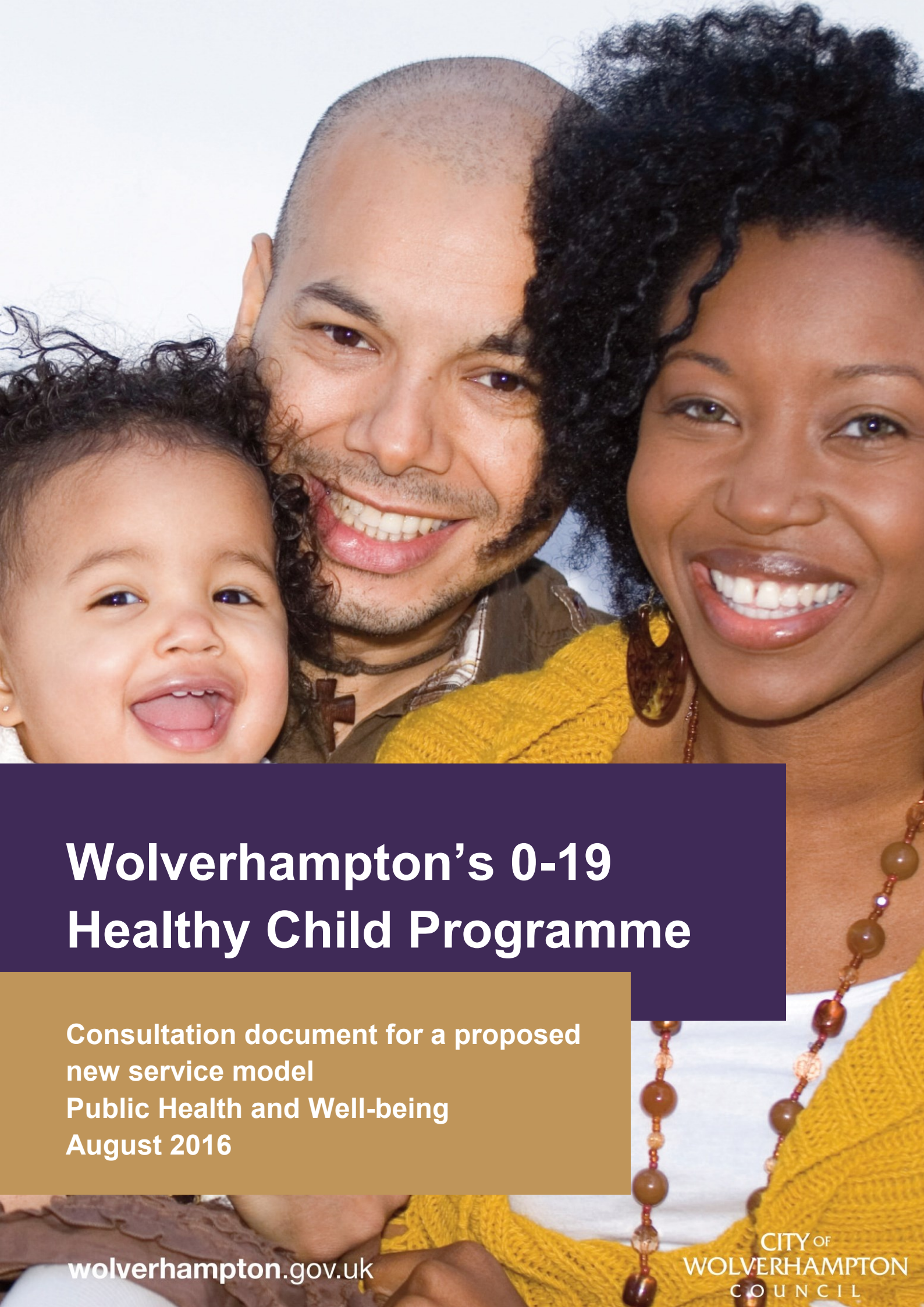


Wolverhampton's 0-19 Healthy Child Programme

Consultation document for a proposed new service model
Public Health and Well-being
August 2016

wolverhampton.gov.uk

CITY OF WOLVERHAMPTON COUNCIL

Contents

1. Why are we going out to tender for the Healthy Child Programme? 2
2. Purpose of this document 2
3. How can you give us your views? 2
4. A new way of working 3
5. The new service model – informed by service users and professional stakeholders 3
6. What is staying the same? 3
7. So what is changing? One integrated Healthy Child Programme 4
8. Benefits of an integrated programme 5
9. Expectations of new service providers 6
10. Other key requirements of the new service model (N.B this list is not exhaustive) 8

Appendix 1: Example of a local profile informing achievement of local outcomes 12
Appendix 2: Example of use of web resources to help inform parents about health enhancing activities 13
Appendix 3: Example of a private sector company using live web chat to offer support 14
Appendix 4: Example of a resource developed in Cheshire to support the parent's journey – which services interact with you and when; what you can expect; where to go for help outside of these bus stops 15
Appendix 5 : Information on HeadStart 16

1. Why are we going out to tender for the Healthy Child Programme?

The transfer of commissioning responsibilities for Health Visiting, School Nursing and Family Nurse Partnership from the NHS to local authorities provides an opportunity to take a fresh look at these services. The process of going out to tender enables us to:

- Listen to the voices of parents, young people and professionals from a very wide range of services , teams and organisations about what is going well and where there is room for improvement
- Specify a new service model that supports what is working well and addresses areas that need improvement
- Work with bidders to refine our proposals and get the best possible service model that will improve outcomes for the children, young people and families across the city
- Award a contract to a bidder that will improve outcomes for the best possible value.

2. Purpose of this document

This document does not detail the full service specification. This document:

- Sets out a framework for a new service model
- Describes the rationale for the new model
- Identifies some key expectations of the service provider and
- Stipulates some essential service requirements but this list is not exhaustive
- Provides details of how you can give us your views on the proposed service model.

It is envisaged that, at the time of going out to tender, potential bidders will specify in more detail how they would achieve the aims of the new service model.

3. How can you give us your views?

We are keen to hear all views on the proposed Healthy Child Programme service model. Wherever possible your views will be taken into account. You can give us your views in the following ways:

- By completing our consultation survey here Healthy Child Programme service model consultation survey
- Telephone 01902 558673 or email PublicHealth@wolverhampton.gov.uk to request the survey in a different format.
- Alternatively you can email your views to: PublicHealth@wolverhampton.gov.uk or write to Public Health, Wolverhampton City Council, Civic Centre, St Peter's Square, Wolverhampton, WV1 1RT

4. A new way of working

The new Healthy Child Programme (HCP) does not fit into the traditional 'commissioner-provider split' arrangements that have previously been in place. This tendering exercise is looking not just for a new model of service delivery but a new way of working with commissioners and Children's Services, the Clinical Commissioning Group (CCG) and education. For example, although the Public Health team is the commissioner of these services, it is expected that the new provider will make best use of intelligence on the population available from this team. Co-production will be the cornerstone of this new way of working. The new service model will include a shared view of:

- Need within the population – at city level and smaller geographical levels
- Outcomes to be achieved or improved upon at locality levels
- Priorities as identified either from intelligence such as service reviews, or from engagement with professional stakeholders and service users
- Flexibility of approach as changes occur across population needs / priorities/national guidance, with strategies and action plans developed jointly
- Flexibility as commissioning arrangements change e.g. with the CCG, or with education
- Creative ways of working in partnership with the voluntary sector to support aspects of delivery of the healthy child programme.

All of this has to happen against a backdrop of scarce resource in a climate of continued austerity: it is imperative that service delivery is as smart and efficient as possible without a negative impact on quality.

5. The new service model – informed by service users and professional stakeholders

This service model takes account of information received from a variety of methods, namely:

- An 8 week Engagement process (May-August 2016) including surveys and workshops with parents, young people and professional stakeholders
- Workshops held with frontline workers, health visitors and early years workers, in June 2015
- Data from various sources on needs within the city
- GP locality meetings, city wide GP meetings and discussions with the Local Medical Council (LMC)
- Learning from serious case reviews from across the country
- On-going monitoring of existing services.

6. What is staying the same?

Five developmental reviews undertaken by health visitors (antenatal, new birth visit, 6-8 weeks, 9-12 months and 2-2.5 year check) will remain as is currently mandated.

How these reviews continue beyond March 2017 is out to national consultation and these may change depending on the results of this consultation. Two developmental reviews by school nursing services (reception and year 6) will also remain but the National Child Measurement Programme (NCMP), a key part of these reviews, needs to become part of a healthy weight management plan across the life course developed by the Healthy Child Programme. In line with national guidance, these reviews would ask questions about vision and screening (and other health conditions) and refer on the appropriate specialists. The reason for keeping these reviews is because for both of these services, these models are very familiar with the public and they are still mandated (for example, most parents in the engagement exercise thought the frequency of Health Visiting reviews was about right). These reviews also enable the services to remain benchmarkable with other areas.

7. So what is changing? One integrated Healthy Child Programme

It is proposed that there is one 'Healthy Child Programme' for 0-19 year olds that brings together Health Visiting, School Nursing and Family Nurse Partnership services, underpinned by an electronic case management system, so that each child's contact with services can be tracked over time. This will enable a focus on good outcomes for individual children and families. It will also enable aggregate reports which inform priorities at a locality level. Practitioners within the Healthy Child Programme will be supported to take a population-based view of their locality.

It is proposed that the Healthy Child Programme and its underpinning case management system works as one team the recently established Early Intervention Service. This is a new 0-18 family-centred model, working with whole families, located across 8 Strengthening Families Hubs, integrated with Health Visiting and School Nursing and a range of other services. More information on the Children's Services delivery model can be found here.
As soon as additional needs are identified by a practitioner, unless the needs meet safeguarding thresholds, (which should be referred to the Multi-Agency Safeguarding Hub (MASH)), an Early Help Assessment should be initiated. A collective, multi-agency decision is made about the pathway that the family needs. The pathways are:

- Universal Plus : additional needs met by more contact with the healthy child programme
- Universal Partnership Plus: additional needs met by more than one service
- Universal Partnership Plus +: additional needs met by an intensive nursing support programme

A pictorial representation can be found on page 10 (figure 1).

The 'Universal Partnership Plus +' delivery arm is considered to be a key component of the Healthy Child Programme. This could potentially remain as Family Nurse Partnership (FNP). What is required is local determination of both eligibility criteria and the length of time on the programme. The National FNP unit is looking to

become more flexible in these areas and so it may be possible for 'Universal Partnership Plus+' to remain as FNP. Requirements of this part of the team include:

- Highly trained workforce to deliver intensive, therapeutic support to the whole family
- Criteria for which families receive this service to be determined in a multi-agency way, i.e. with local flexibility, including maternity services, primary care, children's services and healthy child programme practitioners
- Between 60 and 70% of cases to have social work involvement
- For these cases, initial assessments to be discussed with social workers and plans to be developed alongside social workers
- The service would aim to achieve a 40% de-escalation of need (e.g. child protection status or child in need status reduced to early help or universal provision)
- The service would also expect to escalate need in 8 – 10% of cases because of the early identification of vulnerability
- Flexibility required in the length of time that intensive support is offered so that the families benefit from continuity with a particular practitioner for a good length of time (e.g. 1 year to 18 months) but in a way that builds capacity and resilience and where necessary, brings in support from other, less intensive agencies as soon as possible
- Learning from cases requiring intensive support to be shared with other staff within the Healthy Child Programme and Strengthening Families Hubs on a regular basis: annual schedule to be developed. This would support other members of staff in their work with complex cases and also support the prevention agenda e.g. identifying young women at risk of becoming pregnant and intervening to reduce risk.

N.B It is appreciated that particular groups within the city, such as young offenders, new arrivals, homeless families, travelling communities may need a different service model. What is required is a service that meets the needs of these communities, and delivers good outcomes for these communities, whilst supporting and developing skills across the workforce as broadly as possible. The delivery model for certain key groups needs to be developed in partnership with Early Intervention Services and other key teams such as the Youth Offending Team.

8. Benefits of an integrated programme

- A 'think family' approach and a life course approach supporting a child and their family to achieve good outcomes. The service will demonstrate how contacts contribute towards good outcomes for children (historically the focus has been more about numbers of contacts in a given time period and commissioners have not asked enough about the quality of these contacts and the difference they have made).

  For example, this model will more easily enable the development and implementation of plans for good mental health across the life course, good

oral health across the life course, healthy weight across the life course – produced in a way which acknowledges the challenges at different stages for children and their families and draws on the expertise of the different workforces. It is envisaged that these plans and associated pathways will be developed in partnership with other services such as the Healthy Lifestyle Service (now based within Public Health), Healthy Minds and Recovery Near You.

- Smoother and more fluid transition between health visitors and school nurses. For example, a school nurse could support the family from when a child enters nursery rather than waiting until reception year and improve the chances of the child being 'school ready'
- More efficient partnership working with key services such as primary care and the MASH (Multi Agency Safeguarding Hub)
  For example, the Healthy Child Programme could be represented at meetings with key services by one practitioner (either a health visitor or a school nurse)
- A more resilient service for example, improving accessibility throughout the working day and during school holidays as well as when staff are on sick leave
- An ability to work as part of an integrated, multi-agency team within Strengthening Families Hubs, jointly assessing levels of vulnerability, using common tools for assessment and planning and common methods for charting progress against a plan and reporting on outcomes achieved
- A strengthened strategic leadership role of the health visitor in holistically assessing a child's/family's needs and collaborating with other services to meet those needs and improve outcomes for the child/family. Historically, Health visitors have always undertaken family assessments but the information gained has not been asked for by commissioners
- Joint development and implementation of pathways and procedures which ensure a multi-agency adherence to city wide protocols and national guidance e.g. local safeguarding thresholds, Wolverhampton domestic violence standards, national guidance on Child Sexual Exploitation and Female genital mutilation
- Jointly developed training schedule
- Jointly developed audit schedule
- A shared understanding of needs and priorities and outcomes at a locality level (see appendix 1 as an example of a local profile informing local outcomes)
- More efficient use of administrative resources across the Healthy Child Programme and Strengthening Families teams.

9. Expectations of new service providers

To enable the above benefits to be achieved, the new service requires:

- A serious and unwavering commitment to a digital transformation programme underpinning delivery of the healthy child programme which comprises:
  - Electronic case management

  - Agile working : remote access to systems whilst on the go
  - Development of web resources, optimised for smart phones, to support practitioners and parents and young people (see appendix 2 as an example of an app to promote health enhancing activities from Kent)
  - Development of resources for people for whom English is not their first language
  - Use of skype, facetime, texting, auto-reminders
  - Live 'web chat' for example with young people and with parents (see appendix 3 for an example of web chat supporting customer services in the private sector).

- Demonstrable commitment to workforce development with high quality on-going training which ensures the service is always attractive to potential applicants and establishes a reputation of having a workforce of the highest calibre
- The expertise of the workforce in the development of resources to support parents with challenges that they can face on a daily basis – to be done in a way that encourages self-help and resilience. This requirement seeks to address a recurring issue that emerged from the engagement process; namely that current service specifications and delivery models and reporting requirements do not use practitioners' expertise to best effect
- Greater mix of skills where qualified health visitors and school nurses appropriately delegate work to other staff whilst assuring themselves of the quality of the work with robust clinical governance and supervision arrangements. Delegation always to be done in accordance with national guidance, local safeguarding protocols and Care Quality Commission (CQC) recommendations
- Development of resources, both physical and electronic, to support the parents' journey from antenatal to school and beyond of what can be expected of services as well as child development (see appendix 4 as a small example from Cheshire)
- Delivery of a culturally sensitive and non-discriminatory service
- Development of resources, both physical and electronic, to support the reduction of risk-taking behaviour amongst adolescents
- Implementation of a comprehensive marketing strategy to service users and professional stakeholders. Lessons from the recent engagement process and other activities have shown that messages need to be repeated with regularity for them to 'land'
- On-going demonstrable commitment to addressing the lessons learned from serious case reviews and domestic homicide reviews. For example, communication with primary care is a recurring theme in these reviews. A collated document of serious case review recommendations is available here.
- Demonstrable continuous quality improvement informed by the views of service users.
- The support to and the facilitation of parents' groups which maximise the opportunity to impart high quality information to parents on: (N.B this list is not exhaustive)

- Breaking the myth that parents just know what to do 'naturally' when a child is born
- The importance of asking for help
- Building confidence and resilience
- Secure attachment: what it looks like and why it is important
- Child development: what to expect
- the challenges of parenting and some solutions/handy hints and tips e.g introducing solids, oral health, physical activity talking and reading to your child, managing behaviour
- Encouraging self-help
- Where and how to ask for help
- Content that is specific for Dads
- Supporting parents to become 'work ready'.

10. Other key requirements of the new service model (N.B this list is not exhaustive)

As much as possible in the preceding pages, this document sets out to provide an overarching framework for a new service model without getting into too much detail. However, there remain some aspects of delivery that do need to be stipulated. The following describes some key requirements of the new service model but this list is not exhaustive.

- Safeguarding and proactive co-operation with the MASH
  Safeguarding and child protection will be embedded across all levels and will be prioritised as a protected element of the integrated HCP workforce's role. The workforce will address safeguarding issues and ensure adherence with the safeguarding policies of the city and national standards including the 2015 publication 'Working Together'. Any changes to ways of working will be subject to agreement with the Wolverhampton Safeguarding Children's Board.

- Violence Against Women and Girls which includes domestic violence and abuse, sexual violence, Female Genital Mutilation, forced marriage and honour based violence: there is an expectation that the service will adhere to the Wolverhampton domestic violence standards including use of Domestic Abuse, Stalking and Honour Based Violence (DASH) risk assessment, agreed pathways and procedures to respond to domestic violence and abuse. Training, supervision and support of staff in domestic violence and abuse will be commensurate with their role.

- Child Sexual Exploitation: there is an expectation that the service will be fully trained and active in identifying and responding to CSE and completing the CSE Screening Tool where appropriate.

- Addressing infant mortality
  The Healthy Child Programme workforce to be part of a multi-agency group which seeks to reduce infant mortality and plays a key role in implementing the action plan. The latest version can be found here.

- Contribute to Looked After Children (LAC) health reviews – this activity to be jointly commissioned with the Clinical Commissioning Group (CCG).

- Additional health reviews by school nursing: Although it has been stated that the existing mandated reviews should remain, there has been a strong recommendation from the engagement process that school nurses undertake additional reviews, for example at year 3 and year 10 and post 16, especially done in a way that improves educational attendance and engagement.

- Robust interface with maternity services
  There is an expectation that improvements achieved under the most recent NHS contract (2015/16) which strengthens the maternity – health visitor notification pathway will be built on and improved further. Given that maternity services are often the first service to identify vulnerability with a pregnant woman, the input they can offer to a multi-agency assessment of need and support is invaluable. In particular they have a key part to play in identifying which women should be offered 'Universal Partnership Plus +'.

- Mental wellbeing
  The Healthy Child Programme practitioners have a strong focus on prevention, early intervention and this focus needs to include resilience and mental wellbeing, such as the '5 ways to wellbeing'. School nurses have a specific responsibility to support good mental health whilst addressing other health needs of pupils and their families and especially those issues which form barriers to education. The role of the school nurse – health professionals in an educational setting – provides them with a unique place in children's services. Specifically this includes:

    - Working in an advisory capacity with school staff on health matters
    - Developing strong partnership arrangements with CAMHS
    - Strong partnership working with HeadStart, which has just received funding from the Big Lottery for a further 5 years, including being an integral part of the 'HeadStart Hubs' in four geographical areas but also taking universal messages out to other schools (see appendix 5 for more information on HeadStart).

- Personal Health, Social and Economic Education (PHSE) including Relationship and Sex Education (RSE)
  School nurses to work in partnership with schools and the wider education to plan and deliver components of the PSHE Education curriculum and support the delivery of other components to improve educational attendance. It is envisaged that this includes a minimum equitable PSHE education entitlement for each school that focuses on current Public Health and school priorities. It would require a good knowledge of school provision to signpost parents/young people in to school based interventions.

- School nurses to discuss health priorities with key members of school staff and SLT and provide guidance to schools in the design of health and wellbeing provision and appropriate referral to secondary services.

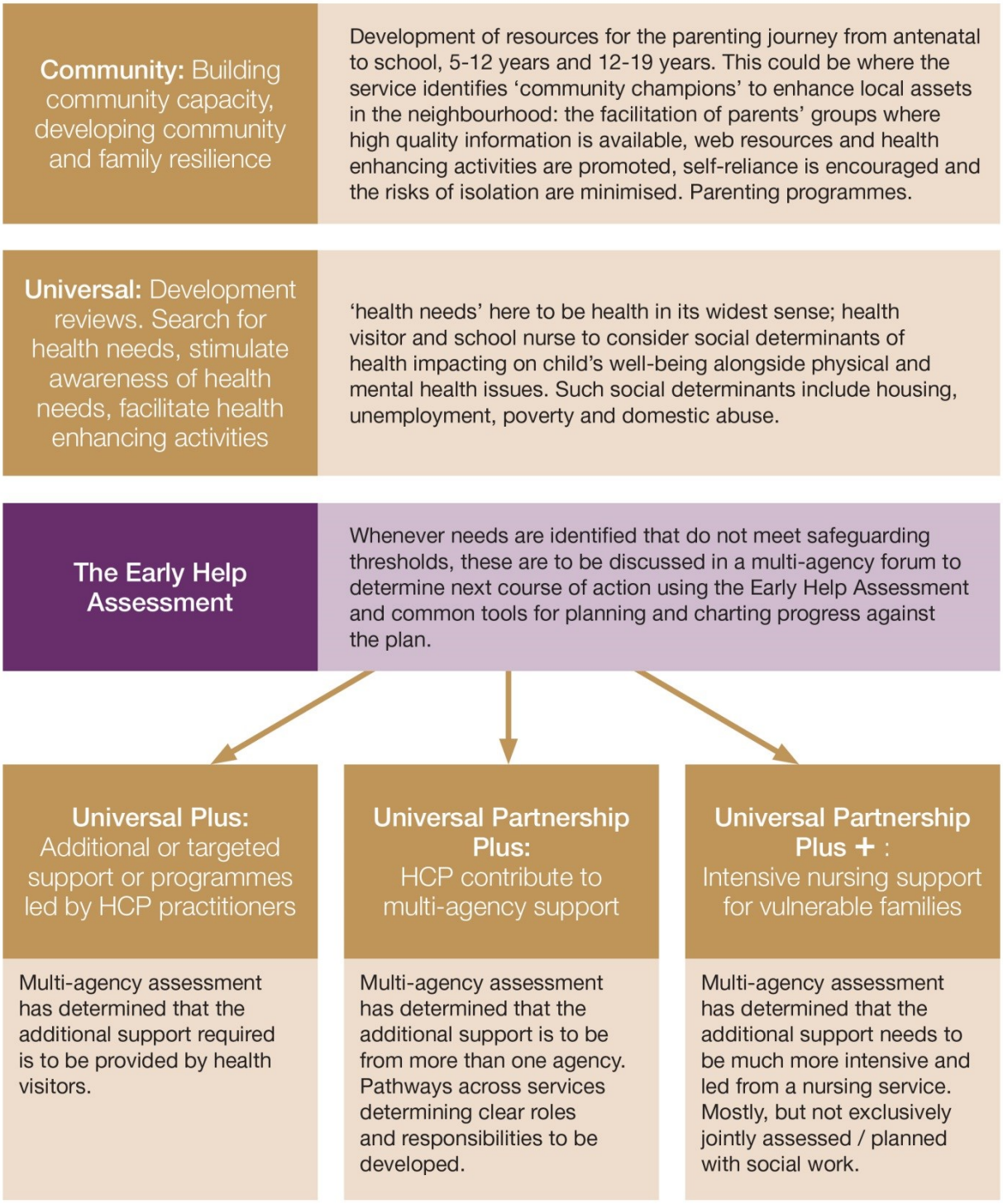
- NCMP and child weight management – planning, delivery and administration of the NCMP in line with Department of Health guidance and local evaluation and as part of an overarching weight management plan developed by the Healthy Child Programme. Referral of children and young people in to local child weight management provision as available/appropriate to ensure clear and seamless pathways (not limited to NCMP mandated years).

- Special Educational Needs and Disability (SEND)
  There are increasing numbers of children with SEND in mainstream schools, and it is important that school nurses are aware of their needs and where appropriate, participate in Education, Health and Social Care Plans (EHCP).

- Oral Health
  There is an expectation that oral health plans across the life course will be developed and implemented in partnership with Public Health England and public health to reduce levels of tooth decay.

- Drop-ins and sexual health
  It is envisaged that drop in clinics at school and community venues are implemented in such a way as to best address the needs of children and young people whilst also being as smart and efficient as possible with the staffing resource, using the digital transformation to help achieve this. It is expected that the school nursing service will have strong working relationships with sexual health services.

Figure 1: The proposed new Healthy Child Programme service model and pathway



Appendix 1: Example of a local profile informing achievement of local outcomes

Working with Strengthening Families Workers as one team will enable the development of local profiles, one for each Strengthening Family Hub. A local profile could include indicators such as:

- Numbers of births in a year, broken down by Universal, Universal Plus, Universal Partnership Plus and by country of origin
- Prevalence of deficits in children's development at 2 – 2.5 year check
- Early years foundation stage results
- Prevalence of overweight/obese children at reception and year 6
- Hospital admissions for tooth decay in the under 5s
- A&E attendances, aged 0-4 and 5-19
- Vaccination levels
- Numbers of Children in Need, Child Protection, Looked After Children
- Numbers of teenage pregnancies
- Employment levels amongst parents
- Health related behaviour survey results
- Educational attainment
- Educational attendance

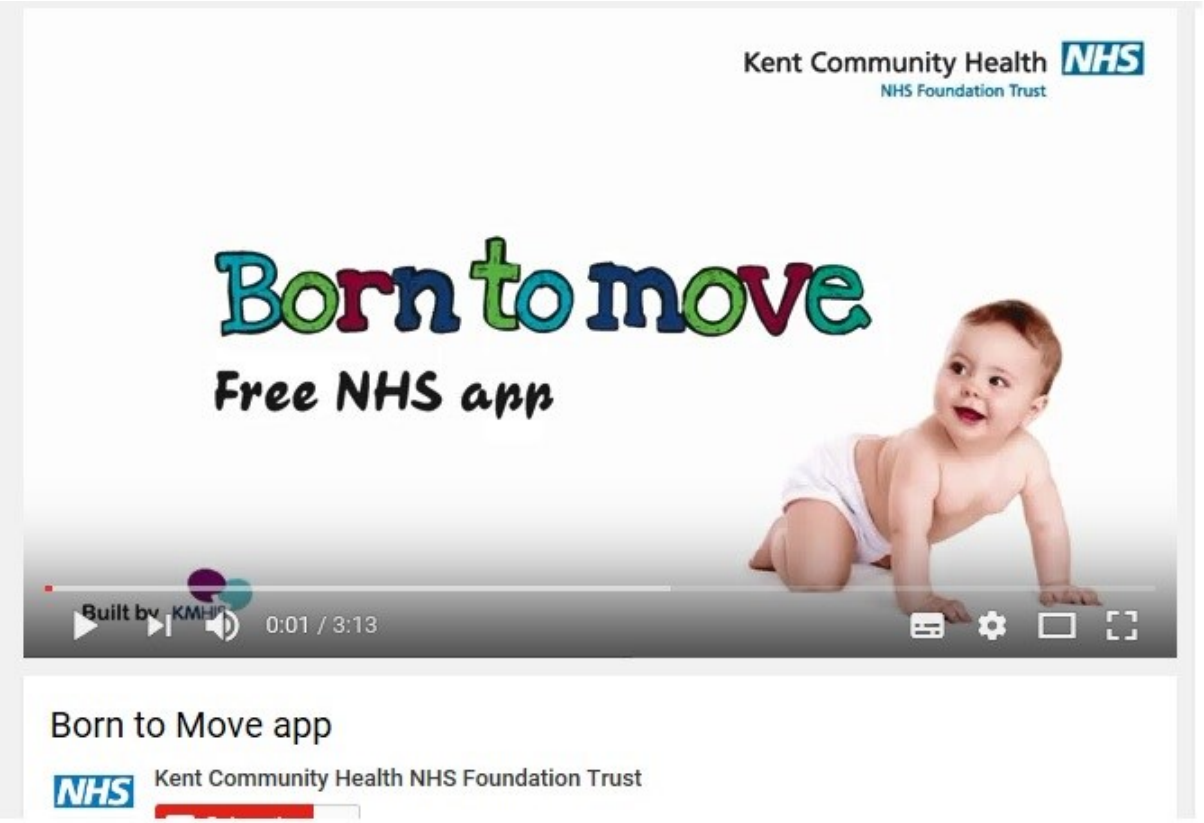
Development of such a profile would then inform collective decisions on the allocation of resources such as do more staff need to be brought to a particular area of higher need

Repeating these profiles, for example on a bi-annual cycle, will indicate where progress is being made at a locality level on these indicators, not just at an individual child level. For example:

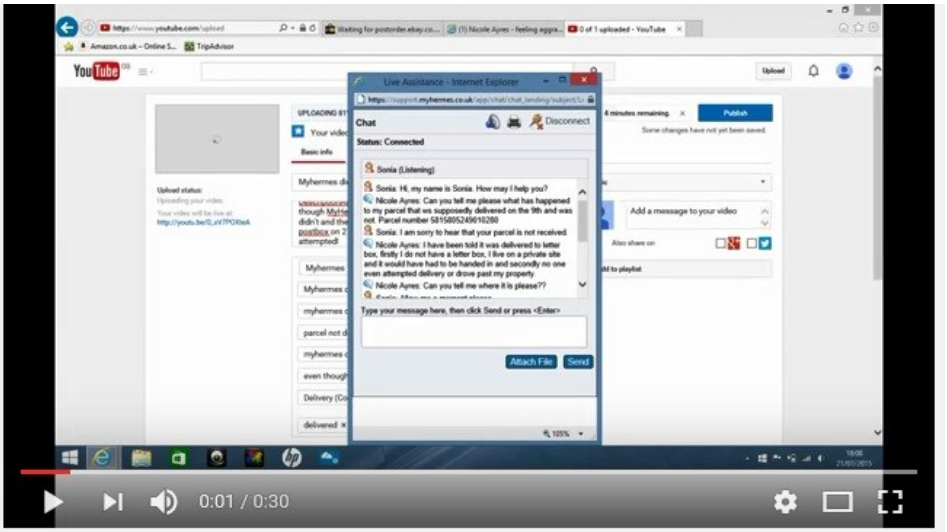
- Reduced prevalence of deficits in children's development at the 2 – 2.5 year check
- Improved Early years foundation stage results
- Reduced prevalence of overweight/obese children at reception and year 6
- Reduced numbers of admissions for tooth decay in the under 5s
- Reduced A&E attendances, aged 0-4 and 5-19
- Improved child health including vaccination levels
- Reduced numbers of Children in Need, Child Protection, Looked After Children
- Reduced numbers of teenage pregnancies
- Reduced inequalities in school attendance and attainment
- Improved employment levels for parents

It is assumed that achieving improvements on each of these areas will require partnership working with relevant agencies and services and that they are not the sole responsibility of any one service or team.

Appendix 2: Example of use of web resources to help inform parents about health enhancing activities

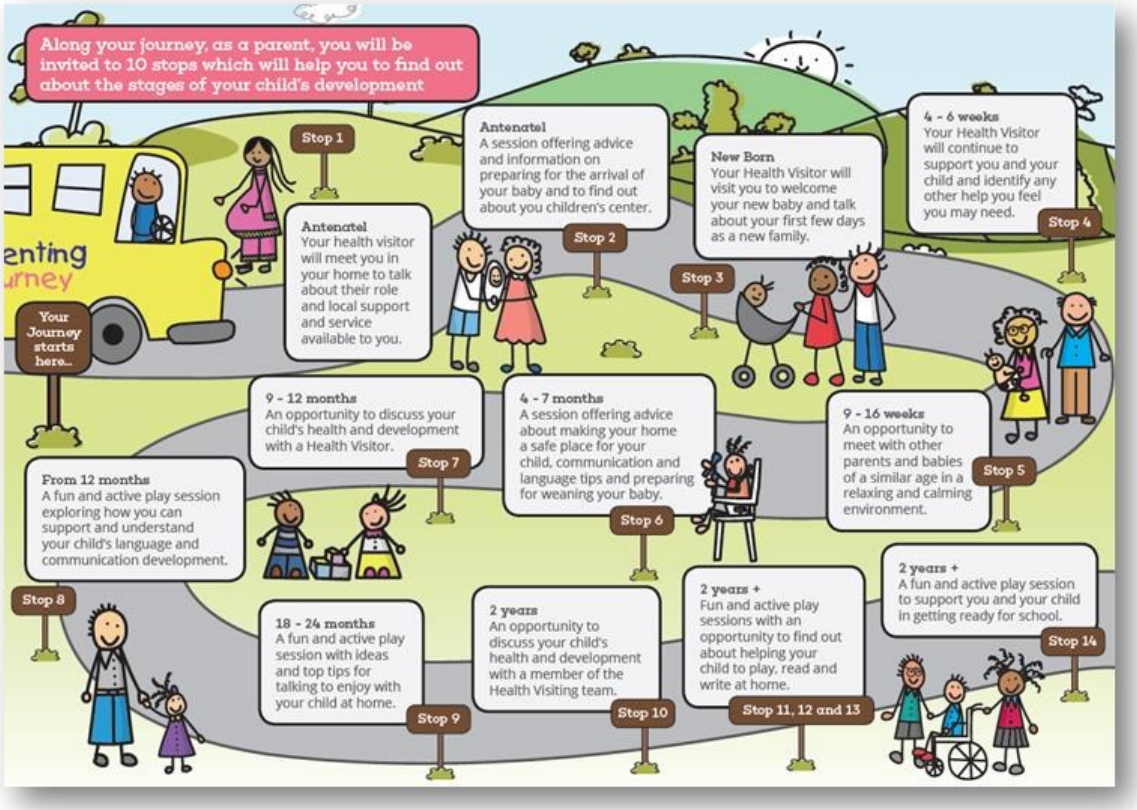


Appendix 3: Example of a private sector company using live web chat to offer support



Myhermes webchat of 21/07/2015

Appendix 4: Example of a resource developed in Cheshire to support the parent's journey – which services interact with you and when; what you can expect; where to go for help outside of these bus stops



Appendix 5: Information on HeadStart

Headstart schools will be those who commit to a whole system change agenda with staff who are knowledgeable about mental health and the challenges young people face. Staff will be equipped to be able to not only teach resilience and coping strategies within the curriculum but also to support young people, thus making every contact count. A common language, driven through a SUMO (Stop Understand Move On) approach, will be developed across schools, families and communities, and school nurses can play a critical role as Headstart champions, providing additional support and contributing to the whole school initiative. All this will be supported by a major workforce development strategy for all staff working with young people and all layers within a school.

The school model has a reliance on school to school support in order to drive the coverage of resilience and mental wellbeing approaches and again, the network of school nurses can support this. There will be four Headstart hubs where the Headstart staff assigned will work from (alongside police community officers and CAMHS link workers) and based in the heart of each of the four geographical areas and utilising existing community based assets. Opportunities to link the school nurses based in the schools within each hub into this network and multi-agency approach seem too good to be missed. For further information see http://www.headstart.fm/bidsuccess