Lancashire County Council

Health Scrutiny Committee

Tuesday, 2 September, 2014 at 10.30 am in Cabinet Room 'C' - County Hall, Preston

Agenda

Part 1 (Open to Press and Public)

No.	Item	
1.	**Apologies**	
2.	**Disclosure of Pecuniary and Non-Pecuniary Interests** Members are asked to consider any Pecuniary and Non-Pecuniary Interests they may have to disclose to the meeting in relation to matters under consideration on the Agenda.	
3.	**Minutes of the Meeting Held on 22 July 2014**	(Pages 1 - 8)
4.	**Lancashire Children and Young People Plan: our starting well strategy**	(Pages 9 - 12)
5.	**School Nursing and Health Visiting**	(Pages 13 - 88)
6.	**Report of the Health Scrutiny Committee Steering Group**	(Pages 89 - 128)
7.	**Work Plan 2014/15**	(Pages 129 - 134)
8.	**Recent and Forthcoming Decisions**	(Pages 135 - 136)
9.	**Urgent Business** An item of urgent business may only be considered under this heading where, by reason of special circumstances to be recorded in the Minutes, the Chair of the meeting is of the opinion that the item should be considered at the meeting as a matter of urgency. Wherever possible, the Chief Executive should be given advance warning of any Member's intention to raise a matter under this heading.	

Lancashire County Council

10. Date of Next Meeting

The next meeting of the Health Scrutiny Committee will be held on Tuesday 7 October 2014 at 10.30am at County Hall, Preston.

I Young
County Secretary and Solicitor

County Hall
Preston

Lancashire County Council

Health Scrutiny Committee

Minutes of the Meeting held on Tuesday, 22nd July, 2014 at 10.30 am in Cabinet Room 'C' - County Hall, Preston

Present:

County Councillor Steven Holgate (Chair)

County Councillors

M Brindle	A Kay
Mrs F Craig-Wilson	Y Motala
G Dowding	M Otter
N Hennessy	N Penney
M Iqbal	

Co-opted members

Councillor Brenda Ackers, (Fylde Borough Council Representative)
Councillor Julia Berry, (Chorley Borough Council Representative)
Councillor Trish Ellis, (Burnley Borough Council)
Councillor Carolyn Evans, (West Lancashire Borough Council)
Councillor Paul Gardner, (Lancaster City Council Representative)
Councillor Bridget Hilton, (Ribble Valley Borough Council Representative)
Councillor Roy Leeming, (Preston City Council)
Councillor Asjad Mahmood, (Pendle Borough Council)
Councillor Mrs Kerry Molineux, (Hyndburn Borough Council)
Councillor Julie Robinson, (Wyre Borough Council Representative)
Councillor M J Titherington, (South Ribble Borough Council Representative)

1. Apologies

County Councillors Christian Wakeford and Richard Newman-Thompson attended in place of County Councillors Keith Iddon and Bev Murray respectively and Councillor Helen Jackson attended in place of Councillor Liz McInnes (Rossendale Borough Council).

Apologies for absence were presented on behalf of County Councillor Alycia James and Councillor Bridget Hilton (Ribble Valley Borough Council

2. Disclosure of Pecuniary and Non-Pecuniary Interests

None disclosed

3. Minutes of the Meeting Held on 10 June 2014

The Minutes of the Health Scrutiny Committee meeting held on the 10 June 2014 were presented and agreed.

Resolved: That the Minutes of the Health Scrutiny Committee held on the 10 June 2014 be confirmed and signed by the Chair.

4. Starting Well: A scrutiny overview of pregnancy, early years and healthy lifestyles

The Chair welcomed officers from the Adult Services, Health and Wellbeing Directorate:

- Mike Leaf, Director of Health Improvement;
- Karen Thompson, Consultant in Public Health;
- Sheridan Townsend, Public Health Specialist (Children, Young People & Families); and

From the Directorate for Children and Young People:

- Theresa Moore, Early Years Lead.

The Health Scrutiny Committee had previously agreed to structure its work programme around the three key strands of Lancashire's Health and Wellbeing Strategy: Starting Well, Living Well and Ageing Well. As part of Starting Well the Committee had requested additional information about pregnancy, early years and healthy lifestyles.

The report now presented therefore provided a focus on: pregnancy, early years initiatives and support for families to make healthy lifestyle choices. It provided brief background information to each of these themes and suggested how elected members could contribute to the Public Health agenda.

A PowerPoint presentation was used to set out some key statistics relating to breast feeding, vaccination coverage, obesity, oral health, chlamydia, and under age 18 conceptions. It included brief details of a range of current initiatives to encourage healthy lifestyle choices. There was also information about services and initiatives delivered by Lancashire Children's Centres. It highlighted key challenges and opportunities for the future. A copy of the presentation is appended to these minutes.

Members raised a number of comments / questions and below is a summary of the main points:

- There was some discussion about the reasons for a drop-off in breast feeding after 6-8 weeks, for example return to work, lack of facilities in public places, peer pressure. It was suggested also that problems could arise when babies were being weaned owing to lactose intolerance, especially among Asian families.
- In response the Committee was assured that health visitors worked hard with new mothers to encourage breast feeding and they were very familiar with a range of possible barriers / complications and able to provide support strategies for weaning. Health visitors now routinely made an antenatal visit, which provided an opportunity to talk about breast feeding before the birth and therefore address any concerns at that stage also. Health visitors were currently commissioned by NHS England, however the county council would commission their services from October 2015.
- It was a key challenge to reach a point where breastfeeding was universally accepted in this country, as it currently was abroad. It was considered very important to tackle a negative perception of breast feeding in public and to promote and publicise facilities.
- Hyndburn Borough Council had been awarded gold standard for its baby friendly initiative, which included local businesses, and it was suggested by the district councillor that the approach taken by Hyndburn might be rolled out countywide.
- It appeared that the message about the importance of breast feeding in the early weeks had been effective and the benefits now well understood, but perhaps a changed message should now be promoted to extend the period during which some mothers breast feed. Officers agreed that there were many reasons to promote breastfeeding beyond just the early weeks and that health visitors would be key to achieving this.
- It was suggested that there should be more emphasis on the role of fathers, for example through the Bump to Birth and Beyond (BBB) programme intended to provide support to new families; there was evidence of an increase in domestic violence around the time a new baby was born and support for new fathers was important.
- In response, the Committee was assured that much work was ongoing through Children's Centres to involve fathers and that events/services were delivered at different times of day to make them accessible. Services were advertised across the district and delivered by professionals including trained midwives and health visitors. Details of the services available would be provided to members on request.
- The BBB sessions enabled vulnerable families to be identified and appropriate interventions offered. Access levels to Lancashire Children's Centres were higher than the national average.
- One member suggested that it was important to educate young people, before puberty, about issues such as the dangers of unprotected sex, the effect of smoking and drinking on fertility, and the benefits of breast feeding.
- Officers were asked whether there was any data on the growth of e-cigarette shops and how / whether they influenced smoking among pregnant women.

Mike Leaf undertook to check if there were any local or national figures and report back to the Committee.

- It was noted that inconsistent delivery and fragmented commissioning were among the key challenges listed in the report and officers were asked what was being done to meet those challenges to ensure that services were reaching the most vulnerable. It was explained that allocation of resources would be driven by Marmot's principles, the social determinants of health, sometimes referred to as the 'causes of causes', and also the '1001 critical days manifesto', a cross party political vision for improving the lives of children from conception to age two which would have a lifelong impact on mental and emotional health.
- It was recognised that there were many determinants of health and wellbeing and that some GPs were now recognising the importance of prevention rather than their traditional diagnostic / treatment role, however not all were yet taking this approach.
- In response to a question asking specifically how priorities were determined and resources allocated, it was explained that there was now a need for a sophisticated formula approach and confidence that providers could deliver what was needed. Currently, spending tended to be based on historical factors and wasn't needs based. It was acknowledged that work was needed to establish a needs-based process.
- Members were reminded that there had been a huge reorganisation in health services and that the 'dust was only now beginning to settle', but the time was right to start detailed discussions. GPs had not previously had the opportunity to commission services as they now had through their membership of Clinical Commissioning Groups, but change could be difficult where behaviour was entrenched.
- There was a view from the Committee that as responsibility for Public Health had now been with the county council for16 months it was time to move forward.
- It was explained that the county council was bound by legal contracts that it had inherited from the NHS trusts, some of which would require 12 months' notice. It was important for the county council to be clear about what services need to be re-commissioned. There would be some 500-600 contracts from April 2016. It was confirmed that Members could see contracts on request.
- Regarding Children's Centre priorities, the Committee received a detailed explanation of the approach used to in each catchment area to ensure that issues were identified, priorities set and outcomes reviewed; priorities differed from area to area, for example in some areas breast feeding wasn't an issue.
- There was some concern that University Hospitals of Morecambe Bay NHS Trust and Lancashire Teaching Hospitals NHS Trust had not engaged with the UNICEF UK Baby Friendly Initiative accreditation. Officers reassured the Committee that these Trusts were maintaining the process, but agreed that scrutiny was important and engagement with partners was key to future success.
- Officers confirmed that it was possible to evaluate and test outcomes depending on the evidence base. If a performance indicator was 'red' it was important to understand why and what needed to be done to make a difference. Public Health was looking at the core offer and whether

adjustments were needed. Pump priming would be necessary to fund innovative approaches.

- The Committee was assured that infant mortality (deaths of babies under one year of age) was monitored very closely. The number of deaths per year was reducing but was higher than the national average and there were significant variations between wards within divisions. A whole-system approach was necessary and it was essential that all partners addressed this issue.
- One member suggested that the subjects being discussed were too broad for one meeting. She also requested that any statistics provided to members be broken down by division to ensure relevant issues were being targeted.
- Regarding challenges around obesity, it was pointed out that the food industry made millions of pounds from selling processed food containing high levels of fat and sugar. In this context much work was needed both nationally and internationally. There was a need to educate people and encourage healthy behaviours such as breastfeeding, regular activity and lifestyle choices. It was important for the county council to take opportunities to encourage and support active lifestyles, for example the building of a new road could provide an opportunity to include a cycle track and / or a safe walking facility.

The Chair thanked officers for an informative session. He felt that the Committee needed to be confident that the county council's approach to Public Health was having a positive impact on the health and wellbeing of Lancashire residents, and that it was in a position to measure outcomes.

Resolved: That,

- The report be noted; and

- A further report on the 'Starting Well' theme be brought to the September meeting of this Committee, after which the Committee would consider clear recommendations regarding its preferred Public Health priorities.

5. Report of the Health Scrutiny Committee Steering Group

It was reported that on 2 May the Steering Group had met with Mark Hindle, Chief Executive of Calderstones NHS Trust to update members on the Trust's annual and 5 year plans and also received a further update from Lancashire Care Foundation Trust on inpatient facilities. A summary of the meeting was at Appendix A to the report now presented.

On 13 June the Steering Group had met with University Hospitals Morecambe Bay Trust to discuss the forthcoming publication of the CQC inspection report and other recent developments. A summary of the meeting was at Appendix B to the report now presented.

It was confirmed that there had been an exchange of correspondence between the Steering Group and University Hospitals Morecambe Bay Trust about

pharmacy services and there was to be a meeting between the two parties to discuss this issue.

6. Work Plan 2014/15

Appendix A to the report now presented set out a draft work plan for both the Health Scrutiny Committee and its Steering Group, including current Task Group reviews.

It was suggested that when the Committee was to consider the theme 'Ageing Well' that 'exercise on prescription' be included as part of that item.

Resolved: That the work plan be noted subject to inclusion of 'exercise on prescription' as referred to above.

7. Recent and Forthcoming Decisions

The Committee's attention was drawn to forthcoming decisions and decisions recently made by the Cabinet and individual Cabinet Members in areas relevant to the remit of the committee, in order that this could inform possible future areas of work.

Recent and forthcoming decisions taken by Cabinet Members or the Cabinet can be accessed here:

http://council.lancashire.gov.uk/mgDelegatedDecisions.aspx?bcr=1

Resolved: That the report be received.

8. Urgent Business

No urgent business was reported.

9. Date of Next Meeting

It was noted that the next meeting of the Committee would be held on Tuesday 2 September 2014 at 10.30am at County Hall, Preston.

I M Fisher
County Secretary and Solicitor

County Hall
Preston

Health Overview and Scrutiny Committee
Meeting to be held on 2 September 2014

Electoral Division affected:
All

Lancashire Children and Young People Plan: our starting well strategy

Contact for further information:
Richard Cooke, 01772 536051, Children and Young People
Richard.cooke@lancashire.gov.uk

Executive Summary

The Children and Young People's Plan (CYPP) 2014-17 is the key multi agency strategy for children and young people in Lancashire, which has been endorsed by the Health and Wellbeing Board and adopted as the Starting Well strand of the Health and Wellbeing Strategy. The CYPP is a three year strategy that sets out how we want to work alongside children, young people and families and in doing so, the outcomes we want them to achieve. It is a statement of our collective ambition for how services, teams and individuals involved in improving the wellbeing of children and young people will work together in a way that provides the best support.

The CYPP has been developed through analysis of data and information, through consultation with partners and most importantly, through talking to Lancashire's children and young people. Over 2,000 children and young people told us what Lancashire is like now, what they would like it to be in the future, and what will help them to get there.

Recommendation

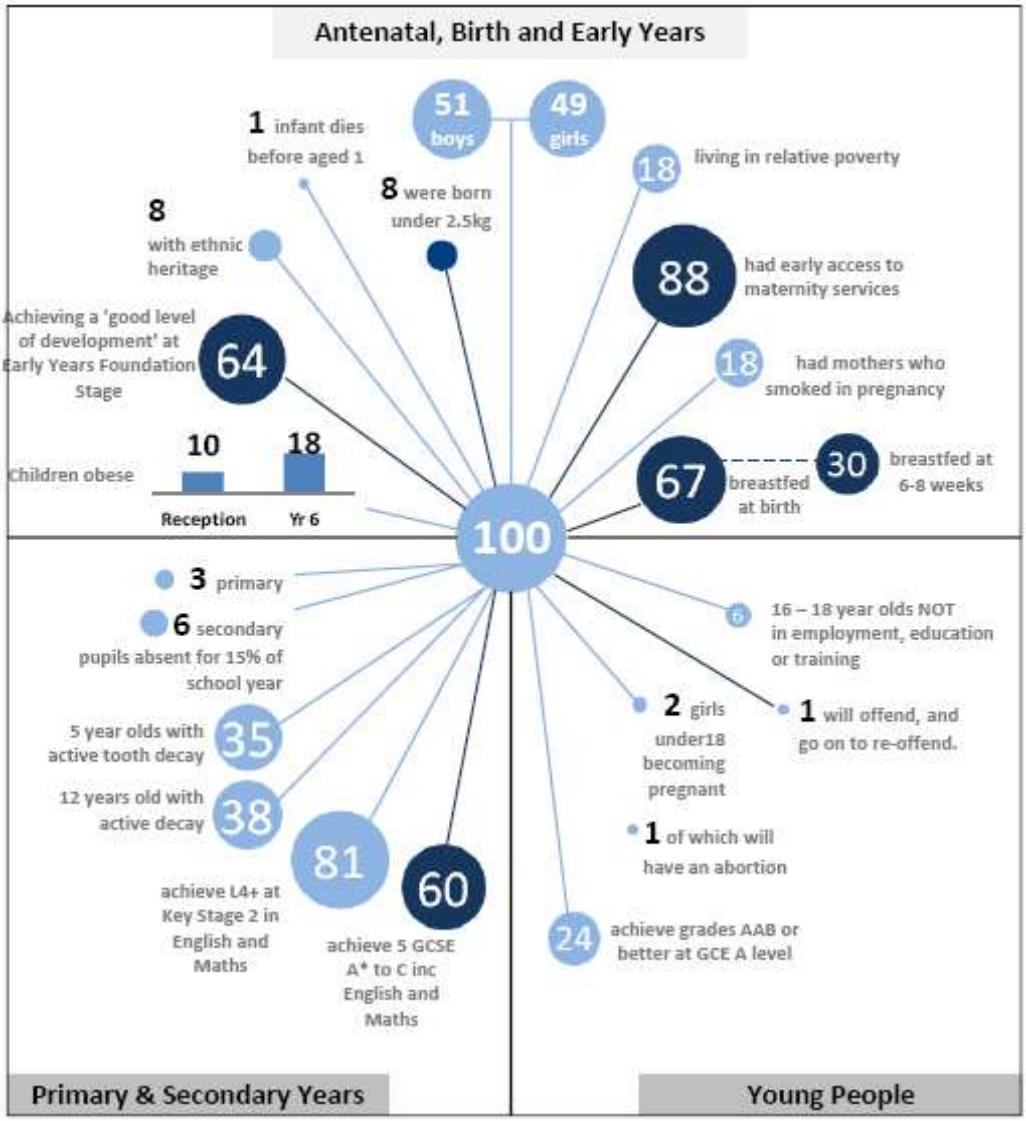
The Committee is recommended to note and comment on the report.

Background and Advice

Alongside information provided by children and young people themselves, the Children and Young People's Plan 2014-17 was informed by a refreshed Joint Strategic Needs Assessment (JSNA) which provided a wealth of data and information from across all sectors of the children's workforce.

The diagram below shows some of the key data from the 2013 JSNA depicted in the style of, if Lancashire was a village of 100 children.....

Lancashire County Council



Key principles

The CYPP identifies a number of key principles that we should embed in the way we deliver services that support children and young people. These themes have been developed over a number of years, continue to develop, and are fundamental to how we work in the future. It is important that we take this learning that is highlighted in the CYPP so that there we are all clear on and agree to the principles that underpin how we will work together. These key principles include:

Prioritising vulnerable groups – we want to improve outcomes for all children and young people in Lancashire, but, we know that there are many groups of children that are particularly vulnerable and will find it more difficult to secure those positive outcomes. We need to be clear that these are a focus for our services and we will work hard to ensure that we will provide proportionally more support and resources for these groups

Maintaining a family focus – whilst this is a Plan about how we intend to support better outcomes for children and young people we recognise a significant factor in how successful this is, is the family and support around the child. We are committed to supporting the whole family so that we can work together in the best interests of the child.

Identifying support early – we know that very often the outcomes for families are far better if we are able to identify issues and provide the appropriate support at the earliest opportunity. We also know that this is a far better use of resources

Building resilience – we want to work 'with' families and not do 'to them'. We want families to take ownership of the issues they are facing and to help them build the skills, understanding and confidence to overcome them.

Promoting localism – this Plan sets out how we will work with families across Lancashire. Partner organisations will work together locally to understand the needs and strengths of a community and develop priorities that reflect this Plan and other complementary developments, projects and strategies.

Recognising community 'assets' – every child, young person, family and community has a wealth of strengths and assets. This should be the starting point for our conversations with families. Identifying their strengths and looking at how we can build on these and work with the family to overcome the issues they are facing while building their support networks. We also need to be aware of the physical assets in a community, the public spaces, buildings and resources that families can access.

Raising aspirations – we want children and young people to achieve the very best that they can and we want them to aspire to be the very best that they can. We will ensure that we create the stimulus, environment and the support that enables this.

Enabling workforce development – by far the biggest asset and resource that we have to support children and young people is the thousands of practitioners that work with them on a daily basis. We need to ensure that they have the skills and confidence to continue to offer the highest quality services, and how changes can be made to work together better across sectors to help us continually improve.

Better commissioning - we will work with communities to use the commissioning process to understand needs and assets, to plan and design ways to make the best use of resources to improve outcomes for families and to review the impact of services.

The Role of Elected Members

The Children and Young People's Plan is the agreed strategy that is in place to deliver the Starting Well strand of the Health and Wellbeing Strategy. Elected members should ensure that when they consider and scrutinise elements of delivery that support children and young people (ie Starting Well) that this in line with the priorities and principles agreed through the Children and Young People's Plan.

Consultations

Over 2000 children and young people have provided feedback on what life is like in Lancashire, what can be done to improve their lives and how services can better support them. Many of these children and young people consulted with were from vulnerable backgrounds. These included children in care, children with disabilities and young carers. In addition, the priorities in the Plan were also informed by dialogue and feedback from key partner organisations and sectors.

Implications:

This item has the following implications, as indicated:

Risk management

There are no risk management implications arising from this report.

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Directorate/Tel
Children and Young People's Plan CYPP 2014-17	April 2014	Richard Cooke, CYP Directorate, 01772 536051
CYP Joint Strategic Needs Assessment (see link below) CYP Joint Strategic Needs Assessment 2013	July 2013	Ian Bashall, CYP Directorate, 01772 532739
Children and Young People's Consultation CYP Consultation Report	March 2014	Hannah Peak, CYP Directorate, 01772 532686

Reason for inclusion in Part II, if appropriate

Health Overview and Scrutiny Committee
Meeting to be held on 2 September 2014

Electoral Division affected:
All

School Nursing and Health Visiting
(Appendices A, B and C refer)

Contact for further information:
Wendy Broadley, OCE, 07825 584684
Wendy.broadley@lancashire.gov.uk

Executive Summary

As part of the ongoing scrutiny of the 'Starting Well' element of the Health & Wellbeing Strategy the Committee has agreed to look at the services relating to school nursing and health visiting.

To enable an effective understanding of the whole approach to these services, officers representing both the commissioners and service providers will attend Committee to provide members with information relating to the different roles and responsibilities they each carry out.

A number of appendices have been included with the report to provide members with additional background and they are:

- Appendix A – Maximising the school nursing team contribution to the public health of school-aged children (guidance to support commissioning)
- Appendix B – A 2 page briefing aimed at Lead Members of Children's Services on School Health Service (produced by the Department of Health and Local Government Association)
- Appendix C – The National Health Visitor Plan: progress to date and implementation 2013 onwards

Recommendation

The Committee is recommended to note and comment on the report and presentations and consider any further scrutiny of the school nursing service or health visiting service they may wish to undertake in the future.

Background and Advice

As part of the work plan of the Health Scrutiny Committee, members agreed that at the September Committee meeting they would receive a presentation on the commissioning and provision of the school nursing and health visiting services.

Lancashire County Council

These topics are within the remit of the 'Starting Well' strand of Lancashire's Health & Well Being Strategy and are a national progression to follow on from the previous Committee meeting where members discussed strategies, policies and provision for early years.

To enable the Committee to get a clear picture of the provision within Lancashire, members will receive presentations from both commissioners and providers - officers in attendance will be:

- Mike Leaf – Director of Health Improvement, Lancashire County Council
- Sheridan Townsend, Public Health Specialist (Children, Young People & Families), Lancashire County Council
- Jane Cass – Head of Public Health, NHS England – Lancashire Area Team
- Tricia Spedding – Public Health Commissioning Manager, NHS England – Lancashire Area Team
- Michelle Cox – Service Line Manager, Universal Services, Lancashire Care Foundation Trust
- Gill Wildon – Head of Universal Children's Services, Blackpool Teaching Hospitals NHS Foundation Trust

As much of the detail of the services both commissioned and provided will be delivered within the presentations from the attending officers the report includes a number of attachments to provide the Committee with background information relating to the two services.

The appendices are:

Appendix A – Maximising the school nursing team contribution to the public health of school-aged children (guidance to support commissioning)
The guidance is aimed at local commissioners and providers to provide them with a framework for commissioning local services that will be dependent on local needs It aims to set out the core school nurse offer and the innovative ways that school nursing services can be commissioned and developed to meet local need to ensure effective, seamless delivery of public health for school-aged children and young people. Local Authorities are key commissioners and hold an array of statutory duties for children, including: improving educational achievement; improving the wellbeing of young people; reducing child poverty; and protecting children and families.

Appendix B – A two-page briefing aimed at Lead Members of Children's Services on School Health Service (produced by the Department of Health and Local Government Association)
It provides an overview of the School Health Service and shares top tips to help Lead Members think about how they can use the School Health services to deliver better health outcomes for 5-19 year olds. From April 2013, local authorities are statutorily responsible for delivering and commissioning public health services for children and young people aged 5-19. This will include providing prevention and early intervention services, delivering the Healthy Child Programme and addressing key public health issues such as sexual health, emotional health and wellbeing issues, obesity, drug, alcohol and tobacco misuse.

Appendix C – The National Health Visitor Plan: progress to date and implementation 2013 onwards

The Healthy Child Programme (HCP) is the key universal service for improving the health and wellbeing of children, through health and development reviews, health promotion, parenting support, screening and immunisation programmes. Its goals are to identify and treat problems early, help parents to care well for their children, change health behaviours and protect against preventable diseases. The programme is based on a systematic review of evidence and is expected to prevent problems in child health and development and contribute to a reduction in health inequalities. As evidence for early intervention grows, health visitors in their role as leaders of the HCP, are vital to identifying needs and working with other services to ensure prompt preventative care is provided. As public health practitioners, health visitors also contribute to health needs analysis and work with local communities to improve health and reduce inequalities.

The expansion of the health visiting service is intended to:

- improve health and wellbeing outcomes for under-fives;
- reduce health inequalities;
- improve access to services; and,
- improve the experience of children and families.

Also additional information on the service specification for the health visiting service can be found at www.england.nhs.uk/wp-content/uploads/2014/03/hv-serv-spec.pdf

Consultations

N/A

Implications:

This item has the following implications, as indicated:

Risk management

There are no risk management implications arising from this report.

Local Government (Access to Information) Act 1985
List of Background Papers

N/A

Reason for inclusion in Part II, if appropriate

N/A

Department of Health

Public Health England

Maximising the school nursing team contribution to the public health of school-aged children

Guidance to support the commissioning of public health provision for school aged children 5-19

April 2014

This guidance has been developed with our key partners, including SOLACE, Association of Directors of Public Health and the Local Government Association.

Title: Maximising the school nursing team contribution to the public health of school-aged children
Author: PHD-PHN/32420
Document Purpose: Guidance
Publication date: April 2014
Target audience: Local commissioners and providers of school nursing services
Contact details: Public Health Nursing 164 Richmond House 79 Whitehall London SW1A 2AS Wendy.nicholson@dh.gsi.gov.uk

Published to gov.uk, in PDF format only.

www.gov.uk/dh

Maximising the school nursing team contribution to the public health of school-aged children

Guidance to support the commissioning of public health provision for school aged children 5-19

Prepared by Wendy Nicholson, Professional Officer for School and Community Nursing, Public Health Nursing team, Department of Health

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1. Purpose of the guidance

Many local authorities are turning their minds to the provision of school nursing services. Commissioning of local services will be dependent on local needs, hence this document is provided as guidance, providing a framework for local commissioners and providers. It aims to set out the core school nurse offer and the innovative ways that school nursing services can be commissioned and developed to meet local need to ensure effective, seamless delivery of public health for school-aged children and young people. This guidance supports the development of local service specifications and should be read in conjunction with Getting it right for children, young people and families: Maximising the contribution of the school nursing team: Vision and call to action.

Local Authorities are key commissioners and hold an array of statutory duties for children, including: improving educational achievement; improving the wellbeing of young people; reducing child poverty; and protecting children and families.

In addition to this guidance we are developing a series of joint local briefings with the Local Government Association to accompany this guidance to support commissioning of school nursing services, these will be published shortly. The briefings will be aimed at senior officers and lead members to help them to embed this guidance into local commissioning.

1.1 Workforce and a focus on school nursing teams

Public health nurses have a significant role in leading and co-ordinating delivery of public health interventions to address individual and population needs. The school nursing workforce is relatively small and cannot deliver the extensive Healthy Child Programme agenda in isolation. It is therefore important that the role of school nurses' contribution is clearly defined locally and robust arrangements are put into place to support multi-agency working.

School nurses are qualified nurses who hold an additional specialist public health qualification, which is recordable with the Nursing and Midwifery Council. School nurses, with their teams, co-ordinate and deliver public health interventions for school-aged children. The nature of their work requires clinical input and effective leadership, which qualified school nurses are equipped to provide. The skill mix within school nursing teams needs to reflect local need and should be underpinned by a **robust workforce plan** which takes into account **workload capacity** and **population health needs**.

School nurses are:

- The single biggest workforce specifically trained and skilled to deliver public health for school-aged children (5-19);
- Clinically skilled in providing holistic, individualised and population health; assessment, with a broad range of skills at Tier 1 and Tier 2 health interventions;
- In a unique position within community and education settings to support multi-disciplinary teams, with relationships within primary and secondary care;

- Skilled in managing the relationships between child, family and school settings;
- Trusted and valued by children and young people[1].

School nursing services configuration and delivery vary across England. Additionally, there are creative and innovative models of commissioning and delivery emerging, including co-commissioning with schools. This guidance builds on these good practice examples and aims to:

- Ensure a consistent and equitable approach across England. This guidance can be used to benchmark and monitor provision;
- Outline services and provide quality indicators related to the health and wellbeing of school aged children;
- Support a whole systems approach to support school-aged children aged 5 to 19 years and their families through the delivery of integrated pathways from competent and clinically skilled practitioners;
- Support an effective and high quality preventative service through implementation of the Healthy Child Programme (5-19)[2];
- Ensure that children, young people and their families health needs are assessed and supported, and where additional health needs are identified, they receive an early response, including appropriate referral to specialist services and signposting to other agencies as per the relevant pathway.

1.2 Commissioning public health for children and young people aged 5-19

Since April 2013 Local Authorities have been responsible for commissioning public health services for school-aged children (5-19). This presents new opportunities for bringing together a robust approach for improving outcomes for young people across both health and local authority led services. The local authority's key responsibilities for child health include:

- Improving the health and wellbeing of school-aged children and young people;
- Bringing together holistic approaches to health and wellbeing across the full range of their responsibilities;
- Optimising the ring-fenced public health budget to improve outcomes for children and young people;
- Leading commissioning of public health services, for example, health improvement, drugs, and sexual health;
- Responding to emergency planning, including outbreak response in schools.

The core public health offer for school-aged children which encompasses the Healthy Child Programme (5-19) and includes:

  - Public health;
  - Health promotion and prevention by the multi-disciplinary team;
  - Defined support for children with additional and complex health needs;

[1] http://www.byc.org.uk/media/75447/byc_school_nurse_report_web.pdf

[2] http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_108866.pdf

- Additional or targeted school nursing support as identified in the Joint Strategic Needs Assessment.

Directors of Public Health and Lead Members for Children's Services, based within local authorities, have specific functions to bring together the local public health system and provide strategic leadership to:

- Ensure delivery of Local Authority functions;
- Assure health protection plans;
- Work with partners to enable effective delivery of screening and immunisation programmes;
- Provide the core offer as outlined in the Healthy Child programme.

Directors of Public Health are the lead commissioners for school nursing services, and school nursing services are funded from the public health grant. There is an intentional join-up with the 0-5 commissioning, which will be moving to the local authority as part of the public health grant by October 2015.

Under the terms of the Health and Social Care Act 2012, upper tier Local Authorities are now responsible for improving the health of their population. Local Authorities are key commissioners and hold an array of statutory duties for children, including:

- Driving the high educational achievement of all children;
- Leading, promoting and creating opportunities for co-operation with partners to improve the wellbeing of young people;
- Establishing arrangements to reduce child poverty; promote the interests of children in development of health and wellbeing strategies (joining up commissioning plans for clinical and public health services with social care, education to address identified local health and wellbeing needs);
- Leading partners and the public to ensure children are safeguarded and their welfare promoted.

All the duties of the Director of Children's Services are underpinned by the need to ensure equality in access to services and to be a champion for the needs of the most vulnerable. The transfer of public health duties is an opportunity to further strengthen our approach to these key duties and to provide integrated services across all local authority led services such as social care, leisure and children and adult services.

The responsibility for commissioning **immunisation and vaccinations**, together with clinical support for children with additional health needs for long terms conditions and disabilities, lies with NHS England. There will be local variation regarding immunisation programmes, with some school nursing teams providing this, whilst others may be commissioned separately. However, in both cases, there needs to be close working arrangements between the Local Authority commissioner, NHS England commissioner and provider services to ensure high uptake.

In addition, special school nursing services will need to be commissioned by Clinical Commissioning Groups to provide specialist clinical input for children with specific health needs. For example, children with complex health needs who require ventilatory support or enteral feeding. Appendix 1 summaries the organisational responsibilities as they relate to the universal offer described within the Healthy Child Programme[3].

There are opportunities to explore co-commissioning arrangements with key partners, including school and education providers, to extend service provision where local and/ or school population health and wellbeing needs are identified.

2. Population needs

Commissioners will need a systematic, reliable and robust process to access **population health needs** that provides a basis for designing and reviewing services, together with workforce plans to ensure an **appropriately skilled workforce** can deliver public health locally.

Delivery of the universal elements of the Healthy Child Programme should be underpinned by a robust **Joint Strategic Needs Assessment**, which will need to identify vulnerable and at risk groups, including young carers, Children in Care, young offenders, those not in education, employment or training (NEET) and children with disabilities.[4]

At an individual or family level, services should be developed to meet individual need and tailored to ensure individuals are supported.

Commissioners will need to ensure providers can demonstrate a robust process to capture **service user insight** and the experiences of children and young people as service users. For example the You're Welcome Quality Criteria [5] or the Friends and Family Test[6]. Commissioners need to ensure providers collate and share data, and use this to support behaviour change, achievement of outcomes and to support targeted commissioning.

The Healthy Child Programme (HCP) is the universal public health programme for children and families from pregnancy to 19 years of age. The Healthy Child Programme (0-5) focuses on children from birth to five years of age and is delivered predominantly by Health Visitor Services and is currently commissioned by NHS England, until the transition of responsibilities moves to the local authority in October 2015. During the transition phase it will be essential for NHS England to work closely with local authorities to ensure a seamless transition and delivery of services 0-19 years.

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3 http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_108866.pdf

4 http://www.empho.org.uk/ViewResource.aspx?id=12227

5 https://www.gov.uk/government/publications/quality-criteria-for-young-people-friendly-health-services

6 http://www.england.nhs.uk/ourwork/pe/fft/

The Healthy Child Programme (5-19) focuses on school aged children up to the age of 19 and is commissioned by Local Authorities. It offers children and young people a schedule of health and development reviews, screening tests, immunisations, health promotion guidance and tailored support for children and families, with additional support when they need it most.

The Healthy Child Programme (5-19) provides a framework to support collaborative work and more integrated delivery. The Healthy Child Programme (5-19) aims to:

- Help parents develop and sustain a strong bond with children;
- Encourage care that keeps children healthy and safe;
- Protect children from serious disease, through screening and immunisation;
- Reduce childhood obesity by promoting healthy eating and physical activity;
- Identify health issues early, so support can be provided in a timely manner;
- Make sure children are prepared for and supported in education settings;
- Identify and help children, young people and families with problems that might affect their chances later in life.

Appendix 1 summarises the core elements of the Healthy Child Programme, together with key providers and commissioning organisations. School nurses have a crucial leadership, co-ordination and delivery role[7] within the Healthy Child Programme.

2.1 National / local context and evidence base

The importance of giving every child the best start in life and reducing health inequalities throughout life has been highlighted by Marmot[8] and the Chief Medical Officer[9] (CMO). The Healthy Child Programme is available to all children and aims to ensure that every child gets the good start they need to lay the foundations of a healthy life. School Nursing Services are a key component of the Healthy Child Programme (5-19) and support school-aged children to achieve the best possible health outcomes.

Marmot and the CMO both recognised the importance of building on the support in the early years and sustaining this across the life course for school-aged children and young people to improve outcomes and reduce inequalities through targeted support[10]. There will be challenges within a child's or young person's life and times when they need additional support. Universal and targeted public health services provided by school nursing teams are crucial to improving health and wellbeing of school-aged children.

The Public Health Outcomes Framework[11] and NHS Outcomes Framework[12] clearly define a range of outcome measures that are significant to the school aged population. Table 1 summarises those that apply to this age group.

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[7] https://www.gov.uk/government/publications/healthy-lives-healthy-people-our-strategy-for-public-health-in-england

[8] http://www.local.gov.uk/web/guest/health/-/journal_content/56/10180/3510094/ARTICLE

[9] https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2012-our-children-deserve-better-prevention-pays

[10] http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/publichealth/Healthinequalities/DH_094770?PageOperation=email

[11] https://www.gov.uk/government/news/public-health-outcomes-framework-sets-out-desired-outcomes

[12] https://www.gov.uk/government/publications/nhs-outcomes-framework-2012-to-2013

Table 1: Children and young people's outcomes

- Reducing the number of children in poverty
- Improving School readiness
- Reducing Pupil absence
- Reducing first time entrants to the youth justice system
- Reducing the number of 16-18 year olds not in education, employment or training
- Reducing under 18 conceptions
- Reducing excess weight in 4-5 and 10-11 year olds (all sub-indicators)
- Reducing hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0-14 and 15-24 years
- Improving emotional wellbeing of looked-after children
- Reducing smoking prevalence – 15 year olds
- Reducing Self harm
- Chlamydia diagnoses (15-24 year olds)
- Improving population vaccination coverage (all sub-indicators)
- Reducing tooth decay in children aged 5

Department of Health, NHS England, Public Health England and local government associations signed up to the pledge for better health outcomes for children and young people in February 2013[13]. The pledge puts children, young people and families at the heart of decision making and improving every aspect of health services, and sets out shared ambitions to improve physical and mental health outcomes for all children and young people and reduce health inequalities.

The CMO report[14] emphasised the commitment to:

> *'help children who grow up in the most at-risk families and to help parents give their children the best possible care. We also want to help children be as healthy as possible by preventing illness, and encouraging healthy behaviours from pregnancy onwards. The government is committed to improving all children's chances in life by giving families the help they need to keep their children healthy and safe'.*

There is strong evidence supporting delivery of all aspects of the Healthy Child Programme, which is based on *Health for All Children*[15], the recommendations of the National Screening Committee, guidance from the National Institute of Health and Clinical Excellence (NICE) and a review of health-led parenting programmes by the University of Warwick.

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

[14] https://www.gov.uk/government/publications/cmo-annual-report-2011-volume-one-on-the-state-of-the-public-s-health https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/138331/CMO_Annual_Report_Volume_2_2011.pdf

[15] http://www.healthforallchildren.com/

Additional or targeted support will be determined locally according to individual and population health needs as identified in a Joint Strategic Needs Assessment. This will include support to address specific issues. Separate or additional services may need to be commissioned and funded by the responsible agencies, specifically CAMHS, domestic violence or bereavement support.

2.2 Evidence base

The Healthy Child Programme 5-19 years was developed nationally and is based on relevant evidence bases. Full details can be found within:

- Healthy Child Programme – 5-19 years (DH, 2009 – amended August 2010)
- Healthy Child Programme – The two year review (DH, 2009)

The evidence base and key policy documents include:

- Allen, G. (2011a) Early Intervention: The Next Steps. HM Government: London
- Allen, G. (2011b) Early Intervention: Smart Investment, Massive Savings. HM Government: London
- Department of Health (2013) Getting it right for children and young people : Overcoming cultural barriers in the NHS so as to meet their needs
- Department of Health (2012) The Children and young people's Health Outcomes Strategy
- Department of Health (2012) Improving outcomes and supporting transparency, Part 1: A public health outcomes framework for England, 2013-2016
- Department of Health (2012) Improving outcomes and supporting transparency, Part 2: Summary technical specifications of public health indicators)
- Department of Health (2011) Healthy lives, healthy people: our strategy for public health in England
- Department of Health (2011) Healthy lives, healthy people: update and way forward (DH, 2011)
- Department of Health (2011) Healthy lives, healthy people: a call to action on obesity in England
- Department of Health (2011) National Child Measurement Programme
- Department of Health (2011) You're welcome: quality criteria for young people friendly health services
- Department of Health (2010) Achieving equity and excellence for children. How liberating the NHS will help us meet the needs of children and young people
- Department of Health (2010) Equity and excellence: Liberating the NHS and Liberating the NHS: Legislative framework and next steps
- Field, F. (2010) The Foundation Years: preventing poor children becoming poor adults. HM Government: London.

- Hall, D. and Elliman, D. (2006) Health for All Children (revised 4th edition). Oxford: Oxford University Press.
- HM Government (2013) Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children (HM Government,
- Marmot (2010) The Marmot Review Strategic Review of Health Inequalities in England, post-2010 (Available at http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report)

3. Outcomes

3.1 Children and young people's outcomes

The Marmot Review into health inequalities in England (2010), proposed an evidence based strategy to address the social determinants of health, the conditions in which people are born, grow, live, work and age and which can lead to health inequalities. The evidence base provides local areas to bench mark their progress and identify local solutions to addressing inequalities.

The Child and Maternal (ChiMat) Health Intelligence Network has published a first version of the Children and Young People's Health Benchmarking Tool (http://www.chimat.org.uk/cyphof). This brings together and builds on health outcomes data from the Public Health Outcomes Framework and the NHS Outcomes Framework. It responds to the Children and Young People's Health Outcomes Forum's recommendation that a view of these frameworks be created which highlights areas of particular relevance to improving the health outcomes of children and young people. Further indicators were also recommended by the Children and Young People's Health Outcomes Forum and are being considered. Appendix 2 provides suggested strategies and measures for local areas to use to support delivery and demonstrate impact.

School nursing teams lead and contribute to improving the outcomes for children and young people but are not solely responsible for achieving these and there needs to be a partnership approach. School nursing teams need to work with a number of partners including health and social care teams, teachers and youth workers to deliver the evidence based public health interventions as outlined in the Healthy Child Programme (5-19), and using the core principles of Making Every Contact Count for intelligent, opportunistic interventions.

4. Scope

This guidance covers maintained schools and academies and includes child health surveillance, health promotion, health protection and health improvement and support outlined in the Healthy Child Programme 5-19 and includes:

- The role of school nursing in transition for school-aged children, for example transition between health visiting and school nursing, and into adult services;
- The role of school nursing and its contribution to safeguarding;
- The role of the school nurse in supporting vulnerable children and those not in school, e.g. Children in Care, young carers, home educated or young offenders;
- The support offered as part of the troubled families agenda;

The extended immunisation and vaccination programme will need to be considered by local commissioners from local authorities, Directors of Public Health and Area Teams to ensure synergy between immunisation delivery and public health provision. There is an opportunity through joint commissioning and partnership working within Area Teams to strengthen the school nursing workforce to increase both the health protection and public health input for children and young people through co-ordinated commissioning.

Arrangements for delivery of services in independent schools and further education settings need to be agreed and determined locally.

4.1 Aims and objectives of the service

School nurses and their teams use their **autonomy, clinical skills and professional judgment** to improve the **health and wellbeing of children and young people** and **reduce health inequalities.** Thus ensuring all children and young people receive the full service offer (HCP 5-19), including universal access and early identification of complex needs from school entry, with timely access to specialist services, by:

- Taking the lead in developing effective partnerships and acting as advocate to deliver change to support improvements in health and wellbeing of school aged children;
- Ensuring children have a smooth transition into school and throughout all transition phases in life, building on the early years support[16] to continue to lay down the foundations for healthy lifestyles which will prepare them for adulthood and to ensure they are ready to learn;
- Ensuring synergy between services provided by the health visiting team and recognising the contribution of key partners, for example, children's services and education providers to support school readiness and reducing school absences through health related issues;
- Working in partnership with local communities to build community capacity, demonstrating added value, utilising asset-based approaches, best use of resources and outcomes;

[16] Healthy Child Programme: pregnancy and the first five years of life, Department of Health and Department for Children, Schools and Families, 2009

- Working in partnership with other professionals, including for example, school leaders, teachers and youth services to support children and young people to become healthy decision-makers in lifestyle choices, particularly in relation to: physical activity and healthy eating, emotional well-being, smoking, sexual health, alcohol and substance misuse. Particular attention should be paid to the vulnerable children who experience worst health outcomes, such as Children in Care, NEET, young offenders, children with disabilities and young carers;
- Supporting children, young people and families to navigate the health and social care services to ensure timely access and support;
- Ensuring timely action that focuses services so that the outcomes of the disadvantaged or most at risk children and families are not compromised by poor early experiences and environment;
- Ensuring the service takes a whole system approach to delivery of child centred evidence based practice, prevention and incorporating early intervention and prevention to achieve shared health and social wellbeing outcomes for children, young people and families;
- Promoting emotional well-being through the school-aged years working alongside children and young people to support those with emotional and mental health difficulties and referring to CAMHS where appropriate;
- Ensuring care and support helps to keep children and young people healthy and safe within their community, providing seamless, high quality, accessible and comprehensive service, promoting social inclusion and equality and respecting diversity;
- Ensuring early identification of children, young people and families where additional evidence based preventive programmes will promote and protect health in an effort to reduce the risk of poor future health and wellbeing;
- Working in partnership with primary and secondary care colleagues to support children and young people with long term conditions or complex needs and facilitate appropriate management of health conditions to ensure hospital admissions are kept to a minimum;
- Ensuring providers offer a service delivery model that is based upon a holistic full service offer of care in line with '*Getting it Right for Children and Families; the School Nursing Development Programme' (DH March 2011).*

4.2 Service Description

Delivery by school nursing services: the universal Offer – the healthy child programme (5-19)

Clearly stated in Healthy Lives Healthy People: Our Strategy for Public Health England Nov 2010 under *"Developing Well" 3.22 p 38.*

"Responding to local need, the school nursing service will work with other professionals to support schools in developing health reviews at school entry and key transitions, managing pupils' wellbeing, medical and long-term condition needs and developing schools as health-promoting environments. The Department of Health is developing a new vision for school nurses, reflecting their broad public health role in the school community".

Some elements of the Healthy Child Programme require clinical and specialist public health nursing, whilst other elements could be delivered by partners and by using skill mix, with qualified school nurses taking leadership. The school nursing workforce is relatively small and cannot deliver the extensive Healthy Child Programme in isolation. It is therefore important that the role of school nurses' and partners' contribution needs to be clearly defined locally and with robust arrangements in place to support multi-agency working.

The universal elements of the Healthy Child Programme will be predominately delivered by the school nursing team in a way that is most appropriate to meet local health needs and across a range of settings with a clear focus on school-based delivery, but will include other community settings as determined locally, for example, youth centres and community centres.

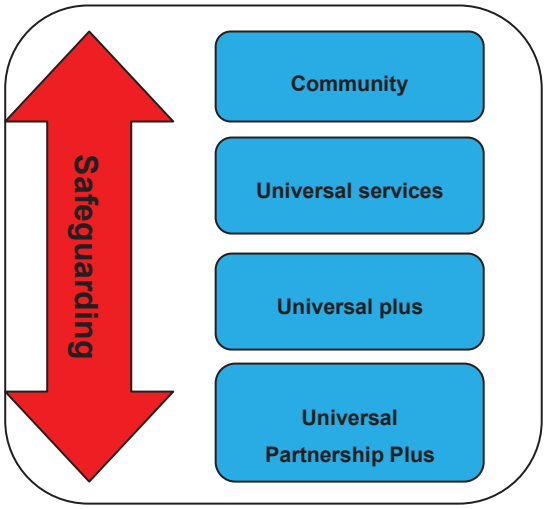
The School Nursing Service (5-19) will:

- Lead and co-ordinate local delivery of the **Healthy Child Programme 5-19** requirements and use the **school nurse vision** as a framework to support delivery;
- Provide an **integrated Public Health Nursing Service** linked to children's centres, general practice and education settings by having locality teams and nominated leads known to the stakeholders, including a named school nurse for every education setting;
- Deliver the universal Healthy Child Programme through assessment of need by appropriately qualified staff, **health promotion advice, screening and surveillance, engagement in health education programmes,** involvement in key public health priority interventions for adults and communities, interventions as specified within the Healthy Child Programme;
- Deliver Public Health interventions support to school-aged **children and young people** and to keep children safe;
- Work with school leaders and school improvement services to identify population health needs;
- Undertake joint visits with other professionals in **response to contact from families**, where appropriate;
- Ensure there is a clear protocol of **addressing the health needs of priority groups** where the service will be maintained and preventing inconsistency ;
- Ensure and be able to evidence that the experience and **involvement of families, carers and childre**n will be taken into account to inform service delivery and improvement;
- Champion and advocate culturally sensitive and non-discriminatory services which promote **social inclusion, dignity and respect;**
- Build on **resilience, strengths and protective factors** to improve autonomy and self- efficacy based on best evidence of child and adolescent development, recognizing the context of family life and how to influence the family to support the outcomes for children;
- Build **personal and family responsibility**, laying the foundation for an independent life;
- Demonstrate the **impact of the service** provided through **improved outcomes** and service user feedback.

The school nursing service provides public health, social and emotional wellbeing and interventions at 4 levels. Figure 1 below shows what this will mean for children, young people and families:

Figure 1 The vision and model for school nursing

An opportunity for school nurses to re-claim their role as Leaders and deliverers of public health to school aged children



Your Community describes a range of health services (including GP and community services) for children and young people and their families. School nurses will be involved in developing and providing these and making sure you know about them.
Universal services from your school nurse team provides the Healthy Child Programme (5-19) to ensure a healthy start for every child. This includes promoting good health, for example through education and health checks; protecting health e.g. by immunisation; and identifying problems early
Universal Plus provides a swift response from your school nurse service when you need specific expert help which might be identified through a health check or through providing accessible services where you can go with concerns. This could include managing long term health needs and additional health needs, reassurance about a health worry, advice on sexual health, and support for emotional and mental wellbeing
Universal Partnership Plus delivers ongoing support by your school nursing team as part of a range of local services working together and with you/your family to deal with more complex problems over a longer period of time

Level 1 community offer: to provide advice to all school-aged children and their families with the local community (5-19yrs), through maximising family support and the development of community resources with the involvement of community and voluntary resources.

Level 2 universal offer: Working in partnership with children, young people and families to lead and deliver the healthy child programme (5-19) working with health visitors to programme a seamless transition upon school entry.

Level 3 universal plus offer: to identify vulnerable children, young people and families, provide and co-ordinate tailored packages of support, including emotional health and wellbeing, safeguarding, children and young people at risk with poor outcomes and with additional or complex health needs.

Level 4 universal partnership plus offer: to work in partnership with partner agencies in the provision of intensive and multi-agency targeted packages of support where additional health needs are identified.

School nurses have a crucial role in leading, coordinating and delivering the Healthy Child Programme (5-19). The school nursing team provides clinical expertise and will work across a range of setting and organisations including education services, general practice, secondary care and children's services

Health Promotion:

- Promoting health and wellbeing;
- Supporting accident prevention and reducing risk taking behaviours;
- Contributing to Personal, Social and Health Education (PSHE).

Identifying individual and population health needs:

- Assessing the child's, young person's and family's strengths, needs and risks;
- Assessing physical health, growth and development and immunisation status;
- Leading, co-ordinating and delivering the National Child Measurement Programme and associated interventions and referrals identified;
- Developing school health profiles and working with school health improvement services to address needs;
- Identification of health needs through individual health needs assessment**;**
- Providing children, young people and parents/carers the opportunity to discuss their health concerns and aspirations;
- Identifying any mental or emotional health issues;
- Ensuring that appropriate support is available to meet health needs such as speech, language and communication;
- Undertaking recommended health assessment and reviews including;
    - Using reception/Year 1 (age 4–5) – school entry assessment (transition from 0–5 HCP (*Healthy Child Programme: Pregnancy and the first five years of life* – DH/DCSF, 2009c))/school entry questionnaire;
    - Providing Year 6/7 (age 10–12) – assessment at transition from primary to secondary school;
    - Supporting mid-teens reviews, when young people are embarking on the next transition stage;
- Working with schools to identify support for children with additional health needs.

The **Children and Families Bill** is currently going through the legislative process and is anticipated to receive Royal assent soon. When it becomes law, a new section of the, then, Children and Families Act will provide that governing bodies must make arrangements for supporting pupils at school with medical conditions. The school nursing service will contribute to identifying support to schools as they take on this new statutory responsibility.

Health protection:

- Identifying and reducing barriers to high coverage for all childhood immunisations in order to prevent serious communicable disease, particularly targeted at vulnerable groups;
- Leading, coordinating and delivering screening programmes including;

    - Chlamydia screening
    - Hearing and vision, working with optometrists and audiologists
- Emergency planning, including outbreak response in schools.

Safeguarding:

- Providing universal public health interventions and preventative measures to reduce risk;
- Working in partnership with other key stakeholders to safeguard and protect children and young people;
- Working collaboratively to support children and young people where there are identified health needs, or where they are in the child protection system, providing therapeutic public health interventions for the child and family and referring children and families to specialist medical support where appropriate;
- Working together to provide support for vulnerable groups, including Children in Care, young carers, children with disabilities, NEET and young offenders;
- Working collaboratively to ensure there is clarity regarding respective roles and responsibilities of appropriate health as identified within local protocols and policies in line with Working Together to safeguard Children[17] and using the Safeguarding Pathway for health visitors and school nurses[18] to provide clarity on roles and responsibilities;
- Supporting safeguarding and access and contribution to targeted family support, including active engagement in the Troubled Families Programme.

Supporting children, young people and families:

- Ensuring that children, young people and families receive support that is appropriate for their needs with the most vulnerable families receiving interventions and coordinated integrated support, including support for Children in Care, children with disabilities, NEET and young offenders;
- Supporting the development and strengthening key interfaces across organisations, practitioners, children, young people and families, and their local communities;
- Ensuring children not in employment, education or training, or children educated at home receive the universal offer.

Using the evidence:

- Service delivery must be underpinned by strong evidence and standards, with regular reviews to determine impact. The Healthy Child Programme schedule includes a number of evidence based preventative interventions, programmes and services.
- Locally there should be an agreed standard set of outcomes and evidence based

[17] https://www.gov.uk/government/publications/working-together-to-safeguard-children

[18] http://media.dh.gov.uk/network/387/files/2012/11/SAFEGUARDING_ENHANCING-PROFESSIONAL-GUIDANCE.pdf

practice which focuses on improving children's health and social wellbeing, whilst adding value.

- Providers will work with commissioners, local authority partners, local safeguarding and children's boards, health and wellbeing boards and clinical commissioning groups, to determine which services are offered locally and by whom.

4.3 Population covered

Careful consideration needs to be given to geographic coverage and boundaries. All children and young people and their families (5-19) who are resident in the local authority should receive the Healthy Child Programme. There may be some local variation regarding boundaries therefore reciprical arrangements need to be in place to ensure children and young people receive the best support available regardless of where they live.

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) of the child or young person must take precedent over any boundary discrepancies or disagreements Clarity needs to be provided regarding the provision for children not in education and how the service will support young people in further education settings

Data collection will enable reports on activity for both the GP registered and the school populations

4.4 Services and pathways

The role of school nursing teams has not always been clear or consistent across local areas. The model illustrates the contribution and leadership role of school nurses and their teams in supporting children and young people, and the importance of partnership approaches. The Department of Health has developed a suite of professional guidance and pathways to support delivery locally and offer clarity around roles and responsibilities for school nursing teams and key partner agencies[19]. The pathways will be of particular interest to commissioners and providers. The pathways include:
Published pathways:

- Safeguarding
- Transition from health visiting to school nursing
- Youth Justice
- Domestic abuse
- Emotional Health and Wellbeing
- Young Carers
- Sexual Health

Further pathways will be published in 2014 and will include:

[19] http://vivbennett.dh.gov.uk/products/

- Supporting children with complex and additional health needs
- Child Sexual Exploitation
- The Health Needs of Looked After Children
- Healthy Lifestyles and Physical Activity
- Transition across the life course (0-19)

4.5 Service Integration

As a preventative, early intervention and surveillance programme, the Healthy Child Programme relies on the following systems which need to be established locally:

- Joint planning and monitoring of child health outcomes and the Healthy Child Programme (5-19), delivery with local authorities (social care, early years and public health) and general practice;
- Supporting transition from Health Visiting services to ensure seamless delivery of services from 0-19 years and into adulthood;
- Integrated pathways of care with education, school health and other services such as those for disabled children;
- Referral pathways to other secondary care services that address identified needs, including speech and language therapy, CAMHS, NHS safeguarding supervision and advice, primary care, secondary care, smoking cessation and contraception services and weight management;
- Referral pathways to non-NHS services, including safeguarding, social care, education and parenting support;
- Information sharing agreements with wider health and local authority services;
- Use of electronic records and implementation of integrated systems across partners;
- Linkage to wider council led services and professional groups e.g. housing and adult social care. A number of tools are available to help providers and commissioners to enhance and extend joint working practices and improve outcomes for children and their families including the Chimat Health of school-aged children hub[20].

4.6 Response time and prioritisation

It is good practice for commissioners to work with providers to ensure that:

a. The four levels of service delivery and care pathways are to be provided in full.
b. All referrals from whatever source (including children, young people and families transferring in) will receive a response to the referrer within 5 working days, with contact made with the child, young person or family within 10 working days.
c. Urgent referrals, including all safeguarding referrals, must receive a same day or next working day response to the referrer and contact within two working days.
d. As a child approaches school entry, transition to the local school nursing service

[20] http://www.chimat.org.uk/schoolhealth

will be initiated in accordance with local policy. Similarly school nursing teams will work with adult services to ensure smooth transition in to adult services.

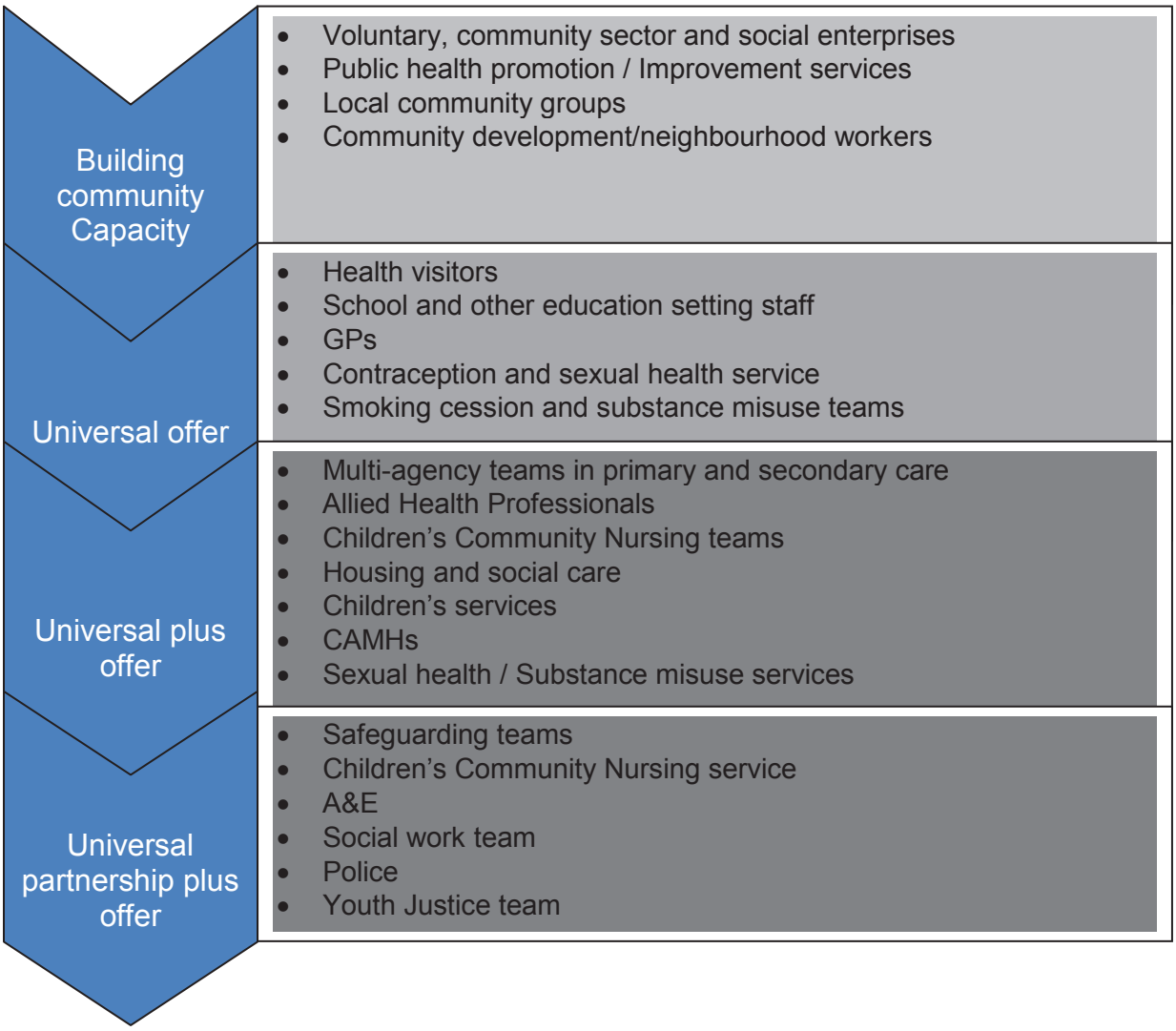
e. Where school nurses are responsible for undertaking Children in Care / Looked After Children Health Assessment/ Review and care plans, these must be done to the national standards and within the statutory timeframe.
f. Where a child moves out-of-area the School nursing service must ensure that the child's health records are transferred to the school nursing service in the new area within 2 weeks of notification. Direct contact must be made to handover all child protection cases. Systems should be in place to assess the risk to children whose whereabouts are unknown.

4.7 Acceptance and inclusion criteria

The service must ensure equal access for all children 5-19yrs and their families, regardless of disability, gender reassignment, marriage and civil partnership, sex or sexual orientation, race - this includes ethnic or national origins, colour or nationality, religion, belief or lack of belief.

4.8 Interdependencies – a whole system approach

The provider must establish good working relationships with all local key partners outlined below



Consideration should also be given to ensuring:

- School nursing representation on the **Health and Well-being Board** and Children's Trust and develop services in line with the Board/Trust's priorities.
- An **area-based** school nursing service structured in line with local children's services, working together to deliver integrated services for children and their families, with a focus on prevention, promotion and early intervention.
- As a minimum, a named school nurse for **every education setting** identified as having needs for Universal Plus/ Partnership Plus.
- A named school nurse linked to each **GP practice** and facilitate an agreed schedule of regular contact meetings for referrals and collaborative service delivery

- A named school nurses on each school management advisory board to:-
    a. Work in direct partnership with schools to provide improved access and delivery of the Healthy Child Programme and, through this, the health and wellbeing core offer.
    b. Support education services in their delivery of health improvements to improve outcomes for children, young people and their families.
    c. Promote and describe the wide range of support that children and their families are entitled to, and, as part of that process, encourage children and young people to access the service
    d. Promote integrated approach to improving child and family health locally including leading partnerships with schools and other partner agencies including social care
- Service user engagement needs to be established in the design, performance monitoring and evaluation of provision.

5. Applicable service standards

5.1 Applicable national standards

Key NICE public health guidance includes:

- PH3 – Prevention of sexually transmitted infections and under 18 conceptions (February 2007)
- PH4 – Interventions to reduce substance misuse amongst vulnerable young people (March 2007)
- PH6 - Behaviour change at population, community and individual level (Oct 2007)
- PH7 – School based interventions on alcohol (November 2007)
- PH8 – Physical activity and the environment (January 2008)
- PH9 - Community engagement (July 2010)
- PH11 - Maternal and child nutrition (March 2008)
- PH12 - Social and emotional wellbeing in primary education (March 2008)
- PH14 – Preventing the uptake of smoking by children and young people (July 2008)
- PH17 - Promoting physical activity for children and young people (Jan 2009)
- PH20 – Social and emotional wellbeing in secondary education (September 2009)
- PH21 - Differences in uptake in immunisations (Sept 2009)
- PH23 – School based interventions to prevent smoking (February 2010)
- PH28 - Looked-after children and young people: Promoting the quality of life of looked-after children and young people (October 2010)
- PH29 - Strategies to prevent unintentional injuries among children and young people aged under 15 (November 2010)
- PH30 – Preventing unintentional injuries among under-15s in the home

(November 2012)

- PH31- Preventing unintentional road injuries among under-15s: road design (November 2010)
- PH41 – Walking and cycling (November 2012)
- PH42 – Obesity – working with local communities (November 2012)
- PH47 – Managing overweight and obesity among children and young people (October 2013)
- QS31 – Health and wellbeing of looked-after children and young people: NICE support for commissioning (April 2013)
- CG89 - When to Suspect Child Maltreatment (July 2009)
- Evidence update 29, Strategies to prevent unintentional injury among children and young people aged under 15 (March 2013)

5.2 Applicable local standards

5.2.1 Supervision

The Provider will develop and maintain a supervision policy and ensure that all school nursing staff access clinical and safeguarding supervision.

Supervision should be provided by individuals with the ability to:

- Create a learning environment within which the team can develop clinical skills and strategies to support vulnerable children, young people and their families. This will include experiential and active learning methods;
- Use strength based, solution focused strategies and motivational interviewing skills to enable school nurses and their teams to work in a consistently safe way utilising the full scope of their authority;
- Provide constructive feedback to school nurses and their teams using advanced communication skills to facilitate reflective supervision;
- Manage strong emotions, sensitive issues and undertake courageous conversations, particularly in circumstances where school nurse support in the Universal Partnership Plus Offer is not able to address concerns for vulnerable children, young people and families;
- Provide guidance on the interpretation of principles and policies to school nursing teams.
- School nurses and their teams should receive a minimum of three-monthly **safeguarding supervision** of their most vulnerable caseload. This will include children on a child protection plan, those who are 'looked-after' at home and those children where there is significant concern. Safeguarding supervision should be provided by colleagues with expert knowledge of child protection. The safeguarding pathway[21] will be of particular interest to providers to support supervision.

[21] http://media.dh.gov.uk/network/387/files/2012/11/SAFEGUARDING_ENHANCING-PROFESSIONAL-GUIDANCE.pdf

5.3 Record keeping, data collection and information sharing

In line with clause 21 Service User Records and clause 27 Data Protection and Freedom of Information, providers will ensure that robust systems are in place to meet the legal requirements of the Data Protection Act 1998 and safeguarding of personal data at all times.

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 social care and the police to enable effective holistic services to be provided to children and their families.

Appropriate **electronic records** will be kept in the CHIS to enable data collection to support the delivery, review and performance management of services.

Providers will ensure that all staff have access to information sharing guidance including sharing information to safeguard or protect children, improve co-ordination and communication between services.

5.4 Materials, tools, equipment and other technical requirements

School nurses and their teams should utilise the Department of Health professional pathways and facts sheets to support delivery, these can be accessed at http://vivbennett.dh.gov.uk/products/ School nurses and their teams will require access to:

- Validated tools for assessing development and identifying health needs;
- IT systems and mobile technology for recording interventions and outcomes in the CHIS;
- Access to equipment to support agile working e.g. mobile phones and tablets. Areas should link into the **nursing technology fund** to support this[22];
- Equipment for measuring children's weight and height;
- Use of social networking and other web based tools to enable workforce training, professional networking and information and support for children, young people and families;
- Health promotion materials.

5.5. Applicable quality requirements

The provider and the commissioner should work together to identify opportunities for leaner working and/or cost and efficiency savings at each quarterly review. This is likely to include considering best use of modern technology and appropriate use of support staff within the school nursing team and wider workforce.

[22] http://www.england.nhs.uk/ourwork/tsd/sst/nursing-technology-fund/

The provider should highlight where there is an absence of local services to refer families on to so that future commissioning plans can include mitigation for/ provision of these. This is particularly urgent where need is identified but NICE guidance pathways are truncated at the onwards referral stage because local services do not currently exist.

6. Location of provider premise

The service should be available and accessible at times and locations that meet the needs of children and young people. The primary location for delivery will be school or education settings. However, where possible, children and young people should be offered a choice of locations which best meets their needs e.g. community centres, youth groups, general practice and, where appropriate, at home.

An appropriate level of service should be maintained throughout the year, including during school holidays. An example of a service planner for the year can be found in Appendix 3. This can be achieved, for example, by providing online, text or telephone support. Services need to be responsive and flexible e.g. early mornings, lunchtimes, after school, evening and weekends and should use technology and innovation to ensure that they reach children and young people.

Specific details of location are to be agreed locally and should be based on feedback from key stakeholders, children and young people. Reviews should be undertaken by the provider regularly to ensure they are suitable for local need and meets the quality indicators.

Acknowledgements

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Appendix 1

The school nursing contribution to the Healthy Child Programme (5-19)

Support for children and families, school nurses leading and working with partners to ensure seamless delivery of the Healthy Child Programme (5-19).

Review	Description	Delivered by	Commissioned by
Health promotion in: **prevention of unintentional injuries and accidents**	A range of activities to minimise risk	A/E and school nursing teams	CCGs and Local Authorities
Health development review	**School entry review** to identify targeted support to full health and social care assessment of needs, risks and choices Health Visiting to School Nursing transition. Identifying the needs of children with additional or complex needs and referring to appropriate services Health assessment Year 6/7 review Mid-teen health review	Health Visiting and School Nursing teams School nurses and schools	Local Authorities and NHS England Local Authorities and Clinical Commissioning Groups
Healthy weight	National Child Measurement Programme, plus interventions on healthy weight and exercise	School Nursing teams	Local Authorities
Targeted support	Looked After Children Young offenders Supporting and training for complex needs Support for young carers' health needs Support for young people at risk of abuse or violence including domestic violence and child sexual exploitation	School Nursing teams and Children's services	Local Authorities and CCGs Education providers / CCGs Local Authorities

Sexual health and contraception	Support to reduce teenage conceptions and reduce STIs including; Puberty sessions, condom distribution; Pregnancy testing, enhanced service to prescribe LARC, emergency hormonal contraception, STI testing	School Nursing teams or Contraceptive and sexual health services	Local Authorities
Drugs, alcohol and tobacco	Drug and alcohol misuse, smoking cessation	School nursing teams and local substance misuse teams	Local Authorities
Emotional wellbeing	Supporting the emotional and health wellbeing early help offer Specialist support	School Nursing teams CAMHs	Local Authorities CCGs
Safeguarding	Supporting children, young people and families through integrated working	School Nursing teams	Local Authorities
Screening	Hearing and vision	Optometrists and audiologists	Local Authorities
Immunisation	Reviewing immunisation and vaccine status and providing; DTP / Men C, HPV, school leaver booster, childhood flu	Immunisation teams or School nurse teams	NHS England / Area teams

Appendix 2

Locally defined strategies to achieve outcomes

School nursing services will contribute to year on year improvements in:

Outcomes	Suggested strategies and data sources
Improving access to public health and early intervention	• School health profile completed, data analysed and identification of agreed priorities for each school or community setting with matching allocation of services to meet identified needs. Number of interventions/contacts with children and young people including vulnerable young people and young people or hard to reach groups • Numbers of young people supported who are within: 1. Universal 2. Universal plus 3. Universal partnership plus
Reducing the prevalence of obesity in school aged children and exercising clinical decision making to support evidence based individual packages of support as appropriate	• Brief Interventions[23] (see definition below) • Active referral and monitoring to Family Weight Management service • Whole school approach to healthy eating within targeted schools (see other guidance on whole school approaches) • Supporting and promoting physical activity
Building capacity e.g. supporting health promoting education and other settings	• Defined delivery options to support the community offer and partnership approaches with community and third sector organisation to ensure delivery
Promoting good mental health and wellbeing, supporting early intervention in mental ill health, and identify and help children and young people, and their families, who need support with their emotional or mental health, including referring for primary care and/or specialist support where appropriate	• Care pathways clearly defined with other organisations and agencies providing level 1,2 and or 3 Mental wellbeing services and other primary care providers • Early identification and access for C&YP showing early signs of emotional distress • Active referral and monitoring to CAMHs • Support schools to adopt a comprehensive 'whole-school' approach to social and emotional wellbeing[24]

[23] By this we mean a conversation that aims to give people the tools to change attitudes and handle underlying problems. It should include assessing an individual's motivation to change, explaining the consequences of behaviours, giving advice to change behaviour, providing a range of options to change, encouraging self efficacy, agreeing steps on the journey and offering follow up.

Promoting emotional wellbeing of looked after children and vulnerable children	• Completion of annual health assessments and anonymised reporting of issues / concerns • Contribution to in care reviews • Early identification of health needs of young carers and support provided tailored to individual need • Identification of health needs of young offenders and sign posting to appropriate services
Improving readiness for school both at primary and secondary	• Handover between health visiting and school nursing • Identification of continence issues and referral to appropriate services • Puberty sessions in schools • Identified tailored packages of care for children with additional or complex health needs
Contributing to a reduction in school absences and supporting educational attainment	• Working with schools to identify persistent absentees due to health and wellbeing including young carers • Delivering support for health and wellbeing to improve attendance
Increasing population immunisation and vaccination cover	• Working with Area Teams and Immunisation providers to achieve 90% coverage for vaccination programmes in all schools • Working with Area Teams and Immunisation providers to implement recovery plans in schools where this is not achieved
Contributing to a reduction in dental decay and promoting oral health	• Brief Interventions • Encourage registration with a dentist • Include within whole school approach to healthy eating within targeted schools

[24] Taken from NICE guidance Social and emotional wellbeing in primary education (PH12) - Develop and agree arrangements as to ensure all primary schools adopt a comprehensive, 'whole school' approach to children's social and emotional wellbeing. All primary schools should: create an ethos and conditions that support positive behaviours for learning and for successful relationships, provide an emotionally secure and safe environment that prevents any form of bullying or violence, support all pupils and, where appropriate, their parents or carers (including adults with responsibility for looked after children), provide specific help for those children most at risk (or already showing signs) of social, emotional and behavioural problems, offer teachers and practitioners in schools training and support in how to develop children's social, emotional and psychological wellbeing.

Contributing to a reduction in the number of children with continence problems	• Identify need on school entry • Sign posting and referral to appropriate providers commissioned by CCGs
Contributing to a reduction in hospital admissions due to unintentional or deliberate injuries in under 18 year olds	• Brief Interventions with parents, children and young people • Awareness raising on injury prevention and promotion of child safety • Actively follow-up A&E attendances and anonymised reporting of issues to offer support and to determine trends • Identify vulnerable families & refer into support services e.g. parenting programmes • Education programmes in schools and communities
Contributing to a reduction in under 18 conception rates and supporting the diagnosis of chlamydia in 15-24 year olds	• Care pathways clearly defined with other organisations and agencies providing level 1,2 and or 3 sexual health services and other primary care providers • Brief Interventions including all related risk-taking behaviour e.g. alcohol and unprotected sex • Active participation in development & delivery of PSHE • Active referral and monitoring to sexual health services • Active promotion and where appropriate prescribing of LARC • Access to EHC and pregnancy testing • Active promotion of national Chlamydia screening programme in all settings
Contributing to a reduction in smoking prevalence in young people	• Brief Interventions • Referrals to appropriate Stop Smoking service • Nicotine Replacement Treatment prescribing • Whole school approach to smoke-free policy within targeted schools[25]

[25] Taken from NICE Guidance School-base interventions to prevent smoking (PH23) - Develop a whole-school or organisation-wide smoke free policy in consultation with young people and staff. This should include smoking prevention activities and staff training and development. Ensure the policy forms part of the wider healthy school or healthy further education strategy on wellbeing, sex and relationships education, drug

Contributing to a reduction in alcohol and drug misuse	• Brief interventions • Use age-specific screening & assessment tools to identify vulnerable young people & refer into services • Establish referral pathways with specialist young people's substance misuse treatment services • Ensure delivery of drug and alcohol education within science & PHSE tailored for primary, secondary and college ages as part of a whole-school, approach to alcohol and drug harm reduction, including parents.

education and behaviour. Apply the policy to everyone using the premises (grounds as well as buildings), for any purpose, at any time. Do not allow any areas in the grounds to be designated for smoking (with the exception of caretakers' homes, as specified by law). Widely publicise the policy and ensure it is easily accessible so that everyone using the premises is aware of its content. (This includes making a printed version available.) Ensure the policy supports smoking cessation in addition to prevention, by making information on local NHS Stop Smoking Services easily available to staff and students. This should include details on the type of help available, when and where, and how to access the services.

Appendix 3

Service planner for the year

Time specific

Focussed time

Flexible

		Delivery detail	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Prevention and early intervention	**Health inequalities**	Supporting delivery of: • SRE / PSHE • Safety e.g. road safety	**Sun safety**					**Road safety – early travel**						
		Identification of additional needs and support for: • Young carers		**Training**					**Training**					
		• Health needs of LAC												
		• Children with SEN												
		• Children with complex needs												
		• Families where there is domestic abuse												
		• Young people in contact with youth justice												

		Delivery Detail	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Prevention and early intervention	**Emotional health and wellbeing**	• Targeted mental health	**Support for exam stress**											
		• Support across the tiers												
		• Bullying							**Assembly**					
	Healthy Weight	• NCMP reception	**Data input**					**School roll list**				**Growth monitoring**		**Letters to parents**
		• NCMP Year 6	**Data input**					**School roll list**	**Data input**					
		• Healthy weight, nutritional advice and physical activity – signposting and parental support							**Year 6**			**Reception**		
	Long term conditions and disabilities	• Care planning												
		• Training for schools												
		• Support for specific needs, e.g. enuresis												
		• Review												

		Delivery detail	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Prevention and early intervention	Teenage pregnancy prevention and sexual health	Contraceptive and sexual health services: • SRE												
		• Condom distribution												
		• Sexual health and contraceptive advice												
		• Pregnancy testing												
		• EHC												
		• LARC												
		• Support for teen parents												
	Drugs, alcohol and tobacco	• Drug screening												
		• Drug and alcohol misuse												
		• Smoking cessation												

		Delivery detail	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Safeguarding	Child protection and safeguarding	• Review				Review and follow up								
		• Therapeutic support												
		• Building resilience												
		• Support for awareness of domestic violence												
Health protection	Health development and review	• Health profiling in schools												
		• Health visitor to school nurse transition / handover												
		• Health assessment – school entry												
		• Year 6/7 health review												
	Screening	• Hearing and vision	Data input					School roll list	Data input					
		• Chlamydia												
	Immunisation	• HPV				Maintain clinic								
		• School leaver booster												
		• MEN C												
		• Childhood flu			Publicity and prep	Publicity and prep	Consent	Delivery	Delivery	Delivery	Publicity and prep			

		Delivery detail	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Signposting	Communication and information	• General												
		• Web based												
		• Text messaging												
		• Social media												
		• Parents evenings												
		• Assemblies		**Stress busting**										
		• Building community capacity												

Department of Health

Local Government Association

Lead Member for Children's Services briefing on School Health Service

This briefing is aimed at Lead Members for Children's Services (LMCS). It provides an overview of the School Health Service and shares top tips to help LMCS think about how they can use the School Health services to deliver better health outcomes for 5-19 year olds.

A new role for local authorities

From April 2013, local authorities are statutorily responsible for delivering and commissioning public health services for children and young people aged 5-19. This will include providing prevention and early intervention services, delivering the Healthy Child Programme and addressing key public health issues such as sexual health, emotional health and wellbeing issues, obesity, drug, alcohol and tobacco misuse.

What is the Healthy Child Programme 5-19?

- A national public health programme for children and young people from 5-19
- Provides a robust evidence based framework and sets out good practice for prevention and early intervention services
- Identifies the school nursing service as crucial to the effective delivery of the Healthy Child Programme
- Assists local areas to ensure services:
  - are based on a robust needs assessment
  - utilise effective practice and prioritise evidence based programmes
  - make best use of their workforce

What are the key public health issues for children?

- Bullying
- Emotional health and wellbeing
- Dental decay
- Obesity and weight management
- Teenage pregnancy
- Sexually Transmitted Infections
- Smoking
- Drug and alcohol misuse

Who are school nurses?

- Qualified nurses with specialist training in the public health needs of school aged children including sign posting and referring to other services where appropriate
- Lead and deliver the Healthy Child Programme (5-19)
- Equipped to work at community, family and individual levels
- Skilled in identifying issues and risks early, providing early intervention
- Work in a range of settings including mainstream education, faith schools, specialist services for looked after children, special schools and alternative education provision
- Support children with illness and disability to enable them to access education and recreation

Elected members play a key role in ensuring the health and social care needs of local school aged children and young people are met through services that are commissioned appropriately. School health services play a vital role in supporting children and young people. School nurses lead and deliver the Healthy Child Programme and work in partnership with other agencies to deliver school health locally. The school nursing offer provides Elected Members with a benchmark to assess and review the local services being provided by school nurses and to decide if they meet local children's and young people's health needs including those who are looked after.

How can the School Nursing Service help?

School nurses are responsible for delivering cost effective public health programmes or interventions to improve health outcomes for school aged children and young people (5-19yrs). This includes reducing childhood obesity, under 18 conception rates, prevalence of chlamydia and management of mental health disorders.

Health Visitors are responsible for input to children 0-5yrs and their family. Health visiting and school nursing services work together to ensure children, young people and families are supported. The school nursing service offers a structured approach to delivering the Healthy Child Programme (5-19), providing public health advice and ensuing the emphasis is on providing early help to children and young people from school nurses.

The school nursing team local service offer:

The 4 tiered service offer helps LMCS to understand what each level of support is.

- **Community**
  All communities have a range of health services (including GP and community services) for children and young people and their families. School nurses develop and provide these and make sure children and young people know about them.
- **Universal services**
  School nurses and their teams provide the Healthy Child Programme and public health services to ensure a healthy start for every child (e.g. immunisations, advice on healthy eating and weight management, health checks). They support children and parents to ensure access to a range of community services.
- **Universal plus**
  Gives children, young people and parents a swift response from your School Health Service when they need additional or specific expert help (e.g. with sexual health, mental health concerns, long-term conditions and additional health needs including asthma, diabetes, learning disabilities).
- **Universal partnership plus**
  Provides ongoing support by the school health team from a range of local services working together and with children and young people, to deal with more complex issues over a period of time, for example, support for children who may need specialist services including child and adolescent mental health services, looked after children, and young carers.

What is the Lead Member for Children's Services (LMCS) role?

LMCS have a key role in improving the health and wellbeing of school age children and young people. LMCS can ensure local school health services are led by school nursing services and delivered by working in partnership to achieve better outcomes for children, young people and families.

How to ensure the school nursing service is effective

1. GET INVOLVED

- Identify the key issues affecting the health and wellbeing of local children and young people including looked after children
- Use your local knowledge and influence to ensure the school health service led by school nurses is a core service
- Ensure other elected members are sufficiently briefed to understand the role of school health services
- Ensure the school health service is visible in strategic plans, supported by strong leadership and clear accountability

2. LISTEN AND SPEAK UP

- Ensure local commissioning and services are shaped by the views of local children, young people and parents
- Ensure there are joined up services for children 0-19yrs with health visitors and school nurses working together with other partners

3. HELP PARTNERS WORK TOGETHER

- Ensure partners including head teachers and governors work to support health services in schools
- Support and encourage multi-agency work and training

4. CHAMPION PROMOTION

- Ensure there are champions for school health within the council and Health and Wellbeing Board
- Champion the shift towards prevention and early intervention – the school health service is evidenced based in this approach

5. MAKE SURE SERVICES ARE EFFECTIVE

- Ensure the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy reflect the needs of school aged children
- Build in means of review and evaluation, build in an evidence base to measure improvements in health and wellbeing
- Drill beneath the data and have access to the views of frontline staff, partners and service users to be assured on quality and judge impact
- Direct resources towards delivering the most effective public health programmes

RESOURCES.

The School Nurse Vision and service offer. Department of Health (2012). *Getting it Right for Children, Young People and Families.* London: Department of Health
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_133352.pdf
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http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_108866.pdfBritish Youth Council (2011). *Our school nurse. Young people's views on the role of the school nurse*. London: British Youth Council. http://www.byc.org.uk/resource-download-log.aspx?doc=/media/75447/byc_school_nurse_report_web.pdf
Local Government Association public health resources www.local.gov.uk/health
Report of the Children and Young People's Health Outcomes Forum
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/156062/CYP-report.pdf.pdf
Improving Children and Young People's Health Outcomes: A system wide response
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/141430/9328-TSO-2900598-DH-SystemWideResponse.pdf.pdf

Department of Health

NHS England

Public Health England

NHS Health Education England

The National Health Visitor Plan:

progress to date and implementation 2013 onwards

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Foreword

The early years are critical in shaping health and wellbeing throughout life. Improving outcomes for children, families and communities, as well as creating services that provide better access and experience, are essential.

The purpose of the Health Visitor Programme, started in 2011, is to secure an extra 4,200 health visitors and transform the health visiting service across England by April 2015. Achieving this will help secure effective, sustainable services to support families to give all children the best start and to promote health and wellbeing in local communities.

We need to continue to build on the progress already made and ensure our organisations work together, with partners, the profession and people who use health visiting services to maintain momentum and manage the challenges ahead.

We are very pleased to be leading this work nationally. We place great importance on a 'healthy start' for all children and families, and each of our organisations have a clear priority to reduce inequalities and improve health outcomes for under fives and their families. We know the critical difference that health visitors can make in leading the Healthy Child Programme (HCP), the key universal, evidence based programme for improving the health and wellbeing of children, and in providing early intervention when families need extra help.

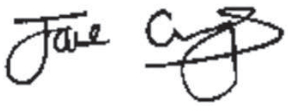
Health visitors have responded positively to the *Health Visitor Implementation Plan 2011-2015: A Call to Action*[1] published in 2011. By using the Early Implementer Sites (EIS) and applying new evidence, health visitors are leading change at the frontline providing high quality support for families and children. They are developing new services, creating strong partnerships and tackling population health issues to deliver better health outcomes. This would not have been possible without service providers and commissioners, higher education institutions, local government, Children's Centres and many other individuals and organisations supporting the programme.

Despite the achievements there is still a lot to be done to ensure we reduce variability in services and outcomes and deliver excellent services everywhere. This will need concerted and coordinated effort from national organisations, continued action locally and support from individuals to transform the service.

1 www.gov.uk/government/publications/health-visitor-implementation-plan-2011-to-2015

We look forward to working with the profession, local organisations and families and communities to deliver the national commitment and ensure there are sustainable transformed health visiting services which meet the needs of children and families up to and beyond 2015

Viv Bennett
Director of Nursing
Department of Health and Public Health England



Jane Cummings
Chief Nursing Officer for England

Dr. Lisa Bayliss-Pratt
Director of Nursing
Health Education England

Dr. Ann Hoskins
Director of Children, Young People and Families
Public Health England

Introduction

This document summarises progress so far, and roles and actions for the Health Visiting Programme 2013-2015, including ensuring the sustainability of health visiting services from 2015 onwards. It has been produced because, two years into the programme, we need to update the plan to build on the progress made so far and to identify how key partners will work together to take the necessary action to continue to expand the workforce and deliver the new health visiting service model.

This document is available at https://www.gov.uk/government/publications/health-visitor-vision. We will add material referred to in this document including links to action plans, programme governance information and supporting tools, learning programmes, case studies and practice guidance. These will be further added to during the remainder of the programme.

The Department of Health will continue to publish, with the input of partner organisations, quarterly reports on progress on delivering the health visiting commitment. NHS England and Health Education England will also publish regular reports on progress in delivering the health visiting commitment as part of their reporting against the mandate, and on progress with their health visiting delivery plan.

Background

The Coalition Government made a commitment in 2010 to increase the health visitor workforce by 4,200 full time equivalents (fte), and transform the health visiting service, by 2015. The Government remains firm in its resolve to meet that commitment. This is based on growing evidence[2] about the importance of the early years for developing emotional resilience and laying the foundations for good health and the role of health visitors in supporting families to achieve this.

> *"There is overwhelming evidence that tells us that the first few years in children's lives shape their future development, and influence how well children do at school, their ongoing health and wellbeing and their achievements later in life. In addition, it is widely acknowledged that a strong focus on the first few years of children's lives leads to huge economic, social and emotional benefits later on, both for individuals and for society as a whole."*
>
> Supporting Families in the Foundation Years, Department for Education & Department for Health, 2011[3]

The Healthy Child Programme (HCP)[4] is the key universal service for improving the health and wellbeing of children, through health and development reviews, health promotion, parenting support, screening and immunisation programmes. Its goals are to identify and treat problems early, help parents to care well for their children, change health behaviours and protect against preventable diseases. The programme is based on a systematic review of evidence and is expected to prevent problems in child health and development and contribute to a reduction in health inequalities.

As evidence for early intervention grows, health visitors in their role as leaders of the HCP, are vital to identifying needs and working with other services to ensure prompt preventative care is provided. As public health practitioners, health visitors also contribute to health needs analysis and work with local communities to improve health and reduce inequalities.

The expansion of the health visiting service is intended to:

- improve health and wellbeing outcomes for under-fives;
- reduce health inequalities;
- improve access to services; and,
- improve the experience of children and families.

2 www.gov.uk/government/uploads/system/uploads/attachment_data/file/127165/health-visiting-information-brochure.pdf.pdf

3 www.gov.uk/government/publications/supporting-families-in-the-foundation-years

4 www.gov.uk/government/publications/healthy-child-programme-pregnancy-and-the-first-5-years-of-life

The Health Visitor Programme is complemented by initiatives to facilitate an effective and broader impact on the health and wellbeing of 0–19 year olds, in particular:

- **Family Nurse Partnership (FNP)**[5] – FNP has the potential to transform the life chances of the most disadvantaged children and families in our society by offering more targeted support for the most disadvantaged young families. The number of places on the Family Nurse Partnership (FNP) will increase to 16,000 by 2015. FNP therefore enhances the health visiting service model. Work is taking place to share the learning from FNP with universal services and to test new practice and service models including group FNP.
- **School Nursing service vision**[6] – the service vision for school nursing sets an ambition that school nursing services will be visible, accessible and deliver universal public health, ensuring that there is early help and extra support available to children and young people at the times when they need it. Health visitors and school nurses work together to ensure an effective transition for children between the respective services.

5 www.fnp.nhs.uk

6 www.gov.uk/government/uploads/system/uploads/attachment_data/file/152212/dh_133352.pdf.pdf

Progress from 2011–13

The first phase of the programme (2011-13) halted and reversed the historical decline in the number of health visitors and training places with over 1,000 new health visitors now in the workforce. It has also readied the health visiting profession to play a lead role in shaping and delivering services. Early Implementer Sites[7] (EIS) were developed to lead the way and demonstrate how service transformation can be achieved.

The workforce

The **workforce has increased** from the May 2010 baseline of 8,092:

- there are now[8] 9,113 health visitors (fte) in post, an increase of 1,021 from the baseline. This is 71 fte or 1% below trajectory;
- in 2012/13, four times as many students began health visiting training compared to 2010/11;
- a successful marketing campaign attracted more applicants to health visiting training;
- this progress was due to strong partnership working with professional and regulatory bodies, higher education institutes, NHS Employers, and service commissioners and providers.

7 www.gov.uk/government/publications/celebrating-early-implementer-achievements-one-year-on

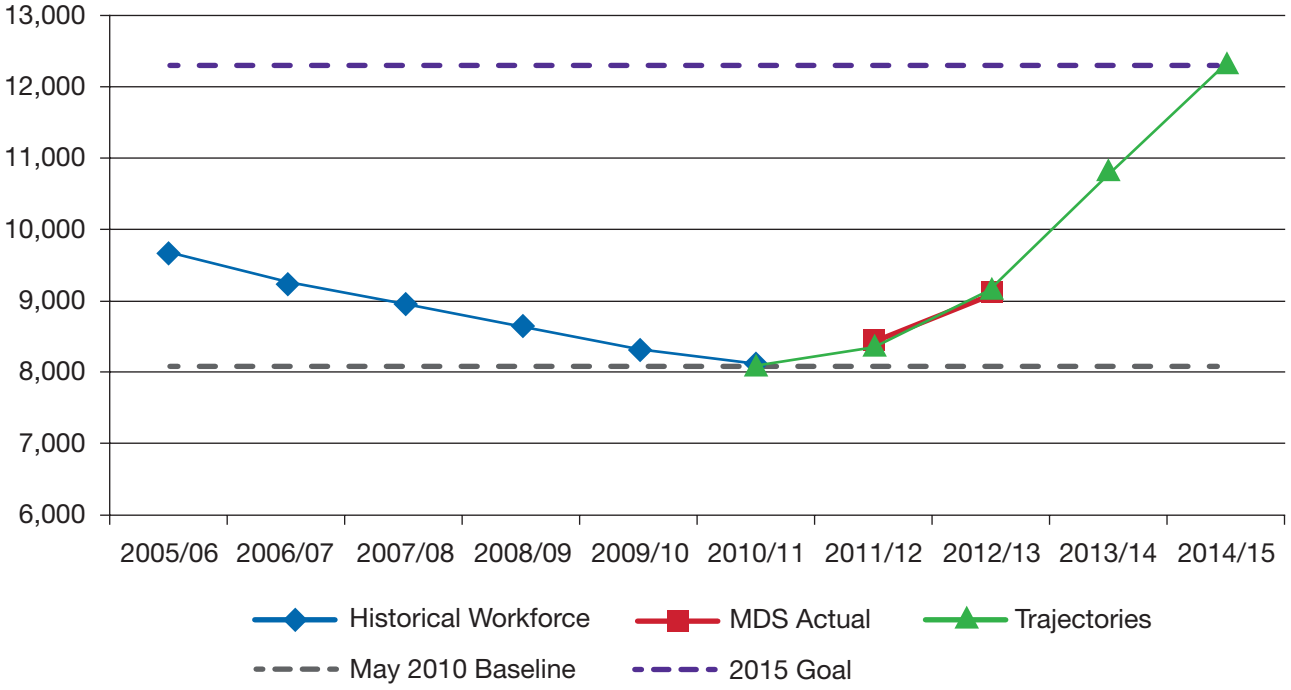
8 As at February 2013. Source: Monthly NHS Hospital and Community Health Service (HCHS) Workforce Statistics in England – February 2013 at http://www.hscic.gov.uk/catalogue/PUB10832

"As a newly qualified health visitor, I am respected, well supported, and my more experienced colleagues not only embrace my ideas and leadership but positively encourage them. I feel I have the opportunity to make a real difference to families and communities, as part of a large health visiting team and growing workforce."

Rachel Dent, Health Visitor

The chart overleaf shows historical health visitor workforce numbers, growth so far and the projected path to achieve the full growth of 4,200.

Health Visitor Workforce (FTE) with progress and future projections



1. Historic data from HSCIC Annual Workforce Census for 2005/06 to 2009/10 as at 30 September. 2010/11 data from HSCIC Monthly Workforce Publication May 2010.
2. MDS Actual from monthly HV MDS. 2012/13 position is as at February 2013.
3. Trajectories taken from 2011/12 and 2012/13 Operating Framework Planning submissions. 2012/13 trajectory is as at February 2013 (9,184 fte).

Service Transformation

Transformation of health visiting services is taking place, using the new service model – a framework for local commissioning and service design which is being embedded across the country. It has four components:

- 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.
- Universal: health visiting teams lead delivery of the Healthy Child Programme. 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.
- 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.
- Universal Partnership Plus: health visitors provide ongoing 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.

The Early Implementer Site Programme has been rolled out:

- 49 EISs are working to deliver a wide range of aspects of the new health visiting service model locally;

- the EISs spearheaded the development of services in new and innovative ways, particularly around:
  - preparing for parenthood and the 2–2½ year child review;
  - improved antenatal services;
  - increasing breast-feeding and immunisation rates;
  - parental confidence and improved information-sharing among practitioners and parents.
- a 'learn and share' event celebrated this work in February 2013, facilitating the exchange of knowledge and ideas;
- over 40 case studies from the EIS's have been published[9].

EIS Case Study: Raising the profile and duration of breastfeeding

Southern Health NHS Foundation Trust, Hampshire, has worked with health visiting teams, Children's Centres and maternity partners, to develop a number of interventions that raise the profile of breastfeeding and provide practical support. Initiatives include: promotion of venues that offer a warm welcome to breastfeeding, development of electronic resources for parents and GPs, and a two-day breastfeeding management course for health visitors and Children's Centre staff. Planned benefits are: increased duration of breastfeeding, consistency of knowledge and improved maternal wellbeing.

Professional leadership and mobilisation

Since the start of the programme **the health visiting profession has improved its skills base, leadership abilities and gained in confidence** as a result of a range of actions including:

- creating understanding and building support for the vision for health visiting through two accelerated learning events and 16 joint DH/CPHVA roadshows and regional events;
- improved professional development for health visitors for example through the Building Community Capacity (BCC) work-based e-learning module[10] to give health visitors the skills to make a wider community impact locally;
- increased opportunities for health visitors to train to be mentors or practice teachers;
- changes to health visitor curricula to better reflect changing service needs;
- published guidance[11] covering:
  - the midwifery to health visiting pathway;
  - the health visiting to school nursing pathway;
  - the maternal mental health pathway;
  - the practice teacher framework;
  - educating for a transformed health visiting service framework;
  - a personal and professional attributes tool;
  - health visitor career expectations in their first two years.

9 https://www.gov.uk/government/publications/health-visiting-programme-case-studies

10 www.e-lfh.org.uk/projects/building-community-capacity/introduction/

11 www.gov.uk/government/publications/health-visitor-information-pack

- establishing regional communities of practice to provide an opportunity for health visitors to share learning and best practice and hear about EIS developments;
- running share and learn events to more closely align early years staff and functions with health visiting work to improve outcomes for 0-5s;
- developing flexible models for teaching and mentoring students;
- advising on related initiatives such as the NHS Information Service for Parents[12].

The programme has also supported the establishment of the Institute of Health Visiting (www.ihv.org.uk) that is dedicated to developing and improving health visiting practice and aims to be a trusted source of professional research and standards.

12 www.nhs.uk/InformationServiceForParents/pages/home.aspx

The Health Visiting Programme – 2013 onwards

Delivering the increased workforce capacity and service transformation is challenging and requires organisations in the new health and care system to work together. This section sets out:

- the roles of different individuals and groups; and,
- actions and next steps

More detailed plans are being developed and will be available at https://www.gov.uk/government/publications/health-visitor-vision

Roles

Delivering the health visiting commitment and ensuring that increased capacity results in transformed services requires many individuals and organisations to continue the momentum for change and to work collaboratively on the challenge ahead. The major contributors and their roles are:

Individual Professionals

- **Health Visitors** – continue to respond positively to the challenges of the *Health Visiting Implementation Plan 2011-15*, promote the profession and develop their professional practice. They are key to providing a safe and supportive environment for those returning to practice, and in working with practice teachers to provide leadership and mentor support for health visiting students. Health visitors are leaders working with local partners and early years providers such as Children's Centres.

  Health visitors have a responsibility to work with parents, communities, local authority (LA) children's services, other nursing professions and primary care using evidence based assessments and interventions to develop and embed the new service for families locally. They can only work effectively across their role if there are strong connections during ante-natal care with midwives, with GPs and primary care teams, with early years staff, for example in preparation for the introduction of the integrated review at 2 years, and at the transition to school (with school nurses).

- **Practice teachers and mentors** – are vital to educating the numbers of students needed to achieve workforce expansion and ensuring that, on qualification, new health visitors are able to provide services based on up to date evidence and the new service models. To enable this to happen practice teachers need to continue the efforts made to work flexibly and through mentors. They are also key to providing support for newly qualified health visitors and other members of the health visiting workforce.

- **Nursery nurses** – as part of the health visiting team they have an important contribution to make, for example in supporting play activities and the

development of children with physical or learning disabilities.

Other professionals and teams

- **Midwives** – work with health visitors during the antenatal period to identify risks and develop early intervention plans, and to support an integrated approach to delivery of preparation for parenthood and parenting programmes. Health visitors should encourage expectant mothers to book in early with the midwife as an effective action to improve outcomes for young children, and one which increases uptake of health visiting services.
- **School nurses** – lead the delivery of services to school aged children in partnership with other professionals. School nursing teams lead the delivery of the HCP (5-19) and provide a variety of services both in and out of school settings to support health and wellbeing. This includes carrying out developmental screening, undertaking health interviews and co-ordinating health protection including immunisations and vaccination programmes.

  Pre-school, health visitors work collaboratively with school nurses to review the general progress and delivery of key health messages on parenting and health and prepare for school entry. This includes identifying additional health needs and the provision of early help where needed. From school age upwards, the school nurse will be the lead professional, with support from health visitor, where there are ongoing or identified additional needs from the child or family.
- **GPs and primary health care teams** – work in partnership with health visiting and local services in delivery of the Healthy Child Programme and support families to achieve better outcomes for themselves and their children.
- **Mental health practitioners** – work closely with health visitors to provide support and advice across a range of maternal, child mental health and wellbeing issues. They also provide specialist support for issues such as postnatal depression.
- **Sure Start Children's Centre staff** – have a key role in supporting and improving outcomes for children and families. By working in partnership with health visitors to deliver services, providing a setting for integrated service delivery such as parenting classes and clinics, endorsing health and wellbeing messages and providing social and educational opportunities they can ensure delivery of joined up services.

National bodies

- **The Secretary of State for Health** – will remain accountable to Parliament for delivering the health visiting commitment
- **The Department of Health** – sets the Mandates for NHS England[13] and Health Education England (HEE)[14], assesses progress against the Mandates' objectives, supports the system wide Health Visiting Programme, develops health visiting policy and provides professional leadership of the health visiting profession through the DH Director of Nursing.
- **NHS England** – is responsible from April 2013 for commissioning health visiting services and delivering workforce growth and service transformation as part of its Mandate objective to:

13 http://mandate.dh.gov.uk/

14 www.gov.uk/government/publications/health-education-england-mandate

improve the standards of care and experience for women and families during pregnancy and the early years of their children's life

Area Teams will lead this locally (see below). More details on NHS England's responsibilities are set out in a Section 7A agreement[15] and Service Specification No. 27[16] which covers the commissioning of 0-5 public health services for which NHS England is responsible to the Secretary of State for Health. In relation to health visiting this includes:

- delivering the required increase in the health visiting workforce; and,
- achieving systematic transformation of all health visiting services, building on the EIS project achievements. This requires delivery of the new model of health visiting and full coverage of the healthy child programme by 2015 by all health visiting services.

- **Health Education England (HEE) and its Local Education and Training Boards (LETBs)** – will ensure that sufficient training places are commissioned to support delivery of workforce expansion and will work closely with NHS England to align training commissions with service plans.
- **Public Health England (PHE)** – will have a key role in sharing the latest evidence base and reporting on the Public Health Outcomes Framework (PHOF). PHE will also support delivery of the programme and, in collaboration with NHS England, the transfer of commissioning of health visiting services to LAs through public health workforce development, developing tools and resources to support implementation and sharing best practice.
- **Health Visiting Taskforce –** this independent group champions and provides strategic challenge to the delivery of the Government's health visiting commitment. The Taskforce includes a wide range of stakeholders including parent representative groups, the voluntary and community sector, and professional organisations.
- **Nursing and Midwifery Council –** sets the standard for entry to the health visitor profession, holds the register and sets some educational requirements for health visiting training programmes.
- **Voluntary and parent representative bodies** – at national and local level are vital to the creation and development of community led services.

Local bodies

Service Commissioners

- **NHS England Area Teams** – lead the commissioning of health visiting and delivery of improved outcomes for young children and their families. They will commission according to a new national core service specification which sets out the expectations of providers in delivery of the increased capacity and the transformed service. They will work closely with providers to ensure that those expectations are met.

  In partnership with PHE, they will also provide leadership across the system to support partnership working with local authorities (children's services and public

15 www.gov.uk/government/uploads/system/uploads/attachment_data/file/192992/s7A-master-131114-final.pdf.pdf

16 www.gov.uk/government/uploads/system/uploads/attachment_data/file/192978/27_Children_s_Public_Health_Services__pregnancy_to_5__VARIATION_130422_-_NA.pdf

health) and primary care. This could include delivery of local, jointly commissioned early years health and wellbeing strategies with a clearly articulated leadership role for health visiting in the delivery of improved health and wellbeing outcomes for 0-5s and their families.

- **Local Authorities (LAs)** – as commissioners of early years' services, children's social services and the school health service (5-19 Healthy Child Programme) LAs are encouraged to work in close partnership with Area Teams and Clinical Commissioning Groups (CCGs) to commission services that deliver improved outcomes for young children and their families. This should include close involvement in the commissioning of health visiting services in preparation for the transfer of commissioning of 0-5 children's public health services to LAs from 2015 and collaboration with LETBs to commission education programmes which meet changing service needs.
- **CCGs** – working with partners and through local health and wellbeing boards are vital to ensure seamless commissioning of services for children and joining up public health with other children's services.
- **Health and wellbeing boards** – set the strategic direction for health and social care commissioning for the whole local community through Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs). Boards cover the whole life course, and have been encouraged to recognise the importance of early years, including its crucial role in the development of the full potential of the future population. They are encouraged to ensure that JSNAs and JHWSs take account of early years and work in full partnership between early years' services, children's social services, CCGs and Area Teams, to make full use of the skills and competencies of health visitors.

Service Providers

- **Providers of health visiting services** – should support their health visiting services to deliver the full core national service specification including maintaining their agreed trajectory and establishment of health visitors and health visiting teams, and to improve outcomes. They should support this through workforce planning, systematic workforce development; provision of the required number of practice placements for trainees; and by providing trained supported practice teachers, mentors and preceptors to support trainees, those returning to practice and newly qualified staff. They should work in partnership with primary care and council commissioned services ensuring that the services they provide are consistent with local health and wellbeing strategies, particularly where the provider covers a number of LA areas.
- **Primary care providers** – are encouraged to work in partnership with health visiting and local services in delivery of the Healthy Child Programme e.g. immunisation and vaccination programmes and supporting families to achieve better outcomes for themselves and their children.
- **Local Authorities** – in addition to commissioning children's services some LAs are also direct providers. In this capacity they are encouraged to work in partnership with communities, the voluntary sector, health visitors and

primary care services to deliver improved outcomes for children and families. They will also wish to engage with LETBs about the commissioning of health visitor education.

Education

- **LETBs** – will commission training places; ensure training programmes are high quality and students supported; promote health visiting as a career; support practice teachers and work with service and education providers to strengthen development opportunities for the existing workforce.
- **Education Providers** – will provide and ensure the quality of health visiting training, including placements, at a local level.

Actions and Next Steps

Here, we describe in brief how the programme will deliver under the following workstreams:

- workforce expansion; and,
- transforming the service and professional leadership

These workstreams will be further developed and added to over time.

Workforce expansion

NHS England, with HEE, are agreeing monthly workforce growth trajectories for 2013-14 and an end of year trajectory for 2014-15 at national, regional and Area Team level. The trajectories will include planned training commissions of over 2,500 for 2013-14. The Health Visitor minimum data set will continue to be collected by Area Teams, supported by LETBs, so that growth can be measured against trajectories.

NHS England has developed a national core service specification and performance management framework with clear expectations on providers for delivery and assurance on recruitment and retention. The specification has been included in 2013-14 contracts.

To ensure the 4,200 commitment is met, and to address potential challenges in meeting trajectories or training commission plans, a detailed delivery plan has been agreed by the joint NHS England and HEE Governance Board. This plan sets out accountabilities and timescales for action. NHS England and HEE will work together to support delivery and take action where necessary.

The delivery plan actions include:

- NHS England will support commissioners and providers to deliver growth including:
  - supporting providers in development of workforce strategies to retain experienced staff including flexible retirement options;
  - improving retention through professional development programmes;
  - exploring recruitment from other countries;
  - closely monitoring recruitment in order to support Area Teams in managing provider delivery of increased capacity; and,
  - supporting the development of local plans to address locality shortfalls.
- NHS England Area Teams will:
  - ensure sufficient posts are created to meet growth trajectories through setting clear expectations on providers;
  - ensure sufficient placements and practice teachers by ensuring that, through contractual and other

methods, providers host sufficient numbers of students and adopt good practice in placement provision through developing mentoring and coaching capacity in experienced nurses to support flexible models of teaching;

- performance manage providers delivery of increased capacity to ensure that funded vacancies are filled promptly; and,
- work with service providers to reduce staff turnover and develop flexible retirement schemes – valuing and engaging experienced and mature members of staff.

- HEE and its LETBs will:
  - promote health visiting as a career;
  - work with service and education providers to market training opportunities;
  - share resources and promote innovative models of teaching;
  - work with service and education providers to attract the best quality candidates to training and reduce attrition from courses; and,
  - ensure effective support for practice teachers and mentors.

Transforming the service and professional leadership

Service transformation aims to provide support for children, families and communities to improve health outcomes, reduce inequalities and provide extra help and early intervention when needed. It should also support improved access to services and better experience.

For service transformation to take place health visitors will need to review services and work in new and innovative ways. We will continue to support innovation and change to enable the new service to be delivered effectively and in line with the needs of the families and local communities.

The culture of provider organisations will need to support professional autonomy, innovation and change to enable transformation to take place. This will continue to be supported through strong professional leadership and mobilisation and development of the profession.

Service transformation

Capitalising on workforce growth, professional mobilisation and the learning in service from the EISs and other sources, the programme will work to spread service transformation nationally, based on the four level service model.

To ensure service transformation, NHS England has set clear expectations for service delivery in a national core service specification that all Area Teams are using with service providers in 2013-14 contracts. However the way in which the specification is delivered will continue to be led by local need**.** Delivery against the service specification will be assured through a performance management framework.

Area Team commissioning leads will ensure defined pathways, as set out in the core service specification, are in place to support Universal, Universal Plus, Universal Partnership Plus and Community levels of service with clear roles for health visitors, primary care, early years, the voluntary sector and, where appropriate, communities themselves.

Professional leadership, mobilisation and development

The Director of Nursing in the Department of Health will continue to lead on professional leadership and mobilisation and, working with others, will:

- establish and maintain strong partnerships and effective communications and leadership with professional bodies, regulators, NHS England, HEE, PHE and the Local Government Association (LGA);
- be a champion for health visiting development and sustain effective networks to ensure the profession remains engaged with programme delivery, through speaking engagements, articles and social media;
- provide professional leadership to health visitors, developing professional guidance and materials to support professional development;
- provide expert professional nursing advice to national policy development;
- continue to engage and re-energise the profession whilst also raising the profile and status of the profession.

Specific products that will be delivered to support health visitors will include:

- a preceptors' charter
- a Public Health Career Framework
- a Perinatal Mental Health training package
- learn and share events with Children's Centre staff
- professional guidance and training tools for Domestic Violence and Abuse.

HEE and LETBs will work with service providers and Area Teams to ensure high quality training and continuing personal and professional development programmes help build capacity and provide the skills needed. They will also have a role helping to develop a learning and engagement culture that supports and sustains health visitors so they can deliver a quality service to families and children and continue to change and develop the service.

NHS England, working with PHE and other stakeholders, will support a programme of commissioner development to support evidenced based commissioning of integrated services for early years. This could include:

- Comprehensive Healthy Child Programme delivery
- Building community capacity
- Meeting the needs of complex families
- Leadership for improved outcomes.

In addition, a programme of professional development for health visitors will be developed by the Department of Health, working with others. This will support working in partnership to deliver outcomes including providing a key leadership role across partnerships for meeting community and individual needs through assessment, care planning and the delivery of evidence-based interventions.

Health Visiting in Greater Manchester

Health visitors are at the heart of a bold vision in Greater Manchester (GM). In the past, services were facing significant capacity and investment challenges. The new vision will see a whole system shift to investment in preventative and early intervention services. The new delivery model will ensure a move from:

- fragmented services that can miss the wider factors influencing a child's development, to a 'whole child' and 'whole family' approach.
- multiple separate assessments, to an integrated and progressive series of assessments timed around crucial child development milestones.
- funding programmes which often have a weak evidence base, to funding interventions proven to be effective and good value for money.
- the most vulnerable and disadvantaged families being allowed to slip through the net, to services that reach out and provide additional support where necessary.

The new delivery model includes:

1. A shared outcomes framework, across all local partners, including public health outcomes for children and parents and improved parenting skills contributing to school readiness;
2. A common assessment pathway across GM with a key leadership role for health visiting: eight common assessment points for an integrated ('whole child' and 'whole family') assessment at key points in the crucial developmental window;
3. Evidence-based assessment tools for use by health visitors and others to identify families reaching clinically diagnosable thresholds for intervention or having multiple risk factors as early as possible;
4. Needs assessment triggers referral into an appropriate evidence-based targeted intervention;
5. A new workforce approach, to drive a shift in culture: enabling frontline professionals to work in a more integrated way in support of the 'whole family' and with other services to collectively reduce dependency and empower parents;
6. Better data systems to ensure the lead professional undertaking each assessment has access to the relevant data to see the whole picture, reduce duplication, track children's progress and support the most vulnerable and disadvantaged;
7. Long-term evaluation to ensure families' needs are being addressed and add to national evidence for effective early intervention.

Health and wellbeing outcomes

The prime purpose of increased workforce capacity and service transformation is that it should contribute to reductions in health inequalities, improvements to health and wellbeing outcomes and better experience for families and children.

The Public Health Outcomes Framework and the NHS Outcomes Framework include a range of outcomes which it is expected will be positively impacted by delivering the programme. Those which have a specific focus for the programme are:

Indicator	Health visiting impact
Under 18 conceptions*	Can be reduced by, for example, health visitors supporting teenage mothers to take up contraception and avoid future pregnancies
Infant mortality#	Can be improved through antenatal work with mothers to support quitting smoking and healthy weight
Low birth weight of term babies*	
Smoking status at time of delivery*	Can be improved through antenatal work with mothers to support quitting smoking
Breastfeeding (Initiation and at 6-8 weeks)*	Can be improved by antenatal support and by early identification and responsiveness to mothers' concerns.
Vaccination coverage*	Can be improved by outreach to parents who do not take up vaccination to support uptake
Child development at 2–2½ years* (placeholder)	Can be improved through delivery of evidence-based parenting programmes and through close working with Sure Start and local authority early years teams.
School readiness* (placeholder)	
Healthy weight 4–5 years*	Can be improved through encouraging breast-feeding and healthy weaning in line with the guidelines as well as healthy family nutrition.
Tooth decay in children age 5*	

Note:

* Public Health Outcomes Framework
# NHS Outcomes Framework
Placeholder status indicates – under development

As other indicators are developed, for example on maternal mental health, these will be considered for their potential use as measures of the impact of the transformed health visiting services.

NHS England have identified, within their core service specification, the NHS outcomes influenced by health visiting:

Domain	Areas where health visiting can impact
Domain 1: Preventing people from dying prematurely	Reducing deaths in babies and young children: • infant mortality • neonatal mortality & stillbirths
Domain 2: Enhancing quality of life for people with long-term conditions	Children's long-term conditions: • reducing emergency admissions for children with asthma, epilepsy and diabetes
Domain 3: Helping people to recover from episodes of ill-health or following injury	Preventing lower respiratory tract infections (LRTI) in children becoming serious: • emergency admissions for children with LRTI
Domain 4: Ensuring people have a positive experience of care	Improving women and their families' experience of maternity services: • women's experience of maternity care • improving children and young people's experience of healthcare
Domain 5: Treating and caring for people in safe environment and protecting them from avoidable harm	Improving the safety of maternity services: • admission of full term babies to neonatal care • delivering safe care to children in acute settings • incidence of harm to children due to a 'failure to monitor

Sustainability and transfer of commissioning from 2015

We want to ensure that the programme leaves a legacy of a strong, vibrant health visiting profession and service beyond 2015. We also want it to support the transfer of commissioning of health visiting services to LAs, alongside the appropriate funding, from 2015, thus making a real difference to children and families.

The Health and Social Care Act gave local government responsibility for local population health improvement and created local health and wellbeing boards. Commissioning of children's public health services from age 5 to 19 was transferred to local government in April 2013; but commissioning of 0-5 services was retained by NHS England to deliver the new service vision by April 2015, before commissioning of these services is also transferred.

We need to ensure that commissioning of public health services for 0-5s is effective and embedded with commissioning of other early years services. We are therefore committed to ensuring that the transfer of commissioning of health visiting services to local government from 2015 is as successful as possible. Therefore a task and finish group of the Children's Health and Wellbeing Partnership is being established to develop a comprehensive transfer plan. The group will consist of members of the Department of Health, NHS England, PHE, the Local Government Association, SOLACE, Association of Directors of Children's Services and other organisations. This group will seek assurance of safe transfer to local government.

There are already actions underway or planned that will help to create stronger partnerships between the NHS and LAs in preparation for the transfer. These will be supported at a national level by NHS England working with the LGA and PHE and include:

- NHS England's core service specification for health visiting services stresses the need for local health visiting service providers to:
  - work closely with LAs to determine which services are offered locally and to improve family and community capacity and champion health promotion;
  - contribute to the development of JSNAs and JHWSs; and,
  - input into local health and wellbeing boards and contribute to the health and wellbeing strategy.
- the LA community will be involved in developing the NHS England health visiting service specification for 2014/15.
- NHS England, in partnership with PHE, will develop its Public Health commissioners to ensure they can work effectively with LAs in the lead up to transition in 2015.
- NHS England is exploring the potential for the joint sign-off of local

commissioning plans for 2014/15 by NHS England Area Teams and LA chief executives.

In addition PHE will:

- continue to collate and disseminate the evidence of what works, including developing tools and resources to support implementation locally.
- publish the Public Health Outcomes Framework so local areas can judge their local progress against national outcomes.
- support sharing good practice at a local level through PHE Centres.
- support on-going development of the public health workforce in LAs to inform commissioning of early years and the on-going support and development of the children's public health nursing workforce.
- HEE and its LETBs are also establishing links with LAs to ensure training commissions meet future needs.

Conclusion

This document both summarises progress for the first two years of the programme to deliver the Governments health visiting commitment and outlines the role and actions that will help to ensure success for the next two years. It also identifies the start of a process to transfer the commissioning of health visiting services to LAs from 2015.

As the programme moves forward plans will be tailored and adapted to ensure that it remains on track and that health visitors continue to deliver for children and families. As one parent from Hampshire said:

"what they do is priceless"

Further information

This document is available at https://www.gov.uk/government/publications/health-visitor-vision. Detailed actions and information about the governance of the programme will also be available on the website. The website will also be a way of accessing links to material referred to in this document and other supporting tools, learning programmes, case studies and practice guidance. We will add to these during the remainder of the programme.

You may also want to visit the relevant webpages of NHS England, HEE and PHE at:

www.england.nhs.uk

http://hee.nhs.uk/work-programmes/health-visiting/

www.gov.uk/phe

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0.5k 26 June 2013
Produced by Williams Lea for the Department of Health

Health Scrutiny Committee
Meeting to be held on 2 September 2014

Electoral Divisions affected:
All

Report of the Health Scrutiny Committee Steering Group
(Appendices A and B refer)

Contact for further information:
Wendy Broadley, 07825 584684, Office of the Chief Executive,
wendy.broadley@lancashire.gov.uk

Executive Summary

On 4 July the Steering Group met with

- Tony Pounder, Head of Care Act Implementation - Adult Services, Health and Well Being Directorate
- Khadija Saeed, Senior Business Partner - County Treasurer's Directorate
- County Councillor Tony Martin, Cabinet Member for Adult and Community Services

The Steering Group received an update on the implications of the Care Act, Home Care Procurement and Telecare.

The Steering Group also met with a number of officers from Lancashire Teaching Hospitals Trust (LTHT)

- Carole Spencer, Strategy & Development Director
- Steve O'Brien, Assistant Director - Quality
- Paul Howard, Trust Secretary

They attended Steering Group to discuss a presentation to be provided to the Care Quality Commission at the start of the inspection process and receive feedback on a draft bulletin for scrutiny members. A summary of the meeting can be found at Appendix A.

On 25 July the Steering Group met with Mark Youlton, Director of Finance - East Lancashire Clinical Commissioning Group and David Rogers, Communications & Engagement – Commissioning Support Unit to discuss Clinical Commissioning Group's commissioning of services from Calderstones NHS Trust. A summary of the meeting can be found at Appendix B.

Recommendation:

The Health Scrutiny Committee is asked to receive the report of the Steering Group.

Lancashire County Council

Background and Advice

The Scrutiny Committee approved the appointment of a Health Scrutiny Steering Group on 11 June 2010 following the restructure of Overview and Scrutiny approved by Full Council on 20 May 2010. The Steering Group is made up of the Chair and Deputy Chair of the Health Scrutiny Committee plus two additional members, one each nominated by the Conservative and Liberal Democrat Groups.

The main purpose of the Steering Group is to manage the workload of the Committee more effectively in the light of the increasing number of changes to health services which are considered to be substantial. The main functions of the Steering Group are listed below:

- To act as the first point of contact between Scrutiny and the Health Service Trusts;
- To make proposals to the main Committee on whether they consider NHS service changes to be 'substantial' thereby instigating further consultation with scrutiny;
- To liaise, on behalf of the Committee, with Health Service Trusts;
- To develop a work programme for the Committee to consider.

It is important to note that the Steering Group is not a formal decision making body and that it will report its activities and any aspect of its work to the full Committee for consideration and agreement.

Consultations

N/A.

Implications:

This item has the following implications, as indicated:

Risk management

This report has no significant risk implications.

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Directorate/Tel
N/A.		

Reason for inclusion in Part II, if appropriate

N/A.

NOTES

Health OSC Steering Group
Friday 4 July 2014 – Scrutiny Chairs Room (B14a)
2.00pm

Present:

- CC Steve Holgate
- CC Margaret Brindle
- CC Fabian Craig-Wilson

Apologies:

- CC Mohammed Iqbal

Also in attendance

- CC Tony Martin – Cabinet Member
- Tony Pounder
- Khadija Saeed

Notes of last meeting
The notes of the Steering Group meeting held on 13 June were agreed.

NHS England – Lancashire Area Team
Richard Jones, Chief Executive (NHSE – LAT) had given his apologies and unfortunately the team were unable to send a substitute officer.

Meeting to be rearranged – now to take place 5 September

Home Care Procurement
Tony Pounder, Head of Care Act Implementation, Adult Services, Health and Well Being Directorate attended the meeting to provide members with an update on the following:

- Care Act – brief update
    - Begins April 2015 but a lot of preparation work is required – small team formed who will report to a programme board to demonstrate that we have the operational issues in place, legally compliant etc.
    - Reports going to Cabinet over the next few months – policy, IT, funding etc
    - Communications –Tony offered to provide Steering Group with regular updates and CC Holgate stated that any assistance that scrutiny can provide will be willingly offered – will be a series of Bite Size Briefings
    - Khadija talked through the finance and detail - feedback is due back to Central Government by of August – see supplementary paper attached for detail
    - Key milestones are from April 15 deferred payment agreements
    - April 2016 – capping care costs, changes in capital limits
    - Cost pressures – what do we think will cost us money (ie other LAs too that feel will cost)

- Many challenges – particularly relating to self-funders
- Means tested limit – increasing from 23K to 118K – challenges re info on number of householders, what those properties will be worth – the entitlement immediately changes but the £72K limit is up to the individual to inform us.
- The 'meter' and 'care accounts' – a basis on working out what the costs of care will be and how we will record it. – an issue for SG to discuss in greater detail.
- Respite vouchers for carers – the most support we provide at the moment. There will be more carers in the mix – and may need additional support. Implications to support their well-being (and it would be up to individuals to determine what support they would need).
- Talking about a whole system change – some money in Better Care Fund to help pay for this transition
- Deferred payments – no-one should have to sell their home to pay for care. – The house can be sold after death and the costs recovered. – Financial implications is that it is a recurrent budget cost.
- Insurance companies may get involved in the 72K cap
- Confusion re what is allowed under the 72K – not food (classed as hospitality)
- Some aspects will produce 'losers'
- Prisons – have 5 – new area of engagement. Working with prison service – end of August a visit is planned to a number of prisons to look at the issues first hand. – Tony to liaise with Wendy re members taking part in a visit. Kirkham is an open prison and takes older prisoners prior to release.
- Work ongoing to determine the long terms challenges of funding – assumptions made on what funding is available and the level of demand.
- Funding only agreed for next April – past that it's not yet finalised. Major challenges
- Further briefings required for Steering Group

- Home Care – an update on what is happening with the procurement.
  Brief update, main points being:
  - PQQ stage completed
  - Procurement gone as expected (87 submissions in total)
  - Briefed CCs and MPs – not aware of any lobbying
  - Some of the unsuccessful providers are not happy – anticipated this and it is being managed
  - Next steps – having one-to-one meetings with unsuccessful providers re their organisations and the people they support. The priority is balanced advice for the service user to enable them to make informed choices for the future.
  - Lot of organisations involved and people appointed to help with this, lots of activity over the next few months.
  - Ultimate benefits and advantages re how we would pay providers and what the rates of pay for carers would be – including terms and conditions.
  - Good news that LCC are making a stand in terms of contracts and pay.

- Will be in top quartile in North West re rates of pay. – there is a difference between a Homecare Living Wage and the National Living Wage rate – the aspiration is that the HLW will eventually match the LCC LW.
- Legally we can influence and encourage but cannot enforce the payment of the National Living Wage.
- Impact of the £7.20 pay rate – in terms of are there ways in which employers might change the rules for breaks and travel time etc.
- One of the additional levers is for LCC to request 'no zero hours' contracts and for the council to provide an element of continuity for workable hours so the employers can guarantee standard hours for their staff.
- A concern in areas where there is an elderly population – therefore the ability to have some type of continuity will attract a better carer (both in hours and pay). The clients will benefit from having a regular, consistent carer.
- It was agreed that Tony would provide further updates to SG every 3-4 months
- Started off with 120 providers and at the end of the process it will be reduced to 30 – many changes ahead.

- Telecare – an opportunity to raise any questions about the Cabinet Report which will be going to Executive Scrutiny and Cabinet in July
    - This a lot of the concerns have been addressed
    - New arrangements to be put in place
    - Going to Exec Scrutiny on 11 July prior to Cabinet
    - CC Martin went to Birmingham to see their system and the key message was that it was essential to train social workers to ensure that savings would be achieved

Lancashire Teaching Hospitals Trust
Carole Spencer, Steve O'Brien and Paul Howard attended the meeting to discuss the presentation they will be providing to the CQC at the start of the inspection process and also request feedback on a draft bulletin for scrutiny members.

A copy of the presentation is appended to the notes

Steve O'Brien talked about the CQC inspection next week (3 days, 40 inspectors, both Preston and Chorley sites). As part of this process the Trust is required to provide a presentation to the inspectors – feedback welcome prior to Monday

A general discussion took place and the main points were:

- Recently had an independent review of governance structures (600 responses from staff to a survey) – will be submitting this to Monitor as part of their Quality Review
- Staffing levels – recruitment challenges, lot of effort gone into this and positive results in terms of retention
- Review of national targets relating to C.difficile- modernisation of the wards help but the main difference is made through good hygiene and hand washing. Automated hand gel systems and better education of visitors. With

staff have moved away from hand gels and gone back to the 5 points of hand washing and this has made a positive difference.

- Definite drop in the number of falls – 50 % of falls happen at the bedside
- Impact of an excessive demand for beds – for some patient groups there is limited local alternatives, therefore they have no choice but to come to hospital - The Trust is exploring how it can work with partners to provide alternative mechanisms.
- Admissions are not reducing so the impact of BCF is key to looking at the system in a different light.
- Over 80s – no trend to types of conditions except that the older and frailer the more complex the mixture of issues. Whilst much can be done in terms of dealing with LTCs and related adaptations, it raises the wider issue of social changes to family support etc.
- Challenges that the community services are not developed at the same rate that demand for them appears.
- Removal of the Liverpool Care Pathway for end of life – need to regain public confidence following this.
- Many care homes don't want to deal with the end of life for residents and therefore they are often sent to hospital to die – this is a national issue but the Trust has been speaking to LCC social care officers to look at ways of addressing this.
- Dentistry – specialist services specifically dealing with and supporting adults with learning disabilities.
- Mortality – emotive subject – Trust disappointed that they had been judged as having higher than averages rates – all CQC indicators are where they should be
- Challenges addressed around Stroke and Diabetes – work with other hospitals to provide a thrombolysis service, use of telemedicine model. Perception can be that the issue is often at the point of calling 999 and waiting for an ambulance.
- People don't often go into hospital because of diabetes but it is discovered that they have it while they're there, or it is a factor that needs to be taken into consideration when delivering treatment and care.
- Occupancy and patient flow has a knock on effect on the ability to meet the standards relating to specific conditions
- Looking at patient level detail to determine whether the Trust can do anything to improve the generic quality of life score
- Specialist wards for dementia patients so has improved the patient experience – less confusion and distress for patients and the environment is more restful and quiet.
- Electronic devices used to capture feedback – however work to be done around communication, in particular letter templates.
- Cancellations and delays in diagnostics and treatment – is this an issue that will be picked up by the CQC. No problems with the services just sometimes the level of demand for services can be an issue
- Improvement since last CQC inspection about making it easier and clearer for patients and relatives to feedback their views and experiences
- PALS system has also been improved.
- Increased levels of stay – at one point a decision was made to cancel some elective surgery and therefore struggled with referrals for treatment targets - Had an independent review of the systems and processes around this.

- Pressures around 62 days cancer waits – was part of the previous review. Trust felt that many patients were coming to them after the 62 day target had been exceeded.
- Expecting to achieve compliance from July onwards – additional need for critical care due to the complexity of treatments available.
- Staff survey results show clear shift in their level of engagement and awareness
- Projected shortfalls in some specialist services (in consultants)
- Financial challenges – balanced against quality and safety
- The Trust hope that the CQC will seek out the teams providing recognised outstanding service.
- Outpatients are a challenge for the Trust (unnecessary appointments).
- Paul/Carole handed out a draft copy of a bulletin they intend to provide for the Committee and/or SG.
- CC Holgate pleased that the Trust is willing to communicate on a regular basis so happy to receive information on a more informal open basis.
- Paul and Wendy to liaise to further develop the bulletin and provide feedback from members

Work plan – work in progress
The current work plan for the Committee and Steering Group was attached for comment and update

Local Authority Health Scrutiny Guidance
A copy of the recent guidance to come out of the Department of Health for scrutiny. Was provided for information and comment.

Dates of future meetings
- 25 July – CCG Commissioning arrangements
- 15 August – NWAS 5 year plan & update from LCFT
- 5 September – Richard Jones, NHS England: Lancashire Area Team
- 26 September - tba

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Lancashire Teaching Hospitals in Numbers...

15 number of miles walked by our porters every day for our patients

5,000 number of meals per day served by our catering teams

390,000 - the local population we serve

1.5 million number of people living in the area where we provide specialised services

100% pass rate achieved by our medical students for the fifth consecutive year

150,000 how many square metres of hospital our domestic assistants clean each day

90,000 surgical procedures performed every year

140,000 packs of medicine distributed each month by our pharmacy department

13,000 mail items processed by our post room every day

850 - number of diagnostic tests performed every day by our imaging teams

24h

4,000 calls handled by our switchboards each day

30,000 number of patients whose hearing is improved every year through our audiology team

3,000 number of patient diagnoses and treatments supported by our pathology staff every day

32,000 learning, development and leadership opportunities for our people each year

3 - our financial risk rating since 2006 - 07

200 number of cancer patients receiving radiotherapy each day

90% number of staff that feel their role makes a difference to patients or service users

4,000 expectant and new mums and their babies cared for each year

101 number of research articles published during 2013

61.7% our response rate for the 2013 staff survey, compared with a national average of 46.9%

21,729 people are members of our foundation trust

700 volunteers give their time freely to support our work

27 - elected and appointed governors on our council of governors

200 number of research studies we are involved in each year

813,000 number of patient contacts per year

Excellent care with compassion


Financial Challenge
EXCELLENT CARE WITH COMPASSION
TERTIARY
LOCAL
EDUCATION RESEARCH & INNOVATION
YOUR DESTINATION VALUES
Caring and compassionate
Recognising individuality
Teamworking
Seeking to involve
Taking personal responsibility
VASCULAR CENTRE
CT SCANNER
BIRTH CENTRE
CRITICAL CARE
Operational effectiveness
Quality
IT
Clinical Services
Organisational development & workforce
Lancashire Teaching Hospitals NHS
NHS Foundation Trust
URGENT CARE REVIEW
Long Term Conditions
Ageing Population
Seven Day Service

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

A Continuous Commitment to Quality – our number 1 priority.

Achievements

- Evidence of reduction in harm demonstrated through
  - Safety thermometer
  - Inpatient fall rates
  - Medication errors
  - C. difficile
- 18.2% reduction in mortality over the last four years
- Improved patient survey performance and sustained levels of positive feedback from patients

Ambitions

- Achievement of 98% harm-free hospital care as it relates to:
  - Inpatient falls
  - Pressure ulcers
  - Venous thromboembolism
  - Catheter associated UTI
- 15% reduction in inpatient mortality ratio
- Achieving and sustaining 90% positive patient feedback relating to the overall experience of care and treatment

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Key challenges

- Workforce metrics
- Recruitment
- Staff engagement
- Finance/Quality Improvement

- Nurse staffing
- Never events
- C. difficile
- Falls
- Patient flow/ capacity

- Complaints
- Bed occupancy
- 18 week performance
- 62-day cancer

- End of life care
- Mortality
- Staffing
- #NOF best practice
- PROMS
- Stroke

- Delays in diagnosis and treatment
- Cancellations
- Friends and family test
- Communication

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NHS Foundation Trust

What we do well

- Nurse staffing
- Incident / StEIS reporting
- Pressure ulcers
- Falls
- Recognition of the deteriorating adult and child
- Safety Champions

Challenges

- Nurse staffing
- Never events
- Falls
- *C.difficile*
- Capacity / Patient flow

Safe Care

Safe

Nurse Staffing

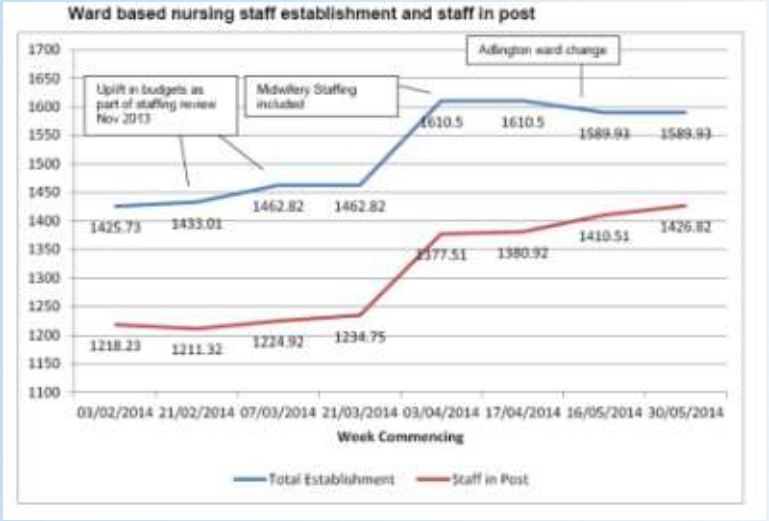
Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Assessment of need

- Triangulated approach
- 6 monthly staffing and skill mix reviews
- Direct involvement of ward managers/matrons
- Review have identified increasing acuity and dependency of patients in our ward environments
- Year-on-year investment totalling £5.5M in nurse staffing since 2007
- £2.2M investment in total in Nov 13 and March14. (126 new posts)

Recruitment

- Very challenging – creativity and energy required, but selectivity essential to maintain quality
- Rolling recruitment programmes
  - Local
  - National
  - international
- Trading on strengths – R&D opportunities, staff development and welfare, links to HEIs,



Safe

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Never Events

2 Never Events reported - both surgical incidents

Actions

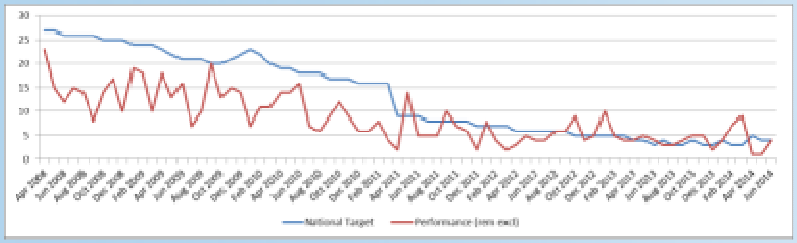
- Leadership and culture
- Individual accountability
- Systems and process
- Skills and knowledge

Assurance

- Executive team visits
- Weekly audits
- Action plan
- Report to Safety and quality subcommittee
- Peer review

Safe

C.difficile



- Year-on-year reduction in incidence
- 15% reduction on the previous year
- Unusual cases
- High risk patient population
- Environment
  - Escalation / capacity
    - Staffing

Falls

- Falls Alarms - implemented Dec 2013
- Trial of new in-patient falls assessment (Apr 2014)
- Embed the process of intentional rounding (re-launch June 2014)
- Falls Collaborative - NHS QUEST; Aintree
- Falls validation / Root Cause Analysis process
- Patient Safety Champions

Safe

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NHS Foundation Trust

Capacity / patient flow

Challenges

- Non-elective demand
- Increased admissions in patients aged>80 (20%)
- Limited local alternatives to acute trust care
- Increased pressure on critical care

Actions taken

- Optimising utilisation of capacity – beds and theatres – reflecting specialty level demand
- Implementation of electronic bed management system
- Health economy-wide review of urgent care systems
- Reduced LOS for patients awaiting home of choice
- Launch of patient flow – clinical incidents
- Early adopter for 7-day working (NHS Improving Quality)

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

What we do well

- End of Life Care
- Nationally recognised leadership development programmes
- Research and Development
- Exemplar clinical services
- Nurse Staffing
- 7-day working

Challenges

- End of Life Care
- Stroke
- Mortality
- # NOF
- PROMS
- Nurse Staffing
- 7-day working

Effective

Effective

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Mortality

Mortality alert – Alcoholic liver disease

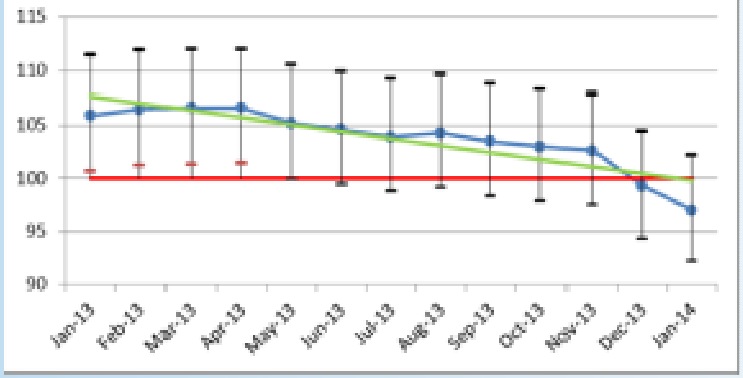
Case note review in progress.
Preliminary findings based on 9 patients:

- No substandard care in 7 patients
- Of the remaining two, both may have benefited from an earlier gastroenterology review but this would not have affected the outcome
- Overall, care was considered good with daily senior clinical review and daily MDT identified as good practice

Mortality alert – Peritonitis with intestinal abscess

- 9/31 patients died (mortality rate = 29% - expected = 11.5%)
  - No substandard care identified on case note review
    - 3 patients incorrectly coded therefore rate reduced to 21.4%

Hospital Standardised Mortality Indicator (HSMR)



HSMR
- Within expected range

Weekend HSMR
- Within expected range

Weekday HSMR
- Within expected range

Death in low risk conditions
- Within expected range

Effective

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NHS Foundation Trust

Stroke

Actions taken

- Escalation policy in place to include release of a bed for acute stroke admission
- Daily review of >4 hour delays
- Validation of all <90% stay in stroke unit
- Review of Specialist nurse and Therapy support for 24/7 day cover
- Regional pilot starting mid July to enable stroke Specialist Nurse to view patient portal upon North West Ambulance Service pre-alerts.
- Emergency Dept. sited CT scanner operational August 2014, estimated time to CT reduction approx. 20mins.

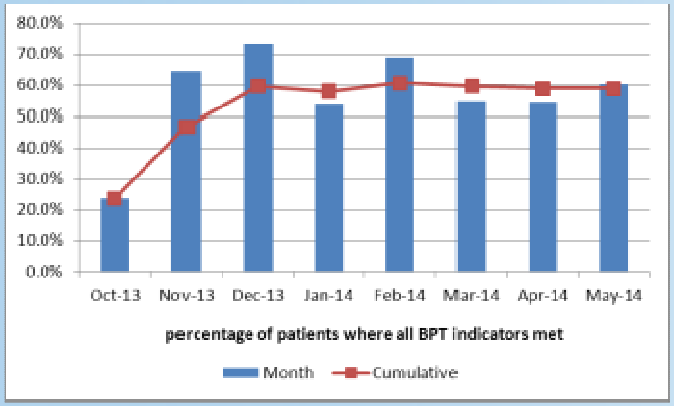
Diabetes

Actions taken

- Currently recruiting an additional full-time Band 6 Diabetic Specialist Nurse (DSN) for the RPH site for inpatients
- A business case has been approved to recruit a substantive third Diabetes Consultant at RPH, with one session per week for Diabetic inpatient review
- Liaising with commissioners regarding a unified DSN Service managed by one Trust
- Diabetes “Hot Foot Line” pathway currently being developed in conjunction with Lancashire Care Foundation Trust
- The additional DSNs to roll-out additional teaching for ward staff/FY1 trainees regarding Diabetes/insulin management

Effective

Best Practice Tariff Compliance (# NOF)



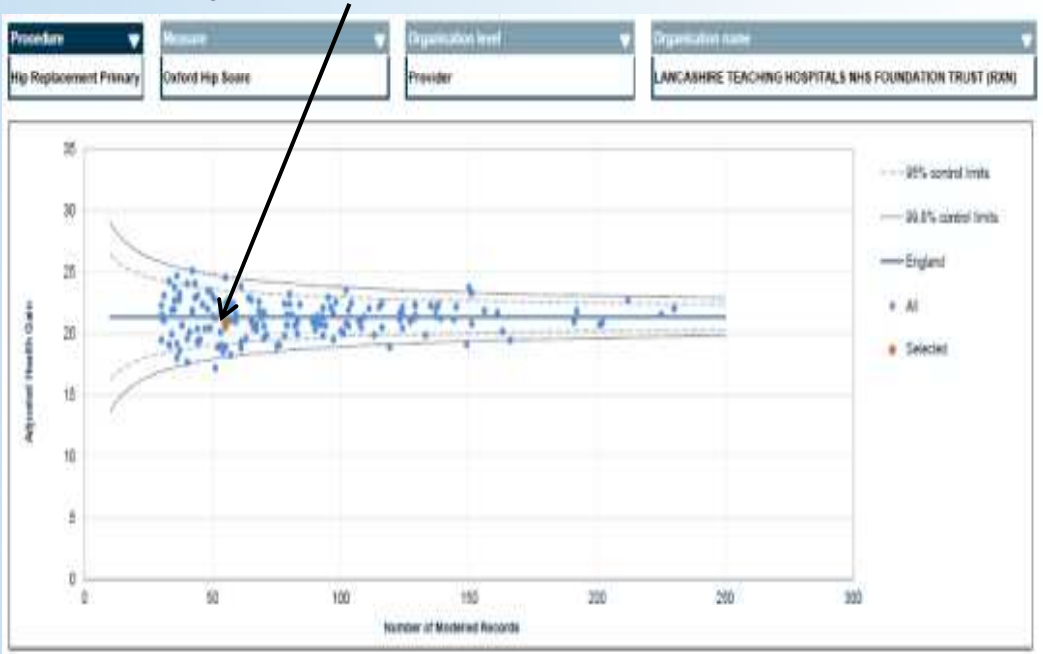
- 2012/13 performance – 5%
- Orthogeriatrician appointed Oct 13
- Overall performance in May – 58%
  - 95% were reviewed by the Orthogeriatrician within 72 hrs.
    - 70% went to theatre within 36 hrs.

Effective

PROMS (primary hip replacement)

Current performance relating to the generic quality of life patient reported outcome measure (PROM - EQ-5D) is poor and within the 90 and 99.8% control limits

However, the condition/procedure specific Oxford score has improved significantly compared to 12/13 data



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NHS Foundation Trust

What we do well

- Dementia Care
- Older person
- Feedback
- Engagement
- Special care dentistry
- Friends and family test

Challenges

- Delays in diagnosis and treatment
- Cancellations
- Communication
- Friends and family test

Caring

Caring

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Patient Communication

Actions:

Accredited patient information systems and processes/ development of iBooks

Review of all letter templates

Copy letters

Increased patient and public consultation and involvement

Development of 'Always Events' programme

Staff training

Bedside handovers

Intentional rounding

Friends and Family Test

Actions:

- Analysis of responses
- Review of patient information
- Identification of local improvement actions to increase the proportion of patients who would be extremely likely to recommend the Trust and reduce the proportion who responded negatively
- Promotion of friends and family test as a valuable method of feedback, particularly in some areas of maternity services where response volumes are lower than expected

Caring

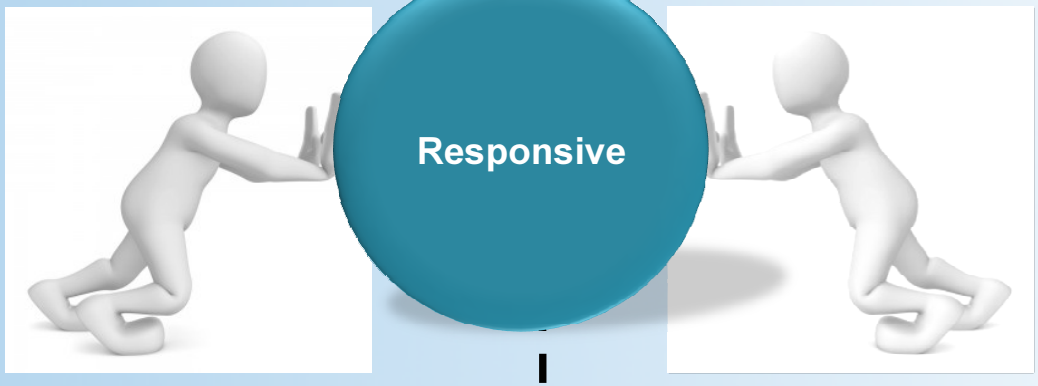
Lancashire Teaching Hospitals NHS
NHS Foundation Trust

What we do well

- Perfect month
- Urgent care programme
- Major trauma
- Diagnostics
- Vascular services
- 7-day working

Challenges

- Complaints
- 18 weeks performance
- 62-day cancer waiting
- Bed occupancy
- Delayed discharges
- 7-day working



Responsive

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Complaints

Complaints management – Ensuring awareness of complaints processes and the quality of investigations and response

Actions:

Investment in customer care – Increased outreach

Expansive communication strategy

Revised policy/procedure

Staff training

Assurance:

Complainant feedback survey

Peer review process

Increased monitoring

Improved reporting

Responsive

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

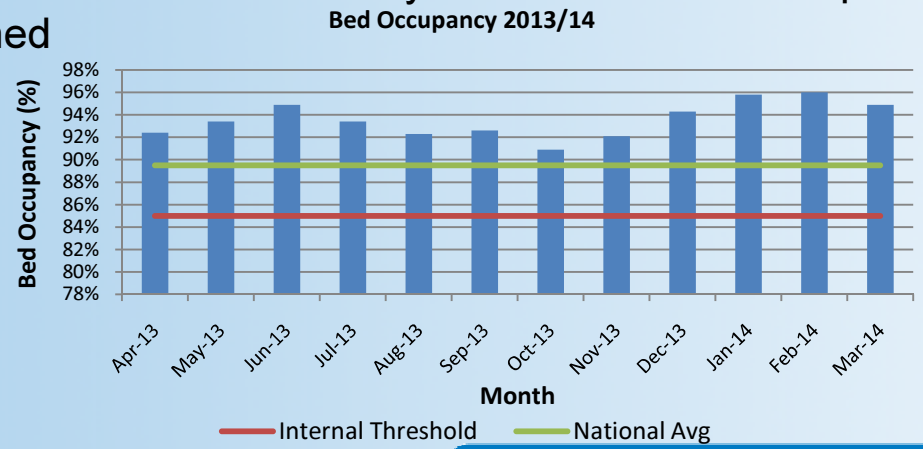
18 week admission/bed occupancy

Challenges

- Bed occupancy consistently higher than national average and internal threshold
- Urgent care pressures
- Impact on elective activity
  - Cancellations/Waiting list growth
- Limited availability of additional NHS/private sector capacity
- Referral to treatment (RTT) backlog (998 at May 2013)
- Neurosciences – 18 week delivery not commissioned

Actions

- System-wide urgent care recovery plan
- Intensive Support Team engagement
  - Diagnostic review of recovery plan
  - Development of robust capacity/demand plans
- RTT backlog (reduced to 412 at May 2014)
- Neurosciences UM review
- Theatre optimisation



Responsive

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

62 day cancer waits

Challenges

- Urgent care pressures in Q4 12/13 and Q1 13/4 displaced elective activity. Increased acuity of patients impacting on bed/critical care capacity
- Significant pressures in Urology, Upper Gastrointestinal and Colorectal tumour groups
- Late tertiary referrals received from partner providers

Actions

- Intensive Support Team engaged in review of internal cancer pathways
- Agreed expansion to critical care capacity
- Work undertaken across Lancashire & Cumbria footprint to align reallocation principles to the Manchester model – effective from 1st July 2014
- Expectation of a return to compliance in Q2 2014-15

Responsive

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

What we do well

- Integration of Trust values
- Staff Engagement
- Partnership working
- Board visibility and engagement

Well-led

- Education, training and development
- Staff recognition

Well-led

Challenges

- Workforce metrics
- Staff Engagement
- Recruitment
- Finance/ Quality Improvement

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Conclusion

Top Challenges

- Workforce availability
- Capacity/patient flow
- Finance
- Health economy challenge

Outstanding achievements

- Clinical Negligence Scheme for Trusts level 3
- Specialist Mobility Rehabilitation Centre
- Older persons programme
- Special care dentistry
- Nutritional team
- Outpatient Antimicrobial Team
- Leadership development programmes

AGENDA

Health OSC Steering Group
Friday 25 July 2014 – Scrutiny Chairs Room E17
2.00pm

Present:

- CC Steve Holgate
- CC Margaret Brindle
- CC Fabian Craig-Wilson

Apologies:

- CC Mohammed Iqbal

Notes of last meeting
The notes of the Steering Group meeting held on 4 July were agreed as correct

Calderstones Commissioning
Mark Youlton, Director of Finance (ELCCG) and David Rogers, Communications and Engagement (CSU) attended the meeting to discuss CCG commissioning of services from Calderstones NHS Trust

A number of documents were provided for information and are appended to these notes:

- Annex A: Briefing for OSC on Calderstones commissioning intentions
- Annex B: Letter to ELCCG members re enhanced support services for adults with learning disabilities.
- Annex C: Paper to ELCCG Board on Learning Disability Enhanced Support Services.

A discussion took place on the services commissioned by the CCGs from Calderstones NHS Trust and the main points were

- Enhanced Support Service (ESS) (£9m of £61m total budget of Calderstones)
- Facilities across the county – houses which are referred to as wards (providing services for 43 patients) and are decorated as a hospital
- CCG going through a process (Lancashire and GM patients) – ELCCG lead commissioner (have the most patients)
- Reviewing all 43 patients (with them) -is this the right care for them, is there somewhere better to allow them to settle back into the community.
- Some will not move and will need to stay
- Looking at potential providers - At same time going through the process with Calderstones re what it means to them if CCGs don't commission the service from them (ie £9m budget deficit)
- All the respective CCGs with patients pay into the £9m pot (inc GM ones)
- ESS may create more capacity for the low secure patients to 'step down'
- Since Winterbourne need new way of doing things – sometimes though an institutional setting is the right place

- Potential that a client after receiving ESS could step down again to supported living with social care support
- Difficult to determine if people are eligible to move on – not all are.
- Not sure how many places will be needed in the future – potential issue of sustainability if the service becomes financially unviable for the Trust.
- There is a group looking at potential other uses for spare capacity within the system – LCC have a rep on this group..
- Mark agreed to keep SG updated on the progress of the way forward

To invite commissioners (ELCCG), providers (Calderstones) and supported living (LCC) to a future meeting to discuss progress.

Work plan – work in progress
The current work plan for the Committee and Steering Group was attached for information and comment.

Dates of future meetings

- 15 August – NWAS 5 year plan & update from LCFT
- 5 September – Richard Jones, NHS England: Lancashire Area Team
- 26 September – CQC
- 17 October – tbc

Briefing for Lancashire OSC Steering Group
July 2014
Calderstones Commissioning Intentions

Since April 2013 Clinical Commissioning Groups have been responsible for the commissioning of the Calderstones Partnership NHS Foundation Trust service.

Calderstones is the only specialist Learning Disability Trust in England. The Trust provides highly specialised in-patient treatment and community care to individuals presenting with complex behavioural, mental health and social care needs. Over the last two decades the Trust has proved itself to be a high quality service, with a strong reputation for its research and innovation borne out by national awards and accreditations. The Trust uses its specialist skills and knowledge to contribute to national events in sharing best and innovative practice. The Trust accepts referrals from the Secure Commissioning team which is part of the North of England Specialist Commissioning Group, for individuals from the age of 18 upwards who require treatment in medium and low secure environments. These are mainly individuals with forensic needs and individuals whose behaviour is extremely challenging to mainstream local services.

Individuals admitted to secure facilities are detained under the provision of the Mental Health Act (1983) or other legislation as required. In addition to the secure services, the Trust also provides a step-down service for those individuals who no longer require a physically secure environment but still need a service where risks can be assessed before they move into a community placement. The Trust also provides an Enhanced Support Service and a Forensic Support Team.

A commissioning group was formed with representation from health and social care commissioners across Lancashire, Greater Manchester and Liverpool. The group has met regularly since July 2013 to consider the needs and priorities of service users of the Enhanced Support Service at Calderstones. As a result of this, the commissioners have agreed a plan to improve the patient care pathway, improve the quality of care planning, and develop a framework to improve choice to service users, offering care closer to home. The aim of this is to improve and achieve high quality patient outcomes for service users, offering independent living in the community for those who are able to.

The Department of Health has called for a fundamental change to take place in the care and treatment of people with learning disabilities in-patient hospital settings. The Department of Health has recommended that such services should be safe, appropriate and high quality, as well as local and community based. A specific recommendation was that all in-patient placements should be reviewed by June 2013, and that anyone who was inappropriately placement in hospital and could be better served in the community, should be supported to move to independent living in the community with support where required as quickly as possible, and no later than 1 June 2014.

On 1 September 2013, commissioners advised Calderstones NHS Foundation Trust that it would be planning to fund services on a patient by patient basis, rather than as a block contract. This approach was felt to support the adoption of the Winterbourne recommendations including the careful and managed transfer of patients from Calderstones to community based support. This is because the funding will be able to follow the patient easily and transparently from Calderstones to community based support if that is the appropriate course of action.

Negotiations between Calderstones and the commissioners are on-going to consider the requirements and where appropriate, ensure that the process of change is undertaken carefully and effectively to ensure that the planned transfer of patients happens in the best interest of the patients, and without significant negative impact on Calderstones.

The Winterbourne concordat is an action plan for people with challenging behaviour in hospital following the Winterbourne View report. The concordat is an agreement that local health and care commissioners who buy services will consider every person with challenging behaviour who are in hospital and if they do not need to be in hospital they will be supported to move to community support by June 2014 if not earlier.

NHS
East Lancashire
Clinical Commissioning Group

East Lancashire Clinical Commissioning Group
Walshaw House
Regent Street
Nelson
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BB9 8AS

Tel: 01282 644700
Fax: 01282 615559
www.eastlancsccg.nhs.uk

Enquiries to: Mike Ions
Contact no: 01282 644684
Email: michael.ions@nhs.net
Our Ref: MI/DCAC

Date: 10 June 2014

Dear Colleague,

Re: Enhanced Support Service for Adults with a Learning Disability – Paper for CCG Agreement July 2014

You will be aware from the discussion at the CCG Network in May 2014 and at the Collaborative Arrangements Group prior to this, that NHS East Lancashire CCG is seeking to establish all associate CCG positions in July 2014 with regards to the above service provision and related contractual arrangements at Calderstones Partnership NHS Foundation Trust (Provider).

A paper is being prepared on your behalf to assist in the process of individual CCG consideration. This will be sent shortly – it will include the summary of the Programme of work to date and the specific recommendations which require CCG consideration and agreement.

Notably, this includes the intention to move to a cost-per-case basis for placements with the enhanced support service instead of the existing block contract. This shift to person-centred care planning for this cohort of patients is a fundamental element in the creation of a strengthened pathway for patients with a high level of need with a learning disability.

You will also be aware that the Provider of the current service has raised issues that they consider the commissioning intention creates for them as an organisation. In their assessment, the potential loss of guaranteed income that would result from cost per case could destabilise their business and threaten their organisational viability, resulting in potential redundancies in Lancashire. As a result, there may be political and media interest in this work. NHS East Lancashire CCG is engaged with the Provider via the Learning Disability ESS Transition Group to understand the reasonable mitigations that can be put in place by both Provider and commissioner such as supporting the modernisation of their model of care.

In addition, workstreams have been established to improve care planning, assessment and treatment options for the patient cohort concerned ensuring that any risks to patients or carers during the transition are managed and mitigated and that the end outcome of any change of process will be greater choice and quality of service for the patients and their carers. These improvements are also key to Lancashire's action plans in relation to Winterbourne and the Learning Disability Joint Health and Social Care Self-Assessment Framework (and NHS England Lancashire Area Team's Case for Change). Further detail will be provided in the paper – and there is a detailed Project Plan, papers from meetings and Communication and Engagement Strategy – all available on request.

Given the risks and profile of this programme of work, NHS East Lancashire CCG is requesting that all CCGs agree a common approach and ensure that their organisations are fully aware of the proposals and the potential implications. It is suggested that it would be advisable to take the paper for agreement to your Governing Body or another decision making body of your choice such as your Executive Team, if you feel this has the necessary delegated authority and keeps your members appropriately informed.

NHS East Lancashire CCG would also like to offer to attend to present and/or support you with the paper if you would find this helpful. Please could you let Helen Rimmer, Service Redesign Officer, NHS Midlands and Lancashire Commissioning Support Unit know on 01772 214207 or Helen.rimmer@lancashirecsu.nhs.uk if you would wish to have a representative present/support as soon as possible so that diary arrangements can be made?

In either case, please could you confirm to Helen Rimmer via the contact details above, the mechanism and date that you will be using in July 2014, for audit trail purposes so that this can be noted in the Project Plan.

A further email will be sent to collect the outcomes of the individual CCG considerations after the meetings have taken place with a view to collating these by the end of July 2014.

Yours sincerely

Michael Ions
Chief Clinical Officer

NHS
East Lancashire
Clinical Commissioning Group

Learning Disability Enhanced Support Service

1. Purpose of the Paper

The purpose of this paper is to:

- Outline the background of the Learning Disability Enhanced Support Service collaborative programme of work;
- Update the CCG on the latest position.

2. Background

The Learning Disability (LD) Enhanced Support Service (ESS) is a service provided by Calderstones Partnership NHS Foundation Trust (Calderstones) which supports people with a learning disability with complex and/or challenging behaviours and/or offending behaviour who no longer require medium or low security but require relational security as part of a discharge pathway. The ESS at Calderstones is provided in a community setting outside the hospital grounds.

The service was previously commissioned as part of the package of secure provision by the (former) North West Specialist Commissioning Team. The commissioning and contractual responsibility migrated to CCGs 1 April 2013. NHS East Lancashire CCG is the lead commissioner and referrals into the service come from pan-Lancashire CCGs, Greater Manchester CCGs and Liverpool CCG.

Learning disability services nationally have been subject to considerable scrutiny in recent years. This has come about due to the effects of a number of well-known events or policy developments – notably the Winterbourne Review[1], the Disability Rights Commission[2] and the effects of premature deaths[3].

An LD ESS Steering Group was established in July 2013 as one of the Lancashire CCG Network's collaborative programmes with representation from CCGs and Local Authorities across the commissioner footprint and NHS England Lancashire Area Team. A current state analysis was undertaken and identified a number of areas where improvement was required in order to have greater adherence to the national directives both for health and social care provision for this client group. The recommendation of the LD ESS Steering Group is that CCGs should move to a cost per case commissioning model enabling greater choice and driving costs down. This recommendation was agreed by the Lancashire Collaborative Arrangements Group (CAG) at the meeting held on 17 September 2013. This shift to person-centred care planning for this cohort of patients is a fundamental element in the creation of a strengthened pathway for patients with a high level of need with a learning disability.

Across the North West there are currently six service users delayed in Calderstones (4 within control / 2 outside control i.e. awaiting a decision from an external body. There are currently 15 delayed in low secure. New protocols for both Lancashire and Greater Manchester will assist with improved patient flow in a timely manner.

3. Commissioning Intentions

NHS East Lancashire CCG, as lead commissioner of the contract issued commissioning intentions to Calderstones on behalf of all associates on 30 September 2013.

Calderstones has raised issues that they consider the commissioning intention creates for them as an organisation. In their assessment, the potential loss of guaranteed income that would result from cost per case could destabilise their business and threaten their organisational viability, resulting in potential redundancies, the majority of them in the Ribble Valley where Calderstones is based but also in Lancaster and in Rochdale where there are satellite service sites. The ESS represents approximately 30% of the organisation's turnover which means that an unmanaged reduction in the funding for ESS could threaten the viability of Calderstones as a Foundation Trust.

Further discussions took place with NHS England Lancashire Area Team and it was subsequently agreed to pause the decision to move to a live cost per case approach for 2014/15, essentially giving Calderstones a minimum income guarantee for 2014/15 based on the number of people in receipt of an ESS service on 31 December 2013 and establish a Transition Group. This group has met monthly since March 2014.

4 Shadow Cost per Case Model

The overall 2014/15 contract value is £8,981,526. The bed usage is approximately split 50:50 across Lancashire and Greater Manchester CCGs. It is intended that better engagement and functioning from LD community services and new case management protocols will reduce the reliance on the ESS over the coming months. However, this is also reliant on both appropriate provision being available in the community and new preventative services being commissioned such as Positive Behavioural Support.

The financial implications and impact on the current provider need to be worked through, but will require service reconfiguration and possibly some interim transitional financial support to the current provider.

5 LD ESS Transition Group

The LD ESS Transition Group includes membership from East Lancashire CCG (lead commissioner), Greater Manchester CCG, Local Authority representation, NHS England Specialist Commissioning, NHS England Lancashire Area Team and Calderstones. The involvement of Monitor and Healthwatch is being considered. The Transition Group is supported by NHS Staffordshire and Lancashire CSU.

NHS East Lancashire CCG is engaged with Calderstones via the LD ESS Transition Group to understand the reasonable mitigations that can be put in place by both Provider and commissioner.

A Communications and Engagement Strategy has been developed and includes a core script and frequently asked questions. Briefings for MPs and Overview and Scrutiny Committees are being developed. An engagement protocol has been drawn up to ensure service user involvement in the transition process and consultations are taking place with current service users, carers and families. Links are being made with LD Partnership Boards to ensure key messages are reported.

6 Developing an LD Provider Framework

A pan-Lancashire LD Engagement Event held on 20 June 2014 obtained a range of views from various providers, service users and carers on what determines good

practice for people with a learning disability. The intelligence from this event will help to determine the model of care across Lancs

Experience from a commissioning perspective have evidenced that there is a lack of crisis accommodation within the region. A task and finish group has been established to commence the exploration of Assessment and Treatment beds for people with a learning disability as a first step in addressing the gaps in provision. Future planning to build capacity within community services is underway.

7 Formal Notification

Given the risks and profile of this programme of work, NHS East Lancashire CCG is requesting that all CCGs agree a common approach and ensure that their organisations are fully aware of the proposals and the potential implications as outlined.

A letter 'Enhanced Support Service for Adults with a Learning Disability – Paper for CCG Agreement July 2014' was sent to CCGs on 10 June 2014, suggesting this paper is discussed at CCG Governing Body level or another decision making body, for example, Executive Team level to allow CCGs to formally confirm in writing to the lead commissioner their intention to decommission the current ESS service and move to a cost per case model. This shift to person-centred care planning for this cohort of patients is a fundamental element in the creation of a strengthened pathway for patients with a high level of need with a learning disability. This will allow NHS East Lancashire CCG to make an informed decision at its Governing Body meeting in time to issue formal notice to Calderstones in August 2014 with an expectation that the change will take place in August 2015.

8 Recommendation

The CCG is recommended to:

- Note the contents of the report;
- Formally confirm in writing to the lead commissioner (NHS East Lancashire CCG) their intention to decommission the current ESS service and move to a cost per case model.

Dr Mike Ions
Chief Clinical Officer
NHS East Lancashire CCG

[1] Department of Health (2012). Department of Health Review: Winterbourne View Hospital. Interim Report
[2] Disability Rights Commission (2006). Equal Treatment: Closing the GAP. London: Disability Rights Commission
[3] Heslop et al (2-13). Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD). Final report http://www.bris.ac.uk/cipold

Health Scrutiny Committee
Meeting to be held on 2 September 2014

Electoral Divisions affected:
All

Health Scrutiny Committee Work Plan 2014/15
(Appendix A refers)

Contact for further information:
Wendy Broadley, 07825 584684, Office of the Chief Executive,
wendy.broadley@lancashire.gov.uk

Executive Summary

The Plan at Appendix A is a draft work plan for both the Health Scrutiny Committee and its Steering Group, including current Task Group reviews.

The topics included were identified at the work planning workshop that members took part in during April 2014

Recommendation

The Health Scrutiny Committee is asked to note and comment on the report.

Background and Advice
A statement of the current status of work being undertaken and considered by the Committee is presented to each meeting for information.

Consultations
N/A.

Implications:
This item has the following implications, as indicated:

Risk management
This report has no significant risk implications.

Lancashire County Council

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Directorate/Tel

N/A.

Reason for inclusion in Part II, if appropriate

N/A.

Appendix A

Health Scrutiny Committee Work Plan 2014/15

Starting Well		
Date	Health Scrutiny Committee	Steering Group
22 July	Families: • Pregnancy • Early years • Healthy lifestyles	• NHS England Lancashire Area Team • Home Care Procurement update • Care Act implementation – challenges for LCC • Response from Cabinet Member to NHS Health Checks task group report • Lancashire Teaching Hospitals Trust – pre CQC inspection discussion • NWAS – 5 year plan • CCG commissioning arrangements for enhanced support services for adults with learning disabilities • CQC – information sharing protocols • Lancashire Care Foundation Trust – inpatient facilities update • NHS England – Lancashire Area Team: relationship with scrutiny
2 September	• Health needs assessments of families • School nurses • Health visitors	

Living Well		

14 October
 	
25 November
 	
13 January
	Economic Impact:
	• Links between economy and public health
	• Role of the LEP
	• Impact on services – who is affected most?
	Self-Care:
	• Improving health literacy to make healthier lifestyle choices
	• Community assets/local solutions – identification and support
	Environment:
	• Healthy spaces
	• Healthy work places
	• Housing
	  ○ Planning processes
	  ○ Affordability
	  ○ Sustainability
		• Food banks
		• Renewable energy
		• Policies affecting different demographics
		• Getting maximum impact from voluntary sector – how they are supported
		• Access to welfare rights
		• Access to sexual health services
		• Emergency planning
		• Climate change
		• Update on recommendations of the Care Complaints task group
		• Health & Wellbeing Board
		• Trust Board Governance

Ageing Well		
4 March 14 April	Independence: • Dementia friendly boroughs • Support for carers • Social isolation • Falls prevention • Access to services for people with LTCs	• Fuel poverty • Mortality reduction • Complaints of domiciliary care (from the Care Complaints task group) • Standards of care in residential and nursing homes

Appendix A

Task Groups		
June	Disabled Facilities Grants	Chair: CC Newman-Thompson

Health Scrutiny Committee
Meeting to be held on 2 September 2014

Electoral Division affected: None

Recent and Forthcoming Decisions

Contact for further information:
Wendy Broadley Office of the Chief Executive, 07825 584684
wendy.broadley@lancashire.gov.uk

Executive Summary

To advise the committee about recent and forthcoming decisions relevant to the work of the committee.

Recommendation

Members are asked to review the recent or forthcoming decisions and agree whether any should be the subject of further consideration by scrutiny.

Background and Advice

It is considered useful for scrutiny to receive information about forthcoming decisions and decisions recently made by the Cabinet and individual Cabinet Members in areas relevant to the remit of the committee, in order that this can inform possible future areas of work.

Recent and forthcoming decisions taken by Cabinet Members or the Cabinet can be accessed here:

http://council.lancashire.gov.uk/mgDelegatedDecisions.aspx?bcr=1

The County Council is required to publish details of a Key Decision at least 28 clear days before the decision is due to be taken. Forthcoming Key Decisions can be identified by setting the 'Date range' field on the above link.

For information, a key decision is an executive decision which is likely:

(a)to result in the council incurring expenditure which is, or the making of savings which are significant having regard to the council's budget for the service or function which the decision relates; or

(b)to be significant in terms of its effects on communities living or working in an area comprising two or more wards or electoral divisions in the area of the council.

Lancashire County Council

For the purposes of paragraph (a), the threshold for "significant" is £1.4million.

The onus is on individual Members to look at Cabinet and Cabinet Member decisions using the link provided above and obtain further information from the officer(s) shown for any decisions which may be of interest to them. The Member may then raise for consideration by the Committee any relevant, proposed decision that he/she wishes the Committee to review.

Consultations

N/A

Implications:

This item has the following implications, as indicated:

Risk management

There are no significant risk management or other implications

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Directorate/Tel

N/A

Reason for inclusion in Part II, if appropriate

N/A