Schedule 2A – Service Specification

Service Specification No. :	Tbc
Service:	**Plymouth Integrated Community Health, Wellbeing and Special Educational Needs and Disabilities Support Services**
Commissioner Lead:	Northern, Eastern and Western Devon Clinical Commissioning Group
Provider Lead:	Tbc
Period:	1 April 2020/21 (7+/-3 years)
Date :	1 February 2018

1. Population Needs

1.1 Introduction and Vision

This service description should be viewed as a component of the Plymouth integrated whole system approach to deliver Integrated Community Health, Wellbeing and Special Educational Needs and Disabilities Support Services in Plymouth. The provider will have an obligation to collaborate with the other key providers in the system - Plymouth Hospitals NHS Trust (PHNT) and Plymouth City Council (PCC). The provider will also have a wider system leadership role across Plymouth.

This service description should be read in conjunction with:

- The Services Strategy document
- Reports of engagement undertaken during the pre-procurement phase
- Joint Strategic Needs Assessment for Plymouth https://www.plymouth.gov.uk/publichealth/factsandfiguresjointstrategicneedsassessment
- Thrive Plymouth - https://www.plymouth.gov.uk/publichealth/thriveplymouth
- Plymouth integrated commissioning strategies https://www.plymouth.gov.uk/adultcareandhealth/integratedcare
- Plymouth The Journey so Far document (appendix 5)

1.2 National context and evidence base

Commissioners require all services to be delivered in line with national legislation and guidance as well as local policy. General service applicable standards are listed in section 4. And additional specific requirements within the service description at Appendices 1-4

1.3 Local Context

System leadership, co-design and co-production are key principles underpinning the improvement and innovation work being undertaken in Plymouth. Providers are expected to, and will have an obligation to collaborate to, support the delivery of improved outcomes for the children and young people of the city of Plymouth, and to the sustainability of the system. This will deliver the best start to life for all children and provision of the right support at the right time for vulnerable children and young people.

In Plymouth, commitment to partnership working has allowed innovation to support more family-centred and joined up approaches to services for children and their families. There are many examples of good practice but the level of ambition is currently limited by the fragmentation of Community Health, Wellbeing and SEND support services within the city. Many examples of the good work to date, and areas for further development, are reflected in the Joint Ofsted/CQC Local

Area Inspection for SEND feedback in October 2016.
In order to deliver the right care, at the right time, in the right place, there is now a need to build upon Plymouth's Children and Young People Commissioning Strategy's ambition to focus on investing in health and wellbeing early and cohesively. This can be a cost effective way of bringing benefits to the whole system of care, enhancing long-term outcomes for children, young people, their families and carers and creating a sustainable system.

This opportunity will incorporate the full service offer of the Healthy Child Programme 0-19, including universal access and early identification of additional and/or complex needs with timely access to support. This will be achieved through the contribution of health visiting and school nursing skill sets; providing specialist public health analysis, defined clinical and public health skills, professional judgment, and autonomy and leadership
The provider will take a strategic lead role to contribute to the delivery of a whole system approach. This will ensure a responsive, outcomes focused, sustainable and value for money model of care that meets the health and wellbeing needs of children, young people, their families and carers.

The 'Plymouth Children and Young People's Commissioning Strategy 2015', sets out the ambition to:

Fully Integrate Specialist Education Support Services, Health Services and Social Care Services, to create a core offer for children (and young people) with SEND (and complex health needs), and provide a core component of delivery for a collaborative model of support for vulnerable children.

This opportunity will also allow us to fully integrate our prevention and health promotion offer embedding health and wellbeing as a core element within this integrated service.
The Plymouth Wellbeing Commissioning Strategy 2015 also states four aims, one of which is to:

Commission only from providers who have a clear and proactive approach to health improvement, prevention of ill health, whole person wellbeing and working with the wider community in which they operate

Sustainability and Transformation Plans (STP) were published nationally in the autumn of 2016. The work streams for the Devon STP include priorities for children and young people:

1. Best Start In Life
2. Adult Behaviours Adversely Affecting Children
3. Children With Additional Needs And Long Term Conditions
4. Emotional Health And Wellbeing

1.4 Demographic Summary
Joint Strategic Needs Assessments (JSNA) and local needs assessments are key strategic documents that provide detailed geographical, demographic and health and social care data which are used to inform commissioning decisions. Provider are required to evaluate and consider the information in the local JSNAs alongside key policies and strategies. The key documents for Plymouth can be found:

https://www.plymouth.gov.uk/publichealth/factsandfiguresjointstrategicneedsassessment

PHE Fingertips tool has additional data on population, child health profiles and deprivation. Available at:

https://fingertips.phe.org.uk/profile-group/child-health/profile/cyphof/data

2. Outcomes

2.1 NHS Outcomes Framework Domains and Indicators

The NHS Outcomes Framework (NHS OF) is a set of indicators that monitors the health outcomes of children and young people in England

The five domains and associated indicators are found in the NHS Outcomes Framework. Available at: **http://content.digital.nhs.uk/nhsof**

2.2 Public Health Framework Domains and Indicators

Available at: **http://www.phoutcomes.info/**

2.3 Local defined outcomes

In addition to the NHS OF there are a number of relevant outcomes and indicators which provide data about the health of children and young people.

As well as reporting against national outcome frameworks, the provider will report on the local Outcomes Framework as described below. Please also refer to the Service Strategy Document.

Table 1: Overarching Outcomes:

Health and Wellbeing (whole population)	Children, young people, their families and carers are empowered and enabled to improve their own health and wellbeing and know how to access information, advice and support if required To increase quality of life and adaptive and self-managing behaviours alongside the prevention and reduction of escalation of need.
Help and Support in the Community	Children, young people, their families and carers get the appropriate help when they need it To reduce out of area inpatient and residential placements by supporting children and families locally To support families and reduce family and carer breakdown To increase awareness of parents/carers/support networks and increase capacity to respond to the needs of children and young people
Access	Children, young people, their families and carers who need additional help receive timely, accessible and effective support. To develop and increase the knowledge, skills and capacity of professionals working with children and young people to be able to respond with the appropriate support, intervention and risk management as needed.
Recovery and independence	Children, young people, their families and carers are supported to sustain recovery, enhancing their resilience and supporting their ability to engage and cope with everyday life
Positive transitions	Children, young people, their families and carers are supported through key transition phases of age and services

Raising aspirations	Children, young people, their families and carers feel empowered to live the lives they choose and are given the right skills to reach their full potential
Choice and control	Children, young people, their families and carers are supported with person-centred care approaches which encourage and enhance independent living To increase the numbers of children and young people who have choice and control around the services those they receive through the use of IPC/PHBs in meeting their health needs. To increase and support the number of children and young people who are making decisions about their care using a method of communication appropriate to their needs to ensure the "Childs Voice" is heard.
Experience	Children, young people, their families and carers have a positive experience of care and support

3. Scope

3.1 Aims and objectives of service

The three key aims of the service are to provide:

- Prevention, early help and early intervention through a joined up service offer that supports the 'system' to promote health and wellbeing, prevent ill health, build resilience and meet need early.
- A holistic and integrated service offer that fully considers children's education and developmental needs, physical health needs, mental health needs and care needs.
- Care wrapped around the child and the family with the ability to deliver interventions needed in a timely planned and coordinated way.

The objectives of the service are to ensure the service model and provision is consistent with the 'critical success factors' and the 'core service principles' as described in the 'Services Strategy' document referred to on page 1 of this description.

Services are predicated on the needs of a child or young person but recognise the interdependency on the family and carers role so where appropriate and applicable wider support will be provided to families and carers.

3.2 Core Service Principles for this service

The overall aim in Plymouth is to develop an integrated offer for Community Health, Wellbeing and SEND Support Services for children, young people, their families and carers. The provider will, throughout the life of the contract, be required to maximise the whole integrated service resource including skill mix to deliver a seamless service model and this will include an obligation to collaborate with other providers.

The provider will need to deliver this through:

- A phased approach across the life of the contract
- Flexibility of skill mix and deployment of workforce
- Flexibility on the time services are available and the place of delivery of services to reflect children, young people and family's needs and wishes

- Contributing to the operational functioning of the Plymouth Gateway (or future equivalent) and the Community Health, Wellbeing and SEND multi-disciplinary group developments
- Flexibility of use of infrastructure i.e. buildings, IT, equipment
- Co-designing with partners and stakeholders pathways of care;
- supporting and enabling partners and communities to work together to design the services they need;
- Sharing of best practice
- Demonstrating system leadership focused on the continual improvement in outcomes for children, young people, families and carers and communities in Plymouth
- Providing leadership and delivery of services that support Thrive Plymouth – the city's 10 year approach to tackling health inequality
- Developing new, and building on existing, relationships with interdependent parts of the wider children's and adults system recognising the collective responsibility to deliver agreed outcomes for children and young people. As a system leader the provider will be expected to work with the third sector and system partners to support a community offer and build system capacity
- Maximising the opportunity that digital technology provides to improve reach to the population; provide access to information, advice and support and empower children, young people and families to better manage their own health and build health literacy. Supporting children, young people, their families and carers to navigate the system through a single point of access and a single, integrated assessment process* (see Plymouth 'The Journey so Far' document in appendix 5)
- Championing the voice of our children, young people and families by being fair and equitable, ensuring our children young people and families feel included and can access opportunities that make a difference to them; listening to what they tell us about the Service and acting on this feedback
- Enabling sustainability and resilience that ensures a positive impact on the lives of children, young people, their families and carers for this generation and those that follow
- Transitions between services or teams happen at the right time, in the right place and are well managed and seamless
- Maximising the potential of the integrated model to work in new and innovative ways through workforce development
- Joining with system partners to facilitate access to services and create opportunities for integrated working with other inter-dependent systems
- Integrated working should embed the principles of parity of esteem between physical and mental health recognising the impact an individual's mental and emotional health has on their life and vice versa
- Design based on the iThrive model that will provide services in a coordinated way with a seamless experience for the individual/family.
- Individuals should be empowered to develop resilience and build support networks wider than those provided by commissioned services through a recovery focused model

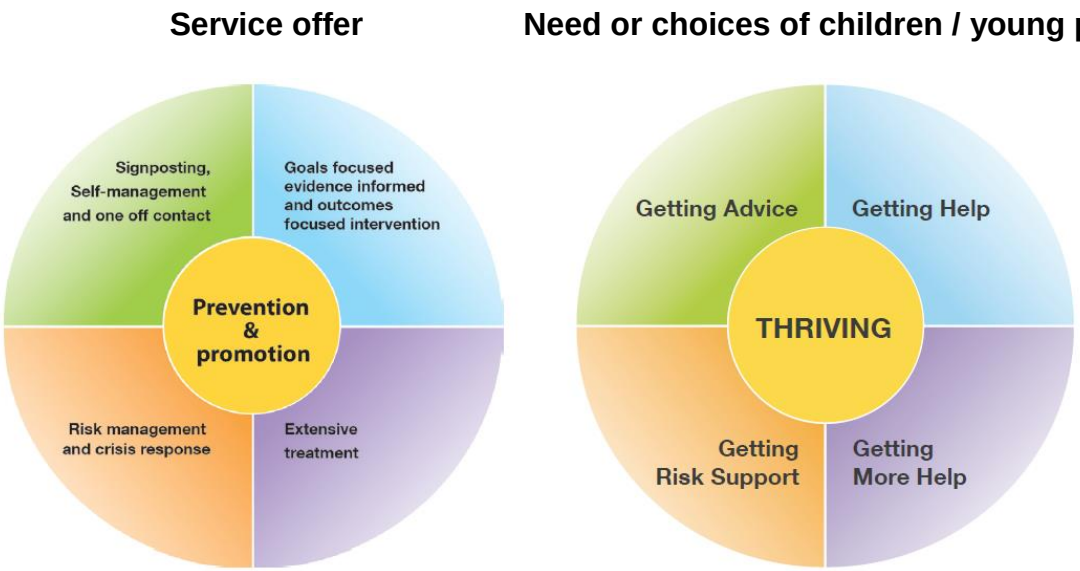
The phased implementation over the life of the contract toward a full and comprehensive integration of the service elements in scope will provide the best opportunity to fundamentally change the way that services are offered to families in Plymouth. This integration will need to embed a shift in organisational culture across the system, to improve the experience of families when they access community health, wellbeing and SEND support services, and with other services supporting need.

The provider will need to evidence delivery and achievement of the stated core service model and operational delivery standards.

The provider will consistently review the population health prevention, promotion and intervention offer, creating plans to meet any gaps in the ability to meet the presenting needs and pathways of care for children and young people, including workforce development plans and skill mix reviews.

3.3 Overarching Service Model

The provider will need to work to the iThrive, Anna Freud Centre/Tavistock and Portman NHS Foundation Trust framework shown below which was designed for CAMHS but is applicable across wider children's services and has underpinned the integration work to date in Plymouth. It operates a graduated approach to meeting need, with a focus on prevention and intervening early with the most appropriate intervention to prevent escalation. It separates the offer into five key areas which are described in the service offers section 3.4 below. Additional information on specific requirements for each service element in scope is set out in the appendices.



3.4 Service Offers:

The THRIVE Framework was developed by a collaboration of authors from the Anna Freud National Centre for Children and Families and the Tavistock and Portman NHS Foundation Trust. This framework outlines groups of children and young people and the sort of support they may need, and tries to draw a clearer distinction between treatments on the one hand and support on the other. The THRIVE framework was developed with a specific focus: supporting children and adolescent mental health. More information around the THRIVE Framework can be accessed: https://www.annafreud.org/media/4817/thrive-elaborated-2nd-edition.pdf

The framework and its underlying principles are ones that we believe would work well here in Devon.

The THRIVE framework depicted in figure 1 above has been illustrated showing what we would expect to see through implementing THRIVE (iTHRIVE) for our population of children and young people in Devon. Within some of the service specifications, there are specific aspects that we would be looking for the provider to deliver against.

Prevention and promotion

The provider will need to operate at both a population and targeted level i.e. for all pregnant mothers, children young people and families resident in Plymouth or children attending Plymouths early years setting or schools. This offer will aim to prevent ill health, promote positive health, resilience and identify need early.

The provider will work with commissioners to bring about the benefit for positive health and well-being outcomes by understanding the wider determinants of health and well-being and the role of resilience. The provider will ensure the service offer has strong networks to the wider community and services and in doing so have a clear community offer that enables professionals from across the system to offer a range of services outside of their direct delivery e.g. making every contact count. The provider will utilise approaches such as asset based community development work to help build capacity in the system (including through peer support) and so support delivery of the outcomes expected.

All services delivered by the provider will need to deliver the prevention and promotion agenda at a whole population level. This is not just the remit of specific services such as public health nursing but all services in scope. Strong and effective internal and external relationships and networks will be developed. The delivery of services will often be in community settings through a range of evidence based interventions focusing on individual, group and community populations.

Good physical and mental health and wellbeing will be promoted to children young people and their families as a natural and normal goal for all. By promoting good physical and mental health and wellbeing on a community-wide basis, a baseline of preventative action will be achieved which will reduce the likelihood of individuals needing to access advice, support or interventions from the system.

The provider will support parents and carers and children and young people to maximise their potential and build their resilience. They will deliver information and advice, triage need and offer early help, enable self-help and promote peer support to better equip children, young people their families and carers to cope with everyday challenges. The provider will provide population wide screening and checks/ reviews within a whole system offer.

The provider will gather and disseminate information about the wider delivery of Public Health initiatives and programmes and, where right and appropriate, jointly work with commissioners and providers on such activities. It is expected that where there is relevant evidence, best practice would be cascaded.

The Healthy Child Programme (HCP) brings together the evidence on delivering good health, wellbeing and resilience for every child. This is delivered as a universal service, which includes the provision of mandatory reviews /checks with additional services for families needing extra support, whether short-term intervention or ongoing help for complex longer-term problems.

The Healthy Child Programme provides a framework to support collaborative work and more integrated delivery. The Programme (0-19) aims to:

- help parents develop and sustain a strong bond with children
- encourage care that keeps children healthy and safe
- protect children from serious disease, through screening and immunisation
- reduce childhood obesity by promoting healthy eating and physical activity
- identify health issues early, so support can be provided in a timely manner
- make sure children are prepared for and supported in all child care, early years and education settings and especially are supported to be 'ready to learn at two and ready for school by five

Roles and activity for the prevention and promotion offer will include:

- Leadership and coordination of the delivery of the Healthy Child Programme 0-19 (or future equivalent) Delivery of the Healthy Child Programme including the delivery of the 5 mandated reviews and the health needs assessment of pupils at reception and Year 7
- Work with wider system partners to help create conditions for improved health outcomes in a range of settings including the home, early years, schools, post 16 and other key community hubs
- Contribution to the delivery of the National Child Measurement Programme by measuring the height and weight of children at Reception and Year 6 in publically funded schools , and support families to respond positively where there are signs of obesity or eating disorder
- Maximising use of 'Making Every Contact Count' to ensure that every child, young person and adult in contact with the whole integrated service is encouraged and helped to make healthier choices to achieve positive long-term behaviour change with a strong focus on supporting 'Thrive Plymouth' the city's 10 year approach to tackling health inequality
- Promotion of evidence based public health information programmes, for example NHS Start to Life / Change for Life as well as apps like Handi App that provides information to parents and carers around common childhood illness
- Work with the community, stakeholders and commissioners to identify local population health needs
- Activity to increase community capacity through maximising use of the skill mix available to the whole integrated service to support improved health outcomes for both the whole population and targeted populations using asset based community development approaches including the promotion and support of peer support
- Early identification of specific health and wellbeing needs and facilitation to access further help so ensuring a seamless link to additional support delivered through the integrated service model

Regardless of the additional support a child, young person or family requires to meet their own specific needs through the iThrive model they will continue to have access to the prevention and promotion offer.

Signposting, and self- management help and one off contact

Children, young people, their families and carers using this support offer may be adjusting to life circumstances, with mild or temporary difficulties, or with chronic, fluctuating or on-going needs or difficulties for which they are choosing to manage their own health and/or are on the road to recovery or where the best intervention is within the community with the possible addition of self-support that fits alongside short term or extensive support.

Provider will need to sign-post to services and actively encourage self-help and self-management for children, young people, their families and carers with emerging or identified physical and mental health needs.

Families will be enabled to support the development needs of their children underpinned through an approach that aims to build and develop positive attachment.

Children, young people, their families and carers will be supported to develop knowledge and understanding that enables them to develop their own goals, manage their own health, communication and behavioural needs in order to build resilience and reach their potential.

As a system leader the provider will be expected to engage with the third sector and system partners to deliver a cohesive community offer which focuses on improved outcomes for children and young people

Provider will promote physical and mental health and wellbeing and encourage resilience. They will deliver information and advice, the triage of need and early help, enable self-help, promote peer support and provide screening.

The provider will ensure easy access to information, advice, consultation and triage through:

Managing identified need, including those with on-going or fluctuating difficulties who are choosing to manage their own health, disability or learning need and those who are on the road to recovery. For the very young this is about the child's parents and carers being enabled to do this for them.

- Developing and supporting inclusive learning environments and tools to enable children with additional (health, wellbeing, development, health and educational) needs to fully engage in the curriculum and achieve to their learning potential. Consideration must also be given to home learning environments – recognising the key role of parents/carers as the child's first educator.
- Ensuring good quality information advice and guidance , through a range of technology such as apps and other digital platforms, on a range of health and learning needs, is available (including self-help) and is promoted through the Plymouth Online Directory (POD) and linked to the advertised SEND Local Offer and early help offer. Ensuring practitioners are available to support the delivery of information, advice and guidance to parents, carers, children, young people and professionals and enable them to develop the knowledge and skills to act upon these
- Developing models for community based triage and brief interventions to prevent the need for specialist intervention or support appropriate onward requests for specialist assessment
- Developing and delivering an evaluated multi-agency training programme for staff in primary care settings, early years and education settings and for parents to enable them to manage particular high prevalence health and development presentations e.g. Autistic Spectrum Condition (ASC), behaviour management, self-harm, attachment problems, bladder bowel incontinence.

Goals and outcome focused, evidence informed (Short term) intervention

The provider will deliver services to those who would benefit from short and medium term, evidence-based intervention, treatment and support. Children, young people, their families and carers need to be able to access help quickly and easily and receive the personalised support they need, when they need it, from the earliest point of identification with support until they can self-manage.

The provider will support the child or young person and their family where the child has a developmental need, and / or a physical or mental difficulty that is significantly impacting on the ability of the parent/carer to meet their needs without additional support in the home or where the ability of the parent/ carer to keep the child safe is compromised.

The plan for this intervention, devised with children, young people their families and carers, will have clear aims and criteria for assessing whether the jointly agreed outcomes have been achieved.

The provider will ensure services help children to receive personalised brief interventions and support to prevent escalation of need and build self-help skills. Help will be available to manage particular issues, care needs or long term condition support. This will also include interventions delivered by specialist public health nurses and the skill mix supported by them.

The provider will create a seamless, dynamic connection with services so that children young people, their families and carers can access the appropriate support when needed.

The Provider will ensure that the professionals that are involved in supporting children young people and parents and carers work together to undertake joint assessments and deliver integrated or joint pathways for those with more complex conditions or care needs.

Where the Local Authority has completed a statutory assessment and the child or young person has an Education Health and Care (EHC) plan, the provider will ensure practitioners contribute information to plans and identify a lead professional. The provider will ensure multi-disciplinary consideration of specialist assessments, integrating assessment pathways for those with co-morbid presentations.

The provider will be responsible for the co-ordination and dissemination of information relating to specific children with attendance at multidisciplinary and multi-agency team meetings as appropriate.

The provider will deliver a range of high quality evidence-based and informed interventions (including group work and parenting support) appropriate to meet the assessed needs of children and young people, as part of their care plan.

Extensive support

The provider will maximise the capacity of families, paid and unpaid carers, professionals and services to provide environments that promote well-being and patterns of behaviour that enable the child to fulfil his/her potential.

The provider will maximise the parent/carers parenting capacity through interventions that support them and increase their resilience and protects their own health and wellbeing (in conjunction with any adult services offer)

The provider will deliver a targeted service of additional Health Visiting support to vulnerable families who require more extensive and sustained intervention such as, for example, the Family Nurse Partnership (FNP) and Maternal Early Childhood Sustained Home Visiting Programme (MECSH) programmes or other relevant universal partnership plus interventions

The provider will ensure longer term support for children, young people their families and carers with complex, multiple and enduring problems, with an integrated care and support plan to meet education, health and care needs. For example, those with complex physical and sensory disabilities, life limiting conditions, continuing health care or complex mental health needs, and multiple vulnerabilities.

This offer will be directed at those children, young people and families who would benefit from personalised extensive long-term care that may include inpatient care, but may also include extensive community outpatient provision. Many of these young people are very unwell and their mental and /or physical health needs impact upon the ability to function in day to day society. Education and support for families to manage need should therefore be considered alongside treatment. Critically, for these young people, the interface with adult provision as they reach transition and some emerging models of care (such as the all age pathway for Psychosis or eating disorders) may require a new service model.

The provider will ensure that children and young people with a range of more complex or enduring need and conditions, that impact significantly on their day to day functioning, receive longer term treatment and support. For example, those with complex physical and sensory disabilities, life limiting conditions, continuing health care needs or complex mental health needs.

The provider will agree a lead professional to co-ordinate the work set out in the Education, Health and Care Plan (EHCP) or multi-agency care plan for the child or young person. Consideration will be given to supporting the emotional well-being of those with physical disabilities and physical health needs of those with mental health difficulties and ensuring that other people in the child/young people's life such as parents and carers' have the right skills and support for themselves. Provider will contribute to 'wrap around' packages of care designed to ensure children and young people can continue to be cared for by their usual care givers.

The provider will deliver a recovery model that focuses on enabling the child or young person to either to progress to recovery or live well with their condition and as independently as possible. The provider will ensure early planning for transition to adulthood, involving the child, families, education and all those involved in the care, alongside adult service professionals.

It is not the role of the provider to recommend any particular school or residential establishment to parents or other professionals.

The provider will support the capacity of families, paid and unpaid carers, professionals and services to provide environments that promote well-being and patterns of behaviour that enable the child to fulfil his/her potential. Therefore, the provider will enable the parent/carers' parenting capacity through interventions that support them and increase their resilience

Intensive intervention (risk management and crisis response)

This offer is aimed at pregnant women (who are assessed for specific Public Health Nursing support), children, young people and their families who are not ready to fully engage in support and remain a significant concern and risk. They may include children and young people who routinely go into crisis, who self-harm, or who have emerging personality disorders or ongoing issues that have not yet responded to treatment/care. Some of these children and young people and their families may be termed 'not ready to engage, or regularly 'do not attend' or term used for younger children 'not brought' or not achieving treatment outcomes. This group needs close multiagency collaboration to ensure there is appropriate and timely access to services at the point of readiness to engage or support the individual to be ready to engage.

The provider will respond where children and young people are at significant risk to help prevent recurring health and/or social care issues escalating. The service is expected to work with children's and family services in the best interests of the young person. An immediate response to manage crises when they occur and expert support will be provided.

The provider will develop an offer, involving a range of appropriate skilled professionals and will work with social care and acute and specialised commissioned services to provide targeted support to:

- Ensure that children at risk of being placed in a care setting outside of the usual home (including an existing care setting) are prioritised for support and receive a timely response to prevent escalation of need
- Develop a co-ordinated approach to statutory care conferences and reviews
- Integrate an approach to managing the need of young people who are of significant concern but do not present as able to engage in treatment.

The provider will ensure compliance with statutory timescales and planning for children with needs who are Children Looked After including timely delivery of the statutory health assessments and duties in respect to this cohort. Within this, the provider will co-design and deliver clear and specific pathway responses and joint offers to:

- Prevent and manage crisis (including family and placement breakdown, presentations to Emergency Department and Emergency Admissions to Hospital or Police detentions), including requirements of the Prevention and Crisis Care Concordat
  http://www.crisiscareconcordat.org.uk/
  https://www.gov.uk/government/collections/prevention-concordat-for-better-mental-health
  Policing and crime act amendments
  https://www.england.nhs.uk/wp-content/uploads/2017/10/mental-health-letter-s135-s136-changes.pdf
- Promote recovery from abuse and trauma

3.5 Population covered

The service will cover all pregnant women, children, young people and their families and carers who are resident within Plymouth City Council boundary.

It is expected, as a minimum, that the commissioned services will be provided to children aged 0-18 years. This will include children and their families who are resident in Plymouth but registered with GP surgeries in neighbouring local authority areas.

For those children and young people attending early year's settings or schools in Plymouth but resident in other areas, they will be entitled to the service offer provided through their early years setting or school. But, any child or young person requiring an extensive or intensive offer not resident in Plymouth but attending a Plymouth early years setting or school would remain under the care of the resident local authority and CCG.

There are some exceptions as follows:
0-19 in a special school
0-19 public health – Healthy Child Programme
0-19 Looked After Children
0-19 Speech and Language Therapy

It should be noted that a small number of Cornish children access services from providers based in Plymouth. This will continue once the new provider is in place. Any variance from 2017/18 figures will be discussed between provider, commissioner and Kernow commissioners.

Age Profile: There is a potential for services to be extended up to age 25 over the life of the contract as agreed with commissioners and concordant with NICE guidance. This parameter is designed to be flexible and enable provider to respond to the individual and families specific needs on a case-by-case basis including crisis response and, in consultation with commissioners, any wider population needs and gaps in service provision that arise over the contract period.

Responsible Commissioners: Responsibilities and exclusions will be in line with NHS Responsible Commissioner Guidance and any locally agreed implementation: http://www.england.nhs.uk/wp-content/uploads/2014/05/who-pays.pdf

As such, CCGs may be the responsible commissioner for Looked After Children and young people who are neither locally resident nor locally registered, e.g. a Looked After Child temporarily admitted to an out of area hospital or placement. Wherever possible, the Provider will continue to provide services to these children and young people if they are placed within reasonable travelling distance (within 20 miles of boundary). Such children and young people will be eligible to receive applicable services on their return to the area. The service will therefore provide assessment and co-ordination to facilitate repatriation.

The provider will be asked to provide services to Looked After Children and young people placed by any local authorities into Plymouth.

Prioritisation: Where a decision is needed for more than one child or young person and the consequences of not immediately meeting clinical need are assessed to be similar, services will prioritise children and young people who are likely to have the poorest long term life outcomes. Among this group, priority will be given to children and young people for whom input is likely to contribute to prevention of breakdown of their home or care situation.

Where children and young people relocate to the service area they should be accepted into service pathways at the appropriate point of the treatment pathway including waiting list position from transferring area and subject to clinical assessment needs and risk. If the request for involvement (referral information) is insufficient to make this assessment, the provider will contact the referring service to obtain all necessary information

Vulnerability and Hard to Reach Groups: The Provider will take a proactive approach to working with vulnerable families and communities that may face barriers in accessing services without support, including but not limited to, homeless families, traveller families and asylum seekers. Consideration must be given to those with low literacy levels with respect to accessible Information Advice and Guidance (IAG) through digital platforms, leaflets and any other written resource or forms of communications.

3.6 Cross Border Agreement

The service will ensure that any coverage/boundary issues that may arise will be dealt with proactively in collaboration with neighbouring provider and commissioners. A cross border agreement between NEW Devon CCG, South Devon and Torbay CCG and Kernow CCG exists. Provider will be expected to adhere to this agreement. Meeting the needs (including safeguarding) of the child or young person or their family or carer must take precedent over any boundary discrepancies or disagreements.

Protocols may not cover all cross border contingencies therefore it is expected that providers will primarily consider the needs of the individual and their family/carers and work with other providers and the commissioners contributing to a constructive and solution focused collaboration that is in the best interests of the child or young person.

3.7 Accessing and Leaving Services

The scope of services within this service description are extensive from population level prevention and promotion to intensive intervention it is therefore expected that the processes for accessing and leaving services will be proportionate to the services being accessed or requested and subject to an appropriate level of risk assessment or best practice guidance for the intervention .
Population based interventions are provided on a universal basis, so should be accessible by all within the population served as set out in section 3.5.

Requests for Involvement (referrals): Requests for involvement to the service can be completed by any professional. Requests for involvement from children and young people aged 14+ years or the person with parental responsibility should be accepted and actively encouraged. Where this is not possible, the provider will discuss this with the commissioner.

Requests for involvement and access to intervention will not be predicated on diagnosis but on the presenting needs of the child or young person and the concern of the family.

There will be a clearly identified route for people who have previously used services to re-establish contact with the relevant service area.

Examples of exclusions that do apply may include requests for service provision that exceed locally assessed need, or expert court directed work e.g. directions from an educational tribunal, court, or a continuing care package that will require specific funding.

Accessing Services:
The provider will coordinate a response to requests for involvement alongside system partners as

described in 'Plymouth the Journey so far' (appendix 5), developing the response timescale framework in order to provide a coordinated offer for the child/ young person.
Accessing Services: The service will ensure that the requestor (referrer) is made aware of the outcome. However, if the request for involvement is considered not to be eligible or in the case where the service requested is not part of the core offer there will be a well-executed handover to a more appropriate provider or service or signposting to self-help as appropriate. This will be appropriately communicated to the requestor and the child/young person/parents and carers. The requestor will be informed of this onward referral. Requests for involvement to the service will be received by a single point of access which will provide rapid triage. There will be a proactive approach to support and help which identifies need and signposts to the appropriate support and/or treatment for the child or young person. With parental consent, the service will notify the education provider or early years setting of any relevant intervention being undertaken.

For young people aged 17+ years, the service will consider at the time of request for involvement whether their needs would be most appropriately met through a referral to an adult service. This would need to be discussed and agreed with the individual, family and adult services. Likewise if a young person will reach 18 whilst undertaking a time limited intervention which will end within months of the individual reaching 18 such that transfer of therapist would be detrimental then the intervention should be completed subject to discussions with the young person and family.

The provider will be expected to acknowledge all routine requests for involvement within 7 working days.

In addition to the overarching service description, specific services will adhere to the following timescales for requests for involvement:

Service	Response needed	Timescales
CAMHS	Emergency/Crisis	Assessment within 4 hours. Intervention within 24 hours
CAMHS	Urgent request for involvement	Assess within 5 working days of request for involvement. Intervention to begin within 2 weeks of assessment
CAHMS	Routine request for involvement	Assess within 6 weeks of receiving request for involvement. Intervention to begin within 4 weeks of assessment.
Eating Disorders	Triaged and classification shared	Within 24 hours
Eating Disorder	Emergency/crisis	Assess and begin treatment within 24 hours of request for involvement
Eating Disorder	Urgent request for involvement	Assess and begin treatment within 1 week of request for involvement
Eating Disorder	Routine request for involvement	Assess and begin treatment within 4 weeks of request for involvement
First Episode Psychosis		Two week Referral to treatment time
Assessment for Continuing Health Care		Assess within 7 days of request for involvement
Assessment of Education, Health and care Plan (EHCP)		Assess within 4 weeks (local target) or national maximum target 6 weeks of request for involvement and/or notification
Specialist Public	Request for	Response to the requestor within 5

Health Nursing: Health Visiting	involvement	working days, with contact made with the family within 5 working days. Where a GP is already a user of the Integrated Electronic Record a response will not be required
Specialist Public Health Nursing: Health Visiting	Urgent request for involvement including for safeguarding	Will receive a same day or next working day response to the requestor and contact with the family within two working days.
Specialist Public Health Nursing: Health Visiting	Ante natal booking form	28 weeks until birth of baby
Specialist Public Health Nursing: Health Visiting	New birth visit	By 14 days of age
Specialist Public Health Nursing: Health Visiting	Inward transfer from outside city	Contact within 5 working days from receipt of information
Specialist Public Health Nursing: Health Visiting	Inward transfer through safeguarding office	Face to face contact within 2 working days of receipt

Waiting Times: When waiting for an appointment the provider will provide the person requesting involvement, the child, young person and/or family with the following as a minimum:

- what to expect at the first appointment and from the service,
- who and how to make contact with any queries whilst waiting
- clarity and updates as to length of wait for an appointment
- who to contact to discuss any concerns that needs are escalating
- where they can access appropriate advice, strategies and/or support whilst waiting that reflects their specific needs

Internal waits and requests for involvement: The provider will ensure that any internal transfers between services will mean not waiting longer than 4 weeks to be seen by the receiving service unless clinically appropriate and safe to do.

The provider must ensure there are robust mechanisms and IT systems to support internal requests for involvement. Any information held by the provider services will accompany the child, young person and/or family.

Assessment: The provider will offer a proactive approach to support and help to identify need and signpost appropriately for support/treatment for the child/young person to other services outside of the commissioned contract. Every child or young person, those requesting involvement and those identified as key people involved in their care will be provided with a clear plan and understanding of how, where and when to gain support.

The provider will record the clinical outcome measure and the outcome of the assessment in the service users' notes. The strengths, needs and risks relating to each service user should be clearly identified. Clinicians will pass on relevant information onto other services involved in the care of the child/young person and their family (in line with consent) and following safeguarding protocols.

Clinicians must ensure that the children, young people, their families and carers leave the assessment (whether it be virtual or face to face) with a clear understanding of findings and/or next steps. The service will provide key information in a written format that is clear and sets out next steps or the service offer.

The provider will ensure that all information is communicated appropriately taking into account the developmental needs of the children, young people, their families and carers (e.g. age, literacy levels and needs, English as a second language, developmental needs). This information should be sent to the family as soon as possible and no later than 10 working days after assessment is concluded.

Non-Attendance/ Non-attendance refers to appointments where the child or young person has not attended or been brought to an appointment or where the appointment has been cancelled.

The provider will:

- Work to ensure that no child, young person or their family or carer miss consecutive appointments.
- When there is non-attendance, a risk assessment should be made, documented and acted upon.

Transitioning: Good Practice guidance such as:

- The Department of Health's good practice guide Transition; Moving On Well (2008) and the NICE guideline (NG43) outlines the characteristics and quality standards of good transitions and experience between young people's and adult services.
- Preparing for Adulthood (The National development team for inclusion) should be embedded by locally agreed protocols which follow these standards and best practice for health and social care services.

Transition protocols should be jointly agreed with adult services and GP's and involve young people and parents/carers in the planning.
This should consider transitions for young people within Devon and for those who move out of area whether permanent or temporary (e.g. CAMHS inpatient unit, LAC placement).
This should consider transitions for young people within Plymouth and for those who move out of area.

The child or young person will be supported by the service at any transition point in their life and with a clear focus on transitioning into adulthood. The service will be part of a clear plan to ensure the young person moves smoothly into other services and/or into adulthood and have the right support from the relevant services. Children, young people and their families should feel supported throughout the process by individuals they know and trust.

Those with additional vulnerabilities will need particularly robust transition processes including:

- Looked After Children (including unaccompanied asylum seekers and refugees)
- Care leavers moving to independent living
- Young people entering or leaving inpatient care
- Young people entering or leaving prison
- Young offenders
- Children and young people with learning disabilities and/or neurodevelopmental needs
- Children and young people with caring responsibilities
- Those not in education, employment or training (NEET).

- Young people with long term physical or mental health needs who are moving away from home e.g. to university

Every young person with complex physical and mental health needs, should have from the age of 14:

- A key accountable individual responsible for supporting their move to adult health services.
- A documented person-centred transition plan that includes their health needs that is held by the young person or their parents/carers and a copy is maintained by their GP.
- A communication or 'health and wellbeing passport' to ensure relevant professionals have access to essential information about the young person and the young person knows what to do if they become unwell.
- Services provided in an appropriate environment that takes account of their needs without gaps in provision between children's and adult services.
- Training and advice to prepare them and their parents for the transition to adult care, including consent and advocacy.
- Access to other services and provider of a range of health and social skills interventions to support the young person through puberty, adolescence and transition to adulthood.
- Clearly considered and documented risks or safeguarding concerns
- Relevance and meaning pertaining to mental capacity and consent relating to becoming 18 years old.

Discharge: The provider will ensure they have a discharge policy and a transfer of care policy that:

- Describes the way in which the service will plan the expected length of contact, and therefore expected end date with the child, young person and their family at the start of any individual care episode
- Ensures a systematic approach to closing cases
- Ensures a systematic approach to transferring responsibility between teams and/or other services and/or other providers
- Ensures that no child or young person is discharged without informing whoever requested involvement, the GP and those key people in the service users' life, in line with consent
- Ensures the discharge plan involves the engagement of other agencies where necessary to ensure appropriate and timely follow-up from services should children and families continue to need help and support.
- Ensures that the child or young person can get back into the service, as necessary, without the need to start a new request for involvement or implement a full re-assessment process
- Ensures the monitoring of repeat attenders and reviews of care plans to ensure children are safely discharged, including identifying any barriers to discharge outside the control of the commissioner.

The provider will ensure follow up and oversight of any child who has to travel out of area to access residential or in-patient/CAMHS inpatient unit care ensuring:

- Continuity of care through a smooth transfer assessment, treatment requirements and records
- Identification of a named local care co-ordinator, who contributes to Care Treatment Reviews, Care Planning Assessments (CPA)
- Periodic communication with the placement to assess progress and potential date for

discharge
- Education, health and care planning to ensure those who are ready to return to the area are enabled to do so on line with local Transforming Care Partnership (TCP) plans

3.8 Interdependence with other services/providers and wider children's system

The provider should function as a strategic lead that enables effective integrated models of care and practice across the system of community services; they should promote a strong culture of integration across the system and a obligation to collaborate.

It is key that reference is made to the 'Plymouth Journey So Far' (appendix 5). This paper sets out the key system integration partners which are part of the Community Health, Wellbeing and SEND support services integration that are not part of the services in scope of this specification. These partners are Plymouth NHS Hospital Trust, Plymouth City Council and Schools and the paper describes the specific services these partners provide that sit outside of this specification. The provider will be expected to fully engage in this on-going work to maximise the benefit of an integrated system.

This service description articulates part of the wider system of services and support available to children, young people, their families and carers in Plymouth. Children and families will require varying levels of support to meet their full range of needs and support their outcomes.

The provider will act as a system leader and shall proactively ensure that highly effective links and partnership working arrangements are in place and sustained with people and services that support children and young people.

These include, but are not limited to:

- GPs
- NHS 111 and GP out of hour providers
- Schools, further education colleges and other education providers
- Maternity Services, Children's centres and early years settings (nurseries)
- Early help providers
- Other mental health services (adult, specialist, forensic, perinatal)
- Voluntary and community sector providers
- Inpatient and other highly specialised services
- Youth services
- (Local Safeguarding Adults Board)
- New local safeguarding arrangements for children in line with future implementation of Working Together 2018 (superseding the Safeguarding Children's Board –children and adults (Local Safeguarding Children's Board)
- Local authorities
- Acute sector hospitals
- Emergency departments
- Community child health
- Youth Offending services
- Substance Misuse
- Job centres and careers advice
- Local independent providers
- Hospices
- Secondary and tertiary care

- Police

There are a wide variety of system interfaces arrangements where clear arrangements and contributions are needed to ensure effective seamless service delivery. These will improve experiences for children, young people and families and also avoid duplication. In turn this will increase system sustainability. Examples where the provider needs to contribute include:

- Information sharing to agreed standards and processes
- Contribution to workforce training across universal services and co-design pathways with GPs to ensure provision is end to end in line with the elements of the iThrive model
- Links to the voluntary and third sector, particularly in work with seldom heard communities and vulnerable groups
- The provider will maintain up to date knowledge of the local voluntary sector resource in order to signpost children, young people and their families to additional or alternative sources of support which can help meet their physical and emotional health needs
- General Practice/primary care: agreeing shared care responsibility for individual children where appropriate, access to GP clinical systems to update child health information
- Links between Public Health Nursing and GPs to ensure key leads identified and joint working on key priorities. And to ensure GP's are able to support a child or young person within primary care and have clear information to support targeted and specialist requests for involvement
- Public Health Nursing Interface with change from primary to secondary schools and into post 16 settings and with GPs
- Public Health Nursing links with maternity services; early years settings including children centres; services supporting a wide range of need including emotional wellbeing and mental health; sexual health; substance misuse
- Acute care in hospital: the Provider to maintain an interface with acute services in order to develop care pathways for children who need hospital services, and to promote the delivery of care closer to home.
- Work with Mental Health Services to ensure smooth transition to adult services and for other services identified in care pathways such as early intervention in psychosis, children in care, and children who have parents with mental health and addiction problems.
- Have a collaborative working relationship with the Local Authorities 0-25 Special Educational Needs, Disability Services and schools, contributing to the integrated assessment and management of children and young people with Education, Health and Care Plans and those eligible for Children's Continuing Care.

3.9 Leadership and Management

The provider will ensure there is senior strategic leadership with expertise in the delivery of children's health, public health, education and care services who are able to represent and make decisions for children's services and advocate for children in the wider system, for example at the Health and Wellbeing Board or the Children's Partnership meeting structure.

The provider will ensure effective leadership that supports partnership aligned to and part of the Accountable Care Delivery systems and Accountable Care Organisations as these arrangements begin to emerge. The provider will be expected to contribute clinical and leadership expertise to the strategic priorities and models of care across primary, secondary and tertiary healthcare services alongside education, social care and wider stakeholders. Models of care should have effective locality/place based hubs that identify local need and provide targeted support for vulnerable groups or those at risk of or experiencing health inequalities.

The provider will be proactive and take a leadership role in developing and building relationships with organisations supporting other parts of the system to ensure an integrated approach and seamless support to children and young people and families that is joined up across the system.

There is a strong expectation that the provider of this contract will co-design its service and on-going transformational developments with service users and key partners/significant other stakeholders. Central to this approach will be ensuring service design is driven by what children, young people and families say and need. There is therefore a clear anticipation that the provider will use a range of approaches that seek to maximise how children, young people and families can feedback on service provision and influence design over the life-time of the contract. This expectation is applied to all sub-contracts.

The provider will work closely and collaboratively with commissioners to problem solve difficulties in delivery in the context of challenging financial constraints. Commissioners are clear that they want the provider to be innovative and proactive in identifying potential solutions to bring to discussion with commissioners. Commissioners are also clear these on-going collaborative discussions should take place in a culture that maximises the opportunities the contract provides to deliver the outcomes through integrated creative solutions.

3.10 Care Pathways

The provider will ensure a clear response and offer which reflects the overarching model of service and integrated working and ensure that:

- Care pathways are clear and easy for all to understand
- Care pathways are developed for all key conditions and those which cross services show expected standards and outcomes
- Care pathways need to emphasise particularly where on the pathway prevention and early intervention activities should take place
- All care pathways will have associated clinical policies and procedures which will reflect national guidance and evidence base
- All information about pathways will be available and published on an easily accessible website
- A regular review of training, skill mix and intervention offers into pathways measured against the performance of the service and the presenting need of children, to ensure continuous service improvement in delivering outcomes.

3.11 Integrated Personalised Commissioning, Choice and Personal Budgets (PHB)

Personalisation in the NHS is focused on enabling choice and control around the services that individuals receive to meet their health needs. This requires a departure from the way that traditional NHS services have functioned and been delivered in the past as the focus shifts to tailoring services around individuals. This provides the opportunity to deliver integration of services at an individual level, wrapping health, care and other support through implementation of a co-ordination function. It is organised differently for children and young people than it is for adults.

- All children and young people, carers and families who can benefit (particularly those eligible for Continuing Care and Education, Health and Care (EHC) plans meeting the NHS criteria for funding of a contribution to an individually commissioned placement or care package) should be offered personal budgets, personal health budgets or integrated personal budgets
- Personal health budgets should also be considered for Looked After Children with identified mental health needs who are eligible for an NHS funded service.

The Service will support CCG Commissioners in implementing person centred care plans for children with complex health needs across all children's community services. The Service will support personalisation and integration in the delivery of services and adopt a patient centred culture that is focused on the individual needs of each service user whilst maintaining value for money and equity.

Those who receive a personal health or integrated budget will only do so if they meet the threshold in terms of needs for the traditional service provided. They do not introduce new money but are a way of using existing resources in a different way. The Service will therefore need to ensure that funding for this can be segregated to enable personal health budgets and integrated budgets. More information on personal health budgets are found here:

https://www.newdevonccg.nhs.uk/information-for-patients/personal-health-budgets-102038

Integrated personalised commissioning should be considered as a means to facilitate personalised support across care, health and education.

3.12 Traded Offer

Where the provider supplies services to other commissioners outside of this contract such as schools or other CCGs (either as spot purchase or block), an appropriate charging mechanism should be in place and services traded should be appropriately resourced and not be delivered by core staff. Income from traded services should be included in finance reports to the commissioners. The provider may keep this income and will need to demonstrate to commissioners that it is being invested in the provision of additional services.

3.13 Safeguarding

As per the NHS standard contract for community services clause 4A Safeguarding children and adults in vulnerable circumstances, The Provider shall comply with the CCG Operating Principles and service shall comply with the Quality Standards for safeguarding children, as described in reporting schedule 11 Part 5 of that contract and as amended from time to time. The Provider will be responsible for compliance with their duty to make arrangements to safeguard and promote the welfare of children under Children ACT 1989 and 2004 specifically section 11 of the Children Act 2004 and with statutory guidance in Working Together to Safeguard Children (HM Government 2015 and updated versions expected 2018) and to follow the South West Child Protection Procedures Available at https://www.proceduresonline.com/swcpp/

The provider will comply with Safeguarding Vulnerable People in the NHS – Accountability and Assurance NHS England 2015 (update expected 2018). Health provider are required to demonstrate that they have executive level safeguarding leadership expertise and commitment at all levels of their organisation and that they are fully engaged and in support of local accountability and assurance structures, in particular via the LSCBs. The provider will ensure reporting that sets out assurance and compliance is and in regular monitoring meetings with their commissioners.
Health provider must ensure staff are appropriately trained in safeguarding children at a level commensurate with their role and in line with the respective intercollegiate document (Safeguarding Children 2014, LAC 2015, Adults 2015) and implement future workforce guidance that may be produce to support training of staff.

The provider will ensure the local agreements with Multi Agency Safeguarding Hubs (MASH) or equivalents are supported.

3.14 Prescribing

The provider shall prescribe evidence based medicines in accordance with the local Joint Formulary.

Prescribing costs will remain with the provider of the service and not be transferred to the commissioner or another provider without explicit consent on a case by case basis.

The provider shall record and monitor the amount, type and ranges of medication prescribed and provide quarterly reports to commissioners. The Provider shall produce annual evidence of prescribing audits, outcomes and improvements made.

3.15 Equality and Diversity

The public sector equality duties 2011 outlines that a public authority must, in the exercise of its functions, have due regard to the need to:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

3.16 Workforce

In order to deliver flexible, equitable and accessible services to pregnant women, children, young people and families , the service will have sufficient workforce capacity, capability and skill mix to ensure that the outcomes are achieved in the most effective time frame and there are minimal breaks in the delivery of care. Staffing establishment should be based upon guidance and be able to change according to the local population need.

In order to deliver the service vision and values as set out in this service description, the provider will have in place policies and procedures to recruit, retain, train and develop a suitably qualified workforce with an expectation that the provider will work with the Commissioner to ensure the workforce is able to sustainably meet the needs of the population.

As a system leader this will include working to support the sharing and development of competencies across the system, building resilience and community capacity, for example, peer support networks

The provider will have clear working practices in place to protect the emotional health and wellbeing of its own workforce.

3.17 Business continuity, emergency planning and resilience

The provider will have a robust business continuity plan that is regularly reviewed with Commissioners to ensure any potential shortage of staff, serious incident or disaster does not negatively impact on service delivery. This plan or policies shall be recorded in Schedule 2G.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

The standards and guidance listed below are applicable to all services:

- NICE Clinical Guidelines (CG)
- NICE Quality Standards (QS)
- NICE Technology Appraisal (TA)

- NICE Public Health Guidelines (PH)
- National Screening guidance

Provider will maintain an awareness of and audit themselves against relevant NICE standards and changes. Levels of compliance will be agreed with commissioners.

The provider will assure the quality and effectiveness of services through membership to national and local clinical networks and collegiate forums to ensure outcomes, quality of care, clinical standards and best practise are embedded in all clinical care and pathways. The provider will ensure that recruitment and workforce training enables the workforce to have all the relevant training and CPD to deliver this standard of clinical care and pathways.

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

- Royal College of Paediatrics and Child Health Roles and Competences for Health care Staff, Intercollegiate Document (2014) sets out the required competencies of health care staff in relation to safeguarding
- Royal College of Paediatrics and Child Health Roles and Competences for Health care Staff, Intercollegiate Document (2015) sets out the required competencies of health care staff in relation to Looked After Children
- Standards of Proficiency for Specialist Community Public Health Nursing (2015).

4.3 Applicable local standards

For example:

- GMC General Medical Council Updated
- NMC Nursing and Midwifery Council
- HCPC The Health and Social Care Professionals (standards)
- Royal Colleges and the British Psychological society.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4A-D)

National quality requirements are as stated in the NHS Standard Contract Schedule 4 Parts [A-D])
Local Quality Requirements are set out in Annex 'X' below

5.2 Applicable CQUIN goals (See Schedule 4E)

To be agreed.

6. Location of Provider Premises

The provider will fully consider all potential access needs in the planning and delivery of the service. Young people should be offered choice to be seen in clinic or another setting.

The services will be delivered, as far as is practical, within settings where pregnant women, children, young people and families already attend e.g. early years settings, schools and the service user's home/place of residence when necessary in order to ensure the children and parents wishes are met and provide an effective accessible service.

The Provider will co-locate service, where possible, and where advantageous to the delivery of an integrated system offer with other children's services e.g. local authority services, schools, voluntary sector organisations and community groups.

Department of Health young people friendly standard 'You're Welcome' will be applied in all service delivery areas.

Accommodation will be provided in compliance with all statutory and mandatory regulations, guidance and good practice applicable to healthcare accommodation for children and young people.

Accommodation will be maintained and serviced in accordance with statutory and healthcare guidance which will be evidenced by due diligence testing.

The Provider will ensure that total costs of all accommodation are separately identified and listed.

Lease and recharge arrangements will be in place for all properties not owned by the Provider.

Accommodation will meet privacy and dignity standards and to be compliant with segregation requirements for access to clinical accommodation between children and adults.

The provider will provide clinical equipment, medical supplies including medicines, drugs, instruments, appliances and material necessary for patient care which shall be adequate, functional and effective for all the services.

The provider shall also provide non-clinical equipment to furnish the services including computers, telephones, desks, desk chairs, couches, trolleys, etc.

7. Key Performance Indicators/reporting requirements

Appendices

Whilst the following descriptions relate to the specific requirements for service areas, it is not the intention of commissioners that they should be considered in isolation. Providers will need to ensure that the offer delivered meets the underpinning principles described above (section 3.2). Integrated working both internally and with other providers, ensuring that services focus on the individual at the centre and avoiding duplication. Providers should consider creative and flexible use of workforce which can support meeting the service standards described.

This service description should be read in conjunction with 'Plymouth – The Journey so Far' document (appendix 5) which describes elements of services provided by PHNT and PCC. It is anticipated that the integrated model of working will deliver a seamless service regardless of provider.

Appendix 1 – Additional requirements Children's Speech and Language Therapy Service

1.0 Background

Speech, language and communication needs (SLCN) cover a diverse range of difficulties. These can include difficulties with fluency, forming sounds and words, formulating sentences, understanding what others say and using language socially. In addition, children and young people may experience secondary SLCN associated with other difficulties such as autism, cerebral palsy, hearing loss or more general learning difficulties.

There is good evidence to suggest that children who find communication hard find life hard:

- As well as being more likely to be bullied than other children, SLCN also impacts on children and young people's ability to make friends and, potentially, their safety;
- Children and young people who struggle to communicate will often also struggle to engage in and enjoy education, as almost all aspects of school life are language based. Educational achievement statistics show a significant gap between the achievement of children and young people with SLCN and their peers; and
- Research indicates that the result of an inability to interact with others and to access the curriculum can, in some cases, lead to behavioural problems in children and young people with SLCN. Children with primary language difficulties are at higher risk of developing behavioural, emotional and social difficulties. This increases the risk of their exclusion from school and, in the most extreme cases, can lead to young people entering the criminal justice system.

2.0 Scope

2.1 Aims and objectives of service

The aim of the service is to provide a sustained improvement in the speech, language and communication abilities of children and young people referred to the service, supporting the ability of children and young people's social, emotional and educational development.

The primary objectives of the service include, but are not limited, to:

- Enabling all children and young people referred to the service with SLCN (including feeding and swallowing difficulties) to achieve their full potential in relation to health, social, and educational wellbeing.
- Maintaining a needs-led service for children and young people with SLCN, offering appropriate advice, assessment, intervention (therapy), monitoring, and discharge planning.
- Provide practical advice to children receiving intervention from the service, their families and

other professionals who are in contact with them on how to limit the negative impact of SLCN.
- Enable participation of children, young people and their families in the planning and delivery of the care they receive and the monitoring of its outcomes
  To work collaboratively with other health, education, or social care colleagues with children receiving intervention from the service with complex, special needs to maximise the potential communication of the child or young person.

The provider will:
- Following discussion and agreement with commissioners, proportionally reduce the spend on the high cost end of crisis support and proportionally increase spend on prevention and early intervention approaches.
- Ensure robust and well- resourced data collection and management processes are in place that accurately capture activity and outputs to inform achievements of outcomes. This should also apply to local, regional and/or national data collection requirements.
- Cascade knowledge and evidence based practice that enables families and those engaging with children and young people to create healthy environments
- Build capacity within the community and universal settings so that children and young people's communication needs can be identified and supported, at the earliest point).
- Ensure that children, young people and their families who require more extensive treatment are able to access and receive high quality levels of support and evidence base treatments.
- Ensure that children, young people and their families are able to access support and interventions from clinicians within their community.
- Ensure that specialist staff are directly involved in the training, supervision and consultation of others who may be best placed/more appropriately placed to support children and young people. This may include (but not exclusively) early years settings, class teachers, pastoral support, families, youth workers and allied health professionals.
- Use recognised Outcome Measures to actively guide treatment/intervention in a collaborative manner with children, young people and their families to determine the overall effectiveness of services and intervention.
- Use knowledge gained from use of Outcome Measures (e.g. through an audit process) to inform care and intervention approaches and clinical effectiveness at an individual and service level.

2.2 Service description

The Children's Speech and Language Therapy (SALT) Service is a targeted and specialist assessment and treatment service for children and young people with SLCN. This means the Children's SALT Service will:
- Support parents and carers;
- Support the environment to facilitate communication;
- Support the wider workforce to facilitate communication;
- Identify children and young people's SLCN; and
- Provide interventions for children and young people's SLCN.

The provider will determine treatment options through consideration of :
- Age appropriate best practice/evidence based intervention;
- Environmental and occupational/educational interventions or provision;
- The availability of a multimedia prevention package whilst on a waiting list;
- Environmental and occupational/educational interventions or provision;
- Engagement, flexibility and choice.

The provider will ensure that any planning for children and young people with special educational needs takes account of and be part of the child or young person's statement of Education Health and Care Plan (EHCP).

The provider will ensure that any planning for children and young people with additional vulnerabilities takes account of and be part of relevant statutory processes, especially if time bound.

The provider will work collaboratively with commissioners on practice standards which will be reviewed quarterly.

Targeted service provision
Provision of targeted Children's SALT Services delivers more intensive input than is available at a universal level, implementing evidence based interventions that can require specific skills and training, to provide help and support for children and young people who have additional SLCN.

The provider will work in such a way as to enable education staff to incorporate the aims of the speech and language therapy intervention in the planning of the educational programme for each child and young person in receipt of intervention from the service, within the context of the broader curriculum. This will include but is not limited to:

- Close collaboration with Special Educational Coordinators (SENCOs) and Learning Support Assistants/Teaching Assistants (TAs) to set out and carry out learning targets; and
- Consultation and advice about resources and strategies to support children in class.

The provider will ensure that the targeted service will provide assessment, diagnosis and intervention for children and young people with a wide range of SLCN, including, but not limited to, children and young people with delayed and disordered speech and language development, dysfluency, resonance disorders and children with Autistic Spectrum Disorder and social communication difficulties. Children and young people with English as an Additional Language (EAL), deaf/hearing impaired children and young people, and bi-lingual children and young people should also be able to access the targeted service.

Specialist service provision
Provision of specialist Children's SALT services delivers more intensive input than is available at a targeted level, implementing evidence based interventions that require specific skills and training, to provide help and support for children and young people with the most severe and complex SLCN.

The provider will work in such a way as to ensure that the specialist service will provide assessment, diagnosis and intervention for children and young people with the most complex or severe SLCN, including, but not limited to, children and young people with dysfluency, hearing impairment, physical and/or learning disabilities, Autistic Spectrum Disorder, Velopharyngeal insufficiency/cleft palate, and those requiring alternative and augmentive communication (AAC). Children and young people with English as an Additional Language (EAL), deaf/hearing impaired children and young people, and bi-lingual children and young people should also be able to access the specialist service.

The provider will ensure that therapists working with children and young people in special schools will be involved in supporting the staff in those settings to make environmental changes that will

optimise the inclusion of all children with SLCN within class activities. This will include working with staff and parents/carers to integrate speech and language therapy targets into the child or young person's daily activities at school or in the home.

Service requirements

The provider will make arrangements to ensure a team of sufficient size and appropriate skill-mix, training and support to function effectively to deliver targeted and specialist assessment and interventions for 0-19 year olds with SLCN and training to colleagues in early years settings, schools etc.

The provider will make arrangements to ensure that there is sufficient flexibility within the service model to ensure an equitable level of provision for children and young people with SLCN across the city.

The provider will ensure that the model of specialist provision to special schools and settings across the city is sufficiently flexible to meet the needs of all children and young people in those settings. The model for specialist provision to special schools should ensure that there is equity of provision based on an assessment of need, rather than through the allocation of specific therapists to individual special schools and settings.

The provider will make arrangements to ensure assessment and intervention for children and young people takes place in the most appropriate setting. This will include but is not limited to working in pre-school and early years settings, mainstream schools, health clinics, and special schools.

The provider will treat all children, young people and carers with respect and dignity, ensuring they are appropriately safeguarded and are enabled to contribute to planning their care, enabling choice and care that is personalised wherever possible.

Case Closure and Discharge

The provider will ensure they have a discharge procedure in place that delivers a systematic approach to closing cases. It is expected that a child or young person's case will be discharged or 'closed' to the Children's SALT service following an episode of care when:

- The goals identified from referral have been achieved through intervention or appropriate advice/equipment has been provided to help support achieving them;
- The child has made optimum progress for that stage in their development;
- The child no longer meets the age requirement for the service;
- The child has moved and is no longer registered with a Plymouth GP;
- The child is no longer attending a special school within Plymouth; and
- Children's SALT is not indicated following the initial assessment.

The provider will ensure that children and young people are not discharged without notifying the referrer and other agencies involved with the child or young person.

The provider will ensure the discharge plan involves the engagement of other agencies and requests for involvement where necessary to ensure appropriate and timely follow-up from other systems should children and families continue to need help and support from another service. When the child or young person continues to have multiple and complex needs but no longer requires SALT intervention the provider will utilise the Early Help and Targeted Support Assessment Tool (EHAT) to secure the engagement of other services.

The provider will ensure that when a child transitions to adult services, moves out of Plymouth, or no longer attends one of the special schools in Plymouth, that a full discharge handover is provided for the receiving service to ensure continuity of care. The provider will ensure the process of transition to adult services complies with the Multi Agency Protocol for Transition.

Eligibility criteria

Requests for intervention will be accepted when they meet the Acceptance Criteria for Assessment, which could include the successful completion of the Boosting Language Auditory Skills and Talking (BLAST) programme for those children referred between the age of 3-4 years old.

Appendix 2 – additional requirements Child and Adolescent Mental Health Services (CAMHs)

The Place of Safety (PoS) for children this does not form part of this re-procurement. The provider will need to ensure that there excellent joint working arrangements with respect to use of the PoS and CAMHs inpatient unit services to support admissions and discharge planning.

Schools: currently 2 CAMHS workers are funded by investment from schools. The provider will be responsible for the continued delivery of this offer until August 2019

1.0 Scope

1.1 Aims and objectives of service

Aims have been aligned to the iThrive framework. The aims of the service are to provide:

- The wider system and local communities with the knowledge and skills to enable children and young people to live and interact within emotionally healthy environments that promotes the development of resilience and emotional wellbeing and mental health.
- Children and young people and their families with the knowledge, understanding and skills to manage their own emotional wellbeing and mental health.
- Children and young people with lower levels of mental health needs and their families with personalised, evidence informed treatment to enable sustained recovery and self-management of their emotional wellbeing and mental health.
- Children and young people with higher levels and potentially enduring mental health needs and their families with personalised, specialist, evidence based informed treatment within a coordinated package of care supported by a Team Around the Child/Family and Lead Professional to enable sustained recovery and self-management of their emotional health and wellbeing.
- Children and young people who are at significant risk with regard to their emotional wellbeing and mental health and their families with timely, expert support to help prevent crises from occurring, as well as responding to manage crises when they occur. Through this the child or young person can move into other quadrants of the iThrive framework e.g. getting advice, getting help, more help.
- Care as close to home as possible, minimising the need for CYPs to access acute and/or inpatient units.

Please note: 'family' should be interpreted in its broadest sense to include those that are central to the child or young person's life**.**

The provider will:

- Following discussion and agreement with commissioners, proportionally reduce the spend on the high cost end of crisis support and proportionally increase spend on prevention and early intervention approaches.
- Ensure robust and well-resourced data collection and management processes are in place that accurately captures activity and outputs to inform achievements of outcomes. This should also apply to local, regional and/or national data collection requirements e.g. providing data to as part of the Mental Health Dataset .
- Cascade knowledge and evidence based practice that enables families and those engaging with CYPs to create emotionally healthy environments and prevent psychological harm.
- Build capacity within the community and universal settings so that CYPs emotional wellbeing and mental health needs can be identified (at the earliest point), as well as to support and

manage recovery and/or risk.

- Ensure that CYPs and their families who require more extensive treatment are able to access and receive high quality levels of support and evidence base treatments.
- Ensure that CYPs and their families are able to access support and interventions from clinicians within their community.
- Work flexibly with and through others to deliver the support the CYPs and their family need.
- Ensure that specialist staff are directly involved in the training, supervision and consultation of others who may be best placed/more appropriately placed to support children and young people. This may include (but not exclusively) class teachers, pastoral support, families, youth workers and allied health professionals.
- Deliver a model of care that aims to minimise the number of children and young people needing acute and/or CAMHs inpatient unit admissions.
- Deliver an effective 24/7 emotional wellbeing and mental health emergency and crisis response
- Use recognised Routine Outcome Measures to actively guide treatment/intervention in a collaborative manner with CYPs and their families to determine the overall effectiveness of services and intervention.
- Use knowledge gained from use of Routine Outcome Measures (e.g. through an audit process) to inform care and intervention approaches and clinical effectiveness at an individual and service level.

1.2 Service Description

The provider will conduct a full initial assessment which includes a comprehensive psychosocial assessment, for example, using the Choice and Partnership Approach (unless this approach will have a negative clinical impact on the CYP)

Continuing care and assessment:

In addition to the overarching service specification, the provider will:

- Ensure that care management plans (following the Care Programme Approach [CPA], where applicable) are in place for all people receiving support for emotional wellbeing and mental health difficulties. These plans should be coordinated across agencies, teams and or disciplines; be clearly written; identify the key coordinator and be developed in collaboration with children/young people and parents/carers where possible. A copy should be given to the CYP, parent/carer (if appropriate) and other agencies such as the GP.

- The provider will ensure that the care management plan includes appropriate risk management and crisis planning; so that the CYP, their family and those around them know what to do in an emotional wellbeing and mental health crisis, even if this crisis is not clinically indicated at the time.

- The provider will review the care plan with the service user and parent/carer (if appropriate), including the goals of treatment, and revise the care plan at agreed intervals. The dates for review should be set out in writing and depend on the nature of the problem – many problems should be reviewed every three months but others may require a less/more frequent review. Where a significant change has taken place, or when there is a change in the care management plan, review should be carried out as soon as is practical.

The provider will determine treatment options through consideration of:

- Age appropriate best practise/evidence based psychological intervention;

- Pharmacological and psychosocial interventions;
- Environmental and occupational/educational interventions or provision;
- The availability of a multimedia prevention package whilst on waiting list;
- Environmental and occupational/educational interventions or provision;
- Engagement, flexibility and choice.

Ensure that any planning for children and young people with special educational needs takes account of and be part of the child or young person's statement/Education Health and Care plan.

The provider will ensure that any planning for children and young people with additional vulnerabilities takes account of and be part of relevant statutory processes, especially if time bound.

The provider will work collaboratively with commissioners on practice standards which will be reviewed quarterly.

The provider will ensure that clinical interventions offered are evidence based such as those endorsed by CYP –IAPT, NICE Guidance, Royal College Standards. Non-clinical interventions delivered in accordance with this specification such as leisure activities may not be evidence based but rather based on what the CYPs feels will be effective to meet their individual needs at that time. The provider will ensure the impact of Adverse Childhood Experiences, trauma, abuse or neglect in the lives of children and young people is properly considered when identifying appropriate interventions.

The provider will ensure that if emotional wellbeing and mental health needs escalate or children and young people disengage from the service it is not as a result of the provider being unable to deliver services which meet the standards required.

These standards include but are not limited to ensuring the service is:

- responsive to individual needs;
- temporally or geographically accessible;
- delivered by staff working at the appropriate level within a skilled team

The provider will ensure Children Looked After are prioritised both in terms of response times and duration of intervention. Specific consideration should be made in policies regarding attendance at appointments for the additional needs of this group to ensure they are not unduly prevented from access to support by virtue of behaviour.

The provider will ensure that children and young people with additional vulnerabilities are appropriately prioritised and supported (in terms of both response time and duration of intervention). Vulnerable groups may change across the lifetime of the contract to reflect population changes and/or external events. Vulnerable groups currently include:

- Children and young people who have experienced abuse and/or neglect
- Children and young people with Learning Disabilities,
- Children and young people with Special Educational Needs and/or Long term conditions.
- Children and young people with Neuro developmental needs,
- Children and young people within Troubled Families and/or at risk of entering the criminal justice system
- Children and young people who are already known to Youth Offending Services
- Young carers,

- Infants and young children with emerging mental health needs and their families, from pregnancy through to the child's fifth birthday
- Children and young people who are not in school e.g. school refusers
- Children and young people with substance misuse and co-morbid mental health difficulties.

The provider will ensure access to treatment reflecting co-morbid presentations.
Ensure that CYPs receive the timely trauma recovery support they need.

The provider will ensure that there is (and adhere to) a formal route for referring children and young people to highly specialist mental health services such as specialist outpatient services when assessed as appropriate.

The provider will support, lead and coordinate the step up/step down for all children and young people using acute and/or inpatient services. This must include attendance either in person or virtually at Care Reviews for children and young people.

The provider will ensure oversight of the care-plan whilst a young person is in an acute /specialist placement to be actively engaged in supporting discharge planning for young people to minimise lengths of stay and support recovery

The provider will ensure reimbursement of reasonable travel and accommodation costs for the parents/cares of those CYP who require specialist inpatient treatment outside the county of Devon. Reasonable travel and accommodation costs will be defined in agreed reasonable expenses policy . It should be noted that reimbursement of any travel and accommodation costs must be in line with eth care plan of the child or young person.

The provider will provide specialist CAMH's workers as part of the Psychiatric Liaison team at Plymouth Hospitals Trust and support training of adult staff to enable them to act appropriately when Children or young people present.

The provider will ensure that services are in place to deliver a 24/7 emergency and crisis response in line with national and local standards, guidance and the growing evidence base. If necessary, the provider will ensure appropriate protocols are in place across providers across the local geography to ensure coordination and a robust delivery of a 24/7 emergency response; with clear understanding of roles and responsibilities across providers for out-of-hours and/or emergency mental health responses should support or consultation be required.

The provider will provide specialist CAMH's workers as part of the Psychiatric Liaison team at PHNT and support training of adult staff to enable them to act appropriately when Children or young people present.
The provider will ensure that children and young people who are not improving with treatment and remain of significant concern and risk receive immediate and on-going support that is timely, coordinated and keeps them safe.

The provider will ensure that families (including parents, carers and siblings) are offered support to enable them to manage their own needs in response to their child's/siblings emotional health and wellbeing needs. This support will sit outside of any therapy intervention sessions that they may attend with their child/sibling.

Provision within Youth Offending Teams
As part of whole system measures to reduce offending and reoffending and improve outcomes for

these children and young people, the provider will ensure staff are provided to work in an integrated way within Youth Offending Teams in Plymouth The provider will:

- Co-locate practitioners with appropriate knowledge and expertise of the cohort, within the local Youth Offending Team/s (YOT) working as an integral member of that Team/s;
- Ensure that an Emotional Wellbeing and Mental Health screening process is embedded within the YOT;
- Ensure mental health assessments are completed where screening carried out by the YOT indicates possible emotional wellbeing and mental health needs. These will be completed in a timely manner; adhering to any police, YOT and/or court requirements. This assessment should result in an understanding of the CYPs emotional wellbeing and mental health strengths and needs;
- Ensure that evidence informed intervention is provided according to the outcome of the assessment;
- Provide children/ families with a choice of personalised interventions appropriate to their need through a variety of means including (but not exclusively):
- Work directly with children and young people;
- Develop and advise on programmes of work for others to complete;
- Identify strategies to sustain/increase engagement;
- Meet with the children and young people and/or their families to enable them to understand the children and young person's own needs, strengths and advise on appropriate strategies;
- Provide advice and guidance for promoting good mental health to young people directly, or through their worker;
- Provide clinical expertise to other professionals as part of the children and young person's plan;
- Advise and support others working with the children and young people including (but not exclusively) school staff, drug and alcohol workers. This may include providing training and advice specific to the child or young person's needs;
- Ensure police Liaison and Diversion Services are aware of the service provision and can access it through close working relationships with the YOT Managers;
- Where neurodevelopmental difficulties are suspected (e.g. Autism Spectrum Disorder, Attention Deficit Hyperactive Disorder), make a referral to existing diagnostic pathways whilst continuing intervention;
- Ensure children and young people leaving the service have an agreed and documented discharge plan that supports self-management where possible and explains how to access help if this becomes necessary. Where a young person is moving to another service, whether to adult mental health services or to a different service or provision either locally or out of area, the provider will ensure that locally agreed transition protocols are followed;
- Commissioners are aware of any risks to the delivery of the service and/or the safety of children and young people who either need or are accessing the service as soon as possible, but at most within five working days.

The Youth Offending Provision will be delivered to the following cohort:

Children and young people who have not yet offended, but whose actions, behaviours and other associated risk factors indicate that unless support provided they are likely to come into contact with the courts. Requests for intervention could come from social workers, schools, police and early help hubs;

- Children and young people who have already had some contact with the police but have not reached court; for example, committed a public order offence and received a caution;
- Children and young people who have either been cautioned and reoffended or who have committed a serious offence for which going to court is required;

- Children and young peoples referred from Police Liaison and Diversion Services.

Provision for CYPs who are Looked After Children (LAC), Care Leavers and Unaccompanied Asylum Seeking Children (UASC)

The provider will:

- Deliver a screening process for children and young people who are looked after that enables emotional wellbeing and mental health strengths and needs to be identified (SDQ Score).

- Review screening measures obtained and undertake a further comprehensive assessment of the child or young person's emotional wellbeing and mental health where screening indicates need which would benefit from clinical recommendations and or support. This assessment will reflect a triangulated approach of information from across education, social care and health.

- Ensure that children and young people who are looked after are then prioritised and able to access the relevant intervention based on their needs; or alternative interventions outlined if not available in the skill mix of local team.

- Ensure children and young people Looked After (where further assessment has been undertaken) and all those involved in the care and support of the child and young person have an understanding of the child or young person's emotional wellbeing and mental health needs and recommendations associated with the management and supporting of these needs.

- Provide consultation and advice to local teams including foster carers, residential support workers and Social Work and education staff working with this cohort of children and young people.

- Provide relevant input and information to children and young people Statutory Review meetings in partnership with other multi-agency professionals and wherever possible attend these meetings in person.

- Develop a crisis response to prevent placement breakdown and act as part of a wrap-around team including Assertive outreach and Intensive Behaviour Support.

- Work closely with social work staff where a child or young person who is Looked After is placed in a secure or CAMHs inpatient unit setting, to plan effectively for discharge and step down. The provider will offer outreach support to placement providers, expert guidance to social work staff to facilitate successful transition and placement stability and recovery.

- Co-locate with social care teams to facilitate joint working.

- Develop opportunities for children and young people who are Looked After to make use of personal budgets to improve their emotional wellbeing.

- Ensure access to self-help and early help brief interventions throughout Care episode.

- Work Closely with the Children in Care Nursing Team

Provision for children and young people with an eating disorder

Provision of a community based eating disorder service should be considered part of the CAMHs service, however in addition the provider will:

Ensure a multi-agency, community based eating disorder* team (eating disorders refers to anorexia nervosa, bulimia, binge eating and atypical eating disorders). The team will deliver's a NICE compliant, evidence based pathway for eating disorders. At a minimum this should include access to:

- Psychiatric assessment;
- Medical assessment and monitoring (including dietetics);
- Staff trained to supervisory level for evidence based psychological interventions for eating disorders to include CBT/CBT-E and targeted family interventions;
- Community care: the team should have the experience to be able to provide home treatment and family support;
- Acute service and paediatric support: support should be provided to these services 7 days a week;
- Provision to support children and young people who may present with comorbid mental health difficulties alongside their eating disorder.

The provider will be a member of the Quality Network for Community Eating Disorder (QNCC-ED).

The provider will ensure that those making requests for intervention have an adequate understanding of eating disorders; recognition of signs, symptoms and risks; and understand local care pathways including referrals processes so that CYPS needs are identified as soon as possible.

The provider will ensure that interventions are delivered within nationally specified wait times.

The provider will develop an integrated all age pathway with the adult Eating Disorder service in Plymouth.

Provision of First Episode Psychosis services

The provider will work collaboratively with the provider of the treatment pathway for 14yrs+ experiencing First Episode Psychosis (EIP) or who are deemed of at risk of first episode psychosis (ARM's); so that children and young people can access treatment at the earliest possible point at which Psychosis is suspected and work with the adult EIP service to ensure appropriate transitions where necessary.

The provider will ensure a community based EIP service offers NICE compliant, evidence based pathway for EIP. At a minimum this should include access to:

- Psychiatric assessment;
- Medical assessment and monitoring;
- Staff trained to supervisory level for evidence based psychological interventions for EIP to include CBT and targeted family interventions;
- Community care: the team should have the experience to be able to provide home treatment and family support;
- ARM's assessment and service.

The provider will ensure that interventions are delivered within nationally specified wait times.

Provision to Schools
The service will provide 0.5 days per week link time to each secondary and special school this will initially last until August 2019. This offer is co-commissioned by the schools who fund the equivalent of 2 posts the remainder is funded in the core contract value by the CCG. The subsequent offer will be negotiated with commissioners dependent on the outcome of the evaluation of the current schools offer and co-commissioning arrangements with schools post August 2019.

Service Developments
Over the lifetime of this contract support the development of a pathway and service for CYP with Autistic Spectrum disorder and behaviour which challenges supporting a multiagency response

Over the lifetime of this contract, pathways and support for children and young people with behavioural which challenges (including children who are Looked After) will be developed and it is anticipated that the provider will have a critical role in guiding, leading and being part of a multiagency response.

Over the lifetime of this contract, pathways for children and young people with medically unexplained symptoms will be developed and it is anticipated that the provider will have a critical role in guiding, leading and being part of a multiagency response.

Appendix 3 – additional requirements Looked After Children (LAC) Nurses

1. Population Needs

1.2 National Context and Evidence Base

In UK law, children in care are referred to as "Looked After Children". A child is "looked after" if they are in the care of the local authority for more than 24 hours. Legally this could be when they are:-

- Living in accommodation provided by the local authority with the parents' agreement
- The subject of an interim or full care order
- The subject of an emergency legal order to remove them from immediate danger
- Detained in a secure children's home, secure training centre or young offender institution
- Unaccompanied asylum seeking children

The term "LAC" is used throughout this document to abbreviate "Looked After Children and Young People", or "Looked After Child / Young Person."

It is important to understand the legal status of the LAC due to the complexities of consent for this group.

LAC should have an Initial Health Assessment (IHA) within 4 weeks of becoming looked after by the local authority. Children under 5 years should receive a Review Health Assessment (RHA) 6 monthly and for children over 5 years annually.

The number of LAC has continued to rise and as of 31 March 2016 there were 70,440 nationally a 5% increase since 2012[1]. The NHS has a major role in ensuring the timely and effective delivery of health services to Looked After Children and, by extension, to care leavers by commissioning effective services, delivering through provider organisations, and through individual practitioners providing coordinated care for each child (Promoting the Health and Well-being of Looked After Children 2015[2]).

Most children become looked after as a result of abuse and neglect. Although they have many of the same health issues as their peers, the extent of these is often greater because of their past experiences.

LAC may have missed health surveillance, screening tests and immunisations as well as other health appointments. Wherever possible, these children and young people should have priority when health services are allocated to counteract the gaps created by their previous poor access to services, their increased health needs and the requirement to improve outcomes for this especially vulnerable group.

National figures suggest that 45% of LAC have been assessed as having a mental health disorder, and this rises to 72% for those in residential care. Two thirds of LAC have at least one physical health complaint and are more likely to have speech and language difficulties, bedwetting, co-ordination difficulties and sight problems.

[1] National Child and Maternal Health Intelligence Network 2016
[2] Department of Education / Department of Health (2015) Promoting the health and well-being of looked-after children Statutory guidance for local authorities, clinical commissioning groups and NHS England

In addition to the LAC that move into local authority care as a result of abuse or neglect there is an increasing number of unaccompanied asylum seeking children (UASC) and young people who have been trafficked. UASC are children and young people under the age of 18 years, who have applied for asylum in their own right, who are outside their country of origin and are separated from their parents, or from their previous legal/customary primary care giver. Since the government's decision in February to close the 'Dubs' scheme there has been a reduction of UASC entering legally into the country.

All UASC should have had an enhanced Initial Health Assessment which can include:

- Access to x-ray (chest x-ray for TB/x-ray of other injury sustained in transit)
- Access to Haematology (BBV screens, malnutrition/other diagnostics)
- Access to sexual health services as indicated.
- Fast track referral arrangements to other hospital departments and health services,
- including CAHMS

The complexities of needs identified in the UASC population are likely to mean additional input by the LAC nursing service to follow up outstanding health issues. Access to an interpreter where required is essential.

Evidence Base

The key documents and drivers for the delivery of this service are:

- Promoting the Health of Looked After Children (2015)
- Looked After Children Roles, Skills and Competencies of Health Care Staff Looked After Children Intercollegiate Document (2015)
- Health and Social Care Act (2012)
- Looked After children and young people (NICE public health guidance, Issued 2010, Modified 2013)
- NICE Quality Standard 2013 updated 2016 due for review August 2017
- Safeguarding Vulnerable People in the NHS – Accountability and Assurance framework (2015)
- The Children's Act 1989 and 2004
- Health Lives, Brighter Futures: the strategy for children and young people's health (2009)
- The Children Act 1989 Guidance and Regulations. Volume 2: Care Planning, Placement and Case Review (2010)
- Working Together to Safeguard Children (DCSF 2015)
- Children and Social Work Act 2017
- Care of Unaccompanied Asylum Seeking and Trafficked Children (DfE 2014)
- Health Needs of unaccompanied asylum seeking children 2016 Kent public health Observatory
- The Children and Families Act 2014 (Special Educational Needs and/or Disability Code of Practice)

1.3 Local Context

1.3.1 Local Looked After Children Population

Though the numbers LAC across Devon Sustainable and Transformation Plan (STP) footprint have stayed relatively stable for several years this continues to be higher than

the national average.

Local Authority	Number of Looked After Children at 31st March 2017 under the care of the STP Local Authorities	Placed in Devon STP footprint by other local authorities
Plymouth	393	80

Under the National Transfer Scheme the STP area could take up 154 unaccompanied Asylum Seeking Children (UASC) over the next two years.

Numbers of children and young people becoming Looked After Children per month varies though a similar number leave care each month. The fluctuation in numbers entering and leaving care has an impact on the provision of health services.

2. Outcomes

2.1 NHS Outcomes Framework Domains and Indicators

Please refer to the overarching spec which sets out the NHS outcomes framework and those applicable to partner commissioning organisations.

2.2 Locally defined outcomes (KPI)

Although the expectation is that the Local Authority will give early notification of children who become Looked After Children, the trigger for an Initial Health Assessment in the Acute Trust is a request and paperwork for assessment plus consent being received by the Trust. The same expectation is in place for Review Health Assessment with the trigger being receipt of request and paperwork from the Local Authority.

The provider will report on patient outcomes, patient experience, adherence to service standards and activity volumes according to the outcomes framework and the indicators described in the Table 1 below:

Table 1

Key Performance indicator	**All data to be provided split by responsible CCG, Local Authority and Locality**
The number and percentage of children 0-5 years placed in the STP area by Devon, Plymouth and Torbay local authorities who have received a Review Health Assessment (RHA) within 6 months of their previous health assessment (either IHA or RHA).	Monthly reporting Target of 90% compliance reported monthly with exception reporting for non-compliance.
The number and percentage of children and young people placed in the STP area by Devon, Plymouth and Torbay local authorities over 5 years who have received a RHA within 12 months of their previous health assessment (IHA or RHA).	Monthly reporting Target of 90% compliance reported monthly with exception reporting for non-compliance.
The number and percentage of Devon Torbay and Plymouth LA children placed	Monthly reporting Target of 90% compliance reported

out of county 0-5 years who have received a RHA within 6 months of their previous health assessment (IHA or RHA).	monthly with exception reporting for non-compliance including evidence of escalation to Designated Nurse in placement Authority.
The number and percentage of Devon Torbay and Plymouth children and young people placed out of county over 5 years who have received a RHA within 12 months of their previous health assessment (IHA or RHA)	Monthly reporting Target of 90% compliance reported monthly with exception reporting for non-compliance including evidence of escalation to Designated Nurse in placement Authority
Quarterly audit of the quality of health information and evidence of the child's voice within the RHA and health plan. Using a standardised benchmarking tool	Quarterly reporting on findings with exception reporting for those not meeting the quality standards
The number of out of area health reviews requested and number completed. Information on quality of RHA and voice of child in health plan to be included	Quarterly report. To include any escalations to CCGs.
The number and percentage of children 0-5 years placed into the STP area from other LAs who have received a statutory health assessment (IHA or RHA) within 4 weeks from point of request being received.	Quarterly reporting with exception report
The number and percentage of children over 5 years placed into the STP area from other LAs who have received a statutory health assessment (IHA or RHA) within 4 weeks from point of request being received.	Quarterly reporting with exception report
Annual audit of RHAs to evidence the quality of health information and evidence of the child's voice using a qualitative tool.	Annual sample audit with exception reporting for those not meeting the quality standards. The sample needs to be minimum of 90 RHAs (which must include age ranges 0-5, 5-10, 10-17 and be inclusive of UASC and children with SEND
The number and percentage of Devon Plymouth and Torbay children and young people who have up to date childhood immunisation recorded at the time of their RHA.	Target 90% by end of year reporting with exception reporting for non-compliance
The number and percentage of Devon Plymouth and Torbay children and young people (from 2 years of age) who have had their teeth checked by a dentist between 31st March and 1st April.	Target 90% reported annually with exception reporting of reason given for no check. *NB this may become a local* authority KPI
The percentage of Care Leavers (aged 16 years and over) who are offered a health	100% young people will be offered a health passport

passport.	
LAC policy in place that is fit for purpose and reflects National Guidance	100% compliance of LAC policy developed and in use.
The number and percentage of children and young people aged four years and over who have been assessed as requiring CAMHS intervention have received the intervention.	Target 95% reported quarterly by month with exception reporting of reason given for non-compliance
Number and percentage of children and young people aged 17 (at time of last RHA before 18 years) with a transition plan in place.	100% children and young people have a transition plan in place – Reported annually at year end. The report will identify the responsible commissioner.
Annual assurance report in locally agreed template To include how young people experienced their health Assessment	Annual report submitted to commissioner in June each year.
The percentage of care leavers whom are offered an update health assessment 3 months after their statutory RHA at age 17	100% young people will have been offered an update.
The number and percentage of children and young people recorded as having SEND and education health and care plans (EHC) in place.	For this group of children 100% evidence of how assessing practitioner contributes to the EHCP process.
All Plymouth Devon and Torbay children with SEND will receive additional health information where appropriate for their EHCP	100% compliance will have additional health information provided where appropriate
On receipt of a RHA request the Named Nurse should check if an EHCP is in place. If there is an EHCP, a copy of the completed RHA should be sent to the 0-25 team in line with SEND the strategy.	100% compliance

3. Scope

3.1 Aims and objectives of service

3.1.1 Purpose of the Looked After Children's Nursing Service

The Looked After Children's Nursing Service is a targeted health service which aims to promote the physical and mental health and social wellbeing of LAC. The service will provide a comprehensive programme of holistic, co-ordinated care through assessment, statutory review health assessments and follow up to ensure health needs are being met. In addition the service will provide professional advice and support to this defined client group, their families and carers to empower and enable achievement of healthy lifestyles by addressing concerns about health and wellbeing.

The provider will be responsible for tracking and quality assuring RHAs review health assessments under taken for LAC placed out of area by PCC for whom NEW Devon are the responsible commissioners.

3.1.2 Aims

The aim of the Looked After Children's Nursing Service is to deliver a service which may

be accessed as flexibly as possible. The service aims to be responsive to diversity and to address individual communication needs e.g. through information leaflets being made available to service users in a format which is suitable to them and the availability of an approved translation service.

The aim of the RHA is to enable a full assessment of the health needs of the LAC and will necessitate gathering information as identified to inform the assessment e.g. EHCP. This assessment will be used to identify any outstanding health needs and ongoing referrals required and will inform the individual child or young person's health plan. This plan will identify need for review and ongoing advice and support.
The statutory RHA will be under taken six monthly for children under five years and annually for children over five years.

Each health assessment will identify the need for ongoing review. The timeframe for further review must be clearly documented on completion of the assessment. It should also identify the practitioner with ongoing responsibility to undertake this review.

The review health assessment should be integrated with any other assessments and plans such as the child's Core Assessment or an Education, Health and Care Plan where the child has special educational needs.

3.1.3 Strategic objectives

- To support all LAC to achieve good physical, mental, emotional and sexual health, access a healthy lifestyle and avoid substance misuse and other risky behaviours.
- To ensure the health and wellbeing of LAC are an identified local priority.
- To ensure that structures are in place to plan, manage and monitor the delivery of health care for LAC with strong links to other health services.
- To ensure that clinical governance and audit arrangements are in place.
- To ensure that systems are in place so that LAC are not disadvantaged when they move from one NHS area to another e.g. placement moves.
- To ensure that systems are in place to collect and report achievement against the key indicators for health of LAC.
- To ensure that robust quality assured processes are in place to monitor and report on the emotional health and well-being of LAC.
- Ensure information governance arrangements are in place for information sharing so there is a free flow of information.

3.1.4 Service Objectives

- To assess the health of all LAC within four weeks of receipt of request by the local authority.
- To engage and involve families and carers as appropriate to promote optimum health and development of all Looked After Children.
- To ensure for children in respite care for over 75 days and are under Section 20 of the Children Act RHA's are linked to their ongoing nursing assessment and any ECHP
- To work in conjunction with the local authority and other partners to promote the health and well-being of Looked After Children.
- To assess and review the health needs of the individual and to involve the carer (where appropriate) in the process of meeting the health needs.
- To take appropriate action to protect vulnerable children at risk.

- To promote health for LAC in the wider community by working with NHS colleagues and other agencies; statutory and voluntary, in order to reduce inequalities in health.
- To identify and address barriers to accessing health services and make them accessible to LAC.
- To provide expert health advice and training for other health professionals, partner agencies and carers in the needs of this specific client group.
- To provide or facilitate access to appropriate supports and services for health related issues for all those who care for this vulnerable group, including residential workers and foster carers.
- Have in place appropriately qualified and competent nurses/midwives who have the knowledge and skills to undertake their roles and responsibilities in line with statutory guidance Promoting the Health and Well-being of Looked After Children 2015.
- To actively ensure that the young person contributes to their health review and their views, as appropriate are included in the health assessment and health plan. Ensuring barriers to communication are reduced by ensuring interpreters are available and communication aides available.
- To take appropriate action to protect vulnerable children at risk.
- To identify and address barriers to accessing health services and ensure they are accessible to LAC.
- To formulate, implement and monitor holistic health plans for LAC.
- To engage with young people and carers in relation to health assessments and plans, and to ensure that their voice is heard.
- To positively promote and have a process in place to identify where difficulties arise in GP registration.
- Ensure that arrangements are in place for transition from child to adult services with a clear transition plan formulated with the young person.
- To comply with statutory guidance for LAC, as amended over time.
- To encourage children to become health decision-makers in lifestyle choices, particularly in relation to physical activity and healthy eating (to impact on obesity prevention), emotional well-being, smoking, sexual health and substance misuse.
- Work in partnership to improve outcomes for LAC.
- Ensure all Looked After Children have access to universal services and the Healthy Child Programme as needs identify.

3.1.5 Service Resource

The service will be delivered by a team of registered nurses or midwives[3]. In line with the intercollegiate guidance there will be a minimum of 1 dedicated WTE Named Nurse LAC for each LAC provider service who can hold a caseload maximum of 50 LAC in addition to the operational, training and education aspects of the role. The precise caseload of LAC held by the Named Nurse will be dependent on the complexity, geography, population and size of the catchment area served. There will be a minimum of 0.5WTE dedicated administrative support for each Named Nurse. There will be 1 WTE specialist registered nurse or midwife per 100 LAC.

The LAC nursing service will work closely with specialist doctors, paediatrician's in

[3] Department of Education / Department of Health (2015) Promoting the health and well-being of looked-after children Statutory guidance for local authorities, clinical commissioning groups and NHS England

regards to training and awareness raising of issues relating to LAC This includes medical advisers for adoption and fostering, specialist paediatrician's and training grade doctors who work under supervision.

3.1.6 Referrals
There may be a need for ongoing referral to health and other professionals after a health assessment is completed. Up to date information should be included in the referral and families/ carers should be made aware (where appropriate) of the need for ongoing referrals.

3.2 Service Description/care Pathway
The LAC nursing service is directed by national and local guidance as part of a multi-agency approach to deliver health services that improve outcomes for LAC

The LAC nursing service will ensure that the identification of safeguarding and child protection is robust; ensuring that good practice supports best the needs and outcomes of individual children and young people.

NB
Initial Health Assessments will be undertaken by paediatricians in the acute providers, where the initial health plan will be developed (with the child or young person where possible). Separate KPIs will be collected around uptake and compliance. Arrangements will be made with each Local Authority to inform the Named Doctor and LAC nursing service of children and young people who move into Local Authority Care.

The objectives of the Review Health Assessment should follow the statutory guidance in Promoting Health of Looked After Children guidance and include:

- Assess health risk and provide an opportunity to redress past health neglect, collate health history, including perinatal history.
- Ascertain and advise on relevant family history.
- Review immunisation status and missed child health screening episodes, including dental and oral health with advice and or referral to support any unmet health needs.
- Assess current physical and emotional health concerns.
- Review and advice on known existing health problems and risk factors.
- Ascertain outstanding appointments and places on waiting lists.
- Identify unrecognised health needs.
- Identify mental health, behavioural and emotional problems.
- Recognise developmental or learning concerns.
- Plan appropriate action and ensure recommendations are carried through.
- Discuss lifestyle issues, including (as appropriate) sexual health, contraception, drug and alcohol use, female genital mutilation (FGM) GM and sexual exploitation.
- Plan follow up and monitor health needs between health assessments

Consent for Health Assessments

- If a child is subject to a full care order the child's social worker should provide consent for IHAs and RHAs. The consent will be evident on the statutory RHA paperwork (British Adoption and Fostering forms, BAAF) sent from children's social care to health. Where a child is considered competent (refer to Fraser Guidelines) consent should be sought from the child or young person to share

their confidential information.

- Where the child or young person refuses to allow information to be shared, clinicians should refer to locally agreed information sharing protocols.
- If the child /young person or parent does not consent, information may still be shared if a child or young person or someone else is at risk of harm.
- If a child or young person refuses consent to an assessment, and they are deemed competent to make this decision, the wishes of the child and or young person must be respected and recorded. However, the assessing practitioner may offer alternative ways of engagement and an audit trail documenting the refusal should be retained and children's Social Care informed in writing. A refusal once does not preclude further offers of RHAs at an appropriate future point.

Not Being Brought or Non-attendance at Review Health Assessment

If a child or young person is not brought or fails to attend an appointment the child's social worker should be notified re failure to attend. This should be recorded on the child's health record. A second appointment should be offered. If the young person fails to attend for this second appointment the child/young person's social worker should be notified and a plan of action should be agreed. All actions and discussions must be carefully recorded.

Review Health Assessments

The RHA should build on the child's Initial Health Assessment which would have resulted in a health plan within four weeks after becoming looked after. This plan is then used at the first RHA.

- RHAs will routinely be carried out by the LAC nursing service and/or dependant on Public Health Commissioning arrangements, Health Visitors or School Nurses. The staff will have relevant competencies as per the Intercollegiate Role Framework.
- RHAs should take place twice a year for children under 5 years old and annually for children and young people 5 years and over.
- The RHA will include information gathering from other agencies and health professionals in advance of the face to face contact with the child or young person., including a discussion with the LAC's social worker
- Children and young people should be involved in the assessment and the development of resultant care plan
- Immunisation status and missed child health screening episodes, including dental and oral health will be reviewed.
- Current physical and emotional health concerns will be assessed.
- Review and advice on known existing health problems and risk factors.
- Ascertain outstanding appointments and places on waiting lists.
- Identify unrecognised health needs.
- Identify mental health, behavioural and emotional problems.
- Recognise developmental or learning concerns.
- Plan appropriate action and ensure recommendations are carried through.
- Discuss lifestyle issues, including (as appropriate) sexual health, contraception, drug and alcohol use, FGM, sexual exploitation.
- Involve children and young people in the assessment.
- Following the health assessment, the Provider should provide a written report of the assessment and a health plan for the child or young person.

- Following the RHA, the provider should provide a written report of the assessment and a comprehensive health plan for the child or young person.

Change of placement
Arrangements will be made with each Local Authority for the LAC nursing service to be informed within one working day if a child changes placement.

Health plans
The health plan should be included as part of the child's overall care plan. This should include intended outcomes, measurable objectives to achieve outcomes, actions needed, timescales and responsibilities.
The health plan should be reviewed, including tracking and updating actions, in line with requirements for the statutory RHA. The health plan should include:

- The child's state of health, including physical, emotional and mental health;
- The child's health history including, as far as practicable, their family's health history;
- The effect of the child's health history on their development;
- Arrangements for the child's medical and dental care appropriate to their needs, including:
- Routine checks of the child's general state of health, including dental health
- Treatment and monitoring for identified health (including physical, emotional and mental health) or dental care needs
- Preventative measures such as immunisations
- Screening for defects of vision or hearing; (not enhanced – targeted screening for those of concern)
- Advice and guidance on promoting health and effective personal care
- Any planned changes to the arrangements
- Access to all elements of the Healthy Child Programme
- Sexual health screening appropriate to age of child / young person
- A named person should be identified as a health contact for a child's health plan and social worker
- The lead health record for the LAC should be the GP held record. A copy of the health summary and health recommendations should be forwarded to the GP. A copy of the summary and recommendations with an age appropriate letter is sent to the child / young person by the LAC nursing service.

Health records
The health record for each LAC should be maintained as per organisational and professional standards. The record should be accessible to the foster carer and / or child as appropriate and in consultation with Fraser Guidelines around competency. This record should be regularly updated in partnership with the child's social work team and should move with the child.

Strengths and Difficulties Questionnaires (SDQ)
The SDQ is an internationally validated brief behavioural screening questionnaire about 4-16 year olds. It exists in three parts: one for the carer, another for the child's teacher and a third part for the child. While the Department for Education requires local authorities to provide SDQ data to be completed for looked-after children by their foster carer or residential care worker, local authorities should not see this as purely a data

collection exercise by central government with which they must comply.
The LAC nursing service will work with children's social worker and health professionals to decide whether to triangulate the scores with an SDQ the child needs to be referred for further diagnostic assessment of their mental health

Out of area placements
The LAC nursing service will take responsibility for organising health assessments for children placed outside the STP area to be undertaken within the required timescales. This may include commissioning other providers to carry out assessments for children placed 'out of authority', on behalf of the CCGs. Where this is required, the LAC nursing service will liaise with the CCG commissioning team to arrange funding and appropriate contractual documentation.
Where children from other authorities are placed within Devon STP area, the LAC nursing service will support the CCGs in its responsibility to ensure that arrangements are in place for a health assessment if required.

Access to health services
All LAC and their carers will be provided with information on how and who to contact.
LAC moving into the STP area from other areas will receive a welcome letter, leaflet about the LAC nursing service with up to date contact for the team
LAC child should have access to all universal and primary care services. When a child is on a waiting list for treatment and moved placement, this should not affect them accessing services. When a child moves out of area the Named Nurse should facilitate the LAC receiving care in their receiving authority. Where there are difficulties this should be escalated to the commissioning authority.

Care Leavers
A robust pathway is in place to support the health needs of care leavers as they approach the transition into adult services. A key contact will be in place six months before their 18th birthday to identify who is best to support their ongoing health needs with appropriate referrals as required.
Care leavers should be offered a health passport prior to leaving care. Where there is a requirement for health care services in to adulthood a transition plan should be formulated to ensure that services are available and are in place prior to turning 18 years.

3.3 Population covered
All LAC 0-18 years who are placed by Plymouth local authority and placed within the Plymouth footprint or placed outside the Plymouth footprint and LAC placed within the Plymouth foot print by other local authorities. The age range may move to cover young care leavers up to the age of 25 years.

3.4 Any acceptance and exclusion criteria and thresholds
No
3.5 Interdependencies with other services/providers
The provider will ensure the service has well developed working relationships with:-

- Designated Nurses within each of the CCGs
- Children's Services
- Parents, children and young people involvement in their own care packages regarding the development of local services.
- Named Doctors for LAC

- Neighbouring Health providers and Acute Paediatric Services
- Fostering
- General Practitioners and Primary Care Professionals
- Maternity Services
- Children's Centres
- Provider Public Health Service
- Local Schools and School Improvement Partners.
- Early Response Team and Further Response services.
- Sexual Health Services/ Walk in Centres
- Youth Participation Workers
- CAMHS
- Designated Clinical Officer and Designated Medical Officer for SEND
- Care leaver services.

4. Applicable Service Standards

4.1 Applicable national standards i.e. NICE and how they will be assessed.

- National Institute for Health and Clinical Excellence Guidelines – specifically
  - QS31: Health and wellbeing of Looked After Children and young people
  - QS34: Self Harm
  - CG28: Depression in children and young people: identification and management
  - QS39: Attention deficit hyperactivity disorder
  - NICE briefing Social and Emotional Wellbeing for Children and Young People (Sep 2013)
  - NG43: Transition from children's to adults' services for young people using health or social care services
- NICE PH28 Looked-after children and young people (2010)
- NICE Quality Standard 2013 updated 2016 due for review August 2017
- DfE/DH Promoting the health and wellbeing of looked-after children: Statutory guidance for local authorities, clinical commissioning groups and NHS England 2015
- Mental Capacity Act 2005
- Children's and Families Act 2014 including specific duties in relation to children and young people with SEND.
- Department for Education. Statutory guidance SEND code of practice: 0 to 25 years. 2014
- Equality Act 2010

4.2 Applicable standards as set out in guidance and / or issued by a competent body e.g. Royal Colleges and how they will be assessed.

All service provision must meet the following requirements or contribute to the following standards:-

- Nursing and Midwifery Council Standards
- Promoting the Health and Wellbeing of Looked After Children 2015
- Care and Quality Commissioning
- National Service Framework Core Standards
- National Institute for Health and Clinical Excellence Guidelines
- Working Together to Safeguard Children 2015

4.3 Applicable local standards and how they will be assessed.
Key Performance indicators will be reported as requested by commissioners.

5. Applicable quality requirements and CQUIN goals (Optional use)

5.1 Applicable Quality Requirements (see schedule 4A-D)

5.2 Applicable CQUIN goals (see schedule 4E)

6. Location of Provider Premises (Optional use)

7. Individual Service User Placement (Optional use)

Appendix 4 – additional requirements Specialist Community Public Health Nursing

1.0 Scope

1.1 Aims and objectives of service

To ensure that all families, children and young people receive the full service offer (Healthy Child Programme 0-19), including universal access and early identification of additional and/or complex needs with timely access to support including through the single point of access. This will be achieved by health visiting and school nursing skillsets together contributing to improved local outcomes and reduced health inequalities for children and young people, through specialist public health analysis, defined clinical and public health skills, professional judgment, and autonomy and leadership.

Objectives

- supporting families to give children the best start in life based on current evidence of 1001 Critical Days: The Importance of the Conception to Age Two Period as a foundation on which to build support in the early years and beyond;
- providing expert advice and support to families to enable them to provide a secure environment to lay down the foundations for emotional resilience and good physical and mental health;
- enabling children to be ready to learn at 2, ready for school by 5, and able to achieve the best possible educational outcomes;
- 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 the health and social care services to ensure timely access and support;
- working in partnership with local communities to build community capacity; demonstrating population value, utilising asset-based approaches, promoting peer support, best use of resources and outcomes; and ensuring effective use of community-based assets;
- taking the lead in developing effective partnerships that will support the achievement of public health outcomes and acting as advocate to deliver change to support improvements in health and wellbeing of all children and families;
- working in partnership with public health commissioners to actively support the delivery of wider public health initiatives and programmes;
- working in partnership with other professionals and stakeholders, ensuring care and support helps to keep children and young people healthy and safe within their community, providing seamless, high quality, accessible and comprehensive service, promoting social inclusion and equality and respecting diversity;
- ensuring early identification of children, young people and families where early help and additional evidence-based preventive programmes will promote and protect health, wellbeing and child development in an effort to reduce the risk of poor future health wellbeing and educational outcomes;
- work with Plymouth's Early Help and targeted support system to ensure that whole families are identified and supported to improve the breadth of their health development
- provide resource to support the on-going work of the Early Help and Targeted Support Gateway (or future equivalent)

Service Description

The Specialist Community Public Health Nursing Service (0-19) (SPHN) will:

- lead and co-ordinate local delivery of the Healthy Child Programme 0-19;
- deliver the service offer in line with the four five-six approach for health visiting and school nursing
- provide an integrated public health nursing service working closely and proactively with primary and secondary care, early years, childcare and educational settings,
- have teams and nominated leads working in partnership with key stakeholders, for example:
    - Children's centres
    - Publicly funded primary and secondary schools/colleges (including Further Education Colleges offering courses to 16-19yr-olds, Free Schools, Academies and Pupil Referral Units)
    - GP surgeries
    - Maternity services
    - Emergency departments, MIUs
    - Sexual Health Services
    - Substance Misuse Services
    - Youth Offending Teams
    - Elective Home Education
    - Children's Social Work

Teams and Leads will engage through networks, meetings and forums and use their professional expertise to cascade best practice Information Advice Guidance (IAG) to those settings to build their capacity to have conversations / provide IAG to children, young people and parents

- deliver the universal Healthy Child Programme through assessment of need by appropriately qualified staff; health promotion, including advice on accessing the Healthy Start Programme; promoting screening, immunisation and surveillance programmes; engagement in health education programmes; involvement in key public health priority interventions and communities; interventions as specified within the Healthy Child Programme; a community model of Newborn Hearing Screening Programme;
- deliver early identification and intervention for specific health and wellbeing needs (e.g. Speech, Language and Communication Needs, perinatal mental health), and provide timely request for support from appropriate services;
- contribute to the delivery of the National Child Measurement Programme by measuring the height and weight of children at Reception and Year 6 in publicly funded schools, and supporting families to respond positively where there are signs of obesity or eating disorder;
- deliver public health interventions at the appropriate level to identified children, young people and families in order to keep them safe and reduce health-related risks across the life-course;
- deliver a specific service for young people who are overweight or obese
- deliver additional Health Visiting support to families who require more extensive and sustained intervention in line with UPP or other specific intervention (for example but not limited to FNP / MECSH);
- work with the community, stakeholders and commissioners to identify local population public health needs (e.g. at school cluster, geographical areas or with specific population groups), and work with partners to develop community

initiatives that meet those needs;

- undertake joint visits or consultations with other professionals/ practitioners in response to contact from children, young people and families, where appropriate;
- work with local Public Health, Local Authority and health commissioners and relevant providers to ensure that local health promotion strategies are integrated within the work of public health nursing teams, and that clear care pathways exist between public health nursing teams and key services that children, young people and their families access such as:
    - maternity services;
    - childrens centre services
    - acute care services;
    - Looked After children services;
    - substance misuse services;
    - emotional and mental health services; including perinatal mental health
    - domestic and sexual violence services;
    - healthy lifestyles, including mental wellbeing, breastfeeding, smoking cessation, weight management, healthy eating, dental health and physical activity;
    - access to, up to date and consistent information about sexual and reproductive health;
    - engagement in active partnerships with local specialist sexual and reproductive health services (including pharmacies and GP's where appropriate) and signpost young people;
    - promotion of the Plymouth C-Card scheme for young people (13-24) and support the young person to register for the scheme and provide condoms where appropriate. In some circumstances school nurses may provide access to chlamydia screening kits;
    - provision of services that follow Young People Friendly (Department of Health You're Welcome Standards);
    - screening programme delivery partners;

- in line with both local and the national Making Every Contact Count (MECC) approach, ensure that every child, young person and adult in contact with the service is encouraged and helped to make healthier choices to achieve positive long-term behaviour change both as individuals and as family units
- ensure there is a clear working model for addressing the Public Health needs of priority groups, such as:

    - Looked After Children, including the provision as appropriate of Review Health Assessments to under 5s where they are known to a Health Visitor;
    - Young Offenders;
    - Children and young people with Special Educational Needs and/or Disability (SEND);
    - Children and young people who have been subject to, or are at risk of, child sexual exploitation (CSE);
    - Children and young people who have been subject to, or are at risk of, female genital mutilation (FGM);
    - Young Carers;
    - Teenage parents and vulnerable first time parents under 25
    - Lesbian, Gay, Bisexual, Transexual young people;
    - Gypsy, Roma and traveller communities;

- other ethnic communities with specific Public Health needs.

- ensure and be able to evidence that the experience and involvement of families, carers, children and young people will be taken into account to inform service delivery and improvement
- deliver champion and advocate culturally sensitive and non-discriminatory services that promote social inclusion, dignity and respect
- build on resilience, strengths and protective factors, using strength-based approaches to improve autonomy and self-efficacy based on best evidence of child and adolescent development, recognising the context of family life and how to influence the family to support the outcomes for children
- build personal and family responsibility, laying the foundation for an independent life
- demonstrate the impact of the service provided through improved outcomes and service user feedback

System Integration/Interface

SPHN (Health Visiting/School Nursing) is one of a number of services in scope of the Community Health, Wellbeing and SEND integration in Plymouth. Services that are part of this integration will be expected over the lifetime of the contract to move to increasingly seamless working interfaces / practices driven by a shared responsibility to improve both the outcomes for children, young people and families and their experience of the services they use. Additionally by building a sustainable integrated offer additional value should be achieved for children, young people and families, commissioners and the tax payer. From the SPHN perspective this would be reflected through:

- Efficiencies in management and administration by having structures that avoid duplication and support safe, effective and creative operational delivery;
- Development of a single digital offer across all the services in scope of the integration to include access to information and advice that builds health literacy for the whole population and targeted populations as well as access to health professionals; promotes use of e.g. NHS Start for Life / Change for Life and apps such as Handi App to help managing childhood illnesses and also Plymouth Online Directory, etc..
- Effective use of the skill mix from the services in scope supported by the SPHN workforce who can deliver training to colleagues in regard to health improvement and making ‘Making Every Contact Count’;
- Ensuring that those children, young people and families, no matter where and to what level they are receiving additional care, will continue to have access to community and universal levels of provision available to the whole population;
- Utilising the skill mix across services in scope to support public health activity for example, contributing to the delivery of medicines training for school staff and delivery of therapeutic support for young people when receiving healthy weight interventions, supporting breastfeeding and early weaning and parent support;
- Maximising the capability of services in scope to safely and efficiently meet safeguarding and chid protection responsibilities.

The SPHN will create and maintain interfaces to the following systems for the delivery of care within Plymouth:

- the maternity and early years system;

- the vulnerable children and young people system;
- systems that provide care to adults where those services support young people and / or parents;
- Plymouth wellbeing strategy.

SPHN also interface with national programmes for screening and will ensure they interface with the relevant national, regional and local organisations within this system for the delivery and oversight of these, and any associated governance requirements.

Appendix 5 - Plymouth - the journey so far:

Plymouth City Council (PCC) and New Devon CCG have been working together for a number of years to develop an integrated approach to services for children, young people and adults. The creation of a pooled budget and co-location of the commissioning team were some of the first steps on this journey, alongside the creation of integrated commissioning plans.

The principle of co-production underpins all commissioning work; with system partners in the widest sense. The approach puts individuals at the centre of all that we do and focuses on the need to reduce inequity by improving health and wellbeing across Plymouth.

The background to the journey to integrated commissioning can be found here: https://www.plymouth.gov.uk/sites/default/files/IntegratedCommissioningSystem.pdf

Within Plymouth there is an agreed aim to achieve the integration of community health and wellbeing and SEND support services across all partners in order to support the commissioning intentions sets out in the Children and Young people Integrated Commissioning strategy.

The four Integrated Commissioning Strategies can be found here:

https://www.plymouth.gov.uk/adultcareandhealth/integratedcare

The integration of community health, wellbeing and SEND support services is being approached in a phased way. It is anticipated that phase 1 will be complete by April 2019.

Phase 1 involves:

- The creation of a single point of access across providers
- Embedding trusted triage and clinical decision making
- Single View IMT

To that aim, a Memorandum of Understanding (MoU) is being created between Plymouth Hospital's NHS Trust (PHNT); Plymouth City Council (PCC) Children's Services and Livewell Southwest (LWSW). It is the services provided by Livewell Southwest which are being tendered.

Evidence demonstrates that full integration of services requires at least five years to embed and it will be a requirement that the successful bidder will continue the journey already commenced and work closely with PCC and PHNT.

The System offers

Schools:
Schools are key partners in supporting children and young people in Plymouth, and hold a wealth of knowledge about our children and their needs.

There is a strong partnership relationship between PCC and schools, forged over a number of years. In February 2016, 26 schools signed a Commissioning and Procurement MOU with PCC. This enabled the PCC to procure services on behalf of schools and for schools to agree to work together strategically to ensure effective data collection, involvement in the monitoring of services and the provision of resources to enable the successful delivery of support by external service providers.

There was extensive co-design work with schools and the following services were procured:

- Progeny – a whole school approach to emotional health and wellbeing. The Zone was awarded the contract for this service. The service supports schools to undertake an audit of their current 'whole school approach' to emotional health and wellbeing using the 8 principles as set out in Public Health England guidance. The service supports schools to develop a bespoke delivery plan to enable them to monitor their progress of embedding a whole school approach over 3 years. The Zone supports schools to achieve their delivery plans through direct delivery, collation and coordination of external offers and distribution of good practice. The Zone will pilot a peer mentoring scheme in 3 schools in year 1 of the project and dependent on evaluation roll out to all schools in years 2 and 3. The Zone will also coordinate an annual conference with the Public Health team.

- Theraplay – Special Schools have received staff training in Theraplay level 1. Level 2 training took place in October 2016 with 20 members of staff being trained.

- Counselling – this offer is available to 19 secondary schools, including ACE. Xenzone working in partnership with Young Devon were awarded the contract for this service. Online support and counselling is available through Kooth.com and each school will receive a minimum of 5 hours per week face to face counselling. Community based counselling hours are also available, along with group interventions.

- CAMHS early intervention – Schools have funded the equivalent of two Band 6 workers. These workers have been recruited into the main CAMHS service and embedded as part of the new way of working through the wider Transformation Plan. The new model of working includes school based workers, which enables early conversations with school based staff where concerns are raised. On-going communication will enable more effective triage and links to wider CAMHS teams when required and will enable schools to continue to support young people through early help plans and with recovery pathways by enabling appropriate risk share and expert knowledge at the earliest opportunity.

These services are procured until August 2019 – any successful bidder will be required to continue the offer from CAMHS. Work will commence with schools and the wider system in 2018 to plan for post August 2019.

Plymouth Hospital NHS Trust

Geographical area Plymouth – the service is available to children registered with a GP practice in Plymouth City Boundaries, regardless of the actual address of the child.

Geographical area Devon – the service is available to children registered with a GP practice in the following areas - regardless of the child's address:

- West Devon – area from the A30 south and including Lifton, Lewdown, Brentor, Mary Tavy, Peter Tavy, Tavistock, Milton Abbott, Horrabridge, princetown, Yelverton and Woolwell
- South Devon – are including Wembury, Yealmpton, Modbury, Ivybridge, Ugborough, Kingsbridge and Salcombe

Age Range: children aged 0 – 18 years (19 years if they remain in special schools in area)

Services provided:

In all areas the following services are provided:

- Community Paediatrics
- Medical input Looked After Children and the Adoption and Fostering Service
- Children's Community Nursing Service (including Palliative Care)
- Community and inpatient Clinical Psychology Service
- Continence Service
- Learning Disability Nursing team
- Community Physiotherapy Service
- Community Occupational Therapy Service (health needs)
- Speech and Language Therapists for the ASD assessment pathways. Pre-school pathway covers Plymouth and Devon but the school age pathway is for Plymouth only. A small cohort of children with complex feeding difficulties will also be seen following their discharge from NICU/acute paediatric wards/specialist tertiary centres

Plymouth City Council

Geographical area Plymouth – the service is available to children and young people who are residents within the PCC footprint.

Age range: Children and young people aged 0 – 18 years (19 years in Special Schools). However, oversee work relating to a young person's Education, Health and Care Plan (EHCP) up to the age of 25 years old. Many of the teams provide a support offer into schools.

Services provided:

- Early Years Inclusion Team (Portage, Advisory Teachers, Specialist Support Workers)
- Advisory Teaching and Support
    - Sensory Support (vision/hearing)
    - Community Interaction (Autism Spectrum Condition/ Language)
- Children's Occupational Therapy (social care)

- Short Breaks for children with disabilities
- Children's Disability Social Work Team
- 0-25 SEND Statutory Assessment Team
- Educational Psychologists
- A small cohort of children with complex feeding difficulties will also be seen following their discharge from NICU/acute paediatric wards/specialist tertiary centres