City of Bradford Metropolitan District Council

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

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1. INTRODUCTION

This is the Business Plan for the review of Health Visiting and Family Nurse Partnership (FNP) service for children age 0-5 and sets out the proposals for a new model which supports and contributes to the Councils vision 'For every one of our children to have the best possible start in life' through the commissioning and delivery of an evidence based service which considers the needs of our local communities. The Plan initially sets out the background for the Health Visiting and FNP Service and its purpose, examining literature, strategic policy context, needs of young people and informs the service model. It then proceeds to outline 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.

1.1 Purpose

The purpose of the report is to:

1.1.1 To brief Members and Strategic Partners on the Councils review of the Health Visiting and Family Nurse Partnership (FNP) service.

1.1.2 To highlight key findings from the review, detail the draft service model in order to gain approval from the Council Executive to proceed with re-commissioning or re-design of the Health Visiting and FNP Service.

1.1.3 To identify any proposals affecting the local Clinical Commissioning Groups (CCGs) and Children's Services which will be taken for discussion through the Bradford Health and Care Commissioners Group (BHCC) and the Children's and Maternity Transformation and Integration Group (TIG).

2. BACKGROUND INFORMATION

2.1 Aim of the review

The transfer of commissioning responsibilities to the Council has provided an opportunity to review the Health Visiting Service and Family Nurse Partnership service including:

1.1.1 Review current guidance, policy and good practice to inform/identify a set of standards of which to review the current service and service model

1.1.2 Analyse the current and emerging health and wellbeing needs of parents and the 0-5 (years) population within the Bradford District

1.1.3 Engage with key stakeholders; Parents, GPs, Early Years etc.

1.1.4 Develop a model that meets current and emerging need, demonstrating quality and value for money.

1.1.5 Integrating with current early years services for young children.

1.1.6 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.

2.2 Commissioning Health visiting and Family Nurse Partnership services

2.2.1 From 1 October 2015 public health commissioning responsibilities for children aged 0 to 5 transferred from NHS England to local authorities. This will mark 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.

2.2.2 NHS England Area Team put in place a single contract for the full-year of 2015/16, with a deed of novation.

2.2.3 Health visiting and family nurses partnership are now commissioned by the Bradford Metropolitan District Council and is one of the largest funded contracts managed within Public Health, currently delivered by Bradford District Care NHS Foundation Trust (BDCFT).

2.2.4 The current contract is based on national KPIs with some local variations agreed prior to transition, and is based on "resident populations". A joint statement on resident populations has been agreed for West Yorkshire to ensure providers had protocols in place to ensure no child or family is left without a Health Visitor, both during the transition of 0-5 PH Commissioning and following the transfer of commissioning into local authorities.

2.2.5 The transfer of commissioning responsibilities to Public Health has provided opportunity to review the Health Visiting Service and Family Nurse Partnership (FNP) service with the overall aim to improve health and wellbeing outcomes for babies, children and their families.

2.3 Strategic National context

Detailed information on key national policy drivers can be found in *Appendix 2*. Health visitors lead delivery of 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. It is underpinned by an up-to-date evidence base and national standards as highlighted in section 3, 5 and 5 in *Appendix 2*.

2.3.1 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.

2.3.2 Best start in life and beyond: Improving public health outcomes for children, young people and families – Published in January 2016, this 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 delivery of public health for children aged 0-19. This includes the 4-5-6 service model described in 'Best start in life and beyond':

- **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
- **Five** universal Healthy Child pathway (HCP) checks and reviews in line with the proposed mandate of local authority commissioning of the five universal checks and reviews. A significant addition to the performance report is the percentage of children who receive a six to eight week review.
- **Six** high impact areas – maternal mental health, transition to parenthood, breastfeeding, healthy weight, child development and managing minor illness/ accident prevention

2.3.3 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.

2.3.4 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

2.3.5 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)

2.3.6 The Health Visitor Implementation Plan 2011-15 published in February 2011 set 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)

2.3.7 One of the Department of Health (DH) key policy drivers is to give all children a healthy start in life. *The healthy child programme: pregnancy and the first 5 years of life* 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.

2.3.8 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.

2.3.9 Frank Field's review (2010) 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.

2.3.10 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.

2.3.11 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. 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.

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

2.4 Local Policy Context

Detailed information on key local policy drivers can be found in *Appendix 3*. In addition to key 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. Focussing on delivery of interventions to improve health and wellbeing and reduce health inequalities in children and young people include:

2.4.1 New Deal for Council - Good Start in Life and Good schools for all children

2.4.2 Health and Well Being Strategy & Health Inequalities Action Plan 2015-2018 - Infant mortality, Oral health, Obesity, Parenting & early years, children SEN and disabilities and Child poverty

2.4.3 Children & Young People's Strategic Plan 2014-16

2.4.4 Key Strategic Outcomes for Integrated Early Years Strategy (0-7 years) Bradford district 2015-2018 - Infant mortality, Oral health, Obesity and School readiness (Good level of development), Year 1 Phonics and KS1 phonics Year 2 reading, writing and maths

2.4.5 Better Start Bradford –improved outcomes for pregnant women and young children aged 0-3 years - School readiness, obesity and other key outcomes. 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

2.4.6 Integrated Care Pathway (ICP) in 2014 incorporating health visitors, midwifery and children services for children age 0-5 is key

2.4.7 Children Centres : Health visiting services are an important in relation to the Children centre (CC) services and CC Review –both services have similar focus and targets and effective integrated working is key for the future

2.4.8 Five Year Forward Plan for Bradford Airedale and Craven & 3 CCG Plans - Improved Maternal and Child Health

2.5 Demographics of Children 0-5 years

Bradford District is one of the most deprived local authority 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.

The number and proportion of the district's total population aged under 19 years is increasing. 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. Detailed information can be found in *Appendix 4*

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

- There are 49,270 children aged 0-5 in Bradford District this equates to 9% of the total population (Mid 2014 population estimates, ONS.)
- The sub national population projections suggest that the 0-5 population is due to increase by 10% by 2021.
- A third (33.1%) of all births in Bradford are to mothers born outside the UK, higher than the average for England (27.3%).

2.6 Health and wellbeing needs of young children

Bradford has significant inequalities compared to both regionally and nationally, with local variations where some areas within the District are worst than others. These are highlighted below and further information is available in *Appendix 5.*

2.6.1 Infant mortality: 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.

- 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.

2.6.2 Obesity: Obesity rates are higher than regionally or nationally. Health Visitors have an important role in relation to a healthy start from birth to five where diet and weaning advice is crucial.

2.6.3 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. 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.

2.6.4 Emergency admissions for unintentional injuries (2012/13):
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.

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%**

2.6.5 School readiness: 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 versus 66% for England, and worse in more deprived areas.

3. CURRENT HEALTH VISITING & FAMILY NURSE PARTNERSHIP SERVICE

Detailed information on the health visiting service can be found in *Appendix 6* and detailed background to the Family Nurse Partnership can be found in *Appendix 9.* The health visiting contract including Family Nurse Partnership (FNP) is one of the largest contracts managed by Public health and delivered by the Bradford District Care Foundation NHS Trust, commissioned as detailed in 2.2 above.

3.1 Current Level of service

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**	**39,918**	**94.1%**
Tier 2	**Universal Plus**	**1,577**	**3.7%**
Tier 3	**Partnership**	**767**	**1.8%**
Tier 4	**Partnership Plus**	**180**	**0.4%**
Total		**42,442**	**100%**

3.2 Staffing and Finance

The current service transferred from NHSE with a part year budget and Contract value £6,020,319 for 2015/16. The contract value for 2016/17 is £10,692,530.

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:

- WTE HV staff 215.66
- FNP staff 12.61
- Total Staff 228.27

3.3 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 the following four domains:

1. Improving the wider determinants of health ▪ PHOF 1.2: School readiness
2. 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
3. Health Protection ▪ Population vaccination coverage (PHOF 3.3)
4. Healthcare public health and preventing premature mortality ▪ PHOF 4.1: Infant mortality ▪ PHOF 4.2: Tooth decay in children aged 5

In July 2012, the Children and Young People's Health Outcomes Forum recommended a number of new outcome measures, some of which are relevant to the Public Health of 0-5 year olds. For example, an outcome measure of mother's mental health.

3.4 The universal elements of the Healthy child pathway

The universal elements of the Healthy Child pathway are delivered by a team led by health visitors working in 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:

- 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.
- Screening – support with screening is an integral part of the universal HCP.
- Immunisations – At every contact, members of the HCP team should identify the immunisations status of the child.
- 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 decide when specialist input is needed.
- Support for parenting **–** One of the core functions of the HCP is to support parenting using evidence-based programmes
- Effective promotion of health and behavioural change – Delivery of population, individual and community-level interventions based on NICE public health guidance.
- Sick children – Supporting parents to know what to do when their child is ill.
- Children with a disability – Early diagnosis and early help.

3.5 The current service reflects the 4-5-6 model which includes:

Further information is available in *Appendix 6*.

- **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
- **Five** universal HCP checks and reviews in line with the proposed mandate of local authority commissioning of the five universal checks and reviews. A significant addition to the performance report is the percentage of children who receive a six to eight week review.
- **Six** high impact areas – maternal mental health, transition to parenthood, breastfeeding, healthy weight, child development and managing minor illness/ accident prevention.

3.6 Targeted Services and Safeguarding

An important part of the health visiting services includes both targeted and universal services as highlighted in *Appendix 6* (section 3). The current service has access to a multidisciplinary team consisting of a safeguarding team which is recognised a major strength locally.

3.7 Delivery of the Five universal Healthy Child pathway (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 is detailed in *Appendix 6* (4b).

3.8 Delivery of 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 current specification highlights the health visiting contribution as experts and leaders in delivering better health and wellbeing for 0-5s. 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'**

3.9 Current Service Performance

Various metrics have been set to performance manage the current service, with new KPIs such as the use of the ASQ to monitor child development outcomes at age 2 to 2½ years is a new indicator in the 2015/16 collection. A new indicator for child development outcomes will be included in the PHOF from 2015/16. In the first instance this indicator will be coverage of the ASQ but later iterations will include achievement of child development milestones across a number of dimensions.

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.

3.9.1 Mandated Health Checks

Current performance based on the nationally defined five mandated health checks following transition from NHSE into local authority includes the areas identified in 3.7.

3.9.2 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 as can be seen in *Appendix 9*.

4. HEALTH VISITING AND FNP SERVICE REVIEW

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 where a system change is also necessary which means Public Health 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 years 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.

4.1 Purpose

The purpose is highlighted in 1.1 but the main purpose of the HV and FNP Review is to detail the draft service model in order to gain approval from the Council Executive and to proceed with the commissioning of a new model of Health Visiting and FNP Service.

4.2 Objectives

The overall objective is to consider the Local Authorities local vision for the health and wellbeing of babies, young children and families to ensure that the transfer adds value to local efforts to address health inequalities among this age group, which include:

- To identify if and how the current service model meets current and emerging need taking into consideration the changing demographic profile of children and young people within the Bradford District
- To review how the service model fits with children and young people's services with particular emphasis on the new offer for children and young people.
- To identify key opportunities to make improvements in prevention and early intervention in partnership with key stakeholders such as schools, primary care, Children's Social Care, Voluntary and Community Groups and other organisations

4.3 Leadership & Governance

- A Project Board was established for the 0-5 Health Visiting Review.
- This review was led by a Project Board made up of representatives from the following Council departments and organisations:
  - Airedale, Wharfedale and Craven Clinical Commissioning Group
  - BMDC Department of Childrens Services
  - BMDC Department of Public Health
  - Bradford City Clinical Commissioning Group
  - Bradford Districts Clinical Commissioning Group
- A Project Plan was developed to identify the key tasks, stakeholders, methods of engagement and timescales
- Consultation and engagement with key stakeholders, including health visitors, family Nurses, staff, service users, families
- Information and evidence collated into a final report (Business Case) document detailing the findings of the review

4.4 Scope of Review

The scope of the review includes Health Visiting and FNP
The review does not include the immunisation and vaccination service commissioned by NHS England Commissioning Board.

4.5 Risks

- Funding cuts of 6.2% have been agreed nationally in year for 2015/16
- There is no guarantee that the Public Health allocations will remain the same.

- Local Authority Regulations (2015) and the HV National Service Specification both refer to a local authority's area and defined geographical population in line with Local Authority boundaries and localities, unlike current CCG boundaries.
- RCT findings on Family Nurse Partnership

4.6 Methodology

The methodology used for the HV and FNP Review was based on three key priority areas.

4.6.1 Literature review of key national and local policy context and strategy as summarised in 2.3 and 2.4 above and detailed in *Appendix 2.*

4.6.2 Demographics and health and wellbeing needs of children age 0-5 so this informs the development of a new service model. Detailed information is available in *Appendix 4 and 5* and summarised in section 2.5 and 2.6 above.

4.6.3. Consultation and engagement using both qualitative and quantitative methods of consultation and engagement were used in order to consult with key stakeholders. As part of the review of Health Visiting Services and the Family Nurse Partnership, the views of stakeholders were sought using Questionnaires and Organised group discussions. Three different questionnaires were used, to collect the opinions of:

- Families in receipt of Health Visiting Services
- Families in receipt of the services of the Family Nurse Partnership
- Stakeholders with an interest in Health Visiting Services and the Family Nurse Partnership

Organised discussion groups were also carried out using SWOT analysis with the following groups:

- Families with experience of Health Visiting Services and / or the Family Nurse Partnership, Health Visitors, Family Nurse Partnership staff, Health Visitor Service Strategic Management Group, Maternity Partnership, Children's Centres, Early Years Services, Education, Children's Transformation and Integration Group, Children's Social Care, Clinical Commissioning Groups and General Practitioners.

4.7 Findings

4.7.1 Literature review

Details of literature review can be found in *Appendix 2.* It is apparent from literature nationally and locally that there is a real emphasis on integrated working as well as a focus on early intervention and prevention, and targeted work in areas of greatest need.

4.7.2 Demographics

Bradford District is one of the most deprived local authorities in the whole of England with a changing population and a growing population of young children. A significant number of children age 0-5 are from diverse backgrounds, mainly Pakistani mothers, who are not all born in the UK. Further information is available in *Appendix 4*.

4.7.3 Health and wellbeing needs and Health Inequalities

There are huge inequalities within the district and targeting these early is an important part of the health visiting and FNP service as this is a universal service providing huge opportunities in terms of access and targeted interventions. Further detail is provided in *Appendix 5.*

4.7.4 Consultation for Health Visiting services

Details of the full consultation report can be found in *Appendix 12.* The aim of the consultation was to understand how people feel the system is working currently, and what their future expectations are of the services. There were two main methods used to obtain these opinions: (A) Questionnaires which were available both online and on paper and (B) Organised group discussions.

(A) Questionnaires
There were three questionnaires designed to obtain views from;

I. *Families in receipt of Health Visiting Services*;
- 227 respondents
- Majority female
- 77% aged 20-39
- 60% of respondents described themselves as White or White British, 15% as Asian or Asian British, 4% as Central or East European remaining 21% from other minority ethnic groups. There is an over representation from the White British population.

II. *Families in receipt of the services of the Family Nurse Partnership*;
- 62 respondents
- Majority female
- 56% aged 19 and under, 32% aged 20-25 years which is expected with the nature of the service.
- 84% of respondents described themselves as White or White British and 6% as Asian or Asian British; 10% of respondents did not complete the question. This is consistent with the ethnic groups within the service population.

III. *Stakeholders with an interest in Health Visiting Services and the Family Nurse Partnership;*
- 129 Responses
- Respondents were asked to identify which organisation they were responding on behalf of 49 selected 'other,' those who selected 'Other' included a number of people from the Bradford District Care Trust, including health professionals and commissioners, and from Family Centres, Nurseries and Social Services. 44 of which were GPs, 19 childrens centres, 11 voluntary and community sector, 5 from education.

(B) Organised Group Discussions
For Health visitors there were seven events set up to get the views of HV staff and key stakeholders, the attendees at each event consisted of:

- Event 1- Strategic Management Team**;** 13 attendees
- Event 2 (Bradford) and 3 (Keighley) – Health visiting teams**;** 28 attendees in Bradford and 26 in Keighley
- Event 4 and 6 - Stakeholders (Allied Professionals); 31 attendees in total
- Event 5 and 7 – GPs and Practice Managers; 104 attendees in total
- Families in receipt of HV service; In total there were 115 participants of which, 105 were female and 10 were male.
- 27% identified themselves as White or White British and 51% Asian or Asian British 10% did not disclose their ethnicity, the groups were diverse and gave views of people who may not necessarily complete the questionnaire.

Summary of key findings for consultation on Health Visiting Services:

Access
1. There is concern around the difficulties that service users experience when

	trying to contact their Health Visitor (HV); the most challenging aspect for families, HVs and allied professionals alike is the single point of access hub. Families also see the requirement to disclose their problems to an unknown intermediary as challenging.
2.	There is concern about the equity of access and the consistency of care given to service users and their families by HVs, both in terms of the amount and quality of support provided, and the clarity and consistency of the health messages offered.
3.	Participants feel that the location of services, and the environment in which they are delivered, are crucial to determining whether services are used efficiently and effectively; the key point made was that services should be delivered in locations that families already access routinely.
People's experience of the service	
4.	Experiences of health visiting services reported by participating families have tended to be positive, but this positive view is not necessarily matched by the views of other stakeholders (Allied professionals.)
5.	The experiences of support received by mothers have tended to be positive; however, the amount and quality of support provided has not always been sufficient eg Breastfeeding and support around postnatal depression
6.	Participants feel that greater attention needs to be paid to continuity of care because service users get more out of the service, and say that they feel safer, when they are able to rely on a HV with whom they have established a trust based relationship.
7.	Participants report that the willingness of families to disclose personal issues is influenced by the environment in which the conversations with their HV take place; participants feel that services, whether these are delivered in a community setting or in the family home, need to afford greater privacy than is currently available.
Organisational concerns	
8.	Participants expressed concerns about whether current IT systems will support integrated working and data sharing between HVs and all of the other organisations involved in delivering services to children aged 0-5 years and their families.
9.	Participants are aware of the pressures under which HVs operate and feel that this has a negative impact on the quality of services; concerns were expressed about the capacity of HVs to meet the demands of their increasing workloads and continue to perform their role to required standards.
10.	The current "flat" structures of HV teams, and the consequent lack of leadership, were perceived as a problem by participants.
11.	Amongst participants a range of views were expressed about the organisation and alignment of HV teams; the majority of HV staff and stakeholders from partner organisations were in favour of geographical alignment and GPs expressed views that they wanted GP alignment to remain.
12.	Whilst many participants regard partnership working as strength of the current HV service, it was suggested that the service may function better through closer working and better integration with other services; the examples given included better integration with midwifery services, school nurses, general practitioners and Children's Centres.
Needs	
13.	Participants understand that Bradford has a particularly diverse population and that needs vary from community to community; they feel that particular attention needs to be paid to the availability and quality of interpretation services and how these services are used in practice.
14.	There is acknowledgement of the prevailing economic environment of austerity across all services amongst participants, and a recognition that this will impact upon the HV service in the future.

4.7.5 Consultation for Family Nurse Partnership (FNP)

There were four events to obtain views of FNP staff members, key stakeholders and families in receipt of FNP. The attendees at each event consisted of;

I. Event 1- FNP Staff Members; 12 attendees
II. Event 2 - Stakeholders (Allied Professionals); 9 Attendees
III. Event 3 - (Keighley) and 4 (Bradford) – Families in receipt of FNP**;** 11 attendees in Keighley and 3 in Bradford

This report on the consultation can be found in *Appendix 12*

Summary of Key findings for consultation for Family Nurse Partnership (FNP):

Access
1. The Family Nurse Partnership (FNP) service is seen as providing very good support for a very small number of mothers and children. However, families in receipt of HV and FNP services reported that they feel care is not delivered equitably across the district or across the population.
2. Participants report that the service provided by their Family Nurse is accessible and fits around the needs of the family; it is seen as providing them with "valued continuity of care" and "robust support from very early on in pregnancy until (the) child is 2" to "break the cycle of deprivation".
People's experience of the service
3. Families in contact with FNP services value the continuity of care provided by their Family Nurse and the consistency of their advice and support. FNP clients welcome the structured support provided by their Family Nurse and feel that "it prepares us properly for parenthood".
4. Knowledge and understanding the role of the HV is poor amongst clients of the FNP. The step from intensive support to the lower level of support provided through the general service is a challenge for clients who do not have the same trust-based, well established relationship with their HV as they do with their Family Nurse. Participants report finding the transition abrupt and also challenging because they are not sure that continuity of care will be maintained with the HV.
Organisational concerns
5. Concerns were expressed about whether the FNP service will continue in Bradford in the face of continuing funding restrictions, the organisational changes currently underway and the negative findings of the recent national evaluation of the FNP.
6. Participants see the possibility of losing the FNP service, or it becoming 'watered down', as a significant threat to the children and families that the service supports who, because of the nature of FNP, are some of the most vulnerable families living the most deprived areas of the district.
Opportunities for the future
7. Participants expressed concern about the results of the national evaluation of FNP services, which showed no significant improvement in some short term outcomes for participants. Locally in Bradford, there is a strong belief that the programme has made a difference.

5. RECOMMENDATIONS FOR A PROPOSED NEW MODEL

5.1 Recommendations for proposed new Health visiting service model

National and local policy context is being implemented locally and overall we have good HV and FNP services in place with both national and local performance monitoring arrangements established. 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 new model which is fit for purpose for the future 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.

Throughout the review there has been consistency in the identification of the priorities and high-level service expectations. This has been reflected in national and local policy, guidance, planning and informed by our key stakeholders and partners. A Summary of the proposed Service Model which will incorporate the key themes is provided in *Appendix 14*, with a summary of the high level principles provided below:

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.
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 prevention and early intervention.
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.
5. Improved communication and resources according to community needs, ensuring more "visibility" of health visitors and information and resources in appropriate languages.
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.
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.
8. Service delivery to incorporate 'Journey to Excellence' with 'Early Help' and 'Signs of Safety' as well as "Integrated Early Years Strategy for Children 0-7"
9. A caseloads model to be developed and delivered according to need and priority.
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 into Early Years and schools, and close working with the School Nursing and Early Years Service.

5.2 Recommendations for a new Family Nurse Partnership model

In conclusion, 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 literature review and in particular

the recent publication of the RCT, details of the RCT and outcomes is available in *Appendix 11*. A Summary of the proposed Service Model which will incorporate the key themes is provided in *Appendix 15*, with a summary of the high level principles provided below.

1. Develop a new model of 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. Consideration needs to be given to the longer term outcomes and wider determinants such as educational achievement and how these can be obtained and 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.

5.3 Service specification

It is recommended that a detailed service specification be developed to articulate the proposed service model. The new service specification will be developed with advice from the Council's Commercial Team and supported by a working group consisting of commissioning colleagues from Health, CCGs, BMDC Children's Services (and other specialist input where it is required).

5.4 Key Milestones

Key milestones will be developed following approval at Council Executive and will include:

DATE	MILESTONE	OBJECTIVE
1/5/16	**CMT/DMT MEETING**	Agree final business case/report
6/5/16	**BHCC MEETING**	Agree final business case/report
18/5/16	**HV REVIEW BOARD**	Amend final business case/report
14/6/16	**EXECUTIVE/OSC APPROVAL**	Final business case/report to be approved with preferred option

5.5 Performance Management

5.5.1 During the Mobilisation period and the first six months, the provider will be required to meet with Public Health Commissioners on a monthly basis. Following this, the Provider will be required to submit quarterly performance monitoring information and meet (quarterly) with Public Health Commissioners to discuss performance.

5.5.2 The contract and service specification will include a suite of performance indicators and targets. Robust contract management arrangements will be put in

place to ensure that services are delivered effectively and in accordance with the Council's expectations.

5.6 Understanding Service Demand

5.8.1 As highlighted in Appendix 3 the sub national population projections suggest that the 0-5 population is due to increase by 10% by 2021. 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. 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%). 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

5.8.2 If the new contract is to improve the health and wellbeing of babies, children and their families and reduce health inequalities it will need to allow scope for innovation and include consideration of:

- Better utilisation of the workforce and skill mix, including delivery models based on geographical alignment
- Integration with other key early years services to ensure effective efficient delivery of services including integrated pathways and joint training using the latest evidence to ensure interventions work effectively and have high impact on Children and families
- Improved outcomes especially in those most at risk of health and well being inequalities
- A focus on 'must do' business and identification of areas of current work that are no longer required or could be delivered by other services
- A focus on 'New Deal' principles; focusing on 'Early Help', and empowering families and communities.

6. COUNCIL POLICIES AND PRIORITIES

6.1 Equality and Diversity

An Equality Impact Assessment has been undertaken and is included as *Appendix 16* of this report and assesses the equality and diversity impact of the recommendations and proposed service model described in this report.

6.2 Council Policies and Priorities

6.2.1 Bradford Council Strategic Priorities; despite the financial challenges that the district faces the Council remains committed to achieving the key objectives of:

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

6.2.2 The commissioning of health visiting services directly supports the delivery of objectives and priorities from a range of Council strategies including the:

- Health and Well Being Strategy & Health Inequalities Action Plan 2015-2018
- Children & Young People's Strategic Plan
- Integrated Early Years Strategy (0-7 years) Bradford district 2015-2018
- Better Start Bradford –improved outcomes for pregnant women and young children aged 0-3 years - School readiness, obesity and other key outcomes.

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

- Integrated Care Pathway (ICP) in 2014 incorporating health visitors, midwifery and children services for children age 0-5 is key
- Children Centres : Health visiting services are an important in relation to the Children centre (CC) services and CC Review –both services have similar focus and targets and effective integrated working is key for the future

6.3 New Deal

6.3.1 New Deal is the Council's approach to changing the way the Council and other public services work with people, communities, businesses and the voluntary sector to improve and protect the quality of life for people in the Bradford District.

6.3.2 In order for the Council to achieve the key priorities, the Council will need to make changes to the type of services we buy and the way they are delivered by:

- Reducing the demand for services by changing expectations and promoting involvement
- Investing in prevention and early intervention
- Reducing inequality

6.4 Resources and Value for Money

6.4.1 Like all Councils, Bradford has to cut spending. Government funding for Council funded services has been cut by £165 million over the last few years and the reductions are set to continue.

6.4.2 Between now and 2020, the money for Council services (under the Council's direct control) is forecast to reduce by at least another 25%, on top of the savings already made.

6.4.3 The numbers of younger and older people are growing and so are the numbers of people with disabilities. Other challenges include more children needing care and protection and managing the increase in costs associated with Inflation. This all puts pressure on services.

Given the current financial climate, it is likely that the total cost of investment will be reduced so innovative solutions will need to be considered to ensure the proposed service model demonstrates value for money whilst managing an increase in demand and changing demographic need.

6.5 Legal Implications

The re-commissioning of the Health Visiting and FNP service will be conducted in accordance with the Council's Contract Standing Orders, National and European procurement regulations. Public Health is working with the Council's Commercial Team to agree an appropriate sourcing option.

6.6 Risk Management

6.6.1 Risks associated with the re-commission of the health visiting service have been identified, reviewed and managed through fortnightly Project Team meetings and four weekly Project Board meetings.

6.6.2 The identification of new and increasing risks is an on-going process and will continue to be identified and managed through the life of the project.

7. CONCLUSION

National and local policy context is being implemented locally and overall we have a good HV and FNP services for children aged 0-5 years with both national and local performance monitoring arrangements in place. 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 for the future and geographically aligned. Given the current financial climate it is important we have a model which is cost effective and demonstrates value for money, as well as ensuring we develop a new model according to the needs and findings identified within the review process.

8. RECOMMENDATION

It is recommended that the Executive Committee consider the Business Case for review of Health visiting and Family Nurse Partnership and give approval to proceed with the development of a detailed service specification to articulate the proposed service model.

The new service specification will be developed with advice from the Council's Commercial Team and supported by a working group consisting of commissioning colleagues from Health, CCGs, BMDC Children's Services (and other specialist input where it is required).

9. BACKGROUND DOCUMENTS

Please refer to the Appendices document for the following Appendices:

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