our client group can’t be affected by the changes because we prescribe to a license”.

Staff involvement

The review of the business plan, and notes from CMST staff meetings, confirmed that a mutual model of delivery demands a very high level of staff involvement in planning and decision making. Interviews found that staff felt that their involvement was very important: there were differing views about whether involvement had been achieved during interviews in Sweep 1:

“I think we have a voice definitely. In the meetings we are definitely asked our opinion...we are being involved and our opinions have been listened to”.
(Therapist)

“... the therapists themselves really have very little knowledge of what goes on”.
(Supervisor)

A perceived lack of information sharing in the early stages resulted in staff questioning the ‘nuts and bolts’ of the move to the mutual and raising questions around the terms and conditions for staff and the TUPE process. Staff commented that there have been few opportunities to collectively discuss the plans.

“I don’t think I know enough to really have a full grasp of what it will involve to know what this means for CMST in the future”. (Therapist)

“Obviously anxious about the job still being there and how it’s going to work”.
(Therapist)

Second sweep interviews found a higher degree of involvement in preparations. Staff indicated that involvement had become a two-way interaction, with interviewees saying they had made an effort to learn more. Staff said they had the “right level” of knowledge, and responses showed that staff had made time for a greater proactive investment in developing their awareness and knowledge about preparations.

“Enough info - mainly from attending meetings and also communication that has gone around. And from discussions from various people”. (Therapist)

“I think in the beginning there was a problem with that but we were able to air those views and I think they were listened to and we are able to attend all the meetings” (Therapist).

Therapeutic staff said they wanted to focus on the delivery of CMST and leave the preparation for the mutual to managers. Responses at both sweeps of interviews showed that staff generally supported managers’ efforts and that they accepted, and felt positive about, the move to a mutual.

“... sitting in the meeting I feel I understand but it’s quite hard to articulate what it is but I am satisfied that I understand what the future will be like, and what it all entails”. (Therapist)

“Once people have said this is what we are going to do, you can’t really not be supportive of it, don’t think people have particularly been active in the process”. (Therapist)

Analysis of responses from CMST supervisors and managers showed that they agreed that staff were sufficiently involved and were being consulted on issues in a way that was conducive to working as a mutual and this was, according to staff, exemplified by the election of a staff representative to the board:

“We have an elected staff rep who comes to board meetings. We have to spend a bit of time looking at relationship between board and staff”. (Manager)

Gaining CCC approval for the move to a mutual

CMST had anticipated that CCC’s approval for the FPM would be gained in September 2015. According to interviewees, the process of gaining CCC approval has been subject to a continuing delay for the following reasons:

- senior CCC stakeholders moved on, altering the decision-making process
- a need, identified through ongoing stakeholder dialogue, to revisit and prove CMST’s value, when compared with other services available locally. These other services include the Specialist Family Support Services (SFSS), the Family Information Partnership (FIP) and Alternative to Care (ATC) and other specialist services provided by the NSPCC and others.
- the business case for the move to a mutual needed ongoing consideration and revision and, according to CMST managers, CCC also engaged in a learning process, gradually addressing the implications and practicalities of CMST’s move to the FPM. A manager said:

“With respect to the council, there is the whole project timeline of CMST stepping out which the council hardly ever utilise so it has been a learning curve for people within the council and for us”.

- CMST consideration of expanding their service offer

CMST managers described in the second sweep of interviews how the strategic approach of the council had changed, and that preparation took far longer,, and had been more complex than had been anticipated for both CCC and CMST. One manager described a newly responsive and flexible approach:

“What we didn’t want to do is present something to them and get them to say yes or no at too early a stage, because we knew they needed time to warm up to the idea. We said this is where we got to at this stage and we will come back after 6 months with all this stuff worked out”.

Interview responses during the second sweep indicate the outlook for CCC approval for the FPM was positive. A manager reflected:

“... they now have agreed we can go as a mutual but they have not 100% agreed for a second team. But they are looking into it, in the context of all the other services that are working with kids and what their needs are and I think we have a few meetings about where everyone is saying, yes there is a need for MST”.

Stakeholder buy-in

Stakeholder buy-in has been an important strategic goal for CMST from the outset. In the view of CMST managers, their efforts to make the case for the CMST move to a mutual had gained support from some stakeholders within CCC who were involved in the development of the business case, and interviews with stakeholders confirmed that they were supportive of the plans and well-informed about the preparation and business case for the move.

“... the particular situation that Cambridgeshire is experiencing, threshold and gatekeeping around dysfunctional families and children finishing up in the care system that probably ought not to, so I see MST...as valuable”. (Stakeholder)
“It feels opportunist which is no bad thing. But the ambition to provide that kind of service on a larger scale within the region is what is driving it”. (Stakeholder)

One stakeholder, during Sweep 2, indicated that there was still work for CMST to do on engagement, saying, “I still know nothing about the plans, I need to know more”. Otherwise, responses from stakeholders who had had direct input in the preparation for the FPM, demonstrated detailed knowledge about the plans for the CMST and the efficacy of CMST’s engagement efforts.

Preparing for the FPM

Although the CMST had not yet made the move to the FPM, analysis of evidence enabled the preparation for the move to be explored. Key findings are presented in relation to:

- paying for and protecting the CMST
- the impact of preparation for the FPM on the delivery of CMST

- spinning out the CMST (spinning out means the expansion of the service to include new offers or types of MST)

Financial drivers

Interviewees explained, confirmed by the business case, that CMST anticipated that each local authority service would be expected to share in cost reductions, but that the limits on changing the mode of delivery meant that the CMST service could not be “sliced” in a piecemeal way. Interviewees agreed that the most important reason for moving to a mutual was to protect CMST from cost reductions. There was uncertainty about CMST’s financial future; interviewees said CMST were waiting for CCC’s decision to allow the move to a mutual and for funding and commissioning arrangements to be confirmed with existing funders.

CMST’s model of delivery

MST is a highly prescribed model of intervention, bound by a licensing agreement and overseen by a consultant. Interview responses reflected this:

- therapeutic staff and supervisors said that the delivery of CMST (MST Standard and MST Problem Sexual Behaviour (PSB)) was not expected to change, and could not change because of the licensing of the intervention
- therapeutic staff reported that their roles had not altered as a result of preparation for the planned move, nor did they expect them to. Some members of staff said that they anticipated involvement in some marketing activities
- senior managers had experienced changes to roles and responsibilities as a result of preparing for the FPM. They reported additional responsibilities in relation to the design and management of the mutual, and new roles related to business development. This has some effect on the MST model of delivery, because some senior managers were directly involved in supervising those in therapeutic roles.
- supervisors reported some additional responsibilities related to the planning process, but did not see this as related to their responsibilities in terms of delivering CMST; their roles as supervisors were not seen to be affected.
- interviewees explained that there had been changes to the governance of CMST during preparation for the move to a mutual
- staff representation on the board was part of a new governance structure and this role was to be shared by staff on a rota basis

Spinning out and expanding CMST

In line with the business plan, interviewees explained CMST's intention to move the service to a mutual and to expand CMST's service offer. These plans included:

- extending the CMST offer to include Functional Family Therapy (FFT) and MST Health and adding a second CMST standard team
- offering the MST's consultancy service to other authorities to support their development of MST services

Interviewees were positive about plans for spinning out CMST. Management said that it was important for the future financial health of the service: "actually to be efficient and to have an impact on savings we need 2 teams" (Manager).

Therapeutic staff also commented on the opportunity, as they saw it, to offer an expanded MST able to serve more clients:

"expand and do more therapies – definitely got that under way" (Therapist)

"We can expand to a second team which would be good for the clients, cos then we can take on more cases". (Therapist)

Administrative staff said they had experienced increases in their workload and were concerned about a lack of additional capacity to support the planned new teams and an expanded service:

"My workload has probably multiplied 2 and half times since March as I have taken on new aspects such as the finance". (Administrator)

Managers also mentioned that moving outside of local authority control, meant losing all of the backroom support and administrative logistics associated with a county council, recognising that this had entailed additional workloads for administration staff in preparing for the move..

The process of preparation

This section reports on our exploration of processes to date and key findings are presented in relation to:

- processes of change
- the business case
- staff engagement
- fidelity to the MST model

Processes needed for change

CMST's business plan outlines the milestones and processes in preparing for the move to the FPM. Milestones included business plan finalisation, legal entity set up and gaining approval from the council to establish a mutual.

The rapid review found that, in order to implement evidence-based programmes successfully in children's services, a sustained and active process of implementation is required to achieve fidelity to what has been proven to benefit users (Fixen et al, 2009, quoting Greenhalgh et al, 2004). The CMST service took steps to identify service need and then present their business case around the proven outcomes of MST as an intervention. CMST involved staff by arranging workshops and setting up an FPM project team.

Business case

The CMST service took the following steps to identify and test the case for a move to a mutual:

- MST market and needs analysis
- a feasibility study (in relation to diabetes care)
- the cost benefit case for the Council and commissioners

The CMST service used the information from market analyses and feasibility studies and combined it with data about outcomes and impacts of MST and cost benefit information to build its business case.

The resulting CMST business plan presented the cost benefit case for interventions like MST in relation to high numbers of looked after children in England and their poor outcomes. The business case used data from the United States of America (USA) on cost savings: "Data from the Washington State Institute for Public Policy indicates that evidence based interventions such as MST generates savings per \$1 spent of \$12 – \$2813" and set this against UK research that found reductions in re-arrest rates and out of home placements for young people following MST participation: "It has been shown to reduce re-arrest rates by 25 – 70% and reduce out-of-home placements by 47–64%".

Staff involvement

Interview responses during sweep 1 showed that staff involvement in the planning for the move to a mutual took time to develop. Most of the therapeutic staff had not been directly involved in the process of preparing for the move to a mutual, hence, did not report changes to their existing roles and responsibilities related to the mutual.

Comments from the same staff in second sweep interviews found that involvement was developing, an example being this comment from a therapist during sweep 1 interviews:

“I don’t think I know enough to really have a full grasp of what it is or what this means for MST.”

The same interviewee during the second sweep said of FPM preparation meetings:

“all getting into these meetings together and then I feel more confident in actually being able to say stuff cos otherwise before you might not want to say something but now you get the impression that you can impact on decisions”.

Throughout the process of preparation for the FPM, staff were involved via:

- workshops, meetings and an FPM project group, specifically to discuss the move to a mutual, although staff said that it could be difficult to attend meetings and that options to attend via conference call would be useful and welcomed
- staff representation at board level
- email communications

Fidelity to the MST model

The CMST business plan sets out the evidence related to how MST improved child and parent outcomes, and the importance of fidelity to the MST model in achieving these outcomes.

Throughout both sweeps of interviews, staff consistently said that CMST would remain the same. They said that maintaining fidelity to the model was, in an effort to insulate against financial cuts, a key driver in moving to a mutual. One therapist commented:

“Shouldn’t change anything in delivery of service...it would compromise the service itself”.

Document reviews and interviews also showed that market analysis for the move to a mutual has driven innovation, with plans to develop and expand the CMST’s services and proposals for a second standard team.

Support for preparation

The rapid review found that the development of the mutual model of delivery demands a high level of staff involvement. CMST managers and administrative staff interviews found that the 2 administrative personnel (a third left CMST shortly after sweep 1 interviews) and three managers had experienced significant changes to their

responsibilities. Therapeutic staff on the other hand, said that they had experienced little change in their activities.

“I think the area of our service affected most has been business support. They are just busier, a lot of responsibilities with respect to moving the project forward”.
(Manager)

“... my day to day role will be support of the MST teams...now it's kinda like more setting up a business”. (Manager)

Three broad categories of development needs were identified:

- general development needs
- development to enable the delivery of an expanded service offer
- support for CMST staff to develop and prepare for a mutual

General development needs

CMST staff identified a range of continued professional development needs associated with their contribution to CMST. In response, CMST managers have reworked the supervision structure within CMST, and realigned their approach to performance management. CMST managers have also received support from Social Finance, Mutual Ventures and Winkworth Sherwood (as part of the Cabinet Office's Mutual Support Programme).

“For me it has been much more of a learning curve in terms of just stepping into any type of business environment”. (Manager)

“I can say I have actual training. We had these events which were generally informative and they offered networking opportunities, you learn from them”.
(Supervisor)

Expanding CMST's offer

With the proposed spinning out of CMST, the possible addition of a second standard MST team and an expansion to CMST's offer, staff said that development needs may surface after the move to a mutual was completed. During the second sweep of interviews, staff responses also showed that there was enthusiasm about new opportunities for development.

“... our team now is going into this thing called FIT which is where we are having this DBT training”. (Manager)

“I have booked on to a training course in Manchester so we are qualified to carry out or use the structure and risk assessment tools”. (Therapist)

Developing skills for consultancy

The literature review found consultancy and specialist support to be important in preparing for a move to a mutual. Social Ventures and Social Incubator have provided consultancy support to CMST. CMST managers completed training on models of social enterprise and were provided with tools designed to help develop business plans and pitches. CMST staff who had received this consultancy support were very positive about their experience.

“Largest amount of learning came from going to the social ventures weekend”.
(Supervisor)

“We can access consultants and things like that. I went to a few of their offerings, in term of days and different workshops and things like that”. (Supervisor)

Economic evaluation

In order to make an economic assessment of the FPM, York Consulting established a baseline model of the costs and benefits using data for all (34) CMST cases served in the 2014/15 financial year. Building on the baseline model, forecasts were made for the FPM with one and 2 teams, capable of serving 35 and 80 cases respectively.

The analysis focused on the delivery costs of MST, as this is where potential cost-efficiencies of moving to the FPM are identifiable. However, for completeness, analysis is provided for both the total delivery costs and total service costs. Total service costs include fixed overheads.

In relation to benefits, positive outcomes were identified for each CMST case and, drawing on national research and local data, financial proxies applied. Although not all individual outcomes can be translated into a financial value, they are supportive of wider benefits such as the family being closed to social care. Benefits relating to preventing looked after status (or reunification) were only counted for cases where the young person was deemed edge of care (using DfE guidance).

To account for attribution and sustainability, benefits were weighted-down if there was evidence of additional support following CMST intervention and a 12-month follow-up for the 34 CMST cases was conducted.

Baseline cost-benefit model

The duration of CMST support ranged from 20 to 27 weeks. The average delivery cost per case was £10,558. This comprised the total hours of support from CMST practitioners and supervisors and additional cost elements identified as critical to delivery (for example, travel, licencing, subscriptions and service user support grants). The total cost of supporting 34 cases was £358,977.

There was evidence of wide ranging and significant outcomes achieved as a result of CMST support. Table 2 (Appendix C) details the outcomes observed in the 34 cases that were reviewed. Where possible, financial proxies were applied to outcomes and the resulting benefits weighted-down if there was evidence of on-going support. The total benefits (detailed in Table 3 (Appendix C)) resulting from CMST support were £1,080,184.

The fiscal return on investment (FROI) (benefits divided by costs) was 3.0 – for every £1 spent supporting young people with MST, there was a return of £3. The 12-month follow-up revealed that 89% (£960,986) of benefits were maintained over the longer-term and the FROI remained positive at 2.7.

FPM cost-benefit model

Economies of scale

In order to achieve economies of scale, the FPM have the following variables which they can influence:

1. the number of young people they support.
2. staff time/costs (through improvements in productivity and staff retention).
3. overhead costs.
4. dropout rates (through more appropriate referrals).
5. proportion of cases defined as 'edge of care'.
6. successful case closures.
7. sustainability of outcomes.

The FPM could consist of one or 2 teams. With one team there is likely to be less scope to influence all these variables, particularly 1 – 3. However, with 2 teams, it is thought that the FPM will accrue greater economies of scale by being able to change all variables. For example, with 2 teams, staff will spend less time travelling and therefore can deliver MST with greater efficiency (supporting an estimated 80 young people per year) and overheads will be split across a larger caseload.

FPM costs and benefits

With one team, total delivery costs are likely to be the same as baseline costs. However, with 2 teams working across Cambridgeshire, we can assume an increase in the number of cases served due to more efficient delivery (for example, less time spent travelling). Dividing the total delivery costs of 2 teams (£358,977 × 2 = £717,994) by the anticipated 80 cases served per annum reveals an average delivery cost of £8,975.

In addition to greater efficiencies in delivery, it is anticipated that some overheads can be split over the 2 teams, reducing the overhead charge to 15%.

It can reasonably be assumed that outcomes or financial benefits associated with cases to be supported will be at least as good as those observed in the baseline model (with greater staff retention and tailoring of services, outcomes may improve over time). It is therefore possible to apply the average benefit of these cases to those that will be supported by the FPM.

It was necessary to calculate the average benefit for 2 distinct types of cases – those that are edge of care and those that are not. Based on the 2014/15 cases, the average benefits were: edge of care: £52,032; not edge of care: £8,976.

18 (53%) of the 34 cases analysed were deemed edge of care. As CMST moves to the FPM, it is expected that the proportion of edge of care cases will increase, because of a combination of greater control over referrals, and other local authorities, with higher proportions of edge of care cases, spot purchasing MST interventions.

Assuming an increase to 65% of cases being edge of care, the total benefit for these cases will be in the region of £1.2m with one team, and £2.7m with 2 teams. The remaining non-edge of care cases will account for an additional £110k - £250k in benefits. The total estimated benefit of the FPM over the course of 12 months with one team is £1.3m and £3m with 2 teams – with FROIs of 3.6 and 4.1, respectively.

Table 4 (Appendix C) provides a detailed comparison of CMST in 2014/15 to the FPM.

Transferable learning

The following are potentially transferable principles related to the preparation for the move to a mutual:

- staff involvement and engagement. Recognise that specific plans need to reflect local resource and staffing realities. Develop staff involvement and ownership over preparation as early in the process as possible
- ongoing mapping of, and structured engagement with, commissioning and decision-making stakeholders. The delay in the move to a mutual owed much to

the challenge of stakeholder involvement and engagement and to maintaining engagement over time

- secure funding sources and confirmed contracts before the transformation is enacted. The rapid review found that secure funding sources before roll out were important in building a successful mutual
- the rationale for the move is important. The staff group appeared united behind the idea that the move was necessary, because otherwise it would be a risk, due to cuts to council budgets
- accurately calculate the cost, and cost the advantages, of the new service. Interviews with management described the challenges of costing the new service and convincing existing commissioners to continue to fund the service
- consider the processes involved in the transformation and allow significant time for decision making and approvals. The experience of the CMST was marked by delays in developing the business case and securing the sign off of the local council
- acknowledge risk. Managers acknowledged the risk in becoming an independent mutual. The business plan acknowledges the possibility that the service will not gain sufficient funding to remain operational
- get advice from others who have made the transition. CMST staff said that they would have liked to hear more from others who had completed the transition. Management also spoke of the value of gaining consultancy support from Mutual ventures

An MST service is based on a tightly prescribed delivery model, and the size of county, public purse and demand for MST services are relevant (see section 6.6). The factors we have found that have implications for transferability relate to:

- support of officers and funders. Developing and convincing Council officers and members is a key part of the process in moving to a mutual, as is time for local authorities to determine how to respond and manage the change process. However, this aspect of the process is subject to officer turnover and the election cycle. Our findings indicate that undertaking a similar preparation in local authorities, themselves undergoing a period of change needs very careful consideration, and that allowing for these types of challenge is important, as is the time to address and mitigate the impact of them
- staff with the experience and belief in advantages of a mutual. Considerable commitment and drive from leadership is required for the development of a mutual. A key element in attempting a move to a mutual is the presence of staff with the leadership skills, network knowledge, sector experience and who have a passionate belief in their efforts

- using statistical neighbour information to tailor and target the sharing of learning generated by MST services generally, and CMST about their move to a mutual. We suggest selecting authorities that are similar to CCC, so that they, too, are able to consider developing their own MST service where there currently is not one. We suggest that, where authorities do have MST services, they may find the learning about attempting a move to a mutual helpful. We would also suggest sharing learning about MST service options with authorities who are not in a position to fund their own MST service, covering regional MST commissioning, spot purchasing and consultancy mentoring
- costs and available funding. It would be challenging for Councils with smaller purses than CCC to fund their own MST service. The mutualisation and planned expansion of CMST means that commissioners in smaller local authorities have the opportunity, and are able to buy a small number of cases and spot purchase should they need more. Commissioners and MST services situated within strategic regional centres may draw useful learning from this approach
- Social Impact Bonds (SIBs). SIBs are relatively new and therefore, the example of their use provided by CMST's preparation for the move is a useful one for others
- how to facilitate, achieve and benefit from greater staff involvement in decision making. A staff-led mutual model requires greater staff involvement in decision making, and the learning from this evaluation about how to approach and achieve staff involvement, and its benefits, is applicable to all public sector workplaces, whether or not they are preparing to move to a mutual model of delivery

Evaluating CMST in the longer-term

Strands 3 and 4 of the evaluation involved mapping current CMST evaluation plans and using this information to support CMST to develop an evaluation framework and strategy for their self-delivered, long term evaluation of their service. The mapping of the current approach to evaluation found that CMST, as a result of their licence agreement, collected a range of outcomes data. Data included client management information, as well as pre- and post-intervention client questionnaires, completed by therapists with clients, and the collection of case-related follow-up metrics. CMST's business case outlines the quality assurance mechanisms to be used for each case, which include:

- therapist adherence measure – a survey conducted with clients to ascertain the level of adherence to the model
- supervision: weekly group supervision and fortnightly one to one supervision
- consultation, weekly, with an MST expert
- therapist performance measure through bimonthly surveys
- instrumental outcomes measured at case closure

Based on a logic model approach and York Consulting's economic evaluation, CMST intends to select quantitative outcome measures and use qualitative interviews with clients, staff and stakeholders to inform business development and improve planning. CMST's business plan pledges an organisation that is strongly outcome focussed. CMST's business plan outlines the possibility of a new data analyst role to gather and analyse data on the effectiveness of CMST. As well as this new role, the business plan describes a range of potential methods of data collection, including evidence based questionnaires, session by session outcomes measures for new services adopted by CMST, and performance management structures.

CMST's business plan allows for further development work on the evaluation questionnaires and, supported by SCIE, they will help develop a strategy that integrates new evaluation methods into practice, and incorporates a data analyst role.

Joining up learning across MST services

The findings reported here suggest not only a range of opportunities for joining up the evaluation and learning generated across MST providers, but also the timely need to do so. MST services could usefully consider:

- value for money, cost benefit and what counts as evidence. Economic evaluation is important. The cost benefit analysis conducted here has been critical in creating an analytical framework that can simulate likely impacts based on actual baselines and best-estimate assumptions of future operation. The results which show a positive return on investment could assist negotiations on funding, particularly the importance of a scale approach. There is scope for replicating the approach and benchmarking across a range of MST projects. The model also highlights the importance of outcome achievement on pricing and market demand for a mutual model and premium pricing for spot customers
- evaluation and economies of scale. MST licensing means there is much similarity across services, which represents a potential opportunity for MST services to join up and agree common evaluation efforts. Generating collective evaluation learning and evidence about impacts would provide a broader, deeper and more compelling case for commissioners and one that is not overly associated with one locality
- harmonising and disseminating individual MST service monitoring and evaluation. It would be potentially advantageous to explore opportunities to fund the synthesis of findings already generated by individual MST service evaluation and reporting efforts
- quantitative client-focused impact evaluation. Case through-put in MST services are relative small. MST services joining together in their evaluation would mitigate the challenges of low case through-puts

- developing a centrally funded research and evaluation resource. MST services could explore sharing learning, and the resource burdens of learning, by joint commissioning longer-term impact evaluation of MST services nationally and/or fund a few internal posts to develop a jointly-owned MST action learning unit
- spinning out an MST service. It would be beneficial for CMST to identify, and partner with, other MST services who are also spinning out and/or expanding their services, specifically to achieve economies of scale and improve the strength of outcomes in the minds of commissioners
- learning from the longest established MST service. CMST is the longest established MST service, and has a wealth of learning and experience to share about delivering core MST services; about preparing to move to a mutual, and in relation to expanding their service offer

Key findings, conclusions and implications

What worked

Evidence shows that what has worked best in preparing for the move to FPM aligns well with what has developed to mitigate and address challenges. For instance:

- making the case for a CMST move to FPM involved developing new relationships with stakeholders, and encouraged a level of awareness and buy-in that was not present prior to preparation for the move
- addressing financial security has involved economic evaluation informing a compelling case for service development and expansion
- securing staff involvement and engagement has resulted in developing new governance structures and an improved understanding of the business, and increased active support amongst staff

The implications of evidence about what has worked and challenges are:

- addressing challenges has been a key driver of innovation, facilitated by the shift in culture to a staff-led business where high value is placed on the input of all staff
- political, economic and CCC staffing factors are a reality in local government and any move to a mutual can expect to have to face them. Evidence suggests that addressing these challenges has provided CMST with the opportunity to strengthen the planning, and provide more time to garner, and earn, staff and stakeholder buy-in
- that there is a challenge around entrenched interpretations of value for money in local contexts

- even where a move to mutual is not being attempted, other local authority services could replicate, and benefit from, involving and engaging their staff in the way CMST have done, and which the mutual model demands

CMST's delivery model

CMST's move to the FPM has involved:

- management development. Building commercial and business development skills have been important outcome for service managers
- administration and service logistics. In developing the business case and preparing to be self-managing, the scope and burdens of administration have also grown
- innovation culture. Thinking about spinning the service out and expanding the offer has become a jointly owned interest amongst all staff

The implications are:

- stability of funding. Key funders remain local authorities, and the delay to CCC approval for the move has caused, and continues to cause, anxiety. However, the need to develop longer-term funding has been an important driver of innovative service thinking in relation to spinning out CMST
- stability of the MST delivery model. Responses show that, because MST is a fixed model, this has meant little change in therapeutic staff roles. The stability of the model means that others attempting a similar move would also enjoy the same advantage
- stability and development for staff. The approach to detailed business planning and staff involvement has enabled staff to buy into the originally manager-led vision and direction intended for the FPM

The process of preparation

Taking time to make the complex case for the move to a mutual; conduct market analysis; develop detailed plans; engage CCC and external stakeholders, and involve staff in all aspects of planning have been important elements in CMST's preparation for the move to a mutual. The implications arising from the process of the move to the FPM are that time is needed:

- to develop an evidence-based business plan. Market analysis, cost benefits case, service development planning and governance changes take time to develop

- to undertake informed and evidence-led change management. Involvement and engagement of staff and stakeholders takes time and is facilitated and determined by the ability to provide convincing evidence
- to involve and engage staff, in a way that does not impact of existing service delivery. It takes time to gradually develop involvement and engagement as evidence and the business case evolves and develops
- for the local authority and other stakeholders to consider, learn about and plan their response to a service move to a mutual model of delivery

Support for preparation

Findings show that the most pressing and prioritised learning and development needs were related to CMST staff closest to the change process. Fieldwork confirmed the evidence from the literature review that the specialist support offered by consultants was valued by managers. While uncertain about the detailed development needs, staff were enthusiastic about the implications for development opportunities that they thought would align with spinning out services. The implications are:

- the importance to any organisation of expert input when attempting the move to a mutual
- the gaps that can be left in administrative support and infrastructure, when a public service moves out of public authority control
- the importance of business development skills, which leaders in commercial organisations must have to enable them to lead and develop sustainable businesses

Economic evaluation

Based on the 34 cases supported in 2014/15, we have developed and applied a robust and tailored cost benefit model that is underpinned by highly detailed and consisted data supplied by the CMST. The resulting cost-benefit model can be applied to historical cases and new cases. At an economic level, CMST represents value for money for CCC. The baseline analysis revealed a return on investment of 3. Assuming projections regarding the costs and annual caseloads for the FPM with one and 2 teams hold true, there is potential for further savings (in terms of adverse outcomes avoided) for local authorities. The estimated return on investment for the FPM with one team was 3.6 and for 2 teams 4.1 – for every £1 spent directly supporting young people there could be a return on £4.10. The FPM would be most efficient with 2 standard teams at full capacity - supporting 80 young people per annum. This would reduce practitioner time spent travelling and, in relation to overheads, the per case costs.

Transferable learning

While the impact and learning of the move to a mutual has yet to unfold, the preparation for the move provides invaluable learning for others attempting a similar venture. The complexity of a move to a mutual requires time address.

Evaluating CMST in the longer-term

CMST is working to harness the existing potential offered by the data it already collects, but which it has not always had time to exploit. CMST has an advantage in that it collects outcome material as part of its licensed MST delivery. There are additional plans under consideration to enhance evaluation methods, facilitated by this evaluation. CMST have existing evaluation expertise within the team and a workforce accustomed to collecting outcome data. Time from SCIE to support the final stages of the development of a final evaluation framework and strategy has been banked to be used after the move to a mutual has been achieved.

Joining up learning across MST services

The recommendations presented in 6.9, set in the context of austerity and uncertainty in local public service provision, suggest a range of opportunities for joining up the evaluation and learning generated across MST providers.

Limitations of this evaluation and plans for the future

Limitations of this evaluation

The evaluation was not a pilot or an evaluation of the efficacy of the MST approach or the mutual delivery model. Hence, the evaluation did not:

- evaluate outcomes for clients of CMST service
- comparatively explore the efficacy of developing and implementing a mutual model of MST delivery

The CMST's move to a mutual was delayed, and had not taken place at the time of the second visit or writing of this report. Therefore, the evaluation was unable to explore post-move staff and stakeholder perspectives and so we cannot comment on the post-move impact and outcomes for CMST, staff and other stakeholders.

The primary limitation of the cost benefit analysis is that it was conducted before CMST moved to the FPM. Therefore, it was necessary to make assumptions regarding operating costs and structure of delivery. The assumptions, however, have been agreed with all parties to be as accurate as possible. On this basis, the method can be held to be as robust a prediction of likely benefits as possible. One of the advantages of conducting the economic evaluation in advance of the move to the FPM was that it helped shape the direction of CMST development. This applies particularly to the option of having 2 MST teams which was shown by the evaluation to be the most cost effective approach. We recommend that the economic evaluation be repeated at the end of the first full year of FPM operation to update cost and benefit estimates with actual data. This will help ensure that the FPM establishes robust monitoring systems (including client tracking) to record costs and outcomes.

Appropriateness of evaluation approach

Overall, the decision to conduct a mixed methods, action research process impact evaluation of CMST's move to a mutual was appropriate. Findings have been shared with the CMST and have been used to inform and develop the preparation for the move to the FPM. However, the intended second round of post-move interviews were completed ahead of the actual move. Importantly, as our findings show, the second round of interviews did enable the evaluation to explore how preparation for the move to a mutual had developed over time, and the impact preparation had on processes, governance, staff and stakeholders.

Evaluation and CMST capacity building

Prior to the evaluation commencing, CMST were already an evidence-based service; they continue to collect extensive management information, conduct pre- and post-intervention questionnaires with clients, and collect follow-up information on cases. In line with Stands 3 and 4 of our approach, the evaluation team are working with CMST to develop an overarching framework for evaluation, which they will take forward. To date, this has involved supporting CMST to develop a logic model, which enabled the evaluation team to conduct a workshop with CMST to explore options for a realist evaluation strategy that would work over time to demonstrate service value, inform business development and organisational development and improvement. The final stage of this work will be completed after the move to a mutual has taken place.

Future evaluation

CMST intend to carry on evaluating their service, including its expansion, using the monitoring and client feedback and the cost benefit tool provided by York Consulting. The evaluation team will finish the evaluation sustainability support with the CMST after they have moved to the FPM. This will include developing an evaluation strategy and a final workshop to present and consider it with CMST staff. More generally, because of the importance of local context shown in our findings, we would suggest supporting small-scale local co-operative participative process evaluations of similar attempts to move from local authority control to a mutual. Findings, as with those reported here, at the local level can make a genuine and useful contribution to evidence-led improvement, help underpin reflective and enquiry based learning and work to enable, embed and sustain a research informed culture.

Implications and recommendations

Capacity and sustainability

Our evidence about CMSTs preparation journey so far suggests that the capacity to sustain the move to a FPM is being developed. Our evaluation shows that:

- preparation for the move has enabled CMST to engage and inform stakeholders about, and raise awareness regarding, their service and its value, and ultimately to gain CCC approval for their move to the FPM
- staff are developing ownership of the direction of their service and increased confidence in the future of CMST, the move to the FPM and the development and expansion of their services
- the governance of CMST is explained in their business plan and elements are already in place, such as the FPM project group, board and new supervision and administrative processes
- a cost benefit case demonstrating the value of the CMST has been developed, which supports the case for a second standard MST team and expanding CMST's offer
- a culture of evidence and evaluation is embedded within CMST and findings will both inform service improvement and be used to sell the service

However, there are also challenges regarding capacity and suitability. The preparation for the move has put administrative staff under strain. Also, CMST and its move to the mutual remains dependent on a few key members of staff, although CMST has sought to mitigate this risk by diversifying responsibility to other staff.

Conditions necessary for the long-term

As interviews and the cost benefit analysis indicate, the CMST's long-term future depends on:

- securing funding for a second standard MST team
- securing long-term commissions from CCC and others; our literature review suggested that a 5-year period of stability was important to developing a sustainable mutual
- continued support from the Cabinet Office, innovation funders such as DfE and the support of expert mentors
- CMST being able to harness and deploy responsibility to a wider staff base, so that it both reflects the ideals of a mutual, and mitigates the risk of being overly reliant on one or 2 key individuals

- successfully spinning out CMST and expanding services and gaining commissions regionally for these services
- being able to use longer-term monitoring and evaluation to inform service delivery and improvement, and to demonstrate value to existing and potential commissioners

Continued development and wider application

No comment can be made on continued development prior to the move to a mutual being made in relation to the service evaluated. However, there are implications to be drawn for the wider application of using a mutual mode of delivery:

- the prescriptive nature of MST service meant that while the preparation for a move to a mutual causes anxiety and uncertainty, mitigated by the reality that most staff do not experience upheaval in their actual work, which remains consistent during the move and is anticipated as not differing afterwards. This means that mutuals are able to maintain a stability and job certainty that perhaps other types of service would not be able to provide during such a transformative period of development
- the spinning-out of the MST service, the expansion of its offer to smaller authorities, and consultancy support to larger authorities to develop MST services, provides the opportunity for other MST services to apply a similar model, perhaps encouraging the development of a network of CMST-like regional MST hubs
- the approach required of a mutual to involve and engage staff in decision-making could be usefully harnessed in any care sector workplace. An organisation does not need to be a mutual to have staff representation in director-level meetings or a board, or to innovate, or to streamline decision-making. The principles underpinning CMST's preparation for the move to a mutual, and the harnessing of employee capital, are applicable to most workplaces

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Appendix A. Discussion guides and coding frame

A1 CMST staff, first sweep

Cambridgeshire MST evaluation

Interviewee code	MST [1, 2, 3 or 4]
Date of Interview	
Interviewer	

Researcher: please check the following information with the interviewee:

Introduction

SCIE have been selected by Cambridgeshire MST to undertake a process evaluation of their potential move to a mutual model of service delivery. As part of this work, we are conducting a series of one-to-one interviews with MST staff, partners and others to explore people's knowledge about, and perceptions of, these plans. Specifically, we are interested in conducting interviews before the move to a mutual model and after, so as to best explore the story and any impacts associated with the move to a new model. This interview represents the first set, before the move to a mutual begins. The interviews allows you to answer in your own words and there are no right or wrong answers and this is in no way a 'test'. You are able to end participation in the interview at any point if you need to. All information you give will be treated confidentially in line with Data Protection Act 1998. You will be assigned an interviewee code that will provide anonymity. However, should you say something that leads me to believe that you and/or someone else is at risk of serious physical and or emotional harm, I will point this out to you and I will need to discuss with you how we address this.

Are you happy to proceed with the interview?

Note to researcher: Make sure you get the consent signed. Ask for permission to record the interview (confirm on recorder).

A. Background:

1. What is your current role?

2. What do you think a mutual model/way of delivering public services means?

Probe: How do you know this?
Has your understanding changed?
How have plans been communicated?
What do you think of employing a mutual model of delivery?
Prompts: What it means to the/the service/clients/future of

3. Why is Cambridgeshire intending to move to a mutual model for MST delivery?

Prompts: Main reasons for deciding to pursue the mutual delivery, efficiency/why now now/what about the future. What does it mean for the future. What are the consequences of the bid to move being unsuccessful.

Probe: If 'don't know': Why do you think the move is being attempted?

Prompts: Why is it needed now? Going forward, in the short, medium and long term, how do you see it contributing in the future?

B. MST mutual development and delivery:

4. What does/will the move to a mutual involve?

Prompts: Preparation/actual change management and delivery/Main parts/elements/for staff/for clients
What will be the effect of the move on
- Service delivery
- Roles and Responsibilities
- Organisational structure
- Logistics

Probe: How do you know this?

Probe: If 'don't know': What do you think the move will involve?

5. What role do you think you will play in relation to Cambridgeshire's move to a mutual model of service delivery?

Prompts: direct service delivery/referrals/involvement in 'selling' the business, adapting to new team? New variants of MST.

Probe: If 'don't know': What role might you have?

6. Have you received any preparation for this role?

Prompts: Training, development undertaken to come or needed and preparation for delivery.

Probe: If 'none': What preparation if any do you anticipate needing?

7. What might be/have been the main challenges?

Probes: To what extent do you think these challenges have been addressed?

Prompts: Any particular risks? Barriers to overcome?

8. What might be/have been the main opportunities?

Probes: To what extent do you think these opportunities are achievable?

Prompts: Any particular risks? Barriers to overcome?

9. What do you think has been learnt during the current process to move to a mutual model of delivery?

Prompts: What did you learn? Who did you share it with? Why? What has changed as a result?

What has been the effect on?

- Stakeholder relations

- Relationships within the team

- Service delivery and business model

Probes: How have you shared learning?

C. Process evaluation design (scoping interviews only)

10. How could we best ensure that learning generated by our evaluation best contributes to mutual development before our final report?

11. Is there anything else you would like to add regarding the Cambridgeshire's MST service and its move to a mutual service delivery model that you thought would be covered, that has not been?

-Thank you for your time-

A2 Stakeholders, first sweep

Cambridgeshire MST evaluation

Interviewee code	MST [1, 2, 3 or 4]
Date of Interview	
Interviewer	

Researcher: please check the following information with the interviewee:

Introduction

SCIE have been selected by Cambridgeshire MST to undertake a process evaluation of their potential move to a mutual model of service delivery. As part of this work, we are conducting a series of one-to-one interviews with MST staff, partners and others to explore people's knowledge about, and perceptions, of these plans. Specifically, we are interested in conducting interviews before the move to a mutual model and after, so as to best explore the story and any impacts associated with the move to a new model. This interview represents the first set, before the move to a mutual begins. The interviews allows you to answer in your own words and there are no right or wrong answers and this is in no way a test. You are able to end participation in the interview at any point if you need to. All information you give will be treated confidentially in line with Data Protection Act 1998. You will be assigned an interviewee code that will provide anonymity. However, should you say something that leads me to believe that you and/or someone else is at risk of serious physical and or emotional harm, I will point this out to you and I will need to discuss with you how we address this.

Are you happy to proceed with the interview?

Note to researcher: Make sure you get the consent signed. Ask for permission to record the interview (confirm on recorder).

- 1. What is your current role?**
- 2. What is your knowledge of the MST service's current delivery?**
Prompts: How do you currently work with the MST service?
Probe: How closely do you work with the MST service?
- 3. What is your knowledge of what the MST service is planning to change about its mode of delivery?**

Prompts: How do you know this?
Probe: How will this change manifest itself?
Probe: If 'don't know': Terminate interview?

4. What is your understanding of the changes to the mode of delivery, what does it mean to you?

Prompts: How will the move affect you in your role?
Probe: Do you think it will affect the way the therapeutic service is delivered?
Probe: If 'don't know': What do you think the move will involve?

5. What does the change to the mode of delivery mean for the council?

Prompts: Will it affect direct service delivery/referrals?
Probe: If 'don't know': What role might you have?

6. Do you have any unanswered questions or concerns about the future of the MST service?

Prompts: Do you know enough about what the change will involve?
Probe: Do you know how it will impact on your role?

-Thank you for your time-

A3 CMST staff, second sweep

Family Psychology Mutual evaluation

Interviewee code	Family Psychology Mutual [1, 2, 3 or 4]
Date of Interview	
Interviewer	

Researcher: please check the following information with the interviewee:

Introduction

SCIE have been selected by Family Psychology Mutual to undertake a process evaluation of their potential move to a mutual model of service delivery. As part of this work we are conducting a series of one-to-one interviews with Family Psychology Mutual staff and other stakeholders to explore people's knowledge about, and perceptions of, these plans. We conducted interviews in August, when preparation for the move to a mutual was in its earliest stages. This interview, part of our second round, will help us explore and understand how your service has prepared for the move to a mutual; the changes that have happened and your experiences of it, and any intentions and expectations for the future. The interviews allows you to answer in your own words and there are no right or wrong answers and this is in no way a 'test'. You are able to end participation in the interview at any point if you need to. All information you give will be treated confidentially in line with Data Protection Act 1998. You will be assigned an interviewee code that will provide anonymity. However, should you say something that leads me to believe that you and or someone else is at risk of serious physical and or emotional harm, I will point this out to you and I will need to discuss with you how we address this.

Are you happy to proceed with the interview?

Note to researcher: Make sure you get the consent signed. Ask for permission to record the interview (confirm on recorder).

A. Background:

1. What is your current role?

Probe: How if at all, have your responsibilities/duties changed?

If different, Probe: Has this changed as a result of preparation for the move to the mutual?

Prompt: Extent to which any change are the result the move to a mutual

2. Why do you think Family Psychology Mutual wanted to move to a mutual model for delivery?

Prompts: Main reasons for deciding to pursue the mutual delivery, efficiency/why now now/what about the future. What does it mean for the future, what are the consequences of the bid to move being successful.

Probe: Have your views about the reasons and consequences for a move changed over time?

3. What do you now understand a mutual model/way of delivering your service to mean?

Prompts: Model of delivery (referrals); commissioning changes; staff involvement/input, equality, conditions of employment/how do you know this

Probe: Has your understanding about what kind of service a mutual would be, changed over time?
If it has changed: Why?
What do you think of employing a mutual model of delivery?

B. Family Psychology Mutual development and change:

4. What has the move to a mutual meant for the Family Psychology Mutual service?

Prompts: Preparation/actual change management and delivery/Main parts/elements/for staff/for clients

Probes: What has it meant, in terms of changes, if any, for:
- Service delivery
- Staff roles and Responsibilities
- Organisational structure
- Logistics (including referrals)
- Funding (business development/funding diversification)
- Clients

5. What has the move to a mutual meant for your contribution to the Family Psychology Mutual service?

Prompts: Changes in relation to how you contribute to the service/including decision-making, direct service delivery/referrals/involvement in 'selling' the business, adapting to new team? New variants of Family Psychology Mutual. Any changes in the way you work with clients.

Probe: Do you think there will be other changes for you?
How do you feel about these changes?

6. What, if any, preparation have you had for the changes to the service?

Prompts: Training, development undertaken, to come, or needed and preparation for delivery.

Probe: If 'none': What further preparation, if any, do you need?

Probe: In terms of supporting development, what if any support with development do you think the Family Psychology Mutual service would benefit from over the next few months?

7. What have been the main challenges?

Prompts: Getting support from Council/making the case/any difference in what you had expected/imagined to be challenges/organizing the business plan/negotiating roles and responsibilities, information sharing internally, getting questions answered, being clear about the reasons and implications for the move

Probes: To what extent do you think these challenges have been addressed?

8. What do you now see as the main opportunities of the move to a mutual?

Prompts: Service/client side/commercial, for instance, efficiencies, diversification, scope of provision, spinning out the service; diversifying funding base/any difference in what you had expected/imagined to be opportunities

Probes: To what extent do you think these opportunities have already been realised?

Prompts: What is going to help/hinder the future of the service?

9. What was learnt during preparation for the move to a mutual model of delivery?

Prompts: For you/for the service/what did you learn? Who did you share it with? Why? What has changed as a result?

Probes: What would you say has been learned in relation to?

- Stakeholder relations
- Relationships within the team
- Service delivery and business model
 - Staff roles and Responsibilities
 - Organisational structure
 - Logistics (including referrals)
 - Funding (business development/funding diversification)
 - Clients

Probe: If another colleague/service was thinking about a similar development for their service what advice would you provide? (managers only?)

Prompts: Staff involvement, planning, time

C. Reflections and looking at the future:

10a. So far, what do you think have been the benefits of the move to a mutual?

Prompts: Service delivery/work with clients/your role/for the clients

Probe: What other benefits do you anticipate/expect?

10b. What plans are in place (that you are aware of) to evaluate your service?

Prompts: In relation to external relationships, service delivery, service governance, impact and outcomes for clients?

Probe: What do think evaluation going forward should focus on?

Prompts: What key questions need answering? Impact of changes to service delivery, external relations, outcomes for staff, outcomes for clients, client experience, spinning out of the service, CBA?

Probe: How is the service collecting/planning to collect 'evidence'?
What role will/could you play in helping evaluate what your service does?
How do you think SCIE might best support you at this point in developing your approach to evaluation going forward?

- 11. In what ways do you think SCIE could help your service prepare for the future?**
- 12. What would you say to other similar public services considering or undertaking a move to a mutual?**
Prompts: Challenges/what to avoid/what works well
- 13. Is there anything else you would like to add regarding the Cambridgeshire's Family Psychology Mutual service and its move to a mutual service delivery model that you thought would be covered, that has not been?**

-Thank you for your time-

A4 Stakeholders, second sweep

Cambridgeshire MST evaluation

Interviewee code	MST [1, 2, 3 or 4]
Date of Interview	
Interviewer	

Researcher: please check the following information with the interviewee:

Introduction

SCIE have been selected by Cambridgeshire MST to undertake a process evaluation of their potential move to a mutual model of service delivery. As part of this work we are conducting a series of one-to-one interviews with MST staff, partners and others to explore people's knowledge about, and perceptions of these plans. Specifically, we are interested in conducting interviews before the move to a mutual model and after, so as to best explore the story and any impacts associated with the move to a new model. This interview represents the first set, before the move to a mutual begins. The interviews allows you to answer in your own words and there are no right or wrong answers and this is in no way a 'test'. You are able to end participation in the interview at any point if you need to. All information you give will be treated confidentially in line with Data Protection Act 1998. You will be assigned an interviewee code that will provide anonymity. However, should you say something that leads me to believe that you and/or someone else is at risk of serious physical and or emotional harm, I will point this out to you and I will need to discuss with you how we address this.

Are you happy to proceed with the interview?

Note to researcher: Make sure you get the consent signed. Ask for permission to record the interview (confirm on recorder).

- 1. What is your current role?**
- 2. What is your knowledge of the MST service's current delivery?**
Prompts: How do you currently work with the MST service?
Probe: How closely do you work with the MST service?
- 3. What is your knowledge of what the MST service is planning to change about its mode of delivery?**

Prompts: How do you know this?
Probe: How will this change manifest itself?
Probe: If 'don't know': Terminate interview

4. What is your understanding of the changes to the mode of delivery, what does it mean to you?

Prompts: How will the move affect you in your role?
Probe: Do you think it will affect the way the therapeutic service is delivered?
Probe: If 'don't know': What do you think the move will involve?

5. What does the change to the mode of delivery mean for the council?

Prompts: Will it affect direct service delivery/referrals?
Probe: If 'don't know': What role might you have?

6. Do you have any unanswered questions or concerns about the future of the MST service?

Prompts: Do you know enough about what the change will involve?
Probe: Do you know how it will impact on your role?

-Thank you for your time-

A5 CMST focus group, first sweep

Number/profile participants	MST [1, 2, 3 or 4]
Date of Interview	
Facilitator	

Researcher: please check the following information with the participants:

Introduction

SCIE have been selected by Cambridgeshire MST to undertake a process evaluation of their potential move to a mutual model of service delivery. As part of this work we are conducting a series of one to one interviews and focus groups with MST staff, partners and others to explore people's knowledge about and perceptions of these plans. Specifically, we are interested in conducting focus groups before the move to a mutual model and after, so as to best explore the story and any impacts associated with the move to a new model.

This focus group is intended to look at what moving to a mutual looks like to you. The normal rules of respect apply; we would prefer it if only one person were to speak at a time. I will set some general discussion topics but then allow the group to determine the content and specific direction the discussion takes. All information you give will be treated confidentially, in line with Data Protection Act 1998. Are you happy to proceed with the discussion?

Note to researcher Ask for permission to record the group (confirm on recorder).

Logistics: generally use flip chart to record and focus discussion; possible to refer back to key issues.

1. **How do you think a mutual model of delivery differ from the one used at the moment?**
2. **Why is a mutual mode of delivery being considered/attempted?**
3. **What do you think it's going to take to successfully move to a mutual mode of delivery?**
4. **What does the journey mean for you and what you do?**
5. **What will getting the mutual mode of delivery right look like (how will you know when you're there?)**
6. **What is there on the journey to a mutual that would prove challenging?**

A6 Coding frame

ROOT – 1. How does the mutual mode of delivery compare with experiences of delivery prior to the move to a mutual model?

Branch –

Security and Sustainability

Multi-Systemic Therapy as a Model

Expansion of the Service

Staff contribution, involvement, ownership.

ROOT – 2. What are the processes involved in the move from a public to a mutual mode of delivery?

Branch –

Motivations for Move to a Mutual

Staff Involvement

Improvements to the service

Process of the Move to a Mutual

Strategic Buy-In

ROOT – 3. What works in developing a mutual model of delivery in Cambridgeshire (what are the challenges)?

Branch –

Rationale for the move, planning, preparation and governance

Engaging and persuading partners and decision-makers

Process of the Move

The Position of MST in the Local Authority

The Future

Involving and engaging staff

Challenges

Responding to challenge and change

Dealing with and addressing questions

Designing delivery

ROOT – 4. What professional development and/or support materials work to help develop a mutual model of delivery?

Branch –

Development of materials to deliver a new business model.

Support and training around: Networking and selling the service

Communications, briefings, minutes

Second sweep???

ROOT – 5. What learning is useful to those outside Cambridgeshire in adopting a mutual model of delivery?

Branch –

Timing and decision making

Making the case / Rationale

Engaging Stakeholders

Engaging and involving staff

Milestones, deliverables, monitoring and tracking progress

Flexibility in a transformation environment

Local service delivery, transparency, accountability and statutory provision

ROOT – 6. How can MST impact and outcomes for both the service and clients be best evaluated by Cambridgeshire's MST in the medium and longer term?

ROOT – 7. What opportunities exist for joining up learning and evaluation coming out of other MST programmes and projects?

Appendix B. Additional contextual information

Cambridge County Council (CCC) comprises 5 district councils, which form the lower part of a two-tier system of local government: Cambridge, East Cambridgeshire, Fenland, Huntingdonshire and South Cambridgeshire. Since the 2011 Census, the population of Cambridgeshire has increased by 5.1% to an estimated 653,000 in 2016.³ The County has a significant ageing population, with older people (65+) accounting for 18% of the overall estimated population in 2016, but expected to make up 25% in 2039. The number of children and young people (aged 0-19) is approximately 150,000. This demographic group currently represents 23% of the whole population but is projected marginally to decrease to 21.5% by 2039.⁴ For the last ten years, the economic performance of Cambridgeshire has been consistently better than the East of England and East Anglia regional averages, and the UK average. The Gross Value Added per head has seen a steady increase from £19,340 in 2004 to £27,023 in 2014.⁵ Data for the period July 2015-June 2016 shows that Cambridgeshire has an employment rate of 78.7%, which compares favourably with the East of England regional average (77.1%) and Great Britain's significantly lower average (73.8%).⁶ The unemployment rate for the same period was 4.1%, slightly higher than the 3.7% rate in the East, but one point lower than the 5.1% rate in Great Britain.⁷ Only 1.07% of Cambridgeshire Lower Super Output Areas are among the most deprived 10% nationally, while the County as a whole ranks 133 out of the 152 local authorities in England, in the Index of Multiple Deprivation average (where a local authority with a rank of 1 is the most deprived, and the area ranked 152 is the least deprived).^{8,9} There are, however, significant variations across the districts, with deprivation concentrating in Fenland and urban areas and South Cambridgeshire being the least deprived.¹⁰ The Marmot indicators 2015, measuring the social determinants of health, health outcomes and social inequality, show that for the majority of measures Cambridgeshire fared considerably better than the England average, or that variations were not significant. The County, however, performed

³ Office For National Statistics, "2014-Based Subnational Population Projections for Local Authorities and Higher Administrative Areas in England: Table 2," (Fareham: Office For National Statistics, 2016).

⁴ Ibid.

⁵ "Regional Gross Value Added (Income Approach), 1997 to 2014," (Newport: Office for National Statistics, 2015).

⁶ "Nomis: Labour Market Profile - Cambridgeshire," (Newport: Office for National Statistics, 2016).

⁷ Ibid.

⁸ Great Britain. Department for Communities and Local Government, "English Indices of Deprivation 2015: File 11 Upper-Tier Local Authority Summaries," (London: Great Britain. Department for Communities and Local Government, 2015).

⁹ The Indices of Deprivation 2015 is based on 7 domains of deprivation: income deprivation; employment deprivation; education, skills and training deprivation; health deprivation and disability; crime; barriers to housing and services; living environment deprivation. In addition to the Index of Multiple Deprivation and the 7 domain indices, there are two supplementary indices: the Income Deprivation Affecting Children Index (IDACI) and the Income Deprivation Affecting Older People Index (IDAOPI).

¹⁰ Cambridgeshire County Council, *Business Plan for Cambridgeshire 2013-2014: Statistical Tables* (Cambridge: Cambridgeshire County Council, 2013).

significantly worse than the England average with respect to 2 key children-related indicators: the percentage with a good level of development at age 5 with free school meal status, and the percentage of GCSEs achieved at 5A*-C including English and Maths, with free school meal status.¹¹

For the purpose of this report and the implications arising from our work, we briefly reviewed CCC's performance in children's services with the group of authorities having similar socio-economic characteristics. Cambridgeshire's statistical neighbours, according to the Children's Services Statistical Neighbour Benchmarking Tool (CSSNBT), are: Oxfordshire (extremely close), Hampshire (very close), Wiltshire (VC), Bath and North East Somerset (VC), West Berkshire (VC), West Sussex (VC), Hertfordshire (VC), Worcestershire (VC) and South Gloucestershire (VC).¹² In Cambridgeshire, the rate of children in need at 31 March 2016 per 10,000 children, was 226.7, significantly lower than the rate for East England (297.0), for England (337.7)¹³ and Cambridgeshire statistical neighbours (294.92 in 2015).¹⁴ Of these, only 4.7% had a recorded disability (compared to 14.7% for the whole of East England). Of the children in need with a recorded disability, 18.9% had a behaviour related impairment and 45.5% a learning disability.¹⁵ The looked after children rate per 10,000 children aged under 18 was 46 in 2016, compared to 42.3 in Cambridgeshire's statistical neighbours, 49 in the East of England, and 60 in England. The data on child protection measures shows that the rate per 10,000 of referrals to Children's Social Services was 340.60 in 2015, significantly lower than its statistical neighbours (401.93), East of England (409.8), and England (548.3).¹⁶ In 2014 the percentage of children under 16 in low income families in Cambridgeshire was 12.9%, slightly higher than in comparable localities (12.66%) but significantly lower than in England (20.1%). The data on youth offending shows that, compared to its statistical neighbours, in 2015, Cambridgeshire had the lowest number of first time entrants aged 10-17 to the youth justice system (264.7 Vs. 332.09).¹⁷ In addition to the comparator groups used in NFER Children's Services Statistical Neighbour Benchmarking, other approaches are employed to measure degrees of similarities between local authorities. The CIPFA Nearest Neighbour Model uses a range of socio-economic variables to generate comparator groups for each local authority. The model indicates that Cambridgeshire Nearest Neighbours (County Councils only) are Oxfordshire, Warwickshire, Gloucestershire, Leicestershire, Suffolk, Worcestershire, Buckinghamshire, Hampshire, Northamptonshire, Somerset,

¹¹ University College London. Institute of Health Equity, *Marmot Indicators for Local Authorities in England, 2015 - Cambridgeshire* (London: University College London. Institute of Health Equity, 2015).

¹² National Foundation for Educational Research, "Children's Services Statistical Neighbour Benchmarking Tool," (Slough: National Foundation for Educational Research, 2014).

¹³ Great Britain. Department for Education, "Characteristics of Children in Need: 2015 to 2016," (Manchester: Great Britain. Department for Education, 2016).

¹⁴ "Local Authority Interactive Tool," (Manchester: Great Britain. Department for Education, 2016).

¹⁵ "Characteristics of Children in Need: 2015 to 2016."

¹⁶ "Local Authority Interactive Tool."

¹⁷ Ibid.

Staffordshire, Essex, North Yorkshire, Hertfordshire and West Sussex.¹⁸¹⁹ The Cambridgeshire comparator group, comprising all types of local authorities with similar characteristics (except non-metropolitan districts), includes Oxfordshire, Leicestershire, Wiltshire, Warwickshire, Gloucestershire, Central Bedfordshire, Worcestershire, North Yorkshire, Suffolk, Northamptonshire, Cheshire East, Shropshire, Staffordshire, Somerset, Bath & North East Somerset.²⁰

¹⁸ Chartered Institute of Public Finance & Accountancy, "Nearest Neighbours: Interactive Database," (London: CIPFA, 2016).

¹⁹ The list of statistical neighbours is based on the following indicators: Population, Population aged 0 to 17, Population aged 75 to 84, Population aged 85 plus, Output Area Density, Output Area Based sparsity, Tax base per head of population, % Unemployment, Retail premises per 1,000 population, Housing benefit caseload (Percentage of population in receipt), % of people born outside UK and Ireland, % of households with less than 4 rooms, % of households in social rented accommodation, % of persons in lower NS-SEC (Social groups), Standardised morbidity ratio for all persons, Authorities with a coast, Non-Domestic rateable value per head of population, % of properties in Bands A to D, % of properties in Bands E to H, Area cost adjustment (other services block)

²⁰ Ibid.

Appendix C. Economic evaluation tables

Table 2: Outcomes observed on exit

	Preventing LAC status outcomes	
	No.	% of cases
Prevented LAC	14	78%
Reunification	2	11%
BASE	18	100%

	Reduced reliance on services outcomes	
	No.	% of cases
Closed to SC	15	44%
Closed to SC & YOS	2	6%
Stepped down	1	3%
Closed to YOS	1	3%
BASE	34	100%

	Progress against overarching goals	
	No.	% of cases
Physical aggression	29	85%
Verbal aggression	23	68%
Attendance at school	21	62%
Behaviour at school	11	32%
Substance misuse	8	24%
Family relationships	7	21%
Offending behaviour	6	18%
Reduced offending	6	18%
Curfew	5	15%
Family conflict	5	15%
Peers	4	12%
Risk taking behaviour	3	9%
Personal hygiene	2	6%
Anti-social behaviour	1	3%
Anxiety	1	3%
Boundaries	1	3%
Family communication	1	3%
Living arrangements	1	3%
Oppositional behaviour	1	3%
BASE	34	100%

Table 3: Total financial benefits of support

	Preventing LAC status	
	No.	Benefit
Prevented LAC	14	£639,200
Reunification	2	£95,200
Total	16	£734,400

	Reduced reliance on services	
	No.	Benefit
Closed to SC	15	£40,698
Closed to SC & YOS	2	£12,952
Stepped down	1	£468
Closed to YOS	1	£3,620
Total	19	£57,738

	Progress on overarching goals	
	No.	Benefit
Behaviour at school	11	£106,125
Physical and verbal aggression	29	£68,064
Reduced offending	6	£38,000
Attendance at school	21	£31,926
Substance misuse	8	£25,157
Offending behaviour (including theft)	6	£18,100
Anti-social behaviour	1	£673
Total	82	£288,046 (due to rounding from £288,045)

Table 4: MST 2014/15 and MST mutual comparison

		MST 2014/15	Mutual (1 team)	Mutual (2 teams)	Change (2014/15 to a 2 team Mutual)
A:	Number of teams	1	1	2	+1
B:	Annual caseload	34	35	80	+46
C:	Proportion edge of care	53%	65%	65%	+12%
D:	Delivery cost per case	£10,558	£10,256	£8,975	-£1,583
E:	Average benefit (edge of care cases)	£52,032	£52,032	£52,032	£0
F:	Average benefit (non-edge of care cases)	£8,976	£8,976	£8,976	£0
G:	Total benefits (edge of care) B × C × E	£936,576	£1,183,728	£2,705,664	+£1,769,088
H:	Total benefits (non-edge of care cases) B × (100% - C) × F	£143,616	£109,956	£251,328	+£107,712
I:	Total benefits* (all cases) G + H	£1,080,192	£1,293,684	£2,956,992	+£1,876,800
J:	Total delivery cost B × D	£358,977	£358,977	£717,994	+£358,997
K:	Fiscal return on investment I ÷ J	3.0	3.6	4.1	+1.1
L:	Total service cost	£430,772	£430,772	£825,693	+£394,921
M:	Whole service FROI I ÷ L	2.5	3.0	3.6	+1.1



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