Securing Excellence
In Commissioning
For
Healthy Child
Programme 0-5
Years 2013 - 2015
### Document Purpose
Securing Excellence In Commissioning For Healthy Child Programme 0-5 Years

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NHS England

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### Target Audience
CCG Clinical Leaders, CCG Chief Officers, Medical Directors, Directors of PH, Directors of Nursing, NHS England Area Directors, GPs, Directors of Children's Services

### Additional Circulation List
CCG Clinical Leaders, CCG Chief Officers, Medical Directors, Directors of PH, Directors of Nursing, NHS England Regional Directors, NHS Trust Board Chairs, Allied Health Professionals, GPs, Directors of Children's Services

### Description
iii. This document is one of a series describing the arrangements NHS England has put in place for those services that it directly commissions. These include a range of services that affect children, namely the Healthy Child Programme 0-5 years, the National Immunisation and Screening Services, Primary Care, Specialised Services for Children and Child Health Information Systems.

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### Document Status
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Securing Excellence in Commissioning For Healthy Child Programme 0-5 Years

Gateway no. 00308

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Introduction

Purpose of the document

i. From April 2013, NHS England took up its full duties to ensure that the NHS delivers better outcomes for patients and the public within its available resources and upholds and promotes the NHS Constitution. As a single national organisation, NHS England is responsible for ensuring that services are commissioned in ways that support consistency not centralisation; consistency in ensuring high standards of quality and outcomes across the country. NHS England works through its National, Regional and Area Teams to discharge these responsibilities.

ii. One of NHS England’s responsibilities is to commission directly the universal elements of the Healthy Child Programme 0-5 years. This document sets out the operating model through which NHS England will secure the best possible health outcomes for children and young families.

iii. This document is one of a series describing the arrangements NHS England has put in place for those services that it directly commissions. These include a range of services that affect children, namely the Healthy Child Programme 0-5 years, the National Immunisation and Screening Services, Primary Care, Specialised Services for Children and Child Health Information Systems.

iv. NHS England’s ambition is to ensure the commissioning system secures consistent, high quality, integrated services that deliver excellent outcomes, including excellent outcomes for children aged 0-5 years. NHS England will develop national strategy that, when applied locally, lead to better outcomes and reduce inequalities in health.

Overview

v. NHS England is responsible for ensuring that services are commissioned in ways that secure services that are of consistently high standards of quality and that deliver consistently excellent outcomes across the country. It is also responsible for promoting the NHS Constitution and ensuring that the requirements of the Secretary of State’s Mandate and the section 7a Agreement with NHS England are delivered.

vi. Section 22 of the Health and Social Care Act 2012\(^1\) inserts a clause in section 7A of the NHS Act 2006 that creates a new power which enables the Secretary of State, by agreement, to delegate the funding and commissioning of public health services to NHS England. The Secretary of State and NHS England have agreed that children’s public health services from pregnancy to age 5 will be commissioned by NHS England until the commissioning responsibility for this programme are transferred to local government from 2015.\(^2\)

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vii. *Developing the NHS Commissioning Board (July 2011)* \(^3\) set out a number of features that will characterise the culture of NHS England. The commissioning arrangements for the Healthy Child Programme 0-5 years reflect these characteristics:

- A clear **sense of purpose** focused on improving quality and outcomes
- A commitment to putting **patients and the public, clinicians and carers** at the heart of decision-making.
- An **energised and proactive** organisation, offering leadership and direction.
- A **focused and professional** organisation, easy to do business with
- An **objective** culture, using evidence to inform the full range of its activities.
- A **flexible** organisation, promoting integration, working across boundaries and performing tasks at the right level, whether national or local.
- An organisation committed to **working in partnership** to achieve its goals, in particular by developing an effective and mutually supportive relationship with clinical commissioning groups.
- An **open and transparent** approach, sharing information freely wherever appropriate.
- An organisation with clear **accountability arrangements** and a grip on those things for which it will be held to account.
- Consistent with the institution’s needs for maintaining appropriate levels of security.

**Context of the Healthy Child Programme 0-5 years.**

viii. From April 2015, several different bodies, including NHS England, Clinical Commissioning Groups (CCGs) and local authorities will be responsible for commissioning health related services for children (see paragraph 16 below). It will be essential that these bodies work closely and constructively with each other to coordinate their commissioning. Failure to do so would greatly increase the risk of service fragmentation, when the aim is to commission services that are better coordinated and integrated than ever before. A major aim of the commissioning model described in this document is to ensure that NHS England Area Teams work closely with local partners through Health and Wellbeing Boards and Children’s Partnerships to help achieve the necessary local coordination of commissioning of services for children.

ix. The commissioning responsibilities for Healthy Child Programme 0-5 years can be divided into three service delivery areas:

a. The universal elements of the Healthy Child Programme 0-5 years.

\(^3\) ‘Developing the NHS Commissioning Board’, DH, 2011
The Healthy Child Programme is an early intervention and prevention programme, which is offered universally to every family with children of appropriate age. It offers screening, immunisations, developmental reviews and information to support the healthy development of children and of parenting. It is founded on the principle of providing support to all families with more help when needed (progressive universalism), to ensure that all children are given the opportunity to receive care appropriate to their needs. Many health professionals are involved in providing the full Programme, including Midwives, Health Visitors, GPs, and Social Care.

b. Health Visitors, including the Health Visitor Implementation Plan 2011-2015

Health Visitors have a crucial role in ensuring that children have the best possible start in life, and lead delivery of the Healthy Child Programme 0-5 years, in partnership with other health and social care colleagues. The Plan was published in February 2011, and set out a call to action to expand and strengthen health visiting services including increasing the number of health visitors by 4,200 (full time equivalents) by 2015. The Plan focuses on training, recruitment and retention, professional development and improved commissioning of the service over a four year period to 2015. The Plan was updated in June 2013 to reflect changes in organisational responsibilities, including the commissioning of health visiting services and the potential for more integrated commissioning leading up to the transfer of commissioning responsibilities to local authorities from 2015.

c. Family Nurse Partnership Programme.

The Family Nurse Partnership Programme is an evidence-based licensed programme targeting young mothers in their first pregnancy. The Programme is highly structured and supports families from early pregnancy until the child is two years old, with three aims of improving: outcomes in pregnancy; child health and development; and parental self-efficacy. The Government is committed to increasing the number of places available at any one time to 16,000 places by 2015. Appendix 1 summarises of the FNP Strategy for 13/14 to 14/15.

x. These three elements combine to form an important and powerful programme that, properly delivered, will make a significant contribution to improving health and reducing inequalities health. It will be a significant contributor to the outcomes sought in the NHS Mandate and quantified in the NHS and Public Health Outcomes Frameworks.

xi. The separation of the commissioning of the Healthy Child Programme 0-5 years from the Healthy Child Programme 5-19 and from the commissioning of other community and secondary services for children will require NHS and local authority commissioners to take active steps to establish robust local working arrangements that avoid fragmentation or duplication of services. NHS England’s stewardship of the commissioning arrangements for 0-5 public health services must ensure seamless transfer of commissioning responsibilities to local authorities from 2015. This is a core principle that will underpin the transition.
xii. NHS England will commission children’s 0-5 public health services to ensure that the commitments below are honoured. The Secretary of State’s Mandate to NHS England, which sets out the Government’s expectations of the NHS, contains the following reference to child health⁴:

“Our ambition is to help give children the best start in life, and promote their health and resilience as they grow up; and the Government’s commitment to an additional 4,200 health visitors by 2015 will help to ensure this vital support for new families”.

xiii. NHS England in partnership with Local Education and Training Boards (LETBs) has agreed a trajectory for increasing health visitor numbers with each Area Team. This sets out each Area Team’s contribution to the overall required increase. Similarly, Area Teams will maintain existing numbers of Family Nurse Partnership places in their areas, honour any inherited commitments to increase the numbers of places, and deliver the number of new Family Nurse Partnership places agreed with the Family Nurse Partnership National Support Team.

xiv. Steady progress has already made towards achieving the commitments for Health Visitor numbers and Family Nurse Partnership places as follows:

<table>
<thead>
<tr>
<th>Programme</th>
<th>Baseline</th>
<th>Progress March 2013</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Visitors</td>
<td>8,092</td>
<td>9133</td>
<td>12,292</td>
</tr>
<tr>
<td>Family Nurse Partnership</td>
<td>6,500</td>
<td>11,475</td>
<td>16,000</td>
</tr>
</tbody>
</table>

xv. The direct commissioning responsibility for public health services for children aged 0-5 (other than the national immunisation and screening programmes) will transfer to local government from 2015. Although NHS England Area Teams will not be required to develop transition plans until 2014, the local arrangements they put in place for the commissioning of these services should be developed in light of the knowledge that commissioning responsibility for them will transfer to local government from 2015. This offers considerable potential for developing more integrated approaches to commissioning for 0-5s in 2013-14 and 14-15.

Interdependencies and ensuring a seamless pathway

xvi. It is essential that the Healthy Child Programme 0-5 years is not commissioned or provided in isolation of other healthcare services. It is also crucial that operational relationships with colleagues in local government, such as Children’s Centres, are maintained and strengthened. The new commissioning arrangement split responsibility for the commissioning of the children’s pathway between three responsible commissioners. In addition to the Healthy Child Programme 0-5 years, NHS England will commission other important services used by children including primary care services and specialised services. CCG’s will commission Maternity Services, children’s community services and most secondary care

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services, and local authorities will commission a wide range of services for children, including Healthy Child Programme 5-19 years, children social services, and many education related services. All commissioners share a responsibility for safeguarding. Some of the high level interdependencies are represented in the figure below.

xvii. This splitting of responsibility may lead to the possibility of fragmentation of the pathway, or duplication of effort, cost or time, or, most importantly, gaps in safeguarding provision. NHS England’s commissioning arrangements will minimise these risks by working closely with local partners through the Health and Wellbeing Board (HWB) and Children’s Partnerships. Where appropriate they will make use of joint commissioning arrangements, single pathway specifications and shared information/monitoring systems.

**Commissioning Functions**

xviii. NHS England is responsible for specifying, securing and monitoring an agreed set of services for:

- The universal elements of the Healthy Child Programme 0-5 years.
- Health Visitors, including the Health Visitor Implementation Plan.
- Family Nurse Partnership, including the planned expansion of services to 16,000 places.

xix. The functions which underpin this responsibility are:

a. **Specifying** – Services must be specified to deliver the outcomes and national standards expected of them. National service specifications are set out in the section 7A public health functions to be exercised by NHS England agreement. PHE are responsible for keeping service specifications under review as part of its role in offering evidence and analysis to support NHS England in its commissioning functions. Specifications should also reflect local ambitions as set out in local Health and Wellbeing Strategies to ensure that services meet the needs of the population as set out in the Joint Strategic Needs Assessment. Area Teams will work with key stakeholders on Health and Wellbeing Boards and Children’s Partnerships to develop detailed local service specifications, **Securing services** - using relevant service specifications to procure new services or to achieve new standards, establishing robust contracts through which providers can be held to
account for delivering high quality and outcomes for children aged 0-5 years and new families that are characterised by continuity of care and integration of services.

b. **Monitoring** – assessing and challenging the quality of services with an ever increasing focus on the outcomes achieved rather than inputs and processes; and using this intelligence to design and commission continuously improving services for the future.

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**The New Commissioning Landscape**

xx. The following organisations have roles to play in the commissioning of health care for children aged 0-5 years and new families:

a. **Department of Health (DH)** – the DH is the lead organisation for policy development. It will continue to set out the Secretary of State’s expectations and requirements of the NHS and reflect them in the annual mandate provided to NHS England, which will also set out the resources allocated by government to the NHS. The Secretary of State retains responsibility for public health services and will either discharge those enter into agreements for these responsibilities to be discharged by Local Authorities and Public Health England or, by agreement, through NHS England.

b. **NHS England** - NHS England is responsible for the direct commissioning of a range of public health services as set out in a section 7a Agreement and accompanying Specification 27 with the Secretary of State - including Healthy Child Programme 0-5 years, health visiting, family nurse partnership and child health services in the short term until transferred to local authority commissioning - as well as other important services used by children including primary care and specialised services.

c. **Clinical Commissioning Groups (CCG)** – CCGs are responsible for commissioning acute and community health services for children aged 0-5 years, excluding the universal elements of Healthy Child Programme 0-5 years, national screening and immunisation programmes and specialised care. They are also responsible for commissioning maternity and mental health services for parents and children. CCGs are responsible for the commissioning of emergency care services for “every person present in its area.” This means that emergency services such as Accident and Emergency and ambulance services must be available to all people in the CCG area.

d. **Local Authorities (LA)** – LAs are responsible for commissioning many of public health services for people in their area, including the Healthy Child Programme 5-19 years and school nursing. The direct commissioning responsibility for public health services for children

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5[^5]: [https://www.gov.uk/](https://www.gov.uk/).../27_Children_s_Public_Health_Services__pregnancy to age 5....
aged 0-5 (other than the national immunisation and screening programmes) will transfer to local government from 2015.

e. **Public Health England (PHE)** – PHE is the national voice for improving and protecting the public’s health and reducing health inequalities. PHE operates through its 15 Centres that work with NHS England’s Area Teams, 4 regions and nationally, and through PHE staff embedded in these teams. PHE is responsible for producing the service specifications for the Section 7a services, ensuring that there is professional public health advice for NHS England’s public health commissioning teams and publishing the Public Health Outcomes Framework. PHE support NHS England in its commissioning responsibilities through the provision of scientific, rigorous impartial advice, evidence and analysis.

There are already actions underway or planned that will help to create stronger partnerships between the NHS and LAs in preparation for the transfer. These will be supported at a national level by NHS England working with the Department of Health LGA, PHE and others, and include:

- The national, core service specification, as set out in the Section 7A agreement for public health functions exercised by NHS England, for health visiting services which stresses the need for local health visiting service providers to:
  - Work closely with LAs and Directors of Public Health to determine which services are offered locally and to improve family and community capacity and champion health promotion.
  - Contribute to the development of Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs) Input into local health and wellbeing boards and contribute to the health and wellbeing strategy.

The LA community will be involved in developing the NHS England health visiting service specification for 2014/15.

NHS England, in partnership with PHE, will develop its Public Health commissioners to ensure they can work effectively with LAs in the lead up to transition in 2015.

NHS England is exploring the potential for the joint sign-off of local commissioning plans for 2014/15 by NHS England Area Teams, PHE Centres and LA chief executives, and Directors of Public Health.

In addition PHE will:

- Continue to collate and disseminate the evidence of what works, including developing tools and resources to support implementation locally.
• Publish and report on the Public Health Outcomes Framework so local areas can judge their local progress against national outcomes.
• Support sharing good practice at a local level through PHE Centres.
• Support on-going development of the public health workforce in LAs to inform commissioning of early years and the on-going support and development of the children’s public health nursing workforce.

A task and finish group of the Children’s Health and Wellbeing Partnership has been established to develop a transfer plan. The group consists of members of the Department of Health, NHS England, PHE, the Local Government Association, Society of Local Authority Chief Executives (SOLACE), Association of Directors of Children’s Services and other organisations.

**Value and principles**

xxi. The Government and NHS England are committed to reducing inequalities in health and access to services. The Marmot Review 'Fair Society, Healthy Lives'\(^6\) primary recommendation was that to effectively reduce inequalities for life is to offer every child the best start in life. In the Health Visitor Implementation Plan it is stated:

> “The Government wants to ensure that all parents and children have access to the support they need to get off to the best possible start, with early intervention to ensure additional support for those who need it, including the most vulnerable families.”

xxii. Ensuring high standards of patient care for commissioned services is one of the core values within the NHS Constitution and therefore places a requirement on all providers to strive to deliver high quality and safe care to patients. In addition, commissioners of health care have an important role in driving quality improvement and gaining assurance around the quality of care delivered by the provider organisations from whom they commission services. NHS England’s commissioning of services for children is informed by the work and recommendations of the Children and Young People’s Health Outcome Forum and the Children and Young People’s Health Outcomes Forum.

xxiii. NHS England is at the heart of an integrated system of organisations and services that are bound together by the value and principles of the NHS Constitution. NHS England is committed to joint working relationships with a wide range of organisations at a national and local level to ensure that there are continuous improvements in health and well-being.

xxiv. NHS England works locally and nationally to ensure that its work on commissioning services for children is well coordinated with the commissioning of services for children undertaken by other bodies.

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The Integrated Commissioning Model

xxv. NHS England is structured into central teams, four regions and 27 Area Teams. Public Health leads in Area Teams should identify an officer within the team to take lead responsibility for overseeing the commissioning of the Healthy Child Programme 0-5 years, building relationships with stakeholders and managing the transition process to local authorities from 2015.

xxvi. NHS England receives funding for NHS care through the Mandate for primary care and specialised services, and for public health services for Healthy Child Programme 0-5 years through the Section 7a agreement. Area Team budgets will reflect their specific trajectories for Health Visitor numbers and Family Nurse Partnership places.

xxvii. Local financial plans should be agreed and performance monitoring, including information systems put in place. Area Teams will inherit contracts for existing Child Health Information Systems (CHIS) that have been ‘lifted and shifted’ from Primary Care Trusts. These will vary from place to place. A new CHIS specification has been developed; details of this are published at http://www.dh.gov.uk/health/tag/chis/. Area Teams should aim to have fully implemented the new service specification by 2015.

xxviii. Public Health leads in Area Teams should establish arrangements for coordinated and integrated commissioning of Healthy Child Programme 0-5 years with commissioning of other health and social care services for children, including Local Authority commissioning of Healthy Child Programme 5-19 years, and CCG commissioning of other children and maternity services, at a minimum through involvement with Children’s Partnerships Health and Wellbeing Boards. Consideration should be given to the early transfer of commissioning responsibility to local authority teams.

xxix. NHS England Area Teams will be working through Health and Wellbeing Boards including their Children’s Subcommittees and with Children’s Partnerships. They will seek to work with Children’s Partnerships to ensure they contribute to the children’s section of Joint Strategic Needs Assessments and to Joint Health and Wellbeing Strategies. They will be prepared to work closely with other local commissioners on Children’s Partnerships so that, together they can work together to the use the resources at their disposal to commission services that deliver the outcomes for children set out in the Joint Health and Wellbeing Strategy. Public health commissioners have an opportunity to lead the development of partnership 0-5 strategies to improve outcomes for young children and their families including explicit roles for FNP and leadership roles for health visitors.

xxx. This close working with local partners will both reduce the risk of poorly coordinated commissioning and service fragmentation, and facilitate a smooth handover of commissioning responsibility for the Healthy Child Programme 0-5 years to local authorities from 2015.
The Operating Model

xxxi. The scope of health commissioning for the Healthy Child Programme 0-5 years transferring to the NHS England will be set out in Section 7A and associated specifications.

xxxii. The national responsibility for the commissioning of Healthy Child Programme 0-5 years lies with the Operations Directorate of NHS England. A central national support team informed by expert advice from Public Health England will provide the framework to Area Teams to ensure commissioning consistency across the country. It will set the national strategic direction.

xxxiii. NHS England will develop a single approach for agreeing what will be commissioned, to what standard within available resources. This will help reduce inequalities of access to services which children aged 0-5 years and new families currently experience across England.

xxxiv. NHS England has inherited many and varied contractual forms and service level agreements which will have been locally negotiated. Initially, Area Teams will ‘lift and shift’ these local agreements, managing these locally negotiated contracts until such a time that services are commissioned in a way that deliver the nationally required specifications, standards and outcomes. The intention is that this should be achieved by 2015. It will also be important that Area Teams review the current contract content to ensure it is fit for purpose and consistent with the agreed national approach and section 7a specifications and, where they fall short, to develop a trajectory to commission services that deliver the national expectations by 2015.

Content of the Framework

xxxv. The new commissioning system aims to be combine local with shared national values and behaviours with information flowing between local and national teams contributing to the key outcomes and improvement areas, namely:

a. Reducing health inequalities.
b. Ensuring services are integrated.
c. Reducing health risk factors.

xxxvi. At a national level NHS England works with key stakeholders to determine the outcomes expected of Healthy Child Programme 0-5 years, and ensuring these are integrated with the NHS, Public Health, Children’s, Social Care and Commissioning outcome frameworks.

xxxvii. To support this, NHS England will, over time, build a range of standard national operating procedures. These will be kept under review to ensure their continuing fitness for purpose within the context of the developing commissioning system.
Relationship to Outcomes Frameworks

xxxviii. The Public Health Outcomes Framework\textsuperscript{7} and NHS Outcomes Framework\textsuperscript{8} include outcome indicators that are relevant to the Healthy Child Programme 0-5 years, health visiting and FNP and will form part of the overall assurance to NHS England. Key relevant outcomes are:

- Improving the wider determinants of health
  - Children in poverty
  - School readiness
  - Domestic abuse
- Health improvement
  - Low birth-weight
  - Breastfeeding
  - Smoking at time of delivery
  - Under 18s conceptions
  - Child development at 2 to 2 and a half years
  - Excess weight in 4-5 year olds
  - Hospital admissions of unintentional and deliberate injuries
- Health protection
  - Vaccination coverage
- Healthcare public health
  - Infant mortality
  - Tooth decay in children aged 5

xxxix. These include outcomes related to the:

- National immunisation programmes
- National routine screening programmes (non-cancer)
- Infant feeding programmes
- Development in infancy and the early years

The data collection and reporting required for these will be enabled by:

- Child health information systems, \url{http://www.dh.gov.uk/health/tag/chis/}.
- Child health information services.
- The maternity and children’s dataset, \url{http://ic.nhs.uk/maternityandchildren/}.


\textsuperscript{8} The NHS Outcomes Framework 2012/13 \url{http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131723.pdf}
Public Health Outcomes Framework

- Promoting healthy lifestyles and improving public health
- Reducing health inequalities and improving access to healthcare
- Preventing disease and promoting healthy living
- Ensuring safe and healthy working conditions
- Ensuring that people have fun and healthy experiences of work
- Helping people overcome fear, anxiety and health challenges
- Enhancing quality of life and promoting long-term wellbeing

NHS Outcomes Framework

- Health improvement
- Public health

HCP 0-5
Key Principles

xl. NHS England will usually manage contractual relationships within a consistent framework. However, in doing so it will also demonstrate enough flexibility to allow service developments and improvements to be locally responsive to meet the needs of individuals and local circumstances. All commissioning decisions will be based on outcomes and value for money and have regard to changing policy and nationally agreed commissioning guidance.

xli. Commissioning should aim to reduce inequalities in care provision and show improvements against the wider factors that affect health and wellbeing and health inequalities. It will take account of the 2010 Equality Act and other relevant legislation.

xlii. Area Teams will be working as part of one system and working to one set of operating principles, but in ways that are sensitive to the local circumstances.

Commissioning Support Service Functions

xliii. The arrangements for commissioning support are set out in Developing Commissioning Support; Towards Service Excellence (February 2012).

xliv. It is likely that the following functions will be purchased from commissioning support units (CSU).

- Specialist Procurement support:
  - Market analysis.
  - Identifying best value providers to respond to service needs.
  - Lead on the tendering process up to the point of contract award.

- Business intelligence support:
  - Data collection and information analysis (Secondary care and contractual data).
  - Data validation.
  - Database management.
  - Monitoring of achievement of key performance indicators and quantitative service standards.
  - Contract reporting and forecasting.

The following functions will be provided by the Health and Social Care Information Centre:

- Central collection of the children and young people’s health services secondary uses dataset.
- Central collation of the maternity and children’s dataset.
- Centralised readily accessible, user friendly reporting and benchmarking from the maternity and children’s dataset available at a local level.
- Health visiting minimum data set
The Local/Central relationship

xliv. The relationship between the local NHS England team, Health and Wellbeing Boards and Children’s Partnerships is central to the operating model. This will be a new way of working and will benefit from access to clinical and other professional support and expertise along with high quality management and systems. It will also be important that all commissioners, including the NHS England Area Teams, develop strong relationships with local citizens and representatives of service users and their families.

xlvi. The central NHS England team will provide the frameworks to ensure consistency in commissioning. They will draw on nationwide insight and intelligence and reflect innovation, clinical knowledge and expertise, the NHS Constitution, NHS Mandate and expert advice from Public Health England.

xlvii. A national framework will be developed that local teams can use to shape performance management processes, the management of local relationships and routine quality assurance and improvement.

xlviii. The centre, regions and Area Teams need to work in a fully coordinated and integrated way to ensure the local activity informs the national strategy and vice versa. To improve outcomes, there must be a strong connection between design and delivery and this requires capacity and capability as well as strategic leadership.

Common operating procedures and principles

xlix. Area Team Directors need to identify Healthy Child Programme 0-5 years leads. They will work with other key stakeholders and NHS England central team to develop a series of common operating policies and principles to guide the work of Area Teams. These include policies on the management of the important commissioning interface of public health services with relevant stakeholders including local authorities, CCGs, and children commissioners.

a. Standard policies for the delivery of the public health service specifications which are relevant to this cohort of people

b. Work within the national IT programme to ensure standardised services and specifications.

c. Standard models for delivery for Learning & Disability services.

Indicators

l. The set of indicators that reflect the performance and outcomes of the Healthy Child Programme 0-5 years includes:

a. NHS Outcomes Framework indicators that are clinically significant to the Healthy Child Programme 0-5 years.
b. Public Health & Children’s Outcomes Framework indicators that increase the life expectancy and reduce the inequalities of care for this community. A list of the indicators aimed at children and young people can be found in Appendix 2 (please note some of these indicators do not specifically relate to children aged 0-5, or have an effect beyond 2015).

c. Indicators that are not currently in any of the frameworks but are felt to be significant for this health community that meet the overall aims of reducing inequalities.

d. Indicators relevant for the meeting the needs of children and young people.

e. New indicators recommended by the Children and Young People’s Health Outcomes Forum.

**IT and Data Management**

ii. Although the Healthy Child Programme 0-5 years is a nationally defined programme, there is inconsistency in coverage and access to elements of the Healthy Child Programme across England. The degree of this variation is not fully understood, as PCTs were not required to record or monitor provision. Area Teams will use 2013 to establish local performance baselines for the programme. NHS England team, working with the DH and PHE will agree the data set.

iii. In addition, as described in paragraph 28, Area Teams will develop plans to have fully commissioned the new national specification (see http://www.dh.gov.uk/health/tag/chis/) for Child Health Information Systems by 2015.

**Roles and Functions**

iii. The table below sets out roles of teams within NHS England:

<table>
<thead>
<tr>
<th>Specifying</th>
<th>Services to meet national standards and local ambitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Team</td>
<td>• Develop commissioning policy working through HWBs and with Children’s Partnerships</td>
</tr>
<tr>
<td></td>
<td>• HCP 0-5 commissioning outcomes framework</td>
</tr>
<tr>
<td></td>
<td>• HCP 0-5 healthcare budgets</td>
</tr>
<tr>
<td></td>
<td>• Manage and engage with key local stakeholders</td>
</tr>
<tr>
<td></td>
<td>• Develop National Policy</td>
</tr>
<tr>
<td></td>
<td>• Implement national policy and strategic vision</td>
</tr>
<tr>
<td></td>
<td>• Ensure that HCP 0-5 is intergrated into local joint strategic needs assessments and joint health and wellbeing strategies</td>
</tr>
<tr>
<td></td>
<td>• Engage and consult with key stakeholders, including CCGs, Health &amp; Wellbeing Board, Local Authorities, Local Safeguarding Boards, PHE, Directors of Public Health</td>
</tr>
<tr>
<td></td>
<td>• Agree commissioning plans</td>
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<td></td>
<td>• Undertake service reviews</td>
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<tr>
<td></td>
<td>• Health &amp; Wellbeing Assessments</td>
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<tr>
<td></td>
<td>• Citizen and Service User Consultation &amp; involvement</td>
</tr>
<tr>
<td>Regional Team</td>
<td>Will support and work with the national &amp; local teams to develop policy and strategy.</td>
</tr>
<tr>
<td>Local Team</td>
<td>Provides guidance on local implementation of national model of commissioning.</td>
</tr>
<tr>
<td></td>
<td>Agree application of national performance frameworks with partners.</td>
</tr>
<tr>
<td></td>
<td>Ensure that services meet national targets on outcomes, quality and cost.</td>
</tr>
<tr>
<td></td>
<td>Commission of appropriate outcomes and service quality for the local setting.</td>
</tr>
<tr>
<td></td>
<td>Develop local service specifications.</td>
</tr>
<tr>
<td></td>
<td>Support providers in the delivery of services.</td>
</tr>
<tr>
<td></td>
<td>Agree contractual agreements.</td>
</tr>
<tr>
<td>Regional Team</td>
<td>Will support and work with the national &amp; local teams.</td>
</tr>
<tr>
<td>Monitoring</td>
<td>Monitoring, assessing and where necessary challenging quality and outcomes, including arrangements for contract management.</td>
</tr>
<tr>
<td>Local Team</td>
<td>Manage contingencies and risks.</td>
</tr>
<tr>
<td></td>
<td>Provide data to enable national performance monitoring.</td>
</tr>
<tr>
<td></td>
<td>Identify, assess and manage risk.</td>
</tr>
<tr>
<td></td>
<td>Manages contracts.</td>
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<tr>
<td></td>
<td>Oversee remedial action plans.</td>
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<tr>
<td></td>
<td>Advise providers on delivery, through service specification and contract variation.</td>
</tr>
<tr>
<td></td>
<td>Carry out commissioning audits.</td>
</tr>
<tr>
<td></td>
<td>Assure quality of service delivery.</td>
</tr>
<tr>
<td></td>
<td>Monitor of budgets, outcomes and performance.</td>
</tr>
<tr>
<td></td>
<td>Model demand.</td>
</tr>
<tr>
<td>Regional Team</td>
<td>Will support and work with the national &amp; local teams.</td>
</tr>
</tbody>
</table>

**Next Steps**

liv. The priorities in the coming months will be to:

a) Ensure achievement of Health Visitor targets.
b) Review existing providers to ensure delivery targets will be met.
c) Undertake additional commissioning as required at Area Team level.
d) Ensure providers are fully geared up to deliver.
e) Gain assurance to ensure delivery on track.

**Acknowledgements**

lv. We are very grateful to the Children and Families Team at the Department of Health, the Family Nurse Partnership National Unit, and Health Visitor National Team and others in the development of this model for their commitment and work in helping to design the framework.
Summary FNP Commissioning Strategy – 2013/14 to 2014/15

NHS England
From April 2013 to March 2015 the Family Nurse Partnership programme (FNP) will be commissioned by NHS England after which it will be commissioned by local authorities as part of wider 0-19 children’s public health services. This document sets out principles to inform the commissioning of FNP between April 2013 and March 2015 so as to achieve both the Government’s current commitment of 16,000 FNP places by 2015 and meet the programme’s licensing requirements. It supports the Section 7a agreement between the Secretary of State for Health and NHS England, which sets out the public health functions to be exercised by the NHS England and the accompanying service specification for Public Health Services for Children (from pregnancy to age 5), which includes FNP.

In April 2013 there were approximately 11,000 FNP programme places available covering around 10-15% of the eligible population in England (first time young mothers).

Starting with a wider ambition to have access to FNP in every local authority area the key principles for commissioning FNP from April 2013 are:

- FNP should continue to be commissioned where it is currently commissioned, at current levels;
- FNP should be commissioned in 2013/14 in those areas that have made substantial progress in preparing for FNP in 2012/13 and are committed to implementing or expanding FNP in 2013/14;
- FNP should be available in as many areas (top tier local authority) as possible, starting with the most disadvantaged (using the Index of Multiple Deprivation) and those with the highest numbers of eligible population;
- FNP coverage should be increased in existing FNP areas with low levels of coverage of eligible population, focussing first on those with the highest levels of disadvantage.
- Priority should be given to those areas with strategic level commitment to growing and sustaining FNP especially beyond 2015 when commissioning moves to local authorities.

There will need to be some flexibility in balancing these principles, given the range of factors which can influence whether a site is ready to deliver FNP. NHS England and the FNP National Unit will agree this on a case by case basis.

The FNP National Unit
The FNP National Unit is responsible for preparing sites for FNP delivery and expansion and then for ensuring high quality implementation in accordance with the programme’s license. DH are licensed nationally by the University of Colorado to deliver FNP with the FNP National Unit issuing sub-licenses to local FNP commissioners and providers when they are ready to deliver. The preparation process for new sites typically takes between 9 and 12 months.

Expansion Principles
A number of shared principles have been identified that should underpin the commissioning of FNP and support its high quality delivery so that outcomes for vulnerable young families and children are improved and align with the Government and NHS England’s priorities. These are:
• FNP should be commissioned in areas that want to implement the programme and integrate it into its range of services as this has been shown to lead to high quality delivery and better outcomes.
• FNP should continue to be commissioned where it is currently commissioned, at current levels.
• FNP should be commissioned in 13/14 in those areas that have been preparing, for and are committed to implementing or expanding FNP in 13/14.
• FNP should be available in as many areas (top tier local authority) as possible, starting with the most disadvantaged and those with the highest numbers of eligible population.
• FNP coverage should be increased in existing FNP areas with low levels of coverage of eligible population, focusing first on those with the highest levels of disadvantage.
• Priority should be given to those areas with strategic level commitment to growing and sustaining FNP beyond 2015 when commissioning moves to local authorities.
• Opportunities for small scale expansion into neighbouring areas, especially if such areas are unable to sustain a full FNP team themselves and other innovative commissioning models should be explored.
• If an area doesn’t currently wish to implement FNP or isn’t ready for FNP, for NHSE and FNP NU to work with them to help them reach this stage, recognising this will take time and support.

This strategy assumes that the full cost for delivering FNP locally will be provided to local areas by NHS England through contractual arrangements. Where joint commissioning arrangements (e.g. Local Authority contributions to local FNP commissioning) are in place, these should be honoured and maintained; as stated in the Section 7a service specification.

FNP Site Preparation
One of the key factors in ensuring good outcomes from FNP is that new sites are fully prepared to start delivering FNP. Part of this preparation is building local understanding of and commitment to FNP so it can be delivered well. These are FNP license requirements. This preparation process typically takes between 9 and 12 months but can be longer where local commitment to deliver FNP needs building. In order to bring new places on stream in 13/14 and 14/15 FNP NU must start working with areas around 9-12 months in advance. This needs to be taken into account in delivering this strategy.
### Outcomes frameworks 2012/13: indicators aimed specifically at children/young people

#### NHS outcomes framework

<table>
<thead>
<tr>
<th>Domain</th>
<th>Improvement area(s)</th>
<th>Indicator(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Preventing people from dying prematurely</td>
<td>Reducing deaths in babies and young children</td>
<td>Infant mortality and stillbirths</td>
</tr>
<tr>
<td>2. Enhancing quality of life for people with long-term conditions</td>
<td>Reducing time spent in hospital by people with long-term conditions</td>
<td>Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s</td>
</tr>
<tr>
<td>3. Helping people to recover from episodes of ill health or following injury</td>
<td>Preventing lower respiratory tract infections (LRTI) in children from becoming serious</td>
<td>Emergency admissions for children with LRTI</td>
</tr>
<tr>
<td>4. Ensuring that people have a positive experience of care</td>
<td>Improving women’s and their families’ experience of maternity services</td>
<td>Men’s experience of healthcare</td>
</tr>
<tr>
<td>5. Treating &amp; caring for people in a safe environment &amp; protecting them from avoidable harm</td>
<td>Improving the safety of maternity services</td>
<td>Admission of full-term babies to neonatal care</td>
</tr>
<tr>
<td></td>
<td>Delivering safe care to children in acute settings</td>
<td>Incidence of harm to children due to ‘failure to monitor’</td>
</tr>
</tbody>
</table>
### Public health outcomes framework

|--------|-----------------------------------------------|-----------------------|----------------------|-------------------------------------------------------------|
| Indicator(s) | • Children in poverty  
  • School readiness  (placeholder)  
  • Pupil absence  
  • First time entrants to the youth justice system  
  • 16-18 year olds not in education, employment or training | • Low birth weight of term babies  
  • Breastfeeding  
  • Smoking status at time of delivery  
  • Under 18 conceptions  
  • Child development at 2 – 2.5 years  (Placeholder)  
  • Excess weight in 4-5 and 10-11 year olds  
  • Hospital admissions caused by unintentional and deliberate injuries in under 18s  
  • Emotional well-being of looked after children  (Placeholder)  
  • Smoking prevalence – 15 year olds  (Placeholder) | • Chlamydia diagnoses  (15-24 year olds)  
  • Population vaccine coverage | • Infant mortality  
  • Tooth decay in children aged 5 |