States of Jersey

A Proposed New System for Health and Social Services

# Refocusing Services for Children: Early Intervention

## Scheme-level Outline Business Case (OBC)

**Version 2.0**

**13 June 2012**

# This document

## Purpose of the Outline Business Case

The Green Paper, *'Caring for each other, caring for ourselves'*, was produced in May 2011. Following public consultation, eight service areas were selected for early service development in 2012 – 2015. Sustaining Acute Services was identified as being 'Business As Usual', and was removed from the OBC list, therefore, seven OBCs have been produced.

Each proposed service change has been developed robustly, with full involvement from stakeholders. Working groups have used an Outline Business Case (OBC) template when discussing and developing the service changes, in order to ensure that all relevant aspects have been considered. The template incorporates guidelines from the UK Government's website on Business Cases as well as the template on the Treasury & Resources website.

Once approved, each OBC will be progressed to Full Business Case (FBC) – this is anticipated to be by Autumn 2012. The FBC will provide detail on the service change, including detailed timescales and action plans for implementation. Service implementation commences once the FBC has been approved and fund secured from the Medium Term Financial Plan, which is due to be agreed in late Autumn 2012.

## Structure of this document

This Outline Business Case presents the elements of service change that must be considered in order for plans to be robust, stakeholders to be fully engaged, and risks to be managed effectively.

The case for change for refocusing services for children is presented, building from the case for change in the Green Paper. The linkage with the HSSD strategic principles and with the relevant services' strategies is clearly identified. The outcome of the Green Paper consultation, and in particular the views of stakeholders received during the consultation period have been presented where applicable, in recognition of the importance of these views.

The OBC then outlines the proposed service change, and the elements thereof, for example, the impact on workforce, on costs and on service delivery / quality.

Indicative costs and benefits are outlined. Some rounding adjustments have been made. All costs are presented at prices relevant to the each year, to ensure that the full cost of the proposals is understood. Costs and benefits which are quantitative and qualitative, short and long term and relevant to patients / service users / carers / families, clinicians and the public have been considered.

Implementation considerations are then presented, including stakeholder engagement and communication, key risks and issues for both the implementation period and for the full service delivery.

## Revision history

| Version | Date | Author | Description |
|---|---|---|---|
| 0.02 | 20.11.11 | Andrew Heaven | Second Draft minus financials |
| 0.003 | 01.11.11 | Andrew Heaven | Revised OBC Structure + financials |
| 0.004 - 5 | 2.11.11 | Scott Maslin | Overall review of document |
| 0.006 | 7.11.11 | Andrew Heaven | With references + Illustrations |
| 0.10 | 30.11.11 | Scott Maslin | Generic updates |
| 0.11 | 16.12.11 | Andrew Heaven | Revised Financials |
| 0.12 | 15.03.12 | Andrew Heaven | Revised Financials + Revised Timeline |
| 1.0 | 20.05.12 | Rachel Williams | Final review and revision |
| 1.1 | 20.05.12 | Andrew Heaven | Final review and revision + SRO Comments |
| 2.0 | 13.06.12 | Rachel Williams | Finalisation |

# Table of Contents

# Abbreviations and Definitions

| Abbreviation | Definition |
|---|---|
| CAMHS | Children Adolescent Mental Health Services |
| CIN | Children in Need |
| CP | Child Protection |
| ESC | Education Sports and Culture |
| FBC | Full Business Case |
| HSSD | Health And Social Services Department |
| JCAF | Jersey Common Assessment Framework |
| JCCT | Jersey Child Care Trust |
| JCPC | Jersey Child Protection Committee |
| LAC | Looked After Children |
| MESCH | Maternal Early Childhood Sustained Home-visiting |
| MTFP | Medium Term Financial Plan |
| OBC | Outline Business Case |
| SUI | Serious Untoward Incident |

# 1 Executive Summary

In common with jurisdictions and countries across the world, Jersey faces substantial current challenges in ensuring the availability of high quality health and social care for its citizens within a financially affordable sum. The KPMG technical document and the Green Paper, both published in May 2011, demonstrated that health and social care services in Jersey are at a crossroads. Existing capacity is due to be exceeded in some services in the near future, the elderly population is rising disproportionately and almost 60% of the medical workforce is due to retire in the next 10 years.

In early 2011 the vision for health and social care in Jersey was agreed. This clearly stated that services must be safe, sustainable and affordable.

The public consultation on the future of health and social services in Jersey concluded on 22 August 2011. Since that time, a Working Group has been considering the service changes that are required urgently; this Outline Business Case is a result of that process.

## 1.1 Strategic Context

Children's health matters to children, families and communities. The protection and promotion of a child's health is much more than the endeavours of staff within a hospital. It is the culmination of many individuals' interventions, from parents and siblings to Health Visitors and Nursery Workers and many more. The underpinning principle behind this OBC is that we all have a part to play in ensuring children continue to thrive within our community, and that only by working together with a shared aim will we achieve this ambition. National research into this area supports the view that investment in children and their families during early years will be repaid many times over in later years. We believe that Jersey would be no different.

## 1.2 The case for change

Over the past decade evidence has emerged that the quality of experiences in the first five years of life can have a profound impact on a child's future development, learning, behaviour, health and the ability to build positive, secure attachments, and on truancy, conduct disorder and risk-taking behaviours such as substance misuse and mental illness. Potential economic implications include an estimated cost for each child with untreated behavioural problems of £70,000 a year by the time they reach 28 years old – 10 times the cost of children without behavioural problems, an average estimated cost of £430,000 for an individual spending a lifetime on benefits.

'Early Intervention' improves a child's social and emotional capability to help break intergenerational cycle of disadvantage and underachievement. Health economists have calculated that a return of up to 3 to 7 times the original investment could be achievable by the time the young person is 21 years.

### Local challenges

The KPMG 'Technical Document' in May 2011 concluded that the current institutionalised model of care had led to increasing and unsustainable demands being placed on Statutory Services for Children, including Residential and Fostering Services. It also identified high levels of Emergency Department activity for children

which could be more appropriately seen within Primary Care, limited Maternity provision in Primary Care and pressure due to very high referral rates and the difficulty of securing a good supply of foster carers.

At an operational level there is much passion and energy. There is a diverse range of different programmes delivered by an equally diverse range of agencies. However, services can be uncoordinated, and coordination is required between the key statutory and voluntary agency partners in order that the right child gets the right intervention at the right time. Joint and interagency planning with common goals is vital.

There is an absence of published local outcome measures, although anecdotal evidence from colleagues working in the education system note a significant variance in children's school readiness at age five.

Investing in Services for Children to deliver prevention and early intervention during the first five years of life would provide a vital social and emotional foundation and would result in a reduction in demand for statutory based residential services for children, costs and a reduction in crime and antisocial behaviour as more young people mature into adulthood with better preparation for employment and increased ability to play an active part in the community in which they live.

### 1.3 Service Objectives for Refocusing Services for Children

The overall aim of the developments in Services for Children in 2013 – 15 is to increase 'school readiness'. This objective is shared with the Education, Sport & Culture Department.

### 1.4 Redesigning Services for Children (0 – 5 years) by 2015

This 'Early Intervention' OBC comprises:

1. **Increased awareness and self help**. Easily accessible self help materials which assist parents to develop their skills and knowledge about parenting. Improve signposting towards local community groups and primary care to assist parents in sharing their experiences and promoting a healthy, thriving child.
2. **Improved access to Primary Care -** for children under 5 years' olds whose parents require rapid access to health advice or assessment when hospital is not appropriate.
3. **Care co-ordination**. Key workers for families of all children under five with complex needs, to work in partnership to co-ordinate service provision around the child and provide a clear point of first reference for the family.
4. **Graded support, depending on the level of complexity / need**. A targeted Early Intervention programme (a two year home visiting programme providing an integrated and appropriate level of support across primary and community care). Focused on those families assessed as having additional needs, this will provide both parent and child the best chance of developing resilient, positive relationships which enable the child to thrive during the early years of life and lay the foundations for a healthy life.

Essential 'enablers' are:

- **Commissioning**, service integration and supporting a range of providers. The Early Years sector comprises many constituent parts, many of whom would be interested in delivering elements of Services for Children outlined in this OBC. Effective performance management will underpin Commissioning, providing visibility of outcomes and value for money.
- **Integrated working and leadership**, including shared goals, the development of clear outcome measures, clinical and professional leadership, partnership working between statutory and Third Sector providers and policy alignment across States Departments.

Benefits include:

- Reduction in children who are registered as 'looked after' (in care)
- Reduction in obstetric complications as a result of pre-birth support given to vulnerable families
- Longer term reduction in children entering residential care
- Children from vulnerable families meet development milestones
- Improved maternal / child relationship
- Reduced postnatal mental health issues
- Reduced inappropriate referral to children services
- Improved joint working in relation to child protection and safeguarding
- More timely interventions
- Reduced inappropriate Emergency Department activity
- Improved choice, control and self help behaviour
- Single point of access for professionals/workforce which will help inter-agency working
- Early identification of health & social problems
- Improved joint working between primary and community care in relation to child protection
- Longer term reductions in antisocial behaviour and crime
- Integrated working, particularly approach with Education Sport & Culture and with a wide range of Third Sector organisations
- Clear, common outcome measures
- Clear commissioning priorities, which build on local needs assessment
- Integrated policy development
- Meaningful stakeholder engagement
- Robust governance

### 1.4.1 The Financial Case

The recurrent annual cost for this OBC by 2015 (at 2015 prices) is £637,000. Implementation costs total £8000 over the period 2013-2015.
The service will require an additional 11.10 FTE.

The cost of overall investment is offset by an estimated annual cost containment of £244,000 (by 2015), which comprises (by Q2, 2015):

- reduction in caseloads for existing Health Visitors
- reduction in management of cases by Children's Services

### 1.4.2 Implementation Actions and Timescales

Refocusing Services for Children (Early Intervention) will be fully implemented by 2015:

| | 2012 | | | | 2013 | | | | 2014 | | | | 2015 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| Align Children & Young People's Strategic Framework with OBC | | | | | | | | | | | | | | | | |
| Develop outcome measures, including 'school readiness' indicator | | | | | | | | | | | | | | | | |
| Self help parenting support | | | | | | | | | | | | | | | | |
| Begin recruitment to Community Midwifery Services | | | | | | | | | | | | | | | | |
| Implement Workforce development | | | | | | | | | | | | | | | | |
| Begin recruitment to Early Intervention programme (MESCH) | | | | | | | | | | | | | | | | |
| Mellow Parenting programme | | | | | | | | | | | | | | | | |
| Rapid access urgent care (Primary Care) | | | | | | | | | | | | | | | | |
| Care co-ordinator for children with complex needs | | | | | | | | | | | | | | | | |

## 1.5 Stakeholders, risks, issues, dependencies and enablers

### 1.5.1 Stakeholders

This OBC has been developed by a Working Group comprising HSSD clinicians (both physical and mental health) and professionals, Public Health, Children's Service, Health Service Human Resource and Finance representatives, Third Sector organisations (including FNHC, JCCT and Brighter Futures), GPs and Education representatives. Additional stakeholders to be engaged as the OBC develops into an FBC include acute hospital services clinicians, managers and hospital governance teams.

### 1.5.2 Risks and Issues

- Lack of strategic leadership and coordination resulting in service duplication
- Delayed workforce development and failure to change practice
- Primary Care funding availability and mechanisms (for under 5s)
- Failure to secure a robust commissioning process could exaggerate fragmentation and hamper partnership working
- Limited outcome data, which reduces certainty of future impacts and also makes assessment of efficacy of current schemes difficult
- Diversity of practice and funding streams in Third Sector
- No previous mapping of existing services for this age group
- Lack of a coherent Social Policy framework to address wider determinants which promote/protect children's health and development
- Service providers (including GPs) not engaged or disagreeing with the direction of services
- Differing and competing priorities between organisations reduce shared objectives

### 1.5.3 Dependencies

Refocused Services for Children would be supported by the development of robust Commissioning processes. Policy integration for Children, including the Children's and Young People's Strategic Framework for Jersey and the Children's Policy Group will be key to continued joint working.

### 1.5.4 Enablers

The development of refocused Services for Children will require workforce and organisational development, as a range of service providers will need to work jointly. IT and informatics will be critical to the service's success, as these will support multidisciplinary working and coordination. ESC are in the final stages of an Early Years Co-ordinator (0-3yrs), and JCPC have developed a policy on referral thresholds and are also working up JCAF. Both pieces of work are critical to improving the coordination of activity across services. The Primary Care Quality Contract will enable alternative funding mechanisms for Primary Care.

## 1.6 Next steps

- Establish current baseline indicators for activity and services delivery of the current enhanced Health Visiting service
- Explore and develop indicators and outcome measure, e.g. school readiness, using as a starting point the Early Years Six areas of learning and language development indicators
- Assess the impact of current services, including Mellow Parenting
- Consider mechanisms for delivering Primary Care to under fives
- Identify key challenges of workforce development
- Ensure OBC is endorsed by the Children's Policy Group
- Continue engaging with stakeholders
- Complete the Full Business Case, including developing detailed service design.

# 2 Introduction and background

## 2.1 A Global challenge

Every health and social care system is experiencing similar challenges:

- Demographic change is dramatically increasing demand on all health and social care systems.
- Technological advances are allowing efficiency and quality improvements but also creating major new costs.
- Societal change is altering the relationship between services and service users, professionals and the public and between the state and individuals.
- Increasing regulation in health and social care is increasing quality but also reducing freedom to act atypically.
- Service ethos is shifting from treatment to prevention and promoting independence.

Health, social care and Third Sector partners and multi-agency teams need to work closely with one another and with patients, service users and carers to provide tools and evidence-based services aimed at managing demand, promoting health and wellbeing, ensuring equality of access and protecting / safeguarding vulnerable people. Our aspiration is to enable people to be cared for in the most appropriate place, living as productive and independent lives as possible.

## 2.2 The Challenge for Health and Social Care in Jersey

Jersey is experiencing many of the same challenges as all other health and social care systems internationally, but it also has some unique challenges.

**A small island**

In normal circumstances our population of just under 100,000 would be considered too small to support comprehensive acute hospital services and very specialist social care services – this would normally be provided for a population of over 250,000. However, geographical isolation and infrequent but material travel difficulties mean that providing a significant level of acute and emergency services locally is essential, and that it is desirable to provide local care packages for people with complex needs.

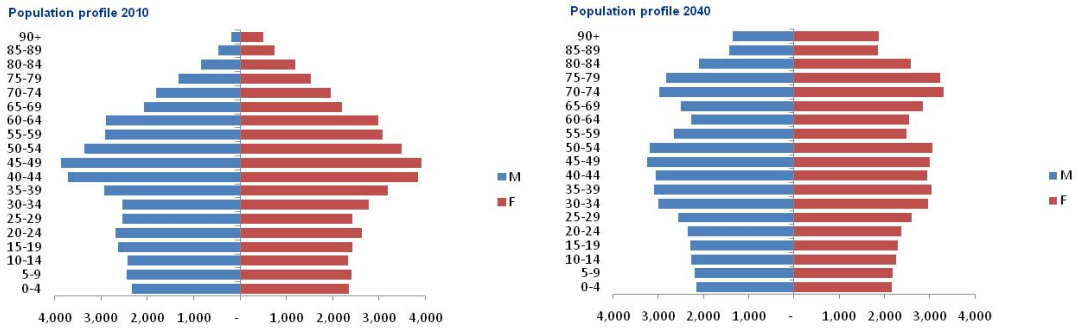
Accordingly, the unit cost of delivering hospital and social services in Jersey is higher compared with systems serving larger populations. This is because the fixed costs of key services such as Accident and Emergency, intensive care, and secure residential accommodation, which are still necessary to support relatively low levels of activity. This, along with the cost of living (including the cost of land and buildings) in Jersey leads to an additional funding “premium”, which increases unit costs. Secondly, it can produce vulnerable services due to workforce models, particularly in the medical workforce, which are relatively light, highly reliant on very small numbers of individuals and where the achievement and maintenance of specialist skills is difficult given relatively low patient numbers.

### 2.2.1 Demography

Given immigration controls the population of Jersey is rising only slowly. But it is ageing rapidly. Over the 30 years from 2010 to 2040 the numbers of residents over 65 is projected to rise by 95%; in the period to 2020 the increase is projected to be 35%.

This demographic change will create a huge surge in demand for health and social care services which will overwhelm the current capacity of the existing services.

**Fig 1. Demographic change in Jersey**




Within 5 years, the current numbers of hospital beds, operating theatres, residential and nursing care beds and other key community services will be inadequate to meet demand. These services therefore need to be expanded, supplemented and/or changed urgently to ensure that services can be safely and sustainably provided for the growing elderly population.

## 2.3 Strategic Principles

The vision of services which are safe, sustainable and affordable was distilled into a set of strategic design principles in late 2010. These were developed by stakeholders across health and social care, and ratified by Ministers:

- Create a sustainable service model – efficient, effective, engaging the public in self-management and with consistent access and thresholds
- Ensure clinical/service viability – overcome the challenges of low patient volumes, delivering high quality care and minimising risk
- Ensure financial viability – reduce the impact of diseconomies of scale, with value for money, an understanding of the costs of care in Jersey and robust procurement
- How should we fund health and social care? – establishing a charging model that incentivises care and cooperation
- Optimising estate utilisation – ensuring the estate is fit for purpose and utilised to maximum efficiency
- Workforce utilisation and development – supporting and utilising the workforce to the best of their abilities
- Clinical governance – sustaining a culture of safety, learning and transparency
- Use of business intelligence - with robust data to support decision making based on fact, and including patients and the public in service design and decision making

**Service principles and assertions**:

- Social care and health should be integrated as seamlessly as possible on a service user's/patient's life journey, with teams of social care, home care, medical, nursing, occupational therapy, psychology and other staff working together, working with the third sector and private sector providers
- Integration will be supported by an organisational and professional mindset that puts people first and at the centre of decision making about their care package, and

ensures that needs drive services and not the reverse, to improve emotional, social and health wellbeing.

- Single, integrated care pathways, single assessment and a move towards personalisation and needs driven care will provide choice and empowerment. At present, complex services are provided by a multiplicity of providers, teams and professionals with different referral and access points, assessment frameworks, eligibility criteria and pathways. Simplifying and standardising the current range of approaches would improve co-ordination, providing a holistic, streamlined service which provides support, enablement and choice of care setting for older people and support for their carers.
- Services should be planned and delivered within partnerships brining together all sectors of our Islands community and economy
- Where appropriate, service provision should move away from residential care and institutionalisation within social care towards an increase in community provision to allow service users to integrate and lead independent and productive lives as much as possible.

## 2.4 Stakeholders and public opinion

Between November 2010 and April 2011 a number of stakeholders were interviewed to ascertain their views on the future for health and social care. The key themes were:

- The development of an overall strategic plan as an overarching context for the development of the above is essential. This should address any changes required in the structure of services and relationships between them, as well as future funding mechanism to ensure the changes in service provision required will be delivered
- There is a groundswell of appetite for change
- Considerable scope exists for improvement in the coordination, collaboration and communication between different services and service providers
- Some gaps in service provision exist
- Elements of the operational infrastructure would benefit from strengthening. This includes improved mechanisms for data collection and distribution, recruitment and retention of key staff, and improvement and better use of estate

## 2.5 Results of the Green Paper consultation

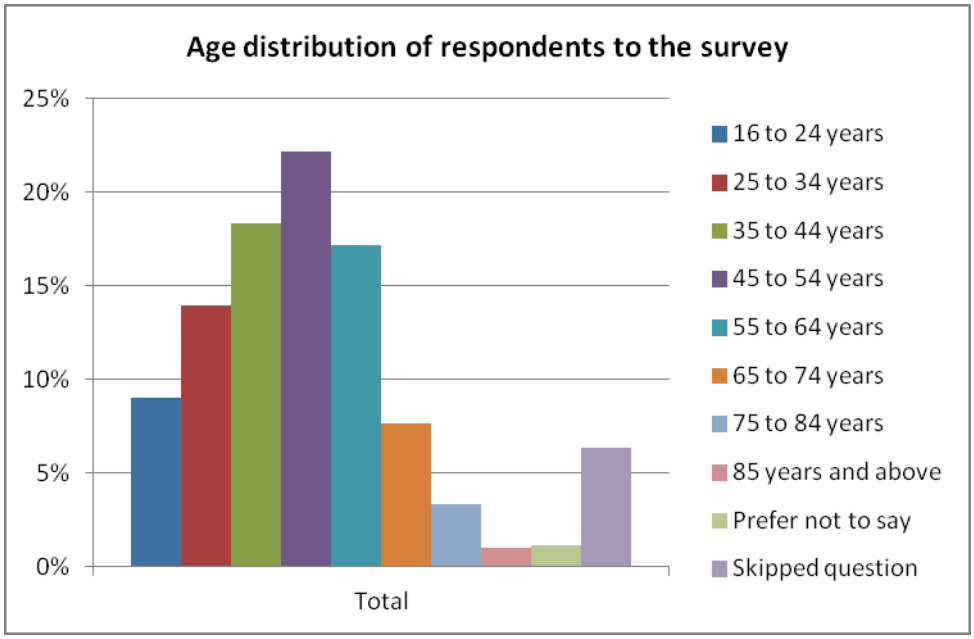
Between May and August 2010 HSSD consulted on the Green Paper 'Caring for each other, Caring for ourselves'. More than 1,300 Islanders responded to the consultation. The response was overwhelmingly in favour of redesigning health and social services so that they continue to be safe and affordable for the future (86%), and many respondents included detailed comments and viewpoints.

The Green Paper sought views on three scenarios for the future of health and social care:

- Scenario One: "Business as usual" – services continue to be provided in the same way and through the same structures as in 2010; spending increases to meet growing demand.
- Scenario Two: "A small increase in funding" – the funding allocation does not increase. Services have to be prioritised within this budget and many services will be subject to 'means testing' or will be stopped.

- Scenario Three: “A new model for health and social care” – prioritised changes to service delivery, to ensure health and social services are safe, sustainable and affordable and are able to meet projected increases in demand.

Responses were received from across all age groups. 69% of responses were received from individuals; 17% from organisations, such as Family Nursing and Home Care, dDeaf Awareness Group and Mind Jersey. More women than men responded.




**Responses**

The overwhelming message from the consultation was the positive views of Islanders about their health and social services. The majority of the respondents believe it is very (81%) or fairly important (16%) to continue providing a wide range of health and social care services on island. The remaining questions elicited the following responses:

- The majority find it very important (82%) or fairly important (16%) that in future these services are free, or affordable, and available to all.
- The vast majority of people (90%) agreed that “The States should ensure that preventing ill health is as important as curing ill health”. Some people felt that a large benefit could be gained from this area in the long term, whilst others were not sure whether this would be possible.
- Mixed views were received regarding having “responsibility for your own health” – whether this was for longer waiting times or increased charges for people who choose not to look after their own health. In particular, there were concerns about “self-inflicted” injuries or illnesses. Some respondents argued that it was not always possible for everyone to look after themselves and that vulnerable, ill or disabled individuals should not be disadvantaged.
- Most respondents agreed that “People should be able to live in their own home for as long as possible, providing they have the right health and social care support from the States of Jersey, the Third Sector and parishes.
- The vast majority of people (90%) agreed that “Instead of going to a hospital doctor or GP, I would be happy to be seen by a nurse, a pharmacist or other care

professional, for appropriate minor procedures such as measuring blood pressure or monitoring my diabetes."

- Most respondents said they would welcome qualified nurses working with GPs to free up their time, but others were not in favour of nurses doing what they considered to be the work of a GP. Some respondents commented that the GP system in Jersey was already very efficient and they were concerned about damaging patient-GP relations, and others were concerned about the cost of Primary Care to individual patients.
- Respondents also indicated that off-island travel was acceptable for some treatments. Some respondents would rather not have off island treatment, whilst others felt that going away for care to be inevitable on a small island like Jersey. Respondents also expressed views on whether patients should travel off island to see a doctor, or whether doctors should visit Jersey to treat patients.
- Professionals working together to deliver better integrated care was important, but some respondents noted that Jersey's charities should receive more funding and support.
- The vast majority of respondents thought that health and social care should be accessible and affordable, if not free, to all. However, there was a range of views about who should fund this care, and how.
- The need for affordable care was often stressed, and many respondents felt payment and funding needed to be explored in more depth.
- Most respondents said that those who cannot pay should still enjoy high quality health and social care. Opinion was then split about whether the amount of free care available for each person should be capped, with respondents expressing concern about the costs of care for people with long term illnesses and whether they would be able to pay.
- Some respondents commented that if health and social care was capped, for some conditions or for all, this should be means tested. However, others disagreed with means testing and felt that if someone had worked all their lives, they should have as much right to free care as others.
- Some respondents felt it would be fair that those who had lived in Jersey all their lives received free access to treatment – but that people who have not paid into the system should not enjoy the same benefits.
- According to many respondents, significant numbers of people visit the Emergency Department rather than seeing a GP because there is a charge associated with the GP, while a visit to the Emergency Department is free. The majority agreed that if a charge applied to visit the Emergency Department for treatment of a minor condition, they would be more likely to go to see their GP. Many also suggested that GP consultation costs should be reviewed at the same time as Emergency Department costs.
- Many respondents felt that there are opportunities to improve current system. Suggested ways to improve efficiency included reducing bureaucracy in health and social services, improving communication between organisations and bringing in more third party and profit making organisations to provide care.

## 2.6 Development of the Outline Business Case

This Outline Business Case (OBC) presents the case for change for the alcohol pathway. It explains, within the context of current and future safety, sustainability and affordability and against the strategic principles agreed by Ministers in late 2010, the reasons why 'do nothing' is not an option.

The OBC was developed by a Working Group between August and November 2011. Between November 2011 and March 2012, significant work was undertaken with Treasury to ensure that financial projections are within an indicative cost envelope and sufficiently detailed and accurate for the Medium term Financial Plan submissions in Summer 2012.

The OBC outlines in brief the preferred options that have been identified by the Working Group in connection with the proposed new service being introduced, referring to the three Scenarios outlined in the Technical Document and Green Paper. It presents an outline cost/benefit analysis of the options.

The OBC then outlines the features and timescales of the proposed service changes and assesses the potential impact against a range of factors, including workforce, cost and quality.

This OBC has been prepared by Andrew Heaven, Head of Health Improvement, with Susan Turnbull, Medical Officer of Health as Senior Responsible Officer, after consultation with service providers, Third Sector organisations, service users and carers.

# 3 The Preferred Option

## 3.1 The Service Case

### International evidence

Over the past decade evidence (e.g. the Marmot Strategic Review[1]) has emerged that the quality of experiences in the first five years of life can have a profound impact on a child's future development, learning, behaviour, health and the ability to build positive, secure attachments, and on truancy, conduct disorder and risk-taking behaviours such as substance misuse and mental illness.[2] [3]

The recent reports recently published by Graham Allen MP[4][5] identified a long list of financial costs to society and of failure to pre-empt dysfunction, including:

- Each child with untreated behavioural problems costs statutory services an average of £70,000 a year by the time they reach 28 years old – 10 times the cost of children without behavioural problems
- The average cost of an individual spending a lifetime on benefits is £430,000 not including lost tax revenue
- Young people between the ages of 16 – 18 years who are not in employment, education or training cost an additional £45,000 in resource costs and £52,000 in public finance costs per annum
- The societal costs associated with mental health problems in the UK are estimated at £105.2 billion per annum. This represents an increase of 36% since 2002-03 and an increase in the health and social care share of these costs of over 70%

'Early Intervention' are programmes which ensure that babies, children, and young people build a strong bedrock of social and emotional capabilities to fulfill their potential and help break intergenerational cycle of disadvantage and underachievement. Health economists have calculated that a return of up to 3 to 7 times the original investment could be achievable by the time the young person is 21 years.

There is also a considerable amount of evidence[6][7][8] supporting the key role of Primary Care in early childhood interventions and treatment. General practice should be the default for initial child health queries from families.

## 3.2 Current Services in Jersey

A range of services for children are currently provided on the Island. These services provide preventive, protective, clinical and emotional support to children and their families across different levels of need.

The diversity of provision from Statutory Services to Third and Private Sector is a challenge when setting and communicating a strategic direction. However, there are a

1 Fair Society, Healthy Lives. The Marmot Review; A Strategic Review of Health Inequalities in England Post 2010
2 Lyons & Zeanah, 1993: Infant Mental Health Journal, Vol. 19(3), 282–289 (1998)
3 Widom & Maxfield: 2007: Child Maltreat August 2007 vol. 12 no. 3 203-207
4 Graham Allen: January 2010: Early Intervention, The Next Steps: An Independent Review to Her Majesty's Government
5 Graham Allen 2011: Early Intervention: Smart Investment, Massive Savings: The second Independent Report to Hear Majesty's Government.
6 National Institute Clinical Excellence: 2008: Routine Antenatal Care for Healthy Pregnant Women: Clinical Guidance 62
7 National Institute Clinical Excellence: 2008: Maternal and Child Health: Public Health Guidance 11
8 National Institute Clinical Excellence: 2009: When to Suspect Maltreatment: Clinical Guidance 89

number of important forums which bring together key service providers. For example the Jersey Child Protection Committee, Early Years Childcare Partnership and most recently the Children's Policy Group which has produced the Children and Young Peoples Framework.

The traditional model of reactive services is no longer appropriate. The KPMG 'Technical Document' in May 2011 concluded that the current institutionalised model of care had led to increasing and unsustainable demands being placed on Statutory Services for Children, including Residential and Fostering Services. The same report also showed high levels of Emergency Department activity for children which could be more appropriately seen within Primary Care. Children's services are under pressure because of very high referral rates and the difficulty of securing a good supply of foster carers.

At an operational level there is much passion and energy. There is a diverse range of different programmes delivered by an equally diverse range of agencies. However, services can be uncoordinated, and coordination is required between the key statutory and voluntary agency partners in order that the right child gets the right intervention at the right time. Joint planning and interagency planning with common goals are vital.

There is an absence of published local outcome measures, although anecdotal evidence from colleagues working in the education system note a significant variance in children's school readiness at age five.

Past surveys[9][10] show that the current cost attached to general practice deters requests for consultations instead families attend the Emergency Department, which is currently free at point of delivery.

There are a number of challenges with the current service model:

9 Confrey.B:2011: Report of Parent Experiences in Pre and Post natal phase: Early Years Child Care Partnership
10 States of Jersey Statistics Unit: 2007: Jersey Annual Social Survey 2007

| Service design principle | Challenges of the current services |
|---|---|
| Create a sustainable service model | • Limited planning of preventative interventions informed by better health intelligence, common assessment tools and better joint working<br>• Lack of robust Commissioning, underpinned by strategic needs assessment<br>• A recent social care audit revealed that more than 80% of referrals were from the police and almost 50% of these were declared "No Further Action" after investigation[11]. This is not uncommon with UK local authorities but suggests that in Jersey there needs to be more collaborative working to stem these referrals<br>• Approximately 8% of all Emergency Department attendances are by children under 5. Between 1,200 – 1,400 attendances are estimated to be Primary Care type activity |
| Ensure Clinical/service viability | • Recently developed referral thresholds to Community and Social Services are not yet embedded in practice<br>• Common assessment framework is still in development and training is not yet rolled out<br>• Families can be referred to a diverse range of agencies which can lead to a duplication of effort and cost<br>• Some lack of coordination in service provision, including strategic alignment<br>• Limited Maternity services provided in the community and Primary Care, and limited shared care between GPs and Maternity Services |
| Ensure financial viability | • It is estimated that every attendance in the Emergency Department costs £86.00. This means that in 2010 between £103,000 - £120,000 worth of Primary Care-type activity was delivered in the Emergency Department[12].<br>• Services for Children rely heavily on Third Sector provision, some of which are funded predominantly by charitable means. Commissioning, procurement and supplier management is not yet robust<br>• Services which become unfit for purpose are not decommissioned<br>• Limited visibility of value for money |
| Optimising estate utilisation | • Services for Children are located on different sites<br>• Families are required to make several different journeys for appointments<br>• Multidisciplinary working and integration is hampered |

11 JCPC Audit of Referrals to Children's Services (June 2011)
12 Under five figures extrapolated from A/E Attendance data. Consultant Paediatrician reviewed reason for attendance to determine whether primary care level presentation. Finance Department identified basic unit cost for a local A/E admission.

| Service design principle | Challenges of the current services |
|---|---|
| Workforce utilisation and development | • Diverse range of practitioners with a variety of different skills working in the pre-school children's sector<br>• Lack of mapping of skill gaps<br>• Recent JCPC policies regarding Multi-Agency Child Protection Procedures (and the future development of a JCAF) are important in informing future workforce development to all agencies working with this group[13].<br>• One of the highest rates of female participation in the economy with a related high level of children under 5 in child care settings<br>• Ensuring quality childcare provision which promotes the principles of early intervention<br>• Ongoing requirement to develop practitioners to be able to deliver targeted enhanced support for families with additional need |
| Clinical governance | • Limited policy and practice consistent with a model of integrated governance across a multiagency context<br>• Cases from the UK have highlighted the safeguarding dangers associated with poor communication between agencies and organisations involved in a child's health and social care. Closer working between professionals and agreed care plans ensuring that the multiple inputs are co-ordinated would help to minimise risk and support safeguarding |
| Use of business intelligence | • Limitations of systems to assist with understanding activity and outcomes<br>• Very limited use of health intelligence to inform service development |

If Jersey invests in capacity to enable community and primary care services for children to deliver prevention and early intervention during the first five years of life, we can give children a vital social and emotional foundation which will keep them healthy and achieving throughout their lives. This would result in a reduction in demand for statutory based residential children's services, costs and a reduction in crime and antisocial behaviour as more young people mature into adulthood with better preparation for employment and increased ability to play an active part in the community in which they live.

13 Jersey Child Protection Committee:2011: Multi-Agency Child Protection Procedures

## 3.3 Description of Service

The aim of Refocused Services for Children (Early Intervention) is to continually improve children's 'school readiness 'at aged five.

The importance of 'readiness to learn' is that it represents a fundamental developmental stage which is indicative of the overall health of a child. Education Sport and Culture have recently been given a statutory duty to collect measures of 'readiness to learn' once the child enters foundation stage. This data set will provide a unique outcomes based barometer as to the collective success of early interventions[14].

The focus is on services for children from pre-birth to aged five.

Services for Children will be underpinned by a coordinated plan for early intervention, which is based on local health intelligence and recent evidence. A tiered approach will be delivered, as outlined in the existing multi-agency child protection policy and procedures, consistent with current developments towards a local Common Assessment Framework.

Integrated Services for Children will 'wrap around' the child and family, with agencies and organisations working together using common tools and language to ensure there are no gaps or overlaps between services in health, social care and education. Joint needs assessment will be undertaken at a population level, with joint training of practitioners from across the tiers and integrated governance structures enabling information sharing and referral between agencies.

Services for Children comprises targeted early interventions programmes such as the MESCH programme[15][16]and the Mellow Parenting[17] programmes which work intensively with children and families with additional and complex needs. These families would be assessed in universal services and referred promptly. As a result of a successful intervention the families would be referred back into universal services.

Universal high profile signposting and self help guidance will be aimed at assisting all families with children under five through the various milestones such as antenatal classes, breastfeeding, weaning, childcare, parenting skills and support, accessing services etc. The citizen's portal, which can utilise social networking, will ensure ease of access to vital information for both families and professionals.

In parallel to specific investment in new programmes the OBC also identifies investment in workforce development for universal services which will ensure key child care agencies, working with children under five, have the essential skills and knowledge to work toward the shared goal of preparing the child for school at aged

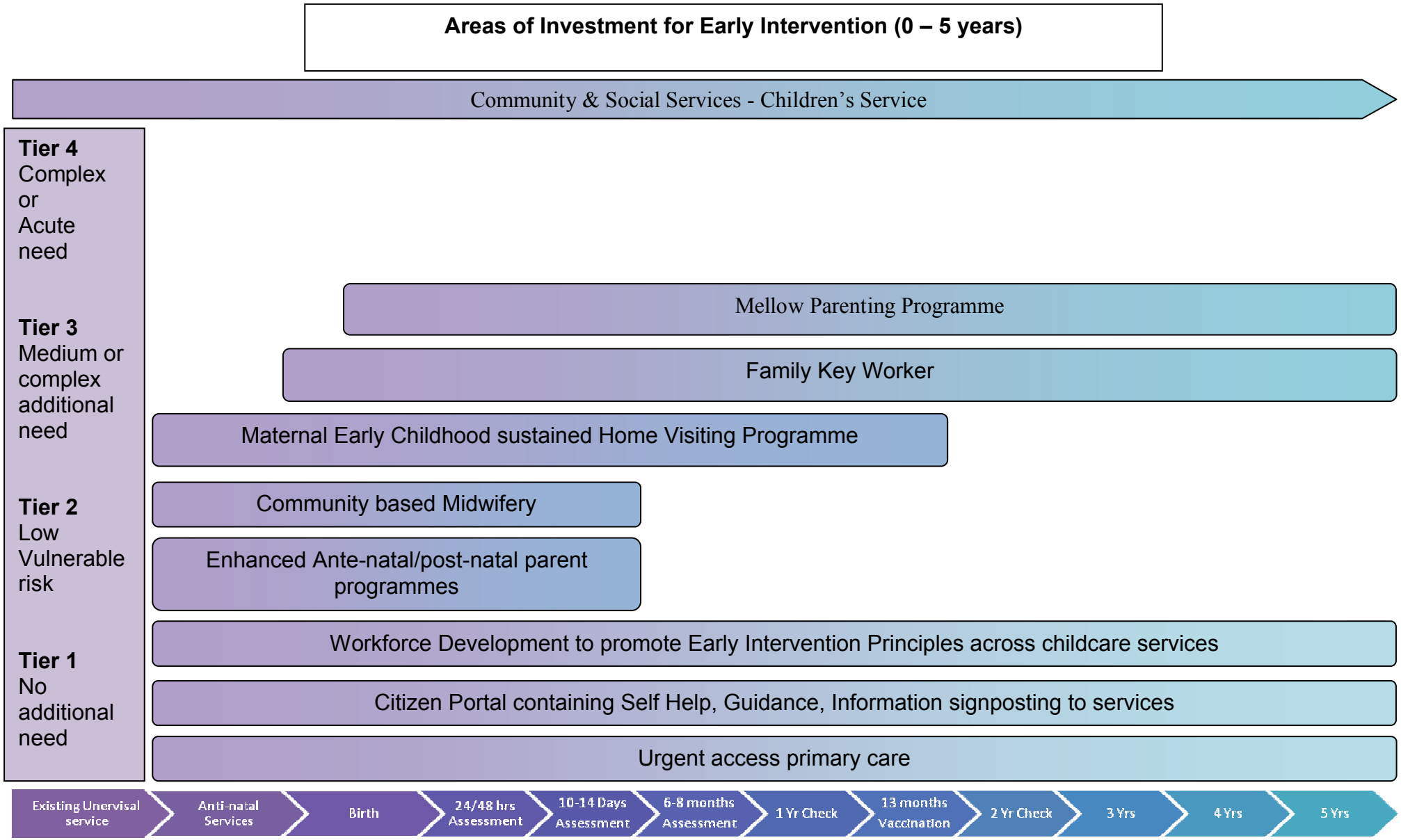
14 Education Sport & Culture: 2010: Guidelines for implementing the Jersey Foundation Stage Profile
15 Centre for Primary Health Care and Equity: 2010: Maternal Early Childhood Sustained Home-visiting, Program Description.
16 Kemp L, Harris E, McMahon C, Matthey S, Vimpani G, Andrewson T: 2008: Early Childhood Sustained Home visiting (MESCH) trial: BMC Public Health: 8:424.
17 Available on Mellow Parenting website: URL
http://www.mellowparenting.org/cm/templates/mp.aspx?articleid=41&zoneid=8

five. Assessment and referral management would also be enhanced to support a more consistent approach across services.

The OBC also identifies key changes to existing services. For example, the proposed introduction of case workers and care co-ordinators for families with children who have complex needs to allow an enhanced level of support to be offered to each family and promote their resilience.

The Health and Social Services Department along with colleagues in other States Departments will take a more robust approach to commissioning, procurement and supplier management, including Services for Children. A renewed focus on outcomes which will indicate the success of early intervention ('school readiness').

Plurality and diversity of provision will be encouraged, to support a range of providers and minimise spot purchasing in favour of longer term contracts. Identifying gaps in current service provision and then shaping and developing market provision, commissioning collaborative models and working in partnership.


Areas of Investment for Early Intervention (0 – 5 years)
Community & Social Services - Children's Service
Tier 4
Complex or Acute need
Tier 3
Medium or complex additional need
Tier 2
Low Vulnerable risk
Tier 1
No additional need
Mellow Parenting Programme
Family Key Worker
Maternal Early Childhood sustained Home Visiting Programme
Community based Midwifery
Enhanced Ante-natal/post-natal parent programmes
Workforce Development to promote Early Intervention Principles across childcare services
Citizen Portal containing Self Help, Guidance, Information signposting to services
Urgent access primary care
Existing Unervisal service
Anti-natal Services
Birth
24/48 hrs Assessment
10-14 Days Assessment
6-8 months Assessment
1 Yr Check
13 months Vaccination
2 Yr Check
3 Yrs
4 Yrs
5 Yrs

The refocused Services for Children (Early Intervention) comprise:

- Increased awareness and self help
- Improved access to Primary Care
- Care co-ordination
- Graded support, depending on the level of complexity / need

### 3.3.1 Increased awareness and self help

The range of providers will work together to increase awareness and information. This will build upon the current resources, for example, The Bridge. It will also include a Citizens Portal to assist with self care. This is a high quality and interactive web-presence, which will signpost parents to guided self help materials covering all aspects of ante-natal and post natal issues. In addition this resource would include directory of services and their locations which can be accessed by parents, children and professionals. The website would support interactive Q&A on topic specific issues such as breastfeeding, weaning etc and have other social media functionality e.g. Facebook, Twitter. Social Marketing strategies would be used to raise the profile and use of the site to key target groups.

### 3.3.2 Improved Access to Primary Care

A combination of better self help materials being available on the citizens portal and more accessible services would lead to a reduction Emergency Department activity which in turn could release capacity within the hospital.

Currently 8% of Emergency Department activity is accounted for by under 5 presentations, with over 70% of this activity requiring no onward admission. The most common conditions were respiratory infections, poisoning, accidents and ear related conditions.

The GP Quality Contract would be developed in order to provide an appropriate mechanism to divert inappropriate demand away from the Hospital for this specific group.

Joint working between Maternity Services and General Practice will also be increased.

### 3.3.3 Care co-ordination

There are approximately 40 children under 5 years who have complex care needs. Each child with complex care needs in receipt of care either through the Child Development Centre or CAHMS will have an allocated key worker (care co-ordinator) who is not part of the package of specialist services.

The care co-ordinator will be responsible for focusing on the family. They would oversee and review the delivery of the agreed package and help the family negotiate their way around services.

Where appropriate the Common Assessment Framework will consider the needs of the family as well as the child, supporting them to meet the identified needs of the child. This role is outlined in DH best practice frameworks.[18] [19]

### 3.3.4 Graded support, depending on the level of complexity / need

Working with children aged 0 to 5 years and their families is an identified gap in service provision within Jersey CAMHS. These families will include the most vulnerable in our community, for example, parents who have complex difficulties such as mental health problems/disorders, learning disabilities, domestic violence, substance & alcohol misuse and teenage parents.

Evidence[20][21][22][23] suggests these difficulties, particularly when they involve parenting children under the age of 5 years, need support to improve their parent-infant/child relationship and need intensive work to equip them with appropriate parenting skills and strategies. To address these needs requires a high level of expertise and services targeted, co-ordinated and personalised to the needs of the child and their family:

**Maternal Early Childhood Sustained Home Visiting (MECSH):** A targeted (tier 2) early intervention service would be delivered using the MECSH programme model.

The midwife would assess and identify families with the appropriate level of need for the programme. The assessment, completed by the mother, consists of a psychosocial and depression rating questionnaire.

The programme would then start at 20 weeks with sustained home visiting from the Health Visitor for the first two years of the child's life. During this period particular aspects of parenting and child development are covered.

A multi agency network would be formed around the family as required.

All Health Visitors involved in delivering this programme would maintain an element of their universal practice caseload, thereby enabling skills and competency to be developed and shared throughout the wider workforce. Supervision and support would be provided to the Health Visitors leading this programme by a CAMHS clinician and a social care practitioner.

18 Department for Education Skills / Department of Health: 2003: Together from the Start: Practitioner Guidance.
19 19 Department for Education Skills: 2004: Early Support Professional Guidance.
20 Karoly LA., Lilburn, MR & Cannon JS. (2005) Early Childhood Interventions: Proven Results, Future Promise. Santa Monica CA: RAND Corporation

21 Lynch, T. (2003). Benefit cost analysis of the Florida Infant & Young Child Mental Health Pilot Project. Centre for Economic Forecasting and Analysis, Florida.

22 Osofsky, J.D., Kronenburg, M. & Hayes Hammer, J. et al (2007). The development and evaluation of the intervention model for the Florida Infant Mental Health Pilot Program. Infant Mental Health Journal, Vol. 28(3), 259-280.

23 Social Care Institute for Excellence. (2009). Think child, think parent, think family: A guide to parental mental health and child welfare, London.

**Mellow Parenting**. A therapeutic fourteen week programme with a proven track record of engagement with (Tier 3/4) parents.

Parents who have experienced neglect or trauma in their childhood or substantive difficulties with their wellbeing as adults are brought together in a small group setting to work on their own wellbeing and their parenting skills whilst their children are cared for in a crèche. A Department of Health[24] evaluation has demonstrated a range of positive outcomes in maternal wellbeing and child behaviour and development, most compelling is evidence that when Mellow children reach school age they do not stand out from their peers which is remarkable given the range of risk factors which they experience at the time of entry to the programme. Preliminary data from the first year of a pilot programme in Jersey shows that it is replicating these positive outcomes.

### 3.3.5 Commissioning

At present there is no co-ordinated, holistic population needs assessment. Resource is required in order that improvements can be monitored and services commissioned accordingly.

### 3.3.6 Integrated working and leadership

Investment would be consistent with best practice in services for children that have a key role in leading preventative and early interventions for this age group. Initial priorities include would include language for life, infant feeding and family foundations programme. All these programmes will be connected to Highlands College from the outset as it remains the main provider of child care qualifications in the Island.

## 3.4 Activity Impacts

The activity impacts have been informed by the current evidence base and estimates by local professionals working in the service.

There are real challenges about estimating the size of the impact on health service activity and any figure contained within this OBC should be considered as an estimate in the first instance with a view to further discussion and testing with key stakeholders as part of any further business case.

24 NICE/SCIE (2007) 'Parent-training/education programmes in the management of children with conduct disorders' NICE Technology Appraisal Guidance 102. Quick reference Guide

| Service | Activity Impact |
|---|---|
| **Increased awareness and self care** | Approximately 3,000 attendances each year for under 5yrs at Emergency Department. Of those attendances approximately 1,400 present with Primary Care level need<br>Existing evidence[25] would support a proposed reduction of 10% hospital admissions as a result of improved access to Primary Care. |
| **Rapid Access to Primary Care** | Approximately 2,000 ward attendees annually to Robyn Ward as a result of Primary Care level presentations in either the Emergency Department or Paediatric Outpatients |
| **Community Midwifery** | 1,000 births a year with approximately 50% of women receiving initial booking and antenatal care in a community setting. This would increase to above 70% (300 women) completing an initial booking and antenatal care outside of a hospital setting |
| **Care Co-ordinator** | Caseworker support for estimated 40 families with complex needs, which will reduce the need for costly emergency respite care or hospitalisation |
| **MESCH Programme** | Increased number of women who are able to have natural births (in 2010 approximately 51% women had a normal delivery, 11% instrumental delivery and 32% had a caesarean section)<br>The expected hospital stay would also reduce (on average there is a 2 to 3 days hospital stay following a normal delivery 3 to 4 day hospital stay following an instrumental delivery and a 4 to 5 day hospital stay following a caesarean section).<br><br>Currently 23% of foster care placements are for children under 5 years old. In 2011, 15 children under five received foster care placements. The need for placements would be reduced with more support provided to families in early years.<br><br>Currently 4 off-island beds are provided for Looked After Children at a cost of £1.2m p.a (£300k p.a per child). With earlier interventions in place it is likely that vulnerable children's needs would be managed earlier and more effectively reducing escalation to the point of requiring off-island support. It is estimated that a reduction of one off island placement would be achieved by 2015 |
| **Mellow Parenting** | Around 50 families will have received the programme in 2011/12<br>It is estimated that from 2013-2015 the programme will support 108 – 144 families. This will lead to:<br>• Reduction in referrals to Children's Services in those families whose parents have attended the programme<br>• Reduction in average time children spent on a Child Protection register for those families whose parents have attended the programme |
| **Workforce Development** | Increased capacity of Early Years practitioners to deliver best practice interventions, to promote language development and parental attachment, leading to improved 'school readiness outcomes' in language development and social skills at reception age assessment. |

[25] Purdy.s: 2010: Avoiding Hospital Admissions, what does the evidence say : Kings Fund

## 3.5 Workforce Impacts

| Service | Staff | Number | Comment (e.g. timing) |
|---|---|---|---|
| **Increased awareness and self care** | | | FTE included in IT cross cutting theme |
| **Rapid Access Primary Care** | - | Estimated increase in GP activity of at least 140 attendees resulting from improved rapid access to primary care | Difficult to estimate exactly the likely increase in GP activity as other initiatives will influence patient access |
| **Community Midwifery** | | 2 FTE | |
| **Care co-ordinator** | | 1.6 FTE | |
| **MESCH Programme** | Health Visitors<br>Family Support Workers<br>Early Years Co-ordinator | 4 FTE<br>2 FTE<br>1 FTE | |
| **Mellow Parenting** | Psychologist | 0.5 FTE | |
| **Early Years CAMHS Worker** | | | |
| **Child Care Workforce Development** | - | | |
| **Health Intelligence** | | | FTE included in Informatics Cross Cutting Theme |
| **Total** | **11.1 FTE** | | |

## 3.6 Infrastructure Impacts

Estates: Health and Social Services for children are currently operating from many sites, including Overdale, Les Bas Centre, General Hospital, Royde House, and the Bridge. This adds complexity to communication between service providers. It also makes accessing services more difficult for families, especially with a child who has complex needs. As part the ongoing review of estates opportunities should be sought to find one central location from which to cluster service for children. The role of children centres like The Bridge should also be reviewed as part of this process as they currently provide a unique opportunity for families to access a range of services easily.

The new Services for Children will require no additional estate.

IT: From January 2014, health and social care professionals, children, parents and families will access information via a citizen's portal. The citizens' portal will enable care to be designed by the individual and care professional, based on the individual's needs and, where appropriate, they choices. It will also enable care packages to be delivered and monitored in a coherent and co-ordinated manner.

The citizen's portal will provide real time information regarding service availability, self care, family support groups etc, to assist the child and family with feeling more in control of their situation.

### 3.7 Service Delivery Benefits

Refocusing Services for Children on Early Intervention will have measurable impacts and outcomes.

Increased awareness and self care

- Real time information regarding service availability, self care, family support groups etc to assist the child and family with feeling more in control of their situation; this will improve the quality of life these families lead
- Reduced Emergency Department activity
- Single point of information which will facilitate self help behaviour
- Single point of access for professionals/workforce which will help inter-agency working
- Early identification of health & social problems

Improved access to Primary Care

- Reduction in demand for Primary Care level services in the Emergency Department
- Earlier identification and intervention for health and social problems as the GP is better able to identify problems early as they have a better understanding of child's previous history and family background
- Better joint working between primary and community care in relation to child protection as GPs are more able to provide a complete picture of the child and make connections between different health events
- Reduction in medication prescribed to this group and more appropriate use of health care resources
- Reduction in obstetric complications as a result of pre-birth support given to vulnerable families
- More proactive intensive pre-natal support to women during pregnancy, leading to better outcomes at birth such as reducing low weight babies requiring admission to special care baby unit

Care co-ordinators

- More timely interventions for families
- Reductions in crisis and referral to statutory services
- Consistency in referrals leading
- Better joint working in relation to child protection and safeguarding
- Improved flow of clients across the tiers as a response to assessed need
- Less variance between children in relation to key development indicators e.g. language development, cognitive ability, physical milestones as they reach foundation stage

- Improved transition and attainment in vulnerable children during foundation stage
- Longer term reductions in antisocial behaviour and crime

Graded support depending on the level of complexity and need

- Healthy Child Programme outcomes - can be compared to Jersey averages of children not on the programme i.e. with no additional needs, to asses the added value that the programmes have achieved
- Reduced need for statutory services
- Reduction in children who are registered as looked after
- Longer term reduction in children entering residential care
- More children from vulnerable families meet development milestones e.g. language development, cognitive ability, physical milestones
- Improved maternal / child relationship
- Reduced postnatal mental health issues

Other benefits, from a more robust and integrated approach

- Integrated approach with Education Sports & Culture and the Third Sector
- Clear, common outcome measures
- Clear commissioning priorities
- De-commissioning services that are duplicated or not appropriate
- Integrated policy development which builds on local needs assessment
- Meaningful stakeholder engagement
- Increased support for the Third Sector, supporting sustainability

### 3.8 Anticipated risks

Anticipated risks include:

- Lack of strategic leadership and coordination resulting in service duplication
- Delayed workforce development and failure to change practice
- Primary Care funding availability and mechanisms (for under 5s)
- Failure to secure a robust commissioning process could exaggerate fragmentation and hamper partnership working
- Limited outcome data, which reduces certainty of future impacts and also makes assessment of efficacy of current schemes difficult
- Diversity of practice and funding streams in Third Sector
- No previous mapping of existing services for this age group
- Lack of a coherent Social Policy framework to address wider determinants which promote/protect children's health and development
- Service providers (including GPs) are not engaged or do not agree with the direction of services
- Differing and competing priorities between organisations reduce shared objectives

## 3.9 Dependencies and enablers

Interactions with:

- The entire range of services provided for children and their families
- Other States Departments, particularly Education Sport and Culture
- Children's' Policy Group
- Third Sector organisations

And with:

- Social Policy. Joined up social policy is required in order to support the impact of early interventions – so that family and child health is promoted through adequate housing, affordable child care, employment and stable employment
- Children and Young People's Strategic Framework. The Minister for Health and Social Services has led the development of a Children's and Young Peoples Strategic Framework, as recommended by the Williamson Review. The plan has six outcomes which mirror *Every Child Matters* in the UK. The governance structure identified to deliver future actions under the Children and Young People's Strategic Framework represents a good opportunity to include existing advisory and Third Sector stakeholders. Any future implantation group for this OBC should also be part of the same structure.
- Jersey Child Protection Committee. The Multi-Agency Child Protection Procedures Policy outlined clear thresholds for referral. The policy will also be supported by the development of Jersey Common Assessment Framework - a common template and approach to assessing need. The implementation of this policy is critical to reducing the inappropriate numbers of referrals currently being received by Children's Services.
- HSSD Business Plan 2012
- States Strategic Plan
- Medium Term Financial Plan
- Health and Social Services White Paper

**Workforce:**

The different service providers are enthusiastic about providing training for each other. Areas of existing training range from breastfeeding awareness to child protection.

More clarity is needed on the priorities for training and its relevance to agreed policy objectives.

Highlands College are a key provider of education and training. They could be asked to provide an extended level of workforce development.

**Estates:**

See section 3.10.3

**Commissioning:**

Education and Health have legitimate interest in child health, albeit from different perspectives. At present the Departments have limited joint planning and commissioning arrangements. This results in avoidable duplication and expense and frustration from Third Sector. The Commissioning function needs to be strengthened, with more clarity provided to the range of potential service providers, better partnership

working, robust population needs assessment and greater visibility of outcomes and value for money.

**Primary Care:**
It is believed that the high rates of child health attendances in the Emergency Department is a direct result of the fee for service in General Practice. This was confirmed by a survey by the Early Years Partnership, where parents stated that they avoided GP consultations as cost were prohibitive. Reforming the Primary Care regulations to enable better access to Primary Care would enhance the Tier 1 service offered to families with children under 5.

**IT:**
Awareness and information will require a range of media, including the citizen's portal.
In addition, IT will be required to support the community multidisciplinary team working.

Investment is required to develop indicators and monitoring arrangements have been included as part of the Health Informatics OBC.

**Informatics:**
Key outcomes measures for Early Intervention are often described as enabling the child to be 'school ready'. Future work on developing the pre-school policy framework and its associated key outcome areas represent a real chance to measure outcomes across the early year's population. The data that would support this outcome is currently being collected for the first time. It is important that outcome data is shared and profiled meaningfully in order to assess the effectiveness of current interventions for children in this age group.

**Finance:**
See 2.10.5 and 3.10.6

**Legislation:**
The Children and Young People's Framework commits to a review of legislation for children. It is estimated that approximately a third of the addition cases at any one time are taken on by children's services due to the local nature of existing regulations concerning fostering services.

## 3.10 Financial Case

### 3.10.1 Revenue costs

The total additional annual recurrent cost for Services for Children increases to £637,000 by 2015. Cash releasing savings of £244,000 are projected.

The revenue cost is estimated to be:
2013 - £416,000
2014 - £521,000
2015 - £637,000.

Implementation costs total £8000.

| Summary costs 2013 -2015 | 2013 | 2014 | 2015 |
|---|---|---|---|
| | £'000 | £'000 | £'000 |
| Implementation Costs | 2 | 6 | - |
| Recurrent revenue costs | 416 | 521 | 637 |
| Capital costs | - | - | - |
| **TOTAL** | **418** | **527** | **637** |

11.10 FTE would be required to implement the changes proposed.

Appendix 5.6 contains detailed financial information describing the annual investment across the OBC.

**3.10.2 Revenue savings**

The most optimistic estimates for additional cost containment £453,000 by2015, including cash releasing savings of £244,000.

Returns on investment are most likely to come from:

- Release in workforce capacity within statutory social services. Early Intervention will demand and activity away from children's services, as vulnerable families avoid a downward spiral of problems leading to crisis and remedial action. Research evidence from the MESCH programme identify reductions in the number of children requiring residential care and increases in natural births, which in turn lead to reduced hospital length of stay post birth.

  There will be an estimated reduction of 100 cases. This would result in a release of social worker capacity, equivalent to approximately £242,000 over 2013 – 15 in total. Any cash released for social work capacity would be achieved through natural wastage. Reductions in staff only occur once the children's service is assured of being 'Laiming Compliant'.

  In addition, there could be a reduction in off island residential placements which would release up to £300,000 p.a for each placement not required

- Reduced demand for Emergency Department consultations

  It is estimated that the annual costs for children under five treated in the Emergency Department with a Primary Care level of need is £120,000. Increasing appropriate Primary Care access for under 5's would release capacity within the Emergency Department workforce

- Cost containment impacts in the Education Department, resulting from reduced demand on specialised resources required in behaviour management and special educational needs.

Many other projected savings are long term and attributed to the wider society, for example US studies on Family Nurse Partnerships demonstrated the benefit to cost

ratios of 3:1 – 5:1 over fifteen years, but these were not exclusively related to health specific services. Accordingly, these benefits have not been costed in this OBC.

Appendix 5.6 contains detailed financial information describing the annual investment across the OBC.

### 3.10.3 Capital costs

There are no additional planned capital costs.

An existing plan to work towards clustering services for children into Le Bas Centre is already being progressed as part of HSSD estate management and capital plan.

### 3.10.4 Funding

Existing payment mechanisms will need to be considered, reviewed and costed in order to improve rapid access to primary care for under 5's. This will be progressed as part of the Primary Care and the quality contract. In addition, a review of existing user pays options and specific health care benefits should be considered in order to subsidise antenatal and postnatal parenting services.

Subsequent to the OBC work on early interventions additional investment for Professional Fostering and Respite Services has been brought forward and included in the Financial Analysis for this OBC (Appendix 6).

### 3.10.5 Managing risk

In order to minimise the financial risk, the following actions must be taken:

- Identify intended benefits carefully
- Monitor the delivery of refocused Services for Children and work collaboratively to ensure that maximum efficiency is achieved delivering a value for money service
- Monitor the success of the service closely
- Make staged investments once the expected benefits are realised

### 3.10.6 Sensitivity analysis – scenarios

Emergency Department Activity

The predicted savings in Emergency Department activity are based on between 1,200 and 1,400 attendances. The assumed cost for incentivising GP activity for each of these attendances is based on a flat rate fee of £35.00 per consultation during normal working hours and £43.00 per consultation out of hours.

The proportion of attendances who present during normal and out of hours is not known, so a 50:50 split has been assumed. The estimated 'savings' are predicated on 1,300 appointments being diverted to GP practice. The saving per consultation is £45 (the difference between £85.00 for an Emergency Department attendance and average cost of £40 for a GP consultation).

Community Midwifery:

Increased midwifery in Primary Care would include a user pays fee to cover GP consultation and associated tests. The existing exemplar model which is based in Cleveland Road clinic contains a fee to the mother of approximately £100.00. There is a risk that other practices may charge a different fee.

### 3.10.7 Assessment of affordability and value for money

The international evidence that describe the qualitative results of early interventions targeting vulnerable children under 5 are based on long term models of investment. The returns or cost containment are based on those children becoming older and not requiring the same intensity of services from a range of agencies such as health and social services, education and community safety.

### 3.10.8 Verification procedures and assumptions

Overall assumptions have been informed by the specialists attending the workshops, a range of supporting publications and relevant local and national health intelligence.

All staff gradings in this OBC have been verified by appropriate line managers and HSSD's Human Resources Department. They are comparable to existing employees in existing roles.

Estimates of impact against existing activity have been developed in discussion with local practitioners working in that area. Their perspectives have been supplemented where ever possible (within the short time frames) with electronic activity data (e.g. Emergency Department attendances) which have been analysed by the Health Intelligence Unit and checked with key clinicians regarding interpretation. Estimations for associated cost have been calculated from the HSSD Finance Department.

The largest investment in this OBC is for the MESCH programme. External advice and guidance as to the nature of this investment has come from published research, and the original authors themselves. Local expertise has been used to scale the investment to the known client group and estimated demand (assuming a caseload of 25 families per MECSH Health Visitor, the required coverage of 100 families would require 5 MECSH-qualified Health Visitors).

More work will need to be completed as part of the Full Business Case to ensure that the existing Health Visitor workforce is not duplicated by this additional investment.

## 3.11 Implementation Actions and Timescales

| Action | 2012 | | | | 2013 | | | | 2014 | | | | 2015 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| Align workstreams for Children's Policy Group and OBC | | | | | | | | | | | | | | | | |
| Review and further define costings and impacts as part of FBC | | | | | | | | | | | | | | | | |
| Scope data, sources, collection analysis | | | | | | | | | | | | | | | | |
| Explore potential areas of joint commissioning with ESC and other SOJ Departments | | | | | | | | | | | | | | | | |
| Begin to recruit to MECSH programme | | | | | | | | | | | | | | | | |
| Recruit Community Midwives | | | | | | | | | | | | | | | | |
| Initiate Pre-birth parenting self help / support | | | | | | | | | | | | | | | | |
| Scope workforce development plan | | | | | | | | | | | | | | | | |
| Roll out workforce development plan | | | | | | | | | | | | | | | | |
| Establish a managed network of practitioners to further develop best practice | | | | | | | | | | | | | | | | |
| Enhance Mellow parenting | | | | | | | | | | | | | | | | |
| Go live citizen's portal | | | | | | | | | | | | | | | | |
| Begin planning for Rapid Access to Primary Care for U5 | | | | | | | | | | | | | | | | |
| Go live MECSH programme | | | | | | | | | | | | | | | | |
| Recruit case workers and care co-ordinators | | | | | | | | | | | | | | | | |
| Monitor MECSH against key outcomes | | | | | | | | | | | | | | | | |
| Monitor Rapid Access Primary Care | | | | | | | | | | | | | | | | |
| Begin handover to mainstream services of first cohort of families post MECSH programme | | | | | | | | | | | | | | | | |

# 4 Stakeholders

## 4.1 Stakeholder involvement in service model development

The preferred model for Services for Children was identified over the course of three workshops which ran from October – November 2011. Follow up discussions with key stakeholders outside the workshops allowed the model to be developed, reviewed and refined.

| Name | Organisation | Responsible | Accountable | Consulted | Informed |
|---|---|---|---|---|---|
| Mark Jones | Paediatric Service | | ✓ | | |
| Julie Gafoor | FNHC | ✓ | | | |
| Yasmine Thebault | ESC | | | ✓ | |
| Susan Turnbull | Medical Officer of Health | | ✓ | | |
| Elaine Torrance | Maternity Services | | ✓ | | |
| Tricia Tumelty | Parenting Services ESC | ✓ | | | |
| Wendy Hurford | Brighter Futures | | | ✓ | |
| Zoe Cameron | General Practitioner | | | ✓ | |
| Fiona Vacher | Jersey Child Care Trust | | | ✓ | |
| Ann Kelly | | | | ✓ | |
| Lisa Perkins | Speech & Language Services | | ✓ | | |
| Carolyn Coverley | CAMHS | | ✓ | | |
| Cheryl Power | CAMHS | ✓ | | | |
| Jill Birbeck | Public Health Department | | ✓ | | |
| Andrew Heaven | Public Health Department | | ✓ | | |

## 4.2 Communications to Internal Stakeholders

A working group which will take forward the development of the full business case will include the key stakeholders. An aspect of this groups focus will be to develop key metrics which will allow improvements to be monitored and described.

A communication plan would need to be developed which allowed wider interested parties to keep up to date with key service developments. Once launched, the citizens portal would become a key conduit for practitioners from across the services to talk to each other effectively.

## 4.3 Communications to External Stakeholders

The third sector have been a key part of the OBC development. There continued participation and involvement in developing the FBC is essential to its success. Once launched, the citizen's portal would become a key conduit for practitioners from across the services to talk to each other effectively.

# 5 Conclusion and Next Steps

## 5.1 Conclusion

The first five years of life is critical in building healthy foundations that will have lasting positive value for that individual.

Investment in early interventions can lead to significant returns. This was outlined by the Children's Services Development Group (a coalition of eight providers of foster care, residential care and specialist educational services) who have estimated that a £1 investment in early intervention leads to a £9.20 saving in later life. The return is based on reduced number of statutory services required to intervene in crisis as well as a return to the wider society as young people develop into healthy economically active citizens. Given the demographic challenge facing the Island with a 95% increase in residents over 65 by 2040, the proportion of young people who are economically active will be critical to the islands economic sustainability.

For Jersey the challenge is carefully applying the evidence base to it's unique system of health and social care.

Initially, additional investment will be required to establish key programmes and better coordinate existing services to deliver this philosophy of early intervention.

Success will be measured through increasing numbers of vulnerable children arriving at school ready to learn as a result of a stimulating and positive early childhood. In addition, statutory service workforce can be reduced as more families are supported and maintain independence despite additional needs.

## 5.2 Capacity and project management requirements

Insufficient capacity exists within HSSD to progress the OBC into a FBC. Careful consideration needs to be given to who should lead this stage of the process as to date the OBC has been developed by the Public Health Department who are non-specialist to the area of services for children and early interventions.

## 5.3 Next steps

This OBC will be developed into a Full Business Case (FBC). The FBC will provide accurate and complete information required to make an informed investment decision. The FBC will aim to:

- Verify the continuing need for investment in the project
- Demonstrate that the preferred solution represents value for money
- Establish that the HSSD is capable of delivering the project
- Confirm that the planned investment is affordable
- Demonstrate that HSSD is capable of managing a successful implementation and subsequently sustaining success
- Provide an essential audit trail for decisions taken
- Identify how benefits will be realised and monitored
- Confirm the investment decision

The FBC will need to be approved and provide sufficient assurance to senior management that the project can proceed and resources can be committed. The FBC

is used as a reference point in the event of any business changes during the project lifecycle and in the event of a post project review or equivalent major review following implementation of the project.

Sign off by Minister
.....

# 6 Appendices

## 6.1 Appendix 1 - Benefits Log

| What is the benefit | Type (Who does this benefit e.g. service users, staff | 'One off' or ongoing benefit? | How will the benefit be measured | What is the baseline (Where are we starting from) | Target (Where we can get it) |
|---|---|---|---|---|---|
| Clear Policy Lead from HSSD and ESC | • Service<br>• Providers | Ongoing | • Tangible metrics to measure outcomes, related to 'school readiness'. | • ESC have developed key indicators for Early Years / Foundation Stage. | First data set being collected currently |
| MECSH<br>Identify vulnerable families pre-birth to 2 years | • Children and families with additional needs | Ongoing | • Improvements in child development milestones<br>• Reduction in children reaching school with language delay<br>• Increased breast feeding<br>• Reduced number of children exposed to second hand smoke | • GP six week check<br>• Outcomes are measured according to Healthy Child Programme<br>• Average time a child spends on CP Register | Ensure children of families with additional needs compare well in school readiness against island average |
| Workforce development<br>Improved identification of risk skill set | • Governance | Ongoing | • Children and families needs are identified earlier and supported in universal services for longer.<br>• Appropriate referrals across the tiers | • JCPC audit found referral made to Children's Services Assessment and Child Protection team over 2 month period was 302 distinct referral (359 distinct children) | Reduction in referrals for children service assessment requiring NFA |
| Improved parent / child relationship / attachment | • Child / family | Ongoing | • Long term reductions in conduct disorder, less family breakdown,<br>• improved educational achievement, reduction in anti- | • Breastfeeding rates at 6 months<br>• Childhood accident U5 | • Increase Breastfeeding rates<br>• Decrease in |

| | | | | | |
|---|---|---|---|---|---|
| | | | social behaviour | (JCAP)<br>• Language delay at age 5 (Not known)<br>• Immunisations coverage (95%) | child accidents<br>• Reduced numbers children with language delay |
| Robust child intelligence including key indications and analysis | • Better planning based on known gaps in the service | Ongoing | • Better focus on those in most need. | • No existing published profile for children health and wellbeing | Improvements in school readiness |

## 6.2 Appendix 2 - Stakeholder log

| | Responsible | Accountable | Consulted | Informed |
|---|---|---|---|---|
| Independent Advisory | | | | |
| JCPC | ✓ | | | |
| Early years care partnership | | | ✓ | |
| Commercial / Private Sector | | | | |
| Family Day carers | ✓ | | | |
| Nursery providers | ✓ | | | |
| General Practitioners | ✓ | | | |
| Playgroups / Preschools Mother and toddler clubs | ✓ | | | |
| States of Jersey Departments | | | | |
| Education Department | | ✓ | | |
| Police | | | ✓ | |
| YAT | | | ✓ | |
| Police | | | ✓ | |
| Parishes Secretaries | | | | ✓ |
| Probation | | | ✓ | |
| Home Affairs | | | ✓ | |

| | | | | |
|---|---|---|---|---|
| Housing | | | ✓ | |
| Employment & Social Security | | | | |
| **Health and Social Services** | | | | |
| Intensive support Social Workers | | | ✓ | |
| Fostering and adoption | | | ✓ | |
| Adult Mental Health | | | ✓ | |
| Paediatric team | | | ✓ | |
| Maternity | ✓ | | | |
| Emergency Department | ✓ | | | |
| Outpatients | | | | ✓ |
| **Third Sector** | | | | |
| Family Nursing and Home Care | ✓ | | | |
| Brighter Futures | | | | |
| The Bridge | ✓ | | | |
| JCCT | ✓ | | | |
| Youth Service (YES) | | | | ✓ |
| Clic Sergeant | | | | ✓ |
| NSPCC Pathways | | | ✓ | |
| Variety Roundtable | | | | ✓ |
| NCT | ✓ | | | |
| Women's Refuge | | | ✓ | |
| Victim Support | | | | ✓ |
| Mind (JERSEY) | | | | ✓ |
| BROOK (Jersey) | | | ✓ | |
| Mencap | | | ✓ | |

## 6.3 Appendix 3- Risk Log

| No | Risk | Consequence | Probability L/M/H | Impact L/M/H | Risk timing | Risk owner | Action | Timing of action | Risk status |
|---|---|---|---|---|---|---|---|---|---|
| **1. Scope of the change** | | | | | | | | | |
| | Fragmented working continues with inconsistent use of JCAF and referral patterns | Continued pressure on Services for Children | H | M | Q1 2012 onward | SRO | Ensure workforce development plan is consistent with JCPC training plan for JCAF across the early years workforce | Q1 2013 | Med |
| **2. Plan and Timescale** | | | | | | | | | |
| | Poor information regarding existing service activity and outcomes | Services are not based on need | H | M | Q1 2012 onward | SRO | Develop more detailed information on local child health needs which can identify service gaps | Q3 2012 | High |
| | Short time frame for planning OBC | Mistakes may have been made in planning assumptions | H | H | Q1 2012 onward | SRO | Full review of assumptions during FBC workup | Q3 2012 | High |
| **3. Resources** | | | | | | | | | |
| | Commissioning of Third Sector services is uncoordinated | Duplication of services and inefficient use of financial resources | H | H | Q1 2012 onward | SRO | Joint planning and collaboration between statutory commissioners on under 5 services | Q3 2012 | High |
| **4. Leadership** | | | | | | | | | |
| | Lack of shared outcomes for under 5 yrs remain across statutory services | Lack of coordination in planning and developing services | H | H | Q4 2012 onward | SRO | Children's Policy Group provides clear leadership and sets a clear strategic vision | Q2 2013 onward | High |

| No | Risk | Consequence | Probability L/M/H | Impact L/M/H | Risk timing | Risk owner | Action | Timing of action | Risk status |
|---|---|---|---|---|---|---|---|---|---|
| **5. Commitment of staff** | | | | | | | | | |
| | Third Sector provider perspectives not captured effectively | Statutory Services perspective and agenda dominate | H | M | Q1 2012 onward | SRO | Managed network of providers meet to ensure an integration of perspectives | Q2 2013 onward | High |
| **6. Data and Information Availability** | | | | | | | | | |
| | Data collection and sharing remains poor | Difficulty in measuring effectiveness or services provided. | M | M | Q1 2012 | SRO | Statutory and commissioned services provide minimum data set against which service can be performance managed / benchmarked/audited | Q3 2012 | High |
| | Child health needs remain poorly understood | Provision remains disjointed and with not improvement in child health | H | H | Q1 2012 | SRO | Establish minimum data set to monitor child health with key indicators for particular aspect of a child's health and wellbeing | Q3 2012 | High |
| **7. Progress** | | | | | | | | | |
| | Governance framework remains undeveloped | Possibility that some activities are not beneficial and could cause harm | H | H | Q1 2012 onward | SRO | Work toward a integrated governance framework for early years | Q1 2013 | High |
| **8. Implementation** | | | | | | | | | |
| | No dedicated resource identified to lead implementation of OBC | Delay in roll out of OBC | H | H | Q1 2012 | SRO | Re-position the Children's Plan Health Lead to assist in delivering OBC. Establish commissioning and service redesign team | Q3 2012 | High |
| **9. Financial** | | | | | | | | | |
| | Short term returns | Cost of services | H | H | Q4 2012 | SRO | Provide further estimates of potential | Q4 2013 | High |

| No | Risk | Consequence | Probability L/M/H | Impact L/M/H | Risk timing | Risk owner | Action | Timing of action | Risk status |
|---|---|---|---|---|---|---|---|---|---|
| | on investment not realised | become more expensive to run | | | | | impact on Statutory Children's Services | | |

## 6.4 Appendix 4 - Issue Log

| No | Risk | Consequence | Probability L/M/H | Impact L/M/H | Risk timing | Risk owner | Action | Timing of action | Risk status |
|---|---|---|---|---|---|---|---|---|---|
| **1. Scope of the change** | | | | | | | | | |
| | No collective shared vision or shared objectives relating to this age group | Service objectives not shared or aligned | H | H | Q1 2012 | SRO | Need to develop high level outcomes for 5 yr olds which can be used as summary indicators for success | Q3-Q4 2012 | High |
| **2. Plan and Timescale** | | | | | | | | | |
| | | | | | | | | | |
| **3. Resources** | | | | | | | | | |
| | Over estimate of existing resources and capacity | Difficulty for services to make transition to new ways of working | M | H | Q1 2012 | SRO | Carefully review with services the impact of transition funding and check assumptions about impact of new funding releasing capacity. | Q3 2012 | High |
| **4. Leadership** | | | | | | | | | |
| | Lack of buy in to existing strategies | Reluctance to invest time and energy to invest in the 'next new thing' | H | H | Q1 2012 | SRO | FBC needs to cross reference more clearly with existing strategies and explore more thoroughly connections to this work stream | Q3 2012 | High |
| **5. Commitment of staff** | | | | | | | | | |
| | Lack of recognition about innovative practice already happening | Existing innovative practice is inhibited by activity outlined in OBC | M | | Q1 2012 | SRO | Use mapping and results of public consultation for Children's and Young People's Strategic Framework to identify areas of innovation which need protecting | Q3 2012 | Med |
| **6. Data and Information Availability** | | | | | | | | | |

| No | Risk | Consequence | Probability L/M/H | Impact L/M/H | Risk timing | Risk owner | Action | Timing of action | Risk status |
|---|---|---|---|---|---|---|---|---|---|
| | Lack of infrastructure to share data | Continued working within silos and overlaps | H | H | Q1 2012 | SRO | As part of FBC, need to explore practical ways of sharing data in order to better understand what each service is adding to the collective goal of improving child health | Q3 2012 | Med |
| **7. Progress** | | | | | | | | | |
| | | | | | | | | | |
| **8. Implementation** | | | | | | | | | |
| | No coordinated body to oversee service development | Services pursue self interest as opposed to meeting demonstrable need | H | H | Q1 2012 | SRO | Need to provide a forum or managed network which allows joined up implementation of OBC | Q3 2012 | Med |
| | Third Sector pursuing short term existence. Lack of time to think long term | Service interested in status quo | H | H | Q1 2012 | SRO | More effective commissioning process which allows practice to flourish and enable strategic thinking. | Q3 2012 | Med |
| **9. Financial** | | | | | | | | | |
| | Poor Commissioning processes increases risk of investment not leading to desired outcomes | Re-commissioning of services | M | H | Q1 2012 | SRO | Ensure robust processes are in place to support commissioning | Q3 2012 | High |

## 6.5 Appendix 5 - Dependency and enablers log

| Description of Dependency | Dependency Lead | Dependency 'Strength' (High/Medium/Low) | Comments (What can we do to align the dependencies, what are the timeframes, etc) |
|---|---|---|---|
| | | | |
| Financial Support – tax relief Child Care | Minister for Health and Social Security | H | Quality child care expensive. Recent increase in low income thresholds welcomed |
| Social Policy | Council of Ministers | H | Absence of wider social policy framework means that minimum wage, maternity leave are never considered with wider impacts such as child health in mind |
| Getting a population based profile will require data sharing from across services and their IT systems, Information sharing protocols and governance | All | H | Health analyst capacity part of OBC with a view to developing joint indicators and common outcomes measurements |
| JCAF for agencies to work to common outcomes and common referral processes<br>Required considerable training which is lead by JCPC | JCPC – Training Officer | H | Investigate progress of ongoing work and ensure capacity to train and raise awareness in this area is included within OBC |

## 6.6 Appendix 6 – Financial Analysis

Note: the costs shown in the table below, and throughout the document, have been inflated to reflect the relevant prices for each year.

| Initiative title & resource requirements | Additional FTE required | Implementation date | Imp costs (£'000) | 2013 revenue (£'000) | 2014 revenue (£'000) | 2015 revenue (£'000) | Total Revenue Including implementation costs |
|---|---|---|---|---|---|---|---|
| Midwife sessions in GP practices: | 2 | Jan-13 | 8 | 119 | 122 | 125 | 374 |
| Parenting Self Help: | - | Jan-13 | - | 29 | 30 | 31 | 90 |
| Workforce Development (Upskill Childcare workers) | - | Jul-13 | - | 15 | 29 | 29 | 73 |
| Multi-Disciplinary Team supporting families in the community- (MESCH Programme) | 7 | Jan 2013 | | 222 | 366 | 504 | 1,092 |
| Case Workers for families with children under 5 who have complex conditions | 1.6 | October 2013 | - | 49 | 101 | 103 | 253 |
| Extend Mellow Parenting funding beyond 2012 | 0.5 | Jan-13 | - | 31 | 31 | 32 | 94 |
| Rapid Access to Under-5 Care: Subsidised GP visits to remove pressure on Accident & Emergency Department at the General Hospital | - | Jan-13 | - | | 43 | 57 | 100 |
| Duplication of Health Visitor Capacity | | | | -49 | -100 | -103 | -252 |
| Early interventions leading to a reduction in Children's Service management of cases | - | | | - | -101 | -141 | -242 |
| **Total - Early Intervention** | 11.1 | | 8 | 416 | 521 | 637 | 1,582 |
| Professional Fostering - fostering co-ordinators | | Jan-13 | | 92 | 94 | 97 | 283 |
| Children's respite services | | Jan-13 | | 115 | 121 | 124 | 360 |
| **Total Services for Children** | | | 8 | 623 | 736 | 858 | 2,225 |