



Department
of Health

NHS
England

Public health functions to be exercised by NHS England

Service specification No.27

Children's public health services (from pregnancy to age 5)

April 2013

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Department of Health

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Service specification No.27

This is a service specification within Part C of the agreement ‘Public health functions to be exercised by the NHS Commissioning Board’ dated November 2012 and amended by variation dated April 2013 (the ‘2013-14 agreement’). This service specification thereby comes into effect and supersedes service specification No.27 dated November 2012.

The 2013-14 agreement is made between the Secretary of State for Health and the National Health Service Commissioning Board (“NHS CB” or “NHS England”) under section 7A of the National Health Service Act 2006 (“the 2006 Act”) as amended by the Health and Social Care Act 2012. The 2013-14 agreement may refer interchangeably to NHS CB or NHS England.

This service specification is to be applied by the NHS CB in accordance with the 2013-14 agreement. An update to this service specification may take effect on an agreed date as a variation made in accordance with the 2013-14 agreement.

This service specification is not intended to replicate, duplicate or supersede any other legislative provisions that may apply.

The 2013-14 agreement including all service specifications within Part C is available at www.gov.uk (search for “commissioning public health”).

Introduction

1 Background and context

- 1.1 Giving every child the best start in life is crucial to reducing health inequalities across the life course. The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and well-being, educational achievement and economic status.¹ Universal and specialist public health services for children are important in promoting the health and wellbeing of all children and reducing inequalities through targeted intervention for vulnerable and disadvantaged children and families. Successive reviews have demonstrated the economic and social value of prevention and early intervention programmes in pregnancy and the early years.^{2,3,4,5}

The Universal Offer – the Healthy Child Programme and Health Visiting

- 1.2 The Healthy Child Programme (HCP) is the universal clinical and public health programme for children and families from pregnancy to 19 years of age. The HCP, led by health visitors and their teams, offers every child a schedule of health and development reviews, screening tests, immunisations, health promotion guidance and support for parents tailored to their needs, with additional support when needed and at key times. There is strong evidence supporting delivery of all aspects of the HCP, which is based on *Health for All Children*,⁶ the recommendations of the National Screening Committee, guidance from the National Institute of Health and Clinical Excellence (NICE) and a review of health-led parenting programmes by the University of Warwick.⁷
- 1.3 The Government has committed to improving the health outcomes for children, families and their communities by increasing the number of full time equivalent (FTE) health visitors by 4,200 and implementing an expanded, rejuvenated and strengthened health visiting service by April 2015. The *Health Visitor Implementation Plan 2011-15 – ‘A Call to Action’*, published in February 2011, sets out how this extra capacity will contribute to improved public health outcomes and better personalised care for all families with children under 5. Health visitors, working closely with the NHS, GPs, local government, etc. will provide parents with critical health and development advice, and connect families to the array of health and wider community resources that help them to give their children the best start in life.

1.4 The Implementation Plan clearly set out what all families can expect from their local health visiting service:

- Health visitors will work to develop and make sure families know about a range of services including services communities can provide for themselves.
- A universal service from health visitors and their teams, providing the Healthy Child Programme to ensure a healthy start for children and family, support for parents and access to a range of community services/resources.
- A rapid response from the health visitor team when parents need specific expert help, for example with postnatal depression, a sleepless baby, weaning or answering any concerns about parenting.
- On-going support from the team, plus a range of local services working together and with families, to deal with more complex issues over a period of time. These include services provided by Sure Start Children's Centres, other community providers including charities and, where appropriate, the Family Nurse Partnership.

The Targeted Offer – The Family Nurse Partnership Programme

1.5 The Family Nurse Partnership programme (FNP) is an evidence-based, preventive programme for vulnerable first time young mothers. It is important to note that FNP is a licensed programme and therefore has a well-defined and detailed service model, which must be adhered to. Structured home visits, delivered by specially trained family nurses, are offered from early pregnancy until the child is two. Participation in the FNP programme is voluntary. When a mother joins the FNP programme, the HCP is delivered by the family nurse instead of by health visitors. The family nurse plays an important role in any necessary safeguarding arrangements alongside statutory and other partners to ensure children are protected.

1.6 FNP has a strong body of research evidence developed over 30 years in the USA with evidence reviews consistently identifying it as the most effective preventive early childhood programme for improving the health and development of vulnerable young mothers and their children. FNP is the UK replication of the Nurse Family Partnership Programme, developed by Professor David Olds and colleagues in the USA. At the University of Colorado, three large-scale randomised control trials of the programme have shown a range of benefits for children and mothers over the short, medium and long-term.⁸ FNP has been tested in England since 2007; an independent evaluation of the first 10 pilot sites showed FNP could be implemented well in England, in accordance with the programme model and in the context of the NHS and that the potential for positive outcomes was good. A large-scale

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randomised control trial to assess the programme's effectiveness in an English context is underway and due to report initially in early 2014. In England, the Parenting Programme Commissioning Toolkit has recently evaluated FNP and rated it as having the highest quality of evidence, one of only a few programmes rated at this level.⁹

- 1.7 The Government has committed to increasing the number of places on the FNP programme to at least 16,000 by April 2015. This does not mean the FNP programme will be available to all those who are eligible. At March 2013, this programme covered FNP sites in over 90 upper tier local authorities, and FNP coverage to the eligible population in these areas varies.

Commissioning responsibilities

- 1.8 In 2013/14 and 2014/15, the NHS Commissioning Board (NHS CB) will commission public health services for children under 5 including:
- The HCP from pregnancy and the first five years of life (working closely with NHS Services such as maternity services, general practice, early years settings and with children's social care),
 - Health promotion and prevention interventions by the multiprofessional team,
 - The expansion and transformation of health visiting services and to meet training and workforce trajectories,
 - The Family Nurse Partnership programme, to meet the Government's expansion commitment, and
 - Child Health Information Systems (CHIS) the service specification for which is set out elsewhere in Part C of this agreement.

Responsibility for commissioning these services is expected to transfer to local authorities in 2015.

- 1.9 Public health services for children aged 5 -19, including public mental health for children will be commissioned by local authorities from April 2013. This will include the HCP 5 - 19, health promotion and prevention interventions by the multiprofessional team and the school nursing service. It will be essential to work closely with local authorities to ensure a seamless transition at 5 years.

2 Purpose of the service specification

- 2.1 To ensure a consistent and equitable approach across England, a common national service specification must be used to govern the provision and monitoring of public health services for children under 5.

- 2.2 The purpose of the service specification for public health services for children under 5 is to outline the service and quality indicators expected by the NHS CB and the populations it is responsible for.
- 2.3 This service specification is not designed to replicate, duplicate or supersede any relevant legislation provisions that may apply (e.g. the Health and Social Care Act 2012). The specification will be reviewed and amended in line with any new guidance.
- 2.4 This service specification needs to be read in conjunction with additional guidance and literature (see Section 18) and importantly ‘*The Healthy Child Programme: Pregnancy and the first five years of life*’ (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_118525.pdf), the *Health Visitor Implementation Plan 2011-15: A Call to Action* and supporting health visitor implementation programme documents (<http://www.dh.gov.uk/health/category/policy-areas/public-health/health-visitors-public-health/>), *Health visitor employment: from training to practice – a guide for employers* (<http://www.nhsemployers.org/PlanningYourWorkforce/childrensandfamiliesworkforce/Healthvisiting/Healthvisitoremploymentfromtrainingtopractice/Pages/Healthvisitoremploymentfromtrainingtopractice.aspx>), the FNP Management Manual and the FNP Sub-licensing agreements for Commissioners and Providers given to sites implementing the FNP programme.

Scope, aims, objectives and outcomes

3 Public health for children under 5 service scope

3.1 The service specification covers:

- The child health surveillance, health promotion and parenting support elements of the HCP for pregnancy and the first five years of life.
- The Government's commitment to increase the number of FTE health visitors by 4,200 against a May 2010 baseline of 8,092 and to transform health visiting services by April 2015. This will entail increasing workforce numbers and working closely with Higher Education England to align growth in training capacity in line with annual trajectories produced by the Department of Health. It also includes ensuring that the health visiting service delivers the new service vision encompassing a universal, universal plus, universal partnership plus and community service as set in the *Call to Action*.
- The Government's commitment to increase the number of places on the FNP programme to at least 16,000 by April 2015. This will entail continuing to commission, and expand, FNP in areas currently delivering FNP and increasing the number of areas commissioning the FNP programme.
- National screening programme and immunisation aspects of the HCP as well as CHIS are separately specified elsewhere in Part C of this agreement – screening, immunisation, CHIS service specs. However, increased uptake of screening and immunisation programmes is included as outcomes from these elements of the HCP.

3.2 Other HCP interdependent NHS services that are out of scope are those secondary services that address identified needs including speech and language therapy, infant and parental mental health, NHS safeguarding supervision and advice, primary care, paediatrics, smoking cessation, contraceptive services and maternity provision (in particular antenatal education). HCP interdependent non-NHS services that are out of scope but need to be available are safeguarding, social care, early years education and parenting support.

4 Aims and objectives

4.1 The overarching aim of public health services for children under 5 is to protect and promote the health and well-being of children in the early years.

4.2 The key objectives are to:

- Improve the health and well-being of children and reduce inequalities in outcomes as part of an integrated approach to supporting children and families;
- Ensure a strong focus on prevention, health promotion, early identification of needs and clear packages of support;
- Ensure delivery of a universal core programme to all children and families;
- Identify and support those who need additional support and targeted interventions, for example, parents who need support with their emotional or mental health and women suffering from postnatal depression;
- Improve services for children, families and local communities through expanding and strengthening health visiting services;
- Improve pregnancy outcomes, child health and development (including school readiness and achievement) and economic self-sufficiency for vulnerable first-time young mothers and their children and families through the FNP programme;
- Deliver the increase in the number of health visitors by 4,200 against a May 2012 baseline of 8,092 and to transform health visiting services by April 2015; and
- Deliver the Government's commitment to increase the number of places on the FNP programme to at least 16,000 by April 2015.

5 Health Outcomes

5.1 Children's public health services contribute to the Public Health Outcomes Framework for England 2013 – 2016 (PHOF) which aims "to improve and protect the nation's health and wellbeing and to improve the health of the poorest fastest."¹⁰ Specifically, children's public health contributes to:

- Health Improvement
 - Breastfeeding initiation and prevalence at 6-8 weeks after birth (PHOF 2.2)
 - Child development at 2-2½ years (PHOF 2.5)
 - Excess weight in 4 – 5 year olds (PHOF 2.6)
 - Hospital admissions caused by unintentional and deliberate injuries in under 5s (PHOF 2.7)
 - Access to non-cancer screening programmes (PHOF 2.21 – ref screening service spec)
- Health Protection
 - Population vaccination coverage (PHOF 3.3 - ref immunisation service spec)

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- Healthcare public health and preventing premature mortality
 - Infant mortality (PHOF 4.1)
 - Tooth decay in children aged 5 (PHOF 4.2)
 - Improving the wider determinants of health
 - School readiness (PHOF 1.2)
- 5.2 The Children and Young People's Health Outcomes Strategy will recommend additional outcome measures that will relate to children's public health when it is published in autumn 2012 for future consideration.

6 Population needs

- 6.1 Children's public health services operate at a population and individual level with activities taking place to promote children's health within communities as well as with individuals.
- 6.2 At a population level, commissioners need a systematic, reliable and consistent process for assessing needs that provides the basis for configuring services and allocating resources including delivering the expansion and transformation of the health visiting service, in line with the Government's commitment, and ensuring that new health visitors are effectively supported and deployed.
- 6.3 FNP is targeted at first time young mothers, as this is the group shown to benefit most from the programme, and also whose children are shown to be at high risk of poor developmental outcomes.^{11,12,13,14,15} The NHS CB should agree a commissioning strategy with DH.
- 6.4 For the universal elements of the HCP, assessments should be undertaken in partnership with local agencies as part of the Joint Strategic Needs Assessment (JSNA) and will need to identify sub-populations in the community (e.g. young parents, travellers, refugees / migrants, black and minority ethnic communities, looked-after children, children with disabilities). PREview (<http://www.chimat.org.uk/preview>) is a set of planning resources that can help commissioners, managers and professionals to target preventive resources, in particular around the Healthy Child Programme, where they are most needed. PREview is based on evidence identifying the factors in pregnancy and infancy that are associated with outcomes for children at five years.
- 6.5 For the universal elements of the HCP, at an individual / family level, services should be developed to ensure all those with health needs are identified and then to determine and personalise the particular provision required.

7 Principles

- 7.1 All individuals will be treated with courtesy, respect and an understanding of their needs.
- 7.2 All those participating will have adequate information on the benefits and risks of individual elements of children's public health services to allow parents to make informed decisions before participating.
- 7.3 The target population, for the universal elements of HCP, will have equitable access to individual elements of children's public health services according to need.
- 7.4 For the universal elements of HCP, a flexible approach should be taken to ensure services could target specific vulnerable groups or families and working parents to deliver suitable packages of support.
- 7.5 Safeguarding is at the heart of children's public health. The NHS CB and providers are required to ensure that services are embedded into local safeguarding arrangements with health and local authorities.

Service delivery

8 Service description for the universal elements of the HCP

8.1 The universal elements of the HCP will be delivered by a team led by health visitors working in way that is most appropriate to local public health needs and across a range of settings and organisations including general practice, maternity services and children's centres (except where families are accessing FNP, in which case the FNP nurse – family nurse – will take on this role until the child is two years old). As an overview, core elements of the HCP include:

- **Health and development reviews** – To assess family strengths, needs and risks; provide parents the opportunity to discuss their concerns and aspirations; assess child growth and social and emotional development; and detect abnormalities.
- **Screening** – Screening is an integral part of the universal HCP. Commissioning of national childhood screening programmes is specified separately elsewhere in Part C of this agreement.
- **Immunisations** – Immunisations should be offered to all children and their parents. General practices and child health record departments maintain a register of children under five years, invite families for immunisations and maintain a record of any adverse reactions in the CHIS.¹⁶ At every contact, members of the HCP team should identify the immunisations status of the child. Commissioning of childhood immunisation programmes is specified separately elsewhere in Part C of this agreement.
- **Promotion of social and emotional development** – The HCP includes opportunities for parents and practitioners to review a child's social and emotional development, for the practitioner to provide evidence-based advice and guidance and for the practitioner to decide when specialist input is needed.
- **Support for parenting** – One of the core functions of the HCP is to support parenting using evidence-based programmes and practitioners who are trained and supervised.¹⁷
- **Effective promotion of health and behavioural change** – Delivery of population, individual and community-level interventions based on NICE public health guidance.
- **Sick children** – Supporting parents to know what to do when their child is ill.

- **Children with a disability** – Early diagnosis and early help.

Table 1 outlines the most appropriate opportunities for delivering the universal elements of the HCP.

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Table 1: Schedule of universal elements of the HCP

Review	Description	Delivered by	Commissioned by
Antenatal Review	A full health and social care assessment of needs, risks and choices by 12 weeks of pregnancy Identifying and sharing information about women eligible for the FNP	Midwives or maternity healthcare professionals	CCGs
	Antenatal screening for fetal conditions	Midwives or maternity healthcare professionals Screening services	NHS CB (ref screening service spec)
Antenatal health promoting visits	Includes preparation for parenthood	Health visitors Family nurse (where the family is accessing FNP)	NHS CB expected to move to LAs in 2015
By 72 hours	Physical examination – heart, hips, eyes, testes (boys), general examination and matters of concern	Midwives or maternity healthcare professionals	CCGs
At 5 – 8 days (ideally 5 days)	Bloodspot screening	Midwives or maternity healthcare professionals Screening services	NHS CB (ref screening service spec)
New Baby Review	Face-to-face review by 14 days with mother and father to include: <ul style="list-style-type: none"> - Infant feeding - Promoting sensitive parenting - Promoting development - Assessing maternal mental health 	Health visitors Family nurse (where the family is accessing FNP)	NHS CB expected to move to LAs in 2015

Review	Description	Delivered by	Commissioned by
	<ul style="list-style-type: none"> - SIDS - Keeping safe - If parents wish or there are professional concerns: <ul style="list-style-type: none"> o An assessment of baby's growth o On-going review and monitoring of the baby's health o Safeguarding 		
6 – 8 Week Assessment	Includes: <ul style="list-style-type: none"> - On-going support with breastfeeding involving both parents - Assessing maternal mental health 	Health visitors Family nurse (where the family is accessing FNP)	NHS CB expected to move to LAs in 2015
	<ul style="list-style-type: none"> - Health review and comprehensive physical examination of the baby with emphasis on eyes, heart and hips (and testes for boys) 	GPs (physical examination of the baby)	NHS CB – through primary care commissioning
By 1 Year	Includes: <ul style="list-style-type: none"> - Assessment of the baby's physical, emotional and social needs in the context of their family, including predictive risk factors - Supporting parenting, provide parents with information about attachment and the type of developmental issues that they may now encounter - Monitoring growth - Health promotion, raise awareness of dental health and prevention, healthy eating, injury and accident prevention relating to mobility, safety in 	Health visitors Family nurse (where the family is accessing FNP)	NHS CB expected to move to LAs in 2015

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Review	Description	Delivered by	Commissioned by
<p>By 2 – 2½ Years</p>	<p>cars and skin cancer prevention</p> <p>Includes:</p> <ul style="list-style-type: none"> - Review with parents the child’s social, emotional, behavioural and language development - Respond to any parental concerns about physical health, growth, development, hearing and vision - Offer parents guidance on behaviour management and opportunity to share concerns - Offer parent information on what to do if worried about their child - Promote language development - Encourage and support to take up early years education - Give health information and guidance - Review immunisation status - Offer advice on nutrition and physical activity for the family - Raise awareness of dental care, accident prevention, sleep management, toilet training and sources of parenting advice and family information 	<p>Health visitors</p> <p>Family nurse (where the family is accessing FNP)</p> <p>Clients on the FNP programme for pregnancy to 2 years will move back to receiving universal services. The 2 year review will usually be done prior to this transition.</p>	<p>NHS CB expected to move to LAs in 2015</p>

- 8.2 In addition to the core universal programme, the HCP schedule includes a number of evidence-based preventive interventions, programmes and services. Commissioners will need to work with other services supporting children and families (e.g. local authority partners, local safeguarding and children's boards, Health and Wellbeing Boards, Clinical Commissioning Groups, etc.) to determine which services are offered locally and by whom.

9 The care pathway for the universal elements of the HCP

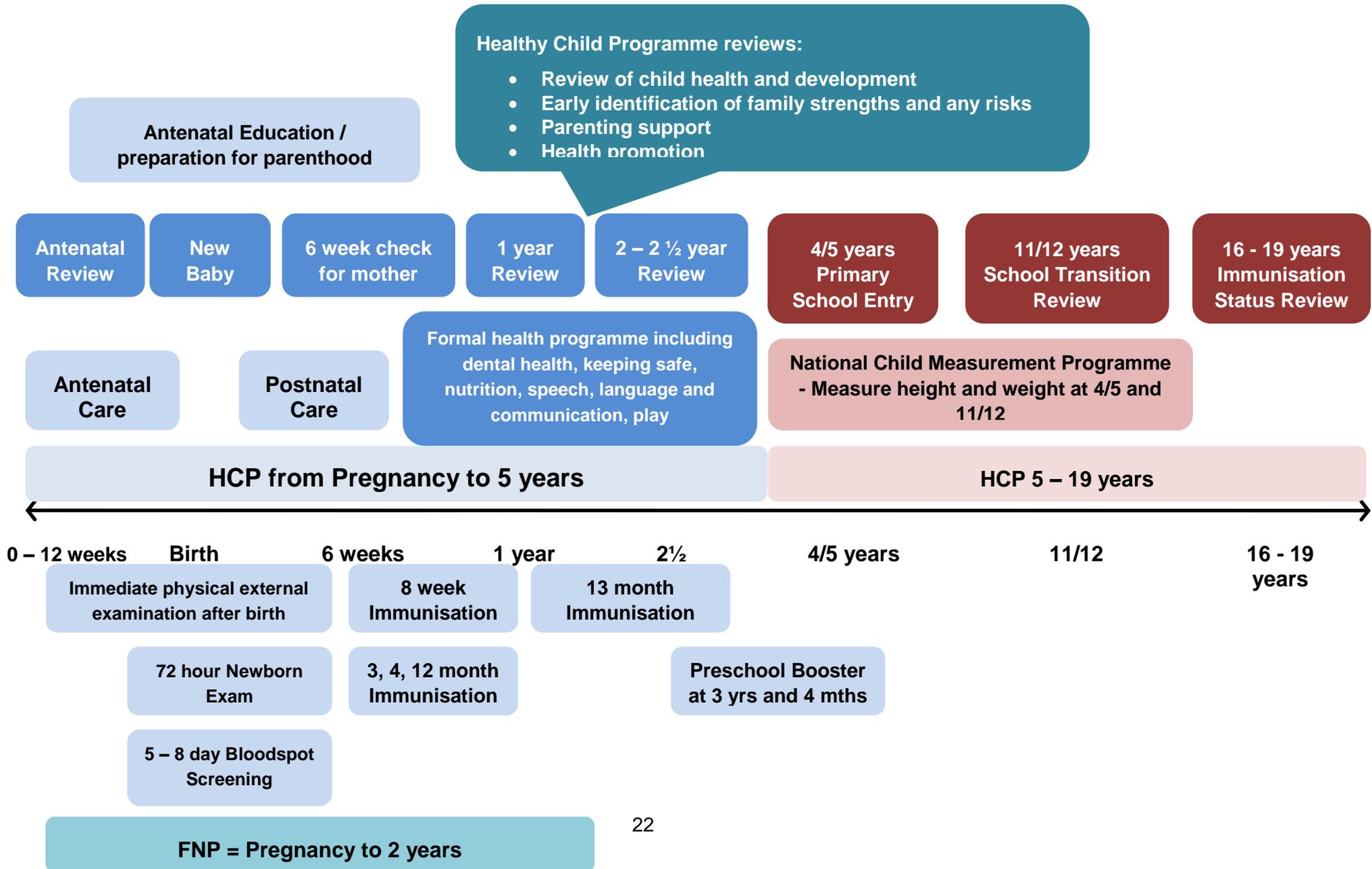
- 9.1 The care pathway for the universal elements of the HCP is outlined below and in Figure 1.

- Following confirmation of pregnancy, women will be signposted to maternity services and a full health and social care assessment carried out. Eligibility for the FNP programme will be assessed at this point in areas where FNP is available and information sharing between service providers to ensure that women receive the antenatal components of the HCP programme.
- There may be a separate preventive care pathway for the most vulnerable children.
- The midwife will be the lead professional for the family until 14-28 days after the birth of the baby ensuring access to the universal and additional aspects of the HCP matched to individual needs of mothers to be and their families.
- Universal provision up to 28 days will include a physical examination of the baby, newborn hearing and blood spot screening.
- The HCP team, led by the health visitor, will make contact with families in pregnancy and offer the HCP to all children and families according to the recommended, evidence-based schedule. Those least likely to access the service will be actively followed-up to ensure equal uptake of all elements of the HCP.
- The GP will deliver aspects of the HCP in particular the screening, surveillance and the immunisation programme, with opportunistic health promotion offered at each contact, deliver evidence-based interventions and make appropriate referrals.
- The health visitor or family nurse will ensure that systems are in place for referral to other services and secondary care.
- Health visitors, family nurses, GPs and children's centres will have systems in place for effective communication, audit and information sharing for all aspects of the HCP.

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- 9.2 Personal Child Health Records (PCHR, also known as ‘the Red Book’) will be given to all women as soon as possible following the birth of their child. The PCHR will be kept by parents and carers and completed by carers and professionals. Copyright for the PCHR is owned by the Institute of Child Health at the Royal College of Paediatrics and Child Health. The Institute designed the national standard and oversee any additions to the content. Copies of the PCHR can be ordered through Harlow Printing. The PCHR can be tailor to include local information for which there is an increased cost.
- 9.3 Professional records will be managed and accessed in accordance with the provider’s record keeping and confidentiality policy. The records will be given to mothers in late pregnancy or very soon after birth (before leaving the maternity unit if born in hospital). The local Child Health Information Department will record information about each child including immunisation status. Information sharing will be in accordance with the Information Sharing Protocol agreed with partner agencies.

Figure 1: The Universal Elements of the Healthy Child Programme



10 Service description and care pathway for the targeted element of the HCP – the Family Nurse Partnership programme

FNP licence and national leadership

- 10.1 The government is committed to increasing the number of places on the FNP programme to at least 16,000 places by 2015. The FNP programme is a licensed programme and therefore has a well-defined and detailed service model, which must be adhered to. The purpose of the licence is to ensure that the programme is implemented as in the original research conditions so as to maximise the likelihood that similar outcomes will be achieved.
- 10.2 The programme is currently led by the DH FNP National Unit, which provides sites with support and guidance for implementation of the programme, delivers the learning programme for family nurses and supervisors, the FNP Information System, quality assurance and improvement processes, networking between sites and the coordination of programme developments and augmentations. From April 2013, these functions will be transferred to a new national delivery partner.

Roles

- 10.3 There will be three bodies involved in delivery of the FNP programme from April 2013. Their individual roles are set out below.
- 10.4 The Department of Health will retain responsibility for the overarching policy for the FNP programme. It will hold the national licence and be responsible for agreeing a sub-licence with the new national delivery partner. Any variations to the licence, and programme augmentations must be approved and developed in conjunction with the new national delivery partner.
- 10.5 The new national delivery partner will be responsible for leading delivery of the FNP programme through providing implementation support and the learning programme as set out in its contract with DH. The role of the new national delivery partner includes providing a quality and improvement process, in line with the FNP licence. When sites are delivering the programme below standard, it will provide intensive support with regular review and follow up. The role also includes research and development, preparing new sites to deliver FNP, agreeing sub-licences with individual FNP sites when they are ready to deliver, and withdrawing licences in the event of on-going failure. It will be required to work in partnership with the other relevant bodies to deliver the FNP programme.
- 10.6 The NHS CB will be responsible for commissioning providers to deliver the FNP programme. The NHS CB should encourage joint commissioning at the

local level and continue joint commissioning arrangements where they are currently in place locally. Going forward, FNP places may also be funded from other sources, which would be additional to places commissioned by the NHS CB. The NHS CB will be responsible for delivering the commitment to increase the number of FNP places available to at least 16,000 places, in line with the agreed commissioning strategy (see section 6.3). It is required to take advice from the new national delivery partner regarding readiness of sites to deliver FNP following a preparation phase and on the quality of delivery and fidelity to licensing requirements across all sites. It will be required to work in partnership with the other relevant bodies to deliver the FNP programme nationally.

FNP target population

10.7 FNP is a voluntary programme, targeted to first time mothers aged 19 and under (at last menstrual period) with the aim to enrol women on the programme as early as possible in pregnancy, ideally before 16 weeks and no later than 28 weeks gestation. Hall and Hall¹⁸ provide further background on the rationale for these criteria. Other specific criteria, regarding geographical location need to be agreed with each site according to predicted population needs; advice can be sought from the new national delivery partner on this. FNP will remain a voluntary programme, working in local areas which have the capacity to deliver it well.

Aims

10.8 FNP shares the over-arching aims of the HCP to reduce inequalities in outcomes and to ensure a strong focus on prevention, health promotion and early identification of needs. It has additional specific aims, which are to:

- improve the outcomes of pregnancy by helping young women improve their ante-natal health and the health of their unborn baby;
- improve children's subsequent health and development by helping parents to provide more consistent competent care for their children; and
- improve women's life course by planning subsequent pregnancies, finishing their education and finding employment.

Service description

10.9 The FNP programme consists of structured home visits from early in pregnancy until the child is two, delivered by family nurses. The visits cover the six domains of personal health, environmental health, life course development, maternal role, family and friends and health and human services. The nurses use licensed programme guidelines, materials, methods and practical activities to work with the mother as well as the father and wider

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family, on understanding their baby, making changes to their behaviour, increasing their parenting capacity, developing emotionally and building positive relationships. FNP is based on the theories of human ecology, attachment and self-efficacy.

- 10.10 FNP is delivered in an integrated way with maternity, general practice, community health services, health visiting, children's centres, Job Centres and third sector providers within the context of integrated children's services and the HCP.
- 10.11 The service will be flexible and responsive, adapting to the individual needs of children and families whilst ensuring fidelity to the licensed FNP programme model.

Expectation of providers

- 10.12 The provider will deliver the implementation and delivery requirements for the FNP programme as set out in the FNP Sub-licensing Agreement for Providers and the FNP Management Manual. These documents are made available to prospective local sites.
- 10.13 Providers will be expected to have systems in place for early recruitment of young women (before 16 weeks gestation) to maximise the enrolment of eligible clients in early pregnancy, enabling them to get maximum benefit from the programme (see section below on recruitment pathways).
- 10.14 Providers will be expected to have clear operational standards in place, in relation to how the FNP interfaces with, and relates to, all of the agencies supporting the delivery of the HCP. Providers will also be expected to have pathways in place for families moving from FNP to universal HCP and children's services. Providers will be expected to provide strong organisational leadership and support so the FNP programme can be delivered well in their area.
- 10.15 Family nurses will work in partnership with parents using the FNP guidelines, other programme materials and methods to enable mothers and fathers to increase their knowledge and understanding, set goals, make behaviour changes and develop their reflective capacity. This will enable them to build strong attachments with their baby, enhance their self-efficacy, develop effective strategies for good infant and toddler care-giving, strengthen and adapt to their parenting role.
- 10.16 Each site is required to recruit an FNP supervisor to lead the clinical implementation of the FNP programme with families. The FNP supervisor is responsible for the quality of programme delivery, using the FNP information system to support their assessment and improvement of implementation quality.

Service model

- 10.17 FNP will be delivered by a team of trained family nurses, led by the FNP supervisor and accountable to the local FNP Advisory Board. The FNP Advisory Board consists of senior decision makers for children and young people's services from the NHS, Local Authority and appropriate partner services. This strategic management group leads, plan, supports and sustains the delivery of the FNP programme locally. FNP will be delivered with fidelity to the FNP model, and meeting the programme's core model elements and fidelity goals as set out in the license agreement.
- 10.18 Programme of FNP visits
- 1 per week first month
 - Every other week during pregnancy
 - 1 per week first 6 weeks after delivery
 - Every other week until 21 months
 - Once a month until age 2
- 10.19 Visits last approximately one hour and cover the following domains:
- Personal health – women's health practices and mental health
 - Environmental health – adequacy of home and neighbourhood
 - Life course development – women's future goals
 - Maternal role – skills and knowledge to promote health and development of their child
 - Family and friends – helping to deal with relationship issues and enhance social support
 - Health and human services – linking to other services
- 10.20 The provider will implement the programme in accordance with the FNP Sub-licensing agreements and the expectations set out in the latest FNP Management Manual, provided by the FNP National Unit (by the new national delivery partner from April 2013); this includes providing local safeguarding arrangements.

Recruitment Pathway

- 10.21 Those eligible will be identified by maternity services and notified to the FNP supervisor at 12 weeks gestation or earlier as far as possible. Clients must be enrolled on the programme no later than 28 weeks gestation with a specific fidelity goal to enrol at least 60% by 16 weeks gestation. Other services (e.g. GPs, education, children's centres) are able to identify and refer potential clients to FNP. Offer of the programme and recruitment will be carried out by

the FNP team. FNP teams are expected to enrol clients onto the programme using a staged approach. Appointments will be generated for attendance at immunisations, screening tests and health reviews. Children/families who do not attend will be actively followed up by the family nurse.

Care Pathway

10.22 The following is an outline of the FNP care pathway:

- First time young mothers aged 19 and under will be offered FNP as part of the preventive pathway within the HCP. Young mothers enrolling on the programme will be visited by the same family nurse until the completion of the programme when the child is 2 years of age.
- The programme will be delivered to young mothers within the context of the immediate and extended families involving fathers and grandparents.
- Young mothers who accept the programme will receive structured visits from the family nurse in line with the FNP programme model.
- The family nurse will work closely with the midwives who will be responsible for the young mother's midwifery care.
- Babies born into the programme will receive the HCP as part of the FNP. The family nurse will deliver the HCP and is responsible for ensuring access to the physical examination, newborn hearing screening, blood spot screening and immunisations.
- Before children reach the age of two years, the family nurse will notify the health visitor lead for the HCP team, and agree future service delivery. Families will be supported to access wider children's services to meet their individual needs.
- The FNP Supervisor will have systems in place for effective communication, audit and information sharing for all aspects of the FNP with midwives, social care, health visitors, GPs and children's centres.
- Young mothers who choose not to enrol on FNP will be notified back to the midwife who will continue to coordinate care for the family until 14-28 days after the birth of the baby ensuring the young mother has access to the universal and progressive aspects of the HCP.
- Every effort will be made by the family nurse to ensure continued engagement of the client in FNP. Clients who leave the programme before their child is 2 years old will be notified to the health visitor who is responsible for universal services, ensuring access to preventive services and to others providing the HCP (eg GPs). FNP teams will follow the new national delivery partner's guidance and local guidance regarding clients

who cannot be traced and will act to safeguard the child or other family members where risks are identified requiring further actions.

- Family nurses and supervisors will use the FNP Information System to record data about their clients and use this to inform how they deliver the programme.
- Where the FNP client has a second child during the time of her involvement with FNP, the family nurse will be responsible for delivery of the HCP to the family for the second child, in addition to the first, until the first child reaches the age of 2 years.

Discharge Criteria and Planning

- 10.23 Discharge from FNP is age related. A client graduates from the programme when the child reaches 2 years of age and responsibility for HCP delivery is transferred back to universal services at this point. The programme includes materials and activities to prepare the client for the end of the programme and the family nurse will have introduced the client and her child to local services before this time.
- 10.24 Before children reach the age of two years the family nurse will notify the health visitor lead for the HCP team and discuss the handover process with the client.
- 10.25 Families will be supported to access children's centres and the HCP matching services and interventions to their individual needs.
- 10.26 When a child and family leave the area, there will be a clear local protocol in place to ensure continuity of services for the family. This may include the client continuing to access FNP from another FNP team or continuing to provide the FNP programme into another local area.
- 10.27 Family nurses will continue to make all efforts to locate clients who cannot be found and persist in their efforts to re-engage clients who indicate that they no longer wish to receive the programme, either directly or by repeated missed visits.
- 10.28 Once 6 months has passed with no client contact, the client will be classified as being an 'inactive' case on the nurse's caseload and the nurse can re-recruit to that vacancy. Inactive clients can subsequently return to the programme if they wish and if there is capacity in the FNP team.
- 10.29 If a client with significant risk or safeguarding factors is not receiving programme visits for any reason, local safeguarding processes should be implemented.
- 10.30 Young mothers who choose not to accept FNP will be notified to the midwife who will continue to coordinate care for the family until 14-28 days after the

birth of the baby ensuring the young mother has access to the universal and progressive aspects of the HCP.

11 Service Integration

11.1 As an early intervention and surveillance programme the HCP relies on the following systems that are out of scope of this service specification being in place:

- Joint planning and monitoring of child health outcomes and HCP delivery with local authorities (social care, early years and public health) and general practice, in particular to ensure a seamless transition at age 5.
- Integrated pathways of care with maternity, school health and other services such as those for disabled children.
- Referral pathways to other NHS secondary care services that address identified needs including speech and language therapy, infant and parental mental health, NHS safeguarding supervision and advice, primary care, paediatrics, smoking cessation contraceptive services and maternity services.
- Referral pathways to non-NHS services including safeguarding, social care, children's centres, early year's education and parenting support.
- Information sharing agreements with wider health and local authority services.

A number of tools are available to help providers and commissioners to enhance and extend joint working practices and improve outcomes for children and their families.¹⁹

12 Workforce

Health visitors

- 12.1 In May 2010, the Government committed to an increase in health visitors of 4,200 full-time equivalents (FTE) by April 2015 against a baseline of 8,092.
- 12.2 The Health Visiting Implementation Plan: A Call to Action – 2011-15 (Feb 2011) set out the Government's commitment to a larger, re-energised health visiting service to deliver a new model of support to families, building on the Healthy Child Programme.
- 12.3 To successfully deliver service expansion and improvement, it is important that all delivery partners are clear about shared expectations until 2015 and that the NHS CB ensures that new health visitors coming through the expanded training pipeline are effectively supported and deployed to meet the Government's commitment.

12.4 The Department of Health will retain policy responsibility for health visiting, however, from April 2013 service delivery will be the responsibility of the NHS CB and as such, it will provide assurance on the following arrangements:

- Health visitor workforce numbers by FTE using data from the Electronic Staff Record (ESR) and health visitor numbers not captured by ESR using data from the Health Visiting Minimum Data Set (HV MDS) (Please note that neither bank nor agency staff are captured by ESR and neither were counted in the May 2010 baseline. Therefore, bank and agency staff should not be included in any part of the return.)
- Delivery is closely tracked in line with agreed plans and progress in all areas in growing the workforce, including training commissions and return to practice towards the additional 4,200 extra health visitors by 2015. This will include work to ensure health visitor training, which from April 2013 will be commissioned by Local Education and Training Boards overseen by Health Education England, is aligned with commissioning of services. The Department of Health has worked with NHS Employers to produce a guide for planners, commissioners and employers of health visitors, which outlines an approach that has proven successful when seeking to grow sections of local NHS workforces in the past by offering employment at the point of recruitment to training. *Health visitor employment: from training to practice – a guide for employers* describes the employment model, its benefits and how to implement in local areas. This offers a model of practice for those who need it and can be found on the NHS Employers website at:
<http://www.nhsemployers.org/Aboutus/Publications/Documents/Health-visitor-employment-from-training-to-practice.pdf> .
- Extended coverage of local delivery of the Healthy Child Programme during 2013/14 and 2014/15 is demonstrated, moving towards delivering a full, universal service offer across England by April 2015.
- Effective support and deployment of health visitors by ensuring adequate and consistent provision of Practice Teachers. Practice Teachers should have sufficient time for teaching, assessment and overview of clinical placements for all health visitor students. In addition, Practice Teachers should be available to provide support to all newly qualified health visitors, whose contribution is regularly quality assured.
- Focus around building service transformation through sharing current good practice, peer review and building local communities of practice. Fully using Early Implementer Sites to help shape and lead this service transformation.
- Close working with partners and stakeholders to the health visiting agenda, including children centres, local authorities, Health and Well-

being Boards, Clinical Commissioning Groups, GPs and wider early year's staff. Moving to a model of partnership working around service delivery and developing joint planning arrangements.

- 12.5 It is vital to delivery of this Government's commitment that the service continues to drive both the transformation of what health visitors do on the ground as well as delivery of the workforce and training trajectories. A centrally modelled indicative trajectory is at Annex A together with a table with a regional breakdown of agreed workforce and training numbers for 2012/13 to 2015 is included as an annex to this letter.

FNP Teams

- 12.6 The NHS CB will be responsible for increasing the number of FNP places to at least 16,000 by 2015 (see section 10.6), and as a result additional family nurses will be needed by 2015. Family nurses can deliver the programme to a maximum caseload of 25 eligible families per full time equivalent, in accordance with the licence requirements.
- 12.7 Currently, the DH FNP National Unit provides access to the FNP learning programme for all family nurses and FNP supervisors; the new national delivery partner will take on this role from April 2013. The FNP clinical learning programme is a combination of large trainings to introduce FNP in pregnancy, infancy (including PIPE – Partners in Parenting Education) and toddlerhood, smaller trainings for specific technical areas of FNP (The Dyadic Assessment of Naturalistic Caregiver-child Experiences (DANCE), and FNP communication skills) and team based learning facilitated by supervisors. The face-to-face training elements of the programme amount to 19 days spread over 15 months.
- 12.8 The FNP supervisor is responsible for leading the local FNP team, clinical and safeguarding supervision, management of the family nurses, meeting their learning needs and team functioning. Supervisors are provided with a 12-month programme of training from the DH FNP NU (new national delivery partner from April 2013) which enables them to undertake their multi-faceted role competently. This includes mentoring from a regional lead supervisor and training in safeguarding supervision.
- 12.9 Implementing sites are responsible for ensuring that they appoint practitioners who meet the expectations of the standard job description and person specifications for the programme. They are also responsible for ensuring that family nurses and supervisors access their FNP learning and training programmes and any additional HCP learning they require. The FNP supervisor will manage the FN's team based learning and achievement of FNP competencies and the provider lead will ensure that the supervisor achieves the FNP supervisor competencies.

13 Locations of Service delivery

- 13.1 Parents will be offered a choice of locations for visits which best meet their needs, e.g. GP surgeries, children's centres, community health services, the home, health centres, etc.
- 13.2 Locations must be easily accessible for all children and families who live in the local vicinity (including accessible by public transport and at times appropriate to the user), children and young family friendly, suitable for multi-disciplinary delivery of services in both individual and group sessions and be conducive to flexible availability (e.g. early mornings, lunchtimes, after school, evenings or weekends).
- 13.3 Specific details are to be agreed locally following engagement with relevant interested parties and feedback from users. Reviews should be taken periodically to ensure the locations are suitable to local needs.
- 13.4 For FNP specifically:
 - FNP is a home based visiting programme, however family nurses will be expected to be able to offer parents a choice of location where this is most appropriate e.g. GP surgeries, children's centres, community health services, extended schools, health centres, café etc.
 - Subject to local determination, it is expected that family nurses will follow their clients across organisational boundaries, when feasible, to maintain engagement in the programme.
 - Hours of operation need to fit around the needs of mothers and fathers, and providers are expected to support nurses to work 'out of hours'.
 - The team will need access to an N3 connection (an NHS secure broadband network, through which NHS information systems are delivered and accessed) in order to access the FNP Information System and consideration should be given to hot-desking, mobile, and working requirements.

14 Materials, tools, equipment and other technical requirements

- 14.1 HCP Team professionals will require access to:
 - Validated tools for assessing development;
 - IT systems and mobile technology for recording interventions and outcomes in the CHIS;
 - Equipment for measuring children's weight, height and head circumference; and
 - Use of social networking and other web based tools to enable workforce training and information and support for parents.

- 14.2 FNP sites will provide the equipment, materials and IT systems necessary for implementation of the programme, as set out in the FNP management manual. In addition, sites will identify and provide any additional functionality to ensure local expectations for record-keeping, reporting or additional HCP requirements are met.

15 Record keeping, data collection systems and information sharing

- 15.1 In line with clause 21 Service User Records and clause 27 Data Protection and Freedom of Information, providers will ensure that robust systems are in place to meet the legal requirements of the Data Protection Act 1998 and the safeguarding of personal data at all times.
- 15.2 In line with the above and following good practice guidance, the provider will have agreed data sharing protocols with partner agencies including other health care providers, children's social care and the police to enable effective holistic services to be provided to children and their families.
- 15.3 The PCHR will be kept by parents and carers and will be completed routinely by both them and professionals working in the provider service.
- 15.4 Appropriate records will be kept in the CHIS to enable data collection to support the delivery, review and performance management of services
- 15.5 Providers will ensure that all staff have access to information sharing guidance including sharing information to safeguard or protect children.
- 15.6 For health visiting specifically:
- FTE health visitor workforce numbers are reported using data from the Electronic Staff Record (ESR) and non ESR sources, in line with agreed definitions of the Health Visiting Minimum Data Set (HV MDS) (Please note that neither bank nor agency staff are captured by ESR and neither were counted in the May 2010 baseline. Therefore, bank and agency staff should not be included in any part of the return.)
- 15.7 For FNP specifically:
- Providers will be expected to have in place mechanisms for the systematic collection of high quality data to meet the core fidelity requirements of data collection for the FNP programme. Use of FNP data forms and the FNP information system (FNP IS) are central to this requirement and can be accessed via a web-based interface using the N3 network and NHS Open Exeter Portal.
 - Family nurses will be required to keep and review records to monitor fidelity to the programme, visit content and for evaluation.

- The supervisor will monitor the collection of the data and ensure its use as a clinical tool.
- The supervisor will generate reports on programme delivery using the FNP IS that are to be used with the team and the FNP Advisory Board to improve and maintain the quality of the programme.
- The FNP team will use local CHIS to record information about each child including immunisation status.
- Family nurses and supervisors will be required to collect high quality data as set out in the programme guidelines and input this into the FNP IS. They will use this to monitor fidelity to the programme and inform continuous quality improvement of programme delivery.
- The FNP team will use local CHIS to maintain clinical records.

16 Resources and efficiencies

- 16.1 *'Currency Options for the Healthy Child Programme – Transforming Community Services'* is a tool; that commissioners can use to develop a transparent approach to paying for these services.²⁰ This document sets out the currency options for community service elements for the first part of the HCP from pregnancy to 5 years of age. Pricing should be carried out locally, based on variables such as deprivation and local need, so that currencies can then be applied to understand required levels of funding.
- 16.2 Opportunities for cost efficiencies include:
- Matching resources to population and individual according to need using evidence-based tools such as PREview;
 - Appropriate use of skill mix;
 - Effective use of new and mobile technologies to communicate with parents and across agencies and thereby maximise the time spent by health professionals directly supporting parents;
 - Integrated working with local authorities and wider health services;
 - Peer and group based methods; and
 - When considering cost efficiencies for FNP, essential requirements detailed in the FNP license and service specification need to be carefully considered.

17 Contribution of NHS CB in commissioning public health services for children under 5

- 17.1 The NHS CB can add value and indicate success / progress in public health services for children under 5 by:

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- Ensuring continuity of services to families;
- Ensuring sustainability of the HCP, health visiting and the FNP programme by preparing local systems for transfer to local authorities in 2015 by engaging local commissioners in the HCP from 2013 onwards;
- Ensuring continued expansion and transformation of the health visitor workforce, and expansion of the FNP programme until April 2015;
- Ensuring coherence across the system aligning screening, immunisation, the FNP programme, general practice, and the HCP;
- Ensuring population needs assessment and resource allocation addresses inequalities in service provision and outcomes - this includes working with the DH to agree an FNP commissioning strategy (see section 6.3);
- Ensuring children, young people and families are themselves engaged in local commissioning processes for CPH 0- 5;
- Ensuring through commissioning, local data transfer between maternity services, HCP, FNP and local authorities as appropriate;
- Using NHS CB mechanisms and partnerships to align the systems for quality and outcomes (workforce, funding, planning and standards); and
- Focusing on national Public Health priorities.

18 National service standards and guidance

18.1 The Healthy Child Programme – Pregnancy to 5 years was developed nationally and is based on relevant evidence bases. Full details can be found within:

- Healthy Child Programme – Pregnancy and the first five years of life (DH, 2009 – amended August 2010)
- Healthy Child Programme – The two year review (DH, 2009)

18.2 The evidence base and key policy documents include:

- The Children and Young People’s Health Outcomes Strategy (DH, 2012)
- Allen, G. (2011a) Early Intervention: The Next Steps. HM Government: London
- Allen, G. (2011b) Early Intervention: Smart Investment, Massive Savings. HM Government: London
- Field, F. (2010) The Foundation Years: preventing poor children becoming poor adults. HM Government: London.
- Health visitor implementation plan 2011-15: A call to action (DH, 2011)

- The Operating Framework for the NHS in England 2012/13 (DH, 2011)
- The NHS Outcomes Framework 2012/13 (DH, 2011)
- Improving outcomes and supporting transparency, Part 1: A public health outcomes framework for England, 2013-2016 (DH, 2012)
- Improving outcomes and supporting transparency, Part 2: Summary technical specifications of public health indicators, (DH, 2012)
- The Marmot Review (2010) Strategic Review of Health Inequalities in England, post-2010 (Available at <http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report>)
- Dame Clare Tickell (2011) The Early Years: Foundations for life, health and learning – An Independent Report on the Early Years Foundation Stage to Her Majesty’s Government (Available at <http://www.education.gov.uk/tickellreview>)
- Hall D and Elliman D (2006) Health for All Children (revised 4th edition). Oxford: Oxford University Press.
- Service vision for health visiting in England (CPHVA conference 20-22 October 2010)
- Equity and excellence: Liberating the NHS (DH, 2010) and Liberating the NHS: Legislative framework and next steps DH, 2011)
- Achieving equity and excellence for children. How liberating the NHS will help us meet the needs of children and young people (DH, 2010)
- Getting it right for children and young people : Overcoming cultural barriers in the NHS so as to meet their needs (DH, 2010)
- Healthy lives, healthy people: our strategy for public health in England (DH, 2010) and Healthy lives, healthy people: update and way forward (DH, 2011)
- Healthy lives, healthy people: a call to action on obesity in England (DH, 2011)
- UK physical activity guidelines (DH, 2011)
- Working Together to Safeguard Children (DFES 2010)
- The Foundation Years: preventing poor children becoming poor adults. The report of the Independent review on Poverty and Life Chances (HM Government, 2010)
- Fair Society, Healthy Lives. A strategic review of health inequalities in England post 2010 (The Marmot Review, 2010)

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- Reaching Out: Think Family Analysis and themes from the families at Risk review (Social Exclusion Task Force, 2007)
- Healthy Lives Brighter Futures: The Strategy of Children and Young People's Health (DH, 2009)
- You're Welcome quality criteria: Making health services young people friendly (DH, 2007)
- The National Service Framework for Children, Young People and Maternity Services (DH, 2004)

18.3 The evidence base and key policy documents for the FNP include:

- Ball, M. et al (2012) Issues emerging from the first 10 pilot sites implementing the Nurse Family Partnership home-visiting programme in England. London, Department of Health
(<https://www.wp.dh.gov.uk/publications/files/2012/08/3-Birkbeck-Final-Issues-Evaluation-Report-For-Publication-July-2012.pdf>)
- Barnes, J. et al (2008) Nurse-Family Partnership Programme: First Year Pilot Sites Implementation in England, London DCSF.
(<http://education.gov.uk/publications/standard/publicationDetail/Page1/DCSF-RW051>)
- Barnes, J et al (2009) Nurse-Family Partnership Programme: Implementation in England – Second Year in 10 Pilot Sites: the infancy period. London DCSF.
(www.education.gov.uk/research/data/uploadfiles/DCSF-RR166.pdf)
- Barnes, J. (2011) The Family-Nurse Partnership Programme in England: Wave 1 Implementation in toddlerhood and a comparison between Waves 1 and 2a implementation in pregnancy and infancy
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- Department of Health (2011) FNP Evidence Summary Leaflet, Department of Health - FNP National Unit
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(<http://dera.ioe.ac.uk/6740/1/DCSF-RW022.pdf>)

18.4 Key NICE public health guidance include:

- PH6 - Behaviour change at population, community and individual level (Oct 2007)
- PH9 - Community engagement (July 2010)
- PH11 - Maternal and child nutrition (March 2008)
- PH17 - Promoting physical activity for children and young people (Jan 2009)
- PH26 - Quitting in smoking in pregnancy and following childbirth (June 2010)
- PH21 - Differences in uptake in immunisations (Sept 2009)
- PH12 - Social and emotional wellbeing in primary education (March 2008)
- PH27 - Weight management before, during and after pregnancy (July 2010)
- PH28 - Looked-after children and young people: Promoting the quality of life of looked-after children and young people (October 2010)
- PH29 - Strategies to prevent unintentional injuries among children and young people aged under 15 Issued (November 2010)
- CG62 - Antenatal care: routine care for the healthy pregnant woman (March 2008)
- CG45 - Antenatal and postnatal mental health: clinical management and service guidance (February 2007)
- CG89 - When to Suspect Child Maltreatment (July 2009)

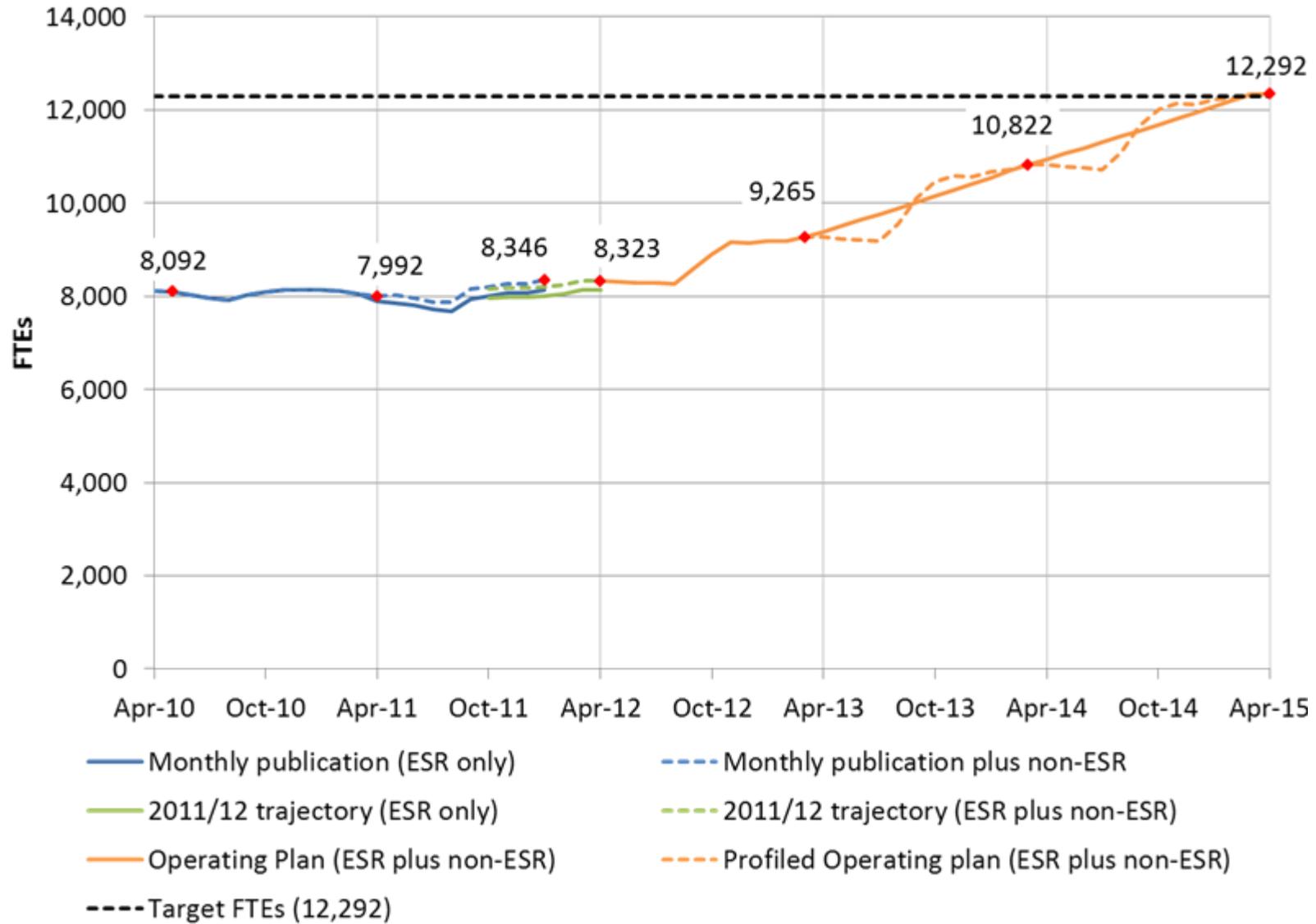
Public health functions to be exercised by NHS England

Health visitor allocation - baseline and milestones (signed-off by SHA Directors of Nursing)

	May 2010 FTEs	March 2013 milestone	March 2014 milestone	April 2015 target	Planned training commissions in 2012/13	Planned training commissions in 2013/14	Planned training commissions in 2014/15
North East	481	629	653	677	57	46	40
North West	1,386	1,463	1,648	1,808	285	285	90
Yorkshire and The Humber	890	1,087	1,211	1,287	221	147	100
East Midlands	664	808	953	1,067	237	237	60
West Midlands	870	964	1,174	1,337	377	315	60
East of England	812	894	1,070	1,268	296	303	70
London	1,151	1,308	1,584	1,842	374	374	100
South East Coast	549	689	803	984	274	274	70
South Central	494	603	716	815	180	180	50
South West	795	820	1,010	1,207	260	295	110
North	2,757	3,179	3,512	3,772	563	478	230
Midlands & East	2,346	2,666	3,197	3,672	910	855	190
London	1,151	1,308	1,584	1,842	374	374	100
South	1,838	2,112	2,529	3,006	714	749	230
England	8,092	9,265	10,822	12,292	2,561	2,456	750

Note: Planned training commissions for 2012/13 and 2013/14 are based on workforce planning assumptions submitted during the 2012-13 planning round and, as such, may be subject to change

Health Visitor trajectories, England



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- ³ Field, F. *The Foundation Years: preventing poor children becoming poor adults - The report of the Independent Review on Poverty and Life Chances*. December 2010.
- ⁴ Dyson, A et al. *Childhood development, education and health inequalities*. Report of task group, Submission to the Marmot Review. 2009.
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- ⁸ Olds, D.L. *The Nurse Family Partnership: an evidence based preventive intervention*. *Infant Mental Health Journal*. 2006. Vol. 27(1). P5-25.
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