Public Health England

Protecting and improving the nation's health

Review of mandation for the universal health visiting service

October 2016

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health, and are a distinct delivery organisation with operational autonomy to advise and support government, local authorities and the NHS in a professionally independent manner.

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Background

- the Health and Social Care Act in 2013 moved the responsibility for commissioning of public health services from the NHS to local government
- transfer of responsibility for health visitor services was deferred to October 2015, including relevant aspects of the Healthy Child Programme 0-5 years, to allow time to complete the National Health Visiting Programme (NHVP)
- NHVP was a five-year investment in health visitor services that increased the workforce by approximately 4,000 (an increase of 50%) and transformed the way in which the service was delivered
- to secure the service through transition, and beyond, regulations were introduced mandating the delivery of five universal health visitor reviews for 18 months (to March 2017) after which time they would automatically expire
- the predominant rationale for mandation was to provide stability and secure long-term benefits from the Healthy Child Programme and investment in NHVP, improving outcomes for children and their families
- the regulations include a review before they expire to provide the minister with evidence as to whether they should be allowed to expire or action taken to continue the mandation
- Public Health England (PHE) was asked by the Department of Health (DH) to undertake this review and to report in October 2016. The timescale allowing for a ministerial decision and further legislative activity in the event that any action, other than simply leaving the regulations to expire, was required
- since these regulations were made, it has been announced that the government will consider options to replace the public health grant (PHG) as part of a move to 100% business rate retention (BRR). The Department for Communities and Local Government has recently completed a consultation on the future scope of BRR and responses are being considered

Methodology

- the review considered the impact of transfer, appetite for mandation, evidence of service transformation and risks to the sustainability from a range of perspectives using data from different sources
- the review was led by PHE's Best Start Programme Board, co-chaired by PHE's Chief Nursing Officer and a local authority chief executive, with representatives from local government, NHS England, Health Education England and other government departments
- Cabinet Office's Infrastructure and Projects Authority provided oversight and an external assessment of methodology, findings and conclusions
- the review team considered a range of official statistics and undertook a survey of stakeholders including local authorities (commissioners), health services

(providers) and health visitors (professionals). This was distributed through professional bodies and membership organisations; covering views on mandation, future commissioning intentions, service delivery, workforce levels and service transformation, as well as the contribution of the health visiting service in six high impact areas with measurable outcomes
- additionally, early consideration was given to how the health visitor workforce might support emerging government priorities in health and other wider family policies

Key findings
- there was a statistically significant increase in the eligible population reached by the universal service during 2015/16. The momentum of the health visitor programme being maintained through the transfer of responsibility
- there is largely a positive national picture of progress with statistically significant improvement observed in many relevant outcomes over the lifetime of the National Health Visiting Programme. However, there are some large local variations and trends in the rates of breastfeeding are disappointing
- the numbers of health visitors in NHS employment remained stable through 2015/16 but have since fallen slightly. This may be due to annual training and recruitment cycles, increases in non-NHS employment and frozen vacancies
- published commissioning intentions and survey responses outline extensive plans for change involving reduced investment, increased integration, skill mixed teams and a greater focus on outcomes
- across all stakeholder groups the majority view is that mandation should continue as is or in a revised form with greater flexibility. This is consistent within local authorities regardless of level or role and is reinforced by professional representatives of local government and the nursing profession
- all agree that these services deliver a positive return on investment and contribute to other government priorities such as childhood obesity, tobacco control and improving maternal mental health. More work is planned to improve and share the economic evidence base
- local authority stakeholders believe these services are comparable to other mandated functions in their potential to improve population health by improving outcomes, reducing inequalities, safeguarding all children

Conclusions and next steps
- early evidence suggests that mandation has helped to maintain the momentum of the National Health Visiting Programme
- this review has found widespread support for mandation to remain in place
- considering these findings and in anticipation of future changes to public health funding, SOLACE, LGA, ADPH and ADCS, representing local authority perspectives, recommend that mandation should remain in place, enabling consideration alongside the work on business rates retention and the public health grant

- the Best Start Programme Board will provide leadership to maximise the role of these services in emerging policy priorities for health and the wider family and to secure the delivery of benefits from the National Health Visiting Programme

Introduction

The Department of Health (DH) commissioned Public Health England (PHE) to review the mandated universal health visiting service following the transfer of commissioning for children's 0-5 public health services to local authorities on 1 October 2015.

The project has been led by PHE's multi-agency Best Start in Life Programme Board (see Appendix 1 for membership) and external assurance on methodology, findings and conclusions provided by the Cabinet Office's Infrastructure and Projects Authority (IPA), managed as part of the closedown of the health visitor programme.

The current regulations are designed to maintain the momentum achieved by the health visitor programme on service coverage, workforce levels and service transformation. The regulations (5A and 5B 2015/921), will expire at the end of March 2017 unless a decision is taken to extend them. The details of the commission and the regulations are included in Appendix 1.

The regulations describe an assessment and review of health and wellbeing for the benefit of pregnant women, children under 5 years and their families, as described in the Healthy Child Programme 0-5 years, of eligible persons, as far as is reasonably practicable, at specific stages of development, within a local authority area, where the review is provided once within the period. Eligible persons are:

- women more than 28 weeks pregnant
- a child aged 1 day to 2 weeks
- a child aged 6 to 8 weeks
- a child aged 9 to 15 months
- a child aged 24 to 30 months

The review should also identify children and families in need of additional health and wellbeing support, children at risk or those suffering from poor health or wellbeing. The regulations do not specify how these additional needs are to be addressed.

The reviews must be carried out by a health visitor or delegated to suitably qualified health professional or nursery nurse with guidance from and under the supervision of a health visitor. A health visitor is a registered nurse or midwife has undertaken a year's further post-registration training in child health, health promotion, public health and education. Health visitors are registered on Part 3 of the National Midwifery Council Register as a specialist community public health nurse. Such suitably qualified health professionals are trained in child health and development.

The obligations on the local authority, set out within the regulations, are that it must act to secure continuous improvement in the percentage of eligible persons participating in universal health visitor reviews.

Mandation of universal health visitor reviews was explicitly introduced to provide the *"context of a national, standard format, thus supporting universal coverage, and families' overall wellbeing; and to ensure local authorities build on the momentum of the Health Visitor Programme working to increase capacity and hence a continuation of service transformation."* Most importantly, *"mandation will also provide a degree of stability for families as the commissioning responsibilities transfer and embed into local authorities."*

The health visitor programme, 2010 to 2015, increased workforce levels by 50% – an addition of approximately 4,000 health visitors – and transformed the way in which they were working for the benefit of pregnant women, children under 5 years and their families.

The review will consider whether the stated objectives of the mandation have been achieved and the extent to which they have been achieved in terms of:

- the provision of five universal reviews
  - securing a national, standard format
  - improving universal coverage
  - improving the overall wellbeing of families

- maintaining the momentum of the health visitor programme
  - ensuring that workforce levels are not diminished by uncertainty
    ensuring that the potential of service transformation is realised

The review will also consider whether the objectives remain appropriate and, if so, the extent to which they could be achieved with less regulation.

PHE's review includes an assessment and assurance of the sustainability of the universal health visiting service and the 0-5 years Healthy Child Programme. Local future commissioning intentions and the impact of innovative service models are also considered. This includes the contribution of health visitors in the six high impact areas which link directly to measurable outcomes and also the potential to support delivery against national priorities such as childhood obesity, social justice and the new tobacco strategy.

Ministers will determine future arrangements based on the outcomes of this review and make a decision whether the regulations are allowed to expire, or continue in force with or without amendment. In compiling this report, PHE has considered the impact of the transfer, the appetite for mandation, the evidence of service

transformation and risks to the sustainability of the service from a range of perspectives using data from different sources.

Currently, the public health services delivered by local authorities are financed by an allocation from central government, which is ring fenced for public health. In October 2015, the Government announced that, by the end of this Parliament, a new model for funding local authorities will be established.

100% retained business rates

By the end of the Parliament, local government will be able to retain 100 per cent of local taxes to spend on local services. This will give councils control of an additional £12.5 billion of in business rates to spend on local services. This move towards self-sufficiency and away from dependence on central government is something councils have long campaigned for and will shape the role and purpose of local government for decades to come. In order to ensure that the reforms are fiscally neutral, these new powers must come with new responsibilities, as well as phasing out grants.

'Progress towards 100% retention of business rates is part of wider reform package – such as the option for local authorities to agree multi-year financial settlements and the abolition of the levy on revenue growth in the current business rates system.'

The purpose of fiscal devolution is to provide communities with the financial independence, stability and incentives to push for local growth and pioneer new models of public service delivery. Further details can be found at http://www.local.gov.uk/business-rates

This is a fundamental change to in the way the operations of local government are financed, including the responsibility for local public health. How this will impact on these services is not yet known.

Methodology

Information was collected from a number of different sources in order to form a rounded view of the current service, the extent to which it is delivering on its objectives, the challenges faced and plans for the future. These included routine data on service delivery and health outcomes, the views of key stakeholder groups and a review of published commissioning intentions. As much as possible data from different sources and perspectives was triangulated in order to verify findings and test assumptions. The detailed analytical methodology is included in Appendix 2.

Service delivery: health visiting service delivery metrics

Quarterly service delivery metrics have been reported to PHE by local authorities on a voluntary basis. These now cover all four quarters of 2015/16, two quarters pre-transfer of commissioning responsibility and two quarters post transfer. Four of these metrics relate directly to the regulations in that they measure service coverage for the population against specific time points. These are:

- percentage of New Birth Visits (NBVs) completed within 14 days
- percentage of 6-8 week reviews completed
- percentage of 12-month development reviews completed by the time the child turns 15 months
- percentage of 2-2½ year reviews completed

For each of these metrics it has been possible to apply statistical tests (see Appendix 2) to determine the trend over time during 2015/16 at national, regional and local levels. These are described as improving, deteriorating, no evidence of trend and insufficient data.

In addition, a composite trend over time has been defined across the four service points balanced in line with the aspirations of the regulations. The detailed definitions and statistical approach is available in Appendix 2 with the overall service delivery trend through transfer described as follows:

- improving
- stable with some areas of improvement
- stable
- deterioration of one or more mandated elements
- insufficient data

These have been calculated at national, regional and local levels.

Health outcomes: PHE's early years' profiles

PHE provides routine monitoring for a range of health and wellbeing outcomes indicators that relate to the 0-5 years population in line with the six high impact areas for the universal health visiting service. These are published in PHE's early years' profiles at national and local levels, as follows:

High impact area	**Outcome indicator**	**Status**
Transition to parenthood and the early weeks	Teenage pregnancy rates	Established
	Smoking in pregnancy	Established
	Low birth weight of term babies	Established
	Infant mortality	Established
Maternal (perinatal) mental health	Maternal mental health	In development
Breastfeeding	Breastfeeding at 6-8 weeks	Established
Healthy weight	Excess weight at 4-5 years	Established
Managing minor illnesses & reducing accidents	A&E attendance rates, under 5 years	Established
	Emergency hospital admissions, under 5 years	Established
	Hospital admissions for injuries, under 5 years	Established
Health, wellbeing and development	Tooth decay at 5 years, average number of decayed teeth	Established
	MMR immunisation coverage at 5 years	Established
	Development outcomes at 2-2 1/2 years	In development
	School readiness, good level of development at end of reception	Established

For each of these established indicators it has been possible to apply statistical tests (see Appendix 2) to determine the trend over time from the baseline of 2010, the start of the health visiting development programme. These trends have been calculated at national, regional and local levels and are each described as improving, deteriorating, stable or too early to say.

Stakeholder views: survey of key stakeholders

The views of a wide range of stakeholders were gathered using an online survey. This covered local leadership arrangements, views on mandation, commissioning intentions, benefits realisation and general comments on sustainability. The questions for the survey were developed and approved by PHE's Best Start in Life Programme Board. A copy is included in Appendix 3.

Links to the survey along with a covering letter inviting participation were distributed to the target audience via their representative bodies or membership organisations as follows:

Stakeholder group	**Individual role**	**Distribution via**
Local authority	Chief executive	Society of Local Authority Chief Executives (SOLACE)
	Director of public health	Association of Directors of Public Health (ADPH)
	Director of children's services	Association of Directors of Children's Services (ADCS)
	Health and wellbeing board chair	Local Government Association (LGA)
	Portfolio holder for public health	
	Lead member for children and young people	
	Commissioner	
Health services, NHS	CCG commissioners	NHS England regions – nursing leads
	Service provider	
Health visitors	Health visitor	Institute of Health Visiting (iHV) Community Practitioners and Health Visiting Association (CPHVA) School and Public Health Nurses Association (SAPHNA) Royal College of Nursing (RCN)

The survey ran from 29 June to 31 July 2016. Response volumes were tracked on a weekly basis and prompts issued to encourage engagement with the process. Survey responses were analysed using a range of quantitative and qualitative techniques. The details of these statistical techniques and approaches are included in

Appendix 2. In broad terms, the closed questions tested for differences of opinion between key stakeholder groups and the open, free text questions were subject to a thematic analysis which was analysed on a proportionate to ensure that the views of each stakeholder group were considered equally. All the survey results are shown throughout the report as tables (showing rounded figures for ease of interpretation) and charts (derived from the unrounded percentages).

Considered feedback from stakeholder representatives and membership organisations

The various representative bodies and/or membership organisations that were asked to help with targeting key stakeholder groups were also invited to comment on the preliminary findings from the national level analysis of the routine service delivery data, the outcome data and the stakeholder survey. SOLACE, ADPH, ADCS and LGA were invited to comment on findings from a local authority perspective, NHS England from a health services perspective and iHV, CPHVA, SAPHNA and RCN from a health visiting or nursing perspective. These consultations were managed predominantly by the members of PHE's Best Start in Life Programme Board, who represent those organisations.

A workshop was held for the nursing profession, with nominated representatives from iHV, CPHVA, SAPHNA and RCN. The preliminary findings from the national level analysis of the service delivery data, the outcome data and the stakeholder survey were presented and discussed in order to bring together a shared view on behalf of the profession.

The national analysis was shared with local authorities (directors of public health, in particular) through the regional PHE Centres. This was supplemented by a regional and local analysis of the service delivery and outcome data. This supported a regionally focused conversation, arranged via regular public health meetings, in order to provide further commentary on and validation of the initial findings.

Other input from academic experts and special interest groups

Whilst the stakeholder survey was open, and the targeted communications ongoing, a number of other stakeholder groups, who had not been included in the commissioned specification, contacted PHE requesting inclusion. These were predominantly academics and other experts involved in the development of the Healthy Child Programme and its associated evidence base and third-sector special interest groups or topic-based networks working on specific aspects of the programme. Examples of these included physical activity, infant feeding and safeguarding. Supplementary information was received from these groups and again used to cross check the main findings from the study.

Published commissioning intentions

Published commissioning intentions were explored by searching for content put into the public domain. To a large extent, this was formally published commissioning intentions, priorities and plans extracted from local authority meeting records and news items relating to service consultations or changes.

This information was reviewed for extraction of the principal forward plans for the service. Messages arising and the findings from this exercise were triangulated with the results of the stakeholder survey which contained specific questions on future commissioning intentions and proposal for service development and innovation.

Health visitor numbers in the workforce

The trends in health visitor numbers in the workforce were considered using official data from different sources. This included the electronic staff register (NHS), which is the master record of current employment and salary payment within the NHS, and also the official statistics published as the health visitor minimum dataset (MDS). Both of these datasets are published by NHS Digital (previously known as the Health and Social Care Information Centre (HSCIC). In addition, data from a special collection, the Indicative Health Visitor Collection (IHVC) published by NHS England as management information in support of the Health visitor programme, was also considered. IHVC was discontinued in September 2015.

External assessment: Infrastructure and Projects Authority

The Cabinet Office's Infrastructure and Projects Authority (IPA) undertook an assessment of the review on the 14 October 2016. This was managed as part of the closedown of the health visitor programme. The assessment considered the management, methodology, findings and conclusions of the review by using information provided by the project team and by interviewing senior stakeholders from the DH, PHE, local government and other government departments.

A final assessment will be made by the IPA in March 2017 when further progress and opportunities will be considered. In particular, this review will consider the benefits realisation strategy for the health visitor programme and delivery against the stated objectives and wider policy expectations, which include:

- improving access to services
- improving health and wellbeing outcomes
- reducing inequalities in health and wellbeing outcomes and
- improving the experience of service users

Results and discussion

Statistical tests have been applied to all results. The details of these tests are described in Appendix 2. All differences in national service delivery metrics, outcome indicators or surveyed opinion by stakeholder group are statistically significant and statistically significantly different from one another, unless marked otherwise.

Service delivery: health visiting service delivery metrics

National data for quarterly health visitor service delivery metrics during 2015/16, the year of transition, is shown in Table 1 below.

Table 1: Summary of trends in health visitor service delivery in England

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Summary of Health Visitor Service Delivery Metrics for England

Overall trends through transfer: Improving

Note: Overall trend is based on trends for indicators C2, C8i, C5 and C6i

Four quarters of 2015/16 (based on quarter 4 submission, data published July 2016)

Indicator	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Trend
C1: Number of mothers who received a first face-to-face antenatal contact with a Health Visitor at 28 weeks or above	60873	63716	64010	65056	**Not applicable**
C2: Percentage of New Birth Visits (NBVs) completed within 14 days	85.6%	86.8%	87.7%	87.8%	**Improving**
C3: Percentage of New Birth Visits (NBVs) completed after 14 days	11.8%	10.3%	10.0%	9.5%	**Not applicable**
C8i: Percentage of 6-8 week reviews completed	79.3%	78.8%	80.1%	82.7%	**Improving**
C8ii: Percentage breastfed at 6-8 weeks	44.1%	43.1%	43.0%	43.7%	**No evidence of trend**
C4: Percentage of 12 month development reviews completed by the time the child turned 12 months	72.5%	72.9%	73.2%	73.6%	**Not applicable**
C5: Percentage of 12 month development reviews completed by the time the child turned 15 months	79.8%	80.0%	80.9%	82.5%	**Improving**
C6i: Percentage of 2-2½ year reviews completed	71.2%	73.0%	74.2%	74.7%	**Improving**
C6ii: Percentage of 2-2½ year reviews completed using ASQ-3 (Ages and Stages Questionnaire)	71.4%	78.0%	86.3%	88.2%	**Improving**

It can be seen that the service is improving on all four of the delivery points, which can be tracked for population coverage and timeliness. These relate to the coverage in quarter 4 2015/16 as follows:

- new birth visit – 87.8%
- the 6-8 week visit – 82.7%

- the 1-year review – 82.5% and
- the 2-2$^{1}/_{2}$ year review – 74.7%.

Commentary from the stakeholder survey explains that parental engagement is slightly more difficult at the older ages as mothers have generally returned to work.

Taking all the trajectories on balance, it can be stated that the overall service delivery trend through transfer is one of improvement at a national level. In other words, on the whole, services have maintained the momentum of the health visitor transformation programme through the transition. It is not possible to say to what extent the improvement may be due to local authority commissioning or simply the result of the existing momentum within the system. Most contracts were novated across from October 2015 and little renegotiation had taken place by the end of 2015/16. Repeating this exercise based on service data to the end of 2016/17 is likely to produce a more accurate representation of the impact of mandation on these services, as by this time local authorities will have held the responsibility for 18 months.

The overall service delivery trend through transfer has also been calculated at a regional level and the results are shown in Table 2.

Table 2: Regional trends in health visitor service delivery metrics

Region	**Overall trend in service delivery**
East Midlands	Stable with some areas of improvement
East of England	Improving
London	Stable with some areas of improvement
North East	Deterioration of one or more mandated elements
North West	Improving
South East	Stable with some areas of improvement
South West	Improving
West Midlands	Deterioration of one or more mandated elements
Yorkshire and the Humber	Improving

The details behind the overall trends at regional level are included in Appendix 4. The deterioration in service noted for the North East and the West Midlands relates only to completion of a review at 6-8 weeks, all other service points are either improving or stable at regional level.

Whilst the picture at national level is encouraging, at a local level it is more mixed with variable assessment of overall trends through transfer. These are shown for 150 different local authorities in 2015/16 (Isles of Scilly is combined with Cornwall and City of London is combined with Hackney because of small numbers) in Table 3 below.

Table 3: Regional distribution of overall trends in health visitor service delivery through transfer

Overall trend through transfer in 2015/16	Number of local authorities
Improving	20
Stable with some areas of improvement	47
Stable	21
Deterioration of one or more mandated elements	52
Not enough evidence	10

Many organisations have struggled with data quality issues through the transition. This is largely due to poor information systems at a local level. The issues were further exacerbated by a switch from the responsible cohort being defined by registration for NHS services (GP practice registration) to residence within a local authority area, which resulted in boundary issues for some services and necessitating changes to commissioning data flows.

It has not been possible to assess the service delivery through transfer for 10 local authorities because of missing data or exceptionally poor data quality, despite the fact that all organisations provided as much information as they were able, on a voluntary basis, to support this process.

In all, 88 local authorities were assessed as stable or improving in an overall sense while 52 organisations saw deterioration in the delivery and population coverage of one or more of the universal reviews. A breakdown of which aspects of service have experienced deterioration at local level is shown in Table 4.

Table 4: Deteriorating elements of service delivery, local authority distribution

Deteriorating elements of mandated service at local level	Number of local authorities
New birth visit and 6-8 week review	4
New birth visit and 1 year review	1
6-8 week review only	32
6-8 week review and 1 year review	3
6-8 week review and 2-21/2 year review	7
1 year review and 2-21/2 year review	4
All four elements	1
Total number	**52**

Table 4 illustrates that the majority of deterioration in service levels at a local level is associated with the review at 6-8 weeks. While some of this may be a real trend,

there are risks that this is an artefact of changes in reporting routines, which relate specifically to the 6-8 week review. Historically, while under the control of health, some areas reported on the GP led assessment (infant physical examination) at 6-8 weeks, in addition to the health visitor led review, which may have artificially boosted coverage. The GP element was later stripped out as focus on the universal health visitor reviews intensified.

The intention of the mandation was to secure the drive for universal coverage and to maintain the momentum of the health visitor programme. Whilst this has, so far, been achieved at a national level and in the majority of local areas some local authorities maybe struggling to either maintain the levels of service coverage which they inherited or to assure the quality of the data which they are using for management reporting.

In addition, and bearing in mind the challenges with data quality, some local areas are reporting almost universal levels of coverage for the health visitor reviews while some local areas are reporting levels which indicate that a very reduced service is available. The regional average picture on population coverage for the four aspects of universal service which can be tracked is shown in Table 5 and Figure 5 for Quarter 4 of 2015/16.

Figure 5: Population coverage for universal services, regional average in Q4 2015/16

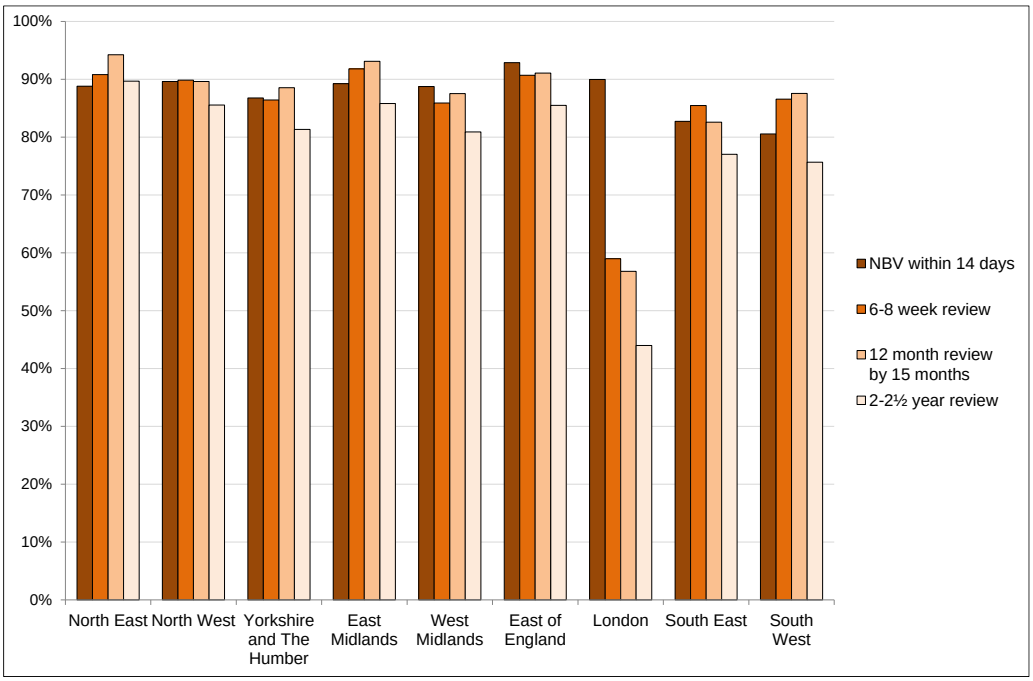


Table 5: Population coverage for universal services, regional average in Q4 2015/16

	C2: Percentage of births that receive a face to face New Birth Visit (NBV) within 14 days by a Health Visitor	C8i: Percentage of infants who received a 6-8 week review by the time they were 8 weeks	C5: Percentage of children who received a 12 month review by the time they turned 15 months	C6i: Percentage of children who received a 2-2½ year review
North East	88.8%	90.8%	94.2%	89.7%
North West	89.6%	89.8%	89.6%	85.5%
Yorkshire and The Humber	86.8%	86.4%	88.5%	81.3%
East Midlands	89.2%	91.8%	93.1%	85.8%
West Midlands	88.8%	85.9%	87.5%	80.9%
East of England	92.9%	90.7%	91.1%	85.5%
London	90.0%	59.0%	56.8%	44.0%
South East	82.7%	85.5%	82.6%	77.0%
South West	80.5%	86.6%	87.5%	75.7%
Please note:				
One local authority in the North West and one in London did not submit any values for 6-8 week reviews; these could therefore not be included in the regional totals				
One local authority in London did not submit any values for 12 month reviews; this could therefore not be included in the regional total				

From Table 5 and Figure 5 it can been seen that for most regions the universal service is delivered on average to around 80% of the eligible population of children and in some regions to 90% or above. The exception is London where although coverage of the new birth visit is high at 90.0%, this tails off for the later visits with only 59.0%, 56.8% and 44.0% of children were seen at 6-8 weeks, 1 year and 2-2$^{1}/_{2}$ years respectively during quarter 4 or 2015/16. Despite data quality issues, reporting problems due to changes in IT systems and difficulties in attracting the desired number of health visitors to the region through the duration of the health visitor programme, London has shown a stable position with some areas of improvement in population coverage during 2015/16 but clearly started from a weaker baseline than the rest of the country.

At a local level the variation in service coverage is even greater with a number of local authorities delivering some elements of the universal service to less than 50% of the eligible population of children in quarter 4 of 2015/16. These figures are shown in Table 6.

Table 6: Number of local authorities in service coverage bands, Q4 2015/16

	Number of local authorities					
	less than 50% completed	between 50 and 60% completed	between 60 and 70% completed	between 70 and 80% completed	between 80 and 90% completed	between 90 and 100% completed
C2: Percentage of births that receive a face to face New Birth Visit (NBV) within 14 days by a Health Visitor	0	2	2	16	49	81
C8i: Percentage of infants who received a 6-8 week review by the time they were 8 weeks	12	4	6	19	42	65
C5: Percentage of children who received a 12 month review by the time they turned 15 months	9	5	8	22	32	73
C6i: Percentage of children who received a 2-2½ year review	20	9	15	20	38	48

Here it can be seen that during quarter 4 2015/16 the service was delivered to less than 50% of the eligible population by 12 local authorities at 6-8 weeks, by 9 local authorities at 1 year and by 20 local authorities at 2-2$^{1}/_{2}$ years. In some specific areas the service was delivered to less than 10% of the eligible child population.

Notwithstanding the underlying issues with data quality and data availability, it seems in some cases that whether or not families benefit from this service depends on where they live in the country. The lower starting point in terms of service

provision at the point of transition may explain this to some extent. The underlying reasons for this variability in service levels are not clear but the picture is reinforced by the commentary provided as part of the stakeholder survey (see section on recommendations on mandation), where issues are raised to do with the sustainability of the service.

Overall it can be seen that the mandation is achieving the objectives for improved service delivery at a national level but has not fully achieved the desired effect in all parts of the country.

Health outcomes: PHE's early years' profiles

National data on health outcomes indicators relating to 0-5 years, which is monitored on an ongoing basis in PHE's early years' profiles, is shown in Figure 7 below.

These indicators have been monitored since 2010, at the start of the health visitor improvement programme, and the most recent annual data relates generally to 2014/15. The data for these indicators derives from multiple sources. Due to the lag inherent in data flows and the national production of official statistics, the trends over time observed can be related to the period of sustained investment in health visiting but not directly to the period of transition from NHS to local authority commissioning. Thus, no comment can be made at this time regarding the impact of either the transfer of commissioning or the mandation of these services on health outcomes. Where there was sufficient data to both calculate the annual indicators and successfully analyse the trends over time, it can be seen that during the period of investment many of these indicators improved. At national level there have been improvements in teenage pregnancy, smoking in pregnancy, infant mortality, excess weight, hospital admissions for injury and coverage of the MMR vaccination. While these improvements cannot be directly attributed to the health visiting service, which is just one component of a complex and dynamic public health system, health visitors are well placed to inform and influence the multiple individual decisions made within families which help to drive these outcomes.

At the same time there has been some deterioration in rates of attendance at A&E and rates of breastfeeding at 6-8 weeks. For breastfeeding, this is regrettable given that rates in England, at 43.8% in 2014/15, compare unfavourably on an international basis. (See Lancet series on breastfeeding)

Increases in A&E attendance rates have been seen in all age groups and this is thought to be predominantly due to structural factors within the NHS such as timely access to GP services.

It should not be overlooked that breastfeeding rates are influenced by a range of complex factors such as cultural norms, health services, community based services,

community groups and direct interaction with key professionals such as midwives, GPs and health visitors. Midwifery services, which are commissioned by CCGs, are critical to provision of breastfeeding information during the antenatal period and have direct impact on the initiation of breastfeeding shortly after delivery. However, breastfeeding is also amenable to influence by the health promotion, nutrition and weaning advice, guidance and support given by health visitors, and the data at 6-8 weeks is reported via this service.

Figure 7: Trends in outcomes indicators at national level

Public Health England

Protecting and improving the nation's health

Early Years Profile: England

Latest data as of July 2016

High impact area	Key performance indicators	Current performance	Range (all local authorities)	Trend since 2010	
Transition to parenthood and the early weeks	Teenage pregnancy rates	22.8 per 1,000 15-17 year olds (2014)	Best: 8.4 Worst: 42.4	**Improving**	↓
	Smoking in pregnancy	11.4% (2014/15)	Best: 2.1% Worst: 27.2%	**Improving**	↓
	Low birth weight of term babies	2.9% (2014)	Best: 1.6% Worst: 5.8%	**Stable**	↔
	Infant mortality	4.0 per 1,000 live births (2012-14)	Best: 1.6 Worst: 7.2	**Improving**	↓
Maternal (perinatal) mental health	Maternal mental health	Metric in development		**Not applicable**	
Breastfeeding	Breastfeeding at 6-8 weeks	43.8% (2014/15)	Best: 81.5% Worst: 19.1%	**Deteriorating**	↓
Healthy weight	Excess weight at 4-5 years	21.9% (2014/15)	Best: 14.9% Worst: 27.4%	**Improving**	↓
Managing minor illnesses & reducing accidents	A&E attendance rates, under 5 years	540.5 per 1,000 (2014/15)	Best: 263.6 Worst: 1761.8	**Deteriorating**	↑
	Emergency hospital admissions, under 5 years	147.0 per 1,000 (2014/15)	Best: 62.3 Worst: 265.8	**Stable**	↔
	Hospital admissions for injuries, under 5 years	137.5 per 10,000 (2014/15)	Best: 45.0 Worst: 292.4	**Improving**	↓
Health, wellbeing and development	Tooth decay at 5 years, average number of decayed teeth	0.84 per child (2014/15)	Best: 0.37 Worst: 2.46	**Too early to say**	
	MMR immunisation coverage at 5 years	88.6% (2014/15)	Best: 97.5% Worst: 64.0%	**Improving**	↑
	Development outcomes at 2- $2^{1}/_{2}$ years	Metric in development		**Not applicable**	
	School readiness, good level of development at end of reception	66.3% (2014/15)	Best: 77.5% Worst: 50.7%	**Too early to say ****	

** Not enough data points to calculate a trend, due to methodological changes in 2012

Key

Increasing, improving	↑
Decreasing, improving	↓
Increasing, deteriorating	↑
Decreasing, deteriorating	↓
Stable	↔

There is a marked variation in breastfeeding rates at 6-8 weeks across the country. During 2014/15, rates for English local authorities varied from 19.1% to 81.5%.

While statistical tests reveal that levels of breastfeeding reported on an annual basis are deteriorating at a national level it has not been possible to calculate the trend in breastfeeding for all regions due to issues with data quality. The status of the breastfeeding trend for all regions is shown in Table 8 below, and this is an area for attention from the perspectives of both policy and practice.

Table 8: Overall trends in breastfeeding rates at regional level

Region	Trends in breastfeeding rates
East Midlands	Improving
East of England	No validated data at regional level
London	No validated data at regional level
North East	No validated data at regional level
North West	No validated data at regional level
South East	No validated data at regional level
South West	No validated data at regional level
West Midlands	No validated data at regional level
Yorkshire and the Humber	No validated data at regional level

The details behind the overall trends at regional level are included in Appendix 5.

The importance of the universal health visiting service to establishing meaningful contact between professionals and families in order to encourage breastfeeding has been reinforced by submissions from the GP Infant Feeding Network (GPIFN) and UNICEF (see Appendix 7).

Note: Planned improvements in data quality are tied to the implementation of a record level data collection by NHS Digital, the Children and Young People's Health Services Dataset (CYPHS).

Health visitor numbers in the workforce

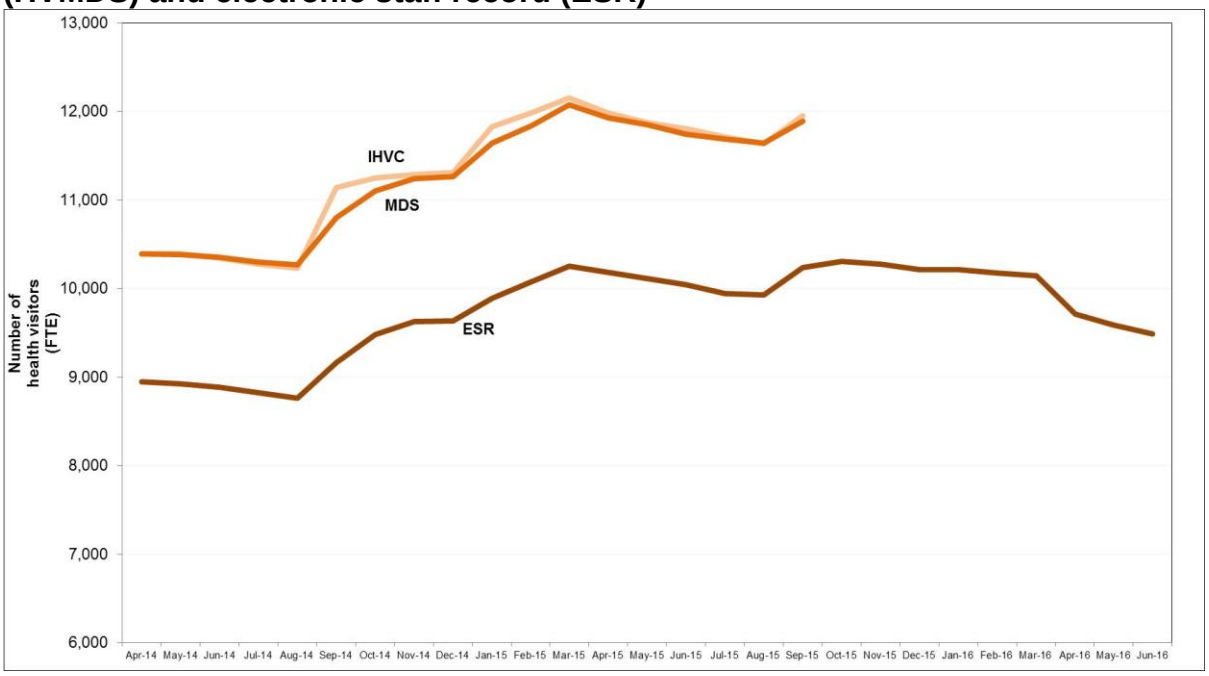
Published statistics on the numbers of health visitors in the workforce are presented in Table 9 and Figure 9 from the three different information sources available.

Table 9: Published Health Visitor numbers, showing gap in reports between Indicative Health Visitor Collection (IHVC), Health Visitor Minimum Dataset (HVMDS) and electronic staff record (ESR)

	Health Visitor Collection (NHS England)	Health Visitor Minimum Dataset (HSCIC)	Electronic Staff Record (NHS Digital)	Difference IHVC and HVMDS	Difference MDS and ESR
Apr-14	10,395	10,389	n/a		
May-14	10,389	10,382	n/a		
Jun-14	10,345	10,350	n/a		
Jul-14	10,274	10,298	n/a		
Aug-14	10,228	10,265	n/a		
Sep-14	11,138	10,800	n/a		
Oct-14	11,247	11,102	n/a		
Nov-14	11,290	11,239	n/a		
Dec-14	11,310	11,268	n/a		
Jan-15	11,828	11,643	9,889	2%	18%
Feb-15	11,982	11,838	10,075	1%	17%
Mar-15	12,157	12,077	10,257	1%	18%
Apr-15	11,984	11,929	10,185	0%	17%
May-15	11,878	11,850	10,111	0%	17%
Jun-15	11,807	11,744	10,042	1%	17%
Jul-15	11,713	11,690	9,943	0%	18%
Aug-15	11,637	11,642	9,928	0%	17%
Sep-15	11,955	11,895	10,236	1%	16%
Oct-15	n/a	n/a	10,309		
Nov-15	n/a	n/a	10,279		
Dec-15	n/a	n/a	10,212		
Jan-16	n/a	n/a	10,213		
Feb-16	n/a	n/a	10,178		
Mar-16	n/a	n/a	10,144		
Apr-16	n/a	n/a	9,711		
May-16	n/a	n/a	9,592		
Jun-16	n/a	n/a	9,491		

Note: The different reporting systems are not directly comparable and careful interpretation of these numbers is required. In addition, ESR data only relates to whole-time equivalent numbers currently employed within the NHS. More detail is provided in the following commentary.

Figure 9: Published health visitor numbers, showing gap in reports between Indicative Health Visitor Collection (IHVC), Health Visitor Minimum Dataset (HVMDS) and electronic staff record (ESR)



The number of health visitors in employment increased by approximately 4,000 between 2010 and 2015. This was a direct result of the activities of the health visitor programme. During the lifetime of the programme, the numbers were tracked via the Health Visitor Minimum Dataset (MDS) a set of official statistics published by the Health and Social Care Information Centre (HSCIC). The Health Visitor MDS included data from the NHS electronic staff record (ESR), which can only report on whole-time equivalent numbers in employment within the NHS at any point in time, data collated on health visitors employed by social enterprises, local authorities and private providers and also data on health visitors returning to practice.

Reporting of the health visitor MDS was not particularly timely due to lengthy quality assurance processes and so an additional special collection, the Indicative Health Visitor Collection (IHVC) was introduced in April 2014. The IHVC was published as management information but provided a more real-time indicative view of the workforce. Through the IHVC it was possible to understand the planned workforce by considering the workforce establishment (including filled posts and any current vacancies) and also to track the pipeline of new health visitors graduating from and engaged in training.

Both the health visitor MDS and the IHVC were stood down in September 2015 as the health visitor programme closed and the responsibility for commissioning these services transferred to local authorities. This also coincided with a consultation and revision of the way in which NHS workforce statistics were reported, which was implemented from September 2015.

Table 9 and Figure 9 show that during the final year of the health visitor programme there was a reasonably consistent gap (approximately 1,700) in health visitor numbers reported by the health visitor MDS and by the NHS ESR. At this time, the gap would be made up of health visitors employed outside the NHS and those returning to or just starting in practice for whom employment had not yet been recorded onto ESR.

Since October 2015, it has only been possible to track health visitor numbers using the ESR. This has limitations as not all health visitors are employed within the NHS and the ESR data includes no information on vacancies. Also the data is reported in arrears and the latest data available is June 2016. In addition, some changes have been made to the way in which ESR data is reported, which were implemented from September 2015 onwards. They include changes to how staff are counted, as well as which organisations are included across the NHS. For this reason, a cautious approach needs to be taken to the interpretation of this data.

Figure 9, using ESR data, shows a stable post-transfer picture for the second half of 2015/16 followed by a decrease in the numbers employed by NHS providers between March 2016 and June 2016. It is too early to say whether this is a true decrease, a periodic fluctuation (as numbers are affected by annual training and recruitment cycles) or a change in commissioning approach. In addition, is it not possible to determine exactly how many health visitors are in employment in non-NHS organisations such as community of interest organisations, social enterprises, local authorities or private sector organisations or indeed how many may have been transferred from an NHS employer to a non-NHS employer as service contracts have been renegotiated and/or services have been brought in house by local authorities. It is also possible that the recent drop may be due to a cautious approach to recruitment on the part of employers, given active recommissioning within the sector, deliberating over decisions on whether or not to fill vacancies.

One of the aims of the regulations was to provide certainty so that the momentum of the health visitor programme would be sustained. While this may have been achieved around the proximity of the transfer, it is too early to tell whether or not it will be sustained in the longer term.

The section on responses to the stakeholder survey covers stakeholder perceptions on the numbers of health visitors required to deliver planned future service models. This and future commissioning intentions, which are described in the same section, also provide some insight into how health visitor numbers might be expected to change in the future.

In addition, it is not currently possible to monitor the evolution of the public health workforce in general and consideration should be given to the extent to which a workforce data collection which crosses different settings and supports future

workforce planning, may be required. This will become increasingly important as the workforce progressively becomes embedded in non-NHS settings.

At the peak of the health visitor programme, funded training places commissioned by Health Education England (HEE) peaked at approximately 1,000 per annum. For the academic year 2015/16 (884/1,042), 85% of these places were filled. It is too early to tell if the gap between the planned and actual education commissions reflects some uncertainty on the part of professionals, is simply due to the winding down of the health visitor programme or organisations looking at new models of service delivery. The current out-turn on trainee numbers will not be published by HEE until December 2016, but funded places have been adjusted to a maintenance level of 817 for 2016/17. A key milestone will be to monitor the impact of the 2016 cohort of trainees as they enter the workforce.

Stakeholder views: Survey of key stakeholders

The stakeholder survey attracted a good response with 3,704 submissions. The majority of these (3,130 responses) were from health visitors themselves. The details of three high level stakeholder groups and respondent role types are shown in Table 10 below.

Table 10: Survey responses received, by respondent role

Role (grouped by type)	Number of responses
Local authority	**284**
- LA chief executive or elected member	41
- Director of public health	79
- Director of children's services	24
- Local authority commissioner	140
Health services, NHS	**290**
- CCG commissioner	61
- Provider of health visiting services	229
Health visitors	**3,130**
Total	**3,704**

A total of 284 responses were from staff based within local authorities ranging from the chief executive and elected members, directors of public health and of children’s services and the commissioners themselves. In some cases, individuals within local authorities responded from their own professional, role-based perspectives. In other cases, they put forward a corporate, shared position. It is clear from some responses that some organisations are working in close collaboration with a common strategic position and shared service contracts.

In the interests of preserving confidentiality and encouraging open responses, the survey did not seek to identify the local authority from which the respondent came,

just the region. This means that as 284 responses came from 150 local authorities, good coverage can be assumed, although it is not known whether the views of all local authorities have been represented. There is, however, a good spread of local authority based respondents across England, as seen in Table 11 below.

Table 11: Regional distribution of responses to stakeholder survey

Region	**Number of local authority responses**
East Midlands	15
East of England	32
London	49
North East	13
North West	39
South East	49
South West	30
West Midlands	25
Yorkshire and the Humber	31

Good coverage can also be assumed from the health service perspective, with responses from all regions. There are currently 209 clinical commissioning groups (CCGs) and approximately 135 providers of health visiting services. A total of 290 responses were received from CCG commissioners and from providers of health visiting services. Approximately one third of the health visitor workforce responded to the survey.

Survey respondents from local authorities were also invited to answer the question: “Within your local authority, which director is responsible for children’s public health 0-5 years?” The results are shown in Table 12 below.

Table 12: How survey respondents working within local authorities answered the question: “Within your local authority, which director is responsible for children’s public health 0-5 years?”

Local responsibility for children’s public health 0-5 years (asked of local authority staff only)	**Number of responses** responses
Director of public health	229
Director of children's services	33
Joint	11
Other	8
Don't know	3

From this it can be seen that in most cases the strategic lead for these services comes from the director of public health. A sizeable minority are led by the director of children’s services and there are also examples of where this leadership is shared

between the public health and children's services functions. Where respondents answered 'other' they were then asked for more detail. Some highlighted the local authority chief executive or another director as providing the overall leadership for the 0-5 public health function.

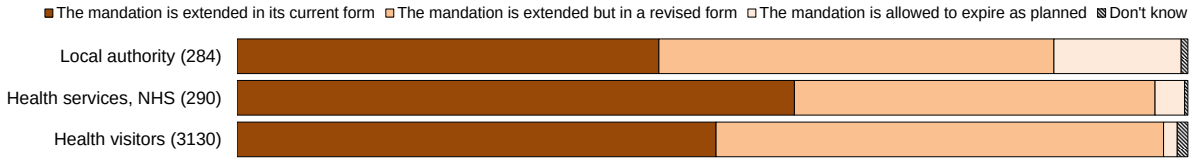
Recommendations on the future of mandation

Each respondent was asked for their recommendation on what should happen next with respect to mandation and these were analysed by the three main stakeholder groups. The exact question was: "Existing legislation, mandating the five universal health visitor reviews are delivered for every child, is due to expire at the end of March 2017. What would you recommend happens next?" The options were:

- the mandation is extended in its current form
- the mandation is extended in a revised form
- the mandation is allowed to expire as planned and
- don't know

The results are shown in Table 13 and depicted graphically in Figure 13.

Figure 13: Responses by stakeholder group to the question: "Existing legislation, mandating the five universal health visitor reviews are delivered for every child, is due to expire at the end of March 2017. What would you recommend happens next?"



Note: Bar lengths represent the proportion of responses in that category from the stakeholder group. The bar lengths were calculated using unrounded percentages, and so may appear slightly inconsistent with the rounded percentages shown in the table.

Table 13: Responses by stakeholder group to the question: "Existing legislation, mandating the five universal health visitor reviews are delivered for every child, is due to expire at the end of March 2017. What would you recommend happens next?"

	Mandation is extended in its current form	Mandation is extended but in a revised form	Mandation is allowed to expire as planned	Don't know
Local authority (284)	44%	42%	13%	1%
Health services, NHS	59%	38%	3%	0%
Health visitors (3130)	50%	47%	1%	1%

All percentages shown reflect the proportion of responses in that category from the stakeholder group. Rows total 100% (subject to rounding). All results are statistically significantly different unless stated otherwise.

It can be seen that there is strong support for the mandation to either be extended in its current form or extended in a revised form. This is true of all stakeholder groups with local authorities at 86% (44% current, 42% revised), health services at 97% (59% current, 38% revised) and health visitors at 97% (50% current, 47% revised). Although local authority support for extending mandation in some form is not quite as strong as the other two stakeholder groups it still represents a significant proportion of responses at 86%.

In order to understand these results further from a local authority perspective the responses to this question from the role based subgroups have been analysed. Due to smaller numbers of respondents in some subgroups it has been necessary to batch responses from local authority chief executives with those from elected members in key roles (lead member for children & young people, health & wellbeing board chair and portfolio holder for public health). The results are shown in Table 14 and Figure 14.

Figure 14: Responses by local authority role based subgroup to the question: "Existing legislation, mandating the five universal health visitor reviews are delivered for every child, is due to expire at the end of March 2017. What would you recommend happens next?"

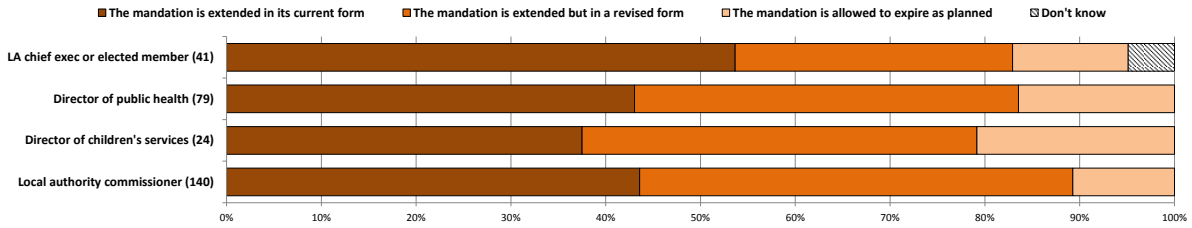


Table 14: Responses by local authority role based subgroup to the question: "Existing legislation, mandating the five universal health visitor reviews are delivered for every child, is due to expire at the end of March 2017. What would you recommend happens next?"

	The mandation is extended in its current form	The mandation is extended but in a revised form	The mandation is allowed to expire as planned	Don't know
LA chief exec or elected member (41)*	54%	29%	12%	5%
Director of public health (79)*	43%	41%	16%	0%
Director of children's services (24)*	38%	42%	21%	0%
Local authority commissioner (140)*	44%	46%	11%	0%

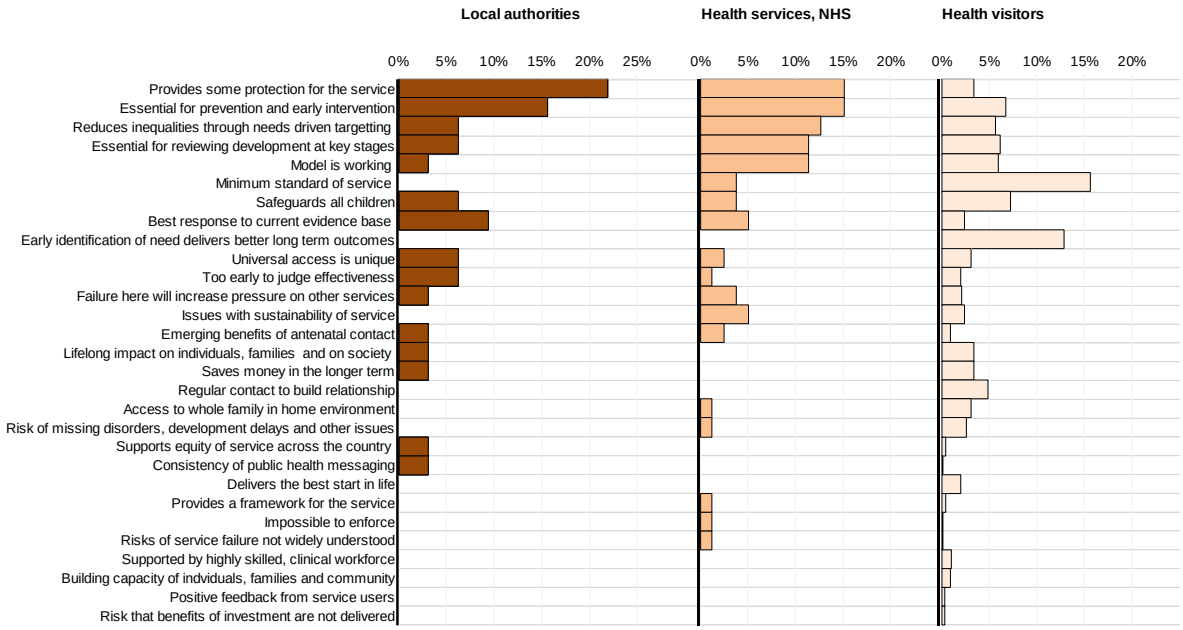
* Results not statistically significantly different from each other

Here it can be seen that the different role-based subgroups within local authorities hold similar views on the future of mandation. There exists strong support for mandation to be extended in its current form or extended in a revised form. It should also be noted that statistical tests have shown that there is no difference between the responses to this question from the differing role-based perspectives within a

local authority. Indeed, there is a good level of consensus on the future of mandation from a local authority perspective.

The reasons behind this recommendation are reasonably consistent and have been analysed thematically within and between each stakeholder group. These are presented graphically in Figure 15 for themes articulated for extending the mandation in its current form and are ordered in terms of the overall extent to which this theme appears in the analysis.

Figure 15: Respondents who recommended the mandation is extended in its current form – main reasons given. Percentages show the proportion of all individual (single-themed) comments received by that stakeholder group



The single most common theme is that mandation provides some sort of protection for the service. This theme is expressed most significantly by local authorities, then by the health service and to a lesser extent by health visitors themselves. The logic for this seems to be that while the service is recognised as important, it is now being commissioned within the context of increasing financial constraints and that mandation will encourage local authorities to prioritise these services as best they can when making difficult decisions on the future allocation of resources. There are also some less frequent comments from the health services and health visiting stakeholder groups about issues surrounding the sustainability of the service and that the risks of service failure are not widely understood.

The second theme is about these services being essential for prevention and early intervention. This point of view was expressed strongly by those working in local authorities and health services and also appears to a lesser extent in the

commentary from health visitors. It is difficult to separate this from any other evidence-based practice in public health or indeed the underpinning rationale for the Healthy Child Programme, which appears in many of the other themes identified. For example:

- the best response to the current evidence base
- essential for prevention and early intervention
- essential for reviewing development at key stages
- risk of missing disorders, development delays and other issues
- failure here will increase pressure on other services
- lifelong impact on individuals, families and society
- saves money in the longer term

Note: The evidence base behind the Healthy Child Programme and the six high impact areas for health visiting is summarised in Appendix 8.

These themes all appear to different extents but are essentially the rationale for a preventative approach and for early intervention, which are consistently identified across all stakeholder groups. Health visitors alone commented that early identification of need delivers better long-term outcomes and this was their second most commonly expressed theme. Again, this is an argument for prevention and early intervention although it may have been articulated slightly differently p as a result of the prevailing culture in that stakeholder group.

The third theme is about these services reducing inequalities by targeting services based on need. This is identified most strongly by the health services and to a lesser extent by local authorities and health visitors. The logic for this can also be combined with other identified themes but essentially all children are seen and their needs within the family context identified. These needs can be addressed through early intervention and the service tailored to meet needs.

The universal aspect of the service is flagged as being unique, because all children are seen but also they are seen in the context of the family; health visitors have privileged and accepted access to the whole family in the home environment. This enables them to deliver services in a non-stigmatising way because they are widely accepted as available to all and the regular contacts support the relationship building required for disclosure. All stakeholder groups identify this as being important in that this safeguards all children and may be particularly important in situations where there is domestic violence, existing or emerging mental health issues, substance misuse, disabilities or other difficult issues. Local authority colleagues highlight the fact that safeguarding all children is a defined responsibility and without this service it is possible for children not to be seen by any professional until they start school or not at all if they are home educated.

The National Network of Designated Health Professionals for Safeguarding Children (NNDHP), the GP Infant Feeding Network (GPIFN) and the National Children's Bureau (NCB) have written to emphasise the importance of the universal service to safeguarding and child protection (see Appendix 7).

Models of health visiting allow for additional support for all families who need it in response to known difficulties or as additional problems arise. The universal services enable early identification of need and early intervention in a non-stigmatising manner for families with new and enduring problems.

The most common theme expressed by health visitors is that the current regulations describe the minimum standard of service. That is the five universal contacts are the minimum number required to support credible identification of the families which need additional input. They are the core of the service upon which everything else is built. This theme is also identified to some extent by the health services but not at all by local authorities. The health visitors feel that all children need and indeed deserve the five contacts and that more contacts would be ideal for all children. This theme will be expanded on in the section on proposed changes for mandation to be extended in a revised form.

There is a widely held view across all stakeholder groups but most prominently articulated by health services that the mandation should be extended because the model is working. This is reinforced by the tentative and somewhat premature analysis of quarterly trends in service delivery metrics through the transition year 15/16, which show improvement at a national level. However, it was clear from the analysis that it would be advisable to allow the service another year before reliable statistics relating to the time of local authority responsibility for commissioning can be generated.

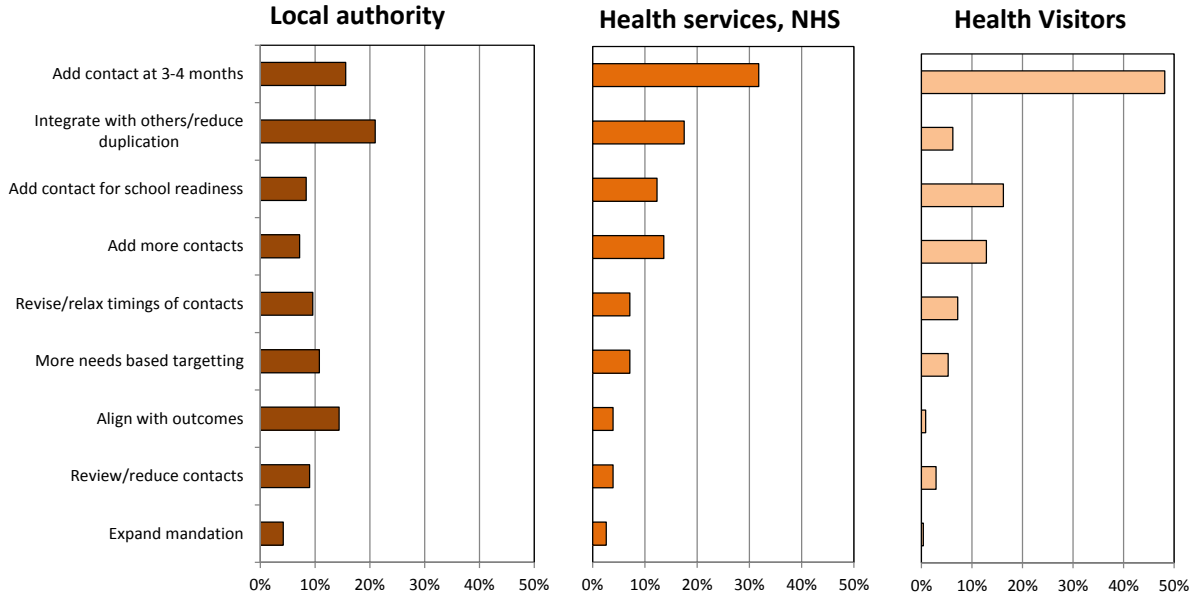
Other less dominant themes relating directly to mandation are that it supports equity of service across the country as all are bound by the same standards and it provides a framework for the service and for commissioning of the service. This is important because one of the aims of the mandation was to secure a national standard format and although it has been shown that service levels do vary across the country and are challenged in some areas, particularly London, the expectations are the same. In addition, potentially extending the mandation is thought to provide a consistency of public health messaging, especially in relation to emphasising the importance and status of these services, as well as helping to mitigate the risks that the benefit from the investment in these services is not delivered.

The National Children's Bureau (NCB) have written (see Appendix 7) to emphasise the importance of the Healthy Child Programme as an evidence-based approach to early intervention and safeguarding, which improves outcomes and reduces inequalities. Noting that health visitors are critical to the identification of special

educational needs and disabilities, which may otherwise remain undetected, they also emphasise the role of regulation in helping to protect investment in key services and helping to mitigate against the risk of disinvestment, which chimes with the main reason the core stakeholder groups would like to keep some form of mandation in place.

Where the recommendation was for mandation to be extended in a revised form survey participants were asked what changes they would like to see. The responses were thematically analysed and the results are depicted graphically in Figure 16.

Figure 16: Respondents who recommended the mandation is extended but in a revised form – detail of revisions proposed. Percentages show the proportion of all individual (single-themed) comments received by that stakeholder group



The most frequently occurring comments relate to either adding more to the service or allowing for more flexibility regarding how the service might be delivered. The health visiting and health services stakeholder groups are more frequently arguing for an expansion of the service, more contacts both general and specific, while the local authorities are more frequently arguing for enhanced flexibility including integration with other services to reduce duplication, reviewing the need for some contacts and aligning more specifically with outcomes. However, all these arguments appear to a greater or lesser extent in responses from all three stakeholder groups.

The most generally held view is that the gap between 6-8 weeks and 1 year is too long and that there should be a contact at 3-4 months. Survey respondents proposed that this would be a focused contact with a very specific remit around maternal mental health, infant attachment and bonding, weaning and nutrition and accident prevention as well as an additional opportunity for consideration of

safeguarding issues. There is some concern that 6-8 weeks is simply too early for an effective maternal mood assessment. Some suggest that 3-4 months is a better timing for assessing a mother's mental wellbeing as well as ideal timing for discussions on weaning and healthy eating, which is pertinent to the agenda on childhood obesity. In addition, at 3-4 months the baby is becoming mobile when physical safety and initiatives to support accident prevention become more important.

An argument is also made for adding more universal visits in general. This also appears from a local authority perspective as a proposal to expand the mandation. Much reference is made to the equivalent Scottish Model which is said to include 11 universal contacts. Understanding this model in more detail may help to provide some external insight. An additional visit for children who transfer into the area is also proposed so that the health visiting team can start to get to know the family as well as checking progress.

There is wide ranging support for the introduction of a contact which specifically deals with pre-school issues, which might take place somewhere between 3 and 5 years. Although a range of timings are offered, the suggestions share the intention of plugging the gap between the existing contact at $2^1/_2$ years and starting school.

Proposals for expanding the mandation also cover referrals to specialist services and the management of children with complex health needs, including follow up for these children and the development of indicators to support performance management in these areas. A popular suggestion is for mandation to be expanded along the life course and in particular to cover the 5-19 years' services. Some respondents ask questions about whether mandation could cover the settings, in which the reviews should take place, re-emphasising the importance of assessing the child in the context of the whole family and the home environment. Issues are also raised concerning the exact nature of the workforce and the extent to which the service should be led by and delivered by qualified health visitors and or other health professionals.

The current regulations require that the universal service is delivered or supervised by a registered health visitor. Tasks may be delegated, at the discretion of the health visitor and with guidance from the health visitor to other health professionals who are suitably qualified and trained in child health and development. This is consistent with the desire for improved integration of services and a more diverse skill mix so long as the universal service is health visitor led.

There is an underlying concern about duplication with other services that might be seen to translate itself into options for integration with other services and other professional groups. Suggestions to review the need for specific contacts, to revise the timings of those contacts or to replace them with different contacts undertaken

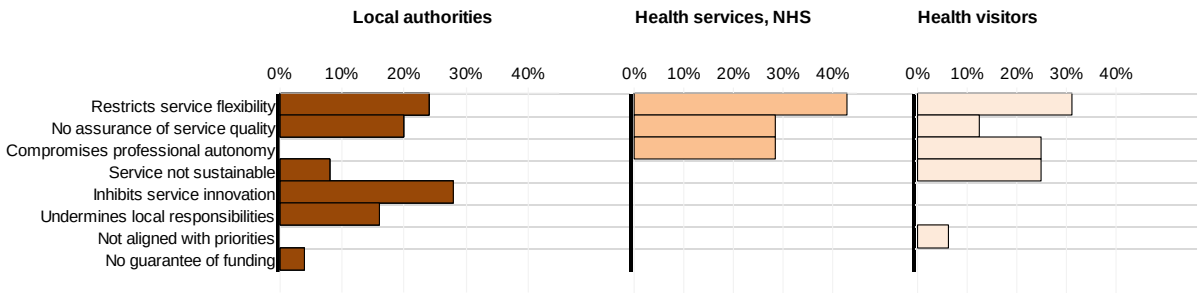
slightly later seem to reflect these concerns. For example, women are under professional midwifery care in the antenatal period and also seen by a GP at 6-8 weeks. There is some suggestion that midwives and health visitors could share responsibilities more efficiently during the antenatal period. There is an argument that although the GP undertakes the infant physical examination at 6-8 weeks they are also in a position to assess maternal mood and discuss infant feeding, two aspects which are currently within the health visiting remit. Likewise, there is a suggestion that health visitors become trained in order to undertake the infant physical examination.

In addition, the later visits overlap with nursery settings and national work has already been undertaken on the development of an integrated health and educational review at 2 to $2^{1}/_{2}$ years. An aspiration to make better use of nursery nurses to help deliver aspects of the healthy child programme is articulated.

Some express a frustration that the existing regulations are driven by process rather than by outcomes and that although the enhanced levels of service are covered they are not currently monitored at national and local levels in the way that the universal aspects of service are. This may have an unintended consequence that the universal aspects of service may, in some cases, receive a disproportionate amount of attention from a commissioning perspective. There appears to be a desire to revise the mandation to re-emphasise needs-based targeting: potentially offering a more intensive programme for first time mothers, more vulnerable groups and those identified as high risk during the antenatal booking appointment with midwives.

The stakeholder survey also probed the reasons why a minority of respondents recommended that the mandation should expire as planned. Responses of this nature were received from all three stakeholder groups representing 13% (37 individuals) of local authority respondents, 3% from health services (9 individuals) and 1% from health visitors (31 individuals). Again the comments have been analysed thematically within and between each stakeholder group. These results are presented graphically in Figure 17, which depicts the themes ordered in terms of the overall extent to which each theme appears in the analysis.

Figure 17: Respondents who recommended that mandation is allowed to expire as planned – main reasons. Percentages show the proportion of all individual (single-themed) comments received by that stakeholder group



The views of the main stakeholder groups differ. However, all agree that mandation restricts service flexibility, which is the single most dominant theme within this group of responses, followed by the fact that it provides no assurance of service quality. This is consistent with perceptions that in some areas the regulations have been applied too prescriptively, focusing on achieving coverage for the universal visits and missing the opportunity for tailoring to achieve the best possible outcomes.

The single most dominant theme for local authority stakeholders, ahead of concerns on flexibility and quality, within responses for this group, is the view that the mandation inhibits service innovation. This is followed by the view that the mandation undermines local responsibilities. For local authorities, charged with achieving the best possible outcomes for their population through the delivery of services at best value for money, this is a delicate balancing act and some desire the maximum possible scope for achieving this. Local authorities also express the view that, because of financial constraints within the system, mandation does not and cannot guarantee that funding will flow to these services. These debates are unique to the local authorities and do not appear in the responses from the health services or the health visitors.

Meanwhile, the health service and health visiting stakeholder groups express a concern that mandation compromises professional autonomy. In the opinion of these respondents this is again tied to overly prescriptive application in some areas, which leaves the services and professionals feeling they cannot adequately use their professional judgement to respond flexibly to the needs of individual families. Such responses advocate offering more visits to families who need more support and also potentially fewer to those assessed as empowered, experienced, functioning well and deemed to be low risk. Health visitors alone also express a view that the current mandation is not, from their perspective, aligned with priorities. Results show that some health visitors have concerns about the sustainability of the service. This is echoed by local authorities as the commissioning entity but not by the health service commissioners or service providers. The logic behind this concern is different for the two different stakeholder groups. For health visitors it is more about workforce numbers and covering the universal visits as well as targeting extra support and therapeutic interventions. For local authorities it is about the affordability of the existing service models and the challenge of reducing financial envelopes.

More detail is added to the issue of service sustainability in a challenging financial environment and the commissioning and service delivery response to this in the section on future commissioning intentions.

Relative value compared to other mandated public health services

The local authority stakeholder group alone was asked, in the context of population

health and wellbeing, how valuable the universal health visitor service was compared to other mandated public health functions. Options for response were

- more valuable
- less valuable
- neither more or less valuable
- don't know

The other mandated public health functions are the National Child Measurement Programme, NHS Health Checks, sexual health services, population health advice and local health protection. The results are shown in Table 18 and in Figure 18.

Figure 18: Responses to the question: "In your opinion, how valuable is universal/consistent performance of the mandated checks for 0-5s to your local population's health and wellbeing compared, for example to other currently mandated services?"

Table 18: Responses to the question: "In your opinion, how valuable is universal/consistent performance of the mandated checks for 0-5s to your local population's health and wellbeing compared, for example to other currently mandated services?"

	More	Neither more or	Less	Don't
All local authority	54%	37%	4%	5%

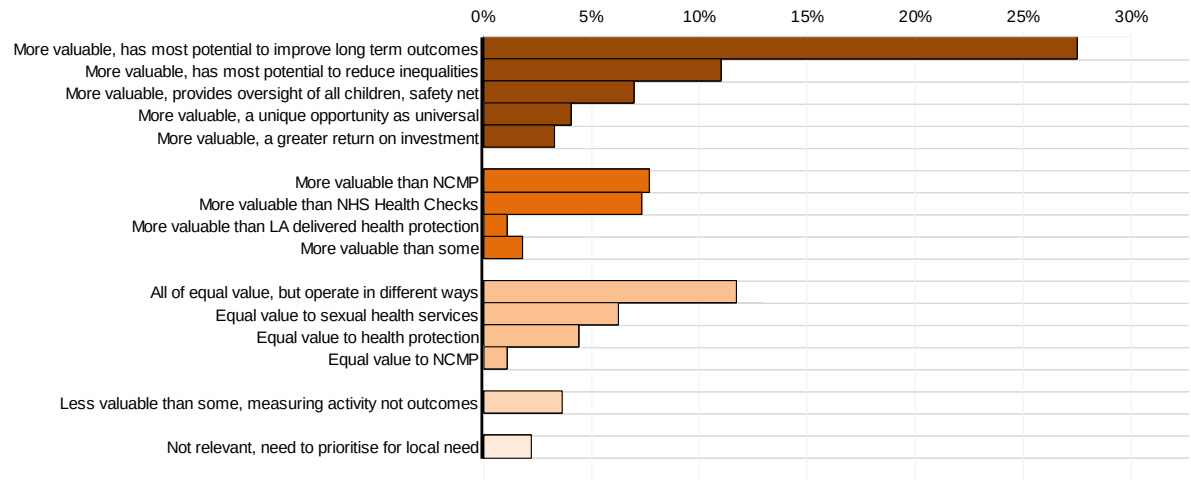
Note: all results are statistically significantly different unless stated otherwise.

The majority of respondents thought that the health visiting services were more important (54%) or of equal importance (37%) to the other mandated functions. However, it should be noted that not all local public health functions are mandated. For example, stop smoking services, which arguably have a very strong evidence base and quantified impact on health, are not mandated.

The reasons behind these views have been analysed thematically. These are presented graphically in Figure 19 and ordered in terms of the overall extent to which this theme appears in the analysis.

Respondents were given an option to expand on the reasons for the response they had chosen in a free-text box. These free-text comments were subject to thematic analysis with the possibility of drawing multiple themes from individual responses. Each theme was assigned to a high level category for presentation.

Figure 19: Reasons for response on relative value compared with other mandated public health services. Percentages show the proportion of all individual (single-themed) comments received by that stakeholder group



A high proportion of comments are consistent with the view that the universal health visitor reviews are more valuable than the other mandated public health functions. The arguments are consistent with many of those expressed for continuing the mandation in its existing form or in a revised form. The most commonly occurring theme is that these services have the most potential to improve longer-term outcomes. This is followed by the view that they also have potential to reduce inequalities, that they provide the universal safety net of oversight for all children and that the universal aspect of the service is a unique opportunity for this safeguarding and for early intervention. There is also a belief that these services are more valuable in the round because they deliver a greater return on investment than the other mandated public health functions. This is reinforced in responses to the specific question on return on investment discussed in that section.

Where specific comparisons have been made on value the views express suggest that the universal health visiting services are more valuable than the National Child Measurement Programme or the NHS Health Checks but are of equal value to sexual health services or local health protection. However, this is strongly qualified by the assertion that the public health functions should not be compared in this way, that they all have value but all operate in different ways and serve different purposes. Instead, it is argued that they should be considered more as a portfolio. For example, the National Child Measurement Programme is used for surveillance, to generate national and local statistics, rather than being a public health intervention in its own right. This cannot be fairly compared with a service offering universal assessment and therapeutic interventions which have evidence-based long term impact.

Where the minority view is expressed that the universal health visiting services are of less value than other mandated public health functions, this appears to be a reflection on the way in which the mandation is set up rather than on the service

itself. For example, it is sometimes regarded as less valuable because it is focussed on and measuring activity rather than outcomes and that it is not relevant because local needs should drive the priorities.

Service delivery from 2015/16 to 2017/18

Stakeholders were asked how service levels for the five universal reviews had changed last year (2015/16), will change this year (2016/17) and are expected to change next year (2017/18). Options for response were:

- improve(d)
- stay(ed) the same
- deteriorate(d)
  don't know

The results are displayed in Table 20 and Figure 20.

Figure 20: Service delivery from 2015/16 to 2017/18, by stakeholder group, allowing comparison of perceived service levels

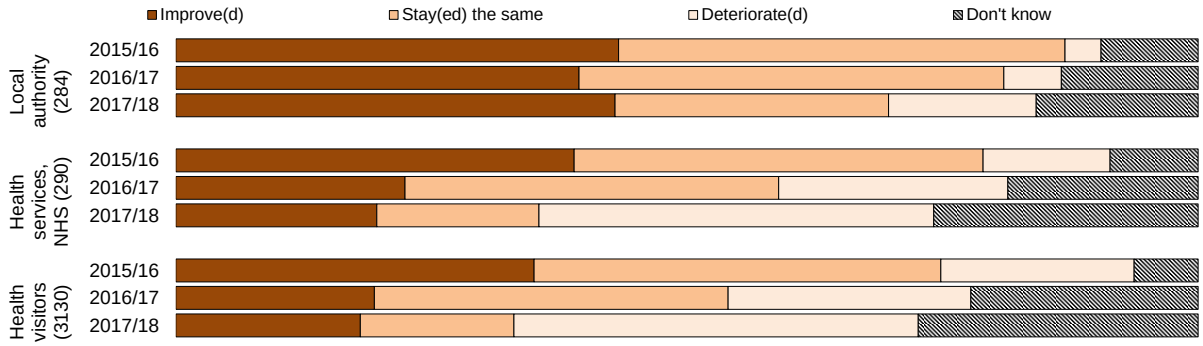


Table 20: Service delivery from 2015/16 to 2017/18, by stakeholder group

	Year	Improve	Stay same	Deteriorate	Don't know
Local authority (284)	2015/16	43%	44%	4%	10%
	2016/17	39%	42%	6%	13%
	2017/18	43%	27%	14%	16%
Health services, NHS (290)	2015/16	39%	40%	12%	9%
	2016/17	22%	37%	22%	19%
	2017/18	20%	16%	39%	26%
Health visitors (3,130)	2015/16	35%	40%	19%	6%
	2016/17	19%	35%	24%	22%
	2017/18	18%	15%	40%	27%

Note: all results are statistically significantly different unless stated otherwise.

Across all stakeholder groups, the majority of respondents described a positive picture for last year 2015/16, the year of transition, with service levels either improving or staying the same. This is corroborated by the statistical evidence from the service delivery metrics, where overall improvement is seen at a national level

with some variation at local level.

Among local authority respondents, 43% state that service levels improved in 2015/16 while 44% said they stayed the same. These are higher than the responses from the health services stakeholder group (39% improved, 40% stayed the same), which are higher again than the responses from the health visitors (35% improved, 40% stayed the same). As the actual performance levels delivered for the five universal reviews is fixed, the data, in this case, is showing the perception of change in service levels rather than the actual service levels themselves. A greater proportion of service commissioners (local authorities) perceive improvement and stability than either the service providers (health services) or the professionals (health visitors).

Among local authority respondents, 39% state that service levels are improving in 2016/17 with a further 42% stating that they are staying the same. Again, these are higher than the responses from the health services stakeholder group (22% improving, 37% staying the same), which are higher than the responses from the health visitors (19% improved, 35% stayed the same). The actual performance levels being delivered in 2016/17 cannot be described in this report as the official data is not yet available, however, the variation in perception between the stakeholder groups remains consistent. A greater proportion of service commissioners (local authorities) perceive improvement and stability than the service providers (health services), who in turn perceive improvement and stability in greater proportions than the professionals (health visitors).

Some 43% of local authority respondents state that service levels are expected to improve in the future, 2017/18, with a further 27% stating that they are expected to stay the same. These are again higher than the responses from the health services stakeholder group (20% improving, 16% staying the same), which are in turn higher again than the responses from the health visitors (18% improved, 15% stayed the same). Again the service commissioners (local authorities) are more confident of future improvement and stability in service coverage than the service providers (health services), who in turn are more confident than the professionals (health visitors) working in the services.

It seems that the local authority stakeholders, who are in control of commissioning contracts, are requiring, at minimum, stability in levels of future service delivery and improvement where possible. Meanwhile, the overall picture sets an expectation that the service delivery momentum built up during the health visitor programme, and shown to be carried forward through transition, may become lost or in the worst case even reversed. It should be noted that among both providers (health services) and professionals (health visitors) more respondents believe the service levels will deteriorate next year (39% health services and 40% health visitors) than believe the service levels will either improve or stay the same (36% health services and 33%

health visitors). This is of concern considering the fact that published data for last year clearly shows overall improvement.

Confidence in effectiveness of new service models

Stakeholders were asked about their levels of confidence in the delivery of improved outcomes from the introduction of new service models. The exact question was: “How confident are you that the introductions of new service models, including the integration of services, has enabled you/ will enable you to commission for/ deliver better outcomes?” The options for response were:

- extremely confident
- very confident
- somewhat confident
- not so confident
- not at all confident
- don’t know

This includes the prospect of service integration, which is discussed in more detail in the section on future commissioning intentions. The results are displayed in Table 21 and Figure 21.

Figure 21: Responses to question: “How confident are you that the introductions of new service models, including the integration of services, has enabled you/ will enable you to commission for/ deliver better outcomes?”

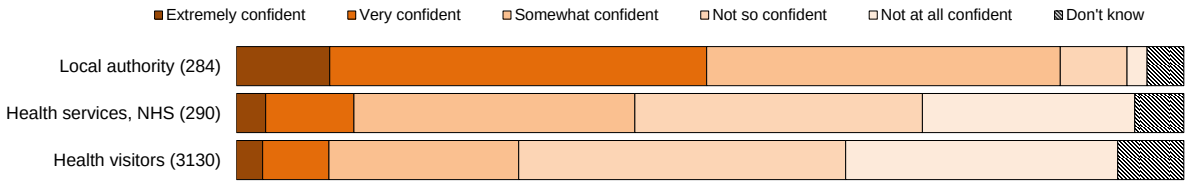


Table 21: Responses to question: “How confident are you that the introductions of new service models, including the integration of services, has enabled you/ will enable you to commission for/ deliver better outcomes?”

	Extremely confident	Very confident	Somewhat confident	Not so confident	Not at all confident	Don't know
Local authority (284)	10%	40%	37%	7%	2%	4%
Health services, NHS (290)	3%	9%	30%	30%	22%	5%
Health visitors (3130)	3%	7%	20%	35%	29%	7%

Note: all results are statistically significantly different unless stated otherwise.

The three groups have differing levels of confidence about whether improved

outcomes can be delivered from new service models. The local authorities, as commissioners, are most confidence with a total of 87% expressing positivity of some magnitude (10% extremely confident, 40% very confident and 37% somewhat confident). This positivity drops significantly to 42% (3% extremely, 9% very and 30% somewhat) for the health services as providers and further reduces to 30% (3% extremely, 7% very and 20% somewhat) for the health visitors as the professionals delivering the services on the ground. It should be noted that among providers and professionals, the negative responses to this question are higher than the positive responses. In all, 52% of health service respondents replied in the negative (30% not so confident and 22% not at all confident) compared to 42% in the positive; 64% of health visitors replied in the negative (35% not so confident and 29% not at all confident) compared to 30% in the positive.

The discrepancy in the views of stakeholder groups is explained in more detail in the section where local authorities describe their future commissioning intentions. The magnitude of planned service change is high with local authorities commissioning for value, considering the overall needs of their population and pressing for both efficiency and quality. This may feel somewhat uncomfortable for providers, and especially for professionals, and it is not clear to what extent they may be involved in planning the change and neither did the survey look into this aspect. There are many unknowns and much variation in plans from locality to locality. Health visitors may be unsettled from a professional point of view and unsure how they can deliver improved outcomes until such a time when there is more clarity on which service models work best, what is the ideal skill mix for a team and in what settings should services be delivered and by whom.

Expected impact on the health visiting workforce

Health visitor numbers increased significantly between 2010 and 2015 as a result of the health visiting improvement programme. The increase was approximately 4,000 whole-time equivalents, representing a 50% growth in the workforce. The increasing numbers were reported by NHS Digital (previously known as the Health and Social Care Information Centre, HSCIC) as official statistics based on data in the health visitor minimum dataset (MDS). This dataset was supplemented by a more timely special collection, which was published by NHS England as management information (the Indicative Health Visitor Collection, IHVC). These are discussed in the section which looks at the official data on health visitor numbers and compares them to the data in the NHS electronic staff record (ESR) (see Table 9 and Figure 9).

The expected impact of future service models on the health visiting workforce was explored in the survey. The exact question posed was: “What impact do you expect future service models for children’s public health will have on the health visiting workforce?” The allowable responses, detailed in Table 22 and Figure 22, were:

- require more health visitors
- require about the same number of health visitors
- require fewer health visitors
- don't know

Figure 22: Responses by stakeholder group to question: "What impact do you expect future service models for children's public health will have on the health visiting workforce?"

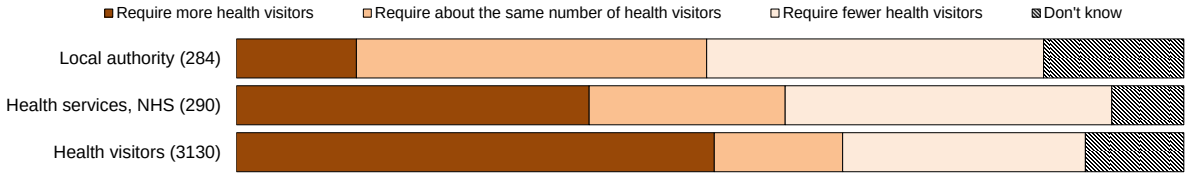


Table 22: Responses by stakeholder group to the question: "What impact do you expect future service models for children's public health will have on the health visiting workforce?"

	Require more health visitors	Require about the same number of health visitors	Require fewer health visitors	Don't know
Local authority (284)	13%	37%	36%	15%
Health services, NHS (290)	37%	21%	34%	8%
Health visitors (3130)	50%	14%	26%	10%

Note: all results are statistically significantly different unless stated otherwise.

The responses from the three stakeholder groups vary significantly. Local authority respondents on the whole expect the service to require the same or fewer health visitors (13% more, 37% same, 36% fewer). The health service providers are less definite, with a reasonably even mix of those expecting the service to require more and those expecting the service to require fewer health visitors (37% more, 21% same, 34% fewer). Health visitors on the other hand were more strongly of the opinion that the service would need more health visitors (50% more, 14% same, 26% fewer). These responses are understandable given that they are coming respectively from the perspectives of the service commissioners, service providers and the professionals delivering the service on the ground.

The responses from the local authorities are consistent with their future commissioning intentions, which are described below. There is a very strong sense of integrating services, introducing more skill-mix to teams and a need to reduce

investment in these services. Alongside this, health visiting roles are being redefined for system leadership, uniquely providing the professional input to more skill-mixed teams. With this in mind the natural conclusion would be that future services will require the same or fewer numbers of health visitors.

Respondents from health services representing the service providers may be less sure how they will rise to this commissioning challenge and how exactly it may be implemented in practice, which may explain why the views are more mixed. Health visitors as a group of professionals may find it more difficult to deal with this scenario, especially when the workforce has recently undergone such a dramatic expansion in such a short space of time. With that backdrop, the concept that successful models could potentially be quickly developed that require fewer health visitors is challenging to reconcile and it may take some time for general acceptance to become embedded.

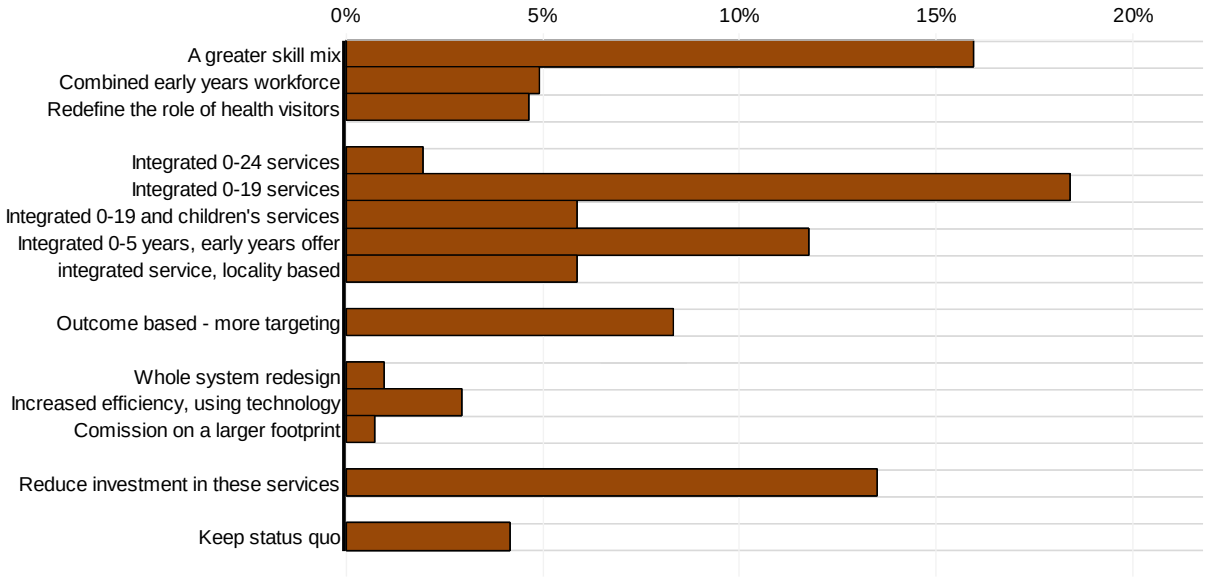
It should also be noted that health visitors recommending that mandation should be extended gave the dominant reason for this as the five universal reviews being a minimum standard of service, which all children and their families deserve and have a right to, see Figure 15. Although overall improvement in coverage of these reviews has been achieved, service levels still fall short of covering all children and do vary significantly from one part of the country to another. Health visitors may simply be anticipating what would be required in terms of available workforce for all children in the country to be able to benefit from this service and on an equitable basis. This is yet more poignant when considering the second most dominant reason for continuing the mandation from the point of view of this professional group, which is a widespread confidence that early identification of need delivers better long-term outcomes, see Figure 15.

In the reasons for the recommendation that mandation be extended, some health visitors and health service providers indicated that there were issues with the sustainability of the service, see Figure 15. Likewise, in the reasons for the recommendation that the mandation should expire as planned, a high proportion of comments stated that the current service was not sustainable, see Figure 17. They indicated that the aspiration for five universal reviews and an enhanced service based on need was becoming increasingly difficult to deliver with existing resources, which helps to explain the view that more resources, (health visitors) are required.

Future commissioning intentions

The local authority stakeholder group was invited to share future commissioning intentions in response to the question: “Please tell us about any future commissioning intentions.” The comments were subject to a thematic analysis and the findings are presented in Figure 23, batched into similar themes.

Figure 23: Responses to the question: "Please tell us about any future commissioning intentions." Percentages show the proportion of all individual (single-themed) comments received by that stakeholder group



The greatest proportion of comments relate to service integration, including the implementation and consideration of a wide range of new models. The most significant of these is integration along the life course with the move to a 0-19 years' service, including the introduction of seamless operation for health visiting, family nurse partnership and school nursing. These services can also be extended to 24 years for children with complex health conditions, learning disabilities or those with looked after status. Examples include strong links to maternity, special education and disability services as well as the non-residential aspects of specialist child and adolescent mental health services (CAMHS tier 2 and 3).

This is followed by a wider 0-5 year offer where the health visiting service is combined with other early help services and particularly focused around children's centres. Examples were given where the 0-19 services are integrated with children's services. This may include services delivered by the children's voluntary sector as well as social services, education and community wellbeing services. The aspiration is to recommission the services so they work in a more seamless manner from the perspective of the child and the family. Particularly ambitious collaborations include not just integration with children's services and social care but a whole, place-based approach where the services are planned seamlessly in partnership with local NHS services, including children's community health services. In some instances, there is a switch to the local authority becoming the employer for the health visitors in order to better enable these collaborative service transformations.

Comments on developing a greater skill-mix in the workforce feature highly and there is a perception in some quarters that a sustained focus on health visitors may

have historically had an adverse impact on skill-mix. The development of combined workforces and multi-disciplinary teams, under single management structures are ongoing. Linked to this, there is the concept of introducing more health visiting assistants into the workforce, with qualified health visitors as the strategic planners, leading on assessment and standards with oversight of a more junior team; thus, potentially redefining the role of health visitors within the system. This model of supervision and oversight is not inconsistent with the content of the existing regulations for the universal health visiting service.

That commissioning intentions will reduce investment in these services is clearly articulated, which is to be expected given the financial challenges ahead. For this reason, local authorities are looking to develop more cost-effective workforce models with expertise tailored to, and at the level of, the specific task in hand. Other efficiency-based re-modelling hinges on well-proven general approaches such as redesigned services across the whole system, commissioning on a larger footprint and more extensive use of digital technologies. These are all well recognised approaches for helping to streamline services and reduce overheads. A number of areas articulated a holding position, extending existing contracts and maintaining the status quo for universal health visiting services. Given all the other commissioning aspirations articulated here, it is unlikely that these positions can be maintained in the longer term. However, some organisations may simply be waiting for best practice to emerge and to learn from others' experience of the new service models.

The commissioning intentions articulated in response to the stakeholder survey are consistent with those in the public domain, which were extracted from a review of local authority websites, press releases and public consultations. A high-level overview of the themes is presented in Appendix 6. They include joint planning and commissioning, with an increased focus on outcomes, in order to deliver integrated services via multi-disciplinary teams making best use of local infrastructure and community-based assets. This is billed as an innovative response to increased financial pressures at a local level due to reductions in the public health grant and proposed future changes in the models for public health financing.

Importance of the universal health visitor reviews to delivering the benefits of the Healthy Child Programme 0-5 years

The Healthy Child Programme 0-5 years and the components which are delivered by the health visiting service are described as six high impact areas, as follows:

- transition to parenthood
- maternal mental health
- breastfeeding
- healthy weight

- managing minor illness and accident prevention and
- healthy two-year-olds and school readiness

These have then been broken down into more detailed task-based areas of activity, especially for transition to parenthood further exploring the specific focus of:

- healthy lifestyle, including home environment
- contraceptive and sexual health advice
- smoking cessation and
- secure attachment and bonding

The evidence base behind the Healthy Child Programme and the six high impact areas for health visiting is summarised in Appendix 8.

Survey respondents were invited to comment on the extent to which they think the universal health visitor reviews are important to delivering the benefits of the healthy child programme by answering the following question:
“How important do you think the universal health visitor reviews are to delivering the benefits of the Healthy Child Programme 0-5 years in the following areas?”

a) Transition to parenthood – supporting the parents, providing advice and guidance healthy lifestyle and preparing the home for the new baby

b) Transition to parenthood – contraceptive and sexual health advice to support planned pregnancies or parenthood

c) Transition to parenthood – advice and guidance on smoking cessation in pregnancy and to reduce harm to baby from second hand smoke (tobacco control priority)

d) Transition to parenthood – advice and guidance on establishing secure attachment and bonding, home learning environment

e) Maternal mental health – assessment, brief intervention and signposting to other support services; being mindful of paternal wellbeing and good mental health as a mechanism for supporting healthy relationships

f) Breastfeeding – advice, education and practical support, including signposting to other support services in order to initiate and sustain breastfeeding (childhood obesity priority)

g) Healthy weight – advice and education on nutrition, weaning, healthy eating (including access to means-tested vouchers for fresh fruit, vegetables and vitamins) and physical activity (childhood obesity priority)

h) Managing minor illnesses and accident prevention – advice and guidance, illness escalation approaches, support uptake of childhood immunisations, home safety environment

i) Healthy two-year-olds and school readiness – safety net on new-born and infant screening, child development assessment aged 2–2 1/2 years, supporting parents to articulate development concerns (special needs) with access to early help, onward referral to other services (paediatrics, speech and language etc)

Allowable responses were:

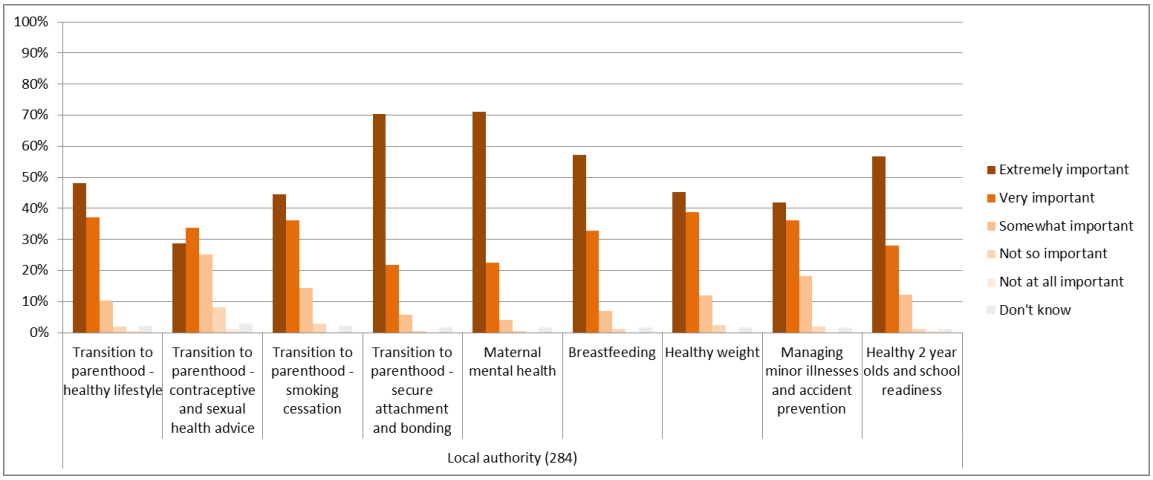
- extremely important
- very important
- somewhat important
- not so important
- not at all important
- don't know

This question was asked of local authority directors of public health, directors of children's services, local authority commissioners, as well as health services staff and health visitors.

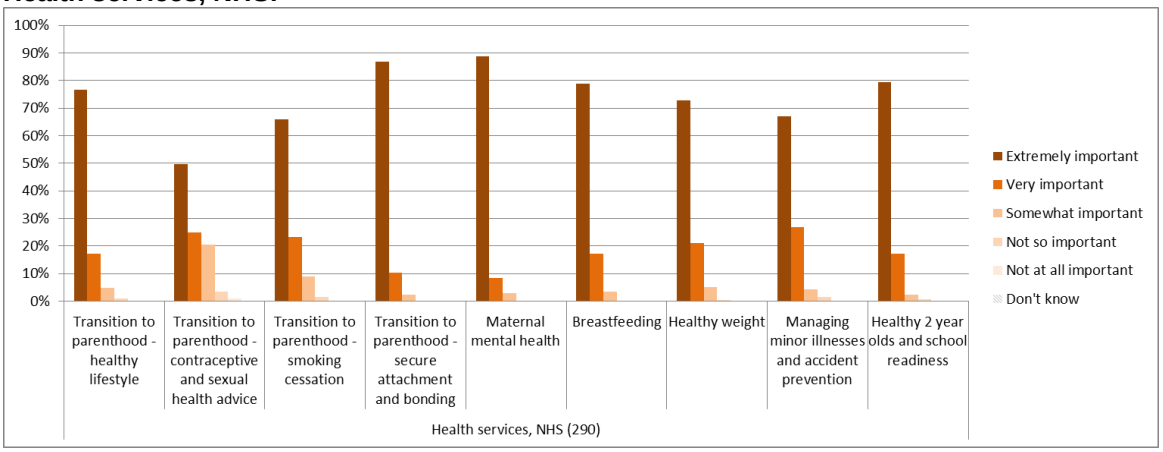
The composite results for all three stakeholder groups are displayed in Table 24 and Figure 24.

Figure 24: Summary of responses to the question: "How important do you think the universal health visitor reviews are to delivering the benefits of the Healthy Child Programme 0-5 years in the following areas?"

Local authorities:



Health services, NHS:



Health visitors:

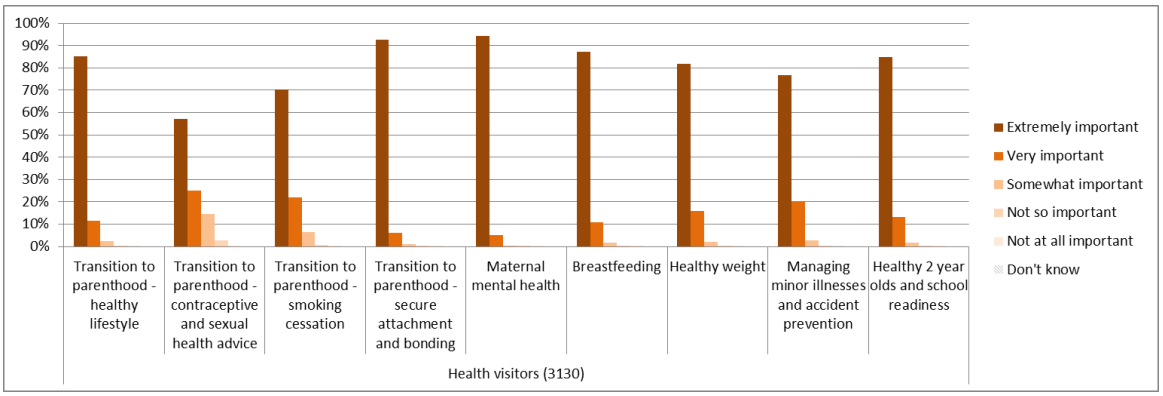


Table 24: Summary of responses to the question: "How important do you think the universal health visitor reviews are to delivering the benefits of the Healthy Child Programme 0-5 years in the following areas?"

	Importance																	
	Extremely	Very	Somewhat	Not so	Not at all	Don't know	Extremely	Very	Somewhat	Not so	Not at all	Don't know	Extremely	Very	Somewhat	Not so	Not at all	Don't know
	Transition to parenthood - healthy lifestyle						Transition to parenthood - contraceptive and sexual health advice						Transition to parenthood - smoking cessation*					
Local authority	48%	37%	10%	2%	0%	2%	29%	34%	25%	8%	1%	3%	44%	36%	14%	3%	0%	2%
Health services, NHS	77%	17%	5%	1%	0%	0%	50%	25%	20%	3%	1%	1%	66%	23%	9%	1%	0%	1%
Health visitors	85%	12%	2%	1%	0%	0%	57%	25%	15%	3%	0%	0%	70%	22%	6%	1%	0%	0%
	Transition to parenthood - secure attachment and bonding						Maternal mental health						Breastfeeding					
Local authority	70%	22%	6%	0%	0%	2%	71%	23%	4%	0%	0%	2%	57%	33%	7%	1%	0%	2%
Health services, NHS	87%	10%	2%	0%	0%	0%	89%	8%	3%	0%	0%	0%	79%	17%	3%	0%	0%	0%
Health visitors	93%	6%	1%	0%	0%	0%	94%	5%	0%	0%	0%	0%	87%	11%	2%	0%	0%	0%
	Healthy weight						Managing minor illnesses and accident prevention						Healthy 2 year olds and school readiness					
Local authority	45%	39%	12%	2%	0%	2%	42%	36%	18%	2%	0%	2%	57%	28%	12%	1%	0%	1%
Health services, NHS	73%	21%	5%	0%	0%	1%	67%	27%	4%	1%	0%	1%	79%	17%	2%	1%	0%	0%
Health visitors	82%	16%	2%	0%	0%	0%	77%	20%	3%	0%	0%	0%	85%	13%	2%	0%	0%	0%

Note: all results are statistically significantly different unless stated otherwise.

* In transition to parenthood – smoking cessation results shown for 'Health services, NHS' and 'Health visitors' are not statistically significantly different from each other

It can be seen from Figure 24 that all aspects relating to the six high impact areas are regarded as important by all stakeholder groups to a greater or lesser extent. Health visitors are more polarised in their views, more often selecting the 'extremely important' category. Health service respondents use the 'very important' category more often than health visitors while the local authority respondents are yet more cautious in their approach making more use of the 'very important' and also the 'somewhat important' category. There are very few respondents who think these services are 'not so or not at all important' to the delivery of the benefits.

Overall, maternal mental health and issues of secure attachment and bonding are rated a slightly more important than other aspects of activity in both the volume and strength of the response on importance across all three stakeholder groups. This is not surprising given the high level of national and local emphasis on this aspect of service following the recommendations of the Mental Health Taskforce and the Maternity Review and the **policy priority to improve perinatal mental health**. In addition, almost all health visitors have been trained as maternal mental health champions.

This focus is also consistent with stakeholder recommendations for changing mandation in order to put more capacity into the system, to focus on maternal mental health, by adding a review at 3-4 months as described in the section on

recommendations for the future of mandation. Breastfeeding, weaning, physical activity and accident prevention are also covered under the recommendation on more support for parents at 3-4 months (see Figure 16 and Figure 24). The extent to which these are thought to be important and the strength of importance falls in the order: breastfeeding, healthy weight (weaning, nutrition and physical activity) and accident prevention, although all are well supported.

The importance of the universal health visiting service to establishing meaningful contact between professionals and families in order to encourage breastfeeding has been reinforced by submissions from the GP Infant Feeding Network (GPIFN) and UNICEF (see Appendix 7). Experts from the British Heart Foundation National Centre for Physical Activity and Health (BHFNC) Early Years Advisory Group have also written to emphasise the importance of these services to the achievement of healthy weight covering both breastfeeding and physical activity (see Appendix 7).

Healthy weight, including diet and physical activity, is one of the six high impact areas of health visiting and PHE has worked with the profession to produce additional guidance in this area. The specification for the mandation review specifically requests that the impact of the universal health visiting service on the government's **childhood obesity priority** is considered. Taking this in isolation, it is clear that the health visitor reviews are seen to be important to achieving a healthy weight by all stakeholder groups. In this context, activities include advice and education on nutrition, weaning, healthy eating (including access to means tested vouchers for fresh fruit, vegetables and vitamins) and physical activity.

Overall, 96% of local authority respondents (45% extremely, 39% very, 12% somewhat), 99% of health service respondents (73% extremely, 21% very, 5% somewhat) and 100% of health visitor respondents (82% extremely, 16% very, 2% somewhat) indicated that it is important to some extent.

This is followed in strength by support for healthy two-year-olds and school readiness. This support is consistent across all three stakeholder groups and ties with the recommendation for changing the mandation, which was to introduce a further, specific review with a focus on school readiness. Again the views of the local authorities are less categorical than the health visitors or the health services, yet still predominantly on the positive side.

A major component of school readiness is the development of speech, language and communication skills, which are in turn influenced by secure bonding, mothers talking to their babies and a rich home communication environment. The importance of the universal health visiting service in encouraging these activities and spotting any delays in the development of these skills has been reinforced by submissions from I CAN, the children's communication charity and the Communication Trust (see Appendix 7). Early development of good communication

skills is in turn pivotal for accessing education, securing employment and **maximising social justice,** which generally result in a positive contribution to society.

The aspect of transition to parenthood, which also includes supporting parents, providing advice and guidance on healthy lifestyle and preparing the home for the new baby, is rated as high in importance but the extremely important rating is much more prevalent with health visitors than it is with local authority respondents. Some of the commentary in support of keeping mandation reinforces the importance of an assessment of the home environment and of understanding the child and providing safeguarding oversight within the context of the whole family and the home environment.

Within the overall context of the healthy child programme 0-5 years, the universal health visitor reviews were regarded as less important to delivering benefits from contraceptive and sexual health advice than from all other aspects of service. It is not clear why this might be, however, within the system this type of advice would also be coming from a number of other sources such as midwives, GPs and specialist family planning or sexual health services. Sexual health services are also mandated services, with their own dedicated workforce, and considered on the whole to be of equal importance to universal health visiting services, see section on relative value of mandated public health services.

The contribution of health visiting to providing advice and guidance on smoking cessation in pregnancy and reducing harm to babies from second hand smoke is considered to be less important than some other aspects of service, although the overall importance is still rated highly. This relative view may be moderated by the fact that midwives are much better placed within the system to deliver advice on the benefits of smoking cessation during pregnancy as they have more contacts during this time period. Also, if attempts to stop smoking are unsuccessful during pregnancy, they may be even more challenging after the baby has returned home. However, health visitors are uniquely placed with their universal access into the home to provide advice and encouragement for new parents to stop smoking or, at minimum, providing encouragement to avoid smoking in the presence of the new baby.

The specification for the mandation review specifically requests that the impact of the universal health visiting service on the government's **tobacco control priority** is considered. Taking this in isolation it can clearly be seen that the health visitor reviews are seen to be important by all stakeholder groups, with 88% of local authority respondents (29% extremely, 34% very, 25% somewhat), 95% of health service respondents (50% extremely, 25% very, 20% somewhat) and 97% of health visitor respondents (57% extremely, 25% very, 15% somewhat) indicating that it is important to some extent. From a statistical perspective, the responses from the health services stakeholder group cannot be distinguished from those of the health

visitors' stakeholder group.

In an open letter, representatives of the Royal College of Nursing, the Royal College of Paediatrics and Child Health, the Royal College of GPs and the Royal Society for Public Health have reinforced the importance of the health visiting service to government priorities, including the reduction of obesity and mental health issues in both adults and children and the promotion of social mobility. They also emphasise the vital and unique role health visitor's play in providing support to all families (see Appendix 7 for more detail).

Importance of the universal health visitor reviews for safeguarding and child protection

Respondents were asked how important they thought the universal reviews were to delivering the benefits of the healthy child programme in the areas of safeguarding and child protection. The question asked was: "How important do you think the universal health visitor reviews are to delivering the benefits of the Healthy Child Programme 0-5 years in the following areas?" Allowable answers were:

- extremely important
- very important
- somewhat important
- not so important
- not at all important
  don't know

The results are shown Table 25 and Figure 25 for safeguarding and in Table 26 and Figure 26 for child protection.

Figure 25: Importance to escalation of safeguarding concerns

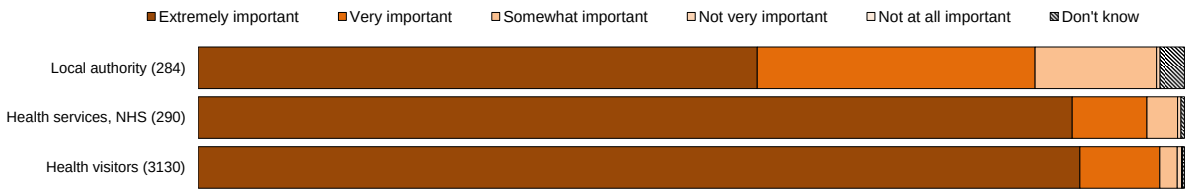


Table 25: Importance to escalation of safeguarding concerns

Importance:	Extremely	Very	Somewhat	Not very	Not at all	Don't know
Local authority (284)	57%	28%	12%	0%	0%	2%
Health, NHS (290)*	89%	8%	3%	0%	0%	0%
Health visitors (3130)*	89%	8%	2%	0%	0%	0%

Note: all results are statistically significantly different unless stated otherwise.

*Results not statistically significantly different from each other.

Figure 26: Importance to child protection

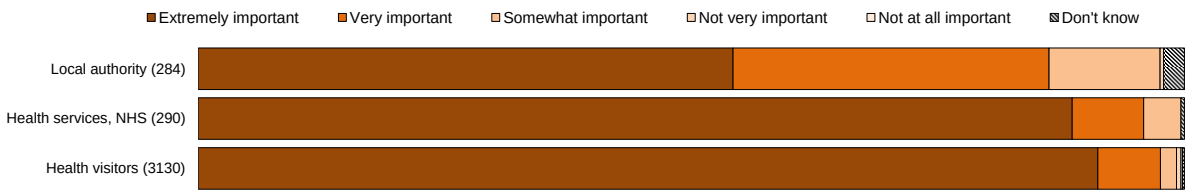


Table 26: Importance to child protection

Importance:	Extremely	Very	Somewhat	Not very	Not at all	Don't know
Local authority (284)	54%	32%	11%	0%	0%	2%
Health, NHS (290)*	89%	7%	4%	0%	0%	0%
Health visitors (3130)*	91%	6%	2%	0%	0%	0%

Note: all results are statistically significantly different unless stated otherwise.

* Results not statistically significantly different from each other

The health visitor reviews are seen to be important to safeguarding by all stakeholder groups, with 98% of local authority respondents (57% extremely, 28% very, 12% somewhat), 100% of health service respondents (89% extremely, 8% very, 3% somewhat) and 100% of health visitor respondents (89% extremely, 8% very, 2% somewhat) indicating that it is important to some extent. From a statistical perspective, the responses from the health services stakeholder group cannot be distinguished from those of the health visitors' stakeholder group.

The health visitor reviews are seen to be important to child protection by all stakeholder groups, with 98% of local authority respondents (54% extremely, 32% very, 11% somewhat), 100% of health service respondents (89% extremely, 7% very, 4% somewhat) and 100% of health visitor respondents (91% extremely, 6% very, 2% somewhat) indicating that it is important to some extent. From a statistical perspective, the responses from the health services stakeholder group cannot be distinguished from those of the health visitors' stakeholder group.

Only a very small minority (2%) of respondents from local authorities think that the universal service is not at all important to either safeguarding or child protection. That the universal health visiting service is important to both safeguarding and child protection is almost universally agreed, which is consistent with the reasons given for wanting the mandation to continue in either its current form or in a revised form (see section on future of mandation) because it 'safeguards all children'.

The National Network of Designated Health Professionals for Safeguarding Children (NNDHP), the GP Infant Feeding Network (GPIFN) and the National Children's Bureau (NCB) have written to emphasise the importance of the universal service to safeguarding and child protection (see Appendix 7).

Return on investment

Stakeholders were asked if they believed the universal health visitor reviews delivered a positive return on investment, in other words that they save more money in the wider system than they cost to deliver. The question posed was: “To what extent do you believe the universal health visitor reviews deliver a positive return on investment, ie, these services save more money in the wider system than they cost to deliver?” Allowable responses were:

- positive (eg save more than they cost)
- neutral (eg save about the same as they cost)
- negative (eg cost more than they could ever save)
  don’t know

The results by major stakeholder group are presented in Table 27 and Figure 27.

Figure 27: Responses by stakeholder group to question: “To what extent do you believe the universal health visitor reviews deliver a positive return on investment?”

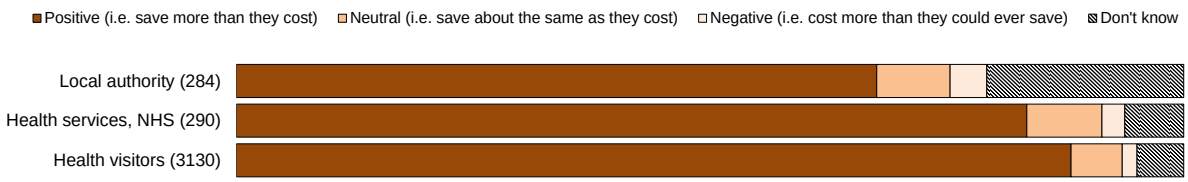


Table 27: Responses by stakeholder group to question: “To what extent do you believe the universal health visitor reviews deliver a positive return on investment?”

	Positive (ie save more than they cost)	Neutral (ie save about the same as they cost)	Negative (ie cost more than they could ever save)	Don't know
Local authority (284)	68%	8%	4%	21%
Health services, NHS (290)	83%	8%	2%	6%
Health visitors (3130)	88%	5%	2%	5%

Note: all results are statistically significantly different unless stated otherwise.

On the whole, all three stakeholder groups believe that the return on investment for these services is positive, in other words that they save money across the wider

system. Positive responses were 68% for local authorities, 83% for health services and 88% for health visitors. This is consistent with some of the reasons given for continuing with mandation namely that 'failure there will increase pressure on other services' and 'saves money in the longer term'.

This belief is held most strongly by those working in the service (the health visitors themselves (88%) followed by those manging the services and commissioning the downstream services, the health services (83%)). Although the majority of local authority respondents (68%) believe there is a positive return on investment this is lower than that for the other stakeholder groups. Among local authority respondents, 21% replied that they did not know if there was a positive return on investment or not. This is a significant minority and clearly more work needs to be done both to improve the quality and accessibility of the economic evidence-base and also to improve the way in which this information is communicated across local authorities.

Considered feedback from stakeholder representatives and membership organisations

The preliminary findings from the analysis of official statistics and stakeholder survey were shared with interested parties in order to elicit feedback. This process was facilitated on a regional basis by the PHE centres and on a national basis by members of the Best Start in Life Programme Board. The purpose of this exercise was to test the findings and conclusions from a range of different perspectives. The full written feedback is included in Appendix 7.
The feedback from regions is summarised in Table 28 below.

Table 28: Regional feedback on preliminary findings

Region	Overall regional comment on mandation
East Midlands	Extend but if revise increase number of contacts
East of England	Continue but with more focus on outcomes
London	Extend but with more flexibility
North East	Continue
North West	Continue but with greater flexibility
South East	Continue but with more focus on outcomes
South West	Extend but not indefinitely, mandate service rather than specific checks
West Midlands	Revise for more flexibility and more outcomes focus
Yorkshire and the Humber	Revise for more flexibility

It can be seen that feedback from regional workshops echoes the findings from the stakeholder survey that mandation should continue, however, on reflection, most

regions favour some sort of revision. In particular, greater emphasis on outcomes rather than process and more scope for flexibility is proposed.
Formal written feedback on the preliminary findings and reflections on mandation, which were received from professional representatives of the core stakeholder groups are summarised in Table 29. The full detail of these responses is in Appendix 7.

Table 29: Summary of written feedback from professional representatives and membership organisations

Stakeholder group	Represented by	Main comments
Local authority	SOLACE	'In agreement with the LGA we would suggest that the government collectively review all mandated public health services including health visiting next year, when the overall position on local government funding and business rates reform is clearer.'
	LGA	'It makes no sense to review the mandation of one public health function in isolation from the others, when they all sit within the same ring-fenced budget.' 'We therefore ask that the government's decision about the future of the mandation of health visiting services and wider mandated public health services are collectively reviewed next year when the position is clearer on business rate reforms.'
	ADPH	'ADPH members are committed to ensuring the offer of universal 0-5 PHN services to the population but the current arrangement is inflexible. Mandation places an emphasis only on process - rather than combining process and outcomes - which is unhelpful.' 'ADPH would support greater flexibility in the timing of reviews and the skill mix of the reviewer based on assessment of need.'
	ADCS	'Maintaining the mandated elements of the 0-5 Healthy Child Programme removes the flexibility which the system needs to continue to improve outcomes in an environment of reduced resources.' 'ADCS members do not believe the mandation should continue if it is not fully funded.' 'We would welcome a review of all mandated public health services. Local authorities must be allowed the freedom to meet the needs of their local population in the most effective way.'

Health services, NHS	NHS England – Nursing directorate and Public Health Commissioning (Section 7a)	The benefits of mandation are demonstrably evident, particularly in relation to the potential to improve equity and consistency of care for pregnant and postpartum women and for children with complex and special educational needs and disability (SEND). Nursing Directorate - Maternity, children with complex needs, special educational needs and learning disabilities and safeguarding – extend mandation in a revised form. Commissioning Public Health Services (Section 7a) – NHS England support an extension of the mandation in its current form Principle reasons are the services do not yet seem completely settled and with a number of new procurements we would want to ensure the new providers are proven before we exit mandation Secondly we have further work to do on connecting LA commissioned services with the data from Child Health Information Services.
Health services, NHS	NHS England – Child Health Digital Programme	We recommend that mandation is continued and extended in the present form. This standardises the delivery of health services for all children. Key health events are defined and information collected at specific times in the standard health pathway providing expected health event pathway for parents, carers and professionals also providing a failsafe mechanism to ensure delivery. If mandation expired or was reduced, then events would not be standardised and the ability to collect key data for a child and the basis of interoperability to share such data would be severely compromised. The vision of appropriate access to information for all in involved in the care of the child could not be achieved.

Health Visitors	iHV, CPHVA, SAPHNA, RCN	'We recommend the continuation of mandation, with a revised schedule to also include a 3-4 month contact. Evidence highlights this a significant time in respect of supporting maternal mental health and promoting attachment (Wave Trust and Department for Education, 2013). It is also a good time to support continued breastfeeding as mothers' plan returning to work after maternity leave, and weaning onto a healthy diet in due course, to prevent obesity. Furthermore it is around this time that babies start to reach out and then to roll over putting them at risk of accidents. Anticipatory guidance from health visitors at this stage will help to protect infants from potential accidents.'

It can be seen that representatives of the nursing profession echo the main findings from the stakeholder survey in that they would like mandation to continue and in a revised form, which includes the introduction of an additional check at 3-4 months. This view is held very strongly by the health visitors and a check at this age is suitable to support other government priorities such as improving maternal mental health and reducing childhood obesity.

NHS England colleagues support the findings from the stakeholder survey. From a public health commissioning perspective, they recommend that mandation is extended so that services have more time to settle into the new arrangements. From a nursing perspective, a number of proposals are made for the revision of mandation with a greater focus on both the antenatal and postnatal periods and more consistent expectations around the role of health visitors in safeguarding. In addition, NHS England commission Child Health Information Services and state that more work is required to ensure these will fully support both current and future models of health visiting.

NHS England's Child Health Digital Programme is implementing the vision:

"Know where every child is and how healthy they are" and

"Appropriate access to information for all involved in the care of children."

The programme has written to emphasise the importance of mandation to maintaining a standardised care pathway, with known care events which can be digitised, enabling key information to be shared among professionals and with parents to ensure the health of all children is protected and promoted.

Representatives of the individual stakeholder sub-groups within local authorities have provided formal written feedback on the preliminary findings of the review. They broadly agree that these services are important but the current arrangements lack the flexibility required for commissioners to best meet the

needs of their local populations within the financial resources available. In anticipation of further changes to public health funding, they recommend that all mandated public health services are collectively reviewed next year. By that time, it will be possible to make a much more robust assessment of the effectiveness of mandation for the universal health visiting service as additional service delivery and outcome data will be available.

Other input from academic experts and special interest groups

Other unsolicited input on the review of mandation, which was received from experts and specialist organisations that were not included in the core scope of the review, has also been included in Appendix 7. Where these perspectives reinforce the findings of the review or coincide with the views of the main stakeholder groups they have been cross-referenced within the discussion as appropriate.

Conclusions

The regulations 5A and 5B 2015/921, which provide mandation for the universal health visitor reviews, were designed with two primary objectives in mind. These were — to secure the provision of five universal reviews for the eligible population of pregnant women and their children and to maintain a focus on the momentum of the health visitor programme through the transition of commissioning to local authorities and beyond. The detail is as follows:

- the provision of 5 universal reviews
  - securing a national, standard format
  - improving universal coverage
  - improving the overall wellbeing of families

- maintaining the momentum of the health visitor programme
  - ensuring that workforce levels are not diminished by uncertainty
  - ensuring that the potential of service transformation is realised

Stakeholders have confirmed that the mandation of the five universal reviews provides a framework for the service, which is helpful from both a commissioning and a service delivery perspective and enhances a uniformity of expectations across the country, helping to ensure that families benefit from the service irrespective of where they live. This national standardisation is reinforced by the central reporting mechanism, enabling local authorities to provide quarterly data to PHE on a voluntary basis, which in turn supports understanding of service provision and benchmarking across the country. The national standards on the universal aspects of the service are clear. There is, however, some confusion over the

enhanced service and the extent to which this may be tailored in line with local needs in order to deliver the best outcomes.

The standardised approach has allowed universal coverage to be tracked using the health visitor service delivery metrics. Although there are only two data points pre-transfer and two post-transfer, statistical tests show an overall improvement in service coverage during 2015/16. The overall picture of improvement in service coverage is also borne out in most regions of the country and coverage levels are similar. The exception is London. Although showing overall stability, with some areas of improvement, London has much lower coverage levels than other parts of the country.

A range of health and wellbeing outcomes are tracked for families and their children on an ongoing basis and a collection relating to the 0-5 years population is published by PHE as Early Years' Profiles. Unfortunately, the reporting for most of these indicators is on an annual cycle in arrears and although time based improvements in many outcomes can be seen, they all predate the transfer of commissioning to local authorities. The improvements in outcomes are attributable to many complex factors but have been selected as those most applicable to health visiting services and were thus subject to influence by the health visitor programme during its lifetime. The data is not yet available to support any conclusions regarding the impact of the regulation on wellbeing outcomes for families.

The service delivery momentum set up by the health visitor programme has been maintained through the transfer of commissioning to local authorities during 2015/16, the mandation supporting safe transition. It is not yet possible to say if this momentum has been maintained during 2016/17 because all data is reported on a quarterly basis in arrears.

The health visitor workforce numbers, which are available on a continued basis (the NHS electronic staff record (ESR)), show that the numbers in employment within the NHS remained stable, and at the high levels enjoyed at the conclusion of the health visitor programme, for the six months post transfer (up to March 2016). Following this they have started to decline. It can thus be stated that the workforce levels were not diminished through uncertainty during the year of transition and that the regulations provided some mitigation. It is too early to say if the decline in numbers during early 2016/17 is a real trend. However, the ambitious future commissioning intentions set out by local authorities are likely to cause uncertainty with messages of reduced investment, improved integration and increasing skill-mix providing stronger incentives for service providers to delay recruitment to vacant posts. In this respect, the sunset clause in the regulations, which automatically causes them to expire in March 2017, introduces uncertainty to the landscape in the longer term.

It is not possible at this stage to draw any conclusions with respect to the realisation of benefits from service transformation associated with the health visitor programme. The required data on health and wellbeing outcomes for children and their families is not yet available. Future commissioning intentions outline a range of options for innovative and extensive service transformation and there remains a risk that due to reductions in public health budgets, the full potential of the health visitor programme may not be realised.

All stakeholder groups, commissioners, providers and professionals, are in agreement that mandation should continue either in the current form or in a revised form. This view is also consistently held across all role-based subgroups within local authorities. The predominant reason stated is not just to provide some form of protection for the universal service but also to support the delivery of the longer-term benefits from the Healthy Child Programme 0-5 years. These include improved health and wellbeing outcomes for children and their families and a positive return on investment.

In addition, all stakeholder groups agree that the universal health visitor reviews have an important role to play in the delivery of other government priorities such as childhood obesity, tobacco control and improving maternal mental health.
From the viewpoint of local authority stakeholders, the universal health visitor service compares favourably with other mandated public health functions in its potential to add value to the health and wellbeing of the population. The rationale for this includes improved outcomes, reduced inequalities, safeguarding of all children and a greater potential for return on investment whilst recognising that all mandated public health functions are different and each has its own role to play within the overall system. Given this level of stakeholder agreement on the potential and status, in terms of relative importance, of the universal health visiting service to the public's overall health and wellbeing it would seem incongruous for it not to continue to be mandated whilst other public health functions benefit from this reinforcement.

Having considered the preliminary findings of this review and in anticipation of proposed future changes to public health funding, professional representatives of the local authority stakeholder group are recommending that all mandated public health services are reviewed collectively next year. By that time, it will be possible to make a more robust assessment of the effectiveness of mandation for the universal health visiting service as additional data on service delivery and health outcomes will be available.

Appendix 1: Commission for PHE to review operation of Universal Health Visitor Reviews

Purpose

1. This note acts as the formal commission for PHE to undertake a review of sections 5A and 5B of Regulations 2015/921 that brought Universal Health Visitor Reviews into force on 1 October 2015.

2. A submission was sent to PS(PH) recommending the review of the Regulations goes ahead and that this was the intention when the Regulations were developed, recognising this would provide a useful measure of their effectiveness, particularly at a time of change as the new commissioning arrangements embed.

3. PS(PH) has agreed to the review and that DH should commission PHE to take this work forward. In addition, the Minister has requested that the review is also used to identify how health visitors can help deliver against national priorities, such as childhood obesity and the new tobacco strategy. A review across the 456 model will meet both requests but with the emphasis being on the 5 Universal Health Visitor Reviews.

4. The review will also form part of evidence to the Infrastructure and Projects Authority (IPA) (previously known as the MPA), in re- assessing and assuring sustainability of the HV/0-5 programme. In addition, the review is referenced in the Shared Delivery Plan - *Commission PHE to review the new model of health visiting with particular regard to the local authority commissioning of mandated universal visits and benefits realisation for the health visiting transformation programme. (during 2016/17)*

Regulations and their requirements

5. The Regulations;

   The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) and Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) (Amendment) Regulations 2015

   require local authorities (LAs) to commission delivery of specific universal elements of the Healthy Child Programme (HCP), termed in the Regulations as Universal Health Visitor Reviews.

   - antenatal health promoting visit;
   - new baby review;
   - 6-8 week assessment;
   - 1 year assessment; and

- 2 to 2½ year review.

6. The Regulations contain a 'sunset' clause that ends their effect on 31 March 2017, 18 months after the transfer of the commissioning role to LAs on 1 October 2015.

7. The Regulations also provide for the Government, should it choose to do so, to undertake a review of the new arrangement, stating: *"The Secretary of State may carry out a review of the operation of regulations….."* The Regulations require the conclusions of the review to be published in a report. This will be considered by Ministers who will determine whether Regulations 5A and 5B will be allowed to expire or continue in force with or without amendment. A further affirmative SI would be needed to continue Regulations 5A and 5B.

8. The Regulations require the report to;
   (a) set out the objectives intended to be achieved by regulations 5A and 5B;
   (b) assess the extent to which those objectives are achieved; and
   (c) assess whether those objectives remain appropriate, and if so, the extent to which they could be achieved with less regulation.

9. The commitment is that the review be completed by the end of March 2017, though in reality, we would need to publish it as soon as possible 12 months after the Regulations came into force, so that sufficient Parliamentary time is available to deliver any required changes.

456 model review to support priority work areas

10. The 456 model is widely recognised within the health visiting profession and summarises the new model of health visiting. It sets out the four levels of service, 5 universal health visitor reviews and 6 high impact areas. By reviewing the 456 model elements in parallel we can take stock of its effectiveness against the overarching objectives of the health visitor programme to improve access, experience, outcomes and to reduce health inequalities.

11. The review should determine a methodology that supports identification of good practice in delivering national priorities and considers how this information can be shared more widely.

Review objectives and criteria

12. Neither the Regulations nor associated documents prescribe expectations about the nature of the review itself. There are however some broad indicators, based upon the initial rationale for mandation that might point the way for the review's focus:

    - mandation was deemed appropriate to ensure provision of the 5 universal reviews in the context of a national, standard format, thus supporting universal coverage, and families' overall wellbeing; and

- an underlying objective of mandation was to maintain local authorities' focus on post Health Visitor programme momentum and delivery of the new service vision around:
  - workforce levels (that they are not diminished by uncertainty over the scope of HV services in the new landscape)
  - service transformation (that the potential of the increased health visiting workforce to continuously improve/transform services for families is fully realised).

13. PHE will determine the methodology for the review of both the Regulations and 456 model, but may want to consider the following information;

    Metrics data – NHS England developed a set of metrics reporting on provider level activity, against health visitor led services including the 5 mandated reviews.

    Following the 0-5 transfer, these metrics are now collated via a new interim reporting system collecting activity at a local authority resident level. Quarter 1 of 2015/16 is the first reporting period and the information is being submitted to PHE by LAs on a voluntary basis.

    Other indirect data reported such as breastfeeding at 6-8 weeks and the use of Ages and Stages Questionnaire at 2 – 21/2 years will provide a richer blend of information.

    Financial data – Data on LA spend on mandated 0-5 children's services will be collected by DCLG. For quarter 3 (the first quarter following transfer) this will see data for 0-5 children's services spend included within the broader collection of data on LAs' spend across all mandated public health services. As such 0 – 5 years data will not be identifiable. Quarter 4 will be the first quarter's data to identify specific 0 – 5 services' spend. This level of granularity would be ideal for the review, however, its planned publication in November 2016, may potentially be too late to influence the review's findings.

    Case studies – case study material is available currently, there are a number of good examples covering the 6 high impact areas but this could be expanded further.

14. PHE may also wish to consider gathering views, from;
    - LA members, LA commissioners, including Directors of Public Health, Directors of Children's Services and local leads of joint strategic needs assessments;
    - provider organisations;
    - CCGs
    - health visitor and other community child health professionals; and
    - families (client experience feedback).

15. The review should consider whether the current requirements should be subject to amendment if there is evidence to support the need to continue the Regulations.

Input from Partners / logistics

16. PHE will want to consider the level of resource available to support the review. The breadth of the review's objectives and the number of components being examined will of course impact requirements. The division of tasks among the review's partner bodies and the manner in which these activities are conducted will also be a factor.

17. A Task and Finish Group set up under the recently established Best Start in Life Governance Board, will lead the review and ensure cross partnership views are incorporated. A separate piece of work, overseen by the BSiL Board, will run in parallel to the review to gather evidence to demonstrate the continued value being delivered by health visitors as a result of the health visitor programme. Both will provide evidence to support a post implementation review by the IPA in October 2016.

Overview of timeline

- **February 2016** – Formal commission to PHE, ToR to be agreed with BSiL.
- **February 2016** onwards – review undertaken
- **April 2016** – Q3 metrics data available
- **July 2016** – Q4 metrics data available
- **October 2016** - submit review's findings to lead minister and agree the recommendation. *If required*, the Department would engage lawyers to ensure legal provision is in place from 1 April 2017, to ensure continuity of the current arrangements
- **Autumn 2016** - publish the report and communicate next steps arrangements to stakeholders.

Membership: Best Start in Life Programme Board

Professor Viv Bennett, Chief Nurse, Public Health England (Co Chair)

Phil Norrey, Chief Executive Devon County Council (Co Chair)

Eustace DeSousa, National Lead Children and Young People and Families, Public Health England (PHE)

Martyn Regan, Centre Director for Yorkshire and Humber, PHE

Sally Burlington, Head of Programme Adults and Children, Local Government Association Sarah Kincaid, Policy Manager, Department of Communities and Local Government

Julia Gault, Deputy Director Family and Children Maintenance Policy, Department of Work and Pensions

Helen Stephenson, Child Poverty and Children's Services Strategy, Department for Education

Nick Adkin, Deputy Director Healthier Lives Division, Department of Health (outgoing)

Dorian Kennedy, Deputy Director Healthier Lives Division, Department of Health (incoming)

Sally Savage, Association of Directors of Children's Services

Virginia Pearson, Association of Directors of Public Health

Sue Hatton, Senior Nursing Policy Manager, Health Education England

Michelle Mellor, Deputy Director of Nursing, NHS England (outgoing)

Lorraine Mulroney, Nursing Directorate, NHS England (incoming)

Membership: Task and Finish Group

Helen Duncan, Programme Director, National Child and Maternal Health Intelligence Network, PHE (Chair)

Coleen Milligan, Programme Manager, National Child and Maternal Health Intelligence Network, PHE

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Nicky Brown, Children and Young People's Lead London, PHE

Sally Savage, Association of Directors of Children's Services

Virginia Pearson, Association of Directors of Public Health

Wendy Nicholson, Nursing Directorate, PHE

Appendix 2: Analytical methodology and statistical tests

Service delivery: summaries from health visitor service delivery metrics overview

Quarterly health visitor service delivery metrics and the associated outcomes have been collected by PHE from local authorities through a voluntary data collection since quarter 1 2015/16. At each quarterly collection, the local authority had the option to revise the data from previous quarters.

The 2015/16 quarter 4 data was published on 27 July 2016 for the first time alongside revisions to the previous three quarters. This publication was used to produce a PDF summary for each local area; a sample is shown below. Similar summaries were prepared for each PHE Centre and a national summary.

Public Health England

Protecting and improving the nation's health

Summary of Health Visitor Service Delivery Metrics for Noshire

Overall trends through transfer: Stable with some areas of improvement

Note: Overall trend is based on trends for indicators C2, C8i, C5 and C6i

Four quarters of 2015/16 (based on quarter 4 submission, data published July 2016)

Indicator	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Trend
C1: Number of mothers who received a first face-to-face antenatal contact with a Health Visitor at 28 weeks or above	75	201	150	115	**Not applicable**
C2: Percentage of New Birth Visits (NBVs) completed within 14 days	92.2%	89.7%	89.2%	90.7%	**No evidence of trend**
C3: Percentage of New Birth Visits (NBVs) completed after 14 days	7.6%	10.1%	10.7%	9.1%	**Not applicable**
C8i: Percentage of 6-8 week reviews completed	85.3%	76.2%	90.4%	90.4%	**Improving**
C8ii: Percentage breastfed at 6-8 weeks	26.5%	23.3%	21.7%	20.8%	**Deteriorating**
C4: Percentage of 12 month development reviews completed by the time the child turned 12 months	90.7%	91.3%	95.2%	92.0%	**Not applicable**
C5: Percentage of 12 month development reviews completed by the time the child turned 15 months	91.4%	91.9%	95.7%	92.4%	**No evidence of trend**
C6i: Percentage of 2-2½ year reviews completed	79.1%	83.4%	81.8%	91.8%	**Improving**
C6ii: Percentage of 2-2½ year reviews completed using ASQ-3 (Ages and Stages Questionnaire)	54.6%	74.0%	51.1%	70.8%	**Improving**

Shaded pink cells denote values from un-validated data

Data collection

Local authorities were asked to report data items quarterly for the following indicators, for their residents:

- number of mothers who received a first face to face antenatal contact with a health visitor at 28 weeks or above
- percentage of New Birth Visits (NBVs) completed within 14 days and after 14 days
- percentage of 6-8 week reviews completed by age 8 weeks
- percentage breastfeeding at 6-8 weeks
- percentage of 12-month development reviews completed by the time the child turned 12 months
- percentage of 12-month development reviews completed by the time the child turned 15 months
- percentage of 2-2½ year reviews completed by age 2½
- percentage of 2-2½ year reviews completed using ASQ-3 (Ages and Stages Questionnaire)

These were submitted to PHE via a web-based system created and managed by the Local Government Association (LGA). Validation was applied as figures were entered to prevent straightforward errors such as reversing the numerator and denominator. Percentages were calculated and displayed by the entry system as figures were entered as a further sense check against local calculations. An option of entering 'DK' was available where a figure was not known.

The system was available during pre-set 'collection windows'. These opened approximately two months following the end of the quarter, and stayed open for data entry for just under one month. During this time, areas could input data and amend data they had previously submitted. Once the collection window closed, the LGA provided the final dataset to PHE.

Data reporting

On receipt of the data, PHE applied a series of validation steps for each indicator to the local authority data, details of which can be found in the statistical publication. If the data items passed all validation, then an indicator value and confidence intervals were calculated and published. If not, the numerator and denominator were shown, with colour coding showing the reasons for each validation failure.

Indicators were calculated for PHE Centres and for England, with numerators and denominators for these being aggregates of their constituent areas which passed the initial, basic validation (valid numerator and denominator). The same further validation as applied to local authority areas was also applied to PHE Centres and to England, with values and confidence intervals only being published if validation was passed. The statistics were

published as excel files, with accompanying statistical commentary, and are available at www.chimat.org.uk/transfer#3

Calculation of trends for service delivery metric summaries

The PDF summaries showed the quarterly data from the publication. In the cases where a valid numerator and denominator had been provided but the data had failed validation (and therefore a value had not been published), for the purposes of these summaries only, a value was calculated and displayed. Data which failed validation is highlighted in pink. For the purposes of producing the statistics, it was important to apply rigorous validation rules to the data provided and be able to demonstrate that the overall publication met certain data quality standards. For the summaries, it was more meaningful to reflect back to local areas the data they had provided, which had been subject to local validation and signed off at director level within the organisation.

Trends over time

In addition, the summaries describe indicator trend during the four quarters shown. This was calculated using a statistical test called the chi-squared test. The test takes the four quarters' data and tests for differences over time. It describes whether a trend is going up or down, weighting later data more heavily than earlier data.

It is noted that running the test on only four data points would not usually be recommended. However due to the restrictions imposed by the timescale of the mandation review, this was a necessary compromise. The test produces two statistics each time it is run:

- the χ^2 value, which is compared to a pre-defined threshold to determine significance. The threshold chosen is arbitrary but two commonly accepted levels of significance in statistics are the 95% level and the 99.8% level, with the 99.8% level implying increased certainty that any significance found is not down to chance.[1] The 99.8% threshold was chosen in this case, in order to be almost certain that any deterioration in one or more indicators was reflective of a 'real' deterioration in the service in that area, rather than a statistical fluctuation
- The second statistic is the β value which describes the slope of the trend. Where the χ^2 value indicated a significant trend, β was used to ascertain whether the trend was increasing or decreasing. The description of the trend for the indicator was therefore one of the following:
  - **improving**: where the χ^2 value indicated a significant trend and the β showed an upward slope
  - **deteriorating**: where the χ^2 value indicated a significant trend and the β showed a downward slope

[1]By definition 1 in 20 findings will be incorrectly considered significant when the threshold is set at 95%; at 99.8% this decreases to one in 500.

- **no evidence of trend**: where the χ^2 value did not indicate a significant trend
- **insufficient data**: where fewer than four quarters of data were available

Trends were calculated for each of the four indicators which track the mandated elements of the universal health visiting service, and their associated outcomes. For antenatal visits, due to the difficulties in defining a denominator, only the total number of antenatal visits could be shown so no statistical tests could be carried out). Thus, a trend could be derived for the following:

- C2: Percentage of New Birth Visits (NBVs) completed within 14 days (service delivery)
- C8i: Percentage of 6-8 week reviews completed (service delivery)
- C8ii: Percentage breastfed at 6-8 weeks (outcome indicator)
- C5: Percentage of 12-month development reviews completed by the time the child turned 15 months (service delivery)
- C6i: Percentage of 2-2½ year reviews completed (service delivery)
  C6ii: Percentage of 2-2½ year reviews completed using ASQ-3 (Ages and Stages Questionnaire) (outcome indicator)

Overall trend through transfer

The four trends relating to service delivery were then combined to ascertain an overall description of how effectively the service as a whole had been maintained throughout the transfer of commissioning responsibilities ("Overall trends through transfer"). The options for this overall assessment were as follows (the logic was applied in the order shown):

- **deterioration of one or more mandated elements:** If any of the four service delivery metrics amenable to trend analysis (C2, C8i, C5, C6i) showed as 'deteriorating', then the service as a whole was assessed to have **not** been maintained through the transfer
- **insufficient data**: If any of the four service delivery metrics was assessed as 'insufficient data', then there was insufficient data to assess whether the service as a whole has been maintained
- **stable**: If all four service delivery metrics showed 'no evidence of trend'
- **stable with some areas of improvement:** One or two service delivery metrics assessed as 'improving', with the other three or two metrics assessed as 'no evidence of trend'
- **improving**: All four service delivery metrics assessed as 'improving, or three areas assessed as 'improving', with the other metrics assessed as 'no evidence of trend'

Health outcomes: From PHE's early years' profiles

PHE's Early Years Profiles (atlas.chimat.org.uk/IAS/dataviews/earlyyearsprofile) are designed to help commissioners and providers of health visiting services to assess the priorities for and outcomes of the transformation of health visiting services. The profiles were developed prior to the mandation review project. They show at a glance how each local area performs against key indicators for outcomes that are potentially influenced by the universal

health visiting service. They provide useful background information and context to current activity levels and outcomes.

It is important to note that the profiles display annual indicators, and because of the associated time lag, at the time of the mandation review all the indicators contained within the profiles relate to period **before** the transfer of commissioning of children's public health in October 2015. PDF versions of the profiles were produced for each local area, as well as each PHE Centre and a national profile.

The indicators in the profiles are drawn from many sources, and detailed metadata is available from the interactive profiles, using the link above. Details of the indicators can be found in the information guidance published for the transfer in October 2015, which describes commissioning data for 0-5 public health: www.gov.uk/government/publications/0-to-5-public-health-services-transfer-of-commissioning

A coloured trend arrow is available on the profiles to describe recent trends in the indicator. The methodology for the trend arrow is the same chi-squared test as described for the service delivery metrics. This test was applied to as many annual data points as were available in the profiles to describe a 'recent trend'; again, the most recent data points were weighted most heavily.

Stakeholder views: Quantitative analysis of survey responses

Views of a wide range of stakeholders on the future of the mandation were gathered using an online survey which ran from 29 June 2016 to 31 July 2016. This covered local leadership arrangements, views on mandation, commissioning intentions, benefits realisation and general comments on sustainability. The questions included in the survey and their wording were explored and approved through PHE's Best Start in Life Board. A full list of the survey questions can be found in Appendix 3. One of the first questions of the survey asked for the respondent's job role. The selection was restricted to one of the following:[2]

- local authority chief executive – local authority
- director of public health – local authority
- director of children's services – local authority
- local authority lead member for children & young people – local authority
- local authority health & wellbeing board chair – local authority
- local authority portfolio holder for public health – local authority
- local authority commissioner – local authority
- CCG commissioner – health services, NHS
- provider of health visiting services (management) – health services, NHS
- health visitor (health visitor team) – health visitor

[2] Based on the Department of Health requirements for the review.

Not all questions were relevant to all respondent types, and so the system used the answer to this question to conditionally select the 'path' through the survey (this is also shown in Appendix 3). Once the survey had closed, the survey results were extracted and analysed. The respondent job roles, described above, were grouped into more general groups of 'local authority', 'health services, NHS' or 'health visitors', and were used to separate out responses, in order to allow for meaningful analysis, and to differentiate between key stakeholder groups.

For each question, the analysis split out the responses for each of the three respondent groups. A statistical test was run to establish whether the groups gave significantly different answers to the questions, as would be expected. This test, known as *Kruskal–Wallis one-way analysis of variance* is a method for testing whether data provided from different groups are in fact significantly different from each other.

Where the Kruskal–Wallis test indicated there were significant differences, a further statistical test, *Dunn's test*, was applied in order to establish the detail of exactly which respondent groups gave statistically different responses. For example, in the table shown below (Table 9c in the report), the local authority responses are significantly different from the other two respondent groups, but they themselves are not significantly different from each other. 44% of local authority respondents said the reviews were 'extremely important' for transition to parenthood – smoking cessation, and this is significantly lower than the other respondent groups. However, although 70% of health visitors said the reviews were 'extremely important' for transition to parenthood – smoking cessation, this is not significantly higher than the 66% of respondents from the 'Health service, NHS' group.

Table example: Importance of the 0-5 universal reviews for transition to parenthood – advice and guidance on smoking cessation in pregnancy and to reduce harm to baby from second hand smoke (tobacco control priority)

Importance:	Extremely	Very	Somewhat	Not so	Not at all	Don't know
Local authority (243)	44%	36%	14%	3%	0%	2%
Health services, NHS (290)*	66%	23%	9%	1%	0%	1%
Health visitors (3130)*	70%	22%	6%	1%	0%	0%

* Results not statistically significantly different from each other

The open-source statistical environment *R* was used to run these tests.

All the results are displayed in the report as tables (showing rounded figures for ease of interpretation) and charts (derived from the unrounded percentages).

Stakeholder views: Qualitative analysis of survey responses

The survey allowed for free text responses in the following areas:

- reasons for recommendation on future of mandation
- proposals for changes if recommendation is for extension in a revised form

- reason for response on value compared to other mandated public health services
- future commissioning intentions
- boundary issues and
- general comments

A thematic analysis was performed on these free text responses subject to the volume of responses being sufficient to draw out some commonly repeated themes. This analysis involved reading through all the responses and the development of a detailed categorisation to which each response was assigned. Within individual responses it was sometimes possible to identify multiple themes depending upon the quality of the response. The detailed themes were then collated into a minimum number of broad themes. The number of times each broad theme was identified within the response from each stakeholder group (local authority, health services and health visitors) was quantified by performing a manual count. As the volume of responses varies significantly from one stakeholder group to another the subsequent analysis only considers the extent to which each broad theme was identified within responses from each stakeholder group. This allows understanding both within and between stakeholder groups on a proportionate basis.

Analysis of the free text responses in this way supported the production of charts in the following areas:

- reasons for recommending that mandation is extended in its current form
- proposals for revisions to mandation where it has been recommended that mandation is extended in a revised form
- reasons for recommending that mandation is allowed to expire as planned
- reasons for response on relative value compared to other mandated public health functions
- future commissioning intentions
- general comments

The free text responses for the following charts:

- reasons for recommending that mandation is extended in its current form
- proposals for revisions to mandation where it has been recommended that mandation is extended in a revised form
- reasons for recommending that mandation is allowed to expire as planned

were available to all stakeholder groups (local authority, health services and NHS, and health visitors). The number of responses differed greatly between the groups, with health visitors providing the majority of responses, and therefore equal weighting was applied to the raw data to prevent the responses from health visitors being over-represented in the combined percentage.

To illustrate this:

- 132 of the 993 comments from health visitors
- 11 of the 57 comments from health services, NHS and

- 5 of the 32 comments from local authorities

said that mandation should be revised to include more contacts. As a raw percentage from the numbers above, 148 of 1082=13.7% of comments were that mandation should be revised to include more contacts.

However, in order to avoid over-representing one group, each stakeholder group was artificially weighted to constitute one third of the total number of responses. Each denominator was scaled to 360 (one third of 1082) and therefore the numerator for each was scaled by the same factor.

The scaled totals (all numbers rounded) are:

- 48 (of 360) comments from health visitors
- 70 (of 360) comments from health services, NHS and
- 56 (of 360) comments from local authorities

The flowing is a worked example of this method which reaches the weighted percentage of 16.1% of respondents said that mandation should be revised to include more contacts.

48+70+56 =174 of the 1082 comments.

The same method was applied to all nine themes of the free text comments for ‘proposals for changes if recommendation is for extension in a revised form’. The weighted percentages were used to rank the themes for this chart.

The free text responses on the reason for response on value compared to other mandated public health services and future commissioning intentions were only available to local authority stakeholders, so no weighting was necessary to rank and order the themes.

Numbers of health visitors in the workforce

Electronic staff record (ESR)

Provisional health visitor numbers are published monthly by NHS Digital, sourcing data from the ESR. These are published as NHS Workforce Statistics digital.nhs.uk/searchcatalogue?topics=0%2fWorkforce&sort=Relevance&size=10&page=1#top
For the purposes of the review of mandation, these were used to calculate a monthly health visitor full-time equivalent (FTE) total from the ESR by summing the field ‘Total FTE’ and restricting records to ones where the field ‘Level’ is ‘006_Health Visitor’.

Health visitor minimum data set (MDS)

The MDS was set up to help support the government’s commitment to improve the health visiting service and recruit more health visitors by 2015. It aimed to collect data from all

employers of health visitors including capturing staff who are not included on ESR. These included those health visitors working for local authority and social enterprise employers. data.gov.uk/dataset/health-visitors
For the purposes of the review of mandation, the 'England' figure in the 'Number of health visitors' sheet was used for each month.

Indicative Health Visitor Collection (IHVC)

A parallel collection was run by NHS England between April 2014 and September 2015 for management information only, in order to provide a more real-time view, and to address some of the known issues with the MDS data. These figures are published as the Indicative Health Visitor Collection (IHVC): www.england.nhs.uk/statistics/statistical-work-areas/health-visitors/indicative-health-visitor-collection-ihvc/
For the purposes of the review of mandation, the figure in cell D12 of each monthly sheet (Total established1 in workforce FTE) was used as the total health visitor FTE from the IHVC.

Appendix 3: Stakeholder survey: questions and intended audience

QUESTION	RESPONSES	LA Chief Exec, H&WBB Chair, LA elected member, LA portfolio holder	DPH, DCS, LA Comnr	CCG Comnr, Service Provider	Health Visitor (Team)
Background					
Please tell us about your role. Are you giving us your views from the position of	• local authority chief executive • director of public health • director of children's services • local authority lead member for children & young people • local authority health & wellbeing board chair • local authority portfolio holder for public health • local authority commissioner • CCG commissioner • provider of health visiting services (management) • health visitor (health visitor team)	Yes	Yes	Yes	Yes
Please tell us which area of the country you work in	• drop down list of all PHE centre areas/Government Office Regions	Yes	Yes	Yes	Yes
Leadership					
Within your Local Authority which Director is responsible for children's public health 0-5 years?	• director of Public Health • director of Children's Services • other • don't know	Yes	Yes	No	No
If other please specify	Free text field	Yes	Yes	No	No
Within your Local Authority which elected member is responsible for children's public health 0-5 years?	• lead member for Children & Young People • portfolio holder for public health • other • don't know	Yes	Yes	No	No

If other please specify	Free text field	Yes	Yes	No	No
Mandation					
Existing legislation, mandating the five universal health visitor reviews (antenatal, new baby, 6-8 weeks, 1 year and 2-2$^{1}/_{2}$ years) are delivered for every child, is due to expire at the end of March 2017. What would you recommend happens next?	• the mandation is extended in its current form • the mandation is extended but in a revised form • the mandation is allowed to expire as planned • don't know	Yes	Yes	Yes	Yes
What are your reasons for this recommendation?	Free text field	Yes	Yes	Yes	Yes
If you are recommending that the mandation is extended in a revised form what changes would you like to see and why?	Free text field	Yes	Yes	Yes	Yes
Do you consider the mandated checks for 0-5s more or less important for your local population's health and wellbeing than the other Public Health mandated functions? *Note: Other mandated Public Health functions include National Child Measurement Programme, NHS Health Checks, Sexual Health Services, Public Health advices and Health protection*	• more important • less important • neither more or less important • don't know	Yes	Yes	No	No
What are your reasons for your response?	Free text field	Yes	Yes	No	No
Commissioning/ Commissioning intentions/Service levels					
In your area how did service levels for the five universal health visitor reviews change last year? (2015/16)	• improved • stayed the same • deteriorated • don't know	Yes	Yes	Yes	Yes
In your area how will service levels for the five universal health visitor reviews change this year? (2016/17)	• improve • stay the same • deteriorate • don't know	Yes	Yes	Yes	Yes
In your area how do you expect service levels for the five universal health visitor reviews to change next year? (2017/18)	• improve • stay the same • deteriorate • don't know	Yes	Yes	Yes	Yes
How confident are you that the introduction of new service models, including the integration of services, has enabled you /will enable you to commission for/deliver better outcomes? *Note: You will be invited at the end of the survey to provide contact details if you would like to share examples of good practice with the review team.*	• extremely confident • very confident • somewhat confident • not so confident • not at all confident • don't know	Yes	Yes	Yes	Yes
What impact do you expect future service models for children's public health will have on the health visiting workforce?	• require more health visitors • require about the same number of health visitors • require fewer health visitors • don't know	Yes	Yes	Yes	Yes
Please tell us about any future commissioning	Free text field	Yes	Yes	No	No

intentions					
Please tell us how you have addressed any boundary issues (registered versus resident population)	Free text field	No	Yes	No	No
Benefits realisation					
How important do you think the universal health visitor reviews are to delivering the benefits of the Healthy Child Programme 0-5 years in the following areas? a) Transition to parenthood – supporting the parents, providing advice and guidance healthy lifestyle and preparing the home for the new baby b) Transition to parenthood –contraceptive and sexual health advice to support planned pregnancies or parenthood c) Transition to parenthood – advice and guidance on smoking cessation in pregnancy and to reduce harm to baby from second hand smoke (tobacco control priority) d) Transition to parenthood – advice and guidance on establishing secure attachment and bonding, home learning environment e) Maternal mental health – assessment, brief intervention and signposting to other support services; being mindful of paternal wellbeing and good mental health as a mechanism for supporting healthy relationships f) Breastfeeding – advice, education and practical support, including signposting to other support services in order to initiate and sustain breastfeeding (childhood obesity priority) g) Healthy weight – advice and education on nutrition, weaning, healthy eating (including access to means tested vouchers for fresh fruit, vegetables and vitamins) and physical activity (childhood obesity priority) h) Managing minor illnesses & accident prevention – advice & guidance, illness escalation approaches, support uptake of childhood immunisations, home safety environment i) Healthy 2 year olds and school readiness – safety net on new-born and infant screening, child development assessment	For each • extremely important • very important • somewhat important • not so important • sot at all important • don't know	No	Yes	Yes	Yes

aged 2 – 2½ years, supporting parents to articulate development concerns (special needs) with access to early help, onward referral to other services (paediatrics, speech and language etc.)					
How important do you believe the universal health visitor reviews are to delivering the wider benefits of child health and wellbeing in the following areas? a) Escalation of safeguarding concerns b) Child protection	For each • very important • somewhat important • not very important • not at all important • don't know	Yes	Yes	Yes	Yes
To what extent do you believe the universal health visitor reviews deliver a positive return on investment? I.e. these services save more money in the wider system than they cost to deliver.	• positive (e.g. save more than they cost) • neutral (e.g. save about the same as they cost) • negative (e.g. cost more than they could ever save) • don't know	Yes	Yes	Yes	Yes
General Comments					
Please let us have any other comments on the sustainability of these services. In particular what are the main risks, mitigating actions and opportunities for innovation?	Free text field	Yes	Yes	Yes	Yes

Appendix 4: Regional trends in service delivery metrics

Summary of Health Visitor Service Delivery Metrics for South West

Overall trends through transfer: Improving

Note: Overall trend is based on trends for indicators C2, C8i, C5 and C6i

Four quarters of 2015/16 (based on quarter 4 submission, data published July 2016)

Indicator	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Trend
C1: Number of mothers who received a first face-to-face antenatal contact with a Health Visitor at 28 weeks or above	6226	6873	6978	6694	**Not applicable**
C2: Percentage of New Birth Visits (NBVs) completed within 14 days	78.8%	80.8%	81.7%	80.5%	**Improving**
C3: Percentage of New Birth Visits (NBVs) completed after 14 days	18.9%	16.7%	15.2%	16.2%	**Not applicable**
C8i: Percentage of 6-8 week reviews completed	84.5%	82.9%	85.6%	86.6%	**Improving**
C8ii: Percentage breastfed at 6-8 weeks	49.9%	45.2%	47.6%	48.2%	**No evidence of trend**
C4: Percentage of 12 month development reviews completed by the time the child turned 12 months	75.9%	78.9%	75.7%	74.6%	**Not applicable**
C5: Percentage of 12 month development reviews completed by the time the child turned 15 months	84.8%	87.0%	87.1%	87.5%	**Improving**
C6i: Percentage of 2-2½ year reviews completed	69.6%	71.9%	73.3%	75.7%	**Improving**
C6ii: Percentage of 2-2½ year reviews completed using ASQ-3 (Ages and Stages Questionnaire)	57.1%	75.3%	91.3%	91.2%	**Improving**

Shaded pink cells denote values from un-validated data

Summary of Health Visitor Service Delivery Metrics for North East

Overall trends through transfer: Deterioration of one or more mandated elements

Note: Overall trend is based on trends for indicators C2, C8i, C5 and C6i

Four quarters of 2015/16 (based on quarter 4 submission, data published July 2016)

Indicator	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Trend
C1: Number of mothers who received a first face-to-face antenatal contact with a Health Visitor at 28 weeks or above	5214	5960	5937	5995	**Not applicable**
C2: Percentage of New Birth Visits (NBVs) completed within 14 days	86.0%	89.6%	87.9%	88.8%	**Improving**
C3: Percentage of New Birth Visits (NBVs) completed after 14 days	10.5%	8.1%	9.1%	8.6%	**Not applicable**
C8i: Percentage of 6-8 week reviews completed	93.0%	90.2%	91.3%	90.8%	**Deteriorating**
C8ii: Percentage breastfed at 6-8 weeks	32.0%	32.1%	31.1%	30.0%	**No evidence of trend**
C4: Percentage of 12 month development reviews completed by the time the child turned 12 months	83.4%	88.0%	85.8%	86.2%	**Not applicable**
C5: Percentage of 12 month development reviews completed by the time the child turned 15 months	92.2%	93.2%	94.9%	94.2%	**Improving**
C6i: Percentage of 2-2½ year reviews completed	86.6%	89.7%	88.4%	89.7%	**Improving**
C6ii: Percentage of 2-2½ year reviews completed using ASQ-3 (Ages and Stages Questionnaire)	62.3%	48.2%	71.4%	79.3%	**Improving**

Shaded pink cells denote values from un-validated data

Summary of Health Visitor Service Delivery Metrics for North West

Overall trends through transfer: Improving

Note: Overall trend is based on trends for indicators C2, C8i, C5 and C6i

Four quarters of 2015/16 (based on quarter 4 submission, data published July 2016)

Indicator	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Trend
C1: Number of mothers who received a first face-to-face antenatal contact with a Health Visitor at 28 weeks or above	6407	6840	7199	7481	**Not applicable**
C2: Percentage of New Birth Visits (NBVs) completed within 14 days	86.2%	88.9%	89.4%	89.6%	**Improving**
C3: Percentage of New Birth Visits (NBVs) completed after 14 days	11.7%	8.5%	8.7%	7.8%	**Not applicable**
C8i: Percentage of 6-8 week reviews completed	82.0%	88.7%	88.8%	89.8%	**Improving**
C8ii: Percentage breastfed at 6-8 weeks	35.2%	35.7%	33.9%	35.1%	**No evidence of trend**
C4: Percentage of 12 month development reviews completed by the time the child turned 12 months	81.0%	82.1%	83.9%	84.1%	**Not applicable**
C5: Percentage of 12 month development reviews completed by the time the child turned 15 months	84.7%	86.4%	87.2%	89.6%	**Improving**
C6i: Percentage of 2-2½ year reviews completed	79.8%	82.7%	85.2%	85.5%	**Improving**
C6ii: Percentage of 2-2½ year reviews completed using ASQ-3 (Ages and Stages Questionnaire)	86.7%	89.2%	95.2%	95.9%	**Improving**

Shaded pink cells denote values from un-validated data

Summary of Health Visitor Service Delivery Metrics for Yorkshire and the Humber

Overall trends through transfer: Improving

Note: Overall trend is based on trends for indicators C2, C8i, C5 and C6i

Four quarters of 2015/16 (based on quarter 4 submission, data published July 2016)

Indicator	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Trend
C1: Number of mothers who received a first face-to-face antenatal contact with a Health Visitor at 28 weeks or above	8898	9908	9801	9823	**Not applicable**
C2: Percentage of New Birth Visits (NBVs) completed within 14 days	78.8%	79.6%	84.7%	86.8%	**Improving**
C3: Percentage of New Birth Visits (NBVs) completed after 14 days	17.4%	17.3%	13.0%	10.8%	**Not applicable**
C8i: Percentage of 6-8 week reviews completed	84.7%	82.6%	85.1%	86.4%	**Improving**
C8ii: Percentage breastfed at 6-8 weeks	39.0%	35.6%	36.6%	36.6%	**Deteriorating**
C4: Percentage of 12 month development reviews completed by the time the child turned 12 months	83.5%	81.3%	81.5%	82.5%	**Not applicable**
C5: Percentage of 12 month development reviews completed by the time the child turned 15 months	86.4%	86.1%	86.1%	88.5%	**Improving**
C6i: Percentage of 2-2½ year reviews completed	81.9%	81.6%	81.4%	81.3%	**No evidence of trend**
C6ii: Percentage of 2-2½ year reviews completed using ASQ-3 (Ages and Stages Questionnaire)	27.8%	54.1%	76.3%	84.3%	**Improving**

Shaded pink cells denote values from un-validated data

Summary of Health Visitor Service Delivery Metrics for East Midlands

Overall trends through transfer: Stable with some areas of improvement

Note: Overall trend is based on trends for indicators C2, C8i, C5 and C6i

Four quarters of 2015/16 (based on quarter 4 submission, data published July 2016)

Indicator	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Trend
C1: Number of mothers who received a first face-to-face antenatal contact with a Health Visitor at 28 weeks or above	6988	7326	7127	7040	**Not applicable**
C2: Percentage of New Birth Visits (NBVs) completed within 14 days	90.1%	90.3%	90.3%	89.2%	**No evidence of trend**
C3: Percentage of New Birth Visits (NBVs) completed after 14 days	8.4%	7.7%	8.1%	7.8%	**Not applicable**
C8i: Percentage of 6-8 week reviews completed	91.8%	91.4%	92.2%	91.8%	**No evidence of trend**
C8ii: Percentage breastfed at 6-8 weeks	43.1%	43.1%	41.8%	42.1%	**No evidence of trend**
C4: Percentage of 12 month development reviews completed by the time the child turned 12 months	84.9%	86.4%	88.2%	85.9%	**Not applicable**
C5: Percentage of 12 month development reviews completed by the time the child turned 15 months	92.1%	92.6%	93.6%	93.1%	**Improving**
C6i: Percentage of 2-2½ year reviews completed	82.8%	86.5%	87.9%	85.8%	**Improving**
C6ii: Percentage of 2-2½ year reviews completed using ASQ-3 (Ages and Stages Questionnaire)	83.5%	85.5%	89.8%	91.3%	**Improving**

Shaded pink cells denote values from un-validated data

Summary of Health Visitor Service Delivery Metrics for West Midlands

Overall trends through transfer: Deterioration of one or more mandated elements

Note: Overall trend is based on trends for indicators C2, C8i, C5 and C6i

Four quarters of 2015/16 (based on quarter 4 submission, data published July 2016)

Indicator	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Trend
C1: Number of mothers who received a first face-to-face antenatal contact with a Health Visitor at 28 weeks or above	5428	6069	6641	6260	**Not applicable**
C2: Percentage of New Birth Visits (NBVs) completed within 14 days	88.5%	89.9%	89.6%	88.8%	**No evidence of trend**
C3: Percentage of New Birth Visits (NBVs) completed after 14 days	9.2%	8.1%	7.2%	7.4%	**Not applicable**
C8i: Percentage of 6-8 week reviews completed	88.5%	89.0%	89.7%	85.9%	**Deteriorating**
C8ii: Percentage breastfed at 6-8 weeks	39.4%	40.3%	40.4%	39.0%	**No evidence of trend**
C4: Percentage of 12 month development reviews completed by the time the child turned 12 months	81.3%	81.7%	82.4%	84.3%	**Not applicable**
C5: Percentage of 12 month development reviews completed by the time the child turned 15 months	86.2%	86.1%	87.4%	87.5%	**Improving**
C6i: Percentage of 2-2½ year reviews completed	80.0%	80.9%	82.7%	80.9%	**Improving**
C6ii: Percentage of 2-2½ year reviews completed using ASQ-3 (Ages and Stages Questionnaire)	80.9%	84.0%	84.2%	81.6%	**No evidence of trend**

Shaded pink cells denote values from un-validated data

Summary of Health Visitor Service Delivery Metrics for East of England

Overall trends through transfer: Improving

Note: Overall trend is based on trends for indicators C2, C8i, C5 and C6i

Four quarters of 2015/16 (based on quarter 4 submission, data published July 2016)

Indicator	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Trend
C1: Number of mothers who received a first face-to-face antenatal contact with a Health Visitor at 28 weeks or above	7138	7675	7329	7615	**Not applicable**
C2: Percentage of New Birth Visits (NBVs) completed within 14 days	91.4%	93.3%	92.7%	92.9%	**Improving**
C3: Percentage of New Birth Visits (NBVs) completed after 14 days	7.5%	5.5%	6.1%	6.0%	**Not applicable**
C8i: Percentage of 6-8 week reviews completed	82.1%	84.4%	86.0%	90.7%	**Improving**
C8ii: Percentage breastfed at 6-8 weeks	44.8%	46.3%	48.6%	48.8%	**Improving**
C4: Percentage of 12 month development reviews completed by the time the child turned 12 months	82.6%	84.7%	86.3%	85.0%	**Not applicable**
C5: Percentage of 12 month development reviews completed by the time the child turned 15 months	89.2%	88.4%	90.6%	91.1%	**Improving**
C6i: Percentage of 2-2½ year reviews completed	82.8%	85.6%	86.8%	85.5%	**Improving**
C6ii: Percentage of 2-2½ year reviews completed using ASQ-3 (Ages and Stages Questionnaire)	94.2%	97.4%	97.2%	98.3%	**Improving**

Shaded pink cells denote values from un-validated data

Summary of Health Visitor Service Delivery Metrics for London

Overall trends through transfer: Stable with some areas of improvement

Note: Overall trend is based on trends for indicators C2, C8i, C5 and C6i

Four quarters of 2015/16 (based on quarter 4 submission, data published July 2016)

Indicator	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Trend
C1: Number of mothers who received a first face-to-face antenatal contact with a Health Visitor at 28 weeks or above	3322	3131	2118	2970	**Not applicable**
C2: Percentage of New Birth Visits (NBVs) completed within 14 days	87.6%	87.1%	89.2%	90.0%	**Improving**
C3: Percentage of New Birth Visits (NBVs) completed after 14 days	9.4%	8.9%	8.9%	8.1%	**Not applicable**
C8i: Percentage of 6-8 week reviews completed	53.1%	44.2%	49.8%	59.0%	**Improving**
C8ii: Percentage breastfed at 6-8 weeks	54.5%	49.6%	47.6%	50.4%	**Deteriorating**
C4: Percentage of 12 month development reviews completed by the time the child turned 12 months	42.7%	40.2%	43.3%	42.9%	**Not applicable**
C5: Percentage of 12 month development reviews completed by the time the child turned 15 months	57.2%	56.7%	55.3%	56.8%	**No evidence of trend**
C6i: Percentage of 2-2½ year reviews completed	43.2%	43.8%	43.6%	44.0%	**No evidence of trend**
C6ii: Percentage of 2-2½ year reviews completed using ASQ-3 (Ages and Stages Questionnaire)	29.9%	63.8%	53.9%	60.2%	**Improving**

Shaded pink cells denote values from un-validated data

Summary of Health Visitor Service Delivery Metrics for South East

Overall trends through transfer: Stable with some areas of improvement

Note: Overall trend is based on trends for indicators C2, C8i, C5 and C6i

Four quarters of 2015/16 (based on quarter 4 submission, data published July 2016)

Indicator	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Trend
C1: Number of mothers who received a first face-to-face antenatal contact with a Health Visitor at 28 weeks or above	11252	9934	10880	11178	**Not applicable**
C2: Percentage of New Birth Visits (NBVs) completed within 14 days	81.7%	83.1%	83.1%	82.7%	**No evidence of trend**
C3: Percentage of New Birth Visits (NBVs) completed after 14 days	14.7%	12.9%	14.0%	13.2%	**Not applicable**
C8i: Percentage of 6-8 week reviews completed	84.3%	84.1%	82.4%	85.5%	**No evidence of trend**
C8ii: Percentage breastfed at 6-8 weeks	48.4%	48.7%	47.6%	49.2%	**No evidence of trend**
C4: Percentage of 12 month development reviews completed by the time the child turned 12 months	71.1%	71.6%	68.3%	72.6%	**Not applicable**
C5: Percentage of 12 month development reviews completed by the time the child turned 15 months	73.3%	74.8%	77.9%	82.6%	**Improving**
C6i: Percentage of 2-2½ year reviews completed	68.0%	69.7%	73.9%	77.0%	**Improving**
C6ii: Percentage of 2-2½ year reviews completed using ASQ-3 (Ages and Stages Questionnaire)	73.5%	67.5%	86.3%	90.2%	**Improving**

Shaded pink cells denote values from un-validated data

Appendix 5: Regional trends in health outcome indicators

Early Years Profile: North East region

Latest data as of July 2016

High impact area	Key performance indicators	Current performance	Range (all local authorities)	Trend since 2010	
Transition to parenthood and the early weeks	Teenage pregnancy rates	30.2 per 1,000 15-17 year olds (2014)	Best: 22.3 Worst: 35.5	**Improving**	↓
	Smoking in pregnancy	18.0% (2014/15)	Best: 12.7 Worst: 25.9	**Improving**	↓
	Low birth weight of term babies	3.0% (2014)	Best: 2 Worst: 4.2	**Stable**	↔
	Infant mortality	3.6 per 1,000 live births (2012-14)	Best: 2.7 Worst: 4.5	**Stable**	↔
Maternal (perinatal) mental health	Maternal mental health	Metric in development		**Not applicable**	
Breastfeeding	Breastfeeding at 6-8 weeks	-% (2014/15)	Best: 46.2 Worst: 20.2	**No validated data**	
Healthy weight	Excess weight at 4-5 years	23.7% (2014/15)	Best: 22.1 Worst: 27.4	**Stable**	↔
Managing minor illnesses & reducing accidents	A&E attendance rates, under 5 years	763.6 per 1,000 (2014/15)	Best: 334.1 Worst: 1358.3	**Deteriorating**	↑
	Emergency hospital admissions, under 5 years	209.6 per 1,000 (2014/15)	Best: 166 Worst: 265	**Improving**	↓
	Hospital admissions for injuries, under 5 years	205.7 per 10,000 (2014/15)	Best: 162.3 Worst: 249.7	**Stable**	↔
Health, wellbeing and development	Tooth decay at 5 years, average number of decayed teeth	0.95 per child (2014/15)	Best: 0.4 Worst: 1.66	**Too early to say**	
	MMR immunisation coverage at 5 years	93.6% (2014/15)	Best: 96.9 Worst: 87.7	**Improving**	↑
	Development outcomes at 2- $2^1/_2$ years	Metric in development		**Not applicable**	
	School readiness, good level of development at end of reception	63.2% (2014/15)	Best: 68.4 Worst: 57.4	**Too early to say ****	

** Not enough data points to calculate a trend, due to methodological changes in 2012

Early Years Profile: North West region

Latest data as of July 2016

High impact area	Key performance indicators	Current performance	Range (all local authorities)	Trend since 2010	
Transition to parenthood and the early weeks	Teenage pregnancy rates	26.8 per 1,000 15-17 year olds (2014)	Best: 16 Worst: 37.3	**Improving**	↓
	Smoking in pregnancy	14.7% (2014/15)	Best: 8.3 Worst: 27.2	**Improving**	↓
	Low birth weight of term babies	2.8% (2014)	Best: 1.9 Worst: 4.3	**Stable**	↔
	Infant mortality	4.3 per 1,000 live births (2012-14)	Best: 2.7 Worst: 5.8	**Stable**	↔
Maternal (perinatal) mental health	Maternal mental health	Metric in development		**Not applicable**	
Breastfeeding	Breastfeeding at 6-8 weeks	-% (2014/15)	Best: 49.9 Worst: 19.1	**No validated data**	
Healthy weight	Excess weight at 4-5 years	22.9% (2014/15)	Best: 18.7 Worst: 26.2	**Stable**	↔
Managing minor illnesses & reducing accidents	A&E attendance rates, under 5 years	630.0 per 1,000 (2014/15)	Best: 353.7 Worst: 1761.8	**Deteriorating**	↑
	Emergency hospital admissions, under 5 years	202.7 per 1,000 (2014/15)	Best: 108.7 Worst: 265.8	**Improving**	↓
	Hospital admissions for injuries, under 5 years	192.8 per 10,000 (2014/15)	Best: 118.4 Worst: 279.8	**Stable**	↔
Health, wellbeing and development	Tooth decay at 5 years, average number of decayed teeth	1.28 per child (2014/15)	Best: 0.63 Worst: 2.46	**Too early to say**	
	MMR immunisation coverage at 5 years	90.7% (2014/15)	Best: 97.5 Worst: 87.3	**Improving**	↑
	Development outcomes at 2- $2^1/_2$ years	Metric in development		**Not applicable**	
	School readiness, good level of development at end of reception	63.7% (2014/15)	Best: 73.4 Worst: 54.7	**Too early to say ****	

** Not enough data points to calculate a trend, due to methodological changes in 2012

Early Years Profile: Yorkshire and the Humber region

Latest data as of July 2016

High impact area	Key performance indicators	Current performance	Range (all local authorities)	Trend since 2010	
Transition to parenthood and the early weeks	Teenage pregnancy rates	26.4 per 1,000 15-17 year olds (2014)	Best: 15.7 Worst: 40.8	**Improving**	↓
	Smoking in pregnancy	15.6% (2014/15)	Best: 10.8 Worst: 22	**Improving**	↓
	Low birth weight of term babies	3.1% (2014)	Best: 1.8 Worst: 3.9	**Stable**	↔
	Infant mortality	4.2 per 1,000 live births (2012-14)	Best: 2.8 Worst: 5.8	**Improving**	↓
Maternal (perinatal) mental health	Maternal mental health	Metric in development		**Not applicable**	
Breastfeeding	Breastfeeding at 6-8 weeks	42.2% (2014/15)	Best: 48.7 Worst: 25.2	**No validated data**	
Healthy weight	Excess weight at 4-5 years	21.5% (2014/15)	Best: 19.1 Worst: 25.1	**Stable**	↔
Managing minor illnesses & reducing accidents	A&E attendance rates, under 5 years	502.1 per 1,000 (2014/15)	Best: 363.4 Worst: 786.3	**Deteriorating**	↑
	Emergency hospital admissions, under 5 years	153.9 per 1,000 (2014/15)	Best: 89.8 Worst: 236	**Improving**	↓
	Hospital admissions for injuries, under 5 years	135.3 per 10,000 (2014/15)	Best: 90.5 Worst: 176.3	**Improving**	↓
Health, wellbeing and development	Tooth decay at 5 years, average number of decayed teeth	1.01 per child (2014/15)	Best: 0.52 Worst: 1.65	**Too early to say**	
	MMR immunisation coverage at 5 years	92.3% (2014/15)	Best: 96.5 Worst: 89	**Improving**	↑
	Development outcomes at 2- $2^1/_2$ years	Metric in development		**Not applicable**	
	School readiness, good level of development at end of reception	64.6% (2014/15)	Best: 70.1 Worst: 60.5	**Too early to say ****	

** Not enough data points to calculate a trend, due to methodological changes in 2012

Early Years Profile: East Midlands region

Latest data as of July 2016

High impact area	Key performance indicators	Current performance	Range (all local authorities)	Trend since 2010	
Transition to parenthood and the early weeks	Teenage pregnancy rates	21.6 per 1,000 15-17 year olds (2014)	Best: 9.8 Worst: 32.8	**Improving**	↓
	Smoking in pregnancy	13.7% (2014/15)	Best: 10.3 Worst: 15.1	**Improving**	↓
	Low birth weight of term babies	2.7% (2014)	Best: 2.2 Worst: 4.2	**Improving**	↓
	Infant mortality	4.3 per 1,000 live births (2012-14)	Best: 3 Worst: 5.7	**Stable**	↔
Maternal (perinatal) mental health	Maternal mental health	Metric in development		**Not applicable**	
Breastfeeding	Breastfeeding at 6-8 weeks	44.4% (2014/15)	Best: 62.1 Worst: 38	**Improving**	↑
Healthy weight	Excess weight at 4-5 years	21.7% (2014/15)	Best: 20.3 Worst: 26.7	**Stable**	↔
Managing minor illnesses & reducing accidents	A&E attendance rates, under 5 years	456.3 per 1,000 (2014/15)	Best: 292.9 Worst: 657.6	**Deteriorating**	↑
	Emergency hospital admissions, under 5 years	126.6 per 1,000 (2014/15)	Best: 68.9 Worst: 172	**Improving**	↓
	Hospital admissions for injuries, under 5 years	112.8 per 10,000 (2014/15)	Best: 45 Worst: 150.8	**Improving**	↓
Health, wellbeing and development	Tooth decay at 5 years, average number of decayed teeth	0.90 per child (2014/15)	Best: 0.61 Worst: 1.87	**Too early to say**	
	MMR immunisation coverage at 5 years	91.2% (2014/15)	Best: 94.9 Worst: 84.7	**Improving**	↑
	Development outcomes at 2- $2^1/_2$ years	Metric in development		**Not applicable**	
	School readiness, good level of development at end of reception	64.0% (2014/15)	Best: 74.8 Worst: 50.7	**Too early to say ****	

** Not enough data points to calculate a trend, due to methodological changes in 2012

Early Years Profile: West Midlands region

Latest data as of July 2016

High impact area	Key performance indicators	Current performance	Range (all local authorities)	Trend since 2010	
Transition to parenthood and the early weeks	Teenage pregnancy rates	26.5 per 1,000 15-17 year olds (2014)	Best: 15.1 Worst: 42.4	**Improving**	↓
	Smoking in pregnancy	14.2% (2014/15)	Best: 10 Worst: 21.2	**Improving**	↓
	Low birth weight of term babies	3.4% (2014)	Best: 2.3 Worst: 5.8	**Stable**	↔
	Infant mortality	5.5 per 1,000 live births (2012-14)	Best: 3.3 Worst: 7.2	**Stable**	↔
Maternal (perinatal) mental health	Maternal mental health	Metric in development		**Not applicable**	
Breastfeeding	Breastfeeding at 6-8 weeks	-% (2014/15)	Best: 52.2 Worst: 31.7	**No validated data**	
Healthy weight	Excess weight at 4-5 years	23.1% (2014/15)	Best: 19.1 Worst: 26.1	**Stable**	↔
Managing minor illnesses & reducing accidents	A&E attendance rates, under 5 years	503.9 per 1,000 (2014/15)	Best: 310.2 Worst: 669.3	**Deteriorating**	↑
	Emergency hospital admissions, under 5 years	172.4 per 1,000 (2014/15)	Best: 115 Worst: 243.4	**Improving**	↓
	Hospital admissions for injuries, under 5 years	143.3 per 10,000 (2014/15)	Best: 102.3 Worst: 179.3	**Improving**	↓
Health, wellbeing and development	Tooth decay at 5 years, average number of decayed teeth	0.72 per child (2014/15)	Best: 0.46 Worst: 1.43	**Too early to say**	
	MMR immunisation coverage at 5 years	90.6% (2014/15)	Best: 95.8 Worst: 85	**Improving**	↑
	Development outcomes at 2- $2^1/_2$ years	Metric in development		**Not applicable**	
	School readiness, good level of development at end of reception	64.3% (2014/15)	Best: 70 Worst: 57.7	**Too early to say ****	

** Not enough data points to calculate a trend, due to methodological changes in 2012

Early Years Profile: East of England region

Latest data as of July 2016

High impact area	Key performance indicators	Current performance	Range (all local authorities)	Trend since 2010	
Transition to parenthood and the early weeks	Teenage pregnancy rates	20.2 per 1,000 15-17 year olds (2014)	Best: 16.2 Worst: 30.2	**Improving**	↓
	Smoking in pregnancy	11.0% (2014/15)	Best: 7.8 Worst: 14.1	**Improving**	↓
	Low birth weight of term babies	2.7% (2014)	Best: 2 Worst: 4.5	**Stable**	↔
	Infant mortality	3.6 per 1,000 live births (2012-14)	Best: 2.8 Worst: 5.1	**Stable**	↔
Maternal (perinatal) mental health	Maternal mental health	Metric in development		**Not applicable**	
Breastfeeding	Breastfeeding at 6-8 weeks	-% (2014/15)	Best: 58.3 Worst: 43.9	**No validated data**	
Healthy weight	Excess weight at 4-5 years	20.7% (2014/15)	Best: 19.4 Worst: 22.3	**Improving**	↓
Managing minor illnesses & reducing accidents	A&E attendance rates, under 5 years	425.1 per 1,000 (2014/15)	Best: 263.6 Worst: 782.5	**Deteriorating**	↑
	Emergency hospital admissions, under 5 years	134.0 per 1,000 (2014/15)	Best: 69.6 Worst: 236.3	**Deteriorating**	↑
	Hospital admissions for injuries, under 5 years	121.5 per 10,000 (2014/15)	Best: 66.3 Worst: 155.8	**Stable**	↔
Health, wellbeing and development	Tooth decay at 5 years, average number of decayed teeth	0.66 per child (2014/15)	Best: 0.49 Worst: 1.69	**Too early to say**	
	MMR immunisation coverage at 5 years	90.8% (2014/15)	Best: 92.8 Worst: 82.6	**Improving**	↑
	Development outcomes at 2- $2^1/_2$ years	Metric in development		**Not applicable**	
	School readiness, good level of development at end of reception	66.6% (2014/15)	Best: 72.5 Worst: 60.4	**Too early to say ****	

** Not enough data points to calculate a trend, due to methodological changes in 2012

Early Years Profile: London region

Latest data as of July 2016

High impact area	Key performance indicators	Current performance	Range (all local authorities)	Trend since 2010	
Transition to parenthood and the early weeks	Teenage pregnancy rates	21.5 per 1,000 15-17 year olds (2014)	Best: 11 Worst: 33.8	**Improving**	↓
	Smoking in pregnancy	4.8% (2014/15)	Best: 2.1 Worst: 10.4	**Improving**	↓
	Low birth weight of term babies	3.2% (2014)	Best: 2.1 Worst: 5	**Stable**	↔
	Infant mortality	3.6 per 1,000 live births (2012-14)	Best: 1.6 Worst: 5.6	**Improving**	↓
Maternal (perinatal) mental health	Maternal mental health	Metric in development		**Not applicable**	
Breastfeeding	Breastfeeding at 6-8 weeks	-% (2014/15)	Best: 81.5 Worst: 62.2	**No validated data**	
Healthy weight	Excess weight at 4-5 years	22.2% (2014/15)	Best: 14.9 Worst: 27.2	**Improving**	↓
Managing minor illnesses & reducing accidents	A&E attendance rates, under 5 years	681.9 per 1,000 (2014/15)	Best: 408.1 Worst: 967	**Deteriorating**	↑
	Emergency hospital admissions, under 5 years	102.1 per 1,000 (2014/15)	Best: 62.3 Worst: 178.6	**Deteriorating**	↑
	Hospital admissions for injuries, under 5 years	100.4 per 10,000 (2014/15)	Best: 66.7 Worst: 143.4	**Improving**	↓
Health, wellbeing and development	Tooth decay at 5 years, average number of decayed teeth	1.00 per child (2014/15)	Best: 0.43 Worst: 1.77	**Too early to say**	
	MMR immunisation coverage at 5 years	81.1% (2014/15)	Best: 89.7 Worst: 64	**Improving**	↑
	Development outcomes at 2- $2^1/_2$ years	Metric in development		**Not applicable**	
	School readiness, good level of development at end of reception	68.1% (2014/15)	Best: 77.5 Worst: 61.6	**Too early to say ****	

** Not enough data points to calculate a trend, due to methodological changes in 2012

Early Years Profile: South East region

Latest data as of July 2016

High impact area	Key performance indicators	Current performance	Range (all local authorities)	Trend since 2010	
Transition to parenthood and the early weeks	Teenage pregnancy rates	18.8 per 1,000 15-17 year olds (2014)	Best: 8.4 Worst: 33.2	**Improving**	↓
	Smoking in pregnancy	10.3% (2014/15)	Best: 6.3 Worst: 17.9	**Improving**	↓
	Low birth weight of term babies	2.4% (2014)	Best: 1.7 Worst: 3	**Stable**	↔
	Infant mortality	3.3 per 1,000 live births (2012-14)	Best: 2 Worst: 5.4	**Stable**	↔
Maternal (perinatal) mental health	Maternal mental health	Metric in development		**Not applicable**	
Breastfeeding	Breastfeeding at 6-8 weeks	-% (2014/15)	Best: 72.5 Worst: 45.8	**No validated data**	
Healthy weight	Excess weight at 4-5 years	20.3% (2014/15)	Best: 16.6 Worst: 23.8	**Improving**	↓
Managing minor illnesses & reducing accidents	A&E attendance rates, under 5 years	466.8 per 1,000 (2014/15)	Best: 322.9 Worst: 848	**Deteriorating**	↑
	Emergency hospital admissions, under 5 years	137.1 per 1,000 (2014/15)	Best: 94.1 Worst: 202.2	**Stable**	↔
	Hospital admissions for injuries, under 5 years	132.8 per 10,000 (2014/15)	Best: 74.8 Worst: 292.4	**Improving**	↓
Health, wellbeing and development	Tooth decay at 5 years, average number of decayed teeth	0.63 per child (2014/15)	Best: 0.37 Worst: 1.78	**Too early to say**	
	MMR immunisation coverage at 5 years	86.8% (2014/15)	Best: 93.2 Worst: 74.1	**Improving**	↑
	Development outcomes at 2- $2^1/_2$ years	Metric in development		**Not applicable**	
	School readiness, good level of development at end of reception	70.1% (2014/15)	Best: 74.3 Worst: 63.5	**Too early to say ****	

** Not enough data points to calculate a trend, due to methodological changes in 2012

Early Years Profile: South West region

Latest data as of July 2016

High impact area	Key performance indicators	Current performance	Range (all local authorities)	Trend since 2010	
Transition to parenthood and the early weeks	Teenage pregnancy rates	18.8 per 1,000 15-17 year olds (2014)	Best: 12.3 Worst: 30.7	**Improving**	↓
	Smoking in pregnancy	11.9% (2014/15)	Best: 9.1 Worst: 16.1	**Improving**	↓
	Low birth weight of term babies	2.5% (2014)	Best: 1.6 Worst: 3	**Stable**	↔
	Infant mortality	3.7 per 1,000 live births (2012-14)	Best: 1.7 Worst: 4.7	**Stable**	↔
Maternal (perinatal) mental health	Maternal mental health	Metric in development		**Not applicable**	
Breastfeeding	Breastfeeding at 6-8 weeks	-% (2014/15)	Best: 58.4 Worst: 35.7	**No validated data**	
Healthy weight	Excess weight at 4-5 years	22.3% (2014/15)	Best: 17.5 Worst: 24.6	**Stable**	↔
Managing minor illnesses & reducing accidents	A&E attendance rates, under 5 years	446.2 per 1,000 (2014/15)	Best: 354.7 Worst: 569.7	**Deteriorating**	↑
	Emergency hospital admissions, under 5 years	142.5 per 1,000 (2014/15)	Best: 90.3 Worst: 195.9	**Deteriorating**	↑
	Hospital admissions for injuries, under 5 years	145.8 per 10,000 (2014/15)	Best: 116.8 Worst: 219	**Stable**	↔
Health, wellbeing and development	Tooth decay at 5 years, average number of decayed teeth	0.66 per child (2014/15)	Best: 0.37 Worst: 1.12	**Too early to say**	
	MMR immunisation coverage at 5 years	90.9% (2014/15)	Best: 94.3 Worst: 88.6	**Improving**	↑
	Development outcomes at 2- $2^1/_2$ years	Metric in development		**Not applicable**	
	School readiness, good level of development at end of reception	67.2% (2014/15)	Best: 75.9 Worst: 62.6	**Too early to say ****	

** Not enough data points to calculate a trend, due to methodological changes in 2012

Appendix 6: Published commissioning intentions

An overview of local authorities' intentions re: commissioning of 0 – 5 years and associated children's services.

1. Introduction:

As part of PHE's review of the mandated arrangements for 0-5 years services, the HV policy team was asked to look at local authorities' stated intentions regarding their 2016/17 public health budget, with particular regards to commitments on commissioning 0-5 years health visitor-led services. At the same time, we looked for wider, resource-related issues and potential 'knock-ons' to LAs' strategic approach to planning future 0 -5 and 5 – 19 years services. This meant that where possible, we were able to capture indications around the likes of service integration and aspects of service delivery, such as children's centres.

2. Method:

There are 152 local authorities. We focused on each one by:

(i) searching for relevant information placed into the public domain. This included material from searches around: the public health (or 0 – 5) budget, the medium-term finance plan, the budget book, scrutiny committees, the Health and Wellbeing Board, JSNA and Cabinet statements.

(ii) conducting a media search, including local/national press and professional journals. This was done in conjunction with DH *Knowledge specialists* who used search terms including: 'health visitors, early years, mandated 0- 5 services, pre-school, public health budget cuts and consultation'.

Whilst we have been systematic in ensuring each LA has been searched via both routes, our description of the evolving 'big picture' is subject to the following caveats/inconsistencies, in particular:

- availability of public domain information about commissioning intentions was found to be placed in different locations/formats in different LAs, which made searches difficult and relatively time consuming,
- in some places there was no information about 0 – 5 commissioning, whilst elsewhere it was not up to date (2016/17), in some cases there was none at all.

Notwithstanding the caveats above, this note:

- sets out some key themes emerging from the exercise
- highlights on a local basis, some of the key points regarding each theme.

The note is supplemented by a spreadsheet which is the basis of our capture of the local findings on an authority by authority basis (again subject to caveats above).

Nicky Brown (PHE London Region), has provided an overview of some LA commissioning intentions for London (as at April 2016). We have contacted PHE's other regional leads, with a view to accessing similar information – which might ultimately be useful in enriching what we have found through non-official routes. London region's intelligence has therefore been brought to bear on this note (and attached spreadsheets), hence London-borough-based information should be regarded as provided in confidence/be checked with Nicky before wider use.

3. Overarching Key Points from the exercise

- There is a range of both official statements and media coverage depicting LAs' views and concerns about the impact of the immediate reduction in PH Grant (2016/17) on local provision of public health services. In some cases LAs see this as a prompt to re-think the approach 0 – 5 services (including early years), whilst in a minority of cases, they reflect on this being a prompt to focus future services around *mandated* service requirements (only).
- Statements and coverage was found to be very much based around the current year's financial picture. At the time of the trawl, some LAs were expecting PH commissioning capacity to deteriorate further this year, though detailed/specific plans for 0 – 5 years, or for health visiting were difficult to locate. Only in the minority of cases were LAs making strategic statements about the period 2017 onwards.
- Council websites tended to be more upfront/place greater emphasis on presenting navigable routes to a range of other areas of LA business (rather than on 0 – 5 PH).
- In general, where specific services were mentioned, there was recognition of the Healthy Child Programme's offer to the local population, which tended to be based on it delivering the best start in life, impacting inequalities, and improving family life in general (rather than it being a universal service per se).
- We found a number of LAs to be consulting the public for views on relative priorities for next year's budget. Some consultations took the form of putting forward areas of wider spend for discussion – eg asking for views on SEND school transport, whilst others started from a 'blank sheet'. Others (eg Birmingham) consulted on services comprising; '*Early Years Health and Wellbeing Services'*.
- There was recurring theme of LAs considering use of children's centres and the role they could play amid wider services going forward.
- Despite some specific searching, there was little description of detailed local arrangements relating to contracts. Some (Doncaster) did reveal services based on contract novation from the NHS.

4. Evidence of service Integration

Many councils are looking to re-commission 0 – 19 yrs PH services.

- **Ealing –** emphasis on move to integrated/multidisciplinary approach with complete cross-section of staff more closely linked to children's centres. More focus to come re: nature of HV service.
- **Manchester** appears to have established a fully integrated Children's Service for education, health and social care – possibly linked to 'Devo-Manc' drivers of wider integration/colaborration.
- **Stockport** is planning joint health and social care commissioning from 2017.

- **Cheshire East** - new integrated health visiting and school nursing service offering support for new parents, children, young people and families from birth right through to leaving school. 'We will support families through dedicated teams of health visitors and school nurses providing advice and at times intensive support combined with the Council's existing dedicated children's workforce'. No mention of budget for HV.
- **Tower Hamlets –** using its "*Vanguard Programme* to end separate commissioning of 0 – 5 & 5 – 19, and better use of infrastructure including Children's Centres. (Points out service integration is not a driver for provider integration).
- **Calderdale** - Plans for a steady state for 18 months with a view to re-commission a 0-5 years service from April 2017, subject to budget allocations following the CSR. Intention to undertake a needs assessment and move to a more integrated 0-5 service from April 2017.
- **Croydon** – intends use of Section 75 based arrangements for HV, FNP and SN, with focus on linkage of families known to local 'Best Start' .
- **Redbridge –** Currently tendering for integrated service 0 – 19 model including FNP – includes some local additions to better meet needs**.**

5. Service redesign

- **Birmingham** - On 30 November 2015 a consultation commenced seeking views on plans for a new EYS model that 'delivers more joined-up health and wellbeing services that support parents and young children'. At the heart of the proposal is that re-organisation would ensure every child "would continue to receive a basic level of service", (the universal offer). The LA is up front in saying that 'some children who require additional support will get more, whilst others who are doing really well, may find services they previously accessed are no longer available to them". Elsewhere the consultation speaks of addressing:
  - duplicated services and a shift to bring all EYS together under one lead organisation,
  - the physical infrastructure of provision to ensure an emphasis on children rather than building maintenance.

  The new services are planned to be in place by 1st September 2017.
- **Barnsley** – Against background of 17% budget reduction 'later this year', LA tendered for 0 – 19 years service provision, but was unable to award the contract, deciding instead to bring the service in-house though 'working in partnership with the local NHS for smooth transition'. The 2016/17 spending envelope is £4.802m representing a recurrent reduction of £1.063m in comparison with current spend on 0-19 yrs of £5.865m). LA state the reduction is not a saving as such, but represents prudent view by the council based on the 2016/17 PHG and states that benchmarking was being used to maximise VFM.
- **Hounslow -** contact extensions for next year signed off in principle, but subject to new service delivery models introduced via the specification and review of FNP eligibility.
- **Barnet –** describes shift over next two years to cross-Dept whole systems approach, with 'skill mixed models across contracts'.
- **Oxfordshire -** plans build on the brand new service for 0-19 year olds agreed by the council's cabinet in February this year would see a service delivered from 18 locations with strengthened outreach services – apparently much broader than originally envisaged. The new £14m service (including the extra £2m) would provide a safe, effective and co-ordinated system that targets resources on protecting the most vulnerable families and

works hand-in-hand with schools, health services, voluntary and community groups. By combining children's social care and early intervention in one seamless service, it represents a completely fresh approach to delivering services for children, young people and their families at a time of rising demand and reduced central funding.

- **Barking & Dagenham –** Pragmatic 0 – 5 & 5 – 19 extensions set up so as to move both services to position where integrated service can be provided by autumn 2017
- **Hackney and City –** new HV contract anticipated this month (July 2016).

6. Service reduction/concerns for future (not exhaustive)

- **Lambeth –** although looking to existing contracts' extension, HV services (rather than SN) likely for cuts.
- **Bolton** Council approved PH cuts of £43 million over 2016/17 - 17/18. Leader stating it would inevitably hit services people are used to receiving. No mention of specific HV or 0-5 service reduction.
- **Tameside** - LA The transfer of the 0-5 Healthy Child programme to Local Authority included a one off resource to support the commissioning of the programme, (to be delivered internally within current staffing resource). The current Home Safety equipment scheme with Gtr Manchester Fire/Rescue child accident training will not be refreshed in 2015/16.
- **Doncaster** For 2016/17 LA has had 'a significant reduction' in the PH Grant of £2.1m which will be met from the remaining public health grant reserve (£0.3m), reducing the internal public health staff team (and public health advice and capacity) through VR/VER (£0.4m) and reducing commissioning spend with third parties (£1.3m) including sexual health services, weight management services, 0-5 public health services, 5-19 public health services and NHS health checks, social marketing for smoking cessation and infection control. It is estimated that £0.31m savings from the recently transferred 0-5 services will contribute towards the £1.3m commissioning savings.
- **Gloucestershire –** children centre-based service reductions in 5 localities as Council moves towards service provision from more efficient 'super hubs', (though some local services will shift to a volunteer run service). Critics point to impact on relatively families living at distance from new hubs losing out on access and are concerned that volunteers cannot be expected to re-provide some of the more specialist activities {Eg. around mental health}, and that service accountability will deteriorate.
- **Thurrock** - DPH stopped all discretionary spend and decommissioned services where there is no financial liability or where financial liability is negligible in comparison to the contract value. 4 posts deliberately left vacant in PH structure. Cut of £224k in 2016/17 (5%) to 0-5 budget. Contract renegotiation might include some reduction in HV service. KPIs have been agreed as part of the negotiation. 5-19 yrs services facing reduction too (see also source material on supporting spreadsheet).
- **Barnsley –** Struggling with capacity to deliver the pre-school free childcare offer. Only one third of nurseries say it's achievable – about 40,000 children stand to miss out on ability to take up their entitlement.
- **Harrow** - In Dec 2015, Harrow overturned its original intention to reduce PH spending overall from around £10.7m in 2015-16 to £5.9m by 2018-19. The biggest reductions were proposed for 2018-19 & included plans to review its entire £3.2m budget for health visiting services – unclear if original proposals may re-surface amid wider pressures.
- **Portsmouth** - LA review of PH contract for early years (including health visiting services) Options are being identified as to how these savings can be realised with minimal impact on service delivery within the existing contract. A reduction in the number of health visitors may occur, though there is commitment to maintaining mandatory services. Recognition that

the service as a whole provides a significant part of the early help offer in the city, hence there would be risk of impact on PH outcomes & on children's social care. Looking to save £279,300 per year for 3 years.

- **York** – HV service brought in-house, 'no reduction to staff', though service is likely to be 'reviewed in future'.
- Some evidence (Harrow) of quickly changing local stance on 0 – 5 services (from reduction to status quo) amid local debate and lobbying etc.

7. Specific statements about 0 – 5 or health visiting services

- **Newcastle** declared there will be no cut in funding for 0-5 services.
- **Doncaster** - At present, Health Visiting and FNP services for Doncaster are provided by Rotherham Doncaster and South Humber foundation trust (RDaSH). It is proposed that RDaSH will continue to provide the service on a similar basis, though an estimated £0.31m savings from 0-5 services will be identified to contribute towards the £1.3m commissioning savings overall.
- **Haringey** - £5m overspend on children's services 15/16 due to cost of looked after children. The LA points to changes/budget pressures stemming from the new commissioning arrangements, which it claims raises '….*broader questions about the long term funding of the service and the likelihood that funding allocations will move towards a more needs-based methodology. However, at least in the short term this allocation will be used to fully support the cost of the transferred health visiting contract'.*
- **Manchester** – LA has commented upon the important role that health visitors play in the community. DPH has advised that the number of qualified health visitors will not reduce.
- Several LA including **Oldham** stated that no details were available and a neutral position was assumed.
- **Bradford** - Focus over the next year stated as health visiting and FNP. Emphasis placed on PH ensuring each service is commissioned in an efficient way and tailored to meet the changing needs of the children and young people across Bradford.
- **Nottingham** – 0 – 5 yrs budget subject to the 'same level of budget cuts as the PH Grant' - equating to in-year reduction of £0.281m. Initial indications regarding the impact for 2016/17, [pending confirmation] - between £0.907m and £0.989m. 'Release of efficiencies' through a review of the 0-5 year old service could lead to £0.088m savings per year for 3 years from 16/17
- **Northamptonshire** - From a 2015-16 baseline, funding changes will reflect a reduction in the total grant, including the full year equivalent of the budget for children aged 0-5, of 2.2% in 2016-17 and a further reduction of 2.5% in 2017-18. The grant allocation for Northamptonshire equates to £36.6m in 2016-17 and £35.7m in 2017-18
- **Wokingham** - Corporate savings for 2015/16 had totalled £202,000 stemming from cuts to range of PH services. PHG had been cut by £419,000 from the former position, to £5,634,000. Financial position remained difficult and acknowledgement of increase in preventative activities required. Consideration may have to be given to decommissioning services (potential to look at mandated services too), even though it could impact PH outcomes. Whilst considerations underway, support would be given to PH department to make the best use of the ring-fenced PHG within the context of the corporate financial position, (reductions in PHG to 2020 etc).

- **Cheshire East** - New integrated HV & SN service, commitment along lines…. *'We will support families through dedicated teams of health visitors and school nurses providing advice and at times intensive support combined with the Council's existing dedicated children's workforce'*. No mention of specific budget intentions for HV.
- **Kent**- strong (visible) commitment to HV service… universally available service that supports over 90,000 young children between the ages of 0-5…. Little by way of open discussion on the service's future.

8. Conclusion

The note has attempted to combine local authority based information sources with that from local media reports, in order to paint a picture of current and future commissioning intentions across the 152 local authorities. Given the fragmented nature of information sources, it does not attempt to draw detailed conclusions. Instead, it conveys a range of local approaches being used by LAs to commission services against a challenging financial backdrop. Notable patterns are:

- the majority of LAs that are already reviewing ((or plan to review) their 0 – 5 services;
- approaches vary, with many are focused on integration/re-visiting service specifications etc, whilst others place emphasis on re-design (including use of children's centres);
- 'budget envelopes' appear under pressure, with at least 2 LAs unable to secure a 'normal' healthcare landscape provider for the allocated resource and having to bring services in-house;
- no evidence of LAs' discontentment at the legacy of HV numbers/service level inherited, nor that relationships with the local, providers have been damaged by the challenges posed.
- some evidence of LAs (mainly London boroughs), joining together to counter the challenges through joint re-and design and collaboration
- some evidence of change to commissions driven through HR route, Eg development of child support workers, use of volunteers etc.

Appendix 7: Stakeholder engagement and feedback

A) PHE Centres

Review of mandation for Universal Health Visiting Service - 2016

Regional commentary facilitated by PHE Centres

Materials made available to support discussion and completion of regional commentary.

- Appendix 1: Regional analysis of quarterly health visiting service delivery metrics for 2015/16 – trends over time and variation within region
- Appendix 2: Regional analysis of annually reported early year's health and wellbeing outcomes for 2015, from Early years Profiles – trends over time and variation within region
- Appendix 3: Preliminary national analysis of responses to stakeholder survey – presented by stakeholder group. Includes all stakeholder groups for comparison purposes.

Main recommendation on mandation
What is your recommendation for the future of mandation? i.e. Expire, extend in current form, extend in a revised form *What are the principal reasons for this recommendation?* *If the mandation were to continue in a revised from what changes would be proposed?* **South West** Directors of Public Health from across the South West discussed this issue at their meeting on 23rd September. There was general consensus that the mandation should be extended but not indefinitely. DPH worried that if they lose the "process" of the service (i.e. 5 checks) and there is a situation locally where money will be taken out of the service, then chunks of the service will be pulled, and they will lose the universal service which the evidence shows is crucial. However, there was some concern that the mandation was too prescribed, and it would be more helpful and promote innovation and local flexibility if the health visiting services was mandated, rather than the specific checks. The key points from the discussion around the mandation were: • Universal element of the service needed to maintained, and removal of the mandation put that at risk, given the pressure on public health funds currently. • There is a need to present the evidence base around the 5 checks more explicitly to Local Authorities if the mandation is to be continued. • The skill mix of the workforce needs to examine: LAs cannot afford the level of HVs that they currently have. Some of the mandated checks could be done by other staff.

- The handover between midwifery and health visiting needs to be better managed and monitored

South East
Continue with mandation but with a move to outcome based success criteria so that local authority areas can commission the service to meet the needs of local populations

East Midlands
Mainly stay the same, one extend in current form.

What are the principal reasons for this recommendation? It is important that the 5 minimum contacts remain universal on order to deliver the prevention agenda. The Critical 1001 days manifesto clearly identifies the impact that the universal service has on health in later childhood and adulthood. Mandation demonstrates commitment to the value of the universality of the service and ensures that LAs also recognise the importance
If not mandated, services will be reduced and universal approach will be lost.

The mandated visits provide a safety net for all children and their families. It is the only opportunity that professionals have to see all children in their own home and is therefore of vital important in identify risks, providing support and linking to other services.

If the mandation were to continue in a revised from what changes would be proposed?
The current 5 reviews are the minimum - of there is a change I would consider that it should be an increase – nb Scotland have 11.

Mandation should relate to contacts not visits, although there are very clear benefits to visiting in the home, this could be adapted to best meet the needs of a local population served.

Mandate should remain in relation to the six high impact areas and 5 mandated assessments to ensure all children receive the full service offer including early identification of additional and/or complex needs with access to specialist services.

East of England
General consensus to continue with mandation but in a revised format to allow room for flexibility on skill mix and innovation. There is a need to think about outcome based success criteria.

Note: Essex would be interested to pilot a non-mandated service model with evaluation

Yorkshire and Humber
Mandation should be kept in a revised form, maintaining a universal face-to-face visit in the early weeks/months, but thereafter allowing flexibility in the service delivery model so local need can determine appropriate targeting of higher intensity support and skill-mix necessary to deliver positive outcomes for children and families in the early years.

We do not support extending mandation in terms of greater specificity of staffing, additional contacts or requiring all contacts to be delivered face to face.

West Midlands
Directors of Public Health across the West Midlands have recommended that the Mandation continue but in a revised format to allow for more flexibility and a greater focus on outcomes.

What are the principal reasons for this recommendation?
If the mandation were to continue in a revised from what changes would be proposed?

The principle reason for this recommendation is that Directors of Public Health in the West Midlands believe that the five reviews form the bedrock of a universal service which can deliver our ambition to give every child the best start in life. However, the shared view is that there must be sufficient flexibility built in to the system to allow, for example, local areas to implement mandated services based upon local circumstances. E.g. being able to choose the most appropriate 5 reviews for an area based upon an understanding of local need. These could be drawn from a list of mandation options and delivered through a mix of skills.

North West

There was general support for the principal of mandation, with 100% support for mandation continuing. Not so concerned over whether amended or not. Some LAs would like greater flexibility around when HV visits take place.

Support for more focus on school readiness – the last mandated visit at 2-2 ½ years is still a long time before children start school. Although some supported an additional visit nearer to time of school entry, there was agreement that no additional funding would be available and no consensus on which visit might be dropped to accommodate this extra visit.
Alternatively, some suggested that the School Nursing service might focus more on school readiness

However all believe that the current provision can be improved but don't feel any of the existing requirements should be dropped making it difficult to identify how it could be revised within the current financial package.

London

All survey responses stated that mandation should remain, either in its current form or in a revised form.

What is your main recommendation on mandation?

Expire	Extend in current form	Extend in a revised form
0	7/15 (46.7%)	8/15 (53.3%)

Flexibility in the timing of the reviews and skill mix to carry out the reviews and funding issues were highlighted as the reasons for mandation to continue in a revised form (Table 1).

Table 1: Proposed changes to mandation

	Number of comments
More flexibility in the timing of reviews based on an assessment of individual parent/child/family needs	3
More flexibility in the use of skill mix to carry out the reviews	2
Enhancement of the overall coverage	1
Mandation needs to reflect funding reductions, which should translate to reductions in the levels of mandation	1
Don't ring fence the budget	1
Mandating for outcomes - ASQ?	1

North East

North East DsPH recommend continuing with the mandation. They were not surprised by the emerging themes from the national survey.
To help secure and maintain service provision.
DsPH felt the current mandation is not as detailed as it needs to be and suggested a focus on factors associated with later resilience.

Comparison with other mandated public health functions

How important are these services considered to be compared with other mandated public health functions? More important, less important, same.
What are the reasons for this?

South West
Health visiting service is a key early intervention service, it is as important as all the other mandated public health functions.

South East
This is one of the most important services to mandate. It is more important than other services mandated although there are also other non-mandated services which are equally important

East Midlands
More important

What are the reasons for this?
Primary prevention
Critical 1001 Days
NCMP is a data collection rather than an intervention
Sexual health is part clinical/treatment so could be argued not wholly PH function
NHS checks are in later life so help more with early identification than prevention
The potential impact of universal, early support is high across the life course. Supporting children and families to make the best start that they can has wide reaching benefits for health and wellbeing of children and whole families. For example, HVs are in key position to identify women at risk of mental health problems, which has positive mental health and wellbeing effects for both mother and baby, and other family members. HVs are in a position to ensure identification of children and families where early help and additional preventative programmes will help promote health and reduce risk of poor future health.
These services are in a prime position to deliver a good deal of the prevention work outlined in STPs, through population coverage by virtue of universal access, MECC and self-care models.

East of England
It is important to consider mandation in the context of the future operations in local government

Yorkshire and Humber
Comparing different mandated services is unhelpful. The mandated elements of the healthy child programme for 0-5s currently, or in any future form, is only one small part of a complex package of interventions for this age group, delivered by a range of services. Delivering the required numbers of mandated visits will not necessarily equate with a high quality service and are not necessarily the most valuable element of the service for delivering positive outcomes for children and families.
North East

West Midlands
These services are considered to be more important compared with other mandated public health function because Early Intervention at 0-2 gives the best return on investment of any preventative intervention (Heckman, Allen etc.). The evidence for the five reviews has recently been confirmed by the Healthy Child Programme 0-5 rapid review. Research has increasingly shown that pregnancy to age 2 is a unique window of opportunity. Children who experience secure attachment at this age, have the brain architecture for life that ensures that they are resilient and can form effective relationships. The brain is especially responsive

to external input at this age and ensuring that there is robust surveillance of babies enables more families to receive timely support to enhance their parenting as well as their health, development and wellbeing.

North West

No strong feelings, this question was not felt to be very helpful or relevant

London

Most (10/14) respondents stated that these services are more important than other mandated public health functions.

How important are these services considered to be compared with other mandated public health functions?

More important	Less important	Same
10/14 (71.4%)	0/14	4/14 (28.6%)

Evidence for improving health outcomes and reducing health inequalities and universal coverage to identify prevention opportunities, social care support and safeguarding needs were highlighted as the reasons for this (Table 2).

Table 2: Comparison with other mandated public health functions

	Number of comments
Evidence for improving long term health outcomes and reducing health inequalities	9
Universal coverage to identify prevention opportunities, social care support and safeguarding needs	3
Early intervention is more cost effective than later intervention	2
It is not possible to compare with other mandated functions	2
Alignment to a number of Council priorities	1
Assessments of child and family that build over time	1

Changes in service levels

How are service levels changing? Deteriorating, improving, staying the same.
N.B. Survey responses can be triangulated with the health visiting service delivery metrics for 2015/16.
How are service levels expected to change in the future? Deteriorate, improve, stay the same.
What are the reasons for this?
How sustainable are these services?
What are the main risks?

South West

Service levels have remained broadly the same over the first year of commissioning. The service delivery metrics in the South West show an improving picture, however this is mainly due to an improvement in data collection rather than improvement in service delivery.

DPHs are concerned that the current levels of Health Visiting numbers cannot be maintained with current funding cuts and that service levels will deteriorate.

South East

The Services are changing by

- More integration with exiting early years provision
- More integration with 0-19 yr. old services
- Pathway approach to children's services, especially for vulnerable children
- Universal element important for picking up children who have complexed and emerging needs

East Midlands

How are service levels changing? Deteriorating, improving, staying the same.
How are service levels expected to change in the future? Deteriorate, improve, stay the same.
Stay the same but too early to be clear and data is not complete/collected from numerous providers

What are the reasons for this?
Move to resident population which has had significant impact due to large number of neighbouring providers, large number of families to transfer and complex process of transition
How sustainable are these services?
Sustainable at the moment
What are the main risks?
Despite the increased training of health visitors as part of the HVIP there are still fairly low numbers generally. Now that mass training has stopped there is a risk that it will be difficult to maintain staffing numbers to deliver the minimum service. Service may also be impacted by continued Public Health and local Authority budget reductions. We are at present not sure of the situation post public health ring fence grant and then the potential impact of business rate retention. Therefore a lot of uncertainty remains, which is obviously true for most of the public sector, so there are risks but also greater opportunities for integration particularly with Public Health being well placed in the LA and local STP developments.

As things stand, these service levels are sustainable. But the risk include: the re-commissioning process included a substantial reduction in budget and this may impact upon provision, re-commissioning processes effective Providers ability to perform (as they focus on the re-commissioning process, and after as the new provider settle into the new contract) the time that the transition from "registered to resident" has taken and the size of the workforce involved in that work which has meant they have struggled to do their other tasks, insecurity going forward about the size of the budget, and what will be commissioned.

East of England

More integration with 0-19 services across the area, decommissioning of Family Nurse Partnership, outcome based commissioning Most areas are either beginning to recommission or awaiting for new services to start.

Therefore it is difficult to say what the impact of changes will be.

Yorkshire and Humber

Unclear of what is meant by 'service levels' in this context. If mean achievement of mandated visits, then across the region this is improving, but that does not necessarily mean that the quality of the service is improving or the capacity of the service is improving. The existing metrics, focused on mandated visits, does not support the reduction of health inequalities by focusing most resource on those most in need.

As the PH grant reduces and the financial pressure across the PH system increases then there is inevitably an impact on service models. There has been a trend of reducing the general prevention offer to focus on the statutory delivery and the needs of those at highest risk. Most areas are looking at reorganisation of services to ensure continued focus on

population focused services and improved outcomes for all 0-5s.

West Midlands

Overall the position across England shows improvement/stability across most indicators. However, the position of A&E attendance rates under 5 and breastfeeding rates at 6 -8 weeks have deteriorated. The overall West Midlands position is similar.

- A&E attendances deteriorated for 7/14
- Emergency attendance for 4/14
- Hospital admissions for injuries 2/14
- Low birth weight 1/14

North West

Getting more challenging to fund and funding has clearly reduced, however DsPH remain cautiously optimistic that services will improve.

Many LAs have service changes/tender for 0-19 provision under way at present
There was acknowledgement that the results of the consultation highlighted differences between LAs and the NHS in relation to positivity for future. Is this because PH are looking at data/outcomes but providers looking at how staff feel? DsPH queried whether this is due to the vulnerability that HVs are feeling.
Some providers are already making large losses but funding continues to decrease.
Integrated services have enabled improved service delivery and greater savings.

North East

In the North East services are changing however this is in part as a response to the higher overhead costs historically applied to services and has not necessarily resulted in service level reductions.

DsPH noted that we need to be careful about the use of the word 'disinvestment' or 'deterioration' – efficiencies can be achieved by reducing overheads (in some places as high as 60%) without always affecting frontline provision.

Commissioning for improvement

Are health and wellbeing outcomes improving over time?
N.B. Survey responses can be triangulated with trend data from the early years profiles.
What is the level of confidence in commissioning for better outcomes? Extremely, very, somewhat, not so, not at all
What are the reasons for this?
What are the main opportunities for innovation?

South West

Early years profiles show that generally in the South West outcomes have been improving over the last few years, with the exception of under 5s attendance at hospital.
DPHs are supportive of commissioning for better outcomes, and see this as much more appropriate way to monitor the service, and a way of being more flexible and innovative with delivery. In particular there is interest in looking at the whole early years workforce within local authorities can work together to improve outcomes. There is also a lot of interest in looking at commissioning 0-19 as whole, rather than split it between early years and school age children.

South East

At this stage it is difficult to say what the impact of changes will be. Most areas are either beginning to recommission or awaiting for new services to start so there is no real evidence

that outcomes have improved although it is anticipated that outcomes will improve and that the joined up provision will improve continuity and care for families.

East Midlands

Are health and wellbeing outcomes improving over time?
Breastfeeding rates continue to be difficult to increase and smoking in pregnancy is also not improved. However, the impact of increased universal antenatal visiting by health visitors may not have been realised yet.
Teenage pregnancy is reducing
High Impact areas – regarding A&E attendance and healthy weight are improved

Some health and wellbeing outcomes are improving, others are not. Over all Life, expectance is improving, but not as quickly as we would like – not at the rate of the England average. Across all outcomes, within the city, there are variations in outcomes, often linked to deprivation.

What is the level of confidence in commissioning for better outcomes? Extremely, very, somewhat, not so, not at all Very
What are the reasons for this? Evidence for the HCP Pregnancy to Five Years indicates that full delivery will lead to improved outcomes, however, how this is implemented and delivered will affect effectiveness
What are the main opportunities for innovation?
Close work between PH, LA children's services and NHS provider and development of integrated service to maximise resource, reduce duplication and provide holistic care to families.

East of England

Overall teenage pregnancy, smoking in pregnancy, excess weight at 4-5 years is improving so is MMR immunisation coverage at 5 years. However, A&E attendance rates and emergency hospital admissions for under 5s are deteriorating. Redesign of services has potential to improve outcomes.

Yorkshire and Humber

Outcomes for the region are generally improving or stable, but these are not down to a single service or a set of mandated visits. Achievement of outcome measures are multifactorial and a result of whole systems working together in supporting children and families in the early years.

West Midlands

The Health Visitor Service Delivery Metrics focuses on the mandated elements of the service. 2015/16 data (Q1-4) on key indicators show an improving trend for England. In the West Midlands the picture is mixed: while there have been improvements in some elements, the percentage of 6-8 week reviews completed has deteriorated. 8/14 local authorities have experienced deterioration in one or more of the indicators used to monitor the service trend through transfer.

We anticipate that the service levels for the five universal health visitor reviews will improve during (2016/17) and we are confident that the introduction of new service models, including the integration of services, will enable the local system to commission for/deliver better outcomes.

North West

Cautiously confident that outcomes will improve
Other cuts are having an impact such as those affecting Children's Centres and wider Children's services

Bringing Health Visiting, School Nursing and Children's Centres together has proven effective, this requires partnership working with other departments to maximise impact. Health Visitors and School nurses are increasingly being pulled into safeguarding, creating a further pressure on service.
It is becoming increasingly difficult to realise savings from integration and remodelling.

London

All respondents had a level of confidence in commissioning for better outcomes; half were extremely or very confident and half were somewhat confident.

What is the level of confidence in commissioning for better outcomes?

Extremely	Very	Somewhat	Not at all
1/14 (7.1%)	6/14 (42.9%)	7/14 (50.0%)	0/14

The development of new delivery models and strong collaboration and leadership were highlighted as the reasons for this. Challenges included funding problems, a dwindling workforce and organisational challenges (Table 3).

Table 3: Commissioning for improvement

	Number of comments
Developing new delivery models	5
Strong collaboration and leadership	3
Organisational challenges	3
Digital innovations to support parenting e.g. apps	1
Gaps in performance information reduces the ability of commissioners to fully evaluate the service impact against outcomes	1
Dwindling workforce	1
Funding problems	1

Health visiting workforce

How is the health visiting workforce expected to change? More, same, fewer health visitors?
What are the reasons for this?
What are the main opportunities for workforce development?

South West

There is an assumption that the current numbers of health visitors is not sustainable, and that over time there will be a reduction in Health Visitor numbers. There is currently no mechanism either regionally or nationally to monitor this reduction, as numbers are not routinely reported, as they were when NHSE were commissioning the service. This makes it difficult to comment on workforce numbers. In the SW Centre, a survey is currently being undertaken at the request of Local Authority Commissioners to look at workforce number one year on since commissioning was transferred.

South East

Change in terms of skill mix and access to services via children's centres as well as/or instead of GP practices

East Midlands

How is the health visiting workforce expected to change? More, same, fewer health visitors? What are the reasons for this? Potentially fewer health visitors as the HVIP led some organisations to reduce the skill mix in order to afford the HV numbers directed. It may be argued that appropriate skill mix can positively impact the effectiveness of the service and deliver better value for money. However, there is significantly more that the health visiting

service is ideally placed to deliver as early interventions e.g. parenting, group-work and more community development that – with increased budget – would require more health visitors
risk of reduction in workforce due to retirement and attrition if transferred outside the NHS. Best way of addressing is to maintain HVs role as independent practitioners who are well linked in to other support services and are given the role of leading the healthy child programme across local populations.
These services are vital, because they provide a foundation for future public health work, support and advice. These contacts can be tailored to meet the needs of the local communities so that key, local and national, public health messages can be promoted. Therefore, these mandated functions are more important that other mandated functions

What are the main opportunities for workforce development?
Integration – sharing of skills and knowledge, between both 0-19 PH nursing team and wider children's workforce.
Continual emerging evidence about baby brain development and new training for this along with interventions to promote infant mental health commencing antenatally,

East of England
Need to retain a health visitor workforce; however how this workforce is quantified and deployed cannot be overly prescriptive.

For example the fifth review at 2-21/2 years has potential to be integrated within the LA children services

Yorkshire and Humber
We would expect new service models to need new workforce models, but the Public Health responsibility is to commission for outcomes and for the commissioner and the provider to work collaboratively to model the service, and the skill-mix and workforce development required.

North West
DsPH agreed that broadly speaking they were happy for the number of HVs to remain the same, but they highlighted a need for modernisation and varying the skill mix to meet the current demand.
Need for increased supervision for Health Visitors especially in relation to early years
There is scope for integration and to consider inclusion of FNP into existing services.

London
Most respondents (8/14) were expecting the health visiting workforce to remain the same; the remainder (6/14) expected the workforce to reduce

How is the health visiting workforce expected to change?		
More	**Same**	**Fewer**
0/14	8/14 (57.1%)	6/14 (42.9%)

The development of new service delivery models and financial constraints were highlighted as reasons for this (Table 4).

Table 4: Health visiting workforce

	Number of comments
New delivery models	7
Financial constraints	5

Currently undertaking a review of the health visiting service	1
Tackling the ageing demographic of the HV staff model	1
Workforce development	1

North East

Services are also changing to have a greater skill mix. As a result the number of health visitors may change, with an increased focus on outcomes (in particular mental health) and being clearer about what is required of the specialist workforce.

North East DsPH and CYP Public Health Leads are working collaboratively with Health Education England North East, local universities and service providers to identify and respond to new and emerging workforce requirements.

Early themes for workforce development include:

- Increasing delivery of brief and targeted interventions i.e. smoking, mental health
- Increasing the delivery of a whole family approach.
- Wider knowledge of local need and services (not necessarily through formal education); training to reflect the wider determinants of health and services that support those such as housing.
- Understanding the variation in models of delivery and importance of alignment/integration to support achieving outcomes.
- Understanding of political environment and the commissioning process.

Benefits of the Healthy Child Programme

How important are the universal reviews to delivering benefits associated with the 6 high impact areas? Extremely, very, somewhat, not so, not at all

Comment on the perception of the relative importance of

- *Transition to parenthood*
- *Maternal mental health*
- *Breastfeeding*
- *Healthy weight*
- *Managing minor illnesses & accident prevention*
- *Healthy 2 year olds and school readiness*

Are some of these considered to be more or less important than others?

What are the reasons for this?

Does this help to form recommendations on mandation? Especially if there is a recommendation for mandation to continue in a revised form.

South West

The universal reviews are extremely important in delivering benefits associated with the 6 high impact areas. To support the continuation of the 5 checks, there is a need to ensure Local Authorities are aware of the evidence base which supports the HCP, and the reasoning for the 5 checks as the times they are prescribed. Within the SW DPH meeting some were uncertain as to why there was a need , for example, for HVs to do a 6-8 week as well as the GP 6-8 week check.

South East

Needs to be part of a whole family/children's approach to families and each council will deliver things via different elements of their services – for example some areas have robust school nursing services, other areas have childhood obesity programmes. The elements of the healthy child programme need to be outcome based but delivery should not be prescriptive.

East Midlands

Comment on the perception of the relative importance of

- Transition to parenthood extremely – health visitors are highly trained on the emotional effects of childbirth and visit all parents to be using promotional interviewing techniques. Collaborative working with midwifery services is crucial to delivering this benefit
- Maternal mental health extremely as above. Also evidence of effectiveness of identification and support health visitors give in relation to maternal mental health
- Breastfeeding very – as above health visitors are highly trained in breastfeeding knowledge and skills which help mothers continue breastfeeding, However, more focus may be needed on changing attitudes to infant feeding in society, with individuals, families and groups in order to influence breastfeeding initiation, delivering the mandatory reviews and early interventions within the budget available means there is little time available to do this
- Healthy weight extremely routine information given at the universal reviews, particularly to families who may not be known to services if they weren't universal
- Managing minor illnesses & accident prevention extremely as above
- Healthy 2 year olds and school readiness extremely as above

Are some of these considered to be more or less important than others? All are important. It would be dependent on the focus of the question e.g. if focus is demand management then could be argued managing minor illness/accident is most important, if longer –term health and prevention is most highly valued then would skew towards – maternal mental health and breastfeeding, which would support healthy weight for example.

East of England

Universal checks are important for all components. . School readiness is very important and in the context of those children in deprived areas, how this is best addressed e.g. through children's centres may vary according to the local situation

Yorkshire and Humber

How useful the universal contacts are in delivering the six high impact areas depends upon the quality of the contact, not the number taking place. This doesn't help inform the continuation of the mandated contacts.

West Midlands

- Transition to parenthood - **Very important**. We are looking to improve the uptake of antenatal reviews to improve the transition to parenting. This is an opportunity for the health visitor to build a relationship with the parents before the baby is born
- Maternal mental health - **Extremely important**. There is a solid evidence base for the importance of parental mental health in producing good outcomes for children. Mothers with mental health issues can find it extremely difficult to form a sensitive and engaged, secure attachment with their baby which is crucial to the future emotional development of the child.
- Breastfeeding-**Very important** – core part of the health visitor role in coordination with infant feeding services. Health visitors are a critical contact point for advice and guidance on infant feeding and evidence shows that effective support for Health Visitors can increase breastfeeding duration
- Healthy weight - **Very important**. Advice on weaning is a frequently asked question with health visitors
- Managing minor illnesses & accident prevention - **Somewhat important**. Advice from Health Visitors can ensure that families are informed and empowered to manage minor illnesses and be vigilant around home safety. The 12 month check is particularly important for safety guidance.
- Healthy 2 year olds and school readiness- **Extremely important**. This is a crucial

milestone in making sure that children are ready to learn and population screening at this age with the validated ASQ-3 tool gives a vital insight into development delays. The review also enables children to be identified for additional support in their early years setting as needed.

Are some of these considered to be more or less important than others? What are the reasons for this?
Maternal mental health - Extremely important. There is a solid evidence base for the importance of parental mental health in producing good outcomes for children. Mothers with mental health issues can find it extremely difficult to form a sensitive and engaged, secure attachment with their baby which is crucial to the future emotional development of the child.
Healthy 2 year olds and school readiness- Extremely important. This is a crucial milestone in making sure that children are ready to learn and population screening at this age with the validated ASQ-3 tool gives a vital insight into development delays

North West

All HV review visits were felt to be important and link with the high impact areas.

Early identification is essential and there needs to be services for families to be referred to.

It would not be helpful to place impact areas (or visits) in order of importance.

Because all visits are important they need to be mandated. There is a need to ensure that resources are available to follow up/manage the issues that are discovered at the HV visits.

London

Most respondents (14/15) thought that the universal reviews were extremely or very important to delivering the benefits associated with the six high impact areas.

How important are the universal reviews to delivering benefits associated with the six high impact areas?

Extremely	Very	Somewhat	Not at all
6/15 (40.0%)	8/15 (53.3%)	1/15 (6.7%)	0/15

Early identification of risks and signposting to other services were highlighted as reasons for this (Table 5).

Table 5: Benefits of the Healthy Child Programme

	Number of comments
Early identification of risks and signposting	8
Safety net in terms of safeguarding	2
Evidence base	2
Improves school readiness	1
Key focus on work on reducing health inequalities	1
Reduces strain on other services	1
Good to have universal reviews in these areas	1
Variation in the quality of the reviews	1
Essential that universal reviews have safe fails built in	1

Safeguarding and child protection

How important are the universal reviews to delivering benefits/discharging responsibilities associated with safeguarding and child protection? Extremely, very, somewhat, not so, not at all Comment on the perception of the relative importance of

- *Safeguarding*
- *Child protection*

Are these considered to be more or less important than other aspects of the Healthy Child Programme?
What are the reasons for this?
Does this help to form recommendations on mandation? Especially if there is a recommendation for mandation to continue in a revised form.

South West

The universal reviews and health visiting generally have a role in safeguarding and child protection. It is important however locally that this role is not seen as more important than the public health role of HV, and resources diverted to safeguarding and child protection at the expense of their health and wellbeing role and building up relationships with families.

South East

Safeguarding is extremely high priority for Local Authorities and this has been integrally linked into service design

East Midlands

How important are the universal reviews to delivering benefits/discharging responsibilities associated with safeguarding and child protection? Extremely, very, somewhat, not so, not at all
Comment on the perception of the relative importance of

- Safeguarding - very – safeguarding is the responsibility of everyone, the universal reviews mean that all children are seen, usually in the home environment at least 5 times in the first
- 2 ½ years of life (including prenatal). In addition, the delivery of the 5 reviews enables the health visitor to identify those requiring more support so they would visit more frequently and identify and support with safeguarding of children. However, the service is preventative not an inspector and the responsibility is no greater than any other service.
- Child protection – somewhat – the service would deliver its child protection responsibilities (i.e. contributing to protection of children identified as at risk of significant harm) irrespective of the mandation of the 5 reviews .However, the reviews help establish a relationship with families which may enable open conversations and disclosure of protection issues and observations of child and home as above may identify those at risk

Are these considered to be more or less important than other aspects of the Healthy Child Programme? Same
What are the reasons for this? Safeguarding and child protection are an integral part of the HCP not a separate aspect
Extremely important – see evidence summary below for comparisons.

Need or issue	High population impact (universal services known to positively affect outcomes)	High impact for at risk groups (targeted services known to positively affect outcomes)	Statutory duty
Transition to parenthood and the early weeks	✓	✓	✓
Maternal (perinatal) mental health	✓	✓	✓

Breastfeeding	✓	✓	
Healthy weight and nutrition, physical activity	✓	✓	✓
Managing minor illnesses, reducing communicable diseases	✓	✓	✓
Oral health promotion		✓	✓
Reducing avoidable injury	✓	✓	✓
Readiness for school	✓	✓	✓
Educational outcomes	✓	✓	✓
Children's mental health and well being	✓	✓	✓
Healthy relationships, reducing teenage pregnancy and STIs	✓	✓	✓
Special groups e.g. young carers, LAC	✓	✓	✓

The universal reviews are a key tool for promoting the high impact areas, and are extremely important; I don't see how this information would otherwise reach parents in such an organised, comprehensive and informative way. They are all equally important as they all form the foundation for good parenting, string attachment and happy, healthy childhood.

Does this help to form recommendations on mandation? Especially if there is a recommendation for mandation to continue in a revised form.
Yes, this absolutely helps inform the belief that we should continue with the current mandated visits

East of England

Safeguarding is very important. This encompasses the wider local system and there needs to be discussions how the Universal Plus service can offer support to vulnerable children in need.

Yorkshire and Humber

This supports the importance of universal face-to-face contact in the early weeks as it allows relationship building with the family; the universal component of the 0-5 public health nursing service sets it apart from other early years services and therefore has the potential to reduce barriers to access children and to assess safeguarding/child protection needs. However, it is again about the quality of that contact and the ability to build that relationship that is key, not a specific number of visits.

West Midlands

- Safeguarding Extremely important - health visitors provide a universal service and so are best placed to spot safeguarding issues
- Child protection – As above

Are these considered to be more or less important than other aspects of the Healthy Child Programme?
These are considered to be equally as important.
What are the reasons for this?
Does this help to form recommendations on mandation? Especially if there is a recommendation for mandation to continue in a revised form.

North West

Both are very important

Continuation of this is critical, often the HV visits are the only contact with services that the family have.

London

Most respondents (14/15) thought that the universal reviews were extremely or very important to delivering the benefits or discharging responsibilities associated with safeguarding and child protection.

How important are the universal reviews to delivering benefits/discharging responsibilities associated with safeguarding and child protection?

Extremely	Very	Somewhat	Not at all
8/15 (53.3%)	6/15 (40.0%)	1/15 (6.7%)	0/15

Early identification of risk, referral and ongoing support, the only service that routinely goes into every home and building relationships with families to respond to needs were highlighted as reasons for this (Table 6).

Table 6: Benefits of the healthy child programme

	Number of comments
Early identification of risk, referral and ongoing support	7
Only service that routinely goes into every home	3
Building relationships with family to respond to need	3
Safeguarding issues could potentially be missed	2
As there are no other universal visits, no attendance flags a risk that would otherwise be lost	1

Return on investment

What is the perception of return on investment for these services? Positive, neutral, negative
What are the reasons for this?

South West

Health Visiting, like all early intervention models, deliver a positive return on investment. This argument needs to be made much more robustly locally, and the work of the Early Intervention Foundation in this area promoted more widely to support these arguments.

South East

Unclear at this moment, although cost savings are required as PH grant and there are cost pressures on these services – the cost transferred over did not match contract costs

East Midlands

Positive although outcomes are long term and difficult to evidence attribution to the service
Positive, when we began the re-commissioning process we identified that this safety net of support and intervention was worth the investment and that without it there would be escalating risk and costs. These mandate visits provided early intervention and stop escalation

East of England

Financial pressures on local government should not be under estimated. The current context of Business Retention Rates and discussions around keeping mandation without ring fence needs to be considered.

Yorkshire and Humber

There is lots of evidence to show that 0-5 programmes yield a high social return on investment (not necessarily a cash-releasing return on investment), but the impact of this service in isolation, and particularly that the mandated elements of this service, is difficult to evidence. As with achievement of health and wellbeing outcomes, this SROI is whole system-generated not service specific.

West Midlands

The perception of return on investment for these services is positive. Work by the economist Heckman http://heckmanequation.org/content/resource/invest-early-childhood-development-reduce-deficits-strengthen-economy has shown that investment in the early years gives the biggest return believe the universal health visitor reviews deliver a positive return on investment? I.e. these services save more money in the wider system than they cost to deliver. The role of the Health Visiting Service is crucial to ensuring that families are supported to give their children the best start in life. As other services such as Children's Centres are shrinking, the demands on the service are likely to increase. There are opportunities for services to be more innovative, integrated and effective however it is extremely challenging to redesign services when future funding is so uncertain and local needs appear to be increasing.

North West

Difficult to judge different service areas against each other but the evidence base supports good economic returns further down the line.

London

Most respondents (12/15) thought that there was a positive return on investment for these services.

What is the perception of return on investment for these services?

Positive	Neutral	Negative
12/15 (80.0%)	3/15 (20.0%)	0/15

The evidence base and a reduction in workload for more specialist healthcare services were highlighted as reasons for this. There were two comments that this was difficult to quantify and two requesting PHE support to model return on investment work (Table 7).

Table 7: Return on investment

	Number of comments
Evidence base	7
Reduction in workload for more specialist healthcare services	2
Difficult to quantify	2
Request for PHE support to model return on investment work	2
Early identification and referral	1
Undertaking an early years review, which aims to ensure a positive return on investment	1
Try to find other ways to influence investment, as return on investment is insufficient in the current climate	1

Other reflections

Other comments

Recommendations on next steps/further work required?

South West

Within the DPH discussion, there was an underlying belief that mandation of the 5 checks as it currently stands was the best way to ensure that the Health Visiting service was "protected" at a time of severe financial pressure. However, fundamentally there was also recognition that mandating a service so tightly, prevented innovation and that it would be better to give local areas more flexibility in how the service was run. So the point about mandating the Health Visiting service, rather than 5 checks within Health Visiting was well supported, and seen as a way of protecting Health Visiting but allowing local flexibility and innovation. There as a recognition however that given the timeframe, it will be easier to extend the current mandation and then give time for further discussion on how health visiting is shaped locally in the future.

East Midlands

Recommendations on next steps/further work required?
Further analysis of data relating to delivery of the 5 reviews once voluntary reporting process and move to resident population is complete.
Consultation with families about their experience and views on the future of health visiting services
Review of current trends in commissioning approaches and changes to services around the country and the impact of these
Review of HV numbers in post and workforce requirements to deliver HCP in full
Review of HV core and enhanced training requirements and funding required to maintain supply, considering age demography of the workforce
Update to HCP Pregnancy to Five, incorporating emerging evidence
The universal reviews are of extreme important for identify and addressing safeguarding and child protection issues. This forms a huge part of the health visitors work load (often as much as 50%). This is more important than all other aspects of the Healthy Child Programme, sometimes the only engagement a family with have with a professional is the Health visitor mandated visits; therefore this is a unique opportunity for staff to identify and address any concerns that they may have. Yes, this absolutely helps inform the belief that we should continue with the current mandated visits

Yorkshire and Humber

We felt these questions focused too much on service metrics rather than outcomes and therefore could contain an inherent bias towards increasing mandation.

It is very difficult to extract one service from a complex system to determine accountability for impact (e.g. upon the high impact areas, safeguard, ROI).

There is no discussion of the impact, or potential of the service on inequalities (the '4' element of the 4-5-6 model), and how mandation can support, or counter, the reduction in inequalities.

West Midlands

We would also like to highlight that PHE WM is working with the ADPH Best Start in Life Network to look at delivery and commissioning models for 0-5/5-19/0-19. A survey in being prepared for distribution throughout the network in September covering this, and a report with the feedback will be prepared in due course.

North West

DsPH in the NW strongly believe there is a need for the mandation.
This should ensure a minimum standard across the country.
Mandation allows benchmarking to compare with other areas.

Need to consider the quality of the provision although this is best achieved locally and not necessarily by mandation.

Commissioning (in a style that maintains a purchaser-provider split) is not the most effective method to achieve our desired goals – this is best done by working in collaboration with providers and other commissioners. Co-designing services with provider through Public Partnership Agreement most effective.
We need to be cautious when setting the outcomes required against the budget available. There needs to be more consideration of different skillsets to deliver early years services

North East
We now have two Councils who have or will be bringing Health Visitors into the employment of the Council. This is mainly as a result of market limitations and again high overheads from acute trusts. However, the 'in house' model also reflects the need for better integration with social care/children's services in Councils as part of a 0-19 or 0-25 service models.

B) Nursing Profession

Responding organisation	**Institute of Health Visiting (iHV)** **Community Practitioners and Health Visitor's Association (CPHVA)**
On behalf of	**Health Visitors**
Approved by:	*Obi Amadi, Lead Professional Officer, Strategy, Policy and Equalities Unite/CPHVA* *Dr Cheryll Adams CBE Executive Director, Institute of Health Visiting Fiona Smith, Professional Lead for Children & Young People's Nursing, Royal College of Nursing* *Sharon White, Professional Officer,* SAPHNA
Main recommendation on mandation	
We recommend the continuation of mandation, with a revised schedule to also include a 3-4 month contact. Evidence highlights this a significant time in respect of supporting maternal mental health and promoting attachment (Wave Trust and Department for Education (2013). It is also a good time to support continued breastfeeding as mothers' plan returning to work after maternity leave, and weaning onto a healthy diet in due course, to prevent obesity. Furthermore it is around this time that babies start to reach out and then to roll over putting them at risk of accidents. Anticipatory guidance from health visitors at this stage will help to protect infants from potential accidents. We believe that it is too early to make significant changes to the schedule of the mandation contacts as a longer time period is necessary for concrete evaluation of the impact that the increase in the number of health visitors has had on children's outcomes. Early indications however show improvement in many of the indicators currently captured which therefore supports continuation of the current mandate. We noted in particular that responses from local authorities emphasised that mandation provided some protection for the service (this response from local authorities may reflect the recognition that much of the local government budget is used for services that are legally required, so provision recommended in policy may be regarded as simply and ideal ('nice-to-do Vs. 'must-do'), that mandation was essential for prevention and early intervention and that the service reduces inequalities through needs driven targeting following identification of individual need at	
the mandated contacts. Overall it was recognised by the majority of respondents that the new service model is working.	
Changes in service levels	
We noted that perceptions varied, with local authorities and health services indicating improved service levels or that service levels remained the same. In contrast health visitors perceived that services had deteriorated, or they predicted that they would in the near future. The latter may be due to changes in specifications to focus on high impact areas and a refinement in activities and knowledge of reduced funding envelopes in current tenders out for review or recently agreed. Conversely local authorities appeared to have confidence in the current and future service, focusing on the right person delivering what was commissioned, along with appropriate skill-mix to support service delivery. Even if mandation continues it was recognised that constraints on funding will remain, with commissioners being faced with tough decisions at local level. The importance of capturing evidence to demonstrate improvement in outcomes is therefore crucial.	
Commissioning for improvement	

Many of the indicators encompassed within the early years' profile are improving or stable, demonstrating the impact of health visitor investment – although as noted later there is a need to develop outcome indicators. For some indicators, such as for example tooth decay at 5, it is too early to have robust evidence available, highlighting the need for continuation of the current mandate, with the potential for an additional 3-4 month contact, as previously highlighted. It was noted that respondents emphasised the need to focus on 0-19 (or 0-24), which includes the school nursing service and care leavers, and not just 0-5, along with integration of children's services.
Health visiting workforce
Overall while there were differences in perceptions, the findings highlighted the expectation that the number of health visitors would be increased or remain the same. Only 13% of local authority respondents anticipated a decrease in the investment in health visiting. We were surprised to note this finding, particularly in light of anecdotes percolating, about cuts to health visitor numbers. We noted that some local authorities sought greater flexibility and service innovation, while still retaining the same level of improvement and quality. The potential for greater skill-mix was highlighted by 16% and, again, the need to focus on 0-19, which includes the school nursing service, (or 0-24), including care leavers, rather than just 0-5.
Benefits of the Healthy Child Programme
We noted that the findings of the survey demonstrated differences in perceptions amongst respondents. While health services and health visitors most common responses were all aspects were 'extremely important', local authorities in particular indicated that the most important elements were in respect of parenthood – attachment, home environment and maternal mental health as well as the 2 year check and school readiness. These responses would support our wish to incorporate a sixth mandated review, as above, at 3-4 months. We believe that it is too early to reduce the focus of mandation as the high impact areas are in effect all interrelated.
Safeguarding and child protection
While there were differences in perceptions, overwhelmingly there was recognition across all respondents that health visitors were extremely important/very important in safeguarding and child protection. These aspects are integral to the Healthy Child Programme, with respondents recognising the universality of the service and the fact that health visitors see the family in the home environment and are able to identify risks and instigate early interventions to safeguard children. The importance of regular and key contacts with children and families should not be underestimated, enabling early help and support to be provided in a timely manner, reducing the need for escalation.
Return on investment
We noted from the findings presented that local authorities truly value the universal nature of the service and indicated that, in comparison with other areas of mandation, health visiting services have the most potential to save more money than they cost, to improve long term outcomes and

to some extent the potential to reduce inequalities. This is supported by a growing body of economic research suggesting, for example, that in general terms, the 'earlier the investment, the greater the return,' (Heckman 2008). Specifically, Bauer et al (2014) suggest that the costs of perinatal mental health problems are at least £1.2bn per year cohort to health and social care services – rising to over £8bn in long term costs to society. Supporting mothers to breast feed exclusively to four months would save an estimated £11m a year to the NHS, by reducing infections (Pokhrel et al 2015), as well as having a major impact on reducing obesity (Cathal et al 2012).

Other reflections

We strongly support the developing systems for capturing data about health visiting inputs and outcomes, and would welcome future research to show the extent to which they are affected by staffing levels and different service models. As yet, the systems are very much in their infancy, and outcomes are relatively long term. We do not, for example, have records of any cohorts who have experienced the new mandated model from pregnancy through to school entry to demonstrate its specific impact. Also, health visitors are far from the only influence on children's lives – breast feeding at six weeks, for instance, is heavily influenced by home, family, culture and maternity care before the health visitor sees the mother at 10-14 days.

The universality and non-stigmatising nature of access to health visiting services for advice and support is greatly appreciated by families. We were therefore disappointed that the review did not capture the essential views of children/families. Their viewpoint would have provided even richer information on which to base decision-making regarding ongoing mandation of health visiting services and the opportunity to develop a 'best -fit' service.

Bauer, A., Parsonage, M., Knapp, M., Lemmi, V., & Adelaja, B. (2014). Costs of perinatal mental health problems. London: London School of Economics and Political Science

Cathal, M.C., Layte, D.R., Breastfeeding and risk of overweight and obesity at nine years of age, Social Science & Medicine (2012), doi: 10.1016/j.socscimed.2012.02.048

Heckman J (2008) Schools, skills and synapses. Economic Inquiry 46 (3) 289-324 www.heckmanequation.org

Pokhrel et al (2015) Potential economic impacts from improving breastfeeding rates in the UK. Arch Dis Child 2015;100:334–340.

Wave Trust and Department for Education. (2013) Conception to Age 2 – the Age of Opportunity http://wavetrust.org/sites/default/files/reports/conception-to-age-2-full-report_0.pdf

C) NHS England

National, stakeholder specific commentary– NHS England

Title:	Draft Review of mandation for the universal health visiting service		NHS England
To:	Hilary Garratt	Director of Nursing, Deputy CNO England	Nursing
From:	Jacqueline Dunkley-Bent Sandra Anglin	Head of Maternity and Children Assistant Head of Public Health Commissioning	Nursing Medical
Approved by:	Michelle Mello Alex Morton	Deputy Director of Nursing Director of Commissioning System Change & Public Health Commissioning	Nursing and Midwifery Team Medical Directorate
Date:	18/10/2016		

Health services, NHS	NHS England – Nursing directorate	**Main comment on mandation** The benefits of mandation are demonstrably evident, particularly in relation to the potential to improve equity and consistency of care for pregnant and postpartum women and for children with complex and special educational needs and disability (SEND). .**Maternity** **Mandation extended in a revised form** The mandation extended in a revised form could create an opportunity for contact to be made by the health visitor during the first trimester of pregnancy. Currently the first face to face antenatal contact with a pregnant woman at 28 weeks or above, limits the potential for early intervention, particularly if social care and or safeguarding concerns have been identified by the midwife. This will mean more contacts by the health visitor during the first trimester of pregnancy where there are for example, women experiencing mental ill health or where there is a requirement to address national priorities such as childhood obesity. This will have a cost implication for the local authority as this service is not paid for by maternity tariff. Better Births, the report of the National Maternity Review (NHS England 2016), makes reference to the vulnerabilities experienced by women and their families during the postnatal period and recommends improvements to this pathway of care. Better postnatal and perinatal mental healthcare, are two vital areas, which can have a significant impact on the life chances and wellbeing of women and their families. Smooth transition of care from the midwife to the health visitor can be enhanced by the health visitor being known to the woman and her family before the birth. Additional contact by the health visitor with the woman and the baby between 6-8 weeks and 1 year would assist in early identification of for example, emerging mental health issues and provide support for the continuation of breast feeding and the development of the parent infant relationship.

		Children with complex needs, special educational needs and learning disabilities and safeguarding An extended but revised mandate would provide an opportunity for the further development of support required for the health visitors role in supporting children with complex needs and SEND, particularly in relation to fulfilling the responsibilities outlined in the Children and Families Act 2014. This would contribute to a reduction in variation in completing 2.5 year checks and improve outcomes for CYP with SEND who have an Education Health and Care Plan. Whilst the main rationale for mandation was to provide protection for the universal service and to secure the delivery of long term benefits from the healthy child programme, the safeguarding role of the health visitor remains variable, from referring cases to social care to hands on practical support. An extended but revised mandate would enable the introduction of an agreed consistent approach to deploying the safeguarding function. This may include for example: consistency in deploying the health visitors safeguarding role when an association is made between delayed child development and safeguarding concerns. The opportunities for innovation also exist but this is not promoted in all areas. The Multi-agency safeguarding hubs are a good example of how health visiting roles can be extended to support the safeguarding of children. **Return on Investment** A positive return on investment for areas such as serious case reviews shows that where HVs are listened to and part of the safeguarding process children can be protected from harm. **Commissioning for improvement** Changes in commissioning have impacted positively on the SEND reforms. The current Local Area SEND inspections have identified areas of good practice and areas where improvements could be made. These include the co-ordination and variable contribution of the specialist Health Visitor roles. **Changes in service level** No comment **HV workforce** No comment

Feedback from NHS England Public Health Section 7a

Main recommendation on mandation

NHS England would support an extension of the mandation in its current form

Principle reasons are the services do not yet seem completely settled and with a number of new procurements we would want to ensure the new providers are proven before we exit mandation

Secondly we have further work to do on connecting LA commissioned services with the data from Child Health Information Services.

Changes in service level

Cannot comment on this, NHS England is aware of a number of procurements by LA that may impact on the connectivity and operation of public health services. There is a requirement to understand the impact on the service provision and outcomes of these re-procurements, and work with PHE to implement the relevant mitigations to reduce impact.

Commissioning for improvement

As above, there is a requirement to have a children centred services, and to ensure we maintain the data flows relevant for the 0 to 5 Healthy Child Programme, supporting the delivery of the recommendations of the NIT, in the interim and run up to the delivery of the Childrens Digital Strategy. Newly commissioned and procured services may result in unintended consequences for the connectivity of HV services to screening and immunisation services. There is a requirement to ensure that LA procurements and the relating specifications clarify the requirement to maintain the data flows between Child Health Information Services, as there is a potential for moving away from a single child health record with a potential impact on outcomes

One of the key risks we have in CHIS at the moment is that Las are beginning to put HV services out to procurement (apparently up to 50% of them) and if new providers win the contract and don't use and share data from CHIS that puts us in a very difficult position for reporting and delivery. We have started working with the DH, PHE and LGA on this, particularly thinking about a 'requirement' to share data with CHIS

HV workforce - No comment

Safeguarding and child protection

Probably worth noting CHIS is not a safeguarding or child protection system but the digital solution responding to the NIT could certainly help here. However if LAs commissioning means CHIS data and connectivity is not utilised then that could present issues and impact

Return on Investment - No comment

National, stakeholder specific commentary– Child Health Digital Programme Board

Responding organisation	**Child Health Digital Programme Board**
On behalf of	**NHS England/NHS Digital/PHE/DH and other constituent members of Digital Child Health Board and Digital Child Health Programme**
Approved by:	**Name and role: Lauren Hughes SRO Digital Child Health Programme Board**

Main recommendation on mandation

Description of DCH Programme

The Digital Child Health Programme which is part of the portfolio of Paperless 2020 delivery on behalf of the Secretary of State for Health would like to raise the following points for consideration by the review commissioned by the Department of Health of the mandation for Universal Health Visiting Services which is being undertaken by Public Health England.

The Vision of this programme is aligned with the "Healthy Children: - a Forward View for Children's Information" which has the vision to "*Know where every child is and how healthy they are"* and *"Appropriate access to information for all involved in the care of children*". This will support and improve the objectives of the health child programme leading to better outcomes for the child.

- **Mandation**
  The current Healthy Child Programme standardises the delivery of health services for all children in England and as a result key health events are defined and information collected at specific times in the standard health pathway These mandated touchpoints provide an expected health event pathway for parents. carers and professionals together providing a failsafe mechanism to ensure delivery. One of the mandated touchpoints is during pregnancy which is essential for assessing the maternal factors which are related to the outcomes for a successful delivery and the future well-being
  and health of the child.
  There has not been sufficient time since Health Visiting services transferred to LAs, for there to be stability in services which is further emphasised by the planned re-procurements of services
  If mandation expired or was reduced, then events would not be standardised and the ability to collect key data for a child and the basis of interoperability to share such data would be severely compromised. The vision of appropriate access to information for all in involved in the care of the child could not be achieved

  We recommend that mandation is continued and extended in the present form

Commissioning for improvement

- Healthcare outcomes are improved by interventions following a standardised and scheduled pathway known to both the family and the professional supported by an information service and population assurance. Information fragmentation and inability to share information were cited in the recent National Incident report [Child Health Information Service (CHIS) – National Incident Team (NIT) phase 2 report 2015] where children did not receive the health child programme interventions. The commissioning of the Digital Child Health Programme is as a response to that report to improve data quality. Information flow and interoperability.

Benefits of the Healthy Child Programme

- All these high impact areas have been shown to have significant effects on the well-being of the child and the outcomes as a young person and an adult with significant social educational and economic effects. The timing of the detection and resultant intervention is evidence based and can only be achieved by assessments related to the course of the pregnancy and the developmental stage of the child – hence mandated touch points should extend in the current form

Safeguarding and child protection

- Reduction in mandation or allowing it to expire would seriously impair the early detection and prevention of neglect and abuse of children, because of the reduction in professional contact and therefore the ability to build confidence and relationships between professionals and families.

Return on investment

- Evidence demonstrates a very positive return on the investment in these preventative services. [Annual Report of Chief Medical Officer 2012 Our Children deserve better: Prevention Pays CMO] The digital child health programme together with Maternity Digital is dependent on the retention of a standard core service delivery pathway supported by mandation touch points to achieve interoperability of data and dataflow to improve efficiency of delivery. improved data quality and real time public health data. In addition, this provides improved an improved information service for parents families and professionals

D) Local Government

Society of Local Authority Chief Executives (SOLACE)

Solace welcomes PHE's review, notwithstanding PHE's judgement that:

"It is too early to judge the effectiveness of mandation by using routine statistics and whilst there is some early evidence that the momentum of the health visitor programme was carried through the transfer there is as yet no evidence that this can be sustained in the longer term."

Anecdotal evidence from Solace members suggests the health visitor programme is broadly seen as beneficial, and the public health benefits of the scheme are not doubted.

However, as the review concerns the future of mandation, not the service itself, Solace's view echoes that of the Local Government Association (LGA).

Referring to the letter sent by the LGA to the Department of Health on 8th September 2016, we agree that:

- LAs public health grant has been cut by £331 million from 2016/17 to 2020/21, following a £200 million in-year reduction in 2015/16. Reduced funding combined with the inflexibility of mandation of public health services forces LAs to direct other public health budgets to mandated services, and;
- This is contrary to our shared belief that LAs should have the freedom to integrate and/or redesign their services in a way that best suits local need and delivers improved outcomes for children and young people in their area.

We therefore believe that further mandation of specific public health services does little to protect them, and, by reducing local flexibility to creatively improve outcomes for local residents, does not ultimately support broader public health goals.

In agreement with the LGA we would suggest that the government collectively review all mandated public health services including health visiting next year, when the overall position on local government funding and business rates reform is clearer.

Solace welcomes continued involvement in discussions with the government and other relevant bodies on the future of public health services.

Local Government Association

Nicola Blackwood MP

Parliamentary Under Secretary of State for Public Health and Innovation

Department of Health,

Richmond House

79, Whitehall

London,

SW1A 2NS

8 September 2016

Dear Minister,

We are writing to request a meeting with you to discuss the future of the five Mandated Universal Health Visitor Reviews and the wider mandation of a number of wider public health services (National Child Measurement Programme, NHS Health Checks, Sexual Health Services, Public Health advices and Health protection).

We have been working with Public Health England on their review of the mandation of health visiting services, and have encouraged participation in the opinion survey undertaken to support the review. We would expect that the survey responses will tend to reflect a range of personal opinions from commissioners, professionals and providers of health visiting services. We would like to contribute, in addition to those personal opinions, a clear strategic view from local government about the future of mandation for 0-5 public health.

As a membership organisation we represent the upper tier local authorities who are now commissioning the 0-5 Healthy Child Programme and health visitors since it transferred last October. Since the transfer councils across the country have been looking at ways they can integrate and/or redesign their health visiting and school nursing services in a way that best suits local need and delivers improved outcomes for children and young people across 0-19/25 (for those in care or with additional needs).

Councils have, in general, sought to protect these services in the face of cuts to their funding. The public health grant to local authorities was cut by £331 million from 2016/17 to 2020/21, following a £200 million in-year reduction in 2015/16. Such cuts will clearly have a negative impact on service delivery, and in principle we would generally want to maximise the discretion of local authorities in order to enable the best possible decisions to be taken locally. According to our analysis of LA budget planning (see Appendix A) there is little evidence that health visiting, school nursing or the healthy child programme have taken the brunt of the financial savings to public health budgets for 2016/17. This is contrary to recent negative media attention and

views from the professional bodies representing health visitors about the alleged decommissioning of health visiting services.

However, it makes no sense to review the mandation of one public health function in isolation from the others, when they all sit within the same ring-fenced budget. Reduced funding combined with the inflexibility of mandation of public health services forces LAs to direct other public health budgets to mandated services. Protecting one part of the public health system will impact on other areas such as school nursing services, weight management or smoking cessation because LAs will ultimately have less flexibility to take a holistic approach to budget setting and redesigning services within a reduced funding envelope in a way that best meets local need. Similarly any setting of targets for numbers of health visitors would needlessly constrain LAs from delivering good skills mix.

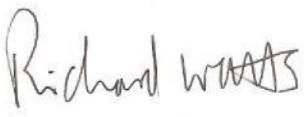
The ongoing consultation on business rate reforms also presents uncertainty about how it will impact on the public health grant. Until we have greater clarity on the implications of the reforms for public health services it may prove premature to agree the further review of mandated public health services.

We therefore ask that the Government's decision about the future of the mandation of health visiting services and wider mandated public health services are collectively reviewed next year when the position is clearer on business rate reforms.

It is crucial that councils are given a free hand in how they choose to deliver services and find savings locally and we would seek government's reassurance on this point. Anything less will make the task of finding the reductions more difficult. Councils are best placed to decide how reduced resources should be used to meet their public health ambitions locally.

We hope that we are able to discuss this further and we look forward to hearing from you in due course.

Yours sincerely



Councillor Isobel Seccombe

Chairman,

Community Wellbeing Board

Councillor Richard Watts

Chairman,

Children and Young People Board

Appendix A: Local Authority Budget setting 2016-17

Detailed Categories	DA 201516 £000's	114 201617	Variance	%Variance
Sexual health services - Contraception (prescribed functions)	191,157	174,501	- 16,656	-9%
Sexual health services - Promotion, prevention and advice (non-prescribed functions)	82,658	76,451	- 6,207	-8%
NHS health check programme (prescribed functions)	81,430	69,925	- 11,505	-14%
Health protection - Local authority role in health protection (prescribed functions)	42,994	37,550	- 5,444	-13%
National child measurement programme (prescribed functions)	29,244	27,738	- 1,506	-5%
Public health advice to NHS commissioners (prescribed functions)	73,252	54,994	- 18,258	-25%
Obesity - adults	71,869	58,585	- 13,284	-18%
Obesity - children	39,365	**40,785**	1,420	4%
Physical activity - adults	71,110	**60,957**	- 10,153	-14%
Physical activity - children	24,804	**25,133**	329	1%
Substance misuse - Treatment for drug misuse in adults	558,864	**408,451**	-	-27%
Substance misuse - Treatment for alcohol misuse in adults	208,059	**183,296**	- 24,763	-12%
Substance misuse - Preventing and reducing harm from drug misuse in adults	-	**72,178**	72,178	NA
Substance misuse - Preventing and reducing harm from alcohol misuse in adults	-	**38,835**	38,835	NA
Substance misuse - Specialist drug and alcohol misuse services for children and young people	62,466	**56,534**	- 5,932	-9%
Smoking and tobacco - Stop smoking services and interventions	141,434	**104,983**	- 36,451	-26%
Smoking and tobacco - Wider tobacco control	18,570	**15,617**	- 2,953	-16%
Children 5-19 public health programmes	276,309	**264,986**	- 11,323	-4%
Health at work	-	**29,665**	29,665	NA
Public mental health	-	**46,991**	46,991	NA
Miscellaneous .ublic health services - other	479 715	**391 759**	- 87 956	-18% -9°A
Miscellaneous public health services - Mandated 0-5 children's services (prescribed functions)	378,255	746,656	368,401	97%
Miscellaneous ⁴ ublic health services - All Other 0-5 children's services non-⁴ rescribed functions	99,668	**148,901**	49,233	49%
Total **Public Health** Spend - including all 0-5 children's services	3,321,242	3,495,775	174,533	5%

Collapsed categories - grouping may change		RA 2015-16	RA 2016-17	Variance "
National child measurement programme (prescribed functions	29,244	27,738	- 1,506	-5%
Health protection - Local authority role in health protection (prescribed functions)	42,994	37,550	- 5,444	-13%
Physical Activity	95,914	86,090	- 9,824	-10%
Other	479,715	468,415	- 11,300	-2%
Children 5-19 public health programmes	276,309	264,986	- 11,323	-4%
NHS health check programme (prescribed functions)	81,430	69,925	- 11,505	-14%
Obesity	111,234	99,370	- 11,864	-11%
Public health advice to NHS commissioners (prescribed functions)	73,252	54,994	- 18,258	-25%
Smoking and tobacco	160,004	120,600	- 39,404	-25%
Sexual Health Services	663,834	611 ,256	- 52,578	-8%
Substance misuse	829,389	759,294	- 70,095	-8%
Total Public Health Spend	2,843,319	2,600,218		-9%
Miscellaneous ⁴ ublic health services - Mandated 0-5 children's services .rescribed and non- .rescrib	477,923	895,557	417,634	87%

Association of Directors of Public Health

Main recommendation on mandation
What is your recommendation for the future of mandation? i.e. Expire, extend in current form, extend in a revised form. What are the principal reasons for this recommendation? ADPH members are committed to ensuring the offer of universal 0-5 PHN services to the population but the current arrangement is inflexible. Mandation places an emphasis only on process - rather than combining process and outcomes - which is unhelpful. If the mandation were to continue in a revised from what changes would be proposed? ADPH would support greater flexibility in the timing of reviews and the skill mix of the reviewer based on assessment of need.
Comparison with other mandated public health functions
How important are these services considered to be compared with other mandated public health functions? More important, less important, same. ADPH supports the LGA position that all mandation should be reviewed together in the light of the removal of the ring-fence and therefore major changes to the 0-5 PHN mandation at this stage may be premature.
Changes in service levels
How are service levels changing? Deteriorating, improving, staying the same. N.B. Survey responses can be triangulated with the health visiting service delivery metrics for 2015/16. ADPH is aware this varies across local authority areas. *How are service levels expected to change in the future? Deteriorate, improve, stay the same.* *What are the reasons for this?* ADPH is aware this varies across local authority areas, although increase in service levels are unlikely due to reductions in the Public Health ring-fenced grant and other pressures on local authorities while NHS funding is protected. *How sustainable are these services?* ADPH members are committed to developing better outcomes for children and young people but this can only be achieved through joint working. ADPH recognises the centrality of 'best start' thinking to tackling inequalities and long-term health improvement. *What are the main risks?* Continuing reductions in local authority budgets while NHS funding is protected. Failure to level up Public Health Grants (which was promised as the solution to local authority areas importing more children than exporting them under registered to resident changes) has created a resource pressure on those areas importing more 0-5s than exporting them. A failure of the service to be able to demonstrate improving health outcomes and value for money and therefore spend coming under scrutiny.
Commissioning for improvement
Are health and wellbeing outcomes improving over time? Yes N.B. Survey responses can be triangulated with trend data from the early years profiles. ADPH is aware of the considerable energy being contributed by its members to improving health outcomes for children and young people. *What is the level of confidence in commissioning for better outcomes? Extremely, very, somewhat, not so, not at all* ADPH members believe this is good. For example, the failure of FNP to demonstrate an advantage over the base offer is most likely to mean that the base offer is actually very effective. *What are the reasons for this?*

ADPH understands that the development of new delivery models and strong collaboration and leadership are the main reasons for confidence in the new arrangements.

What are the main opportunities for innovation?
New models of delivery and improved partnership working with local authority children's services. ADPH recognises the power of sector-led improvement in improving outcomes and value for money.
We need also to focus upon support for mental and emotional wellbeing and health – early years' services are positioned very well to do this.

Health visiting workforce

How is the health visiting workforce expected to change? More, same, fewer health visitors?
ADPH understands that a stable or slightly reduced workforce will end up being in place in local authority areas, depending on local needs and outcomes, with greater emphasis on mental health and emotional wellbeing.

What are the reasons for this?
Response to local needs and priorities.

What are the main opportunities for workforce development?
More joint workforce training. More focus on 0-19 services, rather than 0-5 and 5-19.
Dealing with skillmix challenges, changing workforce demographic and recruitment.

Benefits of the Healthy Child Programme

How important are the universal reviews to delivering benefits associated with the 6 high impact areas? Extremely, very, somewhat, not so, not at all
ADPH members believe these are extremely/very important.

Comment on the perception of the relative importance of

- *Transition to parenthood*
- *Maternal mental health*
- *Breastfeeding*
- *Healthy weight*
- *Managing minor illnesses & accident prevention*
- *Healthy 2 year olds and school readiness*

Are some of these considered to be more or less important than others?
ADPH believes all these are important.

What are the reasons for this?
Evidence base for 1001 days.

Does this help to form recommendations on mandation? Especially if there is a recommendation for mandation to continue in a revised form.
Less prescriptiveness around process measures is needed. If the mandate was simply to ensure that local authorities provided a universal offer to children, then issues of skillmix (who does the checks) and response to need could be left more to local discretion.

Safeguarding and child protection

How important are the universal reviews to delivering benefits/discharging responsibilities associated with safeguarding and child protection? Extremely, very, somewhat, not so, not at all
ADPH members believe that the universal reviews are an extremely important part of child safeguarding.

Comment on the perception of the relative importance of

- *Safeguarding*
- *Child protection*

Equally important *Are these considered to be more or less important than other aspects of the Healthy Child Programme? What are the reasons for this?* They are more important in terms of risk, but without a universal service the opportunity to reduce statutory intervention later on is lost. *Does this help to form recommendations on mandation? Especially if there is a recommendation for mandation to continue in a revised form.* It reinforces the need for a universal offer to be protected.
Return on investment
What is the perception of return on investment for these services? Positive, neutral, negative *ADPH believes this to be positive.* *What are the reasons for this?* Evidence base, early intervention reducing the need for downstream intervention (ref Early Intervention Foundation work).
Other reflections
Other comments ADPH welcomes the opportunity to provide a response but would like the same level of scrutiny to be applied to other areas of mandation. Recommendations on next steps/further work required? ADPH supports the LGA position that all mandation should be reviewed together in the light of the removal of the ring-fence from the Public Health grant.

Association of Directors of Children's Services Ltd (ADCS)

ADCS response to the review of mandation for universal health visiting services – 2016

The Association of Directors of Children's Services Ltd (ADCS) is the professional association for directors of children's services (DCS) and their senior management teams. Under the provisions of the Children Act (2004), the DCS is the chief officer responsible for the discharge of local authority functions with regard to education and children's social care and champion for children across wider children's services.

ACDS has welcomed the opportunity to be part of both the Best Start in Life Programme Board and the review of the mandation for the universal health visiting service. The approach has been thorough and taken into account the views of a wide range of stakeholders. It is perhaps inevitable that the largest number of respondents to the consultation have been health visitors themselves.

ADCS members have welcomed the transfer of responsibilities for 0-5 children's public health commissioning and recognise the vital role that a universal health visiting service plays in laying the foundations for lifelong health and wellbeing. This responsibility fits closely with a range of other early help and preventative services provided by local authorities and therefore allows for closer working to improve outcomes for children and their families. However, maintaining the mandated elements of the 0-5 Healthy Child Programme removes the flexibility which the system needs to continue to improve outcomes in an environment of reduced resources. Given this, and the recent in-year reduction of the public health grant, ADCS members do not believe the mandation should continue if it is not fully funded. Further, we would welcome a review of all mandated public health services. Local authorities must be allowed the freedom to meet the needs of their local population in the most effective way.

Regarding the draft report itself, whilst respondents to the consultation did cite a positive return on investment in the 0-5 Healthy Child Programme, there is no strong evidence to support this view and certainly very little evidence to benchmark this against other interventions. While mandation does provide an element of protection for the service, rigid prescription in the way the service is delivered removes the opportunity to realise the potential benefits of integration and innovative practice.

ADCS members would also urge caution when considering the evidence presented in the review around health visitor numbers. Staffing is not part of the original mandation and the reliability of this information is questionable. It is not valid to conclude that a reduction in numbers of qualified health visitors would automatically reduce a local authority's ability to deliver an affective service for children and their families.

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E) Other interested parties

National Network of Designated Healthcare Professionals for Safeguarding Children (NNDHP)

Review of mandation for Universal Health Visiting Services - 2016

The response of the National Network of Designated Professionals for Safeguarding Children (NNDHP)

Introduction:

The NNDHP membership comprises all NHS Designated Professionals (Doctors and Nurses) who work in the areas of Child Safeguarding, Looked After Children (LAC) and Child Death Overview Panels (CDOP). The Network exists to provide a national voice to Designated Professionals. Its objectives are:

- To influence national strategic objectives and policy
- To provide peer support
- To promote analysis and learning
- To develop review and research partnerships
- To establish a repository of expert material

Description of mandation:

Mandation for Universal Health Visiting Services allows for[3]

- Antenatal health promoting visit;
- The new baby review;
- 6-8 week assessment (the health visitor or Family Nurse led check). The GP led 6-8 week check will continue to be commissioned by NHS England;
- One year assessment; and
- 2-2½ year review.

We note that the mandation is therefore for **contact** as opposed to **specific activity**.

NNDHP position:

We regard mandation as a vital strategic tool to facilitate

- the right of all children to access the best possible health[4], and
- the right of all children to the improvement of their wellbeing[5]
- the recognition of need[6]

Rationale:
We have an obligation to place the needs of our children first and foremost. This principle of paramouncy was established in legislation[7], and is also written into statutory guidance[8].
Government funding for local authorities (LA) has fallen in 28% in real terms over the 2010 spending review period. This reduction will reach 37% by 2015-16 based on illustrative data from the Department.[9] And although the impact of this reduction in LA spending power is reported as varying "widely, with authorities that depend more on government grants seeing bigger falls in spending power", it is hard to be overly confident about the prospects for children's services when the same report states that "Local authorities have tried to protect statutory services".

In the face of this, and the reported increases in workload in child protection and Looked after Children services, as well as significant increases in police reports of crimes against children[10], it is our view that mandation must be continued to ensure that professional wellbeing support continues at a stage in life when children are most vulnerable. Mandation will make an increasing difference in an era of declining resources.

Various learning points in the Brandon report[11] serve to emphasise the vulnerabilities of under fives. The same report also highlights protective factors that would be afforded to all children as well as the wide variety of acknowledged risks that can be hidden without mandated checks.

An extended purpose to Mandation
It is widely recognized by practitioners that families that are not obviously living in deprivation may escape engagement and support. But on the grounds of equity, this is not sustainable. Mandation will continue to ensure that this does not happen. That notwithstanding, it is important not to forget that the most vulnerable families are less likely to be supported by other means because they are the families that are least likely to attend clinics and group facilities. Contact with health visitors can also aid trust in primary care services that otherwise wont be in a position to spot signs of the more chronic developmental problems that would benefit from early intervention.
So as well as the mandated contact, we would suggest that the development of effective positive relationships (the golden thread of relationships as the Care Inquiry so elegantly phrased it[12]) between health visitors and their families and children should be positively supported.

Specifically, observations with regard to the home safety, engagement of fathers, nursery and social absence, social development, awareness of the risks of trafficking, slavery, domestic servitude and sexual exploitation could be usefully added to an expanded mandate for Health Visitors. All these would be in addition to increased awareness building around mental health issues and drug and alcohol dependency, poverty, and nutritional difficulties.

It is understood that these issues are routinely spotted and reported by Health Visitors without it being mandated. Our position is that these functions should be added to the mandation for the reasons outlined above.

Summary:

The NNDHP firmly believes in the benefits of a continued and expanded mandate for health visitors as part of a coherent sustainable approach to promoting childhood wellbeing and access to the best possible health.
13th October 2016.

1. Mandating elements of the Healthy Child Programme through Regulations. Dept of Health March 2015
2. UNCRC Resolution 44/25 of 20th November 1989 Article 24
3. Children Act 2004 Sec
4. Not Seen, Not Heard; (p 5, Recommendation 3) Care Quality Commission report, May 2016
5. Children Act 1989, Sec 1
6. Working Together to Safeguard Children, para 12. HMG March 2015
7. Impact of Funding Reduction on Local Authorities. National Audit Office November 2014
8. How Safe are Our Children, Report NSPCC 2016
9. Brandon et al: Pathways to Harm, Pathways to Protection. DofE May 2016 pps35, 40, 65, 67, 70, 73, 74, 75, 77, 88, 90, 96, 97, 140, 145
10. Making, Not Breaking: The Care Inquiry 2013

I CAN

An open letter from Bob Reitemeier, I CAN Chief Executive, to the Chief Nurse at Public Health England

Posted on: 08-19-2016 by:ICANCharity

The Department of Health has commissioned Public Health England (PHE) to carry out a review into the future of health visitor family checks beyond March 2017. Options put forward to ministers include renewing the mandatory requirement, amending the number of visits, or scrapping the requirement altogether. I CAN's Bob Reitemeier has written to PHE urging them to consider the impact this will have on children with speech, language and communication difficulties.

Dear Viv Bennett,

Re: Children's public health 0-5 years – review of mandatory health checks

We at I CAN, the children's communication charity, know that in some areas of the country **more than 50% of children starting school have delayed language.** That is a shocking number of children without the skills they need to learn and to make friends, ultimately impacting on social mobility and the wider economy.

We also know that age 2 to 3 (1001 first days of a child's life) is a critical time for children and their parents. It is a period of rapid growth, learning and development in a young child's life and is also a key time when a child's need for additional support from health services or the education system can become clear.

We write to you to express our great concerns regarding the options put forward to ministers relating to the five health checks currently expected between the age of 0 and 2 and a half. Suggested options include reviewing the mandatory nature of the requirement, amending the number of visits, or scrapping the requirement altogether.

There is enormous risk attached to the removal of any of the above options. More children with communication difficulties will go unidentified and fail to receive the support they need. They will start school without the skills to access education, going on to fail exams, making it more difficult for them to find work. Children with communication difficulties often end up on the edge of society as adults and many require financial and mental health support from Government during their adulthood. The importance of the integrated review was recognised by the Department for Education in this **report**, the findings of which remain critically important today.

Health checks make a real difference to a child's future outcomes. They enable good parenting practices to be supported, including the achievement of typical communication development. The checks bring together families, health visitors and practitioners and are key in identifying communication difficulties early, so that effective early intervention can be offered for those children who need more support, at an age when interventions are critical and effective.

We know from our evidence that when the correct support is put in place before a child is aged 5 and a half, children are very likely to catch up with typically developing children of the same age. If the five health checks are scrapped, there is likely to be a significant impact on the support and advice parents get for their child's development and on early identification. This is particularly important for the 32% of disadvantaged 2 year olds who are not attending early years settings. They would not receive any formal language checks until they enter school.

Without the five checks and more specifically the Integrated Review at age 2 and a half, the 50% of children in some areas starting school without the language skills they need is extremely likely to grow. Ultimately, this will increase the financial strain for Government and adult services as these children grow older.

I urge you to consider the longer impact a reduction in these checks of any type will have on the future of children and our economy.

Yours sincerely

Bob Reitemeier CBE
I CAN Chief Executive

British Heart Foundation

Responding organisation	Feedback has been provided by three members of the British Heart Foundation National Centre for Physical Activity and Health (BHFNC) Early Years Advisory Group: • Liz Prosser • Dr Lala Manners • Natalie Matthewman
On behalf of	
Approved by:	

Main recommendation on mandation

- The Integrated Review is beset with problems – the initial concept was to get health/education to work more closely together – for a variety of reasons this hasn't happened – not least because they have incompatible software systems – time constraints/geography/language-literacy – all have had an impact. An IR now can be considered a quick phone call to share information – the chances of all relevant parties actually being together in the same room at the same time to assess the same child are very slim indeed : Recommendation : Conduct a comprehensive review of practice – what works/what doesn't – and why. Then research the possibility of up-skilling the EY workforce so they may conduct the components of the *health* part of the IR that is most relevant to their practice/settings. We would also recommend that the role of physical activity in child development is acknowledged within the Integrated Review.
- There is no consensus as to what constitutes 'school-readiness.' Parents/practitioners/health professionals/physiotherapists/psychologists all have very different views. It has become a vague 'blanket' term that seems to cover everything and nothing – the EY workforce dislike the term and won't use it – so no one can establish what - or whom - children are getting ready for – or why. Recommendation : Either by questionnaire or direct consultation with relevant bodies – work out what 'school-readiness' is – agree on the terminology – and stick to it.

Benefits of the Healthy Child Programme

How important are the universal reviews to delivering benefits associated with the 6 high impact areas? Extremely, very, somewhat, not so, not at all

Comment on the perception of the relative importance of

- *Transition to parenthood – very*
- *Maternal mental health – extremely*
- *Breastfeeding – extremely*
- *Healthy weight – extremely*
- *Managing minor illnesses & accident prevention – very*
- *Healthy 2 year olds and school readiness – extremely*

Are some of these considered to be more or less important than others? What are the reasons for this?

- Maternal mental health is considered to be a key factor in a child's development, health and wellbeing
- Breastfeeding is essential for maintaining a healthy weight; Healthy weight is key for preventing and managing child and adult obesity and for chid development, health and wellbeing;
- Health and wellbeing is essential for school readiness and for improving child life chances.

Does this help to form recommendations on mandation? Especially if there is a recommendation for mandation to continue in a revised form.
Safeguarding and child protection
Return on investment
Other reflections
Physical development plays a critical role in supporting children's engagement and enjoyment of curricular activities as they start school. Simple tasks eg. sitting still/holding a pencil/washing hands/lining up are all dependent on well-developed physical skills that may be rehearsed and refined on a daily basis. Screen time is of concern – this not only has a negative impact on the essential skills required for literacy (hands/eyes) – but also on the time afforded for children to experience the physical activities necessary for their overall health/wellbeing and development. The Health Survey for England (2012) has shown that 91% of children aged 2-4 years are not meeting the Chief Medical Officers' Physical Activity Guidelines, and 7% of children aged 2-4 are sedentary for 6 or more hours a day on week days. Health visitors are in a unique position to discuss physical activity with parents and its impact on health and motor skill development through the Healthy Child Programme.

National Children's Bureau

Main recommendation on mandation

What is your recommendation for the future of mandation? i.e. Expire, extend in current form, extend in a revised form

Extend in current form from April 2017 with some small changes considered thereafter.

What are the principal reasons for this recommendation?

We support the Healthy Child Programme as an evidence based programme that ensures young children's needs and those of their parents are identified early, contributing to safeguarding and tackling inequalities in health and other outcomes. We are not aware of any evidence that suggests any particular aspect of the programme prescribed in current regulations is less important than others.

We support innovation by local authorities to meet the needs of their local populations. NCB leads the Lambeth Early Action Partnership – one of five sites across the country that are part of the '*A Better Start*' initiative. *A Better Start* aims to improve the life chances of babies and very young children by delivering a significant increase in the use of preventative approaches in pregnancy and first three years of life. Health visitors are at the heart of local teams driving forward this work and new offers are being built that extend out of the healthy child programme.

The great work that is being carried out as part of 'A better start' and other programmes has not required relaxation in regulations. Furthermore, we believe it would be the wrong time to make significant changes and that doing so could have serious unintended consequences. Local authorities have only just started to get to grips with their new role in children and young people's public health. As will no doubt be echoed by other submissions to this review, many local authorities will have inheritied contracts for the delivery of health visiting services when they first took formal responsibility for public health of under 5s in October 2015. Many will therefore only now be starting to think about how they may want to tailor their offer. Regulations will ensure that all those involved in local decisions will take the responsibility for commissioning these services seriously and encourage them to invest the requisite amount of resources to deliver a viable offer to local parents and young children.

NCB has been collecting evidence on behalf of the All Party Parliamentary Group for children for their inquiry in to children's social care. Many local authorities and voluntary sector organisations have submitted evidence stressing the importance of early intervention services but also that it is hard to maintain investment in these relative to services for children with more acute needs. Submissions attribute this in part to the fact that early intervention work is not subject to the same level of regulation. Spending on safeguarding children and young people services (including social work, child protection, commissioning, and Local Safeguarding Children's Boards) has reduced by 11 per cent between 2010-11 and 2015-16 and on services for looked after children (including those in residential care, foster care, under special guardianship, recently adopted, leaving care or seeking asylum) by 4 per cent over the same period. This suggests not only that regulation can help to protect investment in key services locally, but also, unfortunately, that vulnerable families will now be more reliant on health visiting services because of other early intervention services receding.

Disinvestment is a real risk in the current climate as local authorities face funding pressures, not just from ongoing reduction in the ring-fenced public health grant but also their core revenue support grant. English local authorities overall spending power has decreased by around 20 percent since 2010-11. (House of Commons Library (2014) Local Government Finance Settlement 2014/15). Without continued regulation the temptation for local authorities to disinvest in these services could be too great in some areas leaving a gap in support for families

that could mean long lasting damage for children whose needs are not identified and addressed as a result

If the mandation were to continue in a revised from what changes would be proposed?

We believe that there is potentially some scope to improve the legislative framework for health visiting services and the wider healthy child programme. New statutory guidance should be issued to local authorities, clinical commissioning groups and NHS England setting out their respective responsibilities for the continued delivery of the health child programme.

The current regulations require the provision of five universal health visitor reviews to all eligible persons each including a development review 'as set out in the Healthy Child Programme' – referencing Department of Health guidance from 2009. The referenced guidance was not originally written as statutory guidance for local authorities and is described in its introduction as a 'guide… for primary care trusts (PCTs), local authorities, practice-based commissioners and providers of services in pregnancy and the first years of life' setting out 'the recommended standard for the delivery of the HCP and [demonstrating] how the programme addresses priorities for the health and wellbeing of children.'

While we do not suggest that the suite of recommendations set out in 2009 are themselves out of date, it could be made a lot clearer what local authorities legally 'must', 'should' and 'could' do to deliver the programme. It could also be made much clearer what intervention, support and discussions are expected to be part of the development reviews required by regulations and what are recommendations for services to secured by local authorities and other commissioners.

Any new statutory guidance should take into account the latest available evidence, including that submitted to this review of mandation as well as the *Rapid review to update evidence for the healthy child programme 0 to 5* published by Public Health England in 2015 and the ongoing evaluation of the Family Nurse Partnership. The development of this guidance should also take place in consultation with the wide range of services in the statutory and voluntary sectors who support children and families in the early years, particularly those working with the most vulnerable, as well as parents and children themselves. This process would of course take time and may not be possible to complete in time for new regulations being lade ready for next year. We would therefore suggest that this takes place over the next year to a8 months with regulations being amended in 2018 or 2019.

Benefits of the Healthy Child Programme

How important are the universal reviews to delivering benefits associated with the 6 high impact areas?
Extremely, very, somewhat, not so, not at all
Comment on the perception of the relative importance of

- *Transition to parenthood*
- *Maternal mental health*
- *Breastfeeding*
- *Healthy weight*
- *Managing minor illnesses & accident prevention*
- *Healthy 2 year olds and school readiness*

Are some of these considered to be more or less important than others?
What are the reasons for this?
Does this help to form recommendations on mandation? Especially if there is a recommendation for mandation to continue in a revised form.

The six high impact areas are all very important and make a vital contribution to healthy childhood and tackling health inequalities. We would also like to highlight the vital role that health visitors play in identifying potential special educational needs and disabilities, including through the two and a half year review, allowing plans to be put in place to meet additional needs in early education and school ahead of time.

Safeguarding and child protection

How important are the universal reviews to delivering benefits/discharging responsibilities associated with safeguarding and child protection? Extremely, very, somewhat, not so, not at all
Comment on the perception of the relative importance of

- *Safeguarding*
- *Child protection*

Are these considered to be more or less important than other aspects of the Healthy Child Programme? What are the reasons for this?
Does this help to form recommendations on mandation? Especially if there is a recommendation for mandation to continue in a revised form.

Universal reviews are more important for safeguarding and child protection than they have ever been. As highlighted above vulnerable families will now be more reliant on health visiting services because of other early intervention services receding. Other front line universal services are also under pressure, increasing the risk that vulnerabities and signs of neglect and abuse will be missed.

- In accident and emergency units, for example, the percentage of patients admitted or discharged within four ours has dropped from 98.% in 2009/10 to 91.9% in 2015/16 (NHS England (2016) A&E Attendances and Emergency Admissions 2016-17: Quarterly time series 2004-05 onwards with Annual (11.08.2016))
- While it is welcome that investment in General Practice is to increase, there has still been no action to address the skills gap in working with children faced by many GPs as a result of not having opportunities to work in child hospital settings as part of their initial training (Children and Young People's Health Outcomes Forum Report 2012 p54 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216852/CYP-report.pdf;
  NHS England (2016) *Five year forward view for General Practice)*
- Between 2010- 11 and 2015 - 16 the central government early intervention allocation to local authorities has fallen by 55 per cent in real terms. Some of the biggest falls in local spending have affected Sure Start children's centres which have seen budgets reduced by almost half (48 per cent) in real terms in the last five years. (Action for Children, the National Children's Bureau and The Children's Society (2016) *Losing in the Long Run: Trends in Early Intervention Funding)*

It is absolutely vital that there is some universal element to support for families in the early years, and particularly shortly following birth. It will be hard to identify those families who may be facing difficulties without home visits, particularly given the impact that the arrival of a child can have on the lives of new parents. Furthermore creating a service that is only targeted based on risk could create stigma in accessing such a serve and mistrust such as may be experienced by social work professionals trying to offer a family support. This would create an increased risk of vulnerable families slipping through the net, putting children at risk.

Return on investment

What is the perception of return on investment for these services? Positive, neutral, negative
What are the reasons for this?

There is a wealth of evidence for the return on investment that can be gained from early intervention in children's lives to support better outcomes. (See for a summary (2011) *Early Intervention: The Next Steps An Independent Report to Her Majesty's Government Graham Allen MP,* p31) Health visiting not only represents vital work with children and families at an important time of their lives but also allows the identification of families who have most to benefit from more targeted and intensive early intervention programmes enabling referral and signposting.

Other reflections

Other comments
Recommendations on next steps/further work required?

The Communication Trust

The Communication Trust

Every child understood

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03rd August 2016

Dear Viv Bennett and Phil Norrey

I am writing on behalf of The Communication Trust, a coalition of 53 not for profit organisations who work together to support the children's workforce in ensuring that all children and young people are enabled to develop and use their speech, language and communication skills to the best of their ability.

I have read with interest the information regarding Public Health England's review of the five mandated health visitor reviews and would like to take this opportunity to express some of the coalition's concerns.

Currently, health visitor checks are provided as a universal service; a service that can benefit all families. The universal aspect of these mandatory checks help to ensure that all children and families receive the support they need at the earliest possible time and can prevent children with speech, language and communication needs and SEND from slipping through the net and missing out on vital early support.

Speech, language and communication skills are crucial life skills, and we believe that the support that health visitors provide to families, in particular the 2-2½ year check, provides an essential public health service in promoting the importance of speech, language and communication skills to families and supporting the early identification of children who may not be developing the skills expected for their age. We know that early identification and intervention can make a huge difference to children who are falling behind. Where difficulties are not identified and supported early, this can result in children not being school ready and ultimately impacting on their literacy, learning, social relationships, emotional development and employment prospects. Ofsted's recent report' looking at how Local Authorities support disadvantaged families highlights in particular that local authorities should ensure that a child's health and development checks at age two are completed as a crucial first assessment of their needs, and used as a benchmark for progress across their early education.

> Mandatory health visitor checks are an important public health service, and have the potential to ensure that fewer children start school with speech, language and communication needs lower than expected for their age (which in some areas, can be up to 50% of children). Additionally, in the context of the DfE's Early Years Foundation Stage Profile becoming non-mandatory in September this year, it will become even more important to ensure that frameworks are in place to support early identification and intervention for children with speech, language and communication needs and wider SEND.

Considering the crucial role of the mandatory checks, we would be extremely concerned if that mandation was not extended; these early checks and early support for children and families needs to be seen both as a public health priority and as an investment priority for Local Authorities.

We would very much like the opportunity to meet to discuss these issues and further support that we could provide — I can be contacted on oholland@thecommunicationtrust.org.uk

Yours sincerely,

Octavia Holland

Director, The Communication Trust

UNICEF

Children's public health 0-5 years reviews

Survey deadline: 31 July 2016

Public Health England (PHE) is undertaking a review of the mandation for children's public health 0-5 years (universal health visitor reviews).

Question 3: (page 4)

Mandation

Existing legislation, mandating that five universal health visitor reviews (antenatal, new baby, 6-8 weeks, 1 year and 2-2½ years) are delivered for every child, is due to expire at the end of March 2017. What would you recommend happens next?*

- (•) The mandation is extended in its current form
- ( ) The mandation is extended but in a revised form
- ( ) The mandation is allowed to expire as planned
- ( ) Don't know

Free text box - reasons:

The National Infant Feeding Network (NIFN) co-ordinates and supports health visitors across England. The National Infant Feeding Network aims to improve the health and wellbeing of mothers and infants by enabling excellent practice for infant feeding and relationship building through public services including health visiting.

NIFN fully supports good practice by extending in its current form the mandated health visitor visits. NICE evidence suggests that when women receive; one to one, face to face, predictable support they are more likely to succeed in their breastfeeding choices which will then have a positive impact of the mother baby relationship enhancing the physical and emotional wellbeing of the baby, the mandated HV visits support implementation of this evidence based practice. Where women have had a meaningful contact and conversation in the antenatal period (around infant feeding and importance of connecting with their baby during pregnancy and beyond) they demonstrate greater resilience postnatally and are more likely to both initiate and sustain breastfeeding[i].

Why this is important for public health and for mothers and babies:

- Breastfeeding increases the life chances for all children, reduces obesity and reduces morbidity and mortality in preterm and sick infants[ii],[iii].
- The Lancet breastfeeding series, 2016, identified that the UK had some of the lowest breastfeeding rates in the world - In the UK 81% of mother's initiative breastfeeding at birth, but by 6/8 weeks 76% of all babies have received some formula milk[iv].
- Only 1% of UK women are exclusively breastfeeding to six months as recommended by the WHO/Unicef and the UK Governments, and 34% partially breastfeeding compared to 71% in Norway.
- Positive early mother baby relationships provide the basis for improved emotional wellbeing throughout childhood and into adulthood[v]

The mandated HV visits ensure women get predictable, face to face support to help them to successfully breastfeed for longer and therefore address the very low breastfeeding rates in the UK.

Question 5: Page 6 all are *extremely important

Final section

General comments: suggested text, page 7

Main Risks

- The United Nations Committee on the Rights of the Child (2016[vi]), the Chief Medical Officer (CMO) (2013[vii] & 2014[viii]) and compelling evidence published in the Lancet, 2016[ix], all identify that the UK has some of the lowest breastfeeding rates in the world and calls on government to; systematically collect data on breastfeeding; promote, protect and support breastfeeding in all policy areas where breastfeeding has an impact on child health and fully implement the International Code of Marketing of Breastmilk Substitutes.
- Without mandation there is a REAL risk that health visiting services will be cut and breastfeeding and relationship building reduced to a level that would impact on breastfeeding prevalence.
    a. The health, wellbeing social and economic benefits of breastfeeding are irrefutable; Breastfeeding increases the life chances for all children, reduces obesity and reduces morbidity and mortality in preterm and sick infants[x],[xi].

b. Reducing the incidence of just five illnesses, (ear, chest & gut infections, NEC & breast cancer) protected by breastfeeding, would translate into cost savings for the NHS of more than £48 million and tens of thousands fewer hospital admissions and GP consultations[xii],[xiii].

c. Breastfeeding can provide a child with a natural safety net against the worst effects of poverty. Breastfeeding and supporting all mothers to build a close and loving relationship with their infant, is now recognised as a positive, proactive mechanism to promote mother-infant bonding, reduce child neglect and improve mental health and wellbeing for the mother and child[xiv],[xv],[xvi],[xvii].

- Data collection: since 2010 there has been no UK data reporting mechanism beyond 6/8 weeks. Health visitors are key to collecting infant feeding data and integral to processes to ensure quality control and ensuring robust reporting mechanisms. Without mandated visits there would be no breastfeeding data collection beyond initiation.
    a. The United Nations Committee on the Rights of the Child (2016) call for the UK government to systematically collect data on breastfeeding; to promote, protect and support breastfeeding in all policy areas where breastfeeding has an impact on child health.

Opportunities for innovation

1. The CMO (2013), NICE (2010[xviii],2014[xix], 2015[xx],2016[xxi]), Public Health England (2015[xxii]) PHE and Unicef UK, (2016[xxiii]), the Acta Paediatrica Special issue and the Lancet series (2015[xxiv], 2016[xxv]) all recommend implementation of the Unicef UK Baby Friendly Initiative as an evidence based programme that will help to improve practical help for mothers to initiate and continue to breastfeed across community services – mandating HV services will help to achieve this evidence based practice.

[1] Unicef UK (2013) The evidence and rationale for the Unicef UK Baby Friendly Initiate standards http://www.unicef.org.uk/Documents/Baby_Friendly/Research/baby_friendly_evidence_rationale.pdf .
[1] Acta Paediatrica (2015) Special Issue: Impact of Breastfeeding on Maternal and Child Health, December, Volume 104, Issue Supplement S467, Pages 1–134.
[1] Renfrew MJ, Craig D, Dyson L, McCormick F, Rice S, King SE, Misso K, Stenhouse E, Williams AF (2009) Breastfeeding promotion for infants in neonatal units: a systematic review and economic analysis, August, Health Technology Association.13.No.40
[1] McAndrew F, Thompson J, Fellows L, Large A, Speed M, Renfrew MJ (2012) Infant Feeding Survey 2010, Health and Social Care Information Centre, pp. 111–112
[1] PHE (2015) Rapid Review to Update Evidence for the Healthy Child Programme 0-5. https://www.gov.uk/government/publications/healthy-child-programme-rapid-review-to-update-evidence
[1] UN (2016) Concluding observations on the fifth periodic report of the United Kingdom of Great Britain and Northern Ireland.

http://www.unicef.org.uk/Documents/Baby_Friendly/Reports/UK%20CRC%20Concluding%20observations%202016%20(2).pdf
[1] Davies, S (2013) Chief Medical Officer's annual report 2012: Our Children Deserve Better https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2012-our-childrendeserve-better-prevention-pays
[1] Davies, S (2014) Annual Report of the Chief Medical Officer 2014, The Health of the 51%: Women https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/484383/cmo-report-2014.pdf
[1] Victora CG, Bahl R, Barros AJD, Franca GVA, Horton S, Krasevec J, Murch S, Sankar MJ, Walker N, Rollins NC (2016) Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. The Lancet Series: Breastfeeding 1. Volume 387, No. 10017, p475–490, 30 January
[1] Acta Paediatrica (2015) Special Issue: Impact of Breastfeeding on Maternal and Child Health, December, Volume 104, Issue Supplement S467, Pages 1–134.
[1] Renfrew MJ, Craig D, Dyson L, McCormick F, Rice S, King SE, Misso K, Stenhouse E, Williams AF (2009) Breastfeeding promotion for infants in neonatal units: a systematic review and economic analysis, August, Health Technology Association.13.No.40
[1] Renfrew MJ, Pokhrel S, Quigley M, McCormick F, Fox-Rushby J, Dodds R, Duffy S, Trueman P, Williams T (2012) Preventing disease and saving resources: the potential contribution of increasing breastfeeding rates in the UK, UNICEF UK BFI http://www.unicef.org.uk/Documents/Baby_Friendly/Research/Preventing_disease_saving_resources.pdf
[1] Ajetunmobi OM, Whyte B, Chalmers J et al (2014) Breastfeeding is Associated with Reduced Childhood Hospitalization: Evidence from a Scottish Birth Cohort (1997-2009) The Journal of Pediatrics.http://www.jpeds.com/article/S0022-3476(14)01065-8/fulltext
[1] Strathearn L, Mamun AA, Najman JM, O'Callaghan MJ (2009) Does breastfeeding protect against substantiated child abuse and neglect? A 15-year cohort study. Pediatrics, Feb 123(2), pp483-93.
[1] Borra, C et al (2014) New Evidence on Breastfeeding and Postpartum Depression: The Importance of Understanding Women's Intentions. Matern Child Health Journal,DOI 10.1007/s10995-014-1591-z
[1] Brown, A., Rance, J. & Bennett, P. (2015). Understanding the relationship between breastfeeding and postnatal depression: the role of pain and physical difficulties. Journal of Advanced Nursing, DOI: 10.1111/jan.12832
[1] Borra, C et al (2014) New Evidence on Breastfeeding and Postpartum Depression: The Importance of Understanding Women's Intentions. Matern Child Health Journal,DOI 10.1007/s10995-014-1591-z
[1] NICE (2010) Neonatal specialist care (QS4) https://www.nice.org.uk/guidance/qs4
[1] NICE (2014) NICE Public Health Guidance 11: Improving the nutrition of pregnant and breastfeeding women and children in low-income households, Quick Reference Guide: Maternal and child nutrition. Issued March 2008 (updated September 2014).
[1] NICE (2015) Postnatal Care up to 8 weeks after birth. (CG37). Issued July 2006. (Updated January, 2015) https://www.nice.org.uk/guidance/cg37/history
[1] NICE (2016) Antenatal care for uncomplicated pregnancies. (CG62), Issue date: March 2008, Updated March 2016 https://www.nice.org.uk/Guidance/CG62
[1] PHE (2015) Rapid Review to Update Evidence for the Healthy Child Programme 0-5. https://www.gov.uk/government/publications/healthy-child-programme-rapid-review-to-update-evidence
[1] PHE/Unicef UK (2016) Commissioning Infant Feeding Services https://www.gov.uk/government/publications/infant-feeding-commissioning-services
[1] Acta Paediatrica (2015) Special Issue: Impact of Breastfeeding on Maternal and Child Health, December, Volume 104, Issue Supplement S467, pp. 1–134
[1] Rollins NC, Bhandari N, Hajeebhoy N, Horton S, Lutter CK, Martines JC, Piwoz EG, Richter LM, Victora CG (2016) Why invest, and what it will take to improve breastfeeding practices? The Lancet Series: Breastfeeding 2. Volume 387, No. 10017, p491–504, 30 January.

GP Infant Feeding Network

The GP Infant Feeding Network
Reply to contact@gpifn.org.uk

Viv Bennett

Chief Nurse

Public Health England

West Offices

Station Rise

York

Y01 6GA

26 July 2016

Dear Viv Bennett

Re: Children's public health 0-5 years — review of mandation

We as members of the GP Infant Feeding Network (GPIFN), a UK wide organisation representing GPs who are working towards best practice in infant feeding, are writing to express our deep concern over the review and potential removal of mandation for the Universal Health Visitor reviews in England. Below we outline our reasons:

- **Potential Reduction of Health Visitor Services**
  Universal Health Visitor reviews are a safety-net, for identification of vulnerability. Removal of mandation will likely result in the loss of this universal protective service for under 5s in areas where Local Authority cuts to services are planned.

- Risk **to Child Protection Efforts**
  We believe that removal of mandation is inconsistent with the recent CQC recommendation *more must be done to identify children at risk of harm. The risks to many children are not

always obvious and require a continuous professional curiosity about the child and their circumstances. The emphasis must be on both identifying and supporting those in need of early help, as well as those at risk of 'hidden' harms".

- **Risk to Poverty Reduction and Health Promotion**
  Around II million children live in England and approximately 2.3 million children are living in poverty (and can be defined as vulnerable) at the present time- this is expected to rise to 3.6 million by 2020. A further 400,000 children are in need. A sizeable proportion are looked-after and on the child protection register, and preservation of Universal Health visiting is vital to enable preventative action to reduce these numbers. There is a real danger that removal of mandation will lead to increased difficulty to access health care in these groups, increasing inequity and inequality.

Risk of Reliance on 3rd Sector Services

'Hall 4 - Health for all children' calls for universal joined up multi-professional working. Where care has not been effective or a critical incident occurs, the findings advise an integrated service framework and good communication to prevent further instances, Scotland has moved in this direction to enable the introduction of universal care pathway based on Hall 4 recommendations. We would welcome a similar strategy adopted across the UK. We believe that removal of mandation could prompt reliance on third sector involvement, which though valuable in what can be offered to families, cannot replace a universal screening and safety net and may lead to fragmentation of service, increasing the likelihood of further critical events in future.

Removing Mandation Conflicts with Recent Public Health Recommendations

Public Health England's report ¯Health Matters: Giving Every Child the Best Start in Life' (May 2016) makes the case for early years investment and the Healthy Child Programme, including the mandated Universal Health Reviews and health surveillance. The Healthy Child Programme can 'ensure families receive early help and support upstream before problems develop further and reduce demand on downstream, higher cost specialist services'. The report also refers to research from the London School of Economics and the Centre for Mental Health 'Costs of Perinatal Mental Health Problems' (October 2014) in stating that 'A failure to act early comes at great cost, not only to individuals but to society as a whole. The cost of treating perinatal mental health alone costs £8.1 billion each year'.

Further Risk to Infant Feeding Support

We welcomed the recent The Public Health England report Infant Feeding: Commissioning Services' (July 2016). Health Visiting services frequently provide breastfeeding support, and we believe that removal of mandation is highly likely to lead to further cuts to breastfceding support in Local Authority areas where budget savings are planned. As a network concerned with support for infant feeding this is extremely concerning, particularly considering cuts to breastfceding services in England are already occurring. The health and economic costs of low breastfceding rates in the UK are well documented, including by the recent *Lancet* Breastfeeding Series (January 2016).

- **Risk of Increasing General Practice Workload**
  If removal of mandation occurs and Health Visiting services experience cut to budgets, child health issues that are currently addressed in a systematic way by Health Visitors will require management by the GP, or may be missed altogether, resulting in complex late presentations.

Our network is also concerned with the current extreme workload pressures in General Practice and any risk of this increasing further would mean a potentially unsafe reactive service. We are concerned that individual GPs and Practice Nurses are not being consulted on changes to the Health Visiting services.

The Department of Health report 'Universal Health Visitor Reviews: Advice for local authorities in delivery of the mandated universal health visitor reviews from 1 October 2015' highlighted the six high impact areas where Health Visitors have a vital role to ensure best outcomes. We strongly support continuation of this evidence based policy. **We therefore recommend that the mandation is extended in its current form.**

Yours Sincerely

Members of the GP Infant Feeding Network Executive Team

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Members of the GP Infant Feeding Network

Dr Alison Smith General Practitioner Coventry

Carmen Pagor IBCLC, St George's Specialist Breastfeeding Health Visitor and Children's Centre

Lead Battersea

Various - Open letter to the Editor of the Times

The nation's health is at stake

Sir:

Health visitors play a crucial role in improving the health of the nation, yet there have been alarming reports of imminent cuts to their numbers.

With the health service facing an ever increasing demand for its services, health visitors have a vital and unique role in preventing ill health and offering universal advice and support to all families. However, cuts to Local Authority budgets have left many teams and their client families facing an uncertain future.

The loss of health visitor posts could have irredeemable consequences for children and families, while stunting the progress of several key Government priorities; from reducing the dangerous levels of obesity and mental health issues – in children and adults – to promoting social inclusion.
Any money saved by reducing health visitors would simply be eclipsed by the resulting added pressure on the NHS. Meanwhile, the previous Government's Health Visitor Implementation Plan which boosted the health visiting workforce by more than 4,000, would become a wasted investment should positions be cut.

We call on the Government to secure funding for health visiting services, and protect their fundamental contribution to health care in the UK.

Janet Davies, Chief Executive and General Secretary, RCN
Dr Cheryll Adams CBE, Executive Director, Institute of Health Visiting
Obi Amadi, Lead Professional Officer (strategy, policy and equalities), Unite
Professor Maureen Baker CBE, Chair of the Royal College of GPs
Professor Woody Caan, Professorial Fellow of the Royal Society for Public Health
Dr Carol Ewing, Vice President for Health Policy, RCPCH
Anna Feuchtwang, Chief Executive, National Children's Bureau
Dr Rajalakshmi Lakshman, Consultant in Healthcare & Children's Public Health
Dr Crystal Oldman, Chief Executive, Queen's Nursing Institute (QNI)
Jeremy Todd, Chief Executive, Family Lives
Peter Wanless, CEO, NSPCC

Appendix 8: Summary of evidence base

1. Healthy Child Programme

Health visitors lead delivery of the Healthy Child Programme (HCP) and work in partnership with maternity services, local authority-provided or commissioned early years services, voluntary, private and independent services, primary and secondary care, schools, health improvement teams, Family Nurse Partnership (FNP) colleagues and children's social care services.

The HCP is the key universal public health service for improving the health and wellbeing of children through health and development reviews, health promotion, parenting support, screening and immunisation programmes. The current programme for 0-5 year-olds is based on the evidence available at the time of the last update of the HCP 0-5 years in 2009. As local authorities took on the commissioning of the HCP 0-5 years and its delivery via the universal health visiting service on 1 October 2015 the evidence underpinning the programme was subject to a rapid review. The purpose of the review was to update the evidence about 'what works' in key areas: parental mental health; smoking; alcohol/drug misuse; intimate partner violence; preparation and support for childbirth and the transition to parenthood; attachment; parenting support; unintentional injury in the home; safety from abuse and neglect; nutrition and obesity prevention; and speech, language and communication.

1.1 Return on Investment

The review identified the pressing need for information on the economic case for investing in early intervention, specifically the financial and other gains that potentially derive over a child's lifetime from improving outcomes when they are aged 0-5 years. However, the review acknowledged that trials of interventions typically only measure outcomes in the short term (ie within a year or two of the completion of the intervention). For trials of interventions in the early years, this means that the long-term effects of the intervention are not directly measured. However, the long-term outcomes are more likely to have economic implications for the children, their families, and society.

1.2 Reference

- Public Health England (2015) Healthy Child Programme: rapid review to update evidence

2. Transition to parenthood – healthy lifestyle, contraceptive and sexual health

Heath visitors through contact with the family in both the antenatal and postnatal period, work with families to promote secure attachment, positive parental and infant mental health and parenting skills using assessment scales. This includes the promotion of breastfeeding,

healthy nutrition and healthy lifestyles, working with families to support behaviour change leading to positive lifestyle choices. Health visitors lead delivery of evidence-based antenatal and postnatal groups to promote attachment, for example, parenting classes/groups and Preparing for Pregnancy and Beyond. Lead delivery, in partnership with other agencies, of evidence-based parenting programmes for toddlers and pre-school children such as the Incredible Years Pre-school basic programme and other evidence-based programmes. Through this work they identify early signs of developmental and health needs and signpost and/or refer for investigation, diagnosis, treatment, care and support.

2.1 Evidence

For antenatal education there is no evidence of impact on low birthweight; limited evidence of impact on parental health behaviours, including personal responsibility for healthcare, exercise, and nutrition; and no evidence of impact on the onset of depression, but some evidence to show that group-based social support, including antenatal preparation for parenthood classes, can be effective in supporting women with sub-threshold symptoms of depression and anxiety.

2.2 References

- Public Health England (2015) Healthy Child Programme: rapid review to update evidence
- NHS England (2014) Health visiting service specification 2015/16

3. Transition to parenthood – smoking cessation

National Institute for Clinical Evidence (NICE) says all pregnant women who smoke – and all those who are planning a pregnancy or who have an infant aged under 12 months – should be referred for help to quit smoking

Smoking during pregnancy is strongly associated with a number of factors including age and social economic position. In addition, women with partners who smoke find it harder to quit and are more likely to relapse if they do manage to quit.

Health visitors are key in providing smoking cessation advice and referring mothers and fathers to specialist smoking cessation services in both the antenatal and postnatal period.

3.1 Evidence / Return on Investment

Smoking during pregnancy can cause serious pregnancy-related health problems. These include: complications during labour and an increased risk of miscarriage, premature birth, still birth, low birth-weight and sudden unexpected death in infancy.

The total annual cost to the NHS of smoking during pregnancy is estimated to range between £8.1 and £64 million for treating the resulting problems for mothers and between £12 million and £23.5 million for treating infants (aged 0–12 months)

Children exposed to tobacco smoke in the womb are more likely to experience wheezy illnesses in childhood. In addition, infants of parents who smoke are more likely to suffer from serious respiratory infections (such as bronchitis and pneumonia), symptoms of asthma and problems of the ear, nose and throat (including glue ear). Exposure to smoke in the womb is also associated with psychological problems in childhood such as attention and hyperactivity problems and disruptive and negative behaviour. In addition, it has been suggested that smoking during pregnancy may have a detrimental effect on the child's educational performance

3.2 Reference

- Department of Health (2014), Early Years High Impact Area - Transition to parenthood and early weeks

4. Transition to parenthood – secure attachment and bonding

Transition to Parenthood and the first 1001 days from conception to age two is widely recognised as a crucial period that will have an impact and influence on the rest of the life course.

There is a significant body of evidence that demonstrates the importance of sensitive attuned parenting on the development of the baby's brain and in promoting secure attachment and bonding. Preventing and intervening early to address attachment issues will have an impact on resilience and physical, mental and socio-economic outcomes in later life.

Health visitors undertake a holistic assessment of the family and parental capacity to meet their infant's needs, enabling early identification of needs and risk. This period is an important opportunity for prevention and early intervention.

The contacts during the antenatal period and early weeks inform the level and type of support needed, including safeguarding concerns, potential and actual mental health issues, domestic violence and abuse and alcohol and drug issues.

4.1 Evidence

This period provides opportunities for involvement because it is the time when parents are the most receptive to messages. There are better outcomes when parenting programmes start in pregnancy, parents can be supported to understand and communicate their concerns.

4.2 References

- Department of Health (2014), Early Years High Impact Area - Transition to parenthood and early weeks

- Department of Health (2009), Healthy Chid Programme: Pregnancy and the first five years

5. Maternal Mental Health

During pregnancy, depression and anxiety affects a significant number of women. Postnatal depression or anxiety is often preceded by depression or anxiety during pregnancy. The task of improving maternal mental health is important in terms of its impact not only on the mother but also on both the foetus and infant/child. Poor maternal mental health during pregnancy can affect foetal development, including cellular growth and brain development, with consequences for child physical, cognitive, emotional and behavioural outcomes after birth and through childhood. In the postnatal period, maternal mental health can influence the quality of parent-child interactions and children's socio-emotional development during infancy and childhood. It is therefore essential to support women's mental health during pregnancy and postpartum.

Health visitors are key to the identification, prevention and treatment of depression and anxiety in the antenatal and postnatal period. The way in which the assessment, preventative and treatments are delivered are outlined in NICE guidance on antenatal and postnatal mental health. The guidelines include the assessment of mother baby relationship, drug and alcohol misuse as well as eating disorders

5.1 Evidence

Outcomes are currently only measured in the short term (i.e. number of mothers detected and successfully treated as a result of the health visitor intervention). This means that the long-term effects of the intervention are not directly measured.

References

- National Institute for Health and Care Excellence (2014) Antenatal and postnatal mental health: Clinical management and service guidance, CG192

- National Institute for Health and Care Excellence (2007) Antenatal and postnatal mental health: Clinical guidance,CG45

6. Breastfeeding

There is much evidence that demonstrates breastfeeding contributes to the health of both the mother and child in the short and longer term.

Health visitors in particular are thought to be well positioned to support mothers with breastfeeding because of their continued and active engagement with mothers after childbirth. They provide advice on breastfeeding and medication and have a key role in

developing or signposting mothers to breastfeeding peer support programmes, as well as promoting the benefits of heath visiting with fathers.

6.1 Return on Investment

The health risk associated with not breastfeeding is beyond doubt. Both the mother's and the baby's health will be enhanced by breastfeeding in all circumstances where the mother chooses to do so.

Peer support which achieves a relatively high increase in breastfeeding rates actually saves the NHS money in the long run, because levels of hospitalisation of babies drop, breastfed babies grow up into healthier children and adults, fewer women develop breast cancer, and less has to be spent on infant formula. This is achieved at an estimated 20 percentage point increase in breastfeeding initiation. For example, where only 20% of mothers currently initiate breastfeeding, an increase to 40% or more would be cost saving. So too would be the increase from 60% to 80% or more. However, where the initiation rate currently exceeds 80% further increase is unlikely to be cost saving, as more than 100% of women would need to breastfeed.

6.2 References

- National Institute for Health and Care Excellence (Published 2013 - updated June 2015), Postnatal care up to 8 weeks after birth, Quality Standard 37
- National Institute for Health and Care Excellence (2007), Maternal Child Health Programme: Modelling the cost effectiveness of support to promote breastfeeding

7. Healthy Weight

Good nutrition during infancy has multiple positive outcomes for health during childhood and later life, and breastfeeding is strongly associated with a range of health and wider (eg cognitive) benefits for the child. Adolescent mothers and women from socio-economically disadvantaged backgrounds are least likely to start or continue breastfeeding. Recent research has focused on identifying effective strategies for supporting breastfeeding decision-making for women in these groups, as well as supporting positive nutrition for all families. Nutritional habits formed in early life influence food choices and subsequent nutrition during childhood. Increasing rates of obesity, particularly in childhood, have given rise to a wide range of efforts to promote healthier eating increased physical activity amongst young children. Risk factors for obesity in children include diet, exercise, family history and socio-economic factors.

Health visitors have a key role in delivering antenatal and postnatal strategies to promote breastfeeding, and interventions to prevent and treat being overweight or obese during early childhood, including early identification of issues, supporting health promotion and change management around healthy lifestyles.

7.1 Evidence

The review of individual and group breastfeeding support (both face-to-face and via the telephone) in the antenatal and postnatal period showed an increase in the duration of any breastfeeding

Interventions for parents of young children whether from professionals, paraprofessionals or trained peer supporters, were found to be successful in improving children's diet

7.2 References

- Public Health England (2015) Healthy Child Programme: rapid review to update evidence
- NHS England (2014) Health visiting service specification 2015/16

8. Managing minor illnesses and accident prevention

Illness such as gastroenteritis and upper respiratory tract infections, along with injuries caused by accidents in the home, are the leading causes of attendances at A&E and hospitalisation among the under 5s.

Parenting interventions, most commonly provided by the health visitor within the home, are effective in reducing child injury and improving home safety. Home safety education increases the use of home safety practices and there is some evidence that it can reduce overall injury rates. There remains some conflicting evidence regarding the provision of home safety equipment in terms of its impact on safety practices and injury rates.
Home safety interventions improve poison-prevention practices such as the safe storage of medicines and cleaning products, increasing stair-gate use and reducing baby-walker use.

Health visitors provide education, advice and information about safety are provided during home assessments. Home safety assessments and interventions should be followed up to see if there are any new requirements, and to assess whether the equipment installed is still functional and appropriate

8.1 Evidence

Health visitors are a trusted source of knowledge, advice and information for parents and are often the first point of contact for parents who are unsure on the best course of action when their child is unwell. As such they play an important role in the primary care team and can help to reduce the burden on busy GP surgeries and A&E departments.

8.2 References

- National Institute for Health and Care Excellence (January 2016), Preventing unintentional injuries in the home among children and young people under 15, Quality standard

9. Healthy two-year-olds and school readiness

Measures of 'school readiness' show that the poorest 20% of children are more likely to display conduct problems at age 5 than children from more affluent backgrounds. Most opportunities to close the gap in behavioural, social and educational outcomes occur when the child is preschool age.

Health visitors assess and care for children under 5 for any risks that may pose a risk to the child's social and emotional wellbeing. If factors that may pose a risk to a child's social and emotional wellbeing are identified during these key face-to-face contacts, early action can be taken to prevent or reduce the potential impact on the child. Age 2–2½ is a crucial stage when problems such as speech and language delay or behavioural issues etc become visible and can be addressed by the health visitor before the child starts school. It is also a time when health visitors can support toilet training.

Children and young people with communication difficulties are at increased risk of social, emotional and behavioural difficulties and mental health problems. So, identifying their speech and language needs early is crucial for their health and wellbeing. Many young children whose needs are identified early do catch up with their peers.

9.1 Return on Investment

Early intervention can provide a good return on investment. The cost of not intervening to ensure (or improve) the social and emotional wellbeing of children and their families are significant, for both them and wider society. For example, by the age of 28, the cumulative costs for public services are much higher when supporting someone with a conduct disorder, compared to providing services for someone with no such problems.

9.2 References

- National Institute for Health and Care Excellence (2012), Social and emotional wellbeing: early years, Guideline (PH40) Recommendation 2

- National Institute for Health and Care Excellence (2016), Early years: promoting health and wellbeing in under 5's, Quality Standard 128