HEALTHY CHILD PROGRAMME Ages 0-25

- Health Visiting Service (0-5 years)
- School Nursing Service (5 – 25 years)

Service Specification

Slough Borough Council Healthy Child Programme Service specification

Version	Date	Outline	Author(s)
1.1	3/2/2023	Re-Worked tri-borough template (first draft)	Angela Birch
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1 Introduction

Approximately, 43,800 children and young people (aged under 18 live in slough. (Office for National Statistics 2023) Slough has the youngest population in the Southeast with a median age of 34.

Slough is the 4th most ethnically diverse authority in England and the most ethnically diverse outside of London. The largest ethnic group in Slough are South Asians accounting for 47% of the population.

Slough has high-rates of preventable ill-health amongst children – including obesity, tooth decay and low immunisation take-up.

Slough has the highest infant mortality rate 5.6 per 1000 births, in the Southeast region, significantly higher than the regional (3.4 per 1000) and national (3.0 per 1000) rates (OHID 2021)

The impact of COVID resulted in changes to the provision of 0-19 services particularly the reduction in face-to-face contact and issues with the workforce (recruitment and retention). It has taken over 12 months for providers to be delivering at pre-pandemic levels.

The Health Visiting and School Nursing Services through the delivery of the Healthy Child Programme will assist the Council towards meetings it's corporate plan purpose of *'closing the healthy life expectancy gap by focussing on children.*'

The Authority is seeking a Provider to deliver universal and targeted public health services, that are high quality, innovative and value for money services to improve the health and wellbeing of all children and young people and their families.

The following specification sets out the commissioning arrangements for LOT 1: a Health Visiting Service and a School Nursing Service delivering the Healthy Child Programme (HCP). It is heavily informed by a large evidence base from national guidelines and specifications. Local strategies, needs assessments and local priorities have also been fundamental in shaping the service model for this service.

2 PART A

2.1 Commissioning Intentions

Slough Borough Council is now recommissioning the **Healthy Child Programme (HCP)** for a period of five (5) years, beginning **1st October 2024**, with a potential two (2) year extension

(at the Authority's sole discretion). The Authority seeks to commission HCP services as detailed in this specification.

2.2 Health Visiting

Health Visitors specialise in working with families with a child aged 0 to 5 years old to identify needs as early as possible and improve health and wellbeing by promoting health, preventing ill health, and reducing inequalities. Health Visitors visit families in their own home from the antenatal period up to school entry. They also deliver services in other settings including local community or primary care settings and increasingly through digital platforms and lead the 0 to 5 years elements of the Healthy Child Programme.

The Service must be registered with the Care Quality Commission (CQC).

2.3 School Nursing

School nurses work with school aged children and their families to improve health and wellbeing by promoting health, preventing ill health, and reducing inequalities. School Nursing services work both in and out of school settings, for example through digital and other virtual support, and lead on the 5 to 25 elements of the Healthy Child Programme.

The Service must be registered with the Care Quality Commission (CQC).

Health Visitors and School Nurses are registered on Part 3 of the Nursing and Midwifery Council (NMC) Register as Specialist Community Public Health Nurses. All staff delivering the Services must be registered and in good standing with the NMC at all times.

2.4 Current knowledge gaps and emerging themes

In addition to bringing together data relating to the 0- to 25-year-old population, there are also gaps in local knowledge about the population group, including (but not limited to):

- The impact of the current economic situation and the "Cost of Living crisis", and the numbers of and impacts on refugees and asylum seekers in the borough.
- The prevalence of Adverse Childhood Experiences (ACEs) and how a 0 to 25-year-old public health nursing service can best support those families, working in partnership with other agencies and families themselves;
- A comprehensive understanding of the special educational needs and disabilities (SEND) population and how the service can best support those children and young people, working in partnership with other agencies and families;
- The ongoing impact of Covid-19 on children and young people, families, and communities and how services will need to adapt and enhance their support to 'catch-up' and to meet increasing demand as a result; this will need to be continually monitored;
- The transformation of Children's Centres and the development of Family Hubs; and
- The move towards integrated service delivery and delivering within and with the community and the importance this place on effective collaboration and partnership working.

3 The Healthy Child Programme (HCP)

The Healthy Child Programme[1] (HCP) is the core, early intervention and prevention public health nursing programme that lies at the heart of the universal public health service for children and families. It offers every family a range of evidence-based interventions to build the foundations of a healthy life, improve child health outcomes, and reduce inequalities.

The Authority is fully committed to the HCP and recognises it as a key element in giving every child in Slough the best start in life. Re-commissioning of the Authority's 0 to 25 year Service provides an opportunity to modernise and to respond positively to the needs of our families by increasing community engagement and outreach, and to increase partnership working and collaboration across a range of providers and stakeholders to deliver services on a place- based approach, to improve child health. Additionally, it also provides a unique opportunity and a positive response to the impact of COVID-19 on children, young people and families to ensure that no child gets left behind.[2]

The HCP has been substantially updated by the Department of Health and Social Care (DHSC) Office of Health Improvement and Disparities (OHID) and is now explicitly linked to several other agenda areas **(including Best Start for Life – tackling the first 1001 days, Family Hubs, SEND Code and review, Supporting Families, CYP Mental Health and wellbeing.**

The HCP is branded as 'Universal in Reach – Personalised in Response' and has 4 levels of service – community, universal, targeted and specialist – depending on individual and family need. The modernised programme represents a shift towards developing models of service provision in partnership with a range of stakeholders to provide a greater emphasis on the assessment of children, young people, and family needs, cultural competence and the skills mix required to respond.

Figure 1: Universal in Reach

[1] https://www.gov.uk/government/publications/commissioning-of-public-health-services-for-children/health-visiting-and-school-nursing-service-delivery-model

[2] https://www.gov.uk/government/publications/vulnerability-in-childhood-a-public-health-informed-approach

Table 2. Levels of Service

Levels of Service	Description
1. Community	Working to promote health and wellbeing for children and working with others to increase community participation in promoting and protecting health which will build local capacity to improve health outcomes
2. Universal	Leading, co-ordinating, promoting and providing universal services to deliver the HCP to the 5- to 25-year-old population
3. Targeted	Providing a swift response to ensure that children get extra help and support when they need it, offering early help for example support for additional needs, for emotional and mental health problems and sexual health advice, and by referring or signposting to services
4. Specialist	Provide additional services for vulnerable children who require longer term support for a range of special needs as part of a multi-agency services where there are safeguarding or child protections concerns. Note: Safeguarding is a core part of each level of service provision.

There are six (6) high-impact areas(see section 3.3) associated with the programme which have been evidenced as having the biggest impact in improving outcomes for children and families. Health visitors and school nurses, as leaders and key deliverers of the HCP, have a key role to play in establishing and maintain good working relationships with all local partners.

The HCP also supports a number of statutory duties for children and young people including but not limited to:

- Establishing arrangements to reduce child poverty;
- Promoting the interests of children in the development of health and wellbeing strategies;
- Leading partners and the public to ensure children are safeguarded and their welfare promoted;

- Driving the high educational achievement of all children;
- Leading, promoting and creating opportunities for co-operation with partners to improve the wellbeing of young people; and
- Providing or commissioning oral health improvement programmes and oral health surveys to improve the health and wellbeing of children and young people (NHS Bodies and Local Authorities Regulations 2012).[3]

3.1 Service delivery model

"Universal in Reach – Personalised in Response' model, which is based on Healthy Visitors and School Nurses working across four (4) levels of service depending on individual and family needs.

3.2 Service Delivery

The HCP programme provides a framework to support collaborative work and more integrated delivery at individual, community and population level.

Individual (including but not limited to):

- Contributing to Better Births[4] and the Maternity Transformation Programme;[5]
- Applying current evidence of 1001 Critical Days: The importance of the Conception to Age Two Period;[6]
- Providing expert advice to provide a secure environment to lay down the foundations for emotional resilience and good physical and mental health;
- Ensuring early help and additional evidence-based preventative programmes will promote and protect health in an effort to reduce the risk of poor future health and wellbeing;

[3] Full citation: NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012.

[4] https://www.england.nhs.uk/publication/better-births-improving-outcomes-of-maternity-services-in-england-a-five-year-forward-view-for-maternity-care/

[5] https://www.england.nhs.uk/mat-transformation/

[6] https://www.wavetrust.org/1001-critical-days-the-importance-of-the-conception-to-age-two-period

- Working with the Strengthening Families Programme[7] to ensure health aspects meet the health needs of the whole family;
- Enabling children to be ready to learn at 2, ready for school by 5; and
- To achieve the best possible educational outcomes throughout their school years.

At a community level (including but not limited to):

- Promoting optimal health and wellbeing and resilience throughout the school-aged years;
- Supporting families and young people to engage with their local community through education, training and employment opportunities;
- Supporting children, young people and families to navigate health and social care services to ensure timely access and support;
- Working in partnership with local communities to build community capacity;
- Demonstrating population value through best use of resources and outcomes; and
- Ensuring effective use of community-based assets.

At a population level (including but not limited to):

- Developing effective partnerships and acting as advocate to support improvements in health and wellbeing of all children and families;
- Working in partnership with other professionals ensuring care and support helps to keep children and young people healthy and safe within their community; and
- Providing seamless, high quality, accessible and comprehensive service, promoting social inclusion and equality and respecting diversity.

3.3 High Impact Areas (HIA)

The modernisation of the HCP includes updated guidance and a refresh of the High Impact Areas. These updates support effective, focused services at a universal level, and the identification of additional needs and support.

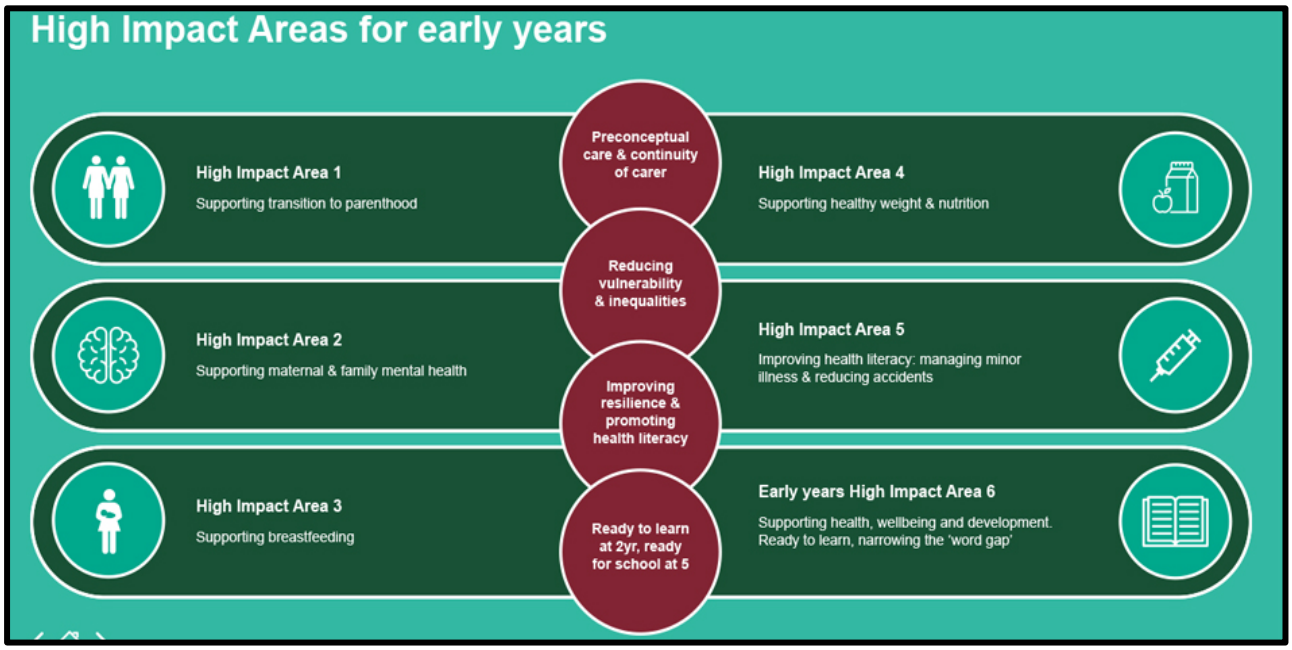
High Impact Areas highlight areas where health visitors and school nurses can have a significant impact on health and wellbeing, and in improving outcomes for children, young people, families and communities.

There are six (6) for early years and 6 for school age years (see figure 2 and figure 3) which, in addition to the Maternity High impact Areas, provide an evidence-based framework for delivering maternal and child public health services from preconception onwards.

High Impact Areas support collaborative working and integrated delivery, by skilled mixed teams of health workers alongside other members of the wider Children's workforce, led by Health Visitors and School Nurses. They are central to the Health Visitor and School Nurse delivery model.

[7] https://www.slough.gov.uk/children-young-people-families/strengthening-families

Figure 2: 6 High Impact Areas for early years (0-5 years)



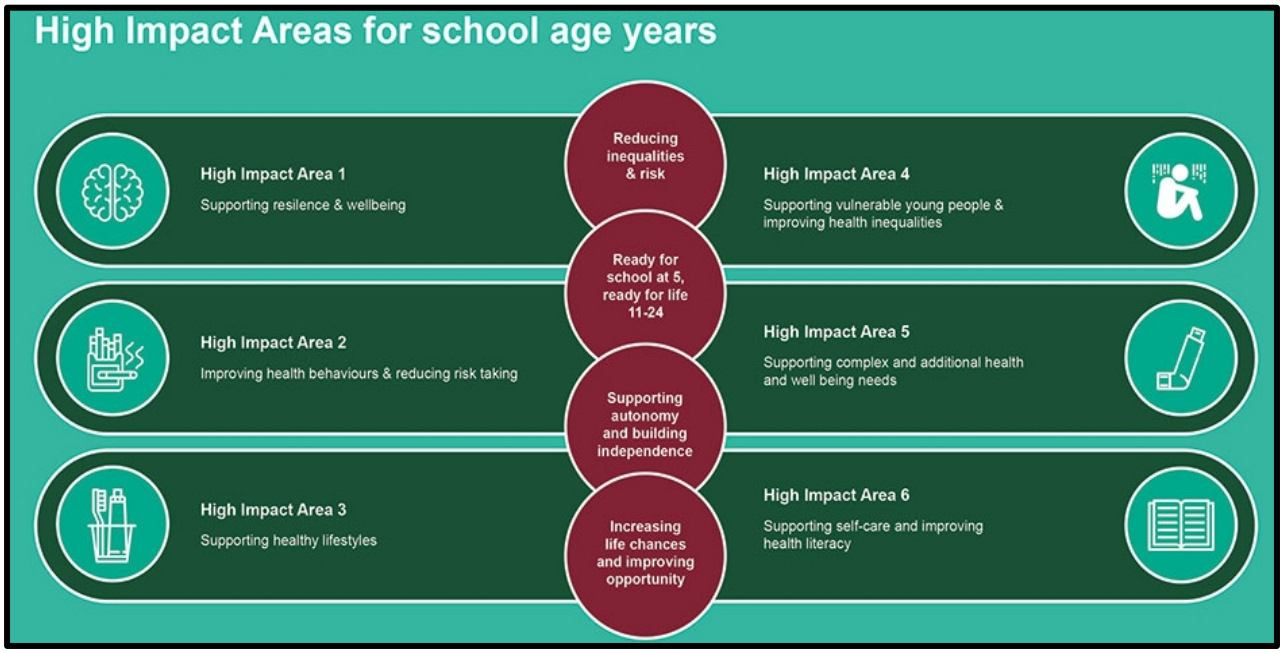
Contacts undertaken by Health Visitors and School Nurses comprise OHID-recommended universal mandated health and wellbeing reviews, including screening tests, immunisations, developmental reviews, and information and guidance to support parenting and healthy choices as part of the overall support provided by School Nurses for 5 to 19 year olds, or 25 years. for children with Special Educational Needs and Disability (SEND).

Health Visitors deliver five (5) mandated universal health and wellbeing reviews and two (2) recommended by the Office for Health Improvement and Disparity (OHID), as additional contacts.

Table 2: HV Mandated and Recommended Reviews

Health Visiting Mandated Health & Wellbeing Reviews	**Recommended additional reviews**
1. Antenatal health promoting review	1. 3-month contact
2. New baby review	2. 6-month contact
3. 6-8-week review	
4. 1-year review	
5. 2 to 2 ½ year review	

Figure 3: 6 High Impact Areas for school age children (5-25 years)



School-aged High Impact Areas enable effective, focused services at a universal level, whilst additional needs are identified and supported recommended reviews are (including but not limited to):

- 4-5-year-old health needs review;
- 7-8-year-old health needs contact;
- 10-11-year-old health needs review;
- 12-13-year-old health needs review;
- School leavers post-16 health needs review;
- Transition to adult services; and
- 18-24-year-old health needs review.

3.4 Community Based Assets Family Hubs

The utilisation of community-based assets is central to the universal offer where health visitors and school nurses are well placed to identify needs, provide evidence-based interventions and signpost to local community support. Contact points or universal health and wellbeing reviews can be utilised to identify needs and to develop a support offer or signpost to specialist services if required.

3.5 Population covered

All families registered with a General Practitioner (GP) who are resident in the area of Slough Borough Council with children aged 0 to 5 years or those children and young people attending school in the borough aged 5 to 19 (up to 25 years where they are owed a statutory responsibility) are eligible to receive the Healthy Child Programme including those who are:

- Home-educated children residing in Slough; and/or
- Young people not in education or training (NEET).

3.6 Public Health Outcomes

The Healthy Child Programme also contributes to the following Public Health Outcomes Framework (PHOF) indicators (including but not limited to):

- Improving life expectancy and healthy life expectancy;
- Reducing infant mortality;
- Reducing low birth weight of term babies;
- Reducing smoking at delivery;
- Improving breastfeeding initiation;
- Increasing breastfeeding prevalence at 6-8 weeks;
- Improving child development at 2-2½ years;
- Reducing the number of children in poverty;
- Improving school readiness;
- Reducing under 18 conceptions;
- Reducing excess weight in 4-5- and 10–11-year-olds;
- Reducing hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0-14 years;
- Improving population vaccination coverage;
- Disease prevention through screening and immunisation programmes; and
- Reducing tooth decay in children aged 5 years old and under.

3.7 Key Principles

The Authority's HCP will be an integrated Health Visiting and School Nursing service which builds upon a set of key requirements (including but not limited to):

- Provides an "upstream" public health service that is needs-led, with action based on the principles of proportionate universalism;
- Incorporated a needs-led approach to identification, assessment and service delivery;
- Health Visitors and School Nurses as leaders of the HCP, must support multi-professional care pathways and seek to integrate with services to support healthy pregnancy and children aged 0 to –19 years old (up to 25 years for those under statutory provisions);
- Staff should comprise of a skill-mix working in partnership with families and the wider system to understand their needs;
- Ensure the needs of families are met through universal provision supplemented by additional tailored support where needed;
- A Service built around the needs of infants, children and their families, to ensure it is (including but not limited to): evidence-driven, accessible, responsive, personalised, collaborative, fairer and effective via professional autonomy and a recognition of the importance of family relationships at the heart of everything;
- A service that is "trauma-informed" that helps to build resilient children, young people, families and communities;[8]

[8] SAMHSA'S framework - https://www.samhsa.gov/sites/default/files/20190620-samhsa-strategic-prevention-framework-guide.pdf

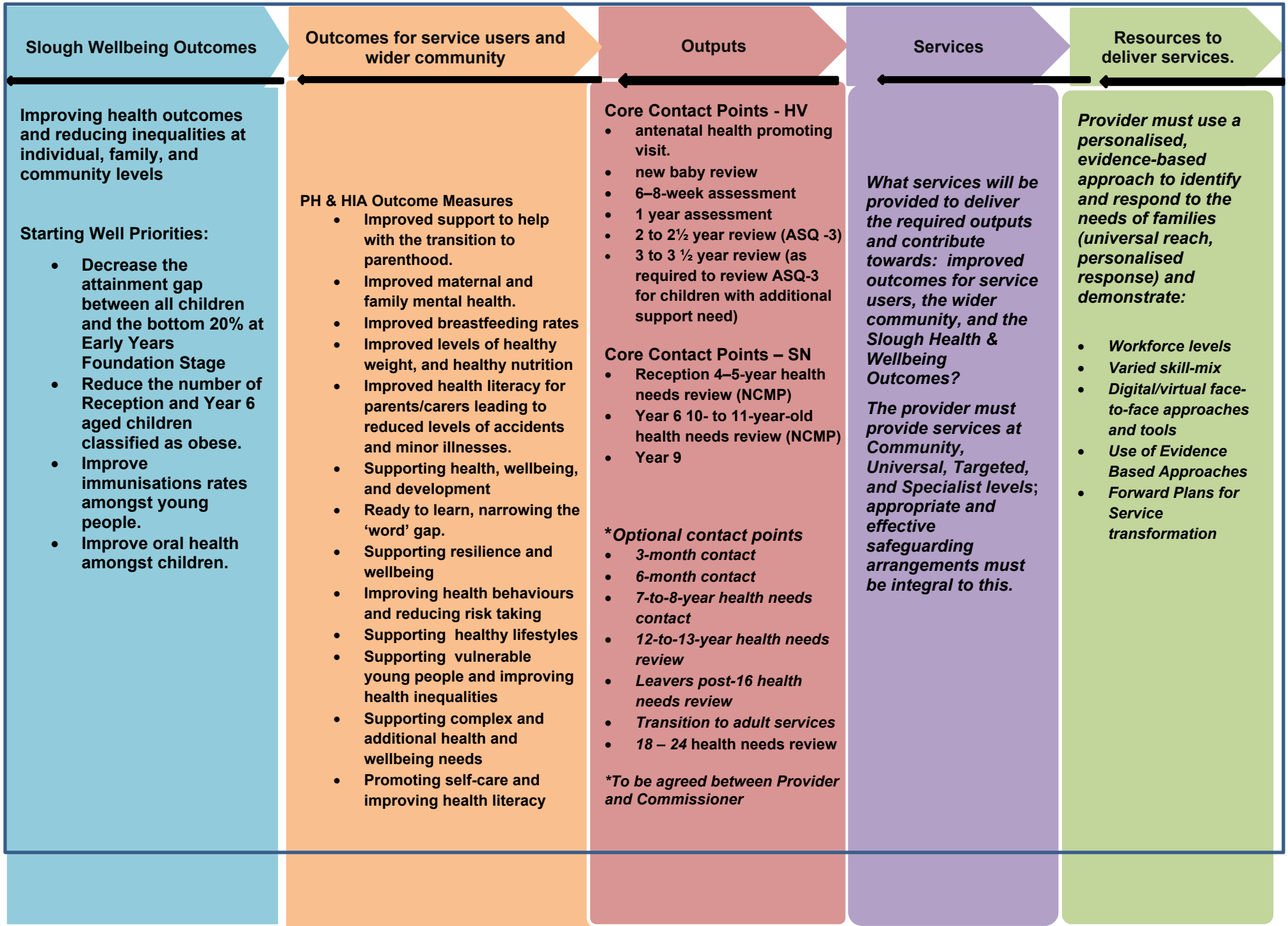
- A digitally aware and competent service that keeps up to date with national digital developments (such as the E-Redbook) and is innovative and creative to engage with families and young people in the digital space;
- Culturally competent to meet the needs of the local diverse communities.

3.8 Local Outcomes Framework

The overarching requirement of the Authority's Healthy Child Programme is to ensure that all children and young people in the borough receive the full-service offer outlined through collaborative working and integrated delivery, by skilled mixed teams of health workers alongside other members of the wider children's workforce.

The Service will be required to demonstrate in collaboration with partners and stakeholders how it contributes to the Authority's Local Outcomes Framework for improving health outcomes for children and young people and reducing inequalities as outlined in figure 4.

Figure 4: Local framework for improving health outcomes and reducing inequalities at individual, family, and community level


Slough Wellbeing Outcomes
Outcomes for service users and wider community
Outputs
Services
Resources to deliver services.
Improving health outcomes and reducing inequalities at individual, family, and community levels
Starting Well Priorities:
Decrease the attainment gap between all children and the bottom 20% at Early Years Foundation Stage
Reduce the number of Reception and Year 6 aged children classified as obese.
Improve immunisations rates amongst young people.
Improve oral health amongst children.
PH & HIA Outcome Measures
Improved support to help with the transition to parenthood.
Improved maternal and family mental health.
Improved breastfeeding rates
Improved levels of healthy weight, and healthy nutrition
Improved health literacy for parents/carers leading to reduced levels of accidents and minor illnesses.
Supporting health, wellbeing, and development
Ready to learn, narrowing the 'word' gap.
Supporting resilience and wellbeing
Improving health behaviours and reducing risk taking
Supporting healthy lifestyles
Supporting vulnerable young people and improving health inequalities
Supporting complex and additional health and wellbeing needs
Promoting self-care and improving health literacy
Core Contact Points - HV
antenatal health promoting visit.
new baby review
6–8-week assessment
1 year assessment
2 to 2½ year review (ASQ -3)
3 to 3 ½ year review (as required to review ASQ-3 for children with additional support need)
Core Contact Points – SN
Reception 4–5-year health needs review (NCMP)
Year 6 10- to 11-year-old health needs review (NCMP)
Year 9
*Optional contact points
3-month contact
6-month contact
7-to-8-year health needs contact
12-to-13-year health needs review
Leavers post-16 health needs review
Transition to adult services
18 – 24 health needs review
*To be agreed between Provider and Commissioner
What services will be provided to deliver the required outputs and contribute towards: improved outcomes for service users, the wider community, and the Slough Health & Wellbeing Outcomes?
The provider must provide services at Community, Universal, Targeted, and Specialist levels; appropriate and effective safeguarding arrangements must be integral to this.
Provider must use a personalised, evidence-based approach to identify and respond to the needs of families (universal reach, personalised response) and demonstrate:
Workforce levels
Varied skill-mix
Digital/virtual face-to-face approaches and tools
Use of Evidence Based Approaches
Forward Plans for Service transformation

4 Health Visiting – General Requirements

Setting the foundations for health and wellbeing during pregnancy and in the early years is crucial to ensure that every child has the very best start in life as possible.

We require a high quality, multi-disciplinary, healthcare professional led health visiting service with components co-located within community settings including Children Centres (Family Hubs) in the Slough borough area. The range of Services must include antenatal care through to services for children aged five (5) years old.

4.1 Eligibility & access

The Service is to be delivered to a defined geographical population in line with local authority boundaries of Slough Borough Council. All families with a child aged 0 to 5 years and all pregnant women resident in the local authority area shall be offered the HCP. If the intervention is refused, this should be recorded and actioned as appropriate depending on the assessment made by the Health Visitor. Any refusals must be recorded and notified to the Authority on a monthly basis in writing. The Authority reserves the right to ask for further information that it may require.

The Service will (including but not limited to):

- collect activity data to support reporting for both the GP registered and the resident population;
- Raise any coverage/ boundary issues proactively with neighbouring providers;
- meet the needs (including safeguarding needs) of the child or family and that this takes precedent over any boundary discrepancies or disagreements;
- Provide equal access for all children up to school entry and their families, irrespective of age, disability, gender reassignment, marriage and civil partnership and race – this includes (but is not limited to) ethnic or national origins, colour or nationality, religion, lack of belief, sex or sexual orientation and in line with the Equality Act 2010;
- Ensure there is active monitoring to reduce inequalities in access and uptake by co-producing and facilitating sessions to suit the needs of the diverse population. This may include (but is not limited to) using interpreters, the use of community venues in specific /targeted locations and/or providing resources and communications in community languages; and
- Undertake an equality impact assessment where changes to the existing contract are proposed.

4.2 Working effectively with Partners

Children Centres/Family Hubs

Services shall be delivered on an area-based geographical basis in alignment with Children Centres/Family Hubs and the four primary care network (PCN) areas with a named Health Visiting lead and team for each area.

Currently in Slough, there are three Children's Centre's delivering the core offer for 0–5-year-olds located at: Penn Road, Chalvey Grove and Romsley Close. These sites will allow whole-family work including ante/nata/post-nata services, child and family health services, early education, child development and parenting support.

Two further Children Centre's located at Yew Tree Road and Monksfield Way will continue to deliver early years education for children aged 2-5 years and support for Special Educational Needs and Disabilities (SEND).

Transformation to a Family Hubs model is underway with a planned approach for a Hubs and spoke model of service delivery within the existing site provision.

There will be a mutual understanding of the Health Visiting Service (and wider HCP 0 to –25 years old) and the roles and scope of partners to enhance the care experience and health of young families in Slough. This shall extend to the co-location of services where demand and capacity allows.

Information sessions and training in health visiting related issues, including infant feeding, oral health and healthy living is to be provided to increase the knowledge and skills of the early year's workforce. This includes (but is not limited to) all Ofsted registered providers, children and family centre staff, health service providers and faith-based & community groups.

4.3 Wider Multi-agency Working

There is to be a named lead for each Primary Care Network to facilitate liaison, information sharing and joint working in the best interests of families. The named lead will ensure the expectations around the Health Visiting service is communicated with GPs and Primary Care Networks on a quarterly basis or as required. Where Primary Care Network liaison meetings are established, the named lead is expected to participate.

The Service Provider will also work in partnership with Children's First to facilitate Integrated Reviews and SEND code of practice: 0 to 25 years[9]

in order to support children's learning and development which prepares them to learn at two (2) years old and be ready for school at five (5) years old and to generate information which can be used to plan early education/learning services and contribute to the reduction of inequalities in children's outcomes.

All Health Visitors must be aware of the Free Early Education Entitlement (FEEE) and will support parents to understand the benefits to their child's learning and development of taking it up particularly for low income, vulnerable, underrepresented, underperforming groups.

To ensure effective operational working, the service will facilitate and/or attend regular multiagency meetings as advised. In line with national pathways and guidance where available, the Service will develop, implement, monitor and review multi-agency care pathways for children and their families, ensuring clarity of roles and responsibilities, reducing duplication and eliminating gaps.

Referral pathways which enable timely access from universal to targeted and specialist services must be developed and, where appropriate the Service will undertake joint visits or consultations with the SCVS (for example with Community Health Champions, Homestart or

[9] as published by the Department for Education and Department for Health and Social Care. This may be amended and updated from time to time. https://www.gov.uk/government/publications/send-code-of-practice-0-to-25

others as appropriate) and other health professionals to maximise outcomes for children and families, particularly for those with more complex needs.

In the interests of delivering improved health outcomes particularly for children seldom reached, the Service (where appropriate) will enter sub-contracting with SCVS organisations as part of their commitment to delivering ‘Community’ level of support.

The service will also focus on developing close links with local private, voluntary and independent (PVI) providers of services to children, not limited to childminders, nurseries and children’s charities as part of their commitment to delivering ‘Community’ level of support.

5 Health Visiting Service: Outcome Requirements

The Service Provider shall be actively aware of the six (6) maternity high impact areas to ensure there is continuity of support from maternity to health visiting services and, support the transition between health visiting and school nursing (Supporting public health: children, young people and families - GOV.UK (www.gov.uk)).

5.1 Care Continuity between Midwifery and Health Visiting Services

Care continuity between midwifery and health visiting enables safe, high quality, personalised care to be delivered in a timely manner. Care continuity can be via joint working, sharing information and postnatal handover, and helps with providing consistent information, in line with the 'making every contact count' agenda. In order to deliver best outcomes for women and families the Service will (including but not limited to):

1. Retain up to date details of local midwifery teams;
2. Share information in a timely manner and establish protocols regarding when, how and with whom to share information;
3. Have knowledge of midwifery services role and remit and understand informational needs;
4. Build opportunities for joint case discussion and provide joint care for those women who need it;
5. Develop and continuously improve service pathways, standard operating procedures and information sharing documents with midwifery services;
6. Share the same resources with women to ensure consistency in information provided; and
7. Encourage and support parents and carers to use the Personal Child Health Record (PCHR) or 'eRed Book' proactively, as their own complete record of key information regarding their child's health, reviews, screening and immunisation status.

5.2 High Impact Areas for Early Years

Although the Health Visiting Service will lead on the six (6) High Impact Areas for Early Years it is expected that this will be achieved through collaborative working and joined up approaches with partners, see outcomes below.

Table 3: Outcomes and Activities HIA 0 – 5yrs

High Impact Area Outcomes (0 – 5)		
1	***Supporting health, wellbeing and development***	Develop effective relationships with parents, starting in the antenatal period, providing health promotion, support and advice. Work with parents, using well evidenced, strengths-based approaches for example motivational interviewing, Think Family and trauma informed to promote positive lifestyle choices and support positive parenting practices. In co-operation with the Slough Community Voluntary Sector and the wider Early Years Sector in the delivery of evidence based antenatal and postnatal parenting groups.

2	***Supporting maternal and family mental health***	Promote good parent and infant mental health and secure attachment, both through educating and supporting parents to develop a close loving bond with their child from conception or as early as possible. Work in partnership with Children and/or Family Hubs to understand measurement of maternal mood and outcomes from Edinburgh Postnatal Depression Scale (EPDS) measurements. Ensure that staff are adequately trained to detect, assess and provide support for low mood and postnatal depression and incorporate robust awareness raising and evidence-based screening methods into the service provision at key points – namely the antenatal health promoting visit, new baby and 6- to 8-week-old visit. Use evidence-based tools recommended by National Institute for Health and Care Excellence (NICE) guidance to support improved outcomes in maternal mental health or parent-infant relationships which may include referral for specialist support or signposting.
3	***Supporting breastfeeding***	Support mothers to continue breastfeeding, those mothers who are unable or do not wish to continue to breastfeed continue to promote responsive feeding, bonding and secure attachments between mother and infant. Collect data on breastfeeding status at the new birth review and 6- to 8-week-old reviews, which will include (but not limited to) recording of ethnicity. Work with partners to attain Level 2 (if not achieved) and UNICEF Baby Friendly accreditation.
4	***Supporting healthy weight and nutrition***	Have a designated Healthy Weight Specialist Health Visitor within the team. In collaboration with the SCVS, food banks and community groups develop innovative pathways to mitigate the health impacts of food poverty on families with young children. This is to include facilitating access to Healthy Start vouchers/vitamins, providing information about physical activity and better nutrition at lower cost to support families to be healthier.[10] Sub-contracting with SCVS/partners, the Service Provider will co-produce culturally appropriate interventions that address Healthy Weight in the under 5-year-olds. Health Visitors will make every contact with the family a health promoting contact and identify and draw on the strengths within the family in providing support and advice, recognising that families have the solutions within themselves to make positive lifestyle changes. Key areas of health promotion and behaviour change that the Service Provider shall address (including but not limited to):

[10] https://www.nhs.uk/healthier-families/

		• Smoking cessation – both parents; • General home health and hygiene and health protection; • Substance misuse including alcohol; • Promoting good mental health; • Safe sleeping and accident prevention; and • Promoting oral health. Note - parents who are pregnant or have children under the age of 4 years old may be eligible for free vouchers for food and milk. The Service must promote the Healthy Start & Vitamins scheme by supporting those who are eligible to apply at all stages of the application process.
5	***Improving health literacy, managing minor illnesses and reducing accidents***	At each review give opportunistic advice and support to parents on managing childhood illnesses and preventing unintentional injuries. Nurse prescribing enhances the health visitor ability to support families to manage minor illnesses and reduce hospital admissions. This includes managing symptoms and providing medication knowledge to enhance advice and support. The Service must respond to common health concerns, discuss treatment options and wider management of conditions and then, as necessary, prescribe medication in accordance with current legislation as part of a holistic approach: Royal College of Nursing (RCN) Guidance on Medicine Management. Where Health Visitors have not undertaken a prescribing module in training, it must be completed within the first two (2) years of practice in accordance with Continuing Professional Development (CPD) requirements. The Service will implement an information sharing protocol with GPs regarding medicines prescribed to ensure effective and safe care. To reduce repeated hospital admissions, a protocol for exchange of information from A&E departments and a criteria on following up on A&E discharges must be agreed. This includes follow-up for all discharged children (including but not limited to): • who are under 1 year of age; • were discharged with a fever of unknown origin; • were admitted due to an accident; • who have attended A&E on a previous occasion within the last 6 months; and/or • where the A&E liaison nurse or other staff have expressly asked for Health Visitor follow-up.
6	***Ready to learn and narrowing the word gap***	The Service will have a designated 'Ready to Learn/Integrated Reviews' Specialist Health Lead to ensure the 2 to 2 ½ year health and development review (Integrated Reviews) is undertaken by all children as part of the Healthy Child Programme. This is to be undertaken in partnership with other

		members of the multi-disciplinary team. The Service must ensure that every child reaches a level of holistic development which enables them at school entry to (including but not limited to): • communicate their needs with a good vocabulary and understand others; any deficits in language development are identified early; • get dressed and go to the toilet independently; • eat independently; • take turns, sit still, listen and play; • socialise with peers, form friendships and separate from parent(s); • enjoy good physical health or have disabilities and complex health needs identified and managed appropriately to maximise access to education; • have a healthy weight for height range and be well nourished and physically active; • attend the dentist regularly and have good oral health; and • benefit from protection against infectious illness, having received all childhood immunisations.

5.3 Health and development reviews

The below five (5) mandated universal health reviews and an additional health review are to be delivered at the six (6) key milestones (including but not limited to):

1. Antenatal health promoting review (28 weeks + review);
2. New birth review (14-day review);
3. 6–8-week review;
4. 1 year review; and
5. 2-2½-year review (ASQ-3);
6. 3-3½-year review as required based on previous ASQ -3 assessment

A strengths-based approach is to be used to assess the needs of families and to build trusting relationships. The reviews are an opportunity to provide time for parents to discuss their concerns and aspirations relating to their child including assessing growth, development and the early detection of abnormalities, communication and language concerns, and social and emotional development.

As a minimum, the service will aim to have the same Health Visitor undertake the new birth review once the baby is 10 to 14 days old and 6 to 8 weeks old undertaking a review to ensure continuity of care within the first 6-8 weeks of parenthood.

Health Visitors will use evidence-based approaches and assessment tools for the reviews such as the Ages and Stages Questionnaire ASQ, and provide expert advice and guidance as required and decide when signposting or referral for specialist intervention is needed.

Mandated reviews will be delivered universally. Where there are difficulties in delivering universally (e.g., workforce is below plan), vulnerable groups will be prioritised for delivery and

outreach. Prioritisation shall be agreed by the Service Provider with the Authority but always with the Authority retaining the power to direct the Service Provider being able to prescribe which groups will be prioritised for delivery and outreach.

The Service must work with partners for example with SCVS to ensure that reviews are culturally sensitive and provides equity of access for families who have English as a second language. Although each of the reviews will be ideally undertaken on a face-to-face basis, when this is not achievable nor practicable, reviews can be undertaken using evaluated virtual methods, providing the family has access to digital platforms. However, the first port of call must be face to face reviews.

Seamless transition between the Healthy Visiting Service and the School Nursing Service must be provided to ensure the continuity of needs of the child.

Any language interpreters and British Sign Language (BSL) interpreters that may be required to provide the Services must be at the sole cost and expense of the Service Provider.

5.4 Drop-in Clinics

The purpose of drop-in clinics is to address parental concerns about child health, check on-growth (not weight) and development, deliver age-appropriate health advice, and to support, signposting and referral.

The number of drop-in clinics however should be demand-led and set up strategically in terms of numbers, locations and times. The Service Provider must consult and inform the Authority of the locations and frequency of drop-in clinics. The Authority reserves the right to prescribe the number and frequency of drop-in clinics should it deem it necessary to do so.

Where provided drop-in clinics must be based in accessible locations in the community, Children Centre's (Family Hubs), health clinics, GP surgeries or other appropriate community venues.

Parents must be able to access clinics by drop-in, invitation or appointment in line with parental choice.

A varied skill mix of staff must be allocated to each child drop-in clinic to provide different approaches and options to deliver and support each touch point, and to meet the needs of a diverse population.

The Health Visitor shall inform the family which drop-in clinics they are aligned to.

5.5 Integrated 2 – 2 1/2 years and 3 – 3 ½ years Review

Integrated health and early education review supports a collaborative approach to a child's developmental review and to the early identification of problems. The integrated review brings together the Early Years Foundation Stage (EYS) at aged 2 years with the Healthy Child Programme 2 – 2 ½ health and developmental review. The addition of the 3 – 3 ½ year review will allow the early identification of problems for children who may require additional support as a result of delays and additional needs identified at the previous assessment. This helps practitioners to (including but not limited to):

- identify the child's progress, strengths and needs in order to promote positive outcomes in health and wellbeing, promote positive behaviour, make appropriate early education

and learning plans, and to ensure that children are ready to make a smooth transition to their nursery provision or school;

- facilitate appropriate early intervention in relation to health, early education/learning and family support for children and their families where developmental delay or additional needs are identified; and
- generate information which can be used to plan services and contribute to the reduction of inequalities in children's outcomes.

The Integrated Review will draw on the content of existing health and educational reviews, focussing on (including but not limited to):

• Speech, language and communication;

• Personal, social and emotional development;

• Physical development, including a review of growth and the promotion of healthy weight and physical activity;

• Learning or cognitive development; and

• Physical health, including oral health and bladder and bowel health to prevent such problems as constipation and urinary tract infections.

Where an Integrated Review is not undertaken, the 2-to-2.5-year review will be offered to all children in the borough, using validated tools, including the Ages and Stages Questionnaire (ASQ) and, a validated evidence-based tool such as, the Early Language Identification Measure (ELIM – see below).

The Service will work with partners to develop referral criteria and pathways based on the outcomes of the ASQ and ELIM (or equivalent measure) to ensure that children access timely support, based on the needs identified by the tools.

5.6 Data sharing to deliver 1 year review, Integrated 2 – 2 ½ year review and 3 – 3 ½ year review

In order to support an integrated pathway for the 2-to-2 ½ -year Integrated Reviews and 3 – 3 ½ year reviews an Information Sharing Agreement must be agreed with the Authority (Children's First).

Robust plans are to be put in place to identify and support the child's development needs in line with EYFS and SEND Code of Practice requirements at the earliest opportunity, particularly those with known or suspected SEND and offer holistic family support as appropriate.

Health Visitors undertaking health reviews for one (1) year olds, 2- to 2 ½ -year-olds and 3 to 3 ½ year olds must obtain consent from parents for their information to be shared with the Authority in order to register the parent on the Children and Family Centres database. This information can then be used to share information about Children Centre services as well as Free Early Education Entitlement (FEEE) and childcare services.

The Service Provider will work pro-actively with the Authority to progress the Authority's restricted access to RIO/EMIS, or any other system commissioned by NHS England, for reporting purposes.

An integrated '0-5 learning and development delay pathway' must be developed with partners, that includes the Early Support, and the Early Years Area Sencos. The Service will participate in multi-disciplinary team (MDT) meetings to triage and assess children's progress and to

provide support as required. If further specialist support is required a referral which is supported by appropriate health and learning assessments and evidence of need is forwarded to relevant services for specialist or targeted intervention.

5.7 ELIM (Early Language Identification Measure)

To ensure the early identification of children's language development, an early language identification measure and intervention tool (ELIM) or a comparable evidence base tool must be used, for use with children aged 2 to 2 and a half years.

ELIM is a holistic assessment designed to focus on a child's strengths and identify any barriers to a child's developmental progress. Information gathered from the review will inform discussions with parents about their child's progress, to identify any problems or delay, and to find solutions or make referrals to more specialist services.

ELIM supports parents by (including but not limited to):

- providing information on ways to promote early language acquisition, such as the home learning environment.
- providing early identification of children with signs of speech and language delay;
- ensuring uptake of appropriate early intervention strategies or specialist support and referral.

An early language identification measure and intervention tool must be introduced from the first year of this Contract and, based on the learning from this, fully implemented as part of the 2-to-2.5-year review/Integrated Review by the second year of the Agreement.

5.8 Additional contacts

Based on the identification of additional needs, additional contacts at 3 to 4 months and 6 months (and 3 – 3 ½ years) shall be undertaken. These additional contacts will include information on immunisations, growth and development, physical and social development, maternal and parental mental health, and raise awareness of services that promote attachment, positive behaviour.

For families receiving targeted or specialist support, a telephone, clinic or home-based contact shall be offered by the Provider (along with support from the SCVS, Homestart or others for example) to discuss the above issues via an enhanced health visiting pathway.

6 Additional Health Visiting outcomes

6.1 Screening

Families are to be encouraged to take up maternal and newborn screening in line with the current National Screening Programme recommendations. (Testing is normally undertaken by midwifery services).

Newborn blood spot screening pathway requirements specification - GOV.UK (www.gov.uk)

- All babies up to but not including their first birthday are eligible for New-born Bloodspot Screening (NBS), with the exception of cystic fibrosis testing.
- Babies who are new to the country or are yet to have a bloodspot test are eligible for testing up to one year old.

Local area new-born blood spot policies and pathways are to be agreed in partnership with local midwifery, CHIS and GP colleagues. This includes a mechanism for checking on the status of children transferred into an area and arrangements for urgent new-born blood spot screening if necessary. The Service Provider shall undertake bloodspot screening for older babies without screening results aged up to one year old.

As standard for all babies, the Health Visitor must check status of, and record all screening results including hearing, New-born Infant Physical Examination (NIPE) and HepB immunisations and refer immediately for any follow up necessary.

6.2 Immunisations (0-5)

All relevant childhood immunisations will be offered to all children and their parents as per the Green Book and in line with PHE's prevailing routine immunisation schedule as follows:

- Immunisation against infectious disease: the green book[11]; and
- Complete routine immunisation schedule.

Parents must be provided with tailored information and support and be given an opportunity to discuss any concerns.

Each child's immunisation status is to be checked in their red book / e-red book during health reviews and at child health clinics with referral / signposting to their GP if unvaccinated. Advice, signposting and referrals to other services will be provided if there are issues of concern linked to immunisations.

Parents are to be made aware that children aged 6 months and over who have a long-term health condition are also eligible for seasonal flu vaccination; the seasonal flu vaccination programme will be promoted to children aged 2 and above.

In partnership with primary care and maternity services, women are to be familiarised with the up to date and local pathways to receive vaccines in pregnancy. The Pertussis vaccination will be prompted to women at 28 weeks of pregnancy and at no later than 32 weeks of pregnancy.

During flu season, the Service Provider shall actively promote the flu vaccination to all pregnant women at the antenatal contact at 28 weeks of pregnancy.

COVID 19 vaccinations will be promoted at 28 weeks of pregnancy and at any post-natal point.

6.3 Supporting Critical Transitions

The safe and effective transition of all children into 5-25 services will be further developed and

[11] Immunisation against infectious disease. The Green Book as published and updated by UK Health Security Agency

maintained through close partnership working with services to meet the needs of children and young people aged up to 25 . A local policy for transition to the school nursing service must be developed, in line with the DH published pathway for this transition, accessible via;

Pathways for supporting health visitors and school nurses interface.[12]

6.4 Children Moving Out of Area

Where a child moves out of area the Service Provider shall ensure that the child's health records are transferred Child Health Information Service (CHIS) or transfer to the receiving Health Visiting Service in the new area within two (2) weeks of notification. A system must be put in place to trace and risk-assess missing children and for those whose address is not known.

Whether a child is being transferred between services or out of the borough, those being supported at specialist level are to be formally identified to the receiving Services and direct, written contact is made to handover all child protection cases to ensure safe and seamless care.

6.5 Children with additional or special needs

The named Health Visitor will coordinate or participate in multi-agency care planning and provides on-going support for babies and children up to school entry with disabilities, long term conditions, behavioural concerns or other health or developmental issues. This includes families with children with special educational needs (SEN).

The Children and Families Act (2014) (Part 3, Section 23) established that health visitors have a statutory duty to bring to the attention of the Authority any child that resides in Slough who is under compulsory school age where, and in the course of undertaking assessments or other functions in relation to a child, the health visitor forms the opinion that the child has (or probably has) special educational needs or a disability (Section 23 duty) and includes their responsibility under the Healthy Child Programme to facilitate access to EYFS based learning opportunities.

The duty also extends to working in an integrated way to assist the Authority in meeting its duties (Section 25 duty) and extends to attendance at multi-agency meetings to consistently review the service being provided (Section 27 duty).[13]

In partnership with other services for example Education, Children Centres (Family Hubs), Health services, and EYS, Health Visitors will support the assessment process and development of EHC plans for children between 0 to 5 years old. This involves sharing information about the child's and family's needs and reviewing in collaboration with other services what support can be put in place to deliver these plans.

In collaboration with the Authority, the Service Provider is to determine the need for additional services in line with population needs and the achievement of outcomes.

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[12] Guidance: Commissioning health visitors and school nurses for public health services for children aged 0 to 19. OHID

[13] Education, Health and Care Plan (EHC). It is a legal document describing a young person aged up to 25 special educational needs, the support they need and the outcome they would like to achieve.

6.6 Access and Timetabling

Core service standard hours will operate from 9am to 5pm Monday to Friday but with flexibility from 8am – 8pm to meet the needs of families. Other working hours as required may be considered by local agreement with the Authority (subject to the Authority's sole and absolute discretion) to meet the needs of families for example child health clinics run on a weekend.

Parents/carers and professionals must be able to easily contact the Health Visiting Service during and outside of service hours. As a minimum these should include telephone contact, including a duty call system, direct mail and electronic routes, and a dedicated website.

6.7 Responding To / Receiving Referrals

All referrals from whatever source (including families transferring in) will receive a response to the referrer within five (5) working days, with contact made with the child, young person or family within ten (10) working days. Urgent referrals, including all safeguarding referrals, must receive a same day or next working day response to the referrer and contact within two working days.

Referrals shall be triaged by a trained individual to ensure that issues are prioritised based on clinical and/or social need. Referrals shall be managed appropriately, and acknowledgement of referral and written feedback shall be provided to the referrer following a service being provided to the child or young person (excluding self-referrals).

6.8 Risk Assessment & Safeguarding

Systems must be in place to identify and refer at-risk children so that appropriate support can be given. The risk assessment shall include protective factors as well as risks and be non-stigmatising in its approach. There shall be explicit assessment of safeguarding risks for the child as necessary.

7 Health Visiting – Workforce Requirements

Health Visitors must be registered (and remain registered and in good standing with the NMC at all times) nurses or midwives with additional specialist community public health nurse training (SCPHN). The Service shall allocate a Specialist Health Visitor High Impact role for Healthy Weight and a Specialist Health Visitor High Impact for School Readiness /Integrated Reviews.

7.1 Workforce Capacity

The overall workforce capacity in respect of staff numbers and roles must be agreed with the Authority on an annual basis. The Authority reserves the right to prescribe the workforce numbers if so required).

As a minimum there will be a named Health Visitor for every family with a child up to one (1) year of age and for all children 0 to 5 years old identified as having needs at the targeted and

specialist levels of need and two (2) designated lead specialist roles.

7.2 Minimum Staffing Requirements

The minimum requirements of staff and expertise for the delivery of a safe and high-quality service must be in place. In view of the recognised national health visiting workforce shortage, it is expected that beyond this, the Service will need to be innovative in generating maximum capacity using an appropriate skill mix (for example including staffing from Education, SCVS or others) which provides a focus on good outcomes.

Details of the Service Provider's staffing intentions and a workforce development plan shall be agreed with the Authority at the outset of the Agreement and annually thereafter (or any other interval at the sole discretion of the Authority).

7.3 Health Visitor role in training outside of the service

In working with the wider health and social care economy, training needs can be met on a regular and substantive basis in both formal and informal ways, which shall include but not be limited to attending partners' network meetings or providing training by holding topic-specific workshops. Specialist posts within the Service will lead on training staff internally and externally in their area of expertise.

8 SCHOOL NURSING SERVICE: OUTCOME REQUIREMENTS

School Nurses lead the delivery of the Healthy Child Programme aged 5 - 25 , which supports collaborative work and integrated delivery, supported by skilled mixed teams of health workers alongside other members of the wider children's workforce.

The School Nursing Service should aspire to the SAPHNA Vision[14], across four levels of provision; *community, universal reach*, *personalised response* and *specialist support* with safeguarding children and young people as a key component running throughout the model.

Building on the principles of proportionate universalism, the service must be universally accessible to all, and offer additional help or make referrals into services for those who need it most.

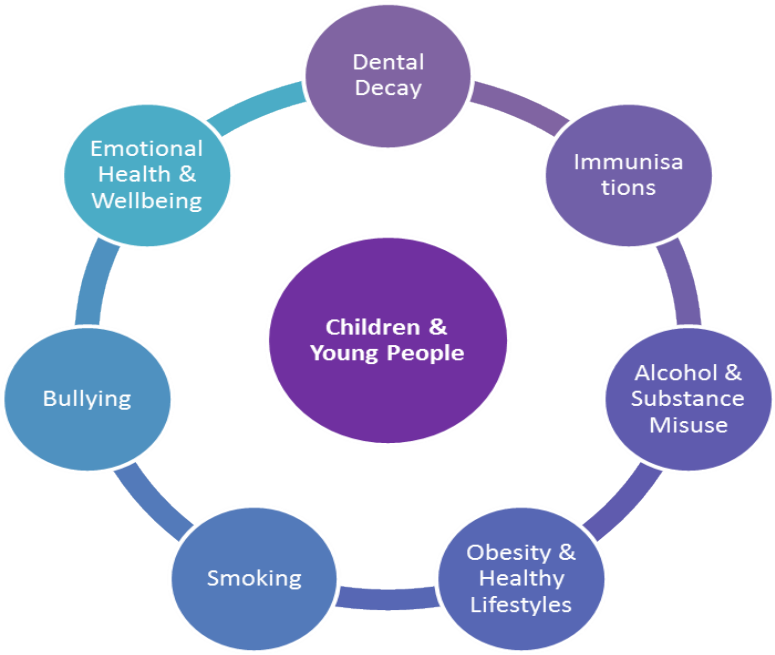
8.1 Care Continuity from Health Visiting Services (including but not limited to)

- Children entering school are to be provided with a seamless transition, including a formal handover of care from the Health Visiting service for children with identified health or social care needs;
- Every local authority school will have a named school nurse, who will act as the school's key link into children's health care;
- Every local authority school must be aware of the named school nurse and be aware of how they can be contacted and accessed;
- Young people at the school (and their parents/carers) must be aware of the named school nurse and how to contact and access them; and
- Young people who are not attending school-based education provision must also be aware of the named school nurse is and how to contact and access them.

8.2 School Nursing – General requirements

Fig 4: Areas of support provided by the School Nursing Service

[14] https://saphna.co/wp-content/uploads/2021/10/SAPHNA-VISION-FOR-SCHOOL-NURSING.pdf



The Service will (including but not limited to):

- reflect best practice, innovation and strategic policy direction and be responsive to emerging legislation and changes;
- develop an inclusive and multi-disciplinary approach in supporting children and families;
- ensure that School Nurses must be a visible presence; young people attending each school must understand the 'core offer' of the school nursing service;
- work in partnership with the community to receive advice, training and support on further promoting the health and well-being of their pupils;
- be actively promoted to young people through a variety of channels and report a high level of satisfaction and provide support to ensure young people are made aware of and understand how to access inter-related services including but not limited to Risky Behaviours, mental health, sexual health, drug and alcohol;
- ensure there is a clear pathway for contact and access to the service for those not attending schools, for example those who electively receive home education, on school exclusions and others;
- be accessible to all groups, paying particular attention to issues of ethnicity, gender and sexuality and SEND and provides equality of access for all young people;
- establish close links with the Youth Health Champions in the school or with School Councils (where present) to promote the service and to disseminate key health and wellbeing messages;
- collaborate with children, young people and their families in service development, review and evaluation; and
- Children will be supported with seamless transition into adulthood and appropriate services.

8.3 Outcomes

The School Nursing Service supports the achievement of the below outcomes (including but not limited to):

- School readiness at the end of primary one;
- Reduced childhood obesity by promoting healthy eating and physical activity, and continued good coverage of the National Child Measurement Programme (NCMP)
- Improved mental health and emotional wellbeing amongst school-age children (including children in care), including reduced bullying and increased resilience;
- A reduction in school absence due to poor health and / or additional health needs or complex needs;
- Children and young people supported to make positive changes to their health and wellbeing;
- Reduction in proportion of young people who frequently use illicit drugs or alcohol, or that smoke;
- Reducing the number of children who require formal safeguarding arrangements – achieved through early identification and intervention; and
- Increased uptake from children, young people and families of preventative services, and evidence-based interventions tailored to their needs through the Healthy Child Programme.

8.4 School nursing – high impact areas for school-aged years (5 – 19)

High Impact Areas are evidence-based areas of activity that lead to significantly improved health outcomes for young people; there are six (6) School-Aged High Impact Areas. Although the School Nursing Service is the lead for the HCP School-Aged High Impact Areas (5 to 19 years old, and up to 25 years where there is a statutory responsibility), these are expected to be delivered in collaboration with partners and stakeholders.

Table 2: Outcomes and Activities HIA 5 -19 (25)

HIGH IMPACT AREAS – – 5 to 19 years old and up to 25 years old where there is a statutory responsibility		
1	***Supporting resilience and wellbeing***	Working in partnership with Mental Health Support Teams and Mental Health Champions (staff) in schools and with CAMHS, with an understanding of local services and pathways; Signposting to locally commissioned wellbeing support provision which shall include KOOTH Work with Youth Health Champions or other groups of young people within the school to deliver health promotion messages.
2	***Improving health behaviours, keeping safe and reducing risk taking***	Working with children and young people with particular behaviour/lifestyle risks. This will include those not in education, employment or training (NEETs), and/or those exhibiting or at increased risk of risk-taking behaviour such as gangs and violence, substance misuse, alcohol and unsafe or exploitative sex; Delivering gender inclusive health promotion sessions on these key topics ensuring that young people know where to go for support with these issues; and Linking to local services, including knowledge of the local services, pathways and how to signpost and refer young people.
3	***Supporting healthy lifestyles***	Provide information, advice, signposting, referral and training which ensures coverage which includes parents/carers and school staff, on (but not restricted to) the following: • Delivering drug and alcohol related workshops, including awareness training, awareness of hidden harm in low level of

		usage, access to and availability of treatment for substance abuse and awareness of parental substance abuse; • Sexual and Reproductive Health Support; • Provide access for secondary school children, including those with SEND and in special schools, in colleges and alternative provisions, to non-judgemental, equitable, factual sexual and reproductive health advice, support, guidance and signposting to outside agencies, including access to condoms where appropriate and in line with school policies; • Be aware of and follow local processes for safeguarding young people at risk of or subject to FGM and any form of Child Sexual Exploitation; • Provide Level One smoking cessation advice and support where needed, including onward referral to specialist smoking cessation support. Note that new standards and toolkits to support young people's sexual health in the course of development.
4	***Supporting vulnerable young people and improving health inequalities***	Provide support and signpost to services, with identifiable leads, for specific groups of vulnerable children, for example (including but not limited to): • Young carers; • Children living with chronic diseases e.g., sickle cell disease, diabetes; • Lesbian, gay, bisexual and trans identifying youth; • Young mothers in education; Youth offenders in education; • Looked After Children; • Sexually active young people; • Traveller communities; and • English for Speakers of Other Languages (ESOL);Children and young people whose family/home background puts them at risk.
5	***Supporting complex and additional health and wellbeing needs***	Provide support and training for schools in managing pupils with long-term conditions. This is likely to include, at a minimum, support to schools to develop health related policies (e.g., pupil medicine management, asthma, epilepsy, and anaphylaxis management), and in understanding relevant devices such as spacer devices or epi pens (Epinephrine Injectors). Developing care pathways and targeted support for children and young people with complex or enhanced needs, including but not limited to children and young people who are ill, disabled, have complex or long-term health needs, have statement of special educational need (SEN) or have mental health problems. Supporting schools in signposting and accessing SEN related health services. In partnership with other services, school nurses shall support the assessment process and development of EHC plans for children between up to age 19 (up to 25 years if appropriate). This shall include sharing information about the child's and family's needs and reviewing in collaboration with other services . The Service shall be aware of changing dynamics in children's health needs and ensure flexibility within the Service to respond to these.

6	***Promoting self-care and improving health literacy***	Provide support for children with long term conditions to contribute to self-care programmes supporting children with chronic disease conditions such as asthma, diabetes and epilepsy.

8.5 SCHOOL NURSING SERVICE: ACTIVITY REQUIREMENTS

8.6 Health Reviews (including but not limited to):

- Children with health needs that impact upon their ability to learn will be identified and supported through health assessment and reviews. This will help manage their health condition so they can be given every chance to thrive in school;
- Structured standardised health and development reviews are to be provided for all children in Reception Year, Year 6 and Year 9. Best practice/evidence-based models should be used to support these reviews, such as 'The Lancaster Health Questionnaire;
- Data on completion of questionnaires and follow up activity (including referrals) will form part of contract monitoring activity.

At a minimum three (3) reviews will be undertaken as per the following:

Reception Year (child aged 4-5yrs) School entry assessment and school entry questionnaire
Parent/carer completes a health and wellbeing questionnaire for each child, which includes a standardised evidence-based assessment of mental wellbeing, nutritional, physical activity, and behaviour and immunisation history. Information on GP registration, access to dental care, immunisation status and recentness of dental check-up shall be requested. National Child Measurement Programme (NCMP) standard collection to undertaken with hearing and sight screening in line with National Screening Guidelines. Assessment of each child's behaviour plus assessment of safeguarding issues, health risks and potential additional needs.
Year 6 (child aged 10-11years) Assessment at transition from primary to secondary school
Ensure completion of the wellbeing questionnaire, including assessment of mental wellbeing, nutritional and physical activity behaviour, immunisation history and access to primary care and dental care. Specifically, information on GP registration, access to dental care, immunisation status and recentness of dental check-up will be requested. Undertake measurement of the height and weight in line with National Child Measurement Programme standard collection. Undertake assessment of each child's behaviour plus assessment of safeguarding issues, health risks and potential additional needs. Undertake assessment of each child's speech, language and communication .

Ensure parent and child have the opportunity to raise any issues of concern and follow-up as appropriate, potentially using a Strengths and Difficulties Questionnaire (SDQ)r similar tool, and/or referral/signpost to appropriate services.
Year 9 (young persons aged 13/14 years) Assessment of preparedness for adulthood/transition
Provide all young persons with opportunity to complete health and wellbeing questionnaire, including assessment of mental wellbeing, nutritional and physical activity behaviour, risky behaviours (e.g., smoking, alcohol, drugs, sexual and reproductive health), registered access to primary care and dental care, and potential safeguarding issues, health risks and additional needs; highlighting areas where the young person would like more information. Work collaboratively with schools to maximise the responses to the questionnaire which includes using time allocated within the school for PHSE sessions. Follow-up individual concerns and provide a follow up assessment for those who indicate needs in two (2) or more of the assessed domains . Include an assessment of mental wellbeing (using SDQ or alternative standardised questionnaire), assessment of risky behaviours (which shall include Drug Use Screening Tool (DUST) tool or equivalent, looking at smoking, alcohol, drugs, sexual and reproductive health), assessment of safeguarding issues, health risks and additional needs. Provide small (up to 10) groups targeted sessions if required (gender, race for example).

8.7 Follow-up after reviews:

- Parents/carers receive a standardised report of the assessments for Reception and Year 6 within one (1) month of the assessment being undertaken, unless there are any urgent issues, which need to be followed up immediately. Where issues are identified, the report shall include signposting to relevant services
- Year 9 Reports will be subject to consent from the pupil concerned for the information to be shared and based on assessment of the young person's competence and safeguarding guidelines;
- Information sessions will provide within schools for parents as a follow up to these reports and signposting and access to appropriate workshops if appropriate. This shall include but not be limited to healthy lifestyle workshops, which can be offered either face to face or digitally ;
- The Service should provide an option for one-to-one support as required. (See Drop-in Sessions: Access for Parents and Young People below);
- GPs should receive a standardised report of the assessments within one (1) month of the assessment being undertaken for Reception, Year 6 and Year 9 unless there are any urgent issues, which need to be followed up immediately. This shall include pupils identified as being obese or seriously obese from the National Child Measurement Programme;
- The Service Provider shall ensure where there has been a face-to-face drop-in consultation or Year 9 review follow-up with a young person, there will be explicit discussion regarding confidentiality, and potential sharing with other parties such as parents, GPs or other professionals based on assessment of the young person's competence and safeguarding guidelines. The Service Provider shall ensure that staff are aware of the Gillick Competency and Fraser guidelines for this purpose.

8.8 Support for different year groups

The Service Provider must ensure the school nurse works in partnership to support vulnerable children and those with additional needs.

- To provide an excellent level of overall support, the Service Provider shall undertake to provide school assemblies, including an offer of follow up one to one support if required, which focus on (but are not limited to):
    - Year 3 (7 to 8 years old): healthy lifestyles and healthy relationships;
    - Year 6 (10 to 11 years old): transition into secondary school;
    - Year 8 (12 to 13 years old): mental health, sexual health, and healthy relationships, body image and self-care; and
    - Year 11 and Year 13: School leavers: relationships, sexual health, self-care, resilience.

8.9 Drop-In Sessions: Access for Parents, Children and Young People

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- As part of the offer to schools, the Service will offer school drop-in sessions for their pupils and parents, run primarily out of the school building (including but not limited to):
    - On a bi-weekly basis, for secondary schools;
    - On a bi-weekly basis, for colleges;
    - On a monthly basis, for primary schools;
    - On a bi-weekly basis for pupil referral units
    - On a half termly basis for special schools.

- The Service may consider the use of community venues for the purpose of drop ins to extend the reach of the Service. This can include but is limited to use of community venues and the youth centres;
- The Service will be accessible to home-schooled children and children not in education, employment or training via domiciliary visits or a community-based site which is accessible for children and their families;
- The Service will provide regular feedback about collaborative working with schools as part of the regular reporting routine to include reference to those schools who do not provide appropriate premises for health reviews or if schools are not enabling drop-in sessions to occur;
- The availability of the drop-in sessions shall be regularly communicated to parents and young people via a variety of methods, including school newsletters, email. phone and social media.

8.10 Virtual clinics support

- The Service will provide interactive virtual clinics as an alternative option to face to face consultations. This offer shall be provided through a range of digital platforms and include, but not be limited to:
    - ‘e’ clinics, as an alternative to face-to-face drop ins, health assessments and brief interventions;
    - Health education/promotion lessons, videos and resources ranging from hand/respiratory hygiene to puberty, school transitions and food poverty;
    - Training for school staff regarding medical conditions in schools;
    - Safeguarding meetings.

- This virtual offer will provide access to a digital offer which provides confidential messaging and enables young people (age 11 – 19) to contact the School Nursing team, such as Chat Health;
- Data on use of this facility will form part of contract monitoring and be part of the regular reporting routine, issues arising, and how they maintain a balance between virtual interaction and face to face activity should be highlighted;
- The availability of the 'virtual offer' must be regularly communicated to parents and young people via a variety of methods, including school newsletters, email and social media;
- The Service will promote a single point of access (SPA) which operates during the service core hours and enables booking of appointments (including virtual appointments) as well as offering advice and support to parents and professionals, including support for children with long term conditions.

8.11 National Child Measurement Programme

- The Service will deliver the National Child Measurement Programme (NCMP). The programme was set up un line with the government's strategy to tackle obesity. Heights and weights are measured and used to calculate a Body Mass Index (BMI) centile. The measurement process is undertaken by healthcare professionals in schools.
- The Service will deliver the programme in line with national guidance, including obtaining parental feedback, and uploading information to the national dataset, for all children in Reception and Year 6 classes. This data will be shared with the Authority;
- Pupil measurement will be incorporated into the Reception and Year 6 health reviews with the requirement that GPs are informed if a child's result is found to be obese or severely obese. Those who are overweight or very overweight must be automatically referred to the local family weight management programme.
- The service will follow operational guidance and work with the local authority and schools (National Child Measurement Programme: operational guidance. OHID August 2023).

8.12 Immunisations and Screening

8.13 Screening: hearing and vision

- Hearing and vision screening will be undertaken simultaneously with the reception aged health review and the NCMP (see above);
- This will be delivered in line with national guidance as provided by the National Screening Committee and provide a seamless approach in adopting a clear referral pathway for those identified as requiring specialist support.

8.14 Immunisations

- NHS England commissions the school aged immunisation programme. The School Nursing Service is not required to deliver immunisations as a part of the 0 to 25 years old Healthy Child Programme service. However, the Service will monitor and promote the take up of immunisations in line with their health promotion responsibilities;
- The NHS England Immunisation Schedule is updated annually

https://www.gov.uk/government/publications/the-complete-routine-immunisation schedule;

- The Service will use every opportunity when in contact with parents or young people to check immunisation status and discuss the importance of vaccination;
- The Service will be familiar with the routine immunisation schedule, promote this wherever possible and, where required, broker relationships between schools and the school aged immunisation provider.

8.15 Special Educational Needs and/or Disabilities (SEND)

The Service Provider shall ensure the School Nurse provides advice to schools of onward referrals required to identify SEND or bringing directly to the Authority's attention any child not already known to a school who may have SEND which includes those new to the country or removals into the country.

8.16 Enuresis Referrals

The Service Provider will make referrals for patients to have access and provision of enuresis services that meet the needs of children and young people with continence problems.

The Service Provider will be expected to work in close partnership with the services commissioned by Berkshire Healthcare NHS Foundation Trust Paediatric Continence Service.

The Service Provider needs to ensure that the parents/carers of children affected by nocturnal enuresis which cannot be self-managed have the appropriate local resources to support them to manage it or be referred on for specialist input if required Outside the scope of this contract is anything detailed in the NICE guidelines beyond 'First-line treatment.'

8.17 Whole School Approach

The Service will support a whole school approach to improving the health and wellbeing of school aged children. A whole-school approach involves all parts of the school working together and being committed. It needs partnership working between senior leaders, teachers and all school staff, as well as parents, carers and the wider community and services.

The Service Provider shall ensure that the School Nursing service contributes to this, by (including but not limited to):

- Working with the Youth Health Champions to ensure that the service, including information on access to the service, is publicised and that key health promotion messages are made available to pupils;
- Provide advice and support to schools who deliver Personal, Social and Health Education (PHSE) when requested;
- Promoting and supporting schools to sign up to initiatives such as the NHS Better health: Healthy Steps Programme aimed at Primary Schools or similar. School Food Standards
- Promoting and supporting future health related projects and initiatives in schools.

8.18 Access and Timetabling

An annual plan, ahead of the start of each academic year, is to be distributed to schools (and the Authority if so requested) indicating when various activities (including but not limited to for example health reviews, NCMP) are expected to be completed.

The Service will provide access to healthcare advice and professional support over fifty-two (52) weeks, from 08:00 to 17:00, five (5) days a week, in a range of accessible community venues, including in schools during school term time and in response to service user demand.

Parents/carers, children and young people and professionals must be able to easily contact the School Nursing Service during and outside of core service hours. These routes shall include telephone, direct mail and electronic routes, including a website and social media.

8.19 Children Moving Out of Area

Where a child moves out-of-area the Service will ensure that the child's health records are transferred to the School Nursing Service in the new area within 2 (two) weeks of notification of a move. Direct contact must be made to handover all child protection cases. Systems must be in place to assess the risk to children whose whereabouts are unknown.

8.20 Responding To / Receiving Referrals

The Service Provider must ensure that all referrals from whatever source (including but not limited to children, young people and families transferring in) shall receive a response to the referrer within 5 (five) Working Days, with contact made with the child, young person or family within 10 (ten) Working Days. Urgent referrals include but is not limited to safeguarding referrals, must receive a same day or next working day response to the referrer and contact within 2 (two) Working Days.

Referrals shall be triaged by a trained (school nurse level) individual to ensure that issues are prioritised based on clinical and/or social need. Referrals shall be managed appropriately, and acknowledgement of referral and written feedback shall be provided to the referrer following a service being provided to the child or young person (excluding self-referrals).

8.21 RISK ASSESSMENT AND SAFEGUARDING

Systems must be in place to identify and refer at-risk children and young people, so that appropriate support can be given. The identification process will be refreshed at key transition points over the child's life, taking advantage of the minimum three health and developmental review stages stated above, as appropriate. This shall involve children and young people and their families. The risk assessment shall include protective factors as well as risks and be non-stigmatising in its approach. There shall be explicit assessment of safeguarding risks for the child and young person where necessary.

9 SCHOOL NURSING SERVICE: WORKFORCE

The Service Provider's School Nurses shall be registered nurses or midwives with additional specialist community public health nurse training (SCPHN).

The School Nursing Service shall have an appropriate protocol in place to work with children and young people educated in settings other than at school and should allocate a specific role

for this purpose i.e., EOTAS (Educated Outside of School) Nurse. This role shall extend to working with the Authority's Youth Offending Service to support and follow up health assessments as appropriate.

9.1 Minimum Staffing requirements

In view of the recognised national workforce shortage, the Service Provider shall be innovative in generating maximum capacity within the service using an appropriate skill mix. Details of the Service Provider's staffing intentions and a workforce development plan shall be agreed with the Authority at the outset of the Agreement and annually thereafter (or any other timeframe at the sole and absolute discretion of the Authority).

This must include consideration of the leadership roles and designated specialist roles referred to in the Service specification when determining workforce capacity (see School Nursing: General Requirements above).

The skill mix in the Service must reflect local needs, maximise skills and strengthen capacity, the Service must ensure (including but not limited to):

- School Nurses attend training sessions to equip themselves with knowledge relating to issues of local community focus such as the impact of gangs and gang culture with a view to providing supportive health related advice and support;
- they collaborate with partner agencies to seek opportunities for the co-location of services to increase the extent of service uptake such as family hubs, youth centres;
- it offers a reciprocal service to external providers to support partnership working and improve holistic outcomes for children;
- that as part of contract performance monitoring information on the (including but not limited to):
    - number of trainings attended and referrals to linked services is provided;
    - delivery of health promotion sessions to linked services is provided; and
    - number of collaborations and partnership working is also provided.

10 PART: B

10.1 COMMUNICATIONS AND ENGAGEMENT

10.2 General Requirements

The Service Provider shall work with the Authority's Communications Team, Public Health, Children Centres & Family Hubs, Healthy Child – Best Start Programme, Children's First, Early Help and wraparound support providers to engage and communicate with resident families. This includes regular and clear communication of the integrated early year's offer, leading campaigns around specific topics, amplifying partner's campaigns, developing parent/carer feedback and co-production opportunities and having an effective complaint resolution process.

10.3 Specific Requirements

The Service Provider shall (including but not limited to):

- Collaborate across the integrated partnership and maintain details of the Healthy Child Programme on the Authority's website and Providers own website;
- Create opportunities for children/young people and parent/carers to feedback, co-produce and guide communications strategies to ensure they are relevant, appealing and engaging through appropriate channels for the target audience;
- Promote and share information from communication campaigns relevant to families with children aged 0-25 led by Children Centres and Family Hubs;
- Actively promote the Healthy Child Programme, the Children Centres and Family Hubs (i.e., leisure centres and 'our parks' exercise offers) through a range of channels including social media, print media and partnership / community locations; and
- Use a range of methods to engage with both children, young people, parents/carers and school staff including attending parent's evenings and school events, organising in-school or community events (for example (including but not limited to) coffee mornings) use social media, and internet to raise the profile of the service and provide opportunistic advice and support.

10.4 Inclusion

- Develop lines of communication with voluntary sector community groups/networks to engage with families, to include but is not limited to via faith-based groups, connecting community's forum and other avenues to communicate support offer;
- Explore and expand use of innovative communication techniques such as direct SMS and peer to peer messaging to increase reach of communications to underserved communities.

10.5 Accessibility

- Maximise the benefit of various digital communication channels including eRedbook and social media whilst preventing exclusion of families due to limited access to wifi/data or devices;
- Consider the needs of residents who may speak languages other than English, have differing sensory or learning abilities and benefit from communications in a variety of

formats for example (including but not limited to) translatable, easy read, audio format etc.

10.6 Engagement and Evaluation

- Initiate, develop and embed opportunities for families' feedback and evaluation as an integral aspect of service evaluation to inform action on improvement;
- Explore and expand opportunities for co-production in Service design and improvement to create services that meet families self-determined needs and are delivered in accordance with their preferences;
- Source and share available data to evaluate reach & potential impact of communications with comms team e.g., website/social media metrics, service user feedback/surveys, and attendance/uptake/referral.

11 QUALITY ASSURANCE PRINCIPLES AND MONITORING

- The Authority is committed to the principle of continuous improvement and will work with the Service Provider to look at ways of improving performance with emphasis on the service provided being person centred and outcomes focused.
- Involvement of people and their views is critical to providing an 'inside out' assessment of the Service Provider. Any conversations will be honest, open and transparent with the needs of the person using the Service central to any discussion. The Authority reserves the right to undertake or commission (including any research, evaluation, monitoring or auditing on any activity that it funds.
- Quality will be assessed through regular contract meetings, service reviews, planned or unannounced visits or through any other appropriate method the Authority decides. As part of such monitoring, the Service Provider shall as required submit to the Authority copies of up-to-date records of all staff employed by them, including Disclosure and Barring Service checks and training undertaken.
- The Authority will at its discretion make enquiries regarding issues relevant to the performance of the contract. The Service Provider shall as required collect and submit information through the use of surveys and/or forms or any other digital system which may be developed and notified to the Provider.
- The Service Provider shall comply with any review or external audit, including data requests, or monitoring visits as arranged by the Authority.
- The Authority shall have the right at any time to inspect the premises, equipment and documentation related to the Agreement and to inspect any associated area of activity forming part of the Agreement.
- For the purpose of monitoring the Service Provider's performance, the Authority will have power to carry out surveys, questionnaires or sampling of service users without prior notification to the Service Provider. In addition to this, the Authority will at its discretion carry out robust exit interviews (service user satisfaction surveys) with those leaving the service to establish their views on the Service they have received. Additionally, the Authority will undertake audits of complaints and compliments logs and audits of policies and procedures.
    a. The Service Provider must share details of all formal and informal complaints whether in writing or verbal complaints on a monthly basis with the Authority. The Service Provider must provide full details to the Authority.
- The Service Provider shall inform the Authority at the earliest opportunity of any safeguarding alert, in line with the Authority's safeguarding procedure.
- The Authority will discuss any issue of concern with the Service Provider in a clear and

transparent manner, offering guidance as and when required, while setting clear expectations and timescales to remedy any issue of concern.

- If, as a result, the Service Provider fails to achieve the desired levels of quality they shall be required to submit a Specific, Measurable, Achievable, Realistic and Timely (SMART) action plan within one (1) month of being notified and to report on achievement of the action plan against agreed timescales.

12 REPORTING ACTIVITY AND PERFORMANCE MANAGEMENT

12.1 Reporting activity: general

The Health Visiting & School Nursing elements of the 0 to25 year old Children's Health Service will be expected to complete a monthly performance dashboard report detailing:

- 0 to 5 year olds Health Visiting KPIs (including Exception Reports / Action Plans);
- 5 to -25 year olds School Nursing KPIs (including Exception Reports / Action Plans);
- Safeguarding referrals;
- Complaints / Compliments (whether in writing or verbal, and formal or informal);
- Serious Incidence Framework SUIs / SCRs; and
- Staffing (Ratios / Caseloads / Vacancies).

The Service will be expected to provide an appropriate level attendance at the monthly performance meeting with the Authorityand undertake self-monitoring to ensure compliance with the specification.

With respect to performance management, the Service Provider shall develop a set of acceptable exception reporting criteria and agree these (at the sole discretion of the Authority) with the Authority.

The Service Provider shall, at their sole cost and expense, develop and maintain IT and data systems to adequately report the agreed exception criteria.

The performance indicators are designed to monitor overall activity, outcomes and progress, particularly in relation to inequalities.

Specific performance measures for the first year of the Agreement will be agreed by the Authority (the Authority has the right to impose the key performance indicators at their absolute and sole discretion) with during the contract mobilisation period. Indicative performance levels of where those targets are expected are included within the Appendix. However, the Service Provider may wish to consider and propose alternative measures comprising a mix of outputs and outcome measures for this purpose

The exact annual targets to be achieved by the Service Provider shall be agreed between the the Authority and the Service Provider each year, two (2) months prior to the annual contract anniversary date. The Authority has the right to impose any performance indicators it sees fit or revert back to the targets will be set by default to the levels agreed in the previous contract year.

If quarterly and annual reports are not provided in a timely fashion, the set targets will be considered to be missed.

It is expected that all of these targets will be met on an ongoing basis. Failure to achieve at least 6 of the KPIs would indicate the specification is not being delivered in a meaningful fashion, and remedial action will be taken.

12.2 Reporting activity: quarterly reporting

The Service Provider shall meet with the Authority's Authorised Representative for the purpose of jointly monitoring and evaluation of the service on a quarterly basis to ensure that the service is being provided. There will be one (1) quarterly meeting for the HCP which combines discussion of both services.

The Service Provider shall ensure that a report is presented at each meeting in the format provided by the Authority (with qualitative and quantitative data as appropriate). These reports shall be provided to the Authority by the Service Provider no less than five (5) Working Days ahead of the scheduled time for the quarterly meetings.

12.3 Reporting activity: annual reporting

The Service Provider shall produce an annual report in September, following the end of each contract year. The template for this annual report shall be agreed with the Authority ahead of time.

The Service Provider shall attend an annual review meeting to consider the Healthy Child Programme's evaluation and impact assessment, within the agreed priorities set out in this Contract.

The Service Provider shall ensure the report details how use of the Service differs by protected characteristics and geography. In addition, the report shall include case studies and qualitative information from staff, service users and other stakeholders.

The Service Provider shall ensure the report includes (but is not limited to):

- how the service has evaluated and measured impact;
- reflection on current practices; and
- forward planning for service development.

If the assessment shows that the Healthy Child Programme is failing to meet its agreed outcomes, an Improvement Notice will be issued and an Improvement Plan will be put in place.

To support the development of the Healthy Child Programme, the Authority's Public Health team will offer guidance and support as and when required.

12.4 PERFORMANCE MANAGEMENT

Key Performance indicators (KPIs)

The performance indicators are designed to monitor overall activity, outcomes and progress, particularly in relation to inequalities.

Specific performance measures for the first year of the contract will be agreed by the Authority with the Provider during the contract mobilisation period. Indicative performance levels of where those targets are expected are included within the Appendix. However, the Provider may wish to consider and propose alternative measures comprising a mix of outputs and outcome measures for this purpose.

The exact annual targets to be achieved by the Provider shall be agreed between the Contract Manager and the Provider each year, two (2) months prior to the annual contract anniversary date. It is expected that all of these targets will be met on an ongoing basis. Failure to achieve at least 6 of the KPIs would indicate the specification is not being delivered in a meaningful fashion, and remedial action will be taken.

The KPIs that will be assessed and performance managed to demonstrate, to the Council, value for money and quality are grouped under the following headings:

a) High quality contact and assessment

b) Public health outcomes

c) Excellent partnerships

d) Safeguarding

e) Service satisfaction (See Appendix for full detail of KPIs)

13 GOVERNANCE

13.1 Corporate Governance

- The Service Provider shall have an identified senior manager who is responsible for the Healthy Child Programme.
- The Service Provider shall undertake regular training audits to ensure that all staff are compliant with professional mandatory and statutory training.
- The Service Provider shall ensure the provision is undertaken in accordance with best practice in health care and shall comply in all respects with the standards and recommendations (including but not limtied to):
    - Issued by the National Institute of Clinical Excellence (NICE);
    - Issued by any relevant professional body for example (including but not limited to the CQC and NMC;
    - Set out in Patient Safety Alerts from the National Patient Safety Agency;
    - From any audit and Adverse Incident Reporting; and
    - Set out in national and local child protection guidance.

13.2 Clinical Governance

- The Service Provider shall have an identified clinical governance lead and a programme of clinical audit to maintain quality and improve service.
- The Service Provider shall ensure all clinical staff have regular clinical supervision in line with their national professional guidelines and safeguarding and child protection frameworks (see Safeguarding section)
- The Service Provider shall adhere to national Clinical Governance guidance, policies, setting out the framework and monitoring systems for clinical governance.

13.3 Medication

- The Service Provider shall have in place an appropriate and relevant medication procedure;
- Ensure all employees are made aware of, understand and receive the appropriate training in relation to in medication management and the Service Provider's procedure in relation to their role and responsibilities;
- Ensure the nature and extent of medication support is agreed with the service user (where possible) and their parent(s) / carer(s) and is clearly stated in writing;
- Ensure all medication is locked away, when not required;
- Ensure all medication prompted, assisted or administered is recorded in a Medication Logbook;
- Ensure all cases of medication mismanagement are promptly reported to the commissioner and the service user's parent(s) / carer(s).

14 POLICIES AND PROCEDURES

The Service Provider shall have, as a minimum, the following policies and procedures by which the service is governed and the Service Provider must have a mechanism in place to

ensure that all relevant individuals have read, understood and are applying those policies or procedures. These policies and procedures shall include, but not be limited to:

- Health and Safety: risk assessment, emergency planning, safe working, including lone working;
- Risk Management;
- Equality and Diversity (staff and service delivery);
- Disability Policy;
- Confidentiality and Data Protection Policy;
- Adverse/ Untoward Incident Reporting;
- Complaints and Grievances;
- Safeguarding Adults and Children;
- Quality Assurance System;
- Service User Choice;
- Whistle Blowing Policy;
- Volunteering Protocol;
- Recruitment and Selection (including vetting and barring policy);
- Business continuity and emergency planning;
- Serious Incidents;
- Induction and Training;
- Peer support and volunteering (including handling of expenses for service users and carers;
- Professional boundaries; and
- Sustainability.

The Authority reserves the right to review and proscribe the contents of the aforementioned policies at their sole and absolute discretion.

15 PARTNERSHIP WORKING: A WHOLE SYSTEM APPROACH

A whole system approach to provide safer, personalised, accessible support and individualised care with vision and shared goals is central to improving outcomes for children, young people and families. Delivering such an approach is reliant on professionals and services working together and making efficient use of information to ensure and deliver high quality services.

Key partners and stakeholders

The Service Provider shall deliver the HCP 0 to 25 years old across a range of settings and communities and therefore will need to work in an engaged way with a series of key strategic partners across Slough, including, but not limited to:

- Private, Voluntary & Independent Nurseries, Childminders and Pre-Schools Children Centres (Family Hubs) universal and targeted providers;
- Health Visiting;
- School Nursing service;
- Schools and Alternative Provisions/Pupil Referral Units;
- Colleges;

- Youth Service providers;
- Voluntary and community groups working with families and young people;
- Frimley Integrated Care Board (ICB);
- Healthwatch;
- GPs and primary care;
- Allied therapies for children and young people e.g., speech and language services;
- Community Dietetics;
- Acute Hospital Providers (including community midwife and maternity services teams at multiple trusts);
- Safeguarding and Child Protection Teams;
- Child Health Information System (CHIS) Record Team;
- School aged immunisation provider;
- Smoking cessation services;
- Sexual and reproductive health services, including the Young Persons Sexual Health team;
- Child and Adolescent Mental Health (CAMHS) services;
- Mental Health Support Teams;
- Adult Mental Health services including IAPT and Perinatal Mental Health Service (PIMHS); and
- Drug and alcohol (substance misuse) services.

The Authority's services (predominantly Slough Public Health and Children's First) including but not limited to:

- Commissioning;
- Education Services;
- Early Years;
- Children's Social Care;
- Adult Social Care;
- Early Help;
- Public Health team; and
- Corporate teams including Digital, Communications, IT, where appropriate.

Additionally:

- Voluntary and Community Sector working with families and children and young people;
- Public Health England;
- NHS England; and
- Department of Health and Social Care.

The Slough Community Voluntary Sector, Parents/carers, children, young people and their families shall be considered as central to all aspects of partnership working, the quality of these relationships will be measured as part of this Agreement.

Working with Children's First

Delivery of the Healthy Child Programme 0 to 5 years old will involve close collaboration between the providers of Early Help and Children Centre/ Family Hubs services.

It is required that formalised joint working arrangements shall be agreed between the partners where appropriate.

This is expected to take the form of a Service Level Agreements (SLAs) or Memorandum of Understanding (MoUs), to be developed prior to the Commencement Date of the Agreement.

These formalised arrangements should include (but not limited to), at a minimum:

- Agreement on information sharing,data collection, and data processing;
- Agreement on freedom of information;
- Agreement of shared roles and responsibilities;
- Agreement of pathways where health needs are identified;
- Agreement on role and timescales in organising the health aspects of the HCP programme;
- Agreement around volume of use of into the HCP programme;
- Agreement around expectations of reception and other support for health activities taking place on Children Centre premises;
- Agreement on responsibility for failure to adhere to the agreed programme (e.g. planned child health clinic not taking place);
- Agreement on shared / complementary branding, digital methods for contacting parents / communicating the entire 0 to 5 year old offer;
- Agreement on mutual promotion of services;
- Agreement on use of best practice guidance and consistent messaging concerning key health messages;
- Agreement on shared outcomes and how best to maximise these in a partnership; and
- Any other clause as required by the Authority.

16 PREMISES, EQUIPMENT AND SECURITY

16.1 General

The Service Provider shall ensure services are available and accessible at times and locations that meet the needs of children and young people and their families.

Co-location of service provision with other elements of the Children Centre/Family Hubs and wider community voluntary sector is encouraged. Consideration should also be given to hot-desking which enables agile working and greater efficiency in movement of staff throughout the working day (i.e., negating a requirement to return to a central office base).

The Service Provider's staff accessing these premises shall be required to maintain good professional relationships with partners providing these premises.

16.2 Premises Managed by the Provider

The Service Provider shall lead on the sourcing and management of any other premises used for the delivery of services and will cover any costs connected with the use of these premises. The Service Provider is solely responsible at their sole cost and expense to have

a premises for its staff.

16.3 Health and Safety

The Service Provider shall ensure all health and safety requirement for other buildings are provided by the building owners or that health and safety assessments are covered within any service or hire agreements. The Service Provider shall undertake and implement all risk assessments in relation to services and activities provided, including daily risk assessment checks before the start of each session.

16.4 School Nursing Service only

The primary location for delivery of the School Nursing Service will be outreach within school or education settings, including infant, primary and secondary schools, special schools, pupil referral units and colleges and in community settings, including youth settings where this is deemed more appropriate.

A full list of Slough schools and colleges including primary, secondary, maintained, academies, free, independent, and special schools and alternative provision such as pupil referral units is included is available at slough.gov.uk The Service Provider shall be required to verify the informationon or before the Commencement Date and ensure that the Service is responsive to changes to this linformationover time and seek to pro-actively negotiate accommodation within school premises. The aforementioned list may be updated at the sole and absolute discretion by the Authority.

The Service Provider is solely responsible at their sole cost and expense to have a premises for its staff and service users to use.

The Service Provider must ensure that provision to home-schooled children and children not in education, employment or training is via domiciliary visits, or a community-based site arranged by the Service Provider. The Service Provider shall be liable for (including but not limited to) any travel, subsistence and accommodation costs for providing the Service.

16.5 Home Visits

The Service Provider shall undertake a large element of Health Visiting to be directly delivered within the home of the family. This includes all new birth visits and 6–8-week reviews, and follow-up work, or work with children at the targeted and specialist level.

16.6 Equipment

The Service Provider shall procure, use, and maintain, the appropriate equipment and resources required by the Service including, but not limited to clinical equipment, measurement equipment within the contract envelope value.

The Service Provider shall be responsible for the safety and suitability of all equipment used in service delivery and shall source and pay any service specific IT costs, for instance an N3 connection (an NHS secure broadband network, through which NHS information

systems are delivered and accessed). All IT costs and expenses shall be borne solely by the Service Provider.

17 RECORD KEEPING, INFORMATION SHARING and DATA COLLECTION

17.1 Core Requirements

In line with contractual requirements, the Service Provider shall ensure that robust technical and organisational measures are in place to meet the legal requirements of the Data Protection Act 2018 and the UK-GDPR so as to ensure the safeguarding of personal data at all times.

The Provider must comply with the Accessible Information Standards.[15] This includes the identification and recording of service users' information and communication needs at the first interaction and on an on-going basis throughout contact with the service. For more information about the standards see https://www.england.nhs.uk/ourwork/accessibleinfo/

In line with the above and following good practice guidance, the Service Provider will be required to sign up to the Authority's Overarching Information Sharing Protocol (Tier 1) and work in partnership with the Authority to develop and agree Service Specific Information Sharing Agreements (Tier 2). This will include any partner organisations the Service Provider commissions. Through this, and following good practice guidance, the Provider will have agreed data sharing protocols with partner agencies, including healthcare providers, children's social care and the police to enable effective holistic services to be provided to children and their families. This will improve the coordination and communication between services and safeguard & protect children.

It is required that as a minimum the Service Provider shall share data on new births and outcomes from the one year and 2 – 2 ½ year review with the Authority's Early Years' Service and with the Children's First/Children Centre provider.

The Service Provider shall ensure that all staff have access to information sharing guidance including information sharing of safeguarding and protection of children. The Service Provider shall ensure Information Governance policies and procedures are in place and understood. Where the Service Provider is accessing the Authority's network or systems, the Service Provider and all staff must adhere to all of the Authority's Information Governance and IT Security policies and procedures.

The Service Provider must ensure that all records and data entry is accurate to enable high quality data collection to support the delivery, review and performance management of services.

The Service Provider shall adhere to the Authority's Technical and Security standards where they provide their own IT hardware and applications.

[15] https://www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/accessibleinfo/

17.2 Staff training

The Service Provider shall ensure that staff are using and trained to use all required systems, applications and electronic equipment such as applications, secure email and secure messaging. This includes, the use, where necessary, to meet needs and make the service accessible through remote access. This includes but is not limited to laptops and tablets, mobile phones, teleconference facilities, video conferencing facilities.

The Service Provider must not use WhatsApp or any similar application for corresponding about service users or for use within the Service. Staff must not use WhatsApp or any other similar application to refer or discuss service users. All communication channels must be formal communication channels.

17.3 Data submission to NHS Digital

The Service Provider shall ensure patient level data and activity delivered by the service is recorded using a suitable Electronic Health Record (EHR) System . Currently NHS England has the responsibility for commissioning Child Health Information Services (CHIS) and the Service Provider shall share information from their EHR in accordance with CHIS requirements. Data and information shall be recorded by the Provider in an easily extractable method to allow reporting and monitoring of services being delivered.

The Service Provider shall ensure that all performance indicators required will be reported on, and considerations on recording and extraction of data be made in light of this. The Authority's nominated officers may request anonymous data for audit purposes which the Service Provider shall make available on request.

The Service Provider shall submit monthly data to the Community Services Data Set (CSDS) at NHS England and have a development plan in place to improve data quality and completeness as required. CSDS Monthly Data Submission Dates

Full Time Equivalent (FTE) Health Visiting workforce numbers are reported using data from the Electronic Staff Record (ESR) and non ESR sources, in line with agreed definitions of the Health Visiting Minimum Data Set (HV MDS). The Provider shall ensure ESR records are updated, including ensuring correct coding of all HVs, on a monthly basis, based on the health and social care information centre workforce data collection and in line with the definition on NHS England HSCIC website

To demonstrate that the UK Government's workforce commitment has been met, accurate workforce data, service delivery and outcomes measures will need to be collated. The Service Provider shall support NHS England in the collection and reporting of health visiting workforce and outcomes data as required.

17.4 Red book and e-red book

The Service Provider shall encourage and support parents and carers to use the Personal Child Health Record (PCHR) or 'Red Book' proactively, as their own complete record of key information regarding their child's health, reviews, screening and immunisation status. The Service Provider shall record key information in the 'red book' to enable practical and inclusive sharing of information between the Providers and parents.

18 SECURITY

The Provider should procure that the relevant employees do not breach the normal security arrangements for the Council's land and buildings.

If the Provider becomes aware of any breaches of the Council's normal security arrangements, it shall immediately notify the Authorised Officer.

The Provider shall be responsible for the safekeeping of any passes and other means of access provided to the Provider by the Council and shall only give such passes and other means of access to those Relevant Employees whose names and addresses have been supplied to the Council and who require the same for the purposes of providing the services. The Provider shall procure that such Relevant Employees safeguard and do not misuse any such passes and any other means of access. The Provider shall ensure that the Authorised Officer is informed immediately of any loss of any passes and other means of access and shall reimburse the Council any costs of replacement and/or any reasonable security measures implemented as a result of such loss.

The Relevant Employees may be required to sign in and out when visiting any of the Council's land or buildings and to wear any badges, passes or other means of identification whilst on the Council's premises.

The Provider shall procure that promptly when requested to do so, or when communicating with others as a representative of the Provider in connection with the Services, all Relevant Employees shall disclose their identity and status as employees of the Provider and shall not attempt to avoid doing so.

The Provider shall procure that all monies or other items found by the Relevant Employees at any Council land or premises shall be handed or notified to the Authorised Officer as soon as possible and a written receipt obtained thereof.

19 19 SAFEGUARDING

Safeguarding is a core part of the Children Centre and Healthy Child Programme. The Service Provider shall provide appropriate and effective safeguarding services and adhere to relevant national and local requirements and guidance and implement wherever necessary. Reference shall be made to the revised supporting guidance to utilise the safeguarding professional guidance Children Act 1989, Children Act 2014 and Working Together to Safeguard Children.

Working together to safeguard children - GOV.UK (www.gov.uk)

19.1 Role in safeguarding

Safeguarding children, which includes child protection and prevention of harm to babies and children is everyone's responsibility and is a public health and Authority's priority. In safeguarding children, the Service Provider shall (including but not limited to):

1. Work within the Slough Multi-Agency Safeguarding Children Partnership Procedures, the Slough Safeguarding Partnership: what to do when a child needs help practice guidance and Working Together to Safeguard Children guidance, as well as locally agreed Local Safeguarding Children's Board (LSCB) protocols.
2. Identify vulnerable babies and children where additional on-going support is required to promote their safety and health and development. Ensure cases are stepped up via Multi-Agency Safeguarding Hub (MASH) using the Request for Help Support and Protection where the concerns are above level 2.
3. Ensure early intervention, for example, parenting support and early referral to targeted and specialist support. This includes utilising the Early Help Assessment tool and undertake the role of lead professional/key worker where appropriate;
4. Ensure appropriate safeguards and interventions are in place to reduce risks and improve health and wellbeing of children for who there are safeguarding and/or child protection concerns. This includes maintaining accountability for babies and children for whom there are safeguarding concerns and working in partnership with other agencies to ensure the best outcomes for these children;
5. Work with other agencies as part of a multi-agency intensive care package for children and families requiring intensive support, particularly children for whom there are safeguarding or child protection concerns;
6. As part of this, fulfil the statutory duty to share information and communicate with other professionals including but not limited to health and agencies where there are safeguarding concerns;
7. Engage in multi-agency working for example (including but not limited to) through weekly multi-disciplinary meetings and child protection conferences as well as the MASH and Multi-Agency Risk Assessment Conference (MARAC);
8. Participate in safeguarding and child protection procedures where related to their direct caseload. In circumstances where individuals are not available for this participation, the Service Provider will ensure participation is covered by a team member only where the child is also known to that substitute team member or submit relevant information which will support those procedures. The Service Provider will enter into a Memorandum of Understanding with the Authority in respect of attendance at child protection and safeguarding meetings for this purpose;
9. Communicate effectively with other agencies including contributing to initial and review case conferences and other safeguarding meetings as appropriate to the needs of the children
10. Work closely with Authority's Children's Social Care to ensure that clear escalation procedures are in place in order to escalate concerns about a child or to escalate difficulties in communication or partnership working between services that may ultimately impact on safeguarding;
11. Work with the Looked After Children (LAC) nurse to contribute to and support assessments of Looked After babies and children with timescales in line with national requirements and contribute to ensuring any action plans are carried out. Ensure provision of the HCP and additional services to meet their health needs;
12. In order to carry out the safeguarding role set out in this specification the Service Provider's staff shall require (including but not limited to):

a. Knowledge around domestic abuse, neglect, child and adult mental health issues, substance and alcohol misuse, physical, sexual and emotional abuse, female genital mutilation, fabricated and induced illness in a child;
b. Key skills and qualities including high levels of communication and interpersonal relating, self-awareness, ability to challenge and to be challenged, understanding of barriers to safe practice.

19.2 Referrals

Urgent safeguarding referrals shall be made by the Service Provider via the Authority's Request for Help and Support or Protection form in full via the Multi-Agency Referral Form (MARF) that will be triaged by the MASH Team. Where a response to a Safeguarding referral is required from the Service Provider this shall be completed within 24 hours. Responses required from the Provider for other referrals or request for information shall be completed by the Provider within five (5) working days (see section on Responding to/Receiving Referrals above)

Early Help Assessments / Plan Intervene & Review: Where appropriate, the Service Provider shall as required contribute to an Early Help Assessment, Plan and Reviews utilising the family's information system.

19.3 Safeguarding supervision

The Service Provider shall ensure that all frontline staff receive a minimum of monthly safeguarding supervisions of their work with their most vulnerable children and young people. These shall include but not be limited to children and young people on a child protection plan, those who are 'looked after' and others for whom the staff member has a high level of concern. The Service Provider shall ensure that safeguarding supervision is provided by colleagues with expert knowledge of child protection to minimise risk.

20 WORKFORCE & TRAINING

20.1 Workforce General Requirements

The Service Provider shall recruit staff for the Healthy Child Programme to fully meet the requirements of the service specification. A workforce development plan shall be agreed by the Service Provider with the Authority's commissioners on an annual basis. This includes ensuring that staff within the service are appropriately qualified, trained, knowledgeable and experienced with the competencies to deliver the service to ensure that outcomes are met, levels of quality are achieved and that the Service remains safe and effective for everyone involved.

The Service Provider shall note and follow the following guidance:

Supporting the Health Visiting and School Nursing Workforce

In line with the Equality Act 2010 the Service Provider shall recruit to staff roles using the principles of positive action in order to secure a workforce representative of the

diverse local community.

Positive Action for Recruitment

20.2 Training Requirement and Competencies

The Service Provider shall ensure that all specialist staff hold appropriate qualifications with a UK registered professional body.

Additionally, and as a minimum, the Service Provider shall ensure that all staff and volunteers (where appropriate):

- have an enhanced Disclosure and Barring Service ("DBS") check;
- be engaged on employment contracts commensurate with their position, current employment legislation and good practice;
- have complete and up-to date statutory and mandatory training in place;
- have completed all tiers of child protection training appropriate to their role
- have access to mental health first aid training;
- have access to ongoing professional development to support their own career development;
- have completed equality and diversity training and are aware of their responsibilities to ensure equitable access for all service users;
- ensure that staff are experienced and culturally competent in and responsive to providing services that are sensitive to the wider issues for underrepresented groups;
- be able to respectfully and professionally communicate with children and their families from a wide cultural diversity, by accessing appropriate interpretation services as required; and
- are capable and confident in working with the range of other providers services.

The Service Provider shall ensure that (including but not limited to):

- All staff working directly with children and families have sufficient knowledge, training and support to promote the physical and psychological well-being of children and their families and to identify early indicators of issues and vulnerability;
- All staff have annual performance management and appraisals to identify skills or training needs to help improve outcomes;
- Training needs assessments are carried out for all staff working within the service and a plan is developed to deliver the core learning and development requirements identified. Resources allocated for the CPD requirements should be identified in the plan and opportunities to access multi-agency training should be maximised;
- Staff are supervised and provided with access to appropriate induction, training, appraisal, supervision and professional development opportunities. The breadth, depth and nature of training shall be appropriate to meet the needs of the people engaged with by the Service;
- An appropriately publicised disciplinary and grievance procedure is in place for all employed staff;

- All employed staff and volunteers clearly understand their roles and responsibilities by providing clear job descriptions and by receiving adequate induction and on-going training / one to one supervision etc. commensurate with their role;
- The diversity and skills of staff reflect the needs and profile of people in Slough, with a particular focus on recruiting male employees into the Service; and
- Opportunistic opportunities are exploited to enhance and develop the skill set and wider knowledge of the Service Provider's workforce, particularly in relation to working in partnership with other service providers.

The Service Provider shall work with NHS England, HEE and Local Education Training Boards (LETBs) to ensure effective support for trainees and newly qualified Health Visitors, School Nurses, Family Nurses and other frontline clinical staff. This shall be delivered by ensuring the provision of: sufficient practice teachers; support through mentoring and supervision for students and newly qualified staff; in line with NMC and HEE requirements.

The Service Provider shall develop and maintain a supervision policy and ensure that all staff across the service access supervision in line with the framework below.

The Service Provider shall ensure that staff have key competencies as outlined below (including but not limited to):

- Excellent communication and engagement skills;
- A positive attitude to supporting people with complex lives;
- An empathic / non-judgmental approach;
- Working in person centred ways, using a supportive and empowering approach; and
- Ability to build credibility, and inspire trust and confidence.

20.3 Supervision

Regardless of the type, the Service Provider shall ensure that supervision has an emotionally restorative function and will be provided by individuals with the ability to (including but not limited to);

- Create a learning environment within which staff in the various teams can develop clinical knowledge, skills and strategies to support vulnerable families;
- Use strengths-based, solution-focused strategies and motivational interviewing skills to enable the teams to work in a consistently safe way utilising the full scope of their authority;
- Provide constructive feedback and challenge to the teams using advanced communication skills to facilitate reflective supervision;
- Manage strong emotions, sensitive issues and undertake courageous conversations;
- Provide guidance on the interpretation of policies and guidance.

The Service Provider shall develop and maintain a supervision policy and ensure that all staff across the service access supervision in line with the framework below:

20.4 Professional Clinical supervision:

The Service Provider shall ensure all staff have clinical supervision according to their needs using emotionally restorative supervision techniques on a regular planned basis.

20.5 Management supervision:

The Service Provider shall ensure all staff with a requirement to line manage staff such as team leaders have access to a senior manager or professional lead to provide one to-one professional management supervision of their work, case load, personal & professional learning and development issues.

The Service Provider shall note and adhere to the code for Professional Standard for Public Health Nursing Workforce

20.6 Health Visitor Practice Teacher Supervision

The Service Provider shall ensure Health Visitor Practice Teachers have access to high quality supervision according to the requirements of their role.

20.7 Workforce Capacity

The Service Provider shall make provision for capacity in the case of staff absence, turnover, hours worked, as well as levels of client vulnerability and/or additional needs of clients that includes but is not limited to safeguarding, English as a second language, Looked After Children.

The Service Provider shall ensure staff contracts are flexible enough to accommodate changes to the operating times of the services which will be shaped by the needs of the service users and agreed with the Authority.

20.8 Sustainability

Over the period of this Agreement, the Service Provider shall develop a Workforce Travel Plan to support Slough's ambition to develop a sustainable environment including exploring opportunities to promote or encourage staff delivering these services to travel via sustainable modes of transport including consideration of encouraging pool car usage.

The Service Provider shall endeavour to develop staff awareness knowledge in fuel poverty which, if undertaking home visits may provide families with guidance on what support is available to help make homes more energy efficient and comfortable and more affordable to run.

20.9 Complaints

From the Commencement Date, The Provider shall operate a clearly defined complaints procedure approved by the Authorised Officer, with agreed performance measures and monitoring systems to enable the numbers and types of complaints to be checked. The complaints procedure shall clearly record the nature of the work involved, the nature of the

complaint, the identity of the person making the complaint, the action taken by the Provider in response and all relevant dates. Such records shall be kept available for inspection by the Authorised Officer at a mutually convenient location at all reasonable times.

The Provider shall deal with any complaints received from whatever source in a prompt, courteous and efficient manner. All complaints shall be properly replied to within 7 days.

The Provider shall notify the Authorised Officer forthwith in writing of all complaints received and action taken by the Provider in response to the complaints.

20.10 Healthy Workplace

The Service Provider shall endeavour to seek accreditation for the Slough Healthy Workplace Award which is intended to enable organisations to design and/or enhance their employee wellbeing strategy.

20.11 Workforce Reporting

The Service Provider shall provide a report to the Authority on the current workforce on a quarterly basis.

Where the Service Provider is unable to meet / fulfil agreed workforce requirements, the Service Provider shall develop and share a detailed recruitment / retention plan with the Authority's commissioner, which will be reviewed quarterly.

The Service Provider shall develop robust workforce analyses and plans to achieve set trajectories, recruitment/retention plans; numbers of retirees; potential leavers; expectations of agency and bank staff to substantive contracts.

The Service Provider shall have in place target and development plans to support workforce development and retention, mobilisation of expanded services, service transformation and service monitoring.

21 FINANCE

The Service Provider shall manage and monitor the Agreement finances and ensure adherence to financial regulations of the Authority.

The Service Provider shall work in partnership with the Authority's Public Health Team to ensure that expenditure for the year remains within the allocated budget and will inform the Authority's Public Health Team of any financial or sustainability concerns as they arise.

The Service Provider shall submit quarterly financial reports on its budget spend in a format determined by the Authority.

22 SUPPORTING LOCAL PUBLIC HEALTH STRATEGY DEVELOPMENT & WIDER PUBLIC HEALTH PROTECTION

Through collection of population health data and the development of expert qualitative intelligence about the communities' assets and health needs the Service Provider shall provide support to inform the Slough Joint Strategic Needs Assessment (JSNA).

The Service Provider shall be able to advise on current best practice in health promotion for children and young people and support appropriate Slough strategies for this purpose.

22.1 Health protection activities

The Service Provider shall respond to a Public Health crisis as required, following emergency planning procedures, and promoting Public Health actions as appropriate to the need. The Provider shall assist with implementing public health control measures (including vaccination and mass prophylaxis) in children's health clinics, school and community settings.

Where there has been a communicable disease exposure of children and young people in any setting, as directed by the Authority's Public Health Team or by PHE, the Service Provider shall respond appropriately and support the Authority and/or Public Health England (PHE) with the risk assessment process.

23 APPENDICES

National context

Commissioning responsibility for 0 to 19 year old services

The Health and Social Care Act 2012 set out local authority's statutory responsibility for commissioning public health services for children and young people aged 0-19 years. This includes services all families with babies to be offered 5 mandated health visitor reviews before their child reaches 2 ½ years old. The Local Authorities Regulations 2015[16] further sets out the main components of the universal health visitor reviews.

It is the responsibility of the Service Provider to be aware of current and future legislative framework governing the delivery of the 0-19 services and ensure that they comply prevailing legislative framework.

Wider national policy context

The 2019 NHS Long Term Plan[17] identifies several common threads that will influence the delivery of the HCP. It sets out a clear commitment for improving maternity health and care, and improving health outcomes for children set out below:

- Children and young people in England will have better physical health, mental health and wellbeing
- Children and young people, and their parents and carers, will experience a seamless service delivered by an integrated health and care system
- There will be a skilled workforce that listens to them, responds, and meets their needs.

The importance of a system-wide approach to embedding prevention in the support provided to women before, during and after pregnancy is detailed in the PHE Maternity High Impact Areas (PHE,2020)[18]. As specialist public health nurses, with a universal and targeted reach, Health Visitors and their teams have a significant opportunity, working alongside partners in the local maternity system and others, to contribute in each of the six high impact areas identified:

1. Improving planning and preparation for pregnancy, including the inter-pregnancy period
2. Importance of supporting good parental mental health
3. Supporting healthy weight before and between pregnancies
4. Reducing the incidences of harms caused by alcohol in pregnancy
5. Supporting parents to have a smoke free pregnancy
6. Reducing the inequalities of outcomes for women from Black, Asian and Minority Ethnic communities and their babies

[16] Full citation of the Regulation is "The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) and Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) (Amendment) Regulations 2015"
[17] https://www.longtermplan.nhs.uk/
[18] https://www.gov.uk/government/publications/commissioning-of-public-health-services-for-children

Modernisation guidance for the National 0-19 Healthy Child Programme (HCP)[19] published in March 2021, placed increased emphasis on personalised care as well as professional and clinical judgement recommending the inclusion of two additional universal contacts at 3-4 months and 6 months to the mandated health visitor reviews.

The wider national context is further reflected in the following documents:

- Better health outcomes for children and young people: Our pledge[20] (Department of Health, 2013)
- Getting it right for children, young people and families: Maximising the contribution of the school nursing team: Vision and call to action [21](Department of Health, 2012);
- Report of the children and young people's health outcomes forum 2013/14;[22]
- Fair Society, Healthy Lives, The Marmot Review, 2010.[23]

Emerging impact of COVID-19

The negative impact of COVID-19 and the lockdown has been evident on children and young people's mental health. The October 2020 NHS Digital's follow-up *report* [24]estimated that the proportion of children and young people aged 5 to 16 years with a probable mental health disorder had risen from 10.8% in 2017 to 16% in July 2020. For 5 –10-year-old boys there had been a significant increase from 9.4% in 2017 to 14.4% in 2020. In 17 to 22-year-olds, 27.2% of young women and 13.3% of young men were identified as having a probable mental health condition.

The Royal College of Paediatrics and Child Health: State of Child Health (2020) [25] recommended that child health in the UK must be urgently prioritised in the aftermath of the pandemic, and this can be achieved by attending to three crucial, overarching issues:

- **Reduce child health inequalities.** Action should be taken to tackle the causes of poverty and reduce variation in outcomes.
- **Prioritise public health, prevention and early intervention.** Preventative measures will reverse current trends and ensure healthy children become healthy adults.
- **Build and strengthen local, cross-sector services.** There should be equitable access to services, resources, advice and support within the local community.

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[19] https://www.gov.uk/government/publications/healthy-child-programme-0-to-19-health-visitor-and-school-nurse-commissioning

[20] https://www.gov.uk/government/publications/national-pledge-to-improve-children-s-health-and-reduce-child-deaths

[21] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216464/dh_133352.pdf

[22] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/307011/CYPHOF_Annual_Report_201314_FORMAT_V1.5.pdf

[23] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/307011/CYPHOF_Annual_Report_201314_FORMAT_V1.5.pdf

[24] https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2020-wave-1-follow-up

[25] https://www.rcpch.ac.uk/resources/state-of-child-health

Evidence base

The Royal College of Paediatrics and Child Health (RCPCH) report, State of child health - England: 1 year on,[26] highlights that children living in England have poorer health outcomes than average across the EU15+ (the 15 EU countries plus Canada, Australia and Norway), including infant mortality, child obesity and low rates of breastfeeding. Though the Health Profile for England indicates that overall child health in England has continued to improve, children living in more deprived areas are more likely to (including but not limited to): [27]

- Be exposed to avoidable risks before birth;
- Get off to a less healthy start from birth;
- Experience poor outcomes by the time they start school - when compared with children who live in less deprived areas.

The Best Start for Life: a vision for the 1,001 critical days[28] highlighted six key areas on which to focus additional support for families (including but not limited to):

- Seamless support for families: a coherent joined up Start for Life offer available to all families;
- A welcoming hub for families: family hubs as a place for families to access Start for Life services;
- The information families need when they need it: designing digital, virtual and telephone offers around the needs of the family;
- An empowered Start for Life workforce: developing a modern skilled workforce to meet the changing needs of families;
- Continually improving the Start for Life offer: improving data, evaluation, outcomes and proportionate inspection;
- Leadership for change: ensuring local and national accountability and building the economic case.

Giving every child the best start in life and reducing health inequalities throughout the life course was highlighted by the 2010 Marmot report[29] (Fair Society, Healthy Lives) and further emphasised by the 2020 Health Equity in England: The Marmot Review 10 Years On[30]. Inequalities in the early years have lifelong impacts as this is the period of life when interventions to disrupt inequalities are most effective, and interventions in the early years have been shown to be cost-effective and yield significant returns on investment.

Many health challenges and inequalities have foundations in early childhood, with the poorest families experiencing the worst health outcomes. Reducing child health inequalities, what's the problem? reports that adverse health outcomes would be reduced by 18% to 59% if all children were as healthy as the most socially advantaged.

[26] https://stateofchildhealth.rcpch.ac.uk/one-year-on/
[27] Office for Health Improvement and Disparities (2022): Healthy beginnings: applying All Our Health
[28] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/973085/Early_Years_Report.pdf
[29] https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review
[30] https://www.instituteofhealthequity.org/resources-reports/marmot-review-10-years-on/the-marmot-review-10-years-on-full-report.pdf

Healthy beginnings: applying All Our Health[31] contains information to help healthcare professionals and care staff use their trusted relationships with children, families and communities to promote the benefits of promoting the best start in life. It also contains important actions that managers and staff holding strategic roles can take to improve outcomes.

Maternal and child health inequalities

Health inequalities are the unfair and avoidable differences in health across the population, and between different groups within society. The 2020 "Maternity high impact area Reducing the inequality of outcomes for women from Black, Asian and Minority Ethnic communities and their babies"[32] recognised some of the factors exacerbating inequalities in maternal and child health among minority ethnic groups including but not limited to:

- Low socio-economic status or social support;
- Lack of proficiency in English;
- Multiple vulnerabilities such as female genital mutilation (FGM) or recent migrant status;
- Policy of charging undocumented migrants for maternity care;
- A 'one size fits all' approach to maternity care which does not consider differences in women's abilities to understand or access care, or serve the most vulnerable appropriately, can result inequalities in healthcare provision, contributing to structural racism; and
- Cultural barriers combined with insufficient training of healthcare professionals in cultural sensitivity and knowledge.

The MBRRACE-UK report (2018)[33] showed that between 2014-16, Black women were five times more likely, and Asian women twice as likely, to die in the perinatal period than White women. The importance of reducing the inequalities of outcomes for all vulnerable women and their babies and those in Black, Asian and other ethnic minority groups, is reflected in the 2021 NICE Guidelines for postnatal care.[34]

Adverse Childhood Experiences (ACEs)

The 1001 Critical Days cross party manifesto[35] sets out a robust evidence base for the importance of prevention and early intervention from conception to two years. Effective intervention, particularly in the first 1001 days has the potential to break intergenerational cycles of transmission of Adverse Childhood Experiences (ACEs) and disadvantage. The impact of ACE's as major cause of toxic stress (categorised as abuse, neglect –physical and emotional or sexual - and household dysfunction including parental mental illness, victim of domestic abuse (DA), divorce, family member in prison or parental substance misuse) is well evidenced (EPPI Centre Review, 2019)[36].

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[31] https://www.gov.uk/government/publications/healthy-beginnings-applying-all-our-health/healthy-beginnings-applying-all-our-health

[32] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942480/Maternity_high_impact_area_6_Reducing_the_inequality_of_outcomes_for_women_from_Black__Asian_and_Minority_Ethnic__BAME__communities_and_their_babies.pdf

[33] https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202018%20-%20Web%20Version.pdf

[34] https://www.nice.org.uk/guidance/ng194/evidence

[35] https://www.nwcscnsenate.nhs.uk/files/8614/7325/1138/1001cdmanifesto.pdf

[36] http://eppi.ioe.ac.uk/cms/Default.aspx?tabid=3755

Frimley ICS Strategy 2019-2025

The strategy[37] aims to ensure that all children get the best possible start in life by (including but not limited to):

- Engaging children and young people in a different way, working with education and building on young people's creativity;
- Providing targeted support for children and families with the highest needs and those who are the hardest to reach;
- Supporting women to be healthy before pregnancy;
- Ensuring births are safe;
- Expanding life choices and opportunities; and
- Increasing happiness and decreasing anxiety.

The strategy aims to achieve the following outcomes for children and young people (including but not limited to):

- Improved mortality for all;
- School readiness in top decile;
- Reduced prevalence and variation in obesity;
- Reduced variation in childhood vaccinations; and
- Improved outcomes for our most vulnerable children.

Slough Strategic priorities

The Slough Joint Wellbeing Strategy 2020-2025, Layout 1 (slough.gov.uk) developed by the Slough Wellbeing Board is based on the needs identified by the JSNA, and four priority areas.

Priority One - Starting Well is led by the Children and Young People's Partnership Board, and aims to:

- Decrease the attainment gap between all children and the bottom 20% at Early Years Foundation Stage;
- Reduce the number of Reception and Year 6 aged children classified as obese;
- Improve immunisations rates amongst young people in Slough;
- Improve oral health amongst children in Slough.

Slough Council's Five-Year Plan 2020 – 2025, was refreshed in 2021 in light of the need to, rethink and change not only what we do but how we do it. The plan aims to reduce inequalities by enabling people to take more responsibility for their own lives, for example, by living healthier lifestyles.

It has four outcomes

- Outcome 1: Slough children will grow up to be happy, healthy, and successful
- Outcome 2: Our people will be healthier and manage their own care needs

[37] https://www.frimleyhealthandcare.org.uk/media/1258/draft-frimley-health-care-system-strategy-narrative-v22-20190927.pdf

Slough Borough Council (SBC) overview of relevant HNA

The Berkshire East Joint Strategic Needs Assessment: Slough Summary shows that the average household size in Slough is 2.8 people, compared to 2.4 in England. Over 6,500 households in Slough were estimated to be overcrowded, significantly higher than regional and England averages; the 2021 Census shows there has been an increase of 49% in the number of households with 7 people and an increase of 92% in the number of households with 8 or more people. Households assessed as homeless at 1.19 per thousand, is also above the regional rate of 1.13 (June 2022).

Sloughs population is relatively young. A total of 43,650 children and young people (aged under 18) live in Slough (Office for National Statistics, 2022) which is the second highest proportion of children aged under 15 years in England and Wales (ONS 2021).

The percentage of children who live in relative poverty at 23% (2021, Census) is above regional and national averages, and continues to increase.

The Child Health Profile shows that health in Slough remains poor. The Borough has the highest total fertility rate in England, the highest proportion of babies born with a low-birth weight and the 2nd highest infant mortality rate in the South East. The borough also has low rates of immunisations, high rates of underweight and obesity, poor oral health and high rates of hospital admissions for children under 1yrs old.

There are 44 state funded schools, 3 special schools and 1 College at the time of writing this specification. 13.4% (134) Secondary School pupils were eligible for free school meals in 2019/20; this increased by 3% to 208 pupils in 2020/21 to 10.4% (342 pupils). 78% of school-aged children are from Black and Minority Ethnic backgrounds; the Asian British multi-ethnic group is the largest group (52%) and of these, British Pakistanis are the largest at 26%.

Table: xxxx

Population (Census 2021)	**158,500 people** - an increase of 13% over the last decade (over 18,000 more people). **Population is one of the youngest in England** with 27% of people aged under 18. While the number of people aged 65 and over has increased by 19% over the last decade, this group only makes up 11% of the total population.
Ethnicity and language (Census 2021)	People from Asian backgrounds are the largest ethnic group in Slough at 47%. A further 18% of the population are from other ethnic minority groups and 12% from white non-British backgrounds. 24% of Slough's population are white British. **Asian ethnic groups have increased in number and proportion in Slough over the last decade (+7% points); people from white British groups have decreased (-11% points)** 5% of people cannot speak English well or at all.
Deprivation (IMD 2019)	**Slough is the most deprived local authority area in Frimley ICS** and is in the 5th most deprived decile in England. None of Slough's neighbourhoods are in the 10% most deprived in the England, however 8% of Slough's population live within England's 10%-20% most deprived areas. These are in areas of Britwell and Northborough, Central, Chalvey, Colnbrook with Poyle and Elliman wards.
Employment (Oct-21 to Sept-22)	**Lower levels of employment** than regional and national figures (72.7% aged 16-64) **Higher levels of unemployment** than regional and national figures (5.3% unemployed) **Lower levels of workless households** 5% of Slough's households were workless in 2021
Housing (Census 2021)	49% of households are owned and 51% are rented (20% social, 31% private) **Much higher percentage of overcrowded households** – 16% in Slough, compared to 4% nationally. Slough's population density is also significantly higher. **Nearly 8% of people live alone** with **27% of those aged 66 and over living alone**
Self-reported health and disability (Census 2021)	**Lower levels of self-reported good health** compared to national and regional figures (when age standardised) - 80% of people in Slough report very good/good health and 6% report very bad/bad health. **Lower levels of self-reported disability** compared to national and regional figures (when age-standardised) - 11% of people report that they have a long-term physical, mental health condition or illness that limits their activities (7,880 people).

Neighbourhood Maps

[To be populated]

- KPI's
- Additional Reporting
- Schools in Slough