Department of Health

Transfer of 0-5 children's public health commissioning to Local Authorities

Equality Analysis

March 2015

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Equality Analysis

Prepared by:

Department of Health - 0-5 Public Health Transfer Team

Contents

1. What are the intended outcomes of this work?

- The Government is 'committed to improving the health outcomes of our children and young people so that they become amongst the best in the world.'[1] [see link]

- The Health Visiting Programme started in 2011 as a national programme of work to deliver on the Government's commitment by 2015 to:
  - increase health visitors by 4,200; and
  - create a transformed, rejuvenated health visiting service providing improved outcomes for children and families with more targeted and tailored support for those who need it.

- It represents a major investment in services for young children and families, and is intended to:
  - Improve access to services;
  - improve the experience of children and families;
  - improve health and wellbeing outcomes for under-fives; and
  - reduce health inequalities.

- As part of this vision, responsibility for commissioning 0-5 children's public health services is transferring from NHS England to local authorities on 1 October 2015.

- In support of this transfer of responsibility, funding will be transferred to local authorities, as part of their public health grant.

- NHS England will continue to commission 0-5 children's public health services until 30 September 2015 and local authorities will assume responsibility from 1 October 2015.

- The allocated budget (including an additional £36m to pay for the full year effect of additional health visitors and Family Nurse Partnership (FNP) places) for 2015/16 for 0-5 children's public health services will be split in half, with NHS England retaining that needed to commission services for the first six months of the year, as per the arrangements set out in the section 7A agreement between The Department of Health and NHS England. Local authorities will receive money to commission services for the second six months of the year.

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/207391/better_health_outcomes_children_young_people_pledge.pdf

- Before responsibility transfers from NHS England to local authorities the Department will have published for each local authority their final funding allocation for commissioning 0-5 children's public health services for the period between 1 October 2015 and 31 March 2016.

- Future allocations for the public health grant are expected to move towards a distribution based on population needs, determined using a fair shares formula based on advice from Advisory Committee on Resource Allocations (ACRA)[2]. The 2015/16 allocations will be used as a starting point and local authorities will move incrementally towards their target share of the overall allocation over a number of years.

- The majority of Local Authorities raised no objections to their proposed figures as set out in the Baseline Agreement Exercise published on 11 December 2014. Most local authority 0-5 allocations were confirmed in *Transfer of 0-5 children's public health commissioning to Local Authorities: Allocations for 2015/16*, published 13 February alongside the original equality analysis.

- A small number of local authorities raised specific issues around whether the funding transferring was an accurate reflection of the lift and shift of the service in their area. We deferred publication of the allocations for 13 Local Authorities to provide more time for local discussions between the Local Authority, the current commissioners (NHS England), and the provider about how to implement the lift and shift of the service.

- The majority of these deferred allocations were published today in Transfer of 0-5 children's public health commissioning to Local Authorities: 0-5 Public Health Allocations for 2015/16 alongside this updated equality analysis. For the remaining two Local Authorities, the local contract negotiation process has identified the need to address a number of complicated issues between commissioners and the provider in these areas.

- All Local Authorities, should they wish to, can make in-year adjustments. Some local authorities and NHS England have indicated to the Department or Public Health England there may be further local conversations about in-year adjustments to reflect any changes needed to the baseline allocation as a result of local circumstances. The in-year adjustment process is available to all local

[2] ACRA is an independent advisory group consisting of GPs, public health experts, NHS managers, local government officers and academics who make recommendations on the preferred relative distribution of health resources to the Secretary of State for Health and NHS England, on public health and healthcare (including Clinical Commissioning Groups (CCG)) allocations, respectively.

authorities. Any material changes to transfer amounts can be agreed locally, and funding transferred accordingly. Sector-led advice and support will be available from Public Health England and the Regional Oversight Groups to help parties reach agreement. Any recurrent adjustments which are agreed will be included in the baseline for 2016/17 allocations.

2. Background

- The following section provides information on the context within which the transfer of funding from NHS England to local authorities is being made, and sets out the background to a number of decisions the Department has made in determining the total allocations for local authority 0-5 children's public health commissioning.

2.1. Transfer of responsibility for commissioning 0-5 children's public health services

- In November 2010, the Government published the White Paper, *Healthy Lives, Healthy People: Our strategy for public health in England*,[3] which set out its vision for a reformed public health system.

- Published alongside this were two consultation documents which considered the funding and commissioning routes for future public health services and the development of a public health outcomes framework. Over 2000 responses were received across the consultations, from national and local organisations.

- The Government's response to the consultation, *Healthy Lives, Healthy People: Update and Way forward*,[4] set out the Government's intention to transfer responsibility for public health to the local level and the Government's intention to prescribe certain services that must be commissioned or provided by local authorities.

- It was decided, as part of this process, that 0-5 children's public health commissioning would transfer in 2015, providing NHS England sufficient time to deliver on the Government's commitment to raise the number of health visitors (see section 2.4) and to support improved stability of the system before the transfer. In 2014, the Government announced its intention to mandate some of the elements of the Healthy Child Programme (HCP) for 18 months (see section 2.5).

[3] https://www.gov.uk/government/publications/healthy-lives-healthy-people-our-strategy-for-public-health-in-england
[4] https://www.gov.uk/government/publications/healthy-lives-healthy-people-update-and-way-forward

- The new arrangements provide an opportunity for the joining up of 0-5 public health services with local authorities' already established role in commissioning 5-19 public health services and services for those with Special Educations Needs and Disabilities [SEND] up to age 25. More information on how the public health grant was determined is given in section 2.6.

- In transferring responsibility to local authorities, the aim is to ensure future commissioning supports sustainable health visiting services and provides the best outcomes for children and their families.

- The Department uses the '4, 5, 6' model to help explain public health services for 0-5s to commissioners: this is; **four** levels of the health visiting service, **five** elements we intend to mandate, leading to **six** high impact areas (see section 2.2 for more information).

2.2. Children's public health services

- 0-5 children's public health services include commissioning of the Healthy Child Programme[5] 0-5 including delivery of the health visiting service and FNP targeted services for teenage parents.

- The **HCP** is a national public health programme to achieve good outcomes for all children from pregnancy to 19 years of age. The HCP 0-5, 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. It sets out the service for all families and for those needing additional support, termed progressive universalism.

- The **four** tier **Health Visiting Service** assesses and responds to children's and families' needs:
  - **Community Services** - linking families and resources and building community capacity.
  - **Universal Services** - primary prevention services and early intervention provided for all families with children aged 0-5 as per the HCP universal schedule of visits, assessments and development reviews.
  - **Universal Plus Services** - time limited support on specific issues offered to families with children aged 0-5 where there has been an assessed or expressed need for more targeted support.
  - **Universal Partnership Plus Services** - offered to families with children aged 0-5 where there is a need for ongoing support and interagency partnership working to help families with continuing complex needs.

[5] https://www.gov.uk/government/publications/healthy-child-programme-pregnancy-and-the-first-5-years-of-life

- Based on best evidence and in discussion with parents, professionals and partners including local authorities we have identified **six** areas where the intervention of health visiting teams is particularly important to tackle major child public health issues. (Details of the 6 High Impact Areas intention and impact metrics can be found here[6]). These are:
  - transition to parenthood and the early weeks;
  - maternal mental health (perinatal depression);
  - breastfeeding (initiation and duration);
  - healthy weight, healthy nutrition (to include physical activity);
  - managing minor illness and reducing accidents (reducing hospital attendance/admissions);
  - health, wellbeing and development of the child aged two – two year old review (integrated review) and support to be 'ready for school.'

- **FNP** is a targeted, evidence-based, preventive programme for vulnerable first time young parents. 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. Family nurses provide intensive support to young mothers and their families, aiming to improve pregnancy outcomes, improve the child's health and development, and help young parents to plan for their family's future, such as employment or returning to education.

2.3. Family Nurse Partnership

- As stated above (see section 2.2) the FNP is a targeted service for vulnerable first time young mothers. It has strong evidence base from over 30 years of experience in the US [see link][7].

- The Family Nurse Partnership began in England in 2007, with initial testing in 10 sites and by 2013 there were 11,000 FNP places offered across England. The programme is currently undergoing expansion (from 2013) with a view to offering more than 16,000 FNP places across England by March 2015 to ensure achievement and sustainability. At the point of transfer of commissioning responsibilities to local authorities, local authorities will be asked to sustain the existing level of service, i.e. local authorities will be expected to provide the same level of service as the NHS at the point of transfer.

- The FNP expansion between 2013 and 2015 was the responsibility of NHS England as part of their section 7A commitments. It was informed by a number of

[6] https://www.gov.uk/government/publications/commissioning-of-public-health-services-for-children

[7] http://fnp.nhs.uk/research-and-development

key principles: that FNP should be available in as many areas as possible, starting with the most disadvantaged (using the Index of Multiple Deprivation) and those with the highest numbers of eligible population. The detail of this is summarised in the *Securing Excellence in Commissioning for Healthy Child Programme 0-5, 2013-2015*.[8]

- FNP coverage of the eligible population varies quite considerably by local authority area from approximately 10% to 75%, with the mean currently between 25%-30%. This does not include 17 local authorities who will not have any FNP provision at March 2015.

2.4. Improving health visitor numbers

- The Government committed to improving health outcomes for children, families and their communities by increasing the number of full time equivalent (FTE) health visitors by 4200, and implementing an expanded, rejuvenated and strengthened health visiting service by April 2015.

- The *Health Visitor Implementation Plan 2011-15: 'A Call to Action'* (February 2011)[9] sets out how this extra capacity will contribute to improved public health outcomes and better personalised care for all families with children under five.

- The Government has made a substantial investment in 0-5 services. NHS England estimate that the spend for 0-5 services for 2015/16 is £840m before any change, so the Department will be investing an additional £36m between 2014/15 and 2015/16 to pay for the full year effect of the additional health visitors and FNP places we have created.

2.5. Mandating elements of the Healthy Child Programme

- Mandation Regulations have now been approved by Parliament and will be in force from 1 October 2015. These require local authorities so far as reasonably practicable to secure the provision of the specified five universal health visitor reviews. The Regulations are publically available.[10]

- Local authorities will be expected to provide the same level of service as the NHS at the point of transfer and act with a view to securing continuous improvement in the uptake of these reviews. We know that the delivery of these universal services is not currently at 100%, and we have been working with the Local Government Association (LGA) and the Department of Communities and Local Government (DCLG) to ensure that we are not imposing an additional unfunded burden upon local authorities. We recognise the starting point local authorities

[8] http://www.england.nhs.uk/wp-content/uploads/2013/08/comm-health-child-prog.pdf
[9] https://www.gov.uk/government/publications/health-visitor-implementation-plan-2011-to-2015
[10] http://www.legislation.gov.uk/ukdsi/2015/9780111128053/memorandum/contents

are working from, and that continuous improvement in both the reviews and the wider service delivery will be an ongoing process as they work with this newly transformed and expanded profession.

- This is similar to the approach we have taken towards mandated services in other public health areas, such as Health Check assessments.

- Evidence suggests that the five universal health visitor reviews that local authorities are required, so far as reasonably practicable, by the Regulations to provide are the key times to ensure that parents are supported to give their baby/child the best start in life and to identify early those families who need extra help.

- The Regulations have been made under Section 6C of the NHS Act 2006 and, they provide for a 'sunset clause'[11] at 18 months that will have the effect of ending mandation, unless further legislation is made that continues the provisions in force. A review, involving PHE, is intended to inform whether the sunsetting needs to be amended.

2.6. The public health grant

- Since 2013/14 local authorities have received an allocated ring-fenced budget from the Department to deliver their public health responsibilities.

- Local authority public health grants were initially determined using three steps:
  - Determining each local authority's fair share of the total resources available for England, based on relative need for public health services;
  - establishing spend on these services in the previous year (known as the baseline spend and based on 2011/12 Primary Care Trust expenditure on those functions which were to become local authority responsibility from April 2013);
  - setting actual grants through pace of change policy, which balances within the available resources, moving areas where baseline spend is less than the fair share towards their fair share and providing stability in funding in all areas.

- ACRA developed the fair shares formula. More information on the formula they used is available in the *Public Health Grants to Local Authorities 2013/14 and 2014/15 Equalities Analysis*.[12]

[11] A provision in a Bill or regulations that gives them an 'expiry date' once passed into law. 'Sunset clauses' are included in legislation when it is felt that Parliament should have the chance to decide on its merits again after a fixed period.
[12] https://www.gov.uk/government/publications/ring-fenced-public-health-grants-to-local-authorities-2013-14-and-2014-15

- The total public health ring fenced budget for 2013/14 was £2.66bn, this rose to £2.79bn in 2014/15.

- All local authorities have received growth in their allocations in 2013/14 and 2014/15, with those authorities which are furthest below their target resource shares receiving the highest levels of growth (over 20% in cash terms).

- On 17 December 2014, the Department confirmed [see link][13] that 2015/16 local authority public health grants would be the same as in 2014/15 (with the exception of adjustments on baseline errors agreed locally), totalling £2.80bn.

- For 2015/16, the public health grant will include an additional half-year's cost of commissioning 0-5 children's public health services and from April 2016, public health grant allocations, as advised by ACRA, will include money for all public health responsibilities transferred to local authorities since 1 April 2013, including 0-5 children's public health services.

- ACRA is developing its proposals for the formula for 2016/17 local authority public health allocations, which will include the 0-5 children's services component. As this is a new area of the public health grant, the Department will facilitate for ACRA a brief exercise with local authorities and others to gather views on the part of the methodology that will take account of need for those 0-5 services as part of the overall public health grant. This engagement exercise will start later in February 2015 to conclude before the end of March 2015.

- Future allocations for the public health grant are expected to move towards a distribution based on population needs, determined using a fair shares formula based on advice from ACRA. The 2015/16 allocations will be used as a starting point and local authorities will move incrementally towards their target share of the overall allocation over a number of years.

2.7. Lift and shift and mid-year transfer

- Our approach is based on the first part of the transfer of public health funding in 2013/14, and tailored to the context of commissioning for 0-5s.

- In *Healthy Lives, Healthy People: Update and Way forward (2011)*[14] it was agreed that 0-5 children's public health commissioning would transfer to local authorities in 2015. This was to support delivery of the Government's commitment to increase the number of health visitors (see section 2.4) and

[13] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/388172/final_PH_grant_determination_and_conditions_2015_16.pdf
[14] https://www.gov.uk/government/publications/healthy-lives-healthy-people-update-and-way-forward

implement an expanded, rejuvenated and strengthened health visiting service by April 2015.

- Public health commissioning for 0-5s has undergone considerable change and expansion over the past four years. To provide a firm foundation for a safe transfer and to support existing services and contracts already in place, a cross-government decision was made in January 2014 to transfer responsibilities to local authorities on 1 October 2015.

- To further support a stable mid-year transfer of responsibilities, the principles of 'lift and shift' have been used to determine allocations for 0-5 children's public health commissioning for the second half of 2015/16. That is, we identified the scope of existing NHS England obligations under service specification 27 of the Section 7A agreement between the Department and NHS England, under which NHS England carries out Secretary of State (SofS) public health functions and funding relating to this provided the main basis for local authority allocations. Some adjustments have been made to take account of issues raised during our engagement process. These are described fully in this document.

- This means that for 2015/16, the public health grant will include an additional half-year's cost of commissioning 0-5 children's public health services.

- From 2016/17, the allocations are expected to move towards a distribution based on population needs, determined using a fair shares formula based on advice from ACRA. The 2015/16 allocations will be used as a starting point and local authorities will move incrementally to the formula position over several years.

3. Objectives in the context of the equality duty

- The Public Sector Equality Duty (under the Equality Act 2010) requires that public bodies have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between different people when carrying out their activities. The SofS also has a number of statutory duties under the NHS Act 2006, including as to promoting autonomy, to promote research, reduce health inequalities between the people of England and improve quality of services through continuous improvement.

- In transferring public health responsibilities to local government, the Government aimed to:
  - Improve significantly the health and wellbeing of local populations;
  - prescribe steps local authorities must take in carrying out their health improvement functions or health improvement functions delegated from the SofS;
  - reduce health inequalities across the life course, including within hard to reach groups; and
  - ensure the provision of population healthcare advice.

- The wider Health Visitor Programme places the revitalisation of health visiting services at the centre of support for all parents and the provision of assistance when needed by families. It aims to:
  - Improve access to evidence based interventions;
  - improve the experience of children and families;
  - improve health and well-being outcomes for under-fives; and
  - reduce health inequalities

- Mandating the five universal health visitor reviews (see section 2.5) in Regulations, if the Regulations are approved by Parliament, would ensure continued provision of evidence-based universal services, supporting the best start for all children and enabling impact to be measured.

- Agreement of the local authority 0-5 children's public health funding allocations for 2015/16 is being undertaken in the context of the wider Health Visitor Programme and FNP, the transfer of 0-5 commissioning responsibilities to local authorities from NHS England and agreement of the process for determining the public health grant in 2016/17. Decisions to date have been scrutinised and assessed for their impact on equality and health inequalities and the evidence is set out in this document.

- This Equalities Analysis will focus on the process taken by the Department for confirming final local authority funding allocations for commissioning of 0-5 children's public health services from 1 October 2015 through to 31 March 2016. It will also consider the impact of final allocations on the public health grant for 2016/17 and where needed will reflect on decisions taken previously which have impacted on the agreed methodology for the transfer of funds from NHS England to local authorities.

4. Who will be affected?

4.1. NHS England (Sender)

- This transfer should have neutral impact on NHS England.

4.2. Local authority commissioners (Receivers)

- *Healthy Lives, Healthy People: Update and way forward*[15] sets out the Government's intention to transfer responsibility for public health to the local level; The Department, as agreed by Ministers in response the consultation, agreed that to support improved stability of the system and to fulfil the Government's commitment to raise the number of health visitors, responsibility for 0-5 services would not transfer until 2015. From 1 October 2015, local authorities will be responsible for commissioning services from 0-19, improving continuity for children and their families.

- Local authorities 0-5 children's public health service allocations for 2015/16 should enable them to deliver the full scope of NHS England's existing commissioning obligations[16].

- Local authorities' will be expected to provide the same level of service as the NHS at the point of transfer and act with a view to securing continuous improvement in the uptake of these reviews. We know that the delivery of these universal services is not currently at 100%, and we have been working with the LGA and the DCLG to ensure that we are not imposing an additional unfunded burden upon local authorities. We recognise the starting point local authorities are working from, and that continuous improvement in both the reviews and the wider service delivery will be an ongoing process as they work with this newly transformed and expanded profession.

- Future allocations for the public health grant are expected to move towards a distribution based on population needs, determined using a fair shares formula based on advice from ACRA. The 2015/16 allocations will be used as a starting point and local authorities will move incrementally towards their target share of the overall allocation over a number of years.

- This transfer should have a neutral impact on local authorities.

[15] https://www.gov.uk/government/publications/healthy-lives-healthy-people-update-and-way-forward
[16] http://www.england.nhs.uk/ourwork/qual-clin-lead/hlth-vistg-prog/info/

- In allowing local authorities to provide a joined-up service for all 0-19 year olds and their families and allowing them to develop local services in which health and foundation year's services are aligned to provide support to all families and early intervention where there is increased need. It can be anticipated that through this process local authorities will be assisted in discharging their separate equalities duties, i.e. advancing equality of opportunity.

4.3. Providers of health visiting services (health visitors)

- It was agreed that responsibility for commissioning 0-5 children's public health services would transfer on 1 October 2015 (see section 2.7). This will support a stable transition process, maintaining service continuity and supporting the continued development of the service. As part of the transition it will be important that clear and robust contractual arrangements are in place.

- The proposed allocations (for the second half of 2015/16) set out in the Baseline Agreement Exercise have been determined on the basis of lift and shift supported by funding adjustments including the minimum floor; that is, we have identified the scope of NHS England's existing obligations under service specification 27 of the Section 7A agreement between the Department and NHS England and funding relating to this will provide the main basis for local authority allocations. This is to ensure that every local authority is able to deliver at least the same level of service in the second half of 2015/16 as the level of service delivered by the NHS at the point of transfer.

- There should be little or no impact on providers of health visiting services, as while the commissioning organisation will change on the 1 October, it is anticipated that the service providers should remain the same.

4.4. All children aged 0-5 and their families (service users)

- Local authorities will be expected to provide the same level of service in relation to these five reviews as is delivered by the NHS at the point of transfer and expected to take a reasonable approach to the duty to secure universal health visitor reviews.

- The proposed allocations (for the second half of 2015/16) set out in the Baseline Agreement Exercise have been determined on the basis of lift and shift supported by funding adjustments including the minimum floor. This is to ensure that every local authority is able to deliver at least the same level of service in the second half of 2015/16 as the level of service delivered by the NHS at the point of transfer.

- The transfer of commissioning responsibility from NHS England to local authorities will join-up 0-5 children's public health services with existing 5-19 public health services. This will support delivery of improved outcomes for children and families.

- Furthermore the wider health visitor programme, which sets the context for this transfer of responsibility aims to; improve access to evidence based interventions; improve the experience of children and families; improve health and well-being outcomes for under-fives; and contribute to reduced health inequalities.

- This transfer should have a neutral or positive impact on service users with relevant protected characteristics, such as pregnant women and mothers and disabled children.

5. Evidence

- This analysis is focussed on the equality impact of the process the Department has used to determine local authority allocations for the period 1 October 2015 until 31 March 2016.

- The transfer is being made as a result of decisions made previously, which are set out earlier in this document (see section 2). These decisions have already been scrutinised for their equality impact and the following documents published as evidence:
  - Equality Analysis for Public health grants to local authorities for 2013/14 and 2014/15[17]
  - Equality Analysis for the Health Visiting Programme (2012)[18]
- The following document is due to be published shortly:
  - Equality Analysis for Mandating elements of the Healthy Child Programme through Regulations (pending publication 2015).

5.1. Determining local authority allocations – an overview of our process

- Our approach is based on the first part of the transfer of public health funding in 2013/14, and tailored to the context of commissioning for 0-5s (see section 2.6).

- As set out earlier in this document (see section 2.7), it was agreed that the transfer would be made mid-year on the basis of lift and shift and this was communicated to all local authorities in August 2014 via a finance factsheet[19] published on gov.uk. We also stated in this factsheet that local authorities would be asked to deliver no more than the NHS at the point of transfer.

- 2015/16 allocations were determined in four stages, in partnership with colleagues at NHS England and PHE.

[17] https://www.gov.uk/government/publications/ring-fenced-public-health-grants-to-local-authorities-2013-14-and-2014-15
[18] https://www.gov.uk/government/publications/equality-analysis-for-the-health-visitor-implementation-plan-2011-15
[19] https://www.gov.uk/government/publications/transfer-of-0-5-childrens-public-health-commissioning-to-local-authorities

- At each stage equalities considerations have been taken into account and health inequalities considered. The transfer aims to ensure stability in the first six months and is based on the level of delivery at the point of transfer and therefore should not impact on those from the protected characteristic groups, where the Department has identified potential impacts. To further support these groups, the Department has made a number of adjustments, detailed below. As a result of this exercise each local authority should have sufficient funding to commission as a minimum the current level of 0-5 children's public health services for their population and therefore should not disadvantage those from protected characteristic groups.

- Throughout this process the Department has worked closely with colleagues at the LGA, the Association of Directors of Public Health (ADPH), the Association of Directors of Children's Services (ACDS) and the Society of Local Authority Chief Executives (SOLACE), to ensure that the Department has fully understood local government considerations. We have also worked with colleagues from NHS England's teams. The fora the Department has used to engage with our colleagues are set out in detail later in this document (see section 7).

- From April 2016, the public health grant will include money for all public health responsibilities transferred to local authorities from 1 April 2013, including 0-5 children's public health services. The formula used to calculate local authority public health grant allocations for 2016/17 will be based on advice from ACRA. See action planning and improvement (see section 9) for more information on this process.

5.2. Stage one:

- NHS England completed the initial return in June 2014 and these included data on current spend on 0-5 services which would be transferring; information on current contracts; and future plans.

- These showed as expected that the overall cost of 0-5 provision will be higher in 2015/16 than 2014/15. This is a consequence of the increasing number of health visitors and FNP places during the course of 2014/15. In particular, the full year effect of the 4,200 increase in health visitors will be felt only after the target has been achieved. Local areas were asked to plan on the basis that the above commissioning intentions are delivered, including 4,200 additional health visitors. The Department set the section 7a funding total for 2015/16 for NHS England in December 2014 [see Table 2 at this link[20] for more information]. As for 2014/15, we will reflect any increase in total costs from delivering Mandate commitments in setting the total.

[20] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/386268/Financial_Directions.pdf

5.3. Stage two:

- NHS England and local authorities were asked to submit their second return by 12 September 2014, refining the numbers collected in June and disaggregating them by local authority. To demonstrate that local agreement had been reached, NHS England were asked to get sign off from local authorities and sharing of information was expected using the principles of open book accounting.

- This process and resulting potential impacts on equality considerations informed changes to NHS England's funding and the proposed local authority allocations. We found:
  - Potential for commissioning costs to be higher in local authorities than they have been in NHS organisations because of the increase in the number of commissioning organisations, which may have diverted funding from delivery of services, and potentially increased health inequalities.
  - Inconsistencies in the treatment of CQUIN and inflationary measures across the proposed local authority allocations, which may have led to inequality in the levels of service provided.
  - Variations in the level of spend per head across the country, which may impact on the levels of service which are able to be provided for 0-5s. [see link to spreadsheet[21]]

- More detail on the resulting changes can be seen in the Baseline Agreement Exercise,[22] but at a high level included:
  - inclusion of Commissioning for Quality and Innovation payments (CQUIN) where it is integral to how providers meet costs, applying 2014/15 prices in 2015/16, unless there was good reason to do otherwise;
  - providing an additional £2m (half year) to cover additional local authority commissioning costs; and
  - putting in place a minimum floor to the amount of resource on adjusted spend per head (0-5) of £160, below which no local authority should fall. This is a positive step for local authorities falling at the bottom of funding distribution.

- These steps support the Department's aim to ensure that the transfer does not disadvantage people from the protected characteristic groups. It is anticipated that the policy should not disadvantage any local authority and therefore any people in local authorities where there is a disproportionate number with a relevant protected characteristic.

5.3.1 The Minimum Floor

[21] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/402466/Minimum_Floor_Calculations_locked.xlsx
[22] https://www.gov.uk/government/publications/allocation-of-funding-for-0-5-public-health-services

- In our initial analysis of funds transferring, we found that allocations based on the principles of lift and shift resulted in a wide variation in spend per head across the country, and considered that this variation could impact on the levels of service provided for 0-5s and the 'pregnancy and maternity' protected characteristic group. As a result of this assessment, to reduce some negative impact, we put in place the minimum floor, of at £160 per head of 0-5s adjusted spend in 2015/16 (based on a full year cost of commissioning).

- The methodology for determining the minimum floor can be seen in the Annex 1 and more detail is shown in sections 5.3.2 and 5.3.3). Data used to determine the minimum floor included the initial returns, submitted by NHS England, mid-year population projections from Office of National Statistics (ONS), and the Market Forces Factor information. Please see the *minimum floor calculations spreadsheet*[23] for more information.

- The Department took the decision to support local authorities falling at the bottom of the funding distribution by putting in a minimum funding floor of at least £160 per head of 0-5s adjusted spend in 2015/16 (based on full year cost of commissioning). We considered that there was a case for those with the lowest spend per head to receive some additional resource in 2015/16 while we work with ACRA to develop a needs-based formula.

5.3.2 Basing the minimum floor on spend per head of 0-5

- Spend per head of 0-5 was used as an interim measure to address the greatest variation in spend per head. The Department expect ACRA will look at deprivation and other factors as part of their work in developing a formula for 2016/17. In the expectation that a needs-based formula would be in place from 2016/17 onwards, the Department considered this to be sufficiently rigorous for a first step towards supporting local authorities at the bottom of the spend per head distribution with some additional resource in 2015/16. The Department remains satisfied that this is a proportionate approach to support a six month funding uplift as a first step towards a more robust needs-based solution. The uplift will then become part of the baseline for 2016/17. In accordance with the principles of lift and shift, it does not include a measure of deprivation as the Department expect this to be addressed more satisfactorily by ACRA's work. However, spend per head figures are weighted using the Market Forces Factor, in order to reflect the real costs of commissioning to each local authority.

[23] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/402466/Minimum_Floor_Calculations_locked.xlsx

- 0-5s (i.e. ages 0, 1, 2, 3, 4, so under 5s) was used as the population measure because funds are being transferred to commission for the whole of 0-5 public health. The four-tier health visiting service has a much broader remit than the five mandated universal health visitor reviews, and includes elements such as readiness for school. The Department expects ACRA to take account of local authority views on this issue.

5.3.3 Setting the minimum floor

- In the Baseline Agreement Exercise, 24 the Department published the methodology used to calculate the minimum floor. Some local authorities have asked us to set this out more clearly and to show more detail of the steps we took in determining the minimum floor.

- Prior to publishing the proposed local authority allocations in the Baseline Agreement Exercise the Department had worked closely with, PHE, DCLG, LGA, ACDS, ADPH, SOLACE and NHS England to ensure any potential impacts of the transfer on children and their families had been considered.

- The National Health Visiting Programme and the subsequent transition of commissioning responsibility for 0-5 children's public health services from the NHS to local authorities will enable local authorities to commission transformed, rejuvenated and sustainable health visiting services, which are joined-up with other local services for children and families. This will support delivery of improved outcomes for children and families. The Department's '4, 5, 6' model (set out in the Baseline Agreement Exercise) sets out what a transformed service looks like. NHS England currently commission health visiting services, under the NHS National Service Specification.[25]

- The HCP to be commissioned by local authorities comprises health visiting services and in many local authorities the FNP. Health visiting services are led and delivered by health visitors working within skill mix teams. Health visitors may delegate to other members of their teams, including, but not exclusively a suitably qualified health professional, i.e. a community staff nurse or a person who is trained in child health and development but not a health professional, i.e. a nursery nurse. Thus the local authority allocations are to commission services for 0-5 services delivered through such teams led by health visitors. Local authorities will commission services from 1 October 2015 based on local need.

[24] https://www.gov.uk/government/publications/transfer-of-0-5-childrens-public-health-commissioning-to-local-authorities
[25] http://www.england.nhs.uk/wp-content/uploads/2014/12/hv-serv-spec-dec14-fin.pdf

- It is not for the Department to determine local arrangements for health visiting teams, skill mix, or delivery arrangements. Health visiting services are led and delivered locally, and so these are matters for local commissioners, providers and teams.

- The Department reached the conclusion that to meet the intentions as set out above, a 'minimum floor' should be introduced, below which no local authority should fall. There is no national formula or specific evidence available upon which to determine the level of the floor and as such the Department used expert professional opinion with respect to health visiting services to sense check its decision.

- Spend per head of 0-5 (i.e. under 5 years), based on full year allocations and calculated according to weighted costs, was used to determine the minimum floor; the Department used this measure as 0-5 children's public health services cover a broad remit, including elements such as readiness for school. The minimum floor was set at £160 per head. The methodology was published in the Baseline Agreement Exercise.

- In order to 'sense check' that £160 per weighted 0-5 head enabled local authorities to commission the '4 5 6' model and sustain the universal reviews the Department used professional evidence and judgement; this was the best available knowledge. Based on this, the Department's Director of Nursing (England's most senior health visitor and Senior Responsible Office of the National Health Visiting Programme) determined that a figure derived from the population ratio of three health visitors (or skill mix teams equivalent) to 1000 families with children aged under five (0, 1, 2, 3 and 4 years) was a reasonable basis to test the floor. This meant that lift and shift model was implemented with a minimum floor thus no local authority was disadvantaged (from their lift and shift position) and that those with lowest per capita allocation were able to commission services to meet the objectives of the transfer, i.e. sustainable delivery of services.

- Arrangements of the delivery of the service model, including those elements delivered under Regulation are for local decision. The health visitor to families' ratio has been used only to sense check resource allocation for the minimum floor and is not intended to determine service delivery and staffing of skill mixed teams.

- We regard this as a positive step that we've taken in advance of receiving ACRA's advice on a funding formula for 2016/17.

5.4. Stage three:

- Proposed allocations were published in the Baseline Agreement Exercise[26] on 11 December 2014. Local authorities were given five weeks to respond, letting the Department know of any factual changes to the figures or any of the changes made as a result of local discussion or to comment and raise concern regarding the accuracy of their allocations. If local authorities were content with their allocation as proposed in the Baseline Agreement Exercise, we did not ask them to respond. The Baseline Agreement Exercise closed on the 16 January 2015.

- The Department received responses from 62 local authorities, of which 12 stated their agreement with the amount proposed. 90 local authorities did not respond, implying they had no issues with the allocation as proposed in the Baseline Agreement Exercise.

- Of those local authorities who raised concerns, the majority have now agreed or are close to agreeing their final allocation. Issues raised included:
  - **An argument for a needs-based allocation:** We have based this transfer on the basis of lift and shift, as explained earlier in this document. We believe this to be supportive of a stable mid-year transfer and safe expansion of the service and reasonable and proportionate to the six month transfer. We will look to ACRA to advise on a funding formula for 2016/17.
  - **Disputes over the initial NHS England returns (stage two) upon which the Baseline Agreement Exercise was based**: Regional Oversight Groups (PHE, LGA, and NHS England) have supported the identification of further information to support local discussion and decision.
  - **Overheads incorrectly reflected in current contracts**: NHS England continue to work with local authorities to ensure that overheads have been correctly apportioned.
  - **Some misunderstanding about the level of mandation, i.e. some local authorities thought it required 100% coverage**: Five universal health visitor reviews have been mandated for 18 months (a review at 12 months, involving PHE, is intended to inform whether the sunsetting needs to be amended). We have been clear that local authorities will be expected to provide the same level of service as the NHS at the point of transfer and act with a view to securing continuous improvement in the uptake of these reviews.

- The Department worked with PHE, the LGA and NHS England through the Regional Oversight Groups to support local authorities in facilitating agreements and identifying supportive information.

[26] https://www.gov.uk/government/publications/allocation-of-funding-for-0-5-public-health-services

- The decisions made have helped to ensure that there are no adverse equality impacts on those affected by this transfer of responsibilities, particularly those in the pregnancy and maternity protected characteristic group. The agreed final allocations should support a continued promotion of equality of service as responsibility transfers on 1 October 2015.

5.5. Stage four:

- Most local authority final allocations were published in the Department's response to the Baseline Agreement Exercise, *Transfer of 0-5 children's public health commissioning to Local Authorities: Allocations for 2015/16*, and an equality analysis was published alongside it.

- A small number of Local Authorities raised specific issues around whether the amounts transferring were an accurate reflection of the lift and shift of the service in their area. Therefore we deferred publication of the allocations for 13 Local Authorities to provide more time for local discussions between the Local Authority, the current commissioners (NHS England), and the provider about how to implement the lift and shift of the service.

- The majority of these deferred allocations were published today in *Transfer of 0-5 children's public health commissioning to Local Authorities: 0-5 Public Health Allocations for 2015/16* alongside this updated equality analysis. For the remaining two Local Authorities, the local contract negotiation process has identified the need to address a number of complicated issues between commissioners and the provider in these areas. These allocations are shown as indicative.

- Equalities issues raised by some Local Authorities have been addressed by making allocations using a fair and reasonable process based on the principles of Lift and Shift. As set out in the Baseline Agreement Exercise, the Department also took the decision to support local authorities falling at the bottom of the funding distribution by putting in a minimum funding floor of at least £160 per head of 0-5s adjusted spend in 2015/16 (based on full year cost of commissioning). We considered that there was a case for those with the lowest spend per head to receive some additional resource in 2015/16 while we work with ACRA to develop a needs-based formula.

- The Department continues to support this, so to ensure that the outcome does not impact on the service providers, or users as regards the elimination of discrimination and any other conduct prohibited by the 2010 Act, or on the advancement of opportunity of those with protected characteristics, or the fostering of good relationships between persons who share a protected characteristic and others.

- All Local Authorities, should they wish to, can make in-year adjustments. Some local authorities and NHS England have indicated to the Department or PHE there may be further local conversations about in-year adjustments to reflect any changes needed to the baseline allocation as a result of local circumstances. The in-year adjustment process is available to all local authorities. Any material changes to transfer amounts can be agreed locally, and funding transferred accordingly. Sector-led advice and support will be available from Public Health England (PHE) and the Regional Oversight Groups to help parties reach agreement. Any recurrent adjustments which are agreed will be included in the baseline for 2016/17 allocations. The in-year adjustment process was previously highlighted in the factsheet[27] circulated in August 2014

- This further supports the notion that the impact of this transfer on senders, receivers and service users remains minimal.

[27] https://www.gov.uk/government/publications/transfer-of-0-5-childrens-public-health-commissioning-to-local-authorities

6. Evidence by protected characteristic group

- The assessment is a broad analysis of the impact of the process for finalising local authority 0-5 children's public health allocations. The area where the impact will be the greatest is on the 'pregnancy and maternity' characteristic group.

6.1. Disability

Wider policy

- The HCP is the universal clinical and public health programme for children and families from pregnancy to five years of age. This programme will help to better identify the most vulnerable young people (including those with disabilities) to help them receive the best available health and social care, therefore promoting equality. As part of the Universal Plus and Universal Partnership Plus (see section 2.2) services for vulnerable families requiring on-going additional support are included, for example for families with a child with a disability.
- The early equality analyses completed for both the Health Visitor Programme[28] and mandating elements of the HCP in Regulations (to be published in 2015), set out the evidence in more detail.

Impact of the allocation

- Allocations have been determined over a period of nine months, using the best available data from NHS England and local authorities. Allocations are based on current provision, and local authorities have been asked to provide no more than the NHS at the point of transfer.
- Funding provided should enable local authorities to provide the full scope of NHS provision at the point of transfer.
- Therefore allocations should not impact upon the level of service being provided, and therefore being received by those within this group. There should neither be a positive or negative impact on this group.

[28] https://www.gov.uk/government/publications/equality-analysis-for-the-health-visitor-implementation-plan-2011-15

6.2. Sex

Wider policy

- The policy intention is to continue to improve health outcomes by ensuring continuation of universal health visiting provision and targeted services like FNP, offering family health services. It also 'champions' wider health and wellbeing, prevention and public health and the building of family and community capacity. This has a particular impact on women (and pregnant women) and socio-economically disadvantaged children.
- Local authorities are public authorities and subject to the equality duty in their own right. They have an ongoing responsibility to consider removing or minimising disadvantages experienced by certain groups of service users. The money provided to commission the transformed health visiting service should enable local authorities to identify and positively target those who may be at risk of further disadvantage, for example women at risk of domestic violence; or to prevent further disadvantage, with, for example, maternal mental health packages, if local evidence shows local need.
- The Government intends to mandate the five universal health visitor reviews, which will enable local authorities to more easily identify those who may be at risk (see section 2.5) and therefore target their services effectively.

Impact of the allocation

- Allocations have been determined over a period of nine months, using the best available data from NHS England and local authorities. Allocations are based on current provision, and local authorities have been asked to provide no more than the NHS at the point of transfer.
- Funding provided should enable local authorities to provide the full scope of NHS provision at the point of transfer.
- Therefore allocations should not impact upon the level of service being provided, and therefore being received, by those within this group. There should neither be a positive or negative impact on this group.

6.3. Race

Wider policy

- Evidence from the *Equality Analysis for the Health Visiting Programme*[29] suggests that some BME groups are disproportionately represented in socially disadvantaged groups and will experience the impact of broader health inequalities.

[29] https://www.gov.uk/government/publications/equality-analysis-for-the-health-visitor-implementation-plan-2011-15

- An enduring policy commitment is that of emphasis on delivery of services in a range of settings to maximise reach into communities, for example, in the home, in children's centres, in community and general practice. The health visitors' *Building Community Capacity*[30] supports health visiting teams in understanding and interaction with their local population and communities, including their racial make-up and lifestyle patterns, such as travelling communities.
- In *The role of the specialist health visitor when working with Gypsy and Traveller families*, [31] published in April 2014, it states that health visitors should be aware of the social and health inequalities experienced by gypsies and travellers and act to influence the design of inclusive services, so that they are culturally sensitive and accessible to the most vulnerable groups.
- In the context of the local Joint Strategic Needs Assessment, health visiting teams are encouraged to adapt services so that a universal offer is available to all parts of the community they serve with an understanding of cultural attitudes to family health. This may involve working with local community groups and providing services in appropriate venues or locations.

Impact of the transfer

- Allocations have been determined over a period of nine months, using the best available data from NHS England and local authorities. Allocations are based on current provision, and local authorities have been asked to provide no more than the NHS at the point of transfer.
- Funding provided should enable local authorities to provide the full scope of NHS provision at the point of transfer.
- Allocations are both proportionate and justifiable – they are for a six month period, and as stated earlier support a stable mid-year transfer. From April 2016, allocations will be included in the public health grant, and the formula will be based on advice from ACRA.
- Therefore allocations should not impact upon the level of service being provided, and therefore being received by those within this group. There should neither be a positive or negative impact on this group.

6.4. Age

Wider policy

- The health visiting service serves those aged 0-5 and their families, and will therefore have a greater impact on this group, than those in different age categories.
- Transfer of responsibilities to local authorities will encourage a more joined-up service for children from 0 through to 19 years.

[30] http://www.e-lfh.org.uk/programmes/building-community-capacity/
[31] http://www.magonlinelibrary.com/doi/full/10.12968/johv.2014.2.4.208

Impact of the transfer

- Allocations have been determined over a period of nine months, using the best available data from NHS England and local authorities. Allocations are based on current provision, and local authorities have been asked to provide no more than the NHS at the point of transfer.
- Funding provided should enable local authorities to provide the full scope of NHS provision at the point of transfer.
- Therefore allocations should not impact upon the level of service being provided, and therefore being received, by those within this group. There should neither be a positive or negative impact on this group.

6.5. Gender reassignment (including transgender)

Wider policy

- Previous equalities analyses have noted that there is no evidence available for this group and impacts of this policy are less likely on this group.

Impact of the transfer

- Allocations have been determined over a period of nine months, using the best available data from NHS England and local authorities. Allocations are based on current provision, and local authorities have been asked to provide no more than the NHS at the point of transfer.
- Funding provided should enable local authorities to provide the full scope of NHS provision at the point of transfer.
- Therefore allocations should not impact upon the level of service being provided, and therefore being received, by those within this group. There should neither be a positive or negative impact on this group.

6.6. Sexual orientation

Wider policy

- Previous equalities analyses have noted that there is no evidence available for this group and impacts of this policy are less likely on this group.

Impact of the transfer

- Allocations have been determined over a period of nine months, using the best available data from NHS England and local authorities. Allocations are based on current provision, and local authorities have been asked to provide no more than the NHS at the point of transfer.
- Funding provided should enable local authorities to provide the full scope of NHS provision at the point of transfer.

- Therefore allocations should not impact upon the level of service being provided, and therefore being received by those within this group. There should neither be a positive or negative impact on this group.

6.7. Religion or Belief

Wider policy

- Previous equalities analyses have noted that there is no evidence available for this group and impacts of this policy are less likely on this group.

Impact of the transfer

- Allocations have been determined over a period of nine months, using the best available data from NHS England and local authorities. Allocations are based on current provision, and local authorities have been asked to provide no more than the NHS at the point of transfer.
- Funding provided should enable local authorities to provide the full scope of NHS provision at the point of transfer.
- Therefore allocations should not impact upon the level of service being provided, and therefore being received, by those within this group. There should neither be a positive or negative impact on this group.

6.8. Pregnancy and maternity

Wider policy

Transfer of responsibilities

- As stated earlier in the document, the transfer of commissioning responsibilities for 0-5 children's public health commissioning to local authorities will have the greatest impact on this group.
- In *Healthy Lives, Healthy People: Our strategy for Public Health in England*[32] (2010) the Department proposed a new role for local government to encourage coherent commissioning strategies, promoting the development of integrated and joined up commissioning plans across the NHS, social care, public health and other local partners. Ultimately, this should deliver better health and wellbeing outcomes, better quality of care, and better value for money, with fewer overlaps or gaps in provision, and different services working sensibly together.
- The Department recognised that transferring services in 2013 (at the same time as they transferred responsibility for the other public health services) may have had negative consequences (see *Healthy Lives, Healthy People: Update and way forward*[33]– page 26) and as such to mitigate, delayed the transfer until 2015.

[32] https://www.gov.uk/government/publications/healthy-lives-healthy-people-our-strategy-for-public-health-in-england
[33] https://www.gov.uk/government/publications/healthy-lives-healthy-people-update-and-way-forward

- Overall this transfer should have a positive impact for local authorities, allowing them to provide a joined up service for all 0-19 year olds and their families.

The Health Visitor Programme

- There is an abundance of evidence relating to health visitors' impact on children and families.
- The *1001 Critical Days*[34] report sets out evidence which emphasises the importance of making the most of interventions and early detection at a time described as 'the critical window of opportunity' and when parents are especially receptive to offers of advice and support. The report cites findings from international studies which suggest that:

  "When a baby's development falls behind the norm during the first year of life, it is then much more likely to fall even further behind in subsequent years."
- Likewise, the Allen report, *Early Intervention, the Next Steps*[35] (Jan 2011) also emphasises early intervention as particularly important:

  "The case, then, is for early intervention programmes as a means to help all children acquire the social and emotional foundation they need."

  "We are missing an opportunity if we don't prevent problems before they arise. It is vital that a focus on the early years is placed at the heart of the policy making process."
- Early intervention (during pregnancy) and the universal antenatal offer provides health visitors with the opportunity to convey to families the benefits of specialist training including the programme's recent investment in health visitor training for domestic violence/abuse and in peri-natal mental health, which has a positive impact on maternal mental health. See: *Inequity in provision of and access to health visiting postnatal depression services*[36] (May 2011).
- The FNP programme provides additional intensive support to vulnerable young parents, offering them support throughout the pregnancy and until the child is two. Family nurses provide intensive support to young mothers and their families, aiming to improve pregnancy outcomes, improve the child's health and development, and help young parents to plan for their family's future, such as employment or returning to education.

Impact of the transfer

- Allocations have been determined over a period of nine months, using the best available data from NHS England and local authorities. Allocations are based on current provision, and local authorities have been asked to provide no more than the NHS at the point of transfer.
- Funding provided should enable local authorities to provide the full scope of NHS provision at the point of transfer.

[34] http://www.andrealeadsom.com/downloads/1001cdmanifesto.pdf
[35] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/284086/early-intervention-next-steps2.pdf
[36] http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2648.2011.05669.x/full

- Therefore allocations should not impact upon the level of service being provided, and therefore being received by those within this group, however with the transfer of responsibilities comes a real chance to improve outcomes for children and their families and as such we could expect a neutral to positive impact on this group.

6.9. Carers

Wider policy

- Health visitors will routinely access, signpost and refer families when extra help and support is required, this may be the case if caring responsibilities are present. The 2011 census (ONS Statistics – link[37]) showed there were 166,363 young carers in England (aged 5-17), an increase of 19% since 2001.
- It is anticipated young carers in particular are a group where health outcomes can be affected by their caring responsibilities – The Young Carers Pathway[38] details how local authorities, schools and nurses can work together to identify and support young carers. Local authorities may, as a result of their new role in commissioning the proposed mandated services (alongside their established role in commissioning 5-19 years services), find they are better placed to consider opportunities for integrating/improving those services relating to England's young carers.

Impact of the transfer

- Allocations have been determined over a period of nine months, using the best available data from NHS England and local authorities. Allocations are based on current provision, and local authorities have been asked to provide no more than the NHS at the point of transfer.
- Funding provided should enable local authorities to provide the full scope of NHS provision at the point of transfer.
- Therefore allocations should not impact upon the level of service being provided, and therefore being received, by those within this group. There should neither be a positive or negative impact on this group.

6.10. Other identified groups

[37] http://www.ons.gov.uk/ons/rel/census/2011-census-analysis/provision-of-unpaid-care-in-england-and-wales--2011/sty-unpaid-care.html

[38] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/299270/Young_Carers_pathway_Interactive_FINAL.pdf

Low Socio-economic status

Wider policy

- Socio-economic status has significant impacts on health inequalities amongst children. There is evidence that children born in lower socio-economic groups are more likely to be of low birth weight, die in the first year of life and to suffer episodes of mortality (Healthy Lives, Healthy People – Impact Assessment[39]).
- Health visitors initiate or help with a wide range of interventions with parents, for example increased breastfeeding rates, which are known to be the lowest in the lower socio-economic groups. In 2004/5 37.1% of women in low socio-economic groups breastfed compared to 66% of those in high socio-economic groups.
- Recent investment in services and intended mandation of the universal elements of the HCP should support an improvement in the six high impact areas (see section 2.2) – while FNP will particularly impact those in lower socio-economic groups.

Impact of the transfer

- Allocations have been determined over a period of nine months, using the best available data from NHS England and local authorities. Allocations are based on current provision, and local authorities have been asked to provide no more than the NHS at the point of transfer.
- Funding provided should enable local authorities to provide the full scope of NHS provision at the point of transfer.
- Therefore allocations should not impact upon the level of service being provided, and therefore being received by those within this group. There should neither be a positive or negative impact on this group.

[39] https://www.gov.uk/government/publications/healthy-lives-healthy-people-update-and-way-forward

7. Engagement and Involvement

7.1. Was this work subject to cross government code of practice on consultation?

- There was no statutory requirement to consult on the process for determining allocations.

- The policy including the potential for mandating elements of the programme and the funding and commissioning routes were consulted on as part *Healthy Lives, Healthy People*[40] and policy proposals were set out in *Healthy Lives, Healthy People: An update and way forward*.[41]

- We have however run an informal engagement exercise, offering local authorities a chance to respond to the Department with regards to their proposed allocations. [See the Baseline Agreement Exercise[42]]

7.2. How have you engaged stakeholders in gathering evidence or testing the evidence available?

- The evidence-base that highlights the importance of early intervention, prevention and signposting by health visitors of specialist services is well established and a range of stakeholders have between 2011 to 2013 engaged with the Department to discuss development of the programme and associated actions that took forward *The Health Visitor Implementation Plan – A Call to Action*[43] (February 2011).

- Over 2000 people responded to the consultations launched as part of the *Healthy Lives, Healthy People White Paper*.[44]

[40] https://www.gov.uk/government/publications/healthy-lives-healthy-people-our-strategy-for-public-health-in-england
[41] https://www.gov.uk/government/publications/healthy-lives-healthy-people-update-and-way-forward
[42] https://www.gov.uk/government/publications/allocation-of-funding-for-0-5-public-health-services
[43] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213759/dh_124208.pdf
[44] https://www.gov.uk/government/publications/healthy-lives-healthy-people-our-strategy-for-public-health-in-england

7.3. Have you involved stakeholder in testing the policy or programme of proposals? (How and when and key outputs)

- Determination of local authority allocations have been overseen by the 'Finance and Contracting subgroup' and the '0-5 Public Health Commissioning Transfer Programme Board' (Board).

- Members of the Board and subgroup, include colleagues from:
  - Department of Health (DH).
  - NHS England (National and Regional representatives).
  - PHE.
  - LGA.
  - SOLACE.
  - ACDS.
  - ADPH.
  - DCLG.

- The role of the Programme Board is to provide assurance that the overall direction and management of the joint programme will successfully deliver the required outcomes, has played a key part. In summary its role is:
  - to lead on the assurance of the overall programme of transition of 0-5 Healthy Child commissioning to local authorities on behalf of sender and receiver organisations;
  - to be a place where sender (commissioning) and receiver (local authorities) organisations come together to make decisions;
  - to be the policy holder of the programme through accountability to Ministers;
  - to be a decision making body supported by clear escalation routes to resolve specific issues i.e. through Director General or Director led 1:1s, or through relevant reporting boards.

- The Board recognises that local government representatives are from member organisations and therefore cannot commit local authorities to particular actions, but can represent their views and advise on the most acceptable options to inform national policy and approach, and agree actions for the representative bodies.

- The 0-5 Public Health Commissioning Transfer Programme are accountable to the Children's Health and Wellbeing Partnership Board, ensuring the 0-5 Public Health Commissioning Transfer Programme Board has robust and strong decision making powers, with clear escalation routes to resolve specific issues.

- Early iterations of the proposed allocations were shared with both fora, to give them an opportunity to identify potential impacts of the process for agreement of the allocations.

- During the initial stages (stages one and two – see section 5.2 and 5.3) (autumn 2014) the LGA (funded by the Department) ran a number of **regional events** , which provided stakeholders (senders, receivers and providers) with the opportunity to debate the impact of the transfer of responsibilities for commissioning 0-5 children's public health services, and to highlight any areas of concern. [See link][45]

- The Department ran an **engagement exercise** (stage three – see section 5.4) from 11 December 2014 until 16 January 2015, proposed allocations were published in the Baseline Agreement Exercise, and local authorities were asked to let the Department know of any factual changes to the figures or any of the changes made as a result of local discussion. Local authorities were offered support through Regional Oversight Groups (PHE, LGA and NHS England) to support local authorities in facilitating agreements and identifying supportive information.

- Most local authority allocations were published on 13 February 2015 in the Transfer of 0-5 children's public health commissioning to Local Authorities: Allocations for 2015/16, the original equality analysis was published alongside this. Where local authorities (our **stakeholders**) raised specific issues in respect of whether the amounts transferring were an accurate reflection of the lift and shift of the service in their area, we deferred publication of the allocations to provide more time for local discussions between the Local Authority, the current commissioners (NHS England), and the provider about how to implement the lift and shift of the service.

- The majority of these deferred allocations were published today. For the remaining two Local Authorities, the local contract negotiation process has identified the need to address a number of complicated issues between commissioners and the provider in these areas.

- In determining the allocations we undertook some **scrutiny** of the proposed allocations. Senior colleagues from the NHS, PHE and the Department (finance and policy teams) met to analyse the proposed allocations, decisions taken by this group are explained fully in section 5.

[45] http://www.local.gov.uk/childrens-health/-/journal_content/56/10180/6337136/ARTICLE

- The Department has led a number of **informal meetings and conversations** with key stakeholders to further understand the position of local authorities across England. These have included numerous conversations with local authority public health commissioning leads, and colleagues at London Councils, the LGA and NHS England.

8. Summary of the Analysis

- Overall we believe the evidence suggests a neutral to positive impact on those affected by this transfer, mainly those within the 'pregnancy and maternity' protected characteristic group. The transfer aims to support stability in the system, with a longer term view of moving towards a system based on need, as advised by ACRA.

- In section 5, we have fully outlined the work we have undertaken to ensure that children under five and their families are not disadvantaged by the transfer of commissioning responsibility from NHS England to local authorities.

- The methodology used is proportionate and reasonable. The transfer follows a period of significant investment in health visiting services which has increased the number of health visitors and the number of FNP places offered across England. It ensures stability in the first six months and is based on the level of delivery at the point of transfer.

- From 2016/17 the 0-5 allocation will be included in the public health grant, which will be based on need, as advised by ACRA.

9. Action planning for improvement

- We recognise that the adjustments we have made to local authority allocations, in response to identified needs do not equate to a full needs based analysis, but that they begin to ameliorate potential inequalities to ensure that no child is disadvantaged by the transfer. These are our first steps in supporting those local authorities.

- Our approach is based on the first part of the transfer of public health funding in 2013/14, and tailored to the context of commissioning for 0-5s. Local authority allocations have been determined on the basis of lift and shift supported by funding adjustments including the minimum floor, that is, we have identified the scope of NHS England's existing obligations under service specification 27 of the Section 7A agreement between the Department and NHS England and funding relating to this will provide the main basis for local authority allocations. This is to ensure every local authority is able to deliver at least the same level of service in the second half of 2015/16 as the level of service delivered by the NHS at the point of transfer.

- For 2015/16, the public health grant will include an additional half-year's cost of commissioning 0-5 children's public health services and from April 2016, public health grant allocations, as advised by ACRA will include money for all public health responsibilities transferred to local authorities since 1 April 2013, including 0-5 children's public health services.

- An equality analysis looking at the local authority public health grants for 2013/14 and 2014/15 was published in January 2013. It considered the impact of the agreed process for determining local authority allocations, 0-5 was considered in this context, though it was agreed that the transfer would happen later. The summary of responses to the consultation is available here [46] and the overview of the responses to the engagement presented to ACRA is available on the Department's website.

- ACRA is developing its proposals for the formula for 2016/17 local authority public health allocations, which will include the 0-5 children's services component. As this is a new area of the public health great, the Department will facilitate for ACRA a brief exercise with local authorities and others to gather views on the part of the methodology that will take account of need for those 0-5 services as part of the overall public health grant. This engagement exercise will start later in February 2015 to conclude before the end of March 2015.

[46] http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_128840.pdf

- It should be noted that local authorities are public authorities and are subject to the equality duty in their own right. They have an ongoing responsibility to consider removing or minimising disadvantages experienced by certain groups of service users. In this vein, they should use the evidence available locally (e.g. from JSNAs) to inform their commissioning to ensure equitable delivery and continue to review this, mitigating any future negative impacts.

- The Department will continue to support local authorities in commissioning the four levels of health visiting service. Delivering the full service vision of which the five universal health visitor reviews are part, will give children and families the best possible outcomes. So commissioners should be mindful of the risk of over-focussing on the five universal health visitor reviews, which we intend to mandate. It's anticipated that the planned review of mandation (in 18 months), which will be led by the Department, with input from PHE will look at the impact of mandating the five universal checks on the broader service and the six high impact areas.

10. Next steps, challenges and opportunities

- As set out in Section 9, allocations for commissioning 0-5 children's public health services will be included in the wider public health grant from April 2016. ACRA will continue to develop the formula and will consult on this during 2015.

11. Annex 1

- The methodology we have used to calculate the minimum floor is set out below.

- NHS England led the process to determine how much money they are currently spending on commissioning 0-5 public health services, to ascertain what will transfer to local authorities on 1 October 2015. The second return refined the numbers and disaggregated costs by local authority and we made some central adjustments, as described in this document. This was our starting point.

- The spend per head was calculated by dividing the allocations (set out in the initial returns) by the projected mid-year population figures from ONS, for persons aged under 5.

- To ensure that these figures are comparable at local authority level, the allocations were divided by the Market Forces Factor (MFF), which takes account of the differences in the cost of delivering services across the country. These are now known as the adjusted spend per head totals.

- The MFF used is from the public health exposition book[47].

- All local authorities which were found to have an adjusted spend per head of £160 or less were then levelled up to this level. All other local authority proposed allocations remain the same.

- The new proposed allocations (for those local authorities with an adjusted spend per head of less than £160) were then recalculated by multiplying the spend per head by the population figures. The MFF is then reapplied to give the final actual allocations amount. This figure has been compared to the original allocation submitted by NHS England to see the uplift each local authority will receive.

[47] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/190643/Exposition_Book_Public_Health_Allocations_2014-15_April_2013.xlsx