The London Borough of Ealing

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DRAFT SERVICE SPECIFICATION

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CHILDREN AND YOUNG PEOPLE'S PUBLIC HEALTH NURSING SERVICE: HEALTH VISITING, SCHOOL NURSING, FAMILY NURSE PARTNERSHIP & THE HEALTH VISITOR ADVISORY SERVICE

JANUARY 2018

Ealing
www.ealing.gov.uk

Version Control Change Log

Version	Date	Updates
0.1	09.01.17	LB
0.2	29.01.17	LB and MW
0.3	05.02.17	LB and MW

Contents

1 Introduction

1.1.1 The Children and Young People's Public Health Nursing Service comprising of Health Visiting (HV) and School Nursing (SN) services, referred to as the '*Service*', will provide leadership, co-ordination and local delivery of the Healthy Child Programme (HCP) 0-19 requirements in the London Borough of Ealing (LBE). To support delivery, 4 levels of service interventions will be offered along with a range of mandated assessments/reviews, and the High Impact Areas will be used to prioritise and ensure resources are targeted appropriately, according to health need, to maximise health outcomes.

1.1.2 The Service will also include delivery of the Health Visitor Advisory Service and Family Nurse Partnership (FNP) programme. The requirements for the latter element, namely the FNP Programme, is included as Appendix 1 to this specification and will be reviewed on an annual basis during the lifetime of the contract.

1.1.3 The Service forms part of '*Early Start Ealing*' which is a holistic offer focused on improving outcomes for young children aged 0 - 5 and reducing inequalities at individual, family and community level. It brings together Health Visiting Teams, the Health Visitor Advisory Service, FNP, Social Workers, Therapists and the Council's Early Years services.

1.1.4 Pivotal to its success will be partnership working within the integrated team and with a wide range of other services, including maternity, local authority-provided or commissioned early years' services, voluntary, private and independent services, primary and secondary care, education settings, public health and health improvement teams, and children's social care services.

2 Evidence Base

2.1.1 The Marmot review[1] emphasised the importance of giving every child the best start in life to reduce health inequalities across the life course. The foundations for virtually every aspect of human development – physical, intellectual and emotional – are set in place during pregnancy and in early childhood. What happens during these early years has lifelong effects on many aspects of health and wellbeing, educational achievement and economic status.

2.1.2 Successive academic and economic reviews have demonstrated the economic and social value of prevention and early intervention programmes in pregnancy and the early years. In fact, the evidence-base for improved health, social and educational outcomes from a systematic approach to early child development has never been stronger and has been described as a powerful equalizer which merits investment (Irwin et al 2007, Marmot 2010).

2.1.3 Good health, wellbeing and resilience are vital for all our children now and for the future of society. There is firm evidence about what is important to achieve which is brought together in the national HCP 0-19, which includes:

- Healthy Child Programme: Pregnancy and the first five years of life (DH/DCSF, 2009)

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

- Healthy Child Programme rapid review to update evidence (PHE, 2015)

[1] The Marmot Review (2010). *Strategic Review of Health Inequalities in England, post-2010*. http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report

https://www.gov.uk/government/publications/healthy-child-programme-rapid-review-to-update-evidence

- Healthy Child Programme: From 5-19 years old (DH/DCSF, 2009)

http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_108866.pdf

2.1.4 Detailed references for the evidence base that supports this specification are set out in:

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. Commissioning Guide 4: Reference guide to evidence and outcomes (PHE 2016).

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/493625/Service_specification_CG4_FINAL_19Jan2016.pdf

3 Ealing Population – Children & Young People

3.1.1 A detailed account of Ealing's population can be found in the Ealing Joint Strategic Needs Assessment (JSNA) 2014 on LBE's website:

https://www.ealing.gov.uk/downloads/201201/health_and_wellbeing

https://www.ealing.gov.uk/downloads/download/3593/joint_strategic_needs_assessment_jsna_2016

4 Scope

4.1 Service Model

4.1.1 The Service will be a key part of the integrated service delivery model (Early Start Ealing) focused on improving outcomes for young children aged 0 – 5 years. Early Start Ealing will incorporate other Local Authority professionals and will work as integrated service with a single management structure and shared premises.

4.1.2 The Service will lead delivery of the HCP 0-19 and work in partnership with a wide range of services, including maternity, local authority-provided or commissioned early years' services, voluntary, private and independent services, primary and secondary care, education settings, public health and health improvement teams, and children's social care services.

4.1.3 The Service with its four elements, namely Health Visiting, Schools Nursing, the Health Visitor Advisory Service and FNP must be integrated and delivered as one overarching brand so that the Service is recognised by children and families and interventions appear seamless to its users.

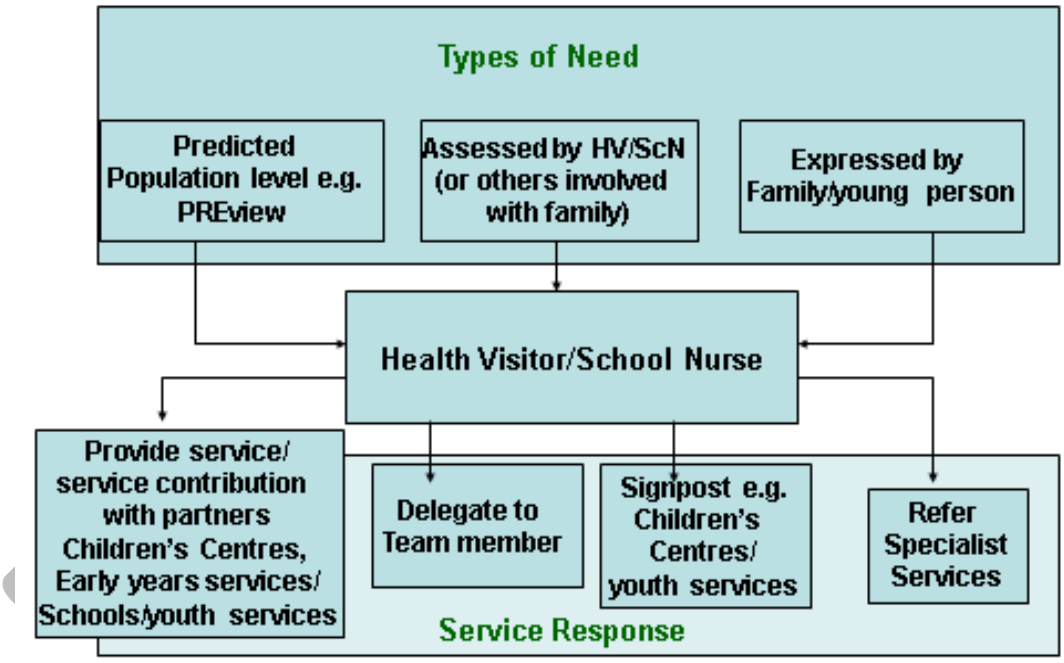
It is, therefore, expected that the workforce will be multidisciplinary and shared; have appropriate skills relevant to each element; make best use of resources such as managers, facilities, equipment and premises; and be led by specialist community public health nurses (registered Health Visitors and School Nurses).This leadership will ensure that individual,

family and community interventions will be brought together to improve health in populations by assessing and responding to local need (Figure 1).

4.1.4 Responding to the new vision for nursing set out in "*Compassion in Practice: Nursing, Midwifery and Care Staff Our Vision and Strategy*" (DH: 2012), health visitors and school nurses will be expected to demonstrate the following.

- Show care, compassion and commitment in how they look after families.
- Find the courage to do the right thing, even if it means standing up to senior people to act for the child or parent's best interests, in a complex and pressured environment.
- Communicate well, particularly with the children, families and communities they serve and demonstrate competence in all their activities and interventions.

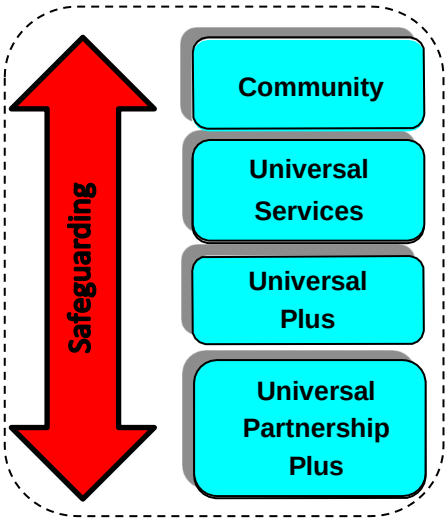
Figure 1: Assessing and Responding to Local Need ('*Population Health*')[2]



4.1.5 The Service will use strength-based approaches and build non-dependent relationships to enable efficient working with their population (children, young people and families) to support behaviour change, promote health protection and keep children safe. Figure 2 illustrates the model for health visiting and school nursing services which will support the delivery of the HCP and details what parents, children and young people can expect to receive.

[2] PHE (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. Commissioning Guide 1: Background information on commissioning and service model*.

Figure 2: The Model for Health Visiting & School Nursing



Your Community describes a range of health services (including GP and community services) for children and young people and their families. Health visitors and school nurses will be involved in developing and providing these and making sure local services are known about.

Universal Services from the health visitor and school nursing team provides the Healthy Child Programme to ensure a healthy start for every child. This includes promoting good health, for example through education and health checks and protecting health e.g. by identifying problems early.

Universal Plus provides a swift response from the health visitor and school nurse service when specific expert help is needed which might be identified through a health check or through providing accessible services that families can go to with concerns. This could include managing long-term health issues and additional health needs, reassurance about a health worry, advice on sexual health, and support for emotional and mental health wellbeing.

Universal Partnership Plus delivers on-going support by the health visitor and school nursing team as part of a range of local services working together with families to deal with more complex problems over a longer period.

4.1.6 Prevention and early intervention lies at the heart of the universal service for children and families and aims to support them at crucial stages of life, to promote child development, improve child health outcomes and ensure that families at risk are identified at the earliest opportunity, which leads to early support and harm reduction as appropriate/necessary.

4.1.7 The High Impact Areas, which describe the areas where the 0-19 workforce can and should have a significant impact on health outcomes, will support the Service to prioritise and ensure resources are targeted appropriately, in accordance with health need, to maximise health outcomes.

The High Impact Areas identified by PHE (2016) for Health Visiting are (0-5):

1. Transition to parenthood, early weeks
2. Maternal (perinatal) mental health
3. Breastfeeding
4. Healthy weight
5. Managing minor illnesses and reducing incidents
6. Health, wellbeing and development at 2 years and support to '*be ready for school'*

The High Impact Areas identified by PHE (2016) for School Nursing are (5-19):

1. Building resilience and supporting emotional wellbeing
2. Keeping safe – managing risk and reducing harm
3. Improving lifestyles
4. Maximising learning and achievement
5. Supporting additional health and wellbeing needs
6. Seamless transition and preparing for adulthood

4.1.8 Safeguarding must be embedded across the levels detailed in Figure 2 with all staff following the principles set out in the national guidance 'Working Together to Safeguard Children' (HM Government 2015) the Pan London Child Protection Procedures and the Ealing Safeguarding Children Board (ESCB) procedures.

4.2 Aims and Objectives of the Service

4.2.1 The aim is to ensure that all children and young people receive the full service offer (Healthy Child Programme 0-19), including universal access and early identification of additional and/or complex needs, with timely access to specialist services, to secure local services that enable health visiting and school nursing teams to contribute to improved local outcomes and reduce health inequalities for children and young people, maximising specialist public health, defined clinical and public health skills, professional judgment, autonomy and leadership. Specifically, it is expected that the Service will:

- Support families to give children the **best start in life** based on current evidence of '*1001 Critical Days: The Importance of the Conception to Age Two Period*' as a foundation on which to build support in the early years and beyond
- Provide **expert advice** and support to families to enable them to provide a secure environment to lay down the foundations for emotional resilience and good physical and mental health
- Enable children to be ready to learn at 2, ready for school by 5 and to achieve the **best possible educational outcomes**
- Support families and young people to engage with their local community through education, training and employment opportunities
- Support children, young people and families to navigate the health and social care services to ensure **timely access and support**
- Work in **partnership with local communities** to build community capacity; demonstrating population value, utilising asset-based approaches, best use of resources and outcomes; and ensuring effective use of community-based assets
- Take the lead in developing effective partnerships and acting as advocate to deliver change to support **improvements in health and wellbeing** of all children and families
- Work in partnership with other professionals and stakeholders, ensuring care and support helps to keep children and young people healthy and safe within their community, **providing seamless, high quality, accessible and comprehensive service**, promoting social inclusion and equality and respecting diversity
- Ensure **early identification** of children, young people and families where early help and additional evidence-based preventive programmes will promote and protect health in an effort to reduce the risk of poor future health and wellbeing; work with your local Troubled Families team to ensure that families are identified and supported to improve the breadth of their health and wellbeing needs through the Troubled Families programme, and to ensure the health aspects of the Troubled Families programme meet the health needs of the whole family

4.3 Service Description

4.3.1 The Service should be accessible to all children, young people and their families. This includes people with disabilities.

4.3.2 The Service will operate at the following four levels of intervention (See Figure 2) and deliver the HCP 0-19 to improve health outcomes, as detailed in National Guidance for Health Visitors and School Nursing. These levels are: Community; Universal; Universal Plus; and Universal Partnership Plus.

4.3.3 **Community:** will contribute to Building Community Capacity (BCC), in order to develop family resilience and independence, as part of a strategic approach. This will underpin all other levels of intervention.

The Service will:

- Provide leadership and expert public health advice and guidance to a range of settings
- Work with communities and partners to build community/family resilience and develop community resources and support, providing expert public health advice, guidance and input. These will include but are not exclusive to community interventions for parenting support, mental health and wellbeing, nutrition (including infant feeding, breastfeeding and responsive bottle feeding and weaning support), and physical activity
- Skill up and provide workforce development and training to other professionals working with children and families so that they can provide effective public health messages and advice and identify any potential risks to health and wellbeing. For the School Nursing Service, there is an expectation that centrally based training will be offered to Schools on a whole day basis once each term.
- Develop and/ or deliver particular community capacity interventions to meet the needs of children within the locality / setting

4.3.4 **Universal**: To include individual level outcomes-based and evidence led interventions and programmes for all children and families that will motivate and support people to:

- Provide safe and positive parenting, including hygiene and prevention of neglect, tooth decay, accidents and injuries
- Understand the short, medium and longer term consequences of their health-related behaviour for themselves and others including smoking, drug and alcohol misuse, unhealthy eating and physical activity
- Recognise the benefits of health enhancing behaviours and changing their health behaviours.
- Plan change in terms of easy steps over time.
- Recognise how social context and relationships may affect their behaviour, and identify and plan for situations that might undermine changes they are trying to make.
- Plan explicit ‘if/then’ coping strategies to prevent relapse.
- Make a personal commitment to adopt health enhancing behaviours by setting and recording goals to undertake clearly defined behaviours in particular contexts over a specified time.
- Share their behaviour change goals with others.

- Promote a self-help approach through boosting family resilience and healthy relationships.
- Develop and access positive social connections and support networks

As part of the Universal offer, there will be a named Health Visitor for every family up to 1 year of age and the Provider will, as a minimum, implement universal assessments/reviews and activities undertaken by appropriately qualified staff, across the lifespan as follows (See Appendix 2 for a more detailed overview):

- **Essential** Pre-birth (between 28th week of pregnancy and birth) face-to-face review in the home or community venue
- **Essential** New Baby (10 to 14 days) face-to-face review in the home
- **Essential** 6-8 weeks review in the home or community venue (linking with the GP)
- 3- 4 months' review in the home or community venue
- **Essential** 1 Year review (between 9 and 12 months)
- **Essential** 2 – 2.5 Year Integrated Health, Early Learning and Development Review (incorporating key recommendations from 1001 days). Face-to-face review in Children's Centre
- **Essential** School entry to Primary School (4 -5 years) health needs assessment via health questionnaire

These checks are intended to assess and review health and development, identify additional health and well-being needs and implement appropriate interventions/referrals to address need. The information gathered from the assessments must be recorded and monitored, and will be reviewed during the contract and subject to change with agreement between the Commissioner and the Provider to reflect priorities and changes to the nationally mandated checks. The Provider is expected to ensure that the assessments/reviews described as '***essential***' are delivered for all eligible children and young people within the timescales, and there is appropriate follow-through of targeted children, young people and families.

These assessments/reviews may be offered in a range of settings, including family homes, Children's Centres, community and educational settings and/ or virtually. Assessments need to effectively identify needs so that these can be addressed swiftly through Early Help and other initiatives, reducing the demand for more costly interventions.

Three of the reviews must be undertaken face-to-face for all within the caseload. Where other checks are undertaken, consideration should be given to the most appropriate form of delivery. As outlined in the innovation section of this specification, we expect the provider to utilise varying methods and skills mix. In cases where there are safeguarding concerns, the reviews must be face to face.

Universal services are essential for primary prevention, early identification of need and early intervention. They lead to early support and harm reduction with subsequent holistic health review and care plan and a named nurse for all children and younger adults with additional needs, vulnerable and first time parents, which identify and appropriately support needs through the universal plus or universal partnership plus model.

4.3.5 **Universal Plus**: The provision of additional, timely, expert and evidence-based advice and support to families when they need it on specific issues such as postnatal depression, infant

feeding (weaning, etc.), sleepless children, continence, parenting support, domestic violence, healthy diet, physical activity including active play, smoking, substance misuse, alcohol, sexual health and contraception. Interventions will be planned and will include regular reviews to assess progress, measure outcomes achieved or escalate for additional support.

4.3.6 **Universal Partnership Plus**: Delivers on-going support as part of a range of local services working together with families with more complex needs over a longer period of time. The Provider will use the Early Help Assessment and Plan (EHAP) to identify strengths and needs and work with a range of partners to develop appropriate care packages. These may cover maternal mental health, loss or death of a child, parenting support, baby/toddler sleep problems, physical development (e.g. immature development of physical abilities) speech and language problems, behaviour management, emotional health and wellbeing – where the service may provide, delegate or refer.

4.3.7 In addition, the Service will:

- Provide an integrated public health nursing service linked to primary and secondary care, early years, childcare and educational settings, by having locality teams and nominated leads known to the stakeholders, including a named health visiting team or school nursing team for every setting. For GP Practices, there should be an agreed schedule of regular contact meetings for referrals, health concerns and collaborative provision.
- Undertake joint visits or consultations with other professionals in response to contact from children, young people and families, where appropriate
- Oversee and manage the delivery of the **National Child Measurement Programme** utilising skill mix staff to undertake height and weight measurements in both Reception and Year 6. This includes:
    - Communicating with schools and parents
    - Providing feedback to parents within 6 weeks. Letters will be designed in conjunction with both public health and Commissioners to signpost parents to other services where appropriate
    - Collating relevant information for the national data return
- Support schools, where requested, to:
    - Develop initial health care plans for children and young people with identified long term conditions and/or complex health needs, including providing health advice and signposting to other services
    - Review health care plans where additional nursing input, including knowledge and expertise, is needed and there is no other relevant specialist nurse or service involved in the care of the child or young person
- Build on resilience, strengths and protective factors to improve autonomy and self-efficacy based on best evidence of child and adolescent development, recognising the context of family life and how to influence the family to support the outcomes for children
- Build personal and family responsibility, laying the foundation for an independent life
- Champion and advocate culturally sensitive and non-discriminatory services that promote social inclusion, dignity and respect

- Ensure and evidence that the experience and involvement of families, carers, children and young people will be taken into account to inform service delivery and improvement
- Work with the community, stakeholders and local commissioners to identify population health needs
- Work with local authority Commissioners to ensure that:
    - Clear care pathways exist between health visiting and school nursing teams and key services that young people access such as substance misuse and sexual or reproductive health services
    - Local health promotion strategies are integrated with health visiting and FNP teams, for example sexual or reproductive health services, teenage pregnancy or substance misuse prevention
- Ensure there is a clear protocol of addressing the health needs of priority groups where the service will be maintained and preventing inconsistency. This includes the need to identify safeguarding risks for children and vulnerable adults, including for children which may be outside of the immediate family, e.g. trafficking, FGM, exploitation in any form
- Ensure proactive links to other CYP health services (not necessarily provided by the same organisation)
- Deliver services in partnership with local authorities to '*troubled families'* and be '*lead professional*' or '*key worker*' for a child 0-5 where appropriate.

4.3.8 Provide **Specialist Nursing** input:

- The Health Visitor Advisory Service
- Family Nurse Partnership Programme (see service specification in Appendix 1)

4.3.9 Achieve and maintain full accreditation of UNICEF Baby Friendly community initiative.

4.3.10 The Service will be expected to monitor and review its impact across the assessment/reviews and activities, and demonstrate improved outcomes and measure service user feedback.

4.4 The Four Elements

Whilst the Service, as a whole, will operate at the following four levels of intervention detailed above (See Figure 2) and deliver the HCP 0-19 to improve health outcomes, there are clear expectations in relation to each element of the service.

4.4.1 The Health Visiting Service

The Health Visiting Service will be accessible to all infants and children resident in LBE aged 0 – 5 years. This includes people with disabilities. It will provide child health surveillance, health promotion, health protection and health improvement and support outlined in the HCP 0-5 and for Ealing includes:

- Delivering the five '***essential***' mandated health assessments/reviews (See 4.3.4. and Appendix 2) as detailed above for all eligible children within the timescales, and ensuring there is appropriate follow-through of targeted children and families
- Utilising the six high impact areas (detailed above for Health Visiting) to support prioritisation and ensure resources are targeted appropriately, in accordance with health need, to maximise health outcomes

- Risk assessing all requests and referrals for support within the 0-5 system as soon as practicable using a robust duty system with clear referral criteria, triage processes and response times.
- Supporting and safeguarding vulnerable children and families
- Allocating a named Health Visitor for all children with additional needs and appropriately support these needs through the universal plus or universal partnership plus model
- Ensuring a named health visiting team for every setting and for GP Practices, there should be an agreed schedule of regular contact meetings for referrals, health concerns and collaborative provision
- Achieving and maintaining full accreditation of UNICEF Baby Friendly community initiative.
- Undertaking joint visits or consultations with other professionals where appropriate
- Delivering services in partnership with local authorities to '*troubled families'* and be '*lead professional*' or '*key worker*' for a child 0-5 where appropriate.

4.4.2 **The School Nursing Service**

The School Nursing Service will be accessible to all maintained primary and secondary schools (excludes special schools), academies, free schools and state funded pupil referral units in LBE and includes child health surveillance, health promotion, health protection and health improvement and support outlined in the HCP 5-19 and for Ealing includes:

- Delivering the **'essential'** mandated School entry to Primary School (4 -5 years) health needs assessment via health questionnaire (See 4.3.4. and Appendix 2) as detailed above for all eligible children within the timescales, and ensuring there is appropriate follow-through of targeted children and families
- Utilising the six high impact areas (detailed above for School Nursing) to support prioritisation and ensure limited resources are targeted appropriately, in accordance with health need, to maximise health outcomes
- Risk assessing all requests and referrals for support within the 5-19 system as soon as practicable using a robust duty system with clear referral criteria, triage processes and response times.
- Delivering a targeted service for vulnerable children and young people with needs such as safeguarding and children in need, with a disability or medical condition.
- Working with LAC nurses and other specialist health staff such as Haemoglobinopathy, Asthma and Diabetes Specialist Nurses as appropriate
- Ensuring school nursing service contact details are provided to schools and GP Practices.
- Supporting schools, where requested, to:
    - Develop initial health care plans for children and young people with identified long term conditions and/or complex health needs, including providing health advice and signposting to other services
    - Review health care plans where additional nursing input, including knowledge and expertise, is needed and there is no other relevant specialist nurse or service involved in the care of the child or young person

- Offering centrally based training to Schools on a whole day basis at least twice within each school term and adapting content to identified need

- Overseeing and managing the delivery of the National Child Measurement Programme utilising skill mix staff to undertake height and weight measurements in both Reception and Year 6.

- Ensuring effective transitions for school-aged children, for example between health visiting and school nursing, and into adult services

4.4.3 **Health Visitor Advisory Service**

The Health Visitor Advisory Service will be delivered in an integrated way within the Ealing Children's Integrated Response Service triage service operated by LBE for all those resident in LBE. Expert advice, consultancy and support will be provided by a qualified Health Visitor on a full-time basis, working 9am to 5pm, Monday to Friday (excludes bank holidays), to Children's Social Care and SAFE (Supportive Action for Families in Ealing) services and a range of professionals including those based within primary care as required.

The Health Visitor input is intended to ensure that there is better understanding of children's health and development and more streamlined assessment and case planning with the aim of providing an efficient, cost effective and appropriate service.

In supporting the triage service and other parts of the Children and Families Service as needed, the Provider will specifically through this post:

- Provide an information, consultancy and assessment service within the whole systems triage process within agreed timescales

- Deliver time limited interventions to children, young people and families, at the direction of the triage manager within agreed timescales

- Strengthen joint working relationships between LBE and universal child health services (health visiting and school health nursing)

- Facilitate joint working relationships with primary care

- Provide an information, consultancy and assessment service to Children's Social Care and the SAFE as and when required within agreed timescales

4.4.4 **Family Nurse Partnership (FNP) programme**

The requirements for this element are detailed in Appendix 1 which will be reviewed on an annual basis during the lifetime of the contract.

5 Population Covered

5.1.1 The Service described in this specification will cover all local authority residents and those registered with an Ealing GP with children 0-5, all pregnant women and all children and young people in attendance at all maintained primary and secondary schools (excludes special schools), academies, free schools and state funded pupil referral units within LBE.

5.1.2 The Service will ensure that any coverage/ boundary issues that may arise will be dealt with proactively in collaboration with neighbouring providers. Delivery of a service that meets the needs (including safeguarding needs) of the child or family must take precedent over any boundary discrepancies or disagreements.

6 Prioritisation

6.1 Entry into Service (referral routes)

6.1.1 The Service is required to develop effective referral routes, including for children / expectant parents who move into the borough. Referrals for children and young people aged 0 – 19 years are accepted from children and families, midwives, education staff and schools, acute services, community health services, GPs, children's services, commissioned providers, voluntary sector organisations and housing. Self-referrals are also accepted. Please note that this list is not exhaustive.

6.1.2 For state funded primary and secondary schools and pupil referral units, the contact details of the Service and information pertaining to the service offer will be provided through a variety of routes. This information will include clear referral criteria and appropriate forms dependent upon need.

6.1.3 Information about the Service will be also made available to ensure children, young people and their families know what to expect.

6.2 Response times

6.2.1 All requests and referrals for support within the 0-19 system should be risk assessed as soon as practicable using a robust duty system with clear referral criteria and triage processes. The referral criteria and triage processes will be agreed with commissioners.

6.2.2 All routine referrals from whatever source (including children, young people and families transferring into area) should receive a response to the referrer within 5 working days, with contact made with the child, young person or family within 10 working days

6.2.3 All urgent referrals, including all safeguarding referrals, should receive a same day or next working day response to the referrer and contact made with the child, young person or family within two working days and be in line with pan London Child Protection and Ealing Safeguarding Children Board Procedures and Ealing Safeguarding Adults Procedures

6.2.4 All assessments/reviews described as '***essential***' are delivered for all eligible children and young people within the timescales, and there is appropriate follow-through of targeted children, young people and families.

6.2.5 Procedures must be in place to trace and risk-assess missing children and those whose address is not known with systems in place to follow up and trace children who do not attend for 9 month and 2 year assessments.

6.2.6 Providers will comply with the national guidance timeframes for the management of safety concerns and incidents in screening programmes and NHS England guidance for the management of serious incidents (http://www.screening.nhs.uk/incidents).

6.3 Exit from the Service (Discharge Criteria and Planning)

6.3.1 The Service operates an "active" and universal caseload. Young people reaching the age of 19 years are discharged and those moving out of the area aged 0 – 19 years will be handed over. Discharge from active caseloads will be in agreement with the child/young person and where appropriate their parent/carer and will follow any local discharge planning protocols. At a universal level, records will be archived. For children and families who are likely to continue to require additional support when the young person reaches 18 or 19, the Service shall initiate a clear multi agency transition plan.

6.3.2 Where a child moves out of the borough, the child's health records must be transferred to the appropriate authority within two weeks of the notification. Where a child and family receiving a universal plus or partnership plus service leave the area, and the Provider is aware of this, there shall be in place a clear local protocol and a written plan to ensure continuity of services for the family. The referral must also be accompanied by direct contact with the appropriate service. Systems should be in place to assess the risk to children whose whereabouts are unknown.

6.4 Equality and Equity

6.4.1 The Provider has a commitment to promote equality, value diversity and human rights in all activities.

6.4.2 The Provider should design and implement policies that meet the diverse needs of the service, population and workforce, ensuring that none are placed at a disadvantage over others. These policies will take into account the provisions of the Equality Act 2010 and advance equal opportunities for all to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (gender) or sexual orientation and vulnerable community groups not specifically covered by legislation, such as socio-economic deprivation, asylum seekers and refugees.

6.4.3 It is the responsibility of the Provider to comply with all current equality legislation and ensure it implements any new equality legislation as it becomes statute and actively meet the requirements of the Equality Duties:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act
- Advance equality of opportunity between people who share a protected characteristic and those who do not
- Foster good relations between people who share a protected characteristic and those who do not

6.4.4 The Provider will ensure that treatment, care and information provided is evidence based, culturally appropriate and is available in a form that is accessible to people who have additional needs, such as people with physical, cognitive or sensory disabilities, and people who do not speak or read English.

6.5 Risk Management

6.5.1 The Provider will ensure that there are robust processes, working practices and systematic activities that prevent or reduce the risk of harm to service users. The Provider will, as a minimum, ensure that:

- They adhere to the Ealing Safeguarding Children Board procedures for the Reporting and Management of Serious Incidents and have robust processes in place to support the reporting and review of all incidents at the earliest opportunity. This will include the documentation, investigation and follow up with appropriate action of all incidents.
- There are robust processes, working practices and systematic activities that prevent or reduce the risk of harm to clients.
- There are robust processes in place for ensuring the safe transfer of clients between services within the Borough, and outside of the Borough.

- There is a robust risk assessment process in place for clients which is regularly reviewed and updated. Any identified risk will inform risk management plans which will contain clear and appropriate actions to minimise risk
- Learning is disseminated across the organisation and shared with the commissioners
- Processes are in place for any staff member to raise concerns in a confidential and structured way
- That an effective complaints procedure for service users is in place, in line with the current Complaints Procedure guidance, to deal with any complaints in relation to the provision of the system, which is available for audit
- The system participates in any multi agency investigations into incidents and/ or serious case reviews and develops the service to incorporate lessons from serious case reviews in LBE and other areas
- Self-audit around internal risk management and safeguarding processes are performed at least annually

6.6 Safeguarding

6.6.1 Safeguarding is a core part of the programme, which runs through the four levels of intervention. The provider will provide appropriate and effective safeguarding services and will be expected to adhere to relevant national and local requirements and guidance, and implement wherever necessary. Reference should be made to the supporting sections of the service specification for requirements on staff, training, supervision, partnership working, information sharing and confidentiality.

6.6.2 The provider will:

- Work in partnership with other key stakeholders to help promote the welfare and safety of children and young people. For example, contributing to keeping pupils safe from the dangers of radicalisation and extremism and promoting safe practices and a culture of safety, including e-safety
- Work collaboratively to support children and young people where there are identified health needs, or where they are in the child protection system, providing therapeutic public health interventions for the child and family, and referring children and families to specialist medical support, where appropriate
- Contribute to reducing the number of children who enter the safeguarding system through preventative and early help work as part of their Community, Universal and Universal Plus role
- Support safeguarding and access and contribution to targeted family support, including active engagement in the Troubled Families (Family Focus) programme for those aged 0-5 years
- Deliver accordingly in line with local inter-agency and internal safeguarding policies and procedures as determined by the local Children's Safeguarding Board
- Be aware of children with an early help assessment, child in need, child protection or Looked After Child plan. Work with the designated school safeguarding lead and local authority services, providing assessments and reports as required
- Contribute to multi-agency decision-making, assessments, planning and interventions, relating to children in need, children at risk of harm and Looked After Children. This

includes providing Review Looked After Child health assessments (in accordance with Promoting the Health and Wellbeing of Looked After Children Statutory Guidance 2015) and reports in accordance with the local Safeguarding Children Board policies and procedures and national guidance such as Working Together to Safeguard Children (HM Government, 2015)

- Where appropriate and the child or young person is known to the provider, senior team members will attend child protection conferences or core group meetings when they are the most appropriate health representative and there is a specific outcome to contribute towards
- Work within inter-agency and single agency protocols, policies and procedures and in accordance with Working Together to Safeguard Children (HM Government, 2015), and use the national Safeguarding pathway for health professionals to provide clarity on roles and responsibilities for this programme
- Be responsible for all general enquiries, contributing to individual case management issues, handling or crisis and emergency situations with other partners as required, informing the commissioner of such activity through routine contract monitoring arrangements or directly where it relates to a crisis or an emergency that warrants this being shared as a matter of urgency
- Have in place Did Not Attend Guidelines to help staff including administrators follow up those children who do not attend appointments or fail to engage. Guidelines will have clear structure and purpose, the safeguarding response and advice to HCPs
- Ensure that all staff are aware of their responsibilities to take action to keep children and adults safe. This includes carrying out their duties in a way that is consistent with legislation, national guidance and the Ealing Safeguarding Children Board and Safeguarding Adults Board Procedures
- Ensure all staff can participate fully in safeguarding meetings, protection planning and core groups and receive appropriate supervision
- Ensure all staff are kept informed of the outcomes of Serious Case Reviews and Learning Reviews and will implement recommendations as required.
- Undertake yearly safeguarding audits to demonstrate that they comply with the arrangements set out above (that are consistent with section 11 (Children Act 1989) and CQC Quality standards.

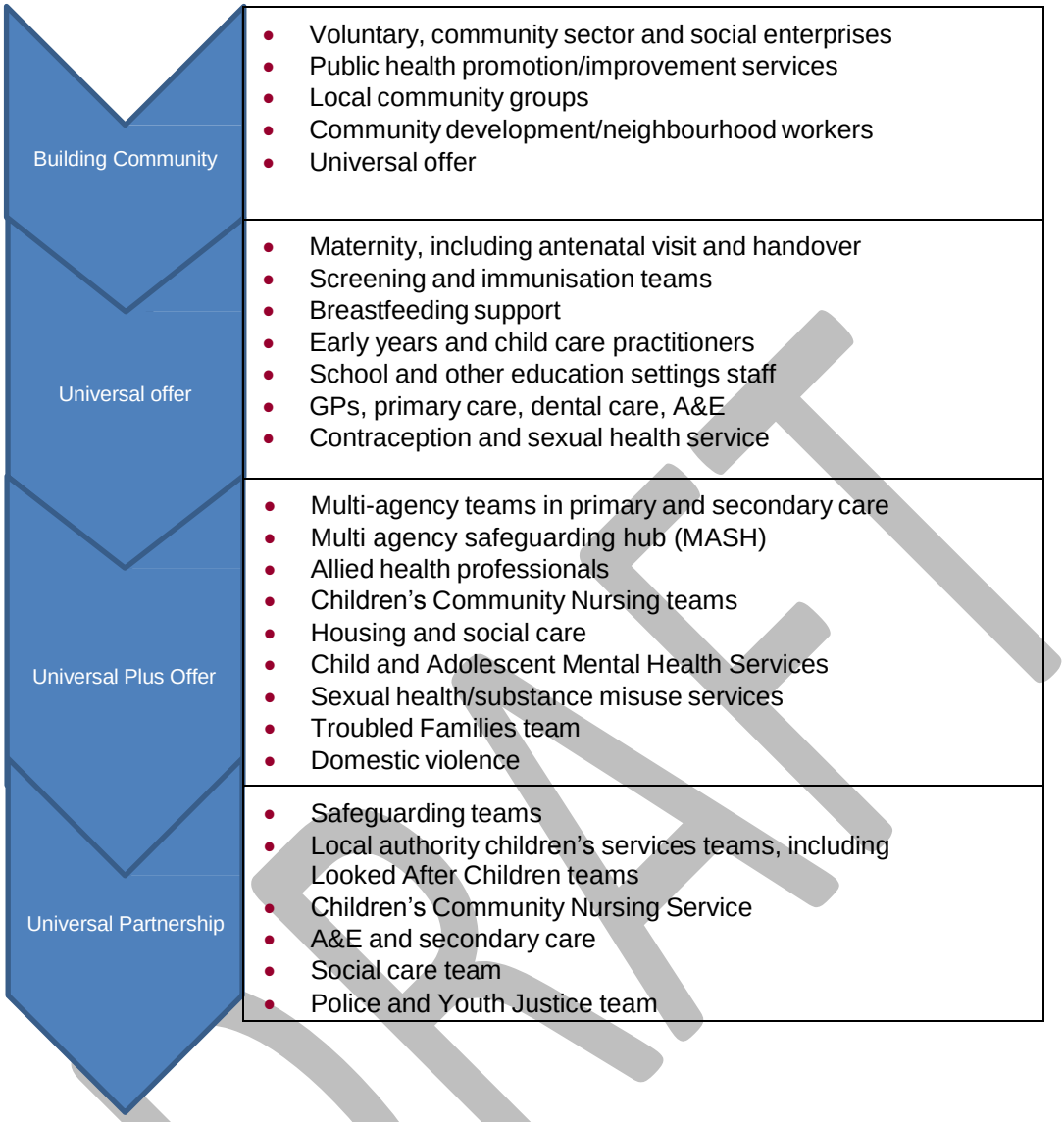
7 Partnerships and User Involvement

7.1 Interdependencies – a whole system approach

7.1.1 Health visitors and school nurses as leaders and key delivers of the HCP must establish good working relationships with all local key partners outlined in Figure 3. This is not an exhaustive list and the Provider will be expected to develop and maintain relationships with other organisations relevant to the delivery of this contract, through regular communication and/ or meetings.

7.1.2 The Provider will ensure that they have a comprehensive knowledge of available services to ensure children, young people and families access these where required. In addition, the Provider should develop a wide range of partnerships to ensure that existing services understand what the service can offer and refer children, young people and their families in if appropriate.

Figure 3: Local Key Partners



7.1.3 To enhance partnerships the Provider will support the ECRIS (Initial response service) in cases from the Multi Agency Safeguarding Hub (MASH) by providing a Health Visitor on a full-time basis (9am to 5 pm, Monday to Friday), to provide expert advice, consultancy and support within ECIRS (**Health Visitor Advisory Service**). The Health Visitor will:

- Work in-line with the requirements set out in Section 4.4.3
- Ensure that information about children's health development and children's universal health services is available to ECIRS
- Take part in joint visits with a social worker, where these are needed, to deliver time limited interventions and to plan the appropriate service response where relevant.

7.2 Service User Engagement

7.2.1 The service delivered needs to be built around the needs of children and their families, not around buildings, institutions and existing organisation processes.

7.2.2 The Provider must ensure and demonstrate that service users are at the heart of their service and should have the opportunity to make informed decisions about the interventions they receive and the impact they make.

7.2.3 The Provider must ensure and demonstrate that the views of service users (including the 'Voice of the Child') are regularly sought and taken into account in designing, planning, delivering and evaluating/improving the service so that individual needs are met. This will include relevant parent/carer groups.

7.2.4 The provider will engage as and when asked with key established groups representing children and young people, this includes:

- Friends and Family Test or equivalent
- Service User Groups as specified by Commissioners
- Heads of Schools

8 Vulnerable Groups

8.1 Key Groups

8.1.1 Within the borough there are key groups who face significant difficulties that can prevent them from reaching their full potential. The Service will need to demonstrate how it is supporting these groups through the essential 2 – 2.5 year Integrated Health, Early Learning and Development Review, specific plans, pathways and partnerships in order to improve their life chances.

Key groups are:

- Children in Need and those who are subject of a Child Protection Plan
- Children with special needs
- Teenage parents
- Those at risk of exploitation (e.g. child sexual exploitation, gangs and radicalisation)
- Care leavers
- Those not in education, employment or training.
- Lesbian, Gay, Bi-sexual and Transgender
- Those at risk of FGM
- First time parents
- Vulnerable parents, parents with complex needs, learning difficulties and disabilities and those experiencing domestic abuse, mental illness and substance misuse

8.2 Support for Children with Special Needs

8.2.1 The Provider will need to ensure the whole service is accessible to all children and young people in the borough including those with SEND.

8.2.2 The Service must work in partnership with other services in supporting the assessment of the education health and care plans for children and young people 0-19 through sharing information about the child's and family's needs and reviewing in collaboration with other

services what they can do to support the delivery of these plans and making sure the appropriate health visiting and school nursing services form part of the high intensity multi-agency services for families where there are safeguarding and child protection concerns.

8.2.3 The Service will provide advice and guidance to parents on navigating the health system, managing lower level health needs and that any negative impact on school attendance is minimised. The point of diagnosis for a child can be difficult for parents/carers. The service should be aware and ensure appropriate support is in place for places, including understanding what peer support is available in the community.

8.3 Family Nurse Partnership and Additional Support for Young or Vulnerable Pregnant Women

8.3.1 The Provider will be expected to deliver the FNP programme in LBE, with a caseload of 92 first time vulnerable young mothers likely to be aged up to 25 years and over 28 weeks of pregnancy, and their partners, until the child is age 2. The Provider will ensure a smooth transition to the 0-19 service for the parent and child at the end of the FNP intervention.

8.3.2 The Provider will be required to deliver on the FNP National Specification, as outlined in Appendix 1, or any subsequent revised national specification. Please note the eligibility criteria has been altered to meet the needs within the LBE.

8.3.3 Full details of the Programme can be found here: http://fnp.nhs.uk/

8.3.4 On an annual basis LBE and the Provider will review the integration of licensed FNP within the broader service model and its impact allowing maximum flexibility year on year.

9 Applicable Service Standards

9.1 Applicable National Standards

9.1.1 The Provider will ensure that they comply with National Institute of Clinical Excellence (NICE) guidelines and requirements. They will also need to ensure that they formulate, and adhere to a coordinated policy framework that reflects these national standards.

9.1.2 The service will be expected to work to new and emerging policy guidance, such as that developed by the National Institute for Clinical Excellence (NICE), Public Health England and the Department of Health.

9.1.3 For evidence and guidance available to support effective local delivery of services for children and young people aged 0-19, please refer to '*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. Commissioning Guide 4: Reference guide to evidence and outcomes*'.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/493625/Service_specification_CG4_FINAL_19Jan2016.pdf

9.1.4 The Provider will ensure that the required Care Quality Commission (CQC) registration is in place, kept updated and that any CQC inspections relevant to the services commissioned via this specification are shared with the Commissioner.

9.1.5 The Provider will ensure that they comply with the CQC Essential Standards of Quality and Safety 2010 requirements (and/ or any subsequent CQC requirements).

9.1.6 The Provider is expected to demonstrate effective and robust governance and financial management and control.

9.1.7 The Provider will ensure that they comply with the UK National Screening Committee Standards and Guidelines and those relating to immunisation. This includes:

- Newborn Bloodspot Screening
- Newborn Hearing Screening
- Newborn Infant & Physical Examination
- The Green Book which can be found at:

  https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book

9.1.8 As a minimum, the Provider must meet the clinical governance standards laid down in the National Quality Standards and Standards for Better Health. All parties will use the information generated by clinical governance activity such as audits and service reviews (and the recommendations of external inspections) to continuously develop and improve services and operational practice across the 0-19 pathway.

9.1.9 The Provider will ensure the service complies with Working Together to Safeguard Children. A Guide to Inter-agency Working to Safeguard and Promote the Welfare of Children (HM Government 2015).

9.2 Applicable Local Standards

9.2.1 The Provider will ensure that they are cognisant of and, as appropriate, comply with:

- Ealing Children and Young People's Plan 2011 to 2014 (and subsequent editions)
- Early Start Ealing Business Proposal document
- Ealing Joint Strategic Needs Assessment, the 2011 Census and Ealing termly school census
- Ealing Health and Wellbeing Board key priorities
- Ealing Healthy Weight Strategy
- Ealing Health Related Behaviour Survey

9.3 Workforce

9.3.1 The Provider should develop an integrated management and staffing structure, with strong professional and strategic leadership for children and young people. This structure should clearly demonstrate how all elements of the system will work together.

9.3.2 The Provider should develop a healthy workforce and a workforce that promotes good health by using the workplace to promote and support good health and wellbeing of employees.

9.3.3 The Provider should be committed to achieving the London Healthy Workplace Charter

9.3.4 The Provider should also review its workforce to ensure that it is representative of the demographics of the population it serves. The provider should work to address any gaps in underrepresented groups. The provider must be able to provide a breakdown of the workforce against the key characteristics listed within the Equality Act 2010

9.3.5 As part of the borough's work to support the transition to adulthood for key vulnerable groups, the provider should be pro-active in seeking to develop appropriate employment opportunities within the service that these groups could access.

9.4 Workforce Competence, Supervision and Registration

9.4.1 The Provider must ensure:

- All staff involved in the delivery of the service have the experience and relevant professional qualifications to undertake their duties and are competent to provide the aspects of the service for which they are responsible for.
- Appropriate arrangements are in place for maintaining and updating workforce skills and knowledge.
- They are compliant with all statutory employment legislation.
- All staff will have relevant and up to date professional registration including their revalidation of fitness to practice every three years as appropriate and that they work within their respective Codes of Professional Conduct and professional standards of their appropriate Royal College or Professional Association at all times.
- Safer Recruitment procedures are in place, all relevant staff will have been checked by the Disclosure and Barring Service (DBS) and have arrangements in place to review these including a policy on how a positive disclosure would be handled.
- Policies and procedures in place to provide line management supervision, clinical supervision, safeguarding supervision and mechanisms of risk assessment for all elements of the Service
- All staff will receive mandatory training on safeguarding children and adults, information governance, health and safety, infection control, risk management, equality and diversity.
- All staff will receive an annual performance review/appraisal and will be able to demonstrate mechanisms to address under-performance.
- The provider will ensure that Nurses are appropriately trained i.e. Health Visitor (SCPHN Health Visiting), School Nurse (SCPHN School Nursing), Community Staff Nurse (Registered Nurse), Family Nurse (registered Health Visitor/ School Nurse/ Midwife plus appropriate training as designated by the FNP National Unit)
- Staff are trained in completing the National Child Measurement Programme (NCMP), interpreting and feeding back the results
- All staff working with children and young people are trained to deliver brief oral health messages
- All staff working with children and young people are adequately trained to be able to offer clear and concise LGBT guidance.
- All staff are trained and competent to deliver brief advice on physical activity to parents and children
- All staff receive disability awareness training or disability specific training.
- Staff have training on safeguarding disabled children and communicating with disabled children

9.5 Prescribing

9.5.1 Nurse prescribing enhances the clinician's ability to deliver the High Impact Area on minor illness and reducing hospital admissions, not only from the point of view of managing symptoms but also from the medication knowledge that enhances advice and support.

9.5.2 Nurse prescribing has been shown to have a number of benefits, ranging from increased compliance to reduced hospital and GP attendances. This will also impact positively on reducing school absences. Health visitors and School Nurses are in an ideal position to respond to common health concerns, discuss treatment options and wider management of conditions and then to prescribe as part of a holistic approach.

9.5.3 While prescribing is included as a deliverable within the core specification, it is understood that not all public health nurses will have taken this module as part of their training. Therefore, where public health nurses have not undertaken this module in training, it is a requirement of continuing professional development for completion within the first two years of practice.

9.5.4 For more information visit http://www.nmc-uk.org/Nurses-and-midwives/Regulation-in-practice/Medicines-management-and-prescribing/

9.6 Governance

9.6.1 The Provider will demonstrate a robust **clinical governance** framework including:

- Mechanisms to ensure that treatment is safe, effective and evidence based.
- Compliance with all relevant national standards for service quality and clinical governance including compliance with the NHS Standards for Better Health Framework and relevant NICE guidelines.
- Designated clinical leadership and accountability, and clear clinical protocols for clinical staff. Including named, accountable officers.
- Ensure staff are appropriately supported and supervised, including clinical and safeguarding supervision for clinical staff.
- Ensure staff are appropriately qualified and experienced for their role and there are sufficient staff to effectively deliver the service and meet the specification
- Implementation of a clinical audit process to review performance and provide a framework to enable improvements to be made.
- Ensure '*Did Not Attends'* are monitored and actively followed up.
- There is a requirement for the system to report against a quality schedule developed by Commissioner to demonstrate compliance with patient safety, clinical effectiveness and patient experience. This includes compliance with core mandatory functions such as:
    - Infection prevention and control
    - Safeguarding children, young people and adults
    - Comprehensive complaints process
    - Comprehensive incident and serious incident reporting
    - Improvements in patient experience
    - Other quality criteria such as Care Quality Commission registration criteria and professional standards relevant to the system

9.6.2 **Information Governance** is key to sharing information safely which is vital to the care process but will be done with due consideration for client consent and confidentiality. Data will be stored, shared and processed in accordance with the Data Protection Act 1998 and information sharing protocols will be consistent with guidance from the local Caldicott Guardian.

9.6.3 The Provider will have a clear confidentiality/data handling policy, which is understood by all members of staff. The policy should be presented and clearly explained to all clients both verbally and in written form before any intervention begins.

9.6.4 The Provider will develop clear information sharing protocols with partner agencies and robust case management and information management tools to enable the wide sharing of information. The Provider will ensure that data which is collected is accurate, reliable and able to support performance management and the assessment of need in the borough.

9.6.5 The Provider will ensure that all processes and systems for information processing and sharing are informed by the NHS information governance requirements.

9.6.6 The Provider will have achieved at least an IG Toolkit Compliance of Level 2.

10 Innovation and Technology

10.1.1 The Provider will be required to deliver the highest quality service for children, young people and their families in LBE and it is expected that information technology should be at the heart of service delivery.

10.1.2 The service model should consider how technology can be used to help meet the specification of requirements. This includes its potential use in the delivery of the assessment/reviews detailed in Section 4.3 and Appendix 2, particularly for those of low risk within the universal caseload.

10.1.3 The Provider will be expected to outline how they will build virtual / electronic relationships with their clients through the use of databases. Children, young people and families may easily contact the service, whilst the service will be able to provide information, support, prevention messages and advice, reminders (including appointments), courtesy follow-ups, opportunities for user feedback as well as service developments and alerts.

10.1.4 The Commissioner expects the service to engage with and/or implement the following initiatives:

- '*Virtual nurse*' - information and support through methods such as Skype. This may include appointments with low risk clients
- One contact number for the whole service
- Adopt the use of NHS approved apps and evaluate their use with service users
- Utilise social media to communicate
- Utilise social media to support peer support initiatives
- Utilise instant messaging services
- Utilising online-self assessment forms to identify needs and particular concerns / interests of clients. These may be utilised before appointments or to triage / refer clients to other services

- Online or text-based client surveys to identify satisfaction levels or additional needs after a client has accessed the service
- Develop and/or utilise online tutorials
- Engagement and roll out of the eRedbook
- Engagement and roll out of email initiatives, such as Baby emails (start4life)
- Develop and/or utilise new technology and social media to help improve the accessibility of the service for children, young people or parents with SEND

10.1.5 In addition, the Provider will be expected to support remote working, including electronic collection of data and notes. This should include, where possible, structured recording, i.e. not recording information within text fields, to facilitate streamlined and automated reporting of data collected.

11 Record Keeping and Data Collection

11.1 Record Keeping

11.1.1 In line with contractual requirements, the Provider will ensure that robust systems are in place to meet the legal requirements of the Data Protection Act 1998 and the safeguarding of personal data at all times. The Provider should also refer to 'Record Keeping: Guidance for Nurses and Midwives', NMC, 2009.

11.1.2 The Personal Child Health Record (PCHR) – red book or eRedbook will be completed routinely by professionals supporting parents and carers to use proactively.

11.1.3 Appropriate electronic records will be kept in the Child Health Information System (CHIS) to enable high quality data collection to support the delivery, review and performance management of services. This is a key interdependency between local authorities, Public Health England and NHS England. Data returns will be made as appropriate to HSCIC.

11.1.4 Records should be consistent with NHS and Local Authority requirements.

11.1.5 The NHS number should be used as the link identifier. For those Children receiving support from Children's Social Care the Social Care System (currently Frameworki) unique identifier should be recorded on the child's record.

11.2 Data Collection

11.2.1 Commissioners will have access to data collected by the provider to allow discussions regarding system developments and system outcomes. Data pertaining to demographics (ethnicity, age, gender, post code, religion) and protected equality characteristics will be collected and shared with the Commissioner. The Provider will allow data to be accessible at different levels – patient level, GP level, school level, ward level, locality level and/ or city level. Information will be made available to support local Joint Strategic Needs Assessments (JSNAs).

11.2.2 The Provider should ensure that all necessary consent forms are completed in order to share information with the Commissioner. The default option in the case of consent should always be opt-in to sharing information but service users will have the right to actively opt-out of sharing their data. In cases where there are safeguarding concerns or where there is a '*vital interest'*, this opt-out can be overridden. However, this should be approached on a case by case basis.

11.2.3 The Provider will have an integrated data system allowing access to all staff involved in the delivery of care to CYP and their families so that service users need only '*tell their story once'*. This may involve the use of honorary contracts.

11.2.4 The Commissioner shall act reasonably in requesting additional or ad hoc information. The Provider shall provide requested additional or ad hoc information as soon as practicable.

11.2.5 The service will be expected to work closely and have in place clear and agreed systems to share information with Children's Centres/Early Years settings. This includes the sharing of information for registering all the 0-5 caseload with Children's Centres, attending early help groups, the implementation of the integrated 2 year reviews and developing a system for tracking the progress of 2 year olds not in an early years setting.

12 Location of Provider Premises/Equipment/Hours of Operation

12.1 Location of Provider Premises

12.1.1 The Service must have bases of operation within the borough in order to support the delivery of the specification, but these might be shared with other local authority and/or health services.

12.1.2 The Service should be available and accessible at times and locations that meet the needs of children, young people and families. However, where possible, children, young people and families should be offered a choice of locations that best meets their needs, for example, Children's Centres, schools, community centres, youth groups, General Practice and, where appropriate, at home.

12.1.3 Specific details of location are to be agreed locally and should be based on engagement and feedback from key stakeholders, children and young people. Reviews should be undertaken by the Provider regularly to ensure they are suitable for local need and meet the quality indicators.

12.1.4 The Provider will ensure that all premises and equipment used for the provision of the Service are at all times suitable for its delivery and sufficient to meet the reasonable needs of clients.

- Public health nursing teams (0-19) are expected to use the Department of Health professional pathways and facts sheets to support delivery. These can be accessed at https://www.gov.uk/government/collections/developing-the-public-health-contribution-of-nurses-and-midwives-tools-and-models
- Public health nursing teams (0-19) will be required to access:
    - Validated tools for assessing development and identifying health needs
    - Personal child health records (often referred to as '*the red book*') - paper or electronic according to local provision
    - Validated tools for assessing individual health outcomes, eg outcomes star
    - IT systems and mobile technology for recording interventions and outcomes in the CHIS; thus capturing real time data and reducing duplication
    - Access to equipment to support agile working, e.g. mobile phones and tablets
    - Equipment for measuring children's weight and height

- Use of social networking and other web-based tools to enable workforce training, professional networking and information and support for children, young people and families
- National and local campaign materials, for example, Start4Life, Change4Life
- Health promotion materials

12.2 Operating Hours

12.2.1 The core service will operate standard hours of 9am – 5pm Monday to Friday but with flexibility from 8am – 8pm to meet the needs of families. This may be delivered through a range of workforce planning options such as flexible shift times and the use of technology and innovation. Other working hours may be considered by local agreement to meet the needs of families.

12.2.2 The Provider shall agree the hours of operation and any changes with the Commissioner. Hours should be co-ordinated across LBE to ensure access to all levels of service during weekdays, evenings, weekends and school holidays. The Provider should clearly advertise their days and hours of operation and locations to all service users and partners and in all settings, and alternatives when not available.

12.2.3 Days/Hours of operation and service uptake and waiting time breaches will be monitored on a regular basis to ensure optimum access/coverage and will be reviewed in response to patient and public surveys and feedback.

13 Performance Management

13.1 Performance Management Framework

13.1.1 The Commissioner is looking for an organisation that places an emphasis on learning, developing and improving services throughout the life of the contract.

13.1.2 The key driver of this Service is how the Provider demonstrates its impact and the improvements for children, young people and their families over time.

13.1.3 The Performance Management Framework should underpin this in identifying the key strengths and areas of development. While the specification sets out the framework within which the contract will operate, as local priorities and services change the Performance Management Framework may be adjusted accordingly. There is an expectation that the Provider will supply requested information within reasonable timescales and that any data systems used to record service information will have the flexibility to adapt to these changing needs.

13.1.4 As part of the performance management, the commissioner is seeking a Provider who will be pro-active in recommending ways in which to assess the impact of their provision.

13.2 National Reporting

13.2.1 The Provider must comply with any nationally agreed dataset requirements from public bodies, including but not limited to NHS England, Department for Health and Department for Communities and Local Government.

13.3 Local Reporting Arrangements

13.3.1 The Provider will be expected to provide reports on activity and outcome indicators in accordance with the Quality Outcome Indicators detailed in Appendix 3 ensuring that such reports clearly separate out the data for each of the four elements of the Service.

13.3.2 Each quarter, the Provider will be required to undertake audits against the essential assessments/reviews detailed as part of the universal offer (See Section 4.3), by teams and/or individuals, where applicable, to demonstrate activity, performance and quality.

13.3.3 After the first six months of the contract, the Provider will be required to track 20 cases against these essential assessments/reviews (10 for Health Visiting, 5 for School Nursing and 5 for FNP) and demonstrate the impact of the service on the lives of the children, young people and families. The selection of the cases and format will need to be agreed with the commissioner.

13.3.4 These indicators are subject to change through the life of the contact.

13.3.5 To ensure continued delivery of an efficient and effective Service, regular performance review meetings will take place between the Provider and the Commissioners and the Provider shall ensure senior and informed representation at those meetings. These meetings will if possible be aligned with contract review meetings. The frequency of meetings will be between monthly and quarterly, at the discretion of the Commissioner.

13.3.6 Data will be made available to the Commissioner at least 7 working days before the contract meeting.

13.3.7 All contacts will capture key demographic data (age of child and mother/father, ethnicity, post code, level of intervention received). Reporting data by demography will be in agreement with the Commissioner.

13.3.8 Data will be made available at different levels, as below, in agreement with the commissioner to allow further system developments.

- Borough wide level
- Ward level
- Lower super output area
- Children's Centre reach area
- GP level
- School/ college/other educational setting

13.3.9 The provider should submit client details for each caseload each quarter setting out the different caseloads (universal, partnership plus etc.). The provider should ensure that they seek explicit consent from all service users at the first point of contact to share data with the Commissioner for analysis in order to understand needs and improve service delivery. The service user should be informed on how the sharing of information will be used and securely held. Except in instances where there is a safeguarding concerns the users wishes on whether they wish their data to be shared must be adhered.

14 Appendices

Appendix 1 – Family Nurse Partnership Core Service Specification

[Please see separate document – to be inserted in final version]

Appendix 2 – Universal Assessments/Reviews and Activities

Review	Description	Delivered by
Essential Pre-birth (between 28th week of pregnancy and birth) face-to-face review in the home or community venue	To include: ▪ Introducing the service and what it will offer now and in the future, further sources of advice and guidance (including public health online/ phone service, NHS choices and 111, and information service (ECIRS), children's centres and support in the community) ▪ GP registration ▪ Smoking status and brief advice (including household) ▪ Physical activity status and brief advice ▪ Nutrition for pregnancy and beyond, (including 5 a-day status) ▪ Vitamin B12 and D intake and adherence ▪ Infant feeding (including breastfeeding and responsive bottle feeding advice and support) ▪ Mother's and partner's alcohol consumption ▪ Identification of drug usage (mother and partner) (advice and/or referral) ▪ Identification of domestic abuse / violence ▪ Perinatal mental health and wellbeing, partner's mental health and wellbeing, promoting secure attachment and the 5 ways to wellbeing ▪ Accessing full range of benefits (if applicable) ▪ Preparation for parenthood, including caring physically and emotionally for a baby (e.g. feeding, handling, bathing, comforting, communicating) and guidance on preventing sudden infant death in infancy (SUDI) ▪ Registration with their local Children's Centre and information on services ▪ Hygiene and preventing illness and infections ▪ Information and advice on infant development stages ▪ Accident and injury prevention	Health visitors Family nurse (where the family is accessing FNP)
Essential New Baby (10 to 14 days) face-to-face review in the home to include:	To include: ▪ Smoking status and brief advice (including household) ▪ Nutrition, including introduction of solids ▪ Infant feeding (including breastfeeding and responsive bottle feeding advice and support) ▪ Mother's and partner's alcohol consumption ▪ Identification of drug usage (mother and partner) (advice and/or referral) ▪ Identification of domestic abuse / violence ▪ Maternal mental health assessment (incorporating appropriate questions for the identification of depression, such as those recommended by the NICE guidelines on antenatal and postnatal mental health), partner's mental health and wellbeing, promoting secure attachment and the 5 ways to wellbeing ▪ Contraception status and advice	Health visitors Family nurse (where the family is accessing FNP)

Review	Description	Delivered by
	▪ Encouraging and advising on positive age and stage appropriate parenting, communication and play ▪ Guidance on preventing sudden infant death in infancy (SUDI) ▪ Keeping safe and preventing accidents ▪ Assessment of baby's growth ▪ On-going review and monitoring of the baby's health ▪ Assessment of safeguarding concerns ▪ Assessment of early help needs ▪ Positive communication. ▪ Hygiene and preventing illness and infections ▪ Information and advice on infant development stages ▪ Accident and injury prevention ▪ Encouraging and advising on positive age and stage appropriate parenting, communication, learning and play, including for those children with disabilities. ▪ Promotion of immunisations (carried out by the baby's GP) including adherence to vaccination schedule for babies born to women who are hepatitis B positive, assessment of maternal rubella status and follow up of two MMR vaccinations (to protect future pregnancies). ▪ Checking the status of all screening results and taking prompt action to ensure appropriate referral and treatment pathways are followed in line with UK NSC Standards, specifically: ○ Newborn blood spot; ensuring results for all conditions are present ○ Results of NIPE examinations ○ Hearing screening outcome ▪ Further sources of advice and guidance (including public health online/ phone service, NHS choices and 111, ECIRS, children's centres and support in the community)	
Essential 6-8 weeks in the home or community venue	To include: ▪ Assessment of progress from birth to 8 weeks. ▪ Smoking status and brief advice (including household) ▪ Nutrition, including introduction of solids ▪ Infant feeding (including breastfeeding and responsive bottle feeding advice and support) ▪ Mother's and partner's alcohol consumption ▪ Identification of drug usage (mother and partner) (advice and/or referral) ▪ Identification of domestic abuse / violence ▪ Maternal mental health assessment (incorporating appropriate questions for the identification of depression, such as those recommended by the NICE guidelines on antenatal and postnatal mental health), partner's mental health and wellbeing, promoting secure attachment and the 5 ways to wellbeing	Health visitors Family nurse (where the family is accessing FNP)

Review	Description	Delivered by
	▪ Contraception status and advice ▪ Check and promotion of 6-8 week NIPE screen (carried out by the baby's GP or nominated Primary Care examiner) ▪ Promoting engagement with Children's Centre activities. ▪ Assessment of safeguarding concerns ▪ Assessment of early help needs ▪ Monitoring baby's growth ▪ Hygiene and preventing illness and infections ▪ Information and advice on infant development stages ▪ Accident and injury prevention, including in cars ▪ Encouraging and advising on positive age and stage appropriate parenting, communication, learning and play ▪ Check and promotion of immunisations, (carried out by the baby's GP) including adherence to vaccination schedule for babies born to women who are hepatitis B positive ▪ Checking of the status of all screening results and take prompt action to ensure appropriate referral and treatment pathways are followed in line with UK NSC Standards as above in initial check.	
3- 4 months in the home or community venue	To include: ▪ Smoking status and brief advice (including household) ▪ Nutrition, including introduction of solids ▪ Infant feeding (including breastfeeding and responsive bottle feeding advice and support) ▪ Mother's and partner's alcohol consumption ▪ Identification of drug usage (mother and partner) (advice and/or referral) ▪ Identification of domestic abuse / violence ▪ Maternal mental health assessment (incorporating appropriate questions for the identification of depression, such as those recommended by the NICE guidelines on antenatal and postnatal mental health), partner's mental health and wellbeing, promoting secure attachment and the 5 ways to wellbeing ▪ Contraception status and advice ▪ Supporting parenting by providing access to parenting and child health information and guidance and information on Children's Centres and Family Information Services. ▪ Checking the status of Immunisations at three months against diphtheria, tetanus, pertussis, polio, Haemophilus influenzae type B and meningococcus group C (carried out by the baby's GP). ▪ Checking the status of Immunisations at four months against diphtheria, tetanus, pertussis, polio, Haemophilus influenzae type B, pneumococcal infection and meningococcus group C (carried out by the baby's GP). ▪ If parents wish, or if there is or has been professional concern about a baby's growth or risk to normal growth, an	Health visitors Family nurse (where the family is accessing FNP)

Review	Description	Delivered by
	assessment should be carried out. This involves accurate measurement, interpretation and explanation of the baby's weight in relation to length, to growth potential and to any earlier growth measurements of the baby. ▪ Early assessment of potential significant disabilities relating to the child. ▪ Temperament-based anticipatory guidance – practical guidance on managing crying and healthy sleep practices, bath, book, bed routines and activities. ▪ Assessment of parent– infant interaction and promotion of secure attachment using a range of media-based interventions ▪ Promote and encourage Children's Centre activities and use of books, music and interactive activities to promote development and parent–baby relationship ▪ Be alert to risk factors and signs and symptoms of child abuse. Follow local safeguarding procedures where there is cause for concern. ▪ Assessment of early help needs ▪ Hygiene and preventing illness and infections ▪ Information and advice on infant development stages ▪ Accident and injury prevention, including in cars ▪ Encouraging and advising on positive age and stage appropriate parenting, communication, learning and play	
Essential 1 Year (between 9 and 12 months)	To include: ▪ Smoking status and brief advice (including household) ▪ Infant nutrition check ▪ Mother's and partner's alcohol consumption ▪ Identification of drug usage (mother and partner) (advice and/or referral) ▪ Identification of domestic abuse / violence ▪ Parental mental health and wellbeing, promoting secure attachment and the 5 ways to wellbeing ▪ Contraception status and advice ▪ Assessment of the baby's physical, emotional and social development and needs in the context of their family using evidence based tools, for example, Ages and Stages 3 and SE questionnaires ▪ Supporting parenting, provide parents with information about attachment and developmental and parenting issues ▪ Monitoring baby's growth ▪ Oral health and prevention (ensuring that all children are accessing primary dental care services for routine preventive care and advice) ▪ Check new-born blood spot status and arrange for urgent offer of screening if child is under 1 year ▪ Adherence to vaccination schedule and final serology results for babies born to women who are hepatitis B	Health visitors Family nurse (where the family is accessing FNP)

Review	Description	Delivered by
	positive; status of MMR vaccination for women non-immune to rubella. ▪ Assessment of safeguarding concerns ▪ Assessment of early help needs ▪ Hygiene and preventing illness and infections ▪ Information and advice on infant development stages ▪ Accident and injury prevention, including in cars ▪ Encouraging and advising on positive age and stage appropriate parenting, communication, learning and play	
Essential 2 – 2.5 Year Integrated Health, Early Learning and Development Review (incorporating key recommendations from 1001 days). Face-to-face review in Children's Centre This Part One health review should be held wherever possible in the local Children's Centre, be integrated with the Early Years Foundation Stage (EYFS) review and appropriate information shared with the early years setting and/or Children's Centre.	To include: ▪ Smoking status and brief advice (including household) ▪ Child's physical activity status and brief advice ▪ Growth check (weight / height / calculate BMI centile) ▪ Nutrition, including 5 a-day status, healthy eating patterns and using cutlery ▪ Oral health and dentist registration ▪ Mother's and partner's alcohol consumption ▪ Identification of drug usage (mother and partner) (advice and/or referral) ▪ Identification of domestic abuse / violence ▪ Parental mental health and wellbeing, promoting secure attachment and the 5 ways to wellbeing ▪ Contraception status and advice ▪ Review with parents the child's social, emotional, behavioural and language development using ASQ 3 and SE ▪ Respond to any parental concerns about physical health, growth, development, hearing and vision ▪ Offer parents guidance on sleeping and behaviour management and opportunity to share concerns ▪ Encourage and support take up of Together for Twos early years education by eligible families and those meeting local priority criteria ▪ Help parents to understand the Early Years Foundation Stage and support them to access opportunities to strengthen skills to support the prime areas of development. ▪ Review immunisation status ▪ Assessment of early help needs ▪ Hygiene and preventing illness and infections ▪ Information and advice on child development stages ▪ Accident and injury prevention, including in cars ▪ Encouraging and advising on positive age and stage appropriate parenting, communication, learning and play	Health visitors Family nurse (where the family is accessing FNP) Family nurses undertake a full assessment at two years to support a robust handover to health visitors when clients leave the programme
Essential School entry to Primary School (4 -5 years) health needs assessment via	To include: ▪ Identification of health needs and parent concerns including long term conditions, allergies, illnesses, sleeping and behavior problems, continence issues and other diagnoses ▪ Smoking status and brief advice (household)	School Nurses

Review	Description	Delivered by
delivery, review and follow of the health questionnaire	▪ Child's physical activity status ▪ Immunisation check ▪ Nutrition, including 5 a-day status, healthy eating ▪ Oral health and dentist registration ▪ School readiness ▪ Assessment of early help need ▪ Offer parents guidance on sleeping and behaviour management and opportunity to share concerns ▪ Offer advice on hygiene and preventing illness and infections ▪ Sign-post parents to further sources of advice and guidance and/or refer family to expert advice/services (including NHS choices and 111, ECIRS, children's centres and support in the community)	

Appendix 3 – Quality Outcome Indicators