Manchester Health and Wellbeing Board
Report for Resolution

Report to: Manchester Health and Wellbeing Board – 19th September 2012

Subject: Early Years New Delivery Model

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Mike Deegan Chief Executive CMFT
Mike Eeckelaers, Chair, Central Manchester Clinical Commissioning Group

Summary

This joint report and accompanying presentation builds on the previous report submitted to the Board in July and provides an overview of:

- The proposed Early Years New Delivery Model
- The rationale for the proposed model and underlying principles
- The financial cost analysis
- The improved outcomes to be achieved

Recommendations

The Board is asked to:
1. Approve the principles that have underpinned the design of the model.
2. Note the alignment to the Greater Manchester Community Budget Early Years Exemplar.
3. Approve the Early Years New Delivery Model.
4. Approve the proposed Implementation Plan and next steps.

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1.0 Introduction

1.1 This joint report and accompanying presentation is aimed at providing the board with an overview of the proposed integrated new delivery model for early years. It sets out the rationale for the approach; underlying principles; the evidence base and details the benefits that the model aims to achieve. The report does not describe or explain the wider ‘public health’ role of Health Visitors but it does show how key aspects of their role and function will be integrated into the new delivery model.

2.0 Background

2.1 The proposed Early Years New Delivery Model (NDM) takes into account a range of improvement drivers and policy requirements as well as financial and local experiences in its design.

Policy Context

2.2 There are a number of cross cutting Government Reviews which all focus on the importance of prevention, early help and early intervention: Frank Field MP (Poverty and life chances), Graham Allen MP (Early Intervention) and Eileen Munro (Child Protection).

2.3 As proposed in the current consultation, the core purpose of Sure Start children’s centres is to improve outcomes for young children and their families with a particular focus on families in greatest need of support, in order to reduce inequalities and improve:
   • Child development and school readiness;
   • Parenting aspirations, self esteem and parenting skills; and
   • Child and family life chances.

2.4 In Healthy Lives, Healthy People: Update and way forward, the Government states that the NHS Commissioning Board will be best placed to lead the commissioning of public health funded services for children under five in the first instance, including Health Visiting, the Healthy Child Programme and Family Nurse Partnership. However, the Government’s medium-term aim is now to:
   • Unify responsibility for these services within local government from 2015 when the increased health visiting workforce and new health visiting service model and the Healthy Child Programme offer to families should be in place. The funding for these services is expected to be within the ring-fenced public health budget.
   • Transfer responsibility for commissioning effective Child Health Information Systems to the NHS Commissioning Board, also to be funded by the public health budget. This decision will be reviewed in 2015 to determine longer-term plans.
   • Ensure Public Health England retains a close interest in the specification of Child Health Information Systems, to make sure that public health requirements, such as accurate and effective collection on the delivery of childhood immunisations, are met.
2.5 In essence, the Government is signalling the movement over the medium term of all public health commissioning for children into the public health function within councils.

2.6 Manchester's policy priorities of growth, reform and place have informed the development of the Early Years New Delivery Model. To capitalise on the attraction and growth of new jobs, improvements in productivity are required through increasing our skills base and the number of people in work. Developing the skills required and equipping people to access good jobs needs action across the spectrum - early years, in our schools, through post 16 education and training and once people are in work. It also demands that health outcomes, skills and worklessness are addressed through a fundamental shift in how public services are delivered. In order to radically improve outcomes, every child needs to get the best start in life, arriving at school ready to learn. Through picking up quickly where additional help might be needed and providing that in a co-ordinated and effective way will make the greatest impact on the whole family. This is critical to breaking the cycle of poverty and dependency and increasing independence and fostering aspiration from the earliest stages.

Learning from the City Region Work

2.7 The City Region development work included both Better Life Chances and 0-5 years as key work streams. Manchester was one of 7 AGMA local authorities that chose to pilot a new approach to 0-5 years and Ardwick was the chosen ward for Manchester.

2.8 There are a number of key lessons from the Manchester pilot that have influenced the development of the new delivery model. The key areas of work include:

- The use of live birth data to identify cohorts which enabled early visits was vital in delivering the Ardwick model. This information enabled the commissioning of appropriate interventions and ensured that maximum early engagement was achieved.
- The coordination and handover between the midwife and health visitor was crucial
- Piloting new methods of engaging with the whole of the community including those that can be hard to engage saw an increase of engagement with Sure Start/Children’s Centre services of families with newborns from 30% to 91%.

Greater Manchester Community Budgets Early Years Exemplar

2.9 Greater Manchester is at a key point in the development of the Greater Manchester Community Budget Early Years exemplar. The Community Budget Team working with partners has produced a draft narrative and outline business case which focuses on increasing the number of children who are ‘school ready’ with propositions that could form part of a 3-5 year Public Reform Agenda.
2.10 The work to date includes the mapping of a child’s journey from pre-birth to school reception class, agreed engagement and assessment points and evidence based interventions, based on the agreed principles below:

- Integrated – no duplication, therefore more cost effective
- Progressive, not repetitive
- Identifies additional needs at the earliest opportunity and predicts likely eligibility for 2 year old targeted offer
- Enables comparisons, contrasts and impact across GM
- Agency specific assessments will continue
- Supports shared outcomes

The proposed Early Years new delivery model for Manchester is aligned to this ongoing work.

2.11 It is important that, with confidence, we can create a lasting impact on a large number of children in their formative years that enables them to enter formal education successfully which benefits them, their families and the community. This then benefits public services in the short, medium and long term. This outcome matters in the long term for jobs, growth and investment.

3. Community Budgets and the Approach to the New Delivery Model

3.1 The developing new delivery model for early years seeks to put in place a new integrated approach for early year’s services across health and local government services which takes account of the above context and the limitations in resources whilst striving to provide the most effective outcomes for 0-5 years. Work is ongoing to ensure the new delivery model aligns with
Community Budget Model principles. This is where there is work across agency boundaries in a co-ordinated fashion which could involve:

- A single referral or access process
- Joint working to commission or deliver the interventions
- Aligned use/ sequencing of different interventions across those agencies.

The principles that underpin this approach are that it:

- Reduces dependency and demand for public services
- Delivers savings arising from the reduction in demand
- That an element of the savings will be cashable - although the cashable savings may not accrue to the agency who is providing the interventions
- Facilitates the transfer of money around/ between agencies which will overcome the barriers from both perverse incentives within the financial systems and the fact the benefits fall to a different agency(ies) to those who would fund the interventions
- Supports the single approach to the delivery of the interventions and the realisation of the benefits with a view to ultimately scaling up the approach so that the proposition is sustainable
- Is underpinned by a robust evidence base and evaluation framework that will demonstrate how the model is successful and where the benefits actually fall.

The new delivery model will need to address a range of complex challenges in terms of both policy and practice including:

- As part of the Greater Manchester Community Budget Pilot on Early Years work is being done on developing common commissioning intentions as to what the universal and targeted offers may be; the evidential levels of interventions and which interventions/approaches would be invested in at an AGMA and City wide level;
- Improved outcomes will best be achieved through an integrated delivery model from the family’s viewpoint across health and local authority services;
- Increase in birth rate, inward migration and number of complex cases;
- The alignment of Children’s Centre Sure Start Outreach with Health Visiting to maximise the potential workforce at the universal and targeted levels of need to ensure the delivery of the Healthy Child Programme and Sure Start core purpose.

3.2 The model proposed is based on evidence, the term “evidence base” in this context means using assessment tools and interventions that have the highest evaluated levels of successful impact and are able to be costed to enable appropriate commissioning.

3.3 The new model builds upon learning from a range of approaches across the City Region that have been proven to be effective and is strongly aligned to the National Health Visiting Implementation Plan ‘Call to Action’ (the Manchester Health Visiting Task Force has committed to recruit to a total of
173 Health Visitors by 2015, an extra 71 Health Visitors). The model is being developed in parallel to the Greater Manchester Community Budget Exemplar for Early Years and there are shared elements within both the Greater Manchester and Manchester model such as agreed assessment tools.

3.4 The basis of the new delivery model is close working of Manchester City Council and key NHS provider partners on introducing assessments, co-ordination of care and interventions building upon the Healthy Child Programme and the new arrangements for the delivery of Sure Start Core Offer and Assertive Outreach Service.

3.5 A major key element to the design of the New Delivery Model is that these proposed shared assessment tools will be completed by Midwives and Health Visitors as part of the initial home visits and as part of the universal offer. These holistic assessments will be used, along with other early indicators such as non attendance at appointments, to identify where families need additional support and this will help us to assess, triage, sequence evidence based interventions and support, case manage (including case closure planning) and the referral and allocation to the Assertive Outreach Service.

3.6 In implementing the redesign of the Health Visiting Service in response to ‘Call to Action’ a multi-agency Task Force and several jointly chaired work streams have been established to ensure an integrated approach is developed to deliver the ‘Healthy Child Programme’ and the Sure Start Core Purpose (New Delivery Model). A joint governance arrangement has been established to initially oversee integration of health visiting and early year’s services.

3.7 There are four key areas that drive the delivery of a joint service offer:
   a) Assertive Outreach
   b) Integrated Care Pathways
   c) The Safeguarding Role of Health Visitors
   d) Outcome and Benefit Realisation

3.8 These work streams are underpinned by work to develop information and data sharing agreements and processes underpinned by jointly agreed statements on data sharing that meets the requirements and goals of the different organisations.

4. **The New Delivery Model in Practice**

4.1 The New Delivery Model has been developed in partnership between MCC, CMFT, NHS Manchester and North, Central and South Clinical Commissioning Groups (CCGs) and the high level design and its core elements have been endorsed which are summarised below. This is supported by a diagrammatic representation in the cohort analysis in the attached presentation. It is based on the assumption of 8,000 births per year, growth in Health Visitors and the integration of Assertive Outreach workers into the Health Visiting model.
4.2 All expectant mothers will receive a home visit from the midwife and then an initial home visit from health visitor within 10 -14 days (Healthy Child Programme). At this visit the health visitor will encourage the parent to receive Baby Express.

4.3 The health visitor will use agreed additional assessment tools as part of a holistic assessment to identify the need for any targeted services or supportive interventions e.g. FNP, Parenting Courses, Family Intervention Team. Health visitors would carry out further developmental reviews at 8 months and 2 years.

**Early Help - Assertive Approach**

4.4 The model seeks to embed an assertive approach across the full continuum of need for integrated early years’ services including health visiting, children’s centres and targeted evidence based support. This will require all children being seen and assessed after 14 days, 8 months and 2 years by health visitors, with referral into the Assertive Outreach Services if it is assessed a parent needs support in accessing universal/support services. Assertive outreach workers will follow up and persistently engage parents to access support, e.g. parent groups, stay and play sessions. The model as outlined in the presentation works on the assumption that 50% of new births per year will be supported by the Assertive Outreach service (e.g. 4000), and 7% will require referral to a Speech and Language Therapist (e.g. 1600).

4.5 As has been stated, due to the proposed increase in Health Visitors over the next two years, in order to deliver the Healthy Child Programme the model will require an increased investment in Assertive Outreach Workers from 39 to 60 in the short term, which will be flexed over time as the number of Health Visitors increases.

**The Targeted Offer**

4.6 Where the Health Visitor is unable to make contact with the parent or where their assessment identifies a need for specific support the Health Visitor will either deliver a specified package of care or refer into defined services and interventions or refer to a clinical psychologist if considered clinically appropriate. The clinical psychologist will triage these cases and one or a combination of evidence based interventions will be offered e.g. Video Interactive Guidance, Targeted 2 year old offer, Family Intervention Programme. Parents will be supported to access these interventions by a member of the assertive outreach service.

**Manchester Investment Fund and Early Years**

4.7 As part of the MCC budget setting process the Manchester Investment Fund was created which pulled together funding of £36m including £6m relating to the provision of targeted early years services to develop new delivery models
which integrate the delivery of services around families and individuals who have complex needs or who are at risk of developing complex needs.

4.8 This activity is important in demonstrating the way the Council is focusing on supporting people in most need in the most effective and efficient way as its resource base reduces. The key to public service reform is enabling independence and reducing dependency and to do this the resource base of all stakeholders needs to be aligned with the intent to jointly deliver or commission services to optimum outcome impact to stem the potential future flow of troubled or complex families. This enables the delivery of services by those who are best placed to do so and enables the Council to encourage and stimulate those organisations whilst targeting its reducing resources to support those in most need.

4.9 This new delivery model forms one of the exemplar projects across Greater Manchester selected by the Government to demonstrate the concepts of Community budgets across a whole place.

5. Benefits of the New Delivery Model

5.1 Improving outcomes for 0-5 years is the key benefit of the new delivery model. In addition, there are a number of high level benefits to partners through the new approach including:

- Better maternal health and pregnancy care;
- Improved partnership resource allocation through aligned and co-ordinated service delivery;
- Reduction in dental extractions for under 5s;
- Reduced worklessness households.

5.2 Specific benefits for Manchester City Council include:

- Improved partnership resource allocation as a result of the integrated service delivery of the sure start core purpose;
- Stemming the flow of numbers of troubled families needing higher cost interventions;
- Increase in families that are economically active households;
- Decrease in voids and homeless family presentations.

5.3 Specific benefits for health services include:

- Improved handover arrangements between Midwifery and Health Visiting services;
- Increased efficiency and removal of duplication;
- Increase in breast feeding;
- Reduction in smoking during pregnancy and retention of this post-pregnancy;
- Early identification of speech and language delay.

5.4 Specific benefits for schools include:

- Increase in school readiness and,
- Improvement in Early Years Key Foundation Stage
• Increase in school attendance and attainment.

5.5 As part of the implementation of the new delivery model, agreement will be reached with partners on how the above specific benefits will result in a reduction in service demand, and release cashable savings. This will act as a trigger for discussions on future investment and de-commissioning of services. An evaluation framework which uses the evidence bases to predict the specific benefits both in terms of cost and outcome will be part of the implementation planning.

6. **Commissioning and Financial Model Assumptions**

6.1 The financial modelling for the fully scaled up Early Years New Delivery Model is £19.189m as set out below. There is a potential £3.6m shortfall in funding once a city-wide scaled up model is rolled out i.e. in 2015/16.

<table>
<thead>
<tr>
<th>Early Years New Delivery Model</th>
<th>Health Funding</th>
<th>MCC Funding</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000 FTE</td>
<td>£000 FTE</td>
<td>£000 FTE</td>
</tr>
<tr>
<td>Universal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Visitors</td>
<td>7,164 184</td>
<td></td>
<td>7,164 184</td>
</tr>
<tr>
<td>Baby Express</td>
<td>282 6</td>
<td></td>
<td>282 6</td>
</tr>
<tr>
<td>Early Help</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assertive Outreach</td>
<td>1,703 60</td>
<td></td>
<td>1,703 60</td>
</tr>
<tr>
<td>Speech &amp; Language</td>
<td>1,500 -</td>
<td></td>
<td>1,500 -</td>
</tr>
<tr>
<td>Targeted Offer</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Early Intervention Services</td>
<td>3,250 36</td>
<td></td>
<td>3,250 36</td>
</tr>
<tr>
<td>Incredible Years</td>
<td>1,966 -</td>
<td></td>
<td>1,966 -</td>
</tr>
<tr>
<td>Video Interactive Guidance</td>
<td>929 -</td>
<td></td>
<td>929 -</td>
</tr>
<tr>
<td>Targeted Speech &amp; Language</td>
<td>442 6</td>
<td></td>
<td>442 6</td>
</tr>
<tr>
<td>Family Nurse Partnership</td>
<td>1,953 50</td>
<td></td>
<td>1,953 50</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>10,617 234</td>
<td>8,572 108</td>
<td>19,189 342</td>
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</table>

6.2 It is recognised that Health Commissioners have already committed further funding to expand and develop the number of Health Visitors in Manchester. The shortfall will be addressed during the phased implementation of the NDM through a combination of revisiting existing cost assumptions and the projected cohort size, a further understanding and quantification of the benefits of reduced demand and exploring the potential for further new investment models.

6.2 The initial financial model and cost benefit has been illustrated and is set out below. The data needs to be developed in partnership between MCC and Health Services, so that a joint understanding is achieved of the modelled cost and benefit assumptions and the funding requirement. A joint approach to alternative investment proposals (e.g. asks of Whitehall and/or potential for
monies to be drawn down from Pupil Premium Plus funding can be developed and agreed). There will be continued work to understand the potential for transfer of monies through a community budget investment style agreement.

<table>
<thead>
<tr>
<th>Cost</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Integrated Care Pathway</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>MCC</td>
<td></td>
</tr>
<tr>
<td>Reduced safeguarding cost</td>
<td>15,285</td>
</tr>
<tr>
<td><strong>Health</strong></td>
<td></td>
</tr>
<tr>
<td>Reduced health cost</td>
<td>3,106</td>
</tr>
<tr>
<td><strong>DWP</strong></td>
<td></td>
</tr>
<tr>
<td>Benefits payments</td>
<td>1,831</td>
</tr>
<tr>
<td><strong>Total Benefits</strong></td>
<td>20,222</td>
</tr>
<tr>
<td><strong>Cost Benefit Realisation</strong></td>
<td>105.38%</td>
</tr>
</tbody>
</table>

6.3 The learning from the Troubled Families initiative will be applied in the development of an investment approach. The Manchester Investment Fund and NHS Health Visitors monies will be used to implement this initial phase based on theoretical cost benefit analysis. The actual costs and benefits will be tracked and modelled into the future recognising the longer term benefits. The evidence from these actual costs and benefits will be used to inform investment decisions for second phase implementation. This may require new investment models and by this stage it will be known what funding will be needed if any and there will be better evidence upon which to reach an agreement. At this stage a self sustainable model is possible.

6.4 The Cost Benefit Analysis (CBA) will identify which agencies benefit from the NDM and therefore if there are funding gaps where these could from. The intention is to increase the reach of the NDM incrementally and exponentially.

7. Proposed Phased Implementation

7.1 In discussion between the Local Authority and Health providers and commissioners, it has been agreed subject to the Boards approval, that implementation of the Early Years New Delivery Model should be phased in the three Clinical Commissioning Group areas in order to test the proof of concept. An Implementation Task Group will be established at the end of September to determine which three sites should be identified based on a set of agreed principles:

- Starting off small to enable implementation learning issues to be dealt with effectively
- Commissioning agreement to bring forward Health Visitor expansion in the identified areas to the planned 2015 levels.
- Successful recruitment of additional Health Visitors
• Existing levels of integration/co-location maximising the local leadership role of existing champions
• Demographic factors

7.2 A comprehensive project implementation plan will be developed with a detailed timeline and governance arrangements with the aim of beginning the phased implementation in April 2013. Between now and then key steps to be taken by the Implementation Task Group will be to:
• Identify the three areas for scale up based on the above principles
• Undertake movement/recruitment of staff
• Development of assessment tools through Greater Manchester Community Budget pilot Early Years Exemplar work
• Joint work between finance colleagues to define benefits and evaluation framework
• Ongoing discussions with Whitehall through the community budget work to identify opportunities for investment
• Progress reports to be made available to the Board as and when required

8. Recommendations

8.1 This paper and accompanying presentation has outlined the shared approach taken by MCC and Health partners in designing a shared and integrated approach to the design of the Early Years New Delivery Model.

8.2 The Board is asked to:
1) Approve the principles that have underpinned the design of the model.
2) Note the alignment to the Greater Manchester Community Budget Early Years Exemplar.
3) Approve the Early Years New Delivery Model.
4) Approve the proposed next steps to develop the Implementation Plan.
Early Years – New Delivery Model (Appendix to Report)
Health & Wellbeing Board 19th September 2012
## Early Years Offer

### CORE PURPOSE

#### INTEGRATED CARE PATHWAY

**Universal**
- Pre-birth/Health Visiting delivery of Healthy Child Programme (CMFT)
- Baby Express (MCC) (7,000 pa)

**Early help**
- Assertive Outreach (CMFT/MCC) (16,000 visits pa)
- Speech & Language (MCC/CMFT) (1,600 pa)

**Targeted**
- Clinical Psychology (MCC)
- Family Nurse Partnership (CMFT) (1,000 pa)
- Video Interactive Guidance (MCC) (300 pa)
- Parenting Courses (MCC) (1,000 pa)

#### DELIVERY OF CORE PURPOSE

**Community facilities**
- Job centre plus
- Adult learning and employment support
- Group sessions e.g. drop in clinics, stay and play, yummy mummy, dads club, baby massage
- Information, Advice & Guidance

**Sufficiency, Quality Assurance, Market Development**

#### TARGETED DELIVERY OF SUPPORTED DAYCARE

**Three and four year olds free entitlement @ 15 hrs pw**
- Three and four year olds free entitlement @ 15 hrs pw (8,700 pa)
- Three and four year olds free entitlement (800 pa)
- Disadvantaged two year olds (2,250 pa)

### Back office - Performance Management, Contract Monitoring, Business Support

**Pre-school special needs**
- Early Intervention Service

**Child in Need targeted support**

### How it would work in practice (case study)

Carol was new to the area & was referred to preschool psychology clinic by HV as follow on from 2 yr check because HV concerned about parenting style, skills & abilities. Carol did not attend appt so psychologist asked OW to visit Carol at home. When OW saw Carol she was depressed and experiencing major behaviour problems with her son. OW referred her to Local Integrated Connect Team for help with depression/getting back to work and made immediate referral to SLT into to help with son's speech and language delay. OW went to first psychologist appt with Carol which took place at Sure Start Centre. Carol told psychologist that she did not feel that she had a relationship with Tony at all; he never listened & was an embarrassment when they went out. They did not play together at all at home. Psychologist suggested Video Interaction Guidance. After just 4 video clips and 4 feedback sessions Carol now rates her relationship with Tony as 9/10 (compared with 1/10 at start). They play together most days & Carol now enjoys being a mum. OW also showed Carol other support and group sessions at Sure Start and supported Carol on her first few visits. Carol started to make friends as a result of attending Sure Start activities & became aware of other community activities.Carl is now volunteering as a Community Guardian & says that she feels happy about her life. She plans to get paid work when her work experience ends. Tony is really enjoying his time at the targeted 2s daycare & everyone has remarked how much his language skills have come on. Everyone feels far more confident about Tony starting school, school ready.
Early Years New Delivery Model

**What will be different**
- Defined service offer for both core and targeted services from Health, MCC and any other key partners.
- Consistency in delivery; delivery of minimum requirements e.g. visits
- Good practice embedded into core processes and consistently delivered across the city
- Clear understanding and demarcation between roles and responsibilities so that duplication is eliminated and nothing is missed out
- Speech and Language Therapy integrated into New Delivery Model
- Consistent assessment tools based on specified criteria with agreed referral triggers and referral processes
- Consistent communication processes and links between different service providers (including co-location and integrated teams where appropriate/feasible)
- Back office evaluation and analysis to ensure that key triggers are identified e.g. missed appointments
- Agreed information sharing protocols with supporting processes for managing data (paper and electronic)
- Agreed protocols for how the different agencies will work together
- Shared objectives, increased trust and understanding of different roles and requirements and how these contribute to shared objectives

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**Diagrams**

- Designated Sure Start Centre – advice and information about universal and targeted services. Group activities and training sessions, Outreach, Job Centre + & Adult Education
- Live Birth Data from the Registry & NHS matched
- Pre Birth Check
- Family Nurse Partnership
- Registries (Coroners Office)
- Referrals from outreach, daycare, schools/nurseries, sure start staff, GPs, RNPs etc.
- Does not Attend (DNA)
- Referrals to EIT from social workers, outreach and self referrals
- Safeguarding issues addressed via separate referral process (through Corporate Contact Centre)
- Onward Referrals
  - RP, Care Index, Incred. Yrs, Complex Families etc

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*No specific onward referrals at 4th health visit*
### Interventions & Key Roles

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Comment</th>
<th>Basis of evidence</th>
<th>Trigger point</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Designated Sure Start Centre (SSC)</strong></td>
<td>Provides advice and information about universal and targeted services, group activities &amp; training for parents. Assertive Outreach Worker based at SSC assesses needs, provides support &amp; interventions &amp; referral to targeted services.</td>
<td>Statutory requirement</td>
<td>Health visitors/FNP signpost to SSC and Assertive Outreach Worker publicises services, targets vulnerable groups undertaking home visits &amp; shows them round/introduces them on first visit. Assertive Outreach may also be triggered by partners (see below), daycare staff and Sure Start staff.</td>
</tr>
<tr>
<td><strong>Targeted Daycare (Targeted 2’s)</strong></td>
<td>Provides day-care places for Children in Need (CIN) and targeted two year olds (criteria free school meals) for 15 hours free entitlement to day-care provision.</td>
<td>Statutory requirement</td>
<td>Health Visitors/Social Workers and other key professionals will refer children to Childcare Commissioning Team (CIN) and/or Free Entitlement Coordinator (criteria free school meals).</td>
</tr>
<tr>
<td><strong>Assertive Outreach Service (AO)</strong></td>
<td>Targeted Assertive Outreach service following up non-attendance. Assertive Outreach will also refer to other services where appropriate.</td>
<td>Ardwick City Region pilot learning and other GM CR pilots. This is based on FNP in that it delivers very frequent contact with families. It uses assertive challenge to encourage families to attend appointments.</td>
<td>Midwives, GPs, health visitors &amp; FNP can all refer in for families who do not turn up/children have not been seen &amp; for cases where the family need additional social/emotional support.</td>
</tr>
<tr>
<td><strong>Baby Express (BE)</strong></td>
<td>Universal paced based tip sheet on monthly developmental milestones for babies 0-12 months</td>
<td>Subject to an RCT in the USA and is recommended in the NHS Healthy Child Programme. It has also been tested and proven to be effective in Ardwick City Region work.</td>
<td>All health visitors will seek consent from parents to sign them up to receive this monthly paper at home 0-12 months at their primary visit at 10-14 days.</td>
</tr>
<tr>
<td><strong>Incredible Years, Care Index and Video Interactive Guidance (IY or CI/VIG)</strong></td>
<td>Targeted evidence based parenting assessment tools and programmes that ensure a secure attachment is made between parent and infant (significant impact on outcomes, relationship patterns and brain development in babies)</td>
<td>VIG is recommended in the NICE guidelines and Dartington are reviewing the CBA potential of this intervention via GM CB EY work. IY is recommended by Graham Allen has been tested in Manchester in Ardwick and city-wide by Parenting Commissioning. IY has been subject to meta-analysis and CBAs</td>
<td>Health visitors, GPs, midwives and targeted Assertive Outreach workers could refer in to these interventions based on visits/appointments etc. The intervention providers (clinical psychs) will triage if they are appropriate cases and advise which options are best using comparative standard measuring tools.</td>
</tr>
</tbody>
</table>
## Interventions & Key Roles

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Comment</th>
<th>Basis of evidence</th>
<th>Trigger point</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Intervention Team / Family Support</td>
<td>This team forms part of the regulatory requirements for Sure Start Core Purpose. Targeted support provides accessible, evidence based interventions in order to prevent difficulties from escalating. These roles are commissioned and some are directly delivered by MCC with MCC family support workers working in an integrated way with existing commissions across the districts.</td>
<td>EIT workers are trained in a range of evidence based interventions and approaches to problem solving that seek to identify family strengths and encourage parents to take steps to find their own solutions. These include Webster Stratton, Parent Partnership, Solihull Approach and Triple P programme.</td>
<td>Service users can self refer or be referred by a range of agencies e.g. Assertive Outreach workers, area social work teams, Health Visitors. The aim of the service is to target families who lie just below the criteria for statutory intervention. Assessments are made using a checklist e.g. comprehensive support checklist and pre-CAF assessments.</td>
</tr>
<tr>
<td>Speech &amp; Language Therapy (S&amp;LT)</td>
<td>Universal support to all frontline staff in health visiting and children’s centres on helping parents to develop language acquisition of infants. There are also some targeted courses and interventions on offer.</td>
<td>Case study level of evidence support base available. Work needs to be undertaken to develop the evaluation framework for capturing the evidence of the interventions on offer.</td>
<td>Health visitors, GPs, midwives and targeted Assertive Outreach workers could all refer in to these interventions. The intervention providers (clinical psychologists) will triage if they are appropriate cases and advise which options are best using comparative standardised measurement tools.</td>
</tr>
<tr>
<td>Health Visitors</td>
<td>Health Visitors are qualified registered nurses who specialise in public health nursing. They lead and deliver the Healthy Child programme which is designed to offer a core, evidence-based programme of support starting in pregnancy and throughout childhood.</td>
<td>Universal Provision</td>
<td>All births</td>
</tr>
<tr>
<td>Family Nurse Partnership (FNP)</td>
<td>This is a targeted intervention for first time teen parents before 34 weeks gestation until the baby is 2 years old. Intervention delivered at home via structured programme of 64 visits.</td>
<td>FNP is listed in the NHS Healthy Child Programme. It is listed in the Graham Allen review. It has been subject to CBA and meta-analysis and takes key learning from the outcomes achieved in the MCC commissioned S&amp;LT service over previous years.</td>
<td>By midwives usually when first time teen parents come for early midwifery appointments.</td>
</tr>
<tr>
<td>Other Interventions</td>
<td>FIP: FIP forms part of the operational model however there is no financial implications that need to be considered because if a cohort is identified as needing the service, they will be referred into the Troubled Families model Bookstart: The programme is fully funded by the Department of Education and then co-ordinated, resourced and delivered locally. As there is funding in place for this for the foreseeable future, there is no financial implications to be included within this model.</td>
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</table>
Integrated Care Pathway
Financial Modelling Assumptions

• The assumptions around the allocation of families into each of the targeted interventions is based on the scaling up of the services included within the Ardwick pilot and based on current cohort size from analysis of the census/population/live birth data

• Key driver of the financial model is Health Visitors, specifically the 4 health visits scheduled between 0-2y and the associated drawdown of targeted interventions arising from such visits.

• Assertive Outreach of 60 ftes may need to flex with phased recruitment of Health Visitors

• Midwifery not included at this stage – update to be provided from GM community budget work

• Universal Speech and Language – based on Health provision for 0-16 year olds assuming 75% on 0-5

• Early Intervention Team based on current provision of £1.5m MCC provided and £1.8m commissioned

• Family Nurse Partnership costs based on current arrangements for support to targeted cohort
# Cost Benefit Analysis of Integrated Care Pathway

<table>
<thead>
<tr>
<th>Description</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cost</strong></td>
<td></td>
</tr>
<tr>
<td>Integrated Care Pathway</td>
<td>19,189</td>
</tr>
<tr>
<td><strong>Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>MCC</td>
<td></td>
</tr>
<tr>
<td>Reduced safeguarding cost</td>
<td>15,285</td>
</tr>
<tr>
<td>Health</td>
<td></td>
</tr>
<tr>
<td>Reduced health cost</td>
<td>3,106</td>
</tr>
<tr>
<td>DWP</td>
<td></td>
</tr>
<tr>
<td>Benefits payments</td>
<td>1,831</td>
</tr>
<tr>
<td><strong>Total Benefits</strong></td>
<td>20,222</td>
</tr>
<tr>
<td><strong>Cost Benefit Realisation</strong></td>
<td>105.38%</td>
</tr>
</tbody>
</table>
**Cost Benefit Analysis**

**Key Issues**

- The initial CBA modelling is to engage partners in a discussion around funding and cashability of reduced demand for services across the public sector. Ultimately the CBA is a mechanism to agree what key metrics we would track and over what period in order to derive an investment agreement.

- Benefits have been modelled only in the short/medium term (5 years) – the nature of investment in Early Years means we could be missing significant potential savings in the longer term as we improve school readiness across the cohort and the associated longer term outcomes that arise from school readiness (refer Asks of Whitehall page).

- Development of the CBA requires research of academic papers to inform the likely benefits and is a process that is only part complete - further work required with GM colleagues.

- In the USA, the FNP and HV CBA showed savings in crime & disorder spend. These benefits will only accrue 10-15 years further down the line which is why they are outside of the scope of the short term benefits considered here.

- There is a significant element of benefits flowing outside the investing partners in the form of reduced benefit payments. We would need to consider how we might capture such benefits from e.g. work programme primes and alignment with mechanisms already in place around Troubled Families.

- There is a question as to why we would fund interventions such as Assertive Outreach where the costs outweigh the benefits. However, the CBA does not consider any benefits after 5 years, nor does it consider the role of the Assertive Outreach workers in signposting to other services which do have a ratio greater than 1. We should look at the totality of the model once the benefits are completed.
We will apply the learning from the Troubled Families initiative around an investment approach – specifically, implement small scale, collate evidence of real costs and benefits, before next phase of scale up review the evaluation and then discuss the investment required from whom.

Every time we seek to scale up this will be done on the basis of the evaluation of the implementation, incorporating evidence and learning to enhance the effectiveness and efficiency of the model.

The CBA will identify which agencies benefit from the NDM and therefore where any funding gaps should be filled from.

This is consistent with the notion of the phased implementation.
Timescales – Implementation

- Approval of the New Delivery Model by the Health and Wellbeing Board 19th September 2012
- Joint Implementation Board formed by end of September 2012
- Manchester’s proposals included within the GM Community Budget Early Years Exemplar
- Implementation Plan by December 2012
- Proposed phased implementation in 3 CCG areas from April 2013
Challenges and Assumptions

- The total cost of the model will fluctuate depending on actual number of births/population migration compared to current forecast. This is a key risk as some of these services are statutory responsibilities that MCC are required to carry out regardless of changes in demand.
- Whilst we have been unable to determine a cost of assessment at this point, we have made implicit assumptions around the drawdown of additional targeted services.
- Whilst the modelled percentages of people requiring targeted interventions are based on best available evidence (and are broadly in line with DfE estimates), there is an inherent risk in any modelled assumption that the actual data will vary. As such, a small percentage variance in the cohort size will have a sizeable impact on the costs of the model.
- As part of the detailed design phase, we will need revisit and stress test some of the key assumptions.
- Early education, targeted childcare and core purpose are primarily universal service and funded from Council budget and Dedicated Schools Grant.
- Cost assumptions and estimation of financial benefits need to be revisited to ensure affordability of the model.
### Key Risks and Assumptions

<table>
<thead>
<tr>
<th>Assumptions</th>
<th>Implication</th>
<th>Recommendation</th>
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<tbody>
<tr>
<td>Family Nurse Partnership</td>
<td>The Family Nurse Partnership is a pilot which is currently under evaluation with the results due in April 2013. This American model requires full model fidelity to increase the likelihood of being successful and is delivered by Health Visitors. Decisions regarding future funding will be considered as part of the evaluation which will also address outcomes and future provision.</td>
<td>FNP inclusion within the EY New Delivery Model to be reviewed April 2013</td>
</tr>
<tr>
<td>Health Visitors</td>
<td>- The National Programme - Call to Action is leading the recruitment and development of health visitors. An additional 65 Health Visitors are required to be recruited between now and 2015 to enable the Early Years New Delivery to be fully functional and deliver the benefits described.</td>
<td>The Health Visiting Task Force to provide regular progress to the Health and Wellbeing Board The number of Assertive Outreach Workers to be flexed in response to the progress on recruitment</td>
</tr>
<tr>
<td>Buildings</td>
<td>- Funding for the 39 Sure Start Centres is programmed at current levels until March 2014. Work is currently on going to ensure that the Sure Start Centres are sustainable community assets and provide a wide range of integrated services for communities. It is assumed that the work on sustainable community assets will provide 1.5m from April 2014</td>
<td>Any emerging risk to the current programmed activity to be escalated</td>
</tr>
<tr>
<td>Assertive Outreach workers</td>
<td>- 60 Assertive Outreach Workers are profiled, this figure is predicated on the learning from Ardwick and the Health Visitors programmed recruitment. As the number of Health Visitors increases the number of Assertive Outreach Workers is likely to reduce. In order to flex the Outreach activity in line with the recruitment of Health Visitors a mixed model of commissioned and directly provided services will continue.</td>
<td>Regular review of progress on the recruitment of HV and associated impact on Assertive Outreach Workers</td>
</tr>
<tr>
<td>Funding</td>
<td>- The funding for the new model is based upon the current data with regard to provided and commissioned services. Through this work it is recognised that improvements to unit costing and collation of outcomes is required to enable more sophisticated approaches to evidence based new investment models. - The model shows a funding gap of £3m at present. Work is required to bridge this gap.</td>
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**Identifying the Benefits**

<table>
<thead>
<tr>
<th>Issue</th>
<th>Implication</th>
<th>Recommendation</th>
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</table>
| Benefits | - Of the CBA undertaken, benefits accrue to MCC (LAC), work programme (through tackling worklessness) and health (mental health benefits arising from the interventions) although note such benefits will be challenged through the work of the GM team and are likely to change.  
- It is unlikely partners would accept such modelled benefits as they stand without support from actual evidence verified by them in their locality – experience from Troubled Families work has borne this out. Given the timeframes involved in collating and analysing such data however, it is unlikely to be feasible to wait for evidence to arrive.  
- As such, we are faced with a funding shortfall of c£3m if we are to deliver the model on a fully rolled out basis to our modelled cohort. The question is therefore to what extent is their appetite from partners, most likely Whitehall, to pay for EY outcomes delivered and on what basis would such a payment be made? | - The most tangible outcome we have identified is the school readiness metric, specifically the score at the end of the Foundation Stage for children aged 4/5. The unit value in the current funding formula for schools (part of DSG) is £1,276 for each child that scores less than 78 points on the EY Foundation Stage profile. This benefit would be cashable within the Council's DSG until 2014/15. From 2015/16 school funding may well be fully nationalised and then benefit would be cashable in DfE budgets. Clearly, there is a perverse incentive in the system for schools to claim additional funding through identifying a greater amount of low test scoring.  
- We would like to independently test such scores with a view to developing a PBR mechanism that would part fund the EY model. Note that further work is required around the quantum of any payments, any additional metrics that would be relevant and the timing of such payments. |