Appendix 4

Family Hub model options

1. A Task and Finish group was established to identify the likely benefits and associated risks of the different delivery options available to the council, including in-house arrangements. Membership of this group comprised CYP, CWB, Procurement and Transformation officers. The main options explored by the sub-group were:

    - **Commissioned as a single contract** for the whole service. Family Hubs commissioned as part of an integrated service with Public Health 0-19 years' service. The lead provider or consortium would have responsibility for management and delivery, bringing in other delivery partners as required. The provider would be able to meet the requirements for employing Health Professionals and have experience with managing social care, early years and educational requirements.

    - **In-house** – Management and delivery of Family Hubs, including the Public Health 0-19 years' service currently provided by Central London Community Healthcare (CLCH) NHS Trust, would be achieved through in-house arrangements. The Early Help service could manage the Hubs and create strong partnerships across the sector, negotiating delivery of other council and voluntary sector services as identified by local needs analysis and consultation.

    - **Joint arrangements (hybrid model)** – Key elements of the Family Hub model would be delivered in-house from September 2020. This would include parts of what are currently delivered through the Barnardo's Children's Centre contract, including operational management of the buildings and delivery of some of the services that are retained in the Family Hub model, as well as new services that are introduced (e.g. services for young people and families with children of all ages). A key challenge is to offer all of the required model if fully brought in-house, as this will possibly not achieve the required savings. The potential to have some current roles such as administrator / receptionist, Family Mentor and Early Years workers contracted to a voluntary sector partner would more likely achieve service delivery within the allocated budget. It will have the additional benefit of having voluntary sector representation at the operational board. The current contractual arrangements for the Public Health 0-19 years' service would be extended for two years with variations that allow for the fully integrated service model required. A decision on future (22/23 onwards) arrangements for children's Public Health services would be made at a later date in light of the experience of Family Hubs. Reorganisation of some of the Early Help service would facilitate this arrangement.

2. **Single Contract**

2.1 In this model it is expected that a single contract would be awarded to a lead provider or consortium, instead of two or more contracts with separate providers covering different elements of the model. The lead provider would bring in other services as delivery partners as required. This would help to promote an integrated model (within

the single contract) and mitigate accountability-related risks associated with two or more separate contracts managed by the council.

2.2 This model would transfer overall responsibility for management and delivery of the service (and the associated risks) from the council to the lead provider. It should be noted that whilst the transfer of risk is desirable, it also increases the potential for reputational risk to the council in comparison to other options such as where a provider does not deliver to a high standard.

2.3 The Public Health 0-19 service is a clinical service that requires the provider to demonstrate the clinical infrastructure required for clinical service delivery, including Care Quality Commission (CQC) registration. It is expected that the lead provider would be well placed to absorb the costs of this infrastructure – clinical providers typically bear the costs of these arrangements over different contracts and services across multiple boroughs – which is a benefit attributed to both this model and the hybrid model that is not achievable in the in-house option.

2.4 A further key benefit of this model is that the provider, not the council, would be responsible for responding to and managing demographic growth and increases in demand as part of the contract, ensuring clarity of cost from the outset.

2.5 The commissioning and procurement of this type of model generates some key risks, including the chance of an unsuccessful procurement (i.e. the market not being ready) and a provider that is unable to fully deliver what is required. These risks would be mitigated through market engagement and capitalising on the council's existing links with providers, but would remain a key challenge in successfully implementing and delivering the new arrangements.

2.6 Further risks are generated by the comparative lack of flexibility in this model compared to the in-house and hybrid options. It needs the highest degree of specificity at the outset and may require additional council support to maximise local partnerships, including with voluntary and community organisations, to ensure the model meets local needs. In the context of the ending of the Troubled Families programme (April 2020) and uncertainties around replacement funding that will impact Brent's vision for its wider Early Help arrangements, this model may have the least capacity to adapt to ongoing changes in the local and national landscape.

2.7 The delivery of required outcomes in this model requires careful specification and robust contract/performance management. The role of the lead provider would primarily focus on operational management and delivery of service, with potentially less contribution to the ongoing development of the model. This would be mitigated by establishing appropriate governance arrangements, but this option may offer limited strategic grip for the Local Authority.

3. **<u>In-house</u>**

3.1 In this model, management and delivery of Family Hubs, including the Public Health 0-19 years' service currently provided by CLCH, would be achieved through in-house arrangements. A key benefit of this model would be the full control it gives the council in areas including democratic oversight, culture and values and the capacity for the new service to integrate with other areas. It would also enable to council to better utilise

local partnerships and relationships to broker and coordinate additional services, ensuring the model meets local needs.

3.2 Unlike the lead provider model, the in-house option allows the council to be flexible with its resources in response to any potential policy and funding changes (e.g. the ending of the Troubled Families programme). This is a significant benefit in the context of Brent developing a new approach to deliver wider early help arrangements, for example, the Family Solutions teams could be deployed or assimilated into the model in response to relevant changes.

3.3 This option also presents a number of unique risks. Bringing the Public Health 0-19 years' service in-house would require the council to establish and fund the clinical infrastructure needed for clinical service delivery. This would be a new and unfamiliar responsibility for the council and would include gaining CQC registration within challenging timescales and meeting ongoing clinical governance and inspection requirements, as well as the associated costs. As noted above, clinical health providers are able to spread these costs across multiple health services, but this is not possible for the council, so is expected be more expensive to deliver in-house.

3.4 Other risks unique to this option arise from TUPE implications, with the council required to provide terms and conditions, including access to pensions, equivalent to those provided by CLCH (the current provider of the Public Health 0-19 years' service). There are also additional complications from anticipated NHS staff concerns over being brought in-house; this is based on the perception that NHS terms of employment are more favourable than a local authority, which could have subsequent impacts on staff integration and recruitment and related costs.

3.5 A further risk for the in-house option is full responsibility for managing demographic growth and increases in future demand for the life of the model - as funding for the service would not be tied to a contract, additional resources may be required to respond to changes in demand.

4. **Joint-arrangements (hybrid)**

4.1 In the joint-arrangements (hybrid) model the core elements of Family Hubs would be delivered in-house from September 2020. This would include some of what is currently delivered through the Barnardo's Children's Centres contract, including operational management of the Family Hub buildings and delivery of any services that are retained in the Family Hub model (e.g. parenting programmes, family support and services for 0-5 year olds and their parents). Additional in-house services, including Family Solutions and others targeted at wider age groups, would also be introduced into the model from September 2020 as part of a transformative approach. These may be current services or replacement new/changed services to meet the outcomes required.

4.2 The current contractual arrangements for the Public Health 0-19 years' service would be extended for two years with the current provider, CLCH, and would include negotiating a contract variation to accommodate any operational changes required for the service to work from the new Family Hubs and achieve the required integrated services. This would create a hybrid model with the clinical services (and challenging clinical infrastructure requirements) remaining with an external provider, but the core

elements of the old Children's Centre / new Family Hub service returning in-house following the end of the Barnardo's contract.

4.3 This approach would enable greater sharing of risk than the in-house model and would reduce some of the risks of single contract failure presented by the lead provider model. It would also retain many of the benefits presented by the in-house model, including better utilisation of local partnerships and relationships, flexibility to deploy resources in response to future funding and policy changes and the council retaining control over governance.

4.4 By extending the CLCH contract for two years and bringing the other elements in-house, this option would support incremental development of the model (in contrast to the 'big bang' approach of the lead provider and in-house options). This would enable the council to learn and adapt to changes over the first two years, providing a strong platform to refine the model when the extended CLCH contract expires in 2022. This approach would also provide more flexibility in the context of ongoing uncertainty relating to NHS and Public Health funding.

Summary

5.1 The table below provides a summary of the benefits and risks (and mitigations) identified for each model.

Option	Benefits	Risks (*mitigations*)
Lead provider	• Transfers risk to the provider • Provider will manage demographic growth and increases in demand • Provider absorbs clinical infrastructure costs and provides assurance over clinical quality.	• Two or more providers could lead to lack of ownership and clarity re accountability (*mitigated by one contract with a lead provider)* • Unsuccessful procurement i.e. market not ready *(mitigated by market engagement prior to procurement)* • Provider unable to deliver what we want *(mitigated by existing links with providers known to deliver)* • Lack of flexibility in adapting to local and national policy and funding changes *(mitigated by contract specifications)* • Limited resources allocated for wider management structures *(mitigated by robust strategic governance arrangements and council support)*

In-house	• The council has full control of culture, values and integration • The council is best placed to drive programming and meet local needs • Allows the council to be flexible with its resource in adapting to local and national policy and funding changes	• New and unfamiliar responsibilities and costs for the council in meeting clinical infrastructure requirements; including governance, inspection and CQC registration. • Council required to resource clinical infrastructure. • Legal, financial and cultural implications of bringing NHS staff in-house i.e. redundancy, pensions and staff perception that NHS is a more favourable employer than LA • The council would have full responsibility for managing demographic growth and increases in demand • The council is responsible for all management and delivery risks
Joint arrangements (Hybrid)	• Shared risk with the commissioned service • Clinical infrastructure requirements and costs absorbed by commissioned service • The council has control of culture, values and integration • The council is best placed to drive programming and meet local needs • Allows the council to be flexible with its resource in adapting to local and national policy and funding changes • Current Early Help services could be refocussed to deliver from Hubs and manage buildings and services. • Guaranteed savings from 0-19 contract extension • Opportunities to refine and develop model over two years	• Most similar to current model, limiting transformation potential (mitigated by benefits of incremental development over two years)

Governance considerations (all models)

6.1 Strategic governance arrangements for the selected model will be developed to connect or report into the Brent Children's Trust (BCT); either directly or through an appropriate board.

6.2 Under current arrangements Children's Centres, report into the Working with Families Strategic Board (which reports into the BCT).

6.3 The optimal arrangements will balance minimal reporting layers with robust oversight, appropriate time allocation/commitment and board membership with the requisite authority, representation, knowledge and skills to cover all elements of the model (including universal, early help and clinical services).

6.4 A longlist of contracted services managed by CYP and Public Health with links to family hub outcomes (e.g. CAB information and advice, Oral Health promotion, etc.) is being developed. Under all models it is expected that these services (or parts of these services) would be required to deliver either from family hub locations or in alignment with the family hub model. The roles of these services within the selected model would be managed through non-contractual partnership governance arrangements.