BCS BUSINESS CONSULTANCY SERVICES
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FINAL REPORT

DE – Review of the Staffing Structure of Health Professionals in Sure Start

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Department of Education

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CONTENTS

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EXECUTIVE SUMMARY

Introduction

Business Consultancy Service (BCS) of the Department of Finance (DoF) was appointed by the Department of Education (DE) to undertake a review of the Sure Start Model and its use of Health Professionals (HPs).

Baseline Analysis and Findings

Not all Sure Start settings currently have HPs and indeed some settings do not wish to have HPs in their structure. The settings that do not have access to HPs are able to offer their families comparable services that do not impact on their targets or the feedback received from parents. The survey information shows that all settings are able to offer a similar set of services with the only difference being that in some settings there is no HP to lead the delivery and this will impact on the ability to offer medical advice and guidance.

While, one of the most important factors for settings is to retain the ability to base their structure on local need, there is a noted desire for access to HPs in some settings and consultation with settings and other stakeholders outlines the benefits of this access to include early identification of issues and the ability to build relationships with families. While many note the need to have HP resource within their structure, there is also merit in having access to HP advice and guidance through formal links between settings and Trusts. While Trusts provide professional supervision to Trust employed Health Visitors working in Sure Start settings, it is evident from all consultation that there is a desire among many of the settings and health bodies to scale up alignment of Sure Start settings to core health services and to develop formal links with Trusts so settings have access to professional advice. There is evidence of good practice where settings have established formal relationships with Trusts. These formal links are an avenue for access to professional advice and guidance and can help settings to ensure they make the best use of HP resource.

Not least due to the workforce issues being experienced across both HP roles in NI, stakeholders put forward that HP work in settings should be appropriate to their discipline and not work that can be undertaken by family support or another member of the Sure Start team. Going forward, the use of HPs in Sure Start will need to take account of the long-term recruitment issues and the need to ensure the work being undertaken by HPs is appropriate to their professional expertise.

Effectiveness

It was not possible to determine the effectiveness of varying structures or to assess the value added by HPs (see section 3).

There were no direct comparators for the Sure Start programme. England, Scotland and Wales have all, to some degree, moved away from the Sure Start Model. However, there are similarities and good practice that can read across to Sure Start. The following good practices can be seen in comparators and indeed in Sure Start:

- Settings are in the communities for ease of access to services and to develop local knowledge and understanding;
- Holistic approach using centres and home visits using Health Professionals as appropriate;
- Catchment area service, non-stigmatised;

- Use of multi-disciplinary teams in every region;
- Access to HPs, at the very least Health Visitors, across every region. However, the need for midwifery support is deemed important and one comparator that does not currently offer this are taking steps to develop this service
- Metrics used include uptake of the services offered and engagement with the project; signposting to other services; voice of the parent regarding satisfaction and help received through the setting; and the impact on family confidence.

Current progress on metrics to include more longitudinal data being undertaken in Wales is of interest. Part of metric development is looking beyond standard measures. The ability to measure the impact of the interventions by HP staff and to quantify the value that they add to families and child development is key. Use of Subject Matter Experts (SMEs) in behavioural science to identify the alternative measures based on family and child behaviours may provide insight into which activities or interventions provide the greatest outcomes, which may in turn direct the focus of future Sure Start interventions. Examples of this as seen through the information set out on the Flying Start model would be the use of data analysts to determine metrics and track data such as increased confidence levels and the impact of Flying Start interventions on core health services.

While DE recognise a need for longitudinal data and have ongoing longitudinal studies, to add to the ability to measure impact, Sure Start, in consultation with stakeholders in other Departments and health bodies, may wish to develop a set of metrics that reflect the longer term impact Sure Start interventions have on families and on core health services, for example, it may be of interest for Sure Start to understand if HP engagement through Sure Start impacts on the level of family engagement with core health services.

Future State Options

Options 0-6 (see section 4.8) were presented to the Project Steering Group (PSG) and shortlisted and scored based on the following criteria.

Shortlisting Criteria	Description
Feasibility	The degree to which each option can be implemented (based on the number of HPs required for each option considering HP availability pressures)
Viability	The degree to which each option is financially viable and sustainable (based on cost and value for money as outline in Benefits and Challenges of each Option).
Desirability	The degree to which each option meets the strategic aim, objectives and priorities of stakeholders. To include • if the model assists Sure Start in meeting outcomes • if the model aligns with the priorities of consultees in terms of alignment with core health services, standardisation of the HP role, gives settings the autonomy to base their structure on local need and allows for settings to have access to experienced HPs who have the skills and knowledge to work with and develop relationships with the families they engage with.

Option 5: Sure Start Association (local cohorts) scores highest and has emerged as the preferred option. Application of the emerging preferred option will be an iterative process and will take time to implement

in full. It will be critical for success to engage early with all stakeholders and to ensure Sure Start settings are supported throughout this process.

Conclusions

The following conclusions have been noted against the original Terms of Reference.

Terms of Reference	Conclusions
Baseline: Identification of the current arrangements / model for employment of HPs, mainly midwives and Health Visitors, in the Sure Start programme	Not all settings currently have HPs and some settings do not wish to have HPs in their structure. The settings that do not have access to HPs are able to offer their families comparable services that do not impact on their targets or the feedback received from parents. While, one of the most important factors for settings is to retain the ability to base their structure on local need, there is a noted desire for access to HPs in some settings and issues with the wider HP workforce are impacting on this availability.
Workforce model: Analysis of the Early Years HP workforce in NI (availability, ease of recruitment and workforce model)	There are resource and recruitment issues for both the Health Visitor and Midwife workforce. While steps are in place to address shortfalls, there are no quick fixes and Trusts expect to experience workforce pressures for a number of years. Going forward, the use of HPs in Sure Start will need to take account of the long-term recruitment issues and the need to ensure the work being undertaken by HPs is appropriate to their professional expertise.
Effectiveness: Analysis of the effectiveness of the current HP arrangements / model against good practice in deploying health professionals in early intervention within comparators (national / international)	It was not possible to determine the effectiveness of varying structures or to assess the value added by HPs (see section 4). While Sure Start is not replicated in the jurisdictions reviewed for comparison, there is some good practice Sure Start may wish to adopt relating to metrics that reflect the longer term impact Sure Start interventions have on families and on core health services (see Section 3.9).
Impact: An assessment of the impact of deployment of HPs in Sure Start settings on core health services;	The Review Team found no evidence through consultation that HP resource based in Sure Start settings impacts on core health services. As outlined, consultation notes that rather resource pressures can impact the availability for both HP roles in Sure Start settings. Going forward, the use of HPs in Sure Start will need to take account of the long-term recruitment issues and the need to ensure the work being undertaken by HPs is appropriate to their professional expertise.

Options: Develop and assess costed options for a future model to include status quo, adjustment to current model and a regional model	Options 0-6 were presented to PSG and shortlisted and scored based on agreed criteria. A preferred option has been outlined and developed for consideration.

1. INTRODUCTION

1.1 Introduction

Business Consultancy Service (BCS) of the Department of Finance (DoF) was appointed by the Department of Education (DE) to undertake a review of the Sure Start Model and its use of Health Professionals (HPs).

1.2 Background and Context

Sure Start is a key DE Early Years programme. The Programme is targeted at children under the age of four, and their families, living in the most disadvantaged areas in Northern Ireland. There are 38 Sure Start settings across Northern Ireland (NI) who deliver the Sure Start programme through a wide variety of services, designed to support children's learning skills, health and well-being, and social and emotional development. Each setting works with parents, statutory agencies and community-based organisations in the area, to design and provide services appropriate to the needs of local families. All families with children aged 0-3 years living in a Sure Start catchment are eligible to register to avail of Sure Start services.[1].

DE has policy responsibility for the Sure Start programme and works closely with the Department of Health (DOH) in programme oversight. The programme was administered by the Health and Social Care Board (HSCB) until the HSCB closed on 31 March 2022. The Strategic Planning and Performance Group (SPPG) in DoH was set up to undertake the functions of the HSCB from 1 April 2022, including administration of the Sure Start programme.

Funding for Sure Start is allocated to SPPG by DE on the basis of financial projections provided by SPPG who is responsible for the disbursement of funds to each setting. These projections are provided through SPPG assessment of settings' annual business plans, ongoing liaison with the settings and through monitoring performance against targets. The assessment is to ensure each setting has designed services to meet local needs and to effectively contribute towards achievement of Sure Start policy aims and outcomes. The annual business plans developed by each setting provide outline planned activities for the financial year, and how these will contribute towards achievement of the objectives of Sure Start outcomes and how they deliver the six Core Elements as set out in the DE guidance. While settings will structure services to meet local needs, there are core elements and activities planned which are structured against the headings of Sure Start core services to clearly demonstrate how the activities meet the overall outcomes.

Evaluation and monitoring of Sure Start includes use of data on types of services and consideration of best practice. Reporting focuses on service uptake by families and children in Sure Start areas and feedback from parents through a survey. DE also reports on health and educational outcomes making comparison between children and families in Sure Start areas and those outside these areas. The Sure Start programme is also evaluated by the Education and Training Inspectorate (ETI) on an annual basis, reporting to DE on strengths of the programme and areas for improvement.

There are 4 types of accountable body across the Sure Start settings. These are statutory HSC organisations, national and regional voluntary / charitable organisations, community organisations, and private Limited companies.

[1] *https://www.education-ni.gov.uk/articles/sure-start*

All Sure Start settings will be managed by a Project Manager. It is standard practice for the Sure Start Lead or Accountable Body to act as employer for the Sure Start Manager and other Sure Start staff, although some Sure Start settings and other partners can directly employ staff where appropriate. Staff may be employed directly or seconded to the setting through other agencies.

Sure Start settings have the autonomy to create and amend their staffing structure to ensure this is appropriate to meet local needs. As such, there are a number of different staffing models across settings. For HPs, while some settings have opted not to employ Health Visitors and/or Midwives, a number have had difficulty in recruiting for these roles and have adapted other roles over the years to meet their needs.

Many of the Sure Start outcomes for children and families are delivered through the access that Sure Start provides to Health Visitors and midwives.

Currently not all Sure Start settings have a Health Visitor and/or Midwife i.e. 23 of the 38 Sure Starts have Health Visitor posts and 20 have Midwife posts. The full extent of any HP vacancies was not made available to the Review Team as settings are using the funding for other activities / staff. SPPG has worked with settings to provide other staff, for example, public health nurses in lieu of Health Visitors.

The New Decade New Approach agreement committed to establish an independent Expert Panel to examine the links between educational underachievement and socio-economic background and develop an action plan for change to ensure all children and young people are given the best start in life. The Expert Panel was appointed in July 2020 and conducted its work between September 2020 and May 2021. The panel published "A Fair Start"[2] report and action plan, dated May 2021 in which action ii stated that *DE should undertake a review of the Sure Start staffing structure to ensure there is access to the necessary health professions including Health Visitors and Midwives*.

As such, DE engaged BCS to undertake a review to meet this requirement.

1.3 Terms of Reference

The Terms of Reference (ToR) for this project was to:

> Review the Sure Start staffing structure to ensure access to necessary HPs, including health visitors and midwives. This will include considering options and advising a preferred option.

To achieve this the BCS approach was to review the:

- **Baseline:** Identification of the current arrangements / model for employment of HPs, mainly Midwives and Health Visitors, in the Sure Start programme;
- **Workforce model:** Analysis of the Early Years HP workforce in NI (availability, ease of recruitment and workforce model);
- **Effectiveness:** Analysis of the effectiveness of the current HP arrangements / model against good practice in deploying health professionals in early intervention within comparators (national / international);
- **Impact:** An assessment of the impact of deployment of HPs in Sure Start settings on core health services; and

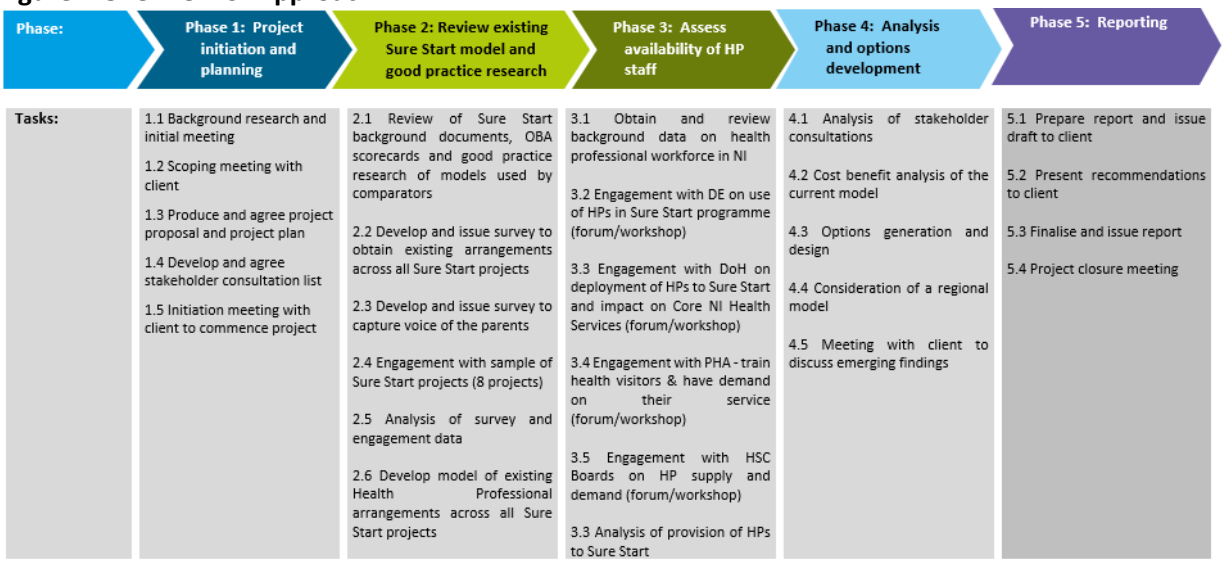
[2] *A Fair Start, expert panel on educational underachievement in Northern Ireland, available at www.education-ni.gov.uk*

- **Options:** Develop and assess costed options for a future model to include status quo, adjustment to current model and a regional model.

1.4 Approach

Figure 1 provides an overview of the approach taken to the evaluation.

Figure 1 Overview of Approach



1.5 Programme Scope and Timeframe

The review fieldwork and engagement commenced in January 2022 and completed in May 2022. The scope of this assignment was to undertake a review of the Sure Start Model and its use of HPs. This review focused on midwives, Health Visitors and non HP staff performing similar activities and roles. All other HPs within the Sure Start settings, e.g. Speech and Language Therapists (SLTs) and Occupational Therapists (OTs) were out of scope of the review. Where HPs are referred to in this report, they therefore relate to Health Visitors and Midwives, unless otherwise stated.

1.6 Acknowledgements

The BCS Review Team would like to thank the PSG and the Stakeholder Reference Group (SRG) for their insight, oversight and guidance during this review. The Review Team would also like to thank the wide range of stakeholders who took part in interviews and surveys to inform the evaluation. The full list of stakeholders consulted is provided in Appendix II.

2. BASELINE ANALYSIS AND FINDINGS

2.1 Introduction

The Review Team, using data captured from background information and consultation, reviewed the wider HP workforce, current Sure Start models, costs of these models and any differences in outcomes or activities based on structure. Wider consultation with relevant stakeholders informed findings on the impact of deployment of HPs in Sure Start settings on core health services. The following section details this analysis.

2.2 Notes on data collection

In undertaking this analysis, the Review Team received data on the wider HP workforce across NI from DOH. It was anticipated a baseline of structures of HPs in all settings would be produced based on information supplied by Sure Start settings through the survey. Not all respondents gave full or consistent information in relation to structure, vacancies, costs and outcomes. To produce this baseline the Review Team received financial and HP resource information on all settings from PSG. This baseline data is attached at Appendix III and has been used as a guide to understand HP resource and costs across settings.

Where the Review Team have referred to vacancies in this section, they have relied on data supplied through the survey and qualitative information gained through consultation with a sample of 8 settings. From engagement with the sample of Sure Start settings, the Review Team is aware that not all vacancies were declared as the settings are using the funding for other activities / services or staff and do not regard these as vacancies.

2.3 Baseline - Workforce data

2.3.1 Health Visitor Workforce

The following tables show the key information in relation to the Health Visitor workforce across NI to include those employed in Sure Start settings.

Table 1 Health Visitor Data

Health Visitor Data	
Health Visitor Numbers NI	Not available
Health Visitor FTE NI	422
Health Visitor Numbers Sure Start	29
Health Visitor FTE Sure Start	18.98
Health Visitor Roles Currently being Recruited across HSC Trusts	72 FTE active

While there is small proportion (4.5%) of the Health Visitor workforce in NI utilised in Sure Start settings, the Review Team has outlined later in this section a desire in some settings for Health Visitor resource and issues with recruitment. There are currently 72 FTE roles being actively recruited for across all Trusts for Health Visitors. However, this is estimated to drop to 31 FTE vacancies once new Health Visitors take up post on completion of their training in September 2022. The data provided is for Trust recruitment only and does not include Sure Start requirements.

2.3.2 Midwife Workforce

The following tables shows the key information in relation to the Midwife workforce across NI to include those employed in Sure Start settings.

Table 2 Midwife Workforce Data

Midwife Data	
Midwife Numbers NI	1292
Midwife FTE NI	1021
Midwife Numbers Sure Start	21
Midwife FTE Sure Start	8.12
Midwife roles currently being Recruited across all HSC Trusts.	100 active

While there is a small proportion (0.8%) of the Midwife workforce in NI utilised in Sure Start settings, the Review Team has outlined, as with Health Visitors, a desire in some settings for Midwife resource and issues with recruitment. There are currently 100 roles being actively recruited across all Trusts for Midwives. The data provided is for Trust recruitment only and does not include Sure Start requirements.

2.3.3 HP Workforce Consultation findings

The Review Team consulted with DE, DOH, the Public Health Agency (PHA), and SPPG to gain insight into the supply and demand of HPs resource across NI and any impact of deployment of resource to Sure Start settings.

Overall, evidence was put forward of workforce issues with both HP disciplines, which aligns with the number of vacancies outlined in the tables above for both HP roles. There are known issues with current resource and while steps are in place to address shortfalls, there are no quick fixes and Trusts expect to experience workforce pressures for a number of years.

There is currently difficulty in recruiting for and training adequate numbers of Midwives and Health Visitors to meet demand. The main reasons for these difficulties are:

- The cost of training. In some routes to qualifications, it may be necessary to pay for the training, continue to pay the student their existing salary and then recruit or backfill their previous post. This is an expensive process.
- Lack of provision of practical experience. A large component of the training for HPs (both Health Visitor and Midwife) involves an element of practical work. An increase in recruitment will lead to a saturation of the practical settings. This means at present that there is a limit to the number of HPs that can be trained due to a limited number of places in practical settings.

This impacts not only on the wider HP workforce across NI but also on the resource available for work in Sure Start settings. Due to the governance structures of Sure Start, some settings are linked to Trusts. While this structure can mean it may be easier to recruit HPs into the settings, it is also the case that Trusts can recall HP resource back to core health services when experiencing workforce pressures.

Despite workforce pressures, the Review Team heard agreement during consultation of a need for access to HPs in Sure Start settings. There is merit in having a HP lead in settings to identify

and gather the information to ensure there are targeted interventions. HPs can help to ensure that the most vulnerable families access the assistance they need.

However, the Heads of Profession in the Trusts noted this should be limited to where HPs are undertaking work that is appropriate to their discipline and not work that can be undertaken by family support or another member of the Sure Start team. Many consultees noted the benefits of more alignment between Sure Start settings and core health services, to develop formal links with Trusts so settings have access to professional advice. There is evidence of good practice where settings have established formal relationships with Trusts. These formal links are an avenue for access to professional advice and guidance and can help settings to ensure they make use of the best use of HP resource.

The Review Team found no evidence through consultation that HP resource based in Sure Start settings impacts negatively on the work of core health services. As outlined later in Section 2.5, consultation notes that rather resource pressures can impact the availability for both HP roles in Sure Start settings. Going forward, the use of HPs in Sure Start will need to take account of the long-term recruitment issues and the need to ensure the work being undertaken by HPs is appropriate to their professional expertise.

2.4 Baseline - Sure Start settings

Sure Start settings have autonomy to create and amend their staffing structure to ensure it is appropriate to meet local needs. As such, there are a number of different staffing models across settings. While some settings have opted not to employ Health Visitors and/or Midwives, a number have had difficulty in recruiting for these roles and have adapted other roles to meet their needs. Table 3 sets out the number of settings that have Health Visitor, Midwife or no HP resource in their structure.

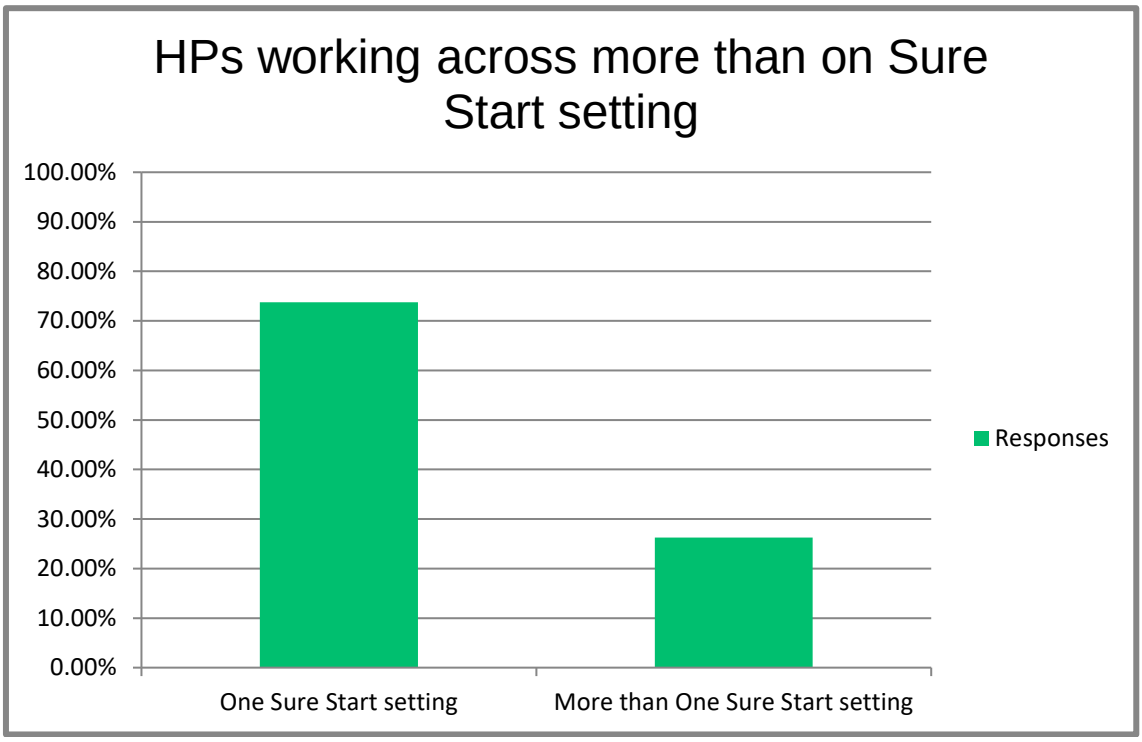
Table 3 HP Resource in Sure Start Settings

HEALTH VISITORS	MIDWIVES
23 of the 38 (61%) settings are using budget for Health Visitors. Across the 23 settings: ▪ 29 Health Visitors are employed (18.98 FTE) ▪ 5 Full Time ▪ 24 Part-Time The majority (**82%**) of Health Visitors are employed by the Trusts to work in the settings	20 of the 38 (53%) settings are using budget for Midwives. Across the 20 settings: ▪ 21 Midwives are employed (8.12 FTE) ▪ 21 Part-Time The majority (**65%**)[3] of Midwives are employed by the Trusts to work in the settings
HEALTH VISITORS IN SETTINGS - EMPLOYERS	**MIDWIVES IN SETTING – EMPLOYERS**
Employer — Nos. Employed	Employer — Nos. Employed
Northern Health & Social Care Trust — 6 South Eastern Trust — 3 Western Health & Social Care Trust — 3 Belfast Health & Social Care Trust — 2 Southern Health & Social Care Trust — 10 Derry Resource Centre — 1 Early Years — 1 Clan Mor Sure Start Co. PLC — 1 Greater Shankill Partnership — 1 Colin Sure Start — 1	Northern Health & Social Care Trust — 3 South Eastern Trust — 1 Belfast Health & Social Care Trust — 2 Southern Health & Social Care Trust — 7 Upper Springfield Development Trust — 1 Early Years — 1 Clan Mor Sure Start Co. PLC — 1 East Belfast Sure Start — 1 Greater Shankill Partnership — 2 Beechmount Sure Start — 1

[3] No information supplied for employer of 1 Midwife

The table shows that HP resource is not always a full time resource; a large majority of both Health Visitor and all Midwife roles are part-time with many of these roles only resourced for a nominal number of hours (see Appendix III). Additionally, as outlined in the figure below, 26% of the HPs surveyed stated that they worked across more than one Sure Start setting. These HPs deliver the same activities across the multiple settings they worked in.

Figure 2 Graph illustrating the percentage of HPs working in more than one Sure Start Setting



2.5 Health Professional vacancies in Sure Start settings

To understand any constraints in recruitment or how settings adapt to HP vacancies, the Review Team gathered information on current HP vacancies within Sure Start settings. The table below outlines HP vacancies reported by settings through the survey. From engagement with the sample of Sure Start settings the Review Team is aware that not all vacancies were declared as the settings are using the funding for other activities / services or staff and do not regard these as vacancies.

Table 4 Sure Start Current HP vacancies

Vacancy	Time Period of Vacancy
Health Visitor	3 vacancies reported lasting 6-12 Months
Health Visitor	1 vacancy reported that had lasted more than 12 Months
Midwife	1 vacancy reported that had lasted for less than 6 Months

Of the five settings with reported vacancies, all have attempted to fill their vacant role/s but have been unable to due to the unavailability of HP staff. Two of the settings reported they have been unable to continue to provide the service during the vacancy. From consultation with settings, we understand this is an ability to provide a HP service in absolute terms, i.e. professional medical advice and guidance. For those settings who have continued to provide a full or reduced service throughout the vacancy, they have split the workload across other members of staff, including

Family Support Workers and other Health Visitors and Midwifes in their setting. Many of these staff have an alternative qualification, such as:

- Birth and Beyond NCT degree
- Hypnobirthing
- Baby massage/baby yoga/baby swim
- Breastfeeding support
- Infant Mental Health

During engagement with the sample of 8 settings they discussed the HP vacancies that they carried and where they had used this funding for alternative services and / or other staff. They did not consider that they had vacancies when completing the survey because they believed they no longer had a budget to pay for the post(s). The conclusion drawn by the Review Team was that approach in completing the survey questions on vacancies by the sample was in all likelihood the approach by the majority of settings. It was therefore not possible for the Review Team to quantify the extent of HP vacancies across Sure Start. The SPPG Sure Start managers are aware of the use of funding for alternative services and/or staff.

38% of these 8 settings reported that while they have been unable to recruit for a HP, they do not count this as a vacancy as this has been ongoing for a number of years. Due to a lack of availability of Health Visitors and/or Midwives across NI, settings have needed to adapt to how services are delivered and have upskilled other members of staff. While these settings would still prefer to recruit for a HP, they have utilised this budget elsewhere to deliver the service and therefore do not consider they hold this vacancy.

Consultees in the sample of settings discussed the wider workforce issues across both HP roles, which has influenced the availability of HPs available to work in Sure Start settings. It will take time to address these issues and the Covid-19 pandemic has further negatively affected availability of this resource. The Review Team was informed that during the Covid-19 pandemic, Trusts needed to withdraw a number of seconded HPs back to core health services (to meet Covid need) leaving these settings without HP resource. While the Trusts and the PHA stated that this could not be done unilaterally and needed the approval of the Sure Start setting manager, it is clear from consultation that settings understand pressures in core health services further impact on HP resource available to them.

As with consultation on the wider workforce (see 2.3), through consultation with the sample of Sure Start settings, the Review Team understand that where settings are linked to a Trust, it can be easier, if not to recruit HPs, then to build relationships where there is a link to this HP advice. Settings note they would welcome a formal link into Trusts with dedicated Health Visitor and Midwife input to complement their existing staff and provide that continuity of service for families with no interruption; settings without HPs are conscious that core health services are under pressure and it can be difficult for families to contact them.

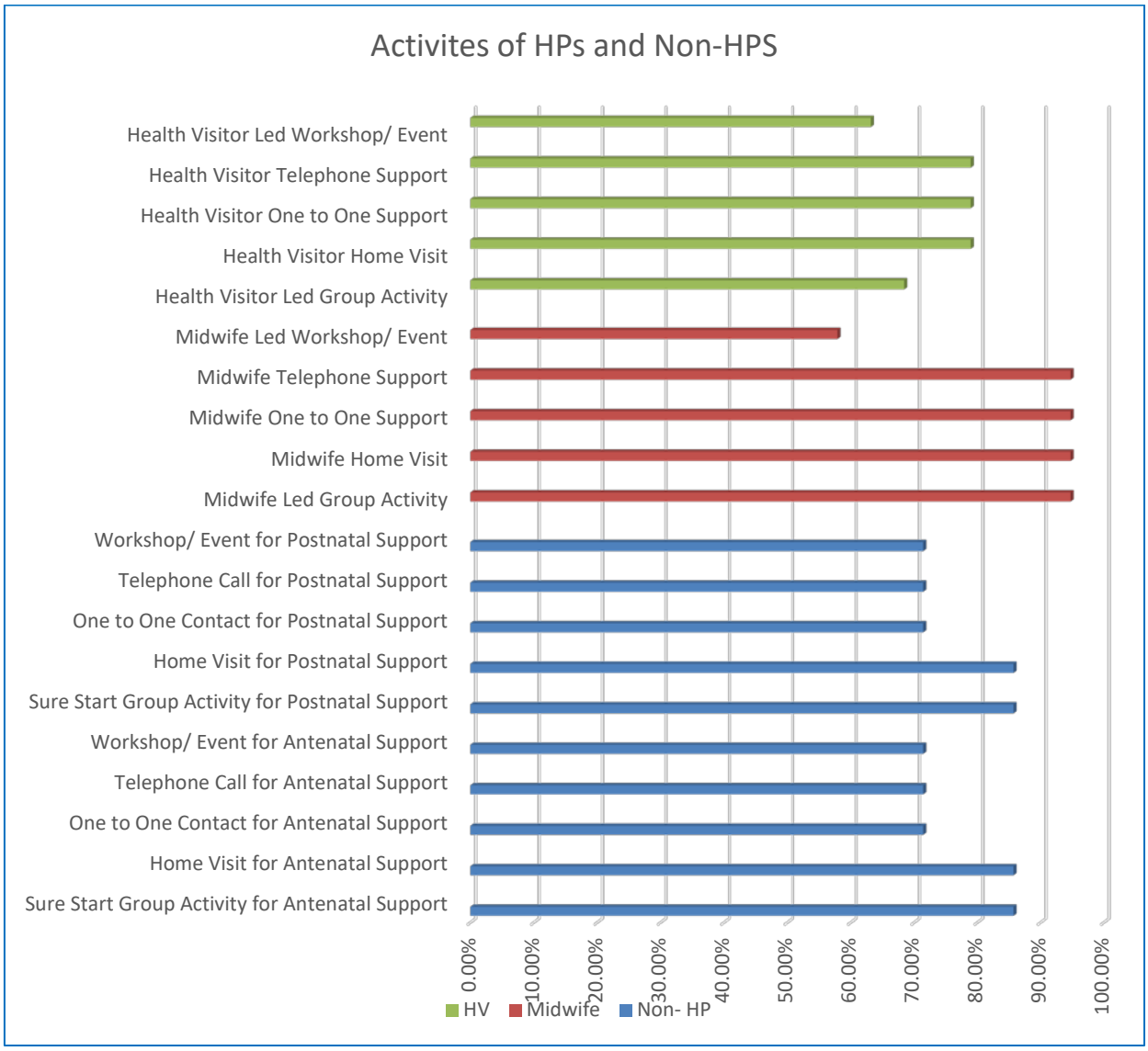
While it has been noted that not all settings (c. 25% from the sample of 8) did not wish to have HP resource in their structure, consultation evidenced there is clear demand for these roles in many settings and issues with resource across NI can affect the ability to recruit.

2.6 Sure Start activities

Using information gathered through the surveys, the Review Team collected data on the activities of the different settings to include Health Visitor activities, Midwife activities and activities

undertaken by other members of staff, which are similar in nature to Health Visitor and Midwife roles. This was in order to ascertain any differences in activities or services dependent on structure. The following graph details these activities.

Figure 3 The extent to which Sure Start activities are provided and the personnel providing them



The responses outlined (from the Sure Start Setting Project Manager Survey) indicate that regardless of structure, the suite of services offered remain largely the same. The only difference lies in whether the activity is led by a HP or another member of staff.

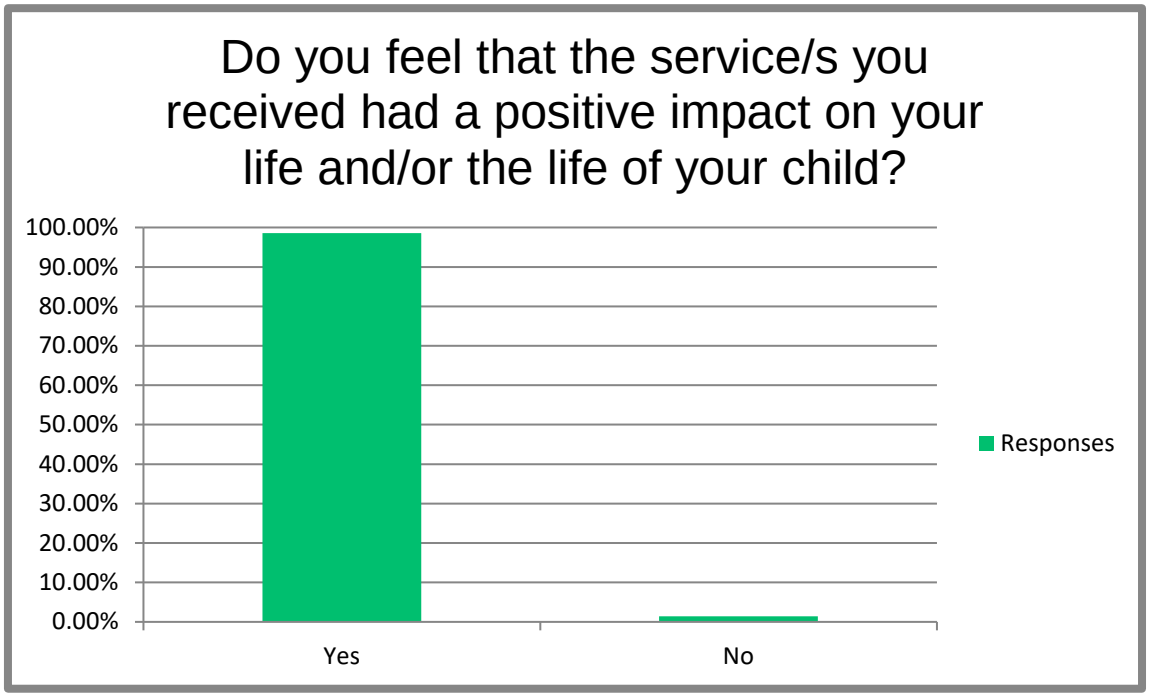
While it was not possible to set out the exact remit of the activities of HPs in settings due to the way activities are recorded, from consultation the Review Team understands that HP involvement in setting activities can vary and some settings note that this ability to tailor approach through a variety of engagements is fundamental to reaching families in need.

The Review Team issued a survey to parents from a representative sample of HP staffing models and geographical areas. The figure below illustrates parents' perception of the services received. Parental feedback regarding the performance of settings was universally positive and was not based on the settings' structures or whether there was HP involvement. Regardless of who

delivered the services, parents believe that settings are providing a worthwhile service that was easy to access and that had made a positive impact in the lives of their child.

A small number of parents referred to a lack of antenatal support but this was put forward in the context of disruption to services because of restrictions imposed throughout the Covid-19 pandemic.

Figure 4: Graph illustrating parental attitude to Sure Start services



2.7 Sure Start outcomes

There are five Sure Start policy outcomes:

- Improved language skills;
- Early identification of developmental delay;
- Enhanced parenting skills;
- Improved access to services; and
- Effectively integrating services.

All Sure Start settings are required to develop an annual business plan. While settings have flexibility to structure services to meet local needs, the core elements and planned activities are developed against the headings of Sure Start core services to clearly demonstrate how they will contribute towards achievement of the Sure Start Outcomes.

While this means there will be variety in the services provided across the Programme, there are core elements, as set out in the DE guidance, which must be incorporated by each Sure Start:

- outreach and home visiting services, to make contact as early as possible in a child's life and draw families into using other services;

- family support including befriending, social support and parenting information, both group and home based;
- speech, language and communication support, at a level within each setting as agreed by DE;
- good quality play, learning and childcare experiences for children, both group and home based;
- primary and community healthcare and advice; and
- support for all children in the community recognising their differing needs.

The Review Team reviewed a sample of action plans and target information for settings. Sure Start settings report on metrics to demonstrate how the activities meet the overall outcomes and there were no notable differences in outcomes or targets met for settings based on structure as outlined in the table below (data taken from survey responses). While a number of settings detailed 'Other' measurements, these relate to one of the key themes outlined in the table. No measurements are in place that evidence the outcome from specific activities or from a role, whether HP or other staff. It was therefore not possible for the Review Team to assess the impact of differing roles.

Settings with HP resource note it is difficult to capture the impact of HPs on outcomes, but overall evaluation takes the form of qualitative and quantitative data through case studies, impact evaluations, parent feedback, Outcomes Star tool or retention levels. There are no notable differences in how this is measured for the varying structures and data from the survey (outlined in table 5) shows similar outcome measurements regardless of structure.

Table 5 Outcomes measured across different Sure Start structures

Outcome	Settings with Health Visitor	Settings with Midwife	Settings with Health Visitor and Midwife	Settings with no HP resource
Child or Parent Health Outcomes	86.67%	86.67%	91.67%	100.00%
Child Educational Outcomes	46.67%	46.67%	50.00%	40.00%
Child Social Development Outcomes	93.33%	93.33%	91.67%	80.00%
Child and Parent Relationship Development	100.00%	100.00%	100.00%	80.00%
Parenting Skills	93.33%	93.33%	100.00%	100.00%
Other (please specify)	33.33%	33.33%	41.67%	0.00%

Consultees from the sample of 8 settings gave comments on the role of HPs on outcomes. In particular, settings with current HP involvement or issues in retention of these staff feel that HP work is integral to Sure Start services and brings a needed level of experience and expertise to the team. They consider that having a balance of a number of different roles to include HPs leads to better outcomes and noted the impact of not having HP resource on early identification of issues.

Approximately 55% of the settings noted through the survey, the impact of not providing HP services. The main themes coming through in the survey were that services can be limited due to the absence of a Health Visitor and Midwife and they feel that this impacts outcomes. While Family Support and other roles are trained to provide similar services, HPs are key to providing early intervention, establishing early relationships and to ensure continutity of care. There may

also be an impact on future uptake if families cannot avail of professional advice through settings and an impact on core health services if settings were to increase referrals for professional advice. Settings who have had issues with recruitment note they miss the public health knowledge that a HP can provide and have had to be creative in upskilling other roles to provide services in lieu of a Health Visitor or Midwife. Some settings note that HP absence slighty reduces the expertise in the multidisciplinary team.

Other settings work closley with their Trust for primary and caseload midwifery and health visiting services especially in relation to health or medical issues. Many settings noted that more established links are needed with core health services to work closely together to have access to professional advice and to include a more integrated and joined up approach where Sure Start can compliment the work of core Health services. However, this needs to be set in the scope of Sure Start not replicating core health services but providing genuine additionality in outcomes.

While it is evident that there is a desire for HP resource in some settings for the impact they can have on outcomes (c. 55% of survey responses)[4], this is not the case across all settings and they have opted not to include this resource in their structure. Through consultation with the sample of 8 settings, 25% stated that they did not require Health Professionals in their structure. All 8 settings did see merit in links with the Trusts for access to professional advice and guidance.

2.8 Sure Start setting costs

Full cost information for each setting, who provided the data, is detailed at Appendix IV.

The Sure Start Project Manager survey requested information in relation to the proportion of cost for Health Visitors, Midwives or other members of staff undertaking similar activities. The Review Team further requested information on total number of families engaged with together with a breakdown of number of families who engaged with Health Visitors, Midwives or other members of staff undertaking like duties. This data was intended for analysis of any difference in costs against the engagement rates and outcomes of different structures. There were a number of limitations with the data received, especially concerning engagement rates. From comments supplied, it is evident that the Covid-19 pandemic impacted services so engagement rates for some settings are not a fair reflection of a typical year. Additionally, settings did not use consistent measurements in their response, for example, some settings recorded one family for multiple engagements, some settings provided number of registered families rather than number of families they engaged with and many settings stated they could not measure this engagement rate due to the multidisciplinary nature of their team as families will engage with a number of different staff.

What the Review Team can assess from baseline cost data is that while the salary costs for HPs will be among the highest salary scales in Sure Start settings, this does not equate to a large proportion of total costs with current structures. The Health Visitor resource cost ranges from 1.8% to 9.5% of total annual costs with Midwife resource costs ranging from 0.8% to 5.7% of total costs. Analysis of this survey data and the baseline data set out in Appendix III shows that no settings will spend more than 15-17% of total costs on HP resource. Costs for other staff undertaking similar services range from 5.7% to 15% of costs and there is a correlation in most settings where HP costs increase, costs for other staff decreases.

[4] Not all of the 38 settings responded to questions on the impact of not providing HP services. The figure of 55% has been estimated from the 21 responses that noted a desire for HP activity in their setting.

2.9 Section Summary

This section has outlined that not all settings currently have HPs and indeed some settings do not wish to have HPs in their structure. The settings that do not have access to HPs are able to offer their families comparable services that do not impact on their targets or the feedback received from parents. The survey information shows that all settings are able to offer a similar set of services with the only difference being that in some settings there is no HP to lead the delivery and this will impact on the ability to offer medical advice and guidance.

While, one of the most important factors for settings is to retain the ability to base their structure on local need, there is a noted desire for access to HPs in some settings. Consultation with settings and other stakeholders outlines the benefits of this access to include early identification of issues and the ability to build relationships with families. While many note the need to have HP resource within their structure, there is also merit in having access to HP advice and guidance through formal links between settings and Trusts. While Trusts provide professional supervision to Trust employed Health Visitors working in Sure Start settings, it is evident from all consultation that there is a desire among many of the settings and health bodies to scale up alignment of Sure Start settings to core health services and to maintain or develop formal links with Trusts so settings have access to professional advice.

Not least due to the workforce issues being experienced across both HP roles in NI, stakeholders put forward that HP work in settings should be appropriate to their discipline and not work that can be undertaken by family support or another member of the Sure Start team. Going forward, the use of HPs in Sure Start will need to take account of the long-term recruitment issues and the need to ensure the work being undertaken by HPs is appropriate to their professional expertise.

3. EFFECTIVENESS

3.1 Introduction

The Review Team sought to determine the effectiveness of Sure Start settings through analysis of the outcomes and measures of the differing Sure Start models and through engagement with a number of comparator organisations. Constraints in this research have been set out below together with findings from information made available to the Review Team.

3.2 Effectiveness of current Health Professional arrangements – constraints

Through analysis of the measurements, targets and outcomes for Sure Start, the Review Team established that there are no notable differences in measurements for the varying structures; outcomes and targets are not attributed to certain members of staff and all settings measure and achieve services linked to outcomes in a consistent way regardless of whether there are HPs in their structure. Due to this limitation with data, it was not possible for the Review Team to assess the effectiveness of the varying structural models within the settings. Counterfactual evidence on the benefits of access to HP resource has been set out in Section 2.

3.3 Comparator Insights

An important element of this Review has been the identification and engagement with a number of comparator organisations. This has been with a view to developing a contrast via comparison insights; exploring aspects of similarity and difference. 4 possible comparators were identified by PSG. Insights were gained from engagement with Scotland and Wales and through desktop research for England and the United States of America (USA) models. The early years models used are:

- Flying Start, Wales
- Early Years, Scotland
- Children's Centres, England
- Early Head Start programmes, USA

3.4 Constraints with Comparator Insights

The Review Team sought to make contact with all jurisdictions including engaging with colleagues from wider DOH and DE to identify links. However, Wales and Scotland were the only jurisdictions to agree to meet and provide insight into their early years provision and the use of HPs in this provision. The Review Team have outlined findings from meetings with early years provision in Wales and Scotland together with desk research completed on early years provision in England.

It is also of note that the Sure Start model is not replicated in these jurisdictions and therefore no like for like comparison has been possible. While this is a key constraint, there is value in this section in the identification of good practices and measurements.

3.5 Comparator Insight 1 – Flying Start Wales

Flying Start is the Welsh Government's targeted Early Years programme for families with children under 4 years of age who live in some of the most disadvantaged areas of Wales (measured using the Welsh Deprivation index). Flying Start, like Sure Start, operates a universal service in these areas irrespective of financial status of the families. Flying Start aims to make a decisive difference

to the life chances of children by mitigating the impact of poverty, which is linked to poor life outcomes in early childhood, including health outcomes. The Programme comprises four entitlements which provide:

- free quality, part-time childcare for 2-3 year olds;
- an intensive health visiting service;
- access to parenting support; and
- support for speech, language and communication development.

Flying Start uses a multidisciplinary team approach to identify all of the needs of the child and their family and provide prudent and proportionate interventions. However, unlike Sure Start, there is no midwifery provision in Flying Start.

Flying Start aims to ensure that children are healthy and thriving; families are capable and coping; and Flying Start children are reaching potential.

The focus is early identification of any needs and the timely application of interventions. While Flying Start offers a distinct programme of health interventions, the programme builds upon the universal programme of Health Visitor interventions set down in Healthy Child Wales Programme (HCWP). While the Flying Start health programme offers additionally to the HCWP, in terms of the regularity and number of interventions provided, the main difference between these two Welsh offerings is that Health Visitors are able to refer to or call upon the support of a multidisciplinary team of other professionals, both health and non-health who can work collaboratively to meet the needs of the child and their family. Families with the greatest level of identified need should receive the greatest intensity of interventions. This compares with the model of Progressive Universalism in Sure Start to provide services according to need.

All Flying Start children and families receive their programme of health visiting and other health interventions from the Flying Start health team (either the Health Visitor or delegated to other members of the health team), rather than the core health service. The Programme also sets down the additional interventions for those families assessed by their Flying Start Health Visitor, as having 'enhanced' or 'intensive' needs. In planning for the future, the Flying Start Programme has identified a need for the addition of Midwives to their multidisciplinary teams and this is under review.

The Cardiff Flying Start programme has employed a data analyst to develop and implement new and innovative ways to measure the success of the interventions. One such way is measuring the distance that families are prepared to travel to access different facilities i.e. leisure, shopping, medical, government, without support. This is used as a measure of the increased confidence of the family and how Flying Start interventions have contributed to this.

The data analyst is also undertaking a longitudinal survey of the impact Flying Start interventions have on the statutory inventions. The Flying Start programme is targeting families in the most deprived areas in Wales and it hoped that through their interventions that the need for statutory interventions further down the line will not be needed for these families. The longitudinal study will test this theory and will give an indicator of the impact that Flying Start has had on these families.

3.6 Comparator Insight 2 – Early Years, Scotland

Scotland moved away from the Sure Start model 10-12 years ago and now provide support to families in line with the "Getting it right for every child model". To ensure consistency and maximise the impact of the health visiting service, in 2013 the then Chief Nursing Officer for

Scotland, directed all Health Boards to enhance the specialist role of Health Visitors towards the delivery of preventative and targeted interventions. This was to be better equipped to address the specific needs of children and families in the first five years of life. Following the directive, the workforce has now doubled and service has been enhanced to follow a routine pathway for delivery, Universal Health Visiting Pathway (UHVP), and includes:

- a more structured home visiting service and refocused role for children aged 0-5
- an increased number of home visits of at least eleven visits before the child enters school, with eight in the first year of life, including three child health reviews
- adaptation of the relevant post graduate education Specialist Community Public Health Nursing (SCPHN) to support the refocused role
- additional training of existing Health Visitors to support the new educational components
- sustainable recruitment of new Health Visitors.

All early years work is based on the Integrated Children Services Plan (reviewed every three years) and the Joint Strategic Needs Assessment (reported on annually).

The increase in funding took the form of a Wellbeing family fund. This fund was worth approximately £40m over 4 years to provide holistic family support. This enabled the Scottish Government to scale up the core Health Visitor service, which has doubled the workforce (approx. 500 Health Visitors). This has helped free up capacity for HPs to deliver their clinical roles.

The early years interventions are targeted in the more deprived areas. Families are identified through various methods and different parts of the system before being referred on to the early years interventions. These inventions are staffed by multi-disciplinary teams, which include but are not limited to, Health Visitors, Family Support Workers, Speech and Language Therapists, Perinatal workers and social workers.

Midwifery services still provide routine care and there are targeted models within different areas of need. The adoption of the "Getting it right for every child model" has changed the way Scotland offers early years interventions. There is now a structured approach to Health Visiting that enabled support for every child under 5. This is possible through a significant investment and a doubling of the Health Visitor workforce to meet this need. There are still targeted inventions for families in more deprived areas as required and these are provided by multidisciplinary teams. The extra funding has also enabled support to be offered by a Family Nurse Practitioner to all mothers under the age of 19.

3.7 Comparator Insight 3 – Children's Centres, England

In 2003 England moved away from the centrally managed Sure Start model and delivered its Early Years interventions and Support through local authority managed Children Centres. Much like Sure Start these centres are based in the most economically deprived communities. Combined with the use of multi-disciplinary teams this allowed the local communities to access the services provided. While no one made themselves available to meet during the course of this review, the Review Team undertook some desk research on a model noted as best practice, the St. Stephen's Children's Centre in London.

St Stephens Children's Centre has been in operation for over 10 years and has received excellent inspection reports. It is based in a school and a multi-disciplinary team ensures that all services are offered from one site. The multi-disciplinary teams consists of:

- education (nursery and primary, from ages three up to 11),

- day care,
- primary health care (Health Visitors),
- antenatal health care (midwifery),
- family support,
- speech and language therapy,
- adult learning,
- parenting classes, and
- family sport/leisure sessions

Funding is from the Local Authority, Newham Council, for the education and children's centre services except for midwifery, which is funded through the local National Health Service Trust. The day care is a fee-paying provision, with some support available for parents through tax credits, plus (at the time of writing) a national provision of 15 hours a week free for every three- and four-year-old.

This comparator highlighted the importance of multidisciplinary teams who are co-located in the same building. This enables families to access all the required services in one place and allows the teams to freely exchange information and provide the best possible service for the family.

There were a number of factors highlighted that have led to the success of the multidisciplinary teams. These are:

- Strong leadership and management
- Joint planning and training
- Trust and respect between partners
- Good communication
- Co-location of agencies and services
- Using and sharing of information

3.8 Comparator Insight 4 – Early Head Start Programme (USA)

Early Head Start (EHS) programmes are available to the family until the child turns 3 years old and is ready to transition into Head Start or another pre-school programme. Services to pregnant mothers and families, including prenatal support and follow-up, are also provided by EHS and delivered by Health Visitors. Many EHS programmes are provided in a child's own home through weekly home visits that support the child's development and family's own goals. Other EHS programmes are located in centres, which provide part day or full day programming for children. EHS Child Care Partnerships are programmes dedicated to offering EHS services to eligible families within the childcare system.

The role of the EHS programmes are to provide:

- Structured, child-focused home visiting that promotes parents' ability to support the child's cognitive, social and emotional, language and literacy, and physical development, and approaches to learning

- Effective strengths-based parent education, including methods to encourage parents as their child's first teacher
- Early childhood development, from birth - 5
- Methods to help parents promote emergent literacy in their children from birth–5
- Working with other providers to eliminate gaps in service by offering annual health, vision, hearing, and developmental screening for children from birth to entry into kindergarten
- Strategies for helping families coping with crisis
- The relationship of health and well-being of pregnant women to prenatal and early child development

An EHS programme must provide enrolled pregnant women, fathers, and partners or other relevant family members, prenatal and postpartum information, education, and services.

A program must also address needs for appropriate supports for emotional well-being, nurturing and responsive caregiving, and father engagement during pregnancy and early childhood.

The EHS programme identifies a need for both home visits and centre based work to ensure that the families involved received a holistic approach to their support. This approach is similar to that adopted in Sure Start. These programmes are delivered by qualified Health Visitors, which is not the case across all Sure Start settings where they have adopted their structure and resource based on local need and availability of Health Visitor staff.

3.9 Comparator Insight Summary

As stated above, there were no direct comparators for the Sure Start programme. England, Scotland and Wales have all, to some degree, moved away from the Sure Start Model. However, there are similarities and good practice that can read across to Sure Start. The following good practices can be seen in comparators and indeed in Sure Start:

- Settings are in the communities for ease of access to services and to develop local knowledge and understanding;
- Holistic approach using centres and home visits using Health Professionals as appropriate;
- Catchment area service, non-stigmatised;
- Use of multi-disciplinary teams in every region;
- Access to HPs, at the very least Health Visitors, across every region. However, the need for midwifery support is deemed important and one comparator that does not currently offer this are taking steps to develop this service
- Metrics used include uptake of the services offered and engagement with the project; signposting to other services; voice of the parent regarding satisfaction and help received through the setting; and the impact on family confidence.

The integration of health interventions, normally provided by core health services, is a feature of the Welsh Flying Start model. This can be compared to the Star Babies model in use by some Sure Start settings.

Current progress on metrics to include more longitudinal data being undertaken in Wales is of interest. Part of metric development is looking beyond standard measures. The ability to measure the impact of the interventions by HP staff and to quantify the value that they add to families and child development is key. Use of Subject Matter Experts (SMEs) in behavioural science to identify the alternative measures based on family and child behaviours may provide

insight into which activities or interventions provide the greatest outcomes, which may in turn direct the focus of future Sure Start interventions. Examples of this as seen through the information set out on the Flying Start model would be the use of data analysts to determine metrics and track data such as increased confidence levels and the impact of Flying Start interventions on core health services.

While DE recognises a need for longitudinal data and have ongoing longitudinal studies, to add to the ability to measure impact, Sure Start, in consultation with stakeholders in other Departments and health bodies, may wish to develop a set of metrics that reflect the longer term impact Sure Start interventions have on families and on core health services, for example, it may be of interest for Sure Start to understand if HP engagement through Sure Start impacts on the level of family engagement with core health services.

4. FUTURE STATE OPTIONS

4.1 Introduction

This section presents the options for consideration. It begins with a list of assumptions made in development of the Options and outlines the conclusions from current state. It then develops with the aims and objectives for choosing a 'long-list' of options, which underpins the subsequent evaluation of options. This section then outlines the options, with a description of each and summarises a number of benefits and challenges. The section ends with an assessment of the long list of options, the shortlist agreed with PSG and identification of the preferred option.

4.2 Assumptions

The Review Team has made the following assumptions in developing a long list of future state options. These are as follows:

- The recommendation made in the Fair Start report that all Sure Start settings have access to HPs is appropriate to implement;
- The recommendation made in the Fair Start report that all Sure Start settings have access to HPs does not refer to an absolute need for HPs to be employed in each setting. Rather it would be that settings do not experience issues in gaining access to HP resource to provide professional expertise, when specifically required in their setting;
- Future state options identified from the review will not impact on the provision of the six core elements of Sure Start;
- The Funding Model for Sure Start will remain as is;
- The Management Structure for Sure Start will remain as is;
- The Management bodies and structures of Sure Start will remain as is;
- Sure Start will continue to operate as multi-disciplinary teams and the purpose of each setting remains unchanged;
- Supply of HPs will remain the same in the short term with potential for available and experienced staff to increase through recruitment and training and return of staff;
- The sample of 8 Sure Start settings that the Review Team engaged with closely are representative of settings as a whole;
- Costs are based on ready reckoner costs supplied for Band 6 HP c.£56,000 for 1 FTE;
- Proportion of full employer costs for HPs (Health Visitors and Midwives) as a % of total setting budget is based on the data provided and is currently c.15-17% maximum;
- For Options requiring management and administration of HP call off banks, the cost of this management and administration will not exceed current costs; and
- For Option 4, proportion of Trust funded work is based on consultation with a setting using the Star Babies model, where they receive approximately 20% of funding for the Health visitor role from the Trust.

The Review Team acknowledges that there is an ongoing review of DE's early years interventions including Sure Start which could impact on some of the assumptions set out.

4.3 Conclusions from Current State

The Review Team considers that there is a case for change based on findings. In particular, a '*do nothing'* option (outlined at Option 0 below) presents a number of issues including the inability to fulfil the Fair Start report recommendation, enabling continued access of HP resources for those settings who choose to use HP resource in their structure.

However, through analysis of the findings the Review Team has further concluded that there is no desire or need in **all** Sure Start settings to have access to HPs in their structure. All settings note that they do not need direction in terms of the staff they require but rather support to recruit HPs where this is necessary. Another finding from consultation is that HP access does not always relate to the ability to have actual HP resource in a setting; Sure Start settings would welcome support in developing formal links with areas of HP expertise within Trusts for professional advice and guidance. Settings wish to continue to set their structure based on local need, which may not always involve the use of HPs, especially in consideration of the upskilling of other staff that has taken place. Rather, settings see merits in a more collaborative approach to support them in recruitment/access to HPs where needed. For these reasons, the Review Team does not conclude that the Fair Start recommendation will be applicable to all settings. In taking forward the preferred option, it will be important for DE to consider the preferred option as a model for use in settings where access to HP resource is required.

4.4 Aims and Objectives

In developing options, the overall aim is to ensure access to HP resource to all Sure Start settings.

Table 6 Objectives for option development

Objectives	Outputs
Objective 1– EASE OF ACCESS TO HP RESOURCE: Integral to enabling settings' access to HP resource, which is a known issue for many settings due to the current workforce issues.	• Where required, settings do not have issues in gaining access to HP resource and can provide professional expertise as part of their offering to users.
Objective 2 - EFFICIENCY: Managing resources efficiently and effectively in order to provide assurance to DE and other stakeholders, ensuring value for money in relation to public funds to improve outcomes for children and families.	• A cost effective, efficient and sustainable function capable of meeting the organisations' existing and emerging needs. • Managing organisations' resources (staff, budgets) to ensure an efficient and effective service, delivering VFM.

4.5 Potential Constraints

The Review Team consider that there are a number of constraints associated with making a transition towards the achievement of the objectives above. While not an exhaustive list, these would include:

- **Capacity to maintain business continuity during change management process**: any change would need to maintain business continuity, ensuring all services remain operational.

- **Availability of suitable staff**: the current issue with availability of HP workforce may impact further on existing HP resource available to Sure Start settings. If the required numbers of HPs are not available, this could potentially constrain the change.

- **Availability of funding**: there is likely to be a finite amount of funding available to support change and to deliver any change to the operating model and staffing levels.

- **Compliance and changes to relevant policy / regulations / employment contracts:** need to ensure compliance with current and changes to policies, regulations and employment contracts.

4.6 Identification and Description of Options

The Review Team initially presented Options 0-6 to PSG for discussion and evaluation.

The long list of options is set out in Table 6 below. This list includes 4 call off options, 3 of which are for HPs employed for use by Sure Start settings (options 1, 2 and 5) and 1 for call off directly from core health services (option 3). There are shared benefits and challenges for each of these, listed along with the specific benefits and challenges for each option.

Table 7 Long List of Future State Options

Option Description	Evidence	Benefits	Challenges	Cost
Option 0: 'As Is' • No change • Some settings have access to HP resource • Use of funding for alternative service provision where HP resource cannot be recruited	• Positive parental feedback for all sample settings regardless of structure • Settings meet intended aims and objectives regardless of structure • Settings have adapted where HP resource is unavailable	• Continuity of service and structure • Currently delivering a service that users are satisfied with	• Does not fulfil the Fair Start recommendation of HP access in all Sure Start settings • Some settings desire access to HPs and this resource is not available • Settings without access to HP resource need to signpost to core health services which is under increasing pressure • Although outside the remit of the BCS review, the Review Team noted that it could be unclear across the Sure Start settings how allocated funding was being used. Where a setting was allocated funding for HP staffing costs but were unable to employ HPs, the funding was used for to deliver other services for the children and families. To ensure clarity of use of public funds, change of commitment agreement, recording and reporting should form part of the governance process	c.£1.5m – existing budget used for HP resource

Option Description	Evidence	Benefits	Challenges	Cost
Option 1: Trust based Call Off HP bank • Call Off list of HP resource in each Trust area for Sure Start settings • HP staff specifically assigned to Sure Start work • Resource based on hours of work required for each setting (and not on number of HPs) • Standardised roles that HP resource undertake in settings, linked to their professional expertise, and to include oversight of work of other roles in Sure Start settings e.g. family support workers	• Tested model (in place for SLTs) • All Sure Start settings do not require access to HP resource • Settings currently have issues in recruiting for HP roles and there is a desire for better links with Trusts for access to HP resource and advice	• Fulfils the Fair Start recommendation of HP access to all Sure Start settings • Creates a link between Sure Start and Trusts work in core health services • Sure Start settings will have access to HP resource when required without the need for recruitment • Standardisation of HP service in Sure Start settings • Value for Money in use of limited and more expensive HP resource • Use of funding allocation for HP resource used for access to this resource	• Core health services may have first call on HP resource in times of work pressures (need for service level agreement) • Distortion of remit of HP roles in settings and core health services (need for work style agreement) • Changes to employment contracts for existing HP resource in settings, where these HPs have been directly recruited. • Potential to impact users' trust needs if there is not continuity in HP resource (will depend on HP numbers in pool) • Potential to lose informal relationship building and early identification of issues if HPs not embedded in Sure Start settings	Settings will pay Trust for hours used. Existing resource would likely be sufficient to cover a more standardised HP resource used only for specialist interventions. Maximum c. £1.5m
Option 2: NI Regional based Call Off HP bank • Call Off list of HP resource across NI for Sure Start settings • HP staff specifically assigned to Sure Start work • Resource based on hours of work required for each setting (and not on number of HPs)	• Tested model (in place for SLTs) • All Sure Start settings do not require access to HP resource • Settings currently have issues in recruiting for HP roles	• Fulfils the Fair Start recommendation of HP access to all Sure Start settings • Creates a link between Sure Start and work in core health services • Sure Start settings will have access to HP resource when	• Core health services may have first call on HP resource in times of work pressures (need for service level agreement) • Distortion of remit of HP roles in settings and core health services (need for work style agreement)	Settings will pay for hours used. Existing resource would likely be sufficient to cover a more standardised HP resource used only for specialist interventions. Maximum c. £1.5m

Option Description	Evidence	Benefits	Challenges	Cost
• Standardised roles that HP resource undertake in settings, linked to their professional expertise, and to include oversight of work of other roles in Sure Start settings e.g. family support workers • Call off list not defined by Trust boundaries across the region, but by availability of HPs at a regional level and settings' requirements		required without the need for recruitment • Standardisation of HP service in Sure Start settings • Value for Money in use of limited and more expensive HP resource • Use of funding allocation for HP resource used for access to this resource	• Changes to employment contracts for existing HP resource in settings, where these HPs have been directly recruited. • Potential to impact users' trust needs if there is not continuity in HP resource (region wide model will impact on this greater than Trust based) • Potential to lose informal relationship building and early identification of issues if HPs not embedded in Sure Start settings	

Option Description	Evidence	Benefits	Challenges	Cost
Option 3: Core health **services Call Off HP facility** • Call Off HP resource from core health services, as required • Resource based on hours of work required for each setting (and not on number of HPs) • Standardised roles that HP resource undertake in settings, linked to their professional expertise, and to include oversight of work of other roles in Sure Start settings e.g. family support workers	• All Sure Start settings do not require access to HP resource • Settings currently have issues in recruiting for HP roles and there is a desire across those involved in core health services for better alignment with HP work in Sure Start settings	• Fulfils the Fair Start recommendation of HP access to all Sure Start settings • Creates a link between Sure Start and work in core health services • Sure Start settings will have access to HP resource when required without the need for recruitment • Standardisation of HP service in Sure Start settings	• Core health services may have first call on HP resource in times of work pressures (need for service level agreement) • Distortion of remit of HP roles in settings and core health services (need for work style agreement) • Changes to employment contracts for existing HP resource in settings, where these HPs have been directly recruited.	Settings will pay core health services for hours used. Existing resource would likely be sufficient to cover a more standardised HP resource used only for specialist interventions. Maximum c. £1.5m

Option Description	Evidence	Benefits	Challenges	Cost
		• Value for Money in use of limited and more expensive HP resource • Use of funding allocation for HP resource used for access to this resource	• Potential to impact users' trust needs if there is not continuity in HP resource • Potential to lose informal relationship building and early identification of issues if HPs not embedded in Sure Start settings	

Option Description	Evidence	Benefits	Challenges	Cost
Option 4: Sure Start and core health services collaboration • Collaboration with core health services. Sharing of HPs with Trusts • Element of core health services work undertaken by HP in Sure Start with majority of work undertaken being Sure Start work • This proportion of core health services work funded by Trust	• Tried and tested model (Star Babies) in some Sure Start settings with positive feedback • CPP Managers understand the merits of this system and have first-hand experience of positive results it can bring	• Fulfils the Fair Start recommendation of HP access to all Sure Start settings • Could take on students and mentor for practical attainment of training • Creates a link between Sure Start and work in core health services • Value for Money in use of funding from Trusts for core health services visits with opportunity to also provide the additionality Sure Start provides • Alignment between work of core health services and Sure Start settings • Reduction in duplication or overlap between work of core	• May require additional HP resource outside that currently employed in Sure Start to fulfil core health services obligations • Model may need to be adapted by some settings which have no desire for HP resource • Distortion of roles in core health services and Sure Start (need for work style agreement) • Settings will still need to recruit or second HP resource • No standardisation of HP services in Sure Start settings • Could impact on Value for Money if HP resource used for tasks not linked to their professional role	Based on Star Babies model. Anticipate this may require additional resource. With core health services contributing to costs this would decrease HP resourcing costs. At a maximum of 1 FTE of each a Health Visitor and Midwife in each setting which would cost c.£4.5m with core health services paying 20% (based on consultation on Star Babies) maximum £3.6m but it is likely this would be less.

Option Description	Evidence	Benefits	Challenges	Cost
		health services and Sure Start settings • Continuity of service for families • Sure Start settings will have the autonomy to use their HP resource outside of core health services work as local needs demand • Better 'buy-in' from Trusts for access to HPs in settings		

Option Description	Evidence	Benefits	Challenges	Cost
Option 5: Sure Start Association (local cohorts) • Call Off list of HP resource across set Sure Start setting cohorts • HP staff specifically assigned to Sure Start work and to role specific duties	• All Sure Start settings do not require access to HP resource • Settings currently have issues in recruiting for HP roles • Some settings have well established formal and informal links for sharing HP resource and for professional supervision of staff	• Fulfils the Fair Start recommendation of HP access to all Sure Start settings • Sure Start settings will have access to HP resource when required without the need for recruitment • Sure Start settings can control their workload without a need for balance with the work of core health services • No changes to employment contracts for existing HP resource in settings	• A finding from consultation was that hard to reach users take time to build trust in the HPs. There is potential to impact users trust needs if there is not continuity in HP resource (local cohort resource should reduce this) • Potential to lose informal relationship building and early identification of issues if HPs not embedded in all Sure Start settings	Settings will pay for hours used. Existing resource could be sufficient to cover a more standardised HP resource used only for specialist interventions. c. £1.5m

Option Description	Evidence	Benefits	Challenges	Cost
		• Standardisation of service within each cohort • Continuity of HP resource within cohorts will enable trust building with HPs for harder to reach families • Continuity of HP resource within cohorts will enable relationship building and early identification of issues	• Potential for ambiguity in the Sure Start settings (need for service level agreement) • No standardisation of HP service across cohorts but will require some agreement on appropriate HP interventions and an assessment of the staffing requirement following this. • No links or alignment with core health services or Trust	

Option Description	Evidence	Benefits	Challenges	Cost
Option 6: Dedicated HP resource in each Sure Start setting • Each of the 38 Sure Start settings recruit for dedicated HP resource	• Expectation at Department level that all settings have access to resource • Some consultees see this as the ideal model to bring expertise and standard advice and services	• Fulfils the Fair Start recommendation of HP access to all Sure Start settings • Consistency of professional expertise of HP resource • Enables trust building with HPs for harder to reach families • No ambiguity of roles between Sure Start and core health services	• Value for Money – HP resource is more expensive and in this scenario they would be partly involved in work not linked directly to their professional role • Will require greater HP resource which is limited • No alignment with Trust or core health services • No standardisation of HP role	Cost at 1 FTE of each HP resource for each setting. Maximum c. £56k for each annually. Maximum cost c. £4.3m.

Option Description	Evidence	Benefits	Challenges	Cost
		• Potential for leadership/oversight of HP resource for other Sure Start non HP roles • Ability for HP resource to build close community links and potentially aid in the early identification of issues	• Could potentially impact on other services in Sure Start – may need to reduce services to fund HP roles • Not all Sure Start settings desire HP resource in their structure	

4.7 Reduction of Options: Initial Shortlisting with PSG

Shortlisting Criteria

The initial long list of options was evaluated to provide a short list of options. The shortlisting criteria were agreed by the client team and are as follows.

Table 8 Agreed Shortlisting Criteria

Shortlisting Criteria	Description
Feasibility	The degree to which each option can be implemented (based on the number of HPs required for each option considering HP availability pressures)
Viability	The degree to which each option is financially viable and sustainable (based on cost and value for money as outline in Benefits and Challenges of each Option).
Desirability	The degree to which each option meets the strategic aim, objectives and priorities of stakeholders. To include • if the model assists Sure Start in meeting outcomes • if the model aligns with the priorities of consultees in terms of alignment with core health services, standardisation of the HP role, gives settings the autonomy to base their structure on local need and allows for settings to have access to experienced HPs who have the skills and knowledge to work with and develop relationships with the families they engage with.

Options Eliminated

Options 0, 1, 2, 3 and 6 were eliminated based on the shortlisting criteria. This is outlined below.

Table 9 Table detailing rationale for Options eliminated

Options	Rationale
Option 0: 'As Is'	Eliminated based on Desirability • **Desirability:** this option will not meet the required strategic objectives. It will not align with the priorities of consultees in terms of alignment with core health services, standardisation of the HP role. It does not present access opportunities for settings who desire access to HPs but who have experienced issues with recruitment.
Option 1: Trust Based Call Off HP bank	Eliminated based on Desirability • **Desirability:** this option will not meet the required strategic objectives. It will not align with the priorities of consultees in terms of guaranteeing access to experienced HPs as it is likely pressures experienced in core health services work would impact on and take

	preference over the work need in Sure Start. It does not meet the needs for continuity of resource of HP to allow for the relationship building which is so important to many of the families settings engage with.
Option 2: NI Regional based Call of HP bank	Eliminated based on Desirability • **Desirability:** this option will not meet the required strategic objectives. It will not align with the priorities of consultees in terms of guaranteeing access to experienced HPs as it is likely pressures experienced in core health services work would impact on and take preference over the work needs in Sure Start. It does not meet the need for continuity of resource of HP to allow for the relationship building, which is so important to many of the families settings engage with.
Option 3: Core health services Call Off HP facility	Eliminated based on Desirability • **Desirability:** this option will not meet the required strategic objectives. It will not align with the priorities of consultees in terms of guaranteeing access to experienced HPs as it is likely pressures experienced in core health services work would impact on and take preference over the work needs in Sure Start. It does not meet the need for continuity of resource of HP to allow for the relationship building, which is so important to many of the families settings engage with.
Option 6: Dedicated HP resource in each Sure Start setting	Eliminated based on Feasibility, Viability and Desirability • **Feasibility:** this option will require a large increase in HP resource which is not feasible considering current workforce pressures • **Viability:** this option will be considerably more expensive than the current model • **Desirability:** this option will not meet required strategic objectives

4.8 Options Shortlisted with PSG

There were 2 options shortlisted for detailed assessment. This shortlist was agreed by PSG.

Table 10 Shortlisted Options

Options	Rationale
Option 4: Sure Start and core health services collaboration	Shortlisted based on Viability and Desirability • **Viability:** this option will be more expensive but with core health services contributing to costs there is value for money in the use of expensive HP resource while allowing for additionality and alignment with core health services (reducing duplication or overlap of work) • **Desirability:** this option will meet required strategic objectives. It will align with the priorities of consultees for alignment with core health services and will help to reduce overlap in the work of core health services and settings. This option can help with the standardisation of HP roles to ensure they undertake work linked to their professional expertise. It will give settings autonomy to base their structure on local need while allowing access to HPs as appropriate. The continuity of HP service between the work of core health and settings will assist in ensuring HPs can develop relationships with the families settings engage with.
Option 5: Sure Start Association (local cohorts)	Shortlisted based on Feasibility, Viability and Desirability • **Feasibility:** this option could require similar HP resource used in settings at present but will require some standardisation of role and agreement on appropriate HP interventions and working patterns • **Viability:** this option will be of a similar cost to that used for HP resource across all settings at present and will aid value for money in use of limited and more expensive HP resource through standardisation of the role • **Desirability:** This option will give settings autonomy to base their structure on local need while allowing access to HPs as appropriate. As HP access will be based on local cohorts, there will be opportunities for continuity in the HP service to assist in ensuring HPs can develop relationships with the families that settings engage with.

4.9 Assessment of Shortlisted Options

The following impact rating has been used to score each of the shortlisted options against the shortlisting criteria.

Table 11 Impact Rating Score

Impact Rating	Score
No Benefit	0
Limited Benefit	5
Acceptable Benefit	10
Good Benefit	15
Maximum Benefit	20

Shortlisted options 4 and 5 have been awarded impact rating scores based on the shortlisting criteria as follows:

Table 12 Assessment and scoring of shortlisted options

Shortlisting Criteria	Description	Option 4		Option 5	
Feasibility	The degree to which each option can be implemented (based on the number of HPs required for each option considering HP availability pressures)	Limited Benefit. This option will require greater HP resource which is limited at least in the short term	5	Good Benefit. This option will use existing HP resource in settings. On implementation, as HP needs are assessed across settings, the resource needs may change so cannot be assessed as Maximum Benefit.	15
Viability	The degree to which each option is financially viable and sustainable (based on cost and value for money as outline in Benefits and Challenges of each Option).	Limited Benefit. While there would be benefit and value for money in the collaboration with core health services, this option will cost more than is currently spent on HP resource in settings.	5	Good Benefit. This option will use existing HP resource in settings and therefore costs will be in line with current HP budget. On implementation, as HP needs are assessed across settings, the resource needs may change so cannot be	15

				assessed as Maximum Benefit.	
Desirability	The degree to which each option meets the strategic aim, objectives and priorities of stakeholders. To include • if the model assists Sure Start in meeting outcomes • if the model aligns with the priorities of consultees for core health services, standardisation of the HP role, gives settings the autonomy to base their structure on local need and allows for settings to have access to experienced HPs who have the skills and knowledge to work with and develop relationships with the families they engage with.	Maximum Benefit. This option will meet required strategic objectives: • Alignment with core health services and will help to reduce overlap in the work of core health services and settings. • Standardisation of HP roles to ensure they undertake work linked to their professional expertise. • Settings will have autonomy to base their structure on local need while allowing access to HPs as appropriate. • Continuity of HP service between the work of core health services and settings will assist in ensuring HPs can develop relationships with the families settings engage with.	20	Acceptable Benefit. This option will meet required strategic objectives: • This option will give settings autonomy to base their structure on local need while allowing access to HPs as appropriate. • Continuity in the HP service to assist in ensuring HPs can develop relationships with the families that settings engage with. • High level standardisation of HP roles, linked to expectations of professional skills, will be required to enable HPs to provide continuity of service across settings while still reflecting needs of each local community This option will not meet: • Alignment with core health services • reduction of overlap in the work of core	10

				health services and settings.	
Total Score			**30**		**35**

Option 5: Sure Start Association (local cohorts) scores highest and has emerged as the preferred option. Application of the emerging preferred option will be an iterative process and will take time to implement in full. It will be critical for success to engage early with all stakeholders and to ensure Sure Start settings are supported throughout this process.

While Option 5 does not score as well as Option 4 for impact on desirability criteria, the Review Team recommends consideration be given to the development of a framework on implementation of the preferred option which will increase the option's ability to address the desirability criteria. This framework should include:

Table 13 Considerations for implementation of preferred option

Framework	Description
Remit of HP roles and work they undertake in settings.	High-level standardisation of HP roles, linked to expectations of professional skills to enable HPs to provide continuity of service across settings while still reflecting needs of each local community and to ensure best use of limited and expensive resource.
Formal relationships with Trusts	Formal relationships established for all settings with their Trust. This should include support in developing links with areas of HP expertise within Trusts for professional advice and guidance and seek to understand how best to reduce overlap and provide continuity in provision.

4.10 Section Summary and Conclusions

This section has developed and assessed a long-list of potential options for change. The analysis of these options has led to an agreed preferred option, which has the potential to meet the recommendation of the Fair Start report.

5. PROJECT CONCLUSION

5.1 Introduction

This section summarises conclusions against the original Terms of Reference.

The Review Team has drawn the following conclusions as per the original Terms of Reference.

Review the Sure Start staffing structure to ensure access to necessary HPs, including Health Visitors and midwives. This will include considering options and advising a preferred option.

Terms of Reference	Conclusions
Baseline: Identification of the current arrangements / model for employment of HPs, mainly midwives and Health Visitors, in the Sure Start programme	Not all settings currently have HPs and some settings do not wish to have HPs in their structure. The settings that do not have access to HPs are able to offer their families comparable services that do not impact on their targets or the feedback received from parents. While, one of the most important factors for settings is to retain the ability to base their structure on local need, there is a noted desire for access to HPs in some settings and issues with the wider HP workforce are impacting on this availability.
Workforce model: Analysis of the Early Years HP workforce in NI (availability, ease of recruitment and workforce model)	There are resource and recruitment issues for both the Health Visitor and Midwife workforce. While steps are in place to address shortfalls, there are no quick fixes and Trusts expect to experience workforce pressures for a number of years. Going forward, the use of HPs in Sure Start will need to take account of the long-term recruitment issues and the need to ensure the work being undertaken by HPs is appropriate to their professional expertise.
Effectiveness: Analysis of the effectiveness of the current HP arrangements / model against good practice in deploying health professionals in early intervention within comparators (national / international)	It was not possible to determine the effectiveness of varying structures or to assess the value added by HPs (see section 4). While Sure Start is not replicated in the jurisdictions reviewed for comparison, there is some good practice Sure Start may wish to adopt relating to metrics that reflect the longer term impact Sure Start interventions have on families and on core health services.
Impact: An assessment of the impact of deployment of HPs in Sure Start settings on core health services;	The Review Team found no evidence through consultation that HP resource based in Sure Start settings impacts on core health services. As outlined, consultation notes that rather resource pressures can impact the availability for both HP

	roles in Sure Start settings. Going forward, the use of HPs in Sure Start will need to take account of the long-term recruitment issues and the need to ensure the work being undertaken by HPs is appropriate to their professional expertise.
Options: Develop and assess costed options for a future model to include status quo, adjustment to current model and a regional model	Options 0-6 were presented to PSG and shortlisted and scored based on agreed criteria. A preferred option has been outlined and developed for consideration.

APPENDIX I: LIST OF ABBREVIATIONS, TABLES AND FIGURES

List of Abbreviations

Abbreviation	In Full
BCS	Business Consultancy Service
DE	Department of Education
DOF	Department of Finance
DOH	Department of Health
EHS	Early Head Start Programme (USA)
ETI	Education and Training Inspectorate
HP	Health Professional
HSCB	Health and Social Care Board
HSCT	Health and Social Care Trust
OTs	Occupational Therapists
PfG	Programme for Government
PHA	Public Health Agency
PSG	Project Steering Group
SLTs	Speech and Language Therapists
SME	Subject Matter Expert
SPPG	Strategic Planning and Performance Group (in DoH)
SRG	Stakeholder Reference Group
TOR	Terms of Reference
USA	United States of America

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APPENDIX II: LIST OF STAKEHOLDERS INCLUDED IN CONSULTATION PHASE

- Sure Start Project Managers
- Sure Start HPs
- Sure Start users (parents)
- Department of Education
- Department of Health
- Public Health Agency
- Health and Social Care Board (now SPPG)
- Flying Start, Wales
- Early Years, Scotland

APPENDIX III: BASELINE DATA FOR SURE START SETTINGS

Setting	Total Allocation 20/21	Health Visitor FTE	Health Visitor Cost	Midwife FTE	Midwife Cost	Health Visitor % of Total Cost	Midwife % of Total Cost
1	£237,621	N/A	N/A	0.2	£8,252	N/A	3.47
2	£594,617	0.27	£10,374	0.37	£14,126	1.74	2.38
3	£545,540	1	£50,432	0.5	£26,364	9.24	4.83
4	£962,877	N/A	N/A	0.45	£15,076	N/A	1.57
5	£513,084	N/A	N/A	0.80	£25,589	N/A	4.99
6	£1,016,492	N/A	N/A	N/A	N/A	N/A	N/A
7	£716,907	0.80	£40,117	0.60	£29,788	5.60	4.16
8	£671,214	0.54	£21,198	0.61	£22,833	3.16	3.40
9	£544,257	1	£50,783	0.59	£29,754	9.33	5.47
10	£578,375	0.81	£40,732	0.41	£20,995	7.04	3.63
11	£1,093,183	N/A	N/A	0.80	£39,265	N/A	3.59
12	£781,630	0.20	£10,959	0.20	£5,114	1.40	0.65
13	£1,196,307	1	£51,748	N/A	N/A	4.33	N/A
14	£1,009,687	N/A	N/A	N/A	N/A	N/A	N/A
15	£662,703	1.65	£87,936	N/A	N/A	13.27	N/A
16	£297,578	0.25	£12,655	0.20	£8,339	4.25	2.80
17	£834,840	0.81	£42,522	0.32	£14,135	5.09	1.69
18	£832,728	1.39	£70,363	0.43	£21,767	8.45	2.61
19	£721,076	0.64	£32,397	N/A	N/A	4.49	N/A
20	£826,561	0.80	£40,497	0.20	£10,500	4.90	1.27
21	£228,099	0.50	£25,835	0.20	£8,477	11.33	3.72
22	£784,766	1.04	£52,646	0.51	£26,075	6.71	3.32
23	£551,206	0.92	£36,222	0.20	£10,225	6.57	1.86
24	£362,669	N/A	N/A	0.20	£10,225	N/A	2.82
25	£350,872	N/A	N/A	N/A	N/A	N/A	N/A
26	£887,758	1	£48,124	0.33	£15,881	5.42	1.79
27	£863,347	0.40	£15,610	N/A	N/A	1.81	N/A
28	£318,235	N/A	N/A	N/A	N/A	N/A	N/A

29	£733,900	1.47	£69,547	N/A	N/A	9.48	N/A
30	£692,221	N/A	N/A	N/A	N/A	N/A	N/A
31	£720,543	N/A	N/A	N/A	N/A	N/A	N/A
32	£889,605	N/A	N/A	N/A	N/A	N/A	N/A
33	£724,016	0.50	£16,723	N/A	N/A	2.31	N/A
34	£437,162	0.59	£23,000	N/A	N/A	5.26	N/A
35	£795,420	1.4	£27,441	N/A	N/A	3.45	N/A
36	£623,391	N/A	N/A	N/A	N/A	N/A	N/A
37	£635,985	N/A	N/A	N/A	N/A	N/A	N/A
38	£549,546	N/A	N/A	N/A	N/A	N/A	N/A

	Health Visitor only
	Neither HP in structure
	Midwife only
	Both HPs in structure

APPENDIX IV: COST AND ENGAGEMENT RATES SURVEY DATA

Table 14 Total setting cost with % proportion of HP costs

Total annual setting cost	Total annual cost for Health Visitor (% of budget)	Total annual cost for Midwife Visitor (% of budget)
£540,398.00	£42,236.00 (7.8%)	£10,334.00 (1.9%)
£281,743.00	£6,303.99 (2.2%)	£5,281.07 (1.9%)
£870,351.00	£49,432.00 (5.7%)	£9,885.00 (1.1%)
£816,440.92	£42,364.83 (5.1%)	£6,181.00 (0.8%)
£784,765.00	£52,000.00 (6.6%)	£26,857.00 (3.4%)
£619,636.00	£20,566.00 (3.3%)	£21,583.00 (3.5%)
£544,257.00	£51,974.00 (9.5%)	£30,165.00 (5.5%)
£567,034.00	£40,329.00 (7.1%)	£32,087.00 (5.7%)
£534,843	£50,431.80 (9.4%)	£26,363.76 (5%)
£810,354.00	£52,921.00 (6.5%)	£25,456.00 (3.1%)
£232,962.00	£4,126.00 (1.8%)	£4,126.00 (1.8%)
£590,000.00	£19,000.00 (3.2%)	£7,000.00 (1.1%)

Table 15 Total setting cost with % proportion of other staff costs

Total annual setting cost	Total annual cost for other staff providing services (% of budget)
£692,221.00	£49,600.00 (7.2%)
£989,889.05	£58,300.00 (5.9%)
£709,820.00	£40,354.00 (5.7%)
£996,561.00	£85,000.00 (8.5%)
£623,391.00	£60,000.00 (9.6%)
£318,235.00	£48,919.40 (15%)

Table 16 Total number of families engaged with (to include resource breakdown)

Total Number of Families engaged with	Total Number of Families engaged with Health Visitor	Total Number of Families engaged with Midwife	Total Number of Families engaged with alternative
529	N/A	115	24
652	127	N/A	97
323	194	N/A	N/A
725	276	154	N/A
223	13	14	N/A
694	N/A	N/A	694
451	240	157	N/A
650	15	N/A	635
622	N/A	N/A	250
864	N/A	N/A	444

511	N/A	100	100
1207	421	125	N/A
1566	0	24	258
568	194	68	214
980	120	0	980
345	57	62	55
882	N/A	N/A	450
574	150	50	N/A
272	N/A	N/A	60

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