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# How to commission for the best start in life

# How to commission for the best start in life

**Summary guide to implementing best preventive and integrative practice in children's health and wellbeing from conception to age 2.**

**These notes provide a prompt but not an exhaustive list of key points to consider at each step in the child's personal journey and at each step in the joint effort to commission circles of support around the child.**

## How to commission for the best start in life: a commissioner's checklist for an integrated preventive approach

1 Joint Strategic Needs Assessment
2 Joint Strategic Assets Assessment
3 Health and Wellbeing Strategy
4 Selection of priority areas for action
5 Joint commissioning intentions
6 Evaluation
7 Sharing the learning
8 Commissioning research for unanswered questions

Each step is amplified in the following sections.

## 1 How to produce a 'Joint Strategic Needs Assessment' (JSNA)

Most JSNA working groups find the process of compiling a JSNA almost as valuable as the product at the end because it brings people together around a common purpose.

A JSNA is a written analysis of the joint understanding of needs, trends, inequalities and opportunities for populations, often broken down into topic areas such as in this guidance for babies and children in the early years.

### How are topics selected?

Each HWB will set its own criteria and process for topic selection, but common criteria include:

- The issue affects a lot of people
- The scope for intervention has a strong evidence base
- The scope for making a difference is large, or the consequences of non-intervention are drastic
- The current service or outcomes compare unfavourably with elsewhere
- There are a lot of resources tied up in the service or there are concerns about value for money

Protecting children in their early years ticks all these boxes.

WAVE Trust's collaborative Age of opportunity makes the following 10 recommendations for primary prevention, which should feature in a JSNA:

- Increase breastfeeding and good antenatal nutrition
- Promote language development
- Reduce domestic violence
- Reduce stress in pregnancy
- Achieve a major reduction in abuse and neglect
- Set up an effective and comprehensive perinatal mental health service working in conjunction with specialised children centre-based infant mental health teams
- Assess and identify where help is needed

- Focus on improving attunement [i.e. connectedness between carer and infant]
- Promote secure attachment
- Ensure good, health-led multi-agency work.

### How is it done?

Some HWBs now have fairly sophisticated arrangements for governance of how these JSNA's topics are selected and the process conducted. Most will draw on three well-established strands of analysis which together build a more robust understanding:

**Data** – epidemiological trends and patterns on population, risk factors, indicators of health and disease, and resources deployed.

**Evidence** – a critical appraisal of the published literature in the field in question – what do we know about what might work here? Evidence may come from research, expert bodies or local evaluations.

**Narrative** – asking populations, focus groups and key informants about what the needs and solutions might be.

Data and narrative can only be processed locally, so a local capacity for this – preferably pooled between HWB partners – is ideal. In most areas this will be coordinated by the Director of Public Health and team. Appraisal of evidence may be coordinated on a wider area basis, and draw on expertise from local universities or Public Health England's knowledge management services.

### How is the understanding shared so the wider population can engage, and how is it kept up to date?

- Most Local Authorities have started to build up an on-line publicly-accessible library of 'deep dive' JSNAs into specific topics.
- Electronic rather than paper format allows frequent review and update.
- It is considered good practice to put a 'review by' date on every needs assessment to encourage updates.

### How can we make sure it happens?

To some extent this will depend on external scrutiny and operating frameworks dictated by policy makers at national level – such pressure for commitment from above improves the likelihood of compliance and quality from the local level.

## 2 How to conduct a 'Joint Strategic Assets Assessment'

Start by examining budgets of the participating agencies, staffing levels and buildings. Understand the status quo before resources are redeployed in new ways to achieve better value (better return on investment). Such initiatives as 'resource mapping' or 'programme budgeting' will have been conducted by individual HWB organisations but not necessarily pooled.

Tap into the crucial assets provided by the talents and commitments of local people, including philanthropic and charitable ventures by local businesses and faith groups – what is known as 'social capital (several HWBs have woken up to the size importance of this).

### How is it done?

The familiar Department of Health's 'programme budgeting' annual returns and the 'Spend and Outcome Tool', now published by Public Health England, that shows spend and outcome in the main disease areas (the 20 chapters of the International Classification of Disease) is a good starting point for shared understanding and highlighting areas for CCG commissioning priorities but it is too clinically-based for much joint working.

An age-based set of programmes is worth exploring – e.g. how much does each HWB invest at present in defined age bands such as 0-2 years?

Relate the choice of programme budget categories, such as age groups or care groups, directly to outcome objectives for those groups so that investment can be tied to return on investment.

Money should not be moved around at the margins, i.e. out of one programme and into another, unless there is evidence there will be a better return in the new programme than was lost in the one from which it came.

## 3 How to compile a 'Health and Wellbeing Strategy'

All HWBs are required to produce and publish a strategy for health and wellbeing and these are almost universally available to read on line. It is expected that all commissioning intentions (see below) will refer to the strategy. It is a joint understanding of the way forward, of what 'success' looks like, and of how to evaluate progress. There is a perfectly legitimate case for insisting every health and wellbeing strategy is clear about the strategic intention to give every child the best possible start in life.

### How is it done?

All strategies, including this one, boil down to simple key elements:

'Where are we now?'

'Where do we want to be?'

'How will we get there?'

'How will we measure progress?'

Guidance issued to Local Authorities and NHS bodies requires these strategies to be based on outcomes. A summary of the national public health outcomes framework is attached at Appendix 4. The outcomes themselves are broken down into domains and this structure can be helpful to authors of HWB strategies. The headings are:

- Improving the wider determinants of health: e.g. housing, parental education and employment
- Improving healthy lifestyles: e.g. nutrition, absence of cigarette smoke
- Protecting health: e.g. environmental health, immunisation
- Improving caring services: e.g. health visiting, General practice, hospitals

There will probably be an external audit and scrutiny of outcomes, and comparative data will be published showing the performance of different local authority areas.

### How can it be improved?

An online search or personal enquiry of a peer local authority and its HWB strategy can be a useful place to start, and become the basis of a continuing learning set.

## 4 Selection of priority areas for action

Armed with the information above, the commissioner is now ready to select the priority areas for action. The need both to implement fully the Healthy Child Programme and to ensure Family Nurse Partnership is delivered wherever appropriate have already been emphasised strongly elsewhere. Therefore, we will not repeat the case for these essential initiatives here but will confine ourselves to very specific components of a good integrative, preventive strategy.
In adopting a preventive approach, selection of key areas has been carefully considered both during the 15-month DfE/WAVE Trust study which resulted in Conception to age 2 – the age of opportunity and in WAVE's subsequent work, including discussions with a few dozen local areas as an adviser to the Big Lottery's A Better Start initiative. This work led to the selection of 10 key recommendations for primary prevention:

- Increase breastfeeding and good antenatal nutrition
- Promote language development
- Reduce domestic violence
- Reduce stress in pregnancy
- Achieve a major reduction in abuse and neglect
- Set up an effective and comprehensive perinatal mental health service and infant mental health service working together
- Assess and identify where help is needed
- Focus on improving attunement
- Promote secure attachment
- Ensure good, health-led multi-agency work.

All of these should feature in a good JSNA.

**Increase breast feeding and good antenatal nutrition:** In addition to protecting mothers from breast cancer and babies from gastroenteritis, respiratory disease, and obesity, breastfeeding has been shown to be associated with improved child cognitive development. (Age of opportunity, p.13 paras 24 and 25).

**Promote language development:** From birth, children's learning results from their interaction with people and their environment. Children need a natural flow of affectionate, stimulating talk, to describe what is happening around them, to describe things they can see, and to think about other people. This is critical for children's language and cognition, their general capacity to engage with new people and new situations, and their ability to learn new skills. (Age of opportunity, p. 17 and 18).

**Reduce stress in pregnancy:** Antenatal anxiety has been linked to behavioural and emotional problems in the child at age 4, with the children of mothers in the top 15% for anxiety at double the risk for emotional or behavioural problems, including ADHD and conduct disorder. The effects on the child's brain can be lifelong. (Age of opportunity, p.12 para 17).

**Reduce domestic violence:** Women are at elevated risk of domestic violence when pregnant, and this increases both direct and indirect risk for the foetus. 25% of children witnessing domestic violence develop serious social and behavioural problems. Prolonged and/or regular exposure to domestic violence can have a very serious impact on children's safety and welfare. (Age of opportunity, p.12 paras 18, 19; p.16, para 42; p.18 para 54).

**Achieve a major reduction in abuse and neglect:** It is where there is abuse or neglect that there is the greatest probability of poor outcomes for the child. 45% of serious case reviews in England relate to babies under 1 year old. Child abuse has a causal role in most mental health problems, including depression, anxiety disorders, eating disorders, substance misuse, personality disorders, and dissociative disorders. Neglect, abuse and domestic violence all contribute to lifelong poorer health outcomes including smoking, fractures, severe obesity, alcohol and drug misuse, ischaemic heart disease, stroke, chest diseases, cancer, diabetes, hepatitis, sexually transmitted diseases, depression, and attempted suicide. (Age of opportunity, p.17 para 43; p.21 para 71; p.22 para 73-75; p.23, para 76; and the Adverse Childhood Experiences studies of Felitti and Anda1, 2).

**Set up an effective and comprehensive perinatal mental health service:** Parental mental health (before and after birth) is a key determinant of the quality of the parent-child relationship and a key factor in safeguarding children from abuse and neglect. Children of mothers with mental health issues are twice as likely to experience a childhood psychiatric disorder. Parental mental illness is associated with: poor birth outcomes, increased risk of sudden infant death and increased child mortality. Postnatal depression and other forms of mental illness are linked to an increase in greater levels of disturbed or disruptive behaviour at primary school, poor peer relationships, and a decrease in self-control with an increase in aggression. (Age of opportunity, p.3 paras 3; p.18 paras 52 and 53). A perinatal team also needs to be able to refer to an infant mental health service, where the clinical focus is not on the parents' mental health but on the caregiving relationship. This can be affected by many other factors than parental mental ill-health (Age of Opportunity, p. 89), and so an infant mental health team will also be working with a wide range of additional issues and agencies.

**Assess and identify where help is needed:** Effective assessment is a key tool to help professionals work out what support children and families need. Age of opportunity recommends:

a) universal risk assessments by midwives during pregnancy
b) health visitor assessment of the quality of parent-infant bonding or attunement at age 3-4 months
c) targeted assessment of attachment at 12-15 months.

(Age of opportunity, p. 28-32).

**Focus on improving attunement:** Parents who lack the ability to attune sensitively to a baby's needs place the baby at risk of insecure attachment and poor social and emotional development. Video Interaction Guidance (VIG) has also been successfully used to improve sensitivity and decrease disrupted communication between mothers and babies and to help mothers with postnatal depression re-connect with their babies.

It has also been shown to promote higher levels of secure attachment. It can have a significant positive impact on vulnerable parents and is also now commonly used therapeutically in families with more complex problems (Age of opportunity, p. 15 and 16, paras 38 and 39; p. 52 and 74).

**Promote secure attachment:** Attachment that is not secure in infancy – particularly for boys – is associated with externalising behaviour problems (e.g. aggression) later in childhood.

Good quality relationships and secure attachment provide a basis for future self-control and cognitive development. Infants with disorganised attachment have elevated risks of aggressive behaviours, mental disorders, school behaviour problems and other psychopathologies. Around 80% of maltreated infants have disorganised attachment (Age of opportunity, p.16, paras 41, 42; p.17 para 44).

**Ensure good, health-led multi-agency work:** The Marmot Review indicated that effective multi-agency practice to address a range of social determinants of poor health was key to improving outcomes, and to giving children the best start. A particularly successful example of multi-agency working is the Highland Region Streamlined Rapid Reaction System. (Age of opportunity, p.38 para 4; p.62, section B1).

## 5. How to produce 'Commissioning intentions'

### What are they?

A joint commitment to invest resources and specify services in ways that draw on the steps above.

### What are the key steps in commissioning a service?

**Service review.** It may be that an obstetric, midwifery, health visiting or other (aspect of) service for unborn babies and young children is due a complete revision. Alternatively there may just need to be marginal changes which can be omitted for a few years. The senior partners represented on the HWB will want to give a steer to such a review and set its membership and terms of reference.

**Service specifications.** This is a written articulation of the pattern, pathway and quality of service expected. Quality can be divided into the classic triad of structure (e.g. the locations, equipment, staff), process (e.g. ways of working, evidence-based practice) and outcome (e.g. the anticipated measurable changes in health status attributable to the interventions provided).

Writing service specification may require a lot of new work, depending on the maturity of current contracts. It is often the case that NHS contracts, and especially those relating to community services, lack detail. It is worth looking round for models that can be adapted to local circumstances. There are many professional bodies and expert reference groups who have issued guidance or model service specifications, e.g. 'Guidance for commissioners of perinatal mental health services' volume 2, practical mental health commissioning, www.jcpmh.info. The specification of skills and training is a huge new opportunity, and where different disciplines or organisations can train their staff together this can reap dividends for integration, understanding and mutual respect.

**Service schedule and the 'contract'.** This is the step where the contract value and contract outputs (activity) are articulated. Due to resource constraints there is a perennial trade-off between

money, activity and quality, and these are the essence of most of the negotiations. In some instances there will be marginal rates set for activity that exceeds anticipated thresholds or for clawing back money where activity or quality falls short.

The contract will specify data reporting requirements and may make provision for announced and unannounced visits by commissioners for quality assurance purposes. It is common in local authority practice for all contracts to be signed off by a senior legal and financial officer, plus the elected member for the health and wellbeing portfolio.

These contracts can in turn be subject to scrutiny and checks by the full local authority cabinet. CCGs and NHS commissioners are not accustomed to this degree of challenge, having previously operated something closer to an internal market, with greater officer discretion and less scrutiny and contestability. Contracts are typically awarded for three years, with explicit break clauses to allow response to changing circumstances or poor performance.

**Procurement or competitive tendering.** This step is also a developmental challenge for the NHS. It may not be completely novel to NHS commissioners, but may be new to some large NHS providers who have enjoyed for decades an effective monopoly or near-monopoly of provision, say of midwifery or health visiting. Budgets for public health services, now including health visiting, have moved from NHS to local authority control and are subject to much tighter procurement and competitive tendering rules. The purpose of this step in commissioning is to improve competition and thereby drive down costs and push up quality. Early examples in this field are smoking cessation services for expectant mothers.

**'Provider development' and 'market development'.** If the desired pattern of service is not available locally there may be a need to work with potential providers in the statutory, voluntary or private sectors to engage in **'provider development'**, sometimes known by its commercial equivalent of **'growing the market'**. HWBs may ask their officers to support the emergence of new providers.

**How and when are commissioning intentions shared?** It is now a requirement that in the annual cycle, typically around September, all partners at HWBs share commissioning intentions as a formal agenda item. Given their complexity, many HWBs choose to hold a development meeting or series of seminars to work through these before they are formally presented. This is a very good learning opportunity and a chance to pool resources for greater effectiveness and efficiency. Most parties already acknowledge the inherent desirability of coordinating their commissioning intentions.

## 6 How to conduct an 'Evaluation'

### What is it and why does it matter?

'Evaluation' is the degree to which a strategy, and all the subsequent commissioning activity and provision of services, has met its stated objectives. The more clearly those objectives are defined the easier and more robust the evaluation will be. Its purpose is primarily developmental, but it will also have practical, contractual and financial implications for providers, along with political implications for statutory bodies and elected members. Its scope would encompass outcomes, activity, standards, user and carer experience, value for money, and ideas for further refinement in the following year.

### How is it done?

Evaluations should be conducted by HWB members and their officers as part of their routine business cycle. Findings would be published as part of the minutes of meetings, and elements of evaluation would also appear in the annual reports of, for example, the Director of Public Health, Director of Children's services, Director of Adult Services and Social Care, or any of the provider organisations. There will also be internal scrutiny by the wider local authority cabinet, and external scrutiny by bodies that scrutinise public sector performance.

## 7 How to share the learning

Since the implementation of the Health and Social Care Act is in its early stages, and much is still untried and tested, dissemination of the learning on what did and did not work well (so others can learn from the evolving experience in this national experiment and contribute to the evidence base) is particularly important.

Regional and national seminars and conferences, formal write-ups in peer-reviewed journals or trade press, and publication of local reports on HWB websites are examples of such dissemination.

It can be helpful to incorporate an obligation to disseminate the learning in the personal work objectives of senior officers of HWB partners and in the annual appraisals of participating general practitioners.

## 8. How to commission further research

HWBs have an opportunity, if not a duty, to articulate research questions where the evidence base is missing or inconclusive.

It is important to use networks and contacts to keep policy makers aware of the strengths and weaknesses of the evidence base so that they can commission national research where needed.

Collaboration with local universities, NHS academic health service networks, Public Health England and such national bodies as NICE is a necessary part of commissioning if it is to remain developmental and keep pushing the boundaries of knowledge and effective, efficient responses to challenges.

## Appendix 1
## Understanding the big picture before commissioning for the details

Further considerations of the role of HWBs
The first rule of problem solving is to understand the nature and scale of the problem so as to articulate the right questions and then find the right answers. Most HWBs have found it necessary to get together, as a whole or in groups, between formal meetings, to work through the questions, understand each other's perspectives, think creatively, pause, reflect, share, triangulate, challenge, learn and collaborate.

Gathering perspectives from the wider population served also takes a lot of effort – through surveys, events and drawing on key informants who can give a voice to those who find it difficult to articulate or be heard. The narrative is every bit as important as the numbers, and the population served is every bit as much a collection of assets as a collection of needs. THE HWB has to build resilience just as individuals and communities must. HWBs offer a hand-up, not a hand-out.

The primary role of the HWB is to agree the **mission**, or common purpose, that will direct all the partners' responses to giving children the best start in life: **protect, prevent and potentiate**.

**A good test of a HWB's likely effectiveness in the field of early years' child protection and development is to ask each of its members to articulate the mission.**

### Economic considerations

If necessity is the mother of invention, then austerity is the mother of innovation. In the present climate of austerity where real savings have to be made, there is a risk on focussing only on what has to be cut. The result of that would be a similar, but diminished, pattern of services that already exist, and that is not progress. The scale of change required means the assets that do remain have to be understood, shared and redeployed in new ways that best meet the needs identified.

Assets are more than just money – they include commitment, time and experience. Austerity offers a real opportunity in disguise.

When it comes to mapping and redeploying resources, the economist's notion of the 'margin' is important. The parties sitting round the HWB table will not be starting with a blank canvas, but will have inherited a status quo with respect to investment in services for women of child-bearing age, infants, young children, and families. Marginal analysis is the evaluation, in incremental steps, of the added cost and added benefit where resources into a programme are increased, or the savings made and the benefit lost when they are withdrawn. There will need to be a piece of work done to establish this status quo and then test ideas for incremental investment or disinvestment.

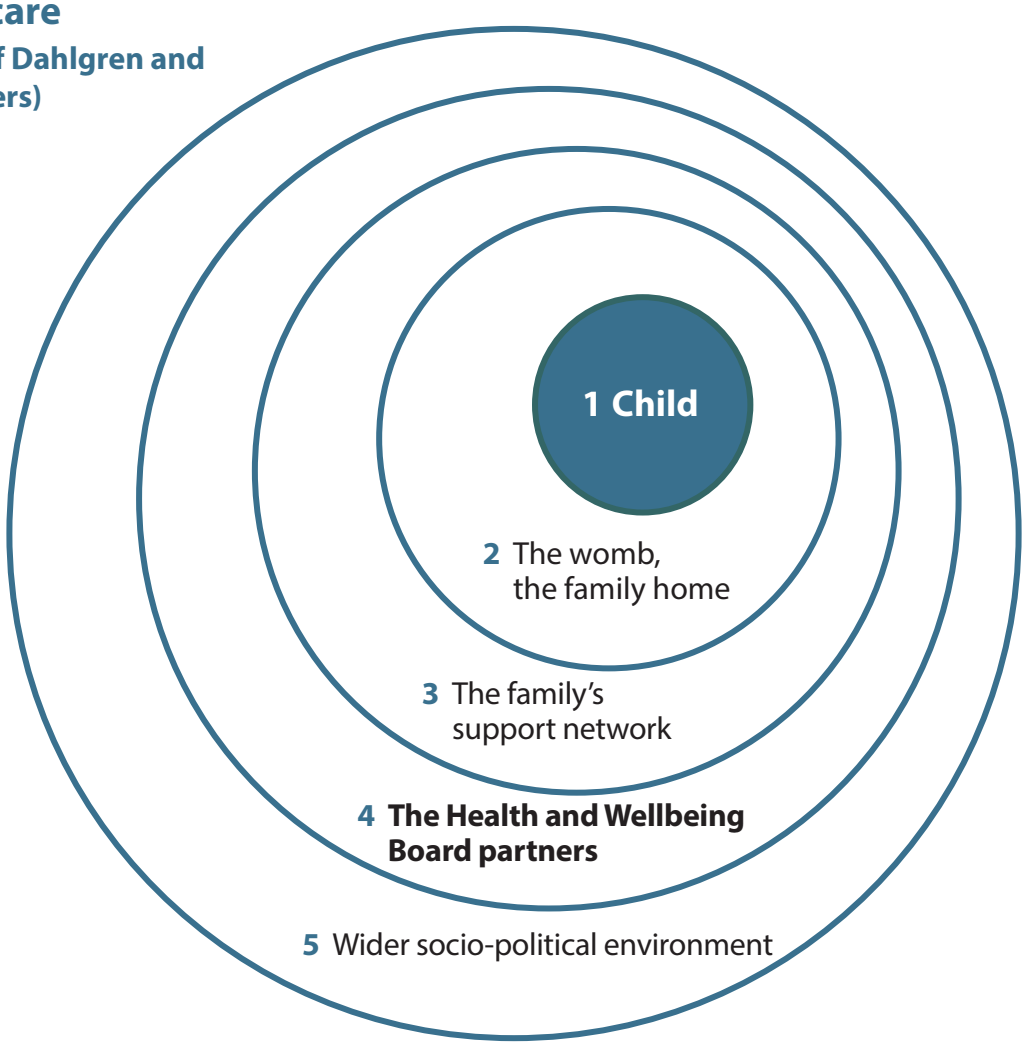
Another notion from economics is the difference between allocative efficiency and technical efficiency. Loosely, the former is the responsibility of the commissioner, the latter the responsibility of the provider. In allocative efficiency the commissioner tries to spread investment between competing programmes in such a way that outcomes are maximised and that no-one who is left out of a programme has greater need than someone who is included. Technical efficiency is where a given objective is agreed (or mandated by law) and the issue is simply delivering it at least cost. Loosely, allocative efficiency is 'doing the right things' and technical efficiency is 'doing things right'. Both are examples of responsible stewardship of public funds. The pursuit of efficiency is an ethical imperative because the price of inefficiency is ultimately borne by the vulnerable child, and the currency in which he or she pays is avoidable developmental delay and a lifelong loss of full potential.

Early intervention is a good investment. In his 2008 report, Heckman showed that the rate of return to investment in human capital was greatest in the first 3 years of life, and diminished through preschool, school and job training. All stages were worthwhile investment but the greatest returns came the earliest the intervention took place.

### Transformation, not just transaction

Commissioning is creative. It requires imagination, lateral thinking, positive attitude and a certain amount of risk-taking entrepreneurialism. Austerity is the mother of innovation. A particular test of creative commissioning is helping communities and individuals help themselves: to become more resilient. An example might be a scheme in which older people read to pre-school children, so that older people become seen as an asset and not a drain on resources, or where women from ethnic minorities run a cooking club and thereby help young mums with nutrition and isolation whilst themselves learning English and integrating. Many such schemes are up and running where good ideas are encouraged and supported by creative commissioning.

## Appendix 2
## Concentric circles of care
**(Modified from the work of Dahlgren and Whitehead, and many others)**




**Key and explanation:**

1 The child, with his or her inherent, unique and special genetic endowment, is the centre and pivot of the model. In most cases there is no problem with development and the objective is simply to protect and nurture the new life. In other cases there may be a case for pre-conceptual or early antenatal diagnosis, counselling or treatment for known genetic or congenital conditions in which clinical intervention can make a difference.
It can be said that life is a succession of steps, each getting 'ready for' the next step.

- Ready to be born
- Ready to walk and talk
- Ready for school
- Ready for work
- Ready to start a family
- Ready for fulfilling retirement
- Ready for a well-managed death.

**2** This is the immediate environment; for example the womb before birth, the special care nursery for those born early or with complications, and then the home. All three merit attention to safety and protection. Again, in most cases, the experience is positive, but this is a circle that the commissioners should reflect on, take advice on, and assure themselves that all is indeed well. Preserving the maternal bond for those babies requiring special care is important in early years' development. Family finance is both an enabler and a constraint. Poverty, and debt in particular, has been shown to

have a strong negative impact on maternal mental health, and the relief of debt a positive impact.

**3** This wider network of support makes the immediate environment safe and supported. This is the territory of the midwife, health visitor, peer supporter, wider family, child minder, GP, and perhaps social worker, paediatrician and others where special need has been identified. Commissioners will be concerned with quality, and quality breaks down into the classic triad of structure, process and outcome – all of which can be covered in service reviews, articulated in service specifications, formalised in contracts, then followed in up in quality assurance. There should be a **strong** emphasis on building **resilience** – defined as the skills and confidence for parents and carers to take on more personal responsibility (e.g. for minor childhood ailments or family budget) and 'bounce back ability' when adverse events do strike (e.g. death or illness of a close family member or loss of a job or house). Resilience applies to mothers, families, communities and professionals working for caring agencies. Resilience is the opposite of dependence. Some HWBs have gone as far as to incorporate 'resilience' and 'making a contribution' as part of their definition of health and wellbeing.

**4** **The fourth ring is the territory of the HWB, including the commissioners of services.** This is the essential integrative ring where all the steps in the first checklist come together to strengthen the net of protection and support around each child. Commissioners might want to think about how adverse events are reported and the learning embedded, and how success is reported and celebrated. Joint training and common standards can be discussed. Much of the work of an HWB takes place in working groups outside formal meetings.

**5** The outer ring is the wider socio-political environment at regional and national level, where policy impacts on outcomes for individuals. This includes employment, benefits, housing, education, legislation and much more. There is a role for the commissioners' host organisations and the HWB collectively to inform policy-makers about experience and ideas. The NHS in particular has been reminded of its 'duty of candour' i.e. to be honest about mistakes or failures. To this might be added a 'duty of can do' i.e. to be committed to an open approach where lessons are learned and change is implemented.

## Relating circles of care to stages of life: who does what and when?

| | **2** The immediate environment of womb then the family | **3** The wider network of support to the family | **4** The Health and Wellbeing Board | **5** The wider socio-political environment |
|---|---|---|---|---|
| From conception to birth | *Maternal and child nutrition and health* | GP, midwife, obstetrician: *Antenatal care* Family: *Emotional and financial support, Active search for babies and families at increased risk* Social worker: *Safety, benefits, financial and debt advice* | JSNA, strategy and commissioning for maternity services, child safety and protection | National policy on NHS maternity services, LAs, housing, benefits |
| From birth to six weeks | *Nutrition, Stimulation, interaction, family lifestyle such as smoking, activity, music* | Midwife, health visitor, GP, specialist where indicated: *Neonatal screening and care. Breastfeeding support.* Wider family and peer support: *Practicalities of child rearing* | JSNA, strategy and commissioning for NHS, LA, and voluntary organisations for early years, child protection, employment, housing, urban design, baby-friendly transport, Children's Centres, courses in parenting skills | National policy on NHS and LAs, children with special needs, families, maternity and paternity leave |
| From six weeks to six months | *Nutrition Stimulation, interaction, family lifestyle such as smoking, activity, music* | GP, health visitor, social worker as indicated Wider family and friends: Nutrition. Immunisation | JSNA, strategy and commissioning for NHS, LA, and voluntary organisations early years | National policy on immunisation, child-related welfare |
| From six months to a year | *Nutrition Stimulation, interaction, family lifestyle such as smoking, activity, music* | GP, Health visitor, wider family and friends, social worker if indicated | JSNA, strategy and commissioning for NHS, LA, and voluntary organisations early years | National policy on immunisation, child-related welfare |
| From the second year of life | *Nutrition Stimulation, interaction, reading and story- telling, outdoor activity, family lifestyle such as smoking, social interaction, music* | GP, wider family and friends, social worker if indicated, educational input if special needs identified, child minder | JSNA, strategy and commissioning for NHS, LA, and voluntary organisations early years | National policy on immunisation, child-related welfare, education, child-minding, employment |

## Appendix 3
## Commissioning for pathways and journeys

### 'Vertical integration': key steps on the child's journey.

| Step on the pathway | Commissioning objectives for the health and wellbeing board members |
|---|---|
| **Child and family may be at increased risk of avoidable developmental problem** | Active screening of all pregnant mothers and their families for known risk factors, and early intervention when present. Universal advice on parenting, nutrition, lifestyle, breastfeeding, etc. |
| **Developmental problem or family dysfunction exists but has not been recognised** | Systematic screening by professionals (e.g. neonatal audiology, Guthrie test); raising awareness of early signs of trouble so parents or carers recognise and report them. |
| **Developmental problem is recognised, but is early and may be remediable** | Rapid access to assessment, diagnostics and effective treatment for clinical problems in child or parent, and support for social problems. |
| **Developmental problem or family circumstances are intractable but prevention of further harm and protection of child's maximum residual potential is still possible** | Reduction where possible in remediable factors like debt and poor housing. Modification of home and immediate environment to minimise handicapping effects of any physical impairment. Support for parents, family and carers to retain and build the child's residual potential, with early educational input. |
| **Severe disadvantage has become established through failure of earlier steps or organic disease** | Long-term educational support, health and social care put in place. Care plan with child's best interest at the centre. |

Commissioners may want to pool some resources and draw up a specification for an entire pathway, and then either commission this in its entirety or put it out to tender in 'lots'. The specification would have a strong emphasis on managing 'upstream', i.e. as early as possible in the pathway.

**'Horizontal integration': integration between HWB partners and professional disciplines at each step in the pathway** – This is the prime role and prime opportunity for HWBs and recognises the essential interdependency between partners.

Horizontal integration creates a stronger and more resilient network of care around the child and family in those crucial early years. This horizontal integration, which is delivered at the front line by thousands of employed staff and commissioned providers across the country in every locality every day, is based on common understanding and common purpose. This is the 'mission' in commissioning. Horizontal integration depends on sharing of information and knowledge, joint training, joint working, pooling of resources and joint evaluation.

# Public Health Outcomes Framework 2013–2016

## At a glance (Autumn 2012)

**VISION**

To improve and protect the nation's health and wellbeing and improve the health of the poorest fastest

**Outcome measures**

Outcome 1) Increased healthy life expectancy, i.e. taking account of the health quality as well as the length of life

Outcome 2) Reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities)

**Alignment across the Health and Care System**

* Indicator shared with the NHS Outcomes Framework.

** Complementary to indicators in the NHS Outcomes Framework

† Indicator shared with the Adult Social Care Outcomes Framework

†† Complementary to indicators in the Adult Social Care Outcomes Framework

*Indicators in italics are placeholders, pending development or identification*

### 1 Improving the wider determinants of health

**Objective**

Improvements against wider factors which affect health and wellbeing and health inequalities

**Indicators**

1.1 Children in poverty

*1.2 School readiness (Placeholder)*

1.3 Pupil absence

1.4 First time entrants to the youth justice system

1.5 16-18 year olds not in education, employment or training

1.6 Adults with a learning disability/in contact with secondary mental health services who live in stable and appropriate accommodation† *(ASCOF 1G and 1H)*

*1.7 People in prison who have a mental illness or a significant mental illness (Placeholder)*

1.8 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services **(I-NHSOF 2.2)* ††*(II-ASCOF 1E)* ***(III-NHSOF 2.5)* †† *(III-ASCOF 1F)*

1.9 Sickness absence rate

1.10 Killed and seriously injured casualties on England's roads

*1.11 Domestic abuse (Placeholder)*

1.12 Violent crime (including sexual violence)

1.13 Re-offending levels

1.14 The percentage of the population affected by noise

1.15 Statutory homelessness

1.16 Utilisation of outdoor space for exercise/health reasons

*1.17 Fuel poverty (Placeholder)*

*1.18 Social isolation (Placeholder)* † *(ASCOF 1I)*

*1.19 Older people's perception of community safety (Placeholder)* †† *(ASCOF 4A)*

### 2 Health improvement

**Objective**

People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities

**Indicators**

2.1 Low birth weight of term babies

2.2 Breastfeeding

2.3 Smoking status at time of delivery

2.4 Under 18 conceptions

*2.5 Child development at 2-2½ years (Placeholder)*

2.6 Excess weight in 4-5 and 10-11 year olds

2.7 Hospital admissions caused by unintentional and deliberate injuries in under 18s

2.8 Emotional well-being of looked after children

*2.9 Smoking prevalence – 15 year olds (Placeholder)*

*2.10 Self-harm (Placeholder)*

2.11 Diet

2.12 Excess weight in adults

2.13 Proportion of physically active and inactive adults

2.14 Smoking prevalence – adults (over 18s)

2.15 Successful completion of drug treatment

2.16 People entering prison with substance dependence issues who are previously not known to community treatment

2.17 Recorded diabetes

*2.18 Alcohol-related admissions to hospital (Placeholder)*

2.19 Cancer diagnosed at stage 1 and 2

2.20 Cancer screening coverage

2.21 Access to non-cancer screening programmes

2.22 Take up of the NHS Health Check programme – by those eligible

2.23 Self-reported well-being

2.24 Injuries due to falls in people aged 65 and over

### 3 Health protection

**Objective**

The population's health is protected from major incidents and other threats, whilst reducing health inequalities

**Indicators**

3.1 Fraction of mortality attributable to particulate air pollution

3.2 Chlamydia diagnoses (15-24 year olds)

3.3 Population vaccination coverage

3.4 People presenting with HIV at a late stage of infection

3.5 Treatment completion for Tuberculosis (TB)

3.6 Public sector organisations with a board approved sustainable development management plan

*3.7 Comprehensive, agreed inter-agency plans for responding to public health incidents and emergencies (Placeholder)*

### 4 Healthcare public health and preventing premature mortality

**Objective**

Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities

**Indicators**

4.1 Infant mortality* *(NHSOF 1.6i)*

4.2 Tooth decay in children aged 5

4.3 Mortality rate from causes considered preventable** *(NHSOF 1a)*

4.4 Under 75 mortality rate from all cardiovascular diseases (including heart disease and stroke)* *(NHSOF 1.1)*

4.5 Under 75 mortality rate from cancer* *(NHSOF 1.4i)*

4.6 Under 75 mortality rate from liver disease* *(NHSOF 1.3)*

4.7 Under 75 mortality rate from respiratory diseases* *(NHSOF 1.2)*

4.8 Mortality rate from infectious and parasitic diseases

4.9 Excess under 75 mortality rate in adults with serious mental illness**(NHSOF 1.5)*

4.10 Suicide rate

4.11 Emergency readmissions within 30 days of discharge from hospital* *(NHSOF 3b)*

4.12 Preventable sight loss

*4.13 Health-related quality of life for older people (Placeholder)*

4.14 Hip fractures in people aged 65 and over

4.15 Excess winter deaths

4.16 Estimated diagnosis rate for people with dementia* *(NHSOF 2.6i)*

## Appendix 5
## Children learn what they live

*Dorothy Law Nolte*

If a child lives with criticism, he learns to condemn.

If a child lives with hostility, she learns to fight.

If a child lives with fear, he learns to be apprehensive.

If a child lives with pity, she learns to feel sorry for herself.

If a child lives with ridicule, he learns to be shy.

If a child lives with jealousy, she learns what envy is.

If a child lives with shame, he learns to feel guilty.

If a child lives with encouragement, she learns to be confident.

If a child lives with tolerance, he learns to be patient.

If a child lives with praise, she learns to be appreciative.

If a child lives with acceptance, he learns to love.

If a child lives with approval, she learns to like herself.

If a child lives with recognition, he learns that it is good to have a goal.

If a child lives with sharing, she learns about generosity.

If a child lives with honesty and fairness, he learns what truth and justice are.

If a child lives with security, she learns to have faith in herself and those around her.

If a child lives with friendliness, he learns that the world is a nice place in which to live.

If you live with serenity, your child will live with peace of mind.

With what is your child living?

*Source:* Canfield J and Wells, HC. *100 ways to enhance self-concept in the classroom: a handbook for teachers and parents.* Boston: Allyn & Bacon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