



Department  
for Education

# **Evaluation of Making Integration Happen in Cornwall**

**Evaluation report**

**June 2020**

**The Institute of Public Care at Oxford  
Brookes University**

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## **Acknowledgements**

The Institute of Public Care at Oxford Brookes University is very grateful to the staff, parents, children and young people in Cornwall who gave their time and shared their experiences, views and insights with us.

## Key messages

This evaluation report concerns a project undertaken by Cornwall Council and its partners between 2017 and 2020, supported by the Department for Education's Children's Social Care Innovation Programme. It was based on a 'One Vision' Partnership Strategy for services for children and young people agreed by all key children's services partners in the county in 2017, and its purpose was to explore the potential of an Alternative Delivery Model (ADM) to achieve its strategic goal for greater integration of health, social care and education services to further improve support for families in localities across the county.

After careful consideration the ADM was rejected as a governance vehicle but more integrated services were introduced under a new 'Together for Families' Directorate within the Council in April 2019 which included staff transferred from the NHS. The Directorate continued with an ambitious long-term programme to take forward further integration of services in localities across the county. This has been achieved so far without many of the negative consequences that are often associated with major changes in services. The evaluation involved tracking the experience of those involved and considering what impact the activities undertaken were perceived to have had. Key messages from the evaluation are:

Even just considering an ADM as a vehicle for governing a large and complex set of professions and services for children and families was experienced as a time-consuming and complicated task for partners in this project. Within the current national statutory and policy context it is hard to see how a local children's services partnership such as Cornwall would be willing to develop an ADM vehicle except for smaller, single service or profession arrangements, or where existing services are clearly failing.

The governance vehicle is only a very small part of a change programme for a children's services partnership. Success in addressing operational issues such as staffing levels and information sharing are much more influential on staff perceptions of the partnership than the nature of the governance vehicle.

While it is not possible to consult or engage with every single stakeholder across a complex system such as children's services, it is crucial to be open to wide influence and flexible to adjust to new situations. In services characterised by professional autonomy such as Together for Families, successful change relies very heavily on practitioner consent, and ongoing dialogue is a key element in achieving this.

Really changing large and complex children's services organisations takes time – you need a long-term perspective and regular review to ensure you are going in the right direction.

# Executive summary

## Introduction

This evaluation report concerns a project undertaken by Cornwall Council and its partners between 2017 and 2020. Its initial purpose was to explore the potential of an Alternative Delivery Model to achieve its strategic goal for greater integration of health, social care and education services to further improve support for families in localities across the county. The project was supported by the Department for Education's Children's Social Care Innovation Programme.

## The project

The project was motivated by the ambition of Cornwall Council and its partners to improve the quality and effectiveness of services to all children, young people and their families in the county and to close the persistent gap in outcomes for the most vulnerable children and young people. It was not driven by any external requirement to improve its services. Rather it was about creating a way forward where the Council's children's services could go, for example, from a 'Good' to 'Outstanding' OFSTED evaluation in the context of rising demand and reduced resources, increased statutory duties and raised standards.

It was originally intended that an ADM would be established by 31 March 2018, initially involving children's education, early years, community health and social care services. After a longer and more intensive period of options appraisal, business case development and political scrutiny than originally planned, the Council rejected the case for the ADM, elected members seeing it as too risky an arrangement for them at the time. Instead it agreed in November 2018 to the development of an integrated Children's Services Directorate within the Council, with a distinct identity and enhanced governance arrangements. The intended population outcomes and service priorities remained broadly the same as for the original ADM. The new Directorate was launched on 1 April 2019 and children's community health staff were transferred at that point. Between then and March 2020, the Directorate worked to further embed an integrated approach to supporting children and families and improving outcomes across the county.

## The evaluation

The evaluation of the project focused on developing a realistic understanding of the approach taken and the impact of the changes made on services, staff, children and families. Key questions were explored in 5 areas:

- Structural and practice changes
- Accurate costs
- Process
- Early impact on the experience of children, young people and families
- Early impact on the workforce

The evaluation was not intended to provide a judgement on whether the approach to governance taken by Cornwall to the development and implementation of a new Directorate was successful or not in terms of the impact on children and families in the county as this would not be measurable in the time available. What was intended was to track the experience of those involved and consider what impact the activities undertaken were perceived to have had. To achieve this, the evaluation involved a rapid research review, interviews and focus groups with staff at 3 different points in the project, a wide staff survey at 2 different points, case file reviews and interviews with children, young people and families at 2 different points, and analysis of activity, performance and financial data from the Council and its partners throughout.

## Key findings

There were 10 key findings from the evaluation.

- Finding 1: The project was considered to have been carefully scoped and resourced prior to commencement.
- Finding 2: The pathway to approval for the ADM was more complex than planned for, and timescales for options appraisal and business case proved too optimistic.
- Finding 3: Agreeing to the very different governance model required by an ADM when services were already seen to be effective proved unacceptable to the Council,
- Finding 4: Engagement with stakeholders was continued throughout and helped leaders to maintain momentum and respond to concerns from staff.
- Finding 5: The costs of the decision-making exercise were within the original budget estimates, but precise calculations were not made.
- Finding 6: The new Directorate inherited a clear service model and a wide commitment to further integration, and was able to continue with the originally intended direction of travel.
- Finding 7: It is too early to tell whether the early help approach is having an impact on demand for more complex provision although initial feedback from families and practitioners is positive.

- Finding 8: There was no evidence that management and structural changes to the Directorate had a negative impact on families or the quality of work that they received from early help, and service improvement appeared to continue through the period.
- Finding 9: The implementation of change in the establishment and then the first operational year of the Directorate was received relatively positively by staff overall.
- Finding 10: Partners shared a common vision about more effective integration from the start. This helped maintain engagement when relationships were strained, or initiatives were struggling.

## Lessons and implications

The good practice points on ADMs identified in the rapid research review conducted at the start of the evaluation were borne out in the 10 key findings. In addition, the following lessons stand out from the experience of Cornwall Council and its partners over the course of the project:

Lesson 1: Even just considering an ADM as a vehicle for governing a large and complex set of professions and services for children and families proved a time-consuming and complicated task for partners in this project. Within the current national statutory and policy context it is hard to see how a local children's services partnership such as Cornwall would want to use the ADM vehicle except for smaller, single service or profession arrangements, or where the existing services are clearly failing.

Lesson 2: The governance vehicle is only a very small part of a change programme for a children's services partnership. Success in addressing operational issues such as staffing levels and information sharing were much more influential on staff perceptions of the partnership than the nature of the governance vehicle.

Lesson 3: While it is not possible to consult or engage with every single stakeholder across a complex system such as children's services, it is crucial to be open to wide influence and flexible to adjust to new situations. In services characterised by professional autonomy such as Together for Families, successful change relies very heavily on practitioner consent, and ongoing dialogue is a key element in achieving this.

Lesson 4: Really changing large and complex children's services organisations takes time – you need a long-term perspective and regular review to ensure you are going in the right direction.

# 1. Overview of the project

## Project context

In 2017 Cornwall Council was the lead agency for protecting and improving the health and welfare of children and young people living in Cornwall. The Council had direct control and governance of education, early years, early help and children's social care services and commissioned some children's community health services (health visiting, school nursing, and specialist health visitors) from Cornwall Partnership NHS Foundation Trust (CPFT). It also commissioned clinical child psychology and other specialist health services to meet the needs of children in its care, care leavers and children with special educational needs and disabilities. Other community health services were commissioned by NHS Kernow Clinical Commissioning Group including child and adolescent mental health services and therapy services. The council was of the view that, despite being the primary commissioner and carrying responsibility for the effectiveness of most children's services in Joint Targeted Area Reviews and Inspections, it did not have direct control of the full range of children's services nor did it have the authority to make further integration happen.

The Council and its partners were committed to integration under the existing Cornwall Devolution Deal and [One Vision](#) (the children and families element of the Sustainability and Transformation Partnership). Residents and families said they wanted integrated services, and feedback from council staff indicated that the majority believed that integrated services could achieve better outcomes for all children, especially vulnerable children at risk of poor outcomes due to adverse childhood experiences. Despite improvements it was felt by the Council that recent service advances, such as joint work on targeted care and support for those doing less well, were piecemeal and not necessarily sustainable, and that organisational barriers meant that the pace of change was too slow.

In March 2017, the Cabinet along with other partners agreed the '[One Vision](#)' Partnership Strategy for services for children and young people. Chapter five of this partnership strategy set out the commitment by the partners to move from a model of collaboration to one of integration. A bid was made to the Department for Education's (DfE) Social Care Innovation Programme in April 2017 and a grant of £1.9m was secured in July 2017 to support the council to explore the potential of an [Alternative Delivery Model](#) (ADM) to achieve its strategic goal for integration. The project was entitled 'Making Integration Happen'.

This was an ambitious and wide-ranging innovation project that aimed to provide a whole-system solution to the challenge of improving children's outcomes. Cornwall

Council intended to develop and implement an ADM involving the creation of a new, legally separate entity wholly owned by the Council.

## Project aims and intended outcomes

Making Integration Happen was initially about establishing a Council-owned Alternative Delivery Model (ADM) that integrated education, early years, children's community health, early help and children's social care services.

The proposal was motivated by the ambition of Cornwall Council to improve the quality and effectiveness of services to all children, young people and their families in the county and to close the persistent gap in outcomes for the most vulnerable children and young people. It was not driven by any external requirement to improve its services. Rather it was about creating a way forward where the Council's children's services could go, for example, from a 'Good' to 'Outstanding' OFSTED evaluation in the context of rising demand and reduced resources, increased statutory duties and raised standards.

It was originally intended that an ADM would be established by 31 March 2018, initially involving children's education, early years, community health and social care services, and it would seek to expand to include wider children's community health services in 2019. It was proposed that the ADM would be responsible for the following services:

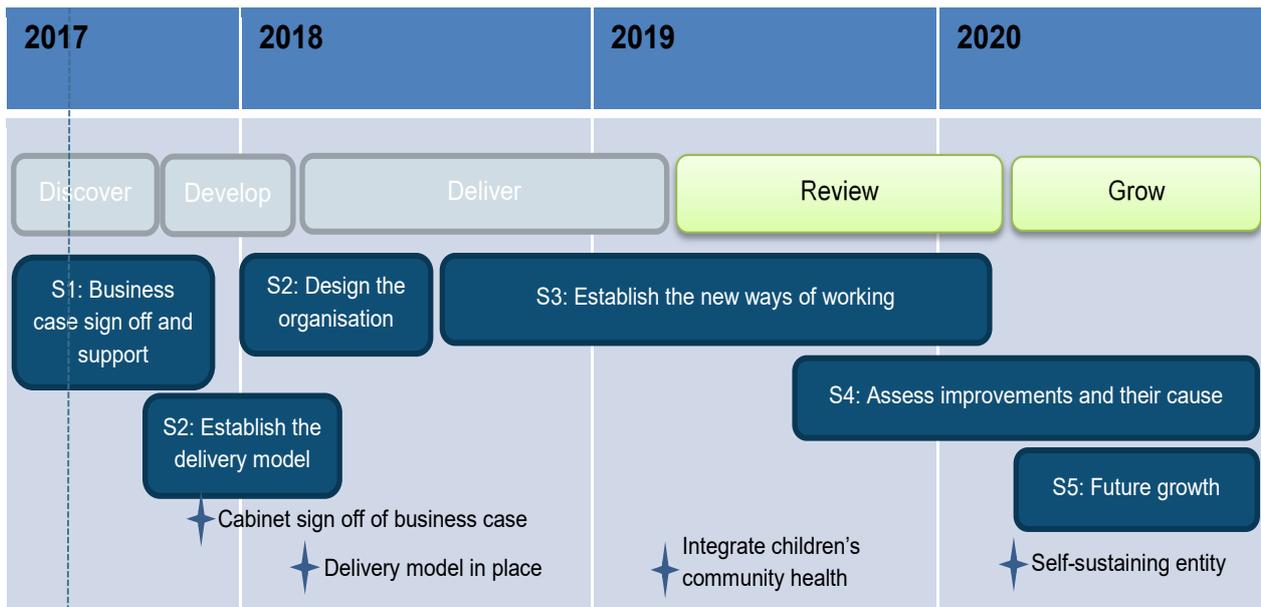
- Education and Early Years (£80.7m – 290 full time equivalent (FTE) staff)
- Children and Families (£68.4m – 804 FTE staff)
- Children's community health services (£9.4m – 239 FTE staff)

After a longer and more intensive period of options appraisal, business case development and political scrutiny than originally planned, the Council rejected the case for the ADM. Instead it agreed in November 2018 to the development of an integrated Children's Services Directorate within the Council, combining the 3 elements above, with a distinct identity and enhanced governance arrangements. The intended population outcomes and service priorities remained broadly the same as for the original ADM. The new Directorate, renamed [Together for Families](#), was launched on 1 April 2019. Between then and March 2020, Together for Families worked to further embed an integrated approach to supporting children and families and improving outcomes across the county.

## Project activities

The initial high-level project plan for setting up the ADM had five phases - Discover, Develop, Deliver, Review, and Grow – and related stages as illustrated by the project plan extract shown below. The initial detailed plan for 2017 is attached at Appendix 2.

Figure 1: ADM Project plan extract as at July 2017



The key stages and actions as originally planned, included:

### Stage 1 (S1) Articulate a compelling business case for change and secure support

- Establish the project team and project governance and agree the ADM sign off
- Communicate the vision and refine it through staff and service user engagement
- Commission specialist ADM consultants
- Develop an options appraisal exploring options for approval by September 2017
- Develop a full business case and five-year business plan for the new organisation, for Cabinet sign off in November 2017

### Stage 2 (S2) Establish the organisation and delivery model

- Determine arrangements for governance, legal set-up, staff transfer, workforce development, property, ICT, support services etc.
- Establish the new organisation by 31 March 2018, including recruiting to the key roles and transferring key staff to the new organisation

### Stage 3 (S3) Establish the new ways of working

- Formulate the new arrangements for integrated working during 2018/19
- Negotiate or bid for the integration of relevant community health services to the new organisation by April 2019

### Stage 4 (S4) Assess improvements and their cause

- Consolidate the new delivery model in 2019/20
- Complete the evaluation

## **Stage 5 (S5) Institutionalise the change and future growth**

- Institutionalise the change in Cornwall and expand outside of Cornwall from April 2020 onwards, for example: bid for relevant contracts outside of Cornwall, and provide a consultancy service for intervention and support

A key assumption in the theory of change for the project (see Appendix 1) was that the creation of the ADM would better enable a model of locality-based, multi-disciplinary teamwork that would lead to more effective early help for vulnerable children, young people and families. It was intended that this would, in the longer term, play a significant role in ensuring that fewer children or young people escalated within the social care system (to child protection and substitute care), and that partners would be able to close the gap between the education and health outcomes for vulnerable children and those of the rest of the children's population in the county.

This assumption was tested and challenged during stages 1 and 2 as the Council and its partners explored organisation options in detail, and then agreed on a different option to the original proposed ADM. The period for this was extended by one year from the original plan to 1 April 2019 when the new Directorate entitled 'Together for Families' was established.

The new Directorate was significantly different from previous arrangements. Its ambition was to drive forward with co-located teams, joined-up interventions, referral and service pathways and management arrangements to support more effective early help and better outcomes for children and families. It comprised 3 service areas:

- Children and Families Services
- Education Services
- A new Children's Health and Wellbeing Service

The organisation arrangements were applied as planned in 2019 and the period from April 2019 – March 2020 consisted primarily of establishing and consolidating the new Together for Families services and delivery model, and in particular assimilating NHS staff into the Children's Health and Wellbeing Service. There was not sufficient enthusiasm in either the NHS or the Council to move further and integrate additional community services such as midwifery (which had been suggested as a possibility originally), and the original ambition to expand services beyond Cornwall was paused in favour of continued consolidation of the service model across Cornwall.

By the end of March 2020, Together for Families had been established for a year, an appropriate point to consider the findings from the evaluation.

## 2. Overview of the evaluation

### Evaluation questions

Making Integration Happen had a range of objectives that it aimed to achieve through the development and implementation of an ADM at a large county scale. The evaluation sought to identify what structural, governance and practice changes were proposed and applied by the Council and whether and how these were implemented, and at what cost. It also aimed to identify the early impact that these changes had on children and families, leadership, workforce, partnerships and practice quality. The evaluation questions were:

#### **A) Structural and practice changes**

1. What structural (for example: operating models) and governance changes were implemented and why?
2. How did delivery arrangements and practice change as a result of the ADM?
3. What resources were required to make these changes?
4. Were these changes made as originally planned, and to what timescale?

#### **B) Accurate costs**

1. How accurate were the budgeted set-up costs?
2. How accurate were the operational budget projections?
3. What factors affected the accuracy of these budgets?

#### **C) Process**

1. What steps were involved in setting up a successful ADM?
2. How did the introduction of the ADM impact on working relationships within the wider professional partnership landscape?
3. What were the key lessons learnt from the process of introducing an ADM?
4. What can other local authorities learn from the set up and implementation of the ADM?

#### **D) Early impact on the experience of children, young people and families**

1. To what extent did perceptions of children, young people and families accessing early help services improve over the period?
2. How did children, young people and families access support within their communities over the period?

3. Have were children, young people and families empowered to be able to do more for themselves and for others?

## **E) Early impact on the workforce**

1. How was the move to the ADM experienced by professional and managerial staff?
2. To what extent did the ADM improve job satisfaction and staff retention?
3. To what extent did the implementation of the ADM improve the quality of professional practice?

## **Evaluation methods**

In April 2018, the Institute of Public Care (IPC) at Oxford Brookes University was appointed independent evaluator for Making Integration Happen. The following evaluation process and methods were agreed and undertaken:

1. Preparation and set-up (April 2018 – August 2018):
  - Obtained ethics committee consent to proceed with the planned evaluation
  - Produced an evaluation framework for the programme, to inform data collection by evaluators and the site itself, and developed research tools
  - Undertook an [ADM rapid research review](#)
2. Baseline research (June 2018 - August 2018):
  - Mapped models of working and analysed costs and performance data
  - Undertook semi-structured interviews and focus groups with 57 staff and stakeholders
  - Surveyed the children's services workforce within the Council and CPFT
  - Undertook case file analysis of 30 children, young people or families accessing early help services and semi-structured interviews with 14 of these families
3. Interim evaluation (May 2019 - June 2019)
  - Semi-structured interviews with staff and stakeholders
  - Focus groups with staff and stakeholders
4. Final evaluation (January 2020 – March 2020)
  - Mapped models of working and analysed costs and performance data
  - Semi-structured interviews and focus groups with staff and stakeholders
  - Surveyed the children's services workforce within the Council

- Analysis of 30 case files and semi-structured interviews with 11 children, young people or families accessing early help services

The evaluation was completed in March 2020.

## Evidence review good practice points

In addition to developing the evaluation questions in the set-up stage, IPC undertook a rapid research review to consider lessons from previous exercises to change governance or move to an alternative delivery model in health, education and social care services, and generated a series of good practice points to inform more detailed analysis of the journey experienced in Cornwall. These suggest :

- The need to clarify the purpose and drivers for the development of a local ADM
- Focus on outcomes and improvements first before considering the structural changes needed to achieve them
- Place a strong emphasis on engagement - engage early in the design process for an ADM before final decisions are made
- Identify the ongoing commissioning and performance monitoring roles in the council for the ADM
- Specify how governance arrangements will involve local partners and stakeholders
- Have clear and inclusive governance and leadership during transition with roles and responsibilities defined in order to build trust and avoid confusion
- Maintain a holistic approach to children's services to allow the new organisation to quickly establish wider networks and address problems end-to-end
- Be clear that any merger is for the creation of a new organisation, not a takeover by one organisation or the other
- Carefully plan system integration and do not underestimate the effort required to achieve this
- Take a wider view of health, wellbeing and outcomes for children and families and communities, including looking at the intended focus and impact of early help approaches
- Do not assume that one governance model is inevitably better than others. Be able and ready to explore how different models can achieve the same goals.

## Changes to evaluation methods

There was a change to the evaluation methodology from the original design. A combination of slight delays to completing a data sharing agreement and signing-off the final evaluation plan, a joint inspection (capacity from the council was diverted), and delays to the planned ADM process meant that the workforce survey and case file analysis (baseline research) needed to be undertaken later than originally planned.

The timescales for agreeing the ADM were put back on several occasions, which required IPC to re-plan the evaluation and allocate additional resource to understanding the complexities of the process (as well as interviewing staff about past activities completed before the evaluation was agreed). A key enabling factor in the evaluation was regular contact between the evaluators and the Council's programme team. IPC jointly reviewed the evaluation plan on an ongoing basis and rescope the activities and timescales to better fit the ADM process as it evolved.

Because the Council decided in November 2018 not to proceed with the ADM and to develop and implement the new Together for Families Directorate, the research questions which were originally focused specifically on the ADM were adjusted to be applied to the revised model.

The final month of the evaluation coincided with the onset of the Covid-19 virus response in the UK and this had a small impact on the availability of performance and activity data from the Council to inform the final report.

## Limitations of the evaluation

The evaluation was not designed to assess whether the approach to governance taken by Cornwall to the development and implementation of a new Directorate was successful or not in terms of the impact on children and families in the county. Governance is only one of a wide range of factors involved in influencing the impact of services, and cannot be separated out, particularly in the timescales available for the evaluation. What was intended was to track the experience of those involved and consider what impact the activities undertaken during the process to develop the new governance arrangements were perceived to have had.

As with any such 'process' evaluation, the final purpose is to offer insights and ideas which might be useful to other agencies in a similar position in the future. Their circumstances will always, inevitably, be different, but they may well benefit from considering some of the successful practices and challenges experienced in this project.

## 3. Key findings

### Deciding on the governance model April 2017 – March 2019

This section focuses on the period prior to the decision to establish a new Directorate in April 2019.

#### The original budget and project plan

The Leadership Team in the Council went into this project with a clear understanding that it would require significant resources. Research and consultation with colleagues undertaking similar programmes of innovation elsewhere in the country had indicated a budget of over three million pounds over three years would be needed to set up an ADM.

Funding of £3,341,215 over three years was allocated. This consisted of £673,933 committed by the council, of which £150,000 was committed from the Troubled families partnership budget, £767,281 worth of contributions in kind (CiK) by Council officers and partners, and the £1,900,000 grant from the Department for Education.

According to Council data the combined annual spend of the services involved was approximately £158.5m per annum, so the investment represented some 0.7% of the total budgets involved over the three years. The cash investment from the Council represented rather less than this at 0.14% of the total budgets involved over three years.

The original estimated costs of exploring and setting up the ADM are shown in Table 1 below, which sets out the key set-up (non-recurrent) costs in the set-up period and the initial operating period. There would also be recurring costs for the council beyond the life of the programme due to new posts such as additional staff to the senior leadership team.

**Table 1: ADM projected budget as at July 2017**

<b>Cost line</b>	<b>Year 1</b>	<b>Year 2</b>	<b>Year 3</b>	<b>Total</b>
Programme management	£152, 831	£223,599	£183,612	£560,042
Core support team	£127,193	£198,513	£154,775	£480,481
Consultancy and advice	£75,000	£55,000	£25,000	£155,000
Programme evaluation		£50,000	£45,000	£95,000
Engagement, communication and design	£65,000	£83,000	£16,000	£164,000
Partnership costs/research	£43,500	£58,000	£58,000	£159,500
IT investment	£27,158	£137,499	£12,000	£176,657
Board members	£27,000	£70,000	£70,000	£167,000
Dissemination of learning		£30,000	£69,500	£99,500
Workforce development		£197,449	£170,000	£367,449
New service director	£10,907	£123,398		£134,305
Recruitment and marketing	£15,000			£15,000
<b>Total before CiK</b>	<b>£543,588</b>	<b>£1,226,458</b>	<b>£803,887</b>	<b>£2,573,934</b>
Staff contribution in kind (CiK)	£245,354	£260,191	£261,736	£767,281
<b>Total cost</b>	<b>£788,942</b>	<b>£1,486,649</b>	<b>£1,065,624</b>	<b>£3,341,215</b>

Source: Figures supplied by Cornwall Council

Key areas of expenditure included:

- The appointment of a full time Programme Manager and two Project Managers and an administrator
- Specialist legal and financial advice (for example on VAT and tax) as well as specialist ADM consultancy from Mutual Ventures
- Backfill for a core support team from Legal, HR, Finance, Property, and IT
- The engagement of Volunteer Cornwall to support co-production work
- The information system development costs to transfer children's community health staff to the Council's system
- Engagement with staff, people who use services and the wider resident group in focus groups, workshops and events to build support for the new model and ensure the model is co-produced
- An ADM board chair and 8 non-executive directors

- Appointment of a Service Director for children's community health
- Contributions in kind from Cornwall staff were estimated based on the percentage of (mostly senior) staff time in the year that would be spent exploring and setting up the ADM – from 5 % to 25 % of people's time

The team swiftly developed detailed project plans and project management arrangements to ensure that resources and activities were managed carefully and that they were able to be adjusted as the project progressed.

**Finding 1: The project was considered to have been carefully scoped and resourced prior to commencement.**

Senior officers considered that a significant budget was set aside for the project and a clear outline plan in a series of stages was established. Governance arrangements were established focusing in particular on internal Council arrangements.

**The pathway to a decision – options appraisal and business case**

The leadership within the Directorate was keen to drive forward the work at pace and quickly established a project team with the capacity to prepare an options appraisal and business case and deliver a communications strategy. The project team comprised dedicated project managers and a backfilled core support team as well as support from a senior responsible officer.

The Council began the options appraisal at the start of June 2017. Initial expectations were for a decision through the Council's investment and commercial board (ICB) in August 2017. However, it soon became apparent to senior officers that interest in and challenge from elected Members about the ADM was proving to be higher than anticipated. An additional series of elected Member engagement activities was organised by senior officers for summer and autumn 2017. Senior officers and Lead Members then decided that because of the level of interest shown by Members the options appraisal required Cabinet approval, which delayed the timescale for approval of the options appraisal to November 2017 and hence the target date for establishing the new organisation was delayed until September 2018.

## **Finding 2: The pathway to approval for the ADM was more complex than planned for, and timescales for options appraisal and business case proved too optimistic**

The original timescales to complete stage one and two of the ADM project plan, have the business case signed off by Cabinet in November 2017 and establish an ADM by 31 March 2018 turned out to be too optimistic. It was a further year before the options appraisal and business case were completed and the new Directorate was established.

The involvement of elected Members at this initial stage of the process was keener than anticipated and the timescales and project plan were revised to ensure full engagement with politicians. Consequently, milestones for signing off the options appraisal and business case were put back. Member engagement activities included:

- Overview and Scrutiny Committee (OSC) workshops
- Full Member briefings
- Informal Cabinet and Cabinet as well as Lead Member meetings
- [Witness enquiry day](#) – Members had the opportunity to ask questions of officers and relevant external stakeholders such as local voluntary organisations, schools, leaders from health partners and other local authorities
- Workshops with Members to review concerns raised during the scrutiny process

The original options appraisal explored potential models of service delivery to integrate education, early years, children's community health, early help and social care services. The three 'best-fit' options were considered to be:

1. Remain 'as is' and continue as a Directorate of the Council with a shift in culture and structure towards a business unit model that has an increased range and level of decision making, including the capacity to trade
2. An ADM wholly owned by the Council (a not-for-profit Company<sup>1</sup> limited by guarantee or shares or Community Interest Company)
3. An ADM under a Joint Venture with a Partner(s)

A set of key criteria and intended outcomes was developed by the Senior Management Team to inform analysis of all the potential options in an options appraisal report to the Cabinet. These included ensuring the Council retained a high level of control, allowing

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<sup>1</sup> The Teckal case sets out exemptions for contracts awarded by Contracting Authorities (like councils) to other bodies outside the application of EU procurement rules.

the flexibility to directly award or passport key aspects of children's services, and enabling the organisation to trade more widely and when appropriate to take direct control of and/or develop other children's services in order to improve outcomes. Consideration of these key criteria ruled out the creation of a charity or industrial provident society or a staff mutual as, under current regulations, the view of the Council was that this type of ADM could not receive 'passported' work or sit within the control of the Council.

The 'As is' model of delivery, even with the additional development of a business unit underpinned with a formal pooled budget arrangement between the Council and the NHS, did not satisfy all the key criteria, particularly in relation to the ability to create free schools and a multi-academy trust. A joint venture ADM was considered to have the potential to deliver many of the key criteria. Whilst there would be higher set-up and ongoing costs, a joint venture with either a health or private partner would mean sharing costs and risks. However, it would also mean sharing control and governance, as well as any revenue surpluses. In terms of sustainability, a joint venture would also rely on the sustainability of the partner organisation. At the options appraisal stage, consideration of the key criteria indicated that a Teckal-compliant ADM, wholly-owned, controlled and governed by the Council was most likely to realise the strategic goal of sustainable integration and achieve the intended outcomes. This option was seen as not without costs or risks. Its likelihood of success was considered to be enhanced with the direct award of the 0-19 public health contracts and exploring the opportunity to tender for other community health services in the future.

The options appraisal [report](#) and [appraisal](#) recommended a not-for-profit Teckal Company, limited by shares and wholly owned by the Council, and that issues identified by the task and finish group and by OSC be addressed through the development of the full business case. The report was endorsed by the ICB in September and the [Children and Families Overview and Scrutiny Committee](#) on 16 October 2017. The [Cabinet's unanimous approval](#) was given on 15 November 2017 for the development of a full business case based on the [Treasury five case model](#).

When the options appraisal was approved the project team had a target of an April 2018 Cabinet sign off for the business case. As part of the business case production, meetings and workshops were held with health partners to consider how the proposed ADM would work under the Accountable Care System and as part of the Accountable Care Partnership. Although health partners were fully supportive of integration, the Cornwall Partnership NHS Foundation Trust (CPFT) expressed reservations about the ability of a wholly Council owned Teckal Company to make integration happen. In addition, public health and the NHS Clinical Commissioning Group (CCG) commissioners were concerned about a possible legal challenge to a direct award to the ADM for public health nursing services when the contract ended on 31 March 2019.

The proposed ADM governance framework is given in the full [Business Case for an Alternative Delivery Model](#). There were further challenges and concerns from Members and additional engagement with Members and other bodies was carried out in early 2018. Additional specialist resource was also procured to support the development of the business case, particularly on the issue of VAT. Independent specialist legal advice was obtained about the direct award of the Council commissioned public health nursing services to a Teckal company wholly owned by the Council. Following scrutiny by ICB and the Corporate Directors Team (CDT) in February 2018, CDT asked for a separate options paper for public health nursing (PHN), by the Director of Public Health, to go to Members prior to the full ADM business case. This focused on three main options for PHN of a) continuing with the current provider, b) going to full procurement and c) integrating public health nursing with education, early years, early help and social care under single management.

The [options appraisal for public health nursing](#) recommended option c – the integration of PHN with Council services and [Cabinet agreed unanimously](#) on 2 May 2018 to bring PHN into a single organisation with the Council's children's services from 1 April 2019. This decision was taken regardless of whether the ADM business case was approved i.e. public health nursing would be brought under the direct control of the Council either through the proposed Teckal Company or an alternative model of service delivery.

Due to the need to first take a proposal to Cabinet on the options for PHN, the timetable for taking the ADM business case to Cabinet was further revised. The business case itself was also revised including further detail on the client side, support services and governance. Meetings with the Leader, Deputy Leader and Lead Member for Children's Services were held to monitor progress and provide direction. In April 2018 CDT reviewed the ADM business case and asked for an independent gateway review by an external organisation, to ensure the business case was robustly tested.

These delays reduced the need for programme management and legal, HR, property, finance and data analyst support from the core team in the first year, and the appointment of board members and the service director was not required. However, changes in process and timescales increased the need for specialist ADM consultancy.

The specialist ADM consultancy identified additional costs that were not originally accounted for such as Ofsted registration, payroll and HR set up costs, including rebranding of ID cards and lanyards. Additional costs linked to the transfer of PHN staff were identified as:

- Property costs, which were unknown at the bid stage
- Information Systems Project Manager - the IT requirements were significantly more than first envisioned and additional support was needed to support PHN integration

To make up the shortfall it was agreed that additional funding from the Troubled Families partnership budget would be used. The budget was increased by £355,000 and reprofiled to move costs from year 1 (2017/18) to year 2 (2018/19) to reflect changes to the process.

The independent gateway review identified that more work would be required on the detail of both the ADM and on the in-house option; a view which was shared by the Chief Executive Officer and Lead Member. The timescales and project plan were revised again to allow for more detailed testing of the ADM and to better explore an Integrated Children's Services Directorate (ICSD) as an alternative to the proposed ADM. Sign-off of the business case by Cabinet was put back until November 2018 to enable the additional work, engagement and scrutiny to be undertaken, including several rounds of engagement with the Overview and Scrutiny Committee, informal Cabinet – known as informal portfolio holder briefings (IPHB) - and CDT.

### **The pathway to a decision – a political judgement in the final stages**

It became apparent to senior officers at this time that Cabinet would not approve the ADM, and so they recommended instead the ICSD. The ICSD could deliver most of the benefits of the ADM set out in the full business case although a key loss was the potential for a wholly Council-owned Multi-Academy Trust.

It was thought by officers that such a, potentially, radical decision for the Council meant that the decision-making discussion and debate was more robust and lengthier than normal Council processes and that they did not plan for this until too late.

At the time of the Innovation Programme bid there was an election and associated purdah period and it was not possible to judge the appetite of the political leadership. As one senior officer reflected

'An error we made was not taking it to the wider political memberships early on... We had support from the Leader and Lead Member but after the [2017] election Cabinet was new and they were unsighted on the [ADM] proposal. Make sure there are no surprises whatsoever for your councillors of all parties.'

Officers acted on the suggestion by the Leader that persuading the Children's Overview and Scrutiny Committee was vital on the basis that if it was content with a proposal then Cabinet would be supportive of it. However:

'We spent a massive amount of time with Overview and Scrutiny, who were fully behind the proposal, but there were reservations in Cabinet and Cabinet are ultimately the decision makers'.

In addition, officers felt that senior Members were understandably nervous about making such a change. Cornwall had been securing improving services over the last few years and they paraphrased the concern as:

‘We’re doing well, why change it if it ain’t broke, why take this risk?’

Adding to this nervousness was the fact that the Director of Children’s Services and the two Service Directors were near retirement age and it was known that they were intending to step down in 2019, albeit that they made a public commitment to staying in post for a further two years following the set-up of the ADM to ensure its smooth initial operation. The senior management team saw the ADM as a way to sustain, after they left, the culture and service improvements that they had led over the past few years. However, for Members their imminent departure increased the risk and contributed to the Cabinet decision to go for what they perceived as the lower risk option of the ICSD. As other officers commented

‘The Directors, and [the DCS] in particular are seen as a ‘trusted adviser’ to Members. There was a nervousness, and if the personnel changed, the Members didn’t know if they would have such high levels of trust in their replacements. That’s an unknown...which is why they wanted such tight controls on the reserved matters and if you have tight controls on reserved matters the ADM is not free to do some of the things you want it to do.’

**Finding 3: Agreeing to the very different governance model required by an ADM when services were already seen to be effective proved unacceptable to the Council.**

There was no significant external requirement on the Council to reshape its services. It was not in intervention or required to adopt an ADM. Elected Members in particular were concerned to test the potential ADM in much more detail than expected and there was greater attention paid to the potential political and service risk as a result.

The full [Business Case for an Alternative Delivery Model](#) and a paper exploring an [Integrated Children’s Services Directorate](#) as an alternative to the proposed ADM were submitted to Cabinet with a recommendation to approve the [proposal to form an ICSD](#) bringing together the Council’s education, early years, community children’s health, early help and social care services as the foundation of integration to further improve the effectiveness of those services. The [Cabinet's unanimous approval](#) was given on 7 November 2018 for the development of an Integrated Children’s Services Directorate with a distinct identity and enhanced governance arrangements as the basis for making integration happen. The enhanced governance arrangements requested for the ICSD are outlined in the [Making Integration Happen](#) report by the Council in September 2018. It

was noted at that meeting that OSC was disappointed that ‘...the ADM was steered away’ and that Cabinet could still consider the benefits of an ADM in the future: ‘...the door is not closed’.

In November 2018 the project to set up the ADM was formally closed. Three interdependent projects continued under the remit of the Making Integration Happen steering group: ICSD Implementation; Public Health Nursing Transfer; and Integrated Place-Based Services (design and implementation of the future model of care).

## **The pathway to a decision – other stakeholders**

The communication and engagement workstream was ongoing throughout the options appraisal and business case development and was seen by senior officers in interviews as key to the progress of the programme. Activity was undertaken to engage with staff, trade unions, schools, the voluntary sector and people who use services as well as health partners and extensive Member engagement through the scrutiny process and Cabinet decision-making process as described above. Engagement activities included:

- Extensive (locality based) staff engagement workshops over 6 ‘rounds’ from September 2017 to December 2018, initially involving only Council staff and from July 2018 also CFT children’s community health staff
- Regular written communications to council and children’s community health staff
- Targeted workshops for the voluntary and community sector from Nov 2017 onwards
- Regular sessions with a key stakeholder group including GPs, health providers and commissioners, Police, the voluntary and community sector, Public Health, Head Teachers, Isles of Scilly Council
- Sessions with Trade Unions and HealthWatch
- Locality based engagement sessions for clients, families, town and parish councils, local Members from October 2018 onwards
- A client and carer survey at the end of 2017
- GPs and Schools surveys in May 2018

The initial staff engagement workshops were positively received with the majority of staff feeling positive about the proposal for an ADM, a large minority feeling neutral and only a very small proportion feeling negative. This was reflected in the interviews and focus groups undertaken as part of the baseline evaluation in early 2018. Most staff felt relatively positive about the changes and said they believed that integration was better for children and families. In the survey undertaken as part of the baseline evaluation in October 2018, 80% of respondents agreed or strongly agreed with the statement ‘I

understand what the Council is trying to achieve in the 'Making Integration Happen' programme' and 77% agreed or strongly agreed with the statement 'I am committed to what the Council is trying to achieve regarding 'Making Integration Happen'.

However, health staff expressed worries about the implications of moving into the Council on their professional identity, terms of employment, job security, and relationships with families who '...know and trust the NHS lanyard'.

They also felt it would distance them from NHS colleagues and they were uncertain about the work they would be doing from April 2019. A senior NHS manager said that 'Health staff are very proud of what they are and do, but now can't see a clear role for themselves in the programme and don't know enough to trust the change'.

The project team commented that the programme constituted a less significant change for Council staff than for health colleagues who faced a risk to their professional identity.

**Finding 4: Engagement with stakeholders was continued throughout and helped leaders to maintain momentum and respond to some concerns from staff.**

Extensive communication and engagement with all stakeholders was an important aspect of the process. It helped to ensure professionals understood and shared the vision, and that their concerns were understood, and helped to steer the priorities of the senior team. It could not ensure that all issues or concerns were addressed.

Senior working relationships with health colleagues were strained during the development of the ADM. In particular health partners felt limited in being able to challenge the process or participate in decisions; they felt 'done to' rather than being partners to the developments. For example, the development of the ADM was tested through the Children's Overview and Scrutiny Committee. If it had been challenged through the Health and Adult Social Care Overview and Scrutiny Committee, the Health Trust CEO would have attended. A senior manager within the Council reflected that

'I think we didn't fully estimate how difficult it would be for our partners'.

Relationships with existing health providers were further strained due to both the direct award of the children's community health services contract to the Council and the practical implications of the transfer for both organisations. The NHS was concerned that losing this large contract would give rise to 'stranded' costs for CPFT i.e. corporate overhead costs related to the contract that cannot be disentangled and removed when the contract ends. Despite this the transfer team at CPFT worked hard with the Council to ensure a safe transfer of services.

## The pathway to a decision– revised costs

The decision to set up the ICSD rather than an ADM led to a decision by the senior management team to review the budget for the project.

It proved difficult to capture the cost of contributions in kind (CiK) by council officers, although analysing calendar entries to identify time spent in meetings relating to Making Integration Happen indicated that Children’s Service Directors spent approximately 5% of their time supporting the programme in this way during 2017/18. In addition to the meetings they will also have had significant email correspondence, review and input in relation to the re-iterations of the business case and direction of travel of the programme. In interviews senior officers accepted that the original estimate of contributions in kind from Cornwall staff - based on an estimate of 20 – 25 % of Directors’ time and 5 – 10% of other senior staff time – stood i.e. £767,281 worth of contributions in kind, giving a total cost of £3,640,586.

**Finding 5: The costs of the decision-making exercise were within the original budget estimates, but precise calculations were not made.**

Overall, despite the additional scrutiny and testing activities involved, the final cost of the exercise was not significantly different to the budget. However, a large proportion of these costs were delivered through contributions in kind and the ability of the evaluation to measure this was very limited.

## The decision – Together for Families

Following a short period of preparation from November 2018 onwards, the new ICSD Directorate [Together for Families](#) was launched on 1 April 2019. The Council felt strongly that the ICSD should have a new name and distinct identity to demonstrate the new beginning and emphasise that education, health and social care services were coming together with equal status and influence on the future of children’s services. The new name was developed using ideas gathered from engagement workshops with staff, partners, clients and local communities. A new visual identity, in line with the Council’s ‘branding’ policy, was adopted across all literature in order to promote the new identity. It was hoped that this would help to avoid the impression that the Council was ‘taking over’ NHS services and that it would help to achieve the cultural change needed for a new integrated service.

## The Together for Families Directorate – the first year

This section focuses on the period between April 2019 and March 2020, the first year of the Together for Families Directorate.

### The new service

The new Together for Families Directorate was a significant change from previous arrangements. Its management structure was very different and it included a new Health and Wellbeing Service which incorporated some services previously part of education as well as local authority commissioned or delivered health services. It had a clear intention to work together on better aligned teams, better communications between professionals particularly in localities, more effective professional interventions, clear and shared referral and service pathways and management arrangements to support more effective early help and better outcomes for children and families. It comprised 3 service directorates:

- Children and Families Services
- Education Services
- Children's Health and Wellbeing

The Children and Families Services changed relatively little in structural terms (apart from the Psychology service moving across to the new Health and Wellbeing Service). It continued with three geographical areas - East, Mid and West – and each area had 2 Early Help Localities. In each area there were:

- Three Family Assessment and Support Teams, made up of Social Workers, Family Workers and Targeted Youth Workers;
- Two Child Protection Teams, made up of Social Workers and Family Workers;
- Children in Care and Care Leavers Team made up of Social Workers, Contact workers and Targeted Youth Support Workers; and
- Two Early Help Locality Teams that incorporate Family Hubs and Spokes.

The service also included a Disabled Children and Therapy Services, with a team in each of the 3 areas. A Multi Agency Referral Unit (MARU) was managed by a Service Manager and was a countywide single point of contact for all contact and referrals into social care where there is a safeguarding concern. Sitting alongside the MARU was a county-wide Early Help Hub. It also included a Practice and Policy Team for the county.

The Education Service incorporated the county-wide School Effectiveness Team, the Virtual School for Children in Care, the Education Access and Sufficiency Service,

Community Adult Education and Learning, the 11-25 Pathways to Employment Service, and a commissioning and partnerships service.

The new Health and Wellbeing directorate was made up of the children's Psychology Services, Early Years and Foundation Stage Service, Special Educational Needs Service, Health Visiting and School Nursing Services in each of the three geographical areas co-located with their Children's Services colleagues.

In the period from April 2019 – March 2020 the organisation arrangements were applied as planned with the transfer of some NHS staff to the Council. The period also consisted of establishing and consolidating the new Together for Families services and delivery model, particularly through:

- Appointing people to new leadership and management roles as a number of senior officers in children's services in the Council reached retirement
- Helping teams to work more closely together including in locality-based offices
- Ensuring that information systems were accessible and useable for all staff
- Designing and implementing new working arrangements including protocols, pathways and referral routes
- Refining intervention and support methods such as Family Group Conferencing and incorporating some additional roles within the overall service
- Introducing three new multi-disciplinary 'Helping Families' teams to support the most vulnerable families in the county
- Expanding the early help resources across the county including in response to increasing demand through the early help hub

In the 6 Early Help Localities the service was working towards much more closely aligned multi-agency and multi-disciplinary working, to support children and families who need support to help them thrive and to avoid the need for more statutory interventions. This included teams being co-located to promote better communications and sharing of information systems across the three directorates to make data and intelligence sharing easier. Although the ADM programme team was stood down in November 2018, a rigorous project management approach was maintained in 2019 including three interdependent projects under the remit of the Making Integration Happen steering group: Implementation of the new directorate; Public Health Nursing Transfer; and Integrated Place-Based Services (design and implementation of the future model of care).

## **Finding 6: The new Directorate inherited a clear service model and a wide commitment to further integration and was able to continue with the originally intended direction of travel.**

Although not having to deal with a transfer to a new ADM, the Together for Families Directorate had to take forward major reconfiguration with the setting up of the new Health and Wellbeing service, transfer of NHS staff, and continued development of locality arrangements and local practice. It helped that there was a clear direction travel already established and agreed with partners.

### **Activity and performance**

One aspiration for the project was to enable more effective early help services and better co-ordinated support to meet family's needs early and thus reduce demand on other more intensive services. For example, Cornwall has had a record of relatively low rates of children needing to be looked after in the county. According to data supplied by the Council these have been between 39 per 10,000 and 43 per 10,000 between 2014-19, compared to a mean of between 65 and 72 per 10,000 for all English single tier and county councils in the same period. It was intended that the project would help to maintain this trend through further investment in early help leading to further reductions. At the time of writing data was not available from Cornwall for the 2019-20 financial year and given the very short timescales involved since the commencement of the Directorate it would be inappropriate to suggest any causal linkage between the investment and the impact. However, according to the Council's data, the project period saw increases in the level of requests to early help services across the county:

- In the 6 months January – June 2018 there were 4,224 requests for early help, including 1,242 requests from schools and 507 from family members
- In the 6 months January – June 2019 this had risen to 4,843 requests, including 1,346 requests from schools and 701 from family members
- In the 6 months September 2019 - February 2020 this had risen again to 5,610 requests, including 1,578 from schools and 1,159 from family members

This suggests that early help services are being accessed more often, and it would be hoped that this trend will, over time, have an impact on other factors including numbers of children looked after, requiring safeguarding or perhaps requiring intensive education support. A number of senior managers and team managers suggested in interviews that the Directorate will need to look carefully at its performance and activity data, to ensure it is measuring the right areas to enable the Directorate to pinpoint where and how early help services are having an impact in the future.

**Finding 7: It is too early to tell whether the Early Help approach is having an impact on demand for more complex provision although initial feedback from families and practitioners is positive.**

Better quality information will be needed about the need, demand and impact of early help services on the overall level of population need, to help the Directorate steer its resources to the most effective areas in the next period.

## **Impact on children and families**

As part of the evaluation IPC interviewed families who had used early help services and considered samples of case files of families with whom the early help services had been involved. These were not intended to be representative, rather illustrative examples. The timescales involved in the project and its evaluation, and the limited number of examples considered means that it would be inappropriate to reach firm conclusions about the impact of the service changes on children and families. Hopefully however it does identify potential further areas for future improvement based on the observations of children and their families and the case files findings.

Families were interviewed twice during the evaluation. In the first period (January – February 2019) 14 families were interviewed and asked to reflect on an early help intervention which had taken place at some point between October 2017 and March 2018 (well before the establishment of the new Together for Families Directorate). 11 families were interviewed in February – March 2020 about early help support they had experienced between June and December 2019 (as the new Directorate was being established). The early help case files of a selection of families were also analysed at the baseline, (January 2019) and at the final stage (February 2020) of the evaluation. For each analysis, 30 families were randomly selected from across all 6 localities:

- For the baseline – families who had had an early help intervention starting between October 2017 and March 2018.
- For the final stage – families who had had an early help intervention starting between June to December 2019.

Overall in both cohorts the families interviewed were very positive about their experience. For example, phrases used by the families and young people to describe the Support Worker role in the first cohort of interviewees included

‘...enthusiastic and kind’, ‘exceptional, off the scale’, ‘brilliant’ ‘perfect’, ‘can’t knock it at all, like a breath of fresh air’, ‘listened and wanted to make the change’, ‘non-judgemental’.

One mother said,

‘She was an absolute pleasure; I don’t think she knows half of what she has done for us’.

A young person said

‘My TYSW (Targeted Youth Support Worker) is the only person so far who I’ve been able to have a really good relationship with and I’m really grateful for that’.

In this first cohort, eight of the families and young people rated the experience as ‘very’ helpful; five rated it as ‘quite’ helpful, and one as ‘not very’ helpful. Two families felt that the support had been very helpful at the time, but over time not a lot had come out of it, or there had not been enough time to embed the impact. Two families commented that they didn’t really use all the support at the time, but that it was reassuring to know they could access it if needed, and one mother was just beginning to access some of the earlier suggested supports at the time of the evaluation interview. A father commented that he had only really realised how helpful it had been afterwards, as at the time he was not really clear what it was all about and what was it trying to achieve.

Phrases used by the families and young people to describe the Support Worker role in the second cohort included

‘...off the scale’, ‘really good and knowledgeable’, ‘lovely approachable person’, ‘really nice and supportive’, ‘brilliant’, ‘positive’.

One couple said,

‘The worker was great; she went beyond what she needed to do and then followed up’.

One father described that

‘...going from having nothing to somebody coming in regularly and supporting was really helpful’.

Two families particularly commented on the co-ordination role,

‘...great coordination, it was about bringing everybody together’.

Regarding the overall early help support received, six of the families and young people rated this as ‘very’ helpful; three rated it as ‘quite’ helpful, and one as ‘not very’ helpful. One family commented it was

‘...all massively helpful, our situation could have been very different without it’.

Overall then, these interviews gave an impression of continuing good quality work by the early help service which was appreciated by families and not undermined by the changes which were taking place in the organisation and governance of the services. There were positive indications in the later cohort that families particularly appreciated the range and co-ordination of the services available to them.

The case files reviewed were evaluated by IPC as being well-presented and clear interventions for the most part, with notable examples of good individual and joint practice which will be made available to the site. The comparison between the two cohorts gave good indications of the improvements in practice which leaders were looking for:

- The case files in the second cohort were characterised by the inclusion and accessibility of the health visitor case notes in the early help files of families with younger children. These were included in the day to day case notes rather than forming a separate entry.
- There was evidence of the Family Workers key role in stronger multi agency working through meetings and co-ordination in the second cohort. At the baseline stage, there was more indication of the Family Workers making referrals to other support services rather than co-ordinating them through multi agency meetings.
- Joint visits were in evidence at both the baseline and final stage analyses. At the baseline these joint visits were most noticeable between social workers and Family Workers as a handover visit in cases that were being stepped down. In the cases looked at in the final stage, there were more examples of joint visits between Health Visitors and Family Worker, or joint visits initiated by the Family Worker to introduce workers from other support services.
- At both baseline and final stage there were examples of the Family Worker role in assisting and accompanying the family to meet and resolve issues they had with their child's school.
- The second cohort had a much higher proportion of self-requests and referrals than the first. Out of the 30 cases, nine were self- referrals, usually from a parent. At the baseline, only 2 cases were self- referrals. The majority of the self-referrals in the final stage were made by the parents via email and the recently introduced online portal for parents, which does seem to have made access easier to the Early Help Hub.

There was evidence of a wide range of support services that the families were able to access in both cohorts – circa 40 different services indicated across the 30 cases. Of this, families accessing universal support from Children's Centres was more evident in the baseline than in the final stage, an indication of the change from Children's Centres to Family Hubs. There were also some very positive examples in the second cohort where the family were provided at referral stage with comprehensive information

regarding the community supports which may be helpful, as well as links to written reports and information sheets. Finally, there was evidence of a great deal of perseverance and determination from workers in exploring ways to engage with family members including in particular with young people.

**Finding 8: There was no evidence that management and structural changes to the Directorate had a negative impact on families or the quality of work that they received from early help, and service improvement appeared to continue through the period.**

The early help service was already in place when the project commenced and was clearly having success with families. This success was continuing when reviewed in 2020, and there were good examples of cases where interventions had been enhanced by improved joint working, more assertive key working and better professional communication.

## Impact on professionals

### HR data and staff surveys 2019 and 2020

The workforce changed over the period of the evaluation as staff from the Trust joined the Directorate in 2019. According to Council figures, total staffing in the two original Directorates in April 2018 was 1,358. This increased to 1,584 in April 2019 around the start of the new Directorate, and then to 1,678 by early 2020.

The Council HR Dashboard data showed, in very general terms, some improvements in some basic attendance patterns in both the Children and Families Services and the Education and Early Years over the period March 2018 – February 2020:

- Sickness rates in Children and Families reduced from 5.38% (March 2018) to 5.17% (March 2019) to 4.77% (February 2020)
- Sickness rates in Education and Early Years reduced from 4.22% (March 2018) to 3.01% (March 2019) to 2.2% (February 2020)
- Sickness rates in Health and Wellbeing Services were not recorded until 2019 when it was created within the Council. In February 2019 the sickness rate stood at 5.16%.

There are no doubt many potential reasons for the general improvement in figures and not too much should be read into them about the impact of the governance changes on staff attendance, but they do indicate that there were certainly not significant increases in absence over the period of change in which the Directorate was established.

This indication is backed up with more detailed information from the staff survey. IPC surveyed the workforce in January 2019, after the Council’s rejection of the ADM but prior to the formal formation of the new Directorate, and then again in January 2020, 9 months into the life of the Together for Families Directorate. The questions were the same on each occasion. In terms of responses:

**Table 2: Responses to Staff Surveys**

<b>Date</b>	<b>Total responses</b>	<b>Children and Family responses</b>	<b>Education responses</b>	<b>Children’s Health and Wellbeing responses</b>
2019	145	60%	19%	22%
2020	404	68%	16%	16%

The survey focused on their perceptions of their job demands and working conditions and overall suggested relatively stable perceptions over the year. For example:

- The proportion of people who felt their workload was always or often too high was 36% in 2019 and 37% in 2020.
- Of the relevant respondents the proportion who agreed or strongly agreed that they had enough time for direct work with children and families was 42% in 2019 and 41% in 2020.
- The proportion who agreed or strongly agreed that they were confident in their role was 86% in 2019 and dropped to 82% in 2020.
- The proportion who agreed or strongly agreed that morale was good where they work was 54% in 2019 and 55% in 2020.
- The proportion who disagreed or strongly disagreed that staff retention was NOT a problem in their practice area was 32% in 2019 and 31% in 2020
- The proportion who agreed or strongly agreed that they work well with colleagues from other services, teams or disciplines was 96 % in 2019 and 93% in 2020.

This points perhaps to the introduction of the Directorate as having relatively little negative impact on many frontline jobs in its first year. Given the many examples from elsewhere in the UK of significant morale problems following a restructure, this might justifiably be considered something of a success. Indeed there was one area where we noted improvements. Those who reported having taken sick leave for stress in the previous year reduced from 9% in 2019 to 5.5% in 2020, and when those who said they were stressed in their current role were asked for the reasons for their stress:

- The proportion who said it was due to insufficient quality of management or support reduced from 23% in 2019 to 18% in 2020
- The proportion who said it was due to working cultures and practices reduced from 48% in 2019 to 33% in 2020

There was more nuanced data gathered from the interviews with staff. These took place at three points – June 2018, May / June 2019 and March 2020.

### **First set of interviews with staff 2018**

In June 2018 the Council was still exploring the possibility of an ADM and had already spent considerable time and energy working up a vision and agenda for greater integration across social care, education and health and in sharing this with staff. In the interviews and focus groups at this point most staff were feeling relatively enthusiastic about integration with lots of examples of what were seen as positive developments already, including: the Early Help Hub, staffed by a team of multi-agency professionals and directly linked to the MARU (Multi-Agency Referral Unit); joint work with schools; Family Hubs with VCS input; and some co-location of health staff with early help teams. Many operational staff were enthusiastic about the potential to work across professions to develop creative early help support for families through interventions such as motivational interviewing, strengths-based assessment and Family Group Conferencing.

However, at this stage there were 3 key issues that professionals in the local authority, NHS and voluntary sectors were concerned about. Firstly, NHS staff expressed worries about the implications of 'coming into the Council' (as they described the ADM) on their professional identity and terms of employment, job security, and relationships with families who 'know and trust the NHS lanyard'. They also felt it would distance them more from their NHS colleagues, and they were uncertain about the work they would be doing from April when they would be working to a new specification. What they saw as a lack of communication and engagement heightened their fears, and it was claimed that this was having an impact on retention and retirements for this cohort of staff.

Secondly, all staff were particularly concerned about what might be termed 'the job basics'. So for staff potentially re-locating this meant having, for example a desk, IT equipment that works, and appropriate parking so that disruption to their work was minimised, and for key tools such as shared information systems, assessment forms and uniforms to be readily available and accessible. This was also related to levels of investment in staff and whether the new body would look to increase or reduce capacity – and if so in which professions or services.

Thirdly, there were different views and different expectations about the operational arrangements for working together. For example, would this mean multi-disciplinary teams of different professionals or co-locations of separate teams? How would referral

and case review arrangements work? What experience and background would operational managers be expected to have?

IPC also interviewed voluntary sector representatives at this point. Their view was that the direction of travel was good, but that, although senior managers were supportive of their input, they were not treated sufficiently as an equal partner and the skills, expertise and different perspectives they bring to working with children and families was undervalued.

They identified areas for improvement, including better and more regular communication between statutory and voluntary sectors, to be more involved at an earlier stage and for their specialist knowledge and skills to be fully recognised and valued.

At this point it was clear that whatever organisational governance arrangement was put in place, the key factors which would indicate the success of the project in the views of interviewed front-line professionals were primarily, if not exclusively, to do with improved working arrangements, service investment and day-to-day management.

### **Second set of interviews with staff 2019**

By May-June 2019 (4-5 months after the first survey) the ADM had been rejected and the new Together for Families Directorate had just been established. Staff interviews were undertaken for a second time at this point. It was notable that overall there was a positive view of the changes that had taken place. In particular the key positives included: the move to a shared IT system (MOSAIC); co-location of early help and health staff; streamlined referral pathways and improved links with the voluntary and community sector (including having a community development worker in Family Hubs). The interviewees also generally felt that the opportunity to engage with the change had been made available, although some felt that more could have been done to communicate about the reasons behind specific changes.

For the NHS staff who had moved into the Directorate however, it had clearly been a challenging time having to learn new systems and adjust working practices. Health managers noted continued teething troubles while settling in including with new HR, electronic recording and reporting systems, recruitment processes and different terms and conditions for similar roles.

Nevertheless NHS interviewees suggested that although there had not been sufficient preparation for the move, they had been given a very warm welcome and that they had received positive messages about integration from senior leaders when they joined:

‘....none of us feel we haven’t been wanted’.

This had been supported by positive experiences in the first few months including a strong commitment to additional investment in School Health Nursing and good IT support to deal with taking on new systems.

Concerns of course remained at this early point in the new Directorate. There were concerns about how recruitment to certain health worker posts might impact on employment and retention of similar Family Worker roles. Some were also concerned about the extent to which a deeper level of integration could be achieved in very practical operational areas such as combined assessments, common thresholds, intervention methods and joint working practices. As one interviewee said,

‘We want to see the impact on the ground floor’.

This was supported by the voluntary sector representatives interviewed. They did recognise areas of progress such as in some localities a well-established voluntary sector post in early help hubs and recent joint initiatives to build social capita. One voluntary sector representative said,

‘It is happening at operational level, better than it was’.

However, they were also clear that there needed to be further improvements in joint working between voluntary and statutory sector colleagues, particularly in localities:

‘There’s more to integration than health and social care’.

### **Third set of interviews with staff 2020**

The third set of interviews took place in March 2020 when the Together for Families Directorate had been established for almost a year. At that point, generally, the interviews with professionals were much more positive and upbeat than the interim stage interviews in 2019. Positive practice and delivery changes included more joint visits, joint training, working to joint policies, joint work with schools by youth workers and school nurses and locality partnership planning, as well as investment in school nursing. Co-location was said to have contributed to greater understanding of roles, more informal communications, shared systems, and less need for formal referrals.

The investment during the year in community development workers in localities was seen to have opened up opportunities to know what community resources professionals could point towards. There were remaining challenges including: consent and sharing information and getting used to the shared Directorate system; that health staff were now unable to access some closed NHS systems; an emerging concern about increased distance now with external health colleagues. From voluntary sector interviewees there were comments that overall partnerships are much stronger and more forward thinking than in other parts of the country, but that further progress towards greater integration

and partnership working is now needed. Finally the Early Help Locality Managers tended to vocalise more positive delivery and practice changes such as

‘Early help plans are increasingly multi agency’.

‘Workers are out more in the community, not just case work’.

‘Staff are working together more visibly now’.

‘There is increased attendance at groups’.

‘I’m really proud of our Family Hub offer now’.

Although interviewees said it was too early to see any impact on long-term outcomes for children, they did say that families had commented on the joined up approach, helpful joint visits, speed of response and getting the same message. Interviewees were clear that they were in the early stages of a long-term change and emphasised the need to further embed, to think about moving towards multi-disciplinary teams, marrying up assessments and undertaking joint supervision.

**Finding 9: The implementation of change in the establishment and then the first operational year of the Directorate was received relatively positively overall by staff.**

Although the decision not to pursue the ADM could have undermined the wider change programme, aside from specific concerns, from those whose role or management was directly affected, staff remained positive about the overall vision and model. A number of specific practice-level developments were successfully delivered during the first year including school nursing investment and shared access to assessment systems, and these had a positive impact on perceptions of progress for practitioners.

## **Experience of senior leaders**

At the same time as interviewing professional and operational managers on the three occasions noted above, IPC interviewed senior managers (Chief Executives, Directors and Heads of Service) in the Council, NHS Trust, CCG and other partner organisations. These people all had some role and responsibility for leading the changes.

In the first set of interviews in June 2018 it was notable that the majority of interviewees expressed a strong commitment to integration and to the One Vision agenda. Discussions around integration had been happening for a long time and there were some positive joint working and examples of good joint developments already happening. Council managers in particular considered this to be a positive opportunity to progress

this, aided by the funding to develop a delivery model, to bring it all together and enable decisions to be made about the fundamental system and structure change needed to embed a different way of working.

The ADM agenda overall was clear but a number of leaders, particularly from outside the Council, said they were not clear about what an ADM was and what it might mean in practice. There was a strong view from NHS leaders that the decision to opt for an ADM was taken without exploring all possible options jointly. Health colleagues, and to some extent education colleagues felt there was a focus on the delivery vehicle rather than developing an agreed wider model that all could sign up to and jointly commission. In addition there was a lot of anxiety around what the changes might mean for individuals, terms and conditions, professional identity, management, career progression and role dilution.

A similar pattern of response could be seen in the second round of interviews in June 2019, a few months after the rejection of the ADM and establishment of the Together for Families Directorate. The majority of interviewees thought that there was a 'very' clear vision about integration and what needs to change. However, they were less clear about the mechanism for getting there - the majority feeling they were 'quite' or 'not very' clear about this. It was considered that this change was still happening with some managers feeling that things may be happening that they are not clear about or may still change – although this was considered to be the result of a consultative, reflective, and not static process. It was around this time that 3 of the senior leadership team confirmed they were retiring and this added to the uncertainty expressed by interviewees about the detailed future design of services, as well as a concern in the Council that this might lead to delay and drift.

Big successes were recognised including a very positive welcome to NHS staff into the Directorate, the roll-out of a shared information system, emerging joint working arrangements and specific interventions, and in general a high degree of engagement with professionals across the services. There were also examples of changes which were not seen positively at this point, particularly in the move of some education staff into the new Children's Health and Wellbeing Service. Some health leaders felt that the Council was driving change and not recognising all of the different cultures and working practices which needed to be addressed.

In March 2020, when the final interviews were conducted, a new senior team was in place and the Together for Children Directorate had been established for almost a year. Some previous concerns continued: some of the education leaders felt that the focus had been too much on health and social care integration; some health leaders remained uncomfortable about the balance of the new Directorate (not enough focus on health) and challenges in linking with the rest of the NHS, and some leaders felt that their original aims of integrated teams and services remained a long way off.

However, it was noticeable that for many of the people interviewed the first year had reduced or allayed concerns and delivered significant progress, particularly in terms of bringing public health nursing and children's services together. This had led to a better service offer in localities - one front door, shared systems, joint working, more understanding of roles - and there were examples of progress with joint working in, for example: joint commissioning strategy, joint supervision policy, joint senior leadership meetings. The locality working and developments were viewed very positively.

Leaders were asked to reflect in particular on the change process over the previous 2 years. The majority did not think the changes could have been made without the introduction of the new organisation model. It indicated a major leap in the level of integration needed, and the system and structure changes that went with it. Notably also the change in the senior management group in 2019 was viewed as having an important impact. For some it slowed things down, but for others it was positive,

'There is the issue of the old senior managers leaving and new senior managers coming in, but I have been really impressed that the new senior managers are trying to understand the journey that the old ones have gone through and they have the same passion and increased energy to take forward'.

The investment from the Council into public health nursing was seen as a real positive, although the move of children's community health services into the Council was seen as a major change, and several leaders felt the scale had been underestimated. Morale and performance was said to have dipped amongst community health services at this time but there was a strong view that it was now improving as roles and conditions had been clarified and the benefits of joint working realised.

The majority view was that it was too early to see the impact on long-term outcomes for children and families, although families may well have noticed an impact on their experience of services, such as better informed practitioners, easy access to hubs and joint approaches across professions. The majority of the senior leaders felt that the Council's ambitions had been achieved. The majority view was that they were still on the journey and had achieved a lot, but now needed to further embed integrated working.

'It's a journey, we have had a really successful first part of the journey but there is still a long way to go'.

**Finding 10: Partners shared a common vision about more effective integration from the start. This helped maintain engagement when relationships were strained, or initiatives were struggling.**

Different partners from the Council, voluntary sector and NHS were challenged in different ways and at different times. The project priorities and activities had to be revised to accommodate these, without undermining the overall direction of travel. By maintaining a shared vision of better integrated locality services able to support families early, partners were able to address these challenges and people's concerns without losing sight of the shared goal.

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

As reported in the Children's Social Care Innovation Programme Round 1 Final Evaluation Report (2017), evidence from the first round of the Innovation Programme led the DfE to identify 7 features of practice and 7 outcomes to explore further in subsequent rounds. This evaluation was intended to consider three of these practice features and outcomes and the findings are summarised below:

**Increasing workforce wellbeing.** The ADM exercise was intended to have a positive influence on workforce wellbeing through more effective partnership and joint-working arrangements. As can be seen from the results of the survey in the key findings section, the Together for Families Directorate did manage to incorporate a new service within the Directorate including staff from the NHS with no appreciable drop in perceived wellbeing or morale. Particularly notable was

- The proportion of those who reported having been absent in the last year due to stress caused by insufficient quality of management or support reduced from 23% in 2019 to 18% in 2020
- The proportion who said it was due to working cultures and practices reduced from 48% in 2019 to 33% in 2020

The Lesson and Implications section considers how this was achieved.

**Increasing workforce stability.** The move to the new Directorate included the creation of the new Children's Health and Wellbeing Service and the transfer of NHS staff to the Council in April 2019. It is too early to draw firm conclusions about the stability of the workforce in this last period, although overall it was clear that there had been no major increases in sickness absence over the last year. There were reported examples of staff leaving or retiring prior to the establishment of the Directorate, but the staff survey in early 2020 and interviews with staff at the same time (described in the Key Findings section) showed a good level of approval of changes in the last year and did not indicate any major further turnover over this time.

**Generating better value for money.** The wide ranging nature of the changes that the evaluation reviewed meant that it was never appropriate or intended to deliver a cost-benefit analysis of the project or the changes it tried to deliver in services. It was clear as shown by the figures in the Key Findings section that the ADM exercise itself was carefully costed and planned, and that despite the additional demands placed on exercise as it progressed, costs remained in control and resources were flexibly deployed to meet changing needs.

## 5. Lessons and implications

The original innovation that this project was intended to evaluate was the ability of an [Alternative Delivery Model](#) (ADM) to achieve a strategic goal for integration of children's services across health, social care and education. At the time of commencement an ADM was considered a realistic potential vehicle to achieve this by the senior officers of the Council, and key stakeholders elsewhere in the Council and in partner agencies were willing to explore it with them. It was undertaken within the context of a wider vision of greater integration built around more effective early help for families in co-terminous localities across the county.

In strictly technical terms, the innovation therefore was not successful, in that it was decided by the Council Cabinet that an ADM represented too big a change in arrangements and too significant a governance risk for an integrated children's service in Cornwall, and it was not therefore applied and evaluated. However, partners did continue to work together successfully to create a new Directorate, and to secure major steps forward in the wider integration and locality-based agenda. This was achieved without many of the negative consequences that are often associated with major changes in services such as a dip in perceived quality or staff approval.

The general good practice points on ADMs identified in Section 2 of this report are borne out in the ten findings from the evaluation in Section 3. In addition, the following particular lessons stand out from the experience of Cornwall Council and its partners over the course of the project as relevant to anyone specifically considering governance vehicles to support greater integration of services for children and families across a wide range of services and professions:

**Lesson 1: Even just considering an ADM as a vehicle for governing a large and complex set of professions and services for children and families proved a time-consuming and complicated task for partners in this project. There is a risk that this can divert senior officer away from crucial ongoing work on improving local services and outcomes for children and families.**

Findings 1,2, 3 and 5 show how this lesson was experienced in Cornwall. Although there is no evidence that the time spent on the project did undermine their improvement agenda, and it was clear that the Council managed the project carefully, it did require significant resources. Had these resources all come from local sources rather than relying heavily on DfE support, they may well have compromised the capacity to drive more local improvement. Within the current national statutory and policy context it is hard to see how a local children's services partnership such as Cornwall would be willing to risk the use of an ADM except for smaller, single service or profession arrangements, or where the existing network of services are clearly failing.

**Lesson 2: The governance vehicle is only a very small part of a change programme for a children's services partnership. Success in addressing operational issues such as staffing levels and information sharing were much more influential on staff perceptions of the partnership than the nature of the governance vehicle.**

Findings 4, 6 and 10 show how Cornwall was fortunate that the ADM exercise was only a relatively small part of a much larger, longer term shared agenda for greater integration and early help for families in localities. This One Vision Partnership helped to ensure that specific or local difficulties were kept in perspective and, for example, that the switch from ADM to Together for Families Directorate did not undermine the longer-term goals. Finding 9 shows that success on operational issues such as staffing levels and information sharing were much more influential on professional perceptions of the partnership than the ADM decision.

**Lesson 3: While it is not possible to consult or engage with every single stakeholder across a complex system such as children's services, it is crucial to be open to wide influence and flexible to adjust to new situations. In services characterised by professional autonomy such as Together for Families, successful change relies very heavily on practitioner consent, and ongoing dialogue is a key element in achieving this.**

The findings 4, 9 and 10 also show how leaders in Cornwall recognised that engagement with stakeholders cannot be treated as an irregular or one-off occasional activity. The One Vision agenda is a very long-term programme made up of many different projects and activities. The leaders recognised from an early point that they needed to develop and maintain flexible and responsive multi-channel links with a network of stakeholders – many of whom would change over time. It also recognised that the purpose of these links – particularly with frontline professionals – was two-fold: firstly to share their thinking with colleagues; and secondly and equally important, to get steers and advice from colleagues. Children and families provision tends to be characterised by high professional autonomy in the delivery of services, and in these agencies in particular successful change relies very heavily on practitioner consent. Ongoing meaningful dialogue is a key element in achieving this.

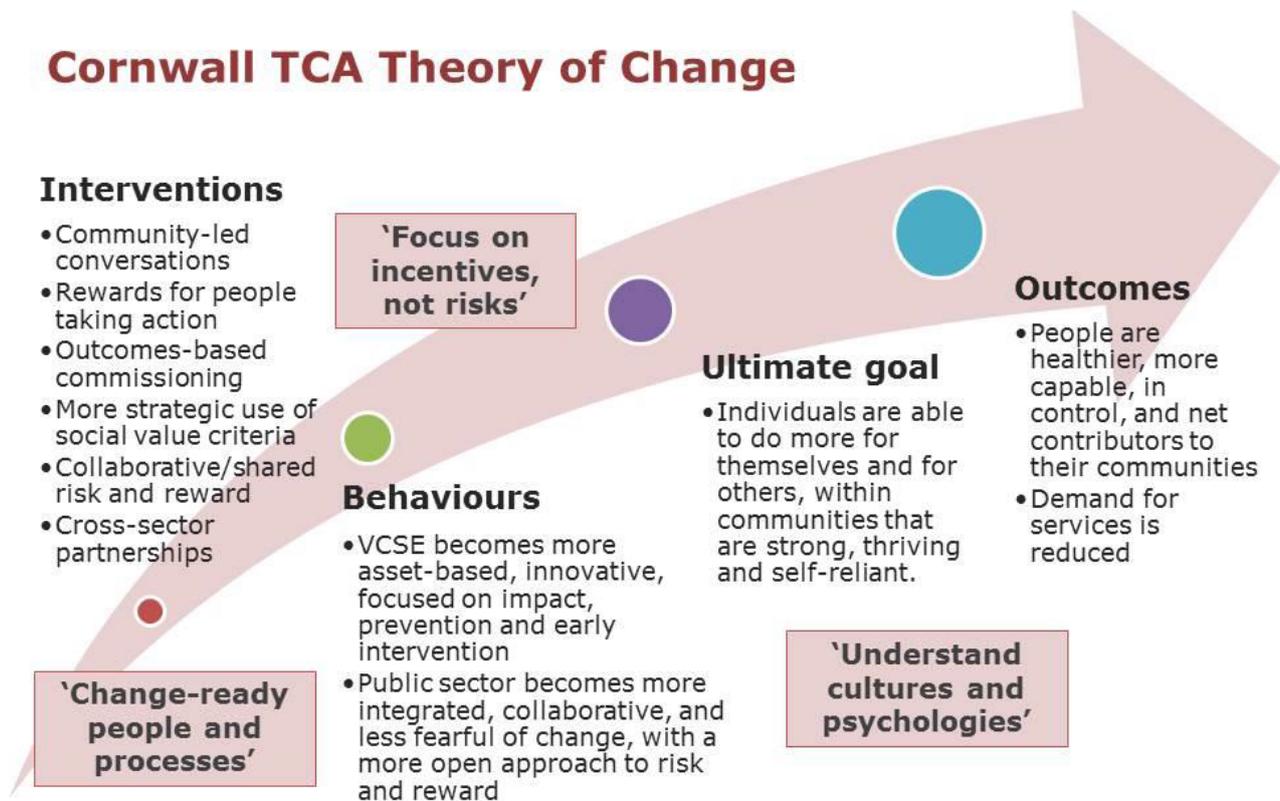
**Lesson 4: Really changing large and complex children's services organisations takes time – you need a long-term perspective and regular review to ensure you are going in the right direction.**

Findings 6 and 10 show the value of the long-term perspective that Cornwall adopted in 2017. Findings 7, 8 and 9 on the other hand show that it is not easy to judge progress against such long-term aims. Changes in organisation and delivery will rarely have an immediate impact on outcomes for children and families, and there is rarely a single causal attributable relationship involved. There is the risk in such circumstances that

over-simplistic measures are employed to make unsafe judgements about impact and outcomes. The approaches employed in this evaluation including case file analysis and professional and family interviews are amongst more subtle methods which are needed in children's services to complement standard performance indicators and create a richer picture to inform practice development, investment and service improvement.

# Appendix 1: Project theory of change

Figure 2: Cornwall Theory of Change



A key assumption in the theory of change for the project was that the creation of the ADM would better enable a model of locality-based, multi-disciplinary teamwork that would lead to more effective early help for vulnerable children, young people and families. It was intended that this would, in the longer term, play a significant role in ensuring that fewer children or young people escalated within the social care system (to child protection and substitute care) and that partners would be able to close the gap between the education and health outcomes for vulnerable children and those of the rest of the children’s population in the county.



## References

None



Department  
for Education

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**Reference: RR1057**

**ISBN: 978-1-83870-176-5**

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