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Introduction

Sure Start Loxford is a second wave programme, and as such has been up and running for the last 4 years. Whilst Sure Start has an established presence in the Loxford community, the service is still evolving to meet new government strategies, in particular the development of Children’s Centres. In light of this, Sure Start Loxford is currently waiting for the completion of their new Family Resource Centre in the summer 2005, which will impact significantly on service provision for all Sure Start services, through providing accessible venue space, co-locating services and increasing the project presence.

For 2003/4 Sure Start Loxford commissioned Cordis Bright Consulting to conduct its annual evaluation. The parameters of the evaluation are to assess three projects funded by the programme. These ‘spotlighted’ services are:

- Family Support Workers’ Service: as provided at Albert Road (AR FSW) and South Park Clinic (SPC FSW)
- Muslim Women Welfare Association: Dress-making class and English classes (MWWA)
- Infant Mental Health Project (IMH): Clinical intervention, training and research

Whilst the nature and structure of the three projects is distinct, the evaluation for each of the three projects has shared objectives, and these have been examined across 6 key dimensions.

- Strategic Dimension: The extent to which they support the achievement of Sure Start objectives and key principles
- Operational Dimension: Efficacy of operational processes and procedures, including extent of partnership working with external agencies
- Implementation Dimension: Overall quality of services; including the extent to which services meet user needs and expectations
- Unit-Cost analysis: including bench-mark costs
- Future Strategy and Planning: strategic analysis of exit strategies and opportunities for mainstreaming of projects
- Cost-benefit Analysis: Overall conclusions, identification of best-practice, value-for-money by taking into account qualitative context and long-term outcomes
However, the evaluation should be read in light of the context of wider Sure Start programme developments, such as the Family Resource Centre developments, which will impact significantly on the cost-benefit of service provision.

This report focuses on the service evaluation of the Family Support Workers project, and was conducted between February and May 2004.
Methodology
To gain an understanding of the service on the six key dimensions, the evaluation necessitates a number of levels of analysis. These include background and desk-top research, consultation across the partnership, qualitative and quantitative analysis of data. Interviews have been conducted at all levels of engagement; with service users, paid staff, and service co-ordinators. This multi-level approach ensures feedback is obtained from people engaged at all levels of service provision and use. A variety of consultation methodologies have been employed.

- **Interviews with Service Managers** (16th April 2004): One hour semi-structured interviews with the Health Team Co-ordinator, managing the South Park Clinic Family Support Workers, and the Deputy Manager, managing the Albert Road Family Support Workers.

- **FSW Team Interviews** (7th April 2004 and 19th April 2004) A 2 hour semi-structured group interview was held with SPC FSWs. An individual interview was held with AR FSW.

- **User interviews** (20th – 22nd April 2004) A total of 12 users were interviewed by telephone (7 current users and 5 ex-users). All respondents were informed by post of the evaluation. Introductory phone calls were made to arrange a suitable time for respondents to conduct a 10 minute structured telephone interview. All interviewees were informed that interviews would be treated as confidential.

- **Stakeholder Focus Group** (16th April 2004) A focus group was held with a range of stakeholders in the FSW project to understand their perceptions of the value and efficacy of the FSW service. Attendees included health visitors, service managers, community development workers, and the post-natal depression co-ordinator.

- **Observation of Service and Intervention Techniques** (19th April 2004) Due to the nature of service provision observation of the majority of services was considered intrusive, and hence observation was restricted to observation of the Baby Rhyme Time group.

- **Unit cost analysis** This was undertaken by using the basic unit cost model which deduces what the average cost of a contact is by reference to the total Sure Start contribution, using data from 2003/4 and the total grant made available in 2003/04. Various bench-
marking costs are provided to enable comparison of unit costs for the purposes of assessing cost effectiveness.
Service Profile
Sure Start Loxford funds 2.42 WTE FSWs in the Loxford Sure Start area. These can ostensibly be split into two models of service provision due to the distinct nature their working practice and client bases (as opposed to the content of support service they provide). This is a result of the different organisations to which the FSW are affiliated; SPC FSWs (2 WTE) and AR FSWs (0.42 WTE). Both services have been running for approximately one year to date.

South Park Clinic Family Support Workers
Objectives
The over-arching objective of the FSW project is to provide additional support to families to ensure optimum child development, with four key sub-objectives;

1. To encourage children’s and clients emotional and cognitive development.
2. To advise parents and carers on child development issues (e.g. breastfeeding
3. To give practical advice and signposting to parents as needed
4. To provide practical support to parents and carers

Targets
There are no project specific targets for this service.

Format
The service comprises a number of elements to provide support to families in the Sure Start area with a strong preventative focus.

- **Health Visiting Outreach**, For those parents referred through the health visitors, FSW provide a two-month check and any additional support required, including breast-feeding, behavioural interventions
- **Groups and clinics**, including Baby Rhyme Time, Baby Clinic, Weaning Group, Three-year Development Assessment with varying attendance between groups.
- **Sure Start Events**, including Christmas and New Year Celebration, Summer fun-events and health promotion events

Staff
The Family Support Workers Service comprises 3 trained Nursery Nurses (working out of South Park Clinic), two of whom job share to equal two full time equivalents. The FSW team is managed by the Health Team Co-ordinator within existing hours.
User Profile
FSW case-loads reflect those of the health visitors which are universal, reflecting a range of parents and children though targeting those with additional and/or complex needs.

Costs
The total cost of the South Park Clinic is £39,704 for 2003/4.

Albert Road Family Support Workers
Objectives
As SPC FSW objectives

Targets
There are no project specific targets for this service.

Format
The service comprises a number of elements to provide support to families in the Sure Start area with a strong focus on intervention with families who have more complex needs.

- **AR Outreach work.** For those parents referred to the Family Centre from social services, a ten-week structured outreach course is generally provided for parents (reviewed subject to need). FSW therefore hold their own case-loads.
- **Health Visiting Outreach work** For those parents referred through the health visitors, FSW provide a two-month check, and limited additional support.
- **Groups.** Baby Massage (six-week courses) and Literacy & Numeracy Groups (run on an on-going basis)

Staff
The Albert Road Family Support Workers Service comprises 1 trained Nursery Nurse, providing 0.42 WTE service. The FSW is line-managed by the Albert Road Team Co-ordinator within existing hours.

User Profile
FSW case-loads include a range of parents and children the majority of whom are “known” to Social Services, again reflecting the nature of the organisation within which the FSW is situated.
Costs
The total cost of the Albert Road FSW is £8,295 for 2003/2004.
Strategic Dimension

The strategic dimension of the evaluation provides an analysis of the extent to which the project objectives and outcomes work towards achieving Sure Start objectives and key principles. The FSW’s objectives are strongly aligned with all four Sure Start objectives, and the impacts of the FSW project stretch across all four objectives.

The key objective impacted upon by the projects is **Objective One: Improving social and emotional development**. (see Appendix One for details). This reflects the core objective of providing support services to parents and children, and is inherent through FSW services.

With a significant health focus the FSW’s role is also strongly aligned with **Objective Two: Improving health**. SPC FSWs provide a baby clinic and weaning group to help identify any health problems with children. Additional health related services include the three-year development checks and Sure Start Loxford also provides two-month contacts.

**Objective 4: Strengthening Families and Communities** is systemic to the objectives of the FSW service. It is impacted through the contribution to other Sure Start objectives, but more specifically through FSW’s role in providing community events to developing health and social awareness.

Further to this, an indirect objective of the FSW service is to ensure children are at their optimal stage of development to access school and develop their learning. Groups, such as Literacy and Numeracy (AR FSW) contribute directly towards this objective. This preparatory work aims to ensure **Objective 3: Improving learning** is achieved within the Sure Start community.

Whilst not a direct measure of impact on objectives, service users stated a demonstrable impact upon their child(ren) and their own health and well-being. The results indicate the service is having greater impact on parents and carers compared to children, with an average of 62% of parents stating the service had impacted on aspects of their health and well-being compared to 39% for children (see Graph A and B below).

For both parents and children, the greatest impact of services was to increase their confidence. Providing social support and reducing stress are also key outcomes of the FSW service. Notably, self-esteem was least impacted, however this is to be expected due to the more generic nature of the support provided.
Graph A: Impact of FSW service upon carers health and well being

(Base = 12, D/Ks not included in percentages)

Direct impact on children appears slightly less than on parents and carers, however parents still perceive a degree of improvement across a range of health and well being factors.

Graph B: Impact of FSW service upon child’s health and well-being

(Base = 12, D/Ks not included in percentages)
Operational Dimension

This dimension examines the efficacy of operational processes and procedures, including extent of partnership working with external agencies. The South Park Clinic and Albert Road Family Support Workers are analysed separately as they have very distinct operational practice.

South Park Clinic Family Support Workers

Overall, the South Park Clinic Family Support workers have effective, but relatively isolated working practice.

Organisational structure and management

SPC provides the location for the health team, and is a part of Redbridge PCT. Therefore FSW have a strong health orientation in their operational practice, which provides a well-established structure to work within.

The FSWs at SPC are line-managed (both clinically and operationally) by the Health Team Co-ordinator. Line management is provided regularly, and on an ad-hoc basis as necessary. In addition each FSW has a mentor (a health visitor) to provide additional support. FSW feel happy with the support mechanisms in place

Integration with other service providers

There is high degree of integration between the health visiting team and the FSW at SPC, with staff sharing the same objectives, values and means of implementation. Co-location allows for a high degree of informal communication, ensuring effective information sharing and linked service development.

However, there is a distinct difference in roles and responsibilities as a result of difference in professional competencies. A health visitor is a qualified nurse with further specialised training and is experienced in child health, health promotion and health education, whereas a FSW is a trained nursery nurse, with additional ad-hoc training according to the post and previous experience. However with the more non-specific responsibilities of the two roles (e.g. emotional and practical support) there can be a high degree of overlap.

This overlap originally created a degree of confusion as to the role of the FSW in relation to the HV team. The FSW role is to provide an auxiliary service to the Health Visitors (i.e. providing extra support to
enhance the service offered from the health team), rather than assuming existing health visitor responsibilities. The similar nature of service provision, and support and informal training provided by Health Visitors, may have resulted in further confusion with regards to these roles. However, additional formal training has also been provided by an external consultant to clarify their roles and responsibilities in relation to the HV team.

Beyond integration with the health visiting team, there is limited integration with other service providers. The FSW do work directly with Sure Start in supporting events and providing signposting to other services (e.g. Infant Mental Health project). However the wider service provision and interaction is limited through the gateway referral system of the health visiting team.

During this first year of operation there has been a degree of integration with the AR FSW through shared training. However with the core training now coming to an end, and increased divergence in roles and practice, integration between the two ‘types’ of FSWs will probably decrease.

Communication with other service providers

Awareness
The limited intervention beyond the scope of health visiting referrals, indicates there may be a lack of awareness of the service provided by the SPC FSWs beyond the health Visiting team and Sure Start projects. If this is the case, this lack of community awareness may also explain the lower levels of attendance at the groups provided by the FSWs.

Referral/ assessment
The FSWs almost exclusively receive referrals from the health visitors at the SPC. The FSW tend to feedback any problems to the health visitors rather than make direct referrals. However, FSW signpost parents to open groups and services, including Loxford Hall for the IMH project, Albert Road Health Centre and Kenwood Gardens for Special Needs children.

Feedback Mechanisms
Feedback on clients is direct to the health visiting team, both verbally and written, formal and informal. Feedback regarding clients is regular and effective.

Professional feedback between team members on their working practice (e.g. suitability of referrals from the HV to FSWs, parameters of roles) is
less regular, and was initially conducted on an ad-hoc basis. The health visitors suggested feedback on the suitability of referrals and the tasks allocated would be useful.

**Training**
All FSW’s have undertaken a significant amount of formal training to support their roles, including:

- Foundation and intermediate child protection skills
- Record keeping
- Basic communication and counselling skills
- Infant massage
- Mandatory Redbridge PCT induction
- Fire training
- Diversity awareness

This formal training was shared with the AR FSW and has provided a degree of integration between the two ‘types’ of FSW in terms of working practice and information sharing.

Training has also been provided by external consultants to clarify roles and responsibilities of FSW in relation to the health visiting team. Additional informal training has also been provided by health visitors, including shadowing and individual mentoring support. FSW feel happy that they have received sufficient training to carry out their duties.

**Albert Road Family Support Worker**

**Organisational structure and management**
Albert Road Family Centre is run by London Borough of Redbridge, providing a range of services such as baby massage, Toy Libraries, and fathers groups. As with SPC FSW, this provides a strong existing organisational structure for the FSW.

The FSW is managed (clinically and operationally) by the Deputy Manager, but also receives peer support from other co-located service providers, including support from a team of local authority funded FSW's.

**Integration with other service providers**
The nature of the organisational structure establishes a limited degree of direct integration across agencies, similar to SPC FSW. With a less exclusive role, the AR FSW does not share the same degree of
integration with the health visiting service. However, around a quarter of the AR FSW time is spent working alongside the health visiting service. The FSW provides the Sure Start two-month contacts and HVs will contact the FSW on an ad hoc basis to address specific support issues.

Whilst integration with SPC FSW was established through shared training, the degree of integration will be significantly limited as the amount of training provided tailors off. This has already occurred to some extent and FSW associate themselves more with their work-place than their shared role.

**Communication with other service providers**

**Awareness**

Beyond the health visiting and social services, awareness of the FSWs outreach service is limited. As with SPC, referring organisations outside the Family Centre do not have a clear picture of the parameters of the FSW role, and the exact nature of the service provided.

**Referral/ assessment**

The majority of the referrals to the FSW at AR Family Centre are from Social Services (estimated at 70%). These clients are referred through the Deputy Manager, who acts as a gateway to the FSW situated at Albert Road. A thorough assessment of these clients is conducted by the Deputy Manager and the AR FSW, and includes a genogram and ecogram to establish families needs.

Referrals from health visitors comprise the remaining 30% of referrals and are direct to the FSWs. As a result the assessment and intervention process for these referrals is more comparable to the FSW at SPC, taking more of an informal format.

**Feedback Mechanisms**

Feedback to social services occurs through

**Training**

All FSW’s have undertaken a significant amount of formal training to support their roles, including:

- Foundation and intermediate child protection skills
- Record keeping
- Basic communication and counselling skills
- Infant massage
In addition SPC FSWs have had training on fire training, Redbridge PCT induction and diversity awareness.

As with the SPC FSW, additional internal training has also been provided for the AR FSW, including IT training, special needs training and training in organisational aspects.
Implementation Dimension

This dimension of the evaluation assesses the overall quality of services; including the extent to which services meet user needs and expectations

Profile of service-use

- Length of service use  Graph C below indicates the range of times that respondents stated that they had received services from the FSWs. (It should be noted that the sample was biased towards those who have used services for over a month to ensure respondents had more experience of the FSW service).

Graph C: Length of time of using FSW service

- Frequency  On average, FSW support was provided one or more times a week.

Quality of service provision

Overall, the service provided was perceived by service users, and service providers, to be of a high quality, in particular in relation to waiting times, capacity and staff.
Accessibility

The FSW service has been successful in providing an accessible service. 75% of the sample noted the times of the visits to be suitable, and similarly, 75% agreed that the duration of the visits was the right length.

The majority of parents were very satisfied with the frequency of receiving the service, however one parent commented "I would have liked to have seen them more often".

In relation to timing, one of the service – improving remarks was "I would have preferred to have their help in the morning".

Waiting times

Ten out of eleven people (91%) cited that it was easy to make on-going appointments with the FSW’s. Similarly, 9 out of 11 (82%) people found the time between requesting FSW services and receiving them to have been short.

Testimony during service-provider focus groups highlighted that the AR FSW had enabled no waiting list at AR, and provision of service by the AR FSW was practically immediate.

There was no discernable pattern regarding missed appointments, which were distributed between a variety of user-led issues such as "child was sick", or "I forgot". Only one respondents from the twelve noted dissatisfaction on the FSW side, stating "they could be more regular and turn up to appointments".

Capacity

The consensus from interviews with FSWs and their line managers was that they were working at capacity. This is corroborated by the unit-cost analysis (see unit-cost analysis pages 21-24). The AR FSW workload was estimated to include 40% of time on outreach work (average 4 cases), 20% on two month contacts, and the SPC FSWs with 54% of their time on outreach (or 8-10 cases) and 30% of time on groups or clinic. In the case of AR FSW, it was proposed that more time was needed to factor in more group work in order to improve the service.

Staff

Staff are providing a high quality service, evidenced by service users perceptions of the qualities of the FSW’s. The most highly praised quality was their trustworthiness (92% very good and 8% quite good), followed by their helpfulness. A consistent and large majority (83%)
found them to be providing a very good service in respect to all other
(see graph D below).

**Graph D: Opinion of the nature/qualities of the FSW service**

(excludes *Don’t Knows*)

This conclusion was supported by users comments, including “*They
were very flexible and responsive*”; “*The Family Support Worker was a
really lovely lady, we had a good rapport and she picked me up
emotionally*. Moreover, when asked ‘*what worked well?*’, responses in
the majority related to the positive supportiveness of the FSW’s.
Comments included “*Good at giving advice*”; “*Having someone to talk
to*”; “*An extra pair of hands*”, “*Listening to problems and helping with
the children*” and “*The Family Support Worker feels like a friend*”.

**Communication with Users**

Communication with service-users is a two-way pathway, enabling
information to flow between service-users and service-providers in order
to improve the service for all parties, and can facilitate a more needs-led output.

**Advertising/Awareness**

Awareness of the FSW service amongst users is relatively low, with the
majority (67%) first hearing about the FSW service through the Health
Visitor and equal numbers of respondents (17%) having heard through
social service, GP’s/nurse or at hospital (see Graph 14 Appendix 2)
Groups
The FSWs at SPC (not discounting efforts by the AR FSW’s) make strategic efforts to advertise, and inform parents about Sure Start groups and events (for example Baby Rhyme Time).

It was proposed from a service-provider level that the AR FSW would benefit from facilitating more groups, placing more of an emphasis on this aspect of the FSW role.

Feedback from parents
Feedback from the carers and service users can help to shape and improve the services on offer. Feedback was evaluated as provided by relevant service-providers and service-users.

From parent’s perspective feedback mechanisms were not in place. Only one respondent was aware that there was any feedback or complaints procedure. Moreover, none of the respondents had ever used the procedure, despite one of the interviewees detailing what they perceived as a bad experience with the service.

Signposting to other services
Focus groups and service-user interviews showed that signposting to other groups worked well. Most service – users were able to list services they had been signposted to. For example: “They recommended me to Loxford Hall for counselling which helped a lot”

Suggestions for Professional Development
Stakeholders in the project suggested a number of areas for professional development for the FSWs.

- **Health development**: For example, provision of infant massage, behavioural intervention. A development in ante-natal work is also considered useful by the FSWs.

- **Mental Health**: For example, training in assessment, such as EPDS which was suggested to support the IMHP. However there are no plans to conduct training in this area in the immediate future as this is not a priority area for development of the FSW’s role.

- **Partnership development**: For example, actively participate in linking services

- **Information dissemination**: For example, ensure parents needs are optimally being met through existing service provision
FSWs identified a benefit in developing their ante-natal work, for which there is a particular need as a result of a midwifery vacancy in the PCT. However as qualified nursery nurses the FSW intervention is based on supporting the relationship between the parent/carer and child, and hence intervention at this stage is outside the remit of the FSW’s role. However improved integration with the mid-wifery service may be advantageous for those clients who are referred to the FSW straight after giving birth.
Unit–Cost analysis

The unit-cost analysis is based on average or approximate data due to the high degree of flexibility of working practice across all services. The unit-cost analysis includes on-costs, such as administration expenditure, capital costs etc.

The cost of one WTE (37.5 hours per week) Family Support Worker (FSW) is directly comparable between Albert Road (£19,752) and PCT (£19,852). However, Albert Road FSW does have 2 days less annual leave comparatively.

South Park Clinic Family Support Worker

Costs are based on total of salary costs £35,555 and on-costs of £4,149 for 2003/2004.

Table 1: Overall breakdown and cost of SPC Family Support Workers Hours per Annum

<table>
<thead>
<tr>
<th>Nature of work</th>
<th>Percentage of time</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach</td>
<td>54</td>
<td>£10,719</td>
</tr>
<tr>
<td>Group/ Clinics</td>
<td>30</td>
<td>£5,956</td>
</tr>
<tr>
<td>Training</td>
<td>9</td>
<td>£1,787</td>
</tr>
<tr>
<td>2 – Month Contacts</td>
<td>5</td>
<td>£993</td>
</tr>
<tr>
<td>Events</td>
<td>2</td>
<td>£397</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100</strong></td>
<td><strong>£19,852</strong></td>
</tr>
</tbody>
</table>

Further breakdown of these costs is shown below.

Outreach

54% of the FSW time is estimated as spent on outreach work. This results in an average cost of £23 per contact (or visit). In addition, associated admin time for each one-to-one is 45 minutes (compared to one hour for AR FSW). This difference may be explained by the more complex nature of the cases seen by AR FSW.

Groups/ Clinics

The SPC FSW spend almost twice the amount of time on groups and clinics as the Albert Road FSW (30% compared to 18%). This reflects the greater number and range of groups run by the SPC FSW as shown in the table below.
Table 2: Breakdown of groups and costs

<table>
<thead>
<tr>
<th>Nature of work</th>
<th>% of time</th>
<th>Cost per Annum</th>
<th>Cost Per group</th>
<th>Av attendance</th>
<th>Cost per contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baby Rhyme Time</td>
<td>9</td>
<td>£1,787</td>
<td>£59 (x 2 FSW)</td>
<td>8</td>
<td>£7.40</td>
</tr>
<tr>
<td>Baby Clinic</td>
<td>9</td>
<td>£1,787</td>
<td>£29</td>
<td>23</td>
<td>£1.30</td>
</tr>
<tr>
<td>Weaning Group</td>
<td>5</td>
<td>£992</td>
<td>£17</td>
<td>5</td>
<td>£3.40</td>
</tr>
<tr>
<td>Three-year Development Assessment</td>
<td>7</td>
<td>£1,390</td>
<td>£22</td>
<td>12</td>
<td>£1.80</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>£5,956</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>

Training
Over the previous year one WTE SPC FSW has spent 9% of their time on training, costing a total of £1,787.

Two-month contacts
One SPC FSW conducts 5 two-month contacts per month on average. This equates to approximately £17 per contact of 1.5 hours.

Events
SPC FSW were involved in five Sure Start events, assuming one day of 7.5 hours for each event, this equates to a total cost of £428.80. This is £85.76 per event.

Albert Road Family Support Worker
Costs are based on total of salary costs £7,425 and on-costs of £870 for 2003/2004.
Table 3: Overall breakdown and cost of Albert Road Family Support Workers (0.42 WTE) Hours per Annum

<table>
<thead>
<tr>
<th>Nature of work</th>
<th>Percentage of time</th>
<th>Total Cost (0.42 x WTE)</th>
<th>Total cost (WTE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach</td>
<td>40</td>
<td>£3,318</td>
<td>£7,901</td>
</tr>
<tr>
<td>Two-month contact</td>
<td>21</td>
<td>£1,742</td>
<td>£4,148</td>
</tr>
<tr>
<td>Groups</td>
<td>18</td>
<td>£1,493</td>
<td>£3,555</td>
</tr>
<tr>
<td>Training</td>
<td>17</td>
<td>£1,410</td>
<td>£3,358</td>
</tr>
<tr>
<td>Other responsibilities (e.g. ad hoc support for HVs)</td>
<td>4</td>
<td>£332</td>
<td>£790</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100</strong></td>
<td><strong>£8,295</strong></td>
<td><strong>£19,752</strong></td>
</tr>
</tbody>
</table>

Further breakdown of these costs is shown below.

**Outreach**

AR FSW run approximately 14 ten-week out-reach courses per annum. Assuming one course is one contact (note: the FSW does extend the duration of the course if necessary however, so this is a maximum figure of contacts and minimum cost) then the cost per course (or contact) is £235, and the cost per session is £23.50.

**Two-month contacts**

AR FSW conducts 3 two-month contacts per month. This equates to £49 per contact. This is relatively expensive compared to the PCT FSW at approximately £17 per contact. There is a query on the accuracy of the data received.

**Groups**

18% of the AR FSW time is spent on running two groups per week, Baby Massage and Literacy & Numeracy. The groups have an average attendance of 3 Sure Start parents. This results in a cost of £16 per group or £5.30 per contact, however, the amount of time spent appears to have been underestimated.

**Training**

As 0.42 WTE the AR FSW has spent a relatively higher proportion of time on training at 17% (compared to 9% of the WTE PCT FSW). Overall training accounts for £1,410 of the FSW costs. However this is expected to be proportionately higher in the first year.
Other HV responsibilities
Other HV responsibilities include outreach referrals and team meetings which costs a total of 332.

Comparative Analysis
Comparative analysis has been conducted to:-

- A comparable Family Support Worker project provided by another Sure Start programme,
- Family support workers studied as part of *Unit Costs of Health and Social Care 2003*

Table 4: Comparative costs of outreach service provision for Family Support Workers

<table>
<thead>
<tr>
<th>Service provided</th>
<th>Family Support Worker - SPC</th>
<th>Family Support Worker – Albert Road</th>
<th>Family Support Worker – Sure Start A</th>
<th>Family Support Worker - Unit Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach – average direct contact cost</td>
<td>£13</td>
<td>£12</td>
<td>£15</td>
<td>£17</td>
</tr>
<tr>
<td>Outreach – average total contact cost (direct &amp; indirect)</td>
<td>£23</td>
<td>£23.50</td>
<td>n/a</td>
<td>£29</td>
</tr>
</tbody>
</table>

(*Note direct contact cost refers to the time spent with client, excluding associated administration costs. These costs are the indirect costs)

Table 5: Comparative costs of group service provision for Family Support Workers

<table>
<thead>
<tr>
<th>Service provided</th>
<th>Family Support Worker - SPC</th>
<th>Family Support Worker – Albert Road</th>
<th>Sure Start A – Toy Library</th>
<th>HV contact clinic - Unit Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group – average cost per FSW per group</td>
<td>£24</td>
<td>£16</td>
<td>£22.53</td>
<td>£60</td>
</tr>
</tbody>
</table>
Future Strategy and Planning

South Park Clinic Family Support Worker

The overlap in roles and responsibilities of the FSW and health visitors (as discussed in the Operational Dimension) has given rise to a range of preferences of how the FSW roles would best develop. A number of stakeholders suggested that it would be beneficial for the FSW to assume more of the health visitor’s conventional responsibilities, and eventually hold client caseloads. This would allow the health visitors to work on a more flexible basis and meet individual needs as they arise across the community. The FSW would also therefore be more pivotal to the care of users.

A number of stakeholders disagree with this preferred direction, not least because of the legal limitations to providing services by this means. With a statutory requirement that children are allocated a ‘named’ health visitor at birth, this automatically gives health visitor’s professional responsibility for individuals, this limits the freedom and flexibility an ‘advanced’ FSW could provide health visitors. The FSW would therefore develop their service in its own right, providing more support services for families and children.

The SPC FSWs have a substantive contract with the PCT, and are currently commissioned by Sure Start. Whilst this does place the FSW in a good position for mainstreaming, there is still a recognised need to demonstrate effective intervention, highlight innovative and best practice and ensure the added-value is recognised by the potential funding organisation.

The services are tailored to meet specific needs within the Loxford Sure Start community and as such, provide an effective preventative service. However, in the light of Children’s Centres and a strong emphasis on integrated working, the FSW role could be augmented through developing partnership working and integration with a wider range of stakeholders.

Whilst this happens to some degree with the Sure Start links, the FSW demonstrate an enthusiasm to become more pivotal in clients care, and this cross-cutting role would ensure optimal service engagement and support integration across the partnership. This need not necessarily impact on the way service are currently provided, but rather would develop an additional focus to the work of the FSWs.
Albert Road Family Support Worker

AR FSW currently holds a larger caseload, and tends to assume more responsibility for clients than the FSWs at SPC. Whilst this does not reflect greater value or amount of work provided by the two roles, it does provide a basic template for the alternative role suggested for the SPC FSWs.

The role of the FSW at AR provides an effective mechanism for providing intensive additional interventions with families. Suggested development of the role is to target it further towards more vulnerable families, assuming greater responsibility for them within the AR Families Centre as a whole.

A further opportunity exists for the AR FSW in extending the amount of group work currently provided. This is demonstrated to be cost-effective if attendance remains high (around 6 parents), indicating a need for increased on-going awareness and referrals. However, this can be negatively impacted by issues of the Sure Start boundaries and restrictions on those accessing the groups.

The ‘boundary problem’ is a nationally recognised issue, but has been specifically identified by those providing the service, and needs an effective resolution to optimise attendance and impact particularly when more targeted work is involved. Best practice examples include establishing minimum levels of attendance at groups (e.g. 75% Sure Start families), to allow for more flexibility or part funding by another agency such as Redbridge Social Services to allow attendance by those outside the Sure Start area. The latter solution would put the project on a good footing for mainstreaming. Alternatively, identification of similar services outside the Sure Start area would help to ensure support for all families in need.

The AR FSW has a substantive contract with London Borough of Redbridge Social Services, and is currently commissioned by Sure Start (similar to the SPC FSWs and the PCT). This also places the AR FSW in a good position for mainstreaming, however, there is still a recognised on-going need to demonstrate the efficacy of intervention, highlight innovative and best practice and ensure the added-value is recognised by the potential funding organisation.
Cost-Benefit Analysis

Whilst the two models of FSW are distinct, this evaluation concludes that both provide a valuable role within the Sure Start portfolio of projects, by effectively impacting on Sure Start objectives and augmenting existing services. As the majority of the support provided is preventative (particularly at SPC), and the social and emotional impacts of the projects are wide ranging, then a rigid, quantitative cost-benefit analysis is impossible. However the evaluation demonstrates a cost-effective service that is strongly aligned with Sure Start objectives, helping to support families’ wider needs and indicating a significant impact on the social and emotional development of parents and children.

The Family Support Worker Project supported by Sure Start Loxford can effectively be categorised into two models of service. This is as a result of the different organisations supporting the two projects; Redbridge PCT (South Park Clinic) and Albert Road Family Centre. Whilst there is a high degree of overlap in the nature of the services provided (emotional and practical support), a differing profile of clients’ needs demands a format and structure of intervention which is significantly different.

South Park Clinic Family Support Workers have a strong preventative and health focus, being employed by the PCT, and almost exclusively working with referrals from the health visiting team. By contrast, the Albert Road Family Support Worker has a strong Social Services emphasis, employed by London Borough of Redbridge and with a majority of referrals received from Social Services. The intervention is more structured, with more formal assessment and ten-week outreach support ‘courses’.

However, the shared nature of the services provided (e.g. outreach, groups) is strongly aligned with Sure Start objectives. The services are tailored to meet specific needs within the Loxford Sure Start community and, as such, add value to existing services. Direct impact of the service in the community on Sure Start objectives is made through the core services provided. The outreach services are cost-effective and show demonstrable impact on parents health and well-being for both models of FSW.

In terms of service development, this indicates both models of service provision are effective (perhaps this is not surprising as both services target similar needs although at differing levels). However there are clear advantages and disadvantages to both. Due to the ad-hoc nature of
the SPC FSW, they have less responsibility for clients, and do not have their own client caseloads. Due to the fairly exclusive nature of their partnership with the co-located health visiting team, these family support workers have less flexibility in the nature of support provided. However closer working creates a more integrated service, with better communication pathways and hence often more targeted, time-effective provision of preventative services.

Contrastingly to SPC, AR FSW have a very structured style of intervention. Whilst this ensures consistency and emotional reassurance for clients, there is less flexibility in the structure and amount of service provision, and hence may be less time-effective, and consequently less cost-effective. However the FSW assumes greater responsibility for clients, indicating a more developed role; allowing increased flexibility in the nature of the support provided through allowing for longer-term intervention.

These two models of service provision are designed to suit the preventative and interventionist natures of AR and SPC FSWs respectively.

In terms of the content of intervention, expansion of professional responsibilities, through increased intervention at the ante-natal stage for mothers, was considered useful in providing extended support and reaching additional need.

Another key method of intervention for the FSWs is groups. Groups can prove a very effective method of providing support to a number of people, and have the added advantage of reducing isolation, encouraging peer support and developing community life. The type and manner of group support provided by the FSW should allow for effective intervention, however current attendance at groups is low, reducing cost-effectiveness. This is to be expected however, as establishing effective groups can take time and focussed awareness-raising. The groups may benefit from added advertising to parents and potential referrers, alongside a relaxation in eligibility criteria.

Beyond direct intervention, added-value is provided through augmenting partnership working between service providers. Whilst this is limited within the wider Sure Start partnership, additional links and signposting have further integrated the Sure Start services (e.g. Infant Mental Health), health visiting role and Social Services.
Appendix 1

Sure Start Targets (PSA’s)

Public Service Agreement Targets are targets which have been set in order to measure Sure Starts’ progress against them.

Objective 1: Improving social and emotional development

In fully operational programmes, achieve by 2005-06 a percent increase in the proportion of babies and young children aged 0 – 5 with normal levels of personal, social and emotional development for their age.

- The target is to improve the personal, social and emotional development of young children aged 0 -5.

Objective 2: Improving health

In fully operational programmes, achieve by 2005-06 a six percentage point reduction in the proportion of mothers who continue to smoke during pregnancy.

- The target is to reduce by 6 percentage points the proportion of women who had a live birth in the measurement period and continued to smoke during pregnancy.

Objective 3: Improving learning

In fully operational programmes, achieve by 2005-06 a per cent increase in the proportion of children having normal levels of communication, language and literacy at the end of the Foundation stage and an increase in the proportion of young children with satisfactory speech and language development at age 2 years.

- Target levels will be set so they aim to narrow gap between children in areas targeted by SSEYCU programmes and children generally.
Objective 4: Strengthening families and communities

In fully operational programmes, to achieve by 2005-06 a 12 percent reduction in the proportion of young children (aged 0–4) living in households where no one is working.

- The target refers to a reduction in the number of children aged 0 – 4 (up until fifth birthday) living in fully operational programme areas that are living in households where no adult of working age is in paid employment.

Service Delivery Agreements (SDA’s)

Service Delivery Agreements support and compliment the PSA targets and objectives. The SDA’s are wider and also contain more specific detail which can effectuate delivery of PSA’s as well as procure other positive benefits.

In order to make it easier for all parents to find the childcare they need when they need it, in particular in the most disadvantaged areas, so that they can work.

Public Service Agreement target for fully operational programmes, by March 2006: a 12% reduction in the proportion of young children living in households where no-one is working.

Sure Start Unit will contribute to the DWP PSA target to reduce the proportion of children in households with no-one in work over the 3 years from Spring 2003 to Spring 2006 by 6.5% and to the joint HMT/DWP PSA target to reduce the number of children in low-income households by at least a quarter by 2004, as a contribution towards the broader target of halving child poverty by 2010 and eradicating it by 2020.

Service Delivery Agreement Targets, by March 2006

1. To create 250,000 new childcare places for at least 450,000 children, (approximately 280,000 children net of turnover) in addition to the new places for 1.6m children to be created between 1997 and 2004.
2. To create 180,000 new childcare places in the 20% most disadvantaged wards (and smaller areas of disadvantage).
3. To create, by 2006, 95,000 new high quality out of school club childcare places for children of school age.

4. To establish Children’s Centres in areas of disadvantage extending core Sure Start services to a further 300,000 children, so that by March 2006 at least 650,000 children have access to Children’s Centre services.

5. To increase the percentage of childcare providers inspected by Ofsted rated as good or better by 2006. \textit{Level to be set by 2004 when Ofsted system in place and initial baseline data available.}

6. To at least double the number of users of the Childcare Link website and local Children’s Information Services.

Objective

Improving learning

\textit{In particular by promoting high quality care and education which supports children’s development and early education, especially in disadvantaged areas and especially through early identification of and support for children with special needs.}

Public Service Agreement for fully operational programmes, by March 2006: Ancrease in the proportion of children having normal levels of communication, language and literacy at the end of the Foundation Stage and an increase in the proportion of young children with satisfactory speech and development at age 2 years.

Service Delivery Agreement targets, by March 2006

7. 95 per cent of Foundation Stage provision inspected by Ofsted rated good or better by 2006.

8. To increase the number of children who have their needs identified in line with early years action and early years action plus of the SEN code of practice and who have either a group or individual action plan in place. \textit{Target percentage increase in number of children to be set by end of 2003-2004 when baseline date available.}

9. To increase the use of libraries by families with young children. \textit{Target percentage increase to be set by 2004 when baseline data available.}
Objective

Improving social & emotional development

In particular in the most disadvantaged areas:

- promoting greater parental understanding of and engagement in children’s development;
- supporting early years and childcare providers in early identification of difficulties;
- increasing the contribution out of school provision makes to older children’s development as citizens.

Public Service Agreement target for fully operational programmes, by March 2006: An increase in the proportion of babies and young children aged 0-5 with normal levels of personal, social and emotional development for their age.

Service Delivery Agreement targets, by March 2006

10. All families with new born babies in Sure Start local programme and Children’s Centre areas to be visited in first 2 months of their babies’ life and given information about the services and support available to them.

Objective

Improving children’s health

By improving awareness of healthy living amongst children and their service providers and, in particular in disadvantaged areas, by helping parents to support their children’s healthy development before and after birth.

Public Service Agreement target for fully operational programmes, by March 2006: a 6 percentage point reduction in the proportion of mothers who continue to smoke during pregnancy.

11. Information and guidance on breastfeeding, nutrition, hygiene and safety available to all families with young children in Sure Start local programme and Children’s Centre areas.
12. Reduce by 10 percent the number of children aged 0-4 living in Sure Start local programme and Children’s Centre areas admitted
to hospital as an emergency with gastro-enteritis, a lower respiratory infection or a severe injury.

13. Ante-natal advice and support available to all pregnant women and their families living in Sure Start local programme and Children’s Centre areas.

**Objective**

**Strengthening families and communities**

*By encouraging all providers of children’s services to take a wider view of their role in the community and, in particular in disadvantaged areas, by involving families in building capacity in the community and creating pathways out of poverty.*

**Public Service Agreement for fully operational programmes, by March 2006: a 12% reduction in the proportion of young children living in households where no-one is working.**

14. An increase in the proportion of families with young children reporting personal evidence of an improvement in the quality of family support services. *Target levels to be set, as percentages for families in disadvantaged areas and in all areas, by end of 2003-2004 when baseline data available.*

15. Local Authorities, Sure Start local programmes and Children’s Centres to have effective links with Jobcentre Plus, local training providers and further/higher institutions.
Appendix 2
Demographic Profile

Age

Graph 1: Age profile of respondents

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Percentage of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 17</td>
<td>4</td>
</tr>
<tr>
<td>18 - 24</td>
<td>17</td>
</tr>
<tr>
<td>25 - 34</td>
<td>58</td>
</tr>
<tr>
<td>35 - 44</td>
<td>25</td>
</tr>
<tr>
<td>45 - 64</td>
<td>8</td>
</tr>
<tr>
<td>65 plus</td>
<td>0</td>
</tr>
</tbody>
</table>
Family status

Graph 3: Percentage pregnant within sample population

- Pregnant: 8%
- Not pregnant: 92%

Graph 4: Lone parent status

- Lone parent: 33%
- Not lone-parent: 67%
Profile of Children

Graph 5: Numbers of children cared for by sample population

[Graph showing the distribution of children cared for by respondents, with categories: One, Two, Three, Four, Five or more, and respective counts: 17, 42, 8, 8, 25. The chart illustrates the percentage of respondents for each category.]
Graph 6: Ages of children cared for by respondents

Graph 7: Level of English comprehension

Additional needs
Graph 8: Children with disabilities or special needs

- Child has no disabilities/special needs: 58%
- Child has some disabilities/special needs: 42%

Service access

Graph 9: Length of time receiving support

- Between 0 and 3 months: 17
- Between 4 and 6 months: 33
- Between 6 months and 1 year: 25
- Between 1 and 2 yrs: 25

Length of time have been receiving FSW service
Graph 10: Frequency of service use

Graph 11: Suitability of length of visit
Graph 12: Suitability of times of visit

Communication

Graph 14: How carers first heard about the FSW service
Satisfaction

Graph 13: Speed of receipt of first time service

Graph 14: Overall satisfaction