



Working with children,
for children

Local authorities' role in public health

Briefing for the children and young people's voluntary sector
February 2016

Contents

Introduction	1
Preventative health services and the Healthy Child Programme	2
Pregnancy and 0-5.....	3
School nursing	6
Other public health services	8
Integrating services and functions	10
Funding for public health and preventative services	12
Measuring progress and targeting improvements	13

Introduction

As part of the health reforms brought in by the Health and Social Care Act 2012, local authorities have a duty to take such steps as they consider appropriate for improving the health of the people in their area. The steps listed in legislation include:

- Providing information and advice
- Providing services or facilities designed to promote healthy living
- Providing services or facilities for the prevention, diagnosis or treatment of illness
- Providing assistance to help individuals to minimise any risks to health arising from their accommodation or environment
- Making any other services or facilities available.¹

Local authorities' public health role also includes ensuring that there are plans in place to protect the local population from health threats, including plans for emergencies, preventative measures such as immunisations and screening and monitoring the plans individual providers have in place. They are also required to provide Clinical Commissioning Groups (CCGs) with population health advice, for example supporting the development of joint strategic needs assessments.²

The management of these functions is led by the local authority's Director of Public Health³ in consultation with its Health and Wellbeing Board comprised of Directors of

¹ Section 2B of the National Health Service Act 2006

² As required by regulations made under Section 6C the National Health Service Act 2006

³ Section 73A of the National Health Service Act 2006

Children and Adults Services, health commissioners, elected members of the local authority and other agencies.⁴

These reforms largely commenced in April 2013. However, certain responsibilities for children under the age of five were not transferred to local authorities until October 2015.

This briefing sets out

- The nature of, and policy context for, services that local authorities are responsible for commissioning for children and young people as part of their public health role
- Opportunities for integration with local authorities other functions
- The latest developments in funding for these services
- How children's public health outcomes in local authority areas can be monitored.

Analysis is provided throughout in the **orange boxes** on the implications of current developments for the future shape of services and the voluntary sector's role in supporting children and young people's public health.

What is public health?

The UK Faculty of Public Health (2010) defines public health as: "The science and art of promoting and protecting health and wellbeing, preventing ill-health and prolonging life through the organised efforts of society." Public health activity can be divided into three domains – health improvement, health protection and health services. Public health policy in the UK usually refers to health protection, health promotion and the use of evidence in these areas, as well as preventative health services.

Preventative health services and the Healthy Child Programme

Under their health improvement duty local authorities have taken over responsibility for commissioning a range of services previously commissioned by NHS England and (now defunct) Primary Care Trusts. This includes services specific to children and young people such as health visiting and school nursing as well as other relevant services such as sexual health and substance misuse services.

The Healthy Child Programme is the main universal health service for improving the health and wellbeing of children, through:

- Health and development reviews
- Health promotion
- Parenting support

⁴ See Sections 194-199 of the Health and Social Care Act 2012, Sections 116-116A of the Local Government and Public Involvement in Health Act 2007 and Department of Health (2013) *Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies*

- Screening and immunisation programmes.

The programme is usually considered in two parts, from pregnancy to age five, which is led by health visitors and from ages 5 to 19, which is led by school nurses.

Non statutory guidance⁵ published by a previous government in 2009 sets out a wide range of evidence-based interventions which local authorities or others can choose to commission as well as a number of universal services which are expected or required by regulations. It is designed according to the principle of progressive universalism whereby all children will receive some service but an increased offer will be provided to those that appear to have the most need. More information on how this is delivered for the two age groups is set out in the sections below.

Pregnancy and 0-5

Health visitors lead the Healthy Child Programme 0-5. The programme is offered to all families and core elements include health and development reviews, screening, immunisations, promotion of social and emotional development, support for parenting, and promotion of health and behaviour change. It also provides opportunities for more intensive or extensive work with families who are vulnerable or have additional needs. Consequently the health visiting offer is modelled around four levels (see box 1, below).⁶ This includes the 'five visits' which are mandated, meaning, local authorities are required by regulations⁷ to provide them. These regulations will be in place until April 2017, when the conclusion of a review by the Department of Health and Public Health England, into whether these requirements should continue, is implemented.⁸

A [suite of guidance](#) was published by Public Health England in January 2016 to support commissioning of health visiting and school nursing services.⁹

The National Health Visiting Programme

The Health Visiting Programme started in 2011 as a National programme of work to deliver on the then Government's commitment by 2015 to:

⁵ Department of Health (2009) Healthy Child Programme: Pregnancy and the First 5 Years of Life <https://www.gov.uk/government/publications/healthy-child-programme-pregnancy-and-the-first-5-years-of-life> ; Department of Health (2009) Healthy Child Programme from 5 to 19 years old http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_107566

⁶ Department of Health (2014) *Scope of 0 to 5 public health services transfer* <https://www.gov.uk/government/publications/transfer-of-0-5-childrens-public-health-commissioning-to-local-authorities>

⁷ The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) and Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) (Amendment) Regulations 2015 <http://www.legislation.gov.uk/uksi/2015/921/contents/made>

⁸ Department of Health (2014) *Mandation Factsheet 1: Commissioning the national Healthy Child Programme -mandation to ensure universal prevention, protection and health promotion services* <https://www.gov.uk/government/publications/transfer-of-0-5-childrens-public-health-commissioning-to-local-authorities>

⁹ Public Health England (2016) *Best start in life and beyond: Improving public health outcomes for children, young people and families: Guidance to support the commissioning of the Healthy Child Programme 0-19: Health Visiting and School Nursing services*

- Increase health visitors by 4,200
- Create a transformed, rejuvenated health visiting service providing improved outcomes for children and families with more targeted and tailored support for those who need it.¹⁰

The Programme nearly met its target, with health visitor numbers (full time equivalents) raising from around 8,000 in May 2010 to nearly 12,000 by September 2015.¹¹

[Practice and guidance](#)¹² was developed focussing on six 'high impact areas':

- Transition to parenthood
- Maternal mental health
- Breastfeeding
- Healthy weight
- Managing minor illness & accident prevention
- Healthy 2 year olds & school readiness.

The Programme was delivered in partnership by the Department of Health (DH), NHS England, Public Health England and Health Education England. The requirement for national leadership of this programme is why responsibility for commissioning public health services for children under the age of five was not transferred to local authorities until the programme had completed in October 2015.

Family Nurse Partnership

The Family Nurse Partnership programme (FNP) is a home visiting programme for vulnerable first time young mothers aged 19 and under. It is not mandated, so as of October 2015 is commissioned at the discretion of individual local authorities.

Structured home visits, delivered by specially trained family nurses, are offered from early pregnancy until the child is two. FNP aims to improve pregnancy outcomes, child health and development and parents' economic self-sufficiency. When a mother enrolls on FNP, the Healthy Child Programme, including the five visits, is delivered by the family nurse instead of by health visitors.

FNP is a licensed programme with a well-defined and detailed service model, which must be adhered to.

Access to Family Nurse Partnership has been rolled out across England in the run up to 2015 by NHS England and its predecessor organisations. An [FNP National Unit](#),

¹⁰ Department of Health (2011), Health Visitor Implementation Plan 2011–15: A Call to Action https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213759/dh_124208.pdf

¹¹ NHS England (2015) Indicative Health Visitor Collection (IHVC) September 2015 <https://www.england.nhs.uk/statistics/statistical-work-areas/health-visitors/indicative-health-visitor-collection-ihvc/>

¹² Department of Health 2014, 'Guidance: Commissioning public health services for children' <https://www.gov.uk/government/publications/commissioning-of-public-health-services-for-children> [accessed 8 February 2016]

which supports continuing implementation, has been commissioned by Public Health England, who also hold the licence for the programme in England.

Box 1: Health visiting service model

Community

This includes the development of health advice and work with the whole community and supporting local health planning through contributing to joint strategic needs assessments.

Universal

All families receive a series of visits reviews and checks (the 'five visits') from the health visitor:

- Antenatal
- New baby
- 6 – 8 weeks
- 9 – 12 months
- 2 – 2 ½ years.

These assess the health of the baby and any concerns of the parents around issues such as breastfeeding, attachment, maternal mental health, and behaviour as well as health promotion advice on issues such as safe sleeping, dental health, and accident prevention. These are in addition to medical checks for the baby and mother at or soon after the time of birth.

Universal Plus

Where the parent, health visitor or another professional expresses concerns about about a particular aspect of the child's development (see issues covered by reviews above) the health visitor will offer advice and support and refer to additional services where relevant.

Universal Partnership Plus

Refers to more intensive multi agency work with particularly vulnerable families, for example where there may be safeguarding concerns. Note that some of the many vulnerable young families will be supported through the Family Nurse Partnership (see below).

The evidence about FNP was developed in the US and there were a range of positive outcomes from trials in the US and the Netherlands. The results of a randomised control trial of the English programme was published in 2015, which also suggests that early child development and mothers social support, relationships and confidence was improved. However the trial did not find FNP to have an impact across the study's four main short term outcomes.¹³ A follow up study, funded by

¹³ Pre-natal tobacco use, birth weight, subsequent pregnancy by 24 months and A&E attendances and hospital admissions in first two years of life. A wide range of secondary outcomes assessed also didn't show significant benefits for FNP <http://fnp.nhs.uk/evidence/>

National Institute of Health Research, is underway examining child outcomes to age six is due to report in 2018.¹⁴

There is a wealth of evidence about the value of supporting health in the early years and how this supports better outcomes across the life course and reduces inequalities. Over the coming years, local authorities will be considering how to use their new responsibility for public health of children under five in more innovative ways. If the 'five visits' are no longer mandated after April 2017 this may present opportunities for the voluntary sector to play a greater role in supporting young children and their parents. It will be important, however, especially in light of the end of the National Health Visiting and Family Nurse Partnership Programmes, for charities working in this area to highlight the value of early intervention and work with vulnerable families in general to ensure that it is prioritised local authorities.

School nursing

The main public health service for school aged children is the school nursing team. School nursing is not mandated, so is commissioned at the discretion of individual local authorities. The role of school nursing in the context of the new public health system is, however, set out in non-statutory guidance produced by the Department of Health and Public Health England in collaboration with SOLACE, the Association of Directors of Public Health and the Local Government Association.¹⁵ The guidance sets out a four-level model (the same as health visiting), outlining a continuum of support that children and young people can expect through school nursing and multi-disciplinary working. Their work includes supporting children with existing health conditions¹⁶ and those with special educational needs and disabilities (SEND)¹⁷ to participate fully in education as well as supporting school aged children in general to stay healthy (see box 2, below).

In January 2016 Public Health England issued a new [suite of guidance](#) to support the commissioning of health visiting and school nursing services, mirroring the service model set out in previous documents.¹⁸ The new guidance includes:

- [Background information on commissioning and service model](#)
- [A model specification for 0 - 19 Healthy Child Programme: Health Visiting and School Nursing Services](#)
- [Information on measuring performance and outcomes](#)

¹⁵ Department of Health (2014) *Maximising the school nursing team contribution to the public health of school-aged children* Guidance to support the commissioning of public health provision for school aged children 5-19 <https://www.gov.uk/government/publications/school-nursing-public-health-services>

¹⁶ Department for Education (2014) *Supporting pupils at school with medical conditions* Statutory guidance for governing bodies of maintained schools and proprietors of academies in England <https://www.gov.uk/government/publications/supporting-pupils-at-school-with-medical-conditions--3>

¹⁷ Department for Education (2014) *Special educational needs and disability code of practice: 0 to 25 years: Statutory guidance for organisations which work with and support children and young people who have special educational needs or disabilities*, pp54-55 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/398815/SEND_Code_of_Practice_January_2015.pdf

¹⁸ Public Health England (2016) *Best start in life and beyond: Improving public health outcomes for children, young people and families: Guidance to support the commissioning of the Healthy Child Programme 0-19: Health Visiting and School Nursing services*

- [A reference guide to evidence and outcomes.](#)

Box 2: School nursing service model

Community

This includes the development of health advice and work with the whole community. It includes school nurses contribution to the planning of local health services through the development of school health profiles and supporting joint strategic needs assessments.

Universal Services

The guidance stresses that school nurses have a crucial leadership, co-ordination and delivery role within the Healthy Child Programme (5-19). Key universal elements of the programme led by school nurses include:

- Health reviews at school entry, years 6/7 (age 10/11) and mid-teens to identify individual children's health and social care needs
- Reviewing and providing key immunisations to school children
- Carrying out the National Child Measurement Programme and providing association advice around healthy weight
- Supporting healthy lifestyles and good sexual health by contributing to PSHE and providing contraception and pregnancy testing or signposting to the provision of these in sexual health services.

Universal Plus

This is the provision of additional support and services for children where a specific health need or concern is identified. This might include individual sexual health advice or management of long term health needs. Since 2014, schools have had a **duty to make arrangements to support children at school with medical conditions**. Common conditions relevant to this duty include asthma, diabetes, epilepsy and anaphalaxis (severe allergies). School nurses are expected play a leading role in developing individual children's health plans. They will also work with the SENCO and health services to meet the health needs of children with special educational needs and disabilities.

Universal Partnership Plus

This refers to ongoing work in partnership with other agencies and services to monitor and meet the needs of children with more complex needs. This might be supporting particularly vulnerable families or working to ensure the health and care needs of disabled children are met.

There are many important ways in which health expertise can be exploited in schools. As this is where children and young people spend so much of their time, it is the obvious place to make accessible health support and advice available to this age group, and it will be where many needs first present themselves. Many children

with health conditions or who are disabled also often rely on additional health related support to ensure they can participate fully in school life.

The broad range of work that school nurses are expected to carry out reflects this. It means that for charities looking to develop or expand work to support the health of school aged children this will be a key profession with which to engage to ensure that it complements existing work and is targeted and the most unmet need. Charities should also look to ensure that their work and how it compliments other services is understood by school nursing teams.

However, this wide range of responsibilities may also be challenging for school nurses to fulfil and there will be variation in the focus of school nurses work between different local authority areas and schools. A survey of school nurses undertaken by NCB suggests that school nurses may in some areas be spread too thinly to fulfil all of these responsibilities. 29 per cent said that they work across 13 or more schools and 74 per cent reported having a high caseload. These pressures, alongside the time taken to meet the needs of children with long-term conditions, may inhibit school nurses ability to engage with pupils and families to offer a preventative service.

Where such gaps in provision open up, charities providing services to children in this age group may need to be especially vigilant about health risks, behaviours and needs and be prepared to offer relevant support and or signposting.

It is also important to note that school nursing services and any other services specifically aimed at children aged 5-19 are not mandated. There are reports of cuts being implemented or considered to school nursing services, which have been the responsibility of local authorities since the initial transfer in 2013. Given evidence of the importance of this age range in the formation of health behaviours it will be difficult for local authorities to justify not providing any services while still meeting their general health improvement duty (see introduction). However it will be important for charities to work together to support understanding of this and to hold councils to account. In doing so they should draw on their knowledge of unmet needs especially of those groups which might be less visible to, or do not engage with, statutory services.

Other public health services

Local authorities are expected or required¹⁹ to commission a number of other services for the community as part of their public health role, some of which are also crucial for children and young people's health and wellbeing.

Sexual health services are a mandated service. They must provide for contraceptive services and treat, test for and prevent the spread of sexually transmitted infections. (this does not include a requirement to specialist HIV services and treatment). They must be open access services – provided to anyone who happens to be in the local authority area.

¹⁹ Regulations are made under Section 6C of the National Health Service Act 2006: *The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013*; and *The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) and Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) (Amendment) Regulations 2015*

It is also a legal requirement for local authorities to carry out the National Child Measurement Programme – the weighing and measuring of children in reception class and year six.

Local authorities are responsible for commissioning the following services and interventions (amongst others) and must report annually on how much of their public health grant (see 'funding for public health and preventative services' below) they have spent on them:

- Mandated children 0-5 services (the five visits)
- Non mandated children 0-5 services (Such as FNP and other health visitor work)
- Reducing obesity in children
- Promoting physical activity in children
- Substance abuse services for young people
- Stop smoking services and interventions
- Children 5-19 public health programmes (including school nursing)
- Nutrition initiatives (reported as miscellaneous spend)
- Programmes to prevent accidents (reported as miscellaneous spend)
- Public mental health (reported as miscellaneous spend)
- Dental public health (reported as miscellaneous spend).²⁰

As set out by NCB's reports, [Poor Beginnings](#) and [Why Children Die](#), the health behaviours of parents (and in particular expectant mothers) can have profound impact on children health and development. It is therefore important for health promotion services to be accessible and effectively targets at vulnerable adults as well as young people.

Sexual health services are (aside from the 'five visits) the only public health provision which is mandated. The extent and type of other provisions such as stop smoking or substance abuse services will be at the discretion of local authorities. Given the high rates of child obesity and tooth decay in some areas (see 'understanding local variation' below) and the impact this has on children's lives, it will also be concerning to many charities that local authorities do not even have to report separately on what they have spent on dental public health and nutrition activities.

Charities will want ensure that local authorities are held to account for commissioning the full range of services to promote the health of children and young people, including specific groups they may work with whose needs may not be immediately obvious to statutory services.

²⁰ Department of Health (2014) *Local Authority Circular: Public health ring-fenced grant conditions - 2015/16*

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/388172/final_PH_grant_determination_and_conditions_2015_16.pdf

Integrating services and functions

Local authorities have a wide range of functions outside of their new public health role that impact on the health and wellbeing of children and young people. The Department of Health and Local Government Association have both highlighted opportunities for bringing together existing local authority functions that impact on health with new public health responsibilities and encourage local authorities to embed public health in all of what they do.²¹ Relevant functions are set out in the box 3, below. In some areas, some of these are led by district councils, in partnership with the local county council which holds responsibility for public health.

Local authorities and other organisations are also subject to specific duties on partnership working. The Health and Social Care Act introduced duties on health commissioners (NHS England and Clinical Commissioning Groups) and local authorities to form Health and Wellbeing Boards for planning services together and encouraging integrated working.²² Under the Children Act 2004, schools, health commissioners, district, county and unitary authorities and a range of other partners have a duty to cooperate to promote local children's wellbeing.²³

Looking at the range of responsibilities that local authorities have, it is easy to understand the rationale for local authorities being given responsibility for public health. In recognition of this, and the role that local authorities played in health before the establishment of the NHS, the transfer of responsibility has been referred to as public health 'coming home'.

The fact that this wider range of services are now under the auspices of local authorities may make the commissioning process simpler for charities carrying out local work to support children's health and wellbeing. In areas where there are county councils, however, there will still be the division between these and district councils to contend with for health related work involving housing or leisure services, for example. Local authorities' declining interaction with schools may also dilute these potential opportunity for simpler commissioning and more integrated services.

²¹ Department of Health (2011) *Local government leading for public health* <http://webarchive.nationalarchives.gov.uk/20130805112926/http://healthandcare.dh.gov.uk/public-health-system/>; Local Government Association (2014) *Resource sheet 3 Understanding the health role of local government* http://www.local.gov.uk/media-centre/-/journal_content/56/10180/3374673/NEWS

²² Sections 194-199 of the Health and Social Care Act 2012

²³ Section 10 of the Children Act 2004

Box 3: Other local authority functions impacting on child health

Early intervention (unitary and county councils)

Early intervention services include the provision of information advice and support to young people, work with teenage parents and, crucially children's centres. In many areas children's centres are a hub for accessing parenting support, childcare and health services and other provision.

Childcare and schools (unitary and county councils)

Local authorities oversee the running a significant proportion early years settings and schools (those 'maintained' by the local authority) and have overarching duties to ensure that there is adequate provision in their local area. Independent early years settings, Academies and Free Schools, however, account for an increasing proportion of provision, and the government announced in December 2015 its intention to reduce local authorities formal role in education.

Additionally local authorities have a range of duties to coordinate support for children with special educational needs and disabilities, particularly with regard to their participation in education.

Children's social services (unitary and county councils)

Children's social services lead efforts to prevent harm to children and are responsible for arranging the care and protection of children who cannot be provided for within their family. This includes working with vulnerable families and the families of disabled children to support them to care for their children.

Housing (unitary and district councils)

As well as maintaining and allocating their own housing stock, local authorities have a number of broader duties on housing in their area. They must keep housing conditions in their area under review, and take action against landlords to address identified hazards to tenant's health and safety. They have duties towards families who are homeless or threatened with homelessness to secure them accommodation.

Licensing (unitary and district councils)

Local authorities make decisions (within a prescribed framework) about licensing entertainment venues, the selling of alcohol and late night food sales.

Leisure (unitary and district councils)

Councils run local leisure centres, sports grounds and swimming pools as well as maintaining many public open spaces.

Spatial planning (unitary and district councils)

Councils are responsible for creating a local development plan, in accordance with the National Planning Policy Framework and granting planning permission for new buildings and other developments in line with this.

Funding for public health and preventative services

Local authorities' public health commissioning responsibilities are funded by a ringfenced public health grant. Allocations are calculated using a formula which takes into account various indicators of need including levels of child poverty and the number of young people.²⁴ Local authorities are required to have regard to the need to reduce health inequalities in their spending of the grant.

At the beginning of 2015/16 the total grant amounted to £2.8 billion per year with around £860m per year to be added to pay for local authorities new responsibilities for children aged under five. However, a £200m in-year cut²⁵ was then made to the grant, and the Spending Review of December 2015 announced further cuts of an average of 3.9 per cent in real terms each year. Government also announced at the Spending Review its intention to eventually abolish the grant altogether, alongside plans for local authorities to retain their business rates.²⁶

Local authorities receive an early intervention funding allocation (previously called the Early Intervention Grant), which Government expects them to use to pay for a wide range of services including children's centres (see above). *Cuts that Cost*, a report by NCB, The Children's Society and Children and Young People Now²⁷ found that between 2010 and 2015 government funding for local authority early intervention services had been cut by £1.8 billion.²⁸ The 2015 Spending Review also announced reductions in the Education Services Grant, which local authorities use to support pupils with additional needs and children's wellbeing in school.²⁹

Reduction in the public health grant, combined with other reductions in local authority funding, is probably the most significant factor mitigated against the potential benefits of the transfer of public health to local authorities. It means that the benefits of innovations such as closer working between health visiting and children's centres may be realised only in efficiencies, rather than an improved service for young children and their families. It also means that charities may have to be cautious about how they encourage local authorities to innovate and commission services from their sector. It will be hard for local authorities to commission any extra services and they will be under pressure to deliver savings from any changes they make to services. Some charities may feel the need to join efforts to protect existing services delivered by the public sector to ensure the maintenance of a certain level of service for the children and avoid more unmet demand presenting at their own services.

While it is welcome that a national formula has been developed that directs money where the highest need is likely to arise, this is set against the modest size of the

²⁴ Department of Health (2015) *Public health grant: proposed target allocation formula for 2016/17* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/468964/1_Public_Health_Grant_-_Proposed_Target_Allocation_Formula_2016-17_-_amended.pdf

²⁵ Department of Health (2015) *Local authority public health grant allocations 2015/16 Government response to public consultation on in-year savings and Equality and health inequalities analysis* <https://www.gov.uk/government/consultations/local-authority-public-health-allocations-2015-to-2016>

²⁶ HM Treasury (2015) SPENDING REVIEW AND AUTUMN STATEMENT 2015, pp32, 88

²⁷ National Children's Bureau and The Children's Society (2015) *Cuts that cost: Trends in funding for early intervention services* London: NCB <http://ncb.org.uk/cutsthatcost>

²⁸ National Children's Bureau, The Children's Society and Children and Young People Now (2015), *Cuts that cost: Trends in Funding for Early Intervention Services* <http://www.ncb.org.uk/cutsthatcost>

²⁹ HM Treasury (2015) SPENDING REVIEW AND AUTUMN STATEMENT 2015, pp91

overall pot of money available for England. The 2010 review of health inequalities in England highlighted the need for increased funding for preventative work, criticising the 4 per cent proportion of NHS money then spent on prevention.³⁰ The size of the public health grant, however, has been modelled on this existing spend and faces significant reductions. Several charities and professional bodies have criticised what they see as a lack of long term thinking and using the change of commissioner as excuse to cut funding.³¹

Attention will also need to be paid to how money is redistributed between local authorities as an increasing proportion of their funding comes from the retention of business rates. Charities will need to be aware of the implications of these changes and support distribution of money reflecting children and young people's needs.

Measuring progress and targeting improvements

Good quality data helps to demonstrate need in a robust way that commissioners are able to use to inform decisions, potentially protecting investment in certain services or commissioning new intervention. A number of new frameworks and tools for accessing this data have been developed which may help charities to better make the case for action on children and young people's health.

Public Health Outcomes Framework

The Public Health Outcomes Framework³² was developed by the Department of Health to set the strategic direction for the delivery of public health interventions and to monitor progress nationally. It sets out priority outcomes and indicators for measuring these, focusing on efforts to improve the health of the general population and reduce health inequalities.

It will inform local authorities and local Directors of Public Health in carrying out their new responsibilities for commissioning public health services. To this end local authorities will have to 'have regard' to it.

It includes a range of outcomes indicators arranged under four domains:

1. Improving the wider determinants of health, including children in poverty, pupil absence, first-time entrants to the youth justice system and 16-18 year olds not in education, employment or training
2. Health improvement, including low birth weight of term babies, breastfeeding, mother's smoking status at time of delivery, under-18 conceptions, excess weight in 4-5 and 10-11 year olds, hospital admissions

³⁰ The Marmot Review (2010) *Fair Society, Healthy Lives* London: The Marmot Review
<http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review>

³¹ National Children's Bureau, Young People's Health Partnership, Teenage Cancer Trust and The Communication Trust (2015) *Response to consultation on Local authority public health allocations 2015/16: in-year-savings* <http://www.ncb.org.uk/what-we-do/policy/consultation-responses>

³² Department of Health (2012) *Improving outcomes and supporting transparency Part 1A: A public health outcomes framework for England, 2013-2016*
<https://www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency>

caused by unintentional and deliberate injuries in under 18s and smoking prevalence in 15 year olds

3. Health protection, including chlamydia diagnoses (15-24 year olds), as well as measures such as immunisation levels and plans for responding to public health incidents

4. Healthcare, public health and preventing premature mortality, including infant mortality and Tooth decay in children aged five as well as measures such as mortality from various diseases.

Child and Maternal Health Intelligence Network

Public Health England's Child and Maternal Health Intelligence Network (ChiMat) maintains a number of tools which allow local areas to view their outcomes across a wide range of young children's health measures as well as guidance on how to use this data. The main tools for comparing outcomes for children and young people across local areas are:

- [Child Health Profiles](#) - summary documents for each local authority area and an interactive tool providing a snapshot of child health and wellbeing using key health indicators
- [Early Years Profiles](#) - summary documents for each local authority area and an interactive tool designed to help commissioners and providers of health visiting services to assess the priorities for and outcomes of the transformation of health visiting services
- [Young People's Profiles](#) - summary documents for each local authority area and an interactive tool showing at a glance performance against key public health outcomes for young people
- [Data Atlas](#) - an interactive mapping tool enabling users to explore, interrogate and view relevant indicators and trends in map, chart and tabular formats. Using Data Atlas, ChiMat brings together a wide range of data from many different sources in a flexible, theme-based tool. The on-line atlas provides access to local, regional and national child and maternal health indicators and statistics over time
- [Children and Young People's Health Benchmarking Tool](#) - brings together and builds upon health outcomes data from the Public Health Outcomes Framework and the NHS Outcomes Framework, based on the recommendations of Children and Young People's Health Outcomes Forum³³
- [Health Behaviours in Young People Tool](#) - provides local authority level estimates for several topic areas, based on what 15 year olds themselves said about their attitudes to healthy lifestyles and (self-reported) risky behaviours. It is based on results of the 2014 'What about YOUTH?' survey which covered

³³ Children and Young People's Health Outcomes Forum (2012) *Report of the Children and Young People's Health Outcomes Forum*, Chapter 3

diet and physical activity, smoking, alcohol, use of drugs, bullying and wellbeing.

Understanding local variation

In 2015, National Children's Bureau published the report, [Poor Beginnings](#), which explores variations in the health and development of young children living in different parts of the country and highlights the challenges that local authorities are taking on with their new responsibility for 0-5s public health.³⁴

Using the latest published data on four key outcomes for the early years – obesity, tooth decay, injuries and 'school readiness' – we explored variations in the health and development of young children across local authorities and regions in England. We found that:

- **There is startling variation in young children's outcomes at regional and local authority level.** For example a five-year old in Leicester is over five times more likely to suffer from tooth decay than one of their peers in West Sussex, and if the North West had the same outcomes as the South East it would have around 5,500 more children achieving a good level of development by the end of Reception.
- **Young children growing up in deprived areas tend to do worse than those living in less deprived areas.** If all local authorities had similar outcomes to the most affluent areas, we could avoid tens of thousands of incidents of early childhood obesity, tooth decay and injury.
- **However, significantly, it is not inevitable that children in poor areas fare worse than those in more prosperous areas.** There are a number of very deprived local authorities where young children are doing as well as, or better than, the national average.

The report also summarises what is known about the main risk factors for poor health outcomes for individual children in the years. These factors include health behaviours of parents and children and other outcomes which local authorities will aim to influence. However, demographic factors including socio-economic status and ethnicity also appear to interact with other risk factors as well as being factors in their own right.

Local authorities and their partners will often identify 'statistical neighbours' - areas which have similar demographics and geographies (i.e. urban/rural) - to compare themselves against. The [Children's Services Statistical Neighbour Benchmarking Tool](#) allows identification of local authority areas that are similar for the purposes of comparing children's outcomes.

The range of indicators in the Public Health Outcomes Framework and tools developed by ChiMat are vital resources for charities, local authorities and other interested parties as they seek to understand the health challenges faced by children and young people in their jurisdictions and where most progress needs to be made. The availability of this data is all the more important given the challenges

³⁴ National Children's Bureau (2015), *Poor Beginnings: Health inequalities among young children across England* <http://www.ncb.org.uk/poorbeginnings>

and pressures facing public health outlined above, as it will help to evidence need and the impact of any potential decisions to deprioritise this work.

While the focus of public health data shows proportionate attention to childhood and adolescence, and especially the early years, there are still some gaps. The What About YOUTH? Survey for example does not collect information about where health behaviours such as drinking pose a risk to health or about sexual behaviour and attitudes, and its future is uncertain. *Poor beginnings*, meanwhile, highlights the gap that will be left in measuring young children's health and development by current plans to change recording requirements on primary schools.

Local authorities and charities working in this area will want to have a good understanding of what kind of progress on children's health outcomes can be targeted and what the most appropriate range of intervention in their area. There is a wide range of research on risk factors for poor health and local authorities, in which public health teams will be well versed in as well their local data. Reasons for local authority level variations in outcomes are less well understood however, and funding pressures mean public health teams will have limited capacity to carry out new investigations. For this reason *Poor Beginnings* recommends that the Department of Health and Public Health England commission further research to understand and address local variation.

In conclusion, the transfer of responsibility for public health to local authorities represents a major change in the way efforts to improve children and young people's health are organised. New opportunities for innovation, integrated working and involvement of the voluntary sector are set against cuts to the public health grant and other local government funding. This will present either direct or indirect challenges to many charities working with children and young people. Organisations will have to think very carefully about the best contribution they can make going forward through services, campaigning and evidence.