

**DRAFT SPECIFICATION**  
**FOR**  
**0-19 PUBLIC HEALTH NURSING SERVICE**  
**APRIL 2018**  
**VERSION 1**

Service Specification No.	
Service	<b>0-19 Public Health Nursing Service</b>
Commissioner Lead	<b>Public Health</b>
Provider Lead	
Period	<b>1 April 2018 – 31 March 2020, plus 3 optional contract extensions for 2020-21; 2021-22; 2022-23</b>
Date of Review	

## **1. Population Needs**

### ***National/local context and evidence base***

#### **National context**

- 1.1 The Healthy Child Programme (HCP) is the core, early intervention and prevention public health programme that lies at the heart of the universal service for children and families. The HCP aims to support parents, promote child development, improve child

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health outcomes and ensure that families, children and young people at risk are identified at the earliest possible opportunity.

- 1.2 Delivery of the HCP is a key outcome that demonstrates the local authority is meeting its statutory duties to promote the health and wellbeing of children and young people, under the Children Act (2004)
- 1.3 The responsibility for commissioning immunisation and screening, clinical support for children with additional health needs or long-term conditions and disabilities and clinical support for enuresis lies with NHS England, via NHS teams. This 0-19 service specification therefore requires joint working and close collaboration between the provider, the local authority commissioner and NHS England/CCGs commissioners in relation to these responsibilities.
- 1.4 Giving every child the best start in life and reducing health inequalities throughout the lifecycle has been highlighted by Marmot (Fair Society, Healthy Lives) and the Chief Medical Officer (CMO) Annual Report 2012. A key element of this best start is 'permanence', that is, a framework of emotional, physical and legal conditions that give a child a sense of security, continuity, commitment and identity. Our aim, in planning for permanence from our earliest involvement with a child and family, is to ensure all children have the best possible chance to grow up in a secure, stable and nurturing family to support them to develop 'felt security', and to build resilience through childhood and beyond.
- 1.5 To this end, the Council's Children & Young People's Plan (2014-2017) sets out six outcome priorities, which focus on creating opportunities to ensure that children and families lead happy, healthy and fulfilling lives. The Council's Joint Strategic Needs Assessment (JSNA) also highlights a range of health and wellbeing outcomes for children, in particular the need to improve the emotional health and wellbeing of children and young people.

### Local context

- 1.6 The Child Health Profile for Bracknell Forest (2017) shows that in 2015 there were:
  - a) 1,488 live births
  - b) 8,000 children aged 0-4 years (6.7% of the total population)
  - c) 30,700 children aged 0-19 years (25.8% of the total population)
- 1.7 The total number of children and young people aged 0-19 years is projected to rise to 33,800 in 2025 (25.9% of the total population)
  - a) In 2016, school children from minority ethnic groups made up 20.4% of the total population.
  - b) In 2014, 10.5% of children under the age of 16 were defined as living in poverty. This is latest data available.

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1.8 Children in Bracknell Forest have better than average levels of obesity; although 17.6% of children aged 4-5 years and nearly 30% of children aged 10-11 years are overweight or obese (excess weight). (Public Health Outcomes Framework, 2017)

1.9 In 2015/16, rates of A&E attendances in under 4s was higher than the England average. Hospital admissions for injury for children and young people were similar to or below the England averages.

### Bracknell Forest School Population

1.10 There are a total of 47 schools in the Bracknell Forest local authority area. This figure includes state funded primary and secondary schools, the state funded special school, the pupil referral unit and independent schools.

1.11 The following information has been taken from the annual school census data in January 2015. The school age population (5 – 19) across Bracknell Forest totals 20,452. Of the total school population, approximately 2.7% have a statement of special educational need (SEN) or an Education Health and Care Plan (EHC) (SFR25/2015).

1.12 The average number of children (those who are looked after, subject to a current child protection order, have a special or medical need, on a short term plan or attend a specialist enuresis clinic) on the school nursing service targeted caseload is currently approximately 214.

### Evidence Base

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

- a) Delivery of the HCP
- b) Assessment and intervention when a need is identified
- c) On-going work with children and families with multiple, complex or safeguarding needs in partnership with other key services including early years, children's social care and primary care

1.14 Successive academic and economic reviews have demonstrated the economic and social value of prevention and early intervention programmes in pregnancy and the early years. In fact, the evidence-base for improved health, social and educational outcomes from a systematic approach to early child development has never been stronger and has been described as a powerful equalizer which merits investment (Irwin et al 2007, Marmot 2010).

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- 1.15 During pregnancy and in the first 2 years, a baby's brain and neurological pathways are being laid down for life with 80% of a baby's brain development taking place during this time. It is therefore the most important period for brain development, and is a key determinant of intellectual, social and emotional health and wellbeing. Research studies in neuroscience and developmental psychology have shown that interactions and experiences with caregivers in the first months of a child's life determine whether the child's developing brain structure will provide a strong or weak foundation for their future health, wellbeing, psychological and social development<sup>1</sup>.
- 1.16 The Government, NHS England, Public Health England (PHE), Royal Colleges, local government organisations and others signed up to the 'Pledge for better health outcomes for children and young people' in February 2013. The Pledge sets out shared ambitions to improve physical and mental health outcomes for all children and young people. It commits signatories to putting children, young people and families at the heart of decision-making and improving every aspect of health services - from pregnancy through to adolescence and beyond.
- 1.17 The Public Health England framework (2015) "Improving Young People's Health and Wellbeing: a framework for public health" highlights the importance of ensuring that every young person has the right level of support to help them to maximise their full potential.
- 1.18 The Public Health and NHS Outcomes Frameworks clearly define a range of measures that are pertinent to children and young people. Effective delivery of the Healthy Child Programme will contribute towards the achievement of many of these outcomes:
- a) Improving life expectancy and healthy life expectancy
  - b) Reducing infant mortality
  - c) Reducing low birth weight of term babies
  - d) Reducing smoking at delivery
  - e) Improving breastfeeding initiation
  - f) Increasing breastfeeding prevalence at 6-8 weeks
  - g) Improving child development at 2-2.5 years
  - h) Reducing the number of children in poverty
  - i) Improving school readiness
  - j) Reducing under 18 conceptions

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<sup>1</sup> [Allen, G. \(2011a\) Early Intervention: The Next Steps. HM Government: London](#)

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- k) Reducing excess weight in 4-5 year and 10-11 year olds
- l) Reducing hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0-14
- m) Improving population vaccination coverage
- n) Disease prevention through screening and immunisation programmes
- o) Reducing tooth decay in children aged 5
- p) Improving School readiness
- q) Reducing Pupil absence
- r) Reducing first time entrants to the youth justice system
- s) Reducing the number of 16-18 year olds not in education, employment or training
- t) Reducing under 18 conceptions
- u) Reducing excess weight in 4-5 and 10-11 year olds (all sub-indicators)
- v) Reducing hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0-14 and 15-24 years
- w) Improving emotional wellbeing of looked-after children
- x) Reducing smoking prevalence – 15 year olds
- y) Reducing self-harm
- z) Chlamydia diagnoses (15-24 year olds)
- aa) Improving population vaccination coverage (all sub-indicators)

## 2. Scope

### *Aims and objectives of service*

#### Core elements of the HCP

2.1 The core elements are:

- a) Health and development reviews – Assessment of family strengths, needs and risks; providing parents with the opportunity to discuss their concerns and aspirations; assess child growth and development, communication and language, social and emotional development; and detect abnormalities. HVs should use evidence-based assessment tools and must use ASQ 3 for the 2 - 2.5 year review. See Appendix E for the full list of universal assessments.

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- b) Screening – in line with the current and forthcoming updated HCP and the National Screening Committee recommendations.
- c) Immunisations – Immunisations should be offered to all children and their parents. Health visiting teams should provide parents and young people with tailored information and support and an opportunity to discuss any concerns. They should check children and young people’s immunisation status during health appointments and refer to their GP if unvaccinated. General practices are the provider of immunisations through the section 7A agreement and child health record departments maintain a register of children under 5 years, invite families for immunisations and maintain a record of any adverse reactions in the Child Health Information System (CHIS).
- d) Promotion of social and emotional development – The HCP includes opportunities for parents and practitioners to review a child’s social and emotional development using evidence-based tools such as ASQ 3 and ASQ SE and for the practitioner to provide evidence-based advice and guidance and decide when specialist intervention is needed.
- e) Support for parenting – One of the core functions of the HCP is to support parenting using evidence-based programmes and practitioners who can work across different agencies who are trained and supervised.
- f) Effective promotion of health and behavioural change – Delivery of individual and community-level interventions based on NICE public health guidance. Encourage the strengths within the family recognising that families have the solutions within themselves to make changes. Make every contact with the family a health promoting contact.
- g) Reducing hospital attendance and admissions – Supporting parents to know what to do when their child is ill. This may include prescribing in line with legislation, providing information about managing childhood conditions and prevention of unintentional injuries.
- h) Children with additional needs – Early identification and assessment and help. Health visiting teams will provide assessment; care planning and on-going support for babies and children up to school entry with disabilities, long term conditions, sleep or behavioural concerns, other health or developmental issues.

### Aims

2.2 The aims of the service are:

- a) lead and co-ordinate local delivery of the Healthy Child Programme for 0-19, working across a number of stakeholders, settings and organisations.
- b) be an area-based, geographical service structured to align with local children and young people’s services, working together and in partnership with other health and social care stakeholders and community groups, to deliver

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integrated, evidence-based services for children and their families, with a focus on prevention, promotion and early intervention

- c) have safeguarding and child protection at its heart, where all team members are alert to signs and symptoms of child abuse and follow local safeguarding procedures where there is a cause for concern.
- d) champion and advocate culturally sensitive and non-discriminatory services that promote social inclusion, dignity and respect.
- e) provide services that build on resilience, strengths and protective factors 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.
- f) demonstrate the impact of the service provided through improved outcomes and service user feedback
- g) comprise two service areas; Health Visiting and School Nursing.
- h) the Council reserves the right to review the services, including the core aims listed above, in order to ensure affordability.

2.3 The Service may be subject to changes in legislation and statutory guidance that may be issued from time to time by the Secretary of State. Where such changes permit the Provider to make charges for the Services, the Provider shall notify the Purchaser of any intent to do so.

### Objectives

2.4 The objectives of the HCP are:

- a) To ensure that all children and young people and their families (0-19) who are resident or attending school in Bracknell Forest unitary authority area 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 specialist services,
- b) To improve the health and wellbeing of children and young people from 0-19 years and reduce inequalities in outcomes, as part of the an integrated multi-agency approach to supporting and empowering children, young people and families
- c) To provide a seamless health and wellbeing journey for children, young people and families from the antenatal period until 19 years
- d) To safeguard babies, children and young people through safe and effective practice in safeguarding and child protection. This will include working with other agencies to intervene effectively in families where there are concerns

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about parenting capacity, adult mental health, alcohol or substance misuse, domestic abuse or child abuse.

- e) To share information with partners as appropriate to ensure families are receiving the right help and support they need at the right time.
- f) To maximise effective use of skills mix, specialist public health, defined clinical and public health skills, professional judgment, autonomy and leadership in order to improve health and wellbeing outcomes, specifically;
  - i. supporting families to give children the best start in life based on current evidence
  - ii. 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
  - iii. 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
  - iv. working with families, children and young people to support behaviour change leading to positive lifestyle choices
  - v. enabling children to be ready to learn at 2, ready for school by 5 and to achieve the best possible educational outcomes, working in partnership with early years services.
  - vi. supporting families and young people to engage with their local community through education, training and employment opportunities
  - vii. supporting children, young people and families to navigate health and social care services and local community groups, to ensure timely access and support and to signpost to trusted sources of information, such as NHS Choices and the Bracknell Forest Public Health Portal.
  - viii. working in partnership with other professionals and stakeholders (including maternity services, early years services, voluntary, private and independent services, primary and secondary care, schools, and children's social care services, parents, carers, children and young people and others) 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.
  - ix. ensuring early identification of children, young people and families where early help and additional evidence-based preventive programmes will promote and protect health in an effort to reduce the risk of poor future health and wellbeing



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### Access and Referrals

- 2.5 Efficient communication systems to be set up to enable prompt and responsive communications both internally between health visiting and school nursing staff, and externally with key stakeholders, including young people, families, GPs and other health and social care professionals.
- 2.6 All referrals from whatever sources (including children, young people and families transferring into area) should receive a response to the referrer within 5 working days, with contact made with the child, young person or family within 10 working days.
- 2.7 Urgent referrals, including all safeguarding referrals, should receive a same day or next working day response to the referrer and contact within two working days and be in line with local safeguarding procedures.
- 2.8 By the time the child reaches 4.5 years of age, there will be a formal handover from the health visiting service to the school nursing service, timed to meet the needs of the child e.g. if the HV is lead professional the handover may be delayed where this will improve outcomes for the child. Similarly, the school nursing service will work with adult services to ensure smooth transition to adult services.

### Safeguarding

- 2.9 The Service will:
  - a) follow the guidance and pathways agreed by the Local Safeguarding Children Board and as set out in the Berkshire Child Protection procedures.
  - b) ensure that policies and procedures relating to safeguarding are adhered to and that staff have undertaken training appropriate for their professional role and that training is updated in line with best practice recommendations or requirements.
  - c) ensure that all staff will be trained in the recognition of Domestic Violence, Child Sexual Exploitation and Female Genital Mutilation, and other significant harms, in addition to Safeguarding training, to an appropriate level to undertake safety planning and risk assessments.
  - d) ensure all staff will have undertaken a three yearly enhanced DBS clearance checks (Disclosure and Barring Service).
  - e) will comply with the Protection of Children Act (1999) and (2004) and all services are duty bound to comply with the Children Acts, 1989 and 2004 and further guidance from government including: Working Together to Safeguard Children, 2010.
  - f) will undertake annual record keeping audits for children and young people on vulnerable caseloads.

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- g) monitor and report the overall safeguarding caseloads of the health visiting and school nursing service and benchmark these so as to provide information for effective capacity management going forward.
- h) safeguard children and young people, ensuring that all identified vulnerable children have a children in need plan and children with a child protection plan have an identified health visitor or school nurse to support their individual care plans as per pathway.
- i) work in close partnership with all key agencies and professionals to safeguard children at risk of and suffering from child maltreatment, including domestic violence.
- j) undertake a comprehensive health assessment for all children referred under Section 47, and develop a care plan if health needs are identified.
- k) contribute to, monitor and respond to any appropriate learning from Serious Case Reviews or multi-professional reviews e.g. in cases such as concealed pregnancy and sexual exploitation.
- l) will continue to deliver early intervention and prevention work as a priority for children identified as vulnerable

### Health Visiting Service Area

2.10 The overarching aim of health visiting services for children under 5 is to protect and promote the health and wellbeing of children and their families. Responding to the new vision for nursing and the “Six C’s”, the national nursing strategy, health visitors will:

- a) Show care, compassion and commitment in how they look after families.
- b) Find the courage to do the right thing, even if it means standing up to senior people to act for the child or parent’s best interests, in a complex and pressured environment.
- c) Communicate well at all times particularly with the children, families and communities they serve and demonstrate competence in all their activities and interventions.

2.11 The Health Visiting service follows the “4-5-6” model:

- a) four levels of service according to the identified need (universal, universal plus, universal partnership plus and community);
- b) five mandated elements of service (the antenatal review, new birth visit, 6-8 weeks review, 1 year review and 2–2.5yr review).
- c) six high impact areas (transition to parenthood and the early weeks, maternal mental health, breastfeeding, healthy weight, managing minor illnesses and

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reducing accidents, health, wellbeing and development at two years and support to be ready for school).

2.12 Drawing on the Health Visitor Implementation Plan and in consultation with professionals and the public in Bracknell Forest, this service specification sets out what families can expect from their local health visiting service, under the following service levels:

- a) Community: health visitors have a broad knowledge of community needs and resources available e.g. Children's Centres and self-help groups and work to develop these and make sure families know about them.
- b) Universal: health visiting teams lead delivery of the HCP. They ensure that every new mother and child have access to a health visitor, receive development checks and receive good information about healthy start issues such as parenting and immunisation.
- c) Universal Plus: families can access timely, expert advice from a health visitor when they need it on specific issues such as postnatal depression, weaning or sleepless children.
- d) Universal Partnership Plus: health visitors provide on-going support, playing a key role in bringing together relevant local services, to help families with continuing complex needs, for example where a child has a long-term condition.

2.13 Universal services for all families: will include individual level interventions and programmes that will motivate and support people to;

- a) Understand the short medium and longer term consequences of their health related behaviour for themselves and others;
- b) Feel positive about the benefits of health enhancing behaviours and changing their behaviours;
- c) Plan change in terms of easy steps over time;
- d) Recognise how their social context and relationships may affect their behaviour, and identify and plan for situations that might undermine changes they are trying to make;
- e) Plan explicit 'if/then' coping strategies to prevent relapse;
- f) Make a personal commitment to adopt health enhancing behaviours by setting and recording goals to undertake clearly defined behaviours in particular contexts over a specified time;

2.14 Additional services as part of Universal Plus and Universal Partnership Plus will include services:

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- a) That any family may need some of the time, for example, care packages for maternal mental health, parenting support and baby/toddler sleep problems – where the HV may provide, delegate or refer. Intervening early to prevent problems developing or worsening.
- b) For vulnerable families requiring on-going additional support for a range of special needs, for example families at social disadvantage, families with a child with a disability, teenage mothers, adult mental health problems or substance misuse.

### Key objectives of the health visiting service area

2.15 The key objectives of the health visiting service area are:

- c) Improve the health and wellbeing of children and reduce inequalities in outcomes as part of an integrated multi-agency approach to supporting and empowering children and families;
- d) Ensure a strong focus on prevention, health promotion, early identification of needs, early intervention and clear packages of support;
- e) Ensure delivery of the HCP to all children and families, including fathers, starting in the antenatal period;
- f) Identify and support those who need additional support and targeted interventions, for example, parents who need support with parenting and women suffering from perinatal mental health issues including postnatal depression in accordance with NICE guidance;
- g) Promote secure attachment, positive parental and infant mental health and parenting skills using evidence based approaches;
- h) Promote breastfeeding, healthy nutrition and healthy lifestyles;
- i) Promote 'school readiness' including working in partnership to improve the speech, communication and language of babies and toddlers and working with parents to improve the home learning environment;
- j) Work with families to support behaviour change leading to positive lifestyle choices;
- k) Safeguard babies and children through safe and effective practice in safeguarding and child protection. This will include working with other agencies to intervene effectively in families where there are concerns about parenting capacity, adult mental health, alcohol or substance misuse, domestic abuse or child abuse;
- l) Develop on-going relationships and support as part of a multi-agency team where the family has complex needs e.g. a child with special educational needs, disability or safeguarding concerns;

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- m) Deliver services in partnership with local authorities to support 'troubled families' and be 'lead professional' or 'key worker' for a child or family where and when appropriate
- n) Improve the Health and Wellbeing journey for children, families and local communities through expanding and strengthening Health Visiting Services to respond to need at individual, community and population level.

### Key objectives of the school nursing service area

2.16 Key objectives of the school nursing service area are:

- a) Provide a core school nursing service offer to school age children attending state-funded schools, including Free Schools and Academies.
- b) Safeguard and promote the welfare of children and young people and to implement child protection measures when required.
- c) Deliver a targeted service in line with evidence based needs at an individual level to at-risk and vulnerable groups of children, young people and their families known to the service and registered with a Bracknell Forest school.
- d) To provide a skilled and experienced team of staff that works flexibly across a range of settings, working in partnership with other professionals and community-based services for children and young people, to ensure that parents and schools have access to the services and support they need.
- e) To support the wider offer of public health wellbeing initiatives aimed at the school age population and schools. The school nursing team will focus particularly on ensuring that the identified health and wellbeing needs of individual, targeted young people and their families are met, as decided jointly with the local authority through local monitoring and performance management arrangements (see performance monitoring framework).
- f) Provide a flexible, accessible and proactive service, in and out of school hours and terms, using technology and appropriate social media approaches to ensure the service is readily accessible directly by the children and young people who attend the Bracknell Forest schools and their families.
- g) Record information and data as agreed with the commissioner to monitor progress and outcomes that contribute to improving the health of school age children and young people.
- h) Ensure that children with identified health needs have continuity of support throughout their school career and where appropriate are communicated to partner agencies (e.g. schools, colleges, social care).

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### *Service description/care pathway*

#### Health Visiting Service Area

- 2.17 Leading, with local partners, in developing, empowering and sustaining families and communities' resilience to support the health and wellbeing of their 0-5 year olds by working with local communities and agencies to improve family and community capacity and champion health promotion and the reduction of health inequalities.
- 2.18 Working in full partnership with all Early Years services in the local area and wider 0-19 services to ensure holistic seamless care to children and families. Collaborative working between the 0-19 service provider and the Children's Centres will be formalised in a Partnership Agreement, signed by both parties.
- 2.19 Leading delivery of the full Healthy Child Programme for 0-5 years, using a collaborative approach in partnership children, families and stakeholders.
- 2.20 Provision of universal services includes promotion of attachment and undertaking holistic assessments of children and families;
- 2.21 Provision of Universal Plus services includes, for example, identifying and intervening with vulnerable babies and children where additional on-going support is required to promote their safety and health and development e.g. Care Of New-born Infant ( Sudden Infant Death Syndrome) and providing interventions to improve maternal mental health;
- 2.22 Provision of Universal Partnership Plus includes ensuring early intervention, for example, parenting support and early referral to targeted support. It also includes utilising the Common Assessment Framework or equivalent and health visitors undertaking the role of Lead Professional/key worker where appropriate.
- 2.23 Ensuring appropriate safeguards and interventions are in place to reduce risks and improve health and wellbeing of children for who there are safeguarding and/or child protection concerns. This includes maintaining accountability for babies and children for whom there are safeguarding concerns and working in partnership with other agencies to ensure the best outcomes for these children
- 2.24 Meeting public health priorities through health visitors' use of their knowledge of the evidence base and skills as trained public health practitioners
- 2.25 Use of the benchmarked child health outcome framework indicators for 0-5s to form a basis for setting shared priorities for action and contributing to the JSNA;
- 2.26 Advising families and professionals on best practice in health promotion in the early years of childhood;
- 2.27 Responding to and supporting delivery of the Joint Health and Wellbeing Strategy;
- 2.28 Responding to childhood communicable disease outbreaks and health protection incidents as directed by PHE or other;

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- 2.29 Ensuring immunisations are recommended as per The Green Book;
- 2.30 Ensuring delivery of the health visiting aspects of the new-born screening programmes, for example, ensuring results are recorded and acted upon in line with UK NSC Programme Standards.

### Delivery of evidenced-based assessments and interventions

- 2.31 Prescribe medication as an independent/supplementary prescriber in accordance with current legislation (See Appendix D for additional information). Where HVs have not undertaken this module in training, it is a requirement of CPD for completion within the first 2 years of practice.
- 2.32 Promote parent and infant mental health and secure attachment as an example via the use of Neonatal Behavioural Observation and Neonatal Behavioural Assessment Scale.
- 2.33 In response to local need, work alongside early years practitioners to co-deliver evidence based antenatal and post natal groups to promote attachment. This could be post natal groups, preparing for Pregnancy and beyond, post natal depression support groups. Promote collaboration for community based self-help support groups, i.e. mother and toddler groups
- 2.34 In response to local need, work alongside early years practitioners to co-deliver evidence-based parenting programmes for toddlers and pre-school children (e.g. Solihull, Time Out) other evidence based programmes.
- 2.35 Maintain full accreditation of UNICEF Baby Friendly community initiative,
- 2.36 Work with parents, using well evidenced, strengths-based approaches e.g. motivational interviewing, Family Partnership Model and Solihull approach to promote positive lifestyle choices and support positive parenting practices to ensure the best start in life for the child.
- 2.37 Identify early signs of developmental and health needs and signpost and/or refer for investigation, diagnosis, treatment, care and support.
- 2.38 Provide responsive care when families have problems or need support or preventative interventions in response to predicted, assessed or expressed need (through intervention using new evidence in developmental psychology).
- 2.39 Ensure a family focus and safe transition into 5-19 services through close partnership working with services meeting the needs of children and young people aged up to 19.
- 2.40 Ensure a family focus and close partnership working with early intervention services such as troubled families including step up and step down transitions.

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### Child protection and safeguarding children

- 2.41 The role of health visiting in child protection and safeguarding children are essential components of the service. Safeguarding children, which includes child protection and prevention of harm to babies and children is a public health priority.
- 2.42 Working with other agencies as part of a multi-agency intensive care package for children and families requiring intensive support, particularly children for whom there are safeguarding or child protection concerns
- 2.43 This includes the statutory duty to share information and communicate with other health professionals and agencies where there are safeguarding concerns and engagement of the health visiting service in multi-agency services e.g. MASH, 'troubled families' and MARAC.
- 2.44 Communicating effectively with other agencies including contributing to initial and review case conferences and other safeguarding meetings as appropriate to the needs of the children.
- 2.45 Working with the Looked After Children (LAC) nurse to contribute to and support assessments of Looked After babies and children aged 0-5 with timescales in line with national requirements and contribute to ensuring any action plans are carried out. Ensure provision of the HCP and additional services to meet their health needs.
- 2.46 Having expert knowledge about child protection and the skills and qualities to intervene to protect children where:
- a) Knowledge needs to include domestic abuse, neglect, child and adult mental health issues, substance and alcohol misuse, physical, sexual and emotional abuse, female genital mutilation, fabricated and induced illness in a child.
  - b) Skills and qualities need to include high levels of communication and interpersonal relating, self-awareness, ability to challenge and to be challenged, understanding of barriers to safe practice e.g. collusion, adult focus, fear, burn-out. HVs need to receive expert supervision for child protection and safeguarding work they are involved in.

### Children with special needs

- 2.47 This includes families with children with special educational needs (SEN). The Children and Families Act 2014 (the 2014 Act) introduced major changes to support for children and young people with SEN, creating education, health and care (EHC) plans to replace SEN statements. The basic goals are to give families a greater involvement in decisions about their support and to encourage social care, education and health services to work together more closely in supporting those with special needs or disabilities.
- 2.48 The 2014 Act includes the requirement that EHC plans will need to be reviewed regularly and cover people up to the age of 25 years.



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- 2.49 The role of HVs is to work in partnership with other services in supporting the assessment of the education health and care plans for children between 0-5 through sharing information about the child's and family's needs and reviewing in collaboration with other services what they can do to support the delivery of these plans and making sure the appropriate health visiting services form part of the high intensity multi-agency services for families where there are safeguarding and child protection concerns.

### Supervision

- 2.50 The provider will work with NHS England, HEE and Local Education Training Boards (LETBs) to ensure effective support for trainees and newly qualified HVs. This will be delivered by ensuring the provision of: sufficient practice teachers; support through mentoring and supervision for students and newly qualified staff; and, placement capacity and high quality placements in line with NMC and HEI requirements.
- 2.51 The provider will develop and maintain a supervision policy and ensure that all health visiting staff access supervision in line with the framework below:

### Clinical supervision

- 2.52 Health visitors will have clinical supervision according to their needs using emotionally restorative supervision techniques on a regular planned basis.

### Safeguarding supervision

- 2.53 Health visitors will receive a minimum of 3 monthly safeguarding supervisions of their work with their most vulnerable babies and children. These are likely to include children on a child protection plan, those who are 'looked after' at home and others for whom the health visitor has a high level of concern. Safeguarding supervision should be provided by colleagues with expert knowledge of child protection to minimise risk. For example, supervision must maintain a focus on the child and consider the impact of fear, sadness and anger on the quality of work with the family.

### Management supervision

- 2.54 HVs with a requirement to line manage in their roles will have access to a HV manager or professional lead to provide one-to-one professional management supervision of their work, case load, personal & professional learning and development issues.

### Practice Teacher Supervision

- 2.55 HV Practice Teachers must have access to high quality supervision according to the requirements of their role.
- 2.56 All the above forms of supervision will have an emotionally restorative function and will be provided by individuals with the ability to:

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- 2.57 Create a learning environment within which HVs can develop clinical knowledge, skills and strategies to support vulnerable families. This will include experiential and active learning methods.
- 2.58 Use strengths-based, solution-focused strategies and motivational interviewing skills to enable HVs to work in a consistently safe way utilising the full scope of their authority.
- 2.59 Provide constructive feedback and challenge to HVs using advanced communication skills to facilitate reflective supervision.
- 2.60 Manage strong emotions, sensitive issues and undertake courageous conversations.

### ***Record keeping, data collection systems and information sharing***

- 2.61 In line with contractual requirements, providers will ensure that robust systems are in place to meet the legal requirements of the Data Protection Act 1998 and the safeguarding of personal data at all times. Providers should also refer to 'Record Keeping: Guidance for Nurses and Midwives', NMC, 2009.
- 2.62 In line with the above and following good practice guidance, the provider will have agreed data sharing protocols with partner agencies including other health care providers, Children's Centres as part of the formal Partnership Agreement, childrens social care and the police to enable effective services to be provided to children and their families. Providers will ensure that all staff have access to information sharing guidance including sharing information to safeguard or protect children.
- 2.63 Providers must ensure information governance policies and procedures are in place and understood.
- 2.64 The Personal Child Health Record (PCHR) will be completed routinely by professionals supporting parents and carers to use proactively.
- 2.65 Appropriate records will be kept in CHIS or similar system to enable high-quality data collection to support the delivery, review and performance management of services.
- 2.66 Providers must ensure that staff are using and are trained to use suitable electronic record keeping equipment that includes data collection systems such as:
- 2.67 Ensure the HV service is accessible to all families with young children. This may require the use of appropriate technology e.g. health promoting apps, secure text messaging with clients, secure email facilities with clients and other agencies
- 2.68 The use, where necessary to meet needs and make the service accessible of remote access e.g. laptops and tablets, mobile phones, teleconference facilities, videoconferencing facilities.
- 2.69 \*2-2.5 year review (Ages and Stages Questionnaire)\* The PHOF indicator 2.5, development at age 2-2.5, requires the implementation of a data collection about the Ages and Stages questionnaire to be used in the 2-2.5 year review.

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- 2.70 Benchmarked outcome data for local areas supported by guides for effective intervention to improve outcomes can be found at <http://atlas.chimat.org.uk/IAS/dataviews/earlyyearsprofile>
- 2.71 A public health outcome measure of child development at age 2-2½ is currently under development, as set out in the Public Health Outcomes Framework. It is expected that data will be collected via the Children and Young People's Health Services data set in due course. More detailed information on the data items that will be required is included in Appendix C
- 2.72 The Health Service Delivery Metrics in Appendix C are included in the Children and Young People's Health Services Secondary Uses Data Set, which integrates the Maternity and Children's dataset published by the NHS England for further information consult <https://www.england.nhs.uk/statistics/statistical-work-areas/health-visitors/>.

### **Assessment of children and families**

- 2.73 Initial assessments of children and families must be carried out by health visitors. Certain elements of the care plan and developmental reviews may be delegated to suitably qualified staff, according to the professional judgement of the HV
- 2.74 The health visiting service area must respond to all referrals.
- a) Referrals, from whatever source, (including families transferring in) will receive a response to the referrer within 5 working days, with contact made with the family within 5 working days.
  - b) Urgent referrals, including all safeguarding referrals, must receive a same day or next working day response to the referrer and contact with the family within two working days. While it is preferable that urgent referrals are dealt with by the named health visitor for the family involved, to ensure these visits are prioritised, providers should have a process in place for when the named health visitor is not available.
- 2.75 When a child transfers into an area the health visiting team must check new-born blood spot status and arrange for urgent screening if necessary.
- 2.76 Providers must develop their own local area new-born blood spot policies and pathways in partnership with local midwifery, CHIS and GP colleagues.
- 2.77 The health visitor team must check status of, and record, all screening results including hearing, New-born Infant Physical Examination (NIPE) and Hep B schedule, immunisation status and refer immediately for any follow up necessary.

### **Caseload holding**

- 2.78 As a minimum there must be a named HV for every family up to 1 year of age and for all children 0-5 identified as having needs at the Universal Plus/ Partnership Plus levels.

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### *Pathway into school nursing service*

- 2.79 By the time the child reaches 4.5 years of age, there will be a formal handover to the School Nursing Service, in accordance with local and national pathways. The provider must ensure that when the youngest child in the family reaches school entry age, the family file or adult records are transferred as per local procedure. The pathway from health visiting to school nursing should follow the DH published pathway for this transition. The pathway can be accessed via [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/216466/dh\\_133020.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216466/dh_133020.pdf)
- 2.80 Children being supported at Universal Partnership Plus must be formally identified to the School Nursing Service as per local procedure in order ensure continued targeted support.

### *Removals out of area*

- 2.81 Where a child moves out of area the Health Visiting Service must ensure that the child's health records are transferred to CHIS for transfer to the receiving Health Visiting Service in the new area within 2 weeks of notification.
- 2.82 Procedures must be in place to trace and risk-assess missing children and those whose address is not known with systems in place to follow up and trace children who do not attend for 9 – 12 month and 2 – 2.5 year assessments this must include, .processes to ensure the service is aware of new GP registrations and movements out of a practice.
- 2.83 Direct contact must be made to handover all child protection cases

### *Integrated working*

- 2.84 The provider will establish:
- a) Excellent and seamless working relationships between the health visiting and school nursing functions of the 0-19 Public Health Nursing Service.
  - b) Excellent working relationships with all stakeholders, including effective joint working at transition points (e.g. midwife/health visiting, health visiting/midwife/ /Local Authority/GP/5-19 services/troubled families/early years providers).
  - c) A named HV on the Children's Centre Advisory Board.
  - d) And ensure there is appropriate senior nurse representation on the Local Children Safeguarding Board, and appropriate nurse representation on the new multi-agency safeguarding hub (MASH) and the Early Help Hub, developing and supporting delivery of services in line with the Board's priorities in the JNSA.

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### Health visitor linked to each GP

2.85 The service will provide a named HV, with contact details, for each GP practice to facilitate liaison, information sharing and joint working in the best interests of families. It is expected that the named health visitor will, as a minimum, attend the relevant GP practice monthly meetings. Other contact points for collaborative service delivery will be agreed between the Service and GP practices.

### Health visitor linked to each Children's Centre

2.86 A named HV on each Children's Centre Advisory Board to work in partnership and in the spirit of total co-operation with children centres.

2.87 A Partnership Agreement between Children's Centres and the 0-19 Public Health Nursing Service which will drawn up, to be signed by both parties. This agreement should have as its aim to provide improved access and delivery of the HCP and, through this, to the Children's Centres' core offer

### Specifics of the Partnership Agreement

2.88 Integrated working with Children's Centres in their delivery of evidence based interventions to improve outcomes for families

- a) Promote and describe the wide range of early years' provision that children and their families are entitled to, and as part of that process encourage all families to register for access to a wider range of provision.
- b) Work in a collaborative manner with Children's Centre teams to agree joint local children's service priorities based on local JSNA.
- c) Work in a collaborative manner with Children's Centre teams to agree how both services will work together
- d) An agreed method of data collection that encourages prompt and easy sharing of information with the families' consent.
- e) Monthly joint health visiting/Children's Centre meetings to discuss individual cases and opportunities to share best practice
- f) A schedule of joint training and induction
- g) Joint visits
- h) A specific protocol for the conduct of the 2 – 2.5yr reviews, which must be fully integrated.

2.89 The service will develop close links with all local providers of services to children, for example, voluntary sector providers, childminders, early year's settings and schools.

2.90 In addition to the core programme, the HCP schedule includes a number of evidence-based preventive interventions, programmes and services. Providers will work with

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Commissioners, local authority partners, local safeguarding and children's boards, Health and Wellbeing Boards, Clinical Commissioning Groups (CCGs), to determine which services are offered locally and by whom. The next section sets out the evidenced based multi-agency pathways that should be developed and implemented.

### **Care Pathways**

- 2.91 The Health Visiting Service will work to develop, implement, monitor and review multi-agency care pathways for priority needs for children and their families, ensuring clarity of roles and responsibilities, reducing duplication and eliminating gaps. These will be based on evidenced-based assessments and interventions with a clear role for HVs underpinned by training in the relevant competencies. These should be in line with national pathways and guidance where these have been developed.
- 2.92 Multi-agency, evidence-based pathways expected to be in place are in Appendix M

### **Service Access**

- 2.93 The core service will operate standard hours of 9am – 5pm Monday to Friday but with flexibility from 8am – 8pm to meet the needs of families, including evenings and weekends as required to meet demand. This may be delivered through a range of workforce planning options such as flexible shift times. Other working hours may be considered by local agreement to meet the needs of families.

### **Targets for the delivery of the mandated elements**

- 2.94 Antenatal Review (face-to-face with a health visitor) at 28 weeks or above - The reviews should be carried out in the most effective way that meets the demands of families and using health visitors' clinical judgement. There is no national or local target for completing antenatal reviews.
- 2.95 New Birth Visit - 95% of all new birth visits to be completed within 14 days (in line with the national health visiting metric).
- 2.96 6-8 Weeks Review - 95% of children receive a 6-8 week review (in line with the national health visiting metric)
- 2.97 1 Year Review - 85% of children receive a 9-12 month review (in line with the national health visiting metric)
- 2.98 2-2.5 Year Review - 85% of children receive a 2-2.5 year review (in line with the national health visiting metric)
- 2.99 Reviewing, in partnership with parents and carers, the health and development of babies at age 9-12 months and 2 – 2.5 years (universal and integrated using ASQ 3) and involving the family in promoting optimum health and development of all children.
- 2.100 Assessing the development of babies and children, using the ASQ for the 12 months and 2 -2.5 year integrated review. The 2 – 2.5 year health visitor review to be fully

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integrated with the Early Years Foundation Stage review to ensure both health visitors and early years practitioners have the broadest picture of the child's development.

### ***Targets for the delivery of other elements***

- 2.101 Breastfeeding Status - 95% of infants whose breastfeeding status at 6-8 weeks is recorded
- 2.102 Breastfeeding at 6-8 weeks - 60% of infants being breastfed at 6-8 weeks.
- 2.103 Health visitor representation on Children's Centre Advisory Board or its successor - 100% of Children's Centre Advisory Board meetings to have health visitor representation at every Board meeting.

### ***School Nursing Service Area***

- 2.104 A core public health school nursing service will be provided to children and young people who attend state funded primary schools and secondary schools and the pupil referral unit in Bracknell Forest.

### ***Service Access***

- 2.105 The service can be accessed by children, young people and their families in schools, community settings or the home.
- 2.106 The service can be accessed directly by all young people without needing to go through another member of the school staff first.
- 2.107 Schools and other key partner agencies can access the service through the 0-19 Public Health Nursing Service by telephone, email or letter. Referrals will be accepted from child and young people (self-referral), parents/carers, and other agencies.
- 2.108 Young people in secondary schools will know how, where and when they can access the service

### ***Universal Elements***

- 2.109 Lead, co-ordinate and provide services for children and young people as set out in the Healthy Child Programme 5–19 years, including working with others to deliver universal services (Department of Health, 2012). Priorities to include:
- 2.110 Conduct routine audiology and vision screening in Reception year and refer to specialist services as required.
- 2.111 Conduct health needs assessment using information from health questionnaires for children in Year R and provide appropriate follow up advice/support for identified needs
- 2.112 Parents of children and young people in Year R and Year 6 will be offered the opportunity to request that their child is weighed and measured as part of the National Child Measurement Programme. This should be offered on an opt-in basis and by



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agreement with primary schools. It is the responsibility of the provider to send results for children in Year R.

- 2.113 If requested by a parent, provide reactive advice and information about their child's weight status and signpost to other services and resources around diet, physical activity and healthy lifestyles and the specialist dietetic service if required.
- 2.114 The school nursing service will provide reactive health and wellbeing information and advice on a case by case basis, using their clinical judgement and signposting to other services or community groups, as required.
- 2.115 Responsibility for the provision of universal health promotion information and advice to young people, parents and schools and public health campaigns aimed at those groups lies with the local authority's public health team. The school nursing service role will focus on providing reactive, individually tailored health and wellbeing advice and signposting to other sources of information and support such as NHS Choices or the Public Health Portal.

### ***Targeted Elements (Universal Plus and Universal Partnership Plus)***

- 2.116 The school nursing service will provide targeted support to state educated children and young people who require extra help and support or who are identified as vulnerable and at risk of poor health outcomes. This includes, but is not limited to, young carers, looked after children and children with physical and/or learning disabilities, children and young people with the Pupil Referral Unit.
- 2.117 The school nursing service will deliver targeted assessments, interventions and support to children and young people in main stream schools with health conditions, including long term health conditions, poor emotional health and well being, child protection and safeguarding concerns.
- 2.118 The school nursing service will deliver annual training to school staff to support the management of chronic health conditions. Wherever possible schools should be clustered to maximise efficiency.
- 2.119 The service will consult with and involve children and young people in the development and evaluation of school nursing priorities and activities as appropriate as well as undertaking an annual satisfaction survey.

### ***Universal Plus***

- 2.120 The Universal Plus provision is for children who have additional health needs that can be responded to.
- 2.121 Offer early help to children with additional health needs (including long term (non complex) medical conditions, emotional or sexual health advice) by providing care or signposting to other services. Ensuring children, young people and families get extra help when they need it (Department of Health, 2012).



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- 2.122 The school nursing service will provide a health drop-in and/or appointment service in schools where there is an identified high level of need as negotiated with the school and the local authority commissioner.
- 2.123 The school nursing service will work with the child/young person to provide ongoing advice and support in accordance with the care pathway. Where appropriate onward referral to other services will be initiated.
- 2.124 The school nursing service will provide targeted health promotion advice in accordance with the needs of individuals supported by the service,
- 2.125 The school nursing service will respond to children with identified emotional health needs in a timely way so as to minimise the impact of the health condition and improve the child's ability to actively participate in school life
- 2.126 Children with long term (non-complex) health needs that impact on their ability to learn will be supported through health assessment and reviews to help manage their health condition and the provider will support the writing of care plans for children with long term (non complex) medical conditions who do not meet the criteria of the specialist community children's nursing team.
- 2.127 The school nursing service will offer annual training updates to school staff on the management of common health conditions (e.g. Asthma, allergies, epilepsy); this excludes first aid and resuscitation training.
- 2.128 School nurses will remain alert to all risks which affect the health and wellbeing of children of school age, including any multicultural issues. If there is cause for concern will follow the appropriate safeguarding procedures of the Provider Trust as agreed by the Local Safeguarding Children's Board.
- 2.129 Provide Tier 1 enuresis assessment in clinic and advice and signposting as required to specialist services for children and their families to meet identified health needs and provide information to the local authorities of the availability and use and outcomes of these clinics through the termly reporting meetings.

### ***Universal Partnership Plus***

- 2.130 The universal partnership plus provision is for children and families that have complex health and social care needs that require a multi-agency response, in mainstream schools.
- 2.131 The school nursing service will work in partnership with other key stakeholders in the children's workforce to provide on-going additional services for vulnerable children, young people and their families. Including those who are looked after, young carers, (NICE guidelines, 2014) those with a non complex disability in mainstream schools, those with mental health needs or substance misuse or risky behaviours, those at risk of female genital mutilation or those at risk of child sexual exploitation (Department of Health, 2012)

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- 2.132 School nurses will provide health leadership when working with other partners to ensure that a vulnerable child has their health and wider social care needs met.
- 2.133 Undertake the annual looked after children review health assessments and working in partnership with the looked after children's team nurse, develop a care plan and develop any necessary interventions with other partners to meet identified health needs.
- 2.134 School nurses will work positively with children who have been identified as children not registered with a GP, or not taken for health appointments and ensure follow up systems are in place and implemented for children considered vulnerable/at risk.
- 2.135 The Service will support vulnerable young people to transition successfully between education and health provision by working closely with special and mainstream school and college pastoral and welfare staff, other health care providers and primary care as required.

### ***Safeguarding responsibilities***

- 2.136 A suitably qualified school nurse will attend Initial Child Protection Conferences and undertake a health assessment on the child.
- 2.137 The school nurse will be on the core group
- 2.138 If there is an identified health need requiring to be addressed by the school nurse and the school nurse is invited to a Review Conference, then s/he will review the child's health records to identify or confirm whether any health needs have arisen and will update the chair at the group meetings.
- 2.139 A school nurse can be elected onto a core group at any point if another professional has concerns that would benefit from school nurse involvement, whether or not the child is known to the school nursing service.

### ***Monitoring of health improvement and service outcomes***

- 2.140 All NCMP and new entrant screening data required for national and local reporting (e.g. details of audiology and height and weight) for children in Reception Year should be provided to Child Health in Thames Valley Primary Care Agency.
- 2.141 All NCMP data required for children in Year 6 should be provided to Informatics and Public Health within agreed timescales.
- 2.142 Performance data will be submitted to the commissioner on a termly basis.
- 2.143 The Provider will attend termly monitoring meetings with the local authority Commissioners to review progress towards agreed outcomes and quality schedule.

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### ***Population covered***

#### **Health Visiting Service Area**

- 2.144 The Health Visiting Service must be delivered to a defined geographical population in line with Bracknell Forest Local Authority boundaries and localities. All families with a child aged 0-5 years and all pregnant women currently resident in the Bracknell Forest local authority area must be offered the HCP. If the intervention is refused this must be recorded and actioned as appropriate depending on the assessment made by the HV of any risks.
- 2.145 Data collection should enable reports on activity for both the GP registered and the resident population.
- 2.146 The service will ensure that any coverage/ boundary issues that may arise will be dealt with proactively in collaboration with neighbouring providers. Delivery of a service that meets the needs (including safeguarding needs) of the child or family must take precedent over any boundary discrepancies or disagreements.

#### **School Nursing Service Area**

- 2.147 The Universal services of the school nursing service will be available to all school age children, young people and their families who are registered with an NHS Berkshire GP and/or attending a state funded primary/secondary school or Pupil Referral Unit, including children who are home educated in Bracknell Forest local authority area.
- 2.148 Children and young people will be provided with contact details for their local school nursing service, where they can access health advice and support, and information about immunisation schedules and how to access them.
- 2.149 The School Nursing service is also available to young people aged 16-18 years referred into the service who are enrolled in sixth forms attached to local authority schools.
- 2.150 The service will ensure that any coverage/ boundary issues that may arise will be dealt with proactively in collaboration with neighbouring providers. Delivery of a service that meets the needs (including safeguarding needs) of the child or family must take precedent over any boundary discrepancies or disagreements.

### ***Acceptance and exclusion criteria and thresholds***

#### **Health Visiting Service Area**

- 2.151 The service must ensure equal access for all children up to school entry and their families, irrespective of age, disability, gender reassignment, marriage and civil partnership and race – this includes ethnic or national origins, colour or nationality, religion, lack of belief, sex or sexual orientation.

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- 2.152 The service must ensure it provides appropriate staff allocation according to population need whilst maintaining the universal offer (as per Healthy Child Programme- Pregnancy and the first five years, DH, 2009 – amended 2010), in line with the model agreed by all partners, which was based on the original work by Cowley and Bidmead. (see Cowley & Bidmead 2009).
- 2.153 The service should provide an equality impact assessment where changes to the existing contract are proposed.

### **School Nursing Service Area**

- 2.154 The school nursing service will offer a core universal level of provision to all state-funded primary and secondary schools in Berkshire, this offer includes Pupil Referral Units, Academies and Free schools. Children and young people who are home educated will be provided with contact details for their local school nursing service, where they can access health advice and support, and information about immunisation schedules and how to access them.
- 2.155 School aged children 4 – 19 years are excluded from the service if they are:
- a) Not attending a state maintained school, free school, PRU or Academy in Berkshire
  - b) Over 19
  - c) Attending FE colleges.

### ***Interdependencies with other services***

#### **Health Visiting Service Area**

- 2.156 The key interdependencies are Maternity services, Children’s Centres, School Nursing and Safeguarding.

#### **School Nursing Service Area**

- 2.157 The service will be expected to work in partnership with children and families, primary and secondary schools and special schools and pupil referral units, the local authority’s childrens and youth services and the public health team, primary care, Health Visiting services, Clinical Commissioning Groups, CAMHS, the Local Safeguarding Children Board, Health and Wellbeing board, sexual health services and third sector providers in delivering the Healthy Child Programme.

## **3. Applicable National and Local Standards**

### ***National service standards, evidence and guidance***

- 3.1 As outlined in “Best Start in Life and Beyond: Improving public health outcomes for children, young people and families. Guidance to support the commissioning of the

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Healthy Child Programme 0-19: Health Visiting and School Nursing services”  
Commissioning Guide 4, Reference guide to evidence and outcomes, PHE January 2016

- 3.2 The Provider will ensure that there is an established programme of audit and evaluation for the service.
- 3.3 A robust system /protocol in place for identifying early, at risk and vulnerable children and families to enable the systematic targeting of services.
- 3.4 All children with a child protection plan and identified health needs to have a named senior practitioner to ensure continuity of care as per safeguarding pathway.
- 3.5 Robust data collection and analysis for needs-led commissioning and service provision.

### **Local standards**

- 3.6 The Provider will ensure that all clinical services are delivered to the highest standard in line with national and locally agreed guidelines, by staff that have been appropriately trained and have the required level of competence and experience while working to provide effective clinical governance and supervision arrangements.
- 3.7 The Provider will need to ensure that the service has access to adequate computer and IT systems, and where necessary provide staff with the appropriate training to allow them to effectively and efficiently evaluate their work.
- 3.8 Collect data on the agreed outcomes and indicators and provide it to the Commissioners on the agreed timescales.
- 3.9 The Service will have in place arrangements for managing pressures associated with vacancies and staff absence to ensure that service safety, quality and consistency are not compromised, including early warning /communication to commissioners in the event of potential difficulties that may arise in order that the situation can be effectively managed.
- 3.10 All registered Nurses will follow NMC policies. All members of the clinical teams will follow NMC record keeping guidance and requirements for both electronic and written documents.
- 3.11 All staff will adhere and be compliant with statutory and mandatory training requirements.

## **4. Any Activity Planning Assumptions**

- 4.1 It is expected that the provider will develop a robust workforce development plan. This plan should facilitate the development of flexible specialist, student and skill mix teams that can adapt to changing levels of demand, emerging priorities and the challenging financial climate.

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### ***Service Transformation***

- 4.2 Service development in response to client experience, feedback from families and caregivers and staff.
- 4.3 Alignment and weighting of the health visiting resource in line with local population needs and local authority boundaries. This includes collection of information about population needs in order to inform the expansion and delivery of services.
- 4.4 Embedding learning from Early Implementer Sites (EIS), national and international research, other evidence and good practice guidance; and sharing good practice through development of local integrated Children's Services networks.
- 4.5 Priorities for the service based on population indicators, Health and Wellbeing Board priorities and public health priorities.
- 4.6 Learning needs analysis of the existing workforce including a plan to develop career progression and succession planning for the service.
- 4.7 Evidence-based intervention audit with training and development plan in conjunction with the Prevention and Early Help Services
- 4.8 Staff development in Building Community Capacity, including the online module and examples of interagency approaches and training.
- 4.9 Staff development to enable innovative and creative health visiting to meet local needs and to add to the body of research evidence for the profession.
- 4.10 CPD programme which supports delivery of the National Core Service Specification particularly evidenced-based assessments and interventions as well as multi-agency learning, leadership and supervision.
- 4.11 Resources allocated for the CPD requirements identified in the plan and access to multi-agency training at every opportunity.

### ***Health Visiting Workforce***

- 4.12 Appropriate use of agency and bank staff where required.
- 4.13 Support for return to practice staff.
- 4.14 Schemes supporting the retention of staff e.g. 'Retaining your health visitor workforce' – NHS Employers; and Recruitment and Retention Premia guidance hosted on the NHS Employers website.
- 4.15 Organisational processes and managerial support in place to ensure that mentors and practice teachers are able to provide high quality placements for HV students in line with the NMC and HEI requirements including role descriptors for mentors and practice teachers.

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- 4.16 Retention and supply of practice teacher roles to support trainees and latterly to support new staff and the development of the wider health visiting team, ensuring evidence-based practice and research focus is maintained.
- 4.17 Provide high quality undergraduate and HV student placements in line with NMC Standards; and development of plans to support workforce development and retention, mobilisation of expanded services, service transformation and service monitoring.
- 4.18 FTE HV workforce numbers are reported using data from the Electronic Staff Record (ESR) and non ESR sources, in line with agreed definitions of the Health Visiting Minimum Data Set (HV MDS). The service provider will ensure ESR records are updated, including ensuring correct coding of all HVs, on a monthly basis, based on the health and social care information centre workforce data collection and in line with the definition on HSCIC website.
- 4.19 Accurate workforce data, service delivery and outcomes measures will need to be collated. Service providers will support NHS England in the collection and reporting of health visiting workforce and outcomes data as required.

## **5. Key Service Outcomes**

### ***Health Visiting Service Area***

- 5.1 Achievement of all the quality and performance indicators outlined in the agreed service monitoring framework and monitor and reported to the local authority commissioner on a quarterly basis.
- 5.2 See Appendix B

### ***School Nursing Service Area***

- 5.3 Achievement of all the quality and performance indicators outlined in the agreed service monitoring framework and monitored and reported to the local authority commissioners on a termly basis.
- 5.4 See Appendix B

## **6. Location of Provider Premises**

### ***Health Visiting Service Area***

- 6.1 Parents should be offered a choice of locations and times for visits which best meet their needs, e.g. GP surgeries, Children's Centres, community health services, the home, health centres, etc. Locations must be easily accessible for all children and families who live in the local vicinity (including access by public transport and at times appropriate to the user), children and young family friendly, suitable for multi-disciplinary delivery of services in both individual and group sessions and be conducive

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to flexible availability (e.g. early mornings, lunchtimes, after school, evenings and weekends).

- 6.2 Specific locations are to be agreed locally following engagement with relevant interested parties and feedback from users. Reviews should be taken periodically to ensure the locations are suitable to local needs. At all times, premises used must have robust physical access controls to prevent unauthorised access or disclosure.
- 6.3 Joint contacts should be provided in partnership with other agencies where this is appropriate and reduces inconvenience for families, for example integrated 2-2.5 year review.
- 6.4 The Health Visiting workforce needs suitable premises for office space and service delivery. The provider organisation must ensure that service delivery is not hampered by inappropriate premises and should work in partnership with local authorities and other providers to ensure that seamless and integrated service delivery is facilitated. There is a presumption that the provider will co-locate the Bracknell Forest health visiting team in the Authority's Children's Centres (subject to availability), for which a charge is made (see Appendix G).

### **School Nursing Service Area**

- 6.5 Specific location(s) are to be agreed locally following engagement with relevant interested parties and feedback from users. Reviews should be taken periodically to ensure the locations are suitable to local needs. At all times, premises used must have robust physical access controls to prevent unauthorised access or disclosure.



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### ***APPENDIX B –QUALITY OUTCOMES INDICATORS AND TARGETS (Health Visiting Service Area)***

If the specifications cannot be followed exactly please indicate how the information you provide differs from the specification.

Health Visiting Services are required to prepare for collection of service delivery metrics and dashboards at the level of local authority resident population.

#### ***Geographical Breakdown***

This data should be reported by provider area of responsibility. Provider area of responsibility is defined as all those who the provider is responsible for providing HV services for. This should be defined on the basis of the infant's local authority of residence. All infants resident within the local authority should be included whether or not they are registered with a GP and, for those registered with a GP, regardless of the location of the GP Practice they are registered with.

#### ***Timeframe***

The data will be collected quarterly.

#### ***Data Specifications***

##### **Guidance notes across all indicators**

All mothers and children are included in each indicator, this includes any being treated privately, or not registered with a GP. We realise that the occurrence of this may vary between areas.

When families move, we have specified with which area/provider they should be included. It is recognised that this will involve some providers counting visits that were carried out by providers in other areas and/or visits that were not carried out in other areas. We have specified where the number of births should be counted and the number of babies should be counted.

#### ***Indicator C1 - Number of mothers who received a first face to face antenatal contact with a Health Visitor at 28 weeks of pregnancy or above.***

##### **Information required**

Count of number of mothers who received a first contact with a health visitor when they were 28 weeks pregnant or later, before they gave birth.

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### Definition

This should be a count of mothers who received a first contact with a health visitor when they were 28 weeks pregnant or greater, before they gave birth. Visits which occurred within the quarter should be counted (e.g. for Q1 2018/19, visits which occurred between 1<sup>st</sup> April and 30<sup>th</sup> June inclusive). The number of visits, not the number of children should be counted.

### Notes

This is defined as a count rather than a percentage because of the difficulty of defining a denominator to which antenatal visits can be linked within current data collection systems.

### ***Indicators C2 & C3 - Percentage of births that receive a face to face New Birth Visit (NBV) within 14 days by a health visitor (Indicator C2), or after 14 days (Indicator C3)***

### Information required

- The total number of infants who turned 30 days within the quarter (denominator C2 and C3).
- Total number of infants who turned 30 days within the quarter who received a face-to-face NBV within 14 days by a health visitor with mother (and ideally father) (numerator C2).
- Total number of infants who turned 30 days within the quarter who received a face-to-face NBV undertaken after 14 days by a health visitor with mother (and ideally father) (numerator C3).

### Definition

The total number of infants who turned 30 days within the quarter is defined as all those infants within the provider area of responsibility who turn 30 days within the quarter.

This is to make sure that we are picking up most NBVs even where they occur after the recommended 10-14 days. The table below shows the ranges of birth dates which should be included in each quarter.

<b>Quarter</b>	<b>Earliest birth date included</b>	<b>Latest birth date included</b>
Q1 (April to June)	2nd March	1st June
Q2 (July to September)	2nd June	1st September
Q3 (October to December)	2nd September	2nd December

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Q4 (January to March)	3rd December	1st March
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NOTE: Count the number of children born, not the number of mothers.

The number of children who turned 30 days within the quarter who received a face-to-face NBV within 14 days is defined as the number of children defined above who also received an NBV within 14 days of their birth.

The number of children who turned 30 days within the quarter who received a face-to-face NBV after 14 days is defined as the number of children defined above who also received an NBV after 14 days after their birth.

We would expect that the vast majority of visits for those under 14 days will occur between 10-14 days as recommended, as midwives will be responsible for care prior to that. However there are occasions when an earlier visit is justified, so there is no lower limit for this indicator on how long after the birth the visit can occur.

Include:

- Each child born, in the case of multiple births this will be more than 1.
- All children born privately, even if they are not seen by a health visitor.

Exclude:

- Babies who die before their NBV.

### Notes

This definition is based on infants who should have received an NBV by the end of the quarter. There are infants who are neither born in the quarter referred to, nor receive an NBV in the quarter referred to. The definition has been set up so that those babies born towards the end of the specified period who receive an NBV later than 14 days are still counted as receiving a visit.

There are cases where it is not possible for an NBV to take place within the recommended period. It is not expected that these indicators would total 100%, nor that areas would achieve 100% under 14 days.

***Indicators C4 & C5 - Percentage of children who received a 12 month review by the time they were 12 months and percentage of children who received a 12 month review by the time they were 15 months.***

### Information required

- The total number of children who turned 12 months in the quarter (denominator C4).
- The number of children due a 12 month review by the end of the quarter who had received a 12 month review by the time they turned 12 months (numerator C4).

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- The total number of children who turned 15 months in the quarter (denominator C5).
- The number of children who turned 15 months in the quarter who had received a 12 month review by the time they turned 15 months (numerator C5).

### Definitions

The number of children due a 12 month review by the end of the quarter is defined as all those who fulfil the following two criteria:

- Are under the responsibility of the provider at the end of the quarter (e.g. for Q1 2018/19 this would be on 30<sup>th</sup> June 2018).
- Were aged 12 months within the quarter (e.g. for Q1 2018/19 this would be those who were aged 12 months between April 2018 and June 2018, i.e. those who were born between 1<sup>st</sup> April 2017 and 30<sup>th</sup> June 2017 inclusive).

The number of children who turned 12 months within the quarter who had received a 12 month review by the time they turned 12 months is defined as the number of those who fulfil the criteria above and who have received a 12 month review by the time they turned 12 months. Note that children who received a review in a previous quarter should be included.

Include:

- All children under the provider's responsibility at the end of the quarter. This includes children who live in the area but are not registered to a GP, and those who are having their paediatric care privately even if they are not seen by a health visitor or GP.

Exclude:

- Children who die before their 12 month review.
- The total number of children who turned 15 months in the quarter is defined as all those who fulfil the following two criteria:
  - Are under the responsibility of the provider at the end of the quarter (e.g. for Q1 2018/19 this would be on 30<sup>th</sup> June 2018).

Were aged 15 months within the quarter (e.g. for Q1 2018/19 this would be those who were aged 15 months between April 2018 and June 2018, i.e. those who were born between 1<sup>st</sup> Jan 2017 and 31<sup>th</sup> March 2018 inclusive).

The number of children who turned 15 months in the quarter who had received a 12 month review by the time they turned 15 months is defined as the number of those who fulfil the criteria above and who have received a 12 month review by the time they turned 15 months. This includes children who received a 12 month review in previous quarters, and those who had it before they turned 12 months.

Include:

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All children under the provider's responsibility at the end of the quarter. This includes children who live in the area but are not registered to a GP, and those who are having their paediatric care privately even if they are not seen by a health visitor or GP.

Exclude:

- Children who die before their 12 month review

### Notes:

The numerator for indicator C5, percentage of children who have had their 12 month review by the time they have turned 15 months, should include all those who have turned 15 months who have received a 12 month review. This should include those who have had their review before the current quarter and also those who have had their review before they turned 12 months, as well as those who had their review between 12 and 15 months.

We would expect indicator C5 to have a greater percentage than indicator C4 (percentage of children who received a 12 month review by the age of 12 months) as it will include all those who have had their 12 month review by the time they were 12 months as well as those who had it between 12 and 15 months.

### ***Indicator C6i - Percentage of children who received a 2-2.5 year review***

#### Information required

- The total number of children due a 2-2.5 year review by the end of the quarter (denominator).
- The number of children due a 2-2.5 year review by the end of the quarter who received a 2-2.5 year review by the time they turned 2.5 years (numerator).

#### Definitions

The number of children due a 2-2.5 year review by the end of the quarter is defined as all those who fulfil the following two criteria:

- Are under the provider's responsibility at the end of the quarter (e.g. for Q1 2018/19 this would be on 30<sup>th</sup> June 2018).
- Were aged 2.5 years within the quarter (e.g. for Q1 2018/19 this would be those who were aged 2.5 years between April 2018 and June 2018, i.e. those who were born in Q3 2016/17, so between 1<sup>st</sup> Oct 2016 and 31<sup>st</sup> Dec 2016 inclusive).

The number of children due a 2-2.5 year review by the end of the quarter who received a 2-2.5 year review by the time they turned 2.5 is defined as the number of those who fulfil the criteria above and who have received a 2-2.5 year review by the time they turned 2.5. Note that this should include those who had a 2-2.5 year review in a previous quarter.

Include:

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- All children under the provider's responsibility at the end of the quarter. This includes children who live in the area but are not registered to a GP, and those who are having their paediatric care privately even if they are not seen by a health visitor or GP.

Exclude:

- Children who die before their 2-2.5 year review.

### **Indicator C6ii - Percentage of children who received a 2-2.5 year review using ASQ 3**

#### Information required

- The total number of children who received a 2-2.5 year review by the end of the quarter (denominator).
- The number of children due a 2-2.5 year review by the end of the quarter for whom the ASQ-3 is completed as part of their 2-2.5 year review (numerator).

#### Definitions

The number of children due a 2-2.5 year review by the end of the quarter is defined as all those who fulfil the following two criteria:

- Are under the provider's responsibility at the end of the quarter (e.g. for Q1 2018/19 this would be on 30<sup>th</sup> June 2018).
- Were aged 2.5 years within the quarter (e.g. for Q1 2018/19 this would be those who were aged 2.5 years between April 2018 and June 2018 i.e. those who were born in Q3 2016/17, so between 1<sup>st</sup> Oct 2016 and 31<sup>st</sup> Dec 2017 inclusive).

The number of children due a 2-2.5 year review by the end of the quarter **who received** a 2-2.5 year review by the time they turned 2.5 (the **denominator**) is defined as the number of those who fulfil the criteria above and who have received a 2-2.5 year review by the time they turned 2.5. Note that this should include those who had a 2-2.5 year review in a previous quarter.

Include:

- All children under the provider's responsibility at the end of the quarter. This includes children who live in the area but are not registered to a GP, and those who are having their paediatric care privately even if they are not seen by a health visitor or GP.
- All children under the provider's responsibility at the end of the quarter. This includes children who live in the area but are not registered to a GP, and those who are having their paediatric care privately even if they are not seen by a health visitor or GP.

Exclude:

- Children who die before their 2-2.5 year review.

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- The number of children who received a 2-2.5 year review by the end of the quarter for whom the ASQ-3 is completed as part of their 2-2.5 year review (the **numerator**) is defined as the number of those who fulfil the criteria above and for whom the ASQ-3 is completed as part of their 2-2.5 year review by the time they turned 2.5. Note that this should include those who had a 2-2.5 year review in a previous quarter.
- Children who die before their 2-2.5 year review.

### ***Indicator C6iii - Percentage of children who received a 2-2.5 year review using ASQ 3***

#### **Information required**

- Numerator: The number of children for whom the ASQ 3 is completed as part of their 2-2½ year review, who scored above the cut off in all five domains
- Denominator: The number of children who received a 2-2½ year review by the end of the quarter for which the ASQ 3 is completed as part of their 2-2½ year review

#### **Definitions**

Percentage of children who score above the cut off in in the five domains of child development: communication, gross motor skills, fine motor skills, problem solving and personal-social development

### ***Indicator C7 - Number of Children's Centre Boards with a HV presence***

#### **Information required:**

- Numerator: Number of Children's Centre Board meetings with a HV presence.
- Denominator: Number of Children's Centre Board meetings.

#### **Definitions**

The number of Children's Centre Board meetings is defined as the number of Children's Centre Board meetings which occur within the defined quarter. The number of meetings with a health visitor presence is defined as the number of those defined previously, which are attended by a health visitor.

### ***Indicator C8 - Percentage of children who received a 6-8 weeks review***

#### **Information required**

- The total number of children due a 6-8 weeks review by the end of the quarter (denominator).

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- This is collected as part of the prevalence of breastfeeding at 6-8 week indicator.
- The number of children due a 6-8 weeks review by the end of the quarter who received a 6-8 weeks review by the time they turned 8 weeks (numerator).

### Definitions

The number of children due a 6-8 weeks review by the end of the quarter is defined as all those who fulfil the following two criteria:

- Are under the provider's responsibility at the end of the quarter (e.g. for Q1 2018/19 this would be on 30<sup>th</sup> June 2018).
- Were aged from 6 to 8 weeks within the quarter. The table below shows the ranges of birth dates which should be included in each quarter.

Quarter	Earliest birth date included	Latest birth date included
Q1 (April to June)	4 <sup>th</sup> February	19 <sup>th</sup> May
Q2 (July to September)	6 <sup>th</sup> May	19 <sup>th</sup> August
Q3 (October to December)	6 <sup>th</sup> August	19 <sup>th</sup> November
Q4 (January to March)	6 <sup>th</sup> November	18 <sup>th</sup> February

NOTE: Count the number of children born, not the number of mothers.

The number of children due a 6-8 weeks review by the end of the quarter who received a 6-8 weeks review by the time they turned 8 weeks is defined as the number of those who fulfil the criteria above and who have received a 6-8 weeks review by the time they turned 8 weeks.

Include:

- All children under the provider's responsibility at the end of the quarter. This includes children who live in the area but are not registered to a GP, and those who are having their paediatric care privately even if they are not seen by a health visitor or GP.

Exclude:

- Children who die before their 6-8 weeks review.



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### ***Indicator C8i – Prevalence of breastfeeding at 6-8 weeks***

#### **Information required**

The number of infants living in the commissioning area due a 6-8 week check during the quarter. Figures should relate to infants born not more than 8 weeks before the quarter start, and born more than eight weeks before the quarter end.

#### **Definitions**

Totally breastfed is defined as infants who are exclusively receiving breast milk (this may be expressed breast milk) at 6-8 weeks of age - that is, they are NOT receiving formula milk, any other liquids or food

Partially breastfed is defined as infants who are currently receiving breast milk (this may be expressed breast milk) at 6-8 weeks of age and who are also receiving formula milk or any other liquids or food

Not at all breastfed is defined as infants who are not currently receiving any breast milk at 6-8 weeks of age

Prevalence is defined as the percentage of infants being breastfed (totally + partially) at the 6-8 week check, numerator/denominator \* 100.

Include:

- Each child due a 6-8 week review, even if seen early or late. In the case of multiple births this will be more than one.
- Infants born who are not registered with a GP but are known to the Child Health Records Department, whether they have a 6-8 week check or not.
- All children having their care privately, even if they are not seen by a GP or health visitor.

Exclude:

- Babies who moved out of the area before their sixth week.
- Babies who die before their 6-8 week review.
- Infants who moved into the area following their 6-8 week check.
- Breastfeeding status recorded at checks that take place as part of the handover from midwives at or before 4 weeks cannot be submitted as the breastfeeding status at 6-8 weeks. If the breastfeeding status for these infants is not recorded at 6-8 weeks then they should be counted as breastfeeding status not known.

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### Local Indicators

Data to be reported on a quarterly basis.

Area of service	Data	Comments
Child Health Clinics	Numbers attending each clinic	
Targeted work	Numbers per targeted caseload per postcode, per quarter  Outcomes for families to be recorded (was the plan achieved with the family or not; what further work needs to be done; timescales; engagement with other services)	Outcome measures to be further refined
CAFs or equivalent	Number of CAFs initiated by the service in the quarter.	
CAFS or equivalent	Number of CAFs sent to the Early Intervention Hub	
New births data	Number of new births per month by postcode	
Ethnicity/first language of new births	Ethnicity/first language of new births per month by postcode	
Transfers in/out	Transfer in /out numbers by postcode per quarter	
Maternal mood	Maternal mood referred on by postcode, per quarter	
Core mandated visits	Nos. declining 5 core mandated visits by postcode, per quarter	
1 yr review	Children not meeting their developmental milestones, by individual	Outcome measures to be

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		further refined
2 – 2.5yr check	Children not meeting their developmental milestones, by individual	Outcome measures to be further refined
2 – 2.5yr check	ASQ3 2 year old scores by individual	
Smoking Status	Smoking status at all 5 mandated visits by postcode, per quarter	
Referrals to other services	Nos. of referrals from HV assessments to other services, by type of service (eg Stop Smoking, Weight Management, Mental Health) and to targeted HV service, per quarter	
Data completeness	Proportion of data completeness of assessment forms	Yearly audit

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### **QUALITY OUTCOMES INDICATORS AND TARGETS (School Nursing Service Area)**

The provider will be required to report into termly performance monitoring meetings with the lead commissioner

The following provides information on the termly performance report requirements.

ref	Outcome	Related activities	Performance measures	Report information requirements	Notes
1	<b>Statutory public health service delivery for school aged children</b>	Offer and implement where requested, the NCMP programme in Yr R and Yr 6 classes on an <b>opt-in</b> basis	n/a	Termly uptake numbers	
2	<b>Statutory public health service delivery for school aged children</b>	All reception children provided with audiology screening	95% of eligible reception children take up offer of audiology screening	Termly uptake % and referral to audiologist %	
3	<b>Statutory public health service delivery for school aged children</b>	All reception children provided with vision screening	95% of eligible reception children take up offer of vision screening	Termly uptake % and referral to orthoptist %	
4	<b>Statutory public health service delivery for school aged children</b>	Parents of all reception children are sent health questionnaire	100% of health questionnaires sent with 90% with needs identified followed up	Termly % requiring follow up of returned health questionnaires	

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ref	Outcome	Related activities	Performance measures	Report information requirements	Notes
5	<b>Vulnerable children on school nurse caseload have their health needs met</b>	Children on a child protection plan have initial health assessment completed and school nurse attendance at initial CP conferences & core groups as per pathway.	100 % CP children have initial health assessment completed.	Termly record keeping audit  Termly snapshot of caseload to show numbers of CP /CIN children & numbers of contacts	
6	<b>Vulnerable children on school nurse caseload have their health needs met</b>	All 'Looked after Children' children have an annual review of their health needs by either a School Nurse or LAC Nurse	100% review health assessments completed	Audit reporting from LAC team  Termly snapshot of caseload to show numbers of LAC children & numbers of contacts	
7	<b>Vulnerable children on school nurse caseload have their health needs met</b>	All Looked after Children with identified health needs in their plan (appropriate to school nursing) have their health needs met	100% of health needs relevant to school nursing are met	Audit reporting from LAC team	
8	<b>Vulnerable children on school nurse</b>	School nurse will contribute to care plan if	100% children on school nurse caseload	Termly Caseload review to ensure all targeted	

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ref	Outcome	Related activities	Performance measures	Report information requirements	Notes
	<b>caseload have their health needs met</b>	required of children with long term non-complex medical conditions and /or disabilities on school nurse caseload .	will have plan in place	children have plan in place  Termly snapshot of caseload of numbers of children with medical needs & contacts	
9.	<b>Children with additional needs on school nurse caseload have their health needs met</b>	Tier 1 Enuresis assessment at an enuresis clinic and advice available locally	100 % clinic attendees will have initial assessment in accordance with NICE guidance & treatment plan put in place	Termly numbers of children discharged when dryness achieved and numbers referred on .	
10	<b>Children with additional needs on school nurse caseload have their health needs met</b>	Children with weight, sexual health or emotional health needs are identified and offered advice and support and/or signposted to other services as required	% of children reporting SN intervention helpful	Termly numbers of children requiring additional support and numbers of contacts	
11	<b>Targeted support to schools identified with high levels of need of agreed with LA/ Public Health</b>	School based drop in	Numbers of drop ins per locality, attendance numbers and reason	Termly numbers per locality and reason for attendance.	

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ref	Outcome	Related activities	Performance measures	Report information requirements	Notes
12	<b>Targeted support to schools identified with high levels need of agreed with LA/ Public Health</b>	Teacher training on medical conditions	All schools requesting training on management of long term conditions will be offered annual update.	Termly sessions/numbers attending per locality	
14	<b>Service Feedback</b>  Parents/teachers aware of school nursing service availability & how to access	Notice board in schools /SN leaflets / websites in place	% of respondents aware of service	Annual survey sample size TBC	To include in the development plan and to agree how this can be completed
15	<b>Service Feedback</b>  Service users report high levels of satisfaction with SN service received	Evaluation of all aspects of service delivery	% satisfied with service	Annual feedback on satisfaction of service users	To include in the development plan

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### ***APPENDIX C - INFORMATION PROVISION AND MANDATORY REPORTING (Equalities Monitoring for 0-19 Public Health Nursing Service)***

The purpose of equalities monitoring is to ensure that the council is providing a fair and equitable service to all residents.

The provider is required to submit an annual Equalities Monitoring report to the local authority commissioner (timetable to be agreed), that provides a breakdown of activity and outcomes for the child/young person and/or family, by the following protected characteristics.

- Age
- Sex
- Race and Ethnicity
- Disability
- Pregnancy/maternity
- Marriage/civil partnership
- Religion/belief
- Sexual orientation



## Annex C

### INFORMATION PROVISION AND MANDATORY REPORTING (Health Visiting Service Area)

## Health Visiting Monitoring

Submit to [PH.information@bracknell-forest.gov.uk](mailto:PH.information@bracknell-forest.gov.uk) , Cc [chris.stannard@bracknell-forest.gov.uk](mailto:chris.stannard@bracknell-forest.gov.uk) and [lisa.mcnally@bracknell-forest.gov.uk](mailto:lisa.mcnally@bracknell-forest.gov.uk)

#### MANDATED ELEMENTS AND/OR REQUIRED FOR CENTRAL REPORTING PURPOSES

### Provider Performance Report – Bracknell Forest Borough Council

	Outcome	MEASURE	Additional information	Target	Data collection/Report
Delivering capacity	Health Visitor Growth	Health Visitors (FTE) in Post - ESR	Health Visitor: An employee who holds a qualification as a <u>Registered Health Visitor under the Specialist Community Public Health Nursing part of the NMC Register</u> and who occupies a post where such a qualification is a requirement. Not below Agenda for Change Band 6. Coded as occupation code N3H only in NHS Workforce information. (NHS IC, (2011) Occupation Code Manual Version 11)		Reported monthly to the HSCIC via Omnibus (Health Visitor Minimum Dataset) To be reviewed with provider.

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	Health Visitors (FTE) in Post - Non-ESR		0	Reported monthly to the HSCIC via Omnibus (Health Visitor Minimum Dataset). To be reviewed with provider
	Total Health Visitors (FTE) in Post – Calculation			Reported monthly to the HSCIC via Omnibus (Health Visitor Minimum Dataset). To be reviewed with provider.
	Leavers (FTE)	FTE of staff who have left the provider	Report monthly and advise if > 5 per month	To LA monthly)
	Joiners (FTE)	Health Visitor joiners separated into newly qualified joiners direct from training, joiners from return to practice and other joiners	Report monthly	To LA monthly
	Number of vacancies (FTE)	Currently unfilled posts	Report monthly	To LA monthly
C2A Student growth delivered				To LA annually

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		Annual report compiled from HV service submissions on Patient Experience feedback from families and caregivers, using validated patient experience measures	In line with NHS Outcome /PH Outcomes Framework: Ensuring people have a positive experience of care	Report Q4	To LA (annually)
	Service offer metrics	Number of mothers who received a <u>first</u> face to face antenatal contact with a Health Visitor at 28 weeks or above	.	Report numbers and approx. % per quarter based on estimated no. of births in the LA area in 2014	To LA (quarterly)
Service Delivery		Percentage of births that receive a face to face NBV within 14 days by a Health Visitor	Numerator: Total number of infants who turned 30 days in the quarter who received a face-to-face New Birth Visits (NBV) undertaken within 14 days from birth, by a Health Visitor with mother (and ideally father) Denominator: Total number of infants who turned 30 days in the quarter Formula: Numerator/Denominator x 100	See table 1.0 below	To LA (quarterly)

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	<p>Percentage of face-to-face NBVs undertaken after 14 days, by a Health Visitor</p>	<p>Numerator: Total number of infants who turned 30 days in the quarter who received a face-to-face New Birth Visits (NBV) undertaken after 14 days from birth, by a Health Visitor with mother (and ideally father)  Denominator: Total number of infants who turned 30 days in the quarter  Formula: Numerator/Denominator x 100</p>	<p>&lt; 5%  See table 1.0 below</p>	<p>To LA (quarterly)</p>
	<p>Percentage of children who received a 12 month review by the time they turned 12 months</p>	<p>Numerator: Total number of children who turned 12 months in the quarter, who received a review by the age of 12 months  Denominator: Total number of children who turned 12 months, in the appropriate quarter  Formula: Numerator/Denominator x 100</p>	<p>See table 1.0 below</p>	<p>To LA (quarterly)</p>
	<p>Percentage of children who received a 12 month review by the time they turned 15 months</p>	<p>Numerator: Total number of children who turned 15 months in the quarter, who received a 12 month a review by the age of 15 months  Denominator: Total number of children who turned 15 months, in the appropriate quarter  Formula: Numerator/Denominator x 100</p>	<p>See table 1.0 below</p>	<p>To LA (quarterly)</p>

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	Percentage of children who received a 2-2.5 year review	<p>Numerator: Total number of children who turned 2.5 years in the quarter who received a 2-2.5 year review, by the age of 2.5 years of age.</p> <p>Denominator: Total number of children who turned 2.5 years, in the appropriate quarter.</p> <p>Formula: Numerator/Denominator x 100</p>	See table 1.0 below	To LA (quarterly)
	Percentage of children who received a 2-2.5 year review using ASQ 3	<p>Numerator: The number of children who received a 2-2.5 year review by the end of the quarter for whom the ASQ-3 is completed as part of their 2-2.5 year review.</p> <p>Denominator: Total number of children who received a 2-2.5 year review by the end of the quarter.</p> <p>Formula: Numerator/Denominator x 100</p>	See table 1.0 below	To LA (quarterly)
	Percentage of Sure Start Advisory Boards with a HV presence	<p>Numerator: Number of Children's Centre Boards with an HV presence</p> <p>Denominator: Number of Sure Start Advisory Boards/Children's Centre Boards</p> <p>Formula: Numerator / Denominator x 100</p>	See table 1.0 below	To LA (quarterly)
	Percentage of children who received a 6-8 weeks review	<p>Numerator: The number of children due a 6-8 weeks review by the end of the quarter who received a 6-8 weeks review by the time they turned 8 weeks.</p> <p>Denominator: The total number of children</p>	See table 1.0 below	To LA (quarterly)

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			due a 6-8 weeks review by the end of the quarter.		
		Percentage of children who received a 3-4 month review	<p>Numerator: The number of children due a 3-4 month review by the end of the quarter who received a 3-4 month review by the time they turned 4 months.</p> <p>Denominator: The total number of children due a 3-4 month review by the end of the quarter.</p>	no target but report on the number completed	To LA (quarterly)
Key Outcomes	Breastfeeding	Percentage of infants for whom breastfeeding status is recorded at 6-8wk check	<p>Numerator: Number of infants where feeding status has been recorded at 6-8wk check</p> <p>Denominator: Total number of infants due 6-8wk check</p> <p>Formula: Numerator / Denominator x 100</p>	See table 1.0 below	Central collection (quarterly) Unify2 and to commissioners. To be reviewed with provider
		Percentage of infants being breastfed at 6-8wks	<p>Numerator: Number of infants recorded as being totally and partially breastfed at 6-8wks</p> <p>Denominator: Total number of infants due 6-8wk check</p> <p>Formula: Numerator / Denominator x 100</p>	See table 1.0 below.	Central collection (quarterly) Unify2 and to commissioners. To be reviewed with provider
Early Identification	Health Visitors	No. of new CAFs completed by HV staff in the month	Number per FTE/% caseload	report as baseline	To be reviewed with provider

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	identifying families at risk of poor outcomes		As part of referral process or at risk of referral		
		Percentage of mothers who received a Maternal Mood review in line with local pathway, by the time infant is aged 8 weeks, based on the quarter when the infant reached 8 weeks of age	<p>Numerator: Total number of mothers with an infant who turned 8 weeks in the quarter, who received a Maternal Mood review by the time infant turned 8 weeks</p> <p>Denominator: Total number of mothers with infants who turned 8 weeks, in the quarter</p> <p>Formula: Numerator/Denominator x 100</p>	<p>Acceptable 90%</p> <p>Achievable 95%</p>	To be reviewed with provider.
		Percentage of maternal mood assessments requiring an onward referral	<p>Numerator: Total number of mothers with an infant who turned 8 weeks in the quarter, who received a Maternal Mood review by the time infant turned 8 weeks &amp; was referred onward.</p> <p>Denominator: Total number of mothers with infants who turned 8 weeks, in the quarter</p> <p>Formula: Numerator/Denominator x 100</p>	No target, report only	To be reviewed with provider
Safeguarding		Percentage of HV staff that have completed mandatory training at levels commensurate with roles and responsibilities (levels 1, 2, 3) in child protection within the last three years.	<p>Numerator: Number of health visiting team (including health visitors and skill mix staff) who have received mandatory child protection training (as per local policy) in the last 36months</p> <p>Denominator: Total number of staff</p>	95%	Annual audit

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			Formula: Numerator / Denominator x 100 expressed on a rolling 36mth basis		
Quality Standards	Annual Audit of 50 randomly selected cases in each category	Annual audit of 50 randomly selected urgent referrals, including all safeguarding referrals  Percentage of urgent referrals, including all safeguarding referrals, which a) received a same day or next working day response to the referrer and b) received a HV contact with the family within two working days.	Numerator: Number of these 50 urgent referrals to HV who received a same day/next working day response to referrer. Denominator: 50 urgent referrals from whatever source (including families transferring in) to HV Formula: Numerator/Denominator x 100	95%	Annual audit
			Numerator: Number of these 50 urgent referrals to HV who received a HV contact within two working days Denominator: 50 urgent referrals from whatever source (including families transferring in) to HV Formula: Numerator/Denominator x 100	95%	Annual audit
		Annual audit of 50 randomly selected referrals from any source  Percentage of all referrals from whatever source (including families transferring in) who a) received a response to the referrer within 5 working days and b) with contact	Numerator: Number of these 50 referrals where referrer received a response within 5 working days. Denominator: 50 referrals from whatever source (including families transferring in) to HV Formula: Numerator/Denominator x 100	95%	Annual audit



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<p>made with the family within 10 working days.</p>	<p>Numerator: Number of these 50 referrals where contact was made with the family within 10 working days. Denominator: 50 referrals from whatever source (including families transferring in) to HV Formula: Numerator/Denominator x 100</p>	<p>95%</p>	<p>Annual audit</p>
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<p>Annual audit of 50 randomly selected cases with a transfer request received</p>	<p>Percentage of cases where a transfer request was received where the records were transferred within 2 weeks. Numerator: Number of these 50 children where the health records were transferred to the HV service in the new area within 2 weeks of notification. Denominator: 50 children where HV service has been notified as moved out of the area Formula: Numerator/Denominator x 100</p>	<p>95%</p>	<p>Annual audit</p>
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<p>Percentage of CP cases where there was direct contact with the HV team in the receiving area of these cases. Numerator: Number of these 50 children who were on a CP plan where there was direct contact to HV team in receiving area. Denominator: Number of these 50 children who were on a CP plan where HV service has been notified that child has moved out of the area Formula: Numerator/Denominator x 100</p>	<p>95%</p>	<p>Annual audit</p>
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		Percentage of children supported by HVs under Universal Partnership Plus (UPP) in the quarter.	<p>Numerator: All LAC, CIN, children with disabilities or other vulnerabilities, children with CP plan and those discussed at Supervision managed under UPP as recorded at a fixed point in the quarter  Numerator: i.e. 30<sup>th</sup> June, Sept, December and March</p> <p>Denominator: total caseload for HV service recorded at the same fixed point in the quarter as above</p> <p>Formula: Numerator/Denominator x 100</p>	No target report only	to LA (quarterly)
		Named HV, including contact details, for each GP surgery (100% compliance).	See service specification 5.20.1 for details	report	<b>Annual</b> report required
		Building Community capacity – evidence of improved outcomes as a result of implementing individual programmes.	See specification 6.1.1.7 and include all projects building community capacity	report	<b>Annual</b> report required
		Infection control – adherence to local and national policy.		report	<b>Annual</b> report required
		Implementation of HV transformation projects	1.2 year review integration project		Quarterly Area team /LA Dashboard and Present progress against spend and outcomes at Health Visitor Programme Board. To be reviewed
			2. maternal mental health, attachment and healthy weight pathway development		
			3.introduction of Solihull training to practitioners and programme delivery to		

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			families in partnership with LA staff		with provider
			4.Ages and Stages introduction and expansion universally		
		Where Health Visitors are responsible for undertaking LAC assessments or reviews these must be done to national standards and within statutory timescales.	See service specification, applicable national standards	report	<b>Annual</b> report required.
		Where there is a child in need or safeguarding concerns or special educational needs the child must transfer with a written record of these concerns to the school nursing service.	At point of entry to full time education e.g 4 years or 5 years specify	report	<b>Annual</b> internal audit required.
		Where a child moves out of area the HV service must ensure that the child's health records are transferred to the HV service in the new area within two weeks of notification. Direct contact must be made to hand over child protection cases.		report	<b>Annual</b> internal audit required.
	CQC	Adherence with CQC standards	Evidence should be available to commissioners on request		Copy of CQC certification requested in ITT.

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### **APPENDIX D – NURSE PRESCRIBING**

Nurse prescribing enhances the clinician's ability to deliver high impact area on minor illness and reducing hospital admissions, not only from the point of view of managing symptoms but also from the medication knowledge that also enhances advice and support. There is a strong clinician view that health visitors welcome the ability to use their prescribing skills and that this is an important element of practice.

Nurse prescribing has been shown to have a number of benefits ranging from increased compliance to reduced hospital and GP attendances.

Health visitors are in an ideal position to respond to common health concerns, discuss treatment options and wider management of conditions and then to prescribe as part of a holistic approach.

While prescribing is included as a deliverable within the service specification, it is understood that not all HVs will have taken this module as part of their training. Therefore where HVs have not undertaken this module in training, it is a requirement of CPD for completion within the first 2 years of practice.

For more information visit <http://www.nmc-uk.org/Nurses-and-midwives/Regulation-in-practice/Medicines-management-and-prescribing/>

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### APPENDIX E – ASSESSMENTS-UNIVERSAL OFFER (Health Visiting Service Area)

Universal Review	Description
<p><b>Antenatal health promoting visits</b></p>	<p>Promotional narrative listening interview</p> <p>Includes preparation for parenthood</p> <p>This should be done as a face-to-face, 1-2-1 interview in a confidential setting.</p>
<p><b>New Baby Review</b></p>	<p>Face-to-face review by <b>14 days</b> with mother and father to include:</p> <ul style="list-style-type: none"> <li>- Completion of Children’s Centre registration form</li> <li>- Infant feeding</li> <li>- Promoting sensitive parenting</li> <li>- Promoting development</li> <li>- Assessing maternal mental health</li> <li>- SIDS prevention including promoting safe sleep</li> <li>- Keeping safe</li> <li>- If parents wish or there are professional concerns:               <ol style="list-style-type: none"> <li>1. An assessment of baby’s growth</li> <li>2. On-going review and monitoring of the baby’s health</li> <li>3. Assessment of safeguarding concerns</li> <li>4. Promotion of secure attachment</li> <li>5. Include promotion of immunisations specifically:</li> </ol> </li> </ul> <p>Adherence to vaccination schedule for babies born to women who are hepatitis B positive</p> <p>Assess maternal rubella status and follow up of two MMR vaccinations (to protect future pregnancies).</p> <p>Checking of the status of all screening results and take prompt action to ensure appropriate referral and treatment pathways are</p>

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	<p>followed in line with UK NSC Standards, specifically:</p> <p>New-born blood spot; ensuring results for all conditions are present</p> <p>Results of NIPE examinations</p> <ol style="list-style-type: none"> <li>1. Hearing screening outcome -             <p>Hearing screening by health visitors to continue until the transition to the new provider has completed, expected by June 2015</p> </li> </ol>
<p><b>6 – 8 Week Assessment</b></p>	<p>Includes:</p> <ul style="list-style-type: none"> <li>- On-going support with breastfeeding involving both parents</li> <li>- Assessing maternal mental health according to NICE guidance</li> </ul> <ol style="list-style-type: none"> <li>1. The baby's GP (or nominated Primary Care examiner) will have responsibility for ensuring the 6-8 week NIPE screen is completed for all registered babies</li> <li>2. Include promotion of immunisations specifically:             <ol style="list-style-type: none"> <li>a. Adherence to vaccination schedule for babies born to women who are hepatitis B positive</li> <li>b. Assess maternal rubella status and follow up of two MMR vaccinations (to protect future pregnancies).</li> <li>c. Checking of the status of all screening results and take prompt action to ensure appropriate referral and treatment pathways are followed in line with UK NSC Standards as above in initial check.</li> </ol> </li> </ol>
<p><b>3 – 4 months</b></p>	<p>For 2018/19, <b>At three to four months - targeted</b> from 6- 8 week review follow up for maternal mood review and / or based on professional judgment to carry out a review</p> <ul style="list-style-type: none"> <li>• Supporting parenting by providing access to parenting and child health information and guidance (telephone helplines, websites, 111a, etc.), and information on Children's Centres and Family Information Services.</li> <li>• Checking the status of Immunisations at three months against diphtheria, tetanus, pertussis, polio, <i>Haemophilus</i></li> </ul>

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*influenzae* type B and meningococcus group C.

- Checking the status of Immunisations at four months against diphtheria, tetanus, pertussis, polio, *Haemophilus influenzae* type B, pneumococcal infection and meningococcus group C.
- If parents wish, or if there is or has been professional concern about a baby's growth or risk to normal growth (including obesity), an assessment should be carried out. This involves accurate measurement, interpretation and explanation of the baby's weight in relation to length, to growth potential and to any earlier growth measurements of the baby.

### **Assessing maternal mental health**

Assessment of the mother's mental health at six to eight weeks and three to four months, by asking appropriate questions for the identification of depression, such as those recommended by the NICE guidelines on antenatal and postnatal mental health.<sup>61</sup>

### **Maintaining infant health**

Temperament-based anticipatory guidance<sup>62</sup> – practical guidance on managing crying and healthy sleep practices, bath, book, bed routines and activities, and encouragement of parent– infant interaction using a range of media-based interventions (e.g. Baby Express newsletters<sup>63</sup> ).

### **Promoting development**

Encouragement to use books, music and interactive activities to promote development and parent–baby relationship (e.g. media-based materials such as Baby Express newsletters and/or Bookstart<sup>64</sup> ).

### **Keeping safe**

Raise awareness of accident prevention in the home and safety in cars. Be alert to risk factors and signs and symptoms of child abuse. Follow local safeguarding procedures where there is cause for concern.

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/167998/Health\\_Child\\_Programme.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf)

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	<a href="ent_data/file/209907/S9_Happy_Healthy_Families_First_Community_EISCS_V121210.pdf">ent_data/file/209907/S9_Happy_Healthy_Families_First_Community_EISCS_V121210.pdf</a>
<b>9- 12 months</b>	<p>Includes:</p> <ul style="list-style-type: none"> <li>- Assessment of the baby's physical, emotional and social development and needs in the context of their family using evidence based tools, for example, Ages and Stages 3 and SE questionnaires;</li> <li>- Supporting parenting, provide parents with information about attachment and developmental and parenting issues;</li> <li>- Monitoring growth;</li> <li>- Health promotion, raise awareness of dental health and prevention (ensuring that all children are accessing primary dental care services for routine preventive care and advice), healthy eating, injury and accident prevention relating to mobility, safety in cars and skin cancer prevention;</li> <li>- Check new-born blood spot status and arrange for urgent offer of screening if child is under 1 year;</li> <li>- Adherence to vaccination schedule and final serology results for babies born to women who are hepatitis B positive; status of MMR vaccination for women non-immune to rubella.</li> </ul>
<b>By 2 – 2½ Years</b>	<p>Includes:</p> <ul style="list-style-type: none"> <li>- Review with parents the child's social, emotional, behavioural and language development using ASQ 3 and SE;</li> <li>- Respond to any parental concerns about physical health, growth, development, hearing and vision;</li> <li>- Offer parents guidance on behaviour management and opportunity to share concerns;</li> <li>- Offer parent information on what to do if worried about their child;</li> <li>- Promote language development;</li> <li>- Encourage and support to take up early years education;</li> </ul>



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	<ul style="list-style-type: none"><li>- Give health information and guidance;</li><li>- Review immunisation status;</li><li>- Offer advice on nutrition and physical activity for the family;</li><li>- Raise awareness of dental care, accident prevention, sleep management, toilet training and sources of parenting advice and family information;</li><li>- This review should be integrated with the Early Years Foundation Stage two year old summary from 2015 as appropriate to the needs of children and families.</li></ul>
<b>By 4 ½ years</b>	<p>4½ years - Formal handover to School Nursing Service timed to meet the needs of the child e.g. if the HV is lead professional the handover may be delayed where this will improve outcomes for the child</p> <p>Children on Universal Plus or Universal Partnership Plus Offer must have a written handover.</p>

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### **APPENDIX F – ACTIVITIES AT COMMUNITIES SERVICE OFFER**

(These are examples – it is expected that the Service will work in partnership with Children's Services and the Public Health Team to ensure that local community assets can flourish and appropriate developments grown.)

**Building social networks;** of families with similar interests, strengths or needs. Expansion of existing social networks to meet public health needs e.g. extended family, postnatal groups, faith groups, father's groups. Introduction and support of families into existing networks.

**Influence other agencies and sectors to improve public health outcomes** through supporting the application of best evidence-based practice in health improvement within and outside of health and early years settings, identifying local public health need and opportunity e.g. in housing, domestic abuse, teenage families, benefits system, schools, council planning/ neighbourhood improvement.

**Use networks to improve public health;** Signposting families to other sources of health and wellbeing advice and information via the Public Health Portal and to other services already existing locally, particularly early years, adult education and training and those run by voluntary and community groups.

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### **APPENDIX G – CO-LOCATION CHARGE FOR PREMISES**

#### **(Health Visiting Service Area)**

At present the health visiting service is partially provided from four Children's Centres located at Fox Hill Primary School site ("The Rowans"); College Town Schools site ("The Alders"); Great Hollands School site ("The Oaks") and Priestwood Youth Centre ("The Willows").

The Authority will endeavour to secure continued use of these centres but if this cannot be obtained the provider will have to make alternative arrangements at its own expense for accommodation.

Subject to availability, from 1<sup>st</sup> April 2018, the Provider is required to pay the Authority a fixed annual charge in order to cover the costs of co-location in the Council's Children's Centres.

This amount includes:

- Use of up to 19 standard desks and chairs
- heating, lighting, cleaning, waste collection including confidential shredding, storage (including storage of a server at 3 sites) during normal opening hours
- use of kitchen facilities and kitchen equipment
- access to bookable meeting rooms
- unlimited parking at 2 Children's Centres and 3 parking spaces at one.

For the avoidance of doubt, this amount does not include:

- ICT equipment and support
- Telecommunications equipment and support
- Internet access unless through public WIFI.

This arrangement and related charges will be reviewed after 12 months

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### **APPENDIX H – QUALITY ASSURANCE**

The provider must deliver a comprehensive high quality 0-19 Public Health Nursing Service which can show evidence that it meets the standards, pathways and guidance set out in this service specification. The service must be safe, effective and customer focussed.

The provider must ensure delivery of the **full Healthy Child Programme 5-19 years**

The provider service must be quality assured against CQC and all applicable quality standards, key performance indicators and service delivery metrics. Information provision and mandatory reporting (Appendix C) must be completed on a quarterly basis, in line with other required data collections as notified.

Providers must provide the commissioner with a robust plan to implement electronic record keeping and data collection for health visiting services.

The provider should highlight to commissioners where there is an absence of local services or evidence-based pathways to refer families onto so that future commissioning plans can include mitigation for/provision of these; this is particularly urgent where need is identified but evidence-based pathways are truncated at the onwards referral stage because local services do not currently exist.

The 0-19 Public Health Nursing service must report the KPIs (national and local) listed in the service specification and must provide evidence of compliance with CQC, other national applicable standards and any other regulative bodies including Ofsted, to assure commissioners and the public of the safety and effectiveness of the service. In order to do this the service must use suitable electronic record keeping and data collection systems which clearly demonstrate improved outcomes for the child and family.

The following items must be delivered:

- Routine collation of service user views to inform service development where possible using validated measuring tools including Friends and Family Tests;
- 0-19 Public Health Nursing team staff engagement and capturing of views;
- Evidence that the 0-19 Public Health Nursing team staff are accessing appropriate leadership training, clinical supervision and are competent in all aspects of safeguarding;
- Evidence that HV practice teachers are maintaining competence to practice in line with national guidance;
- Ongoing quality audit programme;
- Organisation process for ongoing CPD, including appraisals and PDP for the 0-19 Public Health Nursing team staff. Evidence of a 0-19 Public Health Nursing Training Needs Analysis to include action plan for ongoing professional development for the workforce with a focus on evidence-based practice and integrated training where possible. Evidence of a workforce plan which models both current and future workforce requirements in line with priorities for local area outlined in JSNA.

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### ***APPENDIX I – INCIDENTS REQUIRING REPORTING PROCEDURE***

The Provider is required to follow the latest version of the Bracknell Forest Council Incident Reporting and Management Procedure, v3, dated July 2015.

Copy available at

[http://boris.bracknell-forest.gov.uk/incident\\_reporting\\_and\\_management\\_procedure\\_v3.pdf](http://boris.bracknell-forest.gov.uk/incident_reporting_and_management_procedure_v3.pdf)

It is expected that the provider will use the most current version of the policy.

## **Annex C**

### ***APPENDIX J – CONDITIONS PRECEDENT***

Provide the Authority with a copy of the Provider's registration with the CQC where the Provider must be so registered under the Law

Provide the Authority with a copy of the Provider's Employer's Liability Insurance certificate with cover up to £10m.

Provide the Authority with a copy of the Provider's Public Liability Insurance certificate with cover up to £10m.

Provide the Authority with a copy of the Provider's Professional Indemnity Insurance certificate with cover up to £5m.

Provide the Authority with a copy of the Provider's Medical Malpractice Insurance Certificate with cover up to £5m, where available.

## **Annex C**

### ***APPENDIX K - SERVICE USER, CARER AND STAFF SURVEYS***

The provider commits to undertaking 6-monthly surveys of service users, staff and other stakeholders' (as defined by the Commissioner) satisfaction with the service.

## **Annex C**

### ***APPENDIX L – DETAILS OF REVIEW MEETINGS***

To be held quarterly at the Commissioner's premises, in the week following the last month's data return in each quarter, or as otherwise specified by the Commissioner.



## Annex C

### **APPENDIX M – INTEGRATED PATHWAYS**

Safeguarding children including a focus on prevention, early help, targeted support, early intervention and sharing of information. (See [Working Together to Safeguard Children](#) HM Govt 2013).

Post natal maternal mental health ([NICE CG 37](#)).

Young parents including [Family Nurse Partnership](#).

[Substance and alcohol misuse](#).

[Domestic abuse](#).

Parental and infant perinatal mental health and early attachment (for best practice see [Tameside & Glossop Early Attachment Service](#)).

Parenting Programme Pathway (Social and Emotional Development (Greater Manchester Public Service Reform Early Years Programme)

Breastfeeding ([UNICEF baby friendly in the community](#)).

Nutrition and healthy weight including failure to thrive (NCMP and PHE via [www.noo.org.uk](http://www.noo.org.uk))

[Children with additional needs and disabilities](#)

Transitions between midwifery, FNP and health visiting (DH)

Transition from health visiting to school nursing (DH)

[Transition from HV to School Nurse \(see DH website 2013\)](#)

[Seldom heard communities](#) including families with young children from traveller, asylum seeker and refugee communities and homeless families.

Families with complex and multiple needs including 'troubled families'

New-born Blood Spot Programme: <http://newbornbloodspot.screening.nhs.uk/professionals>

New-born Hearing Screening Programme

New-born Infant Physical Examination Programme

Nurse Prescribing guidance: [http://www.nmc-uk.org/Documents/Circulars/2009circulars/NMC%20Circular%2002\\_2009%20Annexe%201.pdf](http://www.nmc-uk.org/Documents/Circulars/2009circulars/NMC%20Circular%2002_2009%20Annexe%201.pdf)