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| **Report to :** | **HEALTH AND WELLBEING BOARD** |
| **Date :** | 12 November 2015 |
| **Executive Member / Reporting Officer:** | Cllr Allison Gwynne, Executive Member Children and Families<br>Angela Hardman, Director of Public Health<br>Debbie Watson, Head of Health and Wellbeing |
| **Subject :** | **UPDATE – TRANSFER OF 0-5 HEALTHY CHILD PROGRAMME FROM NHSE TO TMBC** |
| **Report Summary :** | This document aims to update the Health and Wellbeing Board of the transfer of commissioning responsibilities for 0-5 public health services from National Health Service (England) (NHSE) to the Council and the transformation undertaken by the provider of Health Visiting and Family Nurse Partnership (FNP) services. It will seek to inform future local commissioning decisions and strategy development. |
| **Recommendations :** | The Health and Wellbeing Board are asked to note the key issues presented and updates on the transfer of commissioning responsibilities for 0-5 public health services from the NHSE to Tameside MBC |
| **Links to Health and Wellbeing Strategy :** | Early Years is a key priority programme for action for the Health and Wellbeing Strategy and will add impetus to achievement of the health goals. |
| **Policy Implications :** | Delivery of the 0-5 Healthy Child Programme is a mandatory public health programme for the local authority. This work will inform the work and annual business planning of the Tameside Health and Wellbeing Board. |
| **Financial Implications:**<br>**(Authorised by the Section 151 Officer)** | The confirmed funding that will be allocated to the Council for the commissioning of children's 0-5 public health services from October 2015 is £1.771m. |

| | 15/16 Confirmed £'000 |
|---|---|
| 6 Month: HCP & FNP Allocation From 1 Oct 2015 | 1,712 |
| 6 Month : CQUIN | 44 |
| 6 Month: Commissioning | 15 |
| 6 Month Total | 1,771 |

The evaluation of the estimated expenditure appears adequate with the service at full capacity of 66.6 WTE Health Visitors. If the service is at less than full capacity the contract price will be appropriately adjusted to reflect the level of service provided.

The £15,000 commissioning element has been allocated to the Public Health efficiencies programme and therefore will not be spent.

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|---|---|
| | The expectation is that this funding will be included within the Council's Public Health grant allocation from 2016/2017 onwards. However the Department of Health have stated that there will be no new unfunded burdens placed on local government in relation to the transfer of this responsibility. Future funding arrangements will follow from the government's spending review decisions. |
| **Legal Implications:**<br>**(Authorised by the Borough Solicitor)** | Local Authorities acquired new statutory responsibilities on 1 April 2013 under the Health and Social Care Act 2012 to carry out public health functions. The Government completed the transfer of responsibility from NHS England to local authorities for the commissioning of children's 0-5 public health services for 1 October 2015. The Council needs to consider the most appropriate way to align resources to meet its statutory duties. |
| **Risk Management:** | Risks will be managed via the Early Years Strategy Group. |
| **Access to Information:** | The background papers relating to this report can be inspected by contacting Debbie Watson by:<br>  Telephone:0161 342 3358<br>  e-mail: debbie.watson@tameside.gov.uk |

## 1. PURPOSE

1.1 This document aims to update the Health and Wellbeing Board of the transfer of commissioning responsibilities for 0-5 public health services from NHSE to the Council and the transformation undertaken by the provider of Health Visiting and Family Nurse Partnership (FNP) services. It will seek to inform local commissioning decisions and strategy development. A library of supporting documents (LoSD) will be made available to Local Authorities to provide further information and guidance.

1.2 This report covers the period that NHS England has commissioned these services (April 2013 onwards).

## 2. BACKGROUND

2.1 The Health Visiting 'Call to Action' programme started in 2011 as a National programme of work to deliver on the Government's commitment by 2015 to:

- Increase health visitors by 4,200 whole time equivalent (WTE)
- Create a transformed, rejuvenated health visiting service providing improved outcomes for children and families with more targeted and tailored support for those who need it.

2.2 The significant investment in services for young children and families is intended to:

- Improve access to services;
- Improve the experience of children and families;
- Improve health and wellbeing outcomes for under-fives; and
- Reduce health inequalities.

2.3 On 30 November 2010, the Government published the White Paper *Healthy Lives, Healthy People: Our strategy for public health in England*, which established a vision for a reformed public health system. As a consequence of the White Paper it was agreed that commissioning of children's public health services from pregnancy through to 5 years would transfer from NHSE to Local Authorities 1 October 2015. The delay in transfer was to allow NHSE sufficient time to deliver on the Government's commitment to raise the number of health visitors and support improved stability of the system before the transfer of services.

2.4 The transfer of responsibilities will join up the commissioning already done by Local Authorities for public health services for children and young people aged 5-25 years.

## 3. MANDATION

3.1 In 2014 it was agreed that some elements of the Healthy Child Programme (HCP), would be mandated for 18 months (until March 2017) to further support a stable transfer. In this context mandation means a Public Health step prescribed in regulations made under section 6C of the NHS Act 2006. Each local authority must, so far as reasonably practicable, provide or make arrangements to secure the provision of a universal health visitor review to:

- a woman who is more than 28 weeks pregnant;
- a child who is aged between one day and two weeks;
- a child who is aged between six and eight weeks;
- a child who is aged between nine and 15 months; or
- a child who is aged between 24 months (two years) and 30 months (two years and six months).

3.2 A “universal health visitor review” means an assessment of the health and development of an eligible person as set out in the HCP.

3.3 A universal health visitor review must be carried out by a Health Visitor or FNP Family Nurse, or a suitably qualified health professional under the guidance and delegation of the Health Visitor.

3.4 Health Visitors in Tameside and Glossop (T&G) also work with communities in order to help build community capacity. This includes supporting community groups. A particularly successful project has been working with Homestart to train volunteers in parent infant mental health. A project supporting extended families in promoting health messages is also just starting.

3.5 Health Visitors work with all families from Universal to targeted, as outlined in the four levels of Health Visiting in **Figure 1**.

## 4. HEALTH VISITING

### 4.1 Background and evidence: Health Visiting

- Pregnancy and the first two years of life are critical to emotional and physical health across the entire life span. Adults who were exposed to adverse childhood experiences are much more likely to have poor mental and physical health in later years.

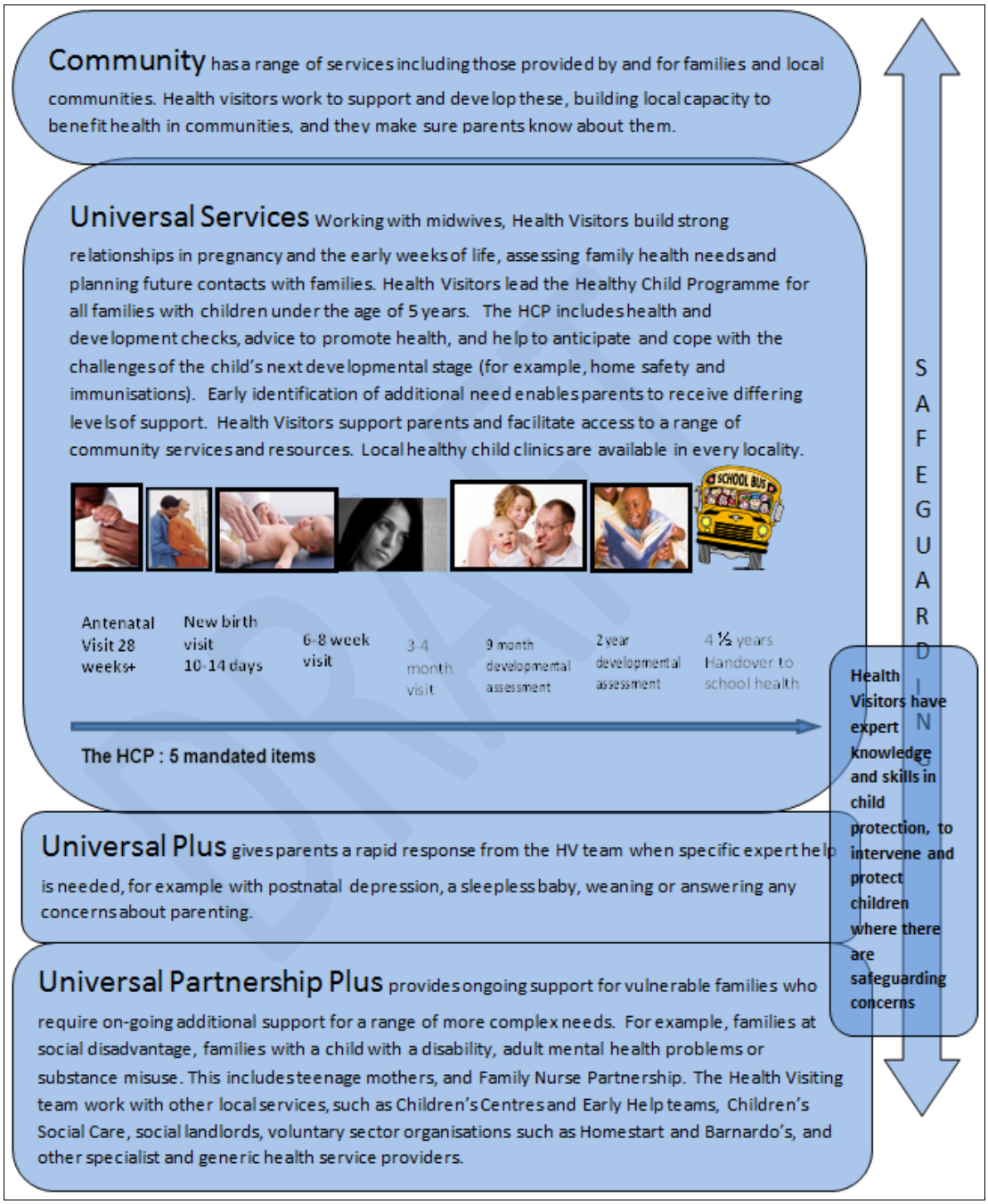
- Early experiences shape a baby’s brain development, and have a lifelong impact on that baby’s mental and emotional health.

- Health visiting is a front line public health service, supporting parents through evidence based public health interventions, carried out in the family home or in community settings. The service is the first to assess the health needs of babies and children under the age of 5, and their families, in these contexts. These holistic assessments are completed at key points starting in the antenatal period. As a universal service, Health Visiting therefore has a vital role in identifying, with every family, their needs at the earliest opportunity possible, and at a time when families are most receptive to change.

- In Greater Manchester, Health Visitors have around 1 million client facing contacts per year to improve the public health outcomes for babies, pre-school children and their families. These contacts include prevention, early identification of and response to child protection issues, breastfeeding, childhood illnesses, parenting and school readiness.

- The Department of Health and Local Government Association (2014) have identified six areas in which there is evidence that health visiting can make the highest impact in children’s early years, leading to improved outcomes for children, families and communities (see table below). There is an obvious synergy between identified local and national public health priorities. The Health Visiting service has a significant contribution to make in key areas in which the population of T&G fares below the national average, which create increased risk of long term poor health and social outcomes and inequality.

**FIGURE 1: FOUR LEVELS OF HEALTH VISITING**




- Health visitors lead delivery of the full Healthy Child Programme and they are commissioned to deliver the National Service Specification with some additional Greater Manchester items in line with the Early Years New Delivery Model. The current Service Specification ensures full delivery of the 0-5 Healthy Child Programme and articulates the health visitor's role in meeting key outcomes for babies and children.

- Intervening early, working with families to build on strengths and improve parenting confidence and, where required, referring early for more specialist help, including specialist mental health services, is the most effective way of dealing with health, developmental and other problems within the family. Health visitors, working in partnership with GPs, midwives, Sure Start Children's Centres, day care settings and other local organisations, have a crucial role in ensuring that this happens (Health Visitor Implementation Plan 2011-2015).

- As highly skilled public health practitioners, Health Visitors have a key leadership role to play in the delivery of the public health agenda for children 0-5 years, their families and their communities. Health visitors in T&G have embraced the Early Years New Delivery Model and Tameside is the only local authority in Greater Manchester to have two early adopter sites. They have been leaders in the development of innovative and quality services and multi-agency pathways. As the workforce now reaches full capacity, Health Visiting leadership will be vital to the success of the full roll out of the New Delivery Model in Tameside.

**The Six Early Years High Impact Areas**
**Tameside and Glossop Health Visitors deliver evidence based interventions and work within multi-agency pathways: this is a brief overview**

1. **Transition to Parenthood and the Early Weeks**
    - *Antenatal and Postnatal Promotional Interviewing (Family Partnership Model)*
    - *Family Nurse Partnership Model*
    - *Teenage Pregnancy Pathway*
    - *Brazelton Neonatal Behavioural Assessment Scale (NBAS) and Newborn Behaviour Observation (NBO) System*
    - *Tameside and Glossop Getting it Right from the Start DVD and Booklet*
    - *Maternity Antenatal Communication Pathway in development*
    - *Solihull Approach, and Solihull Approach Parenting with early years services*
    - *Mellow Parenting programme for high risk / safeguarding families*
2. **Maternal Mental Health (Perinatal Depression)**
    - *Multi-agency parent infant mental health pathway*
    - *Edinburgh Postnatal Depression Scale*
3. **Breastfeeding (Initiation and Duration)**
    - *UNICEF Baby Friendly Stage 3 accredited (with children's centres)*
    - *Infant and pre-schoolchildren feeding guidelines*
4. **Healthy Weight, Healthy Nutrition (including Physical Activity)**
    - *Healthy weight 0-4 years pathway*
    - *Maternal healthy weight pathway*
5. **Managing Minor Illness and reducing Accidents (Reducing Hospital Attendance/Admissions)**
    - *Accident and Emergency unit liaison*
    - *Safety, immunisation, dental health and safe sleep promotion, smoking cessation advice and minor illness advice*
    - *Non-medical prescribing*
6. **Health, Wellbeing and Development of the Child Age 2** – Two year old review (integrated review) and support to be 'ready for school'
    - *Ages and Stages Questionnaire - 3 (Also at 9 Months)*

## 4.2 **Health Visitor performance**

*New birth Visit (10-14 days), 9-12m review, 2-2.5 year review: % delivered within timescales (Tameside & GM):*


4.2.1 The graphs above demonstrate that performance across the three areas measured is improving overall. This reflects the increase in Health Visitor establishment. The service

has worked hard over the past year to improve performance data collection and quality, so that there is now a high degree of confidence in reported data.

4.2.2 All children and families are seen and the graphs above represent those that are seen within prescribed timescales only. Historically in T&G children received a development review between 7 and 15 months of age and coverage was 92% in 2014-15. The graph showing performance for the 9-12 month review measures those children seen by 12 months of age only. Since 2014, considerable effort has gone into meeting the requirements of both the new HV service specification and the AGMA New Delivery Model; the number of children seen by 12 months of age has consequently increased and was at 87% in Q1 of 2015-16. It is expected that performance will improve further.

4.2.3 The 2 year review demonstrates a similar pattern in terms of the effort made to ensure children are reviewed within the prescribed time scales. Nationally it is shown that this older age group is a more challenging review to achieve full coverage on. The service has experienced some additional problems with data collection and reporting and has invested considerable time in understanding and rectifying these problems. Additionally the service has introduced the ASQ-3 and a self-book appointment system to improve overall efficiency, but the transition period has affected performance. The service expects that with increased staffing numbers and the above issues being addressed, performance will improve.

4.2.4 Antenatal health promoting visits have been the last area that Health Visiting teams have chosen to focus on as their teams have grown. It is anticipated that the service will increase significantly from the baseline of 13% coverage when the workforce is at full capacity. The greatest challenge to increasing antenatal visits has been that the main local maternity provider is a different NHS Trust and information sharing has been a major challenge. A new maternity management structure, the introduction of a shared CQUIN between maternity/Health visiting (from 1st October 2015) should see this improve considerably.

4.2.5 The remaining mandated review is the 6-8 week review which has not been reported previously but is well embedded within the majority of Health Visiting teams in GM. T&G was the highest performing service across GM at 96% for Quarter 1 (average 80%; range 51% - 96%).

4.2.6 The data-reporting mechanisms in place between the Provider and NHSE will be replicated by Local Authorities following the transfer.

4.2.7 To quality assure Health visiting services a local nurse-led self-assessment assurance tool was developed and introduced to providers in Quarter 2 14-15. The tool provides a useful frame of reference to help services with self-assessment and highlight areas for development. The T&G Health Visiting service has shown the following improvements evidenced by the quality assurance tool:

- Progressive discussion with the new maternity leadership team at Tameside Hospital regarding the maternity communication pathway
- Ongoing training in NBO and NBAS, Solihull, ASQ-3 and the antenatal and postnatal promotional interviewing tool
- Achievement of UNICEF Baby Friendly Level 3 with children's centres
- Training in and application of the Communication Pathway for Early Years with Speech and Language Therapy and children's centres

- Engagement in the development of several multi-agency pathways including domestic violence

- Health visitor engagement in multi-agency safeguarding training.

### 4.3 Health Visitor Workforce Growth

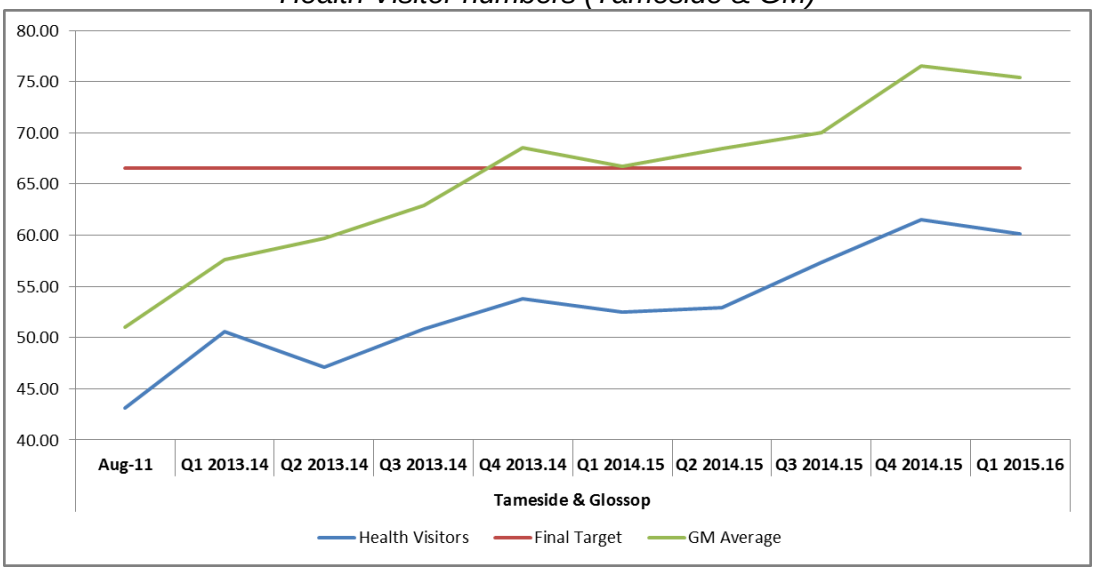
4.3.1 T&G have had a significant challenge to increase workforce numbers from a very low starting point. The workforce has grown by over 50% since 2011. The growth required exceeded all other areas, however despite this the management team worked hard to ensure that the Health Visitors entering the T&G workforce are of an exceptionally high quality.

4.3.2 There has been significant investment in training experienced Health Visitors to take on the role of Community Practice Teacher (CPT), in order to facilitate the extra requirement for student training. T&G have trained 10 CPTs since 2011 (from a baseline of 2 CPTs), ensuring that all students receive quality individual placements and the service is resilient moving forward.

4.3.3 Since 2011 T&G have trained 34 students and another 10 will commence training in September 2015; in this 4 year period T&G would normally have expected to train a maximum of 8. T&G have also supported a 'return to practice' placement and that Health visitor is now employed by T&G.

4.3.4 Workforce numbers have increased steadily over the two years that NHS England has commissioned the service. Plans are in place to ensure that the service is close to full capacity (66.6 WTE) at point of transfer. By the end of October the service expects to be at full capacity and will maintain its commitment to promoting retention and participation rates amongst existing staff. Neighbouring providers are still actively recruiting students due to qualify in mid-October. October numbers will be verified in early November.

*Health Visitor numbers (Tameside & GM)*




4.3.5 Health Visitors are all Registered Nurses with an additional qualification in Specialist Community Public Health Nursing which is a Masters level qualification. The increase in the workforce has been hugely positive, bringing enthusiasm, energy and innovation to teams, and making service improvement and development feel achievable in a way that was not possible in the past. However, the amount of skilled teaching, management, support and supervision that has been, and still will be required must not be underestimated. In October 2015, only 51% of Tameside (67% of Glossop) Health Visitors will have more than 2 years' experience.

4.3.6 Newly qualified Health Visitors undergo a 1-2 year preceptorship period, following the *Department of Health National Induction and Preceptorship Framework for Health Visitors*. This ensures that skills and confidence are developed with the support of an experienced Health Visitor preceptor, and the team leader. Full caseload responsibilities including safeguarding cases can be taken on from 6 months post-qualification. It is important to note that newly qualified Health Visitors may have qualified as Registered Nurses relatively recently, but most have many years' experience in diverse areas of nursing and midwifery.

4.3.7 In T&G a number of Health Visitors have specialist and leadership roles. These include safeguarding, infant feeding, early attachment, public service hub, asylum seeker and refugee, women's refuge, integration lead, team leaders and pathway lead. There is also the Family Nurse Partnership Supervisor and Family Nurses.

4.3.8 Health Visitors are accountable for geographical caseloads. Their teams also include 11.3 Whole Time Equivalent community nursery nurses, who have Nursery Nursing Examination Board, or NVQ Level 3 or equivalent qualifications. Health Visitors are professionally accountable for all duties delegated to Community Nursery Nurses work, as described in the Nursing and Midwifery Council Code of Conduct.

### 4.4 Patient Experience: Health Visiting

4.4.1 The T&G Health Visiting Service has rich client feedback from the following sources:

- Patient Stories;
- Patient Journey;
- 'How Did We Do Today?' Census 20 May 2014;
- UNICEF Baby Friendly Stage 3 Accreditation June 2014;
- Student Health Visitors' Parent Survey July 2014;
- Early Attachment Service Patient Satisfaction Questionnaire;
- Compliments and Complaints.

4.4.2 Positive themes identified are:

- Health Visitors explained their role, arrived on time, parents felt treated with dignity and respect, trusted the Health Visitor, and the Health Visitors' listening skills were specifically valued.
- The Health Visitor's interest in the parent's mood was valued.
- There was high general satisfaction with the visits.
- Information given was useful and easy to understand.
- The service is effective in reaching parents who are 'disengaged' from wider services.

4.4.3 The Service has made significant progress with its action plan to collect comprehensive feedback from clients and is committed to improving services further. Recent data collected includes a number of patient stories, a survey of 228 families in June 2015 and FutureGov qualitative research with parents receiving Health Visiting and early years/ children's centres services in May 2015. Actions include ensuring all parents have information about how to make a complaint if needed, discussing what information is kept about families and how it is used, increasing antenatal visits to promote health behaviours, and improving technology.

### 4.5 Summary of Progress: Health Visiting

4.5.1 The T&G Health Visiting Service has shown steadily increased numbers of families receiving the five mandated contacts and systems are embedded for ensuring that families receive the Healthy Child Programme 0-5.

4.5.2 The Service is working closely with Tameside Council to deliver the Greater Manchester 'New Delivery Model' in the Early Adopter areas, with full roll out already commencing. Health Visiting is in a strong position to move towards integration with Early Years services, and to provide the leadership necessary for the success of the model and full delivery of the Healthy Child Programme. Health Visiting service leaders have been influential in developing aspects of the wider Greater Manchester New Delivery Model and are committed to its principles and success. There is a positive relationship between LA commissioners and the Health Visiting leaders.

4.5.3 The T&G Health Visiting service has strong, positive leadership, with a wealth of experience in delivering services for children. Several aspects of the service are already high profile. In 2014 a Department of Health team shadowed the Stalybridge Health Visiting team to find out what health visiting is really like – and reported they were "really impressed". The Infant feeding Co-ordinator is a UNICEF Baby Friendly national assessor.

4.5.4 The Early Attachment Service and parent infant mental health model is the only service to be named as an exemplar of good practice in the national Health Visiting service specification, several papers have been published and it has been shared at national conferences.

4.5.5 T&G Health Visiting Service is part of Stockport NHS Foundation Trust. The Service has been able to fully benefit from the increased numbers of health visitors because it was already a good and innovative service despite having lower numbers at the start of the 'Call to Action'. Moving forward, there is a will within the organisation and within T&G CCG to deliver services in a locally organised and integrated way. The health visiting service and its leaders are in a strong position to engage in this.

**4.6 Challenges: Health Visiting**

4.6.1 The demographics of the population including the levels of disadvantage, poverty, transience and child protection present a significant challenge to the health visitors.

4.6.2 Record Keeping and Data Collection: There remain challenges to data collection and record keeping with the T&G HV Service still keeping paper based records. Their IT systems do not fully support effective data collection including ASQ 3 scores and demographic information.

4.6.3 Record keeping and collection of KPIs and demographic data should be enabled through use of a single electronic system of data collection and records entry for the health visitors. This will enable service improvement to be fine-tuned. The Service will need support from senior managers in the Trust with responsibility for IT systems to develop this aspect.

4.6.4 Maintenance and stability: With 49% of HVs qualified for under 2 years and 17% newly qualified, it will take at least 6-12 months for the service to reach full operational capacity. Maintaining numbers of health visitors and maintenance of the existing service specification will be important for improving outcomes for children.

4.6.5 The service has always been provided to two local authorities and when the Glossop Health Visiting team TUPE to Derbyshire Community Health Services in April 2015 this will create some temporary disruption.

4.6.6 T&G Health Visiting Service already works closely with LA colleagues and GPs and this can develop further as the partners work towards structural integration and place based services.

## 5. FAMILY NURSE PARTNERSHIP PROGRAMME

5.1 The Family Nurse Partnership (FNP) programme is a targeted offer within the 0-5 healthy child pathway, focusing on vulnerable young mothers (under the age of 20 at conception) in their first pregnancy. This evidence based, licensed programme is highly structured and supports families from early pregnancy until the child is 2 years old. Teenage pregnancy is strongly associated with the most deprived and socially excluded young people and the programmes aim to improve outcomes for these mothers in pregnancy alongside improving child health and development and improve parental self-efficiency.

### 5.2 FNP across Greater Manchester

5.2.1 FNP has operated successfully in the City of Manchester for 8 years and Wigan and Bolton for 4 years. The remaining seven Greater Manchester areas commenced delivery of FNP in 2014/15, commissioned by NHS England (Greater Manchester Area Team). The number of places available in GM has increased from 420 in April 2013 to 1,250 in April 2015.

### 5.3 Predicted level of FNP need.

5.3.1 Across Greater Manchester there were 1,713 live births to mothers under the age of 20 years in 2013 (latest data available). This is a 23.4% decline over a three-year period. The decline in Tameside is in line with the Greater Manchester average with a fall of 23.6% live births to mothers under the age of 20 between 2011 and 2013.

| FNP Area | 2011 | 2012 | 2013 | % Change |
|---|---|---|---|---|
| **Tameside** | 212 | 198 | 162 | -23.6% |
| **GM** | 2,236 | 2,043 | 1713 | -23.4% |

*Source: ONS (accessed Oct 2014)*

5.3.2 To improve robustness of the data NHS England (Greater Manchester area) have created a modelled estimate of the eligible FNP population by local authority area, taking into account births to first time mothers only and births to mothers aged 20 who were 19 years at conception. The modelled data suggests that the eligible population across Greater Manchester in 2013 was 1,780 mothers. In Tameside the modelled estimate of need is 171 clients per year.

### 5.4 Modelled estimate of eligible first time mothers in Tameside (2013)

| Local Authority | Live Births to mothers aged <20 at birth | Births to mothers aged 20 - 20.75yrs[1] | Total Births to mothers aged <20 at conception | Births to first time mothers only [2] |
|---|---|---|---|---|
| **Tameside** | 162 | 73 | 235 | 171 |
| **GM** | 1713 | 806 | 2,442 | 1,780 |

### 5.5 Tameside FNP Programme

5.5.1 The Tameside FNP programme commenced taking notifications in March 2015. The FNP team is currently made up of 1 supervisor, 4 full time nurses and 1 quality support officer. Each full time FNP nurses have a capacity commissioned caseload of 25 clients and the

[1] Figure taken from ONS birth data by area of residence (2013) for 20 yr. old mothers and then multiplied by 0.75 to account for first 9 months only.

[2] All mothers under 20 have the same rate of being first time mothers applied to them (72.9%), as provided by ONS and used in FNP National Modeling

FNP supervisor has a capacity caseload of four clients. When at full capacity (March 2016) the Tameside FNP team capacity caseload is for 100-104 clients.

5.6 **Tameside FNP Team Capacity and predicted levels of need**

| FNP Area | Number of FNP Nurses (Inc. Supervisor) | WTE FNP Nurses (Inc. Supervisor) | Capacity Case load |
|---|---|---|---|
| **Tameside** | 5 | 5 | 104 |
| **GM** | 62 | 59.47 | 1,267 |

5.6.1 Assuming clients are engaged on the FNP programme for 2.5 years and if the national FNP fidelity goal of 75% of mothers offered the programme accepting, we can predict met/unmet need across each local authority. Across Tameside there will be an estimated unmet need for 216 clients. An additional 8.5 nurses would be required to fully meet need (based on modelled estimates).

| Local Authority | Annual number of eligible mothers (75% acceptance) | Number of clients over 2.5 years | Current team capacity | Estimated unmet need | Number of nurses to meet unmet need |
|---|---|---|---|---|---|
| **Tameside** | 128 | 320 | 104 | 216 | 8.5 |
| **GM** | 1336 | 3322 | 1267 | 2055 | 82 |

5.6.2 As the Tameside FNP programme only commenced taking notifications in March 2015 there is limited data available. Tameside FNP has received 20 eligible notifications. This is 47% of the predicted quarterly modelled estimate (43 eligible clients) indicating that further work is required in developing the notification pathways (GM = 77%).

| | Eligible Notifications Received (31st May 2015) | Estimate of expected numbers (6 months) | % of expected Eligible Notifications |
|---|---|---|---|
| **Tameside** | 20 | 43 | 47% |

5.7 **Tameside FNP performance data**

5.7.1 FNP programme performance is monitored by the local Advisory Board (chaired by the Local Authority) and on an annual basis through a local Annual Review by the local Advisory Board and the FNP National Unit. NHS England have put in place a quarterly monitoring system to provide live data on workforce, caseloads and notifications.

5.8 **Recruitment and Enrolment**

5.8.1 At the end of June 2015 the capacity caseload for Tameside FNP was 28 clients. At this point Tameside had an actual caseload of 18 clients meaning they were operating at 64% of current capacity (GM = 72%).

5.8.2 There is a national FNP fidelity goal to recruit clients onto the programme within 16 weeks of gestation, as evidence suggests that the earlier a client is recruited the more effective the programme. In Tameside only 25% of clients (up to end June 2015) were recruited within 16 weeks compared to a programme average of 50.7%. An additional 50% were recruited 17-22 weeks.

5.9 **Intake characteristics**

5.9.1 The following data on the intake characteristics of clients is taken from the FNP Dashboard and covers the period from programme start – 30th June 2015. At this period there were 18

clients enrolled on the Tameside FNP Programme. Due to the very low number of clients the data below needs treating with caution and no significance can be drawn from it.

5.10 **Clients by age of mother**

5.10.1 Whilst the percentage of clients that are aged under 18 reflects the national FNP averages there are fewer Tameside clients aged 19 and over than would be expected across the cohort.

| | <15yrs | 15yrs | 16yrs | 17yrs | 18yrs | 19yrs | >19yrs |
|---|---|---|---|---|---|---|---|
| **Trafford** | 6% | 13% | 19% | 31% | 25% | 6% | 0% |
| **National FNP** | n/a | 6% | 15% | 27% | 25% | 22% | n/a |

5.11 **Ethnic distribution of clients**

5.11.1 All Tameside FNP clients are of white ethnicity. Whilst Tameside is a predominantly White population (94.6%), 4% of the ethnic population are Asian, which at the moment is not representative of the FNP cohort population.

| | White | Asian | Black | Mixed | Other |
|---|---|---|---|---|---|
| **Tameside** | 100% | 0% | 0% | 0% | 0% |
| **National FNP** | 85% | 2% | 6% | 5% | 2% |

5.12 **Intake Characteristics and FNP Public Health Outcomes**

5.12.1 The FNP Dashboard can report on specific intake characteristics of mothers such as education, NEET, mental health, Child in Need Plan and many more. It also reports on public health outcomes such as breastfeeding, smoking in pregnancy, immunisations etc. However Tameside FNP has not been operational for long enough to report on this and therefore the data is not included in this document. The data is available on request from the FNP Supervisor.

## 6. FINANCE

6.1 Levels of funding for Health Visiting services across GM are a direct legacy of Primary Care Trust commissioning. The current level of funding is a combination of the level of funding at transition in April 2013 + total growth in Health Visitors. No other calculations have been made and the Health Visiting contracts have not been rebased. Final values have been inserted into the contract for 2015-16.

## 7. BENCHMARKING

7.1 There have been several approaches to benchmarking service costs by Provider the most frequently observed approach is cost/Health Visitor however this ignores wider skill-mix within the service and leads to false assumptions.

7.2 In late 2014 the Department of Health undertook a *Baseline Agreement Exercise (BAE)* which identified a benchmark formula. The total spend per head was calculated by dividing the allocations by the projected mid-year population figures from ONS, for children under 5 years. To ensure that these figures are comparable at Local Authority level, the allocations were divided by the Market Forces Factor (MFF), which takes account of the differences in the cost of delivering services across the country.

7.3 As part of the BAE the Department of Health introduced a minimum funding floor for Health Visiting services. All GM areas are funded well above this level. From 2016-17 the allocations are expected to be based on population needs following guidance from the Advisory Committee on Resource Allocation (ACRA).

7.4 After the inclusion of necessary 'overheads' such as estates, administration, IT support, and clinical management; much of the remaining costs within Health Visiting services are direct staffing costs. Consequently any increase or decrease to this budget is likely to have a direct impact upon frontline delivery.

| Adjusted spend per head by LA area (0-4 years population) | | |
|---|---|---|
| | Local Authority | Spend |
| **1** | X | £313 |
| **2** | X | £299 |
| **3** | X | £293 |
| **4** | X | £292 |
| **5** | X | £286 |
| **6** | X | £284 |
| **7** | X | £279 |
| **~** | GM Average | £278 |
| **8** | X | £279 |
| **9** | Tameside | £239 |
| **10** | x | £219 |

## 8. CURRENT CONTRACT SITUATION

8.1 A NHS standard contract is in place between T&G CCG and Stockport FT. NHS England and Tameside Council are associate commissioners to this contract. The terms of the contract will vary to transfer the commissioning responsibility from NHSE to Tameside Council 1 October 2015. 6 months' notice is required to terminate this contract which has an end date of 31 March 2016.

8.2 Stockport FT have given notice to T&G CCG on the portfolio of contracts that includes Health Visiting and FNP, consequently this contract will end March 2016.

## 9. GOVERNANCE

- NHSE meets with each Provider up to four times/quarter via six-weekly contract and performance meetings and six-weekly Quality Assurance meetings. From Quarter 3 2014-15 Local Authority commissioners were invited to the contract and performance meetings.

- FNP Advisory Boards are in place in all Local Authority areas.

- Quarterly Early Years Advisory Committee chaired by the Director of Nursing (Lancashire and Greater Manchester) NHSE.

- Bi-monthly AGMA Early Years Transition Group chaired by the Chief Executive of Tameside Council.

- Bi-monthly 0-5 Public Health commissioners group supported by the GM Public Health Network

## 10. PUBLIC HEALTH OUTCOMES

10.1 Children and young people under the age of 20 years make up 24.4% of the population of Tameside with 18.6% of school children from a minority ethnic group and 22.7% of children aged under 16 years are living in poverty (worse than national average).

10.2 The health and wellbeing of children in Tameside is generally worse than the England average. From the table below it can be seen that breastfeeding rates and smoking in pregnancy are significantly worse than the GM average.

10.3 Health Visitor workforce distribution across T&G is regularly reviewed using a weighting tool so that areas with the greatest deprivation and need receive more staff, and levels of Health Visitor experience are balanced with this.

**Health Visiting Caseloads in T&G: breakdown by locality and level of need.**

| | Ashton | Denton, Droylsden & Audenshaw | Mossley, Stalybridge & Dukinfield | Hyde, Hattersley & Longdendale | Glossop | Total |
|---|---|---|---|---|---|---|
| **Universal** | 2,685 | 3,312 | 3,086 | 2,329 | 1,531 | 12,943 |
| **Universal Plus** | 366 | 228 | 167 | 247 | 113 | 1,121 |
| **Universal Partnership Plus** | 202 | 240 | 212 | 186 | 50 | 890 |
| **Total** | 3,253 | 3,780 | 3,465 | 2,762 | 1,694 | 14,954 |

*Data from iPM (May 2015)*

| School readiness: the percentage of children achieving a good level of development at the end of reception (PHOF 1.02i) | 2009/10 | 2010/11 | 2011/12 | 2010/11 | 2012/13 | 2013/14 |
|---|---|---|---|---|---|---|
| Tameside | | | | | 41.80% | 52.13% |
| Greater Manchester | | | | | 47.29% | 55.62% |
| | | | | | | |
| **Low birth weight of term babies (PHOF 2.01)** | **2009/10** | **2010/11** | **2011/12** | **2010/11** | **2012/13** | **2013/14** |
| Tameside | 3.92% | 3.55% | 3.03% | 3.13% | 2.41% | |
| Greater Manchester | 3.25% | 3.24% | 3.17% | 3.25% | 3.04% | |
| | | | | | | |
| **Breastfeeding - Breastfeeding prevalence at 6-8 weeks after** | **2009/10** | **2010/11** | **2011/12** | **2010/11** | **2012/13** | **2013/14** |
| Tameside | | | 34.88% | 32.82% | 34.03% | 22.07% |
| Greater Manchester | | | 37.97% | 38.25% | 38.90% | 34.80% |
| | | | | | | |
| **Smoking status at time of delivery (PHOF 2.03)** | **2009/10** | **2010/11** | **2011/12** | **2010/11** | **2012/13** | **2013/14** |
| Tameside | | | 22.92% | 20.92% | 20.89% | 17.84% |
| Greater Manchester | | | 16.75% | 16.16% | 15.43% | 14.38% |
| | | | | | | |
| **Under 18 conceptions (PHOF 2.04)** | **2009/10** | **2010/11** | **2011/12** | **2010/11** | **2012/13** | **2013/14** |
| Tameside | 59.77 | 58.45 | 46.14 | 45.21 | 32.71 | 29.14 |
| Greater Manchester | 49.37 | 46.61 | 41.57 | 37.80 | 33.32 | 28.23 |
| | | | | | | |
| **Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4 years) (PHOF 2.07i)** | **2009/10** | **2010/11** | **2011/12** | **2010/11** | **2012/13** | **2013/14** |
| Tameside | | | 207.56 | 213.54 | 206.73 | 152.43 |
| Greater Manchester | | | 203.64 | 229.85 | 208.61 | 158.21 |
| | | | | | | |
| **Population vaccination coverage - MMR for two doses (5** | **2009/10** | **2010/11** | **2011/12** | **2010/11** | **2012/13** | **2013/14** |
| Tameside | | | 87.15% | 88.63% | 90.77% | 90.27% |
| Greater Manchester | | | 86.94% | 88.16% | 91.24% | 92.13% |

## 11. GREATER MANCHESTER DEVOLUTION, STARTING WELL: NEXT STEPS

11.1 In the November 2014 Devolution Deal, GM made a commitment to work with Government, developing an effective, robust framework of services for Early Years.

11.2 The March 2015 Health and Social Care Devolution agreement committed to the creation of a clinically and financially sustainable health and social care system in GM predicated on the greatest and fastest growth in population health in GM. The contribution of Early Years interventions to this objective are well evidenced (for example in Marmot 2010).

11.3 Further to this in July 15, Greater Manchester Combined Authority, Public Health England and NHS England signed a unique Memorandum of Understanding to secure a unified public health leadership system for GM. A major programme of work within this, 'Starting Well', will focus on Early Years. In particular, it proposed to build on the strengths of the GM Early Years New Delivery Model and create a broader and unified Early Years: Starting Well Strategy.

11.4 This will be delivered through integration of public services and focusing all Early Years resources on improving the life chances for every child through improved provision of evidence based assessments and interventions, building on the transfer of 0-5 public health services including Family Nurse Partnership and health visiting and the significant resource currently provided through midwifery, early education and Children's Centres.

11.5 Next steps locally include the development of a new integrated universal 0-5 delivery model for Tameside aligned to the Greater Manchester new delivery model for Early Years, an approach that Tameside is already testing and was instrumental in shaping from the start. The model will ensure the delivery of the 8 stage assessment process, the associated intervention pathways and the direct link to the Early Help Offer.

11.6 Key elements of the 8 stage model are being piloted by current providers in Tameside as the implementation phase of the 8 stage project. Full roll out of the programme is set over two phases, beginning 1st April 2014 across the borough, with full roll out to be completed by March 2016.

## 12. RECOMMENDATIONS

12.1 The Health and Wellbeing Board is asked to consider the recommendations set out on the front of the report.