HEALTH & WELLBEING BOARD

Subject Heading:	Transfer of commissioning responsibility for health visiting services
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The subject matter of this report deals with the following priorities of the Health and Wellbeing Strategy

- ☐ Priority 1: Early help for vulnerable people
- ☐ Priority 2: Improved identification and support for people with dementia
- ☐ Priority 3: Earlier detection of cancer
- ☐ Priority 4: Tackling obesity
- ☐ Priority 5: Better integrated care for the ‘frail elderly’ population
- ☒ Priority 6: Better integrated care for vulnerable children
- ☐ Priority 7: Reducing avoidable hospital admissions
- ☐ Priority 8: Improve the quality of services to ensure that patient experience and long-term health outcomes are the best they can be

SUMMARY

The report describes the process whereby responsibility for the commissioning of health visiting services provided by NELFT transferred to the Council on 01/10/15.

At transfer, the service was under-resourced with a relatively small establishment of qualified health visitors and hence high case loads. As a result, the service is unable to deliver the national '4,5,6' model of health visiting in full. However, delivery of the mandated health reviews element of the service specification is similar to if not better than that in adjacent boroughs and the service has agreed to pilot new ways of working.

The cost of the service is charged to the Council's Public Health Allocation. It is unlikely that the Public Health Allocation will grow in the foreseeable future. Therefore further investment in health visiting would require disinvestment elsewhere and/or investment from other sources.

Health visitors have a central role in identifying and supporting families with additional needs; often in collaboration with colleagues from Children's Services and Learning and Achievement.

There is good evidence, supported by the views of local professionals, that improvements in prevention, early identification and intervention during the early years is both effective and cost effective – improving health, education and social outcomes and in so doing reducing the overall cost to the public purse.

On this basis, and despite the obvious financial obstacles, further improvement of the health visiting service as part of a coordinated early years offer spanning health, public health, children's services and learning and achievement should be a priority.

RECOMMENDATIONS

Members of the health and wellbeing board are asked to note the contents of the report.

REPORT DETAIL

1.0 Background

Health visitors are crucial to the delivery of the 0-5 element of the Healthy Child Programme (HCP) – the universal preventative service for improving the health and wellbeing of children, through health and development reviews, health promotion, parenting support, screening and immunisation programmes. The goals of the HCP are to identify and treat problems early, help parents to care well for their children, change health behaviours and protect against preventable diseases. The programme is based on a systematic review of evidence and is expected to prevent problems in child health and development and contribute to a reduction in health inequalities.

The final part of the transfer of public health responsibilities from the NHS to local government was delayed until 2015 whilst central Government made good on a 2010 commitment to increase the national health visitor workforce by 4,200 full time whole time equivalents (wtes).

This commitment was underpinned by evidence about the importance of the early years for developing emotional resilience and laying the foundations for good health and the role of health visitors in supporting families to achieve this.

Responsibility for the commissioning of health visiting eventually transferred on 1st October 2015.

In many areas, but not Havering, responsibility for commissioning Family Nurse Partnership (FNP) services also transferred. FNP is a targeted support service for teenage mothers. However FNP was never commissioned in Havering as the programme was focused on areas with higher numbers of first time teen mothers.

All health visitors remain employed by the relevant provider organisations i.e. for Havering, the North East London Foundation Trust (NELFT).

Commissioning responsibility for some resources relevant to the 0-5 HCP was retained by NHS England:-

- Child Health Information Systems (CHIS) in order to improve systems nationally. This will be reassessed in 2020.
- the six to eight week GP check (also known as the Child Health Surveillance) because of its complex commissioning arrangements.

2.0 Resources

2.1 Financial

Funding for health visiting for the period October 2015 to March 2016 is provided in the form of a one-off increase to the Council's public health allocation. As the transfer is intended to be a 'lift and shift', the additional funding was based on existing spending on health visiting services (and any spending on FNP) as captured in a baseline assessment exercise (BAE) undertaken by NHS England. Subsequently, the Dept. of Health established a minimum funding floor such that no local authority would receive less than £160 per child aged 0-4. Locally, spend per head on health visiting was only £118. Therefore, as a result of the minimum funding floor, the addition to the PH allocation to cover the cost of health visiting for the remaining half of 2015/16 is £350K more than the value of the existing contract between NHS England and NELFT. Thus, at the time of its announcement, it appeared that there would be the opportunity for significant additional investment.

Table 1: Existing spend, spend per head and final allocation for health visiting, London Borough of Havering and other boroughs in ONEL[1].

Local Authority	Existing spend identified in BAE (£000s) - Full year	Adjustments* post BAE (£000s) – Full year	Effective existing spend (£000s) - full year	Estimated population 0-4, 2015	Adjusted** spend per head (£)	New allocations (£000s) - Full year Increased to minimum of £160 per head of 0-4	New allocations (£000s) - Half year	New allocations, including commissioning costs (£000s) - Half year	Difference between existing spend and new allocation (£000s) - Half year
Barking & Dagenham	4,790	204	4,994	19,900	229	4,994	2,497	2,512	0
Redbridge	2,903	200	3,103	23,600	118	4,195	2,097	2,112	546
Waltham Forest	5,557	229	5,786	22,400	231	5,786	2,893	2,908	0
Havering	**1,856**	**150**	**2,006**	**15,500**	**118**	**2,714**	**1,357**	**1,372**	**354**

*In ONEL, existing spend was increased to raise contract overhead from 9 to 15%
** includes impact of market forces factor

However, following the election, the Treasury announced that the public health allocation to local authorities in England would be reduced by £200m or 7% in-year. The exact impact of this reduction at individual local authority level has still to be announced but assuming a 7% reduction is applied uniformly to all local authorities, the 15/16 allocation to Havering will be reduced by £690K thereby removing any opportunity for additional investment in health visiting this financial year.

In 2016/17 and beyond, monies for health visiting will be included within the overall public health allocation. The PH allocation for 16/17 will be announced in

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/465521/Minimum_Floor_Calculations.xlsx

December. As public health spending is not included within the NHS ring-fence and therefore liable to cuts in the forthcoming spending review, it is likely that the in-year cut applied in 2015/16 will be made recurrent and possibly further extended. Therefore, as the Council's public health allocation is already entirely committed, any additional investment in health visiting would probably require disinvestment from other services or securing investment from elsewhere.

2.2 Staffing at transfer

As noted above, the Health Visitor call to action (C2A) committed central government to increase the national health visitor complement by 4200 wtes by 2015. Unlike some neighbouring boroughs Havering did not benefit to any great extent from this growth so that the health visiting establishment at transfer remains small and the ratio of children to staff high.

Table 2: Growth in qualified Health Visitors posts resulting from the Call to Action (C2A) and ratio of children aged 0-4 to qualified health visitors posts; Havering and other boroughs in ONEL

	Establishment pre C2A (wte)	C2A growth (wte)	HV establishment at transfer (wte)	0-4 pop 2015	ratio 0-4 pop : HV posts
Barking and Dagenham	40.84	41.5	82.34	19900	242
Redbridge	32.07	11	43.07	23600	548
Waltham Forest	31.1	63.8	94.9	22400	236
Havering	**22.93**	**4.6**	**27.53**	**15500**	**563**

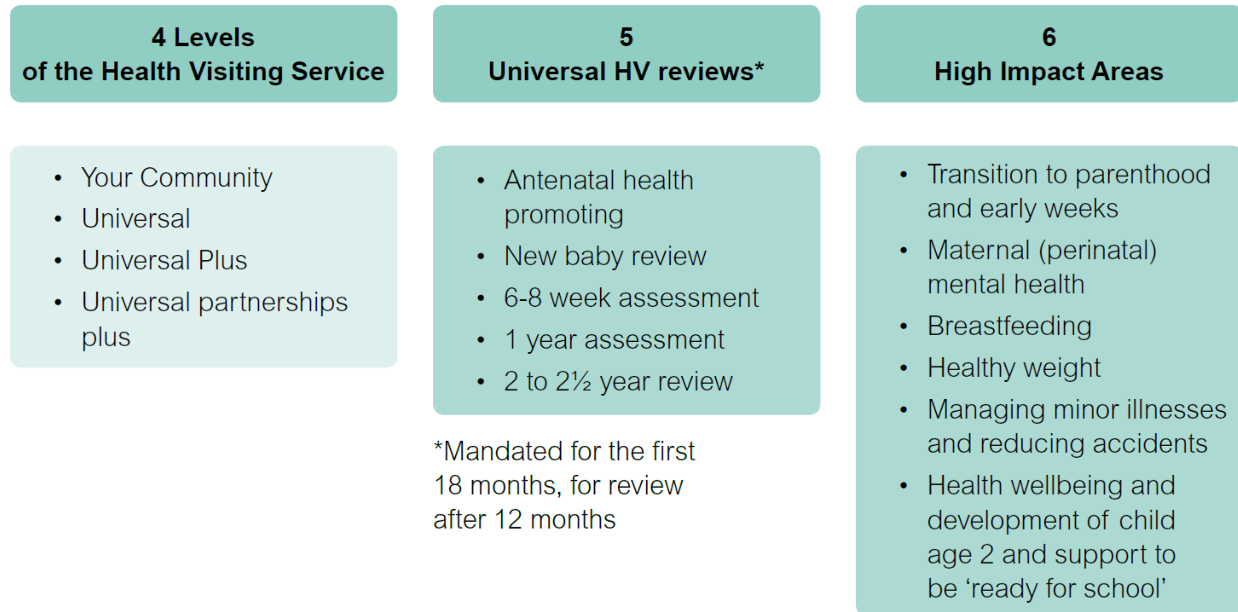
Source: NHSE

Prior to transfer, and whilst there appeared to be a realistic prospect of further investment, NELFT estimated that an additional 20+ wtes was necessary to bring caseloads down to levels (<300) needed to deliver the new national service specification in full.

3.0 Contract and new service specification

On the basis of legal advice, the Council has issued a contract variation to add the health visiting service specification to the existing school nursing contract with NELFT to elapse in April 2018. The service specification sets out the '4,5,6 model' of transformed health visiting.

Figure1: the '4,5,6 model' of transformed health visiting.



Describing a services that works at 4 levels: -

1. Community: health visitors have a broad knowledge of community needs and resources available e.g. Children with Disabilities (0-5) Service, Children's Centres and self-help groups and work to develop these and make sure families know about them.
2. Universal: health visiting teams lead delivery of the HCP. They ensure that every new mother and child have access to a health visitor, receive 5 developmental checks (mandated for at least 18 months after transfer) and receive good information about healthy start issues such as parenting and immunisation[2].
3. Universal Plus: families can access timely, expert advice from a health visitor when they need it on specific issues such as postnatal depression, weaning or sleepless children.
4. Universal Partnership Plus: health visitors provide ongoing support, playing a key role in bringing together relevant local services, to help families with continuing complex needs, for example where a child has a long-term condition or special learning or physical additional needs.

Making a significant contribution to the health and wellbeing of children particularly in the 6 high impact areas.

4.0 Current performance

In the run up to transfer, NELFT has been clear that the service is inadequately resourced to deliver the '4,5,6' model in full. Limited resources are pulled towards children and families with greater needs, particularly where there are safeguarding

[2] The Childhood Immunisation Programme is delivered by general practice. Uptake is recorded on the CHIS.

concerns[3], at the expense of the universal and particularly community elements of the service.

Of the 5 mandated checks, the new birth, 1 year and 2- 2½ year checks are offered universally but uptake is lower for older children. The 6-8 week check is targeted on a broadly defined cohort of children percieved to be at increased risk following the new birth check or based on the advice of other health and social care professionals. Antenatal checks are only undertaken in exceptional circumstances guided by concerns of midwifery services. The interaction of universal versus targeted offer, together with the decline in uptake with age is such that the great majority of babies get a new birth check; a half or more of all children receive the 6-8 week, 1 year and 2 ½ year checks and very few mothers are seen by a health visitor antenatally. This performance is similar to, if not better than that achieved in adjacent boroughs served by NELFT and the average for England and London.

Table 3: Delivery of mandated health checks, Q1 2015/16, boroughs in ONEL

LA Name	% of children who received new birth check within 14 days of birth	% eligible children who received a 6-8 week check by 8 weeks	% of children who received 1 year check by age 15 months	% eligible children getting 2 - 2.5 year check by age 2.5 years
BARKING AND DAGENHAM	86%	27%	58%	24%
HAVERING	87%	45%	78%	61%
REDBRIDGE	89%	72%	68%	2%
WALTHAM FOREST	85%	23%	44%	27%

Data source: NELFT

Children who Did Not Attend for an earlier check and / or have an incomplete immunisation history are proactively followed up if they fail to attend the following scheduled check to minimise the chance that individual children go without a review for long periods.

The contract variation agreed between LBH and NELFT regarding the health visiting service includes clear outcome measures and KPIs. These require NELFT to maintain performance at pre-transfer levels with modest service developments regarding the 2- 2 ½ year check (see below).

5.0 Future development of the health visiting services

The regulations regarding the health visitor transfer require local authorities to take a reasonably practicable approach to improve delivery of the mandated[4] elements

[3] Health visitors attend all initial case conferences and review meetings where the child concerned is aged 0-5 or has a sibling in this age group.
[4] The Regulations regarding the transfer provide for a 'sunset clause' after 18 months that will have the effect of ending mandation, unless further legislation is made that continues the provisions in

of the Healthy Child Programme 0-5 years over time but no specific targets regarding improving performance above that achieved at the point of transfer are set.

Although there isn't an external requirement to improve the health visitor offer, an excellent case can be made for doing so to improve outcomes for children in the borough and reduce overall costs to the public purse.

The most obvious opportunities relate to the '6 high impact areas'identified by the Dept. of Health. The 6 high impact areas draw on the extensive evidence base regarding the benefits of early help and prevention emphasising the potential contribution of health visiting to health outcomes.

Reports by Graham Allen[5] and Frank Field[6] concluded that early intervention can reduce a much wider basket of negative, and financially costly outcomes such as absence from school, antisocial behaviour, crime, welfare dependency and the need for statutory social care services.

Allen identified 25 of the best, evidence-based, cost effective early intervention programmes which he encouraged local areas to consider for implementation spanning 3 distinct opportunities for intervention and improvement:-

- 0–5: Readiness for primary school
- 5–11: Readiness for secondary school
- 11–18: Readiness for life stage

The opportunity afforded by the transfer of health visiting to the local authority and future priorities for the service were discussed at the recent series of 'visioning' workshops facilitated by the LBH Public Health Team.

The opportunity to support all children and parents through the universal offer and identify those at risk of problems and signpost them to appropriate community resources and / or refer to more specialist services was widely acknowledged. Equally it was accepted that capacity in the community was limited and many children and their families identifed as being in need nonetheless fall below the threshold to access existing specialist services. Consequently it was recommended that any improvements in the delivery of the mandated checks to identify families with needs should progress in parallel with an expansion in resources to support those families. This support could be fostered by health visitors themselves, and or by linking with a number of Council teams including the Early Years Service, the 0-5 children with disabilities team, the early years quality assurance team and the 0-5 placements team. Thus as a minimum, plans to develop health visiting need to complement work in Early Years and the possible benefits of much closer working should be explored.

Specific opportunities for closer coordination and cooperation exist with Learning and Achievement. Most obviously, the 2–2 ½ year check undertaken by health

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force. A review, involving Public Health England, is intended to inform whether the sunsetting needs to be amended.

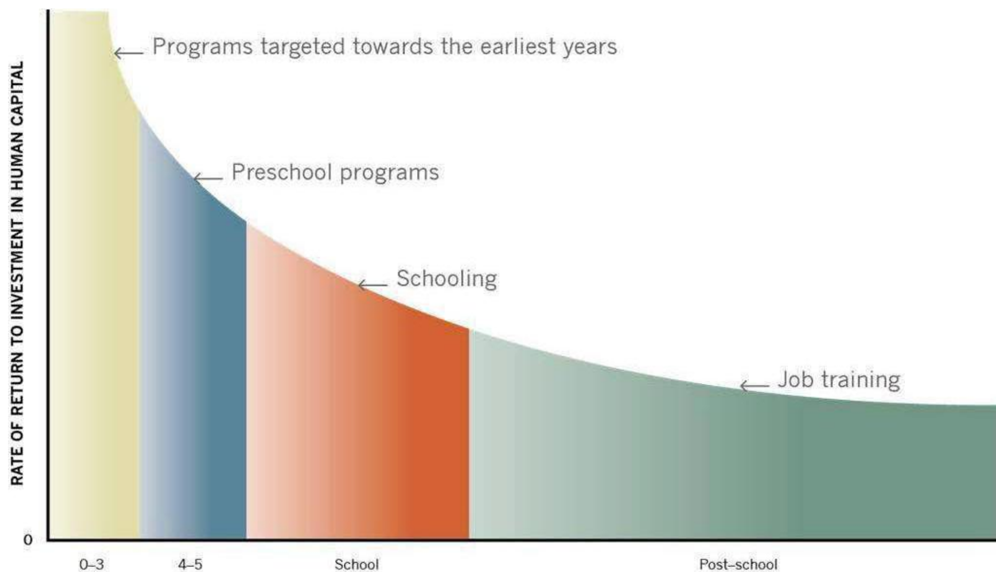
[5] Graham Allen MP – Early Intervention the next steps (Jan 2011)

[6] Frank Field - Review of Poverty and Life Chances, (Feb 2010)

visitors coincides with the progress assessment undertaken by providers of free,state-funded early education. Currently 2-2 ½ year checks in Havering are undertaken by health visitors in clinics for small groups of parents and children, relying on the experience of the health visitor to identify children who may require additional support. As part of the recently agreed contract, NELFT has agreed to pilot the provision of this check in child care settings and the use of the ages and stages questionnaire (ASQ). The ASQ comprises a series of questions to be completed by the parent about their child which serve to compare the child's progress against well established norms to improve the early identification of problems and inform plans as to how they might best be addressed by parents, educational practitioners and health professionals.

The benefits of intervention in early years to improve school readiness was a recurrent theme throughout the visioning workshops e.g. maternal mental health issues predispose to poor parental attachment which increases the risk of poor communication skills which impedes educational progress which may/may not be made good following input from speech and language therapy at a later date. This view is consistent with the available evidence regarding improving skills and educational outcomes which also supports the view that intervention during the early years offers the greatest rate of return from programmes across different stages of childhood.

Figure 2: Rates of return to human capital investment



From [Heckman, J.J. and Masterov, D. (2004) Skills policies for Scotland. Institute for Study of Labour. Discussion Paper 1444]

Accepting that there little chance that the Public Health allocation will be increased allowing for more investment, alternative sources of funding for health visiting and early intervention services to support at risk children and families should be explored.

Given that the potential benefits would be felt very widely, cooperation and coordination across a number of different stakeholders (Public Health, Children's

Services, Learning and Achievement and schools, the CCG) should be encouraged to attract additional investment to support early intervention initiatives and thereby improve outcomes for local children and the cost effectiveness of statutory services.

IMPLICATIONS AND RISKS

None. Decisions will be made within the agreed governance arrangements taking into account financial, legal, HR and equalities implications and risks.

Financial implications and risks:

Legal implications and risks:

Human Resources implications and risks:

Equalities implications and risks:

BACKGROUND PAPERS

None