Template 1: Budget Initiative template

There are five sections of this template agencies need to fill out:

- Overview and context
- Detail on the investment proposal
- Wellbeing impacts and analysis
- Cost understanding and options
- Collaboration

Overview and context

Key Question/area	Comment/answer
Agency to complete	
Portfolio of lead Minister	Dr David Clark
Portfolio(s) of other Ministers involved (if this is a joint initiative)	Julie Anne Genter
Votes impacted	Health
Initiative title	Increase access to and modernise Child Development Services
Initiative description	This funding will be used to modernise and increase access to child development services. Child development services support children who are not meeting their developmental milestones and have additional needs. These needs may be due to neurodisabilities such as autism, physical or sensory impairments, or other factors that mean they are not achieving their developmental milestones. This funding will improve the outcomes of those children. It will enable them to receive intervention that better responds to their needs in environments where it is most likely to be effective (such as in the home).
Type of initiative	Cost Pressure
If this initiative relates to a priority, please outline the specific priority/ies it contributes to	• Reducing child poverty and improving child wellbeing, including addressing family violence
Does this initiative relate to a commitment in the Coalition Agreement, Confidence and Supply Agreement, or the Speech from the Throne?	**Y/N** If Yes, please specify which agreement/speech and specify the commitment.
Agency contact	Amanda Bleckmann, Manager, Disability Directorate s 9(2)(a)
Responsible Vote Analyst	s 9(2)(a)

Funding

Funding Sought ($m)	2019/20	2020/21	2021/22	2022/23 & outyears[1]	TOTAL
Operating	[redacted]	[redacted]	[redacted]	[redacted]	s [redacted]

1. Executive Summary

1.1 EXECUTIVE SUMMARY

A. Short summary of the proposed initiative and expected outcomes.

This initiative seeks to improve the outcomes of children who are not meeting their developmental milestones and who have additional needs eg, neurodisabilities such as autism and physical/sensory impairments. The Science Advisors have identified positive childhood development as critical for future mental wellbeing and averting poor educational, employment, and justice outcomes.

This initiative seeks funding to modernise and increase access to Child Development Services. Child Development Services is an early intervention, non-medical, multidisciplinary allied health and community based service. It is a service for children who are not achieving their developmental milestones and/or have a disability. This funding will enable children who need specialist intervention to receive timely support, in a way that better responds to their presenting needs, and in environments where it is most likely to be effective (such as in the home). This initiative is required as the current model of Child Development Service is unsustainable and is not meeting the demand for services. Many children are missing out on the provision of services due to significant waitlists.

Funding in the modernised Child Development Service will better reflect the child population. The current proposal (without additional funding) is to re-distribute funding proportionate to the total number of under 19s within DHB areas (recognising it is likely that the modernised service will be a regional service).

This method will mean substantial increases in capacity in s 9(2)(f)(iv) [redacted], and a number of services receiving small changes in current funding. In practice, many of the services facing small changes are already at capacity and have waitlists of up to 18 -24 months.

2. The Investment Proposal

This section asks you to outline your overall investment proposal and intervention logic. It should be supplemented with a one page intervention logic map showing the progression from outputs, outcomes and impacts of the initiative. See template 5 for an example of an intervention logic map that you can use as a template or guide.

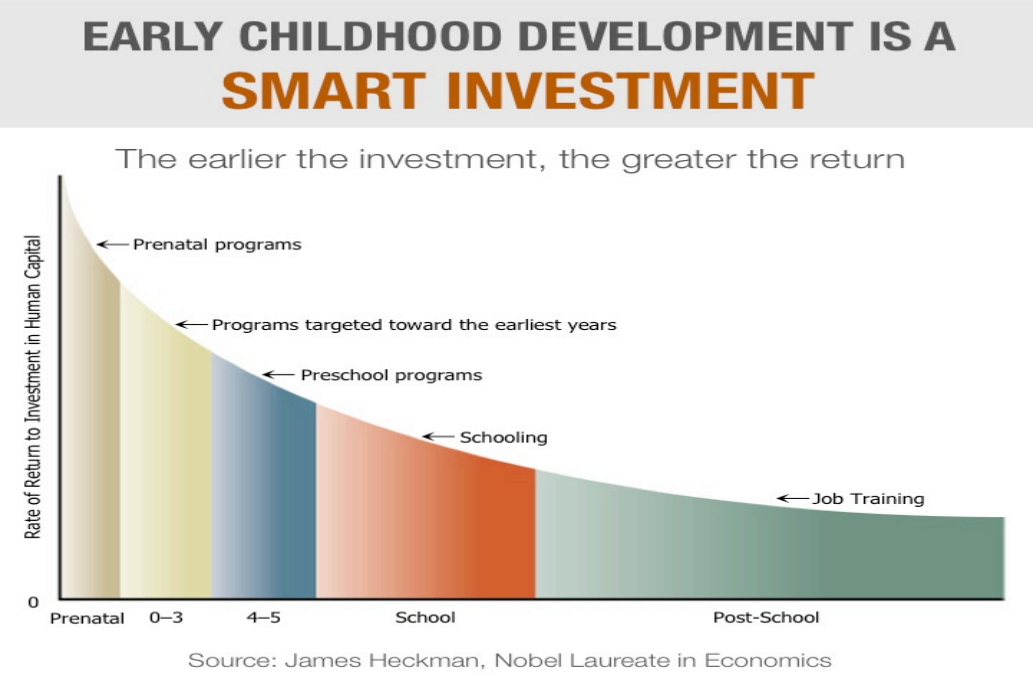
[1] If funding is time-limited and does not carry on into out-years please delete the reference to "& outyears"

What is this initiative seeking funding for?	This funding seeks to improve outcomes for children who are not meeting their developmental milestones and have additional needs. s 9(2)(f) in the first year will enable each of the 31 Child Development Service providers to employ additional FTE to ensure [redacted] o meet current service demand and increase service provision for at least [redacted] more children. Child Development Services are the main specialist response for children under 4 with disabilities or emerging cognitive impairments.[2] The services are nationally contracted by the Ministry, mostly to District Health Boards (DHBs) (although there are 6 NGO providers). They are available to all children and young people experiencing developmental delay, although in practice capacity constraints often mean that access is restricted to those with life threatening needs. This means that most of the current children will have an intellectual, physical, or sensory disability (or all three) with limited ability to make significant gains. Restricted funding (and therefore workforce) makes it is difficult to target support at those children with a lower level of disability but greater ability to benefit. The modernisation of the service would occur by implementing a new service specification and moving all services to an outcomes based reporting model, of which the Ministry will have direct oversight.
Why is it required?	Child Development Services is a cost pressure and service improvement bid. Limited funding over the last decade has resulted in restricted access criteria to services by age and need. Children with high, life threatening needs (eg, inability to swallow) can access the service. However, many children with non-life threatening need (eg, inability to walk and talk at 4 years of age) cannot. Access can depend on location, eg Auckland has had to restrict access to children under 5 with a specific focus on children under 3, whereas Invercargill caters to children under 16. The Heckman equation[3] shows that the highest rate of return in early childhood development comes from investing as early as possible. Starting at age three or four is too late as it fails to recognize that skills beget skills in a complementary and dynamic way. Professor Heckman's work shows that early childhood development directly influences economic, health and social outcomes for individuals and society. Adverse early environments create deficits in skills and abilities that drive down productivity and increase social costs – adding to financial deficits borne by the public. From birth to age five is a critical time to shape productivity. This is when the brain develops rapidly to build the foundation of cognitive and character skills necessary for success in school, health, career and life. Early intervention fosters cognitive skills along with attentiveness, motivation, self-control and sociability – the character skills that turn knowledge into know-how and people into productive citizens. The main principles of the Heckman equation are:

[2] Although the main specialist response for 0-4s, the service specification for CDS allows them to work with children up to 19 years.

[3] https://heckmanequation.org

- Investing in early childhood intervention and education is a cost effective strategy
- Prioritise investment in quality early childhood intervention and education for at-risk children
- Develop cognitive and character skills early. Invest in the whole child
- Provide developmental resources to children and their families



This bid aligns strongly with the child wellbeing work programme. Child Development Services are crucial for ensuring that children are well supported in their first 1000 days, and that **children are thriving socially, emotionally and developmentally in the early years**. Improving Child Development Services will enable children who are not meeting their developmental milestones and who have additional needs to access support early and reduce family stress.

Counterfactual – not increasing funding for the modernised service response

Funding in the modernised CDS will better reflect the child population. The current proposal (without additional funding) is to re-distribute funding proportionate to the total number of under 19s within DHB areas (recognising it is likely that the modernised service will be a regional service).

This method will mean substantial increases in capacity in Auckland and Canterbury, substantial reduction [redacted] in Wellington, and a number of services receiving small changes in current funding. In practice, many of the services facing small changes are already struggling to deliver. For example:

- s 9(2)(g)(i) [redacted]

	• s 9(2)(g)(i) [redacted] • [redacted] • [redacted] • [redacted] A consolidated service would be able to manage some staffing constraints (such as key person loss in a small provider) better, and may create more innovative responses to challenges in rural delivery. However, without an overall funding increase we expect that re-distributing funding based on population will result in some improvements in currently struggling service areas, whilst exacerbating the challenges in others. Specific impacts on the client population groups outcomes' will be estimated further as the bid develops.
What other options were considered in addressing the problem or opportunity?	**Alternative options for Modernisation and increasing access to Child Development Services** Three alternatives were considered: • Integrating further with Ministry of Education early intervention services[4] to streamline capacity use across the two sectors; • Joint commissioning of services with/from Ministry of Education • Devolving the service to DHBs, to achieve greater integration and flexible use of (for example) psychologist capacity in other DHB service areas. *Further integration with Ministry of Education Early Intervention services* The early intervention service is available to children aged 3-5, drawing largely on the same specialist workforce and working in a multi-disciplinary team. There is some potential to manage workforce demands by better integrating the two services. Progress has been made towards integration through the 'Good Start in Life' initiative[5]. However, the variable availability of Ministry of Health funded services,

[4] The Early Intervention Service provides specialist support for children who have a developmental or learning delay, a disability, a behaviour difficulty or a communication difficulty that significantly affects their ability to participate and learn at home or in an early childhood education setting.

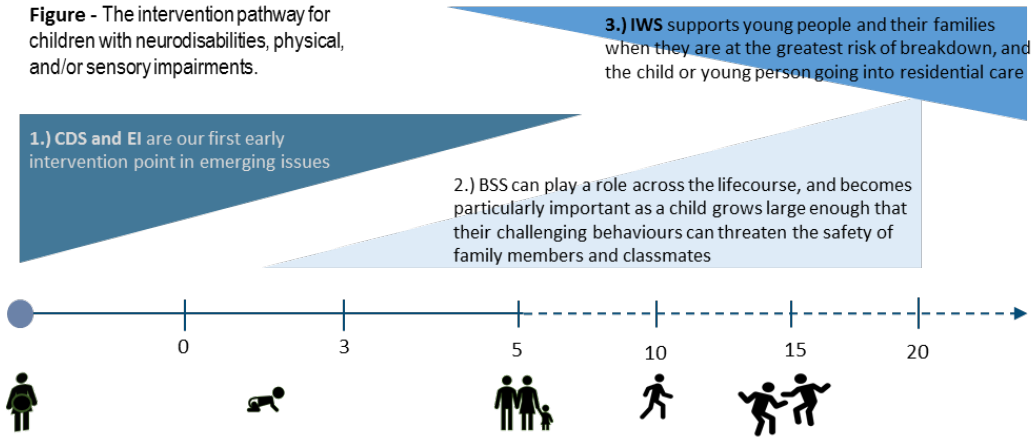
[5] This was developed from the Better Public Services report which included actions aimed at healthy mums and babies and keeping kids healthy. There is a cross agency group that looks at actions to ensure all children get the best start in life possible, Ministry of Health, Ministry of Education and Organga Tamariki are all represented on this group.

	or sometimes absence of service, hampers both the planning and practice of integration. A consistent and reliable Child Development Services is a precondition for achieving greater integration between the two services. *Joint commissioning of services with/from Ministry of Education* Jointly purchasing development interventions with Ministry of Education, or from the early intervention service may better manage capacity challenges. However: • Indications are that there is insufficient funding in Child Development Services to purchase enough 'places' from education to meet existing needs; • Service consolidation across sectors is best considered through the Disability Transformation prototype (Mana Whaikaha) currently happening in MidCentral. *Devolving the service to DHBs* Further integration within the DHBs could theoretically lead to more flexible use of capacity across clinical specialties within the DHB/hospital. However: • Current arrangements where the service is DHB owned and delivered on campus have seldom lead to better integration or more flexible capacity use; • Devolving the service has the potential to see funding re-prioritised away from Child Development Services as an early intervention service and into immediate hospital pressures; and • This would reduce the ability of the Disability Support Transformation to intervene early through Child Development Services in achieving better outcomes for disabled people.
What other similar initiatives or services are currently being delivered?	Developmental services[6], Behaviour Support Services[7], and Intensive Wraparound Services (IWS)[8] each play a role as needs escalate. Behaviour Support Services across education and health have been changed and expanded across the last several years. This initiative will therefore focus on developmental services as early intervention.

[6] Such as Child Development Services

[7] Behaviour Support Services focus on addressing challenging behaviours in disabled children that threaten their ability to participate in ordinary community settings (such as school, or living with their family). Both MoH and MoE fund Behaviour Support Services.

[8] The MoH funded IWS provides support for 40 disabled young people and their families, where the young person is at highest risk of entering residential care. This risk is often exacerbated because challenging behaviours have resulted in family breakdown.



Developmental services

Child Development Services (Ministry of Health)

There are a number of known performance challenges with Child Development Services, including:

- Variable and often inappropriately long wait-times for specialists (2 years to see a Speech Language Therapist or Psychologist in some cases). Inappropriate wait times can result in children falling behind at school or the difficulties they experience compounding.
- Rationing based on clinical severity leading to children at risk of poor downstream cross sector outcomes not being able to access services (for example, where Speech Language Therapists have to prioritise children who can't feed or swallow properly, such that children with communication disorders can't be seen at all, resulting in children with poor or no speech who are therefore disadvantaged in starting school. This affects their learning and their peer relationships).
- Wide regional variation in service accessibility by age (0-2 in some areas, and others well into teens). This variation can create gaps for clients between health and education funded services.

The current variability in service capacity and access has been identified as the single largest barrier to better integration with developmental services funded through education. Resource limitations can also constrain the ability of providers to deliver using best practice models of care, such as working in transdisciplinary teams and working in naturalistic environments such as in the home.

Early Intervention services (Ministry of Education)

The early intervention service provides specialist support for children who have a developmental or learning delay, a disability, a behaviour difficulty or a communication difficulty that significantly affects their ability to participate and learn at home or in an early childhood education setting.

Early intervention service draws on much the same specialities as the Child Development Services. Its focus is working with the adults who spend the most time with the child at the family/whānau's home, an early childhood education setting, or where best suites the parent or guardian. The Early intervention service itself is primarily a consultative one – providing advice and support to parents and ECE teachers as the people best-placed to work with the child, although it does provide some therapy directly to the child.

Behaviour Support Services

	Behaviour Support Services focus on addressing challenging behaviours in disabled children that threaten their ability to participate in ordinary community settings (such as school, or living with their family). Both health and education fund Behaviour Support Services. The recent modernisation of health funded Behaviour Support Services has been shown to lead to increased efficiency in capacity use (with many more children being seen by the service) and a high level of outcome attainment (measured by the level of behavioural goal achievement across a number of social domains). There is an opportunity to expand Behaviour Support Services to reduce strain on families and schools and enable young people to remain living in the community. We are not pursuing this at this time, as the crossover with the expansion of education funded Behaviour Support Services requires further consideration. The successful 2017 education funding bid for additional learning support saw an extra $34.7 million in the provision of specialist behaviour services for an additional 1000 children aged up to 8 years old. **Intensive Wraparound Services** Intensive Wraparound Service (IWS) provides support for 40 disabled young people and their families, where the young person is at highest risk of entering residential care. This risk is often exacerbated because challenging behaviours have resulted in family breakdown.
What other, non-spending arrangements in pursuit of the same objective are also in place, or have been proposed?	None
Strategic alignment and Government's priorities/direction	The modernisation of Child Development Services relates to improving child wellbeing in New Zealand and ensuring New Zealand is the best place in world for children and young people and ensuring that all children are support in their first 1000 days of life.
Overall outcomes expected from this initiative	The single biggest outcome for this initiative is that at least [redacted] children will be supported to reach their developmental milestones to ensure they have the best start in life and are fully supported within their first 1000 days. The impact on early intervention for children identified as having additional needs has been well documented. The earlier support is put in place the more likely it is that they will go on to reach their full potential and that they are fully prepared for the education system. With the current underfunding of services many children are not receiving the support they need. This results in more children starting school with underdeveloped communication skills and in some cases not yet walking. The impact of this on their education is significant. Children with unmet communication needs are more likely to display challenging behaviour which is difficult not only for the child, but also for teachers and other students in the class.

	Addressing the cause of challenging behaviour is much more difficult as children get older. Preventing the behaviour from occurring in the first place through well-developed communication skills is the best approach to ensuring the greatest outcomes are achieved. Early intervention will reduce the long term impacts on this population. Children who receive intensive early childhood intervention are more likely to achieve educational and employment outcomes later in life, as demonstrated by the Heckman equation in section 2. Increasing access to Child Development Services will enable more children with Fetal Alcohol Spectrum Disorder (FASD) to access early intervention. Currently many children with FASD are not meeting the needs threshold for child development services which is resulting in poor life outcomes such as low levels of education, higher suicide rate and high use of the justice system[9]. Enabling early support for this cohort is expected to reduce the impact of these outcomes later in life. New Zealand currently has very limited data on children with FASD, the increase in services would enable more data to truly understand the prevalence of this disorder in New Zealand. Having well supported children will also decrease family stress for affected families. Having a child with additional needs and not receiving the support required has negative impacts on the family such as increased feeling of isolation, increased family breakdown and more children being place in out of home care as a result of this family stress.
How will the initiative be delivered?	In the first year this initiative will see s 9(2)(f) FTE in each of the Child Development Services. The particular requirement for FTE will be dependent on the needs of that service. The Service Specifications will be updated to reflect the requirement for each service to have at least one Speech Language Therapist, one Occupational Therapist and one Child Psychologist. This is a minimum and nearly all services will require more than one of each staff. From previous recruitment processes we are confident that the workforce is available, recruitment may be affected by the other budget bids from the Ministry of Education and Oranga Tamariki. Increasing access to the service can be done immediately following an increase in funding. All child development services will be moved to outcomes based reporting. This means that the Ministry will have more control over what outcomes are being achieved.
How will the implementation of the initiative be monitored?	The initiative will be monitored through outcomes based reporting. This will be done internally at the Ministry to ensure that there is direct guidance on whether the desired outcomes are being achieved.

[9] Thanh TX, Jonsson E. 2009. Costs of fetal alcohol spectrum disorder in Alberta, Canada. Canadian Journal of Clinical Pharmacology 16(1): e80−e90. See also Popova S et al. (2016). Comorbidity of fetal alcohol spectrum disorder: a systematic review and meta-analysis. *The Lancet* 387(10022): 978-987.

[10] This doesn't necessarily have to include a full implementation and evaluation plan, however the information provided must provide confidence that the proposal will be successfully delivered and there is a plan to ensure that the outcomes described are actually achieved.

Describe how the initiative will be evaluated	The initiative will be evaluated based on how many children are accessing the service and average wait times in different regions. Moving the services to outcomes based reporting will enable us to monitor the specific outcomes being achieved. This information will be included in the reporting process and will enable the Ministry to ensure that all outcomes are being met.

3. Wellbeing Impacts and Analysis

3.1 Wellbeing domains – People's experience of wellbeing over time

Identify and quantify how the initiative impacts on wellbeing domains

Please fill in Table 3.1 below. Impacts need to be grouped under the relevant domains, as provided in the key below. Use the relevant domains, ordering them from top to bottom according to which domain your initiative achieves the greatest impact in. This analysis must also capture any negative impacts.

The wellbeing domains are outlined here for you to use in your table:

Civic engagement and governance	Jobs and earnings
Cultural identity	Knowledge and skills
Environment	Safety
Health	Social connections
Housing	Subjective wellbeing
Income and consumption	Time-use
	Other

3.1 Wellbeing domains – People's experience of wellbeing over time

The table below uses an illustrative example of vaccination for children. Please delete the example complete the table for your initiative.

Domains List domains, using the key above, where there is an impact. Order domains by magnitude of impact, i.e. largest impact domain first[11].	**Impact(s) description** Identify the impacts, with a separate line for each impact relating to a specific domain *Note you can identify multiple impacts for a particular domain. Delete/add rows as needed.*	**Who are affected?** Individuals/families/government/etc? Be as specific as possible. Are there distributional differences?	**Magnitude of impact** Relative to the counterfactual key assumptions, quantified to extent possible, and where possible monetised	**How big?** High/ Moderate/ Low, or where possible present value	**Realised** in <5 / 5-10 / 10+ years	**Evidence base** Nature of evidence and key references	**Evidence quality** High/ Medium/ Low
Health Primary	QALY gains	Children	Early intervention and access to services will increase the number of quality adjusted life years for children. This will be experienced through out life as the impact of early intervention creates benefits over the course of a life, including education and employment outcomes.	High	<5 years ongoing	Key source: Heckman equation	High
	Fewer Disability Support Services	Government – Ministry of Health and DHBs	Reduced expenditure in Disability Support Services over the lifetime. Early intervention will reduce the life time costs of Disability Support Services, health services and early education services.It is likely that this will result in a reduction in the need for residential care for young people which has major cost implications for the government	High	5-10 years ongoing	Assumption: CDS will be effective at reducing the level of need in the medium-long term Key source: Heckman equation as outlined in section 2	High
	Improvements in physical and mental health	Children Families	Children would be supported to reach developmental milestones so that they are likely to be in better physical health and experience increased social connectedness leading to increase mental health	High	<5 years ongoing	Assumption: Children will reach developmental milestones with support Key source: Heckman equation as outlined in section 2	High
Safety Secondary	Reduced justice system involvement	Adolescents/young adults	Challenging behaviour is strongly associated with increased use of the justice system. Addressing the cause of the challenging behaviour early in life will reduce the number of young people accessing the justice system. Cost savings to justice system	Med	10+ years	Assumption: Challenging behaviour will reduce as a result of increased support early in life	Medium
Knowledge and skills Secondary	School attendance and learning	Government – schools	Less disruption of schooling. Children are more prepared for the education system through ensuring they have support to reach communication milestones and are able to communicate before starting school. Higher numbers of people achieving NCEA L1 and 2	Med	<5 years ongoing	Key source: Heckman equation as outlined in section 2	High
Social connections secondary	Higher rates of society participation	Individuals Families	Decreased feelings of loneliness due to increased communication skills and increased ability to access their community.	$70m	<5 years ongoing	Costed by 4 point increase in reduction of loneliness	Medium

[11] *Please note that in CFISnet, you will need to include the primary domain impacted, and up to two secondary domains impacted by the initiative. You can include as many domains as relevant in this table.*

3.2 Wellbeing capitals – Sustainability for future wellbeing

Wellbeing capitals	Please fill out the table below to demonstrate how your initiative may contribute positively, negatively or neutrally to the four capitals.

Capitals	**Describe the impact and its magnitude**	**Realised in** <5 / 5-10 / 10+ years
Financial/Physical	**Decrease:** In the short term this initiative will decrease financial capital due to the need to draw down funds to fund the initiative. In the longer term financial capital may improve due to a reduced need for long term Disability Support Services, health and learning support services as a result of this initiative.	<5 years 5-10 years + ongoing
Human	**Increase.** This initiative is focussed on improving individual and family health and wellbeing by increasing early access to support services for children with additional needs. The improved health and wellbeing outcomes will lead to increased educational opportunities with more young people achieving NCEA, able to find employment and less likely to interact with the criminal justice system.	5-10 years + ongoing
Natural	***Maintain**. This initiative has no impact on natural capital.*	N/A, as no impact
Social	**Increase.** This initiative will improve the physical and mental health of children and families, resulting in increased social connectedness and increased participation in social collaboration.	10+ years

3.3 Risk and resilience narrative

Does the initiative respond to or build resilience?	This initiative will build resilience that will assist New Zealand to improve its existing levels of wellbeing. Ensuring all children are supported in their first 1000 days of life will enable more communities to increase levels of diversity and to be more inclusive of vulnerable populations. The evidence of the Heckman equation outlined in section 2, shows that there is strong evidence that early intervention leads to more resilient communities and higher rates of educational and employment achievement. This initiative also responds to the reality that Child Development Services are operating in a manner that does not meet the needs of children in New Zealand and the risk that the service is unsustainable.

4. Costing understanding and options

This section will provide further information on the costs of delivering the initiative and options for scaling and phasing to support assessment, prioritisation and decision-making.

4.1 Detailed funding breakdown

Please provide a breakdown of the costs of this initiative

The funding sought will recruit s 9(2)(f) staff in the first year. This will be a mix of occupational therapists, speech language therapists, physiotherapists and child psychologists. The make-up of each profession will depend on what each individual service currently has and what the needs of the local population are to ensure that the service runs as efficiently as possible.

Updating the service specification will be done in the first year of funding and will be completed within baseline. Discussions with providers on the new specifications has started to ensure that services are prepared for the changes. Outcome based reporting will also begin implementation in the second year. The model for implementation of the new reporting requirements will not need additional resource.

The assumptions underlying these assumptions are that:

- Demand for the service will continue to increase
- The additional FTEs will be able to be recruited within the first year
- Existing IT systems will not need a complete overhaul to implement the new reporting model

($m)	2019/20	2020/21	2021/22	2022/23
FTEs	s 9(2)(f)(iv)			
Updating Service Specification		Within baseline		
Outcomes Based Reporting including infrastructure		Within baseline	Within baseline	
Evaluation				Within Baseline

4.2 Options for scaling and phasing

Scaling, phasing or deferring - including 75% and 50% scenarios	**Scaling Option A – 50%** If 50% of the funding was granted the modernisation and increased access to Child Development Services could be scaled to reflect this. [redacted] additional FTEs would be recruited and the number of new children able to access the service would be reduced to [redacted] It is likely that with this option the additional FTEs would be used to in areas of highest deprivation, rather than an increase across the country. This would also impact on the implementation of the service specification and outcomes based reporting. These would still occur but be at a reduced scale and over a longer period of time. **Scaling Option [redacted] over three years** A scaling option for [redacted] over three years has been considered. This would be broken down into [redacted] in the first year, [redacted] in the second year and [redacted] in the third year. In this option we could develop the existing services within the first year and move all services to an outcomes based reporting model. In the second year we could expand services by investing in [redacted] more FTEs which would be spread out over the country according to population and see an additional [redacted] children receiving services. In the third year the [redacted] would be used to evaluate the change and add extra capacity where needed. **Risks of Scaling** The risks for scaling back this initiative is that more children will continue to not get the support they require early in life. There has been an increase in demand for Child Development Services given the medical advances of recent years which means more babies are surviving with conditions that previously they would not. This trend is unlikely to change in the coming years and we expect demand for the service to continue to grow.

5. Collaboration

5.1 Collaboration and evidence	
What type of cross-agency and/or cross-portfolio initiative is this?	• not a cross-agency and/or cross-portfolio bid where there is collective responsibility, but there are **cross-agency relationships and implications**
Agencies and Ministers that have been engaged in initiative development	Ministry of Education – The Ministry of Education bid for increased investment in early intervention services pre-school children will sit alongside this bid for investment in Child Development Services. Engagement with Ministry of Education focussed on their view of the workforce and the ability to recruit additional FTEs. A draft of this budget bid has been provided to the Ministry of Education. The cross-agency group a Good Start in Life will provide input on the roll-out of additional service capacity to ensure that the most vulnerable children are reached. Oranga Tamariki and the Ministry of Education are both represented on this group. A good Start in Life evolved in response to the Disability Action Plan in 2013. The intent of the group was to ensure that parents, family and whānau, of disabled children were able to access the correct supports and information at the right time and without having to go to multiple places to find the correct support. This group meets regularly to discuss current concerns within the sector and possible responses. A draft of this budget bid has also been shared with Oranga Tamariki. Conversations with Oranga Tamariki will be ongoing as we understand that the lack of provision of services by health has meant that they have had to purchase services privately. We are hopeful that this will decrease with the expanded Child Development Service.
Impact of cross-agency collaboration	The impact of cross-agency collaboration has monitored expectations of the workforce and ensured that the workforce is able to meet demand should all relevant budget bids be approved for funding. The ongoing collaboration between the Ministry of Health and the Ministry of Education will ensure that more children are supported in their first 1000 days.
Risks and challenges	All three agencies are competing for the same workforce. This creates a risk that there will not be enough workforce to meet all the requirements of each agency. There is a challenge in ensuring we clear about how each agency works with the family and the child. Often children with additional needs will be seen by each agency for different things. It is important that the services provided by each agency are implemented in a way that complement each other and work alongside each other – not against each other. This may include having an open and transparent agreement between agencies on the way services will be offered.