

# Public Health: Commissioning Intentions for 0-19 Integrated Healthy Child Programme (HCP)

## Proposal and Integrated Impact Assessment (IIA)

Informing our approach to fairness

<b>Name of proposal</b>	Public Health: Proposals for future commissioning of Childrens 0-19 Integrated Healthy Child Service in Newcastle
<b>Date of original assessment</b>	July 2016
<b>Lead officer</b>	Eugene Milne
<b>Assessment team</b>	Helen Robinson, Kirsty Williams, Rachael Black, Catherine Blenkinsop
<b>Review date</b>	29 July 2016

### Version control

<b>Version</b>	1
<b>Date</b>	14 July 2016
<b>Replaces version</b>	

## Section A: Introduction and background

As part of the 2016-17 budget setting process, the Council consulted on its plans to undertake a service redesign and develop a new service specification in order to commission a 0-19 integrated Healthy Child service which would encompass both the School Nursing and 0-5 Health Visiting Service – with the intention to deliver both efficiencies and better streamlined services and outcomes for children and families.

In commissioning an Integrated 0-19 integrated Healthy Child service we are seeking to develop:

- integrated public health nursing services as part of a coherent prevention and early help programme for children and young people (0-19 years) and their families
- effective partnerships with health, education, social care and voluntary and community sector partners in order to support wider improvements in the health and wellbeing of the 0-19 population
- co-ordinated approaches to the prevention, early help and treatment of young people's risky behaviours (including offending, smoking, unprotected sex, drugs and alcohol), so that behaviours are not treated in isolation
- high quality, accessible prevention and early help services which enable children, young people and their families to access help and support as early as possible, to improve their health and wellbeing.

As part of the service redesign process, we have undertaken a full health needs assessment which:

- summarises national guidance and best practice relating to 0-19 health services;
- provides an overview of socio-demographics and population of Newcastle;
- describes the current provision of 0-19 health services, assessing service performance and service delivery, identifying any gaps between 0-19 health needs and service provision

A copy of the draft health needs assessment can be found at <https://letstalknewcastle.co.uk/>

We have also engaged with a range of stakeholders to inform the service redesign process. The consultation phase ran from 23 May to 17 June 2016 and included:

- a consultation page on Let's Talk with questionnaires for professionals (34), students (226) and parents and carers (226). The project team worked closely with the current provider, colleagues in Education and Communities to promote the consultation through schools, and the Youth Council to promote the consultation with young people.
- 3 workshops for practitioners and professionals (145)
- 1 workshop for parents, carers and professionals (18)
- 1 workshop for students (15)
- Attendance at a staff meeting at Freeman Hospital (100), Newcastle & Gateshead CCG Practice Manager Meetings (24) and the North of Tyne Local Pharmaceutical Committee (4).

Over 650 service users and professionals engaged with us as part of the review this was conducted face to face and through surveys during May and June 2016. Detailed feedback from the consultation can be found at <https://letstalknewcastle.co.uk/>

The health needs assessment findings and feedback from the consultation will be key in informing future requirements within the service specification for future service delivery.

This document now sets out our key redesign proposals in recommissioning an integrated 0-19 health service. It is intended for use by a range of stakeholders in order to develop a cooperative approach to our commissioning plans, for example:

- Existing and potential providers who will be able to use the information presented to identify the role they can play and to help develop their business plans. We hope that this document will enable provider partners to respond to a redesigned 0-19 integrated Healthy Child service, identify potential opportunities for collaborative working, as well as bring forward new and innovative ways of working in the future;
- Voluntary and community organisations and groups who make a key contribution to 0-19 health across the city. We hope these partners, who may or may not deliver commissioned services, will be able to use this document to understand proposed changes to the commissioned service provision and to develop links between commissioned and non-commissioned support; and
- Community stakeholders and Newcastle residents who wish to contribute to the development of a fit for the future integrated '0-19 integrated Healthy Child service in Newcastle.

**This is the final stage of our consultation with stakeholders, prior to procuring an integrated 0-19 service. You can leave your feedback on the recommissioning proposal set out in this document through <https://letstalknewcastle.co.uk/> or by email to [catherine.blenkinsop@newcastle.gov.uk](mailto:catherine.blenkinsop@newcastle.gov.uk).**

**Any final responses to this consultation should be sent no later than 26 July 2016.**

## **Section B: Current services**

### **1. What services are currently commissioned?**

The Healthy Child Programme (HCP) is the universal clinical and public health programme for children and families from pregnancy to 19 years of age.

It offers a programme of screening tests, immunisations, developmental reviews, information and guidance on parenting and healthy choices. Due to its universal reach the HCP aims to identify families who need additional support or are at risk of poor health outcomes. The HCP is made up of three core documents:

1. Healthy Child Programme: pregnancy and the first five years
2. Healthy Child Programme: the two year review
3. Healthy Child Programme: from 5 to 19 years old

The recommended standard for the delivery of the HCP depends on services for children and families being fully integrated. If effectively implemented, in terms of overall aims, the HCP should lead to:

- Strong parent-child attachment and positive parenting, resulting in better social and emotional well-being in children
- Care that helps to keep children healthy and safe
- Healthy eating and increased activity, leading to a reduction in obesity
- Prevention of some serious and communicable diseases
- Increased rates of breastfeeding initiation and continuation of breastfeeding beyond 6 -8 weeks
- Readiness for school and improved learning
- Early recognition of growth disorders and risk factors for obesity
- Early detection of – and action to address – developmental delay, abnormalities and ill health, and concerns about safety
- Identification of factors that could influence health and well-being in families
- Better short- and long-term outcomes for children who are at risk of social exclusion

The Healthy Child Programme (HCP) recognises the key role of a variety of professionals in promoting children and young people’s wellbeing and is aimed at the full range of practitioners in children’s services, with a particular focus on:

- Health visiting/family nurse partnership from pregnancy to 5 years, and
- School nursing for 5-19 year olds.

## 2. Who the services are for?

### **The 0 to 5 Healthy Child Programme (HCP)**

The 0-5 HCP is an early intervention and evidenced based programme led and delivered by health visitors. It sets out the health and development reviews, health promotion, parenting support and screening and immunisation programmes that should be provided for all children aged 0 to 5.

The objectives of the Healthy Child Programme are to:

- identify and treat problems early
- help parents to care well for their children
- change behaviours which contribute to ill health
- protect against preventable diseases.

As part of the programme’s delivery, **health visitors** act as a vital link between primary care, early years, public health, young children and their families. They provide a unique, universal and non-stigmatising service to communities by building trusting relationships that support parents and children, which can support the delivery of early intervention and prevention. They strengthen partnership working to enable the integration of early year’s services and community assets around the needs of children and families. Health visitors play a key role in working with the early education sector to maximise opportunities, including working with Sure Start Children’s Centres which can be a hub for local service provision.

**The 0-5 Healthy Child Programme** also includes the delivery of the Family Nurse Partnership (FNP) which is an intensive, structured, home visiting programme, which is offered to first time parents under the age of 20. A specially trained family nurse visits the mother regularly from early pregnancy until the baby is 2 years old. FNP has three aims, namely to improve pregnancy outcomes; to improve child health and development; to improve parents’ economic self-sufficiency.

### **School Nursing Service - 5 to 19 years old Healthy Child Programme**

The primary purpose of the school nursing service is to provide evidence-based intervention to early identification, early intervention, prevention, health promotion and health protection programmes designed to help all school aged children and young people to achieve their full potential for physical, mental, social, psychological and emotional wellbeing and to gain maximum benefit from their education. Interventions enable children and young people to achieve their optimum health, potential to learn and to reduce the impact of illness and disability on their health and wellbeing.

This service is available to all school aged children and young people, who attend Local Authority Maintained Schools, Free Schools and Academies in the City. This equates to approximately 37,000 children & young people.

Immunisation programmes are also delivered to all children attending schools in Newcastle, including private schools. NHS England is responsible for the commissioning of immunisation programmes for 5-19s.

A national model for School Nursing has been published by the Department of Health with the expectation that local areas implement the model ensuring a consistent, evidence based approach to the delivery of school nursing services and the Healthy Child Programme. The model builds on and compliments the national specification for 0-5 Health Visiting Services.

### **3. What are our statutory requirements?**

Certain universal elements of the Healthy Child Programme have been legally mandated with a 'sunset clause' (that will have the effect of ending mandation, unless further legislation is made that continues the provisions in force) at 18 months and review at 12 months by the government as part of the agreement to transfer funding to local authorities. These elements are:

- Antenatal health promoting visits
- New baby review
- 6-8 week assessment
- 1 year assessment
- 2-2.5 year review

These are key times to ensure that parents are supported to give their child the best start in life, and to identify early, those families who need extra help. However we do not anticipate a change in delivery of these key contacts irrespective of the outcome of the government review. These elements are currently delivered by health visitors or through the Family Nurse Partnership service.

Delivery of the universal elements of the Healthy Child Programme should be underpinned by a robust Joint Strategic Needs Assessment, which identify vulnerable and at risk groups, including young carers, Children in Care, young offenders, those not in education, employment or training (NEET) and children with disabilities. At an individual or family level, services should be developed to meet individual need and tailored to ensure individuals and their families are supported.

## **Section C: Change proposal**

### **1. What is the proposal to change the way services are currently commissioned?**

Throughout the consultation it was acknowledged that current service provision is valued by professionals, parents, carers and young people. There was recognition of the difference between resource allocation for health visiting and school nursing. The school nursing service consists of a smaller workforce and this affects capacity, at a time when need for the service is rising.

The consultation feedback identified the following main opportunities:

### **Gaps and areas for development identified by professionals in and around the services**

Although current delivery of the health visiting service and the school nursing service is geographically based, each service operates on a different footprint, and neither is currently aligned with the locality model of the Community Family Hub. It was felt strongly that delivery of service provision for children, young people and families through the same geographical footprints would improve delivery of services and help to improve networks and understanding of services within the localities.

Information sharing to improve service delivery, improved pathways to avoid duplication, increased use of technology to improve service delivery such as mobile working, improved networking to have a better understanding of roles, improve relationships and understanding of local services, and review methods of referrals between services to improve consistency were all identified as areas that could improve efficiency and service delivery to young people and their families.

### **Gaps and areas for development identified by parents and young people**

Capacity of the school nurse service to respond to need in light of increasing demand from young people, increased mental health support for young people, need to promote services, increased use of technology such as text messaging, the need to review service availability and accessibility.

Further detail on the feedback received as part of the consultation can be found at

<https://letstalknewcastle.co.uk/>

### **Proposal summary:**

The proposed principles and approach underpinning commissioning of a new integrated 0-19 service include:

- Delivery of an integrated range of interventions that meet individual and family need
- A focus on prevention from the earliest stage
- Soundly based on national guidance but developed locally to deliver on key outcomes.
- Enables staff to utilise skills more effectively under a multi-disciplinary model

**In commissioning a single integrated 0-19 healthy child programme service, we propose that:**

#### **1. The functions of the health visiting and school nursing services are combined into a single integrated delivery model.**

It is proposed that integrating the health visiting and school nursing teams will provide a more flexible workforce who are better able to respond to the changing needs of children, young people and their parents. It seeks to ensure that parents, children and young people are able to access the most appropriate type of support as quickly as possible, and that relevant support and interventions are coordinated around the needs of the whole family, as well as individual need. It also seeks to build the capacity of the workforce through improved opportunities for sharing best practice, as well as learning and training opportunities.

#### **2. The integrated service be structured geographically around 3 localities to align with other early help and family support services in the city.**

The new service model seeks to enhance greater integration, not only between Health Visiting and School Nursing, but also the Early Help and Family Support services. There is a greater emphasis

on a 'whole family' approach reflecting the ethos of the local authority in supporting children and families, with a focus on universal services, early help and prevention of risk taking behaviours. In order to promote integrated working, it is proposed that the service is structured to create 3 area based teams in line with the localities for early help and family support services. These locality areas are East, West and Central as set out in the maps at Appendix 1. The locality maps also indicate, for information purposes, the Super Output Areas ranked most disadvantaged using 0-30% Index of Multiple Deprivation (IMD) data. The integrated service will need to tailor delivery across each of the 3 locality areas to ensure the specific needs of the communities and families within these locality areas are met.

In aligning delivery to these 3 locality areas, we believe that there is greater opportunity to strengthen integrated responses for children, young people and families that will focus on early intervention to improve health and reduce inequalities. The proposed alignment will specifically enable greater integration between the 0-19 integrated Healthy Child service and Newcastle's Community Family Hub which is the Council's adopted model for the delivery of Sure Start and intensive family support for families with children of all ages identified as having additional needs. Opportunities for co-location between the 0-19 integrated Healthy Child service and the Community Hub Family area based teams should be explored as part of facilitating integrated responses which seek to meet the needs of children, young people and families holistically.

Joining up these services across the age spectrum of 0 to 19 seeks to strengthen primary prevention and early help by bringing together a robust approach for improving outcomes for young people.

Working to a common geography also presents opportunities for service delivery organisations to be more jointly responsive to local needs as the needs and aspirations of communities can be collectively understood.

Having the same geographical delivery model as the other early help and support services will not only provide opportunities to improve service delivery to families, but will also be more efficient.

- **the Family Nurse Partnership be decommissioned and a vulnerable parent pathway be developed**

In coming to this view, we have considered the results of the Randomised Control Trial which concluded that the programme did not have an impact across the study's four primary outcomes – pre-natal tobacco use, birth weight, subsequent pregnancy by 24 months and A&E attendances and hospital admissions in first two years of life. This probably reflects the effectiveness of the health visitor base offer in our system. We acknowledge that locally the FNP programme is valued by service users, but in the absence of evidence for significant additional effect that alone is not sufficient to justify its continuation.

We noted also that there were some secondary effects among the many variables assessed, and that these related to parent child interaction and speech and language development. In order to address the need for particular attention to young mothers, and to ensure a proper focus on these potential beneficial areas of intervention, the successful Provider will be required to develop a vulnerable parent's pathway to address the needs of those young parents who would have normally accessed the FNP.

- **We build upon national specifications, evidence and good practice, tailoring to meet local need**

Our future service specification for an integrated 0-19 integrated Healthy Child service will have, at its core, the requirements set out in the national specifications for health visiting and school nursing. This will include the Public Health England Guidance published in January 2016 to support the commissioning of the Healthy Child Programme 0-19 which includes a model specification for 0-19 Healthy Child Programme: Health Visiting and School Nursing. It will also build upon the National Health Visiting Core Service Specification 2015-16 details the core elements for the commissioning of Health Visiting Services. This document was developed by stakeholders across the Local Government Association (gaining input from SOLACE, ADPH, ADCS), the Department of Health, Public Health England, Health Education England and post an engagement process involving other key organisations and partners such as CHPVA, IHVA and NHS England Area Teams, CCGs and the Health Visiting Taskforce.

Our specification will also be informed by our consultation feedback, as well as evidence, best practice, local needs and wider reviews of children's health and social care.

Our approach will continue to deliver an integrated service which is based on four levels of intervention: Community, Universal Services, Universal Plus and Universal Partnership Plus. It will also continue to deliver the five mandated elements of health visiting.

### **Benefits of this model**

It is proposed that the above will:

- Reduce duplication and allow for a greater use of skills sets to deliver differently to families.
- Allow for integration between the staff.
- Allow to explore colocation options with other services including early help and family support services.
- Provides greater flexibility across the workforce to respond to emerging and changing need.
- Allow for a whole family approach to service delivery reflecting the local authority model.
- Bring the two services together to enable a greater skill mix, building capacity and resilience in the service and allowing for efficiency savings to be made.
- Provide the opportunity to review service accessibility and staff availability.

### **Risks of this model**

- Reduced intensive support for the young parents who would have accessed the Family Nurse Partnership.

### **How much will it cost:**

The longer term benefits of aligning school nursing and health visiting procurement across the 0-19 Healthy Child Programme include the potential to deliver financial efficiencies, as well as operational efficiencies and a more streamlined service for families.

In commissioning an integrated service model, we are therefore seeking to secure efficiencies on current investment levels. The Council faces significant reductions in its Public Health budget up to 2020-21 as a result of Government cuts – this is on top of the in-year cut made in 2015-16. As a result of our proposals, we are seeking to achieve savings of 20% on current spend by 2020. We anticipate that the savings will be achieved through a combination of efficiencies and decommissioning of the FNP.



The 2016-17 budget process identified savings of £313k be achieved in 2016-17 in relation to 0-19 expenditure. These savings have not been achieved through our partner negotiations. The savings achieved through this recommissioning process will contribute to the required savings for 2016-17, and will contribute to delivery of a sustainable funding model in the context of further government cuts up to 2020.

The final contract value will be determined prior to procuring the integrated 0-19 service.

**Key dates and milestones:**

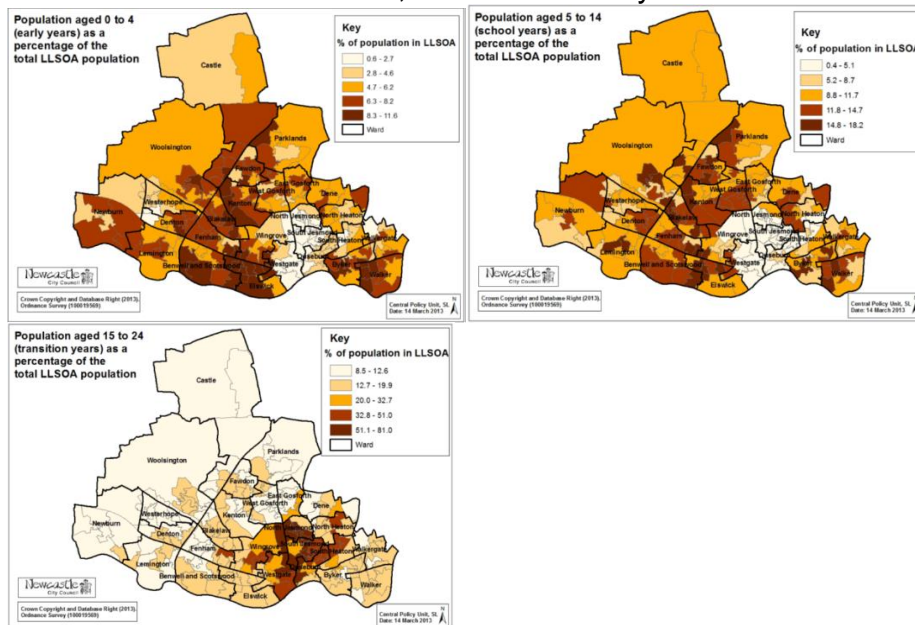
It is anticipated that the new integrated 0-19 service will be commissioned to commence February 2017. This is to enable a sufficient transition period from the existing arrangements, to the new arrangements.

**3. Evidence that has informed this proposal**

Information source	What has this told you?						
0-19 Health Needs Assessment	More detailed information relating to current service provision and health needs of the population (including trends over time) can be found in the 0-19 Needs Assessment April 2016 available at <a href="https://letstalknewcastle.co.uk/">https://letstalknewcastle.co.uk/</a> . A summary of the information shows:						
Newcastle Future Needs Assessment (JSNA)	<p>The table below sets out the number and percentage Newcastle’s population by the different life stages across 0-24 age range:</p> <table border="1" data-bbox="395 1173 1445 1337"> <tbody> <tr> <td data-bbox="395 1173 919 1227">Early years (0-4 years)</td> <td data-bbox="924 1173 1445 1227">17,000 (6%)</td> </tr> <tr> <td data-bbox="395 1227 919 1281">School years (5-14 years)</td> <td data-bbox="924 1227 1445 1281">28,800 (10.1%)</td> </tr> <tr> <td data-bbox="395 1281 919 1335">Transition years (15-24 years)</td> <td data-bbox="924 1281 1445 1335">59,100 (21%)</td> </tr> </tbody> </table> <p><b>Early years (0-4 years)</b> There are currently around 17,000 children living in Newcastle. The numbers are expected to reduce to 16,200 by 2030 (a 4.6% reduction) based on ONS projects. However the Newcastle growth forecast – which reflects local policy intervention and migration patterns – suggests the population is more likely to increase over the period to 2030 (to 17,700).</p> <p><b>School years (5-14 years)</b> ONS data shows that in 2013, there were 28,800 children and young people aged between 5 and 14, and overall the number of children in this life stage is expected to increase, by almost 11% by 2030. The Newcastle growth forecast shows a similar trend but a sharper increase over the same period (17.4%). The 10-14 year group are expected to grow more than the 5-9 year age group. Table 1.5-1 and Figure 1.5-1 show further detail.</p> <p><b>Transition years (15-24 years)</b> ONS projections suggest there are currently around 59,100 people in this age group. If recent trends continue, this age group is expected to slightly increase to 2030 with a continuing positive trend over the longer term. Table 1.6-1</p>	Early years (0-4 years)	17,000 (6%)	School years (5-14 years)	28,800 (10.1%)	Transition years (15-24 years)	59,100 (21%)
Early years (0-4 years)	17,000 (6%)						
School years (5-14 years)	28,800 (10.1%)						
Transition years (15-24 years)	59,100 (21%)						

shows the two age bands within the transition years group have different trends, where 15-19 years are projected to increase and 20-24 years to decrease. Newcastle's growth forecast show similar patterns, 15-19 year olds are forecast to increase but by a larger margin - by 8.1% to 2030 and 20-24 years decrease by 1.1%.

Mapping of the key life stages shows a higher concentration of 0-15 year olds outside of the central wards, whereas 15-24 years olds show a reversal.



### Children in low income families

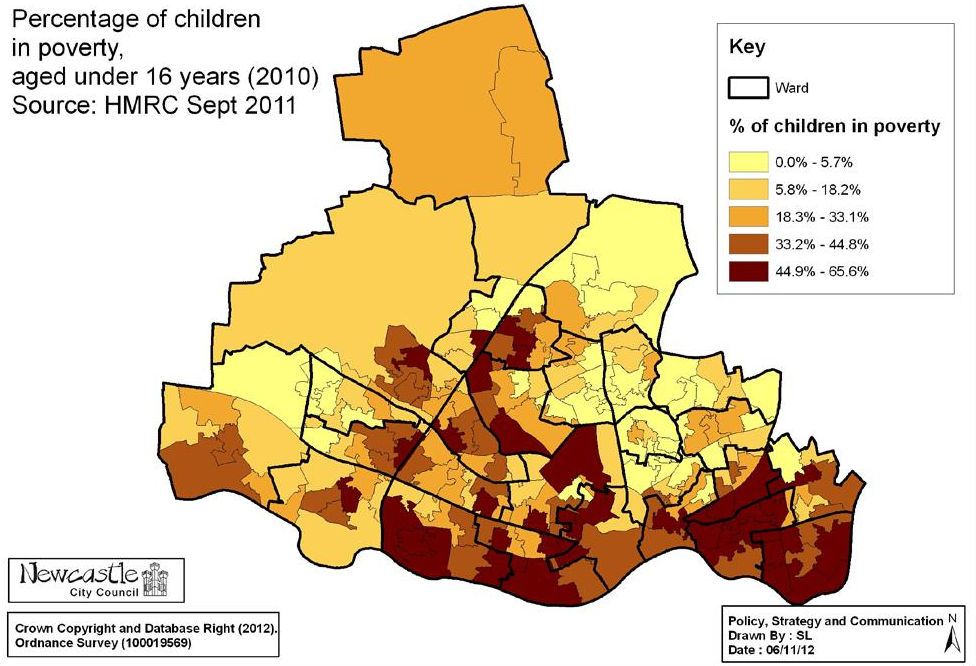
There are a number of factors that influence the risk of a child living in poverty. Children in out-of-work households are at greater risk of poverty, however in terms of actual numbers there are now more children who are classed as living in poverty who live in households where someone is working (in work poverty). Children of lone parents, disabled children, children in large families (4 or more children) and those from certain (but not all) BME backgrounds are also at greater risk of living in poverty. Highest levels of child poverty are seen in households with children aged 0 to 4.

### The Children in Low-Income Families Local Measure

This measures the proportion of children living in families either in receipt of out-of-work benefits or in receipt of tax credits with a reported income which is less than 60% of national median income.

In 2011 (the latest data available), 29.0% of children aged under 16 (equivalent to 13,235 children) lived in low income families in Newcastle. This compares with an England and Wales average of 20.7%.

Percentage of children in poverty, aged under 16 years (2010)  
Source: HMRC Sept 2011



Additional insights into children living in poverty can be gained from data on the number/proportion of children entitled for free school meals. The 2012 School Census data suggests 27% of children who live in Newcastle and attend a Newcastle state funded school are entitled to free school meals, equivalent to 7,413 children.

A range of health indicators are available which highlight key areas within a child's development. Selected indicators are considered below, for further detail, trends over time and geographical variations please refer to the 0-19 needs assessment document.

**Low birth weight**

- Low birth weight can increase the risk of mortality, and development problems alongside poorer health in later life. There are links with low birth weight and inequality.
- 3.7% of live births in Newcastle were considered low birth weight (<2500g) in 2014, an increase compared to 2005 (2.5%), which is significantly worse than the England average

**Smoking at time of delivery**

- Smoking during pregnancy can increase the risk of complications during pregnancy and labour such as miscarriage, and can also result in low birthweight, genetic abnormalities and sudden infant death syndrome.
- 14.3% of pregnant women were smoking at the time of delivery during 2014/15, which is significantly worse than the England average, though has reduced from 18% in 2010/11

**Breastfeeding**

- Increases in breastfeeding rates not only have health and nutrition benefits for mother and child, this can also reduce illness in young

children and lead to a decline in hospital admissions for infections in infants

- The rate of breastfeeding initiation with 48 hours of delivery is 68.4% in Newcastle during 2014/15, an increase compared to 62.4% in 2010/11, but still significantly worse compared to the England average
- Breastfeeding prevalence at 6-8 weeks after birth is at 46.2% during the same period, the highest rate over a 5 year period, and significantly better than the England average

### Immunisations

- Vaccination coverage is the best indicator of the level of protection a population will have against vaccine preventable communicable diseases
- Newcastle performs significantly better than the 90% coverage rate target for a range of childhood vaccinations:

Vaccination	Newcastle % 2014/15	England % 2014/15
Diphtheria, tetanus, pertussis, polio and Haemophilus influenza type b (1 year old)	93.7	94.2
Diphtheria, tetanus, pertussis, polio and Haemophilus influenza type b (2 year old)	96.9	95.7
MMR one dose (2 years)	94.7	92.3
MMR two doses (5 years)	91.1	88.6
Pneumococcal (1 year)	93.0	93.9
Meningococcal C (1 year)	93.4	93.9

### Child obesity

- Nationally there is concern about the rise of childhood obesity and the implications of obesity persisting into adulthood, the risk in adulthood and of future obesity related ill health are greater as children get older.
- The National Child Measurement Programme measures the height and weight of children at age 4-5 and 10-11 each year, the latest data for 2014/15 shows:
- 22.4% of 4-5 years old in Newcastle are overweight or obese, similar to the England average and a decline compared to 29.8% in 2010/11
- 37.8% of children aged 10-11 in Newcastle are overweight or obese, significantly worse than the England average and similar to that of the 2010/11 rate of 38%

### Dental health

- Tooth decay is a predominantly preventable disease, significant levels remain resulting in pain, sleep loss, time off school and in some cases treatment under general anaesthetic
- Amongst 3 year old children surveyed in 2012/13, 6.9% had tooth decay in Newcastle
- Amongst 5 year old children surveyed in 2011/12, 22.6% had decayed, missing or filled teeth

### Teenage Conceptions

- Teenage pregnancies are often unplanned and around half result in abortion, with research showing associations with poorer outcomes for young parents and their children

	<ul style="list-style-type: none"> <li>• In Newcastle the rate of under-18 conceptions during 2014 was 34.7 per 1000, which is significantly worse than the England average, but a reduction since 1998 (52.8 per 1000)</li> <li>• Under-16 conceptions were 6.8 per 1000 in 2014, significantly worse than the England average, but a reduction since 2010 (10.1 per 1000)</li> </ul>
Public Contracts Regulations 2015	<p>The Public Contracts Regulations 2015 (“PCR 2015”) implement in England and Wales the new EU Directive 2014/24/EU (the “Directive”) on public procurement.</p> <p>The PCR 2015 came into force from 26th February 2015 and replaced the Public Contracts Regulations 2006 (“PCR 2006”) from that date.</p> <p>Under the PCR 2006, contracts for so-called Part B Services were exempt from the full application of the rules (particularly, there was no requirement to advertise in the OJEU). Under the PCR 2015, the distinction between Part A and Part B Services has been removed and replaced by what is becoming known as the “Light Touch” regime. A services contract falls within the scope of the Light Touch regime if it is for the certain types of health, social and other services listed at Schedule 3 of the PCR 2015. For these Light Touch regime contracts, a higher threshold than that for ordinary service contracts applies, before the Light Touch regime is applicable.</p> <p>The thresholds for light touch regime contracts from 1 January 2016 is £589,148</p> <p>While the Light Touch regime is not prescriptive as to how contracting authorities design their procurement process for Light Touch regime services contracts, it does for the first time require that services contracts that fall within the Light Touch regime are advertised.</p>
Other local authority recommissioning plans	<p>A number of authorities have already recommissioned, or are in the process of recommissioning their 0-19 public health provision as a result of the opportunities presented by the transfer of the 0-5 HCP to local authorities. Examples include: Darlington, Durham, Hull, Islington, Nottinghamshire, Warrington and York.</p>
Family Nurse Partnership Randomised Control Trial	<p>The FNP programme appeared to improve early child development, particularly early language development at 24 months and may also help protect children from serious injury, abuse and neglect through early identification of safeguarding risks. There were also some small improvements in mothers’ social support, relationship quality and self-efficacy. Young mothers were positive about the FNP programme, engaged very well with it and feel it helped to them to be good parents. They especially valued the close and trusting relationship with their family nurse. The study also found that the FNP programme was implemented well on the whole, in line with the US licensed model.</p> <p>FNP however, did not have an impact across the study’s four main short term outcomes – pre-natal tobacco use, birth weight, subsequent pregnancy by 24 months and A&amp;E attendances and hospital admissions in first two years of life. Neither was there any impact on these outcomes by key sub-groups (age, NEET, problems with basic life skills, area deprivation) or by variation in programme implementation. A wide range of secondary outcomes assessed also didn’t show significant benefits for FNP at this stage.</p>

	<p>The study also highlighted the apparently high levels of vulnerability amongst first time teen mothers and their children suggesting the case for additional support for this group remains strong. Of trial participants 48% were Not in Education, Employment or Training (NEET) at recruitment, 35% had previously been arrested, 46% had been suspended, expelled or excluded from school, 56% were smoking in late pregnancy and 40% had experienced domestic violence in the 12 months preceding their child's second birthday.</p> <p>The research was not able to explain why FNP appears not to be making a difference on key outcomes at this stage, although some suggestions are put forward. These include that the target group, all first time young mothers to be, may not be as disadvantaged as those in US NFP trials, and that the control groups received relatively high levels of both universal and specialist services. Engagement with ante-natal care is high for both the intervention and control groups</p>
<p>Consultation and Engagement on existing 0-19 public health provision</p>	<p>Detailed feedback from the consultation can be found at <a href="https://letstalknewcastle.co.uk/">https://letstalknewcastle.co.uk/</a></p>

### 3. Engagement about the current 0-19 Public Health provision (23 May - 17 June 2016)

Date	Who	No. of people	Main issues raised
28/4/16	Commissioners Workshop	12	Importance of fully integrating all 0-19 services. Importance of retaining close links between Health Visitors and GPs. Importance of School Nurse Service and delivery of PHSE. The need to consider safeguarding in any new service model.
24/5/16	Staff meeting at Freeman Hospital	Approx. 100	TUPE, and concerns regarding maintaining service provision.
23/5/16 27/5/16 8/6/16	Multi discipline workshops – inc Health Visitors, School Nurses, GPs, Early Years staff, and VCS	145	See consultation report <a href="https://letstalknewcastle.co.uk/">https://letstalknewcastle.co.uk/</a>
17/6/16	Children and Young People Workshop	15	Importance of maintaining school nurse service Lack of support available for young people with mental health issues while going through the referral process.
17/6/16	Parent, carer and professionals workshop	18	See consultation report <a href="https://letstalknewcastle.co.uk/">https://letstalknewcastle.co.uk/</a>
23/5/16 – 17/6/16	Parents/carers, students and professionals via Let's Talk	97	See consultation report <a href="https://letstalknewcastle.co.uk/">https://letstalknewcastle.co.uk/</a>

6/6/16	Newcastle & Gateshead CCG (West) Practice Manager Meetings	12	Discussion regarding retaining close links between Health Visitors and GPs and improving links with School Nurses.
7/6/16	Newcastle & Gateshead CCG (North and East) Practice Manager Meetings	12	Discussion regarding importance of retaining close links between Health Visitors and GPs and improving links with School Nurses.
10/6/16	North of Tyne Local Pharmaceutical Committee	4	

#### 4. Planned consultation for this proposal

Date	Who	No. of people	Main issues raised
14/7/16 – 26/7/16	Current and potential providers, service users and general public on Let's Talk Newcastle.		
22/7/16	Current and potential providers, service users and general public at a drop in session at Civic Centre, Newcastle.		



<b>4. What are the potential impacts of the proposal?</b>				
<b>Staff / service users</b>	<b>Specific group / subject</b>	<b>Impact</b> (actual / potential disadvantage, beneficial outcome or none)	<b>Detail of impact</b>	<b>How will you address or mitigate disadvantage?</b>
<b>People with protected characteristics</b>				
Service users	Younger people and / or older people (age)	Potential disadvantage to families with young children and young people due to reduction in budget and therefore service capacity.	Front line service delivery may be reduced because of a reduced budget. This may make it harder for families and young people to receive advice support and guidance.	We are not anticipating a significant impact on delivery of universal services as a result of the savings, and we will work with the successful provider to ensure that front line service delivery is prioritised to meet the needs of the population.
Service users	Disabled people	None	There is no available evidence to suggest the proposal will have a disproportionately negative impact on disabled people.	
Service users	Carers	None	There is no available evidence to suggest the proposal will have a disproportionately negative impact on carers.	Not applicable

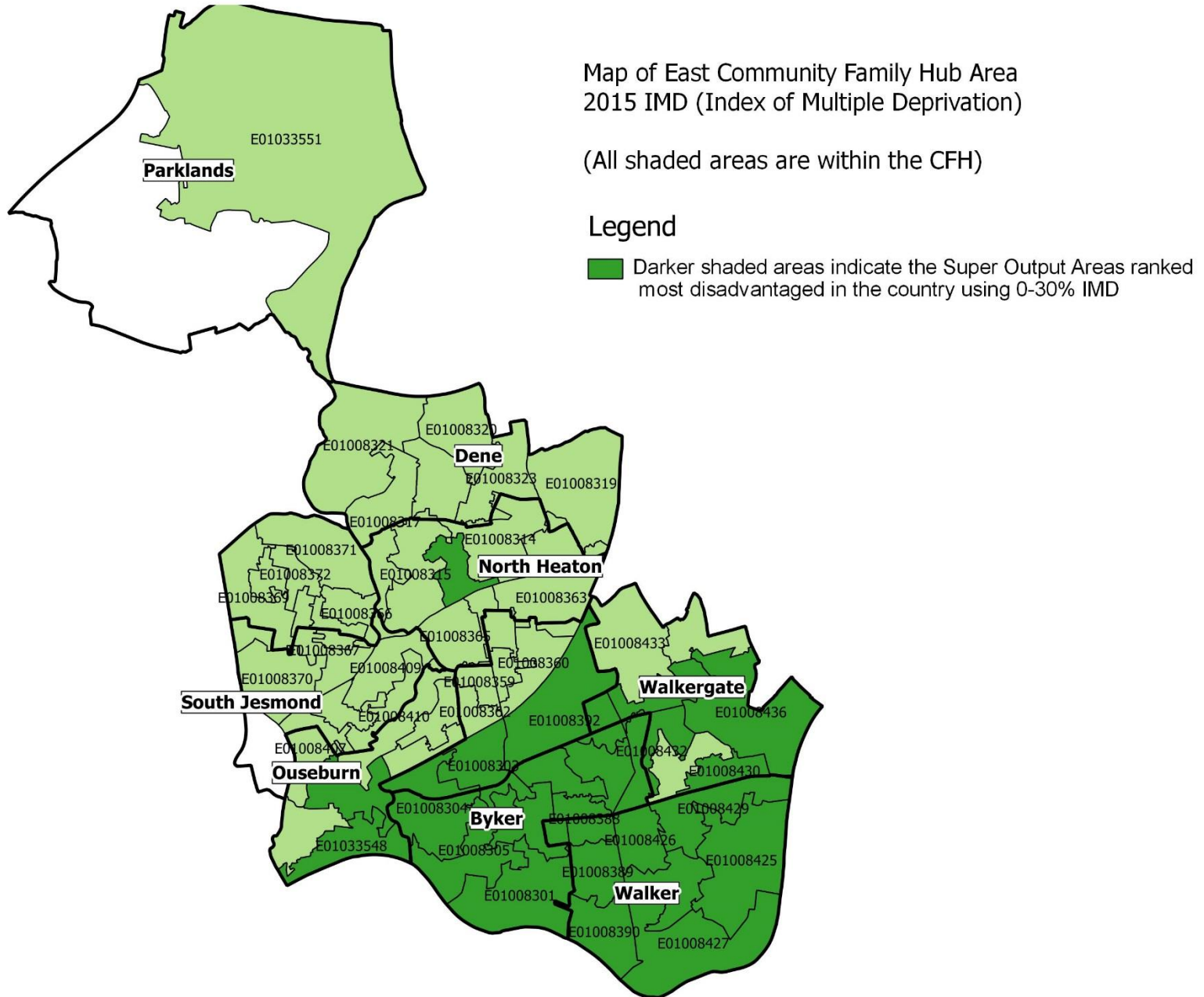
Service users	People who are married or in civil partnerships	None	There is no available evidence to suggest the proposal will have a disproportionately negative impact on people because of their partnership status.	Not applicable
Service users	Sex or gender (including transgender, pregnancy and maternity)	Potential for reduced contact during pregnancy.	Due to the reduced budget there is potential for service users to receive reduced contact during pregnancy.	We are not anticipating a significant impact on delivery of universal services as a result of the savings, and we will work with the successful provider to ensure that front line service delivery is prioritised to meet the needs of the population.
Service users	People's sexual orientation	None	There is no available evidence to suggest the proposal will have a disproportionately negative impact on people because of their religion or belief.	
Service users	People of different races	None	There is no available evidence to suggest the proposal will have a disproportionately negative impact on people because of their religion or belief.	

Service users	People who have different religions or beliefs	None	There is no available evidence to suggest the proposal will have a disproportionately negative impact on people because of their religion or belief.	Not applicable
Service users	People living in deprived areas	Potential disadvantage to families with young children and young people living in deprived areas, due to reduction in budget and therefore service capacity.	The decommissioning of FNP may have an impact on vulnerable first time young parents. Front line service delivery may be reduced because of a reduced budget. This may make it harder for families and young people to receive advice support and guidance.	The successful Provider would be required to develop a vulnerable parent's pathway to capture those young parents who would have normally accessed the FNP. We will work with the successful provider to ensure that front line service delivery is prioritised to meet the needs of the population
Service users	People in low paid employment or in households with low incomes	Potential disadvantage to families with young children and young people who are in low paid employment or in households with low incomes, due to reduction in budget and therefore service capacity.	Front line service delivery may be reduced because of a reduced budget. This may make it harder for families and young people to receive advice support and guidance	We will work with the successful provider to ensure that front line service delivery is prioritised to meet the needs of the population

Service users	People facing barriers to gaining employment, such as low levels of educational attainment	None	There is no available evidence to suggest the proposal will have a disproportionately negative impact on people because of their religion or belief.	
Service users	Looked after children	Potential disadvantage to looked after children and their families due to reduction in budget and therefore service capacity.	Front line service delivery may be reduced because of a reduced budget. This may make it harder for families and young people to receive advice support and guidance.	We are not anticipating a significant impact on delivery of universal services as a result of the savings, and we will work with the successful provider to ensure that front line service delivery is prioritised to meet the needs of the population.
Service users	People facing multiple deprivation, through a combination of factors such as poor health or poor housing / homelessness	Potential disadvantage to families with young children and young people facing multiple deprivation, due to reduction in budget and therefore service capacity.	The decommissioning of FNP may have an impact on vulnerable first time young parents. Front line service delivery may be reduced because of a reduced budget. This may make it harder for families and young people to receive advice support and guidance.	The successful Provider would be required to develop a vulnerable parent's pathway to capture those young parents who would have normally accessed the FNP. We are not anticipating a significant impact on delivery of universal services as a result of the savings, and we will work with the successful provider to

				ensure that front line service delivery is prioritised to meet the needs of the population.
N/A	Businesses providing current or future jobs in the city	Potential disadvantage	Current provider may not be successful in the tendering process.	We will work with providers to help them understand the procurement process.
N/A	Area, wards, neighbourhoods	None	There is no available evidence to suggest the proposal will have a disproportionately negative impact on areas, wards or neighbourhoods.	Not applicable
N/A	Community cohesion	None	There is no available evidence to suggest the proposal will have a disproportionately negative impact on community cohesion.	Not applicable
N/A	Community safety	None	There is no available evidence to suggest the proposal will have a disproportionately negative impact on community safety.	Not applicable
N/A	Environment	None	There is no available evidence to suggest the proposal will have a disproportionately negative impact on the environment.	Not applicable


Appendix 1

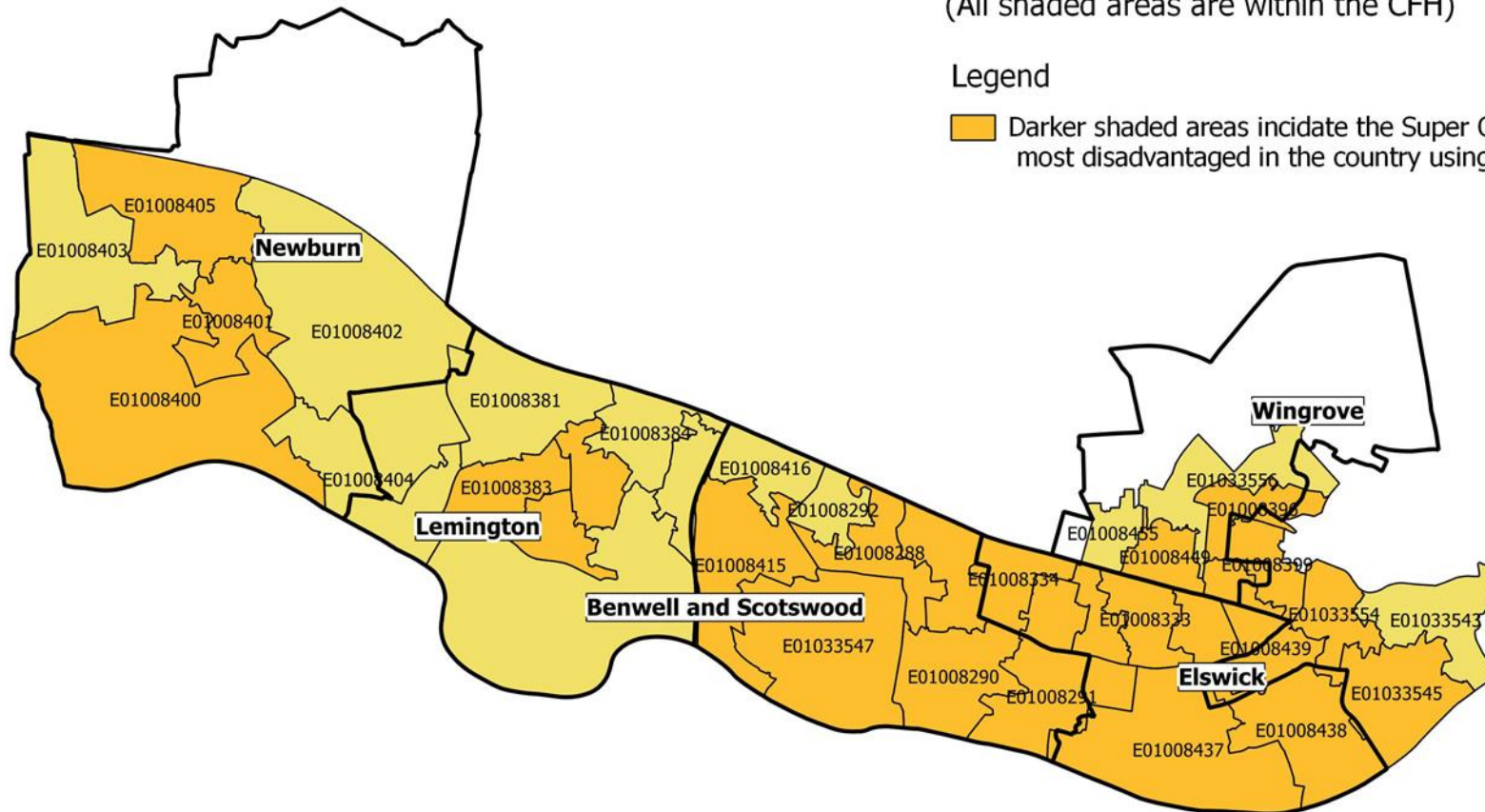


# Map of West Community Family Hub Area 2015 IMD (Index of Multiple Deprivation)

(All shaded areas are within the CFH)

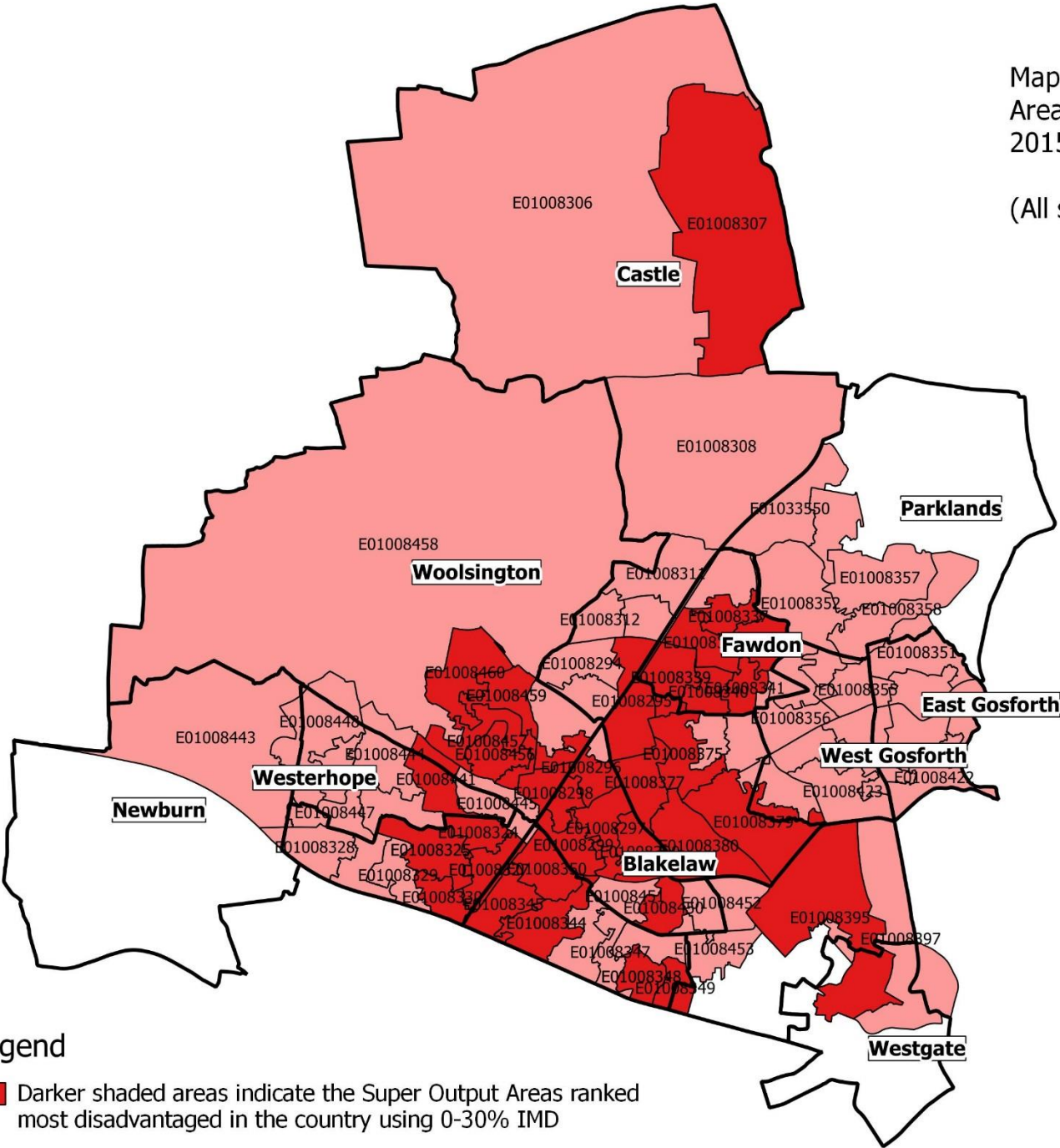
## Legend

 Darker shaded areas indicate the Super Output Areas ranked most disadvantaged in the country using 0-30% IMD




Map of Central Community Family Hub Area  
2015 IMD (Index of Multiple Deprivation)

(All shaded areas are within the CFH)



Legend

 Darker shaded areas indicate the Super Output Areas ranked most disadvantaged in the country using 0-30% IMD