

Currency Options for the Healthy Child Programme –

Transforming Community Services

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Executive summary

Community services have historically been funded on block contracting arrangements. The DH publication, "*Currency and Pricing Options for Community Services*", published in January 2009, signalled the need to replace block contracts with more sophisticated funding approaches to reflect local priorities.

This current document is a tool for commissioners to use in the development of a more transparent outcome based approach in paying for the community services element of the first five years of the universal Healthy Child Programme (HCP). The development of more accurate currency and pricing approaches will reward quality and productivity and encourage activity which promotes the aims and outcomes of the HCP. The HCP, released in March 2008 and updated in October 2009, describes the evidence based universal public health programme for child health¹.

This guidance is a further step on the journey toward defining appropriate currencies that are linked to service outcomes and it is expected that use of the proposed approach will help to inform further thinking. This guidance is not intended to be the final point in defining how commissioning for the HCP should take place.

Reducing inequalities requires different levels of preventive intervention. These interventions are called "progressive universal" elements and are aimed at all children and families. This guidance excludes specialist and intensive preventive programmes for the more vulnerable groups.

This document sets out the currency options for community service elements for the first part of the HCP from pregnancy to 5 years of age. Pricing should be carried out locally, based on variables such as deprivation and local need, so that currencies can then be applied to understand required levels of funding. The Transforming Community Services Programme has led this work, in partnership with DH colleagues in Payment by Results and the Children, Families and Maternity policy team, and has drawn on the expertise of commissioners, providers and clinicians from within the NHS.

The exploration and use of national currencies for community elements of the HCP does not sit in isolation. Increasingly, children's services may be commissioned jointly under the auspices of Children's Trusts and delivered by integrated children's services. Currencies need to support these developments. This publication should be used in conjunction with outcomes and recommendations set out for all aspects of child health outlined in "*Maternity Matters*", "*National Service Framework for Children, Young People and Families*" and "*Healthy Lives, Brighter Futures*", to ensure consistent high quality of preventive care for the nation's children. In addition, the recently published "*2 year Health Review*" provides detailed clinical guidance on the process and content of the HCP at 2 years.

¹ www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107563

Further development will also see key links with other DH and DCSF initiatives under development for child health, such as the “PREview” model² and the project to renew antenatal education and preparation for parenthood.

It is recommended that Primary Care Trust/Local Authority commissioners and providers of the HCP should start to implement the guidance set out here. Benefits include:

- > better matching of clinical and economic resources to prevention;
- > incentivising evidence based prevention to reduce future health spend;
- > clearer understanding of components of current block contracting arrangements;
- > clarity on expenditure and outcomes for the HCP, supporting commissioners to improve quality and value for money;
- > improved outcomes and reduced inequalities in the health and well-being of children.

² PREview is a DH project to identify factors in pregnancy and around birth that are associated with child outcomes aged 5 and develop a population tool to support decision making by commissioners.

Strategic Context

1. The quality and productivity challenge facing the NHS and local authorities requires commissioners to extract maximum quality and value for money from historic block contracting arrangements. At present, much of the healthcare delivered by Community Services are paid by block contracting arrangements. These arrangements do not allow payment to be based on quality and productivity or incentivise evidence based interventions that demonstrate quality. The recent focus on Community Services has seen a series of initiatives which aim to link the appropriate payment method to the outcomes and quality set out in national policy.

The Next Stage Review

2. *The Next Stage Review Primary and Community Care Strategy* set out a compelling vision for transformational change within community services. *High Quality Care for All* set the challenge that quality should be the organising principle of the NHS. For this to happen, appropriate measures and incentives need to be in place and aligned across all aspects of healthcare. *High Quality Care for All* affirmed that community services should move away from being funded on a block contract basis, giving further impetus to local efforts to develop currencies and prices.

Currency and Pricing Options for Community Services³

3. *Currency and Pricing options for Community Services* is intended as a resource to be used by commissioners and providers of community services to help create transparent models of funding, through the use of new currencies and better pricing at a local level. New currencies (the units of healthcare for which a provider is funded) and better pricing are key to transforming community services, enabling commissioners to incentivise improvements in quality and value. The document stated that for most community services, this should be done locally to reflect need. However, the Department of Health made a commitment to explore national currencies with local pricing for the community service aspects of the Healthy Child Programme.

Payment by Results

4. Respondents to the consultation on the *Options for the Future of Payment by Results: 2008/09–2010/11* highlighted community services as the second highest priority, after mental health, for inclusion in any expansion of the scope of PbR. The consultation also introduced the idea of three tiers of PbR (see Annex A) which offer more scope for local development.

³ www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093008

Every Child Matters⁴

5. *Every Child Matters: Change for Children* sets out the national framework for local change programmes to build services around the needs of children and young people so that we maximise opportunity and minimise risk. The services that reach every child and young person have a crucial role to play in shifting the focus from dealing with the consequences of difficulties in children's lives to preventing things from going wrong in the first place. The transformation that we need can only be delivered through local leaders working together in strong partnership with local communities on a programme of change that strengthens prevention and early intervention.

Healthy Lives, Brighter Futures – The Healthy Child Programme

6. In 2009, the Department of Health and the Department for Children, Schools and Families published *Healthy Lives, Brighter Futures: A strategy for children and young people's health*.⁵ This joint DH/DCSF strategy presents the Government's vision for children and young people's health and wellbeing. It sets out how we will build on progress through: world-class outcomes for children and young people; high quality services; excellent experience in using those services; and reducing health inequalities. The Healthy Child Programme is seen as a key driver for achieving health and well being for all children and is a named priority in the NHS Operating Framework 2010/11.

Developing pathways

The evidence base

7. The Healthy Child Programme sets out the evidence based preventative programme that should be offered to all families with children from pregnancy to 5 years. The foundations for health and well-being in child and adulthood are laid down in pregnancy and the first years of life. Emerging scientific knowledge of neurological and infant development creates an imperative for an evidence based preventive programme that focuses particularly on pregnancy and the first years of life. Therefore, the programme includes a schedule of contacts for developmental reviews, screening tests, immunisation, health promotion and parenting support. The name of the programme has changed over time and the evidence base has strengthened. The latest guidance built on the children's National Service Framework and was published in 2008.

⁴ www.dcsf.gov.uk/everychildmatters/

⁵ www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_094400

8. The HCP is a progressive universal programme tailored to individual child and family needs and anticipated outcomes. It includes a universal minimal core for all children with enhanced and additional preventative services and programmes for children and families where outcomes are expected to be less positive. To make best use of resources, and improve access for parents, the HCP requires integrated working between community services, general practice and children's centres.
9. The HCP focuses on public health priorities of obesity prevention, breast feeding, social and emotional development and helps commissioners to meet their commitments on breast-feeding, obesity prevention and infant mortality.
10. This document should be used in conjunction with *"Healthy Lives, Brighter Futures"*, *"National Service Framework for Children, Young People and Families"* and *"Maternity Matters"*⁶ to understand how currency and pricing for the community element of the HCP should be considered in context of wider contracting arrangements and outcomes.

Working through steps outlined in "Currency and Pricing Options for Community Services"

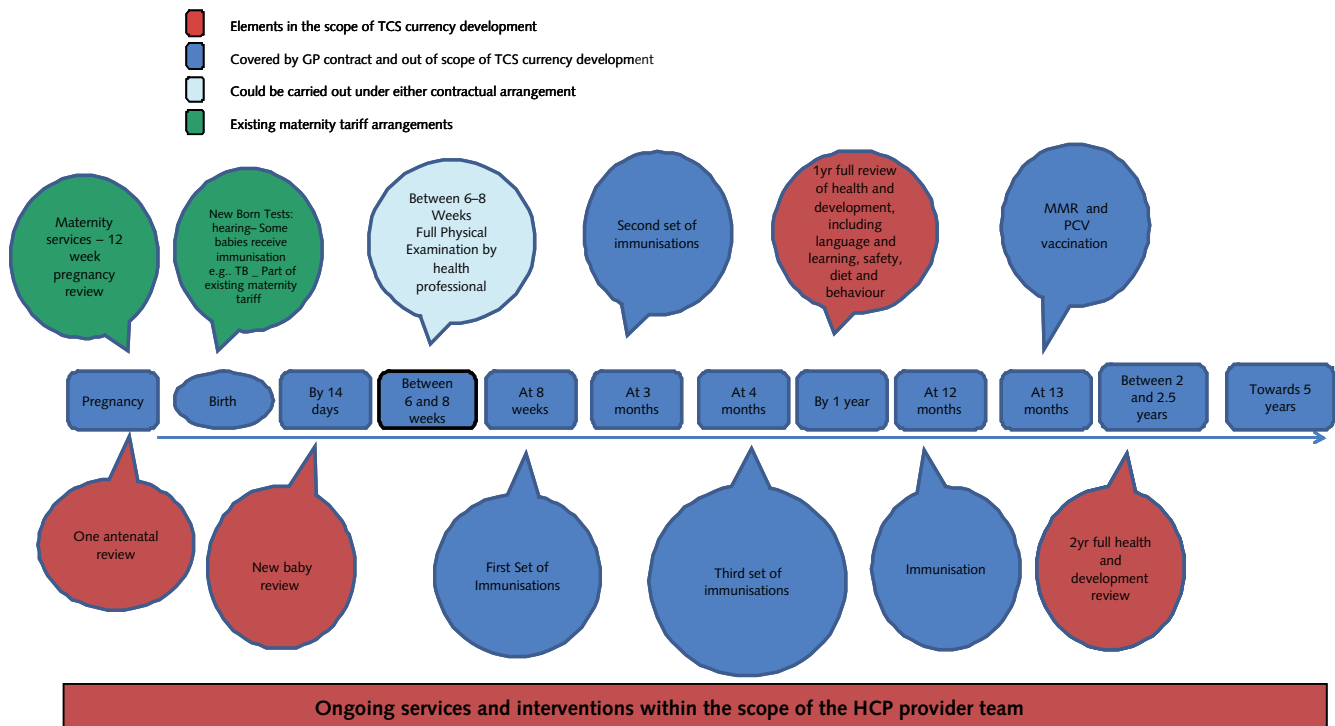
11. In January 2009, The DH released *"Currency and Pricing Options for Community Services"*, outlining the processes required for currency development. The development of pathways and currencies for community service elements of the Healthy Child Programme followed the currency development approach and steps highlighted in this document.

National working group

12. A national working group was set up by the Department of Health, tasked with the remit of pathway and currency development for the Healthy Child Programme.
13. In line with the principles in *"Currency and Pricing Options for Community Services"*, this group involved front line staff to ensure clinical engagement. National policy leads, PCT commissioners, and payment by results / currency leads from the Department of Health also played a role.
14. The group took the steer from the existing national clinical guidance which outline key contact points between the health professionals and child/family to agree on the following pathway:

⁶ www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073312

Community Service Elements – pregnancy to five years of age⁷



15. This reflects contractual elements of the HCP, but commissioners and providers should ensure that the HCP is delivered as an integrated pathway across maternity, general practice, community services and Sure Start Children's Centres.

What is in/out of scope for the community element of the pathway

16. In the development of this pathway, a shared understanding of the different contractual arrangements for each of the key elements should be agreed by commissioners and providers.
17. This mitigates any potential confusion around provision of service and payments linked to elements of the overall pathway. For example, immunisations play a key part in the Healthy Child Programme but delivery of these are within the scope of GP contract and QOF payments. Commissioners need to be aware of who provides these elements of the pathway and how they are paid for. However, there is a key role for community services in promoting immunisation uptake through public health education for individuals and communities.

⁷ The underpinning services that provide ongoing reactive support and progressive preventive interventions to parents in between scheduled contacts such as child health clinics, telephone advice, post natal and ad hoc support on a range of health issues in a number of settings including home visits.

18. There is scope for local flexibility around the skill mix of staff carrying out certain key stages of the HCP. National guidance specifies the important lead role of the health visitor for the HCP and the need for suitably qualified staff and supervision with payment mechanisms reflecting this.
19. Elements of the pathway delivered by other organisations should be aligned to ensure a clear focus on prevention and partnership working, starting in pregnancy and the 12 week booking (antenatal services picked up in Maternity Tariff arrangements) and including immunisations. The 12 week maternity review information should be shared between midwives and health visitors to ensure that preventive services are centred around pregnant mothers and the developing child, with onward referral for specialist preventive services as required.
20. This pathway focuses on the progressive universal aspects of the Healthy Child Programme as part of the entire HCP budget. This includes the minimal core for all children and additional preventive interventions for specific needs that are within the scope of the team providing the HCP. Universalism is important for the early identification of vulnerable children, because prediction of poor outcomes is an inexact science and because the greatest population gains results from universal services. An effective, early intervention and prevention service ensures fewer numbers of children require costly health and social care services in later years⁸.
21. Please refer to *“Maternity Matters”*, *“National Service Framework for Children, Young People and Maternity”* and *“Healthy Lives, Brighter Futures”* to ensure that whole system outcomes and contracting arrangements are considered in partnership with the community elements of currency and pricing.

Developing Currencies

Outcome of pathway

22. Children should receive the progressive universal Healthy Child Programme as set out in the guidance to maximise their potential.
23. This will be demonstrated by the following outcomes:
 - > strong parent–child attachment and positive parenting, resulting in better social and emotional wellbeing among children;
 - > care that helps to keep children healthy and safe;

⁸ www.developingchild.harvard.edu/content/publications.html

- > increased rates of initiation and continuation of breastfeeding;
- > healthy eating and increased activity, leading to a reduction in obesity;
- > prevention of some serious and communicable diseases;
- > readiness for school and improved learning;
- > early recognition of growth disorders and risk factors for obesity;
- > early detection of – and action to address – developmental delay, abnormalities and ill health, and concerns about safety.

Development of incentives

24. Incentives along the pathway, including those that are non community service based also need to reflect the HCP and locally selected outcomes including those to reduce inequalities.
25. Incentivising provision of key preventive interventions along the pathway through appropriate currencies will relate to meeting stated outcomes. Collection of relevant information linked to these incentivised key interventions will assure that service delivery has taken place.
26. For much of the HCP, the outcomes will be seen after the end of the pathway; for example, obesity prevention. In these instances, incentives along the pathway need to be based on evidence which shows clear and justifiable links between the preventive intervention and the desired outcome.
27. Therefore, the elements of evidence based incentives (linked to the outcome) that need to be considered should be linked to those outlined under paragraph 23.
28. Immunisation is one example where partnership between healthcare professionals benefits the child population. In many cases, the GP contracting arrangements will be the method of payment to ensure immunisation takes place. In order to ensure greatest possible immunisation rates, health visitor teams can be incentivised to improve immunisation uptake and ensure this has happened as part of the routine 1 year and 2.5 year reviews. If immunisations have not happened at these stages, action taken to refer for immunisation can be built into the appropriate currency payment.

Appropriate currencies

29. In developing currencies the DH, PCTs, DCSF and LAs should also consider perverse incentives:
- > *the type and level of information and knowledge needed for the successful delivery of service(s) you are considering;*
 - > *how to avoid commissioners paying twice for the delivery of the same service. This can occur when currencies are not well defined or the interface between services and pathways are not well understood by the commissioner;*
 - > *the possibility of an increase in the bureaucratic burden for front line staff, taking them away from contact with families and children;*
 - > *the danger of demotivating and disempowering practitioners who are intrinsically motivated to deliver the programme well;*
 - > *the potential for adverse selection, by encouraging a focus on easy to reach low need families at the expense of children where outcomes are likely to be poor and who are likely to benefit most.*
30. Therefore, the appropriate currencies are those which meet outcomes, reflect local variables associated with inequalities in health and encourage desired behaviours rather than creating perverse incentives.

Description of currencies

31. The appropriate currencies for the progressive universal community element of the Healthy Child Programme Pathway have been developed on a basis of:
- > *pregnancy to 6 months of age (incorporating one antenatal contact by HV new birth visit, 6-8 week visit);*
 - > *6 months – 2 years of age (incorporating the full health review by one year of age;*
 - > *2 years – 5 years (incorporating the full health review between 2 and 2.5 years);*
 - > *the underpinning services that provide ongoing reactive support to parents in between scheduled contacts such as child health clinics, telephone advice, post natal and ad hoc support on a range of health issues in a number of settings including additional home visits.*

32. These currencies have been selected so that services can be paid where it is clear what happens to which child and when. The method of payment within existing funding envelopes may be weighted to reflect local priorities for harder to reach groups. For instance, a commissioner and provider may agree that those children and families identified as harder to reach attract double the currency payment.
33. Funding will be based in the first instance on historical costs. This funding can then be weighted, based upon the three currencies above, to reflect local priorities where commissioners may choose to shift funding to key elements.
34. Commissioners should also work with providers and HCP lead clinicians and use existing population stratification to understand the breakdown between those children requiring the universal minimal core programme, progressive ie. enhanced prevention and specialist prevention for the most vulnerable. This will include historical public health data. In future, it is envisaged that the PREview model being developed by ChiMat and DH may support commissioners to stratify the child population according to factors influencing child health and wellbeing outcomes at 5 years. Once stratification has occurred, block contract monies can then be allocated against levels of need.
35. Existing assessments (public health, needs and equality impact) should allow commissioners to understand the percentage breakdown of children against different levels of need and public health data should underpin the expected volumes of use. Where possible, commissioners should consider levels of tolerance to mitigate higher than expected need.

Developing local pricing

Historical Costs

36. Historical funding will provide a view on the entire envelope of the Healthy Child programme provision. Therefore, commissioners should consider that the entire envelope for Healthy Child Programme provision is comprised of the progressive universal and targeted elements. This document is focussed on the progressive universal elements as defined in para 20.
37. Pricing should be carried out at local levels based on variables such as deprivation and local need. The proposed national currencies can then be applied against the local pricing to reflect service requirements.
38. Understanding the breakdown of existing block contracts, based on current staff activity or stratification of child health population need has to be undertaken in order to understand aggregation of payments required for currencies.

39. Commissioners should also consider the wider Healthy Child Programme pathway and all contractual elements involved to identify efficiency opportunities. This will allow a shift in funds if they are not currently providing all preventative community service aspects of the Healthy Child Programme or making the most of the contribution other children's services can make to the HCP, especially between two years and school entry.
40. The goal of prevention, as evidenced in "*Brighter Lives, Better Futures*", is to maximise the child's health and well-being and reduce future costs to health, social care and education services.
41. For further information please refer to the DH publication "Currency and Pricing Options for Community Services", Jan 2009.

Collecting "patient level information" – costing methodology

42. In collecting patient level information, each aspect of care within the scope of the community currency can be collected and aggregated to provide a view of all components that make up individual care.
43. If staff costs for those providing the service are understood and activity can be mapped, it may then be possible to produce a total cost for the currency of care for an individual child and family. Reference costs will be of some help in understanding the costs of the services, but significant variation exists in how reference costs for community services are calculated. Reference costs are reported on the basis of professional groups and numbers of contacts which may not fit with the chosen currency model.

Improving Data Quality and Use

44. Good quality data is crucial. The DH has been working with the NHS Information Centre on developing a data set and standard classifications for community services. Subject to agreement, this will allow the description and benchmarking of services across the country. Information on this will be published as the work progresses throughout 2010.
45. Some information within the upcoming Child Health data set and maternity data set may provide information already being collected to assure community service performance. Please refer to these data sets when available and signed off by the Information Standards Board. Implicit understanding of community service provision is no longer sufficient for appropriate currency development and quality improvements.

Assuring performance

46. Commissioners and providers should agree on the local priorities and outcomes of delivery for the HCP by Community Service Providers with reference to the Healthy Child Programme – Pregnancy and the First Five Years of Life, reissued in October 2009.
47. In order to assure delivery is taking place, preventive need is met and contracts are fulfilled, the assurance process is key. At present, without national community data sets, assurance needs to be linked to the HCP Quality Indicators and universal goals. Commissioners may choose to agree these local assurance options with providers. The assurance process should inform and be useful to both parties. It should be proportionate and care should be taken that it does not negatively impact upon service delivery.
48. The Healthy Child Programme Team are working with the service to collate indicators for ensuring the quality of the services provided and these will be shared with SHAs when finalised. This will complement the development of the Community Services data set and other nationally collectable indicators in the Maternity, QOF and Child Health data sets, subject to ROCR approval, along with information from public health observatories. Commissioners and providers will wish to agree on indicators and measures to be used locally to address agreed local priorities.

Weighting currencies based on local priorities

49. Once the HCP universal service budget is understood, commissioners and providers should agree the local priorities with which to focus the national currency structures upon. The following examples are for illustrative use and are a pragmatic approach, given current information capability, with which to pay for public health prevention highlighted in the HCP.
50. Commissioners and providers may choose to agree on wider outcomes, such as no child entering school without their needs being identified and addressed. Using the three currency blocks, payment can be weighted against key assurance indicators which show delivery of the service. This weighting and assurance is down to local determination based on local priorities; it may be due to a greater requirement for home visiting for socially excluded groups, additional skills for practitioners for working with vulnerable families, where interpreters are needed etc. However, an indicative example is highlighted on page 16.

	Pregnancy – 6 months	6 months – 2 years	2 years – 5 years
Assurance	% NOT picked up the three health + wellbeing reviews	% of reviews undertaken at 1, 2 years	Early years foundation stage assessment at school entry
Weighting	eg. 35% payment	eg. 35% payment	eg. 30% payment

Local priority – every child in areas of deprivation completes the HCP by 5 years of age

51. Commissioners and providers may also choose to focus on more specific local priorities, identified by current public health data, levels of preventable outcomes or the future need for services. This will require an understanding of elements of the overall universal HCP community budget, which is apportioned to delivery of service elements against that need.
52. For instance, childhood obesity could be a local priority. Using the HCP as a preventative tool, commissioners could incentivise delivery of elements of the service most likely to impact positively. The following example shows a weighted payment option for the delivery of higher percentages of breastfeeding – evidenced to reduce childhood obesity⁹.

⁹ Horta B et al, *Evidence on the long-term effects of breastfeeding*, Geneva: World Health Organization, 2007.

	Pregnancy – 6 months	6 months – 2 years	2 years – 5 years
Assurance	% babies breastfed at 8 weeks old review	Health/wellbeing advice takes place as per HCP guidance	Health/wellbeing advice takes place as per HCP guidance
Weighting	eg. 50% payment	eg. 25% payment	eg. 25% payment

Local priority – Prevention of Childhood Obesity

53. The methodology could also apply to immunisation uptake and commissioners could choose to weight payment based on percentages of uptake. This would incentivise providers of the service to identify immunisation benefits and have these discussions with parents at the early stage, highlighted below:

	Pregnancy – 6 months	6 months – 2 years	2 years – 5 years
Assurance	Advice/discussion takes place as per HCP guidance	Agreed % for immunisation uptake at 1, 2 years	Advice and potential referral if not had immunisation
Weighting	eg. 20% payment	eg. 70% payment	eg. 10% payment

Local priority – Increase immunisation uptake

54. To ensure appropriate children and families are targeted, commissioners may choose to weight payments against priorities based on public health data and Index of Multiple Deprivation scores. Examples of use could be linked to Super Output Areas, (found in local public health data) highlighting the neighbourhoods in each local setting.

Links to initiatives

Development of the Healthy Child Programme Currencies

55. Throughout 2009, the DH has been developing the community services universal provision component of the HCP, such as the 2 year review. This is the first step in further development of wider currency and pricing for the HCP.
56. There are also key links to be made with the development of other DH initiatives including the new antenatal and preparation for parenthood programme and “Preview model” which will reinforce and further inform the currencies involved in the community service universal HCP services.

2 Year Review

57. The DH has developed guidance on the HCP “2 Year Review”¹⁰ review aimed at further improving the outcomes of the child at this age along with an increase in the coverage of health assessments. It has been estimated that the 6–8 week assessment attracts a coverage of 96% of births whereas at 2–2.5 years, this drops to around 50%.
58. In such cases as immunisation coverage where contractual arrangements sit with the GP, it is still possible to incentivise the Health Visitor team to work with practice staff in order to increase uptake.
59. The future development of Healthy Child currencies for the community service aspect needs to link closely to the development of this work to ensure that outcomes and incentives are aligned.

PREview Tool – Supporting a Progressive Universal HCP

60. The DH is working with ChiMat to develop a model or tool that provides commissioners with a systematic way of using existing data to stratify the child population according to future need and outcomes to inform allocations of preventive resource matched to need.
61. Influenced by the key drivers for quality and efficiency, it will demonstrate quality by using scientific and academic rigour to underpin commissioning. Innovative approaches of using data to support all stages of the child’s preventive care can be evidenced and the allocation of resources to support better outcomes exemplifies the preventative aspect of the tool.

¹⁰ www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107565

62. The DH is planning to share the early learning in 2010/11 and test the system more widely (subject to funding).

Development of Healthy Child Programme Commissioning Tools

63. *Healthy Lives, Brighter Futures* set out a DH commitment to review the current state of play around commissioning the Healthy Child Programme (HCP) local levels. Various initiatives to support this are already in place with others under consideration, including:
- > a service specification for the HCP based around the standard community contract published in December 2008;
 - > the Transforming Community Services “High Impact Change” publication, part of the clinical guide for Children and Families;
 - > the DCSF’s Commissioning Programme which feeds directly into the local authority arena and Children’s Trusts will do some focussed work on HCP commissioning;
 - > the development of HCP specific quality indicators.

Next steps

For Commissioners and Providers

64. This guidance should be used alongside the HCP and all other Healthy Child policy and commissioning tools referred to in this document, available on the DH website at: <http://www.dh.gov.uk/en/Healthcare/Children/Maternity/index.htm>
65. Commissioners and providers should assess public health data to identify those areas with lower coverage of Healthy Child Programme service.
66. Providers and commissioners may shadow test these currencies based on local priorities for an agreed period.
67. Ensure active clinical engagement to identify local priorities which can be weighted against existing Healthy Child Programme service budgets.

68. Commissioners and providers may also aim to be able to demonstrate the costs of components of that make up their service provision depending on ability to collect relevant information. These components can be grouped together to create a price for the proposed currencies. The following may provide useful context:

> *Enabling New Patterns of Provision* (published January 2009)

> The Clinical Costing Standards for England and the NHS Costing Manual

For Strategic Health Authorities

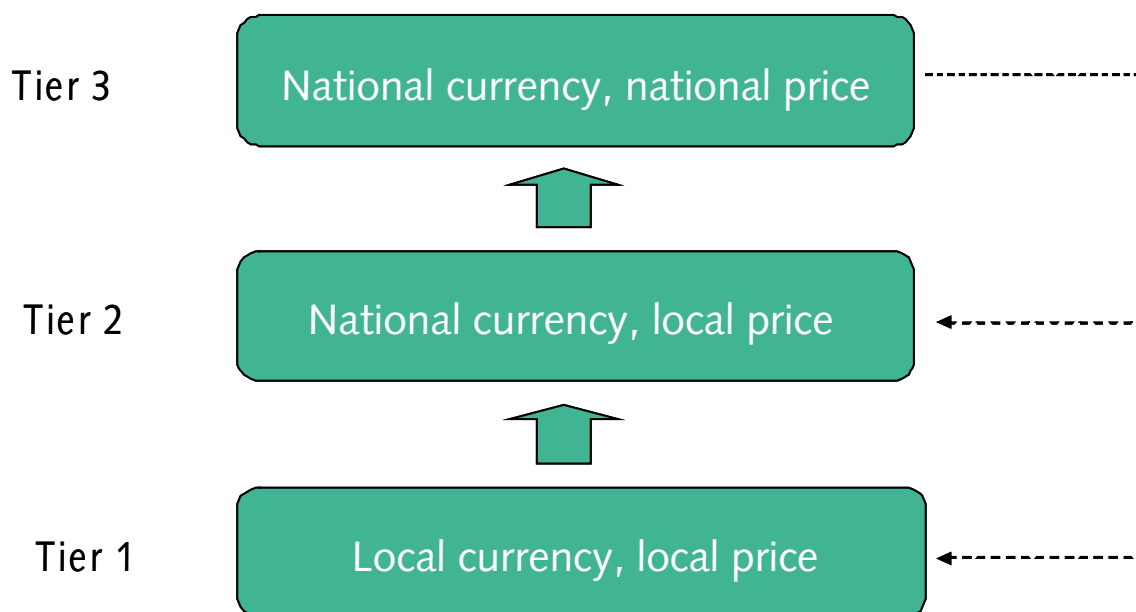
69. Strategic health authorities should, where possible, support local initiatives by commissioners and providers. This support may come in the form of initialising and leading sector wide projects which are focused on local or SHA wide priorities.

For the Department of Health

70. The DH has a further role to consider appropriate community service currencies as the Healthy Child Programme develops.
71. The DH will also remain in contact with those sites who are focusing on specific priorities so that any learning can be shared through repeatable currency weighting models.

Annex A: Three Tiers of Payment by Results

72. National currencies with national prices, such as the national tariff for acute care, provide an incentive for providers to increase efficiency and best practice by allowing national benchmarking. Where there is a high degree of uniformity in service configuration, this is likely to be the best long-term option. This approach will also support patient choice and the creation of personal budgets, as there will be a common way of describing and paying for services. The drawback is that national price setting is reliant on robust and high quality data, which is currently not available nationally for most community services.
73. National currencies with local prices will reflect variations in service provision and historical cost, while also providing a basis for benchmarking. However, it will be important to ensure that the use of national classifications does not constrain innovation, particularly where service providers are implementing new skill mixes and providing care in new settings. The national currency development work that the DH is leading will be flexible enough in design so that local currencies can be used alongside them for related services.
74. Local currencies with local prices will be essential where services are provided in very different ways and to widely differing individuals. Health services for homeless people, for example, will be very sensitive to local circumstances and could be provided as outreach, drop-in, group, one to one, multi-disciplinary or single professional group. It would not make sense to constrain this necessary variation by specifying a national unit of account.





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