Title:
Mandatory public health functions of local authorities to provide health visiting services to children aged 0-5
IA No: 1026

Lead department or agency:
Department of Health
Other departments or agencies:

Impact Assessment (IA)

Date: 21/01/2015
Stage: Final
Source of intervention: Domestic
Type of measure: Secondary legislation
Contact for enquiries: Roger Wallis

Summary: Intervention and Options

RPC Opinion: Not Applicable

Cost of Preferred (or more likely) Option				
Total Net Present Value	**Business Net Present Value**	**Net cost to business per year** (EANCB on 2009 prices)	**In scope of One-In, Two-Out?**	**Measure qualifies as**
£0m	£0m	£0m	No	NA

What is the problem under consideration? Why is government intervention necessary?

Local Authorities (LAs) have a duty under section 2B of the NHS Act 2006 (amended by Health and Social Care Act 2012) to take appropriate steps for improving the health of the people in its area. LAs are free to commission services within the public health ringfenced budget as they see fit. In April 2013 LAs became responsible for commissioning a range of public health services, some of which were mandated by Government. The commissioning of children's 0-5 public health services will transfer to LAs on 1 October 2015. Mandating the universal health and development assessment and reviews that form part of the 0-5 services will ensure the ongoing provision of a service that is essential to supporting health and well being of families and children at a critical stage of development.

What are the policy objectives and the intended effects?

To secure a safe and sustainable transfer of the commissioning of 0-5 services which will ensure stable health visiting services for families and children aged 0-5 and ensure the provision of a universal health visiting service through the transfer period and for a limited period beyond. This will also contribute to an effective public health system that maximises total health benefit at both local and national level, whilst supporting the delivery of the Coalition's commitment to expanding the health visting workforce by 4,200 full time equivalents and transform services by April 2015.

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

Option 1: LAs have full autonomy in spending the additional funding for children's 0-5 public health services, that will be added to their ring-fenced public health budget on 1 October 2015, on services that best meet identified local public health needs.
Option 2: LAs are mandated to take steps to maintain the provision of key universal elements of health visiting services from October 2015. The mandated functions will support ongoing delivery of universal health visiting services thus providing substantial additional benefits to society when provided to all. This ensures that LAs retain autonomy over which services to commission locally with at least 69% of the ring-fenced budget. This is the preferred option.

Will the policy be reviewed? It will be reviewed. **If applicable, set review date:** 04/2017

Does implementation go beyond minimum EU requirements?			N/A		
Are any of these organisations in scope? If Micros not exempted set out reason in Evidence Base.	**Micro** No	**< 20** No	**Small** No	**Medium** No	**Large** No
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)			**Traded:** N/A	**Non-traded:** N/A	

I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) that the benefits justify the costs.

Signed by the responsible Minister: DAN POULTER Date: 26/1/15

Summary: Analysis & Evidence

Policy Option 1

Description: No change - there are no requirements on which 0-5 children's public health (PH) services LAs commissions.

FULL ECONOMIC ASSESSMENT

Price Base Year 2015	PV Base Year 2015	Time Period Years N/A	Net Benefit (Present Value (PV)) (£m)		
			Low: Optional	**High:** Optional	**Best Estimate:** 0

COSTS (£m)	**Total Transition** (Constant Price)	Years	**Average Annual** (excl. Transition) (Constant Price)	**Total Cost** (Present Value)
Low	Optional	N/A	Optional	**Optional**
High	Optional		Optional	**Optional**
Best Estimate	0		0	**0**

Description and scale of key monetised costs by 'main affected groups'

These are defined to be zero.

Other key non-monetised costs by 'main affected groups'

These are defined to be zero.

BENEFITS (£m)	**Total Transition** (Constant Price)	Years	**Average Annual** (excl. Transition) (Constant Price)	**Total Benefit** (Present Value)
Low	Optional		Optional	**Optional**
High	Optional		Optional	**Optional**
Best Estimate	0		0	**0**

Description and scale of key monetised benefits by 'main affected groups'

These are defined to be zero.

Other key non-monetised benefits by 'main affected groups'

These are defined to be zero.

Key assumptions/sensitivities/risks — **Discount rate (%)**

Assumes the public health needs of the local population are correctly identified, which the LAs act upon when commissioning. This option risks the under provision of universal health visiting services which would potentially lead to a reduction in wider benefits to society through reductions in lifelong health and social care needs and where under provision would put at risk the ability to monitor the PHOF. It also risks the Government investment in Health Visitor numbers and services.

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			In scope of OITO?	Measure qualifies as
Costs: 0	**Benefits:** 0	**Net:** 0	No	N/A

Summary: Analysis & Evidence

Policy Option 2

Description: LAs are mandated to take steps to maintain the provision of five key universal elements of health visiting services from October 2015

FULL ECONOMIC ASSESSMENT

Price Base Year 2015	PV Base Year 2015	Time Period Years N/A	Net Benefit (Present Value (PV)) (£m)		
			Low: Unknown	**High:** Unknown	**Best Estimate:** Unknown

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	Unknown	N/A	Unknown	**Unknown**
High	Unknown		Unknown	**Unknown**
Best Estimate	Unknown		Unknown	**Unknown**

Description and scale of key monetised costs by 'main affected groups'

No expected financial costs associated in prescribing LAs to deliver functions (Option 2). DH estimates no more than around £366m (illustration purposes, est. cost of 100% coverage of the mandated functions - in practice the ask is no higher coverage than at transfer) of the LAs' already identified PH ringfenced (RF) budget would be required to provide the proposed mandatory functions. However, this is not an additional cost but fully funded subtotal amount from the total RF budget of £3.0bn.

Other key non-monetised costs by 'main affected groups'

The mandated functions under option 2 may be different from those that LAs would choose to commission under option 1. The cost of implementing option 2 is the opportunity costs, which are the foregone benefits that would have been experienced under option 1. Whilst LAs' commissioning decisions are unknown under option 1, we can assume the decision would be similar to the mandatory functions in option 2 and serve the same population, therefore the opportunity cost is thought to be small.

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	Unknown	N/A	Unknown	**Unknown**
High	Unknown		Unknown	**Unknown**
Best Estimate	Unknown		Unknown	**Unknown**

Description and scale of key monetised benefits by 'main affected groups'

The benefits of the Healthy Child Programme (HCP), and all the services included within it, were outlined at its introduction. As the mandated services are all part of the HCP, and do not include new services, there are no additional monetised benefits realised for this option. Some benefits of the mandated services have been outlined in the background.

Other key non-monetised benefits by 'main affected groups'

The local populations benefit from LAs retaining the majority of the ring-fenced budget to commission services that directly target their needs. The local and national populations benefit from ensuring the provision of services that help deliver an effective national public health system. The combination of targeting local public health needs and ensuring an effective national public health system will help maximise the public health benefit experienced by the entire population.

Key assumptions/sensitivities/risks **Discount rate (%)**

This option assumes that the local Joint Strategic Needs Assessment and the Health and Wellbeing Strategy correctly identify the public health needs of the local population, which the LAs will act upon when commissioning services.

BUSINESS ASSESSMENT (Option 2)

Direct impact on business (Equivalent Annual) £m:			In scope of OIOO?	Measure qualifies as
Costs: 0	**Benefits:** 0	**Net:** 0	No	NA

Evidence Base (for summary sheets)

There is discretion for departments and regulators as to how to set out the evidence base. However, it is desirable that the following points are covered:

Problem under consideration and rationale for intervention

1. The main issue is the potential risk that LAs may disinvest in health visiting services when the transfer of 0-5 commissioning responsibilities to LAs takes place. The effect of this could be two-fold:

    a. The universal provision of health visiting services to all children and families would be put at risk which in turn puts at risk:
        i. Realisation of opportunities to reduce health and social care needs later in life is not fully met;
        ii. Contributions to the reduction of disease e.g. through reviewing immunisation status; and,
        iii. Collection of data at a national level that enables measurement against elements of the Public Health Outcomes Framework (PHOF) e.g. breast-feeding rates.

    b. Health visiting careers would be less attractive and thus put at risk the achievement of the Government's plan to grow the health visiting workforce by 4,200 fte and transform the health visiting service by April 2015.

2. To mitigate this risk, the Department of Health is working with key stakeholders to develop a transfer plan and manage implementation. The group was convened in January 2013 and meets monthly.

3. Specifically, the group is taking forward work on a number of fronts to mitigate the risk in paragraph 10. This work is intended to:

    a. ensure that LAs are fully aware of the health benefits of the health visiting service and the Healthy Child Programme (HCP) and how they can contribute to LAs wider health, social and economic responsibilities; and
    b. maximise opportunities for joint working between NHS England and LAs in order to provide service stability, the joint agreement of 0-5 public health services contracts for 2015-16 and the novation of contracts across the transfer period, possibly up to March 2017.

4. However, given the local accountability structures, such as the PHOF, some LAs may not be fully incentivised to prioritise health visiting services that offer additional benefits at the national level. As a result, full autonomy in 0-5 public health commissioning decisions by LAs risks sub-optimal public health outcomes at the local and national level.

5. Therefore, in 2014 the Government announced its intention, as part of making clear its commitment to health visitor transformation and expansion, to mandate the provision by each LA of specific HCP opportunities to deliver the universal elements of the HCP. These are:
    a. currently identified in a Section 7A agreement Service Specification[1] with NHS England; and,
    b. have been highlighted as due to transfer to LAs as part of the transfer of 0-5 commissioning responsibilities.

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[1] Service specification No.27 - Children's public health services (from pregnancy to age 5), (November 2013)

6. In summary, these areas are the provision of:
   a. Antenatal health promoting visits;
   b. New baby review;
   c. 6-8 week assessment;
   d. 1 year assessment; and,
   e. 2-2½ year review.

7. Health visitors lead delivery of the HCP, this is a prevention and early intervention public health programme that lies at the heart of the universal service for children and families and aims to support parents at this crucial stage of life, promote child development, improve child health outcomes and ensure that families at risk are identified at the earliest opportunity.

8. Each of the opportunities listed at (6) above are part of the HCP schedule, involve to varying degrees the leadership of, or delivery by, health visitors and provide a range of checks, assessments and opportunities for advice and support to parents and families. The checks can also be delivered by family nurses as part of the Family Nurse Partnership programme.

9. In addition to specifying these services, we are also seeking to specify, where appropriate, that these services are led by or delivered by a health visitor. Doing so will further support the Government's goal of achieving an extra 4,200 full time equivalent health visitors by April 2015 by providing increased opportunity for service stability before, during and after the transfer. These services will be expected to be delivered at the level at which their commissioning is transferred to LAs on 1 October 2015. And there is an expectation that LAs will act with a view to securing continuous improvement.

10. This approach will address the problem we are seeking to resolve, but will still allow LAs the flexibility to organise the delivery of the mandated services and freedom to determine how best to commission other elements of 0-5 public health services that we are not seeking to mandate.

11. Mandation of these elements of the HCP will help ensure the ongoing provision of the universal health visiting service, which is essential to supporting the health and well-being of families and children at a critical stage of development. The universal services under consideration are not currently being delivered at 100% coverage across the country, and mandation of these services does not impose an absolute requirement on LAs that coverage should be 100%. Nevertheless, it is anticipated that local authorities will want to consider how to use the opportunity presented through the new commissioning arrangement as the basis to further improve coverage and, thereby, outcomes.

12. This combination of LA autonomy in commissioning public health services and ensuring the uniform provision of the above named services will help maximise the total public health benefit to the population.

13. This Impact Assessment directly impacts LAs.

Background – the transfer of public health duties and currently mandated services

14. Public health documents published by the Department of Health, in particular, "*Healthy Lives Healthy People, Update and Way Forward* " [2011], following earlier consultation, already proposed mandating local authorities to provide a small number of services, in conjunction with retaining the majority of the ring-fenced budget for LAs to commission local services as they see best. For example, mandatory functions were mentioned in the White Paper and in the public health reforms update fact sheets[2].

15. In deciding which services to commission LAs are guided by the locally produced Joint Strategic Needs Assessment (JSNA) and the local Health and Wellbeing Strategy. They will assess and report on local public health needs. Both Clinical Commissioning Groups and LAs will then be expected to base commissioning strategies on the local JSNA and Health and Wellbeing Strategy.

16. To measure improvement of their local population's public health, LAs will have to have regard for the PHOF[3]. PHOF is a set of indicators that sets out the desired outcomes for public health and how these will be measured. For example, the PHOF indicator that relates to 'alcohol-related admissions to hospitals' will incentivise the appropriate provision of alcohol services by each LA that are specific to their local population. The process of giving regard to the PHOF is likely to incentivise improvement in each local population's public health and to achieve the best PHOF outcomes in England.

17. The Government wishes, wherever possible, to transfer responsibility and power to the local level, allowing local services to be shaped to meet local needs. But there are some circumstances where a greater degree of uniformity is required.

18. Therefore the Secretary of State is able to require under section 6C of the National Health Service Act 2006, a local authority to exercise public health functions by taking certain steps.

19. The Government consulted[4] on which public health services should be prescribed (or mandated) in this way and subsequently set out principles to guide decisions on which services would be mandated:

    a. services that need to be provided in a universal fashion if they are to be provided at all;
    b. services that the Secretary of State is already under a legal duty to provide a certain service, but in practice intends to delegate this function to local authorities; and,
    c. services that involve certain steps that are critical to the effective running of the new public health system.

20. It was decided therefore to mandate the following functions:

[2] 'Local government's new public health functions.pdf', Department of Health (2011), http://healthandcare.dh.gov.uk/public-health-system/
[3] Public Health Outcomes Framework (PHOF), Department of Health (2012), http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132358
[4] Healthy Lives, Healthy People: consultation on the funding and commissioning routes for public health (December 2010)

a. Sexual health services;
b. Public health advice to commissioners
c. National Child Measurement Programme
d. NHS Health Checks
e. Steps LAs must take to protect the health of their population
f. universal elements of the HCP, which is led by, and largely delivered by health visitors.

21. Functions (a) to (e) were mandated as part of the 2013 transfer to LAs. Mandation of Function (f) had to wait until now as the commissioning of 0-5 services transfers in October 2015.

22. Regulations for (a)-(e) were supported by an Impact Assessment (Mandatory public health functions for LAs to provide on improving the health of their populations [IA: 3095]), link: http://www.legislation.gov.uk/uksi/2013/351/impacts

Background – health visiting and the transfer of public health duties

23. The Coalition Agreement set out the Government's intention to increase the health visitor workforce by 4200 (an increase of 50%) and to transform health visiting services by April 2015. In April 2011 a four year transformational programme commenced that set out to deliver the Coalition intention. The aim was to secure a health visiting service that is universal, energised and fit for long-term growth.

24. Health visiting is a public health duty and belongs in the category of children's 0-5 public health services. Under the NHS Act 2006, as amended by the Health and Social Care Act 2012, from April 2013 unitary and upper tier LAs were given a duty to take appropriate steps to improve the health of their populations. The LAs are free to decide which services to commission that target the public health needs of the local population using their ring-fenced public health budget.

25. However, the Government deferred the transfer of 0-5 public health commissioning because it believed that the commitment to raise numbers of health visitors and transform the service by 2015 would be best achieved through NHS commissioning. Therefore NHS England should lead commissioning in this area in the short-term.

26. A commitment was made that the Government would complete the transfer of 0-5 public health commissioning responsibilities in 2015. Subsequently a decision was made in December 2013 on the date for the transfer from NHS England to LAs to take place. This has been announced as 1 October 2015.

27. In the interim (i.e. since April 2013) the Secretary of State, through the Section 7A agreement held with NHS England, has agreed that NHS England should commission children's 0-5 public health services.

28. The precise amount of funding that will transfer into local authorities has not been finalised yet. A Baseline Allocation Exercise was published on 11 December 2014 with almost final funding figures for each LA for 2015/16 from October 2015. Work is underway to finalise these and the expected transfer amount for **half year** from Oct 2015 to end March 2016 is likely to be in the region of £425m.

Description of options considered (including do nothing)

Option 1 - No change - there are no requirements on which 0-5 children's public health services LAs commission, (ie. it is transfer of the role without mandate).

29. LAs have full autonomy in spending the additional funding for commissioning children's 0-5 public health services that will be transferred into their ring-fenced public health budget on services that are locally identified as best targeting the local population's public health needs. There are no requirements on which services they are to deliver.

30. There are mechanisms that will help ensure that local needs are addressed within a national policy framework. A local JSNA and Health and Wellbeing Strategy will be written in each LA to help identify local public health needs and therefore help guide LAs in deciding which services to commission. The achievement of each LA in improving their local population's public health will be shown by the PHOF indicators, which each LA will have to give regard to. The indicators for each LA will be published annually by Public Health England. These mechanisms justify the default position of giving LAs full autonomy in commissioning services with the ring-fenced public health budget to best address local public health needs.

Option 2 – A small number of 0-5 HCP opportunities are mandated for all LAs to provide, whilst LAs retain autonomy in commissioning other 0-5 public health services in the light of local need, as is already in place for existing LA public health responsibilities.

31. LAs are mandated to take steps to maintain the provision of key universal elements of health visiting services from October 2015. The mandated functions will support ongoing delivery of universal health visiting services thus providing substantial additional benefits to society when provided to all.

32. Mandating these functions will increase the ear-mark from approximately 27% of the total budget to a maximum of 31% in 2015/16. This ensures that LAs retain autonomy over which services to commission locally with at least 69% of the ring-fenced budget.

33. Description of the mandatory HCP checks and assessments

    a. Antenatal health promoting visits;
    Promotional narrative listening interview. Includes preparation for parenthood.

    b. New baby review;
    Face-to-face review by 14 days with mother and father to include:
    - *Infant feeding*
    - *Promoting sensitive parenting*
    - *Promoting development*
    - *Assessing maternal mental health*
    - *Sudden Infant Death Syndrome*
    - *Keeping safe*

    c. 6-8 week assessment;
    Includes:
    - *On-going support with breastfeeding involving both parents*
    - *Assessing maternal mental health according to the National Institute of Health and Care Excellence guidance*

d. 1 year assessment;
   Includes:
   - *Assessment of the baby's physical, emotional and social development and needs*
   - *Supporting parenting, provide parents with information about attachment and developmental and parenting issues*
   - *Monitoring growth*
   - *Health promotion, raise awareness of dental health and prevention, healthy eating, injury and accident prevention relating to mobility, safety in cars and skin cancer prevention*

e. 2-2½ year review
   Includes:
   - *Review with parents the child's social, emotional, behavioural and language development using ages and stages questionnaire*
   - *Respond to any parental concerns about physical health, growth, development, hearing and vision*
   - *Offer parents guidance on behaviour management and opportunity to share concerns*
   - *Offer parent information on what to do if worried about their child*
   - *Promote language development*
   - *Encourage and support to take up early years education*
   - *Give health information and guidance*
   - *Review immunisation status*
   - *Offer advice on nutrition and physical activity for the family*
   - *Raise awareness of dental care, accident prevention, sleep management, toilet training and sources of parenting advice and family information*

Monetised and non-monetised costs and benefits of each option (including administrative burden)

Option 1

Costs of Option 1

34. There are no expected financial costs associated with Option 1. As Option 1 is the baseline case, the costs are defined as zero, and the public health services will be delivered using an already identified £3.0bn ring-fenced budget, with £0.6bn of this delivered on previously mandated services as defined above.

Benefits of Option 1

35. Local populations will benefit from Option 1 because LAs will have complete freedom in determining where and how to spend the additional funds they receive for children's 0-5 public health services

Risks and assumption of Option 1

36. Assumes that the JSNA and the joint Health and Wellbeing Board correctly assess the public health needs of children aged 0-5 and effectively commission such services. This

assumption is based on the basis that local health professionals are best placed to identify their needs, which are specific to local demographics.

37. There is a risk that some LAs, JSNAs or Health and Wellbeing Boards do not correctly assess needs and that LAs do not commission effectively. In particular a reduction in delivery of the universal reviews would impact on the public health of the local population.

Option 2

38. The following section describes the expected costs and benefits of option 2 based on analysis conducted by the Department of Health. A possible method of sourcing evidence for this analysis would have been to contact LAs directly to better understand how option 2 affects them. However, given that LAs have not currently finalised which public health services they will decide to commission from October 2015 and their commissioning decisions are therefore unknown this is not information upon which to drawn estimates of more exact and quantified costs and benefits.

Costs of option 2

39. As under option 1, the LAs will receive an increase in their ring-fenced public health budget for commissioning their new responsibility for children's 0-5 public health services. This is not an additional cost of option 2 as it is an already contained within the identified ring-fenced budget.

40. Option 2 will ear-mark a proportion of this additional funding for spend on the mandatory functions outlined above. The Department of Health estimates the maximum spend to deliver the mandated functions to be around £366m full year cost (based on 2014 prices – see table below). This is an estimate of the time costs of a health visitor or equivalent delivering the five mandated checks to <u>every</u> eligible pregnant mother or child, ie 100% delivery of the mandated services, (an approximate breakdown of spend on each mandated function outlined below). In reality the actual coverage of each of the mandated functions will vary and is likely to be below 100%.This figure is therefore provided for <u>illustrative purposes</u> and does not imply that this is the case for each authority. In practice the costs of delivery of the 5 mandated functions will be full funded within the funds transferred to LAs. There is therefore no direct financial cost to *mandating* the local authorities to provide the identified mandatory functions and hence the monetised financial cost of option 2 is zero.

Function	**Number of hours**	**HV cost per hour**[1]	**Population (000s)**[2]	**Total (£m)**
Antenatal review	1	76	692	52.6
New baby review	2	76	692	105.2
6-8 weeks check	1	76	692	52.6
1 year review	1	76	689	52.4
2 to 2.5 years review	2	76	683	103.8
Full year total cost				**366.6**

[1] Source: PSSRU Unit Costs of Health and Social Care 2014, p 189.
[2] Source: ONS Birth and Population Projections. 2012-based Subnational Population Projections with Components of Change (Births, Deaths and Migration) for Regions and Local Authorities in England (Table 5), and 2012-based sub-national population projections (Table Z08).

41. The non-monetised cost associated with option 2 is an opportunity cost. That is, the benefits foregone by not implementing option 1. The mandated functions may be different from those that the LAs would choose to commission under option 1. The opportunity cost is the

benefits under option 1 foregone because of the decision to implement option 2. However, this displacement is thought to be small. This is because, whilst LAs commissioning decisions are unknown, they are likely to commission services similar to the mandated functions. Mandating them helps minimise the risk that any of these services are under-provided to any degree. In addition, the LAs will still be able to implement their highest priority services with the remaining ring-fenced budget. The opportunity cost of option 2 is therefore estimated to be small.

Benefits of Option 2

42. The local populations' benefits from LAs retaining the majority of their ring-fenced budget to commission services that directly target their needs. In addition, the local and national population benefit from ensuring the provision of a service that helps deliver an effective and coherent national public health system. The combination of these will help maximise the public health benefit experienced by the entire population.

43. The benefit of option 2 as compared to option 1 is unknown given that it is not possible to know the benefits accrued by LA commissioning decisions under option 1 compare to option 2 with the earmarked figure. This section therefore qualitively describes the gross benefits of option 2 because the incremental benefits on top of option 1 are unknown. In addition, quantative gross benefits are not possible to calculate for the same reason. Example scenarios are therefore presented to show the potential benefits of mandating these functions.

44. These are presented as a qualitative description of gross benefits of the functions as a whole rather than the total incremental benefits as compared to option 1. This is because the local commissioning decisions of the LAs under both option 1 and option 2 are unknown. As a result, the incremental benefits of option 2 are unknown.

45. What happens early in a baby's life, including the first few weeks, affects its development and future outcomes. How the baby's parents make the transition to their new role also has an effect. Each of the five mandated services, and carried out by Health Visitors or family nurses, provides an opportunity to give support and advice to parents and promote positive parenting, health behaviours, emotional attachment and bonding.

46. Mandation of these reviews/assessments/checks ensures continuity and stability of the universal services during the transition period. As well as the benefits of these services, set out below, ensuring coverage of the universal service will have an cumulative effect, as the provision of universal services will lead to families being identified who require the Universal Plus Services (offered to families with children aged 0-5 with specific issues) and Universal Partnership Plus Services (offered to families with children aged 0-5 with complex needs). Benefits of the provision of the higher tier of services will then also be seen.

Risks and assumption of Option 2

47. Mandation of the identified opportunities may prevent or discourage innovation by LAs – for example by limiting some of the flexibility to find completely new ways of using the skill mix and resources to provide services to this group.

48. This option assumes that the JSNA and the joint health and well-being strategy correctly identify the public health needs of the local population, which the LAs will act upon when commissioning services. This assumption is made on the basis that local health

professionals, who assist with the JSNA and the strategy are best placed to assess the local population's needs.

49. The Impact Assessment's costings related to the funding to be made available to local authorities are for 2015/16, (Eg at paragraph 28). As with wider public health funding etc, full year funding for 2016/17 and thereafter will be subject to the next Spending Review settlement.

Rationale and evidence that justify the level of analysis used in the Impact Assessment (proportionality approach)

50. The five universal checks are taken from the Healthy Child Programme, an evidence-based public health programme which can be found here:

    https://www.gov.uk/government/publications/healthy-child-programme-pregnancy-and-the-first-5-years-of-life

Direct costs and benefits to business calculations (following One-In, Two-Out (OITO) methodology)

51. There are no direct impacts on businesses under option 2. The OITO implication is therefore zero.

52. There will be an indirect impact on businesses given that option 2 will impact on the services that are commissioned by the LAs. Whilst commissioning of the mandated services will be ensured for 18 months, the other services delivered are decided by each individual LA and are currently unknown. The impact on local businesses is therefore indirect and unknown.

Wider impacts (consider the impacts of your proposals, the questions on pages 16 to 18 of the Impact Assessment Toolkit are useful prompts. Document any relevant impact here and by attaching any relevant specific impact analysis (e.g. small and medium enterprises (SME) and equalities) in the annexes to this template)

Equality Analysis

53. The Equality Analysis is being developed and will be published in due course.

SMEs

54. Under option 1 it is unknown what the impact on SMEs will be because it is not known what services each individual LA will decide to commission compared to what is already being delivered.

55. Under option 2 there will be a degree of secured commissioning across the country, within each LA. Ensuring the continued delivery of the prescribed functions, through mandation, makes it more likely that any small and medium organisations that currently provide the services will continue to do so.

Environmental impacts

56. There are not expected to be any impacts on greenhouse gas emissions, energy use, carbon dioxide changes or wider environmental issues as a result of this policy.

Health impacts

57. The combination of locally commissioned services and a small number of mandated services across all LAs under option 2 will help maximise the total public health benefits to the population.

Summary and preferred option with description of implementation plan.

58. The preferred option is option 2. This will help maximise the total public health benefit of the population, and ensure continuation and stability of service provision. It does so by providing LAs with considerable autonomy in commissioning services that best meet the public health needs of the local population, whilst ensuring uniform and universal provision of services that provide an additional benefit when provided nationally. The LAs will retain at least an estimated 68% of the total £3.0bn ring-fenced public health budget, whilst a maximum of 11% of the budget is allocated to the mandated functions outlined above, and 20% allocated to the functions mandated from April 2013.

59. This policy will be implemented by mandating LAs to provide the services stated as mandatory from October 2015. The Regulations have a sunset date of 30 March 2017 written into them. The mandated functions will then cease to be mandated 18 months after the commissioning of 0-5 services are transferred to LAs, unless, following a review during the mandated period and after 12 months, the Government decides otherwise and amends the Regulations.

60. The policy objectives will be evaluated and reviewed as set out in the Post Implementation Review detailed in the Annex of IA3095.