



Department
of Health

Mandating elements of the Healthy Child Programme through Regulations

Equality Analysis

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Mandating elements of the Healthy Child Programme through Regulations

Equality Analysis

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1 What are the intended outcomes of this work?

From 1 October 2015 Local Authorities (LAs) will take over responsibility from NHS England for commissioning (i.e. planning and paying for) public health services for children aged 0-5. These services include delivery of the Healthy Child Programme (HCP) and Family Nurse Partnership (FNP) services for teenage parents.

The HCP is a national public health programme to achieve good outcomes for all children from pregnancy through to 19 years of age. The HCP 0-5, led by health visitors and their teams, offers every child a schedule of health and development reviews, screening tests, immunisations, health promotion guidance and support for parents tailored to their needs, with additional support when needed and at key times.

The draft Regulations are being made under Section 6C of the NHS Act 2006. Subject to Parliamentary approval, the aim is that the Regulations will be in place which provide for a 'sunset clause' at 18 months that will have the effect of ending mandation, unless further legislation is made that continues the provisions in force. A review, involving Public Health England (PHE), is intended to inform whether the sunseting needs to be amended.

Through this work we intend to mandate (i.e. require LAs), as far as is reasonably practicable, to secure provision of, the following specified universal elements of the 0-5 HCP (in the draft Regulations these are referred to as the universal health visitor reviews and in this analysis as the '5 reviews'): These include:

- 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.

Evidence shows that these are the key times to ensure that parents are supported to give their baby/child the best start in life, and to identify early those families who need extra help.

This will help ensure all children under 5 and their parents get the support they need, whilst also providing an opportunity to identify those families where extra support may be needed. More specifically, offering the reviews universally* contributes a wider benefit to society as it:

- offers the opportunity to reduce health and social care needs later in life;
- contributes to the reduction of disease, ie. through reviewing immunisation status; and
- allows for the collection of data at a national level that enables measurement against elements of the Public Health Outcomes Framework.

1 What are the intended outcomes of this work?

. * Universal services are those available to all families (Eg health and development reviews, supplemented by advice around health, wellbeing and parenting) at the local level. They are provided in the context of a national, standard format, to ensure access to everyone

2 Background

Local Authority Commissioning Responsibilities

*Healthy Lives, Healthy People: Our strategy for public health in England*¹ (November 2010) set out the Government's ambitious vision to help people live longer, healthier and more fulfilling lives, and to improve the health of the poorest fastest. [Link: <https://www.gov.uk/government/publications/healthy-lives-healthy-people-our-strategy-for-public-health-in-england>]. It also paved the way for changes to commissioning arrangements to which these Regulations relate. Further detail is available in the associated explanatory memo accompanying these Regulations.

Local authorities have a duty under section 2B of the NHS Act 2006, (amended by Health and Social Care Act 2012), to take appropriate steps for improving the health of the people in their area. LAs are free to commission services within the public health ring-fenced budget as they see fit for the benefit of their population. In April 2013, they became responsible for commissioning a range of public health services, some of which were mandated by requirements imposed in legislation (i.e. by Government).

The new arrangements provide an opportunity for the joining up of 0–5 commissioning with LAs already established role in commissioning 5–19 years public health services (and services for those with Special Educational Needs and Disabilities [SEND] up to age 25).

The Public Health Grant

In January 2013 the Department allocated ring fenced public health grants to LAs for 2013-14 and 2014-15 to deliver their new public health responsibilities from April 2013. A specific equality analysis was attached to this exercise¹. In December 2014, LAs were informed of their proposed allocations for 2015-16 [Link: <https://www.gov.uk/government/publications/ring-fenced-public-health-grants-to-local-authorities-2013-14-and-2014-15>] and the details of the health premium incentive scheme. On 17 December 2014, the Department confirmed that 2015-16 LA public health grants would be the same as in 2014-15 (with the exception of adjustments on baseline errors agreed locally). In 2015-16 the public health grant will additionally include a half year's cost of commissioning the 0-5 children's public health services responsibility for which is being transferred to LAs. From 2016, the public health grant, as advised by the Advisory Committee on Resource Allocations (ACRA) will include all public health responsibilities transferred to LAs.

Improving Health Visitor Numbers

The Government has committed to improving the health outcomes for children, families and their communities by increasing the number of full time equivalent (FTE) health visitors by 4,200

¹ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213325/PH-formula-EA1.pdf

and implementing an expanded, rejuvenated and strengthened health visiting service by April 2015. The *Health Visitor Implementation Plan 2011-15 – ‘A Call to Action’*,² (February 2011), sets out how this extra capacity will contribute to improved public health outcomes and better personalised care for all families with children under 5.

This work forms part of a broader ambition, to ensure that:

- a) progress towards achieving the health visiting commitment of an extra 4,200 FTE by April 2015 is not diminished by uncertainty over the level and scope of health visiting services when commissioning responsibility transfers to LAs; and,
- b) the potential of the increased health visiting workforce to improve and transform services for families is fully realised.

The Health Visiting Service

The four tier **Health Visiting Service** assesses and responds to children’s and families’ needs:

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

The Family Nurse Partnership

FNP is a targeted, evidence-based, preventive programme for vulnerable first time young parents. Structured home visits, delivered by specially trained family nurses are offered from early pregnancy until the child is two. FNP aims to improve pregnancy outcomes, child health and development and parents’ economic self-sufficiency. FNP participation is voluntary. When a mother joins the FNP programme the HCP is delivered by a family nurse. The family nurse plays an important role in any necessary safeguarding arrangements alongside statutory and other partners to ensure children are protected. In those areas where FNP is available, then for those mothers who have joined the programme, a family nurse will administer the 5 reviews.

More information about FNP is available at: www.fnp.nhs.uk.

What do we want to achieve?

Our aim is to ensure that future commissioning supports sustainable health visiting services and provides the best outcomes for children and their families. We are using the model of ‘4 5 6 to help explain public health services for public health commissioners. This comprises: the four levels of health visiting service, the five elements we intend to mandate, leading to the six high impact areas which are:

²https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213759/dh_124208.pdf

- transition to parenthood and the early weeks;
- maternal mental health (perinatal depression);
- breastfeeding (initiation and duration);
- healthy weight, healthy nutrition (to include physical activity);
- managing minor illness and reducing accidents (reducing hospital attendance/admissions); and
- health, wellbeing and development of the child age two – two year old review (integrated review) and support to be ‘ready for school.’

Mandated services

The potential for mandating elements of the HCP was set out in *Healthy Lives, Healthy People: Update and Way forward*,³ which was part of the Government’s intention to prescribe certain services that must be commissioned or provided by LAs. Government announced in 2014, its intention to mandate some of the elements of the HCP for 18 months to ensure the ongoing provision of a service that is essential to supporting health and well-being of families and children at a critical stage of development.

The rationale for mandating LAs in this way is an acknowledgment that some services need to be provided in the context of a national, standard format – supporting the aim of universal coverage. This will better ensure that the nation’s health and wellbeing overall is improved and protected.

LAs are very well placed to identify health needs and commission services for local people to improve health. The Government’s aim is to enable local services to be shaped to meet local needs.

³ <https://www.gov.uk/government/publications/healthy-lives-healthy-people-update-and-way-forward>

3 Objectives in the context of the equality duty

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

In transferring public health responsibilities to local government, the Government aimed to:

- improve significantly the health and wellbeing of local populations;
- prescribe steps local authorities must take in carrying out their health improvement functions or health improvement functions delegated from the Secretary of State;
- reduce health inequalities across the life course, including within hard to reach groups; and
- ensure the provision of population healthcare advice.

The key policy drivers associated with the Department of Health's (DH) Health Visitor Programme, (which began in 2010/11), have been delivered by DH and partner organisations over the past four years or so.

The programme's key aim has been to deliver:

- Expansion of the health visitor workforce by 4,200 full time equivalents (by 2015); and
- transformation of the HV service, centred on a 4 tiered model that sees health visitors and their teams lead delivery of the HCP.

As such, the policy aim places the revitalisation of health visiting services at the centre of support for all parents and the provision of assistance when needed by families. It aims to:

- Improve access to evidence-based interventions;
- improve the experience of children and families;
- improve health and wellbeing outcomes for under-fives; and
- reduce health inequalities.

Mandating the five universal health visitor reviews in Regulations, subject to Parliamentary approval, would ensure continued provision of evidence-based universal services, supporting the best start for all children and enabling impact to be measured.

The draft Regulations are being made under Section 6C of the NHS Act 2006 and are time-limited for an 18 month period, unless further legislation is made that continues the provisions in force. The Regulations make provision such that if a review takes place, it must be completed and the resulting report published by 30 March 2017. The intention is that a review will be carried out by DH with input from Public Health England (PHE).

This equalities analysis will focus on the process taken by the Department for agreeing which elements of the HCP the Government intends to mandate from 1 October 2015 for 18 months, the process through which the sun setting clause was agreed and plans for the intended review. It will consider the impact of mandating the 5 universal health visitor reviews, and where needed

will reflect on decisions taken previously which have impacted on the decision to mandate some elements of the HCP.

4 Who will be affected?

The requirement that the 5 mandated services be commissioned will apply to all LAs.

All children aged 0-5 and their families (service users): The Regulations should have a neutral or positive impact on service users with relevant protected characteristics, such as pregnant women and mothers and disabled children. LAs will be expected to provide the same level of service as the NHS at the point of transfer and act with a view to securing continuous improvement in the uptake of these reviews. It is expected that service users should see no difference between the service provided before the transfer and that provided after it. The transfer of commissioning responsibility from NHS England to LAs will join up 0-5 children's public health services with existing 5-19 services. This will support delivery of improved outcomes for children.

Health visitors: The key consideration for the Department and national partners (NHS England and PHE) in the transfer of commissioning responsibilities for 0-5 children's public health services is to ensure a stable transition process, which will maintain service continuity and support the continued development of the service. There should therefore be little or no impact on health visitors.

Service commissioners: *Healthy Lives, Healthy People: Update and Way forward*⁴ set out the Government's intention to change commissioning arrangements for 0-5 children's public health services. The Government always intended that children's 0-5 public health service commissioning should be part of LAs' duty to improve the public health of their populations (see also the 'Background' section of this analysis). The Government intends to put in place Regulations that mandate LAs to provide specific elements of the HCP (the 5 universal health visitor reviews) and hence will impact LAs by broadening the scope of their commissioning role. In the context of commissioning the wider 0-5 programme, this is expected to have a positive impact on LAs commissioners, enabling them to provide a joined up service for 0-19 year olds, with better linkage to other services including: special educational needs, other children's/early years services, housing and disability.

⁴ <https://www.gov.uk/government/publications/healthy-lives-healthy-people-update-and-way-forward>

5 Evidence

The analysis has considered a broad range of relevant source material to provide evidence about the equality implications of mandating the 5 reviews in the Regulations. In general, cross-references to the sources, especially weblinks, have either been inserted within the main text of the document, or is footnoted.

A document with specific relevance to our analysis of mandation on those with protected characteristics is the Equality Analysis for the Health Visiting Programme, (2012), link below.

[Link:https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212891/Equality-Analysis-Health-Visiting-Programme-PDF-148K.pdf]

A full Equality Analysis has also been completed for the methodology the Department have used to determine local authority allocations. A high level summary has been given in this document, but the full document can be accessed using the following link. [Link: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/403984/Equality_Analysis.pdf]

Context:

The current National Health Visiting Core Service Specification was published by NHS England (October 2014). [Link: <http://www.england.nhs.uk/ourwork/qual-clin-lead/hlth-vistg-prog/info/docs-res/#serv-spec>]

It describes the health visiting service workforce as consisting of specialist community public health nurses (SCPHN) and teams who provide expert information, assessments and interventions for babies, children and families, including first time mothers and fathers and families with complex needs. Health visitors help to empower parents to make decisions that affect their family's health and wellbeing and their role is central to improving the health outcomes of populations and reducing inequalities.

(i) Consideration of broad-based evidence

The same national specification also states that..... *'Giving every child the best start in life is crucial to reducing health inequalities across the life course. The foundations for virtually every aspect of human development – physical, intellectual and emotional – are set in place during pregnancy and in early childhood. What happens during these early years has lifelong effects on many aspects of health and wellbeing, educational achievement and economic status. Universal and specialist public health services for children are important in promoting the health and wellbeing of all children and reducing inequalities including:*

- *delivery of the HCP;*
- *assessment and intervention when a need is identified; and*
- *on-going work with children and families with multiple, complex or safeguarding needs in partnership with other key services including early years, children's social care and primary care.*

Successive academic and economic reviews have demonstrated the economic and social value of prevention and early intervention programmes in pregnancy and the early years. It is acknowledged that in many ways the evidence-base for improved health, social and educational outcomes from a systematic approach to early child development has never been stronger.'

Government intends to mandate in Regulations, the 5 universal health visitor reviews from the HCP and the benefits of this, along with those of an expanded health visitor workforce and service transformation are intended to positively impact upon the 0–5 group, mothers and families on a population-wide basis.

The five universal reviews will provide a robust generic basis from which the service can benefit the children, mothers and families. With regards to the nine protected characteristic groups, the greatest impact of mandation is on the 'pregnancy and maternity' category and this is where our evidence is greatest. This analysis also explores the extent to which mandation impacts other characteristic groups; coverage of all groups is set out below:

(ii) Determination of local authority funding allocations and consideration of equality impact

The Department and its partners have undertaken considerable work to determine LA allocations for their new role in commissioning 0-5 children's public health services from 1 October 2015. Decisions taken, in determining the methodology used have been scrutinised and assessed for their impact on equality and health inequalities.

Lift and shift and mid-year transfer

This is a high level outline of the decisions taken by the Department in determining LA allocations for commissioning of children's public health services between 1 October 2015 and 31 March 2016. A fuller explanation can be seen in the equality analysis, (published alongside the final allocations) that also provides information about the decision to undertake a mid-year transfer and the methods used to determine LA allocations, [Link: <https://www.gov.uk/government/publications/ring-fenced-public-health-grants-to-local-authorities-2013-14-and-2014-15>].

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

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

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

The Baseline Agreement Exercise

Proposed allocations (published in the Baseline Agreement Exercise) were determined over a number of months, and a three stage process:

Stage 1: NHS England completed the initial return in June 2014, including: data on current spend on 0-5 services transferring; information on current contracts; and future plans. This resulted in an expectation that costs for 2015/16 would be higher than in 2014/15 due to the full year effect of the 4200 increase in health visitors and FNP places.

Stage 2: NHS England and LA's completed the second return in September 2014; this refined the numbers collected in June and disaggregated them by LA. To demonstrate that local agreement had been reached, NHS England were asked to get sign off from LAs and sharing of information was expected using the principles of open book accounting.

This process and resulting potential impacts on equality considerations informed changes to NHS England's funding and the proposed local authority allocations. We found:

- potential for commissioning costs to be higher in LAs than they have been in NHS organisations because of the increase in the number of commissioning organisations, which may have diverted funding from delivery of services, and potentially increased health inequalities.
- inconsistencies in the treatment of Commissioning for Quality and Innovation payments (CQUIN) and inflationary measures across the proposed local authority allocations, which may have led to inequality in the levels of service provided, and.
- variations in the level of spend per head across the country, which may impact on the levels of service which are able to be provided for 0-5s. [see [link to spreadsheet](#)⁵]

More detail on the resulting changes can be seen in the [Baseline Agreement Exercise](#)⁶. At a high level this publication included:

- CQUIN payments where it is integral to how providers meet costs, applying 2014/15 prices in 2015/16, unless there was good reason to do otherwise;
- provision for an additional £2m (half year) to cover additional local authority commissioning costs; and
- putting in place a minimum floor to the amount of resource on adjusted spend per head (0-5) of £160, below which no local authority should fall. This is a positive step for LAs falling at the bottom of funding distribution.

⁵https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/402466/Minimum_Floor_Calculations_locked.xlsx

⁶ <https://www.gov.uk/government/publications/allocation-of-funding-for-0-5-public-health-services>

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

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

Stage 3: Proposed allocations were published in the [Baseline Agreement Exercise](#)⁷ on 11 December 2014. LAs were given five weeks to respond, informing the Department of any factual changes to the figures or any of the changes made as a result of local discussion or to comment and raise concern regarding the accuracy of their allocations. If LAs were content with their allocation as proposed in the Baseline Agreement Exercise, we did not ask them to respond. The Baseline Agreement Exercise closed on the 16 January 2015.

The Department received responses from 62 LAs, of which 12 stated their agreement with the amount proposed. The remaining 50 LAs raised queries, requested additional funding, or notified the Department of a locally agreed adjustment. 90 LAs did not respond, implying they had no issues with the allocation as proposed in the Baseline Agreement Exercise.

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

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

Final LA allocations

Most LA allocations were published in the Department's response to the [Baseline Agreement Exercise](#)⁷, 'Final Allocations for 2015/16' in February 2015, link: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/403983/Allocations_15-16.pdf

⁷ <https://www.gov.uk/government/publications/allocation-of-funding-for-0-5-public-health-services>

A small number of LAs have raised specific issues in respect of whether the amounts transferring are a proper reflection of the lift and shift of the service in their area which, after examination, the Department consider merit further analysis and understanding prior to concluding final allocations. The Department's view is that these issues require further discussions between the current commissioners (NHS England), the local authority and the provider. They should be considered as part of local discussion that are already taking place with NHS England and specifically as part of the contracting process. We expect to publish allocations for the remaining 13 LAs by the end of March.

LAs where allocations have not yet been finalised are identified with an asterisk in Annex 1 of the Final Allocations for 2015/16 document.

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

In some other areas final allocations are announced. However LAs and NHS England have indicated to the Department/PHE there may be further local conversations about in-year adjustments to reflect any changes needed to the baseline allocation as a result of local circumstances. The in-year adjustment process is available to all LAs, though this is without prejudice to the outcome. Any material changes to transfer amounts can be agreed locally, and funding transferred accordingly. Sector-led advice and support will be available from PHE and the Regional Oversight Groups to help parties reach agreement. Any recurrent adjustments which are agreed will be included in the baseline for 2016/17 allocations. This further supports the notion that the impact of this transfer on senders, receivers and service users remains minimal.

(iii) Reviewing the mandated arrangements

The draft Regulations are being made under Section 6C of the NHS Act 2006, and subject to Parliamentary approval, the aim is that the Regulations will be in place which provide for a 'sunset clause' at 18 months that will have the effect of ending mandation, unless further legislation is made that continues the provisions in force.

The Department intends to carry out a review of the new mandated commissioning arrangement (involving Public Health England), and publish a report on the review before 30 March 2017. This will inform future commissioning arrangements.

6 Evidence by protected characteristic

6.1 Disability

The equalities assessment for the Health Visitor Programme, states that, “*Failure to meet the health needs of children and young people can lead to problems or difficulties in the future and have a profound impact on their adult health*’. The principle of ‘early help’ delivered via the 5 reviews is crucial to identifying need, including identifying disabilities in children so that specialist services can be put in place for them and their families as early in their lives as possible.

Early help and the signposting of specialist services for children with a disability is therefore part of the core offer. Mandation of the five reviews in Regulations will help to encourage early identification of disabilities and timely provision of specialist support. It will also encourage joint working with key partners including social care services.

The study “*Health visiting: the voice of service users. Learning from service users’ experiences to*

inform the development of UK health visiting, (National Nursing Research Unit (NNRU) at the Florence Nightingale School of Nursing and Midwifery, King’s College London, 2013), illustrates the role of the health visitor in relation to a child diagnosed with a physical disability:the health visitor was the professional who provided continuity of support to the family through this difficult time when “*there really wasn’t anybody to talk to.....The health visitor visited the family regularly while they were waiting for treatment and identified groups and activities that might help mother and daughter...*” thereby having the effect of helping to eliminate discrimination, advance opportunity and foster good relations between children with a disability and others.

Link to Equality Analysis for the Health Visitor Programme:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212891/Equality-Analysis-Health-Visiting-Programme-PDF-148K.pdf

Link to the NNRU study available at:

<http://www.kcl.ac.uk/nursing/research/nnr/publications/Reports/Voice-of-service-user-report-July-2013-FINAL.pdf>

6.2 Sex

The policy intention is to continue to improve health outcomes by ensuring continuation of universal health visiting provision and targeted services like FNP, offering family health services. Delivery of the five reviews under the Regulations, supports families, ensuring information about a range of signposted services and potential interventions is available for those with greater needs. It also ‘champions’ wider health and wellbeing, prevention and public

health and the building of family and community capacity. This has a particular impact on women (and pregnant woman), and on socio- economically disadvantaged children.

6.3 Race

Evidence from the *Equality Analysis for the Health Visiting Programme* suggests that some BME groups are disproportionately represented in socially disadvantaged groups.

Delivery of the five mandated reviews would be expected to strengthen health visitors' role in delivering the HCP in a range of settings and to different BME groups within the community, supporting equality of opportunity.

This role will continue to be supported by initiatives such as *Building Community Capacity* training. [link: <http://www.e-lfh.org.uk/projects/building-community-capacity/>] This is a professional development package for health visitors, which combines learning through education materials and practical application in the workplace and local community. It supports health visitors and their teams to better understand their interaction with their local population and communities including BME groups.

In the context of the local *Joint Strategic Needs Assessment* [link: <http://www.hscic.gov.uk/jsna>]

health visiting teams are encouraged to adapt services so that a universal offer is available to all parts of the community they serve with an understanding of cultural attitudes to family health. This may involve working with local community groups and providing services in appropriate venues or locations so delivering equality of opportunity.

In “*The role of the specialist health visitor when working with Gypsy and Traveller Families*”, (Sheila Lally , Apr 2014) [Link: <http://www.magonlinelibrary.com/doi/full/10.12968/johv.2014.2.4.208>]

The study points out, “*as health visitors, we need to be aware of the social and health inequalities experienced by Gypsies and travellers, and act to influence the design of inclusive services—services that are culturally sensitive and accessible to the most vulnerable group living in our society*”.

Mandation of the five key reviews will put the service would be expected to help increase local providers' awareness of specific need, take/signpost actions and help ensure the wider context (strategic planning tools etc) are able to take into account particular BME communities' needs that are identified by health visitors.

6.4 Age

The health visiting service serves those ages 0-5 and their families and discharge of the duties in the Regulations will therefore have a greater impact on this group, than those in different age categories. Delivery of the 5 reviews will better enable health visitors to utilise the professional

pathways for midwives, health visitors and school nurses to ensure effective join-up of services for children, young people and families from pregnancy to 19 years.

For example, “*Health Visiting and School Nursing Programmes: supporting implementation of the new service model: School nursing and health visiting partnership*”, (DH 2013) [Link:https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216466/dh_133020.pdf] provides a structured approach to addressing the common issues identified by both professionals associated with the transition of a family and child from health visiting to school nursing services. The pathway builds on good practice and provides a systematic solution-focused approach on which to base future local practice. It focuses on addressing the support required for children, primarily aged between 3 and 6 years. As such, information gathered from the mandated reviews, especially the 2-2½ year review is key in ensuring the range of children’s needs are taken on board.

6.5 Gender reassignment (including transgender)

We have searched relevant studies for potential evidence in this area of the protected characteristics, no evidence of impact of mandating these elements has been noted; impacts of the policy are less likely on this group. (See also broader expectations of LAs taking forward their own roles in relation to equality duties – ‘action plan’ section refers.)

6.6 Sexual orientation

We have searched relevant studies for potential evidence in this area of the protected characteristics, no evidence of impact of mandating these elements has been noted;. (See also broader expectations of LAs taking forward their own roles relating to equality duties – ‘action plan’ section refers.)

Health visitors offer same sex parents HCP services and mandation of the five reviews should support delivery of the HCP to all parents, including those who are lesbian, gay and bisexual.

Health visitors are trained to work sensitively with people in same-sex relationships and there is a strong theme throughout their training of being non - judgemental and supportive of the diverse range of individuals and families with whom health visitor teams come into contact.

Additionally, health visitors are bound by the NMC code of conduct and have a duty to not discriminate against any group.

6.6 Religion or belief

We have searched relevant studies for potential evidence in this area of the protected characteristics, no evidence of impact of mandating these elements has been noted. (See also broader expectations of LAs taking forward their own roles in relation to equality duties – ‘action plan’ section refers.)

Health visitors are trained to work sensitively with people from different faiths. Delivery of the five mandated reviews would be expected to strengthen health visitors’ role in leading the delivery of the HCP in a range of settings and to different religious groups within the community, supporting equality of opportunity.

6.7 Pregnancy and maternity

There is an abundance of evidence relating to health visitors’ impact on children and families. The mandated reviews will provide the platform to help maximise this role, improving health outcomes for pregnant mothers, babies and families as a whole, therefore advancing the equality of opportunity, and eliminating discrimination between those from the pregnancy and maternity protected characteristic group and others.

The *1001 Critical Days* report [link:

<http://www.andrealeadsom.com/downloads/1001cdmanifesto.pdf>] sets out evidence emphasising the importance of making the most of interventions and early detection at a time described as ‘*a critical window of opportunity, when parents are especially receptive to offers of advice and support*’ Early intervention can better support:

- The child’s cognitive development;
- reduction of stress for both mother and baby; and
- attachment between the mother and care giver.

The report also points to the findings from international studies which suggest that, ‘*when a baby’s development falls behind the norm during the first year of life, it is then much more likely to fall even further behind in subsequent years,*’ again emphasising the important nature of the 5 mandated reviews and their role in advancing equality of opportunity between those from the pregnancy and maternity protected characteristic group and others.

Likewise, the Allen report “*Early Intervention, the Next Steps*” (Jan 2011) [link:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/284086/early-intervention-next-steps2.pdf] also emphasises these areas.

‘The case, then, is for early intervention programmes as a means to help all children acquire the social and emotional foundation they need. We are missing an opportunity if we don’t prevent problems before they arise. It is vital that a focus on the early years is placed at the heart of the policy making process.’

Mandating the 5 reviews, provides health visitors with the opportunity to convey to all families the benefits of their specialist training, including the programme’s recent investment in health visitor training for domestic violence/abuse and in peri-natal mental health. ‘*Inequity in provision of and access to health visiting postnatal depression services, May 2011*’ [link:

<http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2648.2011.05669.x/full>]

One particular area where mandation of the five reviews will support women is in the area of perinatal mental health. Maternal depression and anxiety in pregnancy and during a child's early life affects 10-15% of pregnant women. With the birth rate at just under 700,000 per year, this means that around 100,000 women every year would be expected to experience some type of pregnancy-related mental health issue. The NSPCC's "*Spotlight on Perinatal Mental Health*" (2013), report [link: <http://www.nspcc.org.uk/globalassets/documents/research-reports/all-babies-count-spotlight-perinatal-mental-health.pdf>] estimates 3,000 women a year develop postpartum psychosis.

As part of the transformation of the health visiting service, health visitors have been given the opportunity to undertake additional training on maternal mental health. This has covered fundamental requirements necessary for health visitors to manage anxiety, mild to moderate depression and other perinatal mental disorder - either by intervening themselves or through referral on to GP or specialist. This training enables participants to become local perinatal mental health champions and to disseminate their skills and knowledge locally. All health visitors also have access to supportive interactive e-learning modules to help them in the detection and management of perinatal depression and other maternal mental health conditions.

Health visitors have also had the opportunity to undertake additional training to gain skills in assessing maternal mental health, including the use of assessment and screening tools such as the *Edinburgh Postnatal Depression Scale* (recommended by NICE), alongside their professional judgement. In more serious cases they have been trained to work with other professions such as GPs, child and adolescent mental health services and social care to ensure the baby's wellbeing, and support the woman and her family through recovery. Furthermore, over 500 health visitors across England have been trained by the Institute of Health Visitors (iHV) to become perinatal mental health 'champions.'

Separately, around 300 health visitors have undertaken domestic violence and abuse training via iHV under a parallel 'champions' model, aided by an e-learning support initiative.

The mandated reviews provide an excellent opportunity to utilise this additional training.

6.8 Carers

Health visitors will routinely assess, signpost and refer families when extra help and support is required - this may be the case if there are carers within the family. .

The 2011 census (ONS Statistics) ([link⁸](#)) showed there were 166,363 young carers in England (aged 5-17), an increase of 19% since 2001. Facts from Barnardo's [link:

⁸ <http://www.ons.gov.uk/ons/rel/census/2011-census-analysis/provision-of-unpaid-care-in-england-and-wales--2011/sty-unpaid-care.html>

http://www.barnardos.org.uk/what_we_do/our_work/young_carers/young_carers_real_stories.htm

state that the average age of a young carer is 12. More than half of young carers live in one-parent families and almost a third care for someone with mental health problems.

It is anticipated that young carers in particular, are a group where health outcomes can be affected by their caring responsibilities –The [Young Carers Pathway](#)⁹ details how LAs, schools and nurses can work together to identify and support young carers. LAs may, as a result of their new role in commissioning the proposed mandated services (alongside their established role in commissioning 5-19 years services), find they are better placed to consider opportunities for integrating/improving those services relating to young carers in England.

The proposed five mandated reviews mandated in Regulations will maximise the health visitor team's opportunities to identify young carers and in the context of the wider 0- 19 Health Child Programme, ensure they are properly supported – this helps advance equality of opportunity for carers.

6.9 Other identified groups

Socio-economic status has a significant impact on health inequalities amongst children. There is evidence in the Public Health White Paper, *Healthy Lives, Health People Impact Assessment*, [link: <https://www.gov.uk/government/publications/healthy-lives-healthy-people-impact-assessments>]

that children born to lower socio-economic groups are more likely to be of low birth weight, die in the first year of life and to suffer significant episodes of mortality. This assessment highlights the importance of '*continuation of universal health visiting provision, offering family health services with more extended contracts to support new families and a range of interventions for those with greater*

needs,' and links this to the wider health and wellbeing, prevention and public health. It points out that this is likely to have a particular impact on women (and pregnant women) and socio-economically disadvantaged children.

Health visitors initiate or help with a wide range of interventions with parents, for example increasing breast-feeding rates, which are known to be lowest in the lower socio-economic groups. In 1995, 37.7 per cent of women in the lowest socioeconomic group were breastfeeding their babies at 6 months, compared with 53.1 per cent of women in the highest socioeconomic group. In 2004/05, the proportions in these two groups were 37.1 per cent and 66 per cent, respectively. It is anticipated mandation of the five reviews will help improve access amid the most disadvantaged group of mothers and thus bolster equality of opportunity among this, (shared characteristic) group.

⁹https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/299270/Young_Carers_pathway_Interactive_FINAL.pdf

7 Engagement and involvement

7.1 Was this work subject to the requirements of the cross-government Code of Practice on Consultation.

There was no statutory requirement to consult on these mandate Regulations. Potential mandation of elements of the HCP was set out in ‘*Healthy Lives Healthy People – Update and Way Forward*’, which was itself subject to wide consultation. [Link: <https://www.gov.uk/government/publications/healthy-lives-healthy-people-update-and-way-forward>]

7.2 Have you engaged stakeholders in gathering evidence or testing the evidence available?

The evidence-base that highlights the importance of early intervention, prevention and signposting by health visitors of specialist services is well established and a range of stakeholders engaged with the Department between 2011 and 2013 to discuss development of the programme and associated actions that took forward ‘*The Health Visitor Implementation Plan – A Call to Action*’ (February 2011). [Link: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213759/dh_124208.pdf]

Against the above background it was not necessary to run a formal consultation. However, the Department has also engaged with a number of key stakeholders using various routes including via the:

- *0–5 years Public Health Commissioning Transfer Programme Board*. The purpose of this has been to provide assurance that the overall direction and management of the joint programme (ie. undertaken with DH’s partners), will successfully deliver the required outcomes. In summary its role is to:
 - lead on the assurance of the overall programme of transition of 0-5 Healthy Child commissioning to LAs on behalf of sender and receiver organisations;
 - be a place where sender (commissioning) and receiver (LAs) organisations come together to make decisions;
 - be the policy holder of the programme through accountability to Ministers; and
 - be a decision making body supported by clear escalation routes to resolve specific issues i.e. through Director General or Director led 1:1s, or through relevant reporting boards.

The Board recognises that local government representatives are from member organisations and therefore cannot commit LAs to particular actions, but can represent their views and advise

on the most acceptable options to inform national policy and approach, and agree actions for the representative bodies.

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

*also comprises the following sub groups: finance and contracting, data and Information, preparedness and assurance, and communications.

Informal meetings and conversations: the Department has a professional officer for health visiting, who has formal and informal contact with the service. She also has formal links with the Community Practitioners Health Visitor Association (CPHVA) and iHV. Members of the health visiting policy team have had informal conversations with practicing health visitors and visited a service in 2014 to gain an insight into how these changes would affect the service.

The independent Health Visitor Taskforce: comprising representatives of specific stakeholders and acts as a 'critical friend' to the Department, has been kept updated with progress, with its views being played into broader decisions at policy level.

LA allocations for 2015-16: In determining LA allocations, the Department led an engagement exercise (from the 11 December 2014 to the 16 January 2015) on the proposed allocations, as set out in the [Baseline Agreement Exercise](#). LAs were asked to let the Department know of any factual changes to the figures or any of the changes made as a result of local discussion. LAs were offered support through Regional Oversight Groups (PHE, LGA and NHS England) to support LAs in facilities agreements and identifying supportive information.

Most local authority allocations have been published in the 'Transfer of 0-5 children's public health commissioning to local authorities: Allocations for 2015/16,' [link at:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/403983/Allocations_15-16.pdf

In response, where stakeholders have raised specific issues in respect of whether the amounts transferring are a proper reflection of the lift and shift of the service in their area which, after examination, the Department considered merit further analysis and understanding prior to concluding final allocations. The Department believes that these issues require further discussions between the current commissioners (NHS England), the LA and the provider. They should be considered as part of local discussions that are already taking place with NHS England and specifically as part of the contracting process. We expect to publish allocations for remaining LAs by the end of March 2015. LAs where allocations have not yet been finalised are [at the time of writing], identified with an asterisk in annex 1 of the allocations for 2015/16 document.

7.3 Have you involved stakeholder in testing the policy or programme of proposals?

Since 2013, the Department has worked alongside the partner organisations who deliver the national Health Visitor Programme (NHS England, PHE, Health Education England), thus ensuring broad based organisational input has been used in the testing and aligning of the evidence base with next steps actions relating to transition of 0 – 5 years public health services, including plans to mandate the 5 reviews.

In parallel with this, the Department established infrastructure described above to help oversee implementation of the activity relating to the broader transfer of the 0–5 children’s public health service commissioning function to LAs from October 2015.

This has been conducive to the Department working with key partners including:

- the Local Government Association (LGA)
- Society of Local Authority Chief Executives (SOLACE)
- Association of Directors of Child Services (ADCS)
- Association of Directors of Public Health (ADPH)

Engaging such bodies about the nature of mandated services and operational/logistical aspects of them being implemented, including the timing of mandating the universal health visitor reviews, has been invaluable.

The Department has also ensured that professional leads and senior managers in the Department have spent time with services and front line staff. The Director of Nursing (DH PHE) has professional lead for health visiting and has worked with professionals and partners throughout the programmes development. We have used a variety of face to face, hard copy and social media to enable ongoing dialogue.

Furthermore, a series of regional events run by the LGA, took place in autumn 2014, link:

http://www.local.gov.uk/events/-/journal_content/56/10180/6372084/

These provided an opportunity for further local stakeholder debate (many participants being from a commissioning background) on the impact of mandating and the wider transfer of 0 – 5 public health services.

7.4 Stakeholder participation activities

Contact with stakeholders about mandating the five reviews has been ongoing . More recently, the ‘*Preparedness*’ sub group of the ‘*0 – 5 years Public Health Commissioning Transfer Programme Board*’ has engaged with a range of stakeholders to better understand and help address logistical issues associated with both transition of 0 – 5 years services in general as well as the 5 mandated reviews.

Also, the finance and contracting sub group met to talk about the logistics of the financial transfer to LAs and the impact it may have. Through this group we have engaged with the LGA, NHS England Teams, DCLG and LAs as well as the core national groups, PHE, NHS England and DH colleagues.

As stated above, the Department's professional leadership role has also undertaken informal liaison and engagement with key organisations including: the Royal College of Nursing, the Nursing and Midwifery Council, the CPHVA and the Institute of Health Visiting.

More generally, the Department has utilised dedicated communications resource to publish material, (such as factsheets and frequently asked questions), with a view to keeping stakeholders up to date with plans relating to both 0 – 5 public health services in general, as well as those relating to mandation of the 5 reviews, for example through material at the following links:

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

<http://www.local.gov.uk/documents/10180/6410150/Transfer+of+0-5+children%27s+public+health+commissioning+to+local+authorities+finance+issues/570e8a83-2e91-4cf0-887a-6bcf25674894>

8 Summary of Analysis

The sections above that focus on the protected and other characteristic groups contain the details of our broad analysis of the evidence related to anticipated impact on equality of mandating elements of 0 – 5 years services through Regulations. The most obvious impact area of the protected characteristic groups is ‘pregnancy and maternity’, along with ‘sex’ (focus on women/maternal health), though the analysis has investigated evidence re: all groups.

8.1 Eliminate discrimination, harassment and victimisation

Our analysis found no evidence to suggest the requirements to set out in Regulations to provide the five reviews as part of the 0 – 5 children’s public health services impacts this area.

8.2 Advance equality of opportunity

The proposed mandation requirements in Regulations of LAs to undertake the 5 reviews will support delivery of all families’ access to the HCP. Whilst it is not intended to suggest that the full scope of the HCP is covered simply by the 5 reviews, their delivery will provide a ‘gateway’ to identify additional needs that the HCP guidance addresses.

8.3 Promote good relations between groups

There is no evidence to suggest that the requirements set out in Regulations to provide the five reviews as part of the delivery of 0 – 5 years children’s public health services is a cause of tension within or between the protected characteristic groups.

8.4 What is the overall impact?

Based on the evidence available and consultation with partners to date, it is expected that the proposed mandation in Regulations of the 5 reviews will in general have a neutral or slightly positive impact.

Mandation of these reviews in Regulations will help ensure the ongoing provision of the universal health visiting service, which is essential to supporting the health and well-being of families and children at critical stages of development.

In designing the mandation requirements, the intention is that expectations of local authorities be clear. These services are not currently being delivered at 100% coverage across the country, (and mandation of these services does not impose an absolute requirement on LAs that coverage should be 100%). The expectation is that uptake of the five mandated reviews will continue to be delivered, and, as with other already mandated functions, LAs must act with a view to securing continuous improvement in their uptake. This expectation, and the delivery of the mandated reviews, is “as far as reasonably practicable”. That is, there would not be an

expectation that delivery of the reviews will suddenly be expected to be 100% after the point of transfer.

There is no evidence that requiring provision of the five reviews in Regulations will impact differentially on individuals/groups/the protected characteristics. It is anticipated that LAs are public authorities, subject in their own right to the equality duties, they will want to utilise increasing levels of outcome data to support them in their ongoing responsibilities to consider removing or minimising any disadvantages that might emerge vis a vis certain groups of service users. In this vein, LAs will be able to use the evidence available locally (e.g. from JSNAs) to inform their commissioning to ensure equitable delivery.

At a national level, it is anticipated that the review of the Regulations that is intended to be carried out and reported on by 30th March 2017, will be able to consider this point from an equality perspective (i.e. by looking at whether mandation of the 5 reviews has resulted in a reduced broader level of 0 – 5 years services, and if so, whether there is impact on specific individuals/groups).

8.5 Addressing the impact on equalities

Mandation of the five reviews in Regulations is likely to ensure people using the service with the protected characteristics can be assured of access to services which meet their/ families' needs, (see 'action planning for improvement' below for context).

9 Action planning for improvement

The analysis has not identified any major risks or service ‘gaps’ vis a vis the protected characteristic groups.

Against the background of the expectation that LAs take a reasonable approach to the duty to provide or make arrangements for universal health visitor reviews and discharge appropriately their duty of continuous improvement. Then going forward, as LAs take the lead for commissioning these services, it is anticipated they will want to utilise the range of information sources (*details* in section below), that help review commissioning decisions etc. Such mechanisms will help ensure that local needs are addressed within a national policy framework. In particular, the local JSNA and Health and Wellbeing Strategy will help identify local public health needs and therefore help guide LAs in commissioning these services.

The achievement of each LA in improving their local population’s public health will be shown by the Public Health Outcome Framework indicators, which each LA will have to give regard to. The indicators for each LA will be published annually by PHE.

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

It is acknowledged that there is likely to be a need to monitor if any ‘perverse incentives’ are created as a result of the focus on the 5 mandated reviews, (e.g. LAs actually reducing aspects of the broader 0 – 5 years service as a result of the requirements in Regulations to offer the mandated reviews). Here, it is anticipated that the intended review of the mandated arrangements that DH would lead on (with input from PHE), to be completed by 30th March 2017, and will examine whether the proposed focus on 5 mandated reviews has in any way led to an imbalance of commissioning across the broader 0 – 5 years service .

10 Next steps, challenges and opportunities

The Section 7A (NHS Act 2006) between the Secretary of State (SoS) and NHS England, under which NHS England carries out specified SoS public health functions, sets out the outcomes to be achieved by NHS England and arrangements for funding from the public health budget. The agreement helps set out, at a high level, what should be delivered by the 0 – 5 years service - currently commissioned by NHS England. It ceases to have effect on 1st October 2015 when responsibility for commissioning the wider service, including the 5 reviews mandated in Regulations, moves to LAs.

LAs have full autonomy in spending the additional funding for commissioning children's 0-5 public health services that will be transferred into their ring-fenced public health budget on services that are locally identified as best targeting the local population's public health needs.

There are mechanisms that will help ensure that local needs are addressed within a national policy framework. A local JSNA and Health and Wellbeing Strategy will be written in each LA to help identify local public health needs and therefore help guide LAs in deciding which services (over and above the mandated ones) to commission. The achievement of each LA in improving their local population's public health will be shown by the PHOF indicators, which each LA will have to have regard to. The indicators for each LA will be published annually by PHE. These mechanisms justify the *default* position of giving LAs full autonomy in commissioning services with the ring-fenced public health budget to best address local public health needs

Indications are that LAs are positive about commissioning 0-5 public health services as an opportunity to join universal and early intervention to benefit local families and communities.

It is acknowledged that as the broader infrastructure of demonstrating delivery of these services changes, LAs will want to adjudge for themselves the success of the new mandated arrangements. At this stage the Department and its partners have been working to establish the basis for supporting evaluation of the 5 reviews, (see also action plan template at rear).

The HCP itself goes forward as a key evidence-based document against which LAs can assess the mandated services' impact on inequality. The evidence, especially in relation to the 0-5 years group is continually being updated/reviewed as the outcomes of research is published. It is important for LAs that the new health visiting service is based on the latest evidence and topics included within the scope of the intended the evidence review include:

- parenting skills
- parent/infant attachment
- nutrition including breastfeeding, weaning guidelines and healthy diet/reducing obesity, latest evidence/best practice on growth monitoring
- speech, language and communication
- parental emotional and mental health (notably impact on outcomes for the child)

- perinatal mental health – assessment and management
- smoking / alcohol /drug misuse
- domestic violence
- unintentional injury in the home
- dealing with neglect

More generally, the Department and its partners are working with Directors of Public Health and Directors of Children’s Services, LAs’ elected members and officials and health visitor teams to make sure health visitors’ work is used to maximum effect and to highlight how the arrangements mandated in Regulations (the 5 reviews), play a key role in effective service delivery, and will help cement the role of those delivering the 5 reviews as being vital – for matters ranging from community development, to leading and providing universal services and expert support for families in difficulty.

The Department has summarised the transformed health visiting service as a **‘4 5 6 approach’**, ie. the four tiered service, five mandated elements and six high impact areas ([see annex 2 for diagrammatic explanation](#)). The Department and partners will continue to work with LAs providing evidence and sharing good practice in respect of how service elements can have most impact on improving services and outcomes locally.

The 6 High Impact Areas published in summer 2014, link: (<https://www.gov.uk/government/publications/commissioning-of-public-health-services-for-children>)

will support the new commissioning arrangements (sometimes known as transition), by articulating the contribution of health visitors to the 0-5 agenda, and describing areas where health visitors have a significant impact on health and wellbeing and improving outcomes for children, families and communities. As such they support the transition of responsibility for commissioning to LAs and help inform decisions around the commissioning of the health visiting service and of integrated children’s early years services.

Local authorities will want to ensure key indicators of local impact are going in the right direction – for example, progress can be demonstrated via relevant Public Health Outcome Framework indicators, (and ultimately the Maternity and Children Data Set (MCDS), the Child Health Information System (CHIS) data) and ‘early years’ profiles.

The *‘2015 – 16 National Health Visiting Core Service Specification’* sets out (at page 7) a range of outcomes which will be improved by an effective 0 – 5 years’ public health services, and these outcomes can help inform local authorities’ assessment of the service.

For example, *NHS England* and the *Child and Maternal Health Intelligence Network* have developed a health profile of public health outcomes relating to early years (children aged 0-5 years). *The Early Years Profiles* are designed to help commissioners and providers of health visiting services to assess service priorities/impact etc. Use of the profiles, will enable local

authorities to study how their specific area performs against key indicators and to compare the data with other authorities (and nationally).

<http://atlas.chimat.org.uk/IAS/dataviews/earlyyearsprofile>

It is possible to take each one of the six high impact areas as a conduit through which progress can be assessed via themes of: access, experience, outcomes and (over time), the impact on inequalities. In this sense, the health visitor service delivery metrics measure whether specific visits occurred, (as such represent health visitor activity). For example, for breastfeeding (initiation and duration), local authorities might want to consider how the 5 reviews mandated in the Regulations are impacting by considering the follows prompts:

Access: Implementation of evidence-based infant feeding policies,

evidence of up to date, evidence-based multi-agency infant feeding policies setting out best practice in relation to breastfeeding support.

- Experience: feedback from health visitor service user experience questionnaires on satisfaction with breast feeding support etc.
- Outcomes and links to impacting inequality: Public Health Outcomes Framework (PHOF) 2.2(ii) – {more details in National Service Specification}, breastfeeding prevalence at 6 – 8 weeks.
- Inequalities: Over time, the PHOF is likely to be able to demonstrate for example, increased duration of breastfeeding among those otherwise least likely to breastfeed.

Action plan template

This part of the template is to help you develop your action plan. You might want to change the categories in the first column to reflect the actions needed for your policy.

Category	Actions	Target date	Person responsible and their Directorate
Involvement and consultation	Engagement with local authorities (LAs) continues, so as to enable the Department (and its Health Visitor programme partners) to support them in establishing means to undertake assessment of the impact on equality of the new commissioning arrangements.	Ongoing	Nursing Division, Public Health Directorate
Data collection and evidencing	<p>The 0-5 Public Health Commissioning Transfer Programme Board has compiled a guide for local authorities to help them prepare for transition.</p> <p>As LAs are public authorities and are subject to the equality duty in their own right, they have an ongoing responsibility to consider removing or minimising disadvantages experienced by certain groups of service users.</p> <p>It is acknowledged at this point (pre-transfer of the commissioning role for 0 – 5 years services to LAs), that from a national perspective, the focus of data collection has been on aggregated data. However, it is intended that the strategic solutions (post-transfer), for ongoing data flows and reporting around the 5 reviews – including what</p>	<p>Ongoing - Autumn 2015</p> <p>Ongoing</p>	0-5 Public Health Commissioning Transfer Programme Board & its associate Data and Information sub-group.

	is currently known as the metrics data, will support LAs' delivery of equality assessments in the context of the 5 mandated reviews.		
Analysis of evidence and assessment	<p>The 0-5 Public Health Commissioning Transfer Programme Board to facilitate the means of analysis of evidence (as above). NHS England as current commissioners, LGA/LAs and provider organisations are all likely to contribute to development of potential means of analysis.</p> <p>LAs will be able to utilise this data in conjunction with evidence available locally (e.g. from JSNAs) to inform commissioning decisions so as to ensure equitable delivery.</p> <p>.</p>	<p>Ongoing to autumn 2015</p> <p>from October 2015</p>	
Monitoring, evaluating and reviewing	LAs are public authorities and are subject to the equality duty in their own right, they have an ongoing responsibility to consider removing or minimising disadvantages experienced by certain groups of service users.	From autumn 2015	LAs and local Directors of Public Health
Transparency (including publication)	<p>LAs will use available data to help adjudge impact of commissioning the 5 mandated reviews in relation to the 9 'protected characteristic' groups.....</p> <p>Joint determination of future data flows will contribute.</p>	Ongoing	0-5 Public Health Commissioning Transfer Programme Board & its associate Data and Information sub-group.

For the record

Name of person who carried out this assessment: Roger Wallis

Date assessment completed: March 2015

Name of responsible Director/Director General: Dr Felicity Harvey

Date assessment was signed: March 2015

Annex 1

Key points: the case for early intervention and importance of the five mandated reviews therein (taken from a DH synopsis on evidence of benefits).

There is a robust evidence base for the importance of early years in influencing outcomes and inequalities¹⁰ throughout life. How we treat 0-2 year-olds shapes their lives – and ultimately our society. Loving, secure and reliable relationships with parents, together with the quality of the home learning environment, foster a child's: emotional and mental wellbeing; capacity to form and maintain positive relationships with others; language and brain development (80% of brain cell development takes place by age three and ability to learn).¹¹

Health visitors are public health-trained nurses and early-years experts and as such **lead** the delivery of the evidence-based HCP¹² to improve health and wellbeing outcomes for young children and their families, working closely with Early Years, Children's Centres and primary care.

Summary:

Early childhood prevention - improving outcomes, reducing costs

- 2-5% of babies born each year who will have poor outcomes and will incur high costs for Governments and society over the years ahead
- Early experiences matter – critical programming for future development is set down in pregnancy and early life – a child's development at age 3 is highly predictive of its development at 5 and beyond
- Early parenting matters – some children don't have good early parenting experiences and this impacts on the whole life course development
- Pressure on intervention services such as health and social care is growing and is costly therefore focus on avoiding child maltreatment is essential and the need to work with vulnerable families paramount
- The case for prevention and early intervention has never been stronger

¹⁰ <http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review>

¹¹ http://www.wavetrust.org/sites/default/files/reports/conception-to-age-2-full-report_0.pdf

¹²

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf

- Advances in neuro-science and our understanding of pregnancy show just how important early life is for emotional and cognitive development of children
- A child's early experience, including in pregnancy, has a long lasting impact on the architecture of the brain, their behaviours and their development
- Pregnancy and early life is a sensitive period when adversities become biologically embedded – fetal programming
- Pregnancy and birth is a key time for change – mothers have an instinctive drive to protect their young and first time parents in particular want their child to be healthy and happy and do well in life
- There is scientific consensus that origins of adult disease are often found in pregnancy and infancy with a strong link to disadvantage
- Evidence based preventative interventions in early life can make a difference-to life long health and wellbeing, educational achievement, economic productivity and responsible citizenship throughout life and achieve significant cost savings

Benefits to children and mothers of the HV programme

- Improved ante-natal health and behaviours – less smoking, better nutrition, fewer infections
- Improved children's cognitive development, school readiness and academic achievement
- Better parenting
- Reduced child maltreatment and neglect
- Improved children's emotional and behavioural development
- Improved life course development
- Increased father involvement
- Reduced involvement of child crime and anti-social behaviour later in life
- Reduced A&E attendances and admissions

Evidence themes: the HCP evidence based universal programme to improve the health outcomes for children and young people

- From Neuro-science
- What works in prevention/health promotion
- Impact of early years on adult health
- Impact of parenting in early years on life chances
- Early intervention – long term investment
- Setting the scene – the underpinning evidence of what works in Child Public Health in the Foundation Years

Public health priorities

- Shift from focus on high rates of mortality from infectious diseases to concerns about millennial morbidities including:
 - Obesity and re-emergence of nutritional deficiencies Vit D, Iron and other micronutrients
 - Well-being/emotional health
 - Speech, language, communication and cognition
 - Keeping immunisation rates up

- Injury prevention/NAI (largest cause of A&E admissions)
- Adolescent lifestyle behaviours change (violence alcohol, drugs, smoking etc).
- Health inequalities

Role of health visitors in meeting these challenges

To lead and support delivery of preventative programmes for infants and children including Child health surveillance

Child Health Promotion and the HCP

The ten prime outcomes of the HCP are:

- Strong attachment
- Positive parenting
- Improved social/emotional well being
- Care which promotes health and safety
- Increased breast feeding
- Healthy nutrition and increased physical activity
- Prevention of communicable diseases
- Readiness for school and improved learning
- Early recognition of growth disorders and risk factors to obesity
- Early detection of deviations from normal physical and neuro developmental pathways

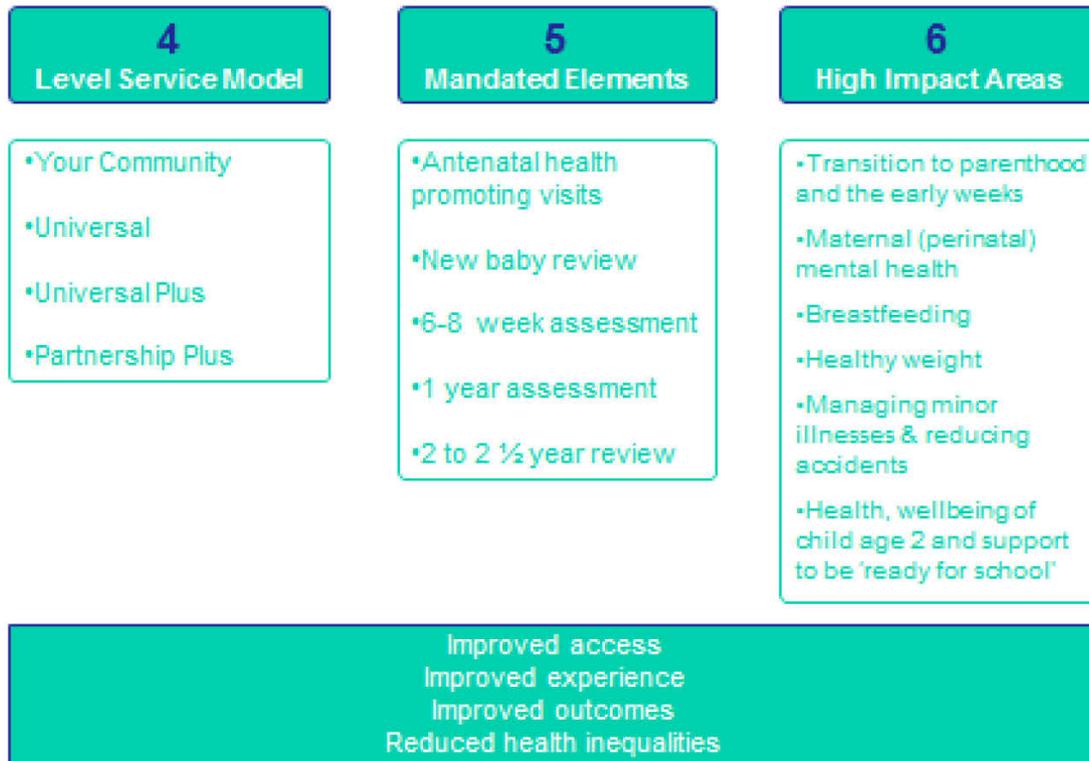
Specific topics include

- Screening
- Obesity/ nutrition
- Developing healthy lifestyles (parenting, Modelling, authoritative parenting, whole family approach, play inactivity and sleep)
- Immunisations
- Injury prevention (promoting hazard awareness, informing parents of where to access safety equipment and what, injury prevention advice)
- Speech, Communication and Language (early exposure to books and reading, importance of talking to your baby/encouraging child, rhymes and songs positive relationships that build and support communication)
- Social and emotional development (development of a secure and positive attachment between parent and child, authoritative and sensitive parenting, close relationships leading to growth of self assurance, structured environment, interaction, toilet training).

Annex 2

The '4 , 5 , 6' matrix to support future service delivery

4, 5, 6 – Transformed Health Visiting Services



Health visiting services use a 4 tiered progressive model to build community capacity to support children. This involves building community capacity to support parents of young children; universal reviews to identify need for early intervention and targeted services; targeted packages of care to meet identified need for example on early attachment, maternal mental health or breastfeeding or nutrition, and contributing and/or leading packages of integrated care for those identified as having complex needs or being at risk, including troubled families and safeguarding.

The 5 evidence-based reviews are the mandated HCP health and development assessments, reviews forming the basis for a range of preventive and early intervention services to meet need– the antenatal health promoting visit; new baby review; 6-8 week (health visiting) assessment; one year assessment and two to two and a half year review.

The 6 high impact outcomes of health visiting and 0-5 services contribute to setting the foundation for future health and wellbeing set out above. These six are the transition to parenthood and supporting early attachment; maternal mental health; breast-feeding; healthy weight; preventing accidents and managing minor illness, and development at two, underpinning school readiness