CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

15 September 2016

Time 12.30 pm **Public Meeting?** YES **Type of meeting** Scrutiny

Venue **Training** - People Conference room second floor Civic Centre
Meeting - Committee Room 3 - Civic Centre, St Peter's Square, Wolverhampton WV1 1SH

Membership

Chair Cllr Jasbir Jaspal (Lab)
Vice-chair Cllr Wendy Thompson (Con)

Labour	**Conservative**
Cllr Craig Collingswood	Cllr Arun Photay
Cllr Peter O'Neill	
Cllr Phil Page	
Cllr Judith Rowley	
Cllr Stephen Simkins	
Cllr Martin Waite	

Quorum for this meeting is two Councillors.

Information for the Public

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Some items are discussed in private because of their confidential or commercial nature. These reports are not available to the public.

Agenda

Part 1 – items open to the press and public

Item No. *Title*

TRAINING

Training will be held for all Members of the Health Scrutiny Panel from 12.00 until 13.30.

The Training will be held in The People Conference Room, Second Floor, Civic Centre.

Lunch will then be provided before commencement of the meeting at 14.00.

The meeting will be held in Committee Room 3, Third Floor, Civic Centre.

MEETING BUSINESS ITEMS

1 **Apologies**

2 **Declarations of Interest**

3 **Minutes of Previous Meeting** (Pages 3 - 8)
[To approve the minutes of the previous meeting as a correct record.]

4 **Matters Arising**
[To consider any matters arising from the minutes.]

5 **Health Scrutiny Partners and Work Planning 2016-17** (Pages 9 - 26)
[Opportunity to share information about priorities and risks and to update the Work Programme accordingly]

DISCUSSION ITEMS

6 **Healthy Child Programme Update** (Pages 27 - 104)
[To provide an update report in relation to the Healthy Child Programme]

7 **Any Other Business**

CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

Minutes - 23 June 2016 Agenda Item No: 3

Attendance

Members of the Health Scrutiny Panel

Cllr Craig Collingswood
Cllr Jasbir Jaspal (Chair)
Cllr Peter O'Neill
Cllr Phil Page
Cllr Stephen Simkins
Cllr Wendy Thompson (Vice-Chair)
Cllr Martin Waite

Employees

Ros Jervis	Service Director Health and Well Being
Deborah Breedon	Scrutiny Officer

In attendance

Stephen Marshall	Clinical Commissioning Group
Helen Hibbs	Clinical Commissioning Group
David Loughton	Royal Wolverhampton Trust
Jeremy Vanes	Royal Wolverhampton Trust
Tracey Cresswell	Health Watch

Part 1 – items open to the press and public

Item No. *Title*

1 **Apologies**
Apologies were submitted on behalf of Cllr Judith Rowley and Cllr Arun Photay

2 **Declarations of Interest**
Cllr Martin Waite declared a disclosable pecuniary interest as an employee of the West Midlands Ambulance Service

3 **Minutes of previous meetings**
Resolved

That the minutes of the meeting be approved as a correct record subject to Don McIntosh being added to the attendance list.

4 **Matters Arising**
Resolved

That an update report relating to the progress made in the implementation of the Joint Mental Health strategy be reported to the next meeting of the Health Scrutiny Panel.

5 **Royal Wolverhampton NHS Trust (RWT) - Quality Account**
Jeremy Vanes Chair of Royal Wolverhampton NHS Trust (RWT) and David Loughton Chief Executive of RWT provided the draft Quality Account . He advised that there had been changes to the report since publication of the draft version and that it was an evolving document. He highlighted the priorities around safe nurse staffing levels, safe care and the sign up to the safety issues such as sepsis, preventing infection and patient experience. He invited the panel to comment and provide a statement from this panel to be included in the document when published on 30 June 2016.

The Chair Cllr Jasbir Jaspal advised that a draft statement was in preparation and any comments of the panel would be included in the response statement.

In response to points raised the Chief Executive RWT confirmed that there were currently 230 vacancies which were approximately nine per cent of total nurse staffing. He clarified that there was some evidence to indicate that the shortage is impacting on the service provided but that this issue was not unique to Wolverhampton and that it was a national problem. He indicated that recruiting nurses from outside of the EU was a slow process out of 220 nurse posts offered to Philippine applicants earlier in the year only six visa's had been secured, he suggested that when competing with Canada and the USA for nursing applicants the visa process needs to be more efficient. He highlighted that a big problem for recruiting nurses in the NHS moving forward was the removal of a bursary for student nurses, meaning that student nurses now would have to apply for a student loan. The full impact on the numbers of trainee nurses due to the bursary being removed would not be known until August 2016.

In response to questions from Cllr Wendy Thompson relating to the bursary scheme, medical training and recruitment, the Chief Executive advised that approximately half of trainees complete the training and that Doctors are recruited from overseas on the basis that they carry out both clinical and academic training. The recruitment on the basis responds to the need for staff and reduces the use of interims or agency staff.

Helen Hibbs, CCG responded to further questions about why more universities do not establish specialist training facilities highlighting that there was a high dropout rate. The Chief Executive RWT advised that the has previously been on the Government Advisory Board and although it is preferable that the number of medical schools are increased it would be a ten to twelve year journey and that in his opinion it was unlikely that there would be an expansion of medical schools in the UK in the short term, there may however be more spaces created at existing facilities. He clarified that RWT were in final discussion with the armed services about Accident and Emergency services. (A&E).

Cllr Peter O'Neill welcomed the style of the document, well put together, open and transparent. He particularly welcomed the 'never events' being included on the calendar and suggested that the RWT risk register and never events should be looked at during the scrutiny work programme this year.

The Chair RWT advised that the judgements in the document relate to the Care Quality Commission (CQC) inspection 2015. Safety in the medical wards was highlighted by CQC and the RWT did not agree; the number of vacancies impacted on the 'well led' section of the inspection as well. David Loughton advised that RWT had appealed the ratings and nine months on there had been no response to the appeal.

Following a discussion about never events it was agreed that further information about never events and the risk register should be submitted to Health Scrutiny Panel.

In response to questions from Cllr Martin Waite the Chair RWT advised that work would be undertaken over the next couple of years to adapt nursing roles, upgrading and looking at emerging and interesting areas. He advised they would be looking at the way the bank of nurses in used; he further advised that to keep the numbers of nurses in the bank up they needed to upgrade the bank.

The panel considered other sections of the draft report including the clinical audit and the catalogue of previous report, highlighting that changes take time to implement and sometimes do not work out too well. They highlighted that following CQC inspections at Stoke and Stafford there are improvements and financially they are achieving what they wanted to.

The Chief Executive RWT responded to questions about the maternity services and how the Trust had invested money, where neighbouring Authorities had not. He advised that approximately 600 additional maternity cases were coming through Wolverhampton as a result of CQC decision to push maternity cases to RWT. He advised that there was good news data to share with the panel.

Cllr Stephen Simkins voiced concerns that the lack of capacity would have impact on delivery of services and care of the patient. The Chief Executive acknowledged the concerns about capacity and advised that there would be an announcement about potential closures shortly. The panel recognised the need for more money to be allocated to hospitals and that things cannot be run if money is not sufficient.

Tracey Cresswell, Health Watch representative advised the panel that there had been no negative experience feedback from patients travelling to Cannock Hospital, the only issues seemed to be the cost of travel. She asked about the plans for 2016-17 and the increased patient and user engagement (including improving links within the community in particular the marginalised groups), and asked how the RWT would engage hard to reach groups. The Chair RWT advised that the Head of Complaints was carrying out some ambitious work to engage people. He advised that the Board had been charged with challenging targets and that there would be more efficiency savings to come over the next couple of years.

There was reference to the future Sustainability and Transformation Programmes (STPs) and how the RWT had worked closely to shape STPs. The Panel requested further information on STPs.

Resolved

1. That Panel welcome the Quality report and agree that the Chair forward a statement to respond to the document.
2. That further information about never events and the risk register should be submitted to Health Scrutiny Panel.
3. That further information about Sustainability and Transformation Programmes (STPs) be submitted to Health Scrutiny Panel.

6 **RWT CQC Inspection Improvement Plan and update**

Jeremy Vanes, The Chair of Royal Wolverhampton NHS Trust (RWT) provided a verbal update to the Panel. He advised that following the CQC inspection, where 70 inspectors had been present for a whole week, 145 actions had been identified. He advised that all but 11 small scale actions had been completed and that many of the actions had been consumed into other action plans.

The Chair advised that the first round of inspections had been on a large scale and that the process has since been revised, the CQC will have a smaller inspection regime with a different style of report.

Resolved

1. That the update be noted.

7 **Update on the Accident and Emergency Department RWT**

Jeremy Vanes, the Chair of Royal Wolverhampton NHS Trust (RWT) gave a verbal update relating to the Accident and Emergency (A&E) Department. He advised that there are more than average referrals in the drugs and alcohol referral scheme last year (648). Ros Jervis, Service Director Health and Well Being, explained that the Community Drugs and Alcohol Team have a good relationship with the clinicians and help people to seek support and that this can be a motivation to change due to the teachable moment (event). Panel were advised that there were also patients who do not want to change, revolving doors patients but that there seem to be reducing numbers of them and Panel were encouraged to hear that the mortality level was also falling.

Panel considered that there were several groups of people on the journey of dangerous drinking levels for a variety of reasons (including binge drinkers and young people). They recognised that prevention and early intervention work and that this was an uphill battle to reduce the impact of drinking. The Service Director advised that the business community in the City Centre now pay for the services.

In response to questions The Chief Executive RWT advised that the Police work hand in glove with RWT and multiagency services but that the RWT cannot breach Patient confidentiality. The Chair RWT responded to questions from Cllr Martin Waite relating to proportion of patients that attend on the weekends, the ageing

population and Stafford ambulance crews bringing them into Wolverhampton during the night. The Chief Executive confirmed that patients under the influence of drink or drugs are in a separate section from other patients he advised that these issues were part of system reform. He acknowledged that as an employer of 9000 staff there was a need to help staff with specific alcohol problems.

In response to Cllr Patricia Patten's questions about levels of teenage drinking the Service Director advised that the highest affected group was males aged 35-45 and that there were not large numbers of young drinkers. It was clarified that the highest number of chronic drinking and liver related illnesses tend to be in middle aged males.

Helen Hibbs, CCG highlighted the number of elderly and frail people admitted to hospitals and explained there are other ways of caring and that it was not all about going into hospital.

The Chair RWT gave an update relating to the Urgent Care Centre which had opened in April 2016. He advised that there had been several developments including the recruitment of nurses, who were waiting to start. He outlined the success of the joint triage and the benefits of having a senior Doctors diagnosis earlier in the process. He advised that admission rates were down 15% as a result of this. In terms of performance he advised that the A&E unit had recently demonstrated the 24th best performance in the Country.

Resolved

1. Panel welcomed the outstanding performance and noted the update report

8 **Clinical Commissioning Group (CCG) Primary Care Strategy Update**

Stephen Marshall CCG and Helen Hibbs CCG provided a report to update the Panel on the progress of the Primary Care Strategy Implementation. Helen Hibbs outlined the work force development initiatives taking place to address the work force crisis. She advised that CCG were jointly commissioning healthcare with NHS England from April 2017.

Panel voiced concerns relating to the numbers of General Practitioners (GPs), highlighting that there were not enough GPs. Helen Hibbs responded that the GP profession had become an unattractive career prospect, that the pressure was unbelievable, administration backing up systems and so forth. She advised where there was a large practice with a central administration facility it made a big difference to the practitioners.

Cllr Stephen Simkins asked whether Cabinet Members sat on the Governing body for the CCG and was advised that the Cabinet Member was a member of the Health and Wellbeing Board. He requested officers to investigate allocation of a seat on both Boards for the relevant Cabinet Member.

Resolved

1. That Panel note the progress update

9 **Scrutiny Panel request for information relating to training costs for nursing staff and Doctors at RWT New Cross hospital**

Jeremy Vanes, Chair RWT provided a verbal update he advised the Panel that the RWT receives educational funding for health professionals via an annual education contract with health Education England West Midlands (HEWM).
This contract is called the Learning and Development Agreement (LDA)
The contract is renewed annually dependent on performance against student and trainee numbers, and national professional educational quality standards.
The LDA for the Trust equates to circa £14 million, this is ring fenced for educational purposes soley. For medical staff this equates to circa £12.8 million, for nursing and other health professional staff this equates to £1.2 million.
Quarterly performance reporting is mandatory against the contract value and this framework supports further financial payments for each quarter.

Resolved

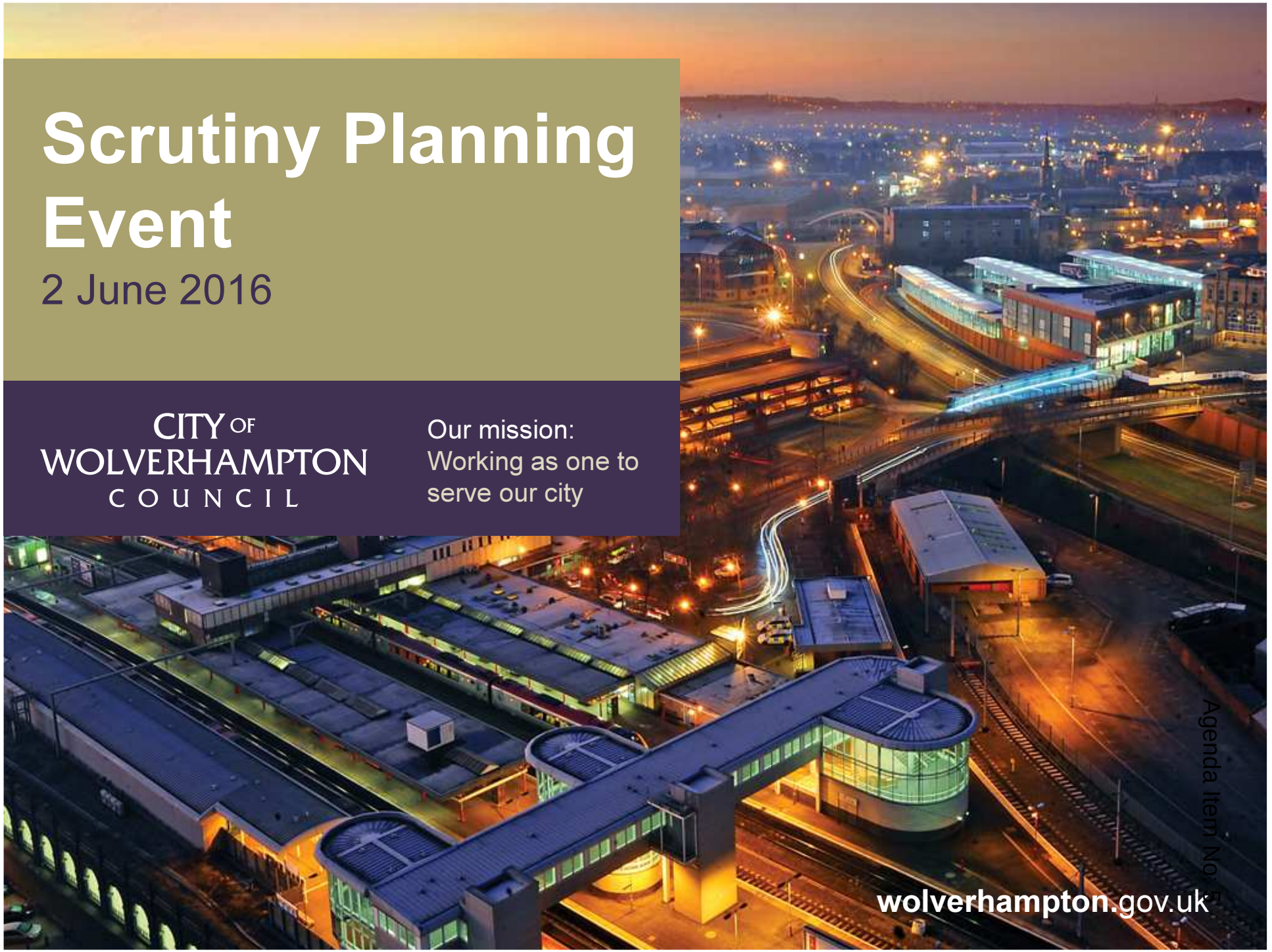
That Panel note the information provided.

Scrutiny Planning Event

2 June 2016

CITY OF WOLVERHAMPTON COUNCIL

Our mission:
Working as one to serve our city



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Introduction

Key Context

- Vision 2030
- Corporate Plan

Adults and Safer City Scrutiny Panel

Context

- Promoting independence
- Personalisation
- Promoting and enabling healthy lifestyles
- Adults Transformation Programme
- Safeguarding

Adults and Safer City Scrutiny Panel

Key Challenges

- Obesity Challenge
- Promoting enablement, reablement, resettlement
- Increased use of Better Care Technology
- Information and signposting
- Employment for people with disabilities/mental health
- Building Community resilience
- Development of Adult MASH

Health Scrutiny Panel

Context

- Urgent care
- Planned care
- Primary and community care strategy
- NHS 5 year plan
- Sustainability and Transformation Plan (STP)

Health Scrutiny Panel

Key Challenges

- Mental Health and CAMHS transformation programme
- Integration across health and social care
- Delivery of the sustainability and transformation plans
- Financial sustainability
- Reducing Infant deaths

Children, Families and Young People Scrutiny Panel

Context

- Strengthening families where children are at risk
- Early Years (0-5)
- Children's transformation programme
- Troubled families programme
- Headstart programme
- Safeguarding

Children, Families and Young People Scrutiny Panel

Key Challenges

- Being Ofsted ready
- SEND reforms – joint area inspection
- Delivery of children's transformation programme
- Child Sexual Exploitation
- Development of Children's MASH

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BOARD ASSURANCE FRAMEWORK & NEVER EVENTS

Debra Hickman Deputy Chief Nurse RWT

September 2016

Board Assurance Framework – what is it?

A Simple but comprehensive method for effective and focussed management of the principle risks that arise in meeting the Trust objectives.

Strategic objectives

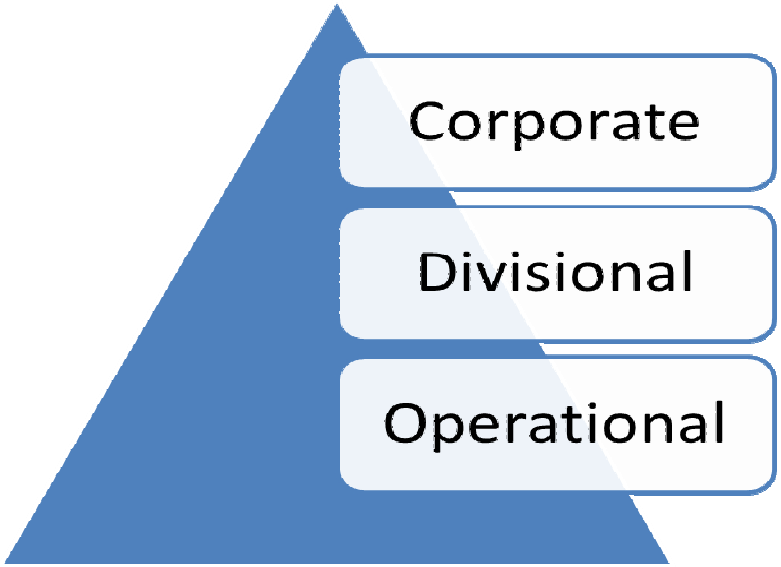
- Creating a culture of compassion, safety & quality
- Be in the top quartile for all performance indicators
- Proactively seek opportunities to develop our services
- To have an effective & well integrated organisation that operates efficiently
- Maintain financial health – appropriate investment enhancement to patient services
- Attract, retain & develop our staff & improve employee engagement.

Significant risks / threats

- Closure of a service
- Seriously prejudice / threaten achievement of a principle objective
- Threaten the safety of service users
- Threaten the reputation of the Trust and/or NHS
- Lead to significant financial imbalance and/or need additional funding to resolve and/or result in significant diversion of resources from another aspect of the business.

Process

- Operational risks are identified at local level and graded using a matrix system (consequence/likelihood).
- Smoke alarm.
- Reviewed bi monthly.
- Director led and Sub committee detailed review.



Never Events – what are they?

Introduced in 2009 by the National Patient Safety Agency -

Serious, largely preventable patient safety incidents that should not occur if National guidance / safety recommendations have been implemented.

Latest iteration of 2015 lists 14 Never Events.

National picture

Reported across England during June 2016 were:

- 8 Wrong site surgical interventions
- 7 retained foreign objects post invasive procedure
- 5 wrong implant / prosthesis
- 3 wrong route medication administrations
- 3 misplaced nasogastric/orogastric tubes
- 1 chest / neck entrapment due to bedrails
- 1 incompatible blood component transfusion

RWT picture

Year	Number
2010/11	2
2011/12	10
2012/13	3
2013/14	4
2014/15	5
2015/16	1

All Never Events have a detailed RCA

Actions following lessons learnt since 2010:

- Review of policies / processes.
- Training from Association for Peri-operative Practitioners
- Introduction of Human factors training via Simulation
- Introduction of Process Communication Model (PCM)
- Trust wide sharing of lessons learnt from incidents.
- Currently reviewing policies/procedures in line with National Safety standards for invasive

Agenda Item No: 6

CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

15 September 2016

Report title

Summary of findings from engagement and consultation on proposed 0-19 Healthy Child Programme service model (Health Visiting, Family Nurse Partnership and School Nursing services).

Cabinet member with lead responsibility	Councillor Paul Sweet Public Health and Wellbeing	Councillor Val Gibson Children and Young People
Wards affected	All	
Accountable director	Ros Jervis, Public Health and Wellbeing	
Originating service	People – Public Health and Wellbeing	
Accountable employee(s)	Neeraj Malhotra Consultant Public Health Tel 01902 558667 Neeraj.Malhotra@wolverhampton.gov.uk	Sarah New Healthy Child Programme Manager Tel 01902 558667 sarah.new@wolverhampton.gov.uk

Report to be/has been considered by	People Leadership Team	01/08/16
	0-19 Healthy Child Programme Commissioning & Governance Steering Group	30/08/16
	Public Health Senior Management Team	01/09/16
	Cllr Sweeney	05/09/16
	Cllr Gibson	06/09/16

Recommendation(s) for action or decision:

The Panel is recommended to:

1. To consider the findings from the recent engagement that has informed the development of the proposed new service model for delivery of the Healthy Child Programme.
2. To consider the findings of the six week formal consultation on the proposed service model and comment on these.

The Panel is asked to note:

1. The findings of the engagement with stakeholders as detailed in the report attached in Appendix One.
2. The proposed new service model for the Healthy Child Programme as attached in Appendix Two.
3. This report has also been submitted to Children, Young People and Families Scrutiny Panel for comments.

1.0 Purpose

1.1 This report aims to update the Children, Young Peoples and Families Scrutiny Panel on the findings of the engagement and consultation with stakeholders for the re-commissioning of the city's 0-19 Healthy Child Programme (HCP) by Public Health.

1.2 The report provides panel members with an opportunity to consider some of the key findings of the engagement and emerging feedback regarding the proposed service model for the Healthy Child Programme.

1.3 The report provides an opportunity for panel members to be engaged and comment upon the proposed service model.

1.4 The paper describes how the engagement and consultation were conducted and summarises some of the key findings.

1.5 The paper also provides information about the proposed future service model for the Healthy Child Programme. The service model has been developed following the formal engagement process and takes into account wherever possible the views of key stakeholders. The emerging findings from the current formal consultation are described.

2.0 Background

2.1 The '0-19 The Healthy Child Programme' (HCP) sets out a recommended framework for services for children and young people to promote health and wellbeing, prevent ill health and provide early intervention when required. The HCP delivers universal services to all children and families including routine screening and development checks. Through the programme, families in need of additional support and children who are at risk of poor outcomes can be identified and the appropriate support provided; a key aim of the HCP is to reduce inequalities.

2.2 This report presents the key findings from the engagement and consultation processes.

2.3 Engagement with stakeholders commenced in 2015 and this was followed by a formal eight week engagement process undertaken between May and July 2016.

2.3 The engagement process sought to obtain the views of key stakeholders on current services and to identify the best future service model to improve outcomes for children and families. This specifically relates to health visiting, family nurse partnership and school nursing services. Over 450 professionals, parents, carers and young people were engaged and wherever possible the views of stakeholders were considered in the development of the proposed service model framework for the 0-19 Healthy Child Programme.

2.4 A formal six week consultation commenced on 8 August 2016 and will end on 19 September 2016. The purpose of the consultation is to obtain stakeholders views on the proposed new service model prior to development of the final service model. We are inviting all key stakeholders to give their views which include health, social care, education and the voluntary sector.

We are also asking parents and young people to give us their views on how they want services to be delivered via an on-line survey. The findings of the consultation will be considered prior to commencing a tender process in November 2016 to enable a new 0-19 Healthy Child Programme service to be in place from 1 August 2017.

2.5 Early in the commissioning process we established a Healthy Child Programme (HCP) steering group. The steering group was responsible for overseeing the commissioning and tender process. Children's services and the Clinical Commissioning Group are represented on the group along with a GP representative and key council employees, including the head of service for early intervention and safeguarding representatives. The HCP steering group has provided advice and support on plans for engaging and consulting with different stakeholder groups.

2.6 A member of staff from Wolverhampton Health Watch supported the early engagement work with parents and young people and advised on development of the surveys as did wider colleagues in public health and children's services.

3.0 How we engaged with stakeholders

3.1 A variety of methods were used to obtain feedback from key stakeholders. This included attending stakeholder meetings and holding engagement events for professionals. In addition, five separate on-line surveys for prospective bidders, professionals, head teachers, parents and young people were undertaken. A number of focus discussion groups with service users were also held. Samples of the materials used to engage with parents and young people and publicise the on-line surveys and engagement to parents and young people are attached in **Appendix One**. The Council Communications team used Facebook and Twitter to publicise the engagement process. The members of the public health and wellbeing team shall continue to conduct focus discussion groups throughout the formal consultation period to help inform the development of the new service model and service specification.

3.2 The members of the public health and wellbeing team attended key meetings with professional stakeholders to inform them of the proposed commissioning process and obtain their views on current services and priorities for the new service model. This included attendance at GP locality and primary care meetings, meetings with Head teachers and Personal and Social Health Education (PSHE) leads in schools.

3.3 The public health and wellbeing team were fortunate to work with some young people from Wolverhampton Youth Council, care leavers forum and care leavers board. The young people advised the team over a number of weekly meetings on the development of the young people's survey and shared their views on the school nursing service.

3.4 The public health and wellbeing team met with parents and carers of children with additional needs via the Voice for Parents Forum, who shared their views on current services. In addition, some of the parents kindly advised on the development of the parent's survey questionnaire. The team also engaged with members of the Foster Carer's forum to obtain their views on services.

3.5 The public health and wellbeing team held two multi-agency workshop events for professionals. The events were used to share initial findings from the engagement and to discuss key issues arising from the new service model. The overall aim of the workshops was to identify how the future service model could support children, young people and families to achieve good outcomes and to enable a wide range of stakeholders to express their views. The workshop events also provided an opportunity to consider the emerging themes from the engagement with stakeholders and to explore some key issues that had been identified. In total, 75 stakeholders attended the various workshops, representing a wide range of backgrounds including health, social care, primary care, voluntary sector and potential service providers/bidders.

3.6 The public health and wellbeing team engaged with Councillors for Public Health and Wellbeing and Children, Young people and Families and senior management within the Council by attending Councillor Briefing meetings and attendance at People Leadership Team and Public Health senior management team meetings. The public health and wellbeing team have produced and sent briefings to key stakeholders via the Wolverhampton Voluntary Sector Council, Council Due North Procurement website, and GP, Councillor and Schools bulletins.

3.7 A summary of the main stakeholders we have engaged with is detailed in the table below. Over 450 stakeholders have expressed their views to date.

How we engaged with stakeholders	Who we engaged
Market engagement survey	A range of potential bidders including NHS trusts and the voluntary sector.
Stakeholder workshop	Managers and staff in current services and their key partners.
Two professional stakeholders engagement events	75 professionals from partner agencies including health, social care, education, early years and voluntary sector.
Young people's discussion and survey planning group	8 young volunteers from youth council, care leavers forum and care leavers board.
Young people's discussion planning group	3 young volunteers from The Way.
Parents forum discussion group	9 parents
Foster carers forum discussion group	24 foster carers
Parents on-line survey	136 parents
Young people's on-line survey	49 young people
Briefing to youth council members	13 young people
Two focus groups at Orchard Centre	14 young people
Teachers attending PSHE network	12 staff
Head teachers forum	40 staff
GPs and primary care via GP locality meetings, Team W, Practice nurses and practice managers forums and Local Medical Committee (LMC).	75 Staff

3.8 The characteristics of the 136 parents who completed our on-line survey were as follows:

- 7% were aged between 16 and 24 years of age, 38% were aged 25-34 years, 36% were aged 35-44 years of age with 19% over the age of 44.
- 15% told us that they had a child with a disability.
- 12% identified that they themselves had a disability.
- 88% of people who completed the survey were mothers with the remainder being fathers, grandparents or guardians.
- The majority of parents and carers were female (93%) with 6 males and 1 person who preferred not to say their gender completing the survey.
- 92% of parents described themselves as heterosexual with the remainder describing themselves as lesbian, bisexual or preferring not to say.
- The ethnicity of parents were:
    - 78% classified themselves as White British.
    - 10 % were Asian British Indian.
    - 3% were Black British Caribbean.
    - The survey was also completed by 1 Chinese parent, 1 White and Black Caribbean, 1 Black African and 2 White Other Europeans.
- 49% of parents described themselves as Christian, 32% were of no religion, 8% were Sikh, 2% Hindu, 2% Muslim and the remainder stating other religion or preferring not to say.
- 48% of parents had a child aged 0-4 years of age.
- 50% of parents had a child aged 5-11 years.
- 28% of parents had a child aged 12-19 years.

3.9 The characteristics of the 76 young people completing our survey were as follows:

- Only 40 young people completed the equality questions on the survey. The majority were aged between 12 and 18. One young person under the age of 12 completed the survey. 5% were aged 12, 2.5% were 13 years old, 17.5% were aged 14, 47% were aged 15 years, 5% were 16 years old, 12.5% were aged 17 and 7.5% were aged 18.

- The young people were from 13 different schools and pupil referral units including one college student.

- 56% described themselves as female, 37% as male. 2 young people described themselves as gender neutral. The remainder preferred not to say.

- 92% had the same gender identity as assigned at birth. 2 young people did not have the same gender identity as assigned at birth and the remainder preferred not to say.

- 75% of young people identified as heterosexual, 11% were unsure of their sexuality, 2% identifying as a gay man, 7% identifying as bisexual and the remainder preferring not to say.

- 14% of young people identified themselves as being young person who is looked after by the local authority (in care or looked after by a foster carer).

- 60% described themselves as White British, 9% White and Black Caribbean, 7 % Asian British Indian, 7% Black British Caribbean, 5% Other White European, 2% Chinese, 2% White and Asian, 2% Black British African and the remainder other or preferred not to say.

- 49% described themselves as having no religion, 34% Christian, 2% Hindu, 2% Sikh, and 7 % other religion and the remainder preferred not to say.

- 21% of young people stated that they had a disability.

4.0 Overview of key findings from the engagement with stakeholders

4.1 A full report detailing the findings of the engagement is attached in Appendix One. (http://www.wolverhampton.gov.uk/CHttpHandler.ashx?id=10431&p=0).

The key messages identified for the new service model that came out of the engagement with parents, carers, young people and professionals are:

4.2 Consistency

A key theme was that whilst many stakeholders gave positive feedback about working with or receiving services from an individual health visitor or school nurse there was an inconsistent approach to service delivery as a whole.

4.3 Continuity

This was of particular importance for parents and foster carers. They would like to be able to develop a relationship with a named member of staff who has knowledge of the family and child. Parents don't want to have to repeat information to different staff.

4.4 Make better use of technology to support service delivery

Technology needs to be used much more effectively to support service delivery. Staff should be supplied with appropriate devices i.e. smart phones or I pads. Improve information sharing and record keeping through instigation of electronic record keeping that enables staff to readily access and input data into electronic records during visits. Better use of social media to engage with young people. Better use of websites, apps and Skype to communicate with and provide information to parents and young people.

4.5 Communication

All stakeholders including parents and young people identified that communication needs to be improved particularly communication between health visitors and GPs.

4.6 Accessibility

Many parents stated difficulty in contact their health visitor or booking an appointment; need for drop-in without appointment or telephone contact. Young people also wanted to be able to access their school nurse more often in their school.

4.7 **Early help and prevention**

Stakeholders want the new service model to intervene earlier, making greater use of 'early help' assessments. To provide joined up working to support families including working closely with strengthening family's teams to provide a multi-agency model. Also a strengthened role in supporting emotional health and mental wellbeing.

4.8 **Family Nurse Partnership (FNP) and supporting vulnerable families**

The public health and wellbeing team received positive feedback regarding the Family Nurse Partnership nurses and the individual support they provide for young parents. However, there was an overall concern expressed regarding the current limited capacity of FNP to meet the needs of all young first time mothers who meet the criteria. A consistent theme was the need to expand the current criteria of FNP to include wider vulnerable families. The current criteria means that services are provided only to first time young mums, aged 19 years or under until their child is two. Many stakeholders felt that the criteria was too narrow and that there were other vulnerable families who could benefit from an intensive home visiting programme as offered by FNP. Stakeholders suggested broadening the current criteria to allow other families to benefit thereby providing a more equitable service to families. Stakeholders also suggested building capacity within the health visiting service itself to be able to address their needs ideally freeing up health visitors/reducing caseloads to enable them to increase visibility and regular contact with vulnerable families.

4.9 **Principles, mandated health development reviews and proposal for 0-19 Service Model**

Overwhelmingly stakeholders agreed with the principles we proposed for the new service model. The public health and wellbeing team found support for delivering an integrated 0-19 Healthy Child Programme service as a cost effective solution and offering a better quality service via a seamless pathway for children and young people. Stakeholders support the continuation of the mandated development reviews and some suggested consideration of additional developmental checks e.g. at 3 years.

5.0 Development of the proposed service model

The public health and wellbeing team have considered the findings of the engagement process and in partnership with members of the Healthy Child Programme Steering Group have developed a proposed future service model framework. Wherever possible the views of stakeholders have been taken into account in the development of the new service model.

5.1 The proposed service model takes account of information received from a variety of methods, namely:

- An 8 week engagement process including surveys and workshops with parents, young people and professional stakeholders.
- Workshops held with frontline workers, health visitors and early year's workers, in June 2015.

- Data from various sources on needs within the city.
- Learning from serious case reviews from across the country.
- On-going monitoring of existing services.

5.2 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. The proposed change will also enable aggregate reports to inform priorities at a locality level. Practitioners within the Healthy Child Programme will be supported to take a population-based view of their locality i.e. looking at the health outcomes of a group of individuals, including the distribution of such outcomes within the group. It is an approach to health that aims to improve the health of an entire human population and includes working with key partners at a locality level for example Schools, to identify needs, develop local profiles and work together to address underlying social determinants of health such as poverty.

5.3 It is proposed that the Healthy Child Programme and its underpinning case management system works as one team with Strengthening Families Hubs. There are 8 Strengthening Families Hubs across the city and these hubs form the key components of a transformed Children's Services landscape which has been happening over the last few years.

5.4 A framework document providing more detail on the proposed service model is attached in **Appendix Two**.

6.0 Consultation with stakeholders

6.1 A formal six week consultation process commenced on 8 August 2016 and will run until 19 September 2016.

6.2 To support the consultation process two key documents have been produced that provide detailed information about the proposed service model (**Appendix Two**) and report on findings of the engagement (**Appendix One**).

6.3 An on-line survey for professional stakeholders has been launched and the parents and young people's surveys remain open to enable as many stakeholders to comment as possible. The Healthy Child Programme website has been updated and key documents are available on the site. City of Wolverhampton Council - Healthy Child Programme service model consultation

6.4 The consultation has been widely communicated to key stakeholders including briefings via councillor, GPs, voluntary sector and schools bulletin.

6.5 We are seeking assistance from our partners to undertake additional discussion groups with groups of parents and young people and to continue to publicise the on-line surveys.

7.0 Findings from the formal consultation

Please note that the formal consultation ends on 19 September 2016. At time of writing this report it is too early to provide detailed feedback from the consultation. More detailed verbal feedback on the findings will be provided at the scrutiny meeting.

7.1 To date (5 September 2016) 50 professional stakeholders have expressed their views via the on-line survey as regards the proposed new service model.

7.2 Early results indicate broad agreement from stakeholders for the proposed service model and agree that the proposed 0-19 integrated way of working is the best approach to improving outcomes for children and families locally.

8.0 Next steps

8.1 Next steps are to:

- Consider the views and comments of the Health and Children, Families and Young People's scrutiny panels before finalising the final Healthy Child Programme Service Model.
- Consider any further consultation feedback provided by stakeholders up until 19 September and wherever possible take this into account when finalising the final Healthy Child Programme Service Model.
- Report to Cabinet Resource Panel for their approval and request delegated authority to go out to tender and award contract.
- Produce service specification based on approved service model and commence tender process in November 2016.
- Deadline for final submission of bids from prospective providers will be by 9 January 2017.
- A tender assessment panel will be established to evaluate bids and inform bidders of outcome by end January 2017.
- Intent to commence contract negations and mobilisation with successful bidder in February 2017.
- New service will commence on 1 August 2017.

9.0 Financial implications

The cost of the consultation will be met from existing budgets held within Public Health. The Health Visiting, Family Nurse Partnership and School Nursing services contract will be met from the Public Health ring fenced grant. The allocation for Wolverhampton in 2016/17 is £21.9 million. [GS/02092016/H]

10.0 Legal implications

There are no direct legal implications arising for the report.

TC/01092016/G

11.0 Equalities implications - Initial Equality Impact Screen

11.1 An initial equality analysis was undertaken prior to the commencement of the engagement and findings shared with the 0-19 Healthy Child Programme Steering Group and local authority Equalities Officer. At this stage there was no evidence that the proposed engagement and consultation processes are discriminatory across the equality strands and therefore a full equality impact assessment on the consultation process was not conducted. We have collected equality data from respondents to the online survey and from participants taking part in focus discussion groups. The surveys have been proactively promoted to organisations working across the equality strands for e.g. disability forums, Lesbian, Gay, Bisexual, Transgender and Black and minority ethnic communities. Please note that the formal consultation finishes on the 19th September and the findings will be then be analysed fully. A full equality analysis will be determined upon the outcome of the feedback from the consultation.

12.0 Environmental implications

No environmental implications have been identified relating to the consultation process.

13.0 Human resources implications

No human resource implications have been identified relating to the consultation process.

14.0 Corporate landlord implications

There are no corporate landlord implications relating to the consultation and engagement process, however moving forward with the proposals there will be asset implications in relation to the co-location of the staff. There is representation from Asset Management, Corporate Landlord on the HCP Steering Group.

It has been highlighted that Health Visitors are currently based in Strengthening Families Hubs and it is proposed that school nurses join them there as a base, but will still work mostly out in schools and other education settings. The tender and service specification will need to consider this proposal.

The service model proposes close working and potential co-location with the 0-19 Strengthening Families Hubs.

15.0 Schedule of background papers

Department of Health Commissioning guidance for 0-19 Healthy Child Programme
https://www.gov.uk/government/publications/transfer-of-0-5-childrens-public-health-commissioning-to-local-authorities

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/493617/Service_specification_0_to_19_CG1_19Jan2016.pdf

Rapid Review to Update Evidence for the Healthy Child Programme 0–5 (Public Health England, 2015)

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/429740/150520RapidReviewHealthyChildProg_UPDATE_poisons_final.pdf

Healthy Child Programme – Pregnancy and the first five years of life (DH, 2009 – amended August 2010)
https://www.gov.uk/government/publications/healthy-child-Programme-pregnancy-and-the-first-5-years-of-life

Department of Health (2009) Healthy Child Programme – 5-19 years (amended August 2010)
http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_108866.pdf

Public Health Outcomes Framework 2013 to 2016 (DH, 2014)
https://www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency

APPENDIX ONE

Engagement Report.

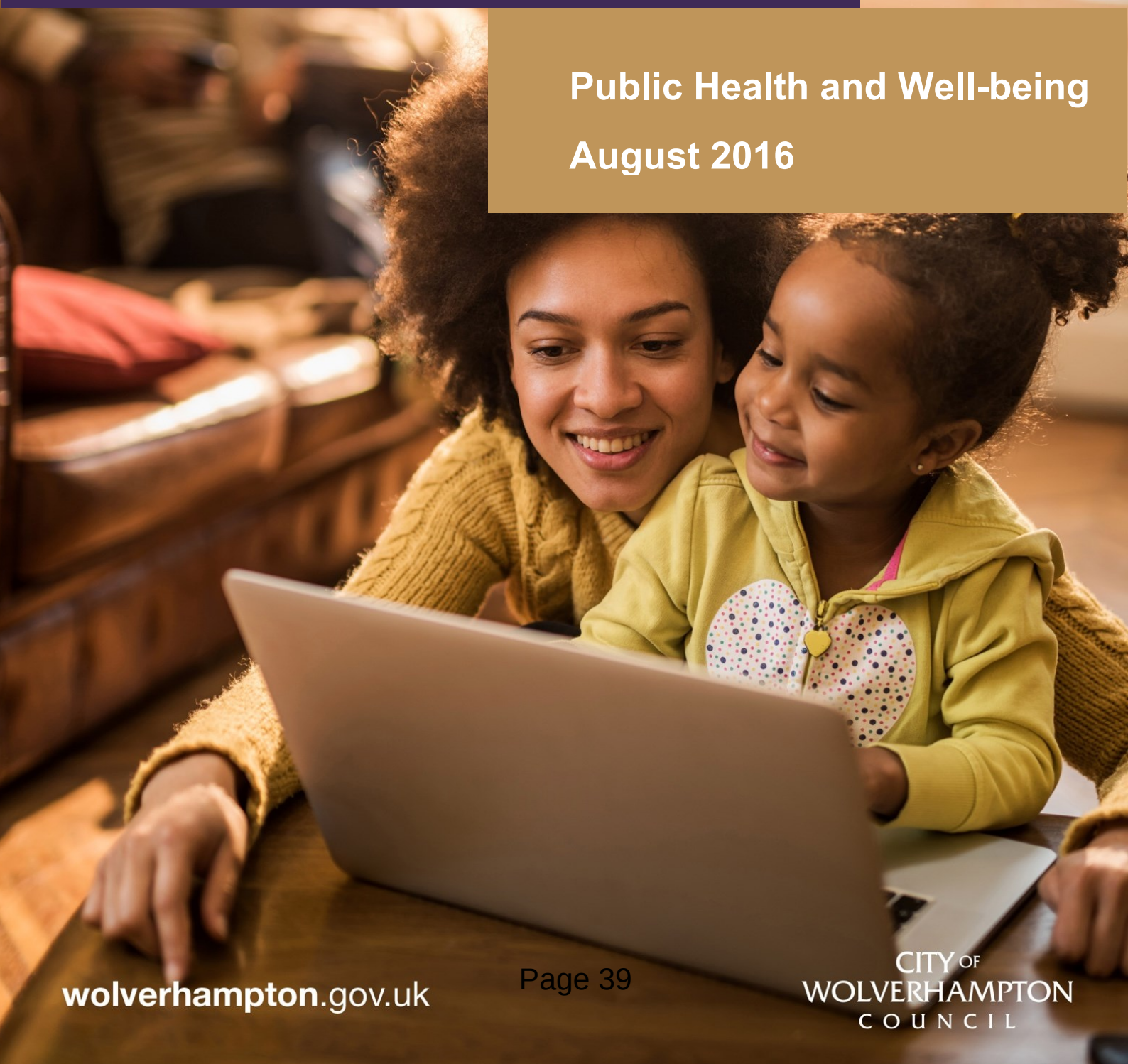
APPENDIX TWO

Service Model Framework Consultation document.

Wolverhampton Healthy Child Programme – Findings from Stakeholder Engagement

Public Health and Well-being

August 2016



Contents

1. Introduction

The City of Wolverhampton Council's public health team, as part of the commissioning process, engaged with key stakeholders regarding the future 0-19 Healthy Child Programme service model.

Engagement with stakeholders commenced in 2015 and this was followed by a formal 8 week engagement process undertaken between May and July 2016. This document details the findings from the engagement.

The engagement process sought to obtain the views of key stakeholders on current services and to identify the best future service model to improve outcomes for children and families. This specifically relates to health visiting, family nurse partnership and school nursing services. To date we have engaged with over 450 professionals, parents, carers and young people to inform the development of our proposed service model.

Wherever possible the views of our stakeholders have been considered and incorporated into a new service model framework for the 0-19 Healthy Child Programme. We will consult on this new service model during August and September 2016 prior to commencing a tender process to enable a new 0-19 Healthy Child Programme service to be in place from 1 August 2017. Further background information about details of how you can provide feedback on the proposed new service model is available on our website at City of Wolverhampton Council - The Healthy Child Programme .

2. How we engaged with stakeholders

We employed a variety of methods to obtain feedback from our key stakeholders. This included attending stakeholder meetings and holding engagement events for professionals. We conducted five separate on-line surveys for prospective bidders, professionals, head teachers, parents and young people. We also conducted a number of focus discussion groups with service users. Samples of the materials used to engage with parents and young people and publicise the on-line surveys and engagement to parents and young people are attached in Appendix One. With the assistance of the Council Communications team Facebook and twitter were used to publicise the engagement process. We shall continue to conduct focus discussion groups throughout the formal consultation period to help inform the development of our new service model and service specification.

We attended key meetings with professional stakeholders to inform them of the proposed commissioning process and obtain their views on current services and priorities for the new service model. This included attendance at GP locality and primary care meetings, meetings with Head teachers and Personal and Social Health Education (PSHE) leads in schools.

We were fortunate to work with some young people from the youth council, care leavers forum and care leavers board who advised us over a number of weekly

meetings on the development of the young people's survey and shared their views on school nursing services.

We were fortunate to meet parents and carers of children with additional needs via the Voice for Parents Forum who shared their views on current services. Some parents kindly advised on the development of the parent's survey questionnaire. We also engaged with the Foster carer's forum to obtain their views on the services. A member of staff from Health Watch supported the early engagement work advising on the surveys as did colleagues in public health.

We held two multi-agency events for professionals where we shared initial findings from the engagement and discussed key issues that had arisen and implications for the new service model.

In addition we have engaged with Health Scrutiny and the Scrutiny board who further advised on the engagement and consultation process. We continue to engage with the Councillor for Public Health and Wellbeing, the Councillor for Children, Young people and Families and senior management within the Council. We have produced and sent briefings to key stakeholders via the Wolverhampton Voluntary Sector Council, The Council's Due North Procurement website, as well as GP, Councillor and School bulletins.

Early in the commissioning process we established a Healthy Child Programme (HCP) steering group with responsibility for overseeing the development of commissioning options and any subsequent tender process. This has included advising on and supporting the engagement process. Children's services and the Clinical Commissioning Group are represented on the group along with a GP representative and key council officers including the head of service for early intervention and safeguarding representatives. Steering group members have advised on the development and implementation of the engagement and consultation plans.

A summary of the main stakeholders we have engaged with is detailed in the table below. Over 450 stakeholders have expressed their views to date.

How we engaged with stakeholders	Who we engaged
Market engagement survey	A range of potential bidders including NHS trusts and the voluntary sector.
Stakeholder workshop	Managers and staff in current services and their key partners.
Two professional stakeholders	75 professionals from partner agencies

engagement events	including health, social care, education, early years and voluntary sector.
Young people's discussion and survey planning group	8 young volunteers from youth council, care leavers forum and care leavers board.
Young people's discussion planning group	3 young volunteers from The Way.
Parents forum discussion group	9 parents
Foster carers forum discussion group	24 foster carers
Parents on-line survey	136 parents
Young people's on-line survey	49 young people
Briefing to youth council members	13 young people
Two focus groups at Orchard Centre	14 young people
Teachers attending PSHE network	12 staff
Head teachers forum	40 staff
GPs and primary care via GP locality meetings, Team W, Practice nurses and practice managers forums and Local Medical Committee (LMC).	70 staff

3. Overview of key themes identified from engagement with stake holders

The key messages identified for the new service model that came out of the engagement with parents, carers, young people and professionals are:

Consistency

A key theme was that whilst many stakeholders gave positive feedback about working with or receiving services from an individual health visitor or school nurse there was an inconsistent approach to service delivery as a whole.

Continuity

This was of particular importance for parents and foster carers. They would like to be able to develop a relationship with a named member of staff who has knowledge of

the family and child. Parents don't want to have to repeat information to different staff.

Make better use of technology to support service delivery

Technology needs to be used much more effectively to support service delivery. Staff should be supplied with appropriate devices i.e. smart phones or Ipads. Improve information sharing and record keeping through instigation of electronic record keeping that enables staff to readily access and input data into electronic records during visits. Better use of social media to engage with young people. Better use of websites, apps and Skype to communicate with and provide information to parents and young people.

Communication

All stakeholders including parents and young people identified that communication needs to be improved particularly communication between health visitors and GPs.

Accessibility

Many parents stated difficulty in contacting their health visitor or booking an appointment; they expressed a need for drop-in without appointment or telephone contact. Young people also wanted to be able to access their school nurse more often in their school.

Early help and prevention

Stakeholders want the new service model to intervene earlier, making greater use of 'early help' assessments. To provide joined up working to support families including working closely with strengthening family's teams to provide a multi-agency model. Also a strengthened role in supporting emotional health and mental wellbeing.

Family Nurse Partnership and supporting vulnerable families

We received positive feedback regarding the Family Nurse Partnership nurses and the individual support they provide for young parents. However there was an overall concern expressed regarding the current limited capacity of FNP to meet the needs of all young first time mothers who meet the criteria. A consistent theme was the need to expand the current criteria of FNP. Additionally, there were requests to build capacity within the health visiting service itself to be more able to address the needs of vulnerable and/or complex families.

The new service model

Overwhelmingly stakeholders agreed with the principles we proposed for the new service model. We found support for delivering an integrated 0-19 Healthy Child Programme service as a cost effective solution and offering a better quality service

via a seamless pathway for children and young people. Stakeholders support the continuation of the mandated development reviews and suggested consideration of additional checks e.g. at 3 years.

4. What professionals and partners told us in the on-line survey

Characteristics of respondents

70 professionals from a variety of backgrounds including health, primary care, education, early years, social care and the voluntary sector responded individually to our on-line survey**.** All of the respondents stated that they worked in Wolverhampton. Most of the respondents to our survey had some experience of working with at least one of the three services and many had experience of all three. There were also a small number of health visitors and school nurses who completed the survey. The findings and the emerging themes from this survey and the Head teachers' survey were considered at our subsequent engagement events for professionals.

5. Views regarding current health visiting services

We asked stakeholders to consider what in their opinion does the current health visiting service do well. Respondents to the survey highlighted that they appreciate the following about current services:

- Recognition of the value of health visitors' universal access to families without stigma and engagement with families.
- Acknowledgement that many health visitors are very skilled practitioners who liaise and communicate well and adapt their approach as needed.
- The potential that delivery of the Healthy Child Programme has to offer a standardised level of support to all families based on their needs and provide active support for vulnerable families.
- Many stakeholders described the current service as good, that services generally provided by health visitors are professional and efficient, .however acknowledged there are sometimes issues due to capacity.
- Health visitors have excellent knowledge of families and will follow up quickly any safeguarding concern.
- Health visitors are proactive about identifying developmental or medical concerns with children and referring them appropriately and promptly.
- Some examples of innovative work were shared e.g. well attended Saturday morning development clinic.
- Health visitors work collaboratively with social work teams.
- Provide additional support to struggling parents.
- Good liaison with the school nursing service.
- Responding to GP safeguarding concerns.

One stakeholder commented:

"On the whole the service provided is professional and efficient but caring."

6. We asked stakeholders how the health visiting service be improved in the new service model.

There were a number of key areas identified by respondents that could be improved in the new service model. These are summarised in the table below.

Key themes	Suggestions from stakeholders on how health visiting services can be improved in the new service model.
Expand the current mandated development reviews/checks.	Include an additional check at 3-4 months to support maternal mental health, child safety and healthy eating habits. Provide an additional check at age 3 years. Some GPs would like the measuring and weighing of babies at 6-8 weeks reinstated.
Intervene earlier with families to address needs, provide early help and strengthen multi-agency working.	Requires greater use of and lead on 'early help' assessments. More joined up working to support families including working within strengthening families teams to provide a multi-agency model. A move to electronic record keeping is key to supporting above. Intervene early to provide support to parents via clinics e.g. for children with sleep problems or finicky eaters to prevent problems escalating and later referrals to specialist services.
Better integration with the Violence Against Women and Girls (VAWG) agenda.	This includes addressing domestic violence and abuse, sexual violence, female genital mutilation, forced marriage and honour based violence. Need to identifying victims and potential victims, accessing pathways and providing education to families.
Better engagement and integration with GP practices.	Improve the communication between health visitors and primary care as a matter of priority as a number of GPs and practice nurses have stated that this has worsened since health visitors no longer located within GP practices. Consider a named health visitor for each GP practice. Health visitors to proactively chase and encourage children who fail to attend for immunisations. Feedback to surgeries regarding domestic incidents as currently not routinely reported.
Partnership working.	Improve the liaison and communication between health visitors and schools. Closer partnership working with nurseries and better work around school readiness including undertaking the two year old assessments at the nursery and ensuring that the two year check information is shared with the nursery. Clarify roles and responsibilities to avoid duplication especially in relation to safeguarding.

Improve communication with parents.	Make better use of technology e.g. a website for parents to enable access to sound evidence based information and to include a mechanism to ask health visitors questions.
Improve parents access to services.	Some GPs described receiving complaints from parents who find booking an appointment a barrier to seeking help from the health visitors at the time of need which could be resolved by provision of drop-in clinic appointments. Have a named health visitor allocated to each family.
Ensure adequate levels of staffing to deliver the new service model.	A number of respondents commented on issues relating to perceived lack of capacity and highlighted the need to ensure that there are adequate staffing levels to deliver the new service model and address the deprivation and high level of needs of families in the City.

7. What professional stakeholders told us about the family nurse partnership (FNP) service and how services for vulnerable families could be improved in the new service model

Most stakeholders commented on how well the family nurse partnership service provided support to vulnerable young families and there was an acknowledgement of the high standard and quality of the services provided. It was noted that this was made possible as FNP staff have the time to support vulnerable parents with smaller caseloads unlike health visitors in the universal service. It was also acknowledged that family nurses are well supported in their role as they have access to high quality resources, training and supervision.

We received positive feedback regarding the Family nurses themselves and the individual support they provided to young families. Their motivation and how they go above and beyond their roles to help the families was noted.

Despite the positive feedback about FNP there were a number of concerns expressed by many of the respondents about the programme as a whole.
The first concern respondents highlighted was regarding the current lack of capacity of the FNP programme to enable all young families who meet the FNP criteria to access the service. A number highlighted their experience of young women having been offered FNP services but later declined due to lack of FNP capacity which they saw as disappointing and a missed opportunity for their clients to have benefitted from the service.

The second concern raised was as regards how equitable the FNP service is in terms of families who may be eligible for the service but are unable to receive due to limited capacity and for wider vulnerable families who don't meet the FNP criteria. It was suggested that additional investment in FNP was required to increase the capacity of family nurses so that more eligible young people could receive the service. It was also suggested that the current FNP service should be reviewed and

widening of the current criteria be explored to make the service more equitable and enable more vulnerable families to access intensive support when they require it. Stakeholders also made clear that there is a need to build the capacity within the health visiting service itself to be able to address the needs of vulnerable families and enable them to have more regular contact with vulnerable families.

Key themes	Suggestions from stakeholders on how services for vulnerable families can be improved in the new service model
Need to address the current unmet needs of young parents who meet FNP criteria but are unable to avail of the service due to FNP capacity.	Expand the number of FNP staff to enable more vulnerable families to be supported. FNP consider offering less intensive support to families so that FNP could be offered to more families. . Consider role of universal health visitors and integration of FNP into the health visiting service.
Need to broaden the FNP criteria to enable more vulnerable families to be supported.	Widen the criteria of FNP and expand the number of staff to enable more vulnerable families to be supported The need to expand the numbers of families being supported should not be at the cost of diluting the input as this would make the FNP programme less effective.
Grow the FNP model by integrating into the universal health visiting service.	Integrate and share the learning from FNP across the universal health visiting service which could include rotation of health visiting staff to enable development of skills and knowledge.
Improve partnership working to address needs of vulnerable families.	Allocate a named social worker and health visitor to each vulnerable family. Better use of technology could support health visitors i.e. enable quicker and safer use of information and promote greater awareness of shared services. Increase capacity within universal health visiting to enable health visitors to spend more time with vulnerable families. Better engagement with 'troubled families' and Violence Against Women and Girls (VAWG) agenda. Improve working relationships and communication between GPs and health visitors to enable concerns re families to be readily and easily discussed.

8. What professional stakeholders told us about the school nursing service and how services could be improved in the new service model

We asked stakeholders what in their opinion the current school nursing service does well. Stakeholders clearly value the role of school nurses and contribution they make in schools in a number of ways. These include:

- The skills of the school nurse in terms of excellent communication skills, knowledge of the school population and their ability to work with young people at their level.
- Health promotion delivered by school nurses and provision of sexual health including the c-card scheme and delivery of the national child measurement programme.
- The support provided for children with additional needs to families, children and schools including health plans and advice re medicines management.
- The input into safeguarding including attendance at meetings and liaising with schools on Child Protection and Children in Need cases and providing advice when requested.
- Excellent source of knowledge about health and how to refer to specialist services.
- Appreciation of the health input into all schools, including presence in schools and the links to wider school initiatives.

Some of our stakeholders comments about school nursing:

"Having a named school nurse provides an excellent opportunity for face to face communication where any concerns regarding students may be discussed and acted upon if necessary. Our school nurse responds quickly to any emails and deals with matters speedily and efficiently. She is an excellent source of knowledge regarding health care and is able to add 'background' knowledge regarding the care/conditions of some of our pupils."

"They manage many demands. They work across all agencies. They have multiple qualifications and experience. They are flexible and responsive to need. Schools value their input and support. Working relationships are excellent."

"We are very lucky at present, we have a regular service with two nurses, one does the drop in for the C card and is there for sexual health and advice and the other one is our support with individual cases, working with self-harmers, dealing with mental health and seeing students who are on CIN, CP, LAC etc."

"From *my point of view I feel the school nurses are paramount to our working day. We need the on-going advice, teacher training on particular subject areas which are necessary to enable staff to relate to students well with particular problems. Education is key and the school nurses are paramount to this learning process."*

9. How school nursing services can be improved in the new service model

We asked stakeholders to tell us how school nursing services might be improved in the new service model. There were a number of key areas identified by respondents that could be improved in the new service model. These are summarised in the table below.

Key themes	Suggestions from stakeholders on how school nursing services can be improved in the new service model.
Improve the access to a school nurse in the school setting.	Increase visibility of the school nurse and increase the number of days that school nurses are available in schools. School nurses currently do not spend enough time in school to be able to see the children. Take a more active role in some schools. Increased contact with parents and children. Provide a clear service offer to all schools. Allocate more time to secondary schools. More delivery of health promotion especially sexual health. More preventative work e.g. asthma management.
Expand the role of the school nurse to enable wider work to be undertaken with families.	School Nurses should go out to work with the families as a whole. Work with vulnerable children needs to be done at home with their families as well as in the school. Teachers and families should be directing children with behavioural problems directly to the school nurse as a first point of contact. Utilise their skills to offer more targeted support with all families.
Improve partnership working.	Work more collaboratively and avoid repetition. Provide a more integrated approach with other agencies - not in a silo with education. Explore links with other organisations as well as schools for e.g. Third Sector. Publicise their role to other organisations more. Locate in the city strengthening families' hubs. More integration with the Violence Against Women and Girls agenda.
Increase capacity of the school nurses.	School Nursing is stretched to its capacity and offers a more reactive service than a preventive service. Increasing staff numbers and allowing school nursing to work with families with early intervention which then reduces the pressures on other services. Increase capacity of nurses in line with increasing school population due to more children moving in to the City and increasing birth rate. Address need to provide services to more schools Consider impact on school nursing due to the increase in statutory school age and due to new schools opening. Increase capacity to enable school nurses to contribute to Education, Health and Care plans as currently do not have the capacity to do this. Need to increase number of school nurses in specialist roles such as home education. Address increasing demands due to the statutory

	safeguarding, Looked After Children and Children in Need work.
Make better use of the skills and expertise of school nurses.	Maximise opportunities for more proactive work i.e. health promotion, parents groups. To become more public health focused and not do everybody else's jobs. Increase skills in behaviour management. Provide opportunities for staff to shadow strengthening family's hub staff and increase understanding of thresholds.
Strengthen role in emotional wellbeing and mental health.	More engagement with CAMHS; beyond just making referrals. Much more emphasis on prevention and early intervention on emotional, behavioural and mental health issues. Be more proactive and better linked up with, for example, HeadStart.
Improve communication and better use of technology.	Make better use of technology to share information and to communicate with pupils and parents.

10. What stakeholders think about Health development reviews

Evidence shows us that there are key times for health checks or development reviews to be undertaken to ensure that parents are supported to give their baby or child the best start in life, and to identify early those families who need extra help. These are universal checks meaning that they are offered to every parent.

It is currently recommended nationally that health visitors provide reviews at:

- Antenatal Health Promoting Review from 28 weeks of pregnancy
- New baby review within 10-14 days of birthdate
- 6-8 week assessment (Maternal Mental health)
- 1 year review
- 2-2.5 year review

In addition Schools nurses provide reviews at:

- School entry
- In Year 6/7 (transition to secondary school)

Some Local Authorities have chosen to deliver additional checks at different stages based on their local families' needs. We asked our stakeholders if beyond the development reviews listed above, were there any additional times or stages in a child's life when an additional health review may be beneficial.

The majority of stakeholders support the continuation of the mandated checks as detailed above. 73.4% of respondents recommended additional times or stages in a child's life when a health review may be beneficial. Suggestions for additional reviews were:

- When a child is three years old.
- At some point during primary school years between the school entry and Year 6 transition reviews.
- Additional reviews during the secondary school years including mid-teens and school leaving check in year 11.
- It was also highlighted that there is a long time between the 6-8 week check and the one year check where parents may be in need of additional support.
- Some GPs would like health visitors to undertake the measuring and weighing of babies at 6-8 weeks which is currently a GP responsibility.

11. What professional stakeholders think are the most important issues affecting children, young people and families in the city today

The new service model will need to address the findings of the public health needs assessment and the key priorities of the Wolverhampton Children & Young People's Plan. This plan seeks to ensure that:

- Fewer children are obese
- The rate of infant mortality is reduced
- Fewer parents, children and young people suffer from mental ill-health
- More parents, children and young people who misuse substances are supported through treatment

We asked our professional stakeholders what in their opinion are the most important issues affecting children, young people and families today that should be addressed by the new service model. A wide range of issues were identified. The main three issues were that were consistently highlighted as priorities that the service model needs to address are:

- Obesity (including prevention and including lack of physical activity).
- Mental health and wellbeing.
- Prevention and early identification of problems and help for parents.

The table below provides more detail on issues raised by stakeholders that they would like the new service model to address.

Summary of priorities identified by stakeholders for the new service model to address:
Obesity • Lack of physical activity in all age groups. • Healthy eating including provision of cooking classes and addressing lack of cooking skills. • Education of parents to reduce the risk of childhood obesity. • Address maternal obesity.

Mental health and wellbeing • More preventative work to address mental health problems including building resilience and promoting emotional wellbeing. • Supporting mental health of parents as parental emotional well-being and mental health issues affecting ability to parent consistently. Address parental alcohol and substance misuse. • Collaborative work between school nurses champions of mental health prevention in schools. Address body image and self-harming in schools. • More resources available for parenting programmes e.g. triple P. More knowledgeable and supported parents will result in lower chances of mental health disorders emerging.
Early identification of problems, prevention and early help • Early identification of problems so that children, young people and parents are supported and increased early intervention capacity to support early help. • Early intervention remains key, with antenatal and new birth contacts establishing a relationship between professionals and families that will endure to support them throughout the early years. Health visitors are best placed to deliver this support and develop the family/ professional relationship. • A multi-disciplinary approach is required and better communication about the care, notes sharing and concern about the children. • Supporting parents of children with additional needs to allow them to access services and enable their children to reach their full potential and ensuring children have healthy lifestyles to allow them to become healthy adults.
Neglect and safeguarding issues • Working with vulnerable families • Coping with substance misuse (especially alcohol) in parents. • Domestic violence and violence against women & girls.
Parenting and parenting programmes • Address lack of parenting skills, lack of parental engagement and lack of parental attention. • A lack of structure and discipline in the home. • Promote positive parenting • Parenting support • Many children falling through the cracks that could be addressed with more resources available for parenting programmes e.g. triple P More knowledgeable and supported parents will result in lower chances of mental health disorders emerging.
Promotion of healthier lifestyles • Health promotion/healthier lifestyles for children and their parents and

promotion of lifestyle services. • Address teenage pregnancy, sexual health and attitudes to sex and body image due to social media and internet • Substance misuse, alcohol, smoking, maternal smoking. • Ensuring children with a medical condition to be well controlled to allow them to become healthy adults, includes both physical and emotional health with early identification of issues to allow them to be managed promptly. • 'hands-on' learning to show children through living a healthier lifestyle is beneficial, not just showing them through a talk or a presentation but through doing, such as cooking classes or exercise groups that are interesting.
Poverty, child poverty and issues associated with deprivation • Recognition that poverty and poor education lead to poor health so consider needs of children and young people living in poverty. • In particular areas of the city breaking the cycle of unemployment/ lack of educational achievement and aspiration and deprivation is a primary challenge and one with which interagency working is key. • Address poverty, unemployment, lack of social mobility and aspiration, less ability to access facilities.
Relating to how future services should be delivered including better access to services, communication and sharing of information • Provide access to more support and services. • Improve communication. • Monitoring of non- attendance of hospital appointments • Ensuring that children from all ethnic and socio-economic backgrounds can equally access support and services. • Address language barriers and mobile families. • Health services to be able to share information in a better way. • Everyone is working in silo and greater awareness of what and who and where is required • To be proactive in the health of the child, providing the support required and go that extra mile to undertake this. • That every child is known to a health service professional or have access to a named professional

12. Principles of the new service model

The new service model will largely be drawn from the evidence based national service specifications for health visiting, family nurse partnership and school nursing as detailed in the 0-19 Healthy Child Programme Commissioning Guidance which can be found on City of Wolverhampton Council - Further information

However we have developed with the Healthy Child Programme steering group a number of key principles for the new service model. The new service model will:

- Ensure that all children and young people are supported to achieve good outcomes.
- Be underpinned by an evidence base.
- Share a holistic view of a child's health, well-being and development with partners as much as possible.
- Build on current service components that are working well.
- Address service areas identified as needing improvement.
- Have a clear and strong commitment to addressing inequalities and evidencing this commitment.
- Identify those at risk of poor outcomes early, is part of joint working arrangements to address these, and reports on outcomes achieved.
- Continually learn and apply lessons from serious case reviews.
- Demonstrably adhere to new national guidance as it emerges for e.g. new guidance on child sexual exploitation.
- Encourage a culture of self-help within the community.
- Contribute to and support robust systems between health, social care and education.
- Seek opportunities for innovative service delivery through involvement of the voluntary sector in delivery of the Healthy Child Programme.

We asked our professional stakeholders to consider these principles and consider whether they agreed with them. The vast majority agreed with predominantly all the principles i.e. over 90%. The only principle that had less response was the principle to seek opportunities for innovative service delivery through involvement of the voluntary sector in delivery of the Healthy Child Programme. Only 78% supported this principle.

We asked if there was anything missing from our key principles. 70% said that there was nothing to be added to our principles. We were asked to consider the following comments and gaps in relation to the principles:

- There is no reference to the fact that Wolverhampton is a multicultural city and there are areas which are unique within its population. Some of these need targeted intervention.
- Evidence base can sometimes lead to an over rigid criteria for engagement e.g. Family Nurse Partnership might work with others too.
- Encourages a culture of self-help in the community but don't do this as an alternative to providing services but as building on assets.
- Inter-agency education/learning of knowledge and skills (inter-agency CPD for improving care to CYP).
- Identify who is the lead in the delivery of the healthy child programme.

- Early identification and referral for SEN e.g. Speech, language and communication disorder and delay, sensory needs etc.
- Explicit principle re prevention and early intervention of mental health issues.
- Addressing emotional wellbeing through working with appropriate agencies within schools.
- Encourages awareness of the very many excellent (often free or cheap) services available in the City.
- That the service is developed and monitored through co-production with young people and parents.
- Ensures that children and parents/families take responsibility for their own health. Too much emphasis on helping families actually dis empowers them and we can easily create a culture of dependency. GP services are flooded by users who do not take any responsibility for their health and feels that it is everyone else's duty to help them. Self-reliance and self-care and empowering families to take care of themselves should be a main part of the strategy otherwise we are setting up a generation of families to be forever dependant on others.
- Ensure staffing is adequate and fulfil expectations. Short staffing is not conducive to good practice.
- Ensure learning from Domestic Homicide Reviews (DHRs), Suspicious Activity Reporting (SARs) as well as Serious Case Reviews (SCRs) - there are implications for children.
- More advice and support during pregnancy about being good parents.
- Information governance.

13. Future role of the voluntary sector in delivering the Healthy Child Programme

We asked a specific question regarding the future potential role for the voluntary sector to support delivery of some aspects of the Healthy Child Programme in the new service model. Responses to this question were divided with 56% agreeing that there was a role for the voluntary sector and 43% stating that there was not. Respondents made additional comments in support of their choice of answer. We found that some respondents urged a little caution before delivering services via the voluntary sector and should only be considered if staff have the appropriate training, support and supervision in order for them to adhere to guidelines and understand how best to support the children and families. Some stakeholders expressed the following reservations:

"I would worry that this may mean essential skills, key role elements being farmed out to services because they are cheaper but not of a similar standard."

"To support and complement - not to be used instead of funding long term changes though"

However many respondents acknowledged and supported the possibility of the voluntary sector working in partnership with health services to deliver elements of the HCP and suggested that potential benefits would include:

- The reach and ability to engage with some communities that mainstream public sectors struggle to engage with
- Providing non-statutory point of connection with health services - more accessible and approachable.
- Voluntary sector can provide community based services that are targeted at particular at risk groups and can adapt to meet needs more easily than statutory services or schools.
- Delivering non-clinical programmes of support for e.g. parenting
- Other respondents highlighted other areas of good practice including breast feeding peer support, healthy lifestyles, relateen etc.
- Providing buddying support alongside families along lines of Home Start.
- Building on community assets and encouraging communities to become more self-reliant.
- Providing accessible and acceptable venues at a neighbourhood level.
- Providing a whole family holistic approach.
- An example was given of HeadStart driving the development of a mental wellbeing consortium of quality assured VCOs.
- It was suggested that the voluntary sector could support delivery of parenting programmes, breastfeeding support and support national child measurement programme.

14. Future service model options

Prior to commencing the formal engagement process commissioning options were discussed and developed by the Healthy Child Programme Commissioning and Governance Steering Group. Two possible future commissioning options were identified and we asked our stakeholders for their views on these during the engagement process:

Option 1 - delivering the Healthy Child Programme via three distinct services; health visiting, school nursing and the family nurse partnership

OR

Option 2 - delivering the Healthy Child Programme via an integrated 0-19 Healthy Child Programme service.

Overall the feedback we obtained from our stakeholders suggests that a single integrated 0-19 Healthy Child Programme service model would be the most preferable option with the best potential locally for improving children's outcomes.

We undertook a market survey to obtain the views of our potential bidders. Several potential future service providers with experience of delivering Healthy Child Programme responded to our survey. We found that the majority of potential bidders would prefer to bid for a 0-19 Healthy Child Programme in its entirety as opposed to bidding separately for health visiting, family nurse partnership and school nursing services. It was suggested that this model has potential to be the most cost effective solution especially given current financial pressures and that the model had potential to offer a better quality service via a seamless pathway for children and young people.

We had more mixed views from the professionals who completed the on-line survey. We found that a third of respondents supported delivery via an integrated 0-19 model and a third supported continuing to deliver the Healthy Child Programme via three distinct services; health visiting, school nursing and the family nurse partnership. The remainder of on-line respondents felt either model would be acceptable or had no preference at all.

We specifically ran a workshop to explore this further in our professionals engagement workshop attended by 75 professionals.

We found that there was support from participants attending for a 0-19 model. Participants thought that a 0-19 model best represented the child's journey. Participants identified a wide range of potential benefits from delivering services in this way which included:

- Potential for better communication and clearer service offer to families and professionals.
- Having a holistic view of families across the age range.
- Better dialogue on families if school nurses and health visitors based together.
- Potential for improved data sharing supported by a single 0-19 information system as opposed to separate IT systems.
- Potential for stopping children slip through the net e.g. health visitors could continue to support a child and their family at school entry or school nurses could offer support prior to children prior to school entry.
- Could offer seamless transition at key life stages e.g. school entry.
- Opportunity to have better links and communication by having a named link health visitor or school nurse from the 0-19 service for GPs and social workers.

However some participants also highlighted a number of concerns and issues that would require consideration in delivery of a 0-19 model:

- It's important to have the right support and infrastructure in place to support delivery of a 0-19 model i.e. data systems.
- Need to have clearly defined roles and the skill mix to deliver.
- Budgets were raised as a potential issue i.e. who gets the biggest slice of the pie. Need to ensure that all key elements of the 0-19 service are adequately resourced.
- Staff working within the current services were concerned that a move to a 0-19 service might mean a move to being a 0-19 worker and felt that there were particular skills and strengths that health visitors and school nurses had that should not be lost. A plea was made to note lose the specialisms of health visitor or school nurse.
- The 0-19 programme provides an opportunity to consider a different approach to delivery in schools for example breaking down service delivery into 5-12 years banding/stage and 12-19 years acknowledging the different skills and expertise required to address the needs of children and teenagers.

15. Young People's feedback

76 young people have to date provided their views via group discussion or on-line survey. We also held a number of discussion groups with young people from the youth council, care levers and looked after children's forum, The Way and the Orchard school. Further views were obtained by including specific questions about school nurses in the Behaviour school survey of around 1000 pupils.

The characteristics of the young people completing our survey were as follows:

Only 40 young people completed the equality questions on the survey. The majority were aged between 12 and 18. One young person under the age of 12 completed the survey. 5% were aged 12, 2.5% were 13 years old, 17.5% were aged 14, 47% were aged 15 years, 5% were 16 years old, 12.5% were aged 17 and 7.5% were aged 18.

The young people were from 13 different schools and pupil referral units including one college student.

56% described themselves as female, 37% as male. 2 young people described themselves as gender neutral. The remainder preferred not to say

92% had the same gender identity as assigned at birth. 2 young people did not have the same gender identity as assigned at birth and the remainder preferred not to say.

75% of young people identified as heterosexual, 11% were unsure of their sexuality, 2% identifying as a gay man, 7% identifying as bisexual and the remainder preferring not to say.

14% of young people identified themselves as being young person who is looked after by the local authority (in care or looked after by a foster carer).

60% described themselves as White British, 9% White and Black Caribbean, 7 % Asian British Indian, 7% Black British Caribbean, 5% Other White European, 2% Chinese, 2% White and Asian, 2% Black British African and the remainder other or preferred not to say.

49% described themselves as having no religion, 34% Christian, 2% Hindu, 2% Sikh, and 7 % other religion and the remainder preferred not to say.

21% of young people stated that they had a disability.

16. What do young people think school nurses are doing well?

We asked young people their views on current services provided by their school nurse. Young people overwhelmingly mentioned how approachable, friendly and kind their school nurse was.

The majority of young people responding to the on-line survey said they know how to access their school nurse and rate the service as good and would recommend the service to their friends. This was contrary to the findings of the larger Health Related Behaviour Survey 2016 as detailed below.

Young people value the confidentiality offered by the school nurse making the school nurse very approachable**.**

Some of the individual responses received to the question about what young people like about the support and services provided by school nurses in their school are detailed below.

"That she is always there to help"

"Easy to find her and know she is here every week at drop in to talk to"

"I could tell my nurse everything and she would listen to everything"

"Non-judgmental, confidential, trustworthy, supportive"

"We are like a family here – we are all different – but she treats us equally" - Orchard School pupil.

"Understands me – doesn't speak down to me – doesn't speak

like we are children"

17. What needs to be considered in the new service model?

Increase access to the school nurse within the school setting

The majority of young people said that access to the school nurse and drop-ins should be increased in their school. On the whole young people would like to be able to see the school nurse during the school day or immediately before and after the school day. Some young people would also like to be able to access the school nurse during the holidays. Most preferred to be able to meet the school nurse within their school as opposed to another venue. Young people would like choices on how they access the nurse including being able to book an appointment, attend a drop-in without appointment and to be able to access advice from the nurse via telephone, confidential email and Skype.

Improve communication

Improving communication was a key theme. Young people would like to be able to contact the school nurse in a variety of different ways including phone, text, email and Skype.

Young people have a number of suggestions as to how school nurses could promote themselves more and improve communication including:

- having specific school nursing notice boards with a photograph of the nurse in schools and classrooms detailing how to access the nurse and providing health information
- promoting the service in school assemblies
- school nurse to provide an annual reminder to pupils about the service and introduce herself to new pupils
- Some suggested that the school nurse could attend school council meetings to discuss issues

18. Services young people would like in their school in future

The majority of young people valued the services provided by school nurses and wanted more provided in their school. A large number of young people felt that school nurses could provide more support to young people in relation to mental health including providing advice and support and helping to reduce the stigma attached by talking about mental health issues more and advising for e.g. on exam stress. Other areas highlighted as important were continuing the drop-in's especially in relation to provision of sexual health and pregnancy advice. Young people suggested that school nurses could do more in relation to personal, social and health

education (PSHE) by teaching more lessons particularly relating to mental health, sexual health, sexuality, teenage pregnancy, drugs and smoking.

Young people in the groups highlighted that they liked the C card free condoms scheme and this should be provided by the new service.

Other areas highlighted were body image, sex education for LGBT young people, advice for transgender and non-binary people, gaming advice, blood checks and treatment of minor injuries.

One of the group discussions also highlighted a potential role in advising and encouraging young people who wished to pursue a career in health including access to modern apprenticeships and jobs in health settings.

19. Most important issues for young people in Wolverhampton today

The top four issues facing young people today raised by the majority of young people were obesity (including diet, exercise and not eating), sexual health, mental health and alcohol. Other issues raised by smaller numbers of young people were smoking, drugs and keeping young people safe.

20. Findings from the Health Related Behaviour Survey

Wolverhampton schools have been using the Health Related Behaviour Survey every two years since 2006 as a way of collecting robust information about young people. We included specific questions about school nursing in the 2016 survey. 2283 year 8, 9 and 10 pupils responded to specific questions about school nurses as detailed below. The data demonstrates a need to promote the school nurse services to young people and how they can access as many young people did not know how to access the school nurse. Only 42% of children sampled knew who their school nurse was. Only 38% knew when the school nurse was available in school. Very few pupils knew how to access the school nurse when not in school.

21. Views of Parents and carers

136 parents completed our on-line survey. In addition we spoke to 9 parents at a meeting of the Voice for Parents Forum where they gave us their views on services and advised on the development of the parents' survey.

The characteristics of the 136 parents who completed our on-line survey were as follows:

- 7% were aged between 16 and 24 years of age, 38% were aged 25-34 years, 36% were aged 35-44 years of age with 19% over the age of 44.
- 15% told us that they had a child with a disability.

- 12% identified that they themselves had a disability.
- 88% of people who completed the survey were mothers with the remainder being fathers, grandparents or guardians.
- The majority of parents and carers were female (93%) with 6 males and 1 person who preferred not to say their gender completing the survey.
- 92% of parents described themselves as heterosexual with the remainder describing themselves as lesbian, bisexual or preferring not to say.
- The ethnicity of parents was:
    - 78% classified themselves as White British.
    - 10 % were Asian British Indian.
    - 3% were Black British Caribbean.
    - The survey was also completed by 1 Chinese parent, 1 White and Black Caribbean, 1 Black African and 2 White Other Europeans.
- 49% of parents described themselves as Christian, 32% were of no religion, 8% were Sikh, 2% Hindu, 2% Muslim and the remainder stating other religion or preferring not to say.
- 48% of parents had a child aged 0-4 years of age.
- 50% of parents had a child aged 5-11 years.
- 28% of parents had a child aged 12-19 years.

22. Contact with the health visitor and health reviews

We asked parents to consider the contact they had with their health visitor. 40% of parents felt that the number of visits they received from their health visitor was enough. Only 5% of parents felt they had too much contact. However 24% of parents felt they would have liked more support from their health visitor. They told us that they would have liked:

- Being able to have the same health visitor so that they get to know their children and can also develop a relationship with the parents.
- Being able to have the health visitor visit the home to carry out checks and provide support.
- Being able to access extra support from the health visiting service when experiencing postnatal depression, when a single parent, or as parents of twins/triplets.
- Parents whose children have additional needs being able to access extra help and support for example those with life limiting illnesses or long term conditions.
- Extra advice and support at key development stages e.g. weaning.

Some of the individual comments we received from parents about contact with their health visitor included:

"I would like to have seen the same one so the health visitor knew my children"

"As a first time parent who was also single I felt I was just left with no information or help"

"I had lots of support but I always went to them."

"As a new mom the service was fine I had good support from allocated health visitor"

Some parents compared the health visiting support they had received for an earlier child and felt that they had not received the same level of support with a later child and that it was difficult to access health visitors for support. Some other parents told us that they had received their health checks late and some believed that they hadn't received all the relevant checks.

A number of parents felt that it was important for the health visitors to provide more support in the first year and suggested that the health visitor could telephone the parents more often in the first year to check that they were ok. Some suggested:

"For first year the health visitor should come to your home to check on you more often and that you're not just left to it."

"6 months checks by phone to make sure mum or dad or both are OK with their child's development at school"

23. Schools nursing health development reviews

We received mixed responses from parents when we asked if they remembered their child receiving a health review from the school nurse at school entry or transition from primary to secondary school and how useful it was for them and their child.

Of the 117 who responded only 50% of parents remembered receiving a review at school entry. 25% found the review useful but equally 25% did not find useful.

Even smaller numbers of parents remembering their child having a review at transition to secondary school with around 10% remembering this and finding this review helpful and 10% remembered but did not find this review helpful.

24. Additional comments about health development reviews

We asked parents if they had ever been offered a review and declined this and reasons for this. Only 12 parents told us that they had been offered and declined a visit/review from the health visitor or school nurse. A variety of reasons were given

from thinking that they didn't need the service to a minority reporting that they didn't like how the health visitors interacted with them feeling judged.

We asked parents if there any other times or stages in their child's life that would be helpful to be offered a health review/visit from the health visitor or school nurse and found that the majority of parents were happy with the current development checks on offer.

28% of parents suggested the following as additional times when checks may be useful:

- Before and when starting school.
- More frequently during primary – rather than just offered at school entry and transition to secondary school. Some parents commented on puberty being a key time and reflected that this is occurring earlier and information available for parents was limited.
- More frequently during secondary school and when leaving school at Year 11.
- Some parents felt more support was required on an individual basis e.g. when a child becomes diagnosed with a long term condition or has other additional needs identified e.g. mental health.
- A small number of parents felt the need for even more contact suggesting six monthly or annual reviews.

25. What parents like about the support and services that they or their child received from the health visitor, family nurse or school nurse

Only half of respondents answered this question and the responses were mixed with a small minority of parents stating that they had received very little support from the services and therefore had nothing to recommend them. It would appear that there is inconsistency in the services currently provided to parents. Some parents praised the level of support they received but some said they only received a basic service and faced difficulties in accessing staff for help.

"I don't even know who our school nurse is and my 14 year old son has a long term medical condition. I have never met the school nurse and as far as I know, neither has he."

However it's clear that those parents who recalled having received services clearly do value the support and advice they received. They described staff in the services as being helpful, kind, accessible and friendly. This is a sample of some of the individual comments that we received from parents regarding their positive experience of the services.

"School nurse is helpful as they pick up any underlying issues your child might have, especially if you don't need to visit the doctor

because your child isn't ill often"

"Our school nurse became our keyworker for CAF meetings that I self-referred for. She was our rock, and became a huge part of our lives. She was our support when school wasn't listening."

"The service from the health visitor is good but it is really hard to get in touch with them and appointments at clinic fill up really fast."

"I felt the visits for my newborn baby and 6-8 week checks were positive. The health visitor was clearly experienced and I felt reassured when my questions were answered."

"The School Nursing support is great, hope with disabled young people they and their families can have similar support post 19 years."

"The school including nurse become a second family for our children with complex and additional needs."

"My child's school nurses are excellent, supportive with a great can do attitude!"

"I suffered from post natal depression and if it wasn't for my health visitor I'm not sure I would have got through those early years"

"My Family nurse knows more about me than any other professional. She is always there for me. I hope this service is around to help other young people like me"

"I like that my family nurse has been there consistently throughout my pregnancy and now that my baby is born"

"Love my Family nurse she has helped me so much to be a much better mom"

"I think the FNP service has been excellent and I wouldn't have managed without their support"

26. Parents views on how services can be improved in future

We asked parents their views on how services provided by health visitors, family nurses and school nurses could be improved in future.

Lack of continuity of staff was a major theme identified by parents. Ideally parents would like to have contact with the same member of staff so that they can develop a relationship with them and that staff know their children. Failing this some suggested limiting to two named health visitors for the family. Some of the individual comments we received from parents regarding this include:

"Continuity of care. I don't even know who my health visitor is. The few times I have taken my daughter, I see a different person each time. When I was struggling they failed to signpost me to the services I needed"

"Being able to build a relationship with someone you trust is very important when you have young children or have just given birth, continuity of care therefore is very important."

"When the health visitor comes out antenatally, ensure it's the same lady that comes out at all other key contact visits."

Inconsistency of service delivery appears to be another major theme. The majority of parents asked for a more consistent approach from the services. The parents we spoke to and surveyed had mixed experiences of the services. Some spoke highly of the staff and services that they received whilst others were less than complimentary due to their experiences of health visiting and school nursing services. Comments included:

"Go back to a named health visitor rather than the team. You end up spending most of your time explaining what the other health visitors have said previously"

"Timing – every development review was late."

"Communication has to be improved. I shouldn't have to call 3 or 4 times to get an appointment with the health visitor. I know people who've given up trying to get through and taken baby to the gp instead which is not their job and clogging up our gp surgery"

"The removal of drop in clinics was a detriment to the service. The change of geographic areas has also had an impact. The service also needs to reflect that many parents work and so having appointments between 9 and 3 are no longer suitable and the times should be more in keeping with GP hours with access to the service outside of working hours."

"Feels as if after the 2 year review you don't see them or have any contact. No presence. Baby clinics need improving too busy not enough health visitors. Don't even know who to approach for concerns or help. Need more communication from them."

Parents also highlighted how difficult they felt it was to get appointments when they needed help. Some parents also asked for more flexible opening times that take into account the needs of working parents.

Communication was also identified as an area that needs improving in the new service model. Parents would like to be able to email staff. Parents would like to see

better use of technology and for sharing information with parents. Some parents commented:

"Being able to email your own health visitor for advice would also be great instead of having to phone a generic office phone number and having to wait for someone to call back if the duty health visitor isn't available at that time."

"Contact feels old school - I'd like emails, apps etc."

"Weight and measure in schools is a waste of time. No follow up if your child is overweight. What is the point of upsetting a child by letting them know they are overweight and then doing nothing about it"

"It would be good if the school nurse introduced herself to families at the very least at transition stages so that you knew who she was and could have a point of contact if needed. I have asked school several times over the last few years who the school nurse is. My son is going into Y 10 in September and I still have no idea who the school nurse is"

We asked parents how they would like to be able to contact their health visitor, family nurse or school nurse in future. Parents would like choice in how they contact the services. The most popular way parents want to contact the service is to be able to telephone and speak directly with a member of staff. 75% of parents requested this. However almost as important is the ability to be able to text, email, book an appointment and drop-in to see staff without an appointment. Skype or face time was a less popular method of communication with only 8% of parents advocating this as an option.

We asked parents what the most important health and wellbeing issues are for families, children and young people in Wolverhampton today. These can be grouped into six main issues which are obesity, mental health and wellbeing, poverty, health promotion and healthy lifestyles for whole family, child safety and support for children with additional needs and access to information and support.

The top issue mentioned by parents was around obesity. Parents described this in various ways including weight, healthy eating, diet, nutrition. Parents highlighted the need for a family approach to exercise. It was not just the need for better education about healthy eating but helping families to support this for example by providing free breakfast for children, advising on maintaining a healthy family diet with continuing rising costs of food and guidance on how to budget for nutritious meals rather than convenience foods. Advice too on helping children to stay fit in the age of video games was also mentioned.

The next most mentioned issue was around mental health and wellbeing including promoting healthy minds, addressing poor self and body image in children and addressing the wellbeing of the whole family.

Poverty was cited as the next key issue and parents referred to lack of family income, isolation of families, housing issues, lack of access to social activities outside of school that don't costs a fortune and lack of community spaces for children and play provision for under 5's.

Health promotion and healthy lifestyles was mentioned and parents specifically highlighted mental health, sexual health, smoking and drugs and dental hygiene.

Child safety and safeguarding were also highlighted as important issues with reference to sexual exploitation, gangs, domestic abuse and one parent mentioned and increase in racism 'post-brexit' as of concern.

Parents would like advice about growth and child development and knowing when their child should meet development milestones.

Many parents highlighted difficulty in accessing information, support and services and said that more information and support should be available for parents. Parents highlighted that being able to access help when it's needed as important and that this should be non-judgemental. One parent described this as:

"Catching problems early".

Another parent asked for:

"Just for someone to listen and not to judge".

A wide range of issues were identified by parents that they felt were important for staff to address with either their children or to provide additional support to parents on. These included:

- Obesity, diet, exercise and healthy eating
- Underweight children
- Long term conditions
- Puberty
- Contraception and sexual health
- Head lice
- Mental health
- Vaccinations
- Smoking
- Childhood illnesses
- Migraine

27. Views of parents from the Voice for Parents Forum

We spoke to 9 parents whose children had a long term condition or disability via the Parents Forum. The parents described similar issues and concerns as highlighted by the parents via the on-line survey.

The parents were unclear on what services were on offer to them or how to access their health visitor or school nurse. None of the parents recalled having received a letter or other publicity from the services.

The parents identified a gap in service in relation to emotional wellbeing and links to pastoral support in school and would like the services to have more focus on this. Other gaps identified were that some parents did not know who to contact if a child attends a school out of borough. It was suggested that it would be good if the school nurse could be a link for parents and continue to provide advice to parents and coordinate and communicate on behalf of the family with other services i.e. paediatrician. Some parents expressed a number of frustrations with current services:

- Lack of feedback from services when their child has been referred.
- Lack of communication between GP and paediatricians and services.
- Problems with access to equipment that their child needs.

To note that some of the issues raised by parents relate to wider children's and primary care services.

The parents also expressed frustration about having to tell their child's story every time they go to a different service or GP. The parents suggested how lovely it would be for them to have a school nurse that was consistent throughout their child's life and that parents would know that the school nurse would be meeting with the school pastoral staff and had an understanding of their child.

Some parents provided positive feedback about the annual health assessments conducted with their child on an annual basis and were very appreciative of these.

There appeared to be some confusion amongst the parents as to the different roles of the school nurses and special school nurses.

28. Views from the Foster Carers Forum

We facilitated a workshop with 24 foster carers. Generally feedback was very positive about the services they received. Foster carers said that the annual health checks for looked after children were working well.

Foster carers suggested that the services could be improved by better feedback and sharing of information between the health visitors/schools nurses and foster carers especially in relation to sharing about child's previous illnesses.

Foster carers highlighted that sometimes health policy can be different between local authority areas and gave an example of different breastfeeding policies which caused them some confusion.

A suggestion was made that any new or changes in policy which may impact on foster carers could be bought to the forum by the service provider so that foster carers could seek advice and raise any concerns.

Foster carers think that communication and sharing of information could be improved. They said that very often the 'red books' took months to arrive leaving foster carers without vital information about the child. In addition they identified that whilst the annual reviews went well, they did not receive any feedback from the health staff as regards these reviews which would be helpful.

Similar to the parents' feedback, foster carers highlighted how important it is to have a consistent health visitor and to be able to develop a relationship with them.

The foster carers praised some of the health visitors and school nurses for the support that had been given and were keen to share good practice.

"She (health visitor) was fantastic with filling me in on observations whilst visiting (child's name) who has alcohol fetal syndrome. She was an excellent support to me during those first few weeks of coping with this three year old who had severe, complex problems. She attended his LAC and school PEP meetings."

"The school nurse deals very well with his condition and keeps me up to date with any episodes that happen at school. I have not got any suggestions for improvement in my personal experience."

Attendance at future Foster Carer meetings by service managers would be welcomed by the members of the Forum and would provide an opportunity for foster carers to share any concerns or issues and to highlight to the service the impact of proposed changes in practice in relation to looked after children and foster care.

29. Views from schools

Some school staff and head teachers completed our professionals' on-line survey. However given that they are a key stakeholder especially in relation to school nursing we conducted a separate Head teacher's on-line survey, held discussions with the Personal Social Health Education (PSHE) Forum and attended the Head teacher's forum to brief and obtain their views.

30. Findings from the Head teacher's survey

36 school staff responded to our Head teachers' on-line survey in December 2015. We received responses from staff working across primary, secondary and special schools and pupil referral units.

90% of those who responded rated their school's access to a School Nurse as good or excellent which appears to conflict with the subsequent stakeholder survey which identified a need to improve access to and capacity of school nurses.

We asked for views as regards the contact time between the school and the School Nursing Service and 60% of respondents said that the contact time with the School Nursing service was about right.

75% of respondents said that the School Nursing service did communicate a clear service offer to school. Again this conflicts the findings from the later survey.

90% of respondents said that staff in their school felt supported by the School Nurse Service.

90% said that staff needed more support from the School Nurse Service on health issues that impact on pupil wellbeing.

The most important issues identified by school staff that they would like additional support to address are:

- mental health/emotional wellbeing
- physical health
- healthy lifestyles

31. Views from the Personal and Social Health Education leads meeting

A group discussion was facilitated with 12 teachers with lead responsibility for Personal and Social Health Education (PSHE) in schools.

32. What support schools would like to receive from school nurses

Schools would like school nurses to support consistent delivery of sex and relationships (SRE) in schools. Currently there is an inconsistent offer and the quality varies. School nurses don't appear to have the capacity to provide a consistent delivery of SRE to all schools. Schools would like timely and consistent offer of support to deliver SRE. It was acknowledged that the delivery of SRE by individual school nurses is of good quality but the issue is an inconsistent offer to schools and the quantity and consistency of delivery across all schools. Acknowledge that some targeted delivery of SRE to 'at risk' pupils is delivered which is good however does

not appear to be part of a standard offer to all schools across the City. The drop-in's provided are valued by schools.

Schools value delivery of the National Child Measurement Programme (NCMP) however it was highlighted that there is a considerable amount of time between reception and year 6 and suggest further intervention before year 6 would be beneficial. Staff saw a wider role for school nurses to support families who are overweight.

Schools would like training provided by school nurses on asthma and epi pen to continue as well as support to teachers and families on this issue.

A key message was that the school nursing service needs to develop a standard service offer for all schools that is communicated well to all staff and gives clear information on how schools can contact a school nurse. The view is that the schools 'offer' depends on the relationship with the individual school nurse. Another theme was that whilst the quality of what some school nurses are delivering is good, not enough time is given to enable consistent delivery. School nurses could also have a role in capacity building in schools for example working with mentors.

Priorities that PSHE leads would like school nurses to support in school:	
• Obesity (includes diet, weight management)	• Sex and relationships education, sexual health promotion (secondary school)
• National Child Measurement Programme	• Emotional health and wellbeing including body image
• Education Health Care Plans	• Support for children with medical needs i.e. asthma, diabetes
• Early Help	• Safeguarding
• Substance misuse	• Drop-in's for young people in secondary schools and parents in primary schools
• Smoking	• Provision of general health advice including hygiene

33. PSHE leads views on what works well and what could be improved

The key theme was that many felt that individual school nurses offered a quality service but that this was far from a standard service offer. PSHE leads would like to see a standard menu or service offer for all schools. It was highlighted that the delivery of the NCMP programme was very good but that this could also benefit by being delivered across wider school years than reception and year 6.

Key themes identified by PSHE leads.	How services can be improved
Improve the delivery of sex and relationships education (SRE) in secondary schools and pupil referral units (age appropriate).	• Provide a clear and consistent service offer for all schools/PRUs. • Expand current delivery from year 11 to include earlier school years as appropriate. • Provide regular contact with those that are identified as 'at risk' in terms of sexual health/sexually active. • Consider whether school nurses are best placed to deliver SRE or could alternative service providers be identified to support delivery.
Expand the national child measurement programme.	• Consider expanding delivery to additional school years as too long between reception and year 6 and misses opportunities for early intervention.
Inclusion support/ English as an Additional Language (EAL).	• To clarify what extra support is provided to these pupils and their families as part of the core service offer to schools.
Communication.	• Communication with schools, children and parents needs to be improved. • A clear service offer/menu needs to be developed and communicated with schools.
Improve accessibility.	• School nurses to spend more time in each school. • A 'compulsory' visit for all pupils could de-stigmatise use of drop-in/access to the nurse. • All pupils to have a 'health check' with the school nurse – beneficial to all and would also help to de-stigmatise.
Extend support offered to families.	• School nurse drop-ins in primary schools for parents would be beneficial.
Supporting healthy lifestyles and PSHE.	• Ideally school nurses could deliver health promotion and education to every school year.
Promoting emotional wellbeing and supporting mental health.	• More support to be provided to children in schools and support

	schools to address.
Capacity building in schools.	• More pastoral team/mentors could be trained in C-card. • Opportunity for school nurses to supervise and oversee what school staff could delivery in relation to health and wellbeing.

34. Engagement workshops

We held two half day engagement workshops and invited professionals, partner agencies and potential service providers to attend. The overall aim of the workshops was to identify how the future service model can support children, young people and families to achieve good outcomes and to enable a wide range of stakeholders to express their views. It also provided an opportunity to consider the emerging themes from the engagement with stakeholders and to explore some key issues that had been identified. 75 stakeholders attended the workshops from a wide range of backgrounds including health, social care, primary care, voluntary sector and potential service providers/bidders.

The first workshop enabled participants to explore the child's journey from pregnancy, birth through to 19 years and to identify key issues and gaps. A considerable amount of information was generated via this workshop; some of the key issues identified by stakeholders is summarised in the table below.

The Child's Journey Workshop	Priorities and issues identified
Antenatal.	Expand antenatal classes from 'labour preparation' to include more on parenting and attachment. Address language barriers and consider cultural perspective in delivery of antenatal classes i.e. reflect 34 languages spoken. Better communication between midwives, GPs and health visitors and information sharing e.g. children born outside country. Be proactive re flu immunisation. Improve communication & information for parents. Need to address parental substance misuse and domestic abuse during pregnancy. Review antenatal pathway and clarify roles and responsibilities. Gaps: not enough work pre-conception, with fathers, with mothers not attending antenatally. Lack of support for maternal mental health. Explore voluntary sector role.
Birth to one year.	Difficulty keeping track of mobile families. Parents don't see health visitors (HV) as an important contact. HV's have skills in maternal mental health but don't have opportunity to use. Eliminate duplication of services. Diverse population but not enough capacity in the services to be able to address. Need targeted services for new communities. Need seamless

	communication between GPs and HVs. Need to clarify roles and responsibilities. Need clear service offer. Importance of parents as first educators.
Two to five years.	Need for better information sharing between GPs, HVs, early years, housing, hospitals. Develop parenting programmes/peer support. Special needs/medical needs are not identified before starting school. Children not ready for school – poor toileting, poor communication skills. Overall development delays – lack of stimulation, low parental expectations. Speech and language Need an assessment review around 3 years of age. Address dental decay.
School age.	Children not ready for school. Professionals and parents need better understanding of school readiness. Behaviour issues due to lack of bonding and attachment at infancy. Children commencing school with Speech and Language delays. Need for more services/interventions for teenagers re mental health, wellbeing, low level anxiety, coping with stress, self-harming. Need consistent health education delivery. Consider impact of domestic abuse on children. Support children of parents in substance misuse services. Other issues to address: bullying, child sexual exploitation & grooming. Excessive time spent by children on screens. Address obesity, increase in sedentary behaviour. Consider educating parents on cooking and budgeting. More consideration of transition from children's to adult services.
0-19 years.	Not enough school nurses and health visitors to deliver the core HCP. Universal workforce is an asset; accepted by families, non-stigmatising. Safeguarding requirements across both services limits prevention work with current amount of staff, need to increase capacity. Language barrier issues – need for more interpreting services. Need clear service offers. Need for better integrated working with adult services i.e. mental health and substance misuse. More on emotional health and wellbeing for parents and children.

We considered the feedback received from all our stakeholders and identified 7 key issues which were considered in small groups. These were:

1. 0-19 integrated service model versus three distinct services; health visiting, family nurse partnership and school nursing services.
2. The potential role of the voluntary sector in supporting delivery of the Healthy Child Programme.
3. The Family Nurse Partnership Programme and how to support vulnerable families in future.
4. How communication can be improved in the new service model.
5. How technology can support delivery of the Healthy Child Programme.

6. Evidencing quality and outcomes.
7. Safeguarding versus prevention.

Main findings from workshops to address key issues arising from the engagement	Sample of key findings and recommendations
Workshop 1 0-19 integrated service model versus three distinct services; health visiting, FNP and school nursing services.	Support for 0-19 but requires clarity of health visitor (HV) and school nurse (SN) roles – not to lose specialisms. Provides flexibility, Better transition/seamless pathways e.g. into school. One service could enable HVs to continue support to child if required i.e. extra 6 months or SNs to pick up families earlier e.g. age 3 if to do so supports school readiness and early help. Don't support if 0-19 worker to replace HV and SNs. Need to keep specialism and skills in early years/adolescents. Also consider developing primary age skills (aged 5-12). Could mean holistic care for families. Whole view of family. Better use workforce e.g. links a HV or SN to GPs/social care to represent HCP. Provides opportunity to have multi-disciplinary public health teams consisting of HVs and SNs. Easier record keeping 0-19. Support for co-location of HVs and SNs as were in 1990s and communication was better. Be great to have midwives co-located too. Need to ensure infrastructure in place to support 0-19 i.e. IT, management, skill mix, location. Current IT systems don't talk to each other. Potential for confusing service users by having a 0-19 service as opposed to clearly defined HV or SN services.
Workshop 2 The potential role of the voluntary sector in supporting delivery of the Healthy Child Programme.	Support for voluntary (Vol) sector to complement services in delivery of HCP. Could support parenting, low level emotional wellbeing, school readiness, befriending, obesity prevention, peer support, health education, formalise role models/peer support e.g. supporting the Travelling community. Questions of morality of using volunteers in statutory services. Volunteers not to be used as cheaper option. To be integrated not just an add on. Good practice examples e.g. Home start where volunteers properly trained supervised and supported. Clarify what is statutory and what voluntary sector could deliver. Voluntary sector bring wealth or expertise and experience working with communities. Could bring additional funds. Further engage with Vol sector to explore. Require clear contracts, not short term funded.

	Clear roles and responsibilities. One central referral point for all services.
Workshop 3 The Family Nurse Partnership Programme and how to support vulnerable families in future.	Acknowledge quality of FNP. Not enough capacity in FNP to meet demand. Concern re support for those who meet criteria but can't be offered the service (100 young parents). Clarify what good practice/tools from FNP can be replicated in HV without licence. Need to change criteria of FNP to widen access i.e. Need more investment in HV targeted work with vulnerable families - Specialist HVs have case loads of 350 versus FNP 25 cases. Potential gap when graduate from FNP to HV service – no mandate for HV to go into home – perhaps role for specialist HVs. Future FNP could have HV staff rotating so shared learning and all can deliver. Plus build capacity so all HVs can have the time and tools to support vulnerable families i.e. weekly visits. Concern that FNP is not equitable service and future model should offer support to all vulnerable families. Could Voluntary sector support FNP. Need to do more re DV education in schools. Address poor uptake of antenatal services and review antenatal pathway. Primary care/GPs and midwives need to be part of the locality/hubs to improve communication/support vulnerable families. Develop universal parenting programmes.
Workshop 4 How communication can be improved in the new service model.	Need to improve communication between HVs, SNs, GPs and social care. Staff based in children centres to improve communication. Develop information centre to signpost. One IT system. Better use of texts and electronic referrals. Shared training events for health, social care and education staff. Co-location of staff in strengthening families' hubs. Standard data/consent forms for whole HCP. Handovers for children moving in/cross borders. Staff access to I pads/smart phones so can access info when needed. Standard service offer to all service users that is understood by all. Interpretation/translation services to make services more accessible.

	Address poor communication between HVs and GPs.
Workshop 5 How technology can support delivery of HCP.	Technology needs to be used much more effectively. All staff to be supplied with appropriate devices, agile working, access to records during visits, remote working between visits. Make use of Apps, Skype, and social media to provide support and information to young people and parents Urgent need to move towards integrated e-record system which brings together different record systems currently used. E-referral's. Alert systems for missed appointments. Use Skype for contact with families that may not require physical visit.
Workshop 6 Evidencing quality and outcomes.	Establish electronic data systems to enable more efficient data collection and analysis and the ability to report on outcomes for individual families as well as localities. Integrate the services and share information systems. Integrate community profiling and show services are needs led –requires staff training. Need to track interventions – consider Outcome Star to show journey of family travelled and impact of service on the journey. Develop collective partnership targets and collective reward for improved outcomes. Need to have clear idea of outcome measures but acknowledge challenges i.e. in attributing impact directly to the service, in demonstrating improvements in health and education inequalities. Need quantitative and qualitative targets and exception reporting with reasons why targets not met. Evidence quality through audit. If two year old child assessment results are poor what intervention/referrals are then made across the city/workforce.
Workshop 6 Safeguarding versus prevention.	Need for refocus on prevention as workloads have been too focussed onto the latter end of safeguarding as opposed to prevention and 'early help'. HV and SN capacity impacts on ability to deliver more preventative work. Could attendance at safeguarding meetings be case by case basis i.e. initial meeting attended but if no health issues further if information fed in by email or phone to free staff up. However meeting is non- quorate if health does not attend. Health visitor focus on safeguarding is very beneficial for social services as they are only profession that go into homes. Need better technology to free up HV and SNs so can undertake mobile working, electronic data entry and have instant

	access to information e.g. apps to educate parents. Need better links between GPs and HVs e.g. HV link to meet with primary care every 6 weeks to enable timely flagging of concerns. Transition between services often an issue e.g. HV don't receive timely new birth notification especially when out of area – cross border working and issues. School nurses could do more preventative work re mental health. Consider skill mix i.e. nursery nurses can undertake assessments to support the school nursing/health visiting service if overseen/quality assurance by health visitor/school nurse.

35. Next steps

The new service model framework has been produced. Wherever possible the views from our stakeholders during this engagement period have been considered and taken into account. We are undertaking a formal 6 week consultation on the new service model framework. Feedback that we receive during the consultation will inform the final service model that will be submitted for final approval in November.

The young people's and parents' surveys will remain open over summer 2016 to enable as many people as possible to respond. The views will be considered in the development of the final service model and service specification. Further focus discussion groups may be undertaken to take a 'deeper dive' into particular issues or concerns expressed via the on-line surveys.

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Further background information is available on our Healthy Child Programme website here: City of Wolverhampton Council - Further information

36. Acknowledgements

We would like to thank all those professionals, parents and young people who shared their views during the engagement process. Thanks also to all the staff and partner agencies that supported our engagement process including:

Young people from the youth council, care leavers and looked after children's forums who volunteered over six weeks to share their views and assist the engagement process with young people including advising on the development of the on-line survey.

Special thanks to the Children's Services engagement staff were incredibly helpful and supportive throughout the whole process. Alice Vickers - Corporate Parenting officer and Andrew Scragg - Participation Officer.

Parents from the Voice4Parents Forum (The forum that gives a voice to parents and carers of children with additional needs) who shared their views and advised on the development of the on-line parents' survey.

Alison Baggs, Parent Participation Assistant and Chair of Voice4Parents Wolverhampton.

Tracy Cresswell – Healthwatch - Community Engagement / Volunteer Co-ordinator.

Esther Douglas, Fostering Social Worker.

All the foster carers at the Foster Carers Forum who shared their views and advised on the parents' survey.

Young people at The Way who participated in focus groups.

Darren Burrell - Senior Youth Work Lead - The Way - Wolverhampton Youth Zone.

Pupils at the Orchard centre who participated in focus discussion groups.

Julie Blake - Head of The Orchard Centre.

Mary Evans - Assistant Head of the Orchard Centre.

Louise Sharrod - Children & Young People's Health Improvement Manager – Public health.

PSHE Forum and teachers who participated in discussion group.

Health Visiting and School Nursing staff – Royal Wolverhampton NHS Trust.

Sharon Nanan-Sen - Wolverhampton Voluntary Sector Council.

Baljit Hague - Events and Marketing Officer.

Jenni Crawford-Brown -Management Support & Office Administrator.

Lydia Epangue - Digital Development Officer.

Laura Gilyead - Graduate Management - Trainee – Communications.

Aaron Toussaint - Policy Officer, Transformation Corporate Directorate.

Julie Round - Business Support Assistant – Public health.

Marie Jones – Boho Creative.

Public health staff who advised on the engagement process and surveys:

Mursheda Nessa - Advanced Health Improvement Specialist - Commissioning

Sandra Squires - Health Improvement Principal.

Margaret Liburd - Advanced Health Improvement Specialist.

Sue McKie - Health Improvement Principal.

Ravi Seehra - Public Health Commissioning Officer.

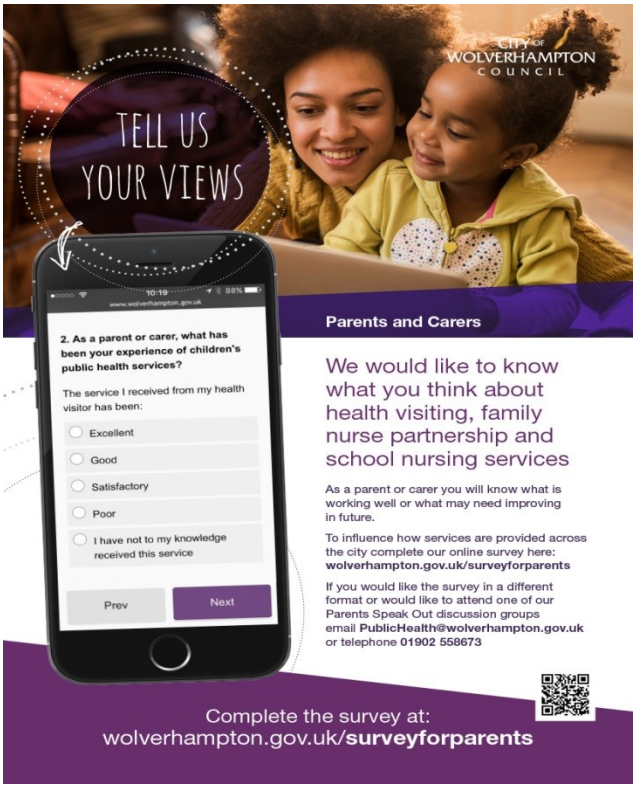
Members of the Healthy Child Programme Steering Group.

Members of Health Scrutiny and Scrutiny Board who advised on engagement process.

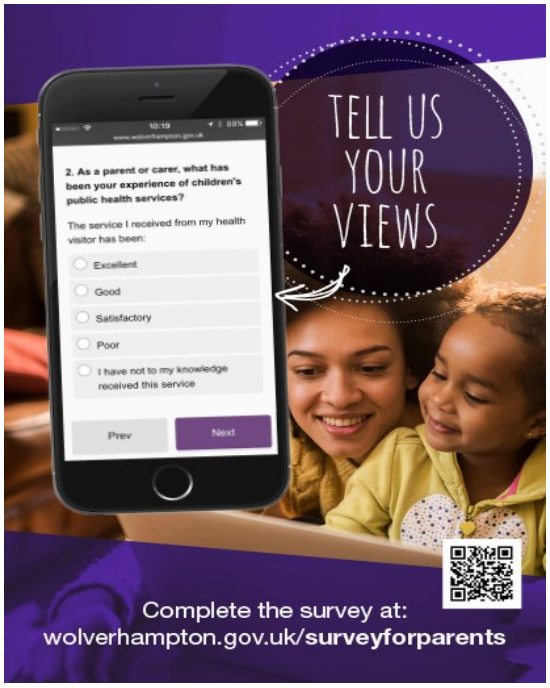
37. Appendix One

Publicity materials used to promote public engagement with parents, carers and young people.

Parents Engagement Poster.

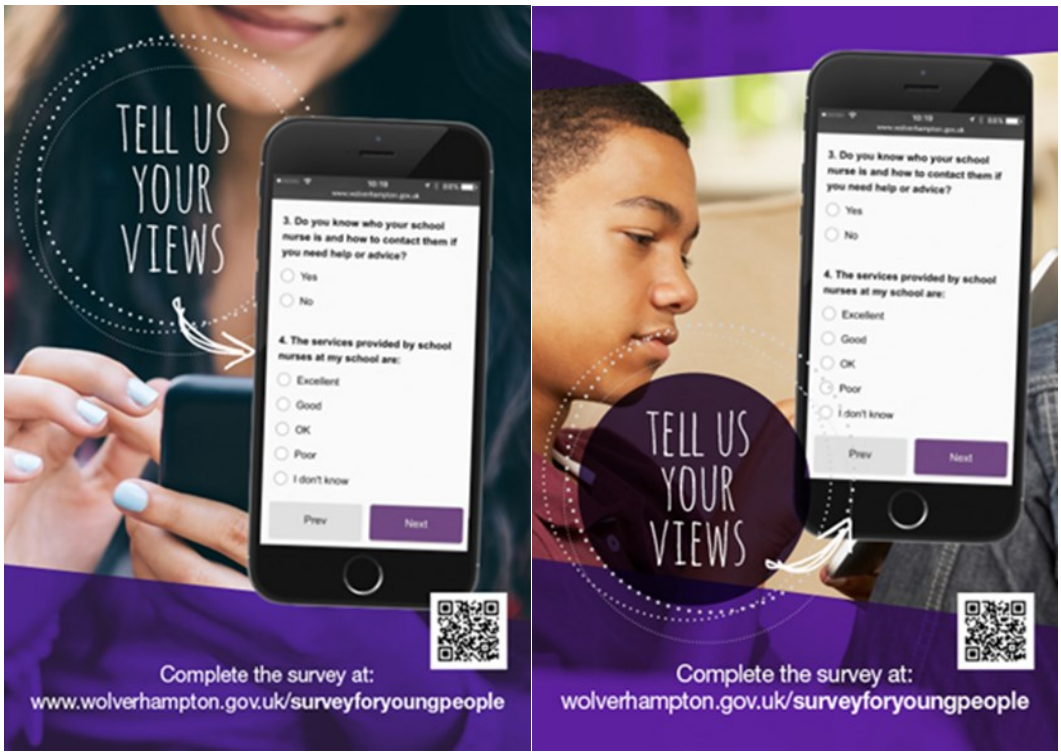


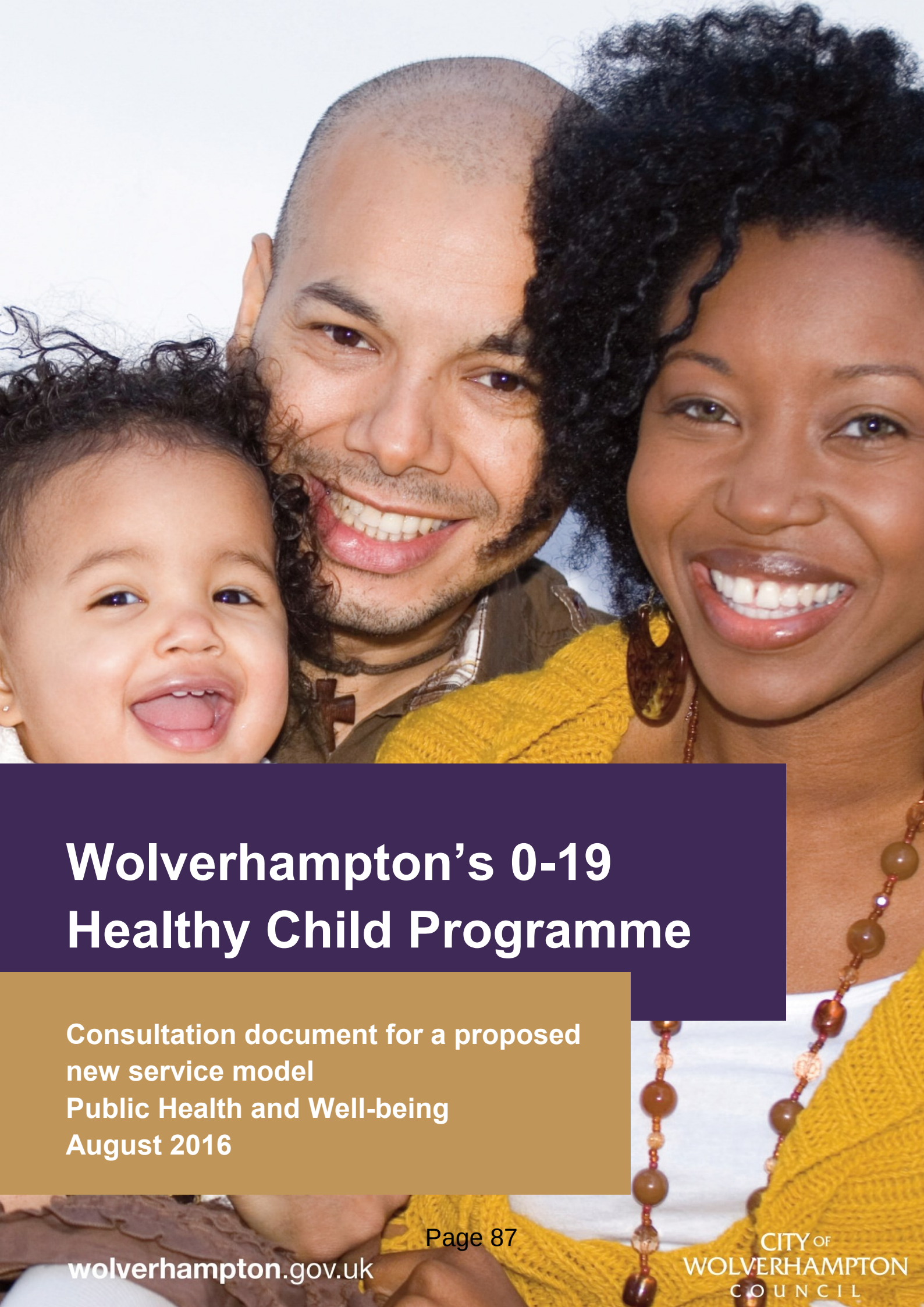
Parent's publicity postcard.



Young person's publicity poster.

Young people's publicity postcards.





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?

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.

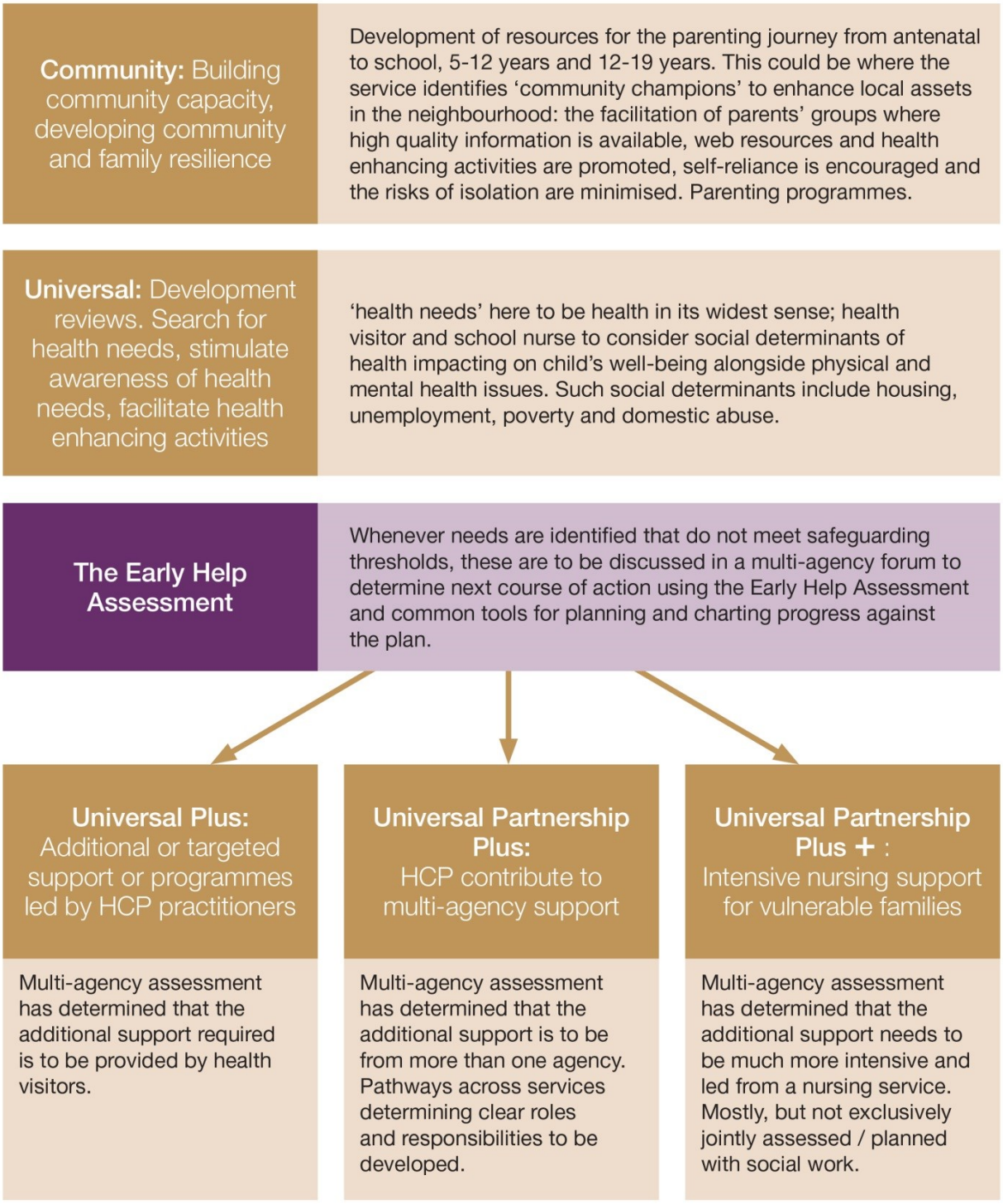
- NCMP and child weight management – planning, delivery and administration of the NCMP in line with Department of Health guidance and local evaluation and as part of an overarching weight management plan developed by the Healthy Child Programme. Referral of children and young people in to local child 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

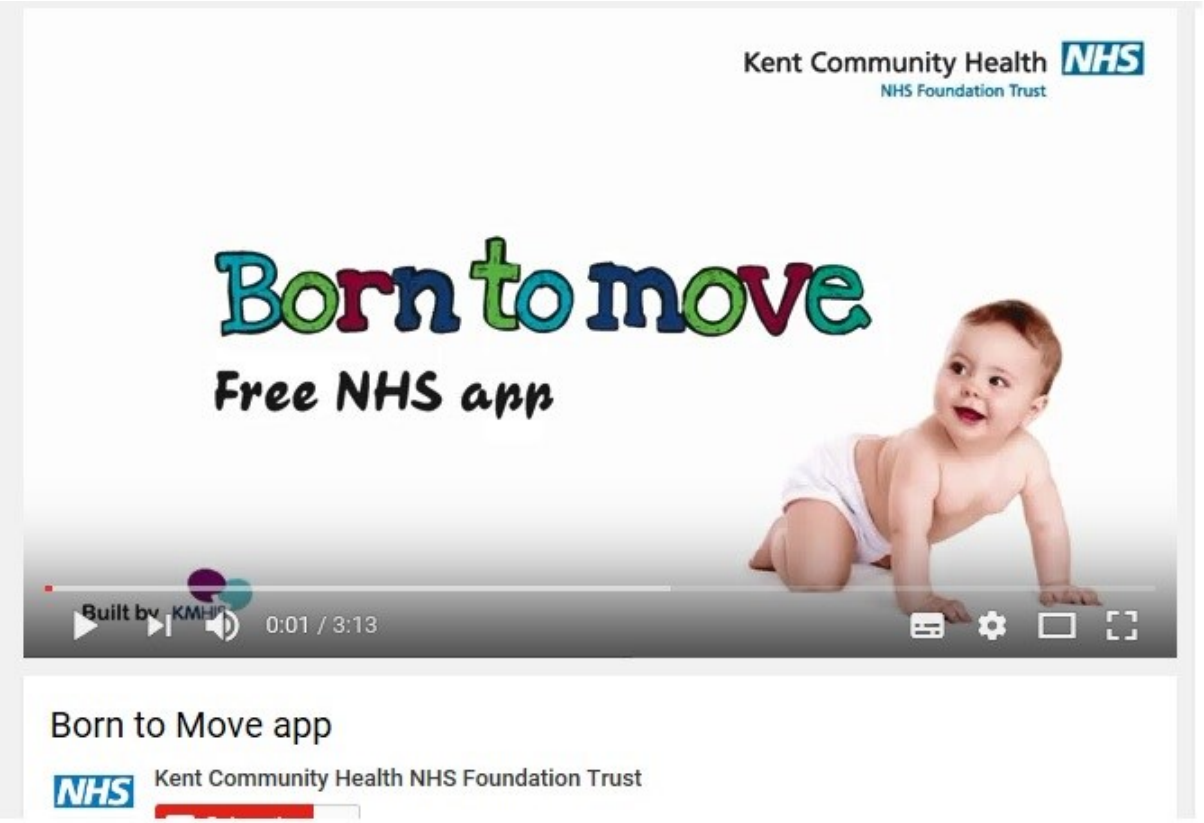
Development of such a profile would then inform collective decisions on the allocation of resources such as do more staff need to be brought to a particular area of higher need

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:

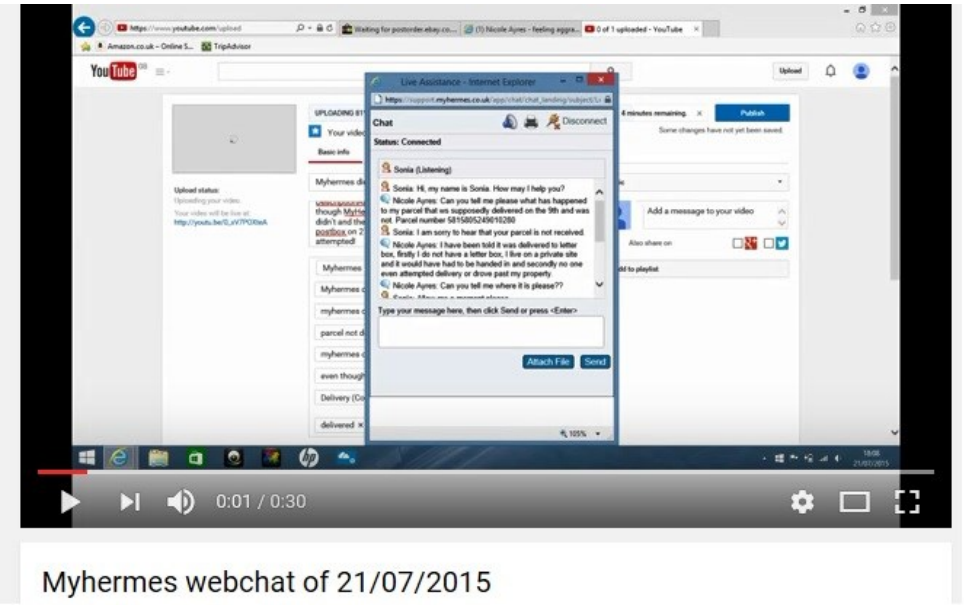
- Reduced prevalence of deficits in children's development at the 2 – 2.5 year check
- Improved Early years foundation stage results
- Reduced prevalence of overweight/obese children at reception and year 6
- Reduced numbers of admissions for tooth decay in the under 5s
- Reduced A&E attendances, aged 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

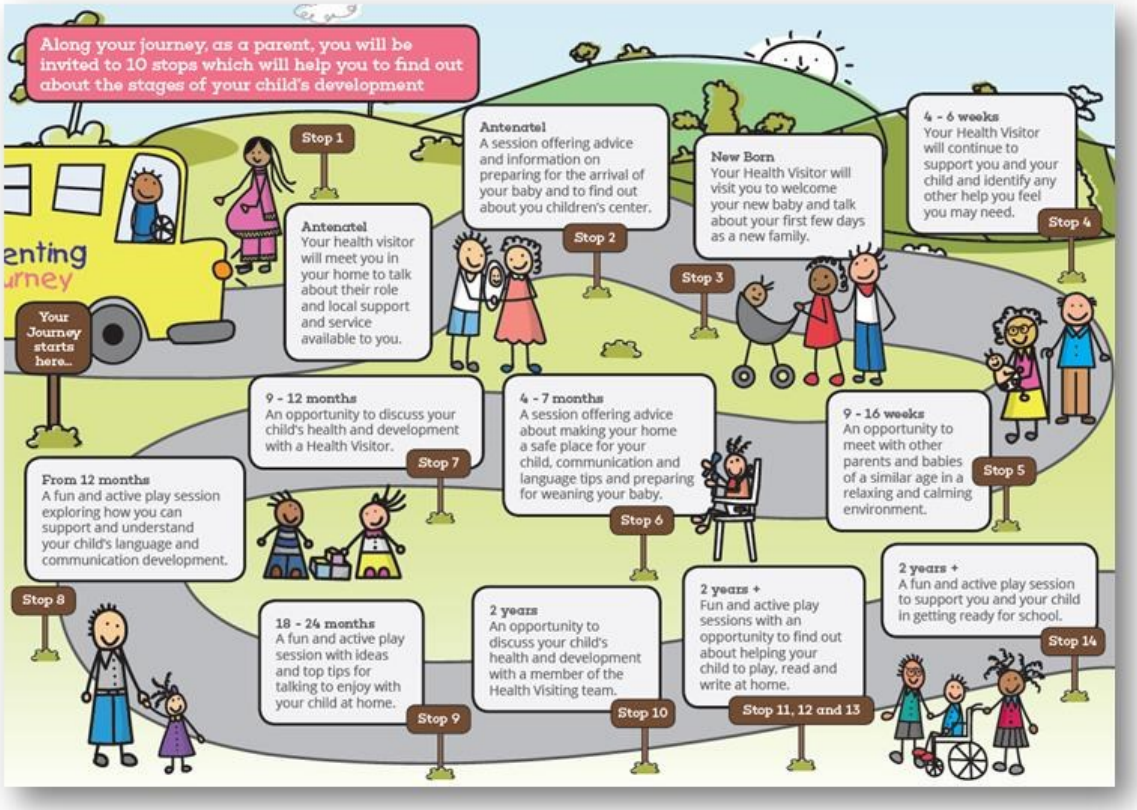


Appendix 3: Example of a private sector company using live web chat to offer support



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

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