



## Registered vs Residency

### Approaches to managing and resolving Registered and Resident Population issues

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On 1 October 2015 local authorities (LA) will take over responsibility for commissioning 0-5 year old children's public health services from NHS England. Progress on the transfer of commissioning arrangements is going smoothly with the majority of contracts now signed and final funding allocations made.

This note seeks to clarify issues relating to registered and resident populations which may be preventing progress from being made, particularly in signing off and transferring contracts before the transfer date. It is based on advice from and discussions with the Department of Health, Public Health England and NHS England.

#### Overview

The [National Health Visiting Service Specification 2014/15](#) required health visiting service providers to provide the 0-5 Healthy Child Programme (HCP) to all children resident in LA and to collect data with regard to both GP registered and the resident population. This would enable activity reporting on both bases. Until this change was applied, health visiting was provided and reported on a GP registered population in England.

Since 2013 providers have been working to ensure their information systems were sufficiently flexible to report by both registered and resident populations.

In some areas the changes have been slow and as a result there is variation in the ability of providers to provide data on a resident basis. This has resulted in the following concerns being raised by some LAs:

- 1) Uncertainty about the ability to measure and report performance on the mandated elements of local authorities' responsibilities, which are based on resident population.
- 2) The need to commission services for own residents where there is more than one provider and arrangements for receiving services from a provider that a LA does not intend to contract with.

Some LAs are interested in one or both of these issues, whilst in other areas they are not significant, or they have already been resolved locally.

## Reaching a resolution

There are no plans to publish national guidance because there is a national service specification in place. Therefore it is for local areas to agree an approach that works for them. Local partners will need to work together to ensure there is continuity of the 0-5 Healthy Child Programme services and good data flows both leading up to and post transfer. LAs can also continue to engage with NHS England on contractual issues prior to the 1st October transfer to ensure that the position is clear on the handover of commissioning responsibility.

Providers should provide the information required by the LA as the future commissioner and as agreed in the contract from 1st October 2015. Separately NHS England has written to providers to remind them that NHS England will no longer commission or pay for 0-5 year old children's public health services from 1st October 2015.

There is an underlying principle that information flows must follow the child and the child must have one complete electronic record in one local IT system. This will ensure records are not split between different IT systems which can have implications for safeguarding arrangements and the national datasets that are in development.

The below steps seek to offer some approaches and principles to support partners to agree a solution. They also aim to clarify the expectations and roles of each partner. In the vast majority of areas we hope step 1 will be workable. Steps 2 and 3 are available if the earlier step(s) cannot be made to work.

### **Step 1: assessing the differences between registered and resident**

- LAs want to secure the data they need prior to the transfer in order to comply with the mandated requirements. LAs may wish to refer to the principles in the [National Health Visitor Service Specification 2014/15](#), which sets out commissioning and reporting expectations.
- Most contracts do not specify the number of children to be seen and contract arrangements are usually based on services commissioned for a geographical population, not an individual. Within an area there might be services provided to registered patients from other areas but in most areas it is likely that there will be patient flows in both directions and the net impact won't be material.
- Service providers are responsible for ensuring that any coverage/ boundary issues that may arise are dealt with proactively in collaboration with neighbouring

providers. The delivery of the service will need to take account of the needs of the child and parent (including safeguarding needs). This should take precedence over any boundary discrepancies or disagreements. Commissioners have defined geographic areas and boundaries set out within their contracts. If providers are not reporting on a resident basis then commissioners through contract monitoring should ensure that providers have systems and an action plan in place. Providers should also work together and report to commissioners what system is in place when asked for this information.

- Public Health England (PHE) has done some mapping work to enable LAs to broadly assess how many children might be affected. PHE has also published the voluntary interim national reporting process and has provided detailed guidance on interim national reporting arrangements by resident population. Further information and support tools can be found at: <http://www.chimat.org.uk/transfer>
- Neighbouring LA commissioners will be able to work with their providers to understand the cross-boundary issues and to agree the best approach for children and families.
- If numbers are small, an arrangement which assumes and agrees that cross boundary issues cancel each other out may be most effective. Partners will want to ensure that the agreed arrangement is documented and monitored through the contracting process. Regional oversight groups may wish to share examples of the arrangements in place already.

## **Step 2: agreeing financial transfers**

- If the approaches outlined under step one have not been successful it may be because the number of children out of area (assessed using the PHE tools mentioned above) represent a significant workload. If so LAs may want to reach financial agreements with neighbouring areas to cover relevant costs. This conversation may have already happened as part of the discussions about the allocations. In general it is likely to be preferable to shift funding rather than disrupting the health visitors providing the service.
- There isn't a national tariff for these services and there are no plans to develop one. Some LAs have already worked together to look at activity between their areas and have reached local agreement on moving amounts of money. The Department of Health has always made it clear that it does not intend to reopen the allocations for 0-5s for 15/16. But if needed then money could be moved locally and an exercise could be run so that adjustments could be made for the 16/17 baselines. Further detail is expected at the beginning of September on the in-year adjustment process.

- Alternatively LAs may wish to use processes which are already in place for other services such as Looked After Children or other public health services such as sexual health.

**Step 3: changing provider arrangements if necessary**

- It is hoped that steps one and two will generally be sufficient for local partners to develop and implement a solution. The ROG can also offer some support and share learning about the approaches other LAs are taking.
- If it is necessary to change the provider and thus the health visitor providing the service, then LAs and their partners will want to consider phasing carefully to maximise continuity of services for all children, but particularly those under 1. Continuity of relationships during the first year are often seen as the most important measure of quality.