Manchester Health and Wellbeing Board
Report for Information

Report to: Health and Wellbeing Board – 10 September 2014

Subject: Early Years Update

Report of: Director of Education and Skills

Summary

This report provides an update on the implementation of the Early Years New Delivery Model and the position and progress that has been made in relation to recruiting Health Visitors to the City. In addition it provides an overview of the planned roll out of the Early Years New Delivery Model from April 2015.

Recommendations

The Board is asked to note the report

Board Priority(s) Addressed:

Priority 1

Contact Officers:

Name: John Edwards
Position: Director Education and Skills, MCC
Telephone: 0161 234 4314
E-mail: j.edwards@manchester.gov.uk

Name: Karen Jarmany
Position: Head of Schools Quality Assurance and Early Years, MCC
Telephone: 0161 234 1078
E-mail: k.jarmany@manchester.gov.uk

Name: Sue Ward
Position: Director of Nursing (Children), CMFT
Telephone: 0161 701 0331
E-mail: sue.ward@cmft.nhs.uk

Background documents (available for public inspection):

None

1. Introduction: The Early Years Offer

1.1 Following statutory consultation in February 2012 the Executive resolved to transform early years services in the City in support of the Community Strategy priorities and in the light of continued evidence of the challenge of ensuring that children in Manchester achieve a good level of development by the age of 5.

1.2 Early Years services are central to reducing low skills and worklessness for parents in support of the wider priority of the Council and support the Community Strategy priority for growth alongside Public Service Reform to reduce dependency. The transformation of Early Years was agreed to include withdrawal from being a direct provider of universal day-care to enable resources to be focused on commissioning a targeted family offer for those most in need, including adopting a model of assertive outreach; and repositioning of buildings as community assets within neighbourhoods.

1.3 In this context a three part Early Years Offer for the City has been developed:
- (i) an Early Years New Delivery Model (see below) working in an integrated way with health partners;
- (ii) access to good quality, accessible and affordable childcare and early learning places across the City; and
- (iii) ensuring families are connected to an integrated and targeted family offer delivered by Sure Start Children's centres through the revised Sure Start Core purpose

2. The Early Years New Delivery Model

2.1 The Early Years New Delivery Model (EYNDM) is an integrated pathway for all children from pre-birth to 5 years of age in partnership with health care and early years professionals. The model supports the delivery of the Sure Start Core Purpose which has at its heart improving outcomes for young children and their families and reducing inequalities in: child development and school readiness; parenting aspirations and parenting skills; and child and family health and life chances. The EYNDM incorporates the new model for Health Visiting in accordance with the national 'Call to Action' as well as sitting within the Living Longer Living Better (LLLB) strategy for the City. Getting the 'right start' is most likely to lead to better physical, social, emotional and educational outcomes, from children being school ready at the end of the Early Years Foundation Stage to having improved life chances in the longer term.

2.2 An 8 stage model based on assessment at key points has been developed across Greater Manchester. It is anticipated that this model will be rolled out across Greater Manchester from April 2015, in line with the national expansion of Health Visitors. The 8 stage model largely aligns to the requirements of the Healthy Child Programme and has a requirement to use the Ages and Stages Questionnaire (ASQ) as the main assessment tool; this is an advantage for Manchester as Manchester Health Visitors already use the ASQ. (Appendix 1 provides a summary of the original AGMA 8 Stage model)

2.3 A further key component of the model is targeted early years assertive outreach to children and families identified through the assessments as requiring interventions to achieve age-appropriate child development and school readiness and/or a secure pathway into work for the parents and carers to reduce long term dependency. These evidenced based interventions are sequenced and support development at family level.

2.4 A catalogue of evidence based interventions has been developed and agreed for use across Greater Manchester; interventions used in Manchester for targeted support are being taken from this list, for example, Parenting Programmes - 'Incredible Years'; Speech and Language Therapy - 'It Takes Two to Talk' and Family Nurse Partnership.

2.5 Progress has been made in Manchester in the early implementation of the model which was fully introduced in Rusholme from 1 April 2013 and extended to Old Moat and Charlestown in November 2013 following Health Visitor (HV) recruitment. Data is continuing to be collected and analysed to support the development of the evidence base and to gather information on the activity and impact of interventions being used.

3. Health Visitor and Out Reach Worker Recruitment

3.1 The Health Visitor (HV) workforce expansion at CMFT requires the doubling of the workforce over a four year period. The profiling of the expansion is up to 1 April 2015 with a target of 173.6 FTE Health Visitors to be recruited by this date. In June 2014 130.58 FTE HVs were in post, leaving 43.02 FTE HVs to be recruited between July 2014 and 1 April 2015.

3.2 A key component of the workforce strategy is a 'grow our own' approach. 32.4 FTE students are set to complete their training and enter the workforce this year. Factoring in a number of planned leavers, and based on the NHS England prediction tool, an estimated further 20 FTE external HV's therefore need to be recruited.

3.3 The workforce action plan includes a high profile, targeted media campaign throughout August and September. There is a well developed Recruitment and Retention Strategy in place which is monitored through the Health Visiting Task Force.

3.4 Out Reach Worker recruitment has been completed apart from three vacancies which will be recruited to before September 2014.

4. Model Fidelity

4.1 Local Authorities across Greater Manchester are at different stages in terms of achieving complete fidelity with the proposed AGMA model. Work has been completed to ensure model fidelity between the Manchester and AGMA models in terms of the eight assessment stages and their associated tools. This reflects some developments in the original AGMA model and the alignment of the AGMA and Manchester models for the 8 assessment stages

has been mapped out. (See Appendix 2) Further work is planned in August 2014 to align the evidence based interventions.

5. Roll out of the Early Years New Delivery Model from April 2015

5.1 The full staffing complement required for delivery, subject to Health Visitor numbers, will be in place from April 2015 across the City as Health Visitor recruitment reaches required levels.

5.2 The full roll out of the EYNDM will mean that in April 2015:

- the staffing infrastructure will be in place
- the Sure Start Core Purpose will be delivered using a place based approach with 14 Sure Start groupings, 6 of which will be managed and organised on behalf of MCC by five public sector and voluntary organisations
- the place based groups will be aligned across the health service estate
- the first five stages of the eight stage assessment model will be in place across the city
- assessment stages 6,7 and 8- subject to finalising- will be trialled in schools in common with authorities across GM.
- Full implementation of the assessment stages and the commissioned evidenced based interventions at scale for all babies born after 1st April 2015
- The MCAF will be the standard multi agency assessment tool

5.3 As a consequence there will be full implementation for 0-1 year olds, compliance with the Healthy Child Programme (HCP) for all under 5s subject to HV recruitment and an integrated team approach for all under 5s. Evidenced based interventions for other age groups (2-5 years) will be below the level of capacity suggested by previous modelling.

6. Financial Modelling

6.1 The financial model for the Early Years New Delivery Model (EYNDM) was provided to the Early Years Steering Group and Early Years Strategic Group in April 2014. This identified an initial estimated gap in funding of £3.4m based on available resources and the estimated costs of delivering the model to meet expected need assuming full scale implementation across the city from 1st April 2015.There is continued modelling of the costs of scaling up interventions to full capacity. Further work has been undertaken in relation to clarifying:

- The cost and volume of current commissions by CCGs, NHS England and the Council for targeted interventions included in the model
- Further explanation of how local need has been identified
- The impact on the funding gap of rolling out the model on a phased basis focussed on new births from April 2015.
- Benefits of alliance contracting for 2015/16

This further work has resulted in a revised financial model, as set out in section 8 below.

6.2 Current Commissions
Funding from Clinical Commissioning Groups for the EYNDM relates to the Speech and Language Therapy for all age children with Central Manchester Foundation Trust and it has been agreed this has an estimated cost of £435k reaching an estimated 584 children. Further information has been requested from CCG commissioners to understand the cost of the contract, price and volume in relation to children under five years old.

6.3 The Council has a current commission with CMFT for £282k for 2000 children. The local assessment of need is a targeted cohort of 2,748 two year olds (30%) needing this intervention. As the estimate is that the CCG contract can fund the intervention for 584 children, this would require the contract to increase for caseload of 164 children at an additional cost of £23k which could be met from additional investment identified for speech and language in the Council's 2015/16 EYNDM. This would remove the identified gap on speech and language of £1.177m.

6.4 Every Child A Talker (ECAT) intervention is not currently commissioned in Manchester, so the unit cost used has been taken from the Social Finance model with a gap in funding of £249k. ECAT is not in the communication and language service specification for the EYNDM. It seems that the specification refers to using the ECAT principles so there may not be a need to commission the actual programme as quoted in the Social Finance model. This would reduce the gap by £249k.

6.5 Since the meeting in April, NHS England has confirmed the value of the contract for Family Nurse Partnership with CMFT to have a cost £835k for 2014/15 with minimum caseload volume of 300 children for the 2-2.5 year programme. This contract value is higher than assumed in the modelling, however as actual annual unit cost per case is around £400 higher than in the Social Finance model the gap is actually increased by £91k.

6.6 Incredible Years: the gap identified based on the Social Finance model is £975k. The costs of the current contract with CMFT are consistent with the Social Finance modelling.

6.7 NHS England has recently confirmed that the CMFT is expected to use NBAS and NBO by end of March 2015 as part of the contract for Health Visiting, within the proposed contract values with the contract incentive (CQuIN) dependent on delivery of this. It is expected that 1 health visitor per locality is trained in NBAS to train and support other colleagues in the area. The identified gap in the model for this was £55k which could be removed on the basis of this information, though this would be subject to contract negotiations.

6.8 The assessment of local prices and current volumes of activity provided has reduced the estimated gap of £3.4m to £2.1m, with further work required to challenge costs of Incredible Years. This is summarised in the table below.

EYNDM - Funding Gap	Current level of provision	Local assessment of need	Shortfall on full scale roll-out
	Cohort	Cohort	£000
Incredible Years	987	2,524	813
Speech & Language	2,584	2,748	0
Family Nurse Partnership	300	772	1,314
			2,127

7. Identification of local need

7.1 In September 2013 a financial modelling exercise was undertaken within MCC. This had two purposes; to plan the affordable rate of intervention and the likely uptake to inform the distribution of spend across the assessment model; and to demonstrate the level of local need in Manchester at ward and CCG level in order to inform the apportioning of investment. This work needs to be revisited in the light of further discussion about model fidelity and refreshed analysis of need.

8. Phased roll out of the model

8.1 As set out in 5.2 above, it is proposed to roll out the NDM on a city wide basis from 1 April 2015 for all new births. Initial plans had been for a city wide roll out for all children aged 0-5, but lack of capacity in some of the key interventions required, particularly Family Nurse Partnership, where it will not be possible to attract and train the workforce in the timescales, alongside affordabilty considerations, require a phased approach. As noted in 5.2 above, most aspects of the full model will be in place for all children aged 0-5 across the City from this date. This is consistent with the advice from the GM Early Years Team and the recommended approach across GM.

8.2 Using the revised modelling set out above, the table below shows how the funding gap would slowly build up if the New Delivery Model continued to be phased in for new births. By year five all children would be on the NDM. The evaluation will track the impact of the NDM on Health Visitor caseloads which will inform future staffing requirements. However, the anticipated increase in referrals to the targeted interventions, particularly Family Nurse Partnership, Incredible Years and Speech and Language therapy means that additional capacity is likely to be required resulting in the total cost modelled below of £2.1m over current funding levels. This is based on modelled assumptions from the Social Finance Investment model. The phased approach to implementation and experience from the three current pilot sites will enable these assumptions to be refined.

8.3 The NDM is fully funded with an estimated financial gap of £1.1m for 2016/17, rising to £1.9m in 2017/18 and £2.1m when the model is fully implemented.

Partners involved in the commissioning and delivery of the NDM have committed to meeting this funding gap between them. Further work is being carried out to refine the costs and assumptions which will inform the commissioning discussions on how the gap can be addressed.

8.4 The affordability has been based on what has been identified as available funding for the NDM and does not necessarily equate to what we spend now.

9. Alliance contracting

9.1 The principle of an alliance contract is to move away from the current situation where providers have individual contracts for their specific services, to one where providers sign up to a single, shared contract covering the whole health and care system. In this way, providers have contractual and financial incentives to work together as an alliance to deliver against shared outcomes.

9.2 Organisations would work together to achieve targets on a shared performance framework. This is one of the key innovations of the alliance contract as it gives more scope to use system level outcome measures rather than output measures for one organisation's part in the system. It also generates the need for closer working between organisations,

9.3 The contract would include a set of principles, agreed by alliance partners, which state how they will work together. It also sets out the high level mechanisms through which alliance partners will work together.

9.4 Current partners for the EYNDM are commissioners Manchester City Council, Manchester CCGs, NHS England and providers being the Central Manchester Foundation Trust as the main citywide provider of health visiting and interventions and schools and early years providers.

9.5 From October 2015 NHS England will transfer all of its commissions in relation to the EYNDM in Manchester to MCC relating to the Health Visiting and Family Nurse Partnership. However NHS England will retain responsibility for the Child Health Information System for which there is a contract with CMFT. Whilst not being specifically part of the model this system is a key part of the delivery of the EYNDM as it notifies of new births, immunisation information, issues NHS numbers and notifies Health Visitors.

9.7 It is recommended that a pre-alliance contract is pursued for 2015/16 between MCC, Manchester CCGs, NHS England and CMFT. It is not recommended that the approach is extended to individual schools and early years providers due to the number of providers and as Department for Education have enshrined in law the basis on which payments to such providers are made. MCC would need to consider scope for incentivising the principles of alliance contracting with those providers.

10. Evaluation

10.1 Data continues to be collected and analysed to support the development of the evidence base and to gather information on the quantity and impact of interventions being used. An evaluation document is being produced which will be aligned as far as possible to an agreed outcomes framework across GM. This GM wide outcomes framework is work in progress. A longitudinal evaluation involving Universities from across the region is under discussion with a further meeting planned for the Autumn.

11. Summary

11.1 Manchester is progressing in terms of delivering the EYND. The work in the early implementation sites has been invaluable in testing the operational issues, the strategic issues in aligning the Healthy Child Programme with the 8 stage model and the issues with data and evaluation.

11.2 Recruitment (and retention) of Health Visitors has made progress and there is a well developed Recruitment and Retention Strategy in place which is monitored through the Health Visiting Task Force.

11.3 System wide issues including a range of information sharing, system and technical issues continue to be addressed to support full scale up of the model.

Appendix 1 – Original AGMA – 8 Stage Assessment Model

Error! Objects cannot be created from editing field codes.

Error! Objects cannot be created from editing field codes.

Appendix 2 Alignment of the AGMA and MCC models – 8 stage assessment

AGMA new delivery model	Manchester new delivery model	Comments
Stage 1 This stage is being reviewed. It may become 28 week to 32 week antenatal contact carried out by the Health Visitor (HV) home visit.	Stage 1 28-32 weeks antenatal contact. Health visitor home visit. **Aligned subject to AGMA review**	AGMA original Stage 1 is under review. Previous Stage 1 – Before 12 weeks - will continue but will be part of the regular contact with the midwife before 12 weeks and at other pregnancy points.
Stage 2 10-14 days HV home health and social assessment. NBO/NBAS plus questions about the home learning environment.	Stage 2 Equates to 14 days new birth visit, HV home visit. NBO/NBAS not currently completed but possible to complete. See comment **Aligned -** review of costing required	View is that home learning environment needs to be in professional's mind throughout all stages 1-8. It is only scored in Stage 6. **Pump priming cost of training and supervision for NBO/NBAS is £80K. This training will be available in February 2015. Rolling cost for training and supervision required**.
Stage 3 2 months, HV home visit using ASQ3. AGMA exploring use a small number of questions relating to Home Learning at this visit.	Stage 3 Equates to 2 month health and development review using ASQ 3 (maternal mood review) **Aligned – requires further clarity from AGMA**	AGMA to finalise what they are asking in terms of how much overlap there will be between the Home Learning Environment Indictors and current health visitor requirements.
Stage 4(a) 9 months ASQ3 HV	Stage 4(a) 9 months ASQ3 HV **Aligned**	LA could consider building in ASQSE. AGMA looking at ASQSE – testing this out as a possible targeted edition not to be used routinely although some LAs are considering ASQSE more routinely.
Stage 4 (b) 18months targeted assessment/light touch- can be carried out by either HV,	Stage 4(b) 18 months targeted- Manchester to trial this. Target concerns arising at the 9	All LAs can negotiate how to use workforce for this assessment stage. Needs a contracting discussion as HV in

ORW, FSW or equivalent professional.	month check. **Work underway to achieve alignment**	Manchester are not commissioned for this assessment currently.
Stage 5 24 months HV, ASQ3	Stage 5 2 year HV Health and Development review **Aligned**	View is that DfE less interested in an integrated review at 2 years (EY and HV). AGMA wants HV to see child at 2 years not 2 years plus. There are too many EY settings for it to be an integrated review - likely to be a virtual integrated model. The outcome is that the information is shared. (Manchester is not one of the 5 pilot sites for the integrated review at 2 years).
Stage 6 36 months ASQ3/ EYFS Use of the Home learning Index - 'a job for the school'	Stage 6 36 months Explore use of the Home Learning Index with the four schools in the early implementation in Manchester. **Aligned**	Conference in September 2014. 4 schools identified: Newall Green PS, Heald Place PS, St Agnes PS, Broadhurst PS. EYFS profile is no longer a statutory requirement from 2016. A new baseline 'test' to be introduced by DfE. Schools can select a test from a range of commercial options. There is a plan to aim for one GM wide baseline tool plus ASQ3 to develop a GM baseline measure.
Stage 7 48 months	Stage 7 48 months **Early Implementation schools will work to develop alignment**	Schools and School health teams to be involved.
Stage 8 Before child's 5th birthday	Stage 8 Before Child's 5th birthday **Early Implementation schools will work to develop alignment**	Schools and School health teams to be involved.