City of Bradford Metropolitan District Council

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Review of Health Visiting and Family Nurse Partnership Service for Children age 0-5

APPENDICES

APPENDIX 1: INTRODUCTION

The aim of the review is to drive a culture change towards prevention, early intervention and integration of services to ensure children, young people and their families can access the support when they need it most, either through universal or targeted services. This is important given the pressure on budgets and the changing demographics and needs of the population. A system change is also necessary which means we need to change the way we commission and deliver services so they are evidence-based and draws on qualitative and quantitative information from key stakeholders, whether primary care, education, early years, health visiting staff or service users.

The review is timely given that an integrated care pathway has already been developed and aligned with children centre clusters and linked to other pathways across early year's services, including the early help offer and signs of safety. It is also an opportunity to ensure the approach links into the school nursing (5-19) review which is also being reviewed by Public Health, so there is a clear transition from early years into school.

This report sets out the background for the Health Visiting and Family Nurse Partnership (FNP) Service and its purpose, examining the strategic policy context, local demographics and population needs. It then proceeds to explore the current service specification and model and outlines the key findings from the service review, detailing the proposed model which will be discussed with the various local Commissioning and Children's Boards and require approval from the Council Executive.

Background

On 1st October 2015 NHS England transferred commissioning responsibilities for children aged 0 to 5 to local authorities. This marks the final part of the much larger transfer of public health functions to local government which took place on 1 April 2013 under the Health and Social Care Act 2012

NHS England Area Team put in place a single contract for the full-year of 2015/16, with a deed of novation transferring the contract to Public Health in year.. Health visiting and family nurses partnership. FNP services are now commissioned by the Bradford Metropolitan District Council and the contract held is one of the largest funded contracts managed within Public Health, currently delivered by a local NHS Provider. The current contract is based on national KPIs with some local variations agreed prior to transition, and is based on the Councils "resident populations" The transfer of commissioning responsibilities to Public Health has provided opportunity to review the Health Visiting and Family Nurse Partnership (FNP) service with the overall aim to improve health and wellbeing outcomes for babies, children and their families.

Overview of the Health Visiting Service

Evidence shows that what happens in pregnancy and the early years of life impacts throughout the life course. Therefore a healthy start for all our children is vital for individuals, families, communities and ultimately society. The experiences during the early years of childhood (including before birth) have lifelong effects on health and wellbeing. Health visitors play a crucial role in ensuring that children have the best possible start in life and lead delivery of the 0 to 5 elements of the Healthy Child Programme (HCP) which is an early intervention and evidenced based programme and is led and delivered by health visitors in partnership with other health and social care colleagues.

Level of service provided by Health visiting teams

Universal services ensure that families can access the Healthy Child Programme and that parents are supported at key times and have access to a range of community services. Universal plus offers rapid response from the local health visiting team when specific expert help is needed for example with postnatal depression, a sleepless baby, weaning or answering any concerns about parenting. Universal partnership plus provides ongoing support from the health visiting team and a range of local services to deal with more complex issues over a period of time. Current level of service provided by Health visiting teams indicate the following level of services for Universal and targeted services.

Level	Service	Number	%
Tier 1	**Universal**	**39918**	**94.1%**
Tier 2	**Universal Plus**	**1577**	**3.7%**
Tier 3	**Partnership**	**767**	**1.8%**
Tier 4	**Partnership Plus**	**180**	**0.4%**
Total		**42442**	

Overview of the Family Nurse Partnership Service

The Family Nurse Partnership (FNP) is a voluntary home-visiting programme for first time young parents aged 19 or under. It is not a universal service. A specially trained family nurse visits the young parent regularly, from early in pregnancy until the child is two years old. Where a family is under the care of the FNP, described in the Regulations as FNP beneficiary, the mandated reviews will be carried out by the family nurse. To ensure continuity for the family, the family nurse should carry out the 2 to 2½ year review.

Aim of Review

The transfer of commissioning responsibilities to the Council has provided an opportunity to review the Health Visiting Service, including:

a) Review current guidance, policy and good practice to inform/identify a set of standards of which to review the current service and service model
b) Analyse the current and emerging health and wellbeing needs of parents and the 0-5 (years) population within the Bradford District
c) Engage with key stakeholders; Parents, GPs, Early Years etc.
d) Develop a model that meets current and emerging need, demonstrating quality and value for money.
e) Integrating with current early years services for young children.
f) To review current national and local policy, guidance and strategy relating to children age 0-5 and the transfer of Public Health into the Council, I order to improve the health and wellbeing outcomes for children and young people and their families.

APPENDIX 2: NATIONAL CONTEXT & EVIDENCE BASE

Nationally new guidance and legislation highlight the importance of delivering prevention and early intervention services which are needs led and targeted to meet the needs of children, young people and their families. In fact the importance of pregnancy, birth and beyond highlights the need to engage with families early through both universal and targeted interventions in areas of greatest need reducing the inequalities gap. Health visitors lead delivery of the HCP, this is a prevention and early intervention public health programme that lies at the heart of the universal service for children and families and aims to support parents at this crucial stage of life, promote child development, improve child health outcomes and ensure that families at risk are identified at the earliest opportunity.

1. National Context

a) The Department of Health, alongside its partners, has produced 6 documents to support local authorities and other stakeholders through the transition. The documents identify 6 areas where health visitors have the most impact on children aged 0 to 5's health and wellbeing. Local authorities should use this information to ensure that health visiting services are commissioned effectively: Best start in life and beyond: Improving public health outcomes for children, young people and families – Guidance to support the commissioning of the Healthy Child Programme 0-19: Health Visiting and School Nursing services. https://www.gov.uk/government/publications/healthy-child-programme-0-to-19-health-visitor-and-school-nurse-commissioning

   Published in January 2016, the Guidance forms a suite of support guides to assist local authorities in the commissioning of health visiting and school nursing services to lead and co-ordinate the delivery of public health for children aged 0-19.

b) Working together to Safeguard Children (revised Guidance) 2015 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf

   The guidance makes clear that everyone who works with children – including teachers, GPs, nurses, midwives, health visitors, early year's professionals, youth workers, police, Accident and Emergency staff, voluntary and community workers and social workers – has a responsibility for keeping them safe.

   The guidance outlines the importance of early help in promoting the welfare of children rather than reacting later. Early help can also prevent further problems arising and professionals should, in particular, be alert to the potential need for early help for children with specific needs or vulnerabilities.

   The guidance also highlights the Section 11 duties of the Childrens Act 2004 which will need to be considered as part of current service provision and alongside the role of School Nurses in their role in safeguarding and Child Protection.

c) A new home for public health services for children aged 0-5 - Nationally, new guidance and legislation for children age 0-5

d) Health visiting service specification for 2015-16 - NHS England has published a national core health visiting service specification for 2015-16. The refreshed specification has a strengthened focus on the role of health visitors as leaders for improving health and wellbeing outcomes for young children and their families. This document is a core specification detailing the core elements for the commissioning of health visiting services. It is an update of the 2014/15 document.

e) Children's public health services contribute to the Public Health Outcomes Framework for England 2013 – 2016 (PHOF) which aims "to improve and protect the nation's health and wellbeing and to improve the health of the poorest fastest." (Healthy Lives, 2012)

f) The healthy child programme: pregnancy and the first 5 years of life - One of the Department of Health (DH) key policy drivers is to give all children a healthy start in life and sets out plans for a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, supplemented by advice around health, wellbeing and parenting. Health Visiting services lead and deliver the *Healthy Child Programme* (HCP), which is designed to offer a core, evidence based programme of support, starting in pregnancy, through the early weeks of life and throughout childhood.

g) Health visitor implementation plan 2011-15: a call to action, February 2011 - Sets out a programme for renewing the Health Visiting Service, stressing the importance of pregnancy and the early years in laying the foundations for future health, learning and wellbeing. *The Health Visitor Implementation Plan 2011-15* sets out the full range of services that families would expect from health visitors and their teams as part of the rejuvenated and transformed health service. The Plan sets out a call to action to expand and strengthen health visiting services (2011-15)

h) Both the Healthy Child Programme 0-19 and the Munro Review acknowledge that integrated services and greater partnership working are essential to improving outcomes for children, young people and their families.

i) The Marmot Review into health inequalities in England was published on February 2010 as 'Fair Society, Healthy Lives'. The Review looked at the differences in health and wellbeing between social groups and described how the social gradient on health inequalities is reflected in the social gradient on educational attainment, employment, income, quality of neighbourhood and so on. Professor Sir Michael Marmot's review of health inequalities gives priority to action in the early years. 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 laid in early childhood.

   http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report

   Central to the Review is the recognition that disadvantage starts before birth and accumulates throughout life, and reducing this disadvantage and associated health inequalities requires action on six policy objectives including:
   - Giving every child the best start in life
   - Enabling all children, young people and adults to maximise their capabilities and have control over their lives
   - Creating fair employment and good work for all
   - Ensuring a healthy standard of living for all
   - Creating and developing sustainable places and communities
   - Strengthening the role and impact of ill-health prevention

j) Healthy lives, healthy people: our strategy for public health in England
   This White Paper sets out the Government's long-term vision for the future of public health in England. The aim is to create a 'wellness' service (Public Health England) and to strengthen both national and local leadership.

k) Annual report of the chief medical officer 2012. Our children deserve better: prevention pays. This is volume two of the Chief Medical Officer's annual report which focuses on children and young people. It is based on an examination of the life course stages experienced by those up to the age of 25 years.

l) Rapid review to update evidence for the healthy child programme 0–5
   The purpose of this rapid review is to update the evidence which underpins the Healthy Child Programme, including systematic review level evidence about 'what works' in key areas: parental mental health; smoking; alcohol etc.

m) Frank Field's (2010) review of child poverty emphasises the importance of improving parenting and children's early development as a means of ending the inter-generational transmission of child poverty. He points to the impact that high-quality

early education for two year olds can have on later life chances, noting that known vocabulary at age five is the best predictor of whether children are able to escape poverty in later life.

n) The new health visiting service will be a key part of the response to the challenges they pose. Developments will also take account of Dame Claire Tickell's Review of the Early Years Foundation Stage and Professor Eileen Munro's Review of Child Protection.

o) Early intervention: the next steps. An independent report to her Majesty's Government - The first independent report to the government by Graham Allen MP considers how costly and damaging social problems for individuals can be eliminated or reduced. Graham Allen's first report sets out his vision for system reform and recommends "early intervention" places, a greater reliance on evidence-based programmes, and an early intervention foundation.

p) Under the Childcare Act 2006 Local authorities have statutory duties to secure sufficient provision of children's centres to meet local need, as far as is reasonably practicable. Every children's centre should have access to a named health visitor.

q) Supporting Families in the Foundation Years is a joint publication between DfE and DH, recognising that, as Graham Allen says, coherent integrated services are essential.

2. Legislative requirements

a) Children Act 2004
http://www.legislation.gov.uk/ukpga/2004/31/contents
The Children Act 2004 provides the legal basis for how social services and other agencies deal with issues relating to children and was designed with guiding principles in mind for the care and support of children. These are:

- To allow children to be healthy
- Allowing children to remain safe in their environments
- Helping children to enjoy life
- Assist children in their quest to succeed
- Help make a contribution – a positive contribution – to the lives of children
- Help achieve economic stability for our children's futures

This act was brought into being in order for the government in conjunction with social and health service bodies to help work towards these common goals.

b) Public Services (Social Value) Act 2012
http://www.legislation.gov.uk/ukpga/2012/3/enacted
The Public Services (Social Value) Act came into force on 31 January 2013 and requires local authorities commissioning public services to consider how they can secure wider social, economic and environmental benefits.
Before the procurement process begins, commissioners should consider about whether the services they are going to buy, or the way they are going to buy them, could secure these benefits for their area or stakeholders.

c) Health and Social Care Act 2012
http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted
Local Authorities are now responsible for improving the health of their population including commissioning of public health services for children and young people Directors of Public Health have taken responsibility as commissioners for school nursing services which are now funded through the Public Health grant, but also oral health improvement for children and more recently the transition into the local authority of health visiting and family Nurse partnership.

d) Children and Families Act 2014
http://www.legislation.gov.uk/ukpga/2014/6/contents/enacted

The Children and Families Act makes provision to provide greater protection to vulnerable children, better support for children whose parents are separating, a new system to help children with special educational needs and disabilities, and help for parents to balance work and family life.

3. Evidence Base, Applicable National Service Standards and Suite of Evidence Based Interventions/Pathways

Best start in life and beyond: Improving public health outcomes for children, young people and families provides guidance to support the commissioning of the Healthy Child Programme 0-19: Health Visiting and School Nursing services as highlighted below (**Commissioning Guide 4**: Reference guide to evidence and outcomes)

- Healthy Child Programme – Pregnancy and the first five years of life (DH, 2009 – amended August 2010)
- Better health outcomes for children and young people Pledge
- The Children and Young People's Health Outcomes Strategy (DH, 2012)
- Allen, G. (2011a) Early Intervention: The Next Steps. HM Government: London
- Allen, G. (2011b) Early Intervention: Smart Investment, Massive Savings. HM Government: London
- Field, F. (2010) The Foundation Years: preventing poor children becoming poor adults. HM Government: London.
- Health visitor implementation plan 2011-15: A call to action (DH, 2011)
- The National Health Visitor Plan: progress to date and implementation 2013 onwards (DH, 2013)
- The Operating Framework for the NHS in England 2012/13 (DH, 2011)
- The NHS Outcomes Framework 2012/13 (DH, 2011)
- Improving outcomes and supporting transparency, Part 1: A public health outcomes framework for England, 2013-2016 (DH, 2012)
- Improving outcomes and supporting transparency, Part 2: Summary technical specifications of public health indicators, (DH, 2012)
- The Marmot Review (2010) Strategic Review of Health Inequalities in England, post-2010
- Dame Clare Tickell (2011) The Early Years: Foundations for life, health and learning – An Independent Report on the Early Years Foundation Stage to Her Majesty's Government
- Hall D and Elliman D (2006) Health for All Children (revised 4th edition). Oxford: Oxford University Press. (Please note: this link opens to the bookstore for purchase of copies of this edition).
- Service vision for health visiting in England (CPHVA conference 20-22 October 2010)
- Securing Excellence in Commissioning for the Healthy Child Programme 0 to 5 Years 2013 – 2015
- Equity and excellence: Liberating the NHS (DH, 2010) and Liberating the NHS: Legislative framework and next steps DH, 2011)
- Achieving equity and excellence for children. How liberating the NHS will help us meet the needs of children and young people (DH, 2010)
- Getting it right for children and young people: Overcoming cultural barriers in the NHS so as to meet their needs (DH, 2010)
- Healthy lives, healthy people: our strategy for public health in England (DH, 2010) and Healthy lives, healthy people: update and way forward (DH, 2011)
- Healthy lives, healthy people: a call to action on obesity in England (DH, 2011)
- UK physical activity guidelines (DH, 2011)

- Working Together to Safeguard Children: A guide to interagency working to safeguard and promote the welfare of children (HM Government 2013)
- Fair Society, Healthy Lives. A strategic review of health inequalities in England post 2010 (The Marmot Review, 2010)
- The 1001 Critical Days: The importance of the conception to age two period. Wave Trust, 2013
- Conception to Age two: The Age of Opportunity. WAVE Trust and DfE
- Annual Report of the Chief medical Officer 2012. Our Children Deserve Better: Prevention Pays. Department of Health, 2013
- UNICEF UK Baby Friendly Initiative

4. Applicable National Standards (NICE public health guidance) includes:

Best start in life and beyond: Improving public health outcomes for children, young people and families provides guidance to support the commissioning of the Healthy Child Programme 0-19: Health Visiting and School Nursing services as highlighted below (**Commissioning Guide 4**: Reference guide to evidence and outcomes)

- PH3 - Prevention of sexually transmitted infections and under 18 conceptions
- PH6 - Behaviour change at population, community and individual level (Oct 2007)
- PH8 - Physical activity and the environment
- PH9 - Community engagement (July 2010)
- PH11 - Maternal and child nutrition
- PH12 - Social and emotional wellbeing in primary education
- PH14 - Preventing the uptake of smoking by children and young people
- PH17 - Promoting physical activity for children and young people
- PH21 - Differences in uptake in immunisations
- PH24 - Alcohol-use disorders: preventing harmful drinking
- PH26 - Quitting in smoking in pregnancy and following childbirth (June 2010)
- PH27 - Weight management before, during and after pregnancy (July 2010)
- PH28 - Looked-after children and young people: Promoting the quality of life of looked-after children and young people (October 2010)
- PH29 - Strategies to prevent unintentional injuries among children and young people aged under 15 Issued (November 2010)
- PH30 - Preventing unintentional injuries among the under-15s in the home
- PH31 - Preventing unintentional road injuries among under-15s
- PH40 - Social and emotional wellbeing – early years: NICE public health guidance 2012
- PH42 - Obesity working with local communities
- PH44 - Physical activity: brief advice for adults in primary care
- PH46 - Assessing body mass index and waits circumference thresholds for intervening to prevent ill heath a premature death among adults from black, Asian and other minority ethnic groups in the UK.
- PH49 - Behaviour change: individual approaches
- CG43 - Obesity: Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children
- CG45 - Antenatal and postnatal mental health: clinical management and service guidance (February 2007)
- CG62 - Antenatal care: routine care for the healthy pregnant woman (March 2008)

- CG89 - When to Suspect Child Maltreatment (July 2009)
- CG93 - Donor milk banks: the operation of donor milk bank services
- CG110 - Pregnancy and complex social factors**:** A model for service prevision for pregnant women with complex social factors
- QS22 - Quality standards for antenatal care
- QS31 - Quality standard for the health and wellbeing of looked**-**after children and young people
- QS37 - Postnatal Care
- QS43 - Smoking cessation**:** supporting people to stop smoking
- QS46 - Multiple pregnancies
- QS48 - Depression in children and young people

5. **The evidence base and key policy documents for the FNP include:**

- Ball, M. et al (2012) Issues emerging from the first 10 pilot sites implementing the Nurse Family Partnership home-visiting programme in England. London, Department of Health (https://www.wp.dh.gov.uk/publications/files/2012/08/3-Birkbeck-Final-Issues-Evaluation-Report-For-Publication-July-2012.pdf)

- Barnes, J. et al (2008) Nurse-Family Partnership Programme: First Year Pilot Sites Implementation in England, London DCSF. (http://education.gov.uk/publications/standard/publicationDetail/Page1/DCSF-RW051)

- Barnes, J et al (2009) Nurse-Family Partnership Programme: Implementation in England – Second Year in 10 Pilot Sites: the infancy period. London DCSF. (www.education.gov.uk/research/data/uploadfiles/DCSF-RR166.pdf)

- Barnes, J. (2011) The Family-Nurse Partnership Programme in England: Wave 1 Implementation in toddlerhood and a comparison between Waves 1 and 2a implementation in pregnancy and infancy (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123238)

- Barnes, J. et al (2012) Eligibility for the Family Nurse Partnership programme: testing new criteria. London, Department of Health (https://www.wp.dh.gov.uk/publications/files/2012/08/Eligibility-for-the-Family-Nurse-Partnership-programme-Testing-new-criteria.pdf)

- Department of Health (2011) FNP Evidence Summary Leaflet, Department of Health - FNP National Unit (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_128008.pdf)

- Hall, D. & Hall, S. (2007). The “Family-Nurse Partnership”: developing an instrument for identification, assessment and recruitment of clients. Research report DCSF-RW022. London: DCSF (http://dera.ioe.ac.uk/6740/1/DCSF-RW022.pdf)

APPENDIX 3: LOCAL CONTEXT

INTRODUCTION

In addition to the themes raised in the national policy context a review of local policy and planning emphasises the importance of working collaboratively with key partners to improve services and get better value for money, all underpinned by the ‘Journey to Excellence’ and ‘New Deal’ programmes and focusing on the delivery of sustainable interventions to improve health and wellbeing and reduce health inequalities. There is a

particular focus on early help and integration of services, with opportunities from Better Start.

1. **New Deal for Bradford Council**

   To support the management of budget reductions, the Council is talking to local people, communities, partners and businesses to develop a 'New Deal' for Bradford. The numbers of younger and older people are growing and so is the number of people with disabilities. Other challenges include more children needing care and protection. Inflation is also increasing costs. This all puts pressure on services. These are:

   1. Good schools and a great start for all our children
   2. Better skills, more good jobs and a growing economy
   3. Better health, better lives
   4. Safe, clean and active communities
   5. Decent homes that people can afford to live in

   The Council is working with partners to innovate, share money and resources, work towards the same goals, and liaise with local people and communities to establish a 'New Deal' about what they can expect from local services, their rights and responsibilities, and how they and other people could help by doing things differently and the support required to achieve. The review of the health visiting service will support New Deal.

2. **Bradford District Health and Well Being Strategy 2015-2018**
   http://www.observatory.bradford.nhs.uk/Documents/Bradford%20and%20Airedale%20Joint%20Health%20and%20Wellbeing%20Strategy%202013.pdf
   Bradford's Health and Wellbeing Strategy "Good Health and Wellbeing: Strategy to improve health and wellbeing and reduce health inequalities 2013-2017 outlines the key objectives, priorities and actions required to secure improvements in health and wellbeing, to reduce health inequalities and ensure life expectancy continues to improve in line with national and regional trends. The Joint Strategic Needs Assessment (JSNA) provides a strategic examination of "need" across the Bradford District and provides the evidence-base to inform the Joint health and Wellbeing Strategy (JHWS), in particular helping to identify the key priorities for the District.

   The following objectives and priorities are particularly relevant to health visiting Service:
   - Objective 1; Give every child the best start in life
   - Objective 2: Enable all children, young people and adults to maximise their capabilities and have control over their lives.
   - in particular Priority 5: Reduce childhood obesity and increase levels of physical activity and healthy eating in children and young people
   - Objective 6: Strengthen the role and impact of ill health prevention

3. **Bradford District Health Inequalities Action Plan 2013 - 2017**
   http://www.observatory.bradford.nhs.uk/Documents/Bradford%20and%20Airedale%20Health%20Inequalities%20Action%20Plan%202013.pdf
   The Health Inequalities Action Plan was developed to support the Joint Health and Wellbeing Strategy to improve health and wellbeing specifically targeting activity to address the significant inequalities within the district; in some parts of the district, people lead far shorter, less healthy lives than those in other areas.
   The Key Priorities for the Action Plan that relate to the Health Visiting Service are Infant mortality, Oral health, Obesity, Parenting & early years, children SEN and disabilities and Child poverty.

4. **Children and Young People's Plan 2014-16**
   http://www.bradford.gov.uk/bmdc/health_wellbeing_and_care/child_care/young_peoples_plan

The Children and Young People's Plan is the joint strategic plan for the Bradford Children's Trust.
The plan identifies how partners will work together to promote the health and wellbeing of children and young people in the Bradford District. It summarises activity to plan, commission or provide services, as well as the impact expected on the lives of children, young people and families.

The key priority areas for the plan are:

- Ensuring that children start school ready to learn
- Acceleration educational attainment and achievement
- Ensuring young people are ready for life and work
- Ensuring that there is education, employment and skills for all
- Safeguarding vulnerable children and young people
- Reducing health and social inequalities

5. **Child Poverty Strategy 2014-2017**
   https://www.bradford.gov.uk/NR/rdonlyres/D5E6B555-992E-4779-A8BF-AD09C053051C/0/ChildPovertyStrategy201417.pdf
   The Child Poverty Strategy describes the most important issues to address to reduce the impact of child poverty.
   In the most recent district child poverty data for 2011, one in four children and young people (25.8%) aged 0-19 lived below the child poverty line in households with less than 60% of average income. Nationally the rate is one in five (21.1%).
   The three priorities of the Strategy are:
   - Boosting educational attainment and skills for children, young people and families in poverty to improve their job prospects and reduce worklessness.
   - Reducing health and social inequalities
   - Creating safe homes and neighbourhoods for all children and young people.

6. **5 Year Forward Plan for Bradford Airedale and Craven & 3 CCG Plans**
   Improved Maternal and Child Health is a key part of the CCG plans

7. **Key Strategic Outcomes for Integrated Early Years Strategy (0-7 years) Bradford district 2015-2018**
   This is particularly relevant to health visiting and FNP services as objectives and priority areas include a focus on infant mortality, Oral health, Obesity and School readiness (Good level of development), Year 1 Phonics and KS1 phonics Year 2 reading, writing and maths.

8. **Better Start Bradford (Improved outcomes for pregnant women and young children aged 0-3 years)**
   HV services and FNP are an important part of the Better Start Bradford**,** £49 million Big Lottery Programme targeting pregnant women and children age 0-3 via 22 evidence based projects to improve outcomes in relation to School readiness, obesity and other key outcomes.

9. **Integrated Care Pathway (ICP)** in 2014 incorporating health visitors, midwifery and children services for children age 0-5 which is key to health visiting.
10. **Children Centres**
    Health visiting services are an important part of Children Centre services and particularly in relation to the integrated care pathway. Health targets in relation to key priorities have also been included into children centre specifications.
    There is also an expectation that there will be a named Health Visitor attached to the children centre and also a health Visitor lead on the Advisory Board.

11. **Children Centre Review**
    Both services have similar focus and targets and effective integrated working is key priority for future. The 7 children centre clusters will have health visitor leadership to deliver on integrated working and support and enhance the care pathways for children

age 0-5 in particular there is a string focus on the two year reviews and child development as well as enhancing support offered for mothers, babies and children.

12. Families First

http://www.bradford.gov.uk/bmdc/BCYPP/families_first

Families First has been recognised within the recent specifications as an important part of the links with health visiting and FNP.

Families First is a local programme forming part of the national Troubled Families Programme, working with families facing serious problems. The programme addresses other issues that these families are likely to experience including: debt and financial difficulties, housing problems, health issues, substance abuse and domestic violence.

Families First is unique in Bradford in that the scheme focuses on the needs of the whole family rather than individual members, the family is supported by a key worker working within a multi-disciplinary team, and includes health. Those families with the greatest needs are targeted, this comprises of up to 600 families a year. The programme is also designed to last beyond the end of the funding, by making long-lasting changes to the way that different agencies, such as the Council, Police and Health Services, work together, in order to improve services and get better value for money.

13. Journey to Excellence

http://www.bradford.gov.uk/bmdc/health_wellbeing_and_care/child_care/journey_to_excellence_thriving_children_strong_families

Journey to Excellence is a new programme of change involving key partners across the district. Its purpose is to ensure there is a shared approach to working with families that builds on their strengths and provides safety and stability for children. Hence is an important part of health visiting and FNP as focuses on developing the integrated Early Help offer across all key agencies which includes:

- develop an 'Early Help' gateway for the public and staff
- develop an approach that takes account of the whole family
- get it right first time to reduce repeat referrals
- focus on reducing the demand on children's specialist services

BMDC Childrens Services are working with partners, including Health Visiting services to develop a plan to use Signs of Safety to cut across the programme. Signs of Safety is a practice tool to identify strengths, risks and clear action plans with families. It provides an assertive and shared approach to assessing needs and draws upon techniques from Solution Focused Brief Therapy. The programme has worked well in other Local Authorities to reduce demand for specialist services and improve outcomes for children and young people.

APPENDIX 4: DEMOGRAPHICS

Bradford District is one of the most deprived local authorities in the whole of England, ranking 19th in the 2015 indices of multiple deprivation (IMD) and 2nd most deprived in the Yorkshire and Humber region (after the City of Kingston upon Hull). This compares to the ranking of 26th for IMD 2010. Bradford's position relative to other English districts has worsened by 7 places.

1. POPULATION

The number and proportion of the district's total population aged under 19 years is increasing and the relatively high proportion that live in poverty is likely to increase the general demand for services and support to families including early help and preventive

services as well as those that seek to reduce the impact of poverty. This presents the District with a growing challenge as over the last decade there has been an increase of over 20% in 0-4 year olds.

Age Groups	2014
0-4yrs	41,018
5-9yrs	40,036
10-14yrs	36,145
15-19yrs	35,393

Source: Mid-2014 Population Estimates, ONS

a) Children aged 0-5

- There are 49,270 children aged 0-5 in Bradford District this equates to 9% of the total population (Mid 2014 population estimates, ONS.)
- In 2013 there were 8,039 live births in Bradford district compared with 8,322 live births in 2012 (a decrease of 3.4%)
- The birth rate fell from 15.9 live births per 1,000 population in 2012 to 15.3 live births per 1,000 population in 2013 despite the birth rate having decreased over the last few years the rate still remains higher than the average for both England and Yorkshire and the Humber.
- The sub national population projections suggest that the 0-5 population is due to increase by 10% by 2021.

b) Deprivation

Of the 8,039 live births registered in 2013, 58.9% (4,731 births) occurred in the most deprived quintile of Bradford. The live birth rate increases as deprivation increases across Bradford district with the crude birth rate for the most deprived quintile of Bradford being 2.5 times greater than the least deprived quintile (19.9 live births per 1,000 population compared to 7.7 live births per 1,000 population respectfully).

c) Gender

As would be expected, there is an even split between the number of girls and boys in Bradford and district.

d) Ethnicity

Bradford district contains a rich mix of ethnic groups and cultures. Approximately just under half of the Districts 0-19 population are from Black and Minority Ethnic (BME) groups. The district has some newly established communities that are growing relatively fast through inward migration. These communities are mostly of white ethnicities from Central or Eastern European countries with a significant Roma/Gypsy element within some of the communities.

Approximately half of the 0-4 population identify themselves as White British or White Other (this category is likely to include individuals from Central Eastern European communities previous years have seen an increase in migration from these communities, however it is difficult to understand the true extent of the migration.) The other half is made up of Black and Minority Ethnic groups, with a significant amount from Pakistani heritage. The following table shows the proportion of 0-4 year olds by ethnicity based on the 2011 census.

Ethnicity	**0 to 4 year olds**
White British	47.3%
White: Other (Including Irish and gypsy or Irish traveller)	3.4%
Mixed/ multiple ethnic group	5.7%
Pakistani	32.3%

Other Asian (Including Indian, Bangladeshi and chinese)	7.6%
Black/African/Caribbean/Black British	1.7%
Other ethnic group	2.0%

e) Religion

It is important that the health visiting service understands the diversity of religious beliefs present in the population of Bradford. According to the 2011 census, the largest religious category amongst 0-14 year olds is Muslim, as the following table shows. It is essential that certain interventions and/or advice may need to take religious beliefs into account. This was highlighted in the consultations where cultural needs were a barrier to access for some services.

Religion	Age 0 to 4	Age 5 to 9	Age 10 to 14	Age 15 to 19
Muslim	38.96%	40.44%	36.73%	32.04%
Christian	26.69%	31.28%	34.64%	36.24%
No religion	24.87%	20.48%	20.89%	23.95%
Not stated	7.90%	6.14%	5.86%	5.86%
All other	1.57%	1.65%	1.87%	1.91%

f) Child poverty

The large and growing 0-19 population in the District mean that a 25.8% child poverty rate equates to 35,820 children and young people aged 0-19. Consistently we find that just over half of children who live in poverty live in 6-8 of the most urban of the District's 30 wards. The most recent figures show that half of children in poverty (51.8%) live in 8 wards. In order of the largest number of children in poverty per ward these are: Bradford Moor, Little Horton, Manningham, Bowling and Barkerend, Tong, Toller, Great Horton and City wards (HM Revenue and Customs, 2013).

This Bradford Public Health Analysis provides a broad analysis of live births and stillbirths within Bradford district as follows:

2. BIRTHS

a) Live births

There were 8,039 live births in Bradford district in 2013 compared with 8,322 live births in 2012 (a decrease of 3.4% compared to a 4.3% decrease for England). Between 2007 and 2010 the total number of births increased year on year from 8,288 in to 2007 to 8,629 in 2010. Since then however, the number of annual live births have fallen and are now below those seen in 2007.

b) Crude live birth rate

The crude live birth rate for Bradford has fallen annually from 16.9 live births per 1,000 population in 2008 to 15.3 live births per 1,000 population in 2013.

c) Stillbirths

The number of stillbirths in Bradford district fell from 59 in 2012 to 58 in 2013. Although the number of live births per year has generally fallen since 2010, the number of stillbirths has remained the same, at an average of 59 per year.
The stillbirth rate in Bradford district increased from 7.0 stillbirths per 1,000 total births in 2012 to 7.2 stillbirths per 1,000 total births in 2013. The increase in stillbirth rate in 2013 can be attributed to by the number of stillbirths remaining the same as previous years, but the number of live births falling from previous years.

d) Low birth weight

The proportion of those babies who have a birth weight less than 2,500g in Bradford district in 2013 was 8.1% compared to 8.6% in 2012. Both the number and proportion of low birth weight babies have generally fallen over the last 7 years, from 808 low birth weight births (9.8%) in 2007 to 646 (8.6%) low birth weight births in 2013

e) Live births to mothers born outside the UK

A third of all births (33.1%) in Bradford are to mothers born outside the UK, higher than the average for England (27.3%). The second highest place of birth for mothers in Bradford are to those born in Pakistan (18.3%) followed by Poland 2.8% and Bangladesh (2.0%).

f) Live births across Bradford district

Bradford East and Bradford West accounted for over half the total live births in 2013 (26.4% and 25.7% respectively). Across Bradford district, live birth rates vary from ward to ward, with higher rates seen in wards such as Manningham, Bradford Moor, Bowling and Barkerend and Little Horton and lower rates seen in Ilkley, Baildon, Bingley Rural and Wharfedale

g) Location of birth

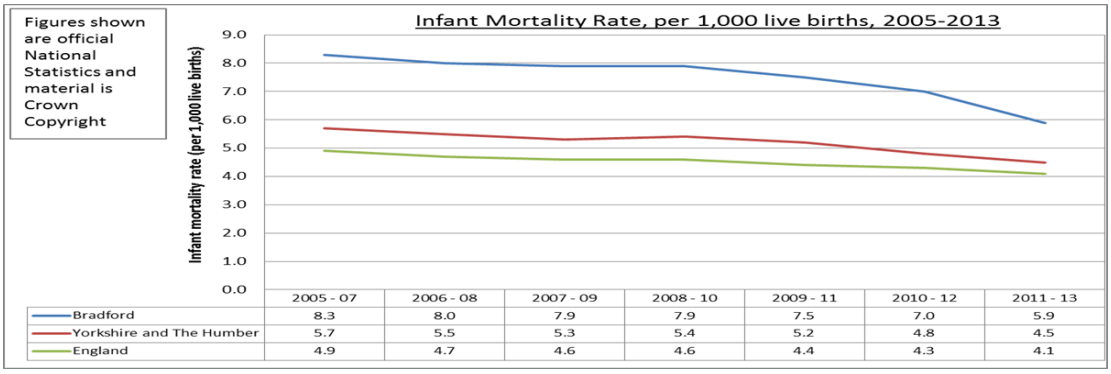
Approximately 90% of all births occur within the two main hospitals in Bradford, with babies born in Bradford Royal Infirmary accounting for over two thirds (69.0% in 2013) of all the births in Bradford district. The proportion of births occurring at each location has remained relatively similar since 2007, with a slight increase being seen in the proportion of live births occurring at home and those births at Bradford Royal Infirmary and a small decrease in the proportion of births occurring at Airedale General.

APPENDIX 5: HEALTH & WELLBEING NEEDS & INEQUALITIES

There are inequalities in the Health and Wellbeing for young children, and those particularly relevant to the Health visiting services which focus on families and children age 0-5. Infant mortality rates, obesity rates and poor oral health are all worse than average compared to regionally and nationally, and are worse in more deprived areas.

a) Infant Mortality

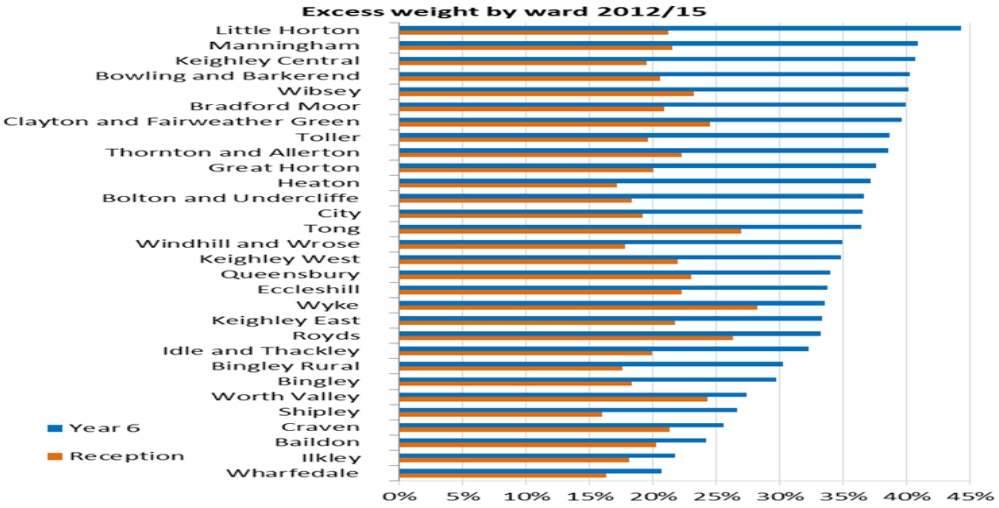
Infant mortality is the death of a child less than one year of age. The latest figures show the infant mortality rate in Bradford was 5.9 per 1,000 live births in 2011-13 but still higher than regionally or nationally. Health visitors have a crucial role as they offer a universal service to all women with children in this age group and offer early intervention, prevention and more targeted support. Health visitors have a crucial role in supporting early access to services.



	2005 - 07	2006 - 08	2007 - 09	2008 - 10	2009 - 11	2010 - 12	2011 - 13
Bradford	8.3	8.0	7.9	7.9	7.5	7.0	5.9
Yorkshire and The Humber	5.7	5.5	5.3	5.4	5.2	4.8	4.5
England	4.9	4.7	4.6	4.6	4.4	4.3	4.1

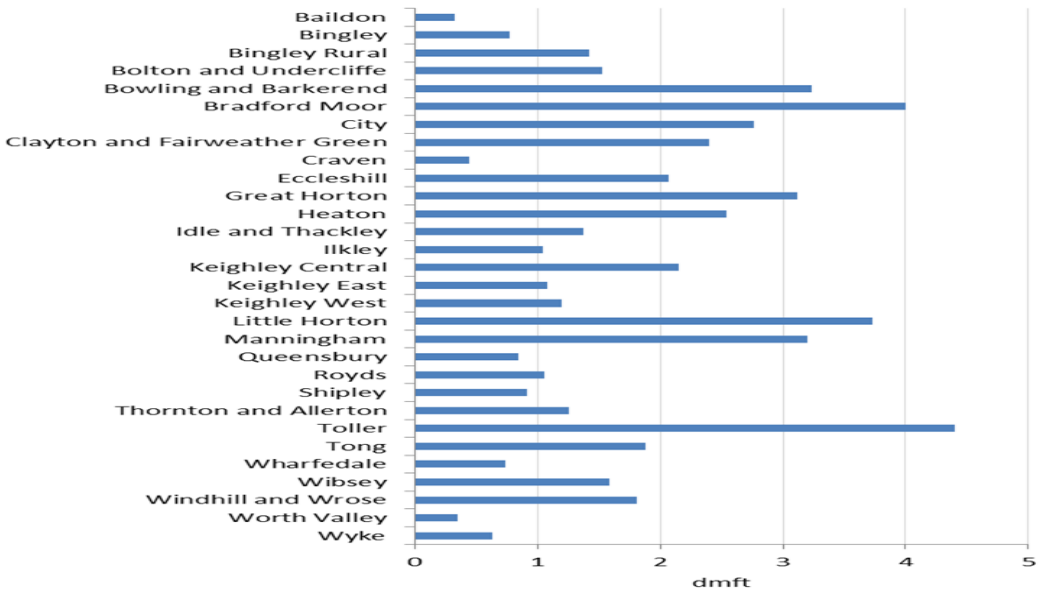
b) Obesity

Obesity rates are higher than regionally or nationally 19.7% of reception pupils in Bradford are overweight or obese (NCMP 2014/15) 35.7% of Year 6 pupils in Bradford are overweight or obese (NCMP 2014/15). Health Visitors have an important role in relation to a healthy start from birth to five where diet and weaning advice is crucial.



c) Oral Health

Tooth decay in 5 year olds is measured as the average number of decayed, missing or filled teeth (dmft).The latest dmft rate in Bradford is 1.98 in 2011/12; higher than nationally or regionally Dmft is significantly higher in wards such as Toller, Bradford Moor and Little Horton. Dmft is significantly lower in wards such as Baildon, Worth Valley and Craven. Oral health has been included as an important part of the health visiting service where a universal service is provided to all children with information



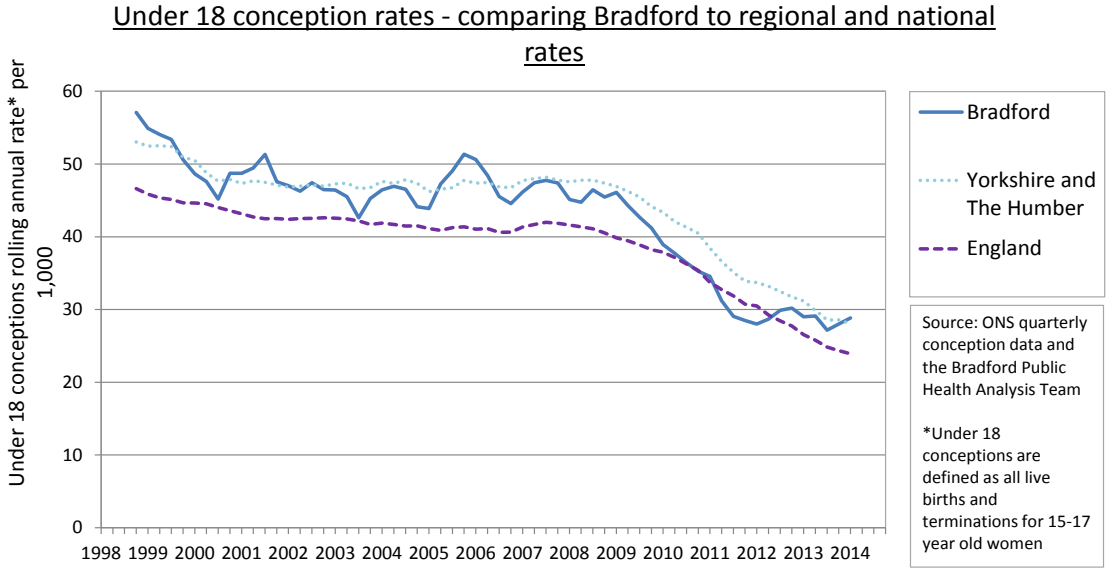
d) Emergency admissions for unintentional injuries (2012/13)

Managing minor illness and reducing accidents (reducing hospital attendance/admissions). Illness such as gastroenteritis and upper respiratory tract infections, along with injuries caused by accidents in the home, are the leading causes of attendances at Accident & Emergency departments and hospitalisation amongst the under 5s. Managing minor illnesses and reducing accidents is identified as one of the six high impact areas for children age 0-5, and an important part of the early intervention and prevention role health visitors can promote. As can be seen from local data ct areas Out of **496** emergency admissions for children age 0-4 for unintentional injuries, the following include the top five areas:

Unintentional injuries (2012/13) for children age 0-4	**%**
1. Open wound of head	25.0%
2. Open wound of wrist and hand	14.1%
3. Other and unspecified injuries of head	9.5%
4. Superficial injury of head	7.9%
5. Fracture of forearm	7.2%
Total	**63.7%**

e) Sexual Health - Teenage conceptions

The latest data shows that, when averaged across the four quarters of Q2 2013 to Q1 2014, the teenage conception rate of 28.9 per 1,000 in the Bradford district was higher than the Yorkshire and The Humber rate of 28.1 per 1,000 and the England rate of 23.9 per 1,000. The Bradford district teenage conception rate has decreased considerably over time from 57.1 per 1,000 in 1998 which, at the time, was the highest rate in West Yorkshire. The trend over time has decreased in all West Yorkshire local authorities and the rates are now very similar. Improved education and working with young people and their parents has been key to reducing teenage pregnancies across the Bradford district, and the role of the School Nurse may be key in influencing this



Across the four quarters of Q2 2013 to Q1 2014, there were 308 conceptions for 15-17 year old women in the Bradford district, although it is unknown what proportion of the conceptions results in a live birth and what proportion terminates the pregnancy.

The following map shows that the wards with the highest teenage conception rates in 2010-2012 were Wyke, Tong and Keighley West. Between 2009-2011 and 2010-2012, the ward with the greatest increase in rate was Wyke which has not been considered a hotspot historically. This highlights the importance of monitoring the changing Public Health needs of local people.

f) Educational outcomes

Below average 'Good levels of development' aged 5 years in Reception year (Early Years Foundation Profile) – also known as 'school readiness' - compared to nationally 62% Bradford compared to 66% for England. This is worse in more deprived areas of the district.

- Educational attainment is improving but remains below national averages and much lower in more deprived areas. 53% of children obtain 5 A-C GCSEs including English and Maths compared to 59% nationally.
- Less children achieve a good level of development at age 5 than nationally. 36% of children eligible for free school meals achieved a 'good' level of development aged 5, compared to 56% of children not so eligible.

g) Child Health Profile – 2016

The Child Health Profile for Bradford local authority is published annually (last updated 15 March 2016) via Public Health England, and provide a snapshot of performance around child health and wellbeing, using 32 selected key health indicators. This profile (below) enables comparisons to be made locally, regionally and nationally.

http://www.chimat.org.uk/resource/view.aspx?RID=273397

Bradford Child Health Profile — March 2016

The chart below shows how children's health and wellbeing in this area compares with the rest of England. The local result for each indicator is shown as a circle, against the range of results for England which are shown as a grey bar. The red line indicates the England average. The key to the colour of the circles is shown below.

- Significantly worse than England average
- Significantly better than England average
- Not significantly different
- Regional average

	Indicator	Local no.	Local value	Eng. ave.	Eng. Worst	Eng. Best
Premature mortality	**1** Infant mortality	47	5.8	4.0	7.2	1.6
	2 Child mortality rate (1-17 years)	24	17.3	12.0	19.3	5.0
Health protection	**3** MMR vaccination for one dose (2 years) >=90% <90%	7,695	94.1	92.3	73.8	98.1
	4 Dtap / IPV / Hib vaccination (2 years) >=90% <90%	7,875	96.3	95.7	79.2	99.2
	5 Children in care immunisations	550	82.1	87.8	64.9	100.0
Wider determinants of ill health	**6** Children achieving a good level of development at the end of reception	5,030	62.2	66.3	50.7	77.5
	7 GCSEs achieved (5 A*-C inc. English and maths)	3,060	47.5	57.3	42.0	71.4
	8 GCSEs achieved (5 A*-C inc. English and maths) for children in care	-	-	12.0	8.0	42.9
	9 16-18 year olds not in education, employment or training	990	5.4	4.7	9.0	1.5
	10 First time entrants to the youth justice system	283	487.2	409.1	808.6	132.9
	11 Children in poverty (under 16 years)	29,595	24.0	18.6	34.4	6.1
	12 Family homelessness	192	0.9	1.8	8.9	0.2
	13 Children in care	880	63	60	158	20
	14 Children killed or seriously injured in road traffic accidents	34	27.5	17.9	51.5	5.5
Health improvement	**15** Low birthweight of term babies	278	3.7	2.9	5.8	1.6
	16 Obese children (4-5 years)	582	8.6	9.1	13.6	4.2
	17 Obese children (10-11 years)	1,345	21.5	19.1	27.8	10.5
	18 Children with one or more decayed, missing or filled teeth	-	46.0	27.9	53.2	12.5
	19 Hospital admissions for dental caries (1-4 years)	164	497.2	322.0	1,406.8	11.7
	20 Under 18 conceptions	299	27.9	24.3	43.9	9.2
	21 Teenage mothers	81	1.1	0.9	2.2	0.2
	22 Hospital admissions due to alcohol specific conditions	45	32.5	40.1	100.0	13.7
	23 Hospital admissions due to substance misuse (15-24 years)	77	111.3	88.8	278.2	24.7
Prevention of ill health	**24** Smoking status at time of delivery	1,192	15.1	11.4	27.2	2.1
	25 Breastfeeding initiation	5,481	70.7	74.3	47.2	92.9
	26 Breastfeeding prevalence at 6-8 weeks after birth	3,226	41.6	43.8	19.1	81.5
	27 A&E attendances (0-4 years)	19,109	465.9	540.5	1,761.8	263.6
	28 Hospital admissions caused by injuries in children (0-14 years)	1,593	135.9	109.6	199.7	61.3
	29 Hospital admissions caused by injuries in young people (15-24 years)	1,238	179.4	131.7	287.1	67.1
	30 Hospital admissions for asthma (under 19 years)	420	287.3	216.1	553.2	73.4
	31 Hospital admissions for mental health conditions	111	79.9	87.4	226.5	28.5
	32 Hospital admissions as a result of self-harm (10-24 years)	483	463.8	398.8	1,388.4	105.2

Notes and definitions - Where data is not available or figures have been suppressed, this is indicated by a dash in the appropriate box.

1 Mortality rate per 1,000 live births (age under 1 year), 2012-2014
2 Directly standardised rate per 100,000 children age 1-17 years, 2012-2014
3 % children immunised against measles, mumps and rubella (first dose by age 2 years), 2014/15
4 % children completing a course of immunisation against diphtheria, tetanus, polio, pertussis and Hib by age 2 years, 2014/15
5 % children in care with up-to-date immunisations, 2015
6 % children achieving a good level of development within Early Years Foundation Stage Profile, 2014/15
7 % pupils achieving 5 or more GCSEs or equivalent including maths and English, 2014/15
8 % children looked after achieving 5 or more GCSEs or equivalent including maths and English, 2014 (provisional)
9 % not in education, employment or training as a proportion of total age 16-18 year olds known to local authority, 2014
10 Rate per 100,000 of 10-17 year olds receiving their first reprimand, warning or conviction, 2014
11 % of children aged under 16 living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income, 2013
12 Statutory homeless households with dependent children or pregnant women per 1,000 households, 2014/15
13 Rate of children looked after at 31 March per 10,000 population aged under 18, 2015
14 Crude rate of children age 0-15 years who were killed or seriously injured in road traffic accidents per 100,000 population, 2012-2014
15 Percentage of live-born babies, born at term, weighing less than 2,500 grams, 2014
16 % school children in Reception year classified as obese, 2014/15
17 % school children in Year 6 classified as obese, 2014/15
18 % children aged 5 years with one or more decayed, missing or filled teeth, 2011/12
19 Crude rate per 100,000 (age 1-4 years) for hospital admissions for dental caries, 2012/13-2014/15
20 Under 18 conception rate per 1,000 females age 15-17 years, 2013
21 % of delivery episodes where the mother is aged less than 18 years, 2014/15
22 Crude rate per 100,000 under 18 year olds for alcohol specific hospital admissions, 2011/12-2013/14
23 Directly standardised rate per 100,000 (age 15-24 years) for hospital admissions for substance misuse, 2012/13-2014/15
24 % of mothers smoking at time of delivery, 2014/15
25 % of mothers initiating breastfeeding, 2014/15
26 % of mothers breastfeeding at 6-8 weeks, 2014/15
27 Crude rate per 1,000 (age 0-4 years) of A&E attendances, 2014/15
28 Crude rate per 10,000 (age 0-14 years) for emergency hospital admissions following injury, 2014/15
29 Crude rate per 10,000 (age 15-24 years) for emergency hospital admissions following injury, 2014/15
30 Crude rate per 100,000 (age 0-18 years) for emergency hospital admissions for asthma, 2014/15
31 Crude rate per 100,000 (age 0-17 years) for hospital admissions for mental health, 2014/15
32 Directly standardised rate per 100,000 (age 10-24 years) for emergency hospital admissions for self-harm, 2014/15

APPENDIX 6: CURRENT HEALTH VISITING SERVICE

Based on the tier waiting lists Bradford District Health Trust (BDFHT) indicate a total number of **42,442** children age 0-5, of which **39,918** are universal contacts (94.1% respectively) as stated below:

Level	Service	Number	%
Tier 1	**Universal**	**39918**	**94.1%**
Tier 2	**Universal Plus**	**1577**	**3.7%**
Tier 3	**Partnership**	**767**	**1.8%**
Tier 4	**Partnership Plus**	**180**	**0.4%**
Total		**42442**	

1. Health Outcomes

Children's public health services contribute to the Public Health Outcomes Framework for England 2013 – 2016 (PHOF) which aims "to improve and protect the nation's health and wellbeing and to improve the health of the poorest fastest." Specifically, children's public health contributes to:

Improving the wider determinants of health	▪ PHOF 1.2: School readiness
Health Improvement	▪ PHOF 2.2: Breastfeeding initiation and prevalence at 6-8 weeks after birth ▪ PHOF 2.5: Child development at 2-2½ years ▪ PHOF 2.6: Excess weight in 4 – 5 year olds ▪ PHOF 2.7: Hospital admissions caused by unintentional and deliberate injuries in under 5s ▪ PHOF 2.21: Access to non-cancer screening programmes
Health Protection	▪ Population vaccination coverage (PHOF 3.3) ▪
Healthcare public health and preventing premature mortality	▪ PHOF 4.1: Infant mortality ▪ PHOF 4.2:Tooth decay in children aged 5

The Government, NHS England, Public Health England, Royal Colleges, local government organisations and others signed up to the pledge for *Better health outcomes for children and young people* in February 2013.

The indicators set out in the Public Health Outcomes Framework can be used to monitor and measure effectiveness of local efforts to improve public health:

- Child development at 2 – 2 ½ years
- Hospital admissions caused by unintentional and deliberate injuries

Other indicators include:

- Children in poverty
- Improved vaccination coverage
- Improved School readiness
- Reduced Pupil absence
- Increase in 16-18 yr olds not in education, employment or training
- reduction in Under 18 conception rate
- reduced 1st time entrants to the youth justice system
- reduced hospital admissions for intentional self-harm
- reduced Hospital admissions for alcohol-related harm
- reduction in Domestic violence
- reduced Rates of violent crime including sexual violence

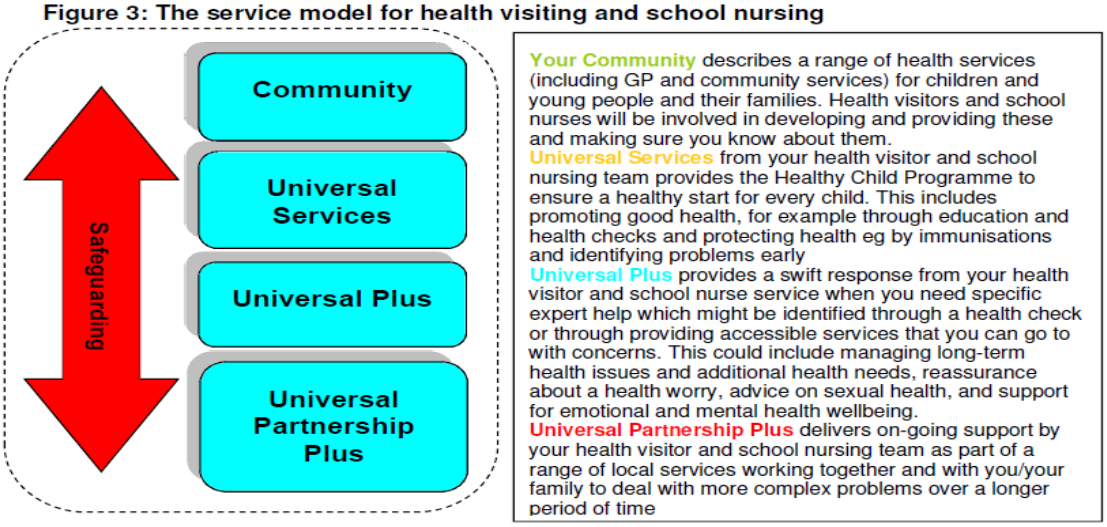
2. Service description for the universal elements of the HCP

The universal elements of the HCP are delivered by a team led by health visitors working in a way that is most appropriate to local public health needs and across a range of settings and organisations including general practice, maternity services and children's centres (except where families are accessing FNP, in which case the FNP nurse – family nurse – will take on this role until the child is two years old). As an overview, core elements of the HCP include:

a) **Health and development reviews** – To assess family strengths, needs and risks; provide parents the opportunity to discuss their concerns and aspirations; assess child growth and social and emotional development; and detect abnormalities.
b) **Screening** – an integral part of the universal HCP. Commissioning of national childhood screening programmes is specified separately (NHSE)
c) **Immunisations** – Immunisations should be offered to all children and their parents. General practices and child health record departments maintain a register of children under five years, invite families for immunisations and maintain a record of any adverse reactions in the CHIS. Commissioning of childhood immunisation programmes is specified separately (NHSE).
d) **Promotion of social and emotional development –** The HCP includes opportunities for parents and practitioners to review a child's social and emotional development, for the practitioner to provide evidence-based advice and guidance and for the practitioner to decide when specialist input is needed.
e) **Support for parenting –** One of the core functions of the HCP is to support parenting using evidence-based programmes and practitioners who are trained and supervised.
f) **Effective promotion of health and behavioural change** – Delivery of population, individual and community-level interventions based on NICE public health guidance.
g) **Sick children** – Supporting parents to know what to do when their child is ill.
h) **Children with a disability** – Early diagnosis and early help.

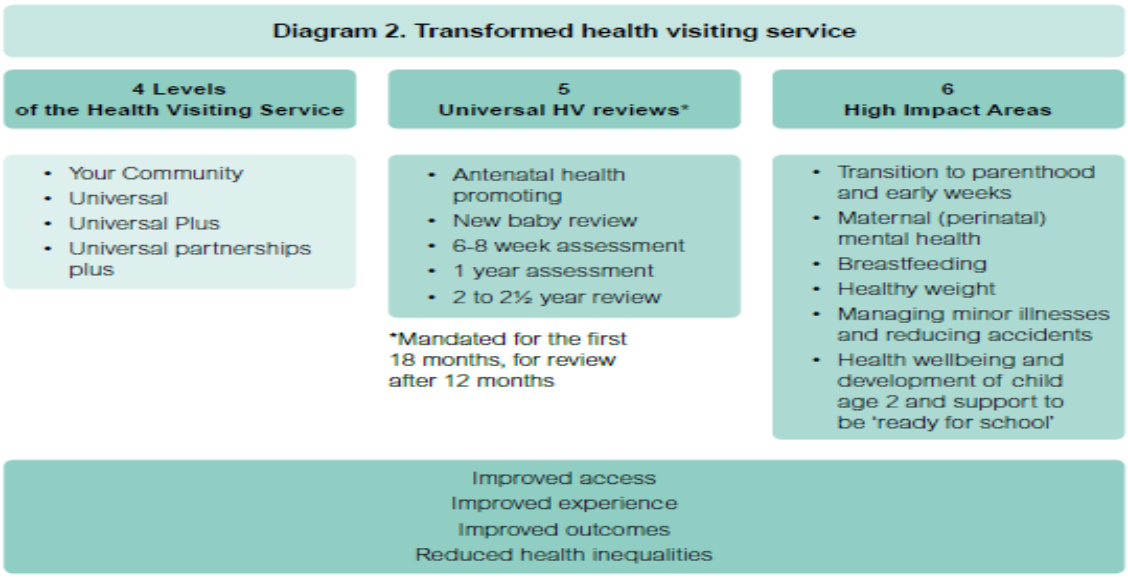
3. Safeguarding

Figure 3: The service model for health visiting and school nursing



4. The specification reflects the 4-5-6 model

a) **Four progressive tiers of health visiting practice** – building community capacity; the universal elements of the Healthy Child Programme; targeted interventions to meet identified need, and partnership working to meet complex needs



b) Delivery of the Five universal HCP checks and reviews

As part of the transfer of services the Department of Health (DH) has mandated local authorities (under section 6C of the NHS Act 2006) to ensure the provision of the following five key elements of the HCP to be delivered by health visitors:

1. **Antenatal health promoting reviews**
2. **New baby reviews**
3. **Six to eight week assessments**
4. **One year assessments and**
5. **Two to two and a half year reviews.**

Health visitor service delivery metrics were developed by NHS England in order to provide assurance on service transformation in England around the five key areas and reporting included the following indications:

- Number of mothers who received a first face to face antenatal contact with a health visitor at 28 weeks or above;
- % of new birth visits completed after 14 days;
- % of 6 to 8 week development reviews completed by 8 weeks;
- % breastfeeding (fully or partially) at 6 to 8 weeks;
- % of 12 month development reviews completed by the time the child turned 12 months;
- % of 12 months development reviews completed by the time the child turned 15 months;
- % of 2 to 2½ year reviews completed by age 2½ years;
- % of 2 to 2½ year development reviews delivered using the ASQ-31 (new indicator).

c) Six high impact areas:

- Working in partnership with other services in supporting assessment of education and health and care plans for children aged 0-5s is a strong focus, including a family centred approach to meeting the needs of children with Special Educational Needs and contributing to high intensity multi-agency services where there are safeguarding or child protection concerns. The specification highlights the health visiting contribution as experts and leaders in delivering better health and wellbeing for 0-5s. The Six High Impact Area documents have been developed to articulate the contribution of health visitors to the 0-5 agenda and describe areas where health

visitors have a significant impact on health and wellbeing and improving outcomes for children, families and communities. This includes:

1. **Transition to Parenthood and the Early Weeks**
2. **Maternal Mental Health (Perinatal Depression)**
3. **Breastfeeding (Initiation and Duration)**
4. **Healthy Weight, Healthy Nutrition (to include Physical Activity)**
5. **Managing Minor Illness and Reducing Accidents (Reducing Hospital Attendance/Admissions)**
6. **Health, Wellbeing and Development of the Child Age 2 – Two year old review (integrated review) and support to be 'ready for school'**

APPENDIX 7: STAFFING AND FINANCE

Staffing

The Health Visiting Service is split into multidisciplinary teams comprising of qualified Nurses, Nursery Nurses and Health Care Support Workers.

Expansion of FNP took place from 2011 over 3 years and is now funded for Supervisors, Family Nurses and Quality Support Officer during 2015. The team has a maximum capacity for delivery of FNP to 245 clients. There are a total of:

- There are a total of 215.66 WTE HV staff (Qualified HV and FNP (Band 6 and above) = 163.12WTE.
- 12.61 FNP staff
- **Totalling 228.27 staff**.

Finance

The current service transferred from NHS England with a part year budget and Contract value of £6,020,319 for 2015/16. At the point of the Review, the contract value for 2016/17 was £10,692,530.

APPENDIX 8: CURRENT PERFORMANCE (HV) SERVICES

Level of service provided by Health visiting teams

Based on the tier waiting lists BDCFHT indicate the following level of services for Universal and targeted services.

Level	Service	Number	%
Tier 1	**Universal**	**39918**	**94.1%**
Tier 2	**Universal Plus**	**1577**	**3.7%**
Tier 3	**Partnership**	**767**	**1.8%**
Tier 4	**Partnership Plus**	**180**	**0.4%**
Total		**42442**	

Current Service Performance

The current service is based on national KPIs, although local variations include Healthy start and oral health, as well as ensuring integrated working and Health Visitor leadership to the children centre clusters of which there are now seven.

Mandated Health Checks

Current measures based on the five mandated health checks and reviews and includes the KPIs highlighted in table below which is collected quarterly.

Indicator/Measurement
Number of mothers who received a first face to face antenatal contact with a health visitor at 28 weeks or above
% of new birth visits completed within 14 days
% of new birth visits completed after 14 days;
Total number due 6-8 week check
Number of infants where breastfeeding status is recorded at 6-8 week check
% breastfeeding (fully or partially) at 6 to 8 weeks;
Total Number of children age2.5 in that qtr
% of 12 month development reviews completed by the time the child turned 12 months;
% of 12 months development reviews completed by the time the child turned 15 months;
% of 2 to 2½ year reviews completed by age 2½ years
Total number of children 2 to 2½ year in that Qtr

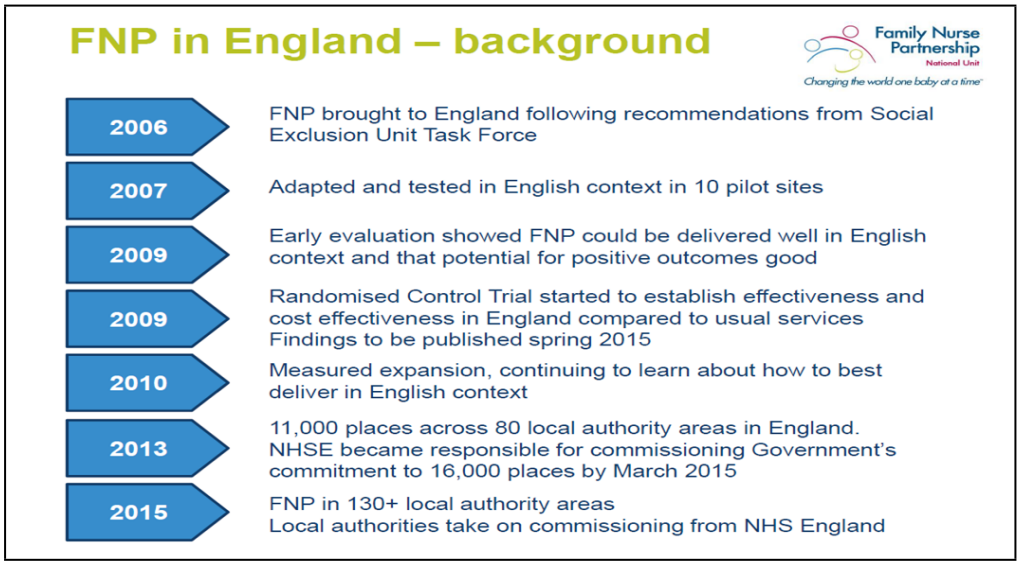
High impact areas

These KPIs relate to local variations which were included at the time of transfer and refer to new KPIs in addition to the nationally defined ones. Hence the data is not complete but shows the level of detail expected as part of the service. Where areas are not met, action plans and reports are provided.

APPENDIX 9: FAMILY NURSE PARTNERSHIP PROGRAMME

1. Background - Why is FNP important?

- Number of births to teenage mothers in England was substantial - 32,000 in 2013
- Teenage mothers often have low economic and psychological resources which can be a barrier to them being an effective parent
- There is strong evidence indicating that children of teenage mothers and mothers themselves are at high risk of poor health and development outcomes over the course of their life as well as increased risk of infant mortality
- Levels of safeguarding and domestic violence are high in young parents



2. FNP licence and national leadership

a) The FNP programme is a licensed programme and therefore has a well-defined and detailed service model, which must be adhered to.

b) DH retains policy responsibility for FNP. The FNP National Unit provides FNP providers with support and guidance for implementation of the programme, provides sub-licences to providers, delivers the learning programme for family nurses and supervisors, provides the FNP Information System, leads quality assurance and improvement processes, offers networking between sites and the coordination of programme developments and augmentations and supports the commissioning of FNP by NHS England.

3. Roles

a) Three key organisations are involved in delivery of the FNP programme. The Department of Health retains responsibility for the overarching policy for the FNP programme. DH holds the national licence for FNP from the University of Colorado, Denver, and must ensure that the programme is delivered in England in accordance with that licence.

b) NHS England was responsible for commissioning providers to deliver the commitment to increase the number of places on the FNP programme to 16,000 by 2015, in line with the agreed commissioning priorities.

c) The FNP National Unit is responsible for ensuring the delivery of the programme to the licence standards. The FNP National Unit leads implementation support and the family nurse and supervisor learning programme as set out in its contract

with DH. It provides a quality improvement programme, in line with the FNP and provides intensive support with regular review and follow up.

d) Public Health in Local Authority took over commissioning in October 2015.

4. FNP target population

FNP is a voluntary programme, targeted to first time mothers aged 19 and under (at last menstrual period) with the aim to enrol women on the programme as early as possible in pregnancy, ideally before 16 weeks and no later than 28 weeks gestation. Other specific criteria include geographical location according to predicted population needs.

5. Aims

FNP shares the over-arching aims of the HCP to reduce inequalities in outcomes and to ensure a strong focus on prevention, health promotion and early identification of needs. It has additional specific aims, which are to:

1. improve the outcomes of pregnancy by helping young women improve their ante-natal health and the health of their unborn baby;
2. Improve children's subsequent health and development by helping parents to provide more consistent competent care for their children; and
3. Improve women's life course by planning subsequent pregnancies, finishing their education and finding employment.

6. Service description

a) The FNP programme consists of structured home visits from early in pregnancy until the child is two, delivered by family nurses. The visits cover the six domains of: personal health, environmental health, life course development, maternal role, family and friends, and health and human services. FNP is based on the theories of human ecology, attachment and self-efficacy.

b) FNP is delivered in an integrated way with maternity, general practice, community health services, health visiting, children's centres, Job Centres and third sector providers within the context of integrated children's services and the HCP.

c) The service will be flexible and responsive, adapting to the individual needs of children and families whilst ensuring fidelity to the licensed FNP programme model.

7. Expectation of Providers

a) Providers will be expected to have systems in place for early recruitment of young women (before 16 weeks gestation) to maximise the enrolment of eligible clients in early pregnancy, enabling them to get maximum benefit from the programme.

b) Providers will be expected to have clear operational standards in place, in relation to how the FNP interfaces with, and relates to, all of the agencies supporting the delivery of the HCP. Providers will also be expected to have pathways in place for families moving from FNP to universal HCP and children's services. Providers will be expected to provide strong organisational leadership and support so the FNP programme can be delivered well in their area.

c) Family nurses will work in partnership with parents using the FNP guidelines, other programme materials and methods to enable mothers and fathers to increase their knowledge and understanding, set goals, make behaviour changes and develop their reflective capacity. This will enable them to build strong attachments with their baby, enhance their self-efficacy, develop effective strategies for good infant and toddler care-giving, strengthen and adapt to their parenting role.

d) Each site is required to recruit an FNP supervisor to lead the clinical implementation of the FNP programme with families. The FNP supervisor is responsible for the quality of programme delivery, using the FNP information system to support their assessment and improvement of implementation quality.

8. Service model

a) FNP will be delivered by a team of trained family nurses, led by the FNP supervisor and accountable to the local FNP Advisory Board. The FNP Advisory Board consists of senior decision makers for children and young people's services from the NHS, Local Authority and appropriate partner services. The Advisory Board is, generally speaking, chaired by the relevant commissioner from an Area Team.
b) Programme of FNP visits include:

- 1 per week first month
- Every other week during pregnancy
- 1 per week first 6 weeks after delivery
- Every other week until 21 months
- Once a month until age 2 10.18 Visits last approximately one hour and cover the following domains:
  - Personal health – women's health practices and mental health
  - Environmental health – adequacy of home and neighbourhood
  - Life course development – women's future goals
  - Maternal role – skills and knowledge to promote health and development of their child
  - Family and friends – helping to deal with relationship issues and enhance social support
  - Health and human services – linking to other services 10.19 The provider will implement the programme in accordance with the FNP Sub-licensing agreements and the expectations set out in the latest FNP Management Manual, provided by the FNP National Unit. This includes providing local safeguarding arrangements.

9. Recruitment Pathway

Those eligible will be identified by maternity services and notified to the FNP supervisor at 12 weeks gestation or earlier as far as possible. Clients must be enrolled on the programme no later than 28 weeks gestation with a specific fidelity goal to enrol at least 60% by 16 weeks gestation. Other services (e.g. GPs, education, children's centres) are able to identify and refer potential clients to FNP. Offer of the programme and recruitment will be carried out by the FNP team. FNP teams are expected to enrol clients onto the programme using a staged approach.

10. Care Pathway

The following is an outline of the FNP care pathway:

a) First time young mothers aged 19 and under will be offered FNP as part of the preventive pathway within the HCP. Young mothers enrolling on the programme will be visited by the same family nurse until the completion of the programme when the child is 2 years of age;

b) The programme will be delivered to young mothers within the context of the immediate and extended families involving fathers and grandparents;

c) Young mothers who accept the programme will receive structured visits from the family nurse in line with the FNP programme model;

d) The family nurse will work closely with the midwives who will be responsible for the young mother's midwifery care;

e) Babies born into the programme will receive the HCP as part of the FNP. The family nurse will deliver the HCP and is responsible for ensuring access to the

physical examination, newborn hearing screening, blood spot screening and immunisations;

f) Before children reach the age of two years, the family nurse will notify the health visitor lead for the HCP team, and agree future service delivery. Families will be supported to access wider children's services to meet their individual needs;

g) The FNP Supervisor will have systems in place for effective communication, audit and information sharing for all aspects of the FNP with midwives, social care, health visitors, GPs and children's centres;

h) Young mothers who choose not to enrol on FNP will be notified back to the midwife who will continue to coordinate care for the family until 14-28 days after the birth of the baby ensuring the young mother has access to the universal and progressive aspects of the HCP;

i) Every effort will be made by the family nurse to ensure continued engagement of the client in FNP. Clients who leave the programme before their child is 2 years old will be notified to the health visitor who is responsible for universal services, ensuring access to preventive services and to others providing the HCP (e.g. GPs). FNP teams will follow the FNP National Unit's guidance and local guidance regarding clients who cannot be traced and will act to safeguard the child or other family members where risks are identified requiring further actions;

j) Family nurses and supervisors will use the FNP Information System to record data about their clients and use this to inform how they deliver the programme; and,

k) Where the FNP client has a second child during the time of her involvement with FNP, the family nurse will be responsible for delivery of the HCP to the family for the second child, in addition to the first, until the first child reaches the age of 2 years.

11. Discharge Criteria and Planning

a) A client graduates from the programme when the child reaches 2 years of age. Responsibility for HCP delivery is transferred back into universal HV services.

b) Before children reach the age of two years the family nurse will notify the health visitor lead for the HCP team and discuss the handover process with the client. Families will be supported to access children's centres and the HCP will match services and interventions to their individual needs.

c) Family nurses will continue to make all efforts to locate clients who cannot be found and persist in their efforts to re-engage clients who indicate that they no longer wish to receive the programme, either directly or by repeated missed visits.

d) If a client with significant risk or safeguarding factors is not receiving programme visits for any reason, local safeguarding processes should be implemented.

e) Young mothers who choose not to accept FNP will be notified to the midwife who will continue to coordinate care for the family until 14-28 days after the birth of the baby ensuring the young mother has access to the universal and progressive aspects of the HCP.

APPENDIX 10: FINDINGS FROM THE RCT & BRADFORD FNP

Family Nurse Partnership

FNP in Bradford & Airedale began in November 2010 as a Wave 3b site with 1 (0.8 WTE) Supervisor, 4 (3.75 WTE) Family Nurses and 1 (0.5 WTE) This gave an approximate coverage of 10% of eligible clients. Recruitment of clients was from identified teenage pregnancy hotspot areas and compliant with licence requirements.

As a result of the successful implementation and evaluation and the measured expansion nationally, expansion of FNP took place from 2011 over 3 years and is now funded for 1.32 WTE Supervisors, 9.42 WTE Family Nurses and 0.96 WTE Quality Support Officer and a maximum capacity for delivery of FNP to 245 clients.

This gives an approximate coverage for 30% of eligible clients.

Clients are currently recruited from the following wards:

Tong, Low Moor, Wyke, Great Horton, Little Horton, Bowling & Barkerend, Allerton, Royds and Keighley

Direct referrals of potential clients from Looked After or Leaving Care systems and Families First are not restricted to geographical areas. Additionally, potential client with other risks such as ongoing mental health issues are considered outside the current geographical area.

The findings of the key national research on FNP published in September 2015 have been discussed with the National FNP Team alongside local data for FNP. Primary health outcomes were not improved but there was evidence of some improvements in other secondary outcomes and the results and implications are under consideration nationally and locally as part of the FNP ADAPT approach

APPENDIX 11: CURRENT PERFORMANCE (FNP)

The current FNP programme has demonstrated high fidelity to the licensed FNP programme and the recent FNP Advisory Board in March 2016 confirmed this. There is evidence that the FNP team overall perform better than similar teams across the country in terms of both fidelity and adherence to the programme and also in terms of improving outcomes for pregnant women and children in a range of areas monitored via this programme.

APPENDIX 12: HEALTH VISITING & FNP CONSULTATION

See pdf attached.

Health Visiting Service Review - Con

APPENDIX 13: PROPOSED MODEL FOR HEALTH VISITING

Future commissioning needs to support sustainable health visiting services and the '4, 5, 6' model helps to explain the public health services for 0-5s. The four levels of health visiting service, the five elements which are mandated, and the six high impact areas focus on evidence based interventions which are up to date and align with early years and other appropriate services.

It is also important that we continue with the 4-5-6 model but align this more effectively within children services so that it is more integrated. As part of this it will be important we review the current integrated care pathways

Although it is anticipated that the Regulations to mandate the five universal reviews will expire on the 31 March 2017, it is important locally that we continue mandating the five universal reviews within the Healthy Child Programme. Future commissioning needs to continue to support sustainable health visiting services identified in the '4-5-6' model. This includes the six high impact areas which focus on evidence based interventions which align more effectively within children services and the CCGs so that services are more integrated. As part of this it will be important we review and enhance the current integrated care pathways, and in conjunction with the children centre review.

National and local policy context is being implemented locally and overall we have a good 0-5 service with both national and local performance monitoring arrangements. Whilst the outcomes of the review and consultation have been mainly positive, we have drawn out areas from the consultation, which require improvement and further development in order to have a model which is fit for purpose and geographically aligned. Given the current financial climate it is even more important we have a model which is cost effective and demonstrates value for money.

Recommendations for proposed model of health visiting services

1. **Effective leadership, coordination and delivery of the Healthy child programme as highlighted in the 4-5-6 model, including the five mandated health checks, 6 high impact areas and both universal and targeted services.**
   a) Effective delivery of both Universal and targeted services in order to deliver mandated health checks and child development reviews in accordance with the integrated care pathway
   b) Effective delivery and support of the six high impact areas

2. **Delivery of evidence based outcome focused interventions to improve health and wellbeing and reduce inequalities by focusing on needs of young children including vulnerable groups.**

3. **Effective teams and partnerships, working across professions and organisations; using evidence based interventions and the development and implementation of appropriate pathways to support families with early help.**
   a) Deliver on an area-based service structured in line with local children's services, using an integrated approach to improving child and family health locally, including leading partnerships within early year's settings, Children centre clusters and other partner agencies including social care and the voluntary and community sector.
   b) Ensure local intelligence and mapping of services is incorporated into appropriate delivery models to improve outcomes for children, young people and their families (with effective signposting).
   c) Provide proactive 'early help' and leadership as part of a multi-agency team with direct partnership with schools to provide improved access and delivery of the Healthy Child Programme and school readiness

d) Develop effective professional partnership pathways working with other parts of the health system so there are clearer pathways and referrals and a single child health record (for example primary care, speech language therapy, audiology, screening and child health systems).
e) Establish positive partnerships with families to support effective lifestyle and behaviour change.

4. **Improved access to health visiting services through a geographically aligned model with clear alignment to children's centre clusters. This includes recognising the important role and links to GPs and Primary care, and mapping of Voluntary and community Sector organisations and groups to support and signpost to where necessary.**
   a) Better access to the health visiting service (not through a hub), and direct access for vulnerable families and special needs.
   b) Access to health visiting services in locations closer to where families live
   c) Access to private facilities with flexibility where needed to target vulnerable groups, such as minority groups and engagement with fathers.
   d) Every family has access to an appropriate interpreter where needed.

5. **Improved communication and resources according to community needs, ensuring more "visibility" of health visitors and information and resources in appropriate languages.**
   a) To ensure a clearer understanding about the role of the health visiting/FNP and what families/services can expect from the service using different methods of communication according to need (social networks/media/campaigns)
   b) To be more visible in the community setting (drop ins)
   c) Information provided in appropriate community languages
   d) Bilingual support available to vulnerable women who do not speak English (Asylum Seeker/Travellers/ Gypsies)

6. **Workforce capacity and development to ensure diverse needs of communities are represented but also appropriate training to ensure a competent workforce and relevant skill mix providing consistency in messages.**
   a) To ensure appropriately skilled and experienced workforce working in multi-disciplinary roles (skill mix and students) with appropriate leadership.
   b) To ensure workforce reflects the diversity of the local population and communities it serves, with an understanding of the diverse and cultural needs of the District.
   c) To undertake Public Health and relevant training as required.

7. **Targeted work with vulnerable Families and children with specific needs, and to ensure appropriate structures in place so families of children age 0-5 and mothers do not miss out on vital health checks**
   a) To identify families with high risk and low protective factors
   b) To utilise specialist skills to identify risk factors in protecting children. Some risk factors may be so high that no amount of protective factors will compensate and action to prevent the child from harm must be taken;
   c) To link to wider stakeholder and services, for example local A&E services and the local Troubled Families Team
   d) To map out services in their geographical areas so women and families can be signposted to (e.g. local areas to Voluntary and community health organisations and groups - such as bereavement support, Homestart, children centres, community groups, obesity groups and other Early years services)
   e) To ensure structures in place so no families with children age 0-5 miss out on vital health checks and reviews – for example women who have not given birth in Bradford (migrant communities) and Mothers with babies with special needs still in hospital.

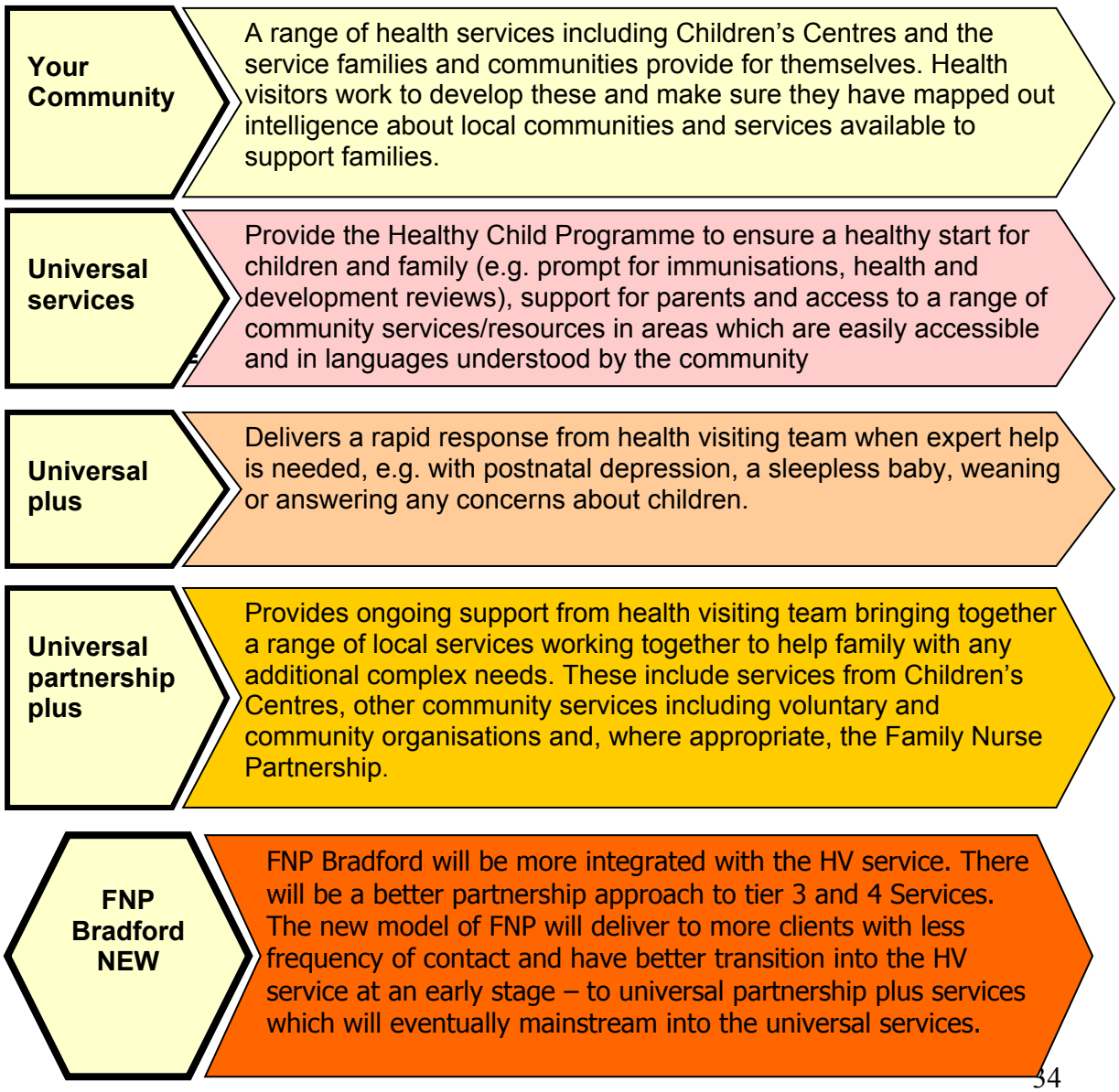
8. **Service delivery to incorporate 'Journey to Excellence' with 'Early Help' and 'Signs of Safety' as well as implementation of the Integrated Early Years Strategy for children age 0-7**
   a) Undertaking comprehensive population, community family and individual needs assessments and undertaking wider public health work to reduce inequalities
   b) Consistency of health messages given to service users and their families.
   c) Support to vulnerable families and those with complex and additional needs;
   d) Working with GPs to ensure referrals and raising of concerns, prompting for 6-8 week check.
   e) Service delivery forming a key part of 'Journey to Excellence' with 'Early Help', 'Signs of Safety' integrated within the service model.

9. **A caseloads model to be developed and delivered according to need and priority**
   To prioritise caseloads according to need.

10. **Nurse prescribing to include advice and support in managing minor illness and reducing hospital admissions, as well as providing level 1 contraceptive advice.**

11. **Ensure robust transition to school for children and close working with the school nursing service.**

The New Service Offer



APPENDIX 14: PROPOSED MODEL FOR FNP

Family Nurse Partnership

One of the key priorities for Public health is to ensure future commissioning supports sustainable public health services for 0-5s, and provides the best outcomes for children and their families, through universal health visiting services and targeted support such as the Family Nurse Partnership (FNP).

Whilst evidence from the consultation and findings from the FNP have provided excellent feedback from service users and stakeholders, this has not correlated with national evidence from literature review and the recent publication of the RCT. Given the funding cuts and recent research highlighting the impact of FNP, it is recommended that a new model of FNP which is fit for purpose is developed locally. This should include how this can be embedded into the local health visiting services with a focus on child development and a smoother transition from FNP to health visiting services

One of the advantages locally in Bradford, unlike other neighbouring areas where decision has been made to decommission FNP - is that we have the Better Start Bradford. This provides a real opportunity to develop and pilot a model which is based on local need and supported by the national team with robust monitoring processes with more locally defined outcomes and criteria.

The current model of FNP would need to include an exit strategy incorporating any risks and a revised model which is based on local outcomes agreed with the national unit. It is proposed that the local model is based on less frequency of contact, which will allow for more targeted work with an increase in the numbers of women targeted. It is proposed that the new model reduces the frequency in terms of number of visits and length from two years to one year, with a smoother transition to the health visiting service which will have a revised model incorporating the learning from the FNP.

Recommendations for a new Family Nurse Partnership model

Recommendations are based, not only on consultation and stakeholder engagement but also contextualised in relation to literature review and current research evidence such as the FNP RCT and discussions with the FNP Board and Better start.

Whilst evidence from the consultation and findings from the FNP have provided excellent feedback from service users and key stakeholders, this has not correlated with national evidence from the literature review and in particular the recent publication of the RCT, and the following recommendations are therefore proposed

1. Develop of a new model of FNP (FNP ADAPT) which is fit for purpose and developed with locally defined outcomes
2. Embed the learning from the FNP into the proposed health visiting service, focusing on child development and a smoother transition from FNP to health visiting services.
3. Work in partnership with Better Start Bradford to develop and pilot a model which is based on local need and supported by the National FNP Team
4. Ensure robust performance and monitoring processes in place which can compare outcomes from Health visiting to FNP
5. Review and inclusion of long term outcomes and wider determinants, such as educational achievement, with attached measures to be monitored as part of FNP.

   This provides an opportunity to embed the learning from the FNP into the local health visiting service, which is identified as a gap in current service provision. This will need to focus on child development and a smoother transition from FNP to health visiting services. One of the advantages locally in Bradford, unlike other

neighbouring areas where - is that we have the Better Start Bradford. This provides a real opportunity to develop and pilot a model which is based on local need and supported by the national team with robust monitoring processes with more locally defined outcomes and criteria.

APPENDIX 15: EQUALITY IMPACT ASSESSMENT

Equality Impact Assessment Form

Department	Public Health	**Version no**	1.0
Assessed by		**Date created**	8.03.2016
Approved by		**Date approved**	
Updated by		**Date updated**	
Final approval		**Date signed off**	

Section 1: What is being assessed?

1.1 Name of proposal to be assessed:

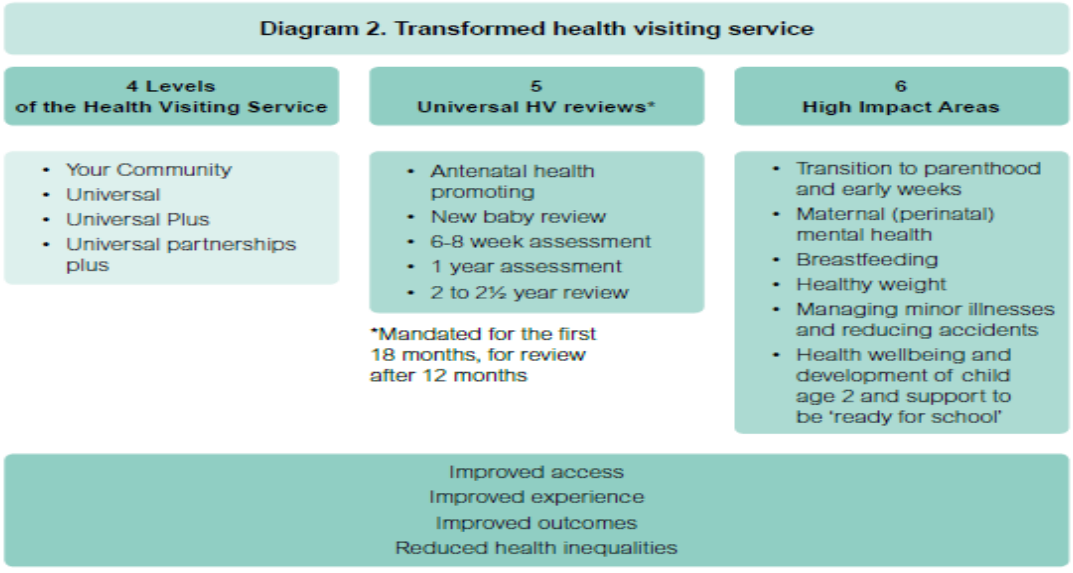
Health Visiting and FNP service for children age 0-5

1.2 Describe the proposal under assessment and what change it would result in if implemented:

Following transition of the 0-5 health visiting service into the local Authority in October 2015, it was a timely opportunity to undertake a review of the health visiting and FNP service.

The purpose of the review was to identify if the current service model meets current and emerging needs, fits within the 'Journey to Excellence' and 'New Deal' programmes and to identify opportunities for service improvement.

The service was reviewed in line with key national and local policy, guidance and strategy and was informed by consultation and engagement with key stakeholders. Key priority areas for Health visiting included both mandated and high impact areas as highlighted:



The current service is based on a national specification with four tiers of services to ensure both a universal and targeted service to ensure safeguarding is at the forefront of service delivery. The current services also includes mandated

services such as the universal reviews, as well as the high impact areas which are already an important part of the local early years strategy and objectives for the district.

Key stakeholders and partners reiterated the importance and strengths of a universal health visiting service identifying areas for improvement which will be outlined in the recommendations. This will result in a more accessible service that is better able to respond to the equality and diverse needs of children, young people and their families.

Section 2: What the impact of the proposal is likely to be

The Equality Act 2010 requires the Council to have due regard to the need to-

- eliminate unlawful discrimination, harassment and victimisation;
- advance equality of opportunity between different groups; and
- foster good relations between different groups

2.1 Will this proposal advance equality of opportunity for people who share a protected characteristic and/or foster good relations between people who share a protected characteristic and those that do not? If yes, please explain further.

The proposal will advance equality of opportunity and support a reduction in health inequalities in children age 0-5 and their families including those with a protected characteristic. The new service model will ensure improved service accessibility for priority groups such as pregnant and breastfeeding mothers, babies and children as well as ensure effective delivery targeted at most vulnerable groups.

2.2 Will this proposal have a positive impact and help to eliminate discrimination and harassment against, or the victimisation of people who share a protected characteristic? If yes, please explain further.

The proposal will not directly eliminate discrimination, harassment or victimisation but it will support this as the focus is on pregnant and maternity which is a protected group.

2.3 Will this proposal potentially have a negative or disproportionate impact on people who share a protected characteristic? If yes, please explain further.

The Equality assessment carried out indicates that this proposal is not likely to have a negative disproportionate impact on most if not all protected characteristics. However, one of the main aims of the new service model is to reduce health inequalities so will therefore have a positive impact on children and young people who experience health inequalities.

2.4 Please indicate the level of negative impact on each of the protected characteristics?
(Please indicate high (H), medium (M), low (L), no effect (N) for each)

The current service is a universal service, hence should not have any negative impact on any group, however in some cases such as the FNP, there will be a positively high impact on low income groups and because the service is for mothers with children age 0-5 will have positive impact on pregnancy and maternity.

Protected Characteristics:	**Impact** (H, M, L, N)
Age	**L**
Disability	**L**
Gender reassignment	**N**
Race	**L**
Religion/Belief	**L**
Pregnancy and maternity	**L**
Sexual Orientation	**L**
Sex	**L**
Marriage and civil partnership	**N**
Additional Consideration:	
Low income/low wage	**L**

2.5 How could the disproportionate negative impacts be mitigated or eliminated?

Consideration has been given to protected characteristics through engagement and consultation with fathers, minority ethnic groups and carers. Evidence collated will support review and recommendations.

Section 3: What evidence you have used?

3.1 What evidence do you hold to back up this assessment?

Consultation and engagement findings, and the Business Case for Health visiting and FNP Review.

3.2 Do you need further evidence?

No

Section 4: Consultation Feedback

4.1 Results from any previous consultations

Yes

4.2 Feedback from current consultation

Yes

4.3 Your departmental response to this feedback – include any changes made to the proposal as a result of the feedback

The proposed service model has been informed by consultation feedback.