Title: Mandatory public health functions of local authorities to provide health visiting services to children aged 0-5 **IA No:** DH3167 **RPC Reference No:** N/A **Lead department or agency:** Department of Health **Other departments or agencies:**	**Impact Assessment (IA)** **Date:** 01/01/2016 **Stage:** Final **Source of intervention:** Domestic **Type of measure:** Primary legislation **Contact for enquiries:** Dorian Kennedy

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** (EANDCB in 2014 prices)	**One-In, Three-Out**	**Business Impact Target Status**
£m	£m	£m	Not in scope	Not a regulatory provision

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

The commissioning of children's 0-5 public health services transferred to Local Authorities (LAs) on 1 October 2015. The universal health and development assessment and reviews that form part of the 0-5 services were mandated, but this mandation is due to expire 31/03/17. There is a risk that some LAs will reduce these services if mandation is not extended and that this may result in a sub-optimal allocation of resources which does not maximise public health. Extending mandation would ensure the ongoing provision across all LAs of a universal service that supports health and well-being of families and children at a critical stage of development.

What are the policy objectives and the intended effects?

The objective of the policy proposal is to maintain the provision of the currently mandated elements of the 0-5 services, so that LAs continue to provide a health visitor led universal health visiting service with the five currently specified visits. Extension of the mandation of these services is intended to ensure that the specified services continue to be provided by all LAs, by obligating them to do so.

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 over 0-5 public health services. LAs can provide these and other non-mandated services in the way they consider to be most effective. This should be considered the preferred option if Ministers believe the potential opportunity costs of mandation outweigh the expected benefits.
Option 2: LAs are mandated to maintain the provision of elements of 0-5 health visiting services, which will support ongoing delivery of universal health visiting services. LAs retain autonomy over which services to commission locally with the ring-fenced budget, aside from what they need to spend to provide mandated services. The expected benefits of the universal health visits are described along with the implications of this for the benefits of mandation. Illustrative examples of the potential opportunity costs of mandation are estimated. This should be considered the preferred option if Ministers believe that the potential benefits of mandation outweigh the potential opportunity costs.

Will the policy be reviewed? It will not be reviewed. **If applicable, set review date:** Month/Year

Does implementation go beyond minimum EU requirements?		N/A		
Are any of these organisations in scope?	**Micro** 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 Nicola Blackwood ***Date:*** 9 February 2017

Summary: Analysis & Evidence

Policy Option 1

Description: Existing Regs – the mandation is allowed to expire and there are no requirements on which 0-5 children's public health services LAs commission.

FULL ECONOMIC ASSESSMENT

Price Base Year 2017	PV Base Year 2017	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 (%)**

There is a risk under this option that some LAs will reduce their provision of the currently mandated 0-5 health visiting services and that this will come at a social and public health cost. LA responses to a questionnaire that formed part of the PHE Review were used to assess the likelihood of this, from this it was assumed that a minority of LAs would make major changes and reduce service provision. Expenditure would be reallocated to other services, which would potentially bring benefits.

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			Score for Business Impact Target (qualifying provisions only) £m:
Costs: 0	**Benefits:** 0	**Net:** 0	

Summary: Analysis & Evidence

Policy Option 2

Description:

FULL ECONOMIC ASSESSMENT

Price Base Year 2017	PV Base Year 2017	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 through mandation. LAs have budgeted £747m for the mandated 0-5 services for 2016-17, equivalent to around 22% of the LAs' Public Health Grant. The cost of Option 1 is the forgone benefit from LAs making their own expenditure and commissioning decisions over these services, such as the forgone benefit from the proportion of the £747m that LAs might spend on alternative services under Option 1. This is unknown but illustrative examples are provided.

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

The IA describes how the cost of Option 2 over Option 1 is the opportunity cost, the foregone benefit of Option 1. LAs' commissioning decisions are unknown under Option 1, it is likely that only a small proportion of the expenditure budgeted for the universal health visits would be reallocated. Potential areas where expenditure could be increased as a result of this are other LA funded areas of Public Health expenditure, such as Stop Smoking Services or Sexual Health Services..

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

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

Because the commissioning decisions of LAs under option 1 are unknown and there is insufficient quantitative evidence on the role of the specific five mandated universal health visits, the benefits of Option 2 over Option 1 could not be quantified.

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

The expected benefits of the mandated universal visits are qualitiatively described. Their expected importance for the identified 6 High Impact Areas is highlighted and evidence around the impact of some of these areas on public health, the health service and wider society is referenced and discussed. The potential incremental benefits over option 1 are also described.

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

There is a risk that LAs would provide better public health services with a better allocation of resources without mandation of the universal 0-5 health visits than with mandation. The opportunity costs could exceed the benefits. Mandating some services restricts LAs flexibility to provide public health services according to their assessment of cost-effectiveness and local need. It is assumed that only a minority of LAs would reduce provision of the currently mandated universal health visits.

BUSINESS ASSESSMENT (Option 2)

Direct impact on business (Equivalent Annual) £m:			Score for Business Impact Target (qualifying provisions only) £m:
Costs: Unknown	**Benefits:** Unknown	**Net:** Unknown	

Evidence Base (for summary sheets)

Problem under consideration and rationale for intervention

1. The main issue is the potential risk that LAs may disinvest in health visiting services if mandation is not renewed. The effect of this could be:

    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. The realisation of opportunities to reduce health and social care needs later in life through information, advice and the identification of the need for further interventions;

        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.

2. 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. The 0-5 health visiting services affect the early period in a child's life and short-run benefits are expected, but many of the benefits are expected to only be seen in the long-run. LAs may focus on the short term impact of the early interventions and underinvest in these services. As a result, full autonomy in 0-5 public health commissioning decisions by LAs may risk sub-optimal public health outcomes at the local and national level.

3. 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 Healthy Child Programme (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.

4. 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.

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

5. The mandation of these areas of provision was subject to review and will expire 31/03/2017. A review was carried out by PHE[2] and the Government proposes to re-mandate these services, this time without a sunset clause requiring further review.

6. Health visitors lead the 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 in need of further intervention are identified at the earliest opportunity.

7. 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.

8. Failure to reinstate the mandated requirements could undermine delivery of the HCP. The 'problem' is set in the wider context of LA commissioners operating in a very challenging financial climate and having to manage significant financial pressures. LAs' year-on-year situation with regard to 0-5 public health funds would not alter at the point at which mandation ends. Nevertheless, LAs' overall public health functions need to fund other services and it is possible that in light of such competing demands, removal of mandation would facilitate potential disinvestment from 0 – 5 public health services – given that the currently mandated elements would no-longer be required.

9. Removal of mandated development checks could also weaken pursuit of national strategic objectives, including reduction of childhood obesity (e.g. by promotion of healthy eating and physical activity).

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. While the services are still health visitor led, some LAs are, for example, varying the skills mix of their workforce delivering these mandated services.

11. This Impact Assessment outlines the potential benefits and potential opportunity costs of mandating these services. If the potential benefits of mandating these services are considered to outweigh the potential opportunity cost then mandation should be extended.

12. This Impact Assessment directly impacts LAs.

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

13. 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

[2] PHE, (2016), Review of mandation for the universal health visiting service

they see best. For example, mandatory functions were mentioned in the White Paper and in the public health reforms update fact sheets.[3]

14. 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.

15. To measure improvement of their local population's public health, LAs will have to have regard for the PHOF[4]. 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.

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

17. 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.

18. The Government consulted[5] 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.

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

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

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

21. 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

22. 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.

23. 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 (under the auspices of the National Health Visitor programme), would be best achieved through NHS commissioning.

24. A commitment was made that the Government would complete the transfer of 0-5 public health commissioning responsibilities in 2015, with NHS England leading commissioning in the short-term.

25. In an interim arrangement (April 2013 onwards), NHS England commissioned children's 0-5 public health services via a Section 7A agreement held between the Department and NHS England. By December 2013 the date for the transfer from NHS England to LAs was agreed as October 2015.

26. 0 – 5 years public health funding was transferred into local authorities on a 'lift and shift' basis, with a baseline allocation exercise (December 2014), setting out funding figures for each LA for 2015/16 from October 2015.

27. Responsibility for commissioning health visitor services transferred to local authorities on 1 October 2015, as part of the transfer of commissioning of public health services for children aged 0-5. Regulations: 2015 No.921; The LA (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) and LA (Public Health, Health and Wellbeing Boards and Health Scrutiny) (Amendment) mandated five key child health reviews, led by health visitors (HV), to ensure the ongoing provision of a service essential to health and wellbeing of families at the critical stage of development. A 'sunset' clause was included - meaning Regulation ceases 31/03/17.

Description of options considered (including do nothing)

Option 1 – Existing Regs – the mandation is allowed to expire and there are no requirements on which 0-5 children's public health services LAs commission.

28. LAs have full autonomy in spending the funding for commissioning children's 0-5 public health services that forms part of their ring-fenced public health budget. It is assumed that LAs will spend it on services that are locally identified as best targeting the local population's public health needs. There are no requirements on which 0-5 services they deliver.

29. There are mechanisms that will help ensure that local needs are addressed within a national policy framework. An annual 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 – The small number of 0-5 HCP opportunities that are currently mandated for all LAs to provide are re-mandated.

30. LAs are mandated to maintain the provision of key universal elements of health visiting services from April 2017. The mandated functions will support ongoing delivery of universal health visiting services.

31. These mandated services were provided by LAs for the half year in 2015-16 from October 2015 at a cost of £402m.[6] LAs have budgeted £747m to deliver them in 2016-17, this represents around 22% of the Public Health Grant to LAs and 83% of expenditure on 0-5 Public Health services provided by LAs.[7]

32. 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*

[6] Net current expenditure. Source: Local authority revenue expenditure and financing England: 2015 to 2016 individual local authority data – outturn, Revenue outturn social care and public health services (RO3) 2015 to 2016, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/569808/RO3_2015-16_data_by_LA.xlsx

[7] Net current expenditure. Source: Local authority revenue expenditure and financing England: 2016 to 2017 budget individual local authority data, Revenue account (RA) budget 2016 to 2017, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/532962/RA_2016-17_data_by_LA.xlsx

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

33. As option 1 is the baseline case, the costs relative to the baseline case are defined as zero.

Benefits of Option 1

34. As option 1 is the baseline case, the benefits relative to the baseline case are defined as zero.

Risks and assumptions of Option 1

35. LA commissioning decisions under option 1 are unknown. Some LAs may reduce delivery of the universal reviews. This reduction, and how these LAs allocate the funding freed up by

this, would impact on the public health of the local population. 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.

36. The PHE Review asked for recommendations on the future of the mandation of these services. LA responses were from LA Chief Executives, Directors of Public Health, Directors of Children's Services and LA Commissioners. Of the LA respondents, most recommended mandation should be extended in its current form or in a revised form (Table 1). The respondents were also asked the reasons for their recommendations.

Table 1: Local Authority respondents' responses to the question: "Existing legislation, mandating the five universal health visitor reviews are delivered for every child, is due to expire at the end of March 2017. What would you recommend happens next?"

Mandation is extended in its current form	Mandation is extended by in a revised form	Mandation is allowed to expire as planned	Don't know
44%	42%	13%	1%

Source: Table 13, Review of mandation for the universal health visiting service, PHE, 2016.

37. LA respondents who recommended that mandation be allowed to expire largely cited that service innovation is inhibited, the restriction on service flexibility and that there is no assurance of service quality, which suggests they would like to make some changes. Around 10% of LA respondents who recommended allowing mandation to expire thought that the service was not sustainable, which could imply they would reduce the services provided in the absence of mandation.[8]

38. Of the LA respondents who thought that mandation should be extended but in a revised form, around 10% of respondents suggested that contacts should be revised or reduced and around 10% that the timings of contacts should be revised or relaxed. More popular responses actually suggested mandating more contacts. LAs have the flexibility to add more visits, if they believe that this would be an effective use of resources, under option 2 as well as option 1. The most popular response was around integration with other services and reduced duplication.[9]

39. LAs were also asked about their future commissioning intentions. The most popular responses to this question were around increasing the skill mix of their workforce and increased integration of services. Around 13% of respondents said that they planned to reduce investment in these services.[10] However, given that it was not specified whether this was in the context of continued mandation or not, this should be treated with caution in assessing the difference between options 1 and 2. Given the financial pressures they face, some LAs are likely to reduce expenditure on these services with or without mandation, such as through increasing the skills mix of the workforce or improving efficiency.

40. In addition to this, the PHE Review also asked about the importance of the universal visits to the delivery of the benefits of the Healthy Child Programme 0-5 years. The majority of LA respondents thought that they were important for these selected areas, with only a small

[8] Figure 17 in: PHE, (2016), Review of mandation for the universal health visiting service

[9] Figure 16 in: PHE, (2016), Review of mandation for the universal health visiting service

[10] Figure 23 in: PHE, (2016), Review of mandation for the universal health visiting service

proportion thinking that they were not important (Table 2). The most popular responses for each area were “extremely” and “very” important. This suggests LAs do consider these services to be important. This is further supported by the responses to questions on whether the universal reviews are important for escalating safeguarding concerns and for child protection (Table 3) and whether they deliver a positive return on investment (Table 4). LA respondents indicated that they thought the universal visits were important for these areas and a majority believed they have a positive return on investment.

Table 2: Summary of Local Authority respondents’ responses to the question: “How important do you think the universal health visitor reviews are to delivering the benefits of the Healthy Child Programme 0-5 years in the following areas?”

	Extremely	Very	Somewhat	Not so	Not at all	Don’t know
Transition to parenthood – healthy lifestyle	48%	37%	10%	2%	0%	2%
Transition to parenthood- contraceptive and sexual health advice	29%	34%	25%	8%	1%	3%
Transition to parenthood – smoking cessation	44%	36%	14%	3%	0%	2%
Transition to parenthood – secure attachment and bonding	70%	22%	6%	0%	0%	2%
Maternal mental health	71%	23%	4%	0%	0%	2%
Breastfeeding	57%	33%	7%	1%	0%	2%
Healthy weight	45%	39%	12%	2%	0%	2%
Managing minor illnesses and accident prevention	42%	36%	18%	2%	0%	2%
Healthy 2 year olds and school readiness	57%	28%	12%	1%	0%	1%

Source: Table 24 in: PHE, (2016), Review of mandation for the universal health visiting service

Table 3: Summary of Local Authority respondents’ views on the importance of the universal visits to the following areas (284 responses)

	Extremely	Very	Somewhat	Not so	Not at all	Don’t know
Escalation of safeguarding concerns	57%	28%	12%	0%	0%	2%
Child protection	54%	32%	11%	0%	0%	3%

Source: Tables 25-26 in: PHE, (2016), Review of mandation for the universal health visiting service

Table 4: Local Authority respondents’ responses to the question: “To what extent do you believe the universal health visitor reviews deliver a positive return on investment?” (284 responses)

Positive (i.e. save more money than they cost)	Neutral (i.e. save about the same as they cost)	Negative (i.e. cost more than they could save)	Don’t know
68%	8%	4%	21%

Source: Table 27 in: PHE, (2016), Review of mandation for the universal health visiting service

41. The LA respondent's answers to these questions enable us, to an extent, to assess: the importance LAs attach to the universal visits, their attitude to mandation and the likelihood that they will make major changes to these services.

42. Overall the findings in the PHE Review suggest that only a minority of LAs would make major changes to reduce provision of the mandated services, but this does mean that there are some that might do, such as through reducing the number of contacts. LAs have had to reduce their expenditure and as part of this LAs may wish to reduce expenditure on the universal health visits as well as other services. This seems to already be planned with mandation in place, through plans to increase skill mix and efficiency. However, with mandation removed some LAs may also reduce provision of the currently mandated 0-5 services in order to reduce expenditure further.

43. For the purposes of this IA it is assumed that expenditure on the 0-5 health visits will reduce under option 1 because a minority of LAs reduce their provision of the mandated services. These LAs might do this by providing one fewer visit for example. It is assumed that these LAs would reallocate this expenditure to other Public Health services where they assess there to be a greater local need or rate of return.

Option 2

44. The following section describes the expected costs and benefits of option 2.

Costs of option 2

45. As under option 1, LAs will receive a ring-fenced public health budget from which their commissioning of children's 0-5 public health services will be funded.

46. Under option 2 LAs are mandated to provide the 5 universal health visits outlined above, this effectively ear-marks a proportion of the LA budget for spending on these mandatory functions. Net current expenditure by LAs on these mandated functions was £402m for the half year period in 2015-16 (from October 2015) after the transfer of responsibility for these services. LAs have budgeted £747m to provide the mandated 0-5 functions for the full 2016-17 financial year. In practice the costs of delivery of the 5 mandated functions will be fully 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.

47. The cost associated with option 2 is an opportunity cost. The mandated functions may be different from those that the LAs would choose to commission under option 1. Mandating that LAs provide and therefore fund the cost of these universal visits means that LAs are unable to reduce them in order to increase expenditure on other services. While free to add extra visits, they are also unable to change these five mandated visits if they consider this to be in the best interests of public health.

48. When reducing their total expenditure, LAs might wish to reduce expenditure across the board. Mandating some areas of expenditure limits LAs' flexibility to do this by limiting the expenditure reductions that can be made in these mandated areas. It is expected that LAs would still provide 0-5 health visiting services under option 1, but that some LAs may reduce provision and not provide them in the way the mandation requires. Some LAs might reallocate some of this expenditure to other services. The opportunity cost of option 2 is the

foregone benefit of these potential changes, including from any increases in expenditure on other services. LAs might increase expenditure on cost-effective services that would benefit public health. There may also be benefits from a different set of visits being provided and greater flexibility to tailor services according to perceived need. Some of the health service and health visitor respondents to the PHE Review talked about the prescriptive application of mandation reducing the ability to use professional judgement to respond flexibly to individual family needs. These respondents supported the idea of providing more visits to families in need of support and potentially less to those assessed not to be in need.

49. As outlined under option 1, LAs are considered likely to commission services similar to the mandated functions. It is therefore expected that under option 1 LAs will spend the majority of what they have budgeted for the 0-5 services on those services. Some LAs may reduce the provision of these services however, such as through reducing the number of visits. They may also change the visits provided.

50. The annual cost to LAs of providing the mandated 0-5 health visits can be quantified from their 2016-17 budgeted expenditure of £747m. We would expect LAs to still spend the majority of this on these services under option 1. As an illustrative example we provide estimates of some of the potential opportunity costs of mandation if under option 1 LAs spent 5% of this (£37m) on other public health services. This could be through, for example, 25% of LAs reducing the number of visits from 5 to 4, assuming that the removal of one visit reduces expenditure by 20%. We estimate some of the benefits that could result if LAs spent this on either stop smoking services or sexual health services using a DH model. These are other public health services provided by LAs and were thought to represent good examples of alternative areas that LAs might allocate some of this expenditure. If LAs spent 5% of what they have budgeted for the 0-5 mandated health visits on stop smoking services then it is estimated that this could result in up to about 30,000 extra smokers quitting, with a health gain of around 36,000 discounted QALYs. This is likely to be an overestimate as it assumes a linear relationship between expenditure and the number of smokers quitting. Alternatively, if this was spent on sexual health services it is estimated that this could result in a reduction in NHS costs resulting from unplanned pregnancies and STI treatment of about £40m. This estimate does not include other benefits of Sexual Health services. These are purely illustrative examples of some of the potential opportunity costs of mandation. We do not know how much LAs might reduce expenditure on the mandated 0-5 services, it might not be as much as this, and we do not know where they would reallocate this spending. LAs were not asked as part of the PHE Review what their commissioning and expenditure decisions would be if mandation was allowed to expire.

Benefits of Option 2

51. The benefit of option 2 as compared to option 1 is unknown because LA commissioning decisions under option 1 are unknown. There is also insufficient quantitative evidence of the impact of these five mandated visits. This section therefore qualitatively describes the gross benefits of option 2 and to an extent the possible incremental benefits relative to option 1 if LAs were to reduce certain elements of the 0-5 universal visits in option 1.

Benefits of the universal 0-5 services

52. What happens early in a baby's life, including the first few weeks, affects its development and future outcomes for the rest of their life.[11] [12] How the baby's parents make the transition to their new role also has an effect. Each of the five mandated visits provides an opportunity to provide support and advice to parents and promote positive parenting, healthy behaviours, emotional attachment and bonding.

53. There is limited quantitative evidence of the impact of health visitors and in particular the specific 5 mandated visits themselves. National data on health outcomes indicators relating to 0-5 years is monitored on an ongoing basis in PHE's early years' profiles since the start of the health visitor improvement programme in 2010. 2014/15 is generally the most recent year of annual data, so the change in these outcomes since the transfer of responsibility to LAs cannot yet be assessed. Even when this data becomes available, it would not be possible to reliably attribute any changes to mandation. Improved outcomes could mean that mandation is successful or that LAs make effective decisions and mandation is unnecessary. The PHE Review analysed the trends in these indicators since 2010 and found that during this period of sustained investment in health visiting many of these indicators improved. At national level there have been falls in the rates of teenage pregnancy, smoking in pregnancy, infant mortality, excess weight and hospital admissions for injury, and an increase in coverage of the MMR vaccination. This is only correlation however and these improvements are not necessarily directly attributable to the health visiting service. There has been some rise in rates of attendance at A&E and falls in rates of breastfeeding at 6-8 weeks. It should be noted that increases in A&E attendance rates have been seen in all age groups and is thought mainly be due to structural factors within the NHS. Maternal decisions around breastfeeding have many influences and breastfeeding rates in England compare unfavourably internationally.

54. Six early years High Impact Areas (HIAs) were identified for children's public health services, these are described in documents that were developed to support the transition of commissioning to LAs and help inform decisions on commissioning and integrating the health visiting services.[13] The early years HIAs describe areas where the universal visits are considered to have an important impact on health and wellbeing and improving outcomes for children, families and communities. The vast majority of respondents to the question in the PHE Review on the importance of the mandated health visits for the high impact areas considered that they were important, only a small proportion thought they were unimportant. This was true across respondent groups: LA responses are shown above in Table 2 while health services and health visitor respondents were even more positive in their responses.[14]

55. The six early years HIAs are:
    a. Transition to parenthood and the early weeks
    b. Maternal mental health
    c. Breastfeeding (initiation and duration)
    d. Healthy weight, healthy nutrition (to include physical activity)
    e. Managing minor illnesses and reducing hospital attendance/admissions

[11] Department of Health, (2016), Early Years High Impact Area – Transition to parenthood

[12] Department of Health, (2009), Healthy Child Programme: Pregnancy and the first five years

[13] PHE, (2016), Overview of the six early years and school aged years high impact areas

[14] Table 24 in: PHE, (2016), Review of mandation for the universal health visiting service

f. Health, wellbeing and development of the child aged 2: Two year old review (integrated review) and support to be 'ready for school'

56. The first visit can be used to provide advice on preparing for parenthood and the earlier visits for advice on infant feeding, breastfeeding and promotion of sensitive parenting and safety. The visits allow monitoring of and advice around maternal mental health, healthy weight and child development. Information and advice is also provided on childhood immunisations and reducing accidental injuries and minor illnesses and their associated hospital attendances and admissions. The last visit is at age 2-2½, which is considered to be an important stage when problems such as speech and language delay, tooth decay or behavioural issues become visible.[15] This visit is also used to provide toilet training and other advice around child development and school readiness.

57. The 5 mandated reviews form a structured base through which health visitors lead the wider 0 – 5 years PH workforce in delivering the HCP. The universal visits are considered to be the minimum service requirement for this and provide useful contact with parents and children before the children start school. In comparison to selective visiting, universality provides a consistent national service and may ensure that the service is non-stigmatising for families. Universality is also seen as important so that the visits can aid in the early identification of mothers, children and families in need of further interventions.[16] For example, the identification of the need for mental health interventions. Health visitors enable timely access to other services through this and refer cases to the appropriate services.[17] Evidence-based targeted interventions and programmes can then be used where need is identified.

58. Early intervention has been shown to be important for improving short and long term outcomes[18] and to have high rates of return.[19] The Marmot Review[20] advocated 'proportionate universalism' to address health inequalities, with a service available to everyone but with additional services for those with greater needs.

59. Studies have shown that breastfeeding has a role in reducing obesity[21] and can create NHS savings through reduced infections.[22] Breastfeeding has also been found to be important for cognitive development, with breastfed children one to six months ahead of those who were never breastfed.[23] Health visitors are considered to have an important role in supporting breastfeeding.[24]

60. The healthy weight element to health visits and the role of breastfeeding in reducing obesity mean that the universal health visits have a role to play in meeting the Government objective

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[15] PHE, (2016), Early years high impact area 6: health, wellbeing and development of the child aged 2

[16] PHE, (2016), Overview of the 6 early years and school aged years high impact areas

[17] Cowley, S., et al., (2013), Why health visiting? A review of the literature about key health visitor interventions, processes and outcomes for children and families, National Nursing Research Unit, London: Kings College London

[18] PHE, (2015), Rapid review to update evidence for the healthy child programme 0 to 5

[19] Heckman, J., (2008), Schools, skills and synapses, Economic Inquiry 46 (3) 289-324

[20] Marmot, M., (2010), Fair Society, Healthy Lives: Strategic review of health inequalities in England post-2010, London: The Marmot Review

[21] McCrory, C., and Layte, D.R., (2012) Breastfeeding and the risk of overweight and obesity at nine years of age, Social Science and Medicine, doi: 10.1016/j.socscimed.2012.02.048

[22] Pokhrel, S., et al., (2015), Potential economic impacts from improving breastfeeding rates in the UK, Arch Dis Child, 2015;100:334-340

[23] Quigley, M.A., et al., (2012), Breastfeeding is associated with improved child cognitive development: a population-based cohort study, J Pediatr. 2012 Jan;160(1):25-32

[24] Cowley, S., et al., (2013), Why health visiting? A review of the literature about key health visitor interventions, processes and outcomes for children and families, National Nursing Research Unit, London: Kings College London

of reducing childhood obesity. In 2015 28% of children aged 2-15 were either overweight (14%) or obese (14%), with children from lower income households more likely to be obese.[25] Health visitors can provide information and advice to parents in relation to their children's weight.

61. In the postnatal period, maternal mental health can affect the quality of parent-child interactions, the socio-emotional development and mental health of the child. Health visitors carry out assessments and advice to help with the identification, prevention and treatment of mental health issues. It has been demonstrated that perinatal mental health problems impose high costs on society, with most of the costs relating to the adverse impact on the child.[26] Some of the main cost areas are health and social care use, loss of quality of life, productivity losses, increased infant deaths, child emotional and conduct problems, special educational needs and leaving school without qualifications. Perinatal mental health problems affect up to 20% of women.[27]

62. Mental health problems often go unrecognised and untreated during pregnancy and the postnatal period. Some women do not seek help as they fear stigma or the intervention by social services. Additionally, the demands of caring for a young child can mean that a woman is unable to attend regular treatment. If untreated, these women can continue to have symptoms that reduce their wellbeing and affect their children and family.[28]

63. Health visitors also provide information on childhood immunisations. These vaccination programmes are cost-effective and deliver an important benefit to public health. The importance of information on vaccination programmes is highlighted by the controversies around the MMR vaccine and the impact that had on uptake, herd immunity and the measles outbreaks that occurred as a result. It is important that herd immunity levels of vaccination are maintained.

64. A child's communication environment is a more dominant predictor of early language than social background is. Children's communication environment and speech and language are an important influence on their performance at school entry.[29] This highlights the importance of a good communication environment for children and ultimately of children's speech and language. Health visitors promote and provide advice on positive parenting and language development. Speech and language and school readiness are part of the focus of the final universal 0-5 health visit. Health visitors can help identify the need for speech and language therapy and provide advice and support to parents. A child's performance at school will affect the rest of their life.

65. Respondents to the PHE Review also regarded the visits as important for safeguarding and child protection. Table 3 shows this for LA respondents, health services and health visitor respondents thought this even more strongly with 89% in each group saying they are extremely important, 8% very important and the rest somewhat important.[30] Cohen et al.

[25] NHS Digital, (2016), Health survey for England 2015

[26] Bauer, A., Parsonage, M., Knapp, M., Lemmi, V., and Adelaja, B., (2014), Costs of perinatal mental health problems, London: London school of Economics and Political Science

[27] PHE, (2016), Early years high impact area 2: maternal mental health

[28] NICE Quality Standard QS115, Antenatal and postnatal mental health, https://www.nice.org.uk/guidance/qs115

[29] Roulstone, S., et al., (2011), Investigating the role of language in children's early educational outcomes, Department for Education, Research Report DFE-RR134

[30] Tables 25 and 26 in PHE, (2016), Review of mandation for the universal health visiting service

(2010) estimated high lifetime costs of child abuse and neglect in the US; the costs include health losses and the costs of increased crime.[31] Abuse and neglect can have a severe impact on people's lives, health visitors can help identify and refer suspected cases.

66. Health visitors can be a trusted source of knowledge, advice and information for parents and can play an important role in reducing the burden on GPs and A&E departments. In universal health visits they raise awareness with parents of common accidents and provide useful and consistent safety advice. On average pre-school children visit GPs 6 times a year and tooth decay is now a leading reason that parents seek medical help and advice. The leading causes of A&E attendances and hospitalisation of under 5s are illnesses like gastroenteritis and upper respiratory tract infections and accidents in the home. The latter is also a major cause of morbidity and premature mortality for children and young people. Inequalities are also present here, there is a strong link between unintentional injury and social deprivation, with children from the most disadvantaged homes more likely to be killed or seriously injured. Children from the poorest social groups are 13 times more likely to die from injury and poisoning.[32]

The implications for the benefit of mandation – the incremental benefit of Option 2 over Option 1

67. Mandation of these reviews/assessments/checks ensures continuity of these universal services. As well as the benefits of these services, ensuring coverage of the universal service 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.

68. The benefits of mandation come through ensuring this national service is maintained, through the value of the visits themselves and through maintaining universal coverage. Universality is intended to aid identification of further need and reduce inequalities. We outlined an illustrative example of the possible opportunity cost of mandation through it preventing LAs reducing provision of the currently universal health visits in order to spend more on other services. Alongside this there would be costs to the health services and public health outcomes through reducing the provision of the 0-5 health visits; the benefit of mandation comes through preventing these costs. It is not possible to demonstrate the impact of the removal of any individual visit. However, given the expected benefits of the visits described above, removal of any of the visits could result in adverse consequences. For example: reduced breastfeeding rates, reduced uptake of immunisations, lower identification of mental health and other issues such as the need for speech and language therapy or safeguarding interventions. Fewer cases may receive the targeted interventions that they need. The potential impact of this could not be quantified, but many targeted early interventions have been shown to be highly effective as they can impact on outcomes over the entire future life of the children. Early interventions also have the benefit of reducing inequalities, as for many of the areas described above there are inequalities across income groups and they affect long term outcomes in the children's lives. For example, as outlined above, childhood obesity is more prevalent in lower income groups and there is a strong link

[31] Cohen, M.A., Piquero, A.R., Jennings, W.G., (2010), Estimating the costs of bad outcomes for at-risk youth and the benefits of early childhood interventions to reduce them, Criminal Justice Policy Review, 21(4) 391-434

[32] PHE, (2016), Early years high impact area 5: managing minor illness and reducing accidents

between unintentional injury and social deprivation. A reduction in the universal health visits may therefore lead to increases inequalities across income groups. There could also be increases in regional inequalities if, in the absence of mandation, some LAs reduced provision of the 0-5 health visiting services while others maintained them.

69. As outlined above, universal coverage is considered to be important for these visits. In 2015-16 there was a statistically significant increase in the eligible population reached by the universal service.[33] This shows that progress in increasing coverage has been maintained under mandation; however it is not possible to say that this increase is attributable to mandation.

Risks and assumption of Option 2

70. Mandation of the currently universal health visits may prevent or discourage innovation by LAs and reduces the flexibility for them to design and deliver these services in the way they consider best. There is a risk that LAs would deliver these and other services in a way that is better for public health outcomes than they would with mandation in place. This means that there is a risk that resources are not being used in a cost-effective a manner relative to option 1, while under option 1 there is a risk of the same relative to option 2.

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

71. The five universal checks form part of 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

72. Due to the lack of availability of quantitative evidence around the impact of the five universal checks, a qualitative description of the expected benefits was provided. Areas where the visits are considered important were identified and evidence on the impact and importance of these for public health and society were referenced. The budgeted cost of the services is known, illustrative examples of the potential opportunity cost of mandation were estimated from this. LAs commissioning decisions in the absence of mandation are unknown, so these examples are purely for illustrative purposes and are not a best estimate of the actual opportunity costs.

Direct costs and benefits to business calculations (following BIT methodology)

73. There are no direct impacts on businesses under option 2. The OI30 implication is therefore zero.

74. 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, 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

[33] PHE, (2016), Review of mandation for the universal health visiting service

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

75. The Equality Analysis of the initial mandation was developed and published at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/410685/Equalities_analysis.pdf

SMEs

76. 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.

77. 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

78. 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

79. The combination of locally commissioned services and a small number of mandated services across all LAs under option 2 will help maintain existing total public health benefits to the population. It is unknown what the effect on public health outcomes would be under LA commissioning decisions in the absence of mandation. It is therefore unknown what the impact on public health of mandation is and the health impacts could not be quantified. Some of the expected health benefits of the mandated health visits have been qualitatively described. Illustrative quantitative examples of the potential opportunity cost of mandation, including in terms of health with the stop smoking services example, were also provided.

Summary and preferred option with description of implementation plan.

80. This Impact Assessment qualitatively describes the expected benefits of the universal health visits and their importance. It also outlines the cost of providing these visits and provides illustrative quantitative examples of the potential opportunity cost that could result from mandation in terms of other Public Health Services. LAs commissioning decisions in the absence of mandation are unknown, so the opportunity cost examples provided were purely for illustrative purposes and are not a best estimate of the actual opportunity costs.

81. If Ministers consider that the qualitatively described benefits and the potential risk to them through not mandating the universal 0-5 health visits outweigh the potential opportunity costs of mandation, then they should agree to extend mandation. If Ministers believe that option 1 would provide greater net benefits then they should reject mandation.

82. The extension of mandation would be open ended without a scheduled review. However, if other mandated services are reviewed in the future, the universal 0-5 health visits would form part of this review.