MILTON KEYNES COUNCIL CONTRACT

SCHEDULE [x]

DRAFT SERVICE SPECIFICATION

PART A

(Public Health Service Contract - Appendix A)

Organisation Name	
Service Name	
Service Address 1	
Service Address 2	
Service Address 3	
Town	
Postcode	

1.0 Service Description

1.1 Service delivery

0-19 Healthy Child Programme (HCP) Service (Health Visiting and School Nursing) Services in Milton Keynes.

1.2 Duration of support

The duration of support will vary according to the needs of the individual and the nature of the issue being addressed.

2.0 Service Availability

2.1 Client group

All Children, young people and their families who reside in or attend a mainstream school or college in Milton Keynes.

2.2 Primary client group ages supported

Every child (from 28+ weeks antenatally) and their family up to 19 years.

2.3 Referral route

All Milton Keynes children and families Any stakeholders working with children and families in MK Any stakeholders working with children and families from elsewhere who are moving in or moving out of MK Stakeholders include (but are not limited to) Midwifery; Children and Family Centres; Milton Keynes Council Adult Social Care; Milton Keynes Council Children's Social Care; Milton Keynes Council Housing department; GPs; District Nursing. (List not exhaustive).

PART B

3.0 Introduction

This specification is for a 0-19 Healthy Child Programme (HCP) for eligible service users as identified in Part A, 2.0.

Giving every child the best start in life is crucial to reducing health inequalities across the life course. The foundations for virtually every aspect of human development are set in place in childhood. What happens during these years has lifelong effects on many aspects of health and well-being, educational achievement and economic status. Universal and specialist public health services for children are important in promoting the health and wellbeing of all children and reducing inequalities.

In 2009, the Department of Health set out an evidence-based programme of best practice, The HCP with the ambition of making *'everywhere as good as the best*' by developing improvements in health and wellbeing for Children and Young People (CYP). In March 2018, Public Health England published revised and updated 0-19 Health visitor and school Nurse commissioning guidance to support further effective local delivery of services for CYP aged 0-19. This service specification is based on that guidance.

The NHS Five Year Forward View, NHS Long Term plan and the Milton Keynes Council Plan all emphasise the importance of partnership working and integration to improve outcomes and reduce health inequalities. Milton Keynes is part of a wider Bedfordshire, Luton and Milton Keynes Integrated Care System; as a place, Milton Keynes has strong ambitions to improve health and wellbeing, provide accessible, integrated care and is working towards becoming an integrated care partnership. The 0-19 HCP provider will be a key partner in this place-based approach and part of this exciting opportunity to work innovatively with partners across the system to transform services.

Working as part of this whole system approach, the HCP is a universal programme available to all children. It aims to ensure every child gets the good start they need to lay the foundations of a healthy life, providing a framework to support collaborative work and more integrated delivery. The universal reach of the HCP provides an invaluable opportunity from early in a child's life to identify families that are in need of additional support and children who are at risk of poor outcomes.

This 0-19 HCP Service will support the improvement in outcomes for CYP as defined in the Joint Health and Wellbeing Strategy for Milton Keynes 2018-2028:

1) Staying Well: a strong focus on prevention
2) Closing the Gap: reducing inequalities in life chances
3) An integrated, innovative approach to health and wellbeing

It will also work in line with Milton Keynes Council Plan (2016-22) aspiration to *ensure children and vulnerable people are protected from harm and neglect and work with partners to integrate services, improve outcomes and reduce health inequalities.*

4.0 Demographics

There are around 73,000 CYP aged 0-18 (inclusive) living in Milton Keynes in 2019. The population in this age range (particularly amongst school aged children) is projected to increase gradually year on year, peaking at just over 76,000 in 2025, following which it begins to fall. Around 44% of school pupils in Milton Keynes are from a BME community.

5.0 Health Outcomes

5.1 Milton Keynes compared to England

Overall, the health and wellbeing of children in Milton Keynes is similar to England though worse for family homelessness and hospital admissions for asthma (under 19 year olds).

- The infant mortality rate of 4.5 per 1,000 is similar to England.
- The teenage pregnancy rate of is similar to England with 89 girls becoming pregnant in a year.
- 11.8% of women smoke while pregnant which is similar to England,
- 80.4% of mothers initiate breastfeeding (better than England). Data for breastfeeding from the 6-8 week review is not available.
- The MMR immunisation level does not meet recommended coverage (95%). By age two, 93.1% of children have had one dose.
- Dental health is similar to England. 21.3% of 5 year olds have one or more decayed, filled or missing teeth.
- Levels of child obesity are similar to England. 9.7% of children in Reception and 21.0% of children in Year 6 are obese.
- The rate of child inpatient admissions for mental health conditions at 42.9 per 100,000 is better than England. The rate for self-harm at 386.2 per 100,000 is similar to England.
- 73.3% of children have achieved a good level of development at the end of Reception (better than England).
- The level of child poverty is better than England with 15.1% of children aged under 16 years living in poverty. The rate of family homelessness is worse than England.

Compared to statistical neighbours Milton Keynes outcomes are worse for family homelessness, hospital admissions for asthma in under 19s, obesity (10-11 yr olds) and smoking at time of delivery.

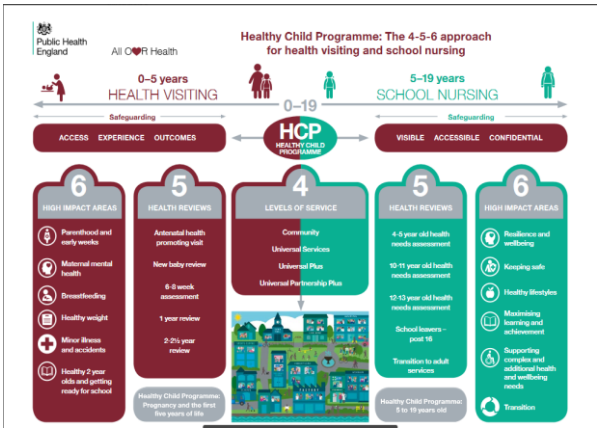
5.2 System wide outcomes

Although the service is commissioned independently of other services for 0-19 year olds across the geography, the provider is expected to work closely with partners to provide a seamless service to families whilst contributing to improvement in system wide outcomes such as:

- More babies being born healthy with the best chance of survival
- Less children attending hospital as an emergency and less unintentional injuries
- More children achieving expected levels of development at age 2.5
- More children being ‘ready for school’
- More CYP have better oral health
- More CYP are of healthy weight
- More babies are fed breast milk (initiation and prevalence)
- More pregnant women, parents, carers and CYP are smoke free
- CYP are supported to reduce substance misuse
- CYP are supported to reduce teenage conceptions and improve sexual health
- Improved access to mental health support for CYP and their families
- Increased population immunisation coverage
- More CYP achieve positive physical and emotional milestones (school readiness)
- More CYP improve academic results (and the deprivation gap in outcomes is reduced)
- More CYP achieve their potential through improved school attendance and reduced NEET

6.0 Service Aim

Working in partnership with professionals and stakeholders to provide a seamless, high quality accessible and comprehensive integrated 0-19 (school nursing and health visiting) service in line with the nationally evidenced 4, 5, 6 approach. The service will focus on early identification of risk and issues, keeping CYP healthy and safe and improving health outcomes for individuals and the population.



7.0 Interdependencies – a whole system approach

Health visiting and school nursing services embed public health and prevention across health service pathways, promoting a whole system, holistic approach to prevention to make it easier for CYP and families to receive the care and health promotion advice they need.

A whole system approach to provide safer, personalised, accessible support and individualised care with vision and shared goals is central to improving outcome for CYP and families. Delivering such an approach is reliant on professionals and services working together to ensure seamless access to high quality services. It is expected that the provider will establish excellent working relationships with all stakeholders including effective joint working at transition points.

In order to support this, provider input is expected at a range of interagency meetings and to be linked into key pathways and systems for CYP and their families across the area.

8.0 Service Objectives

The Service will:

- help parents develop and sustain a strong bond with their children;
- support parents in keeping children healthy and safe and reaching their full potential;
- identify health and wellbeing issues (including those related to behaviour) early, so support and early interventions can be provided in a timely manner;
- focus on the health needs of CYP ensuring they are school ready (SEND Code of Practice 0 – 25 years, 2018)[i];
- provide continued support through the school age years for every child to be supported to thrive, gaining maximum benefit from education;
- identify and help children, young people and families with problems that might affect their chances later in life, including building resilience to cope with the pressures of life
- protect children from serious disease (screening and immunisation)
- promote and support mental health, emotional wellbeing and resilience.
- reduce childhood obesity by promoting healthy eating and physical activity.

9.0 Principles of delivery

The 0-19 HCP will:

- minimise duplication and multiple “hand offs” by offering a seamless service;
- enhance the patient, carers and families’ experience of the service;
- develop services which are responsive to individual patient need, provide value for money and are performance managed to improve patient outcomes;
- use innovations in IT systems that enable information sharing across health (e.g. GP Practices and A&E services), education and care and all sectors of providers to help with service delivery;
- develop preventative approaches in partnership with Public Health, local authority and health services, the local community and voluntary sector organisations;
- ensure that early intervention is a central part of the culture and delivery of the service;
- ensure that service users are provided with a responsive service;
- ensure that services capture the views of CYP and families, and that the services are able to learn and improve from this feedback.

10.0 Service Delivery Model

Six High Impact Areas have been developed in the HCP to improve outcomes for CYP and their families. They are based on evidence of where the services can have a significant positive impact.

The 6 Health Visiting - Early Years High Impact Areas are:

1. transition to parenthood and the early weeks;
2. maternal mental health;
3. breastfeeding (initiation and duration);
4. healthy weight, healthy nutrition (to include physical activity);
5. managing minor illnesses and reducing hospital attendance/admissions;
6. health, wellbeing and development of the child aged 2 and continued support to be ‘ready for school’.

Ready for school is assessed as when every child will have reached a level of emotional development, which enables them to:

- communicate their needs and have good vocabulary;
- become independent in eating, getting dressed and going to the toilet;
- take turns, sit still and listen and play;
- socialise with peers and form friendships and separate from parent(s);
- have physical good health, including dental health;
- be well nourished and within the healthy weight for height range;
- have protection against vaccine-preventable infectious diseases, having received all childhood immunisations.

The 6 School Nursing – School-aged Years High Impact Areas build on early identification of children in need of support and focus on key priority areas, including:

1. building resilience and improving emotional health and wellbeing, working closely with schools, parents and local services;

2. keeping safe, managing risk and reducing harm – including child sexual abuse and exploitation; sexual and domestic abuse; neglect; PREVENT; alcohol and substance misuse; mental health issues;
3. promoting healthy lifestyles - including reducing childhood obesity and increasing physical activity; smoking prevention and cessation; healthy relationships and positive sexual health choices;
4. maximising achievement and learning – helping children to realise their potential and reducing inequalities;
5. supporting additional health needs – supporting Special Educational Needs and Disability (SEND) reforms;
6. transitions and preparing for adulthood – specifically for entry into Reception Year (ages 4/5years); changing school, leaving school and supporting the transfer into further and higher education where needed. develop personalised care and support planning for CYP with complex needs and their carers to include prevention, self-management and appropriate support plans designed to help people maintain their independence and avoid a crisis.

11.0 Service Access

The service will be available and accessible at times and locations that meet the needs of CYP and families. A range of locations will be offered that best meet their needs, for example, children's centres, schools, community centres, youth groups, general practice and, where appropriate, at home.

Providers should work with commissioners to ensure an appropriate level of service is provided throughout the year, including during school holidays. A seamless service utilising digital technology such as online services, text and telephone support is required.

Services need to be responsive and flexible (for example early mornings, lunchtimes, after school, evenings and weekends) and should use technology and innovation to ensure that they reach CYP.

The provider must ensure appropriate access to interpreting services.

Specific details of locations are to be agreed locally and be based on engagement and feedback from key stakeholders, parents/carers and CYP. Shared geographical working in line with other services (for example child protection) should be considered. Reviews to ensure accessibility will be undertaken by the provider regularly to ensure they are suitable for local need and meet the quality indicators.

A Single Point of Access (SPA) service model, offering seamless and integrated 'team around the family' is required.

The full service offer in line with the levels of service provision detailed below will be available, with timely access to health visiting and school nursing services.

1. Individual	Undertaking joint visits or consultations with other professionals in response to contact from CYP and families where appropriate. Building resilience, strength and protective factors to improve autonomy and self-efficacy based on best evidence of child and adolescent development. Building personal and family responsibility, laying the foundations for early life.
2. Community	The Service will provide the full range of health and support services for CYP and families. Specialist Community Public Health Nurses (Health Visitors and School Nurses) will be involved in developing and providing these and making sure that **all families** know about the range of health

	and support services available for them. They will work with local communities and Early Help to ensure they are equipped to deliver local services.
3. Universal (U)	The 0-19 HCP Service will provide a **core service for every family,** which includes assessing the health and wellbeing and development of children, promoting positive physical, emotional and mental health, and supporting parents and families. This will include education and health checks as agreed, and identifying problems early.
4. Universal Plus (UP) (short-term early/additional help)	The 0-19 HCP Service will support parents, children and families to access **swift, expert, advice and interventions** to meet **identified needs early**. They will help to **plan coping strategies** and **positive behaviours to build resilience.** This may include supporting in 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 and wellbeing.
5. Universal Partnership Plus (UPP) (long-term multidisciplinary support - for example, with social disadvantage, illness or disability, safeguarding).	Ongoing support will be provided by the 0-19 HCP Service as part of a **range of local services working together and with families**, to deal with more **complex problems over a longer period of time**.

11.1 0-5 Years HCP Provision

To include all infants and children resident in the local authority area (including those who transfer in), covering child health surveillance; health promotion; health protection and health improvement and support, as outlined in the most current guidance. The service will:

- lead and deliver the 5 mandated health reviews;
- deliver against the 6 high impact areas;
- ensure effective, seamless transition of family public healthcare from maternity to 0-19 HCP services;
- ensure seamless transition from health visiting to school nursing;
- provide appropriate and effective safeguarding services, adhere to relevant national and local requirements and guidance.
- provide enhanced support to vulnerable children and families;
- address inequalities and contribute to the Milton Keynes Strengthening Families Programme (Troubled Families Programme).

11.2 0-5 Years HCP: Detailed Description

11.21 Community Service Provision

The provider must:

- collect and analyse data to ensure that the service understands local priorities and works across the wider system to build community capacity;
- have a broad knowledge of community needs and resources;
- where possible support co-production of appropriate services with users;

- signpost families to other sources of health and wellbeing advice and information and/or to other services that already exist locally as needed;
- support social networks of families with similar interests, strengths or needs by working with Child & Family/Children's Centre staff and other agencies to deliver existing social networks to meet identified public health needs;
- influence other agencies and sectors to improve health outcomes.

11.22 0-5 Universal Service Provision

All families must be offered the 5 mandated contacts. These contacts provide practitioners with the opportunity to undertake a holistic assessment of the health of the baby/child and of any concerns that the parent/carer may have around issues such as attachment, breastfeeding, maternal mental health as well as health promotion advice, information and support on issues such as safe sleeping, oral health, accident prevention, smoking and contraception & sexual health.

If any of the mandated contacts are declined this must be recorded and actioned as appropriate depending on the assessment made by the provider of any risks.

If the national mandated requirements change, the provider must respond accordingly and deliver any new requirements. If mandation ceases, any changes to the delivery of the current contacts must be agreed in discussion with the commissioner. For more information please refer to HCP 0-19 health visitor and school nursing commissioning guidance. Detail behind the visits below is in appendix 1.

a) The Antenatal Contact

The antenatal contact is a holistic assessment of the family to identify parent capacity to meet the infant's needs. The level and type of support needed could include safeguarding concerns; potential and actual mental health issues; domestic abuse/violence and substance misuse.

Prior to 28 weeks of pregnancy, there must be clear and timely lines of communication with maternity services, both those based within Milton Keynes and those on the borders, in order to receive timely notifications from maternity services.

The provider must make contact with the client from 28 weeks of pregnancy. This may be earlier for women where there are additional concerns or risk factors. For all first-time mothers and those with vulnerabilities, a one-to-one contact in the home is required. Where there are concerns about the family, these 'mothers to be' must be prioritised. In addition, where the provider is notified that there is a client with more complex needs, the service must see this individual earlier than 28 weeks.

b) New Baby Review Visit (10 to 14 days after birth)

The New Baby Review visit is a face to face visit by a health visitor within 14 days to check on the health and wellbeing of the parents and baby, support with feeding and other issues and give important advice on keeping safe, and to promote sensitive parenting.

c) The 6-8 Week Review

This review looks at the growth and wellbeing of the baby and the health of the parent/s. Early attachment and good maternal mental health shapes a child's later emotional, behavioural and intellectual development. The review will particularly look for any signs of postnatal depression. It is an opportunity to discuss important public health messages, including breastfeeding oral health, healthy start vitamins and sensitive parenting. This visit is in addition to the 6 to 8-week medical review, which is usually completed by the GP.

d) The 1 Year Health and Development Review

The purpose of the review which takes place between 9-12 months is to:

- assess a child's health, growth and development prior to the infant turning 12 months of age;
- identify the child's progress, strengths and needs at this age in order to promote positive outcomes in health and wellbeing;
- facilitate appropriate intervention and support for children and their families especially those for whom progress is less than expected.

e) The 2-2½ Year Health and Development Review

Where possible this review will be integrated with the Early Years Setting. Age 2-2½ is a crucial stage where problems such as speech and language delay, tooth decay or behavioural issues become visible. The 2-2½ Year Health and Development Review enables a review of the child's progress at this key stage ensuring early intervention is offered as required. It aims to optimise child development and emotional wellbeing, reduce health inequalities and to support children being ready to learn.

11.23 Other Core Elements of the 0-5 Universal Offer

a) Healthy Baby/Child Clinics

The role of the baby/child clinic is to monitor the development and growth for children under the age of 5 years, to provide consistent health promotion advice and information depending on need of the child and family in accordance with the HCP.

The provider must deliver a sufficient number of Baby/Child clinics across Milton Keynes to meet the needs of families. Provision should be mindful of access considering public transport routes and parking nearby.

Where possible, these clinics will be located in Child & Family Centres/ Children's Centres so that families can access other services at the same time. Where this is not possible clinics could be held in other venues in agreement with the commissioner and following consultation with potential service users.

Staffing arrangements must include an appropriate level of skill mix. There are opportunities for the provider to deliver a more holistic service as part of the wider Child & Family Centre Offer incorporating a wider skill mix to deliver clinics for example using the skills of Community Nursery Nurses.

The provider must follow the World Health Organisation (WHO) guidance for weighing a baby including using the UK-WHO growth charts and ensure all relevant staff are up to date with the guidance and provide clear information to families. The provider must have a consistent approach to determining which babies require more frequent weighing. The provider must undertake at least an annual audit in line with the WHO guidance on weighing babies.

The provider must ensure that all information that is given to parents/carers in Baby/Child clinics is based on the most up to date evidence that is available. Information and advice must be provided consistently across Milton Keynes.

b) Feeding Clinics/Baby Cafes

Breastfeeding has important health benefits in the short and long term for both mother and baby. The benefits for the baby include a reduced risk of gastroenteritis, middle ear infections, respiratory infections, urinary tract infections, raised blood pressure and obesity. The benefits for the mother include a reduced risk of breast and ovarian cancer.

The Scientific Advisory Committee on Nutrition (SACN) recommends exclusive breastfeeding (no other food or drink) for around the first 6 months and to continue breastfeeding for at least the first year of life once solid foods have been introduced.

The provider must maintain full UNICEF accreditation and up-date and train staff as required. Parents/carers who have chosen to feed their baby with formula milk must be offered appropriate and tailored advice on safe, responsive infant feeding.

It is expected that the provider would be an active member in the Milton Keynes BF Alliance to ensure professional guidance and experience can be shared locally.

c) Introduction to Solid Foods (complementary feeding/weaning)

The provider must ensure that sufficient information is provided to parents to support the Introduction of Solid food in line with SACN https://www.gov.uk/government/publications/feeding-in-the-first-year-of-life-sacn-report)

The Commissioner will work with the provider to scope what this will look like, also linking with the Children and Family Centres.

Healthy start information should be given to families at each of the assessment touch points.

d) Immunisation

Immunisation is one of the most successful and cost-effective health protection interventions. High immunisation rates are key to preventing the spread of infectious disease, complications and possible early death among individuals and to protecting the population's health through both individual and herd immunity.

The service must provide parents with tailored information and support about immunisations and offer an opportunity to discuss any concerns. Every appropriate opportunity must be taken to check vaccination status and to ensure that immunisation is offered to CYP who may have missed or not fully completed the national routine schedule. If the status of that person is incomplete they should be signposted appropriately.

e) Healthy start vitamins

In line with national guidance the service is responsible for arranging the provision of Healthy Start Vitamins and ensuring each distribution point has sufficient stock (In Milton Keynes, Children and Family Centres currently distribute Healthy Start Vitamins).

f) Screening

Screening is also a part of the universal service offer in line with the HCP and the National Screening Committee recommendations. Health Visitors must check public health aspects of the new-born screening programme and children's screening status during health appointments, and refer all missed screening to the appropriate organisation/service.

g) New-born Screening

The Health Visiting Service (0-5) is a partner in the assurance and delivery of the NHS New-Born Screening programmes: New-born Bloodspot (NBBS), New-born Hearing Screening and New-born & Infant Physical Examination (NIPE). This includes promoting uptake of screening and taking part in the fail-safe system to ensure that all infants have access to screening and are in receipt of screening results/status.

The provider must check the screening status of all new-borns and infants moving into the area and ensure that results are recorded in the Personal Child Health Record.

h) New-born Bloodspot (NBBS)

Where results are missing, the screening sample may need to be taken again in line with national guidance. Any baby older than 28 days who requires a repeat screening sample must be offered and, where accepted, have a repeat sample taken by a trained Bloodspot Screener from the provider and sent to the laboratory for processing.

Where new-born bloodspot results identify sickle cell trait/carrier status, the NBB screening must be recorded and appropriate action taken for any positive results (trait or disease positive) in line with local management and referral protocols.

The provider must check at transfer into the area (Movers in) whether a baby has had a neonatal blood spot screening. Untested babies are defined as those babies who have incomplete, undocumented evidence of screening or a decline notification for each of the conditions for which screening is offered. On identification of untested babies, the provider must offer an urgent screen following national screening guidance and local pathways.

i) New-born Hearing Screening

Where results are missing for babies up to 3 months of age, the provider must offer screening and, where accepted, refer to the local New-born Hearing Screening Programme. For infants aged over 3 months of age, national guidance must be followed.[ii]

12:0 Prioritisation and response times:

- Timings for mandated health reviews must be followed.
- Work in partnership with local maternity care providers to develop effective information sharing to ensure early notification and effective follow up of new pregnancies and births.
- As a child approaches school entry, transition to school nursing caseload should be initiated in accordance with local policy and DH guidance. Similarly, school nursing teams will work with relevant adult services to ensure smooth transition.
- Where there are safeguarding concerns, there must be enhanced handover between health visiting and school nurse.
- Where appropriate the provider must facilitate transition to Milton Keynes CCGs commissioned Special School Nursing Service for those children from any Special School where alternative arrangements are in place.
- Where public health nursing services are responsible for undertaking children in care/Looked After Children Health Assessment/Review and care plans, these must be completed to the national standards and within the statutory timeframe.
- Providers will comply with the most current national guidance for the management of safety concerns and incidents in screening programmes and NHS England guidance for the management of serious incidents.
- The Specialist Community Public Health Nurse (SCPHN) must check the status of, and record, all screening results including hearing, New-born Infant Physical Examination (NIPE) and Hep B schedule, immunisation status and refer immediately for any follow up necessary. The provider must have direct contact with the sending organisation to receive the hand-over of all child protection cases in line with safeguarding processes. This must include specific actions for children subject to a child protection plan or any other ongoing concerns of vulnerability.
- Where a parent/carer has a new partner, the name must be added to the record.
- Systems must be in place to assess the risk to CYP whose whereabouts are unknown and appropriate actions taken. Fail-safe procedures must be in place for incoming children to the local area either from another Child Health Information Services (CHIS) or from outside England.
- 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 any of the mandated checks e.g. one year (9-12 month) and 2-2½ year reviews.

12.1 Referrals to Other Services

Where a child moves out of area, the provider must:

- Ensure that the child's health records are transferred to CHIS for transfer to the receiving service in the new area, within 2 weeks of notification. Direct contact must be made to hand over all child protection cases Systems should be in place to assess the risk to children whose whereabouts are unknown.
- Work in an integrated way with other services supporting children and families within the same age range with the aim of the system providing a seamless service. Where a parent/carer or baby/child is assessed as needing further support that is outside of the remit of the service or that needs a partnership response, then the provider must refer onto appropriate services.
- The service must plan any referrals in partnership with the main parent/carer unless this puts the baby or parent at risk, for example where there is a safeguarding concern or neglect is suspected.

12.2 Referrals into the Service

- The provider must record and respond to all referrals. Where the provider receives inappropriate referrals, the referrer must be contacted and advised.
- Urgent referrals, including all safeguarding referrals, should receive a same day or next working day response to the referrer and contact within 2 working days and be in line with Local Safeguarding procedures.
- Referrals from whatever source (including families transferring in) must receive a response to the referrer within 5 working days, with contact made with the child, young person or family within 10 working days.
- The service is responsible for a referred baby/child until the case is closed or transferred to a different service.

12.3 Was Not Brought

- Every effort must be undertaken to ensure mandated reviews/contacts are undertaken.
- The provider must ensure that children who 'Were Not Brought' for any of the mandated reviews/contacts or any appointment, are monitored and followed up with priority given to vulnerable families. Non-attendance must be documented in the child's record.
- Where a family is not at home and there has been a pre-booked appointment, this must also be documented in the child's record. A further appointment must always be offered.
- There must be at least 2 attempts to contact the family. If contact is not made then the child's records must be reviewed, risk-assessed and advice sought where necessary e.g. from the safeguarding team. A plan of action following the risk assessment must be followed, including always informing the child's GP.

12.4 Reducing Hospital Attendance and Admissions

Parents should be supported to know what to do when their child is ill. To include providing advice and information about managing childhood conditions, providing information on the role of pharmacies, the prevention of unintentional injuries and minor injuries, and prescribing, as appropriate, by Health Visitors in line with legislation.

13.0 0-5 Universal Plus (UP) Service Provision

Families themselves, a SCPHN or other professional may identify concerns about a particular aspect of a child's development. A family may therefore require additional advice, support and follow up from the 0-19 HCP Service. For example, care packages for maternal mental health, parenting support and baby/toddler sleep problems. The service must respond in a timely manner. This may lead to a referral into another service or a more specialist service as appropriate.

A named SCPHN must co-ordinate and remain accountable for care plans and where needed, must provide support directly, delegate, or refer families to community nursery nurses, family support teams or

external partner agencies for aspects of care. This may be the case if other issues emerge that require a different health professional to support a family.

Where additional needs are identified, the 0-19 HCP Service must work along-side families to identify client-led goals and develop care plans with evidence-based interventions to improve health outcomes. Care plans must be jointly reviewed with parents/carers at the end of an intervention to determine the effectiveness of the intervention. These interventions may be provided as one-to-one interventions or as part of a small group programme.

13.1 Enhanced Nutritional Support

a) Breastfeeding

This must include specialist advice, support and encouragement for individual women who are struggling to breastfeed and need additional help beyond the universal breastfeeding group provision or who have specific issues that need to be addressed e.g. babies who have tongue tie.

b) Healthy Diet

A child's diet during the early years affects development, growth and overall health both in the short and long term. SACN identifies that, "around 75% of the children (aged 4 to 18 months) exceeded the estimated average requirements for energy. The same proportion exceeded the WHO growth standard median for weight. These findings suggest that UK infants are exceeding their energy requirements. This is of concern in relation to wider evidence on the prevalence and risk of overweight and obesity in childhood".

SCPHN must offer additional support to families where issues have arisen or been identified. Poor diet can impact on oral health which in turn can negatively impact on children's school readiness and hospital admissions.

The provider must ensure that there is sufficient expertise across the service on infant feeding and nutrition where families have specific problems. This work will support the reduction of childhood obesity along with the promotion of physical activity and oral health.

13.2 Oral Health Promotion (0-19)

Poor oral health can affect children's ability to speak, eat, sleep, play and socialise and can negatively impact on a child's school attendance and wellbeing. In the UK, tooth decay is still the commonest cause of admission to hospital in 5-19 year olds.

The provider must support families to promote the importance of good oral health using a range of evidence based approaches such as: apps and websites through Start4Life and Change4Life; encouraging children and their families to register and attend a dentist if they have not done so already; making every contact count by delivering brief intervention and advice to parents/carers including making the link between healthy eating (low sugar diet/drinks) and good oral health; promoting good oral health practices (tooth brushing and use of fluoride paste) and signpost to Children and Family Centre tooth brushing sessions.

The provider must have information available for schools to promote the importance of good oral health using a range of evidence-based approaches. This must include:

- ensuring that up to date evidence-based information on oral health is available to teaching staff and families including apps and websites through Change4Life;
- encouraging children and their families to register and attend a dentist if they have not done so already;
- making every contact count by delivering brief intervention and advice to parents/carers including making the link between healthy eating (low sugar diet/drinks) and good oral health;
- promoting good oral health practices.

13.3 Maternal/Perinatal Mental Health

The provider must ensure that the service has appropriate expertise in perinatal mental health including having a perinatal mental health lead.

Perinatal mental health refers to a woman's mental health during pregnancy and the first year after birth. Poor maternal mental health is known to increase the risk of children having poorer social, emotional and educational outcomes. On identification or through a referral into the service, the Health Visitor must assess maternal mental health and where women are experiencing poor mental health must intervene and refer appropriately, taking into account NICE (National Institute for Care and Excellence) guidance.

The provider must also make provision to support fathers who are experiencing poor perinatal mental health.

The provider must ensure that infant mental health is given equally high priority and taken into account by any adult mental health service which is supporting a parent.

13.4 Early Years Mental Health and Emotional Wellbeing (please see section 16.3 for 5-19 Mental Health and Emotional Wellbeing):

The service will promote good emotional wellbeing through the early years by:

- Providing perinatal support focussing on parental and infant mental health;
- Delivering universal and targeted emotional health promotion, advice and support;
- Identifying developmental delays early and providing further assessment, support and referral as appropriate to prevent poor mental health developing;
- Supporting children and their families, particularly those from disadvantaged backgrounds, with the elements required to support school readiness.

13.5 Parenting Support

The provider must engage with and offer support to parents who may be struggling with a particular health issue or where there is evidence of poor parenting. For parents who need further support, Health Visitors must refer families into Early Help or other appropriate services.

13.6 Care of Next Infant (CONI)

The service must provide support to parents who are expecting a new baby where either parent has previously experienced the death of a child (less than 2 years of age) through sudden unexpected death. The provider must support the delivery of the CONI/CONI Plus programme to all eligible families and ensure that the programme is delivered compassionately and sensitively. The provider must deliver a service in line with the Lullaby Trust guidelines and any other national guidance.

The provider must also offer CONI Plus to parents:

- of babies who have died under 1 year of age in the post perinatal period from causes other than Sudden Infant Death;
- who have a relative (e.g. sibling, niece/nephew) who have experienced a Sudden Infant Death;
- of an infant who have experienced an Apparent Life Threatening Event (ALTE). Infants who have experienced an ALTE must be referred into the CONI Plus programme by a Paediatrician.

13.7 Vulnerable Parents and Families

The provider is required to prioritise all expectant mothers with a range of risk factors such as:

- seldom heard families including recent asylum seekers; refugees; some Black and Minority Ethnic families such as Gypsies and Travellers; those in temporary accommodation or hostels;
- parental substance misuse (drugs and alcohol);
- parental mental ill health;
- teenage mothers;
- parental learning difficulties;
- non-English speaking;
- a previous unexpected or unexplained death of a baby/child;
- a child in the household who is on a child protection plan;
- a child who has previously been removed either temporarily or by a court order;
- domestic abuse;
- sexual exploitation/trafficking;
- any other concerns where the unborn baby/baby may be at risk of significant harm;

14.0 0-5 Universal Partnership Plus (UPP) Service Provision

Universal Partnership Plus (UPP) refers to more intensive and multi- agency work with particularly vulnerable families where there is additional illness, disability or special educational need, or safeguarding that requires support/intervention over a longer period of time.

The provider will work with parents/carers to develop an individual plan to support the individual child's health and wellbeing in partnership with other agencies as needed.

The service will work with other partner agencies where there are: child(ren) in need, children subject to a Child Protection Plan and/or Children Looked After. Close working with the MK Family Support team is expected.

14.1 Children Looked After (CLA)/ Children in Care (CiC)

Children Looked After (CLA) are some of our most vulnerable children. The statutory guidance on promoting the health and wellbeing of Children Looked After (DfE, DH 2015) recognises the complex reasons for CYP becoming "Looked After" and highlights that whilst CLA share many of the same health risks and problems as their peers it is often to a greater degree with poorer outcomes as a result.

Effective multi-agency and partnership working, together with the development of an effective framework will improve the assessment and management of the health and wellbeing of CLA and thereby improve long term outcomes. The provider must deliver the full HCP to CLA and CIC. For children aged 5 and under, the provider must contribute to initial health assessments as required in accordance with National and local statutory guidance.

14.2 Children with Special Educational Needs and Disabilities (SEND)

The provider must support individual families where there is a child with SEND. These children require early identification and early intervention to ensure the best outcomes possible.

The provider must refer children who may have a SEND and/or disability to relevant services.

The provider must work with their Local Authority colleagues and the Early Support Service to identify what additional support can be offered to children and their families in the community.

The provider must provide assessment, care planning and on-going support for babies and children and their parents upon school entry. In some cases, where needed, the support from the 0-5 Service could continue to the child's sixth birthday.

The role of SCPHNs is also to work in partnership with other services in supporting the assessment of the education, health and care plans for children aged 0-5 through sharing information about the child's and family's health needs. The provider must review what they can do to support the delivery of these plans working in collaboration with other services.

The provider must provide additional support as needed to families who transition from one health care service to another and when a child transitions into primary school.

The provider must ensure active involvement of parents and children in the child's care and that their individual needs are considered at all stages.

The provider must ensure they have an up to date knowledge on, and relationship with agencies that deliver other services for this group of children.

The service must actively promote the local Milton Keynes SEND Offer.

The provider has a legal duty to ensure all children with special educational needs and disabilities that they come into contact with, who are under the age of 5 years, are brought to the attention of the Local Authority.

Where a child has an identified SEND need and has/or needs health visitor or school nursing involvement the provider will work collaboratively with other services as needed for the benefit of the CYP.

15.0 5-19 Years (HCP) provision

The 5-19 provision is for all school aged children including those attending maintained schools, free schools, academies and colleges in the MK local authority area, or home schooled within the local authority area, covering child health surveillance; health promotion; health protection and health improvement and support as outlined in current national guidance. Health assessments and review touchpoints can provide opportunities to access parent capacity to meet children and young people's needs. The level and type of support needed could include safeguarding concerns; potential and actual mental health issues; domestic abuse/violence and substance misuse.

The service will:

- deliver against the 6 high impact areas;
- deliver health assessment and reviews;
- support transition for school-aged children;
- support vulnerable children and those not in school, for example, children in care, young carers, travelling communities, young offenders, home schooled;
- support children who are home educated children and/or receiving alternative education provision;
- provide appropriate and effective safeguarding services, adhere to relevant national and local requirements and guidance and implement wherever necessary;
- provide the support offered as part of the Milton Keynes Strengthening Families Programme (Troubled Families Programme).

School aged provision will be integrated and deliver a seamless service for CYP and their families, to provide services that reflect the needs of the population.

The service will utilise demographic data to ensure that resources are focussed towards individual CYP and geographies with greatest need, with a focus on improving outcomes for those at greatest risk so that health inequalities are reduced.

The service must provide:

Information, guidance and support to enable CYP to be healthy, to develop skills around informed consent, decision making, and knowledge and confidence in how to access health services.

Where CYP are home-schooled, the service will work with the local authority and make every effort to ensure that these children and their families know how and where to access the service.

The service will (working closely with partners) ensure that all school-aged children not in education, e.g. those who are excluded; those who are homeless, in contact with the Youth Justice System or who are Not in Education, Employment, or Training (NEET), and their families will be able to access services and support.

The provider must communicate with schools/colleges at the start of each academic year to inform schools/colleges who their main link will be and how to contact the service in their locality. Schools/colleges will be informed of any changes throughout the year.

15.1 Community 5-19 Pathway

The Service will work with other professionals in an integrated way in order to effectively signpost CYP and their families. They will offer advice and support, promoting community and voluntary networks, build community capacity, and raise awareness of and implement public health programmes and interventions, working closely with other agencies also providing services to 0-19 year olds. This includes the CCG and Local Authority.

The provider will:

- collect and analyse data to ensure that the service understands local priorities and works across the wider system to build community capacity;
- have a broad knowledge of community needs and resources for the 5-19 age group;
- where possible support co-production of appropriate services with young people and families;
- signpost and support CYP to other sources of health and wellbeing advice and information and/or to other services that already exist locally - as needed;
- influence other agencies and sectors to improve health outcomes.

15.2 5-19 Universal Service Provision

The service must lead, co-ordinate and provide services to deliver the HCP in conjunction with schools and other professionals.

15.3 Transition

Starting school can be a difficult time for some children and for their parents/carers. A proportion of children are not ‘school ready’ and may not have the necessary skills to be able to fully access their education which can impact both on their capacity to learn and their wellbeing. The HCP service has an important role in ensuring that children have a seamless transition into school/s.

The provider must support effective transition for all children as they approach school entry. Where there is a safeguarding concern, children must be formally identified to the school aged Service. Other children who are being supported at Universal Partnership Plus (UPP) level must also be formally identified to this service.

The service will target resources to support vulnerable CYP to support transition, where there is an identified health need or role for HCP staff. The provider must also work closely with the Early Help teams who could also offer additional support to these children and families.

Where needed, the provider must support young people as they transition to adult services which are often very different in culture and approach to children's services such as adult social care or adult mental health services. This work may include an annual review of transition planning.

15.4 Transfers In and Out

a) Transfers In

The provider must make contact with a family with children/teenagers who move into the borough to ensure they can access the service. This will include specific actions for children subject to a Child Protection Plan or any other ongoing concerns of vulnerability. If the 'sending' 5-19 Service notifies the provider of safeguarding concerns, then the family must be contacted within 1 working day and the child seen within 2 working days.

Systems must be in place to assess the risk to CYP whose whereabouts are unknown and appropriate actions taken. Fail-safe procedures must be in place for incoming children to the local area either from another Child Health Information System (CHIS) or from outside England.

b) Transfers Out

When the service is notified that a child/young person moves out-of-area, the service must ensure that the CHIS is informed of the transfer out so that the child/young person's health records are transferred to the receiving 5-19 team in the new area within 2 weeks of notification.

15.5 Health needs assessment

An offer of an assessment of the individual health and wellbeing needs of CYP in each school will enable the provider to support schools to plan interventions and services to improve health outcomes both at an individual and school/community population level.

The provider must offer an annual, school health needs assessment in Year R, Year 6 and Year 9 for those pupils who are in school in the local authority. The provider must use a secure, confidential online tool which to collects, collates and analyse this information.

The provider must inform both the school and parents of the online school health needs assessment at the start of each school year. For primary school children, parents must be asked to complete the assessment. For secondary schools, the provider will encourage schools to enable pupils to complete the health assessment within the school timetable. The provider will promote the availability of alternative support and access to IT provision for those families who do not have access to IT to complete the questionnaire. This will include different methods but will include offering families the opportunity to complete the questionnaire at their local Family Centre or libraries for example.

Where specific health needs are identified for individual pupils these must be proactively followed up with the pupil (and their family) and an individualised package of care/support offered.

The details of any individual health issues that are identified, the support offered/given and the outcome(s) that relate to the health needs assessment must be saved to each child/young person's health record.

This data, at a school and locality population level, must also be used to work with the school to identify joint priorities, to inform the health profile and support development of an action plan for the school.

An annual anonymised and aggregated report from the school health needs assessments must be shared with the Public Health Commissioner. This will take the form of a summary report with an appendix of the anonymised data.

15.6 School Health Profile

Every 2 years the provider must ensure the provision of a Health Related Behaviour Survey (HRBS) which is open to all secondary schools.

The provider must offer an annual liaison meeting with each secondary school who is involved in this to review the findings of the HRBS and local health profile to agree the health and wellbeing priorities for the school.

Each school will have a different set of priorities and the provider should respond accordingly. For example, if the health profile showed a high rate of teenage pregnancy in one locality, the provider must work with the school/s to identify the most appropriate intervention and support. This is unlikely to be a priority in a different locality where the teenage pregnancy rate was low.

15.7 Vision Screening

Hearing, Vision and Health Screening should be offered to all Reception aged children.
Screening for visual impairment for children in the Reception Class cohort should be offered by an Orthoptic-led service to identify and support all children in the cohort with visual defects.

Routine audiology and vision screening in Reception year should be conducted in line with most recent guidance for screening this age range, ensuring more than one opportunity to attend and referring to specialist services as required.

15.8 National Child Measurement Programme (NCMP)

Childhood obesity has important consequences across the life course. These include emotional and psychological consequences for CYP, for example as a result of bullying and discrimination, poor sleep and fatigue. Obese CYP are more likely to be ill and be absent from school, which may impact educational achievement at school. They are at increased risk of a range of health problems, for example type 2 diabetes and musculoskeletal problems. They are also more likely to become obese adults, who are at risk of poor health, disability and premature mortality. Tackling childhood obesity early is important as the prevalence of overweight and obesity continues to increase throughout life.

Delivery of the surveillance elements of the NCMP, completing the height and weight measurements of children in Reception (age 4-5 years) and in Year 6 (age 10-11 years) and returning relevant data to NHS Digital is a mandated function of local authorities which is set out in legislation. NCMP data is used to gather population level surveillance data on child weight status, to inform local planning and commissioning and to provide feedback to parents on their child's weight status adhering to NCMP operational guidance https://www.gov.uk/government/publications/national-child-measurement-programme-operational-guidance

The provider shall:

- Follow the most recent NCMP Operational Guidance and standards;
- NCMP Operational Guidance and standards;
- Work with Public Health to agree all written correspondence regarding NCMP;
- Work with schools to communicate NCMP processes to school staff and parents and book in measurement sessions with each school in good time;
- Ensure that effective stakeholder management is undertaken with schools – head teachers, governors and parents and any other interested parties – to ensure they do not opt out of the programme. If any schools opt out, this should be reported to the Public Health Commissioner on a quarterly basis as part of the performance monitoring arrangements;
- Measure the weight and height of Reception Class and Year 6 cohorts at all state-maintained schools including academies and free schools in Milton Keynes;
- Ensure parents and children have the option to 'opt out' and that these children are not measured;
- Ensure records of measurements and identifiable data are stored securely;

- Conduct robust data collection using the NCMP IT system (details on the HSCIC website);
- Send results letter (criteria as agreed with provider) to parents of children that are measured as being above or below the expected weight range for their age and height within 6 weeks of the measurement;
- All efforts should be made to establish an Information Sharing Agreement (ISA) with the local Weight Management provider to enable direct referrals from 0-19 team to the Weight Management service for children above the expected weight range for their height and age. Where this is not possible letters should contain a signposting option to the weight management provider for concerned parents to contact as they choose;
- Engage with the Local Weight Management Service and work collaboratively to promote services;
- Proactively and opportunistically engage with all parents of children who have been identified as overweight or very overweight and offer personalised advice and sign-posting;
- Check and validate 10% of each batch of letters prior to being sent to parents to check for any inaccuracies or abnormalities in results within the letters;
- Inform the Public Health Commissioner in the event that any letters with inaccurate results are sent out as soon as this is identified. The provider must contact the parent/carer as a matter of urgency to inform them of any error and to provide correct data along with an apology in line with the provider's policies;
- Complete the NCMP measurements and report them to the Local Authority by 31st May each year;
- Resolve any data issues in June and report the results to the Public Health Intelligence team by 30th June annually. Consideration is to be given to timescales to enable NCMP targets to be met. Where there are any data issues, the provider must inform the Public Health Commissioner in good time so that any issues can be resolved promptly by the provider before the national submission deadline;
- Use every August to prepare to go into schools from the beginning of every September for the autumn school term;
- Jointly deliver the Vision Screening alongside the NCMP as a cost-effective approach;
- Actively promote and encourage uptake to the Weight Management Service for overweight or obese children and their families and young people who are not part of the NCMP;
- Support any families who contact the service regarding their child's results;
- Respond to all parents/carers' and schools' questions, compliments and complaints in relation to this service;
- Have a data sharing and referral process agreed with the commissioner.

15.9 Accident and Emergency Attendance Follow Up

The provider must:

- develop and implement pathways on following up hospital attendances and discharges.
- assess A&E attendance notifications and follow up in accordance with professional judgement and national protocols.
- examples of children for follow up are those admitted due to an accident or incident, those who have self-harmed, long term conditions, child/young person on a Child Protection Plan, those who have attended A&E on 3 or more occasions within a 6 month period or where the staff in the acute setting have requested a follow up.
- all decisions and action taken should be recorded in the child's electronic personal record.
- set up arrangements to work with acute trusts so that they can receive timely notifications.
- inform the school of the A & E attendance when it is clinically appropriate to do so and where there is parental consent or a young person's consent (depending on their age and Fraser competence).

16.0 5-19 Universal Plus (UP) Service Provision

The service must proactively identify emerging needs and offer early help through the provision of additional support and services for CYP where a specific health need or concern is identified and ongoing support is required to promote their safety, health and development. For example, continence, emotional & mental health, contraception & sexual health, behavioural concerns.

16.1 Continence

The service must provide support to CYP who are experiencing continence problems. The provider must deliver universal, initial support to CYP (and their families) on diurnal, nocturnal enuresis, constipation and toilet training problems. This could include nappy assessments and providing advice, information and support. The provider will utilise digital platforms to provide more immediate support and advice to parents and carers, such as single points of phone contacts and web-based texting services.

Where necessary the provider must signpost and/or refer CYP onto other agencies such as a GP for further support.

16.2 Supporting CYP to have Healthy Lifestyles and improve Health Literacy

At different points in their lives, CYP may need additional, short to medium term support to maintain or improve their health. As part of the core service offer the service will offer information and guidance to young people, parents and carers and will provide more immediate support and advice to parents and carers, such as single points of phone contacts and web based texting services.

As part of the enhanced offer the provider will identify the most appropriate staff member, following agreed pathways, to offer 1-1 support to individual CYP and their families as needed on a range of health issues including:

- mental health and emotional wellbeing (including bullying, depression, stress, anxiety, self-harm);
- healthy weight;
- nutrition and healthy diet;
- physical activity;
- smoking;
- alcohol and drugs (including legal highs);
- sexual health and relationships including active signposting to sexual health and contraception services and signposting to chlamydia screening;
- promoting immunisations*.

*Whilst the provider is not responsible for delivering the immunisation service to school-aged CYP, the provider should raise awareness of the importance of immunisations with pupils, families and schools where it is needed.

16.3 Mental Health and Emotional Wellbeing

Supporting CYP to have good social, emotional and mental health is a national priority as set out in the Government Green Paper on Transforming CYP's Mental Health provision. It is also a priority in the Milton Keynes JSNA. Fifty per cent of diagnosable mental health problems are said to be evident by the age of 14, and 75 per cent by the age of 25.

Understanding the risk factors associated with the development of mental health problems can help early identification and early intervention.

The provider will ensure the service has staff, with the correct skills mix, who are appropriately trained in identifying and responding to risk factors and early signs of poor mental health. Staff will be knowledgeable,

skilled and confident in promoting protective factors and positive relationships and supporting CYP to develop coping mechanisms and strategies to enable them to build their resilience.

For Early Years Mental Health and Emotional Wellbeing please see section 13.3.1

16.4 School aged CYP:

The service will promote good emotional well-being through the school-aged years by:

- Supporting the whole school approach to emotional wellbeing and building resilience
- Working alongside CYP, their families and the school to identify and provide universal and targeted evidence based support to those with emotional and mental health difficulties.
- Making effective referrals to CAMHS or other support as appropriate
- Listening to the voice of CYP, giving them the opportunity to influence service development
- Actively working as part of multi-agency teams as required to support more vulnerable CYP

16.5 CYP with Medical Conditions

The provider must offer support, advice and information to enable CYP with medical conditions and/or long-term conditions to fully participate in school life and to achieve their academic potential.

The provider must offer advice, support and updates to schools to manage medical conditions and develop Individual Healthcare Plans (IHP) where needed for pupils. Schools are the lead agency for IHPs and must follow the Department for Education's (DfE) guidance. Children with an Education, Health and Care Plan (EHCP) will have their IHP integrated into this.

The provider must provide information, advice and support to schools in planning the management of the medical needs of CYP in school. This must include notifying the school when a child has been identified as having a medical condition, where there is parent/carer consent to do so, or a young person gives consent (if they are Fraser competent). The provider must provide information for schools about their responsibilities annually.

17.0 5-19 Universal Partnership Plus (UPP) Service Provision

This refers to the provision of additional support to vulnerable CYP their families who require co-ordinated input from a range of professionals and services to meet their need.

The provider must offer targeted health-related interventions to vulnerable CYP and their families such as children with complex health care needs and disabilities, young carers, children in need, children with a child protection plan, children in care, those attending pupil referral units, youth offenders as well as those who have a disability or learning difficulty. A specific pathway is required to support the Youth Offending Team (YOT) in their assessment and support of the health of service users.

The provider must work proactively with children who have been identified as children who are not registered with a GP or who are not taken for health appointments and will ensure follow-up systems are in place and implemented for children considered vulnerable/at risk.

The provider must work in partnership with other stakeholders in the wider children's workforce to provide on-going support and additional services for vulnerable children, young people and their families including young carers.

18.0 Applicable Service Standards

18.1 National standards

The provider must work in line with the most recent relevant NICE guidance and evidence base related to 0-19 HCP provision.

18.2 Local standards and workforce

19.0 Supervision and registration of health visitors and school nurses

The provider must ensure there are appropriate policies and procedures in place to assure the legal requirements for professional registration, revalidation, professional conduct and appropriate clinical and safeguarding supervision for public health nursing workforce

This must be in line with the most recent statutory requirements for practice issued by the NMC on revalidation (current NMC 2015).

Supervision is expected to include:-

Clinical Supervision according to need utilising emotionally restorative supervision techniques on a regular planned basis.
Safeguarding Supervision minimum 3 monthly (provided by colleagues with expert knowledge of child protection)
Management Supervision Line managing staff will have access to a professional lead to provide one to one professional management supervision of their work, case load, person and professional learning and development issues.
Practice Teacher Supervision Practice Teachers must have access to high quality supervision according to the requirements of their role.

20.0 Workforce

The Provider will be responsible for the effective management and deliver of the service described in this specification, including maintaining the necessary staffing resources and support to undertake the work specified.

The provider will develop and maintain an optimum establishment of SCPHN to effectively deliver the outcomes of the 0-19 service meeting the diverse needs of CYP and their families in Milton Keynes, structuring the service around a skill mix that ensures there is both sufficient leadership and distribution of skills to develop and supply the key assessments and interventions. The service shall be provided by sufficient collective competencies to deliver safe, effective and best value outcomes.

Appropriate skill mix must be put in place across the service which will include different grades of staff including a suitable number of qualified SCPHN's to meet the requirements of the Service Specification. The provider must ensure that there is clear, clinical accountability through appropriate training and supervision of non-clinical staff.

The provider shall complete full, robust workforce analyses with plans to achieve set trajectories which shall include but is not limited to:

- Recruitment/retention plans
- Succession planning
- Student placements
- Support for return to practice staff
- Retention and supply of Practice Teachers
- Vacancy numbers and period of time vacancy held
- Sickness and absence rates
- New students
- Potential retirees

The service will provide appropriate permanent staff allocation geographically, according to population need whilst maintaining the Universal offer.

The provider shall ensure that all staff are suitably trained; supervised and managed to deliver high quality and safe services. All (SCPHN) need to meet the legal requirement for professional registration and revalidation. This must be in line with the most current statutory requirements for practice issued by the NMC on revalidation (NMC 2015).

The provider will ensure they have policies and procedures in place to provide clinical supervision, safeguarding supervision and mechanisms of risk assessment for any public health nursing service involved.

Further details on employer issues can be found in Supporting the public health nursing workforce: health visitors and school nurses delivering public health for CYP (0-19) Guidance for employers (Public Health England, 2018)

21.0 Training and Development

The provider shall develop and provide a robust system to record all training specific qualifications and insurance in order to demonstrate compliance to the Commissioners. This includes evidence of enhanced Disclosure and Barring Service checks for all relevant staff.

a. Medicines Management Training

The Provider will promote the availability of online training to staff working with CYP at the start of each academic year on managing medical conditions (for example asthma, diabetes, epilepsy, anaphylaxis) and medicine management such as inhalers, epipen etc.

b. General Training

The provider will work with the commissioner on an annual basis to assure a training programme to meet the needs of the population. Beyond core CPD and Safeguarding requirements focus areas may be:-

- Speech and Language to also include basic awareness and recommended training from SCLN Best Start in Life Health Visitor training
- Domestic Abuse as per NICE recommendations in how to respond to domestic violence and abuse
- MECC (Making Every Contact Count)
- Mental Health and Wellbeing to also include Mental Health First Aid training
- Adverse Childhood Experiences (ACEs). The HCP workforce must be ACE aware and look at their service through an ACE lens, adhering to Adversity and trauma models of commissioning and care. (Young minds, addressing adversity)

22.0 Safeguarding and Serious incidents

Safeguarding, including child protection and prevention of harm to babies is an essential and priority component of the service. Effective partnership and multi-disciplinary working underpin the core safeguarding principles which are outlined in this section.

The provider must ensure the role of SCPHN's in safeguarding is clearly agreed and must comply at all times with:-

- The most current Milton Keynes Safeguarding Policies and Procedures, http://www.mkscb.org/policy-procedures/
- All staff and volunteers must be trained to follow the Safeguarding of Vulnerable Children reporting procedures and training should be updated at least annually.

- The Authorised Officer must be notified immediately of all instances of suspected abuse pertaining to the contract.
- The Service Provider shall obtain and maintain Disclosure and Barring Service checks in respect of each member of staff or volunteer working with CYP.
- At the reasonable written request of the Authority and by no later than 10 Business Days following receipt of such request, the Provider must provide evidence to the Authority that it is addressing any safeguarding concerns.
- If requested by the Authority, the Provider shall participate in the development of any local multi-agency safeguarding quality indicators and/or plan.

To ensure early intervention, support/appropriate referral to targeted support the SCPHN will utilise the Common Assessment Framework, may undertake the Lead Professional /Key Worker role (where appropriate). S/he will maintain accountability for children for whom there are safeguarding concerns, working in partnership with other agencies as part of a multi-agency intensive care package to ensure the best outcomes.

Safeguarding includes the statutory duty to share information and communicate with other health professionals and agencies where there are safeguarding concerns and engagement in multi-agency services e.g. MASH, MARAC and strengthening families. Communicating effectively with other agencies, including contributing to case conferences and other safeguarding meetings is required.

SPCHN will have expert knowledge* about child protection and the skills* and qualities* to intervene to protect children.

**Knowledge needs to include domestic abuse, neglect, child and adult mental health issues, substance and alcohol misuse, physical, sexual and emotional abuse, female genital mutilation, fabricated and induced illness in a child.*

**Skills and qualities need to include high levels of communication and interpersonal relating, self-awareness, ability to challenge and to be challenged, understanding of barriers to safe practice e.g. collusion, adult focus, fear, burn-out. HVs need to receive expert supervision for child protection and safeguarding work they are involved in.*

22.1 Identifying maltreatment

There are many factors that may contribute to child maltreatment. *Child Maltreatment: when to suspect maltreatment in under 18s - Guidelines (CG89)* provides a summary of clinical features associated with child maltreatment and alerting features that may be observed when a child presents to healthcare professionals. These include physical features such as: bruising, bites, burns, fractures, head injuries, eye trauma, spinal injuries, organ damage, oral injuries, ano-genital signs and symptoms, and other non-specific injuries.

Factors that have been clearly established as placing children at an elevated risk for abuse, neglect and exploitation include parents or carers who:

- have a mental illness that is not adequately managed, including postpartum depression or psychosis;
- are significantly misusing substances and/or alcohol;
- experience/engaged in intimate partner violence;
- have a history of criminal/antisocial behaviours;
- lack knowledge about child development/developmental milestones or having unrealistic expectations about their children's developmentally appropriate behaviours;
- have prior history of requiring child safeguarding or child protection services or have had a child become looked after.

Additionally, children are likely to be more vulnerable in families with parent(s)/carer(s) who have severe intellectual disabilities; a personal history of having been looked after; are isolated from social support; or are from a background or culture that promotes harsh physical discipline.

Children and carers in the above circumstances can have healthy relationships and positive outcomes, but these issues can impact negatively on carer and child. Professionals will need to take into account the full family context and history when assessing risks and needs.

22.2 Milton Keynes Vulnerable Families Guidance

The provider must develop a clear multi-agency enhanced support pathway to include but not limited to: Maternity Services, Perinatal Mental Health, Family Support, Smoking Cessation Services, Contraceptive Services and Children's Services. The provider could develop a 'step on and step off' pathway recognising that not all parents will need the same or continual level of support after the antenatal period. For example, a young mother aged 17 who is living at home and is well supported by her partner and family may need a different level of support from an individual who is living by herself with a learning difficulty and has no family nearby.

The provider must liaise closely with maternity services both within and on the borders of the county to identify these individuals by 12 weeks of pregnancy so that contact can be made with the client. The Provider must also liaise with any specialist teams within maternity services which focuses on supporting vulnerable pregnant women.

The provider must ensure at least 3 antenatal contacts are offered to these individuals by a named nurse who has relationship building skills to work effectively with vulnerable parents. The provider must ensure that there are monthly contacts and at least 6 home visits to each family by the named nurse from the time the baby is born until the 1 year mandated review. The provider should consider how the Service will engage fathers. The provider must identify what support the enhanced offer will give to children and their families from aged 1 year until the child is aged 2 years. For example, the provider could offer up to a further 6 home visits up to the 2 year review.

The provider must identify local support mechanisms in the community and actively signpost and support individuals to make contact with other services. This may include parenting groups, voluntary sector organisations as well as other services who can support individuals back into education, training and employment.

22.3 Serious Incidents

The provider is required to adhere to the most current NHSE Patient Safety Incident Response Framework in conjunction with relevant commissioners and other providers.

23.0 Record keeping, data collection and information sharing

- Providers will ensure that robust systems are in place to meet the legal requirements of the Data Protection Act 1998 and safeguard personal data at all times.
- It is recognised that processes must be in place with regards information governance but in the interests of patient safety, pathways and processes should be put in place to enable pertinent information to be shared with other relevant organisations (such as GPs/parents) In line with the above and following good practice guidance, the provider will have agreed data sharing protocols with partner agencies, including other healthcare providers, children's social care and the police to enable effective holistic services to be provided to children and their families. This will improve the coordination and communication between services, and safeguard and protect children.
- Electronic contemporaneous clinical records should be kept and accurate and appropriate data made available to the Child Health Information Systems (CHIS) to enable local, regional and national data reporting. This will support the delivery, review and performance management of

services. Data sharing agreements and arrangements for operational processes will need to be considered.

- Local commissioners are encouraged to ensure that the delivery metrics and outcomes indicators for the 0-19 HCP are covered in contracts or 'in-house' arrangements in a way that supports local data collection in the standard national format.
- The provider is required to have a system in place in line with the standards of the Health Child Programme IT Operating Model and to upload the national mandated delivery metrics and outcome indictors for the 0-19 HCP on a monthly basis to the community services dataset (NHS Digital) and to the Local Authority in line with the most recent guidance (https://www.gov.uk/government/publications/childrens-public-health-0-to-5-years-national-reporting). A plan should be in place to assure data quality and completeness.
- The provider will develop a data set that supports commissioning to understand the population needs and service activity, some examples are: oral health annual audit, introduction to weaning and solids advice at 3-4 months, No. and % of children identified with developmental delays receive further assessment.

24.0 Materials, tools, equipment and other technical requirements

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**,** for example, 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, for example, 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

25.0 Business Continuity & Viability

- The Provider will ensure that a business continuity plan is in place and is reviewed annually and up dated where necessary.
- The Provider will ensure that regular risk assessments are carried out and recorded in relation to the service.

26.0 Performance Management and information provision

Reporting for the HCP 0-5 mandated checks should follow national guidance https://www.gov.uk/government/publications/childrens-public-health-0-to-5-years-national-reporting

Information sharing must comply with the requirements of the Child Health Information Services (CHIS) and Community Services Minimum Data Set (CSMDS) as set out in the Information Standards Notice (ISN) Phase 1 and 2 https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/dcb3009-healthy-child-programme

The overall performance of the service will be monitored through a combination of:

- Quantitative measures (outputs/activity and key performance indicators)

- Qualitative measures (outcomes and quality assurance)
- Progress against SMART service development plan and objectives
- Open book financial reporting
- Service user feedback

Performance monitoring will be undertaken on a quarterly basis. A monitoring workbook will be provided for the provider to complete which will form the basis of contract monitoring meetings held once per quarter and the provider will ensure the individuals responsible for the service are present. The workbook will be regularly reviewed and updated to take account of service developments and changes over the contract term.

Failure to supply complete monitoring information within deadline may be interpreted as a material breach of the Agreement terms and conditions.

26.1 Other information provision

The provider must share all inspection reports, CQC periodic and special reviews, national/local audit reports and service user/staff surveys relevant to the service.

The provider must notify the commissioner if any clinician's professional registration lapses, is suspended, removed or conditions added; or the clinician has a hearing with the Professional Regulatory Body.

In order for the local authority to comply with the terms of the Public Health Grant (PHG) the provider will make available a breakdown of expenditure through its open book reporting.

All local authority commissioned services are scrutinised and held to account by the local authority and, where appropriate, relevant partnerships. Therefore, summaries of performance will be shared with relevant boards which have a scrutiny or oversight role for public health, crime reduction or local authority commissioned services. On this basis, performance information may reach the public domain and is therefore not considered to be commercially sensitive or confidential. Performance information is also subject to Freedom of Information requests

27.0 Social Value

Milton Keynes Council Corporate Plan sets an overall vision for a Milton Keynes where we 'think differently, create opportunity and believe in people.' Social value is a key part of achieving this vision as it aims to get the widest collective benefit possible for our local communities by thinking differently. Benefits could be social, economic or environmental and relate to the outcomes of the health and wellbeing strategy with a focus on improving the environment, improving mental wellbeing amongst staff and in the community or These can be can be social, economic or environmental some examples you may consider might be:

- Offering volunteering opportunities, taking on local apprentices, using local subcontractors
- Delivering educational sessions and careers events at local schools
- Working with the local community to build community assets

Further examples and tools are on these webpages for Social Value can be found here

https://www.milton-keynes.gov.uk/business/tenders-and-contracts/social-value-information-hub

https://www.sduhealth.org.uk/areas-of-focus/social-value.aspx

Appendix 1

Content of Health Visitor Reviews

Antenatal (health promoting) Contact

The antenatal contact is a promotional narrative listening interview including preparation for parenthood and a holistic assessment of the family to identify parent capacity to meet the infant's needs. The level and type of support needed could include safeguarding concerns; potential and actual mental health issues; domestic abuse/violence and substance misuse.

The antenatal visit is a guided conversation using the evidenced based tool 'Promotional Guide' and updated guidance and pathways according to Public health England/NHS

New Baby Review Visit (Face to Face review)

Face to face review by 14 days with both parents present (if applicable) to include:-

- Infant feeding
- Promoting sensitive parenting
- Promoting development
- Assessing maternal mental health
- SIDS prevention including promoting safe sleep
- Keeping safe
- If parents wish or professional concerns: assessment of baby growth, ongoing review and monitoring of baby health assessment of safeguarding concerns, assessment of attachment using NVO before 8 weeks, promotion of immunisations, checking status of screening results and taking proactive action to ensure appropriate referral and treatment pathways are followed in line with UK NSC Standards, specifically Newborn blood spot, results of NIPE examinations, Hearing screening outcome.

The 6-8 week postnatal and maternal wellbeing contact must include:

- recording breastfeeding status and on-going support with breastfeeding involving both parents (where practical)
- attachment behaviour, communicating with their child to encourage language development
- assessing parental mental health according to National Institute of Clinical Excellence (NICE) guidance
- assessing maternal mental health: Maternal Mood review assessment (Edinburgh Postnatal Depression Scale or PHQ9, GAD7 as appropriate)
- advice on HCP service offer and local support
- promotion of immunisations generally and specifically concerning 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 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 the initial check
- advice on Sudden Infant Deaths including safe sleeping information
- assessing and discussing the factors that may pose a risk to their child's social and emotional wellbeing
- follow up of any A&E attendance notifications using professional judgement to escalate issues or concerns in relation to safeguarding or follow up
- health promotion advice relevant to the child and family such as uptake of healthy vitamins, contraception options
- contraception and sexual health

The 1 year Health and Development Review must include:

- Assessment of the baby's physical, emotional and social development and needs in the context of their family, using evidence based tools i.e. the most current UK Ages and Stages Questionnaire (ASQs), or any other future updates or developments of a screening tool that the Department of Health and Social Care (DHSC) requires
- Supporting parenting, providing parents with information about attachment, communicating with their child to encourage language development, developmental and parenting issues
- Monitoring growth
- Raising awareness of:
    - oral health and prevention based on current evidence of effective practice, refer to oral health pathway if appropriate, ensuring that all families are informed about the importance of accessing primary dental care services for routine preventive care and advice;
    - healthy eating and risk to long term health of obesity;
    - physical activity and active play;
    - smoking cessation;
    - drugs and alcohol, sexual health and contraception;
    - smoke free homes/cars;
    - injury and accident prevention relating to mobility, safety in cars;
    - skin cancer prevention.
- check of new-born blood spot status and offer screening if the child is under 1 year as needed
- review of immunisation status and promote the routine immunisations
- encouragement of parents to take up Early Years education offer

The 2-2.5 year Health and Development Review must include:

Will ideally be an integrated review alongside the Early Years Foundation Stage 2 year old review;

- Reviewing with the parents and setting of the child's social, emotional, behavioural and language development using the UK (ASQ) and Ages and Stages Questionnaire Social-Emotional (ASQ SE) screening tools where clinically indicated or any other future updates or developments of a screening tool that the DHSC requires. For children with additional needs or concerns (SEND), use the Schedule of Growing Skills Tool;
- Responding to any parental or settings concerns about physical health, growth, development, hearing and vision;
- Offering parents advice on behaviour management and opportunity to share concerns
- Offering parents guidance on positive parenting;
- Signposting to further support where applicable;
- Promoting language development;
- If applicable encouraging and supporting to take up of Early Years education offer;
- Giving health information and guidance including contraception and sexual health;
- Reviewing immunisation status if information is available, and provide information about the importance of immunisation;
- Assessing growth;
- offering advice on nutrition (including portion size, fruit and vegetables intake, reduction of sugar). Offer information and guidance on healthy weight and the risk to long term health conditions of obesity. Including taking into account and address the needs of ethnic groups for example vitamin D deficiency in Asian women and children;
- Encouraging active play/physical activity for the family;

- raising awareness of the importance of healthy lifestyles including dental care, accident prevention, behaviours that encourage healthy sleep patterns, toilet training and sources of parenting advice and family information.

References

[i] https://www.gov.uk/government/publications/send-code-of-practice-0-to-25

[ii] https://www.gov.uk/government/publications/surveillance-and-audiological-referral-guidelines