

# Service specification for lead provider and health and well-being services

## Child House Pilot Programme

This version of the specification has been produced to support consultation and engagement with stakeholders about the proposed service model for the Child House Pilot.

This should be considered a working draft document and the commissioners of the proposed service would appreciate feedback from all interested stakeholders. We anticipate continuing to develop the specification over the coming months – particularly around the criminal justice functions to be delivered within the Child House, how the provider of the lead provider and health and well-being service relates to the criminal justice functions and around the core requirements of the specification in terms of areas like information governance, data protection, workforce development etc.

If you have feedback please send your comments to [leanda.richardson@mopac.london.gov.uk](mailto:leanda.richardson@mopac.london.gov.uk) & [Mary.Crawford@mopac.london.gov.uk](mailto:Mary.Crawford@mopac.london.gov.uk) by 31 August 2017.



# **1. INTRODUCTION**

## **1.1 Purpose of this document**

- 1.1.1 This specification sets out the services to be commissioned for London's Child House pilot project. It describes the expectations of the lead provider as the overall co-ordinator of services, together with the health and well-being services which are to be provided.
- 1.1.2 It outlines activities and outputs which need to be delivered and the outcomes to be achieved over the course of the contract period. The nature of the Child House pilot is one of promoting innovation, and ongoing co-design and co-production is encouraged.
- 1.1.3 The Provider will ensure that the Service is provided at all times in accordance with the principles, values and standards referred to in this document, other requirements within the Contract and all relevant national legislative requirements.
- 1.1.4 The specification should be read in conjunction with the terms and conditions section of the contract.

## **1.2 Background to the Child House**

- 1.2.1 The Mayor's Office for Policing and Crime (MOPAC) and NHS England (London region) have been successful in gaining funding from the Home Office for the Child House project. The bid was based on a pilot operating for two years with the intention of evaluating its success to determine the benefits and feasibility of establishing more units across the capital and/or elsewhere. MOPAC and NHS England (London region) have also identified resources to invest in the pilot.
- 1.2.2 The scheme aims to radically improve support to children, young people and their non-offending families following incidents of child sexual abuse including exploitation. In 2014/15 a review of child sexual abuse pathways was commissioned by NHS England (London region) and undertaken by experts from Sexual Assault Referral Centres (SARCs). This showed that only 1 in 4 children who have been abused come to the attention of statutory services. The child is then subjected to a prosecution based process with multiple police interviews. Many cases do not have enough evidence to proceed to trial and those that do can take up to 2 years before they reach court. Conviction rates are low leaving suspected perpetrators free to re-offend.

## **1.3 The vision**

- 1.3.1 The concept is simple and in line with best practice, the European PROMISE agreement and evidence from abroad. The aim is to provide a service which is centred around the child. Rather than the child/ young person having no choice other than to go to numerous agencies and buildings to access different services the Child House will provide support 'under one roof'. The environment will be reflective of the circumstances with an emphasis on being safe, secure and focused around the needs of the child/young person.
- 1.3.2 During the pilot all Forensic Medical Examinations (FMEs) will continue to be undertaken at the Children and Young Peoples' Havens. The Child House will act as a central point overseeing all post FME provision in the designated geographical area. Some key services will be located at the Child House premises particularly the initial investigations, but ongoing support may well be accessed closer to the child's home. The particular circumstances will be informed by the child/young person's needs and wishes, together with those of their non-offending families.
- 1.3.3 It is intended that the Child House will be a single point of access for the delivery of all the support children and young people need including Health and Well-being Services, Social Care, and Criminal Justice Services. Specifically, this will include:
  - Comprehensive medical examination (excluding FMEs)

- Sexual health follow up and aftercare
- Emotional, mental health and well-being assessments
- Psychological and counselling services, including group therapy and 1:1 sessions
- Specialist advocacy and support
- Achieving Best Evidence (ABE) interviews conducted by trained clinical psychologists

Our aspiration is also to provide pre-trial cross examination interviews and/or live links to court all overseen by a presiding judge, for which we are waiting judicial approval.

1.3.4 It is intended that during the pilot the Child House will develop and establish a reputation for its expertise and be in a position to share learning arising from the project. Our long term ambition is to provide the evidence base so that more Child Houses will be established, becoming centres of excellence serving as a place for the advancement of child protection, safety and security as well as family supportive practices. In time, the aim is for the Child Houses to contribute to the international body of literature on all matters relating to child sexual abuse and help change societal attitudes to abuse more broadly.

## **1.4 Expected outcomes**

1.4.1 Commissioners are supporting an outcome based approach to service design and delivery, with the goals for the Child House pilot being:

- Improved referral pathways into and out of the Child House
- Improved CYP, family and carer experience of support received post disclosure
- Improved CYP experience of the criminal justice process post disclosure
- Improved mental health and well-being outcomes for CYP
- Improved professionals awareness, competence and confidence in working with CSA/CSE
- Increased likelihood for CYP who received a Child House service to have cases charged by CPS
- Increased likelihood for CYP who received a Child House service to have their case end in conviction
- Improved partnership working

1.4.2 There are also some longer-term outcomes which have been identified. Due to the timescales around the Child House pilot, it is unlikely that they will be measurable, but they are aspirations which commissioners would like to achieve:

- Providing CSA victims care and support to reduce the long-term impact of victimisation;
- Organisations are committed to being victim focused in their support of CSA victims.

## **2. SCOPE**

### **2.1 What is required?**

2.1.1 The role of the lead provider will be twofold - one of co-ordination and local leadership and another as the provider of health and well-being services.

2.1.2 In its co-ordination role, the lead provider will be required to bring together a range of services under the umbrella of the Child House – health, social care, the police, criminal justice and the voluntary sector. The lead provider will have a key role in co-ordinating criminal justice and social services involvement in the support offered to children and young people alongside the health and well-being services which it will have a responsibility to deliver.

2.1.3 The lead provider will be required to provide the health and well-being services either directly, through working in partnership or sub-contracting with other providers, including the voluntary sector.

- 2.1.4 The lead providers will also have responsibility for the day to day management of the Child House premises. Commissioners will provide further information on the buildings management responsibilities of the provider in due course, once the funding position is made clear.

## 2.2 Overall approach

- 2.2.1 This is very much a pilot project where the intention is to learn and develop through implementation. The lead provider is expected to deliver clinical and managerial leadership to promote the concept as well as the service. The lead provider will need to be proactive in managing local tensions and challenges and will need to exhibit strong clinical leadership in the context of multi-agency working and multi-disciplinary case discussions.
- 2.2.2 The specification is based on the best evidence available at this time and accommodates a process of ongoing co-production and co-design. The lead provider will be integral to this role and is expected to play an active part in supporting continuous improvement and delivering a robust evaluation of the service.

## 3. SERVICE PRINCIPLES, STANDARDS, LEGISLATION AND GUIDANCE

### 3.1 EU PROMISE project

- 3.1.1 The EU PROMISE Project was launched in 2015 and draws on UN, EU and Council of Europe law and good practice to establish child friendly justice and welfare services. The PROMISE Project has since published a set of quality standards which set out pan-European guidelines for Child House Services. They are underpinned by four key principles whereby measures are taken to ensure that:
- re-victimisation and/or re-traumatisation of the child is avoided at all times
  - there is no undue delay; with interviews, assessments and all other interventions taking place on a timely basis
  - the best interest of the child is the primary consideration in all actions
  - the child has a right to be heard and receive information throughout the process

- 3.1.2 It is expected that the lead providers establish services in line with these standards as well as other practice and recommendations arising from the PROMISE Project. It is also a requirement for the lead providers to audit the service against these standards and practices.

- 3.1.3 Further details of the EU PROMISE Project and the published standards are available via the following links:

<http://www.childcentre.info/promise/>

<http://www.childrenatrisk.eu/promise/european-barnahus-quality-standards/>

### 3.2 UK legislation policy and practice

- 3.2.1 'Working together to safeguard children' (March 2015) sets out the legislative requirements and expectations of individual services to safeguard and promote the welfare of children. In this context, it maps out the essential elements for the lead providers and other stakeholders involved in provision via the Child Houses. There are two key principles:
- Safeguarding is everyone's responsibility: for services to be effective each professional and organisation should play their part; and
  - A child-centred approach: for services to be effective they should be based on a clear understanding of the needs and views of children

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/419595/Working\\_Together\\_to\\_Safeguard\\_Children.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf)

- 3.2.2 The guidance must be adhered to as part of the Child House development, this being in accordance with the duties set out within the following legislation:
- Children Act 2004

- Education Acts (Section 175 of the Education Act 2002 and Sections 94(1) and (2) of the Education and Skills Act 2008 and Section 342 of the Education Act 1996)
- Children Act 1989
- Legal Aid, Sentencing and Punishment of Offenders Act 2012
- Police Reform and Social Responsibility Act 2011
- Childcare Act 2006
- Crime and Disorder Act 1998
- Housing Act 1996

### 3.3 London Child Protection Procedures

- 3.3.1 The London Child Protection Procedures are underpinned by 'Working together to safeguard children' (March 2015). They set out how agencies and individuals should work together to safeguard and promote the welfare of children and young people. The target audience is professionals (including unqualified staff and volunteers) and front-line managers who have particular responsibilities for safeguarding and promoting the welfare of children.
- 3.3.2 Where there are concerns about sexual abuse, it is highly likely that the case will meet the statutory child protection threshold. The majority of cases referred to the Child House are likely to be subject to a s47 investigation in accordance with the Children Act 1989.
- 3.3.3 The lead provider and all partner agencies are expected to comply with London Child Protection Procedures and Practice Guidance details of which are available via the following link <http://www.londoncp.co.uk/>

### 3.4 NICE guidance

- 3.4.1 There are numerous NICE documents which provide guidance for services related to Children and Young People, a key selection of which are outlined in appendix x. Only a few of these are directed to those who have experienced abuse, and those that are have a restricted scope e.g. NICE Quality Standard 'Domestic Violence and abuse' (QS116) covers adults and young people aged 16 and over but excludes those under 16 years. Similarly, NICE Clinical Guidance 'Child maltreatment: when to suspect maltreatment in under 18s' (CG89) focuses on the symptoms and signs of maltreatment rather than the response.
- 3.4.2 This gap in the available guidance has been recognised and the Department of Health and Department for Education have asked NICE to develop further documentation on child abuse and neglect. This is currently being drafted and due to be published in September 2017.
- 3.4.3 Compliance with existing and newly developed guidance will be key in the delivery of services within the Child Houses.

### 3.5 Care Quality Commission (CQC)

- 3.5.1 The successful lead provider will be responsible for registering the service with CQC as required. In anticipation of this it is expected that the services will be provided in accordance with the Care Quality Commission five key domains, which are as follows:
- **Safe:** By safe, we mean that people are protected from abuse and avoidable harm
  - **Effective:** By effective, we mean that people's care, treatment and support achieves good outcomes comparable with health outcomes in the general population, promotes a good quality of life and is based on the best available evidence.
  - **Caring:** By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.
  - **Responsive:** By responsive, we mean that services are organised so that they meet people's needs.

- **Well-led:** By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture

3.5.2 The lead provider must ensure that services are delivered in accordance with CQC's standards of quality, access and effectiveness. Any formal or informal inspections / reports should be used to inform service improvements and developments

### 3.6 Service user involvement

3.6.1 Under the National Health Service Act 2006, the NHS has a legal duty to ensure that public, patient / service users and carers are involved in the design and delivery of healthcare services. For the purposes of the Child House the requirement for service user involvement should extend beyond the NHS to encapsulate all aspects of provision including health and well-being, social care, criminal justice and voluntary sector services.

3.6.2 It is expected that the lead provider will build on the engagement work undertaken by commissioners and establish a delivery framework that continues to promote co-design and co-production. This should include but is not restricted to activity such as:

- Further development of the service models
- The development of operational policies
- The recruitment of staff, including encouragement of applications from people with lived experience of CSA
- The management and review of the quality of the service, utilising peer review
- Involvement in the management / governance structures for the service e.g. via a Children's/Young People's Board
- Information on the service for children, young people and their families

3.6.3 The lead provider should provide appropriate and accessible means by which service users can express their views about and their experiences of services, making the best use of the latest available technology and social media as well as conventional methods. As well as capturing service users feedback the lead provider should demonstrate robust systems for analysing and responding to that feedback.

3.6.4 A number of papers are referenced below which help to set out standards and guidance for children and young people's and parents' participation in service design and delivery:

- NICE NG44 [Community engagement: improving health and wellbeing and reducing health inequalities](#)
- Department of Health (2011) [Quality Criteria for young people friendly health services](#) ('You're Welcome') sets out principles to help commissioners and service providers to improve the suitability of NHS and non-NHS health services for young people.
- National Youth Agency (2006) Hear by Right. [Standards for young people's participation](#) (not specifically mental health)
- Health and Social Care Advisory Service (2008) Turning what young people say into what services do. Quality Standards for children and young people's participation in CAMHS is based on the Hear by Right standards above and adapted specifically for CAMHS.
- "Delivering With and Delivering Well" - was developed by young people, commissioners and providers to integrate the principles of the CYP IAPT programme into existing quality assurance and accreditation frameworks.
- GIFT (2014) The involvement of parents and carers in Child and Adolescent Mental Health Services.
- Lavis, P., Hewson, L. (2011) How Many Times Do We Have to Tell You? A Briefing from the National Advisory Council about What Young People Think About Mental Health and Mental Health Services, National Advisory Council for Children's Mental health and Psychological wellbeing.

- 'Reilly, M., Vostanis, P., Taylor, H., Day, C., Street, C., & Wolpert, M. (2012). Service user perspectives of multiagency working: a qualitative study with children with educational and mental health difficulties and their parents. Child and Adolescent Mental Health.
- Street, C. Anderson, Y. Allan, B. et al (2012) "It takes a lot of courage" Children and Young People's experiences of complaints procedures in services for mental health and sexual health, including GPs, The Children's Commissioner.
- Street, C. (2014) Children and young people's views of counselling: improving the tools to gather outcomes, Youth Access  
[http://firststop.net.nspcc.org.uk/AboutTheNSPCC/Functions/NationalServices/Participation/Participation\\_Strategy\\_gf74684.pdf](http://firststop.net.nspcc.org.uk/AboutTheNSPCC/Functions/NationalServices/Participation/Participation_Strategy_gf74684.pdf)

### **3.7 Equality and diversity**

- 3.7.1 Under the Equality Act 2010 public authorities must have due regard to the need to eliminate discrimination, harassment and victimisation, advance equality of opportunity and foster good relations between persons who share a protected characteristic and those who do not. The protected characteristics are defined as age, disability, gender re-assignment, race, religion and belief, sex, sexual orientation, pregnancy and maternity, marriage and civil partnership. The impact of service changes on individuals with protected characteristics needs to be considered and action taken to promote access and reduce any negative effect.
- 3.7.2 The lead provider together with its partner agencies is expected to promote services in line with its responsibilities under the Equalities Act. As part of the co-design process specific mention has been made on the need to consider the LGBT community in particular young boys/men, those in families where there has been arranged/forced marriage, as well as issues associated with some cultural and religious beliefs.

## **4. THE SERVICES**

### **4.1 Locations**

- 4.1.1 The Child House is to be sector based operating from a location as determined by commissioners. Further details will be provided in the supporting information issued with the tender. This will include the terms under which the lead provider will occupy the premises and the expectations required for the day to day management of the building.

### **4.2 Who is the service for?**

- 4.2.1 The service will cater for all children and young people aged up to 18 years where there is suspected or disclosed sexual abuse including exploitation. This includes contact and non-contact abuse. The Child House will also support non-offending family members / carers of the children / young people who have indicated or are suspected victims of sexual abuse including exploitation
- 4.2.2 Referrals will fall into two broad client groups:
- Children aged 0 -12 years
  - Young people aged 13 -17 years
- 4.2.3 It is anticipated that the majority of referrals will be via the police or social services and the CYP Havens, although young people aged 13 years and over will also be able to self-refer. Equally they may be referred by associated local services e.g. sexual health or child and adolescent mental health.
- 4.2.4 Anyone aged 17 years who starts to receive support via the Child House will be able to continue doing so after they reach 18 years.

- 4.2.5 Children and young people eligible for the service will be those residing in the Local Authorities within the sector in which the Child House is located. In exceptional circumstances, the service will cater for people who fall outside of this scope e.g. young people who are homeless. Such referrals will be considered by the provider in conjunction with the commissioners and reported on a case by case basis. Non-offending family members / carers will be supported irrespective of where they live, providing the child/young person resides in the catchment area.
- 4.2.6 Services must be made accessible to all children and young people regardless of race, ethnicity, gender, sexual orientation, disability, economic background, religion, culture, immigration status.
- 4.2.7 The Child House will provide support and intervention up to the 2-year duration of the pilot. If ongoing support is required thereafter individuals will be referred onto local services.
- 4.2.8 During the pilot period the Child House **will not** cater for:
- Children and young people requiring forensic medical examination
  - young people aged 18-25 years with additional needs / vulnerabilities

The potential for the Child House to extend into these areas will be dependent on the success of the pilot and sustainability plans thereafter

### **4.3 Hours of operation**

- 4.3.1 The Child House will operate Monday-Friday 10am-8pm and 10am – 1pm Saturday mornings. Evening and Saturday opening is being supported so that people can attend the centre outside school/college hours and family members do not have to take excessive time off work to attend.

### **4.4 Lead provider as co-ordinator and local leader**

- 4.4.1 The Provider will ensure strong leadership at sector and operational level e.g. by demonstrating overarching leadership and support robust clinical governance structures, overseeing the day to day management of the child house. They will demonstrate similar leadership with all subcontractors.
- 4.4.2 The lead provider is expected to establish the day to day operational arrangements and ensure that services are well co-ordinated once the Child House is open. A means needs to be established by which services come together so that the teams working in the Child House sees any child from any location within the sector, under a single governance process and a single record keeping system.
- 4.4.3 Commissioners have set out a number of milestones that they expect to be delivered as part of the implementation plan. These are outlined in **appendix x (to be agreed)** but include such tasks as:
- writing policies and protocols to be adopted in the Child House
  - establishing MoUs between partners setting out the terms of agreement by which the Child House will be delivered
  - reviewing information sharing protocols to ensure information is managed in accordance with the requisite data and information governance requirements
  - establishing user engagement arrangements
- 4.4.4 The lead providers will have a key role in overseeing the business management aspects of the care pathway. This includes managing the day to day operational arrangements for which processes and protocols will need to be drawn up with partner agencies. Individual cases will need to be tracked, progress through the system will need to be monitored and good quality management reports will need to be produced. Cases will also need to be managed in aggregate and it is envisaged that the lead provider will be responsible for organising weekly caseload management meetings and daily 'hot issues' meetings.
- 4.4.5 The lead provider is required to recruit a dedicated Child House Service Manager who will be instrumental in overseeing this function. The post holder is expected to have a health or care

professional qualification. An outline of the responsibilities and requirements for the post holder is summarised below:

- To provide leadership to the Child House and all staff working under the umbrella of the Child House
- To coordinate the day to day running of the service so that the child is always at the centre of the service and to ensure that the lead provider's role is fulfilled
- To ensure the effective operational functioning of the service and the management and monitoring of all sub-contracting and partnership arrangements
- To monitor partnership working and the effectiveness of the Multiagency MoUs
- To ensure that there is appropriate clinical and managerial supervision available to all staff working under the umbrella of the Child House
- To be responsible for ensuring that all staff working under the umbrella of the Child House have undertaken appropriate training and have in place a programme of professional development.
- To ensure that the agreed information sharing and governance protocols are in place and adhered to
- To ensure that the local care pathways for access to the service, care and treatment within the Child House and transfer/discharge to local services are adhered to
- To ensure that regular multi-disciplinary meetings are held and recorded to review cases and agree care plans
- To ensure that the property is managed in line with the agreed premises and lease arrangements
- To support the development and strengthening of a Service Manager's Network between all Child House, the CSA hubs, and SARCs in the London Region
- To support the monitoring and evaluation of the pilot by ensuring the correct and relevant data is collected and presented as required
- To ensure the timely return of contract performance data and development of any action plans as agreed with commissioners
- To work with NHSE and MOPAC to ensure that the learning from the pilot is recorded and that it informs the consideration and development of a sustainability plan
- To represent the service at a senior level at partnership meetings, public meetings and other forums as required.

#### **4.5 Care pathway**

4.5.1 The Lead Provider must ensure that there is a clear pathway into and out of the Child House and for the period of a child and their family's involvement in the service. This needs to give due consideration to:

- Self and professional referrals
- Whether there will be a triage process
- Initial response e.g. medical examination, investigative interview
- Multi-disciplinary assessment and reviews processes
- Allocation of specific roles e.g. case management, advocate
- Ensuring the separate assessment and care plan for a child/young person and their carer
- Transfer/discharge plans
- Interface between the health/care/child protection and criminal justice system aspects of the pathway

4.5.2 As well as coordinating the care pathway for an individual client the Lead Provider is responsible for managing the overall operation of all cases e.g. daily hot issue meetings, weekly case load management meetings, case tracking and production of case load/management reports.

#### **4.6 Lead provider of health and well-being services**

- 4.6.1 The lead provider will have responsibility for securing the health and well-being services that operate from the Child House. This will include:
- Clinical leadership
  - Paediatric services
  - Mental health and well-being services including clinical psychology, family therapy, counselling, advice from child psychiatry (often remotely) and from CAMHS.
  - Advocacy, including child advocates and young person's advocates (both include family therapy)
  - Play work
- 4.6.2 Set out below are the key roles, anticipated tasks and headline skill requirements for the health and well-being service. These are outlined as they are expected when the pilot Child House is fully operational. It is acknowledged that during the start-up period not all roles may be in place or carry out the full function.
- 4.6.3 Staffing numbers and the exact skill mix will be for the lead provider to propose and agree with the commissioner.
- 4.6.4 All core staff are expected to:
- support and participate in multi-disciplinary reviews of individual clients, of the service as a whole and contribute to the training and development of staff within the sector
  - adhere to the child centred model and work flexibly when required to support a child and their family when at the Child House
  - provide court reports and attend court as required
  - hold appropriate DBS clearance to work with Children and vulnerable adults.
- 4.6.5 It is anticipated that all staff will record their intervention as per the agreement with the lead provider and others who employ staff working under the umbrella of the Child House and that all staff will complete an agreed common dataset.
- 4.6.6 Clinical leadership  
To offer an effective service in line with the Barnahus standards and London Child Protection procedures strong clinical leadership within the Child House will be essential.

The clinical leader will be expected to

- be a champion of the Child House ethos and model
- have an overview of the whole service and play a key role in both strategic and operational review
- lead the development and application of the Child House clinical governance processes
- through their recognised professional competence –
  - ensure that the service operates in the best interests of the child
  - address and shows leadership in the resolution of professional and personal challenges and ethical dilemmas
  - ensure that appropriate clinical/care pathways are in place to support the child and their family during and after time in the Child House.

Whilst there is no specific professional qualification for this role they will be a member of a regulated health profession, hold a senior position within their organisation and/or profession. They will be expected to demonstrate the attributes required to deliver the role. It is anticipated that they will be held in high regard within the sector and well known with a demonstrable ability to work across organisations and professions.

#### 4.7 Role of the paediatric clinical lead

- Provide phone consultation on child abuse cases

- Undertake medical examinations to assess the child's health and wellbeing/development to identify and document injuries and/or areas of concern that may indicate other forms of child abuse or neglect. This role will be carried out in conjunction with a second examiner as required to meet both criminal justice and care requirements e.g. Paediatrician/ Gynaecologist/Nurse with access to the video-colposcope
- Undertake medical and sexual health treatments at the Child House in conjunction with the local sexual health team and resident paediatric nurse
- Where there is a need for further physical care the paediatric lead will refer the child to local health services as clinically required
- Offer follow up related to clinical need within the context of the Child House remit
- Report writing outlining findings of CSA examination and sexual health screening for submission to court
- Court attendances as needed *Commissioners aim to provide a more detailed description of this element of the role*
- Undertake joint case planning and reviews with multidisciplinary colleagues
- Training / peer review to create a network of local expertise and to help grow new expert paediatric examiners
- Support creation of centre of expertise in CSA/CSE including involvement in audit and research and publishing findings in academic journals

#### 4.8 Role of the Paediatric Nurse

- Undertake medical examinations and follow up in conjunction with Paediatric clinical lead
- Undertake medical and sexual health follow up in conjunction with the local sexual health team and paediatric lead; providing results and outcomes of tests in line with agreed pathways
- Undertake joint case planning and coordinate all care including reviews with multidisciplinary colleagues
- Undertaking individual case management responsibilities in the context of fulfilling statutory duties with this being decided on a case by case basis
- Contribute to peer review of relevant aspects of the service
- Contribute to creating a centre of expertise in CSA/CSE including involvement in audit and research and publishing findings in academic journals in conjunction with the paediatric lead
- All paediatric nurses to be qualified RCNs

#### 4.9 Role of mental health practitioners

A team of mental health experts drawn from a range of professionals, including: RMNs, Clinical Psychologists, Counsellors and other Mental Health Practitioners under appropriate clinical leadership and supervision and with access to psychiatric and CAMHS team support. This team would be able to:

- Undertake an initial assessment and development of evidence-based and trauma-informed treatment plan which meets the needs of the child and family at that time. The child/young person and non-offending family members / carers are to have separate care plans.
- Provide bespoke therapeutic intervention offered as per the needs of the child and their family at a time when they are ready to engage.
- Support for all children, young people and their non-offending families (after the forensic interview)
- Undertaking individual case management responsibilities in the context of fulfilling statutory duties with this being decided on a case by case basis
- Refer onto local or specialist services outside of the Child House if required
- Provide reports and attendance at court as needed
- Establish an ongoing relationship with local support networks including voluntary and community sector specialists
- Provide clinical supervision and training to enable the local support network to assist the child/young person outside of the Child House creating a 'team around the worker' including for example:
  - Voluntary and community sector agencies
  - School nurses and school counsellors

- Improving Access to Psychological Therapies (IAPT)
- Youth workers
- Youth Offending Team (YOT) officers

In addition to the therapeutic role described above, suitably trained clinical psychologists will lead the ABE interviewing of children and young people as agreed with the MPS and other CJS partners. Whilst clinical psychologists need to have the capacity and capability to undertake ABE interviews alongside their therapeutic work they cannot provide both functions for the same one child. Where one clinical psychologist undertakes an ABE interview for a child another psychologist must provide the therapeutic support.

#### 4.10 Role of the advocate

- Greet the child/young person and their non-offending family members/ carers the first time they enter the service and provide support and advocacy thereafter until they no longer need the Child House services.
- Be proactive in helping to problem solve issues for the child, young person and their non-offending family members and be the main point of contact in this respect
- Be aware of the nine domains of advocacy: (accessible, client-led, informed decision-making, empowering, emotionally and practically supportive, independence, criminal justice systems supports, multiagency collaboration, complaints and feedback) and evidence them in daily practice and interactions with their clients.
- Ensure that there is continuous access to information about what to expect, especially about the criminal justice and social care systems
- Perform a safety assessment of the family and develop and recommend a safety plan for the child victim and their family/carers
- Support case management for all children and young people, monitoring the multidisciplinary response to ensure that the clients are receiving adequate levels of care and support
- Assist the family in accessing services recommended by the team
- Ensure that the child, young person and their family is settled into the follow up provision if referred out to community-based services in the family support network
- Undertake joint case planning and reviews with multidisciplinary colleagues
- Assist with community education and professional training on child abuse prevention.

The post holders will not be required to have any particular qualifications but need to have a suitable level of appropriate experience, appropriate training, assessed as being competent in the task, of high integrity and good character and be aged over 18 years of age.

#### 4.11 Role of the play worker

This role will support the work of the wider team and play a key part in:

- Using play to help a child understand what the physical examination will include and as such prepare them for it and possibly spend time with them after it if the examining medic feels this would be of benefit
- Support the service to maintain a child focus in their general approach
- Provide general support for child to help reduce traumatisation especially for those aged up to 12
- Support /play with siblings if required to enable mother to be seen alone or with child who has been abused.

This not a regulated profession and there is no standard recognised qualification

#### 4.12 **Associated services**

4.12.1 In addition to the above there will be some other new functions established as part of the Child House initiative. These are:

- A social care liaison officer with responsibility for providing advice and co-ordinating cases between the Child House and the local social care teams.
- A police liaison officer with responsibility for providing advice and co-ordinating cases between the Child Houses and the CAIT and SAPPHIRE teams

4.12.2 Neither of these roles are being commissioned via this contract but are referred to here as the lead provider will be expected to liaise and bring together the functions in the context of its co-ordination role. Further information about these functions will be provided in the supporting information issued with the tender.

#### **4.13 Lead Providers role in supporting the evaluation**

4.13.1 The Child House model has already been proven to achieve better outcomes for the victims of CSA and their families and is now an internationally recognised model. This project is about testing proof of practice within the English judicial and care system with the intention of extending implementation. Consequently, there is heavy emphasis on evaluation and continuous improvement.

4.13.2 MOPAC's Evidence and Insight team are conducting an evaluation of the pilots and a high-level evaluation plan has been produced. Funding has been secured from the Department for Education is help with the scaling up of the concept.

4.13.3 The lead providers are expected to have an integral role in helping implement the evaluation plans and it is expected that the lead providers will work with MOPAC's Evidence and Insight team to do so.

### **5. GENERAL ISSUES AND REQUIREMENTS**

#### **5.1 Demand management**

5.1.1 Commissioners have undertaken some demand analysis and developed a number of scenarios. More precise estimates will be dependent upon the sector in which the Child House is based, a combination of the number of referrals based on the MPS plus self-referrals, the percentage who will access specific services at the Child House and the estimated trajectory. Further information about this will be provided in the support information for the tender.

5.1.2 Once the services are operating the lead provider will have a role in collecting and comparing actual activity against that which was planned.

#### **5.2 Information Sharing, Governance and management**

5.2.1 Following the "*chronic failures to protect children from sexual exploitation in Rotherham*" the Government have focused on improving a number of key areas, including information sharing. The Secretaries of State from DH, Home Office, DCLG and MoJ, have come together to produce a letter on the importance of information sharing, which states:  
*.... a teenager at risk of child sexual exploitation is a child at risk of significant harm. Nothing should stand in the way of sharing information in relation to child sexual abuse, even where there are issues with consent."*

5.2.2 Therefore, it is vital that the Lead Provider works with partners to standardise and improve information sharing in order to meet the needs and best interests of service users. Information sharing agreements should be established between the Lead Provider and all their partners in order to ensure that service users receive appropriate and co-ordinated support in the service and on-going care and support.

5.2.3 The Lead Provider is expected to confirm all parties' duties under Data Protection Legislation and how these will be upheld in the context of the Child House. This needs to be clear within the LPs Memorandum of Understanding with local partners. The LP is expected to be proactive in providing assistance to enable compliance with these duties and address any problems.

5.2.4 Where any Personal Data is processed by any subcontractor of the Lead Provider in connection with this Contract, the Lead Provider shall procure the subcontractor who will comply with the relevant Information Governance obligations are set out and adhered to.

Commissioners will review IG requirements as part of the consultation process [reference to patient to be changed to service users]:

A typical set of requirements are as follows:

The Provider will:

- Make full use of electronic patient record systems to record patient data as data processor or other role as agreed.
- Ensure information governance and patient record system training is provided to all employed and visiting clinical staff as required to ensure standardised high quality of health data recording.
- Comply with legislation including, but not limited to, Data Protection Act 1998, Access to Health Records 1990, Human Rights Act 1998, Computer Misuse Act 1990, Common Law Duty of Confidentiality, and with NHS Codes of Practice including but not limited to Confidentiality: NHS Code of Practice, Records Management: NHS Code of Practice, Care Record Guarantee, Caldicott Principles.
- Carry out and publish an IG assessment using the Health and Social Care Information Centre (HSCIC) IG Toolkit by the 31 March each year. Commissioners are required to ensure that all organisations, from which care is commissioned, including independent contractors and the third sector, are brought within the NHS Information Governance Assurance Framework. This can be demonstrated by the completion of the IG Toolkit on an annual basis. Achievement of level 2 scores demonstrates compliance with the IG Statement of Compliance required for access to the NHS network N3. Therefore, the Provider will perform an annual information governance self-assessment using the NHS information governance toolkit.
- Provide an accessible Fair Processing Notice for patients.
- Have policies to ensure appropriate and routine consent is obtained from patients in relation to the use of their confidential data; to include a patient information consent form and guidance on information sharing relevant to patients in line with legislation and local safeguarding procedures. Ensure that patient consent is recorded electronically so is clearly displayed on electronic records and is transferable to appropriate agencies with information requests- e.g. to primary care in the community.
- Have policies to ensure effective information sharing agreements are in place and there is access to IG and/or Caldicott Guardian expertise if required.
- Ensure there is a systematic and planned approach to the management of records and that data is processed so it serves the purpose it was collected for, is accurate and of high quality and is retained in accordance with the Records Management: NHS Code of Practice. The management of records will ensure that information, including confidential information, will be held securely, protected against unauthorised use or loss and, at NHS England's written discretion, destroyed securely or returned to the NHS England when it is no longer required

- Ensure that all members of staff working under the umbrella of the Child House are aware of the need to maintain full, accurate records, contemporaneous records for all patients attending for treatment and maintain such records in a manner that ensures patient confidentiality in line with NHS standards.
- Ensure that any paper received records for patients will be promptly summarised and key data entered onto the Electronic record. Paper data will subsequently be stored securely or, providing all data has been captured, will be destroyed confidentially and in accordance with NHS standards.
- Make provisions for raising awareness in staff who have access to the patient data of the laws applying to data handling/sharing.
- Provide a framework for securing and transferring patient data safely, whether electronic or paper, and undertaking regular information risk assessments.
- Only transfer electronic patient data that is: (i) necessary for direct patient care; and (ii) encrypted to NHS standards.
- Ensure that no patient data is transferred outside the European Economic Area (EEA)
- Provide a process for granting data subjects access to their medical records, if requested, in line with NHS and Establishment service guidelines and in compliance with the Data Protection Act.
- Assist and co-operate with all Freedom of Information requests and ensure all such information is sent promptly to the Commissioners to respond accordingly.
- Ensure that appropriate links are made with internal provider governance arrangements, including risk registers.
- Provide a process for incident reporting in line with HSCIC guidance and notify NHS England immediately of any information security breaches or near misses (including without limitation any potential or actual breaches of confidentiality or actual information security breaches).
- Have a process for undertaking a privacy impact assessment should patient data be processed in a new or changed way.
- Maintain documented plans and procedures to support business continuity in the event of power failures, system failures, natural disasters and other disruptions.
- Afford NHS England or its representative every reasonable facility to inspect and copy any relevant patient-related books and records in line with NHS confidentiality regulations.
- Maintain records which reflect the patient's wishes and preferences. Advanced planning will be encouraged and documented.

#### 5.2.5 Information management

Commissioners have appointed a Project Manager to identify and support the implementation of a case management/data collection software for the Child House. The Lead Provider will be expected to help with the application of the system to facilitate co-ordination and information sharing between agencies, and to underpin the management and evaluation of the service.

Sections 5.3- to 5.8 will be reviewed during the consultation process

### 5.3 **Data Protection Act**

- 5.3.1 The Service will ensure that it is appropriately registered with the Information Commissioner.
- 5.3.2 The Service will be expected to demonstrate accountability for the appropriate assurance of privacy issues involving the processing and sharing of service users' personal and sensitive information.
- 5.3.3. The Service must have policies in place to manage any loss of data, accidental or otherwise. These policies must include details on how the service provider would:
- implement a recovery plan, including damage limitation
  - assess the risks associated with the breach
  - inform the appropriate people and NHS England that the breach has occurred
  - review their response and update their information security.

#### **5.4 Complaints**

- 5.4.1. The Lead Provider will be expected to have an easily accessible complaints procedure and be able demonstrate to users and commissioners how these have been dealt with and used to improve the service

#### **5.5 Confidentially**

- 5.5.1 The Lead Provider will be expected to ensure that all practice is managed in accordance with NHS confidentiality requirements.

#### **5.6 Risk Management/Incident Reporting**

- 5.6.1 The Provider will ensure that there are robust policies and procedures relating to the identification and reporting of incidents and serious incidents.

#### **5.7 Business Continuity**

- 5.7.1 The Provider must have a business continuity plan covering a broad range of risks that may affect the delivery of services contained within this service specification.

#### **5.8 Workforce development**

- 5.8.1 The Lead Provider for workforce planning ensuring that staffing structures are in place based on the demand assessment, the realities of recruitment and retention, training and competence building and performance management.