Agenda item 14

Cabinet – 15 June 2016

Public Health Services for 0 to 5 year olds

Portfolio: Councillor Robertson, Health

Related portfolios: Councillor Burley, Children's Services and Education

Service: Economy and Environment Directorate - Public Health

Wards: All

Key decision: Yes

Forward plan: Yes

1. Summary

1.1 Ensuring that children have the best start in life is a key priority for Walsall. Infant mortality rates are higher in Walsall than regionally and nationally at 6.8 per 1000 live births. (**See Appendix A**) The main contributors to infant mortality include deprivation, low birth weight and also smoking in pregnancy which are significant issues of concern within Walsall. Interventions early in life to support a healthy pregnancy and first months of a child's life can help to reduce these health inequalities and improve future poor outcomes. Public health services for children aged 0 to 5 have a key role in improving outcomes for this age group

1.2 On the 22 July 2015 Cabinet noted the action plan to develop and procure an integrated public health service for 0-5 year olds by 1 April 2017.

1.3 This report seeks to gain Cabinet approval of the service redesign following the outcomes of consultation and the subsequent procurement of an integrated public health service for 0 to 5 year olds. This will include the following elements:

- A healthy pregnancy service;
- A support service for vulnerable parents both in pregnancy and in the early years of a child's life;
- A Healthy Child Programme for 0 to 5 year olds.

1.4 This is a key decision because:

- The impact will be seen by residents of more than 2 wards across the Borough.

1.5 A further report will be submitted to Cabinet following procurement in order to gain Cabinet approval to award the contract.

2. Recommendations

2.1 That Cabinet notes the feedback from the consultation process on the review of Public Health Services for 0-5 year olds proposals included in paragraph 12 and in **Appendix B** to this report.

2.2 That Cabinet approves the proposals set out under section 3.4 of this report to re-design the delivery of Public Health Services for 0-5 year olds.

2.3 That Cabinet approves the commencement of a procurement process for a new service model for Public Health Services for 0-5 year olds, the outcome of which will be reported back to a future Cabinet for approval of the contract award.

3. Report detail

3.1 Infant mortality is a major issue in Walsall and has been recognised as a priority by Health and Wellbeing Board partner organisations. A review commissioned by Walsall Public Health in 2014 and carried out by the Perinatal Institute provided a number of recommendations to key partners, including a recommendation to Walsall Council's Public Health team to ensure that healthy lifestyle messages are promoted and to ensure additional support for vulnerable women. The proposed new services as detailed in this report are in response to these recommendations. Please see illustration of current and proposed services in **Appendix C.**

3.2 Healthy Pregnancy Service

3.2.1 It is proposed to procure a new service supporting healthy pregnancy as part of the integrated public health services for 0-5 year olds that are being procured by 1 April 2017.

3.2.2 <u>Current Service provision</u>

Women with identified lifestyle risk factors are currently referred by midwives to a variety of support services to address risks to their health in pregnancy, for example, a smoking cessation service or a service to support weight management. This can, at times, result in a fragmented service being offered to women and possible reduction in uptake. Women may need to contact multiple support services to address different risk factors.

Because of constraints within the midwifery service there is limited support available for women at a universal level to maintain their health, for example promotion of vitamins or support for women to maintain their emotional health during pregnancy.

3.2.3 Proposed model of service provision

It is proposed to develop a wider healthy pregnancy service that will:

- support all women to make lifestyle changes during pregnancy and maintain their physical and emotional health;
- provide a single point of service to address all lifestyle issues; and
- maximise accessibility for all.

This will be linked with the existing maternity service offered to women in Walsall.

All providers offering this healthy pregnancy support will be trained to offer advice around all issues relating to a healthy pregnancy so each woman will see just one advisor rather than several advisors.

3.3 Support for vulnerable parents

3.3.1 It is proposed to develop a new service for vulnerable parents as part of the integrated public health services for 0-5 year olds that are to be procured by 1 April 2017. Vulnerable parents are those identified by the Maternity Risk Assessment as vulnerable, for example: parents who are or were in care, those with a mental health issue, learning difficulties, experiencing domestic abuse, or a teen parent.

3.3.2 Current Service

The licenced Family Nurse Partnership (FNP) service currently offers intensive support to approximately half of all first time pregnant teenagers and teen parents in Walsall (maximum 14 visits in pregnancy and 36 visits post pregnancy to age 2). This service is offered until the child is 2 years old. Other vulnerable mothers are supported through the health visiting and teenage pregnancy services. The current contract for this service is due to terminate on 31 March 2017.

3.3.3 A recent randomised control trial was undertaken nationally by Cardiff University and published in The Lancet and by Cardiff University in October 2015 to evaluate the impact of FNP on the health of teen parents and their children (for further details please see **Appendix D)**. This showed that FNP had no impact on the four primary measured outcomes (smoking in late pregnancy, birth weight, child A&E attendances/hospital admissions and subsequent pregnancy). Lancet concluded "*Adding FNP to the usually provided health and social care provided no additional short-term benefit to primary outcomes. Programme continuation is not justified on the basis of available evidence, but could be reconsidered should supportive longer-term evidence emerge*."

3.3.4 Proposed model of service provision

Walsall Public Health propose to procure a new evidence based service model which offers support to all vulnerable parents, for example, care leavers who are pregnant and new parents, people with learning disabilities, people with mental health issues, teen parents and migrant parents.

The revised service model will offer flexible levels of support to vulnerable mothers tailored to individual need rather than based on the licensing requirements of the FNP. This may mean that teenage mothers with low levels of vulnerability who are currently offered intensive support through the FNP may receive reduced levels of support within the new service.

3.4 **Healthy Child Programme for 0-5 year olds**

3.4.1 Current Service

The Healthy Child Programme 0-5 is an evidence based programme led by the Health Visiting Service. It supports all families from 28 weeks in pregnancy until the child is 5 years of age. Support is delivered to families proportionate to their need, with more intensive visits and interventions given to those families with higher need. **(**for the model of support, please see **Appendix E**).

3.4.2 Proposed model of service provision

It is intended to procure a provider to continue to offer this service with an increased emphasis on demonstrating an improvement in outcomes for Walsall children.

3.5 All of the above planned services will link into and work closely with other Walsall wide services for example, the midwifery service, GPs and primary care, the maternal mental health service and teenage pregnancy service.

4. Council priorities

4.1 Infant mortality has been recognised as a priority by the Health and Wellbeing Board and Children and Young People's Partnership Board. It is anticipated that both services will impact on the reduction in infant mortality.

4.2 The provision of support for vulnerable parents and support for a healthy pregnancy as part of Best Start public health services for families with children 0-5 years will impact on the following priorities for the Council outlined in the Corporate Plan:

a) Improving Health and well being, including independence for older people: The proposed service has been developed to increase support to groups of residents who have the greatest potential to benefit. It is anticipated that infant mortality and the risk factors which contribute to this (smoking in pregnancy and post birth, being an unhealthy weight in pregnancy, low vitamin uptake, low birth weight) will be reduced;

b) Improving Safeguarding, Learning and the Life Chances for Children and Young People: The proposed new service model will offer more intensive support to vulnerable parents including parents leaving care, teen parents and parents with mental health or learning disabilities and therefore support their children. It will also support school readiness.

4.3 Best Start services will have a positive and sustained impact on the objectives and priorities set out above and for the Council's Health portfolio generally, both through active engagement with Walsall residents, support for children and through partnership working with various council services but in particular, Children's Services.

5. Risk management

5.1 Failure to deliver demonstrable improvements in Public Health against key national performance indicators may mean that the Council fails to achieve uplifts in Public Health grant allocation from the Department of Health in future years.

5.2 The healthy pregnancy service and service to support vulnerable parents will be procured as elements of the larger procurement exercise of Best Start services. This will be procured as an open tender exercise in accordance with Public Contract Regulations 2015. As with all tender exercises, there are inherent risks which will be mitigated through active transition project planning by the service provider in collaboration with partner agencies and commissioners.

There is a slight risk of challenge from teenage mothers with low levels of vulnerability whose intensive FNP support may be reduced within the new service. This will be mitigated through ensuring that appropriate transitional arrangements will be set in place to ensure that all clients are offered support that meets their needs.

6. Financial implications

6.1 The current costs for health visiting and early childhood services including support for vulnerable parents in scope for procurement are approximately £4.6 million per year. Based on the Council requirement to make savings, the new procurement will be required to show £400,000 savings per year. The new services will be procured for a value of approximately £4.2 million per year.

6.2 There is a recognition that the Council is operating within a challenging financial climate, which will have a direct impact upon the future budget available for these services. In line with procurement advice, there will be break clauses built into contracts to allow for any potential reductions in contract value in line with future Council priorities.

6.3 The new contracts will be managed within the allocated budgets for Public Health.

7. Legal implications

7.1 The guidance which enables local authorities to offer public health support to the population is set out in the Health and Social Care Act 2012. This allows local authorities to exercise any of the public health functions of the Secretary of State relating to the health of the public in the authority's area.

7.2 The Council's Legal Services will assist with using the most appropriate procedures and preparing suitable contracts and any ancillary legal documents.

8. Procurement implications

8.1 The Best Start services are covered by the Public Contracts Regulations 2015, Light Touch Regime (Regulation 74 – award of contracts for social and other specific services) and as such there is a requirement for the Council to undertake a procurement process compliant with the Regulations.

8.2 It is intended that this service will be procured for a period of 3 years until March 2020 with an option to extend for a further two 12 month periods.

8.3 The Council's Procurement Team will assist with conducting and managing the most suitable procurement process in a compliant manner.

8.4 All tenders will be sought in full compliance with the Council's Contract Rules and the Public Contract Regulations 2015.

9. Property implications

None anticipated for Walsall Borough Council.

10. Health and wellbeing implications

10.1 In September 2012 the Council adopted the Marmot objectives as objectives for improving Health and Wellbeing and reducing inequalities for the people of Walsall. These objectives have provided the framework for the Joint Strategic Needs Assessment, the Health and Wellbeing Strategy, the Sustainable Communities Strategy, and "The Walsall Plan".

10.2 Reducing inequalities is an explicit objective of the Joint Strategic Needs Assessment, Health and Wellbeing Strategy and Council's Corporate Plan. Public Health procurements and contracts seek to maximise improvement in health and wellbeing, including narrowing the gap in outcomes between the most deprived and least deprived in the Borough.

10.3 Actions to reduce infant mortality which is a Clinical Commissioning Group and Healthcare Trust as well as Council partnership objective will be supported through the suggested new models of delivery.

10.4 There remains a strong economic case for investing in early intervention in pregnancy and early childhood. The Best Start 0-5 health visiting service, the service for vulnerable parents and healthy pregnancy service are key to meeting the health needs of expectant and new parents and young children and is in a position to identify previously unrecognised social, physical and mental health issues in all families. It works towards priorities identified in the JSNA (Joint Strategic Needs Assessment) and Health and Wellbeing Board.

10.5 There are high levels of vulnerability and need amongst first time teenage mothers, care leavers and parents with mental health issues and learning difficulties in England, which need to be addressed to improve infant mortality, life chances and break intergenerational cycles of deprivation. These groups have high rates of maternal smoking in pregnancy, rapid subsequent pregnancy, Not in Employment, Education or Training (NEET), domestic abuse and continuing mental health problems.

10.6 By improving the health of children, school readiness and therefore attainment will be improved which are key Walsall Borough Council objectives.

11. Staffing implications

None for Council staff.

11. Equality implications

11.1 An initial EqIA was undertaken in October 2015. This indicated positive impacts on the following groups with protected characteristics:

Age: A greater emphasis on supporting families universally. Integrated services for 0-5 set in place resulting in less fragmentation and a service for children prebirth and in the early years responding to their needs as they arise; and

Pregnancy and maternity: A greater emphasis on supporting new parents universally in the ante natal period. Integrated services for prospective and new parents set in place resulting in less fragmentation and an antenatal service and in the early years responding to needs as it arises.

11.2 A more detailed EqIA (please see **Appendix F)** was undertaken following the consultation early 2016. This showed that there was no evidence that indicates potential negative impacts for people with protected characteristics. A further positive impact on age is anticipated with a greater emphasis on tailored support for vulnerable parents including young parents which will meet the specific needs of this group.

12. Consultation

12.1 Consultation has been undertaken in March and April 2016 with residents and stakeholders. Feedback was received from 503 people.

12.2 Results from this consultation show that both health professionals and the public supported the introduction of a new service aimed at vulnerable parents, as this was seen as an identified gap in the current market. Concerns raised from this proposal from both groups, however, were that this may put extra pressure on current services and other groups of people may be overlooked.

12.3 Support during pregnancy was welcomed by residents with breastfeeding and monitoring fetal movements seen as most important messages to be given.

12.4 The views on current early years' health services are positive with the work of health visitors, breastfeeding and parenting advice valued. It was suggested that more should be done to ensure service users and health professionals are aware of care pathways and referral mechanisms in order for users to gain maximum benefit.

12,5 Consultation was also undertaken with stakeholders from Walsall Healthcare Trust, the Clinical Commissioning Group, Dudley and Walsall Mental Health Trust and voluntary sector at an event April 2016. This showed partnership support to develop a healthy pregnancy service and identified the need for a service for vulnerable parents.

Background papers

FNP randomised control trial (known as Building Blocks) as undertaken by Cardiff University and published in The Lancet and by Cardiff University on Wednesday, 14 October 2015 (**Appendix D**).

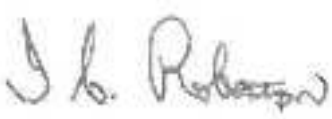
Author

Uma Viswanathan
Consultant in Public Health
☎ 01922 653747
✉ Uma.Viswanathan@walsall.gov.uk

Esther Higdon
Senior Programme Development and Commissioning Manager
☎ 01922 653724
✉ Esther.Higdon@walsall.gov.uk

Barbara Watt
Director of Public Health

6 June 2016



Councillor Robertson
Portfolio holder for Health

6 June 2016

Simon Neilson
Executive Director

6 June 2016

Appendix A

CHIMAT Walsall Child Health Profile

Walsall Child Health Profile — March 2016

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

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

	Indicator	Local no.	Local value	Eng. ave.	Eng. Worst	Eng. Best
Parental mortality	1 Infant mortality	26	6.8	4.0	7.2	1.6
	2 Child mortality rate (1-17 years)	9	14.0	12.0	19.3	5.0
Health protection	3 MMR vaccination for one dose (2 years) ● >=90% ● <90%	3,383	97.4	92.3	73.8	98.1
	4 Dtep / IPV / Hib vaccination (2 years) ● >=90% ● <90%	3,435	98.9	95.7	79.2	99.2
	5 Children in care immunisations	320	67.4	87.8	64.9	100.0
Wider determinants of ill health	6 Children achieving a good level of development at the end of reception	2,238	60.8	66.3	50.7	77.5
	7 GCSEs achieved (5 A*-C inc. English and maths)	1,610	50.6	57.3	42.0	71.4
	8 GCSEs achieved (5 A*-C inc. English and maths) for children in care	-	-	12.0	8.0	42.9
	9 16-18 year olds not in education, employment or training	470	4.6	4.7	9.0	1.5
	10 First time entrants to the youth justice system	116	421.3	409.1	808.6	132.9
	11 Children in poverty (under 16 years)	15,220	27.2	18.6	34.4	6.1
	12 Family homelessness	102	0.9	1.8	8.9	0.2
	13 Children in care	605	94	60	158	20
	14 Children killed or seriously injured in road traffic accidents	18	31.6	17.9	51.5	5.5
Health improvement	15 Low birthweight of term babies	194	5.8	2.9	5.8	1.6
	16 Obese children (4-5 years)	416	11.6	9.1	13.6	4.2
	17 Obese children (10-11 years)	749	23.3	19.1	27.8	10.5
	18 Children with one or more decayed, missing or filled teeth	-	28.3	27.9	53.2	12.5
	19 Hospital admissions for dental caries (1-4 years)	10	66.8	322.0	1,406.8	11.7
	20 Under 18 conceptions	192	36.8	24.3	43.9	9.2
	21 Teenage mothers	57	1.6	0.9	2.2	0.2
	22 Hospital admissions due to alcohol specific conditions	92	48.8	40.1	100.0	13.7
	23 Hospital admissions due to substance misuse (15-24 years)	28	80.1	88.8	278.2	24.7
Prevention of ill health	24 Smoking status at time of delivery	-	-	11.4	27.2	2.1
	25 Breastfeeding initiation	2,335	66.3	74.3	47.2	92.9
	26 Breastfeeding prevalence at 6-8 weeks after birth	1,323	36.5	43.8	19.1	81.5
	27 A&E attendances (0-4 years)	7,914	419.5	540.5	1,761.8	283.6
	28 Hospital admissions caused by injuries in children (0-14 years)	503	93.2	109.6	199.7	61.3
	29 Hospital admissions caused by injuries in young people (15-24 years)	390	112.7	131.7	287.1	67.1
	30 Hospital admissions for asthma (under 19 years)	173	254.5	216.1	553.2	73.4
	31 Hospital admissions for mental health conditions	56	86.7	87.4	226.5	28.5
	32 Hospital admissions as a result of self-harm (10-24 years)	215	416.5	398.8	1,388.4	105.2

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

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

Appendix B

Feedback from the public and stakeholder consultation on the review of Public Health Services for 0-5 year olds March and April 2016

Introduction

A consultation was undertaken with stakeholders and residents in March 2016 around services for expectant and new parents and children in their first 5 years of life. This took the form of a combination of electronic and paper based questionnaires with 20 focus groups being run by Moo Moo Marketing in addition, in order to ensure the views of vulnerable groups were gained. A total of 503 people responded (395 residents and 108 stakeholders).

The consultation closed 29 April 2016.

Summary of findings

Both health professionals and the public supported the introduction of a new service aimed at vulnerable parents, as this was seen as an identified gap in the current market. Concerns raised from this proposal from both groups, however, were that this may put extra pressure on current services and other groups of people may be overlooked.

Support during pregnancy was welcomed by residents with breastfeeding and monitoring fetal movements seen as most important messages to be given.

The views on current early year's health services are positive with many valuing the work of health visitors, breastfeeding and parenting advice. It was suggested that more should be done to ensure service users and health professionals are aware of the referral process and who to contact in the mental health support service. Health visiting is a valued service with many praising its work for pregnant mothers and families; however a viewpoint shared by both stakeholders and parents is that this service is stretched, often impacting on the quality of service delivered. Lack of information puts people off using these services and therefore, more work is required to increase the awareness of services available in order for users to make the most from them.

Stakeholders expressed a need for there to be a clear referral pathway for CAMHS for 0-5s and to improve screening methods and liaison with other specialties during pregnancy.

Support services most requested during early childhood;

Stakeholders

1. Parenting and under 5s advice and support (15.5%)
2. Access to HVs/professionals (15.3%)
3. Mental well being for parents (14.6%)

Parents

1. Access to midwives and health visitors (179 responses)
2. Breastfeeding (168 responses)
3. Parenting and under 5s advice and support which might be offered by health visitors (163 responses)

4. Safety and accident reduction (144 responses)
5. Well Baby Groups (125 responses)

Support services most requested <u>during pregnancy</u>:

<u>Stakeholders</u>

1. Breastfeeding information and advice (18.7%)
2. Mental well-being (18.4%)
3. Stop smoking (12.8%)

<u>Parents</u>

1. Breastfeeding (161 responses)
2. Monitoring fetal movements (154 responses)
3. Healthy eating (106 responses)
4. Healthy weight including physical activity (89 responses)

<u>Service for vulnerable parents</u>

73.1% of stakeholders strongly agreed or agreed to the new proposal to develop a service for vulnerable parents. 25% disagreed with this proposal emphasising that ALL patients should require more support, not just vulnerable adults; some had concerns over the impact such a service would have on universal families. Health Visitors worried about the possible increased time constraints this may have on their service.

77.6% of resident respondents strongly agreed or agreed with the proposal to provide a service that supported a wider range of vulnerable groups, believing that the groups suggested were the groups that require it the most. Of the 41 Respondents who have used the Family Nurse Partnership in the last 5 years, 88% of respondents agreed (58.5% Strongly agreed and 29.3% agreed) with the new proposal to provide a service that supports a wider range of vulnerable groups. This shows that those who had already used the FNP service were more open to the idea of a new service, possibly based on personal experience, knowledge of what a more intensive service offers and benefits, compared to those who hadn't.

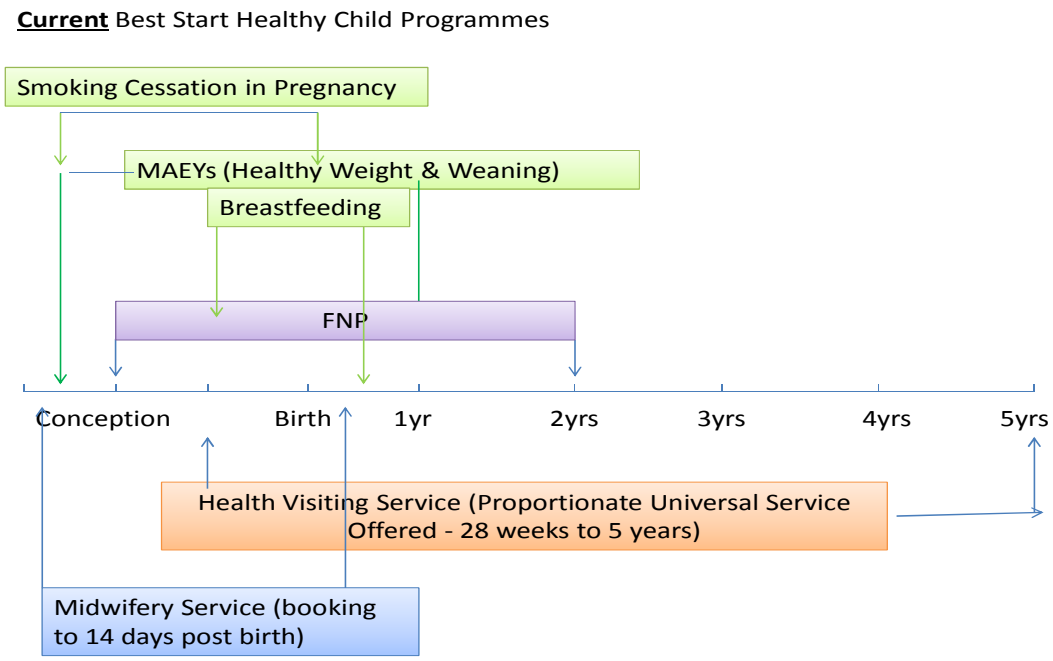
Of those that disagreed or did not know (23%) felt that the service should be aimed at ALL groups of people, not just vulnerable groups. Although many recognised the need for vulnerable groups to have access to these services, they believed that this should not be at the price for other groups being overlooked and under supported. Other groups of people identified as being vulnerable were similar to those identified by stakeholders and included single parents, refugees, alcohol abusers, victims of domestic violence and years 10 and 11 at secondary school.

<u>Accessing services</u>

The majority of residents wanted support to be offered at home on a one to one basis (276 responses) but there was interest in being offered support in the GP surgery, health centre or Childrens Centre.

Appendix C

Timeline of services (current and proposed)



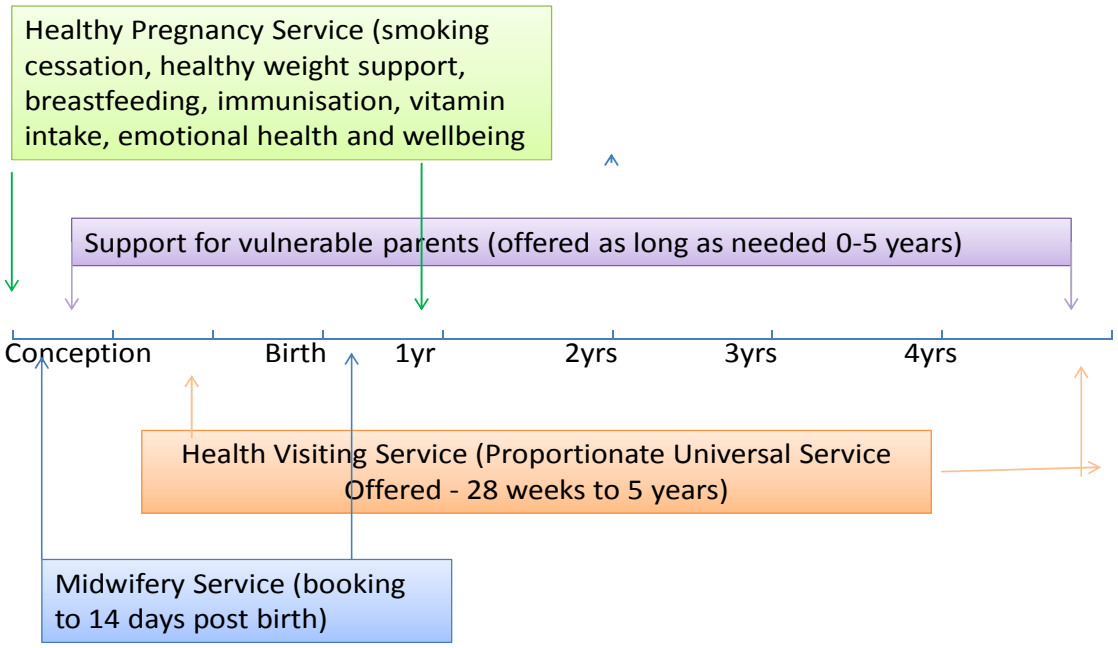
Currently the services funded through Public Health available to support women in pregnancy, new families and young children are:

- Health Visiting service, which includes visits and support for all Walsall families at the following times;
    - 28 week ante natal visit;
    - 14 day post birth visit;
    - 6-8 weeks appointment;
    - 12 month appointment;
    - 24 month appointment (please see **Appendix B**).

  Health Visitors are required to operate to a model of "proportionate universalism" which requires the intensity of support offered to be increased in line with need – (see **Appendix B**).

- Family Nurse Partnership team supporting pregnant teens and new teenage parents;
- Smoking Cessation in pregnancy service managed by the Lifestyle Service team in Walsall Healthcare Trust and also N51 Ltd;
- Support to increase availability of free Healthy Start vitamins;
- Breastfeeding support both pre and immediately post birth and through breastfeeding support groups in the community;
- Healthy Weight support in pregnancy and after birth including weaning.

Proposed Best Start Healthy Child Programme April 2017 onwards



Appendix D

"Building Blocks " Evaluation of the Family Nurse Partnership Programme 2016

The below extract was taken from The Lancet January 2016 outlining the conclusions arising from "Building Blocks", the national randomised control trial undertaken to evaluate the Family Nurse Partnership programme in England commissioned by the Department of Health and carried out by a team led by Cardiff University

The aim of the Building Blocks study was to evaluate the effectiveness of FNP compared to usual services between early pregnancy and the child's second birthday, in three areas:

- Pregnancy and birth
- Child health and development
- Maternal life course

With a focus on four primary outcomes:

- Pre-natal tobacco use
- Birth weight
- A&E attendances and emergency hospital admissions within 24 months of birth of the client's first child
- Subsequent pregnancies within 24 months of birth of client's first child

A range of secondary outcomes were also evaluated, namely; breastfeeding, child health and development, maternal education and employment, mother-child interaction, maternal mental health, domestic abuse.

In addition, economic evaluation and process evaluations were undertaken to understand how well the programme was implemented and the wider context.

Background

Many countries now offer support to teenage mothers to help them to achieve long-term socioeconomic stability and to give a successful start to their children. The Family Nurse Partnership (FNP) is a licensed intensive home-visiting intervention developed in the USA and introduced into practice in England that involves up to 64 structured home visits from early pregnancy until the child's second birthday by specially recruited and trained family nurses. We aimed to assess the effectiveness of giving the programme to teenage first-time mothers on infant and maternal outcomes up to 24 months after birth.

Methods

We did a pragmatic, non-blinded, randomised controlled, parallel-group trial in community midwifery settings at 18 partnerships between local authorities and primary and secondary care organisations in England. Eligible participants were nulliparous and aged 19 years or younger, and were recruited at less than 25 weeks' gestation. Field-based researchers randomly allocated mothers (1:1) via remote randomisation (telephone and web) to FNP plus usual care (publicly funded health and social care) or to usual care alone. Allocation was stratified by site and minimised by gestation (<16 weeks vs *≥16 weeks), smoking status (yes* vs *no), and preferred language of data collection (English* vs *non-English). Mothers and assessors (local researchers at baseline and 24 months' follow-up) were not masked to*

group allocation, but telephone interviewers were blinded. Primary endpoints were biomarker-calibrated self-reported tobacco use by the mother at late pregnancy, birthweight of the baby, the proportion of women with a second pregnancy within 24 months post-partum, and emergency attendances and hospital admissions for the child within 24 months post-partum. Analyses were by intention to treat. This trial is registered with ISRCTN, number ISRCTN23019866.

Findings

Between June 16, 2009, and July 28, 2010, we screened 3251 women. After enrolment, 823 women were randomly assigned to receive FNP and 822 to usual care. All follow-up data were retrieved by April 25, 2014. 304 (56%) of 547 women assigned to FNP and 306 (56%) of 545 assigned to usual care smoked at late pregnancy (adjusted odds ratio [AOR] 0·90, 97·5% CI 0·64–1·28). Mean birthweight of 742 babies with mothers assigned to FNP was 3217·4 g (SD 618·0), whereas birthweight of 768 babies assigned to usual care was 3197·5 g (SD 581·5; adjusted mean difference 20·75 g, 97·5% CI −47·73 to 89·23. 587 (81%) of 725 assessed children with mothers assigned to FNP and 577 (77%) of 753 assessed children assigned to usual care attended an emergency department or were admitted to hospital at least once before their second birthday (AOR 1·32, 97·5% CI 0·99–1·76). 426 (66%) of 643 assessed women assigned to FNP and 427 (66%) 646 assigned to usual care had a second pregnancy within 2 years (AOR 1·01, 0·77–1·33). At least one serious adverse event (mainly clinical events associated with pregnancy and infancy period) was reported for 310 (38%) of 808 participants (mother–child) in the usual care group and 357 (44%) of 810 in the FNP group, none of which were considered related to the intervention.

Interpretation

Adding FNP to the usually provided health and social care provided no additional short-term benefit to our primary outcomes. Programme continuation is not justified on the basis of available evidence, but could be reconsidered should supportive longer-term evidence emerge.

Funding

Department of Health Policy Research Programme.

http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)00392-X/abstract

Appendix E

Model of Health Visiting

Appendix F

Equality Impact Assessment (EqIA) for 0-5 Healthy Child Services

June 2016

Proposal name	**178 0-5 Healthy Child Services**		
Directorate	Environment and Economy		
Service	Public Health		
Responsible Officer	Uma Viswanathan		
EqIA Author	Esther Higdon		
Proposal planning start	October 15	Proposal start date (due or actual)	01/04/2017

Updated June 2016

1	**What is the purpose of the proposal?**	**Yes / No**	**New / revision**
	Policy		
	Procedure		
	Internal service		
	External Service	**Yes**	**New procured service**
	Other - give details		
2	**What are the intended outcomes, reasons for change? (The business case)**		
	To deliver savings by integrating the breast feeding/infant feeding programme with the 0-5 Healthy Child programme (health visiting programme) and to re-procure a redesigned service by April 2017. In conjunction with Children's Services, develop integrated operational working around early year's provision. The redesign of the service would ensure that the needs of Walsall would have been considered and be met and that the skill mix of the service would be adapted to meet the needs of each locality. *In addition to develop a new service to support a healthy pregnancy (not in WMBC budget consultation document)* To provide support for a healthy pregnancy for women in Walsall in order to meet the recommendations made to Public Health WBC by the Peri Natal Institute in its review into		

	how to reduce infant mortality To provide a service tailored to the individual needs of all vulnerable parents to support them during pregnancy and the first 5 years of a child's life. Currently a more intensive support service is offered to approximately half of first time teen parents until the child is 2 years of age with other vulnerable parents being supported by the Health Visiting and teenage pregnancy services. To procure a provider to continue to offer the Healthy Child Programme 0-5 (HCP 5-19) which incorporates the two proposed additional services. The HCP 0-5 is an evidence based programme led by the Health Visiting Service. It supports all families from 28 weeks in pregnancy until the child is 5 years of age. Support is delivered to families proportionate to their need, with more intensive visits and interventions given to those families with higher need.		
3	**Who is the proposal potential likely to affect?**		
	People in Walsall	**Yes / No**	**Detail**
	All		
	Specific group/s	**Yes**	All pregnant women and new parents Prospective and new parents will have an integrated service that is easier to navigate and designed to support their individual needs Vulnerable parents eg. parents who are in or leaving care, parents with mental health problems or learning difficulties or teen parents, will receive a more intensive service proportionate to their need and for as long as this might be needed
	Council employees		
	Other		
4	**Evidence, engagement and consultation**		
4.1	**GETTING IT RIGHT FOR FAMILIES;** A REVIEW OF INTEGRATED SYSTEMS AND PROMISING PRACTICE IN THE EARLY YEARS (Early Intervention Foundation 2014) emphases the importance of integration between Council and Health services for 0-5s. It is anticipated that with responsibility for commissioning the 0-5 HCP coming to Local Authorities, there will be greater opportunities for thorough needs assessment, integration and efficiency savings for this group Commissioning responsibilities for 0-5s came to the Local Authority 1.10.15. Cabinet was informed 22.7.15 that models would be trialled October 15 to March 16 and consulted upon spring 2016 in preparation to reprocure by April 2017. Models around early years readiness assessment and transition to parenthood were piloted October 15 to March 2016 with roll out of these services early summer 2016 A more comprehensive EqIA will be prepared summer 2016 based on findings from this consultation to gain further stakeholder and resident views around this specific service change that will be set in place from April 2017		

Addition to January 2016 EqIA based on consultation findings (May 2016)

A consultation was undertaken with stakeholders and residents in March and April 2016 around services for expectant and new parents and children in their first 5 years of life. This took the form of a combination of electronic and paper based questionnaires with 20 focus groups being run in addition in order to ensure the views of vulnerable groups were gained. A total of 503 people responded (395 residents and 108 stakeholders)

Both health professionals and the public supported the introduction of a new service aimed at vulnerable parents, as this was seen as an identified gap in the current market. Concerns raised from this proposal from both groups, however, were that this may put extra pressure on current services as well as other groups of people who may be overlooked.

Support during pregnancy was welcomed by residents with breastfeeding and monitoring fetal movements seen as most important messages to be given

The views on current early year's health services are positive with many valuing the work of health visitors, breastfeeding and parenting advice. It was suggested that more should be done to ensure service users and health professionals are aware of the referral process and who to contact in the mental health support service. Health visiting is a valued service with many praising its work for pregnant mothers and families; however a viewpoint shared by both stakeholders and parents is that this service is stretched, often impacting on the quality of service delivered. Lack of information puts people off using these services and therefore, more work is required to increase the awareness of services available in order for users to make the most from them.

Stakeholders expressed a need for there to be a clear referral pathway for CAMHS for 0-5s and to improve screening methods and liaison with other specialties during pregnancy.

Support services most requested during early childhood;

Stakeholders

4. Parenting and under 5s advice and support (15.5%)
5. Access to HVs/ professionals (15.3%)
6. Mental well being for parents (14.6%)

Parents

6. Access to midwives and health visitors (179 responses)
7. Breastfeeding (168 responses)
8. Parenting and under 5s advice and support which might be offered by health visitors (163 responses)
9. Safety and accident reduction (144 responses)
10. Well Baby Groups (125 responses)

Top priority services during pregnancy:

Stakeholders

4. Breastfeeding information and advice (18.7%)
5. Mental well-being (18.4%)
6. Stop smoking (12.8%)

Parents

5. Breastfeeding (161 responses)
6. Monitoring fetal movements (154 responses)

	7. Healthy eating (106 responses) 8. Healthy weight including physical activity(89 responses) <u>Service for vulnerable parents</u> 73.1% of stakeholders strongly agreed or agreed to the new proposal to develop a service for vulnerable parents. 25% disagreed with this proposal emphasising that ALL patients should require more support, not just vulnerable adults; some had concerns over the impact such a service would have on universal families. Health Visitors worried about the possible increased time constraints this may have on their service 77.6% of respondents strongly agreed or agreed with the proposal to provide a service that supported a wider range of vulnerable groups, believing that the groups suggested were the groups that require it the most. Of the 41 Respondents who have used the Family Nurse Partnership in the last 5 years, 88% of respondents agreed (58.5% Strongly agreed and 29.3% agreed) with the new proposal to provide a service that supports a wider range of vulnerable groups. This shows that those who had already used the FNP service were more open to the idea of a new service, possibly based on personal experience, knowledge of service offers and benefits, compared to those who hadn't. Of those that disagreed or did not know (23%) felt that the service should be aimed at ALL groups of people, not just vulnerable groups. Although many recognised the need for vulnerable groups to have access to these services, they believed that this should not be at the price for other groups being overlooked and under supported. Other groups of people identified as being vulnerable were similar to those identified by stakeholders and included single parents, refugees, alcohol abusers, victims of domestic violence and years 10 and 11 at secondary school. **<u>Accessing services</u>** The majority of residents wanted support to be offered at home on a one to one basis (276 responses) but there was interest in being offered support in the GP surgery, health centre or Childrens Centre An infant mortality workshop and engagement event was also run for stakeholders in April 2016. 50 people attended. This showed support for a service specifically aimed at vulnerable parents and for a service to support a healthy pregnancy. It offered a number of valuable suggestions eg To increase staff training on pathways ensuring that information gets disseminated to the correct people or to have a multi agency approach to the development of pathways
4.2	**Concise summary of evidence, engagement and consultation**
	20 Focus groups March and April 2016 Online and paper questionnaires March and April 2016 to residents and stakeholders Stakeholder workshop April 2016 From the online, face to face and workshop consultation, there was no evidence that indicates potential negative impacts for people with protected characteristics When commissioning and procuring the services, we will include contract conditions which: • Prohibit the contractor from unlawfully discriminating under the Equality Act

	• Require them to take all reasonable steps to ensure that staff, suppliers and subcontractors meet their obligations under the Equality Act.			
5	**How may the proposal affect each protected characteristic or group? The affect may be positive, negative or neutral.**			
	Characteristic	**Affect**	**Reason**	**Action needed Y or N**
	Age	Y positive	A greater emphasis on supporting families universally. Integrated services for 0-5 set in place resulting in less fragmentation and a service for children prebirth and in the early years responding to their needs as they arise Support for vulnerable parents including young parents will be tailored to the specific needs of this group Development needs of children (ASQ and EYFS) to be met through sharing of information	
	Disability		No foreseen impact	N
	Gender reassignment		No foreseen impact	N
	Marriage and civil partnership		No foreseen impact	N
	Pregnancy and maternity	Y positive	A greater emphasis on supporting new parents universally in the ante natal period. Integrated services for prospective and new parents set in place resulting in less fragmentation and an antenatal service and in the early years responding to needs as it arises Support for vulnerable parents to be emphasised within service which meets their individual needs for support	

			Women in pregnancy to be offered a dedicated service to complement the midwivery service	
	Race		No foreseen impact	N
	Religion or belief		No foreseen impact	N
	Sex		No foreseen impact	N
	Sexual orientation		No foreseen impact	N
	Other (give detail)			
	Further information			

6	**Does your proposal link with other proposals to have a cumulative affect on particular equality groups? If yes, give details below.**	(Delete one) **No**
	The reduction in Childrens Centres has an impact on accessing services for 0-5s, this is mitigated by the universal offer delivered by Health Visitors and the additional intention to support women in pregnancy and vulnerable families This proposal links with the lifestyle services model which will works in a complementary way to support parents and families to improve their health and to achieve their goals pre conception i.e. the service would refer people into and actively support 'healthy weight' and smoking cessation programmes	

7	**Which justifiable action does the evidence, engagement and consultation suggest you take?** (Bold which one applies)	
	A	No major change required
	B	**Adjustments needed to remove barriers or to better promote equality based on response from consultation**
	C	Continue despite possible adverse impact
	D	Stop and rethink your proposal

Action and monitoring plan				
Action Date	**Action**	**Responsibility**	**Outcome Date**	**Outcome**
February 2016	Wider stakeholder and resident consultation around proposed changes and to support design of new service	Esther Higdon	April 2016	Support for development of revised service meeting needs of Council for budgetary savings and stakeholders and residents for a service that meets their needs
July 2016	Procurement of revised service Within the procurement to ensure that findings from the consultations are considered and taken into account to ensure that access to and use of the new service is maintained	Esther Higdon	31 March 2017	New service in place
1 April17	New service in place	Esther Higdon	ongoing	Revised service monitored and evaluated

Update to EqIA	
Date	**Detail**
1.6.16	Details of consultation summary added to 4.1 and 4.2