

# The Starting Well Health Demonstration Project

## Phase Two Plan

January 2005 – March 2006

**Greater Glasgow NHS Board**

**Funding provided by The Scottish Executive (Health Improvement  
Strategy Division)**

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# **The Starting Well Health Demonstration Project**

## **Phase Two – Project Plan**

*“We do need a much more robust approach to putting children and families at the centre of the service network. That will be facilitated by treating all services for children as part of a Children’s Services System and by all staff perceiving themselves as operating within that single system.” (For Scotland’s Children, p.9)*

### **Section One: Introducing the Vision**

Section One will:

- outline the vision for The Starting Well Health Demonstration Project in Phase Two,
- outline the rationale for the Phase Two vision.

#### **1. The Vision – What do we want to do?**

1.1 Our vision for Phase Two reflects an enthusiasm and commitment among stakeholders in early years provision in Glasgow to create optimum opportunities for the achievement of measurable improvements in child and family well being among vulnerable and disadvantaged children. In this context, “well-being” is defined across a range of physical, social and mental parameters.

1.2 The vision has been explicitly developed in the context of Hall 4 (*Health For All Children*) and has been planned as part of the local response to the national requirement for implementation of this strategic document. Hall 4 implementation places emphasis on targeting of intervention for children and families at risk and, among other aims, seeks to:

- ensure that the needs of vulnerable children and families are identified and met;
- promote the development of seamless support through integrated models of service delivery to make best use of available skills and resources across agency boundaries;
- highlight the need for efficient information sharing.

These aims are entirely consistent with our vision for Phase Two and are imbedded within our objectives (See: Section Three).

- 1.3 The vision for Phase Two has been based on extensive consultation with the Scottish Executive, Glasgow City Local Authority partners (Education and Social Work) and other Local Authority partners, NHS Partners (Primary Care Operating Division Management and LHCC Management), the voluntary sector and existing Project Teams. This consultation process informed our belief that the best options for vulnerable children and families rest with a co-ordinated and integrated multi-agency approach to care and service provision.
- 1.4 This vision presents local partners with an opportunity to create synergy across a range of policy directions. Based within Hall 4, the vision explicitly links to developments in Public Health Nursing and other workforce development initiatives, to initiatives seeking greater opportunities for integrated working in children's services and to initiatives in life-long learning. Through timely dissemination of learning, our vision will have significant benefit for national stakeholders.
- 1.5 The vision is also based on formative and vital learning acquired during Phase One and the Transition Phase of Starting Well. In these earlier stages of development, the Project sought to demonstrate that child health could be improved by a programme of intensive home visiting aligned with effective community support. A universal model of service provision was established in two socio-economically deprived areas of Glasgow and implemented through multi-disciplinary Health Visitor-led Project Teams. In Phase Two, through supporting the local and national implementation of Hall 4, the Project will:
- migrate from a universal service to a targeted service, with focused intervention offered to the most vulnerable and disadvantaged children (aged 0-5 years) and their families;
  - extend the current multi-disciplinary Project Teams to include multi-agency colleagues from Social Work and Education;
  - re-design these Teams in order to provide intensive, time-limited and specific intervention and support for the most vulnerable children and families through a referral process from the generic services (which includes a specific agreement within GGNHSB to ensure that the interface between the Project and generic services is established and clearly communicated) ;
  - provide an appropriate combination of intensive home-based and centre-based support (through Family Learning Centres and Nurseries) to vulnerable and disadvantaged families in local areas;
  - pilot common assessment processes among multi-disciplinary/multi-agency partners;
  - realign community support activities within the CHP and Childcare Partnership areas in order to increase capacity for community-based activities with children aged 0-5 years and their families.

## **2. Rationale for the Vision – Why should we do it?**

2.1 The rationale for our vision will be described with reference to:

- The National Policy Context
- Community Health Partnerships
- “Road Show” Consultation
- Local Policy Responses
- National/international evidence

2.2 The National Policy Context

The rationale for our vision is contained across a range of national policy documents and initiatives, including:

- Local Government in Scotland Act 2003
- NHS Reform (Scotland) Bill
- Cabinet Sub-Committee on Closing the Opportunity Gap
- Spending Review 2004 – Health Inequalities Targets
- Improving Health in Scotland – The Challenge
- Nursing for Health (2001)
- Nursing for Health Two Years on (2003)
- Public Health Nursing Review
- Integrated Strategy for the Early Years
- Health for all Children (Hall 4)
- For Scotland’s Children
- Additional Support for Learning (Scotland) Act (2004)
- New Learning Community Initiative
- The Health Inequalities “Agenda”
- Workforce development in public health and nursing transformation

There are common themes among these documents of special relevance to early years intervention. “For Scotland’s Children”, for example, explicitly calls for children’s services to be considered as a single service system and for the co-ordination of both needs assessment and intervention. “Nursing for Health” and “Nursing for Health: Two Years On” place special emphasis on the targeting of services to the most vulnerable and seek active integration between the NHS and local authority partners. “The Local Government in Scotland Act (2003)” seeks to recognize and support good practice in partnership working and advocates the improvement of information sharing processes across agencies. “Hall 4” advocates both the service re-design of the Health Visitor role and greater multi-agency working and places greater emphasis on the targeting of resources to greatest need and continued implementation of evidence-based practice. Both the “Cabinet Sub-Committee on Closing the

Opportunity Gap” and the “Spending Review 2004 – Health Inequalities Targets” provide clear objectives for creating long-term health improvement gains for vulnerable and disadvantaged children and families.

### 2.3 Local Policy Responses

Local policy direction (reflected in the Glasgow City Children’s Service Plan: 2002-2004) has clearly supported the national direction. The Ensuring A Good Start in Life Group (sub-group of the city-wide joint planning structures focussed on children 0-5yrs and their families) defined its strategic aims as:

- to develop an integrated joint approach to the planning, implementation and reviewing of services to young children in Glasgow and their families;
- to promote social inclusion through a positive start in children’s lives;
- to improve and promote the health, social, emotional and educational well being of young children;
- to increase the involvement of families of young children in decision that affect them and the services they require.

The new Children’s Services Plan (April 2005 – April 2008) will strongly support the development of integrated strategies for vulnerable and disadvantaged children and their families.

### 2.4 Community Health Partnerships

There will be five Community Health Partnerships established in Glasgow City. There will be an additional four CHPs established within the wider GGNHSB area with other partner Local Authorities. The agreed model for child health seeks to establish joint assessment approaches at a local level for families, leading to appropriate care pathways with input from specialist joint teams in areas such as Disability, Mental Health and support for vulnerable families.

### 2.5 “Road Show” Consultation

As part of a programme of dissemination of learning from Phase One and the Transition Phase, the Early Years National Learning Network, in association with the Project, seed-funded and co-ordinated a series of “Road Shows” across Scotland. Eight events, planned and implemented in partnership with Health Boards across the country were held in May/June, 2004. The purpose of these events was twofold: to share learning from the Project with stakeholders from across Scotland and to learn national lessons from these stakeholders on local barriers and enablers to effective service provision for children and families. Key themes emerging from these events will be described below.

- Interagency and partnership working was a very prominent, recurrent theme at all the Road Shows. Delegates expressed a strong desire to see more and improved interagency planning and services. Suggestions were made regarding joint training and the “pooling” of resources.
- There was wide-spread support and interest in the model of skill-mix adopted within Starting Well in Phase One and the Transition Phase. The innovative roles assigned to Health Support Workers and Community Nursery Nurses within the Project were universally supported.
- There was general consensus that the model of skill-mix employed within the Project could have been improved by the inclusion of professionals from Social Work and Education. There was also more limited support for the inclusion of Speech and Language Therapists within the same team.
- There was interest and support for the use of a comprehensive and evidence-based parenting programme.

## 2.6 The Wider Evidence Base

- Health inequalities in the adult population are the product of a process of social and economic exclusion whose antecedents exist in childhood (Rutter and Madge, 1976; Lloyd et al, 1997) and studies have demonstrated that children raised in poverty are at increased risk of poor health. Increased prenatal and infant mortality, low birth weight, sudden infant death, increased childhood mortality for respiratory diseases, infectious diseases and childhood behavioural difficulties are all associated with adverse family circumstances.
- A comprehensive literature review undertaken in preparation for the Starting Well Project (Phase One) proposal indicated that many effective interventions designed to support deprived and vulnerable families with very young children were based on models of intensive home support (Power et al, 1997; Olds et al, 1986; Olds et al, 1985; Barnard et al, 1985).
- Studies have described long-term effects, including improvements in socialization (particularly prevalent for boys), improvements in long-term family functioning, lasting positive consequences for the socio-economic status of participating families, reduced substance abuse and reduced prevalence of multiple types and chronic forms of child maltreatment resulting from appropriate early interventions (Seitz et al, 1985; Olds et al, 1997; Eckenrode et al, 2001).
- There is evidence to suggest that team based multi-disciplinary approaches to existing services are perceived as beneficial by both professionals and participating families (Onyskiw, et al, 2004).
- There is evidence to suggest that packages of support that are center based or combine center based and home visiting are more effective than packages which rely on home visiting alone (Gray and McCormack, In Press).

- Service delivery models should allow for packages of support to be tailored for individuals and particular groups including different ethnic groups (Shonkoff and Phillips, 2000).

## 2.7 Summary

Each of these elements combine to demonstrate the importance of integrated service design for effective support of vulnerable and disadvantaged children and families. Developments in Phase One and Transition Phase of Starting Well have been crucial in local service re-design, resulting in improved team working in early years, skill-mix models of care and the implementation of evidence-based protocols for services. In Phase Two, we will extend these developments to include professionals from other Agencies in order to pilot optimal and flexible support options for the target group. Based on the policy direction and available evidence, our model is the “best-fit” between national and local need and available resources.

## **Section Two: Learning from Phase One and the Transition Phase**

Section Two will:

- describe learning achieved through formal evaluation and service development in Phase One and the Transition Phase,
- identify achievements in the Phase One and the Transition Phase, and,
- identify potential areas of achievement for Phase Two.

### **1. Learning the Lessons**

1.1 The Starting Well Project was externally evaluated by the Health Promotion Policy Unit (University of Glasgow). In addition to the External Evaluation, there has been an Internal Evaluation (which is based on data available through the Project data-base). The Internal Evaluation provides information on numbers of participating families, family demographics, visiting patterns, referral patterns, etc. Additional research (conducted by external providers) was also commissioned by the Project on specific areas of Project development.

1.2 The evaluation studies are listed below:

- A. External Evaluation (University of Glasgow)
- B. Internal Evaluation
- C. Health Visitor Goal Setting Study (Caledonian University),
- D. Health Visitor Practice-based Guidelines Study (University of Paisley)
- E. Triple P Study (Scottish Centre for Social Research)
- F. Community Support (Ian McKenzie Consulting Limited).

1.3 Two additional studies were commissioned by the Ensuring A Good Start in Life Group (the joint agency planning group for early years services in Glasgow). Funding for these studies was made available from the Changing Children's Services Fund. The first of these studies, "The Parenting Education Audit", sought to identify the use of parenting education programmes across agencies (including the voluntary sector) in Glasgow City. The second study, "Evaluation of Glasgow Early Years Family Support Audit/Evaluation of Current Implementation of Family Learning Centres in Glasgow", seeks to map existing early years resources in Glasgow and to evaluate and describe current activity within Family Learning Centres in Glasgow. The first of these studies is now complete and the second study is due for completion in early 2005. Available findings from the first study will be considered here. (Findings from the second study will be incorporated into the development of work in Phase Two as these results become available.)

1.4 For reference purposes in this proposal, the first study will be identified as:

G. The Parenting Education Audit

1.5 In this Section, a review of key learning points from this data will be presented. In addition, key learning points derived through reflective learning and service development will also be presented. The learning points will be grouped under themes (Child/Family Health Outcomes, Service Delivery, Practice Development) and will be referenced, where necessary, from the list of evaluation studies presented above.

1.6 The aggregated learning points presented here have been disseminated widely, most recently through the Road Shows (and a subsequent Report), through the Early Years Learning Network web-site and in several recent publications (Ross and de Caestecker, 2003; Beech, et al, 2004; Ross and de Caestecker, In Press). This learning is described here in order to assist in the process of identifying achievements accrued within the Project in Phase One and the Transition Phase and in order to identify areas for further development.

1.7 Theme One: Child/Family Health Outcomes

- Home visiting by the Project Teams led to short-term benefits in the psychological health of study mothers (defined by comparative levels of depressive symptomatology between intervention and control mothers at six months post-natal) and potentially longer-term developmental benefits for study children (defined by comparative measurements of the home environment at eighteen months) (A). These findings are arguably related to the degree of emotional support offered to these families and have clear implications for the implementation of Hall 4 (both in the delivery of "core" services and intensive services).
- Although methodological concerns confound this finding, it was observed that ethnic minority mothers were more likely to demonstrate

higher levels of depressive symptomatology and to achieve lower scores on the measurement of home environment (A). This finding may indicate additional need among this population and has implications for the provision of culturally sensitive services

## 1.8 Theme Two: Service Delivery

- 98% of eligible families (n=1350; from available data in September 2004) were successfully recruited to the Project (B). During early Project development, it had been assumed that families would be unwilling to engage in the Project as a result of previously held positive relationships with existing Health Visitors or because they would find Project protocols intrusive. The response rate by families could be interpreted as indicating a very clear willingness among families to receive additional support.
- Intensive home visiting was described as an effective way of delivering patient-centered, holistic models of care. The effectiveness of the delivery model was apparently mediated by a variety of factors including the convenience of the home setting and a shift in power relations inherent in the mother's control of access to the setting (A).
- Skill-mix Teams were valued by the participating staff and by participating families. The development of these Teams was supported, at a strategic level, by a broader process of service re-orientation to the needs of the most vulnerable and, at an operational level, by extensive change management initiatives. Issues of role clarity within the Teams remained problematic throughout Phase One and the Transition Phase (A) This finding has clear implications for the development, support, training and management of multi-disciplinary teams.
- Change management is a complex process. Specific learning was accrued on the introduction of skill mix to existing service delivery structures (B). The introduction of new staff to existing teams and/or the development of new teams require careful consideration and support.
- The Health Support Worker role developed into a diffuse and flexible adjunct to the Teams (A).
- The employment of the Health Support Workers through a Voluntary Sector organisation with experience of intermediate labour market programmes was invaluable (A).
- The additional supervision requirements placed on Health Visitors as "Team Leaders" deploying and coordinating the activities of other staff can create capacity issues for them in already busy schedules (B).
- The Project was instrumental in the development of a service delivery model for HSW support in West Dunbartonshire. In this model, HSW's were accessed equally by Health, Social Work and Education in providing support for vulnerable children and families. Local evaluation has demonstrated the perceived value of this model to participating families and professional stakeholders (B). We will seek to incorporate this learning in Phase Two

- With populations of ethnic minority families, expert support as offered by a Bilingual Worker with a dual home-based and community-based focus, is invaluable (B).
- Equally, the roles of the Community Support Facilitators and the Bilingual Worker were seen as pivotal to comprehensive Team capacity (B,F).
- Team effectiveness was enhanced by the activities of attached workers from other initiatives (Debt Advice, Full Employment) (B,F).
- Community Support Facilitators provided a specific focus on pre-five community-based activities within the community. Our reflective learning suggests that the Community Support Facilitator role should be aligned with the Public Health Practitioners, within the CHP areas. Our learning also indicates that a dedicated focus on this particular population is vital (B,F).
- Caseload size within the Team was between 80-100 families per whole time equivalent Health Visitor (B). However, due to universal recruitment in Phase One and the Transition Phase, these caseloads included families with varying levels of need. Our reflective learning indicates that where families require intensive support, smaller caseloads will be required.
- Project Teams employed an implicit process of targeting (within the universal model of service provision) which led to the matching of available resources to children and families in greatest need (B).

### 1.9 Theme Three: Practice Development

- Health Visitors met attempts to standardize care delivery through the use of Family Health Plans and Practice Guidelines with some resistance (C,D,E). This has specific implications for the implementation of Hall 4 in relation to development issues like common assessment.
- Although Health Visitors indicated significant use of Practice Guidelines, they were somewhat ambivalent about the value of these documents. This ambivalence seemed to arise out of a perception that standardized approaches to care limit professional judgment (whether evidence-based or not).(D)
- Goal setting was viewed positively by participating families. Health Visitors viewed goal setting as useful in many situations with families and goal setting activity was directed toward both routine, short-term issues and more complex, long-term issues (C).
- Team members (and families) appeared to value the use of an evidence-based parenting programme (Triple P) (E). The majority of members of the Project Teams used Triple P as part of everyday practice. Health Visitors used the programme in both a preventative way with families (introducing general concepts to families at an early stage) and in a more targeted format when specific needs were identified with families. Triple P resources were valued by staff and considered to be useful tools for work with families (E).

- The Triple P model was adapted by Project Teams to ensure cultural sensitivity (E).
- It was noted that the Teams felt that the universal use of parenting programmes was not yet “normalized” and that care had to be taken to ensure that families did not feel stigmatised by the use of parenting interventions (E).
- In Glasgow City, the NHS is the biggest provider of parenting education programmes. Triple P is one of the standardized, evidence-based programmes most frequently employed (G). However, only a minority of programme providers are accredited trainers for the programme they use (G). This suggests that optimum service delivery in parenting education is not being achieved in the NHS in Glasgow.
- An emphasis on staff training/staff development within the Project for all members of the Teams was positively regarded by staff and led to improved confidence in the clinical role (A,B,E).

## **2 What was been achieved in Phase One and the Transition Phase?**

2.1 In addition to the measurable improvements in child and family health identified in the formal evaluation studies, the development and implementation of the Project in Phase One and the Transition Phase led to measurable service innovations, which must be considered achievements for the Project. These innovations included:

- a re-orientation by service providers to the specific needs of vulnerable children and families within the Primary Care setting;
- the development of a functional multi-disciplinary Health-based Team working within a skill-mix ethos to provide appropriate support to children and families;
- the development of a holistic model of support which incorporated a social model of health that sought to address child and family well-being through a range of Health and non-Health based interventions (Debt Advice, support for further education/return to employment, etc.);
- the development of specific tools to guide Health Visitor practice (Practice Guidelines; Family Health Plan);
- the implementation of a standardised, evidence-based parenting education programme (Positive Parenting Programme);
- the development of robust community structures to support and enable activities in the pre-five arena in local communities (including development of Local Implementation Groups and Local Development Funds);
- the acquisition of enhanced experience in the design of training programmes aimed at developing a range of clinical skills and the promotion of effective therapeutic relationships.

## **3 What remains to be achieved?**

3.1 There are a number of potential areas of further development left to be achieved by the Project. These areas will be listed and described below.

- Although the benefits of home-visiting have been demonstrated within the Project, the evidence base demonstrates that greater benefit can be achieved in early years support through a combination of home-based and centre-based services (Gray and McCormick, In Press).
- There were advantages to the model of universal service provision employed in Phase One and the Transition Phase. Families were offered additional support in a non-stigmatising way and benefits for these families were accrued (as identified in the External Evaluation). However, it is important to note that this model of service delivery was associated with implicit (if not explicit) targeting of resources to the most vulnerable and disadvantaged families in the Project areas. It must also be noted that the Project was implemented prior to the introduction of Hall 4 in Scotland.
- With the redistribution of resources (principally Health Visitor time) to the most disadvantaged through implementation of the Hall 4 guidance, the ethos of the Project in Phase One and the Transition Phase will continue to inform services. What remains to be achieved, however, is greater multi-agency emphasis on targeted and intensive support. This imperative is supported both by the evidence base and the general support observed on this issue through the Road Shows. To achieve this aspiration, dedicated commitment (both in terms of staff and financial resource) will be required.
- It is essential for the agencies (Health, Education, Social Work and the Voluntary Sector) to develop a greater understanding of the facilitators and barriers to partnership working that exist at both strategic and operational levels.
- The Project was implemented in two designated areas of Glasgow only and was cost intensive. A wider implementation of a replicable model is required in order to create greater opportunities for equity and sustainability (both locally and nationally).
- In Phase One and the Transition Phase, we piloted the use of Triple P (Positive Parenting Programme). The programme was implemented in both one-to-one and group formats throughout the Project areas. Access to the group formats was available both to families who were part of the Project and to other families in the local areas. Colleagues from other Agencies, including the voluntary sector, were able to access Triple P training opportunities and the programme has achieved a degree of “saturation” within Glasgow. There is considerably more to be achieved in terms of creating further opportunities for parental access to parenting education programmes. The achievement of this aim depends on several factors, including: provision of further training opportunities for multi-agency providers in Triple P, co-ordination of training events and on-going support for parenting education providers to ensure quality of service delivery. Our reflective learning indicated that the capacity of our Teams to confidently provide training to parents was a function of the degree of professional support they received. Dedicated support for the development of education programmes will be essential.

- There is further development required for all the services in assisting and supporting ethnic minority families throughout Scotland with the specific challenges they face. Services must be configured in a culturally sensitive way and particular emphasis on peri-natal mental health for women and parenting support is required.

### **Section Three: Implementing the Vision**

Section Three will:

- identify the central aim for Phase Two and the objectives related to that aim;
- describe detailed implementation plans for the Phase Two proposal.

#### **1 Phase Two Aim**

- 1.1 The aim of the Starting Well Health Demonstration Project in Phase Two will be to *demonstrate that child and family well-being for vulnerable and disadvantaged children and families can be enhanced through a integrated and cohesive multi-disciplinary and multi-agency approach to the provision of care.*

#### **2 Objectives**

- 2.1 The objectives for Phase Two will be described across a series of related headings.

##### **2.2 Creating A Comprehensive Model of Service Integration among Partner Agencies for Early Intervention/Family Support**

- To pilot the integration of multi-disciplinary/multi-agency intensive support Teams for vulnerable children aged 0-5 among partner agencies in Glasgow in response to Hall 4 and in order to support national learning
- To pilot an effective city-wide mechanism for the seamless support of vulnerable families through integration of services within Glasgow within CHP areas (with a specific focus on the development of single access services for this population and the development of a single management structure for the Teams)

##### **2.3 Establishing Multi-Agency/Multi-Disciplinary Family Support Teams**

- To develop, implement and evaluate multi-disciplinary/multi-agency Pre-School Intervention Teams in CHPs in the GGNHSB area in order to ensure that the best use is made of available skills and resources across agency boundaries

- To assist in the implementation of joint assessment processes at the interface between the core services and the Teams to support multi-disciplinary and multi-agency working as part of Hall 4
- To pilot and evaluate the use of a common assessment and record keeping system within the Teams
- To pilot and evaluate models of team development focussed specifically on the needs of multi-disciplinary and multi-agency providers in the Teams
- To ensure that all Team members receive appropriate professional development support and gain enhanced understanding of multi-professional working practices
- To determine optimal caseload size for the Teams

#### 2.4 Promoting Child and Family Well-Being For Vulnerable and Disadvantaged Children

- To ensure that the needs of vulnerable children and families are identified and met and to improve multi-agency recognition of need among vulnerable children and families in Glasgow
- To ensure the provision of integrated packages of Education, Health and Social Work care for the most vulnerable and disadvantaged children and their families with a specific focus on children and families affected by domestic violence, children affected by parental substance misuse, children experiencing ineffective parenting
- To complement the activities of generic services through promoting effective child and family feeding and nutrition, promoting effective oral health and ensuring appropriate support for mothers experiencing post natal mental health difficulties (including mothers from the ethnic minority communities)
- To signpost and promote access by parents to appropriate health promotion initiatives and social care initiatives (Smoking Cessation, Safety Initiatives, Adult Education, Full Employment Initiatives, etc.)
- To provide access for parents to a variety of individual and group-based models of parenting education opportunities within local areas
- To ensure that families receive flexible childcare provision as required
- To ensure that parents are consulted and involved in key decisions that affect them and their children
- To reduce the vulnerability of low income families to financial exclusion and multiple debt (to prevent them becoming over-indebted and/or to lift them out of poverty)

#### 2.5 Disseminating Project Learning

- To continue to disseminate lessons learned during Phase One and the Transition Phase to local and national audiences in partnership with the Early Years National Learning Network via its website, postal and e-mail networks and facilitated seminars/conferences

- To disseminate lessons with direct relevance to Hall 4 acquired during Phase One and the Transition Phase to wider local and national audiences
- To disseminate learning acquired through the development of the Health Support Worker /skill-mix model
- To create short-term secondment opportunities for local and national multi-agency service providers to share in-depth learning with the Project Teams
- To share and exchange learning acquired during Phase Two to national audiences at quarterly intervals in partnership with the Early Years Learning Network and other appropriate fora in order to support national implementation of Hall 4

2.6 These objectives, potential outcomes resulting from these objectives and potential measurement indices are presented in Appendix One. The outcomes and indices suggested in Appendix One are considered indicative at this point.

### **3. Describing the Vision – What Does the Vision Look Like in Detail?**

Phase Two will be implemented through Pre-School Intervention Teams.

#### 3.1 Establishing the Teams

- There will be a phased development period.
- Initially (May to October, 2005) Teams will be established in the Eastern and South East CHPs. This will build on experience acquired by the Starting Well Project in Phase One and the Transition Phase in these areas and will also provide an opportunity to pilot the Team model prior to wider implementation.
- From October, 2005 to the end of the current funding period (end-March, 2006), Teams will be established in two of the three remaining CHP areas in Glasgow City. The configuration of Teams in each CHP will reflect local need and current circumstances and will, therefore, potentially differ slightly from CHP to CHP.

#### 3.2 Team Development

- The effective formation of these multi-disciplinary/multi-agency Teams will rely on appropriate team building/team development interventions. Our experience in Phase One indicated that issues of role clarity must be resolved at an early stage in order to ensure appropriate functionality. In the proposed model, there will be a range of issues requiring timely resolution. The Glasgow Changing Children's Services Fund has agreed to support this aspect of change management through funding both the provision of external consultancy and appropriate evaluation of the team development processes employed.
- As part of the formative development of the Project in Phase Two, this learning will be disseminated to local and national stakeholders,

through the Early Years Learning Network, as soon as useful lessons are accrued.

### 3.3 Team Management and Configuration

- In line with Social Work Areas within the proposed CHPs, there will be two Teams established in each CHP area.
- One Operational Manager (Social Work) will manage both Teams in each CHP.
- Each Team will have a Team Leader.
- Team Leaders will be drawn from either Health or Social Work and the objective will be to ensure a balance between Agencies across Glasgow.
- Staff within each Team will be employed either by Health, Glasgow City Council (Social Work and Education) or One Plus (a voluntary sector provider).
- Each Team will be composed of two Health Visitors, one Community Nursery Nurse, two/three Health Support Workers, Administrative Worker (Health) and one Practice Team Leader, two qualified Social Workers and one/two Social Care Workers (Social Work). Health Support Workers will be recruited and trained by One Plus (under existing contractual arrangements with GGNHSB).
- In addition, there will be a total of 1.5 wte Speech and Language Therapists available.
- Every attempt will be made to ensure that each Team is co-located in each CHP area.

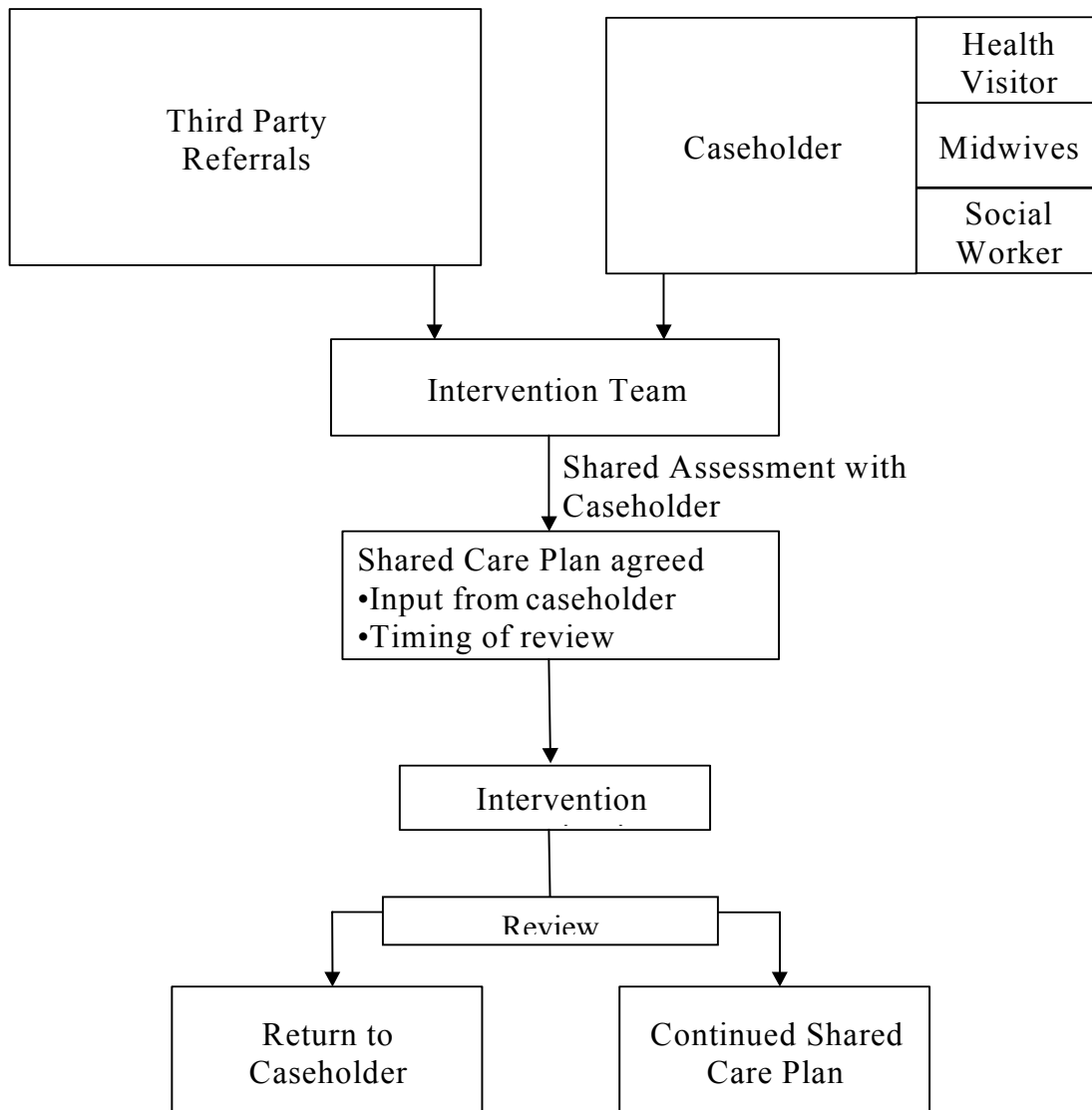
### 3.4 Referral System

- Health/Social Work/Education/Voluntary Sector staff will refer children and families to the Teams in each CHP area.
- Referrals will be made for families with children aged 0-5yrs and will be made for the most vulnerable families in each CHP area for specifically defined support activity by the Team.
- Referral criteria will include: specific concerns for child vulnerability on the basis of safety, child protection, parental substance misuse, family violence, parenting difficulties/child behavioural management difficulties.
- Children and families referred will explicitly require multi-agency support.
- Referrers who are case-holders for referred children/families, will remain closely involved with these clients while they are cared for, through shared-care arrangements, as part of the Team. In Social Work, where Case Management arrangements are in place prior to referral to the Team, these arrangements will continue during the period of time in which the Team cares for the clients. It will be essential that these case-holders and Case Managers contribute to review processes undertaken with children/families.
- It is anticipated that some referrals may come from Midwives for mothers in the ante-natal period. Clearly, Starting Well has developed

expertise in ante-natal (and early post-natal) support in Phase One. These referrals would be considered highly appropriate (See: Appendix Two).

- The Family Learning Centres (and other pre-5 educational establishments, as appropriate) will be both referrers to the Teams and venues for centre-based services (where possible). This link with the Centres will also ensure that the Teams are integrated with the New Learning Communities in each area and that learning needs for children are recognised and supported. The Heads of Centres will be explicitly involved in the development of Team protocols and service delivery.
- Assessment processes for the generic referrers will require development among core services. Developments within core services as part of Hall 4 will also assist in this process and the Project will be actively involved with these developments (with specific responsibility for this area of development devolved to the Project Development Co-ordinator) (See: Appendix Three).
- The Teams will ensure that a comprehensive multi-agency assessment is completed (within the Teams) and that appropriate focused and time-limited intervention is offered as indicated by child/family need.
- Once referred to the Team, children and families will be assessed through a common framework. The proposed model is the “Care First” assessment currently in place in Social Work. (See: Appendix Three).
- A process of case allocation will be established within the Team, ensuring that family need is best matched to available resources.
- Review periods will be determined at the time of assessment.
- Figure One presents the proposed referral pathways and subsequent assessment/review processes for the Teams. (A distinction is made in the Figure between caseholder/Case Manger referrers and other “Third Party” referrers.)

**Figure One: Referral/Assessment/Review Pathways**



### 3.5 Team Intervention

- The Teams will offer specific, time-limited support to referred families on the basis of assessed need. There will be a range of support opportunities available within the Team, defined by home-based and centre-based services provided in individual and/or group-based formats as required. Supports will range from practical support in family/home management to more complex interventions.
- Parenting education and support will be a central activity for the Teams. Triple P will continue to be the programme of choice. The Parenting Co-ordinator will provide on-going professional development in parenting skills for all Team members and will arrange appropriate

multi-disciplinary training opportunities both for Team members and generic staff.

- It is anticipated that for a proportion of referred children and families, statutory orders will be in place. (In the East LHCC, approximately 8% of children receiving care through the Area Teams are on the Child Protection Register; in the South East LHCC, this proportion rises to 13%.)
- The Teams will, in addition to receiving referrals from the generic services, engage in assertive outreach within CHP areas. In this context, “assertive outreach” will be defined both by case finding and provision of intensive support across home and centre-based settings.
- Multi-disciplinary/multi-agency Care Plans will be established for each child/family. These Plans will clearly identify the objectives of care and appropriate interventions to be employed. Goal setting approaches will aid this process.
- As every attempt will be made to avoid duplication of existing service provision: children/families will be referred to other services as required and “sign-posted” to other initiatives (Smoking Cessation). The potential number of children/families likely to be cared for by the Teams has been estimated. This estimate suggests that within the Eastern and South East CHP/LHCCs, approximately 200 children/families will require support at any given time. (These estimates have been based on CHP population size, numbers of children aged 0-5 years within each CHP, numbers of families with children in this age range in each CHP, current referral rates to the Support to Families Teams in Social Work and “best guess” estimates by Health Visitors.)
- Caseloads for qualified staff from Health and Social Work will amount to approximately 15/20 cases per wte staff member. This caseload size is considered optimal for the anticipated level of intensive support likely to be required by families. It must be noted that qualified staff will be supported by unqualified staff in providing interventions within the caseload. This estimated caseload size is comparable to current caseloads carried by the Support to Families Teams (Social Work Teams) currently in place (and which will form the Social Work component of the proposed Teams). One of the objectives for Phase Two will be to determine optimal caseload sizes for the Teams (See: Section Three – Objectives).
- Debt Advice Officers and Full Employment Initiative facilitators will also be attached to the Teams in order to provide maximum support opportunities to participating families.
- A Bilingual Worker will support Team development and implementation in each CHP area.
- Unlike current arrangements, Health Support Workers (provided through Starting Well resources) will be accessed by Health, Social Work and Education for specific work with families supported by the Team. This model builds on learning from Phase One and the success of the model currently in implementation in West Dunbartonshire.

## **4. Steering Group**

4.1 A multi-agency Steering Group will be established to guide the development and implementation of the Project. This Group will be a sub-group of the Ensuring a Good Start in Life Group and will report directly to this Group.

4.2 Responsibilities of the Steering and Development Group will include:

- development of a multi-disciplinary/multi-agency forum to enable progress of Project aims and objectives;
- provision of support and advice to the Project Manager;
- provision of appropriate communication with the Scottish Executive;
- development of implementation plans for long-term sustainability and expansion of the Team model;
- support and direction of monitoring and research and evaluation processes;
- dissemination of acquired learning to a broader national audience.

4.3 Appendix Four presents an organisational map for the Project in Phase Two.

## **5. Implementing the Vision**

A multi-disciplinary/multi-agency Implementation Group will be established to lead the development of the Teams.

Detailed plans for the funding period are presented in Appendix Five. These plans are presented in two formats: in a summary chart which presents a time-line for the essential tasks associated with the development of the proposed Teams only and in a more detailed planning grid.

## **6. Disseminating the Vision**

As in Phase One, local, national and international dissemination of learning will be an important aim in Phase Two. (The objectives related to dissemination are presented in Section Three – Objectives.) A provisional Dissemination Plan is presented in Appendix Six.

NHS Health Scotland will play a pivotal role in both the dissemination of Project learning and Project evaluation (see below). The Early Years Learning Network Co-ordinator post (which is currently being recruited) will provide significant resource in the dissemination process and the Early Years Learning Network Database is maintained through NHS Health Scotland. This important link with NHS Health Scotland ensures that local and national learning is credibly presented and shared.

## **7. Financial Framework**

A financial statement is presented in Appendix Seven. This statement reflects funding requirements to the end of the current funding period (end-March, 2006) and beyond.

### **Section Four: Monitoring and Evaluating the Vision**

Section Four will:

- describe monitoring arrangements for Phase Two,
- describe current evaluation plans.

#### **1. Monitoring: Are we doing what we set out to do?**

On-going development of Starting Well in Phase Two will depend on accurate monitoring of information. This will serve both management and quality assurance requirements. While some of the information required (specifically project inputs) will be available “in-house” (within the Health system), current discussion with colleagues in Social Work indicates that information on service delivery and participant demographics will be available through the “Care First” system

#### **2. Evaluation: Is what we are doing working?**

In the available time, it has been agreed that an external process-focussed feasibility study will form the most useful approach to evaluation for Phase Two. The research protocol is currently under discussion with NHS Health Scotland and The University of Strathclyde Graduate School of Business. It is anticipated that these discussions will be complete by end-May, 2005.

NHS Health Scotland is assisting in the planning of the evaluation protocol, will commission and manage the evaluation and will be actively involved in the dissemination of evaluation findings.

The central purposes of the study will be:

- to describe the development of the Teams from a multi-agency perspective, with specific reference to enablers and barriers in the development process;
- to describe the impact of the development of service on other to describe the development of the proposed teams from a mainstream services and practitioners (including GP’s, Social Workers, Education staff):
- to describe perspectives on the service from families involved in service use;
- to establish, over the course of Phase Two, as the model of implementation develops and reaches maturity, an appropriate set of

indicators (agreed among the partners) to measure the efficacy of the team model in the longer term (beyond the end of the current funding period),

- to formulate a template for longer-term outcome measurement for later use.

In addition, current discussion is also on-going regarding the systematic analysis of data-base information (numbers of families, levels of deprivation, service supports, etc.) acquired during Phase One and the Transition Phase. It is envisaged that this data will be of crucial importance to the implementation of Hall 4 at both a national and local level. These discussions are taking place between the Project and the PEACH Unit (Royal Hospital for Sick Children, Yorkhill). The role of the Project Evaluation Officer will be utilised in the implementation of this analysis. It is anticipated that these discussions will be complete by end-June, 2005.

### **Section Five: Evidencing the Success Criteria**

Section Five will:

- present evidence demonstrating the Success Criteria (defined in the commissioning letter dated 13.04.04) have been met in this proposal.

In the commissioning letter (dated 13.04.04), four Success Criteria were defined. There is evidence in this plan to suggest that these criteria have been met. This evidence will be summarised for each criterion.

Financial sustainability:

- For Phase Two, GGNHSB has agreed to contribute to the current funding package. Funding commitments have been made by Glasgow City Council (Education and “in-kind” staff commitments made by Social Work). The Changing Children’s Services Fund has also made a financial commitment. Further, GGNHSB is committed to the future development and financial support of the Pre-School Intervention Teams in the longer-term.

Senior Level Leadership:

- GGNHSB has demonstrated significant commitment to Phase Two through providing leadership (from senior to middle management) for the development and implementation of this multi-agency initiative. That commitment has been equally demonstrated within all the partner agencies.

#### Applicability for the Rest of Scotland:

- The current plan outlines a template for the development of intensive multi-disciplinary/multi-agency services for vulnerable and disadvantaged children and families in Scotland. Based within an implementation model for Hall 4, this plan offers an opportunity for national learning, as identified through robust plans for service development, monitoring and evaluation and dissemination.

#### Tackling Health Inequalities:

- The Teams described in this plan clearly focus on the targeting of resources to the most disadvantaged in each CHP area. The model of service delivery outlined seeks to address the needs of children and families in a holistic manner (with equal concern for physical and social parameters of family functioning).

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## Appendix One

### Phase Two Objectives, Potential Outcomes and Potential Measurement Indices

Objective: Creating A Comprehensive Model of Service Integration among Partner Agencies for Early Intervention / Family Support

Objective	Outcome	Measurement
<ul style="list-style-type: none"> <li>• To pilot the integration of multi-disciplinary / multi agency intensive Support Teams in Glasgow</li>   <li>• To pilot effective City- wide mechanisms for seamless support for vulnerable families.</li> </ul>	<ul style="list-style-type: none"> <li>• Development of functional Teams in CHPs</li>   <li>• Development of functional Teams</li> <li>• Development of single access referral system</li> <li>• Development of single management structure for Teams</li> </ul>	<ul style="list-style-type: none"> <li>• Presence of Teams in CHPs</li> <li>• Monthly monitoring (no. of children / families referred; treatment / intervention packages employed; utilisation of staff resources)</li>   <li>• Presence of Teams in CHPs</li> <li>• Monthly monitoring of referral systems (referrer, no. of referrals etc.)</li> <li>• Monitoring of management arrangements (per Steering Group)</li> </ul>

Objective: Establishing Multi – Disciplinary Family Support Teams

Objective	Outcome	Measurement
<ul style="list-style-type: none"> <li>• To develop, implement and evaluate multi-disciplinary / multi – agency Teams in CHPs to ensure best use is made of skills / resources across Agencies</li> <li>• To assist in the implementation of joint assessment process at the interface between core services and Teams</li> <li>• To pilot and evaluate use of a common assessment and record keeping system within Teams</li> </ul>	<ul style="list-style-type: none"> <li>• Development of Functional Teams in CHPs</li> <li>• Effective multi – disciplinary / multi agency support for vulnerable families</li> <li>• Development of joint assessment processes / tools (developed in association with Primary Care and other Agencies)</li> <li>• Agreement / use of common assessment and record keeping system</li> </ul>	<ul style="list-style-type: none"> <li>• Presence of Teams in CHPs</li> <li>• Monthly monitoring of services</li> <li>• Monitoring of Team functionality (per Steering Group)</li> <li>• Formal evaluation / research process</li> <li>• Development of Working Group</li> <li>• Piloting of tools</li> <li>• Dissemination of Learning from Phase One</li> <li>• Monitoring processes (per Steering Group)</li> <li>• Pilot use of “Care First”</li> <li>• Evaluate Staff satisfaction with system</li> <li>• Audit system use</li> </ul>

Objective	Outcome	Measurement
<ul style="list-style-type: none"> <li>• To pilot and evaluate models of team development in Teams</li>   <li>• To ensure that all Team members receive appropriate professional development support</li> </ul>	<ul style="list-style-type: none"> <li>• Development of functional Teams</li> <li>• Development of appropriate “team building” packages</li>   <li>• Development of skilled professionals in Team</li> </ul>	<ul style="list-style-type: none"> <li>• Evaluation of Team functionality (perceptions of Team members)</li> <li>• Implementation / evaluation of methods employed</li>   <li>• Evidence of Professional Development programme available to all staff in Teams</li>   <li>• Evaluation by staff of training opportunities</li> </ul>

Objective: Promoting Child and Family Well- Being for Vulnerable and Disadvantaged Children

Objective	Outcome	Measurement
<ul style="list-style-type: none"> <li>• To ensure that the needs of vulnerable children and families are met and to improve multi-agency recognition of need among vulnerable children / families in CHPs in Glasgow</li> <li>• To ensure the provision of integrated packages of Education, Health and Social Work Care for the most vulnerable and disadvantaged children and families in CHPs in Glasgow</li> <li>• To compliment the activities of generic services through promoting:               <ul style="list-style-type: none"> <li>- effective child / family nutrition</li> <li>- promotion of Oral Health</li> <li>- support for Mothers with PND</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Effective case-findings / recognition of need in CHP areas for vulnerable children and families</li> <li>• Single delivery system for support to vulnerable children / families in CHPs</li> <li>• Effective health improvement strategies within Team</li> </ul>	<ul style="list-style-type: none"> <li>• Monitoring of Team function (referrals, source of referrals, etc)</li> <li>• Audit of Team referrals</li> <li>• Monitoring of Case Records</li> <li>• Audit of Team activities</li> <li>• Case Study presentations by staff</li> <li>• Monitoring of Case Records</li> <li>• Audit of Team referrals to other Health – related Support</li> <li>• Case Study presentations</li> </ul>

Objective	Outcome	Measurement
<ul style="list-style-type: none"> <li>• To signpost and promote access by parents to appropriate health Promotion / Social Care initiatives</li> <li>• To provide access for parents to a variety of individual and group based models of parenting education opportunities within CHPs</li> <li>• To ensure that families receive flexible child care provision as required</li> </ul>	<ul style="list-style-type: none"> <li>• Effective health improvement strategies within Team</li> <li>• Effective access opportunities for parents (where required) to training/ employment opportunities</li> <li>• Appropriate provision of child care support in CHPs as required</li> </ul>	<ul style="list-style-type: none"> <li>• Monitoring of Case Records</li> <li>• Audit of Referrals</li> <li>• Case Study presentations</li> <li>• Audit evaluation of parental perceptions of access to resources</li> <li>• Monitoring of Case Records</li> <li>• Audit of referrals</li> <li>• Case Study presentations</li> <li>• Audit / evaluation of parental perceptions of access to resources</li> <li>• Monitoring of Case Records</li> <li>• Audit of referrals to service (industry uptake of resources)</li> <li>• Audit of provision</li> </ul>

Objective	Outcome	Measurement
<ul style="list-style-type: none"> <li>• To ensure that parents are consulted involved in key decisions that effect them / their children</li> <li>• To reduce vulnerability of low income families to financial exclusion and debt</li> </ul>	<ul style="list-style-type: none"> <li>• Parental knowledge of support /reasons for support</li> <li>• Reduce debt in vulnerable households</li> </ul>	<ul style="list-style-type: none"> <li>• Audit of parental perceptions</li> <li>• Monitoring of Case Records</li> <li>• Audit of household debt</li> <li>• Monitoring of debt advice activities with Team</li> </ul>

Objective: Disseminating Project Learning

Objective	Outcome	Measurement
<ul style="list-style-type: none"> <li>• To continue to disseminate lessons learned during Phase One in partnership with Early Years Network</li> <li>• To disseminate lessons with direct relevance to Hall 4 acquired during Phase One</li> <li>• To disseminate learning acquired through the development of the Support Workers /skill mix model</li> </ul>	<ul style="list-style-type: none"> <li>• Provision of multiple opportunities / methods for national learning on the Starting Well Project</li> <li>• Provision of Leadership opportunities for national stakeholders on workforce issues in Child / Family Services</li> </ul>	<ul style="list-style-type: none"> <li>• Presence of material on Web-Site</li> <li>• Development of quarterly activity bulletins (on web-site) through postal services</li> <li>• Development of annual facilitated learning events</li> <li>• Presentations at Conferences</li> <li>• Development of working arrangement with NHS Education for Scotland</li> <li>• Local / national seminars Conference presentations</li> </ul>

Objective	Outcome	Measurement
<ul style="list-style-type: none"> <li>• To create short –term secondment opportunities for local national service providers</li>   <li>• To share and exchange learning acquired during Phase Two to national audience at quarterly intervals in partnership with Early Years Learning Network</li> </ul>	<ul style="list-style-type: none"> <li>• Enhance local / national leadership on project protocols / service models</li>   <li>• Effective and timely dissemination of Project learning</li> </ul>	<ul style="list-style-type: none"> <li>• Audit of secondment opportunities</li> <li>• Evaluation of secondment model</li>   <li>• Monitoring of activities on monthly basis (web-site) presentations</li> <li>• Audit of user (stakeholder) views of dissemination strategies</li> </ul>



## **Appendix Two**

### **Phase Two and Ante-Natal/Early Post-Natal Support**

1. In Phase One, Starting Well clearly developed significant expertise in supporting mothers (and their families) in the ante-natal and early post-natal periods. There is significant evidence suggesting that early support is advantageous to families and particularly where families are vulnerable for any number of social reasons, this support is of even greater value (Olds, et al, 1985).
2. In Phase Two, the Project will focus on the needs of children aged 0-5 years and their families. There will not, therefore, be an exclusive focus on the ante-natal and early post-natal period. However, It is anticipated that referrals will be made to the Pre-School Intervention Teams by Midwives.
3. In Glasgow, there is work currently being developed in Public Health Midwifery (led by GGNHSB). Preliminary discussions on the potential relationship between this work and the Project in Phase Two have been established and further discussions are planned. The current planning in Public Health Midwifery recommends the development of dedicated services to support women/families with substance-misuse, child protection and/or where there are complex social issues present. The service provided at Princess Royal Maternity (Women's Reproductive Health Service) exists to support this population but is only available on the one site. The proposed Pre-School Intervention Teams may a support role to play in this area.
4. Learning acquired during Phase One will be of value both locally and nationally in the implementation of Hall 4. This learning will continue to be disseminated and the Project will seek opportunities to support the core services through a variety of dissemination methods (in association with the Early Years Learning Network).

### Appendix Three

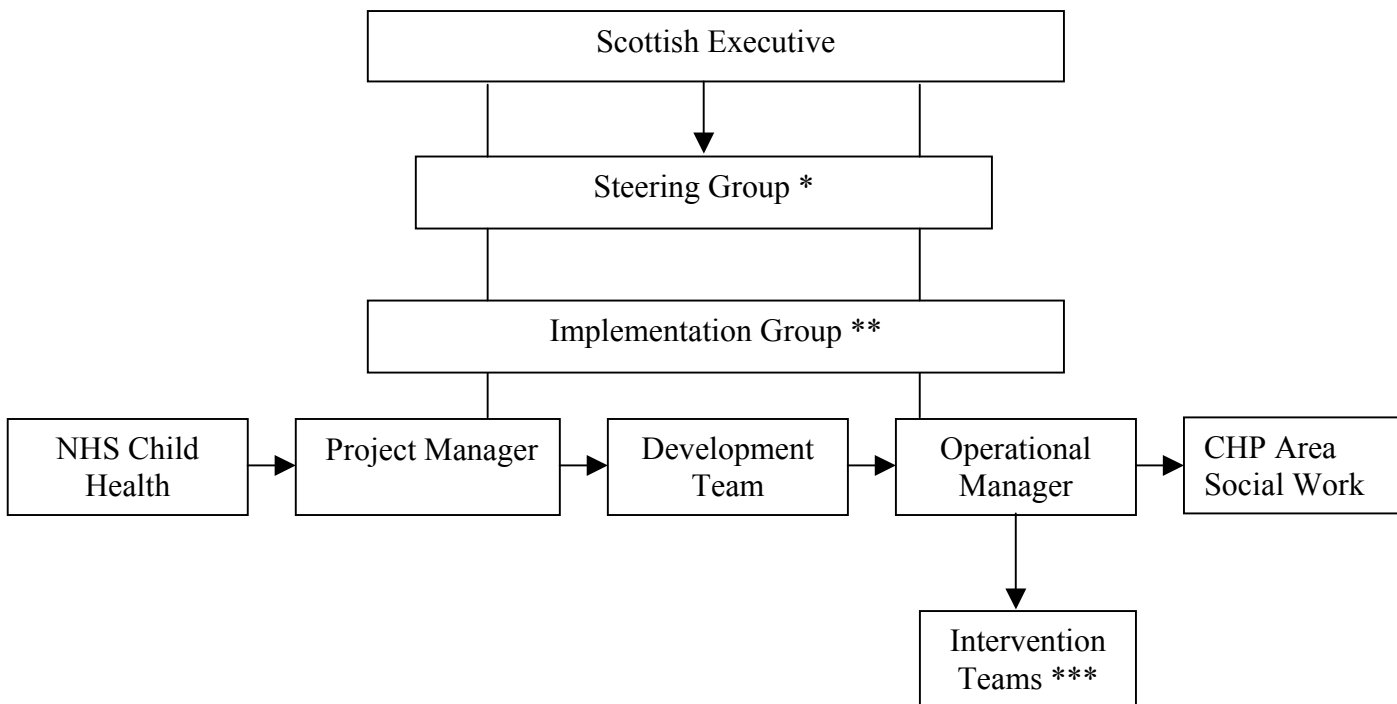
1. It is evident that the appropriate referral of children/families to the Pre-School Intervention Teams will rely on several inter-related factors: knowledge among referrers about appropriate referral criteria and the capacity among the core services to establish effective assessment processes.
2. In Phase One, the Project piloted the use of an assessment model within the Family Health Plan. Expertise was gained in the use of this approach and in the supporting skills (communication, goal setting) that are implicit parts of this process. This learning will be further disseminated in Phase Two. Links established with the West Of Scotland Public Health Nurse Records Project will assist in this process.
3. Within the Teams, it is currently being suggested that the system employed by Social Work, "Care First" be adopted for use among participating agencies. This model has already been developed for multi-agency use in Learning Disabilities and Addictions Services. The obvious advantage to the use of Care First is all members of the Team will be using the same system. There is a "start-up" cost associated with introducing staff to the system (purchase of appropriate IT equipment, etc) of approximately £2,000 per staff member. (This includes training and back-up support.)

## Appendix Four

### Project Organisational Map

1. An organisational map is presented in Figure One. The Project Manager will be responsible for the strategic leadership and performance management of the Project. The Operational Manager (Social Work) will be responsible for the operational management.
2. “Development Team” on the map refers to central Project staff (Practice Development Officer, Evaluation Officer, Development Officer, Parenting Co-ordinator).

Figure One  
Project Organisational Map



#### 1.1 Key

\* Lead Directors: NHS/Social Work/Education/Voluntary Sector

\*\* Operational Managers: NHS/Social Work/Education/Voluntary Sector

\*\*\* NHS/Social Work/Education/Voluntary Sector Staff

**Appendix Five  
Phase Two Planning  
Summary Forward Planning**

<b>Activity</b>	<b><u>Year One</u></b>		<b><u>Year Two</u></b>
	<b>Jan 05 –April 05</b>	<b>May 05 – Oct 05</b>	<b>Nov 05-March 06</b>
Disaggregate current Project services			
<ul style="list-style-type: none"> <li>• Complete transfer of Phase One families to LHCC HVs</li> <li>• Re – align community support within LHCC</li> </ul>			
Establish Intervention Team protocols			
<ul style="list-style-type: none"> <li>• Appoint Project development Co-ordinator</li> <li>• Appoint Team Leaders</li> <li>• Establish Implementation Group</li> <li>• Establish joint assessment, team allocation, recording / monitoring mechanism</li> </ul>			
Implement Intervention Teams in Eastern/SE LHCC/CHP			
<ul style="list-style-type: none"> <li>• Establish functional Teams</li> <li>• Monitor Team activity</li> <li>• Review Team development</li> </ul>			
Plan implementation of Teams in 2/3 Glasgow City CHPs			
<ul style="list-style-type: none"> <li>• Begin / progress consultation with CHPs</li> <li>• Agree implementation strategy with CHPs</li> </ul>			
Implement Intervention Teams in 2/3 Glasgow City CHPs			
<ul style="list-style-type: none"> <li>• Establish functional Teams</li> <li>• Monitor Team activity</li> <li>• Review / evaluate early progress</li> </ul>			

Appendix Five: Starting Well Health Demonstration Project  
Phase Two Planning

Period: Year One (December, 2004 – October, 2005)

Project Component: Establishing Multi-Agency/Multi-Disciplinary Family Support Teams

Objective	Key Task/ Milestone	Lead Officer(s)	Outcomes	Measurement	Target Dates
1. To ensure appropriate forward plans with Project Teams/LHCC staff/Social Work/Education	<ul style="list-style-type: none"> <li>a. Complete Project Team consultation</li> <li>b. Complete consultation with partner agencies</li> <li>c. Agree process for disaggregation of existing Project activities</li> <li>d. End current family recruitment to Project</li> </ul>	<ul style="list-style-type: none"> <li>• Project Manager/ Senior Management Team (SMT)</li> <li>• LHCC Manager</li> <li>• Lead Nurses</li> <li>• SW Manger</li> <li>• HV Co-ordinator</li> </ul>	<ul style="list-style-type: none"> <li>• Effective transition to Phase Two service delivery model</li> <li>• Effective communication between central Project Management/ LHCC's during transition</li> </ul>	<ul style="list-style-type: none"> <li>• Review of transition processes with partners</li> </ul>	<ul style="list-style-type: none"> <li>• October 2004</li> <li>• October 2004</li> <li>• October 2004</li> <li>• September 2004</li> </ul>
1. To disaggregate current Project services in LHCCs	<ul style="list-style-type: none"> <li>a. Complete transfer of families to LHCC HVs</li> <li>b. Re-align community support services within LHCC/Childcare Partnerships (including Local Implementation</li> </ul>	<ul style="list-style-type: none"> <li>• LHCC Manager</li> <li>• HV Co-ordinators</li> <li>• Lead Nurses</li> <li>• Community Support Facilitators</li> </ul>	<ul style="list-style-type: none"> <li>• Effective “closure” of Phase One/Transition Phase service activities</li> <li>• Effective transfer of community support activities to LHCC/CHP structures</li> </ul>	<ul style="list-style-type: none"> <li>• Review of processes with partners</li> </ul>	<ul style="list-style-type: none"> <li>• April 2005</li> <li>• April 2005</li> </ul>

Starting Well Health Demonstration Project  
Phase Two Planning

Period: Year One (December, 2004 – October, 2005)

Project Component: Establishing Multi-Agency/Multi-Disciplinary Family Support Teams

Objective	Key Task/ Milestone	Lead Officer(s)	Outcomes	Measurement	Target Dates
	Group, Development Fund) c. Identify Public Health Role in LHCC/CHP with Pre-5 focus				<ul style="list-style-type: none"> <li>• April 2005</li> </ul>
3. To establish Intervention Team protocols	a. Appoint Project Development Co-ordinator b. Appoint Team Leaders c. Establish Steering Group d. Establish referral criteria/pathways e. Establish joint assessment processes f. Establish Team allocation process g. Establish monitoring protocol/data base recording mechanism h. Enhance Parenting Programme provision across CHP areas i. Agree Accommodation	<ul style="list-style-type: none"> <li>• Project Manager</li> <li>• HV co-ordinator</li> <li>• SW Manager</li> <li>• Early Years Manager (Education)</li> <li>• Parenting Co-ordinator</li> <li>• Bilingual Worker</li> <li>• Evaluation Officer</li> <li>• Parenting Co-ordinator</li> </ul>	<ul style="list-style-type: none"> <li>• Effective establishment of Family Support Team protocols</li> </ul>	<ul style="list-style-type: none"> <li>• Review/evaluation of Family Support Teams</li> </ul>	<ul style="list-style-type: none"> <li>• May 2005</li> <li>• May 2005</li> <li>• May 2005</li> <li>• May 2005</li> <li>• May 2005</li> <li>• May 2005</li> <li>• May 2005</li> <li>• May 2005</li> <li>• May 2005</li> <li>• May 2005</li> </ul>

Starting Well Health Demonstration Project  
Phase Two Planning

Period: Year One (December, 2004 – October, 2005)

Project Component: Establishing Multi-Agency/Multi-Disciplinary Family Support Teams

Objective	Key Task/ Milestone	Lead Officer(s)	Outcomes	Measurement	Target Dates
4. To implement Intervention Teams in Eastern/South-East LHCC/CHP	<ul style="list-style-type: none"> <li>a. Establish functional Teams in Eastern/South-East LHCC/CHP</li> <li>b. Monitor Team activity in development</li> <li>c. Establish evaluation framework</li> <li>d. Review Team development/evaluate early progress</li> </ul>	<ul style="list-style-type: none"> <li>• Project Manager</li> <li>• Practice Development Facilitator</li> <li>• Team Leader</li> <li>• Lead Nurses</li> <li>• LHCC Manager</li> <li>• SW Operational Manager</li> <li>• Evaluation Officer</li> <li>• Parenting Co-ordinator</li> </ul>	<ul style="list-style-type: none"> <li>• Effective implementation of Family Support Team in Eastern/South east LHC's</li> </ul>	<ul style="list-style-type: none"> <li>• Review/evaluation of Family Support Teams</li> </ul>	<ul style="list-style-type: none"> <li>• June 2005</li> <li>• Ongoing</li> <li>• November 2005</li> <li>• November 2005</li> </ul>
5. To prepare/plan implementation of Intervention Teams in 2/3 remaining Glasgow City CHPs	<ul style="list-style-type: none"> <li>a. Complete consultation with CHP management</li> <li>b. Agree implementation strategy with CHP management</li> </ul>	<ul style="list-style-type: none"> <li>• Project Manager</li> <li>• CHP Manager</li> <li>• Lead Nurses</li> <li>• Practice Development Facilitator</li> <li>• SW Manager</li> </ul>	<ul style="list-style-type: none"> <li>• Effective transition to Phase Two service delivery model in remaining Glasgow city CHP's</li> </ul>	<ul style="list-style-type: none"> <li>• Review of transition processes with partners</li> </ul>	<ul style="list-style-type: none"> <li>• October 2005</li> <li>• October 2005</li> </ul>

Objective	Key Task/ Milestone	Lead Officer(s)	Outcomes	Measurement	Target Dates
	<ul style="list-style-type: none"> <li>c. Agree ordering of implementation per CHP</li> <li>d. Appoint Team Leaders in participating CHPs</li> </ul>				<ul style="list-style-type: none"> <li>• June 2005</li> <li>• September 2005</li> </ul>

Starting Well Health Demonstration Project  
Phase Two Planning

Period: Year One (October, 2005 – March, 2006)  
Project Component: Establishing Multi-Agency/Multi-Disciplinary Family Support Teams

Objective	Key Task/ Milestone	Lead Officer(s)	Outcomes	Measurement	Target Dates
1. To maintain/ review development of implemented Intervention Teams	a. Monitor Team activity per CHP management and SMT	<ul style="list-style-type: none"> <li>• Project Manager</li> <li>• Practice Development Facilitator</li> <li>• Team Leader</li> <li>• Lead Nurses</li> <li>• CHP Manager</li> <li>• SW Manager</li> </ul>	<ul style="list-style-type: none"> <li>• Effective maintenance/ further development of Team structures/ functions</li> </ul>	<ul style="list-style-type: none"> <li>• Review/ Evaluation Report data</li> </ul>	<ul style="list-style-type: none"> <li>• On-going</li> </ul>
	b. Review Team development	<ul style="list-style-type: none"> <li>• Parenting Co-ordinator</li> <li>• Bilingual Worker</li> </ul>	<ul style="list-style-type: none"> <li>• As above</li> </ul>	<ul style="list-style-type: none"> <li>• As above</li> </ul>	<ul style="list-style-type: none"> <li>• March 2006</li> </ul>
2. To implement Intervention Teams in 2/3 Glasgow City CHPs	a. Establish functional Team in CHPs	<ul style="list-style-type: none"> <li>• Project Manager</li> <li>• Practice Development Facilitator</li> <li>• Team Leader</li> <li>• Lead Nurses</li> <li>• CHP Management</li> <li>• SW Manager</li> <li>• Parenting Co-ordinator</li> <li>• Bilingual Worker</li> </ul>	<ul style="list-style-type: none"> <li>• Effective implementation of Teams in remaining Glasgow city CHPs</li> </ul>	<ul style="list-style-type: none"> <li>• Review/ Evaluation of Support Teams</li> </ul>	<ul style="list-style-type: none"> <li>• March 2006</li> </ul>
	b. Monitor Team activity in development				<ul style="list-style-type: none"> <li>• March 2006</li> </ul>
	c. Review Team development/ evaluate early progress				<ul style="list-style-type: none"> <li>• March 2006</li> </ul>

**Appendix Six: Phase Two Dissemination Plan (Suggested)**  
(January 2005 – June 2005)

Time Scale	Research & Evaluation	Theme			
		General Reporting	Presentations/ Seminars Events	Press / Media	Secondments
January 2005	<ul style="list-style-type: none"> <li>• Posting of additional research studies (Goal setting, Triple P, Community Support) on Early Years web-site</li> <li>• Completion of feasibility study protocol (Phase Two)</li> </ul>	<ul style="list-style-type: none"> <li>• Printing of Final Report (Phase One)</li> </ul>			
March 2005	<ul style="list-style-type: none"> <li>• Completion of Phase One Internal Evaluation Report.</li> </ul>				
April 2005			<ul style="list-style-type: none"> <li>• Launch of Phase Two</li> <li>• Launch of Phase One Report</li> <li>• Public Health Seminar (GGNHSB): developing Phase Two</li> </ul>	<ul style="list-style-type: none"> <li>• Launch of Phase Two (local / national press)</li> <li>• Launch of Phase One Final Report (Local/ national press)</li> </ul>	
May 2005	<ul style="list-style-type: none"> <li>• Publication of research papers (Phase One) in Journal of Primary Prevention (USA)</li> <li>• Preliminary report on disaggregation processes / protocol development for Phase Two</li> </ul>	<ul style="list-style-type: none"> <li>• Posting of Phase One Final Report on Early Years web-site</li> </ul>			
June 2005	<ul style="list-style-type: none"> <li>• Completion of Evaluation Protocol</li> </ul>	<ul style="list-style-type: none"> <li>• Publication of Starting Well Newsletter</li> </ul>	<ul style="list-style-type: none"> <li>• Seminar: Developing Phase Two</li> </ul>		<ul style="list-style-type: none"> <li>• Introduction of secondment programme among partners</li> </ul>

## Appendix Seven

### Financial Framework

#### 1. Introduction:

The Financial Framework is presented under a series of headings:

- **Section Two** describes additional allocations of funding for early years provision in Glasgow between 2004 and 2006.
- **Section Three** describes how GGNHSB will invest in Starting Well Phase 2 as central funding is tapered over a three-year period.
- **Section Four** describes the current spend profile and the end point (at three years).
- **Section Five** reviews expenditure over the proposed three-year period.
- **Section Six** considers development of our proposed Teams within local authority areas outside Glasgow City.

#### 2. Financial Context

- 2.1 When looking at funding this initiative in early years, it is important to place this in the context of other streams of funding. Over the last three years, funding has come into Children's Services from various sources.
- 2.2 Childcare Strategy funding has been routed through Education Services to achieve an expansion of affordable, accessible quality care for children aged 0-14. The Changing Children's Services Fund was allocated to local authorities, the NHS, the voluntary sector and others to support the change needed to deliver more integrated children's services and improve outcomes for vulnerable and deprived children. The Surestart Scotland programme (again routed through Education) is to ensure targeted support for families with very young children, particularly focused on the vulnerable and deprived, through the provision of a range of integrated services.
- 2.3 A significant proportion of this funding is committed. However, this is in addition to funding available through mainstream/core services.

#### 3. Funding Assumptions

- 3.1 Phase 2 of Starting Well will commence in January 2005, nine months into the financial year 2004/05. There is no anticipated underspend in the period April 2004 to January 2005. Phase 2 will cover 18 months and Scottish Executive funding is expected to continue over that time period. GGNHSB has identified funding to maintain the existing level of annual funding for Starting

Well - £1.4million per annum. Supporting vulnerable families is a priority for the Board, demonstrated by this commitment.

- 3.2. No attempt has been made to allocate specific lines of expenditure to sources of income. It is assumed that income is pooled for the initiative.

#### 4 Start and End Position

- 4.1 This Financial Framework looks at the current profile and spend of the Starting Well team and what that profile looks like at the end of the three year period.

- 4.2 Existing Project Team - September 2004

The existing Team comprises two teams with central support of Project Manager, Evaluation Officer, Development Officer, Parenting Co-ordinator and secretary. The teams based in Govanhill and Easterhouse are led by an H grade Health Visitor with G grade Health Visitors, Community Support Facilitators, Health Support Workers and Community Nursery Nurses and administrative support.

**Table One**  
**Existing Project Team Costs**

	<b>Number</b>	<b>Unit Cost (£k)</b>	<b>Annual Cost (£k)</b>	<b>Funding Source</b>
Project manager	1	51.4	51.4	Scottish Executive
H grade health visitors	2	34.6	69.2	Scottish Executive
G grade health visitors	20.2	28.8	581.8	Scottish Executive
Nursery nurses	4.6	19.6	90.2	Scottish Executive
Bilingual community worker	0.5	25.9	13.0	Scottish Executive
Community support workers	2	25.9	51.8	Health Improvement Fund
Evaluation officer	1	25.9	25.9	Scottish Executive
Parenting co-ordinator	1	32.9	32.9	Health Improvement Fund
Development officer	1	24.4	24.4	Health Improvement Fund
Admin/clerical	5	17.1	85.5	Scottish Executive
	<b>38.3</b>		<b>1026.0</b>	
Health Support workers	16	19.5	312.0	Scottish Executive
	<b>54.3</b>		<b>1338.0</b>	

The Health Support Workers are currently commissioned through One Plus, and the unit cost reflects the overheads of that contract, including management costs and training. One Plus have indicated that they may be able to attract European funding in future years to cover the training element of this, bringing down the unit costs.

In addition, there has been expenditure on supplies and accommodation of up to £300k per year.

#### 4.3 End point staffing requirement - September 2007

By the end of phase 2, we would envisage that central support would have greatly reduced as management and direction will come from the Community Health Partnership. Teams in the five CHPS will comprise 4 Health Visitors, 4 Health Support Workers, 2 Community Nursery Nurses and a secretary. Partners are optimistic that contributions from Surestart from 2005/06 will allow an additional 15 Health Support Workers to work with the teams linking with Family Learning Centres by the end of the three year period.

All costs in the table below are at 2004/05 prices.

**Table Two**  
**End-Point Staffing Requirements (2007)**

	<b>Number</b>	<b>Unit Cost (£k)</b>	<b>Annual Cost (£k)</b>
<b>1 Expenditure</b>			
G grade health visitors	20	28.8	576.0
Nursery nurses	10	19.6	196.0
Health support workers	35	19.5	682.5
Admin/clerical	6	17.1	102.6
Supplies			135.4
			<b>1692.5</b>
<b>2 Income</b>			
GGNHSB			1400.0
Surestart			292.5
			<b>1692.5</b>

The Teams will be supported by other mainstream services in Health, Education and Social Work. Accommodation will be provided through CHPs, or by other local statutory or voluntary sector providers. A full breakdown of supplies costs can be seen at para 5.4.

## 5. Expenditure over the 3 year period

5.1 In order to get to the planned end point, it will be necessary to take some staff out of the existing two areas, reduce the central team and build up teams in the other CHP areas. In parallel with this, inter-agency protocols will have to be established and agreed for this new way of working. An attempt has been made in the Tables below to show how this step change will be achieved over the next three years.

5.2 The first table shows this in staff numbers.

### 2.1.1 Table Three

**Project Staff Numbers (2004-2007)**

	Oct 04 - Mar-05	Apr 05 - Sep-05	Oct 05 - Mar-06	Apr 06 - Sep-06	Oct 06 - Mar-07	Apr 07 - Sep-07
Project manager	1	1	1	1	0	0
H grade health visitors	1	0	0	0	0	0
G grade health visitors	20.2	20	20	20	20	20
Nursery nurses	4.6	4.6	6	10	10	10
Bilingual community worker	0.5	0.5	0.5	0.5	0	0
Community support workers	2	0	0	0	0	0
Evaluation officer	1	1	1	1	1	0
Parenting co-ordinator	1	1	1	1	0	0
Development officer	1	1	1	1	0	0
Admin/clerical	5	5	5	6	6	6
Health Support workers	16	16	18	20	20	20
Nurse practitioner	1	1	1	1	0	0
FLC health support workers	0	4	6	15	15	15

5.3 Again, using 2004/05 costs, the Phase 2 costs of this model would be:

**Table Four**  
**Project Staff Costs (2004-2007)**

	2004/05	2005/06	2006/07	2007/08
<b>Income</b>				
SE Allocation				
Carry forward	234.0			
Transition	771.0			
Phase 2	537.0	1072.0		
Local contribution	50.0	350.0	1400.0	1400.0
Education		90.0	292.5	292.5
<b>Total Income</b>	<b>1592.0</b>	<b>1512.0</b>	<b>1692.5</b>	<b>1692.5</b>
<b>Expenditure</b>				
<u>Staff</u>				
Project manager	58.8	51.4	25.7	
H grade health visitor	76.4			
G grade health visitor	632.2	576.0	576.0	576.0
Nursery nurses	94.0	103.9	196.0	196.0
Bi-lingual community worker	10.4	13.0	6.5	
Community support workers	51.8			
Evaluation officer	9.4	25.9	25.9	
Parenting co-ordinator	34.6	34.6	17.3	
Development officer	16.0	24.4	12.2	
Admin/clerical	108.3	85.5	102.6	102.6
Health support workers	368.2	331.5	390.0	390.0
Nurse practitioner		34.6	17.3	
FLC health support workers		97.5	292.5	292.5
	1460.1	1378.3	1662.0	1557.1
<u>Supplies</u>				
Accommodation	45.0	49.0	49.0	49.0
Community development	40.0			
Training	10.0	25.0	20.0	20.0
Monitoring/ Carefirst		20.0	20.0	20.0
Childcare	5.0			
Consultancy	25.0			
Travel	35.0			
Triple P Resources		15.0		
Dissemination	20.0			
	180.0	109.0	89.0	89.0
<b>Total Expenditure</b>	<b>1640.1</b>	<b>1487.3</b>	<b>1751.0</b>	<b>1646.1</b>

Additional local contribution required	48.1	-24.7	58.5	-46.4
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With agreement (in principle) that the contribution from Surestart will rise from £90k to £292k per annum by the end of year 3, the original finance envelope of £1.4million will cover the costs over the three year period.

## **6. Other Local Authority Areas**

- 6.1 Towards the end of 2006/07 onwards, we will begin to work with non-Glasgow CHPs exploring a similar model and building on the work which has begun in each area. Both East Dunbartonshire and East Renfrewshire experience a lower level of deprivation the Glasgow City, and South Lanarkshire has a smaller population. We would expect the teams in those areas to be smaller:

2 Health Visitors  
2 Health Support Workers  
1 Community Nursery Nurse

In total, at 2004/05 prices, this would cost £116.2k per CHP. West Dunbartonshire has invested Children's Change Fund money in a similar model which we have jointly planned - this should be supplemented by a similar team.

- 6.2 Extending the model beyond Glasgow City will mean securing additional investment from Board and partner agencies' resources. This has not yet been agreed. The cost of expanding into the wider GGHB area would be £464.8k per year, on top of the £1.4million commitment for Glasgow City.