# North Yorkshire County Council

## Executive

### 26 January 2021

### Healthy Child Programme Consultation Report

Report of the Corporate Director for Health & Adult Services

**1.0 Purpose of Report**

1.1 To inform the Executive of the results of the public consultation on changes to the Healthy Child Programme, and potential mitigations proposed as a result of the consultation; and

1.2 To delegate any further mitigations to the service model as a result of the consultation and the approval of the final service model, taking into account the public consultation responses to the proposed changes to the Healthy Child Programme, to the Director of Public Health, in consultation with the Director of Health and Adult Services and Director of Children and Young Peoples Services.

**2.0 Executive Summary**

2.1 The Healthy Child Programme (HCP) is a universal preventative child and family health promotion programme for children aged 0-19 years and its aim is to "Ensure that every child gets the good start they need to lay the foundations of a healthy life."

2.2 The HCP is a local authority mandated programme. In North Yorkshire the programme is currently made up of four separate services:

- Universal or core elements, Healthy Child Service, Health Visiting (0-5) and School Age (5-19) delivered by Harrogate and District NHS Foundation Trust (HDFT); and
- Targeted elements – emotional health and substance misuse delivered by COMPASS and Healthy Choices, Child weight Management Service, delivered by the Council's Children and Young People's Services.

2.3 At the meeting of the Executive on 13th October 2020, approval was given for a 10 week consultation to take place on proposed changes to the service as set out below.

2.4 This report summarises the findings of the public consultation regarding changes to the Healthy Child Programme and sets out the Council's response to the issues raised along with actions taken to mitigate the impact of the proposed service changes.

2.5 There is a second report on HCP which is being taken to this Executive meeting. For clarity, the second report is subject to Executive approving the recommendations contained in this report.

**3.0 Proposals**

3.1 NYCC and HDFT have agreed in principle to work in partnership via a Section 75 Agreement to facilitate the delivery of the Healthy Child Programme. By pursuing a Section 75 approach rather than a more traditional contracting model NYCC and HDFT will be able

to develop a long-term partnership that continuously evolves and develops the service. This approach will place HCP effectively within the wide range of NHS, Public Health and Social Care Service available to Children and Families. HCP will be firmly embedded within this network of services and will benefit from cross system partnership working.

3.2 The Council and HDFT have developed a new service model which both parties believe can safely and effectively meet the needs of the target population. By implementing a new way of working, HCP will support the philosophy of the Childhood Futures Programme, transform 0-19 services and achieve greater collaborative working across the system.

3.3 The consultation pack issued in October 2020 made the following pledge as to the future nature of the service:

**Our commitments**

- All children and young people will receive universal and targeted services to enable them to have the best start in life, through our work in children's early help and social care, schools and community support for children and young people with additional needs.
- We will prioritise our public health grant-funded Healthy Child Programme towards children under five, to support their early development and to ensure that they are ready to learn.
- All new-born babies and their parent(s) will have a face to face visit(s) from a qualified Health Visitor.
- We will continue to provide targeted support for 5-19 year olds, through a range of different programmes and funding streams.
- Our Healthy Child 0-19 services will combine a mix of face to face, online, individual and group work services, tailored to the personal circumstances of each family.
- We will continue to work with children and families, and agencies across the system to ensure that the right support is provided by the right person and at the right time.

3.4 It is important to recognise that HCP forms one part of a wider system of support for children and families across North Yorkshire. This includes the Council's Outstanding Rated CYPS services such as Early Help, Children's Social Work, SEND and strong links into NHS and voluntary sector services. In this way the system is operating from a position of strength and is well placed to adapt to the proposed changes. The revised proposal also meets the financial requirements of a reduction in funding from both the Public Health Grant and HDFT.

3.5 The Council and HDFT are committed that children and young people will be able to access appropriate universal and targeted services to enable them to have the best start in life. Early help and intervention provides timely support when need is identified at any point in a child's life. It is not a specific service but a joined up approach across all service providers to work with children, young people and families to prevent the need for statutory/costly interventions.

We will prioritise our public health grant-funded Healthy Child Programme towards children under five, to support their early development and to ensure that they are ready to learn. There is evidence that indicates a focus on 0-5 years does not only support improving health outcomes, but improves wider societal and economic outcomes. National policy related to providing the best start in life provides further evidence that increasing investment in children aged 0-5 years can impact on childhood obesity, emotional wellbeing and school readiness. Improvements in these areas will in turn support lifelong positive outcomes.

3.6 Healthy Child 0-19 services will combine a mix of face-to-face, online, individual and group work services, tailored to the personal circumstances of each family.

3.7 The Council and HDFT will continue to work with children and families, local service providers in the public and private sector, and voluntary and community groups to ensure that the right support is provided by the right person and at the right time.

3.8 A full description of the proposed model was presented to Executive on 13th October 2020. In summary, the proposals consulted on are as follows:

3.9 <u>0-5 Health Visiting Service</u>

3.9.1 All families will continue to receive the mandated 5 Health Reviews from Health Visitors. These reviews may be delivered in a blended way, comprising both face to face visits and virtual support based on a risk assessment.

3.9.2 All families will receive a face-to-face contact at 10-14 days after birth and 2½ years. The remaining 3 visits will be delivered in the way best suited to the individual needs of the child and family. This mix is not pre-determined and where increased or decreased risk or need is identified, either through a Health Visitor contact or other intervention, the risk assessment and visit mix will be reviewed.

3.9.3 The proposed offer for 0-5s is therefore as follows:

- 28 weeks' pregnancy - health promoting visit;
- 10-14 days after birth - new baby review – Face to face visit;
- 6-8 weeks old - 6-8-week assessment;
- 9-12 months old - 0ne-year assessment; and
- 2-2½ years old review – Face to face visit.

3.9.4 Child in Need and Safeguarding support will continue to be provided.

3.9.5 Enhanced infant feeding, family nutrition and diet programmes will be developed to help refocus local efforts in promoting and supporting families with healthy eating and increased physical activity. This will help in reducing the proportion of older children becoming overweight or obese.

3.10 <u>5-19 School Aged Service</u>

3.10.1 Due to the prioritisation of under 5s to ensure a best start in life, much of the proposed change in service offer will be in the 5-19 service.

3.10.2 The new service offer will be comprised of the following aspects:

- Safeguarding support
- Support for emotional wellbeing and resilience and in reducing risk taking in young people will be enhanced through a standalone service

3.10.3 In the cases of vision and hearing screening, Level 1 incontinence services and drop-ins in schools, the changes in how support is delivered will bring North Yorkshire in line with how Healthy Child provision is delivered in much of the rest of the country. The North Yorkshire model has, through historic decisions, drawn in many service areas which are not-statutorily within the HCP remit. Whilst these are important services and need to be accessible for children and families, there is not a requirement for them to sit directly within the Healthy Child Programme.

3.10.4 The following services will no longer be delivered directly through the Healthy Child Programme, however significant work has been completed in identifying and securing alternative access and provision, these mitigations are set out in Section 8.0

- Hearing and Vision Screening at school entry;
- School nursing drop-ins;
- Level 1 continence support;
- Sexual health services;
- Signing off Educational Health and Care Plans; and
- School Entry and Year 6 Health Questionnaires.

3.10.5 Evaluation on new ways of working as a response to COVID-19 has shown positive feedback from service users and staff on virtual delivery. This provides some flexibility in expanding the scope of the new service model. For example, virtual contacts (telephone and WhatsApp calls) followed by welfare calls which were found to respond to the needs of some children, young people and families and can also help reduce staff workload. In addition, COVID has highlighted other opportunities for for access to services, highlighting the benefits of virtual contacts combined with more traditional approaches.

3.11 Summary of Changes

3.11.1 0-5 Health Visiting

| Current Offer | Proposed Offer |
|---|---|
| 5 Mandated Contacts<br><br>• Antenatal contact 28 -32 weeks gestation<br>• Primary Contact 10 -14 days<br>• 6-8 week Contact<br>• One year development review contact<br>• 2 – 2 ½ year development review contact<br><br>A range of prevention and early intervention and support given to families including safeguarding and supporting vulnerability | 5 Mandated Contacts – to be delivered in a in a mix of face to face and virtual contacts based on risk assessment:<br><br>• Antenatal contact 28 -32 weeks gestation<br>• Primary Contact 10 -14 days – Always face to face<br>• 6-8 week Contact<br>• One year development review contact<br>• 2 – 2 ½ year development review contact – Always face to face<br><br>Child in Need and Safeguarding support |

3.11.2 5-19 Support

| Current Offer | Proposed Offer |
|---|---|
| 5 HEALTH REVIEWS<br>• 4-5 year old health needs assessment<br>• 10-11 year-old health needs assessment<br>• Screening service<br>• National Child Measurement Programme which measures the height and weight of children and brief advice given to families if child is overweight or obese (statutory requirement)<br>• Vision and hearing screening at school entry<br>• Support for emotional wellbeing and resilience and in reducing risk-taking in young people | Safeguarding Support<br>Support for emotional wellbeing & resilience<br><br>Additional Potential Mitigations (See Section 8)<br>• Virtual School Nursing Offer via a Professional Service based within the NYCC Customer Service Centre linked to current MAST arrangements<br><br>• Sexual Health Support into Schools via variation of the current Sexual Health Support contract<br><br>• Audio and Visual Screening either via a revised service offer linked to NCMP or |

| | |
|---|---|
| | through alternative routes such as High Street opticians |

3.12 Safeguarding

There are no changes in the safeguarding arrangements and practices in children aged 0-5 in the new service model. However, a new 5-19 Healthy Child Safeguarding model has been implemented since 1st September 2020. It describes the Healthy Child Service role in ensuring local safeguarding procedures was delivered in accordance with the LA contractual and statutory responsibilities and in accordance with Section 11 requirements of HDFT as a 5-19 healthy child provider. The model includes a team that will be aligned with NYCC MAST and a team of practitioners to support safeguarding procedures where it is deemed appropriate for 5-19 to be engaged beyond the initial strategy meeting.

The 5-19 Healthy Child Service team will continue to prioritise representing the voice of the child at Initial Child and Review Child Protection Conferences where they have had contact with the child/ young person or family in the last 12 months, over presenting child protection reports based on historical health records or partner agency information.

Where the Healthy Child Service are not involved they will inform the social worker which health professional should be invited to the conference. We know that this process is not embedded and Children's Social Care are not always receiving this information in a timely way resulting in a lack of health attendance. Given this, it is proposed that 1fte practitioner is created to sit within the Multi-Agency Screening Team for 12 months, which will support the transition period. This post will ensure attendance at Child Protection Conferences are a priority, provide advice to those health professionals attending and promote quality information sharing.

There is need for a system-wide review to consider the impact of the new 5-19 model on local safeguarding processes, and on cases where there will be no 5-19 representation because they are not the appropriate professionals to do so.

## 4.0 Legal Implications

4.1 The legal implications were confirmed in the report presented to Executive on 13th October 2020 as follows:

4.2 The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 and Local Authorities (Public Health Functions and Entries to Premises by Local Healthwatch Representatives) and Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) (Amendment) Regulations 2015 (The Regulations) provide there should be 5 mandated reviews. The Regulations are silent as to whether the reviews have to be in person or virtually.

4.3 It is important to note that The Department of Health issued guidance entitled *"Universal Health Visitor Reviews, Advice for local authorities in delivery of the mandated universal health visitor reviews from 1 October 2015"* (the Guidance). Under this Guidance, the Department for Health refer to these reviews taking place as result of physical visits. There are a number of extracts from Annex A: The five mandated reviews of the Guidance below:

(a) "First visit, Antenatal visit at 28 weeks or above (health promoting visit)
The first time that the health visitor will meet with parents to discuss any concerns or issues that they may have about becoming parents; this is particularly important for first time parents. The antenatal appointment is the first time that the health visitor will meet

with parents to explain the health visiting service offer and complete the initial holistic family health needs assessment…

(b) Second visit: 10 to 14 days following the birth (the new baby review)
The first visit made by health visitor at home after the baby is born, where health visitors will check on the health and wellbeing of the parents and baby, support with feeding and other issues and give important advice on keeping safe, and to promote sensitive parenting.

The health visitor will ask the parents how they are feeling and how the family is adjusting to the new arrival. They will also enquire if they have any questions, (and listen to any concerns parents may have about baby's health or their health). This visit forms an important part of the ongoing holistic assessment of family risk and resilience factors started by the health visitor during the antenatal period…They may also weigh the baby during their visit…

(c) Third visit: When the baby is 6 to 8 weeks old (6 to 8 week assessment)
This visit is crucial for assessing the baby's growth and wellbeing alongside the health of the parent, particularly looking for signs of postnatal depression. It is a key time for discussing key public health messages, including breastfeeding, immunisations, sensitive parenting and for supporting on specific issues such as sleep. The health visitor will review their general health. They will also give contact details for the local health clinic or children's centre where the mother can get the baby weighed and access a range of support.

This visit is, in addition to the 6 to 8 week medical review, which is often completed by the GP and forms part of the child health surveillance programme.

(d) Fourth visit: A review of the child's development at 9 to12 months (the one year assessment)
This visit may take place in the home, or in a local clinic or children's centre and focuses on the assessment of the baby's development. It provides an opportunity to discuss how to respond to their baby's needs and to look at safety and health promotion messages linked to next stages of development…

(e) Fifth visit: A review of the child's development at 2 to 2½ years (two to two and a half year review)
This visit can take place at the home, local clinic or children's centre. The universal two-year review provides an opportunity to identify children who are not developing as expected and require additional early intervention to achieve PHE's goal of being "ready to learn at two and ready for school at five."

4.4 Clearly from the above, the Guidance states that there should be 5 physical visits, either at the home or through a local clinic or children's centre. Whilst this Guidance is not legislation, it is important to have regard to the Government's Guidance and to specify any deviation from the Guidance and the reasons for that deviation. The consultation proposed a new service model which would have a physical meeting for every review for babies 10-14 days old and at 2 – 2.5 years. Therefore for every child, there would be at least two physical meetings at home (see above). However it is proposed that, amongst other things, with the learning from virtual visits during Covid-19, there could be a risk based approach in adopting mixture of virtual and physical meetings for the remaining 3 reviews. It is proposed that there would still be 5 reviews for each family and that the information obtained from these reviews will feed into the ongoing holistic assessment of family risk and resilience factors. However, it is proposed that some of these meetings would be virtual. Clearly a

virtual meeting will not provide as much information about as a family's home as a physical meeting as there will be a limited view through a virtual meeting and therefore it is important to ensure that appropriate risk based approach is made to determine when a virtual meeting would be suitable and when a physical meeting is needed (as identified in paragraph 9.6).

4.5 It is therefore considered that the proposal complies with the Regulations and, whilst deviating from the Guidance in allowing virtual meetings, there will be appropriate risk assessments to ensure that virtual meetings are only made where appropriate and risk assessed.

4.6 Evidence from the interim COVID model locally and information from around the country where virtual visits are often conducted outside of agreed service models, indicates that this method of delivery can be effective when coupled with robust risk management and strong professional judgment.

4.7 For example, based on the initial 10-14 day visit and existing professional knowledge of the child and family a full risk assessment will be carried out to determine a level of risk, this will be based on a number of factors including:

- First time parents
- Single parent
- Unsupported young parent
- Previous or current safeguarding
- Previous or current drug/alcohol misuse
- Parental mental ill health
- Analysis of cumulative risk including information from partner agencies.
- Parental special educational needs
- Previous child with SEND
- History of domestic abuse

4.8 Where concerns are raised as part of virtual consultations or additional information is received from partner agencies, this will inform a revision of the risk assessment and revaluation of the delivery of visits to that family.

4.9 Based on these factors it is proposed that any child or family designated to be at risk will receive 100% of their visits face to face with only those designated as low risk receiving virtual support.

4.10 The Council has taken into account its statutory duties in the development of Healthy Child Programme and the proposals included in it, and in the associated consultation process.

4.11 It is considered that the proposal complies with the necessary regulations. Whilst the changes to 0-5 services deviate from the Guidance in allowing virtual meetings, there will be appropriate risk assessments to ensure that virtual meetings are only made where appropriate and risk assessed.

## 5.0 Financial Implications

5.1 As set out in the report to Executive on 13th October 2020, the financial profile for the service is as follows:

| Years | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 | Years 6-10 | Total |
|---|---|---|---|---|---|---|---|
| | 2021/22 | 2022/23 | 2023/24 | 2024/24 | 2025/26 | 2026-31 | 2021-2031 |
| Core | 7,541,500 | 7,611,500 | 7,394,500 | 7,154,500 | 6,884,500 | 34,422,500 | 71,009,000 |
| Support | 270,000 | | | (200,000) | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Savings | (200,000) | (217,000) | (240,000) | | | | (657,000) |
| Total | 7,611,500 | 7,394,500 | 7,154,500 | 6,884,500 | 6,884,500 | 34,422,500 | 70,352,000 |

5.2 North Yorkshire County Council Funding

5.2.1 The Healthy Child Programme is funded through the North Yorkshire Public Health Grant which is a funding allocation from Public Health England to the Council. This is a defined pot of funding from central government for the delivery of Public Health services.

5.2.2 The Public Health Grant was subject to 8% national reductions between the financial years 2017/18 and 2019/20, with an inflationary increase only for the financial year 2020-21. The level of future Public Health Grants is announced annually and cannot be predicted. As a result the Council is required to make spending reductions across a range of Public Health services.

5.2.3 Healthy Child services account for approximately a third of North Yorkshire's Public Health spending and they will continue to be at a similar share, despite the reductions in national Grant.

5.2.4 All Public Health programmes are being reviewed and the Healthy Child 0-19 programme will need to transform the service and make savings of £657k by 2024.

5.2.5 Whilst the core HCP is funded through Public Health as above, it should also be recognised that significant additional funding from HDFT for services such as those included at 3.5 is also being withdrawn, or has already been withdrawn. As such, even if the full level of funding required through the Public Health Grant to maintain service levels was made available, it would still be necessary to enact some or all of these measures to keep the service within budget.

## 6.0 Consultation Process

6.1 The meeting of the Executive on 13/10/2020 approved the start of a formal public consultation on the proposed changes to the service as set out above. This consultation ran for 10 weeks, beginning on 26/10/2020 and concluding on 04/01/2021.

6.2 Prior to the start of the consultation the process was benchmarked against a similar previous consultations regarding Home to School Transport. To ensure a meaningful consultation, a benchmark of 150 survey responses and 50 face to face / virtual contacts was set.

6.3 The consultation sought public views on the following questions:

a. In the context of a national reduction in North Yorkshire's Public Health Grant, do you support the proposals to prioritise children under 5, and their families, so that they have the best start in life?

b. In the context of a national reduction in North Yorkshire's Public Health Grant, do you support the proposals for 5-19 year olds which are focussed on:
   - supporting vulnerable young people
   - developing a service for emotional resilience and wellbeing.

   How would you see that support being provided to children and young people?

c. We have learned from how we had to adapt during the Covid-19 pandemic, and in future, we want to deliver some of the Healthy Child programme online and via the

telephone. How do you think digital and telephone services could help support families in North Yorkshire?

6.4 The consultation asked respondents for a Yes / No response to a statement and then asked for any further responses via free text. This has allowed for a rich response which is included in its entirety as Appendix A. A summary of the key issues and concerns raised by respondents along with a full response and link to the relevant mitigation where appropriate is provided below in section 7.

6.4 Due to COVID, the majority of the consultation was completed online via surveys and publically advertised virtual events, however all electronic publicity also featured contact phone numbers via which physical copies of the consultation pack could be accessed.

6.5 Physical posters were made available in libraries and schools. It should be noted that the November – December 2020 lockdown will have reduced the effectiveness of these promotions.

6.6 Promotional materials were also supplied in Polish, Arabic and Romanian with additional languages available on request.

6.7 Events were promoted via the Council and HDFT Websites, Council and HDFT social media, press releases prior to and during the consultation, Red Bags into schools, posters in libraries and other public areas and through existing professional networks. Full details of all promotional activity can be found in the communications plan.

6.8 Given the current context, the consultation team focussed on attending events where parents, users of the service and professionals would already be present to speak to as many people as possible. This included:

- Foster Carers Group;
- Primary School Leadership Meetings in Hambleton & Richmondshire, Ryedale, Scarborough & Selby, Craven and Harrogate;
- Secondary School Leadership
- North Yorkshire Primary Care Commissioning Committee
- Area Constituency Committees

In total 98 people were in attendance at these events.

6.9 In addition to these events, HDFT ran a number of staff briefing events for those directly affected by the proposed changes. Whilst these events largely focussed on the potential implications for the staff group, the new model was discussed with HDFT colleagues informed of how to respond to the consultation.

## 7.0 Consultation Responses

7.1 In total 245 people responded to the online survey, exceeding the benchmark set (120) by 125.

7.2 In total the consultation reached 130 people in face to face / virtual settings exceeding the benchmark set (50) by 80. This number comprises 98 people through pre-existing meetings and 32 who attended HCP specific events hosted by the Council.

7.3 The following tables set out the responses received in terms of locality, gender, ethnicity, age and the capacity in which respondents were completing the survey. The responses

indicate that the consultation was successful in reaching people in all areas of North Yorkshire in proportion to the populations of each locality.

| District | Responses Received | % of Total Responses | % of NY Population living within District |
|---|---|---|---|
| Craven | 25 | 10% | 9% |
| Hambleton | 42 | 17% | 15% |
| Harrogate | 88 | 36% | 26% |
| Richmondshire | 20 | 8% | 9% |
| Ryedale | 18 | 7% | 9% |
| Scarborough | 34 | 14% | 18% |
| Selby | 16 | 7% | 14% |
| Did not answer | 2 | 1% | |

| Gender | Responses Received | % |
|---|---|---|
| Male | 29 | 12% |
| Female | 213 | 87% |
| I describe myself in another way | 2 | 1% |
| Prefer not to say | 1 | 0% |

| Ethnicity | Responses Received | % |
|---|---|---|
| White | 238 | 97% |
| Mixed / Multiple ethnic groups | 1 | 0% |
| Asian / Asian British | 0 | 0% |
| Black/African/Caribbean/Black British | 0 | 0% |
| Other | 0 | 0% |
| Did not answer | 3 | 1% |
| Prefer not to say | 3 | 1% |

| Age Group | Responses Received | % |
|---|---|---|
| Under 16 | 0 | 0% |
| 16-19 | 1 | 0% |
| 20-29 | 17 | 7% |
| 30-39 | 90 | 37% |
| 40-49 | 73 | 30% |
| 50-64 | 47 | 19% |
| 65-74 | 10 | 4% |
| 75-84 | 1 | 0% |
| 85+ | 0 | 0% |
| Prefer not to say | 6 | 2% |

| Role completing survey* | Responses Received |
|---|---|
| Professional / on behalf of organisation | 68 |
| Member of the public | 162 |
| Healthy Child service user | 61 |
| Member of staff affected by the change | 6 |

*Respondents were able to select more than one field for the question so total responses exceed 245.

### 7.4 Response to Question 1

7.4.1 People were asked:

*In the context of a national reduction in North Yorkshire's Public Health Grant, do you support the proposals to prioritise children under 5, and their families, so that they have the best start in life?*

| Response | Responses Received | % |
|---|---|---|
| Yes | 179 | 74% |
| No | 63 | 25% |
| Did not answer | 3 | 1% |

| Response by Locality | Yes | No |
|---|---|---|
| Craven | 57% | 39% |
| Hambleton | 73% | 27% |
| Harrogate | 71% | 28% |
| Richmondshire | 68% | 32% |
| Ryedale | 83% | 17% |
| Scarborough | 90% | 10% |
| Selby | 75% | 25% |

| Response by Role | Yes | No |
|---|---|---|
| Professional / on behalf of organisation | 78% | 22% |
| Member of the public | 72% | 27% |
| Healthy Child Service User | 73% | 27% |
| Member of staff affected by the change | 62% | 38% |

### 7.5 Response to Question 2

7.5.1 People were asked:

*In the context of a national reduction in North Yorkshire's Public Health Grant, do you support the proposals for 5-19 year olds which are focussed on:*

- *supporting vulnerable young people*
- *developing a service for emotional resilience and wellbeing.*

*How would you see that support being provided to children and young people?*

| ***Response*** | ***Responses Received*** | ***%*** |
|---|---|---|
| *Yes* | *179* | *75%* |
| *No* | *62* | *25%* |
| *Did not answer* | *4* | *>1%* |

| ***Response by Locality*** | ***%*** | ***%*** |
|---|---|---|
| *Craven* | *65%* | *22%* |
| *Hambleton* | *76%* | *24%* |

| | | |
|---|---|---|
| *Harrogate* | *74%* | *24%* |
| *Richmondshire* | *74%* | *26%* |
| *Ryedale* | *67%* | *33%* |
| *Scarborough* | *84%* | *16%* |
| *Selby* | *69%* | *31%* |

| ***Response by Role*** | ***%*** | ***%*** |
|---|---|---|
| *Professional / on behalf of organisation* | *73%* | *27%* |
| *Member of the public* | *71%* | *27%* |
| *Healthy Child Service User* | *80%* | *18%* |
| *Member of staff affected by the change* | *46%* | *54%* |

7.6 Summary of consultation feedback and key issues raised

7.6.1 Whilst these specific questions were asked, feedback tended to cover both questions in a single answer. The full feedback is attached as Appendix A. The following summary is provided along thematic lines for ease of reading and response.

| **Key themes regarding changes to 0-5 Health Visiting Services** |
|---|
| *"I feel like parents with younger children need more help/advice."*<br><br>People think the earlier support is given the better – for parents as well as children.<br><br>There are concerns that one visit will not be enough to sufficiently assess a family, and that people who do not receive a future face to face visit will be "forgotten about".<br><br>There are concerns about safeguarding of children that may arise from a blended face to face and virtual approach and lack of school nurses in school<br><br>People feel the proposals mean there will be children and families who "fall through the cracks" without the provision required to support them later on.<br><br>A major concern is that reducing the number of visits and the inclusion of online provision will mean missing vital mental health cues for mothers, developmental issues for children and safeguarding concerns for all.<br><br>People think there is a risk of excluding families who would not be classed as vulnerable. "These new parents still have a lot to learn and get a lot from these services to support them and their children. |
| **Response to key themes identified** |
| The council acknowledges the level of concern regarding this proposal, however the Healthy Child Programme must be seen as part of a constellation of services available to children and families in North Yorkshire. The mitigations set out in Section 8.0 set out how families will be able to continue to access many of the services currently delivered through HCP. |

The proposal for Health Visiting ensures that all children will receive a minimum of 2 face to face visits from a qualified Health Visitor and a further three contacts via a blended approach. In any instance where there is concern for health and wellbeing these visits will be face to face, with additional support through other services made available as part of the wider offer. This includes support from the Council Early Help and Early Years, health services and from community networks and peer support groups.

Many respondents cited inaccurate assumptions as to the nature of the future model, principally that all visits would be completed virtually rather than through a risk assessed and managed approach. Further communication and engagement work is required with the public and key partners to challenge these incorrect assumptions.

| **Key themes regarding Changes to Support Groups** |
| --- |
| A number of people commented on support groups and face to face support provided, particularly breastfeeding groups. Several people noted the importance of such groups and support to help people's mental health and prevent the escalation of issues.<br><br>People attending groups get more out of them than just the intended service provision. For example, as well as getting their baby weighed parents can talk to other families and ask professionals other questions. We will be working with Stronger Communities and wider community networks to develop peer support, building on existing practice. |
| **Response to key themes identified** |
| Provision for breastfeeding groups has been reduced and withdrawn by HDFT as part of their reduced offer over recent years. These services are beyond the scope of the current consultation, however we would again look to signpost parents to relevant local groups and support within the community as part of a health visitor contact or through any other contact where a need was identified. |

| **Key themes regarding withdrawal of Audio and Visual Screening** |
| --- |
| While people agree with the proposal in principle, they do not support the decommissioning of hearing and vision screening.<br><br>*"My child's squint was picked up at her vision screening test in reception and I feel strongly that other children are not now going to get the same service. Many parents work and do not get chance to go to the opticians or know that this service is free."* |
| **Response to key themes identified** |
| This screening programme is not a mandatory part of the HCP and is not delivered in this way in many parts of the country. Evidence from other local authorities where the service has been withdrawn shows no evidence of harm.<br><br>Screening will be considered at all 0-5 health reviews. At any point health visitors can refer direct to audiology and ophthalmology for a test. We will work with Teachers and GPs to support access to visual and audiology services where needed.<br><br>We will work with Teachers and GPs to support access to visual and audiology services where needed. |

| **Key themes regarding School Nursing** |
| --- |
| Respondents felt that the reduced school nursing offer would place additional pressure on teaching staff and primary care. |

Concerns that a reduced offer on sexual health will lead to increased rates of teenage pregnancy, STIs and risk taking behaviour

**Response to key themes identified**

There will not be capacity in the proposed new model for a named school nurse for each school. The service will develop online support for school on a range of issues. The emotional health and resilience team will provide targeted support to children and young people with low level emotional and mental health issues and other issues that they may be presenting with (e.g. sexual health and drug and alcohol problems).

**Key themes regarding future use of technology**

In some circumstances people think it can be more beneficial to be supported by phone or online. For example, when parents are busy it is more efficient. One respondent said their child views their home as a safe space and felt it was being "invaded" by professionals so would have been more at ease being supported virtually.

*"Great idea and expands options for young people and families."*

*"In select cases it will probably be useful."*

People feel parents (particularly first-time parents) get a lot of additional support attending groups in person which won't be available if face to face contact is reduced.

People noted the progress that has been made with online support and while they do think this should be explored further as part of future service provision, they also believe that alternatives should be available and that people should have a choice. Digital should not be the default.

A significant number of professionals responding to this question are wary of the potential for missing cue to any issues and the impact it may have on developing an effective therapeutic relationship with people.

Several responses noted that not everyone has access to the technology or sufficient high quality connections/service to access effective digital support.

**Response to key themes identified**

The responses indicate support for an increased use of technology within the service, but this needs to form part of the offer and not be a blanket approach – this is very much in line with the proposed model.

Concerns centre on the potential for isolation, especially in new parents and the risk of missed cues for areas of concern.

Technology will form a key part of the service but this will be balanced within the risk assessment. As with previous responses, it should again be noted that these contacts form a single part of a wider network of services and supports.

The protection of children and young people from risk and safeguarding remain a priority for the service.

## 8.0 Mitigations

8.1 The consultation process has raised a number of key points for consideration in determining the final structure of the service. Whilst the saving required means an inevitable reduction in the level of service provided, the following mitigations in terms of reinvestment into the service are being actively considered and developed across CYPS and HAS.

8.2 All proposed mitigations will come with additional costs which will need to be considered in the context of the overall service change and savings requirement.

8.3 These mitigations continue to be developed with the intention that any further mitigations to the service model as a result of the consultation, and approval of the final service model are delegated to the Director of Public Health, in consultation with the Director of Health and Adult Services and Director of Children and Young Peoples Services.

8.4 <u>Hearing and Vision Screening at school entry</u>
Mitigation: Hearing and vision will be checked as part of mandated health and wellbeing reviews carried out by health visitors. In relation to vision screening, families can visit their high street opticians for any concerns with their children's sight. There is evidence that once neo-natal hearing assessments were fully rolled out across the country some areas stopped school age screening. We are not aware of any evidence that this has led to harm. We are also developing ways that will enable professionals (e.g. teachers and GPs) to refer children with hearing or vision problems to hospital audiology or ophthalmology services for investigation.

The project will continue to work with HDFT to explore possibilities for integrating a form of screening through the National Child Measurement Programme. Discussions are ongoing with HDFT to fully cost and model this proposal, alternative provision through other sources such as high street opticians are also being fully explored.

8.5 <u>School nursing</u>
Mitigation: There will not be capacity in the 5-19 workforce to provide a named school nurse for each school. The service, working with local partners, will develop online support available to schools. The emotional health and resilience team will provide targeted support to children and young people on low level emotional and mental health issues. The team will also be able to address other issues that young people many present with. We will also explore various options to allow schools to access professional advice remotely – potentially through an enhanced front door offer within the Council.

Some mitigation of the impact of this change could be made through the addition of an advice and support service for schools within the CSC Front Door team with relevant professional capabilities to address areas of need, potentially embedded within the existing MAST structure.

8.6 <u>Level 1 continence support (advice and support about daytime and night time wetting)</u>
Daytime and night time wetting will be considered at 2-2.5 years integrated health review and families be provided with information and advice. We are developing ways that families can access the information and support they need to self-manage these conditions at the level 1 (low level) stage. We are also developing ways that will enable professionals (e.g. teachers and GPs) to refer children with daytime and night time wetting for specialist support. There has been ongoing work to explore developing an integrated incontinence pathway across the system led by the CCGs and service providers.

8.8 Sexual health services

Mitigation: The Council will continue to support the delivery of quality Personal, Social and Health Education (PHSE) and implementation of statutory relationships and sex education (SRE) in schools. The service will provide effective signposting to local sexual health services commissioned through Public Health. The Council will work with sexual health providers to ensure that services are delivered from young people friendly settings.

Mitigation of this change may be achieved by extending the remit of Yorkshire MESMAC (part of NY sexual health services) who currently offer sexual health services to various communities across Yorkshire (including men who have sex with men, BAME and other marginalised races, people misusing drugs, sex workers and LGBT+ young people and adults) in to school settings. Initial discussions have taken place with Public Health commissioners and this would be deliverable via a contract variation.

8.10 Signing off Educational Health and Care Plans

Mitigation: There is not a formal requirement for health care plans to be "signed off" by a health professional. However, the health professional overseeing the child's care would be asked to input into the plan. This can be any health professional and would only be a school nurse if they are overseeing the child's care. The CSC Front Door School Advice (see section 8.5 above) if implemented can provide schools with advice and support on this.

8.11 School Entry and Year 6 Health Questionnaires

Mitigation: We need to look at how we bring together lots of bits of existing information so we can understand needs better. For example, we have the GUNY (Growing Up In NY) survey which assesses health needs in schools. Individual schools get their own reports of the issues that are key in their school. Many schools take part in the survey. Also with the Healthy Schools Award work with a focus at improving the environment in the school to enable more promotion of healthy eating, physical activity, mental health etc. We are also looking at a bigger focus on prevention, including exploring digital and online ways to support families to improve health and wellbeing.

8.12 Safeguarding

As set out at 3.12 above, to ensure the Safeguarding process is fully embedded and that all relevant information is shared, it is proposed that 1 FTE practitioner will be added to the existing Multi-Agency Screening team (MAST) for 12 months following implementation of these proposals.

## 9.0 Overall Consultation Response

9.1 This consultation has generated significant public and professional interest from a wide range of respondents. Responses received significantly exceeded the benchmarks set prior to the start of the consultation which shows the level and intensity of interest in this service.

9.2 74% of respondents gave a positive answer to the Yes / No questions, these responses are therefore supportive of the direction of travel proposed in terms of *prioritising children under 5, and their families, so that they have the best start in life* whilst also *supporting vulnerable young people* and *developing a service for emotional resilience and wellbeing.*

9.3 The narrative responses do set out a more nuanced picture, whilst there is support for the overall direction of travel, many specific concerns have been raised in particular relating to the reduction in audio and visual screening and school nursing provision. Specific consideration has been given to the key themes of response under Section 8 along with associated comment and proposed service mitigations.

9.4 One area not raised significantly during the consultation but of priority to the Council is how changes will affect Safeguarding practice and process as set out in Section 3.12.

9.5 It should be noted that despite best endeavours to set out a clear statement of the future model, a number of responses misunderstand or misrepresent the proposal, most notably when commenting on the blended approach to Health Visitor contacts. Work will continue to articulate the proposal to partners and the public.

9.6 Much of the reduction in service offer relates to services which are not directly mandated under HCP and are not delivered through HCP in other parts of the country.

9.6.1 HCP forms a part of a much wider constellation of services to support children and families. Agencies in North Yorkshire work effectively together to support Children and Families, the proposed approach to service delivery with HDFT will only serve to strengthen the system.

## 10.0 Equalities Impact Assessment

10.1 Please refer to Appendix B.

## 11.0 Recommendations

11.1 It is recommended that the Executive:

i. Acknowledge the result of the public consultation on changes to the Healthy Child Programme, and potential mitigations proposed as a result of the consultation; and

ii. Delegate any further mitigations to the service model as a result of the consultation and the approval of the final service model to the Director of Public Health, in consultation with the Director of Health and Adult Services and Director of Children and Young Peoples Services.

Richard Webb
Corporate Director for Health & Adult Services

County Hall
Northallerton
15 January 2021

Author of report – Michael Rudd
Presenter of report – ?

Appendices:
Appendix A Full Consultation Response
Appendix B: Final EIA
Appendix C: Communications plan
Appendix D: Draft Service Specification outlining service model

Additional Information: Links to relevant legislation:

1. Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2017

   https://www.legislation.gov.uk/uksi/2017/505/pdfs/uksiem_20170505_en.pdf

2. Universal health visitor reviews: advice for local authorities

https://www.gov.uk/government/publications/universal-health-visitor-reviews-advice-for-local-authorities

**Q1:** In the context of a reduction in North Yorkshire's Public Health Grant of up to £4 million in the next few years, do you support the proposals to prioritise children under 5, and their families, so that they have the best start in life?

## All comments from people supporting proposal

In schools there are many children who come that would have benefitted from more family support and early intervention.

These children are not in school, so parents do not know where to go for supoort, once in school staff in the setting can guide parents and also keep an eye on Safeguarding concerns

Children deserve the very best start in life.

parents need to be encouraged to understand and respond appropriately to their children's needs and behaviour- with empathy and warmth, this information can underpin better relationships through childhood

Young children need support to get it right as they grow and develop.

I think the earlier advice and information is given, the better.

It's really important to support children and their families before they start school.

I agree that young children and parents of that age group need plenty of support.

Support for new mums is vital

However face to face is the way forward. One visit will not be enough to assess a family? How can this be done virtually. I really worry I will be forgotten about and my children.

Agree to prioritise but feel 5+ also need support and the school hearing and vision tests etc in school should not be taken away

I feel this is where to help is needed so they get it sooner and set them up for life

This is a crucial period but I do feel that children above 5 need continued intervention too.

New parents need support as there is so much to learn, however this doesn't stop when they get to five.

I agree we need to prioritise children under 5 to ensure they have the best start in life, but cutting the mandated contacts by health visitors is going to be detrimental . There will be children who may be at risk with safeguarding issues in the community . The numbers of health visitors are being cut. This means those left in employment are working so hard that I believe it will result in high sickness rates. The questions asked here are heavily weighted to have the general public believe that you will be providing a better service. I believe this to be disingenuous.

We know the first 5 years of life is vital in establishing good physical health & emotional wellbeing.

The under 5's should be seen in their home at regular intervals to ensure they are safe and being cared for adequately

At this age the children are reliant on adults and so ensuring a family approach is best to give all children the best start.

They need more intense support

Early development is crucial to the outcomes for all the rest of life. A building stands on its foundation.

we must give young families a good start in live

This enables support at crucial time in development and also enables any concerns to be picked up and followed through appropriately, if needed after the age of 5

Any safeguarding issues should hopefully be identified and supported early on.

Because children need a good start in life in order to become successful confident & healthy in later life

I understand the importance of the first 5 years of a childs' life

The brain is still developing in this stage, by providing adequate support to families with children in this age range could and will prevent some children having a negative impact on their brain leading to poor mental health in later life, inability to manage their emotions etc. Get the support in quick before the damage is done.

Early intervention is Key to success.

Agree when children are under 5 its a pivotal point in determining the child and families long term health, education & wellbeing outcomes. Its a key time to support parents in making healthy choices & positive lifestyle habits. Blending universal & targeted families together has lots of benefits. As you say it takes a village to raise a child. Parents are parents no matter their background who are invaluable to one another in supporting positive changes with their children.

A positive start to life and engaging with support and agencies from the beginning reduces reluctance to work with these professionals later if needed. Many health and development concerns can be picked up at a young age with support put in place reducing impact as the child develops.

Research has proven over many years the early years of a child life are crucial to their healthy and positive developmental outcomes and focus should be in this area. However not at the expense of the remaining age ranges.

I support the proposal to prioritise children under 5. I think it's important that families can have the option to request face-to-face support over virtual support, as opposed to this being decided through a risk assessment. I understand that this may initially be risk assessed and virtual support proposed based on the outcome. However, I feel it's important that families have an opportunity to request for this to be done face-to-face (this is also based on my personal experience and situation).

As a mum myself I really benefitted from the advice of the health visitor. In my professional role Health Visitors are often best placed to build positive relationships with families - they are generally well liked & respected

Most importantly, I think services need to work together to support vulnerable families who have children under the age of 5. Online video workshops/ advice for parents to access could be a cheaper way to deliver ongoing support, rather than leaving parents to manage with little input between external professional visits. Online local forums could also help NYCC parents. Even signposting parents to existing forums like Mumsnet, for example, could help.

I do think that there needs to be more support for new parents though. Especially new fathers; in the experience of my family, the support was entirely focused on mum and baby with little regard for the impact any issues may be having on the father - it seemed a slightly outdated model in that respect. There was also very little support with breastfeeding; mum and baby experienced issues initially which eventually turned out to be a medical issue. Were it not for mother's intuition and constantly asking for support, breastfeeding would have stopped in the early days of returning home. We ended up having to employ a private breastfeeding consultant out of desperation and in the search for answers and support.

I feel like parents with younger children need more help/advice

This is obviously a priority but at the expense of services for older children and young people

My baby was born with a tongue tie but they wouldn't fix it because he could eat formula from a bottle. The best start for my baby would have been breast milk but he wasn't allowed it because of Covid. And don't even get me started on having to Google how to do the basics for my new baby, in a hospital ward, 10 feet away from the nurses station because they were too busy drinking tea to help. Focusing on 0-5 is wonderful so long as you are going to get all departments on board and then follow that up with a HV team who actually show up.

Evidence shows a good start is so important

Evidence shows the benefits of early intervention targeted at 1001 critical days

Focusing on the early years will help prevent problems developing that then are costly to fix (cheaper to prevent obesity than treat it). There should be some focus given to how the older age group can still be supported, through systems based work, through harnessing the power of the voluntary sector.

I believe this is a key period in a family's development. In particular, I would like to see face to face group meetings such as breastfeeding groups continue. During that very earlier stage when mums are at their most vulnerable it is a great way to provide a feeling of not being alone. Check in clinics were also incredibly valuable to me in the early stages, as a mum who is anxious - having your baby seen and looked at goes a long way to help a very worried mum.

Absolutely. Lots of families with children under 5 need support.

Early identification and intervention is very important as is taking a whole family approach. Every effort should be made to address /mitigate the likelihood and impact of trauma, deprivation and averse childhood experiences at an early

Prevention starts at the earliest opportunity and should be from a holistic view. understanding the needs and lifestyle choices of parents/guardians can illicit the correct interventions fast.

Parents of young children need face to face support during a potentially very stressful stage in their child’s development. It’s when post natal depression and psychosis and other mental health problems could be left untreated and this would have long term effects on the children involved as well as the parents. At a vulnerable point in your life, in particular when you have your first baby, you need faces around you supporting you and watching out for you. This cannot be done properly unless face to face.

Having the best start in life will minimise burden on system in years to come

These are the years where parents have the least support in bringing up their children, and where it has the biggest impact on a childs life.

Appreciate that services need to be restructured to respond to lower funding and my feeling is that early years a should be a priority. However, certain services must be maintained for all, such as the breastfeeding groups, health visitor check-in and weighing and some of the paid for services (eg baby massage). After having my daughter two years ago, as a middle class person with good support from family, I still struggled with the adjustment to motherhood. The services provided by the breastfeeding drop-in and health visitor drop-in were essential for my own sanity where I could check my baby was ok, and where I could seek current advice. Without this essential support I would have visited the doctor a lot more and my emotional well being would have been significantly worse, during a transition which didn't come naturally to me. The paid for services delivered locally were again important as it would have been possible to travel into [town] for a baby massage class, but at the time I would have found the additional travel time, finding way, parking etc just too overwhelming and wouldn't have done it, rather than just attending a local venue. Again the ability to meet others and a deal with a professional who can offer advice and support was so important to maintain my mental health at that challenging time. I wouldn't qualify for much support under the proposals. Without access to such services, the mental health of new mothers will deteriorate.

Early support is key I believe.

Most vulnerable group of children concerned about timings of initial inputs 10 days!

Children and families need more support in early childhood to ensure that the child has the best start possible and parents have the skills they need.

because it is most beneficial if you can identify needs and put support in place as early as possible

Often very young children's needs are overlooked and not always picked up. in an ideal world I would like to see more input into the under 5 group. If year old and two year old assessments are done virtually sometimes this is not a true reflection of the child's abilities. What happens to children with additional needs? Would there be more input?

It is imperative to focus on childrens early development to give them the best start in life.

Early identification-better start

The earlier any interventions can take place the better. Children need to be reached before school age and parents need more support in that crucial first year. During this first few years parents need to be targeted around - sleep, behaviour management, the use of electronics, how to teach their child to play, how to interact with their child, how to promote independence and as much of these basic parenting skills as possible.

It is paramount that all children receive the best start in life and have access to the correct provision and resources.There needs to be more communication/ collaboration with the Health visiting teams and professionals.

I agree this is a particularly important time for children's wellbeing, especially emotionally.

Early intervention can make a huge difference to a child.

I support ensuring there is a focus on children under 5 whilst continuing to support children of all ages. Focussing on under 5s will address issues earlier and stop them becoming bigger and harder to address, however, there needs to be an interim period where those from 5 upwards continue to have a focus otherwise a generation of children will have fallen through the gap when the priority focus switches.

As a dentist I feel very strongly that early preventative care has a massive impact on a child's general health and oral health, this I turn sets children up better for learning etc.

A qualified health visitor should visit in the 1st year , assessment of the baby, mum and the home is essential.

If support is given earlier it will give the child the best start

As a rule most help is needed during this period

Research has shown support with the under 5's has a massive impact in later life

As long as parents know that they are being supported by staff that are not actually health visitors then I feel you are managing their expectations.

Rightly early years intervention is crucial but also screening for hearing and sight as if not identified early can lead to future problems

Children under 5 need to be prioritised as often they are not seen by professionals (ie not in school) and in cases where there is a neglect this can be concerning. The more support for under 5s the better

Being given the proper support during an indanrs early years will nake a long lasting development impact on their life.

I think the lack of services at the moment is appalling, no baby weigh in clinics, no contact with the health visitor & a distinct lack of interest & care

It is a really important time after having a baby to have the support you need. I struggled to breast feed my daughter and without the support given I wouldnt have been able to continue. The support also given helped me immensely.

The amount of children starting school or Nursery school at 3 yrs old who have not been toilet trained (and no medical reason as to why) has increased significantly over the last 5 years. Parents don't seem to know who their health visitor is or where to access support for their pre-school child. There is also a significant increase in children starting school with very limited / poor speech. Overall, there is much more demand on schools supporting those parental issues which would have normally been picked up by the health visitor and then school nurse.

want baby weigh in clinics to continue

Sadly I don't think you have any other option but I think the loss of service to all ages is palpable and I hope you have made it clear ri Members and MPs the harm that is being done.

It is a sensible preventative approach

Yes. Infant feeding should be prioritised, at the moment the support available for infant feeding is very poor due to the lack of health visitors in the area and lack of training/experience. There should be specific people employed to offer families infant feeding support under the supervision of the health visitors.

However, continued support of school aged children is needed. I worry that this needs to be looked at holistically and where reduction in services to some children and families may be ok to others this would be a complete failing. In terms of the equality act bed wetting/audiology screening etc are still real problems to families and children and early identification of audiology problems may improve a child's ability to learn if support is put in place. How many children will not receive continued support for their best start in life through early years and what will go missed?

Only link to social care support via health visiting team as no support available or direction from other sources available at this age group. Concerns can be picked up by schools in older children

It's been proven that the early years are crucial for development.

I think it is important to give support to parents of young children so that they have the information to raise happy, healthy children. However if it had not been for the vision test my son received when he was five we might not have realised that his vision was quite impaired. As a first time mother I wasn't told that I should take my child to have an eye test that young and as it turns out his vision is very poor and he will need glasses forever. His learning was massively affected and he is still catching up in Year 5. As he didn't have a squint or any other obvious signs of poor eye sight I assumed he was fine. This will always affect me as I blame myself for not realising sooner. I hope that there will be some kind of advice given to parents about taking their child for eye tests sooner as part of the new program of support as it wasn't mentioned to me in any of our health visitor check ups. Maybe it could be added to the red book as a section as I used the red books as a check list to make sure I had sorted other things like age related reviews with health visitors and immunisations. To me the loss of the vision screening is heartbreaking as is the fact that the budgets are being cut.

The reduction is disgraceful, children are our future. My Health Visitor Children's Centre were essential to my wellbeing and my two under 5's

But feel that no age of child should have to be prioritised over another. A child's needs can change so much from 5 yrs old to 19.

The first few months of any child's life can require qualified medical support. In my opinion this is best delivered by the Health Visitors and ideally by one that is allocated to the family. For example. A baby might have undiagnosed tongue tie or other issues (prolonged jaundice) when signed over to the Health Visiting team from the Midwife. In order to meet the WHO guideline that babies be breastfed these babies and Mums need face to face support until breastfeeding is established. Providing the support from one Health Visitor means that the parents will not have to repeat an often traumatic account of the babies early days to a new professional each time they meet. Also the care plan will be consistent. In my experience in London each HV who came into contact with our family provided different advice and changed the plan.

I had very poor care after having twins in 2009 (no antenatal check after a c section until they were 2 weeks old and only because SCBU noticed I hadn't had any checks)

The level of poverty in North York's is shocking, all children deserve the best start in life possible and this means more family support where needed. Not just physical but mental healthcare and emotional . In these days where families live apart and advice and support is not provided by grandparents the education is important to and shared experience

Of course children should have the best start in life but I do feel strongly that school vision screening should continue. Without this service my now 8 year old daughter would not of had her vision improved by the wonderful team at Harrogate hospital . To stop this is completely wrong.

I understand the school vision screening service for reception year is to be withdrawn imminently. This absolutely must not happen. This service picked up the deficiencies in our child's vision. It hadn't even crossed our minds to have his vision checked, and many other first time parents I'm sure will be in the same position.

I don’t know which category this falls under but my little boy had the health test at school in reception class and it changed his life! Without this test we never would have known that there was something seriously wrong with his eye site. He had been for tests at local opticians and it was missed! From the experience of your staff they could tell there was something wrong and we were referred to the hospital where he still goes now as his site is so bad. It would be horrific if this service was cut, as it really does change Childrens life’s

Because this is such a critical time for development.

I agree that this age group should be prioritised and I of course understand the need to rationalise the service in the context of funding reductions. My concern is that the healthy child team is already overstretched and under resourced and there needs to be an easy to refer to and responsive team available still to vulnerable school age children who are able to respond in a timely manner.

The question is loaded. No choice but to focus on under 5s but not good that cuts are being made.

National funding for under 5s is very poor in comparison to funding for primary and secondary aged children. Evidence shows that funding in the early years results has a positive impact on outcomes throughout schooling

The support I have received so far for my newborn has been invaluable. HV has provided consistent support when let down by midwives in early days following birth. As first time mum it is so important to have someone to ask questions and feel that you are not alone.

Too many children slipping through the net. Problems such as obesity need to be caught very early to educate families and support them.

Return on investment is very high for early years interventions. This is why you should reconsider how you have cut this service. This question doesn’t really give any insight in to whether I support the proposed model though .

I agree that the Early Years are vitally important and I have really appreciated the HV team since having my first baby in December 2019.

It is a crucial window for physical and emotional development. If opportunities at this stage are missed it can have a life-long impact. Children of this age are most vulnerable members of society. They cannot express themselves and rely on carers/parents to meet all their needs. I don’t agree with cutting vision and hearing checks on school entry. Most vulnerable will fall through the net. I know this from my experience as early years teacher.

## All comments from people against proposal

Teens should also be prioritised as many are slipping through the cracks

I do think that your proposals do not support or prioritse families with under 5yrs understand the need to reduce budget but your are cutting staff at the wrong level reducing health visitor head count but not managers. Prioritising needs to given to a universal service for under 5yrs to stop them needing help further down the line.

Because this won’t be the reality. They will still slip through the net then there will be NOTHING to enable them to picked up later on.

I don't think it's right to cancel the weekly health clinics. It's not only to weigh your baby, you can get support ask questions etc. If you would do the changes as planned families like ours have no more access to the services. I not only enjoyed the baby groups at [the] children centre (amazing babies / mims) I learned a lot about babies and brain development. Without them I would not have known so many important information which helps my baby or now toddler to grow into a healthy confident person. Although I appreciate that you still want to provide a service for vulnerable families I think you should not exclude"normal" families as we don't know everything and our babies will benefit from this service as well a lot.

Think the services are been short changed by NYCC. The rationale for less core contacts baffles me. The 3-4 month contact should br brought back especially as there is an obesity crisis.

I have experience of working with 5 to 19 years and they have health needs other than emotional resilience and risk taking behaviour and am concerned how other organisations that are not health orientated can facilitate support and provision for them. Family dynamics can change at any time throughout a child's life, so no matter how much support is directed at under 5s, this may lead to a gap in provision when they need it most.

Reduction in the number of visits for families from birth will mean missing vital mental health cues for mothers and development issues for children.

All children matter regardless of their age and it appears as usual that older children again are being left high and dry by your service

I don't think that under 5's should necessarily be prioritized given the current Coronavirus situation. As a mother to a 5 and almost 10 year old I believe younger children are better adapted to deal with the current situation. Older children will face tougher challenges under current circumstances so I believe a balance must be achieved to ensure children aged 5 and over don't become the 'lost generation' that we are all worried about. The grant should be divided more equally to ensure mental health and family support services do not suffer as these areas are consistently underfunded anyway.

This is a leading question. It's not that I don't agree that provision to under 5's isn't important it's simply that many issues only become apparent at a later stage for example when children start school (visual, hearing, attention, behavioural disorders) or when issues such as enuresis don't resolve during primary years. Schools don't have funding or expertise to deal with these issues.

It should be spread proportionally over both areas

As a member of staff with a child over the age of 5 that has been supported by the team at a time in her life where we as a family needed the additional support, it would have been detrimental to her mental health had the support not been available, easily accessible and in a timely manner.

This is too narrow a remit and you have not outlined how you expect services currently being provided eg enuresis support to be provided for in an alternative way.

All ages need to benefit, under 5s already have enough input from health etc.

I have witnessed a decline in services already over the past 5 years between my children being born. With my second, who is 20mths,i have consistently struggled to access health visiting services regularly even pre Covid. The service is clearly already stretched, these plans stretch it even thinner.

I believe that in addition to under 5s there is a need to monitor older children as 5+ is also a crucial age developmentally where problems begin to surface and this is not always picked up in schools as they too have their resources stretched. Furthermore in the family dynamic as siblings come along families can begin to alter in structure due to stress.

It is reducing the service provided to older children

Let's be honest, part of the issue is that I don't accept the reduction in the grant in the first instance - I accept that this is outside the control of the council, but feel we need to be much clearer with the local population as to precisely what risks follow from this. I think there are huge risks in the proposals as they stand. Firstly, I am far from convinced that they do support the under 5s to give "the best start in life". Only one guaranteed face to face interaction with a health visitor means that there is a tangible risk of missing safe guarding concerns, post-natal depression etc. It's not clear from the proposals how you intend to ensure you detect developmental delay, barring relying upon the assessment of parents themselves. How do you intend to ensure that children have the best start in life when you aren't even weighing them regularly any more? To be clear. Children will be harmed as a result of this change. I understand that it follows a cut in your budget, but rather than trying to reframe this all as a good thing, perhaps you should be being honest with our local population?

The changes do not simply support and prioritise children under 5. The loss of clinics (breastfeeding, drop in etc) will impact the support families and children receive, there is a reduction in support for maternal mental health and infant feeding issues will no longer be addressed with no service to replace this loss of support. Having spoken with members of the health cisiting team the service is being dramatically reduced and some families will slip through the net.

We need face to face visits as standard. Weaning over the telephone was very difficult even though the team tried their best

Whilst I am understanding of the funding pressures and NYCC's attempt to make the best of a bad job, this is a only a thinly disguised cut to services. The current needs will no longer be met by the health visiting staff and that workload will be passed to already over-worked GP's

Closing the children's centre in glusburn will have a detrimental impact on parents who need regular interaction and impartial advice from professionals. Having a 'safe' environment to interact with others is pivotal for lots of new parents, particularly single parents, to access much needed support. Given that having a child is one of, if not the most pivotal change in a person's life, it's a real shame that this service is not deemed important enough to retain despite cost cutting.

The sharp increase in reports of abuse of children in their own homes during covid indicates a need for learning. These proposals are too early to be able to state they are based on learning from the changes made during the pandemic. If anything, so far the pandemic has shown the importance of face to face assessments to pick up subtle signs and not to reduce services.

I agree with the premise that early focus has the greatest impact and feel that in particular below 2 is a crucial age when children can be supported to reach their potential. However, I feel that removing service at this stage is a mistake and that there is potential for massive problems being stored up. We already have terribly low breastfeeding rates in the UK and by removing HV involvement in these groups will be putting many children at a disadvantage. Breastfeeding can improve outcomes for baby and mother by improving mental health, wellbeing, interaction and attachment, all of which are evidence based to improve long term outcomes and therefore make savings in the long term. By having fewer face to face services in early years you will miss problems with parent relationships that impact children and have a further impact on costs in health and schools down the line. One service which was invaluable to me was the breastfeeding group set up in Ripon community house. It not only allowed me to get support through my HV for breastfeeding, it also allowed me to forge links with other mums and families which at times was essential for my mental health and for how I interacted with my baby. As it became more established the sessions became more and more autonomous, freeing up the HV time required while still giving the support to mums. I believe it is a mistake to remove sessions like this which are essentially supported by the HV team but require very little input once running but have such value to the community and to the under 5 bracket. In a similar way, there were other sessions run at community house which allowed new mums and dads to meet while also fulfilling aims around parenting or weaning.

I have worked all my life and had to pay for my childcare. I have often been on less exposable income then many people that don't work and are in that bracket. I have never been given any help.

What a leading question. Poor survey design. Face to face support is essential and cannot be replicated by phonecalls. Children and mothers will suffer.

I support but think the reduction in grant is unacceptable

As a parent my child's health needs were only picked up when he had his school health assessment at 5. If it weren't for these checks my child's eye sight would have gone undetected and could have resulted in further sight loss and complications.

I have a 14 year old bedwetter who has relied heavily on enuresis nurse support throughout the past 8 years, We have already experienced reduction in services from attending a clinic appointment getting face to face support to just telephone support. Within the support of [staff] in preparing my son in implementing a good drinking and toileting routine and the administering of Desmopressin my son would never have been able to travel abroad on a school trip. If the current telephone support goes there will be no enuresis service available for my son. Bedwetting is a hereditary condition in our family and has impacted upon many family members. As you can appreciate it is a very embarrassing condition for a teenager which continues to impact about his anxiety and wellbeing.

A lot of issues such as anxiety, dyslexia, bullying, autism, ocd, adhd develop after the age of 5 and children and families need support

I do not feel that this is an appropriate action all children are priority and I don't think by taking funding from other areas of the service is the correct process In terms of hearing screening this is crucial. The newborn hearing screening programme only identifies children with a moderate to profound hearing loss it does not identify those who may have a mild hearing loss or an usual hearing loss. Neither does it identify acquired losses. THe school screen benefits a percentage of children who go on to have an acquired loss or what is deemed an usual loss e.g. reversed slope. Many of which would remain underdiagnosed as parents don't often notice the subtle differences. Concern on how the children who need to be seen will be referred in. Currently GP's are overwhelmed in the area and this will add to their case loads. Local Audiology Services are not set up to take referrals from teachers or parents direct. Should GP's refer our service could be overwhelmed

You should prioritise all children. There is much more for kids under the age of five. Once they get into school and you have issues you are on your own.

This means that primary schools will be required to pick up the majority of work and fight for referrals. Cuts to other services are already significantly impacting on schools being able to undertake their core business of teaching children. This plan puts a whole generation at risk - for goodness sake, please do not cut any further.

In North Yorkshire for a number of years the priority across services has been under 5's. I appreciate the first 5 years of a child's life is a critical time and although I do not dispute that (I am a mum to a 1 year old) it feels that once again, our Young People are being made even less of a priority. It feels like it has to be one or the other.

ALthough 0-5 is a most vulnerable group, I am concerned that there is goign to e a large gap for those older children hose mental heal especially , may deteriorate more without ongoing access to help. Whilst I find that access to kooth and online CBT is helpful I am disappointed that the school nursing service is to be decreased even more. The under5 are served well by HV but I am concisous of using resources wisely and am concerned that by cutting the 5-19 service to the barebones , f the ongoing effect. I am assuming that most of the funding wiull be for safeguarding rather than wellbeing. I do appreciate that this is hard with reduced funding

As a secondary school, we have had much resource removed in this area and we need this without doubt. We understand that there is a funding shortfall, however the proposal doesn’t support those students that are within the years that would miss out. At present we support students through our own school counsellor, Trail Blazer, Youth in Mind and many are referred through Compass Reach and family outreach support workers through NYCC. Further reduction in this area, shall only have a greater knock on effects to schools and we shall have to somehow plug the gap. We can’t afford this!

The question is not written in neutral language. Parents don't need intense scrutiny, however, they need to know support is there if they want it. Also, you stated in your information that health visits are mandatory. No, they are optional. If I felt my health visitor was scrutinising my parenting or monitoring and reporting what was going on I would not have her round again. Luckily ours is fabulous, but I am uncomfortable with what it appears you are suggesting. I have nothing to hide but that level of interference would damage the relationship. In light of your proposals, as babies over 1 year old will no longer get a health visitor check, and instead 'a skilled team' will support. I shall be opting out of the service.

You cannot simply abandon services such as vision screenings for 5-19yo children. Lots of families will end up not being able to access these services and as a result of you prioritising 0-5, older children will suffer and slip through the net.

I agree on the principles of prioritising children under 5, but I believe that the current proposal removing Baby weighing sessions carries very high risks. The risks I feel will be that failure to thrive babies will be missed. My other concerns are that of safeguarding, it will be a lot harder to pick up on cases of neglect and abuse. The weighing sessions also provide a great opportunity to weigh, but also to pick up on soft intelligence and provide information on an opportunistic level. I worry about the consequences of removing this service. Primary care is likely to end up picking up the slack for this, already a service under strain.

I feel there will be a substantial shift of work to primary care including mums presenting concerned about weight, I am also concerned that by not attending liason meetings communication with primary care will worsen and put children at increased risk of harm and safeguarding. This is a retrograde step not an effective one.

As a parent of a 16 and 17 year old with emotional resilience issues and mental health problems there is a woeful lack if resource and when our eldest was bounced to the healthy child team for some liw level intervention he was never contacted by them, not once. He has ended up under a psychiatrist's care because he did not receive early help which might have supported him to work through desire to self harm and prevent deterioration. There is a great deal of support and advice out there for parents of 5 year old and much of it. Support for parents to help their struggling adolescents navigate a complex landscape and numerous life pressures is woeful.

I am concerned about the withdrawal of vision screening for reception children as the screening detected an issue with my child's eyesight which neither myself, the teachers or my child were away of. By early intervention they have corrected her vision in that key stage of development that would have otherwise been missed.

I THINK ALL CHILDREN DESERVE AND EQUAL CHANCE

I think support regarding bed wetting in children aged over 5 is vital and should not be scrapped.

I do not feel you are prioritising under 5s. How can you when cutting health visitor visits

Withdrawing the school vision screening service is a huge mistake. Our daughter used this service aged 5 1/2 and it identified quickly that she had very little vision in one of her eyes and the other eye was doing all of the work - Something that we would not have identified ourselves as her vision out of her good eye was 20/20 and therefore she could see everything clearly. Had my daughter not had this screening we would have continued to think she was fine and would more than likely have missed that tiny window up to the age of 7 to correct her bad eye via patching. The patching was very successful and she now has full vision out of what was her bad eye. After going through the process with our daughter, we then spoke to other friends whose children had not had the test at their school and urged them to take their own children to an optician to be checked out. Without this amazing service, I feel that our daughter would now have very poor eye sight and it would be in correctable as we would have missed the vital window. Please Please Please reconsider removing this service to avoid this happening to other children who maybe won't be taken to opticians.

I am not sure who has designed this questionnaire but it is very poor. Is this because you already have decided that these changes are occurring and you are making the consultation process a paper exercise. There needs to be clear guidelines, where the work health visitors and school nurses do now, will go with the new changes. It must not be dumped onto primary care.

The removal of hearing and sight screening at primary school will allow health issues to go unnoticed. One of my children has a mole on the back of their eye that we would not know about if it were not for the screening done while he was in reception

To withdraw the vital vision screening of reception class children will be detrimental to their development. The National Screening Committee advocates that all children should have a vision test between the age of 4-5 and this is best done in school where there is a captive audience.

I am responding on behalf of the NY CCG Named GPs for safeguarding. The focus needs to be on those with most need regardless of age and whether the needs are physical or mental health. There will be some teenagers who have much higher need for services than some 1 year olds for example. We are very concerned this new proposal leaves significant gaps - who is going to fill these gaps? Primary care do not have capacity, nor are they commissioned, to fill these gaps. There must not be a presumption that primary care will fill the gaps - they are unable to.

By prioritising 0-5 you are aiming to help/educate parents. This is very good, but it needs to be ongoing for children at school. We need to educate/help/advise school aged children - particularly those in secondary education who often make decisions themselves (sometimes risky) How can we focus on 0-5 and reduce the contact with children in the next 13 years of education?

**Q2:** In the context of a reduction in North Yorkshire's Public Health Grant of up to £4 million in the next few years, do you support the proposals for 5-19 year olds which are focussed on:
- supporting vulnerable young people
- developing a service to help young people improve their emotional resilience and wellbeing

**All comments from people supporting proposal**

Mentoring, career advice - stronger links with schools to ensure all treated equally

Young people are often greatly neglected and assumed to be ok until it is too late

Vulnerable children are those most in the need of support from these services.

Via schools family workers embedded in the school could support both the young people and the school. Outreach youth workers they work remote and flexible

Young people at varying ages need access to emotional support and opportunities to explore their feelings and build resilience, they can't always get this at home

There is a worrying increase in young people taking risks and using drugs, which I don't recall to be as prevalent in past.

Yes however children have other needs not just emotional health and resilience

It is important to support the emotional resilience over young children and young adults in our new generation as it seems to be very fragile at the moment.

Being available for that age group, online chats etc...very important to support the vulnerable in these times.

As above, do not take away in school nurse hearing, vision tests etc

This service should still be open to those that perhaps are obviously classed as vulnerable and should be open to continual review.

Physical health is important too, making sure there are no physical blockers to their learning should also be a priority. It should be carefully considered how mental health services are delivered and accessed by young people at such a delicate age.

To retain at least the level of School nursing staff to at least the same numbers as of last year.

The emotional resilience and wellbeing of younger children is fundamental. Especially in a time when mental health is at the forefront of everything at the minute, children are often overlooked and then when issues result in their adult lives the support is no longer there. There is a huge lack of mental health services and we need to ensure that the children growing up are being supported and are resilient.

These 2 areas are key in supporting young people into healthy adulthood. This will increase their chances of an independent, healthy & productive life, & potentially less dependant on statutory support.

At home and in school, over the phone. Used system multiple times and it has worked perfectly. Provides advice for parents and a short intervention for thier child/ children that links up support in school and support at home. Working together with a professional linking support up has a much bigger impact than everyone trying to support with poor understanding or communication.

We must do all we can for young people

Partnership working is key, and services that actually involve young people in planning and provision. Listen to their voices and be inclusive.

Working in partnership with existing groups this could work. Networking is required

More front line services. Stop closing children's centres and offer more drop ins etc

I think that's where the priorities need to lie when resources are scarce

Discussion in schools with the children. Online videos children can watch and discuss with their parents. Health and social care and police working more effectively together to recognise vulnerable children

Support for mental health related issues - so important in this age group.

I would like it to still be available to all children where needed as often a lot of focus is on PP students and sometimes other children need that support also.

I feel universal support that is accessible for all & would then capture the target families too, especially as children get older & are more influenced by their peers etc.

HCT should be available to see young people in the school environment as many children and young people see school as their safe space and a space where they can speak more openly to a professional. HCT should pick up direct work with young people who are struggling with emotional wellbeing/mental health as other NHS services may struggle to cope with an influx of young people requiring help during and following the after math of this pandemic.

I definitely feel developing a service focused on emotional resilience and wellbeing is important, particularly with the national movement to try to support and raise awareness on mental health issues. I feel this will help change the stigma of mental health issues, give them the tools for this and also make them aware of where they can go to for support.

Young people's mental health is a serious concern. Too many young people in England are struggling with their mental health and they are not getting the support they need. I believe money does need to be spent on extending existing CAMHS provision, Community Paediatric Nurse provision and mental health hospital beds, but I realise this is difficult due to current budget constraints and budgets will no doubt be reduced further post-Covid. Nonetheless, mental health needs to have parity with physical health; raising awareness amongst all Children and Young People's Services and schools will in itself undoubtedly benefit many. In terms of cost-effective strategies, if a greater emphasis was placed on mental health and bullying in schools, I believe this could help relieve the pressure on services like CAMHS. Could NYCC develop a county-wide best practice mental health/ bullying strategy for all schools, including academies, to adopt and could progress be monitored by NYCC? Establishing a Gold Standard of mental health care in schools could standardise approaches. The current practice of allowing schools to adopt their own bullying and mental health policies, without them being regularly overseen by the local authority, leads to extremely patchy support for young people. Waiting between two and four years (on average) for Ofsted to investigate the effectiveness of an individual school's mental health and bullying policies is too long; serious risks to health can develop due to poor school environments. One member of a senior leadership team moving elsewhere can lead to a shift in culture in a school; this can sometimes lead to an increase in mental health issues over time. I believe we also need more mandatory mental health training for teachers. Also, buddy systems in school on a rotation basis to allow ALL students to access some individual support at some point could alleviate tension points and ensure young people feel valued and listened to.

As long as alternative services of a similar or better standard are readily available.

Education in schools on mental health, wellbeing, technology addiction, healthy eating and exercise. Benefits and disadvantages of these. Online awareness and education to highlight the dangers. Who they can go too.

Again yes they are a priority

Whilst I mostly agree with the proposals, I don't agree with the hearing tests and night time wetting support being removed. Who will support with this instead? It is hard enough to get a GP appointment as it is. Support in these areas should Continue

I hope that there will be a focus on identifying children and young people who need support in developing emotional well being and that the support will be sustained. I think having a key worker is helpful, a person the child or young person can contact and rely on. I would hope this service would provide counseling, mentoring, workshops and community based activities. I would like children and young people to be provided with opportunities to learn how to care for themselves, how to nurture their emotional selves and their own mental health. I would like to think more children could have the opportunity to learn yoga, relaxation and meditation and other activities that nurture one's self and develop resilience.

School nurse team, better links with health services education establishments and other local services including voluntary sector.

Local services need to be more readily available in rural areas where public transport is sadly lacking. Access to services has to be improved. Providing an out reach service from one district to the next is inadequate, insufficient and is detrimental to the health & welfare of children in the other district. A district had a very successful 0-19 service then NYCC split it to 0-5, 5-19 against advice & evidence to remain 0-19 NOW want to reinstate 0-19 service but with a much reduced number of health professionals and much reduced service provision. Where does Safeguarding feature- no mention in the proposal- it is integral to holistic care of children.

It is vital that children 5-19 are offered appropriate support around their emotional wellbeing and resilience. Particularly now, children and young people need professional support re this. Hopefully support around emotions can continue.

Not sure

From experince at a high school I was surprised (possibly shocked) at the level of care and support that young people needed to improve their wellbeing and confidence. Furthermore, we have had an increasing number of children in primary school who also require such support. Access to CAMHS has also been challenging so I am very keen that such a service is developed to help all children from 5 to 19. It would also be good if a formal evaluation could be incorporated right from the start so that the service can evolve to meet children and young people's changing needs and widen knowledge, skills and practice on the part of the staff.

Again, young people need our full support even if that is at the expense of poorer adult services. We can register our dissatisfaction in a number of ways, they can't. One of the best aspects of universal services is that children are guaranteed to encounter a health professional who can identify concerns and refer appropriately. Alternative means of surveillance for those at risk will need to be found.

Support for SEND children must not be diluted, neither must support from CAMHS be reduced. This is already stretched. It can be difficult for families to access support independently, without support from a professional, and there is a real danger that young people will fall through the net which may have more holes in it than the altered service can initially see.

Cautiously supportive of this, given we've yet to see how it works. I'd also like to see clear justification for dropping school screening. Not sure how to answer this question otherwise - it's not my area of expertise so I just don't know.

Continue what you do now

It is clear that we need to support vulnerable young people in order to help them develop a positive self image and social and emotional wellbeing. If children who have a hearing loss are picked up late, it is likely that this will impact on that Child's emotional health. Without intervention there will be an impact on language development, literacy, social interaction, ability to pick up information incidentally, mishearing and misunderstanding - all aspects that can lead to social isolation and impact on well being. However: We believe if a child is referred to SLT then they would refer for a hearing test as part of the assessment

I think this is vital to children since the teenage years are a challenging time and the transition into adulthood and independence often requires support.

How could one not support such proposals? The proposals also chime with the point made on the previous page.

Close working alongside Early Help, who already deliver group and 1-2-1 emotional resilience and wellbeing services to children and young people. Share intelligence/systems with Early Help and Children's Social Care, to avoid overlap in delivery of these services.

Direct family intervention for vulnerable young people. Clubs/groups to promote welbeing and resilience.

Through schools

A universal and targeted offer would work best. I would see it best by involving the expertise of the voluntary sector to support this. They have different ways of engaging with young people and make it feel less like a parent/child relationship.

but we NEED enuresis clinics we need HCT advice about our kids behaviour,sleeping,eating how can you tell who is vulnerable unless you have better open access for all (they may not see their GP either)

Providing support and developing resilience amongst young people is vitally important to improving their life chances and future physical and emotional health

It's important that vulnerable young people don't slip through the net and, hopefully, people involved with vulnerable families early in life would be able to have time to share information with schools and health visitors later on. Communication between different services and a set person to develop a relationship with rather than a series of strangers involved would be best. Emotional resilience could be taught in school but a pack going out to parents giving ideas of what to look out for, how to react to different warning signs, activities to improve resilience that we can do at home links to online information would be useful. Children are definitely going to be affected emotionally by COVID, whether through anxiety, OCD disorders, depression, loneliness etc or linked to change in circumstance for the family.

With mental health issues on the rise intervention at an earlier age pre any problems is key. Mindfulness, yoga etc

Youth groups, subsidised or free extra curricular activities such as music, drama and sport.

Again, I appreciate the challenge that a funding cut provides and a focus on the most vulnerable is required. My fear is that cutting services for all is that more people (overtly less vulnerable) who are in fact being supported will trip over into the vulnerable category when all access support is cut.

Emotional H & WB and supporting the impact of Covid 19 and the risk to children through spending more time in isolation and online.

Additional funding direct to schools for them to use in the most relevant way for their pupils. Training for school staff

Taking enuresis support away from teenagers would remove their emotional resilience and wellbeing,

A sexual health support service especially for KS4 A nurse allocated to the school to improve consistency of service

However, I feel that the families involved will also need support not just the child. A family focused service would be, in my opinion, beneficial. Children with additional needs will need a more dedicated approach.

In order for people to function. Having a good foundation in their own emotional health and wellbeing is key to being able to be a productive part of society

Essential given the recent and continuing lockdown situation to support and guide with well being and resilience.

More and more young people are struggling with their mental health - this service is vital as many other services only work with higher need cases. All children should have access to some support not just those who are recognised as vulnerable so I hope that you are going to be available to all young people should they need the support. Face to face support is the best option as this allows the young person to build up a trusting relationship with the worker. The young people need to learn how to build their resilience and to be able to think how they are going to manage situations. Text services are good but this takes away the skill of the young person having to try and think for themselves first - they need to be able to develop those skills and not always rely upon a digital voice to help them make decisions.

There needs to be adequate resources provided and taining offered to enhance professionals in delivering support children and young people.

Parents could benefit from knowing they can self refer instead of waiting for the school or GP to do it.

Concerned about the lack of support around bed wetting for older children. Who will do this?

As long as you focus on all vulnerabilities not just significant ones.

Although supporting our most vulnerable must be a priority, I am concerned that other families, children and young people will fall through the net as our universal service become reduced.

Experince in working with teenagers teenagers who are feeling very vulnerable ( especially with covid restricting friendships and access to school), concerns that there would be less structured care available. I would support making resilience and care an improtant challenge

Give more support to mental health

Consultation via school support

Currently there is a huge gap supporting this age group with mental health issues, delivered by Qualified young people's Counsellors- it is currently delivered by staff without a mental health qualification which is not appropriate. You wouldn't go to a cardiologist if you had a broken leg so why would we offer mental health support by a professional not appropriately qualified in mental health?

The vast majority of referrals within school fall within emotional resilience and wellbeing, this is therefore an area we are more than happy to support assuming we can get this support for our young people.

A lot more in school support for emotional well-being.

Pre-teen and teenage mental health is at crisis point, and is set to worsen further in the coming years. We need quick access to Camhs and funded support to help children at their lowest point. I prefer for the budget to be focused here.

Identifying children vulnerable to drugs and being drug mules

There needs to be further and additional support for young people around their mental health and wellbeing there is often a gap in services for those who struggle but do not qualify for CAMHS.. those identified as vulnerable also need targeted support

Wellbeing and mental health is so crucial in today's society

Speedy access to proper mental health support early on is vital as the current system is failing children, placing increased expectations on schools for support yet this support is often inconsistent, as schools do not have the necessary training in place (nor budget) to support the complex needs some children have. Children are increasingly becoming disengaged with their education as mental health needs go undiagnosed and this often results in parents being held wrongly accountable and penalised for school issues, which would not have developed if mental health issues had been picked up early enough by professionals and then the right support had been accessed and put into place.

Make sure that families which include a child 5-19 retain access to services which would otherwise be provided for a fee. Often these fees are not affordable or prioritised and therefore children miss out.

As far as possible via place based community groups. Children live within families and communities and an asset based approach to strengthening the ability of local groups to support families with food, housing, healthy living, community safety, reducing alcohol abuse etc is needed. Less ‘ assessment ‘ and more local action.

Again, I would prefer that these services are not cut, but accept that financial savings need to be made. I particularly worry about teenager mental and sexual health. This age group are unlikely to access GPs or tell their parents about these issues.

I feel there needs to be care taken to ensure there is not overlap with CAMHS services as this could cause confusion with referrals. These pathways need to be very clear so GPs are not left in the middle passing patients too and fro

N/a

Much better mental health and peer group provision for young people with self-esteem and low mood issues. Provision in North Yorkshire is very patchy and not much available outside of York and East Yorkshire. Some are reliant on charity funded private support. Please stop focussing on traditionally vulnerable young people and wake up to the fact that close stable families also have teenagers with mental health difficulties and in the current climate of uncertainty all teenagers are vulnerable. It’s too late once they are broken adults. They can then struggle for life.

I think the service should be there to support any child’s needs/development including close relationships with families by qualified health visitors/school nurses. Many children are vulnerable and it depends how high you set a threshold for help. Needs are not only emotional/resilience.

Education

Those most vulnerable should be a priority and teaching emotional resilience to all children is crucial.

Access to mental health support is vital for young people as untreated mental health issues can have lasting implications for that young person and can affect all aspects of their lives

Mindfulness is a great tool. Yoga and meditation could be incorporated into the school day.

Experience of an individual with high anxiety - prevented attending school but has no doctor's referral. Added pressure to family relationships and their difficulties in reciving help/support. I wonder how many other young people and families are being let down by the system. I used to volunteer at the youth centre each week and chat to young people whilst making them hot chocolate. So sad when everything changed and the young people were just left floundering

Via phone and on line seems sensible when appropriate.  Face to face will be needed I feel in some cases.

There is a huge need for mental health services. This could be do within schools to target all children if the relevant services can work with schools. Private and academy schools should be included.

Support groups Education - wellbeing classes / workshops  Youth clubs  Mentoring  Peer mentors Whole school / family approaches

see above. Should be easy to access and responsive in a timely manner

How to identify these individuals ? Working with partner agencies key to making this effective and efficient.

Emotional support for the next generation is essential as a life skill. The pressures of daily life have increased massively in recent years and if we don't equip our children well they will not cope

Giving support in schools is vital. Done children have no other lifelines.

**All comments from people against proposal**

The school entry hearing test is very important as a lot of children's hearing loss is picked up through this. I think this should be carried on especially as audiology services increasingly reduced elsewhere leading to longer waiting times or longer distances to travel.

Many of the needs required by these children will no longer be offered in the new proposal. There are huge gaps in confidential support available to vulnerable children and the reductions mean that many will have nobody they can speak to in confidence when they most need it. No other services locally offer what these children and there families need so many more will be at crisis point before they can access services such as CAMHS. Evidence based training needs to be give to a qualified skilled workforce in conditions where they can forward plan, cuts will undoubtedly limit access and increase pressure impacting motivation and staff retention. Sexual health services available are extremely limited and no offer is now available to young people in the local area meaning the cycle of teen pregnancy and sexually transmitted infections continue to rise as well as poor understanding of healthy relationships and consent. GP's cannot pick up the gap left by the 5-19 service when they are also at capacity. This plan is narrow minded and puts money above the health of our children causing a bleak outlook for the future. What happened to prevention being better than cure?

There are plenty of children not identified as vulnerable who are actually very vulnerable indeed.

Other service providers such as just b are already filling a gap for emotional health and resilience. Public health messages, general health promotion, sexual health and healthy lifestyles are where school nursing should be focused

Support is available from other agencies for emotional well being with healthy child team either duplicating support offered or carrying out interventions that other agencies could complete eg school camhs early help service. From experience support for emotional well-being of young people can often be passed from agency to agency with little actual support being offered directly. It would be good if clear description of each agencies support is made available.

Reduction in services for families means missing issues and waiting timescales increasing. Parents already find accessing services difficult.

I agree with supporting vulnerable people but surely parents should be responsible for their childs emotional resilience and wellbeing

As stated in my comment above.... There will be far more 5 - 19 year olds in need of extra support due to current circumstances so I believe that this are should be offered a larger sum of funding than the category of up to 5 year olds. The county as a whole is not one where there are huge levels of deprivation like there are in many other counties so I feel that a higher proportion of the grant should be focused on children 5-19.

Again this is a leading question which doesn't allow for physical issues to be considered

It should be spread proportionally over both areas

This is not specific enough and again does not address how support for other needs in this age group currently being provided will be met.

This seems to be aimed more at young people rather than those aged between 5yrs and up but before teens.

School nursing is very stretched. Child protection conferences aren't always attended. Services are withdrawn after health assessment. It's my view that every child has a need for this service if on a Child Protection plan. I struggle to see why school nursing are not actively involved with all of these children. Often no health needs identified etc but these children do have safeguarding concerns. Neglect for example means they are not having their needs met at home. A school nurse should be involved for any impact this has on that child for example not being clean or fed. Any circumstance If a plan can effect The child. School nurses aren't in schools anymore.

I am concerned that children with Continence issues will not be supported. If issues with bladder and bowel are not addressed , children's mental health, self esteem and schooling can be adversely affected. If there is to be no Continence service, school nurses need training to provide help and advice to families, in my experience- recently retired Continence nurse specialist- GPs have little time to advise families.

The limited access to service in rural areas is tokenistic at best at present, reducing this even more will rip through rural areas and devastate families and cause no doubt social disruption

I feel the healthy Child teams usp are being ignored. The vision and hearing screening as well as toileting work and general school health have a big impact on families. Every service is offering emotional resilience and qualified nurses skills are being ignored and overlooked. The nurses role in toileting, fussy eating and general health is greatly missed already. With minimal staff and training they are unlikely to make a difference in the emotional resilience field with other organisations having dedicated funding to provide this. I think you are getting this VERY WROnG and scrapping the vision and hearing is going to be very detrimental to the local population.

This age bracket is far too big for such a sweeping statement. The needs of these age groups are many and varied and need many different approaches and levels of support. Of course vulnerable young people should be supported - this is in no doubt, however young people need to have resources available to them that are easily accessible and without stigma. Increasingly teenagers are wanting questions answered but don't ask a human as internet access is easiest but of course the human element and context are so very crucial to provide balanced support.

This is a reduction in service

Most teens are vulnerable in some way & these children need to support wether classed as vulnerable or not.

"Developing a service to help young people improve their emotional resilience" is, in itself, an entirely meaningless statement. 5-19 year olds generally don't volunteer their problems (or at least, many do not). A service that stands at arms length, ultimately requiring the child to seek them out (with the occasional well intentioned, but largely pointless poster for a text messaging service) is frankly no service at all. You support resilience and wellbeing by being available, present, known to the child. Removing face to face contact does not deliver this. Again, if you never even meet these children, how will you know who they are?

There are many reasons why the school nursing team as it stands is vital to families with older childen. Parents need more help and support around sleep and wetting, not just emotional resilience. For example things like squinting are picked up at vision screening tests in schools and other children are not now going to get the same service. Many parents work and do not get chance to go to the opticians or know that this service is free. Many children will face their poor eyesight not being picked up on because they think their eye sight is normal. This is just not acceptable.Withdrawing this service will be failing a generation of children.

I think that we will miss lots of problems

Again lots of Jargon with little substance to show how 5-19 services will access needed vision and hearing screening, or enuresis? will GP surgeries be expected to pick this up- who has the School Nurse expertise in a surgery, 'alternative services"? what are these and how will families access them.It seems that teachers and school staff will be doing more and more without the level of knowledge and training needed and therefore there will be children who will slip through the net and be harmed because of tase proposals. You make representations about the importance of young people needs being important but blithely cut services to them.Again you mention you"will do a Gap analysis- surely this should have already been done and you should know what will fill the gaps ! I think that the recent information and findings of the 111 services where it was discovered that many nurses were not giving safe advice , and calls had to be re triaged to Doctors should be of concern to you, if you think that peer supporters and peer groups are going to be a safe way to proceed. The document talks about people working directly with children and young people to achieve improved outcomes> Who Where and How will you do this- Who are the voluntary groups and community groups you talk about- how will you assess they are safe to do this work.How will the outcomes of these volunteers and community groups be assessed?

A number of services are already in place to support young people with emotional resilience and wellbeing, school, compass, Early Help, CAMH's who have also started a new project placing staff and resources in school for students to access. It is a worry that if HCT offer the same and/or similar support that young people could be missed, continually passed from one service to another with little actual interventions being offered or for the type of intervention offered to be duplicated.

I DO NOT AGREE WITH THE £4 MILLION CUT. Vision screening is seen by NYCC as a luxury in schools. Parents/carers DO NOT TAKE THEIR CHILDREN TO AN OPTICIAN TO HAVE THERE EYES CHECKED. They are not advised or instructed to do this between the age of 4 - 8 as this is the optimal time to correct any eye problems. Hearing has also picked up on children who have had hearing problems. Children who have a genetic eye condition picked up by us the screeners. Due to Covid 19 we know of children who have or are suffering from anxiety that we could have helped by delivering a presentation in the school covering this topic and others. There is a report by the Royal College of Paediatric and Child Health that states the UK risk failing a generation of children and young people and that the UK are risking performing comparatively poorly and stalling where our children are concerned, this is the UK not a third world country.

I agree in supporting vulnerable young people but feel health professionals should use their health qualifications & offer support around helping schools support young people with additional health needs (e.g diabetes) or supporting families deal with issues around soiling & bedwetting - where there is often an underlying health problem.

**I do support this, but the decision to cease vision and hearing screening is a huge loss for younger children/families. The knock on effect on learning/behaviour etc of undiagnosed hearing and vision issues is huge, and these children will be greatly let down by NYCC due to the scrapping of this service.**

I feel that in there are many services focusing on emotional health and resilience. Compass, Trailblazers, and the in school 'Go To' scheme all focus on emotional health and resilience. I worry that the market will be flooded and the HCT will be lost amongst it all. I feel the HCT would be better focusing more on the services which no one appears to be addressing such as diet and exercise (now Healthy Choices has gone), sleep and more sexual health. I feel in-school clinics addressing these issues would work well, rather than individual appointments. Whole school approaches have been lost and I feel these are invaluable to getting a message across to young people. Evidence has proven the young people are more comfortable and responsive when talking to a non-teaching staff member/pastoral worker/nurse/practitioner about their issues.

There needs to be more focus on healthy relationships to address the emerging concerns about young people in coercive and controlling relationships, sexual exploitation and criminal exploitation. There is not enough support for young people in there areas by health settings.

As a service user with young children, I'm concerned that only focussing on certain areas will miss other important areas. For instance, I've known children who have had vision checks that, without this service, would have fallen through the system, presenting many problems in later life.

Again this isn't giving me an opportunity to answer a fair question. For example do you have any figures around how many children are currently identified as needing help with diet and or hearing/sight as a result of the current testing? How many of these will not be diagnosed and resultant issues continue to be attributed to bad behaviour rather than for example not being able to hear very well?

Experience of children needing help from the 5/19 HCT and they were marvellous, also hearing checked in school and needed to see a specialist.

It appears there won't be much of a school nursing service at all so proposing to target the most vulnerable/in need will be the tip of the iceberg. - the CCG do not have the detailed knowledge of the needs of this age group to commission services to support their physical and mental health needs. I feel NYCC must be aware of this but there is no mention of a relationship with the various CCGs and how they will be advised of what is needed. Perhaps this is not part of the commissioners role but as the equality impact assessment confirms there will be children who no longer receive a service they have previously had It might be the right thing to make contact with the CCG and advise them of likely gaps in service. - I do not believe GP services can make up the short fall once the school nursing service has been decimated.

I don't believe you should stop giving hearing tests!

Supporting the vulnerable and developing emotional resilience is vital however the proposed changes also dramatically reduce support in other areas.

Again this is a thinly disguised cut to services. At this current time with children bearing huge emotional, financial and phsyical hardship during the pandemic, the last thing we need is any cut in the current services. The efects of the current crisis is going to be felt for a number of years to come. Please do not cut any services

I do not support the proposal to reduce the public health grant as this goes against the need to support the foundations of a healthy early life

I think that losing school nurses has been devastating to teenage wellbeing. They can be a first point of call for teens, who are in another crucial stage of development and are experiencing massive change. I think that bringing some kind of support back into schools would be a good first point of call and fail to understand why they are seen as not value for money. Having someone to form relationships with and talk to about wellbeing is crucial for students, especially where teachers are being stretched more and more in their roles.

There should still be opportunity for children young people and their families to have their voices heard and EVERY CHILD should have the chance to ask for help when they need it, be that at key stages, Yr R, Year 6 Year 9 and post 16.

Early help and support is key for all families in order to lay the foundations for a healthy lifestyle.

Again all children need to have easy access to support

How are you defining vulnerable? What are your plans for picking up issues in children if you get rid of screening? They'll need to be advice to parents to undertake screening themselves and support for schools. Parent's who have children with epilepsy lack effective provision in North Yorkshire both for families and in the school who had to provide their own training to staff and travel to teesside for emergency health care training that wasn't funded in North Yorkshire. This is obviously a specific issue but if you are reducing support for the 5-19 year olds are you are potentially causing more similar gaps for other children and need to ensure there is focused support for those that require it.

I truly believe the service is in need of reviewing but not at the loss of screening programmes Hearing loss can damage mental well being and support and if not identified at a young age then this can lead to additional funding at a later date for that child. Often children can be labelled with ADHD but actually have an underlying hearing loss

It appears that the focus on this age group is too narrow particularly as they did not have the priority focus when they were under 5. A dangerous gap in service will appear for this age group who will no longer have access to previous services and won't have had the new priority focus as an under 5 either.

This question has a bias - why are we not fighting harder to secure funding from the government. When services in N Yorks are not making best use of technology across the piste and are incurring costs because of this, why can't a county wide strategy for the development and use of technology be progressed to find cost reductions in admin which can then be used for child focused activities

I am aware that the provision of support for mental health/anxiety issues to children in infant schools is being reduced by the removal of school nurses. The Young Carers organisation only supports children over the age of 7. The current Healthy Child Team is only taking safeguarding cases and what they designate as "serious" mental health problems for which I am told they are offering a course of 6 targeted intervention sessions. There is therefore a gap in provision for children under 7 and for all children if their mental health needs are neither related to their role as Young Carers nor deemed "serious". Not being "serious" doesn't mean they don't have mental health needs, just that they have needs which the service is not addressing. This means that they will deteriorate, affecting their general and educational health and wellbeing, until such time as they are classed as "serious" at which point they will need a greater amount of support and will not be able to achieve what would have been possible with earlier intervention. This is NOT helping improve emotional resilience nor supporting vulnerable children.

Hearing screening is invaluable for finding children with temporary but significant hearing loss (glue ear) and indeed those that did not attend for their newborn hearing screen or who were screened and acquired a permanent hearing loss later in life. It is precisely those vulnerable families you have committed to helping, that may not access other routes to audiological services, and who would only be found through primary school screening programmes. I understand that you have not consulted local NHS audiological services to determine the downstream impact of your decision. Why?

There is not information about what additional support you are going to give to these children. Most need 1:1 especially when children are going through difficult times. Family support may be needed also. I feel this is probably an area service will be cut however this is an age when they are more likely influenced by others by junior school friendship groups have been built and there is a lot of child loneliness, as well as bullying. School nurses are not visible.

The hearing and eye tests in schools are invaluable and should not be removed!! In fact more should be done to ensure the health and well being of our children are provided for

Schools will be left even more stretched with the withdrawal of key services such as the drop-ins.

Every child needs care specific to them, one size does not fit all

OTHER CONDITIONS SHOULD BE RECOGNISED AND ASSISTANCE GIVEN

We are concerned that this proposal will allow children of any age to fall through the gaps - how will this new service ensure this does not happen? The focus should be on those with most need but not just on those who are on child protection plans - the vast majority of children with significant needs are not on a child protection plan. We are concerned about the lack of mention about 0-19 team liaison with primary care - this is vital to the wellbeing of children - who will do this and how is this going to be done?

This question can't be answered unless it's clear what 'developing a service' means. What does that service include or offer?  I feel that vision screening should absolutely remain within the service. You are assuming that a reminder to parents will be enough to ensure that children will be taken to a local optician for screening. I don't believe it will be enough. Experience shows that it isn't just vulnerable children that we find need glasses through screening, so if they haven't taken them to an optician before, why would they now? It is so important that vision defects are found early for a chance to treat/correct, and school screening does this. There isn't another good option. School screening is show to be effective. Approx 94% of other areas have school vision screening. Why wouldn't you want it within our service? Similar argument for keeping audio screening in the service. Experience has shown me that more often than not, parents/teachers do not realise that a child has hearing loss but it can have a huge impact on their learning and behaviour. Poor development and poor behaviour in some children within school can be due to them not understanding what is required of them as they can't hear adequately. Identifying this early is vital.

This question is leading the respondent to support your proposal. If I say yes it appears I support the overall proposal, despite this not being the case

**Q3:** We have learned from how we had to adapt during the Covid-19 pandemic, and in future, we want to deliver some of the Healthy Child programme online and via the telephone. How do you think digital and telephone services could help support families in North Yorkshire?

## All comments

More accessible for some, but people less likely to open up and connect when not in person

I personally prefer telephone calls, not a fan of a healthy Child nurse coming to the home when an individual was struggling as invades their safe space.

Don't nothing replaces face to face support. However there is place for digital platform to be used to do say feeding /sleep support/courses. Running the risk of missing issues.

A blended approach is good but face to face is very important especially as Health Visitors are sometimes the only person a parent may see and may be suffering from PND or from domestic violence and cannot speak about it over the phone but can in person.

There is some use in it but it should not take away the option of face to face contact as particularly teenagers but all ages can feel uncomfortable confiding in somebody and confidentially and the possibility of disclosures is reduced when a perpetrator could be close by listening in. Also not everybody has access to the technology needed.

They can't. People can hide behind it too easily. Face to face and interpreting body language etc is important.

Better access for busy parents rather than waiting in, having to go to a health centre etc

I recognise that more people can be supported this way but if is a huge barrier in building a relationship which is key

All parents should be able to see the health visitor face to face. Otherwise parents will turn to non evidenced based websites and social media . Also this consultation is biased in how you are presenting your plans to the public

Although at the moment not possible I prefer programs, visits and courses face to face

This will not help building trust and professional relationships with families

Telephone and digital will work for some people but face to face is crucial. You cannot pick up on body language via text, email or voicecall, and that is crucial in unpicking some of the issues faced by young people. Younger children will be more dependant on carer/parent to support with this, thereby making this service inaccessible to them

Use of teams to offer some group work and family sessions.

I think the most important thing is to have access to skilled staff, so the methods of delivery are almost irrelevant.

Health visitors have always provided telephone advice. Telephone advice can sometimes support families but many benefit more from seeing someone face to face. I would not like to see face to face contact reduced

Personal benefits found from the face to face drop in clinics. I was able to get advice from a range of health visitors and it helped to talk to other parents. It was also reassuring to have my babies weight checked regularly after lots of feeding problems. Although online services can offer some support it would not be the same as these face to face drop in clinics

No. Families must be seen face to face for professionals to pick up on cues from parent and child. We will be mopping up issues with maternal mental health and child development issues missed for a generation after this pandemic. You will make this even harder. The reduction in this service is appalling. You are cutting services at the very point where they will be most needed. Shame on you.

I dont think it does help. Poor Internet connection etc. I am aware of covid 19 and the risks associated with it however face to face will always be a gold standard of care including health promotion ridiculous how you expect health promotion to be delivered to my child in a virtual manner. This will not make the child feel inclusive or hold their concentration. Also why are services using unregistered staff who have no accountability as usual it boils down to ticking boxes and money. Dont blame the reduction of registered nurses and front line staff on money blame it on too many managers who have no clue what it is really like for parents, children or the staff who I have met and feel totally undervalued by you as a Trust ... appalling

Families are busy nowadays so being able to offer a phone or online support system should be more effective.

Calls checking in on new mums or mums of young children etc...or online chats. More modern approach but needs to be consistently available.

I think health visitors should always be available on the phone or virtually.

Provided it works this could be a useful tool. I had to carry out my child's 2-yr assessment by phone. It was hard to answer without child present as usual. Online video with parents, child and health visitor would have been more beneficial

It allows them to still get support

Preventing new parents feeling isolated with frequent HV phone contact or even a buddy system. Online is very impersonal but can still be a useful source of information for new parents

Could the service develop an app for info to be cascaded? Could digital info be sent via email?

This could usefully be employed. Sometimes those in need may not have access or privacy so should be provided as an option as opposed to the only means of access to help

Having support on the end of the phone is critical, sometimes just for reassurance or guidance no matter what age your child is.

Yes, drop in centres don't work well. Phone calls would reach more people in need of help.

There is nothing that can provide professionals with a full idea of home conditions and parent interaction with their children other than a home visit. The condition of the home including space for children to play cleanliness, evidence if age appropriate toys , cleanliness, smells , interaction of parents to gauge attachment, body language of parents. Gaining trust so either parent can open up in domestic abuse situations so that early help can be put in place. I believe telephone appts would be a barrier to this leaving children in vulnerable situations.

I think this will become very impersonal. How can a professional make a judgement call based on a phone call? It is easy to say one thing when the reality is so much different. What about these children who are missed?

as an addition to good face to face work but not as an alternative. Children need to be seen and visited in their own homes in order to understand a family and to keep children safe.

Modern platforms in use are well set up for virtual consultations, i.e MST, Attend Anywhere: as long as governance/confidntiality needs of all parties can be met.

Because there would be no record of what was said or agreed.

children need to be physically seen and spoken too.  A lot can be lost on the phone.  Also a lot of deprived families don't have internet access or access to a phone.  I know this is a cost saving but it's putting children at risk. School nursing services are invaluable for safeguarding our the vulnerable children. They should be in schools and available to access easily.

I think that children will interact well with digital information, especially if it is provided in a child focused fashion. I used to find that if children find something out for themselves, they are more likely to comply rather than just being told what to do

I find the phones often left unanswered pre and post Covid from the teams. I find appointments difficult to be offered. It feels like a reluctance to help but really it's just that the service is overwhelmed.

Great idea and expands options for young people and families.

In some was this is good, but the risk of not seeing children in the flesh means a distancing from services and this is not what they need. It is important in my view that children become adults that have faith in and familiarity with the support network that they have available to them for rapid and appropriate help.

Whilst I appreciate the issues COVID brings it is likely to be a relatively short term problem. These are long term changes.

I think from a safeguarding perspective as much should happen in the home as possible

Firstly, this is utterly disingenuous. We are both fully aware that these plans were in place before Covid, and attempting to retrofit them to the current pandemic shows an alarming contempt for the public.  Whilst there is something to be gained from digital and telephone services in terms of reduced travel - it's also clear that they carry massive safeguarding risks. It is much harder to assess things like coercive control, you miss the clues that come from body language, or their individual's home.  Equally whilst most have access to digital solutions, the most vulnerable in our population absolutely do not. A service that focuses primarily on digital solutions, is a service designed for the wealthy and healthy, not the people who actually need it.

I think digital support is more helpful for parents. From my experience the face to face is what helps children.

24 x 7 availability for advice and support

yes. This enables maximum use of staff time, and is a medium that families are comfortable with. There must be provision for face to face where needed however.Around safeguarding for instance.

Not as well as face to face. Also not everyone has the technology

I don't think services should be reduced to online, I think extra support should be online

Question and answer opportunities such as through social media (Facebook chat etc). Offering advice / signposting for those who might not attend classes etc (targeting new parents for example)

video calling for some developmental checks such as seeing what the child can do. welfare calls to new parents to check in on their mental health.

I think it's dangerous and Vulnerable children will be missed. Health visitors should be going into homes looking at where the children live and how they interact with their parents, siblings. Non accidental injury's may be missed more. Vulnerable families often ignore telephone calls and advice. How can a health visitor check their weight over the phone they may be malnutrition, failure to thrive etc. For families that need minimal assistance/ support from the health visitor a telephone call would have been ok, but I worry vulnerable mums etc may not be getting the support they need and how do you identify these people if they don't tell you their situation and you are not seeing them.

As a last resort, I would always prefer to see a health worker face to face

Not sure regarding safeguarding issues but counselling sessions could be run via zoom or similar

Families deserve a relationship that is based on face to face visits

In some cases yes, but not suitable to all

I don't think an on line or digital service will help families and children at all- although some teenagers and young people may benefit from a chat line kind of service around emotional well being. The only people who will benefit from these reduced services will be the accountants budget holders and possibly some staff.Although the vast numbers of staff will surely know that they are being placed at risk, children and families are being placed at risk and there will be an increased risk of litigation to the Local Authority, which may well mitigate any savings you are making. What additional training and equipment will staff have to deliver this reduced service, how will safeguarding children be properly addressed?It will be much easier to hide neglect, emotional abuse and even physical abuse, harmful substance mis use etc etc. How will PROPER breast feeding support be delivered- in the initial stages properly regular and direct face to face contact is essential to support women and families to initiate and maintain breast feeding - a massive public health target. we will fail on this even more by delivering this by phone . Horrifyingly I am aware of a young woman who was asked to film herself latching her baby on to her great - to assess whether the baby was feeding/ fixing properly - Totally inappropriate, resulted in the young woman in question giving up breast feeding her baby. How doers the breast feeding initiation rate , feeding at 6 weeks and 8 months and later compare during the Covid19n emergency to a year ago? Have parents and pregnant women been asked how they would like services to be delivered?Awful I would love to know what it is that you have learned during the "Emergency Covid 19" service delivery other than it worked on a very limited and temporary way, allowing you to use it as an excuse to dilute services and therefore reduce potentially the life chances of young people and children in our area. We should be fighting for more money not

Might make it easier to fit around home schedules, might see more uptake perhaps but not necessarily

Yes

Some sessions can be done via zoom, Skype etc gathering of information can be done via these methods or over a telephone call. I have found virtual meetings have sometimes provided people with the opportunity to say what they would not have the courage to say if they were in a face to face situation.

Many young people are happy to access support online/via video links with professionals however this is not for everyone and face to face service should still be a large part of the HCT nurses work.

I think it is definitely good to include a digital approach to the service as this is the way the world is going. It's important the council keeps up to date with the channels that are being used by both parents and children so both can access the support - i.e. FaceBook, Instagram, YouTube. I have recently become aware of the Sendiass service and the information they have available, the regular messages and updates on their digital channels, and their short webinars are really useful for promoting their service and getting a lot of information across to a range of users. Their information and messages about mental health have been very useful during the lockdown situation when my usual support networks and groups have not been available, particularly when children are between the ages of the mandated health visits. Having something online that is tailored to parents' and children's needs and is engaging is really important. It should also include links to other support services and useful information. There should be something clear and easily available for information and where to ask for support. Online groups such as the working parents private chat group is useful for getting in touch with others in a similar position. Whilst I appreciate it may be difficult to moderate a group link this for public use, having some way of linking up parents in similar positions (with their permission of course) to help build a network of support would be something to consider - it's not always possible for people to attend parent and baby groups or to find others in similar positions when you are able to attend.

If we had IT in place that was sufficient to deliver digital services then yes in some cases it would be a good idea. However we struggle with IT issues and as I have previously said new mums want a professional to actually look at their child, and themselves face to face. It also concerns me that an older child on a facetime/teams etc., could have someone there that is influencing their responses or listening into the conversation.

Yes- face to face is good, but using Whats App and facetime etc people still get to see who they are talking to & build a relationship

I only think this will help if it works along side face to face contact. Recognising non verbal communication is vital when dealing with young people, and this won't be possible via telephone/digital means. Seeing a child out of their home environment (which may be the cause of their problems) is important. There is also the issue of trust and privacy. You won't know who listening or sitting in on calls/digital methods. I think during this Pandemic, we have all learned how important face to face/physical contact is.

Digital and telephone support can be more immediate and accessible for many families. Whereas sometimes - particularly in relation to mental health - people need face-to-face contact, there could be a Children and Young People's Services section of the website dedicated to advice, forums and workshops for specific needs. The online advice could make it clear which departments in NYCC could be contacted if parents become more concerned about their child. For example, placing the contact details for the Speech and Language Therapy Service next to information about stammers, hearing problems, developmental milestone issues, etc, so that parents can easily self-refer when they need to. Prior to referral, spending time following online advice in relation to how best deal with a child's stammer for example, could help a significant percentage of parents and children.

Seems a good approach but should not be the default option. I would hope though that it may make the service more accessible as staff are not needing to travel between appointments etc. which in theory could open up more appointment times (or ensure staff have breaks etc.).

Having better access to virtual meetings and telephone meetings would make parents feel more supported

This will help by still ensuring that people have someone they can talk to if needed. Although it won't be face to face it's still nice to have help and advice

Could be used to educate in class via online or dvd etc

I think it works for some families but in my experience most children and young people need a face to face to really connect and open up with you. Often you can see them remotely for ages but one face to face tells a whole different story.

For serious issues such as anxiety, low mood and self esteem, virtual sessions do not work. Many primary age children won't engage virtually and the pressure is placed on parents to facilitate the sessions. You lose the nuance and body language when a session is done virtually. My comments are purely based on my experience working with the 5-19 age group during lockdown. I have heard many positive stories from the 0-5 side but cannot comment on that myself

I think this is okay for general queries / advice, however face to face communication is very important. Things can be picked up on that wouldn't have been on the phone. It is so much more personal and to see someone face to face and build a relationship with the professional that you may eventually feel comfortable enough with to open up to

These may be appropriate for busy parents and some young parents may be more likely to engage digitally than face to face. I think it makes the service more diverse and easier to use. I hope that it will mean that the service is provided more quickly.

I believe a blended approach would be possible Face to face would be the preferred service especially in those crucial early years and when dealing with mental health & well-being.

I refer you to the report from Ofsted Chief Inspector Amanda Spielman revealing the stark figures of the rise in abuse & deaths in infants due to lack of face to face contacts during this Corona Virus Pandemic and ask the question- is this what you want as your foundation of care for children in North Yorkshire? Health Visiting is about prevention and education- this cannot be successfully achieved over the phone. Home visiting / Face to Face Contact remain the best way to properly assess the family and child. Swingeing cuts and change of policy over the period NYCC have worked in "partnership" with Harrogate Health has adversely affected the ability of health visitors to carry out the role required for an effective service. Yes it may seem a costly service provision but it is an investment in children & families for the future.

It is important that some of your support is offered face to face, there is a place for technology but it does not work in all situations and where it is not working face to face needs to be a priority

Certain checks can only be performed in person. Actual contact cannot be replaced. Face to face visits are imperative, not just for emotional support, but simply to be there for people that need to speak to someone in person.

I think some people would find this useful, less intrusive but for myself I prefer face to face, however this is dependent on the problem / issue I am facing. For example the baby clinics were good place/time to ask any questions whilst there, I may not have asked such questions if I had to have made a conscious effort to ring, especially for more minor concerns.

I think you need one to one contact. If a child is seen in school then they are more likely to be able to speak about issues at home. During a Skype call, how do you verify who else is present on the other end? If you are having difficulties at home it may not be the easiest place to answer questions. Also I am sure that a visit to a home would give much more of an insight into the home than the view from a laptop

I think this is something more accessible to many people and may increase engagement in some families. Face to face is still needed though.

I would think some people would like to just talk over the phone. But not my preference, face to face is better, in my opinion.

I think that this all depends on how families use and respond to digital and telephone services and an accurate assessment of this. I suspect where an issue is non contentious then it is likely that families will accept remote services, such as digital and telephone services. This is with the provisio that they won't have to wait too long and the information and/or advice is clear and pitched at their level. Where the issue is unclear and possibly contentious, then I think it may well depend on the assessment and clarification skills of the staff delivering these services. I assume that there will be some information and/or research outcomes in the public domain about the design, delivery and evaluation of such services that you will be able to draw on to inform any decisions.

Clearly technology is key to delivering a more affordable services and it is preferred by some but in addition to the assessments planned on the appropriateness of each case please do not assume all families have the degree of competence or quality of equipment to have services delivered in this way.

Some families may benefit but it must be realised that just because the online service was appreciated during lockdown conditions people may still prefer face to face contact and support. It may well have been welcomed because families were desperate in the unprecedented conditions and "anything is better than nothing"

I'm not 100% convinced about this proposal. Face-to-face contact is so important for mums in particular, especially when their children are babies - I know this from personal experience. Although I support running a service that's as efficient and cost-effective as possible, and I'm sure digital/phone support will be fine for many families, I don't think it should ever be the only form of contact, even for families who are not classed as vulnerable. One concern would be that mums who might be feeling a bit mentally fragile will now have even less reason to leave the house, and if they play down their worries/symptoms then postnatal depression might be missed online or over the phone. Will there be anything to replace baby groups/weighing clinics at health centres, so mums don't miss out on opportunities to socialise? On the other hand, a shift towards digital/phone services could be positive if it parents were able to have more regular contact with health visitors as a result. Current support really drops off as a children get older, yet parents don't stop needing advice. I know I've appreciated all the opportunities along the way to chat with a professional and discuss my child's development, and would have welcomed more.

There is nothing like face to face contact

A live Facebook chat, videos etc would be more useful. Parents often cannot commit to set times to watch live videos, but a bank of videos with tips and information should be accessible whenever needed. More health visitors or supporters in the community, especially rural towns/ villages would make accessing support much easier. Where I live it can be a 20 minute drive of £7 return bus journey to get even a speech and language assessment.

virtual clinics could be helpful for some questions parents have (but not all) - weaning/diet/obesity prevention support - Perhaps some parents would like virtual/phone contact for postnatal depression * I do not think virtual support for breast feeding is adequate provision.

Some practical aspects of intervention can be delivered online and not face to face and our young people are quite used to that. However during moments of a sensitive nature, it will be important to keep the face to face appointments as this is where you can read body language, see the environment and listen to unspoken messages that often can lead to disclosure or aspects of anxiety that may appear physically or mentally, but would be missed if the meeting was remote - perhaps a more blended approach.

Yes that would work.

These services would be great in supporting families/parents who are struggling mentally or financially to offer them support and reassurance.

Let's not pretend that digital and telephone services can effectively replace face to face contact. They don't. Also the closest possible liaison and co-operation needs to developed and maintained between Health Visiting, School Nursing and Child & Family Social Services + other related services like Police and Probation.

No I don't think online services are always a good thing. Many families don't have internet access, are struggling with mental health and may not engage. It may also be harder to Identify any risks that may be posed to a child over the telephone or on a video call compared to a visit in person

Offering delivery of services virtually is a useful tool to compliment face-to-face delivery, but may not always be appropriate for various reasons, including: -For vulnerable/at risk families (you can't get the full/true picture on e.g. video call) -For families who do not have access to technology -For families who are already isolated and where face-to-face interaction is already limited. Attending face-to-face appointments may be one of the things that encourages these families to get up and out of the house. -Issues accessing technology can contribute to feelings of anxiety for some people

Digital and telephone services are the least best way to deliver services, however, I appreciate how covid has caused the need for this. Nothing is better than real life face to face and active engagement.

I have seen/spoken to a health visitor. It's brilliant if you have the facilities to go online or make phone calls but have you given any thought to those who dont have that capability? I, like a lot of people today don't have a "house" phone and rely solely on my mobile. The signal is worse than terrible and the "super fast broadband" that I pay through the nose for couldn't keep up with a snail... Add a new born into that mix and you really see why I and any others need those face to face visits... Not that they are happening anyway!

Yes but alternatives must be available

I do not support this. I believe that during child early years it is important to have face to face contact and most importantly clinics

Utilising telephone and online support via Teams, Zoom or similar services is important and should be utilised more. This works well for many people and the increased use of these methods is one positive from the covid pandemic. Many people do struggle with this or simply prefer not to engage in this way so alternatives must be provided eg face to face when the situation does change.

It needs to be understood that digital technology can never be as thorough in identifying needs and unpicking issues as face to face. Therapeutic relationships underpin all the work we do and this is a barrier to forming these in the best way possible. Virtual clinics also do not provide mums with support networks and the informal support which then means it is picked up later and more work needs to be done so intervention is later and does not save any time or money

Given Covid social distancing / quarantine / isolation issues, use of telephone consultations or video consultations seems very sensible. However it cannot entirely replace face to face meetings and needs to be used carefully, in a targeted way and definitely not as a blanket service. The experience of General Practice is that it is a very useful and often convenient tool, but it can lead to missing problems, it is at best cost neutral and does not always improve efficiency significantly either. There may be some savings if it could be used to reduce travelling times over large distances but beware total reliance on it!

Overall this can be positive and more effective, but must also include an assessment to ensure it reaches those without access to digital devices or appropriate data/wifi.

I don't. Professionals gain so much from regular face to face interactions that can't be ascertained via electronic methods. People by their very nature don't want to admit when they need help, but a professional can often take cues from interactions with parents and children to assess whether further support is needed. Covid has forced people to use electronic forms of communication, but this doesn't necessarily mean that this is their preference and again makes it easier to mask an issue.

Though these methods can help support and improve efficient use of professionals time, it is easy to miss what is happening in the home and with the family which may be picked up from appearances, expressions, state of the home.

As an additional resource I think this could be valuable, but I don't think it can replace the value of a face to face interaction. It is too dependant on parents seeking out information, and will mean that the vulnerable may miss out, while proactive parents will get additional support. Working in an office environment that is now largely online, I also have learnt from experience that you can not have full open conversations online/on the phone, as so much is missed in body language and more can be withheld. Many vulnerable people with mental health issues could be missed. While I understand that during a pandemic people have had to learn to adapt, I don't believe some of these habits will remain when physical contact is allowed again. How many zoom quizzes did you do in first lockdown vs second?

Having the service available even through online and telephone services is better than nothing and can support a lot of families!

Many children and young people will find it easier to communicate through text or other electronic medium and this could be utilised to give a door to be opened where they are feeling in need. Many parents will also be able to access video messages and other so would be a sensible way to cut costs while also supporting families.

Face to face contact is essential for the mental and physical health of infants, young people and parents. Removing school nursing, breastfeeding support or baby clinics would be an appalling decision

They have their place but I do hope they don't replace the face to face clinics. How can I weigh my baby online? Face to face discussions are necessary and a key part to those early months in a babies life. Also the mental health and well being of mothers is likely to be missed if baby clinics are cancelled. As a first time mum I have really struggled without access to these during the pandemic.

Some people are more open with the issues affecting them on-line than they are face to face, others prefer to build trust through face to face meetings. It's important to take a person centred approach , to offer bespoke services according to families needs and wishes whilst also ensuring that phone and on-line contact does not undermine or diminish safeguarding responsibilities as a result of reduced face to face engagement

offering health intervention with a programme that is evidence-based and testing, but that can also offer relevant HNA that is assed by professionals is crucial. Other areas in England are using these tools successfully. SAPHNA would be a good place to start!!

As a second time competent parent I would have been more than happy to receive 1yr reviews onwards over video. Visits for new mums should stay f2f

Yes but there is always also a place for face to face contact

It needs to be face to face. A phone call is definitely not the same as talking person to person - you can pick up on nuance and spot warning signs that could easily be missed in a telephone conversation!

Interactive group zoom session to overcome issues of loneliness, making them realise they’re not going through mental health issues alone.

In select cases it will probably be useful.

Very difficult to properly support families of young children remotely. I absolutely believe that this has to be in-person for all preschool age children (families) - socialising and interacting with people outside the family is so important as well as being able to properly assess the needs of the child. Telephone or remote contact could be used to follow up face to face contact but it has limited capacity. The impact of lack of face to face support over the time of this pandemic has yet to be fully discovered, and even though support services have done their best to make the virtual experience as good as possible, it would have been best if they had been able to remain face to face.

We have all learned during Covid that online and telephone can keep us connected. However, the professionals working in this area are the only people who can say whether the services can be suitably maintained online as in the health and care sector relationships, face to face and just seeing the facts with your own eyes are so important.

some on line courses for parents

I think this will ensure that all families can access the right support.

Can be a part but not a reason to avoid personal contact and home visits. Concerned that the are not more Spaces and more questions.

Good use of time and teachnology: less threatening than having someone in your own space: more reactive

Allow access when transport is not viable.

At first when the enuresis support was changed from face to face clinic appointments to telephone calls we were concerned, but Elaine Hawcutt was always there at the end of the phone when we needed support. So I'm of the opinion that telephone support is better than nothing at all.

A Teams sexual health service would be useful where pupils could speak to a nurse individually.

As previously reported sometimes things can be hidden in virtual services. A parent's view of a child's development may be a little controversial against a Health Visitor's face to face assessment.

Online services delivered by video and telephone conferencing provide an opportunity to meet with more people, ensure flexibility and limit the cost of transport. whilst I do not think that this is the panacea for delivering support and interventions, I believe a more blended approach to this kind of technology will be helpful and cut down on waiting times.

Would not replace the valuable face to face care in my opinion.

Yes they could - this would save travelling time. But face to face contact is more personal and a better way to build relationships with service users and their families.

I think this would be good. Online advice to read and a generic helpline you could call rather than having to chase a specific health visitor would be great.

Initial calls can be done like this but work with vulnerable children is very difficult online, I know this from personal experience with my child.

Hearing screening can not be delivered by phone or online

For some this may improve engagement but for others it may put them off - there is no one size fits all and each family / child must be approached differently.

I believe a blended approach could work for some families and young people but should replace face to face work if preferred.

Only if the service users have the technology.

Very little use for those feeling vulnerable and in crisis. We need people at the sharp end. Yet again schools are picking up the work.

Could make the services more responsive and available.

Being a first time mum and then having no contact sic e 4 weeks old I feel a telephone call would be. Great and a good start

I think for some this could be successful and may take away some of the anxiety of those face to face appointments. However in terms of safeguarding it does worry me if this will mean a a number of things are missed.

I feel this would encourage more parents to seek/find advice if they are made aware of a dedicated resource. It would seem less intimidating than attending a drop in session, which in my experience have major privacy issues. It also removes the issue of transport, taking multiple children with you etc

yes - in primary care a lot of work can be done virtually and this can make economies of transport ( esp in north yorks , and also creative digital solutions. I hope this will be incoporated into the cost cutting

Great on line if all the parents are online. Not everyone is comfortable with technology or capable what are you offering fit these groups to ensure equality of access? You may miss safeguarding or abuse as the person on the other end may not be able to talk fully to disclose. You may miss that these families dynamics have changed. Not relevant for children 5-16. Would be helpful to a lot of 16-18 year olds for quick catch ups to keep contact. But again a quick catch up misses things as usually the caller hasn't been allocated enough time to deal with any issues raised. Also vulnerable may not engage fully they ignore phone calls.

Provide more support sessions as health workers would be able to reduce travel between sessions

Easier to fit in within a busy day

I understand why this seems appealing. My concern would be the more subtle issues may be missed by not having face to face visits

I have had to leave the above questions unanswered because they are strongly slanted towards the desired answer Yes! As a resident of North Yorkshire I think that the Healthy Child Programme should be the last service to be cut back upon. Any such cutbacks represent a false economy. It is in the best interests of society to support children and families when issues first arise and are manageable. It costs far more when they have become worse. The most effective way to support children and families is through face to face personal meetings either in home visits or at clinics or regular groups. Emergency pandemic measures should not become the norm because they are cheaper and more convenient. Using the phone or online / virtual technologies are inferior methods of support. People receiving care and support need person to person contact. And their carers need the opportunity for first hand conversation and observation otherwise important opportunities for offering advice and support will be missed. It is not so easy to ask for help on the phone. And without making observations in person there is a danger that signs of abuse may be missed and children put in danger. Please reconsider the idea of making any cutbacks or changes to this vitally important service. Thank you.

Many of our appointments made through school via externals are cancelled. We can facilitate on line and via telephone as a school.

Honestly my child would struggle with solely digital and telephone but maybe a more supportive school structure would help this.

One of my teenagers would not engage unless face to face. It may work for parental support or general queries about child development, but it is a poor substitute. Mental health issues should be supported in person. Also, how do babies get properly weighed if not by health visitor appointments face to face? Sometimes parents want a physical check of their child to allay worries. Perhaps the health visitor could provide more personal support if first baby or on request, but a more hands off approach for experienced parents.

Fine if families have access to digital services

I worry that it will limit engagement. Many people do not feel they engage as well virtually and it does not always help in understanding situations as a whole. It would depend on the nature of involvement. A mixed approach may be helpful and will help those who struggle to find time to meet in person and may also mean more flexibility. However I do not think all services should be virtual especially for younger children

Quicker response rather than the long waiting list for parents and children to be seen.

I personally would not feel happy using this method of support. I think women and their families need to be seen face to face as many people will not feel happy to divulge information/talk honestly to a stranger over the phone. Many things are picked up by face to face contact that would be missed over the phone.

I think if you are going to do this it needs to be consistent and people still need to feel like the staff providing these services care

Just having a point of contact to ask a question or for reassurance is invaluable.

Digital and telephone services are great for professionals to get in touch with other agencies quickly and efficiently without having to travel to meetings. However, for many young people, especially those with mental health issues, support given this way does not work. They need that personal, face to face contact. Again, 'virtual' meetings provide a much easier way for some young people to disengage from the support process and then it's all to easy for services to sign them off as they are not engaging with the process, thus creating an ongoing cycle of mental health needs not being picked up early enough. Thank you.

I'm not sure how on earth you can possibly expect to replace the bulk of your device with non face to face contact. People on the end of the phone could be telling you more or less anything just to keep themselves off your radar. Virtual meetings and visits do not fill me with confidence that worries or concerns will be listened to nor that possible issues will be picked up.

don't think they are good at all especially for checking on babies and i feel many vulnerable children will be missed. Baby clinics face to face need to re start as these re a lifeline for parents

I think you need to be very careful not to widen inequalities. One of the lessons from Covid is that many many families have very poor access to IT, often only having use of a phone, perhaps one PC or tablet that everyone can access and no privacy when using IT which can be a safeguarding and DV risk. Also the poorest are often reliant on pay as you go mobiles with no smart phones. I think that while the middle classes and professionals have created a new culture of Zoom and Teams and a new set of 'in jokes' about being muted etc, the most needy have been desperate for human contact and someone to actually see them, or their child and provide warmth and support. Please do not use the so called learning from the pandemic to reduce human contact. By all means use IT to reduce staff meetings etc but not to deprive people of human contact.

I think there could be a role for this. But it is really important to recognise that phone consultations do not better seeing people in person. My own personal experience of switching to phone consultations is that although the initial appointment is faster, overall I tend to need more follow up and I feel the whole process from start to finish is slower.

Reduce travelling for staff so more time can be spent in patient contact

I don't think things should move online, experience of working with families on a regular basis I have not come across anyone else who would prefer online support over face to face.

Young people engage fine online. For example, an individual joined an LGBT group online that they wouldn't have had the courage to go to in person but now having got to know them they probably would like to meet them.

I think for some it may be ok but for us we appreciated regular face to face in person health visitor visits. You'll spin the consultation as you like but it's easier to open up with problems at in person home visits and things could get missed easier such as clues from being in a home. I think this should be optional depending on what families want/need.

Being a new parent can be isolating enough without feeling more isolated by non face to face appointments. Getting out the house is a huge part of mental well-being for parents with young children.

Covid has proven that services can be delivered just as effectively remotely... Which will hopefully free up other resources to support those most in need.

It is helpful for people who don't have access to transport or who feel nervous or intimidated by face to face meetings but I personally feel there is no better way to ensure the health and safety of families than a health care professional seeing them in person.

It is no substitute for face to face

I personally found the face to face drop in sessions invaluable when I had a newborn so I really hope they would remain in place. Online consulting doesn't help parents that may already be feeling isolated and afraid to come forward with problems. There is a level of emotion connection you can only get when face to face and it would be easier for a HV to identify any issues that the parent might not feel comfortable discussing.

Not in the early days. New Mums and babies need face to face support. Experiance of an individual who had a posterior tounge tie that was missed and failed to thrive as a result. This was with face to face support. Unfortunately as the tired parents we didn't see our child's percentile drop. It's only now in hindsight from looking at photos that we can see how poorly they were. I would be incredibly concerned if the initial visits from the Health Visiting team were remote. I think that the decision of when each family can move from face to face to remote services should be agreed by the Health Visitor and family on a case by case basis. My eldest needed face to face support until they were 3 months old my youngest needed this until they were 2 months old. We would not have coped without the face to face contact. Without it we would have put extra pressure on the GP service but possibly once things had got much worse for our children.

Perhaps as a first line to identify high risk but not to replace face to face contact as those most vulnerable could be missed

Easier for some families that don't necessarily need to see anyone face to face.

There's no substitute for face to face talk. Too many young people think friendships and relationships can be conducted online. I think this is a feeble way of getting to know someone. No no no

We had one year old review over the phone. I had no concerns and I'm an experienced mum so it worked better

Makes the service accessible to those who are not as able to travel or find time to attend meetings away from the home.

I DON'T REALLY THINK THEY CAN

They will allow more people access to services as reduction in travelling time will benefit staff and ensure they can interact with more families.

I think all services for under 1s should be available in person as a way of identifying and combatting mental health issues which are so common in new mums and identifying safeguarding issues. The option to have a phone or online service would be a great idea for those in a confident mind set. Could it be optional which platform you choose?

You cannot replace visits by phone calls or online resources. The pandemic had to stop some visits but it wasn't the same as having a health visitor check especially for first time parents

I personally don't feel this will be effective. You need to see body language expressions and other tell tell signs to see if something is wrong. I don't believe over the telephone is sufficient

On a practical level - it might be more accessible for some to engage in. In terms of what could be possible - regular welfare check ins.

Think it will be very valuable but need to be aware that some teenagers struggle to open up over the telephone/ online so F2F appointments still need to be available for those in need of this.

Needs clear guidelines. Important to have face to face where appropriate

Video calls make sense

Yes, any support is better than no support

Face to face provision is the most effective approach and digital or telephone support should only be for peripheral services

Digital can be more convenient for some people but always needs to be option of face to face in case observations needed or more hands on support.

There is a need for a robust online resource for families so they can look on one website for information and support on physical and mental health needs. Digital and telephone services are not substitutes for working with the children and families with most need. There also needs to be honest and clear communication with the public about any changes to service and where they can find support. There needs to be preservation of self-referral to the 0-19 team by families. As Named GPs, we are very happy to have further dialogue as it is essential that this new service operates in partnership with primary care.

This is a very poor idea, suited to an emergency situation and lacking in many areas to provide long term support to young people

It can be useful in some areas, but absolutely can not be a replacement in other areas. There still had to be face to face contact - particularly with some children and young people. Digital services can be so impersonal, do not allow the practitioner to get a 'bigger picture' of the child and doesn't allow for non verbal cues to be seen. Not all children or young people will engage with this way of working.

Could reach more people and possibly some families may react better than face to face

These services should be offered in addition to universal face to face services

Phone calls do not replace the benefits of face to face meetings and I would hope that future HV calls are at least video calls to help relocate the visits. Although nothing can replace a HV coming to the house.

The questions are loaded and also closed, and do not allow an appropriate response. To agree that support for children under 5 is a priority is obvious, but this does not mean that other children should be ignored. Equally, obviously support needs to be provided for vulnerable young children aged 5-19, but it does not mean that children deemed to be 'universal' do not need to be supported. Although it was obviously necessary to offer certain services online or by phone during the pandemic, I do not think that these options should be rolled out once the pandemic is over, it is very opportunistic to do this. I think that the importance of face to face contacts cannot be underestimated. I think that cutting certain services such as healthy child clinics, vision and hearing screening, enuresis, is very short sighted and will lead to problems further down the line.

Not necessarily. Face to face is invaluable. It allows health visitors to see and not just hear the situation. My child was poorly when a baby and the face to face support of a health visitor was invaluable. Phone/video should be optional AND combined with face to face visits. Vulnerable children will be missed.

These are closed questions and misleading.  Of course people will support children having the best start in life, but not the way this is proposed being done, at the expense of universal families, cutting face to face contact and cutting screening tests of hearing, sight and enuresis. Virtual contact is not a substitute  for face to face contact and it seems that NYCC and HDFT are misusing the measures introduced as temporary during the pandemic, for cynical reasons. Parents much prefer face to face contact and it is in such situations that they open up and more problems can be identified. I am concerned that the baby clinics are not proposed to be reintroduced. They are invaluable for parents and relatives to raise issues and to build up a relationship with the health visiting team. Parents with mental health issues would find it easier to raise concerns, and such issues could be picked up more easily by the professionals. I am appalled that key screening for eye sight, hearing and enuresis problems are proposed to be scrapped. This could mean children not having such issues picked up until much later, at a cost to their health and education. It is also much easier to pick up problems when the health visiting team see a parent and child face to face, to gain a fuller picture. These measures are not an improvement and will cause long term damage and potentially cost more in the long run, because problems will be picked up later. I think that this survey has not been widely publicised, this consultation has been done under the cover of the pandemic, when it is harder to raise protests effectively and I feel that the wording is misleading . These proposed cuts must not happen. Digital and telephone services are not an effective substitute for face to face contact, baby clinics and  visits . When the world returns to 'normal', temporary pandemic measures should not have replaced what is good about the service for financial and cynical expediency.

I find that the questions are closed and misleading, as surely no one would object to families with children under 5 receiving support, or vulnerable children and young people 5-19 receiving support, but this does not preclude that universal families also need support. As a result, I am not responding to either, but wish to raise my objections to the proposed new service. I am a parent of two young children, and as a result am a service user of both 0-5 and 5-19 healthy child teams. I am concerned that the cuts to the service will have a detrimental effect on universal families. There is no substitute for face to face contact, and I am concerned that emergency measures employed during the pandemic, such as digital and telephone services, are being cynically used afterwards to save money. I am personally sick of virtual meetings/discussions and am desperate to have social interaction with another human being. I feel that it is incredibly short sighted to not reintroduce healthy child baby clinics once the pandemic is over. The value of the clinics is totally overlooked. I am incredibly grateful that I had the opportunity to attend them with my own children. They are not there purely for weighing babies. They are an opportunity to discuss a range of issues, such as immunisations, dental care, behaviour and sleep problems, feeding issues, weight checks, maternal mental health, rashes, general health. They were also an opportunity to build a relationship with the health visiting team. I am also concerned about the proposed cuts to vision and hearing screening and enuresis service. In certain areas, there are not the provisions from other services to meet the gap in provision. I am concerned that the consultation has cynically not been circulated widely to service users who will be shocked at the lack of provision. Surely, there could be other ways to save money, not at the expense of universal families. I trust that NYCC and HDFT will reconsider.

North Yorkshire County Council

# Equality impact assessment (EIA) form: evidencing paying due regard to protected characteristics

(Form updated April 2019)

## *Changes to Universal Healthy Child Service*

If you would like this information in another language or format such as Braille, large print or audio, please contact the Communications Unit on 01609 53 2013 or email communications@northyorks.gov.uk.

যদি আপনি এই ডকুমেন্ট অন্য ভাষায় বা ফরমেটে চান, তাহলে দয়া করে আমাদেরকে বলুন।

如欲索取以另一語文印製或另一格式製作的資料，請與我們聯絡。

اگر آپ کو معلومات کسی دیگر زبان یا دیگر شکل میں درکار ہوں تو برائے مہربانی ہم سے پوچھئے۔

**Equality Impact Assessments (EIAs) are public documents. EIAs accompanying reports going to County Councillors for decisions are published with the committee papers on our website and are available in hard copy at the relevant meeting. To help people to find completed EIAs we also publish them in the Equality and Diversity section of our website. This will help people to see for themselves how we have paid due regard in order to meet statutory requirements.**

| | |
|---|---|
| Name of Directorate and Service Area | Health and Adult Services |
| Lead Officer and contact details | Richard Webb<br>Richard.webb@northyorks.gov.uk |
| Names and roles of other people involved in carrying out the EIA | Victoria Ononeze, Public Health Consultant<br>Emma Lonsdale, Commissioning Manager Health Outcomes<br>Mike Rudd – Head of Commissioning |

| | |
|---|---|
| | Sarah Morton, Senior Solicitor |
| How will you pay due regard? e.g. working group, individual officer | To be regularly reviewed as part of the Childhood Futures Programme 0-19 Service Transformation |
| When did the due regard process start? | Engagement with stakeholders in August 2018 to help inform the development of new service model.<br>Full public consultation completed between October 2020 and January 2021 |

**Section 1. Please describe briefly what this EIA is about.** (e.g. are you starting a new service, changing how you do something, stopping doing something?)

This EIA relates to the decision to develop a new model for the delivery of the Universal Element (Health Visiting (0-5) and School Age (5-19) services) of the Healthy Child Programme (HCP) in North Yorkshire.

In 2018, North Yorkshire County Council (NYCC) initiated a review of the HCP to determine commissioning options from March 2020. This included seeking the views of local partners, staff and service users. The aim is to develop a more integrated 0-19 service that is more responsive to the needs of children, young people and families.

A paper was considered by the Executive in August 2019 which set out the approaches to commissioning the different elements of the programme. For the Universal element of the HCP (Health Visiting and School Age Service), the intention is to pursue a partnership approach between NYCC and Harrogate and District NHS Foundation Trust (HDFT) that will allow HDFT to deliver a new service model on the Council's behalf, using Section 75 Agreement.

The new service model has been agreed within the context of national changes in Public Health Grant which have resulted in a reduction across public health programmes of around 15%. A saving of £750,000 has been applied to the 0-19 services delivered by HDFT.

NYCC and HDFT have developed a new service model which both parties consider to be affordable within the reduced financial envelope.

This EIA will consider the potential impact of the new service model, but also take into account the potential impact should the new service model not be implemented.

**Section 2. Why is this being proposed? What are the aims? What does the authority hope to achieve by it?** (e.g. to save money, meet increased demand, do things in a better way.)

The Health Visiting (0-5) and School Age (5-19) services have been commissioned from HDFT since 2013. The current HDFT contract expired in March 2020 and, in the context of the significant reduction in ring-fenced PH Grant, the Council has proposed developing a single 0-19 core service as part of its savings plan.

The proposal is to develop and implement a new way of working that supports the philosophy of the Childhood Futures Programme, to transform 0-19 services and achieve greater collaborative working across the system.

The learning from the operational response to COVID-19 throughout 2020 has illustrated ways in which services such as this can be safely and effectively delivered through a blended approach of physical and virtual support, the proposal looks to build on this experience and embed it within the future model.

The Council have worked closely with service leads at HDFT to develop the proposed model and approach which responds to the local context and will deliver a service within budgetary constraints that is tailored to needs.

Both parties are keen to be innovative in the way they work with local information and partners to co-ordinate the right level of services and support by the right people for children, young people and families.

- Work together to develop a new service model that meet local needs
- Commitment to providing both universal and targeted approaches to services with some enhanced services
- Ensure a phased and orderly transition to a new service model so that the provider can redeploy and re-train staff
- Set out how, over the next three years, they will work more closely to integrate the HCP with NYCC Children and Young People's Services and the wider system

A Section 75 Agreement will enable partnering arrangements between NYCC and HDFT to achieve the above objectives. The risk around this approach has been understood and accepted, and based on the partnership framework is compliant.

The collaborative partnership approach will ensure maximum efficiency in delivery of the healthy child service.

**Section 3. What will change? What will be different for customers and/or staff?**

The new service model is significantly different from current service model in a number of ways as set out in table below. It will continue to deliver universal services and will allow for resources to be targeted at those most in need, so safeguarding and services for children in need remain a priority.

The key changes are:

- All children and families will continue to receive the 5 mandated contacts from Health Visitors between the ages of 0 and 5. Under the new proposal these will be

via a blended model of physical and virtual visits based on a risk assessment which will be continually reviewed through both HCP and interactions with other partners.

- All contacts with children under 1 year will be delivered by a qualified Health Visitor, and contacts in children over 1-year-old delivered by a skill mixed team. This will allow for a more coordinated and integrated approach to responding to needs
- There will be no generic service delivered to school aged children 5-19 year olds (e.g. vision and hearing screening and bet wetting at night will not be directly provided. Considerable work has been undertaken to mitigate the impacts of these changes, including signposting to partner agencies and other services.

There will also be a reduction in the workforce to deliver the new service model as a result of the reduced service budget. The national shortage of Health Visiting and School Nursing staff creates ongoing risk to recruitment and retention, more so in some parts of the county. The new service model with specialist and skilled mix teams will contribute to a more stable workforce. In addition, the move to a blended approach of physical and virtual visits will allow staff time spent supporting people rather than travelling to be maximised.

However, the evaluation on new ways of working as a response to COVID-19 has shown positive feedback from service users and staff on virtual delivery. This provides some flexibility in expanding the scope of the new service model. For example, virtual contacts (telephone and WhatsApp calls) followed by welfare calls which were found to respond to the needs of some children, young people and families and can also help reduce staff workload. Access to digital consultation and service delivery will be considered as part of the development of the new service and wider services in the county.

Engagement with local partners, service users and the wider public has been undertaken to understand the concerns and issues generated by this proposal. A number of consultation workshops involving local partners took place in March 2020 which looked at the different aspects of developing the new service model. The public consultation held between October 2020 and January 2021 has engaged with a wide range of education and health professionals to understand their concerns and develop mitigations.

**Section 4. Involvement and consultation (**What involvement and consultation has been done regarding the proposal and what are the results? What consultation will be needed and how will it be done?)

North Yorkshire County Council initiated an engagement activity during August 2018 to inform the re-commissioning of the HCP in April 2020. The aim of engagement was to obtain the views of a variety of stakeholders in order to review the services currently offered and inform development of a new service model. The key findings are:

- Support for a 0-19 approach to service planning and delivery and regular health and wellbeing reviews as touchpoints of early identification of needs
- Vulnerable families are a priority
- School readiness, Emotional wellbeing and Adolescent risk taking as priority areas

- Autism Spectrum Disorder (ASD)/ Attention Deficit Hyperactivity Disorder (ADHD) Concern – service offer and workforce skills to respond
- Diverting activity from GP's to Early Help interventions would support 'right place right time' approach to care and support
- Information sharing systems should be improved and interoperability prioritised
- A clear offer required for children with complex health needs
- Healthy Child Safeguarding role a valued element of the service

In March 2020, NYCC and HDFT held a number of consultation workshops involving local partners which looked at the different aspects of developing the new service model. The workshops focused on identifying the impact the new model may have on other services. The feedback has been used to develop the documentation (Appendix 1) for the public consultation on the new service model.

All partners acknowledged that the changes will result in a reduced service with reduced staffing capacity in comparison with what is delivered now and will be significantly different to the current model. In particular, significant changes in the services delivered to school aged children.

However, all recognised that the model presents a different way of working together:

- Help plan and provide collective actions across the system to address key public health priorities
- Facilitate integrated working practices that can help reduce the burden on families repeating their story and being subject to unnecessary assessment
- An opportunity to work flexibly and to respond to local needs
- Can support communities in the delivery of self-care and capacity building
- A clearer more streamlined service offer that utilises the skill set of the workforce
- A safe service that will target the most vulnerable in society
- Partnership working with Early Years settings where there are shared child developmental concerns

Between October 2020 and January 2021 a wide ranging public consultation was held as set out in the report to Executive on 26/01/21. This consultation sought people's views on the proposed changes to the service.
245 people responded to the online survey, well above the benchmark of 120 responses. In addition the HCP project team spoke to 98 people by attending pre-existing meetings and events, whilst an additional 32 people attended bespoke events hosted by the Council. The summarised feedback from the consultation along with a full response can be found in the paper submitted to Executive for 26/01/2021.

**Section 5. What impact will this proposal have on council budgets? Will it be cost neutral, have increased cost or reduce costs?**

The Healthy Child Programme is funded through the North Yorkshire Public Health Grant which is a funding allocation from Public Health England to the Council. This is a defined pot of funding from central government for the delivery of Public Health services.

The Public Health Grant was subject to 8% national reductions between the financial years 2017/18 and 2019/20, with an inflationary increase only for the financial year 2020-21. The level of future Public Health Grants is announced annually and cannot be predicted. As a result the Council is required to make spending reductions across a range of Public Health services.

Healthy Child services account for approximately a third of North Yorkshire's Public Health spending and they will continue to be at a similar share, despite the reductions in national Grant.

This proposal will reduce the direct cost of the Healthy Child Programme by £657,000 by year three of the 5+3+2 year contract.

| **Section 6. How will this proposal affect people with protected characteristics?** | **No impact** | **Make things better** | **Make things worse** | **Why will it have this effect? Provide evidence from engagement, consultation and/or service user data or demographic information etc.** |
|---|---|---|---|---|
| Age | | x | | A single 0-19 offer and more integrated working practices across the system will lead to a more responsive service for children and families.<br><br>Some service performance data are broken down by age and uptake will be monitored.<br><br>The move to a blended model based on risk assessment will allow families to access services remotely where this is appropriate. For some families this will facilitate greater interaction and support. All families who require face to face contact either through additional need or levels of risk will continue to do so. |
| Disability | x | | | Service monitoring does not capture disability. However, the service delivers interventions at home, and Children and Families Hubs which benefited those who with children and young people with disabilities. |

| | | | | |
|---|---|---|---|---|
| Sex | x | | | Any change in the service is more likely to impact on women due to the demographics of those accessing the service. |
| Race | x | | | There is evidence to show poorer outcomes in some black and minority ethnic groups (e.g. low birth weight and lower level of readiness for school).<br><br>In 2011 4.6% of the North Yorkshire population were from a non-white British ethnic groups which is significantly below the national average.<br><br>The ethnic diversity varies between districts with Harrogate having the biggest number of people identifying as non-white; Asian British and mixed /multiple ethic group make up the major part of this diversity in Harrogate. Asian British is the largest group of non-white people in Craven and Richmondshire. |
| Gender reassignment | x | | | It is not anticipated that there will be any adverse impact on this protected characteristic. |
| Sexual orientation | x | | | It is not anticipated that there will be any adverse impact on this protected characteristic. |
| Religion or belief | x | | | The 2011 census shows the majority of the population within North Yorkshire state they identify with Christianity as their religion.<br><br>However, some parts of the county have a higher percentage of the population stating another religion or belief as follows:<br>Richmondshire: 0.7% Buddhist, 1 % Hindu<br>Craven: 0.9% Muslim<br>Scarborough: 0.5 % Muslim<br>Harrogate: 0.4% Muslim14<br><br>it is not anticipated that there will be any adverse impact on this protected characteristic than the entire population. |
| Pregnancy or maternity | | x | | Better joined up working between the HCP and midwives in identifying and |

| | | | | |
|---|---|---|---|---|
| | | | | responding to the needs of vulnerable parents and families.<br><br>Closer working across the system, facilitated by the Section 75 approach will allow for more joined up working and shared interventions where needed. |
| Marriage or civil partnership | x | | | It is not anticipated that there will be any adverse impact on this protected characteristic. |

| **Section 7. How will this proposal affect people who…** | **No impact** | **Make things better** | **Make things worse** | **Why will it have this effect? Provide evidence from engagement, consultation and/or service user data or demographic information etc.** |
|---|---|---|---|---|
| ..live in a rural area? | | x | | Digital and community led solutions to service delivery with regard to access in rural areas in response to engagement and consultation feedback. These will building on exiting initiatives and the learning from COVID-19 responses. |
| …have a low income? | | x | | Prevalence of poor health outcomes is higher in low income families.<br><br>All risk factors and inequalities associated with poor outcomes will be paid regard to in the service specification and performance framework, in response to consultation feedback for more support for vulnerable children and families.<br><br>Risks around digital exclusion linked to low income will be mitigated through risk assessments and utilisation of face to face visits. |
| …are carers (unpaid family or friend)? | | x | | As above |

| **Section 8. Geographic impact – Please detail where the impact will be (please tick all that apply)** | |
|---|---|
| North Yorkshire wide | x |
| Craven district | |

| | |
|---|---|
| Hambleton district | |
| Harrogate district | |
| Richmondshire district | |
| Ryedale district | |
| Scarborough district | |
| Selby district | |
| **If you have ticked one or more districts, will specific town(s)/village(s) be particularly impacted? If so, please specify below.** | |
| | |

**Section 9. Will the proposal affect anyone more because of a combination of protected characteristics?** (e.g. older women or young gay men) **State what you think the effect may be and why, providing evidence from engagement, consultation and/or service user data or demographic information etc.**

No

| **Section 10. Next steps to address the anticipated impact. Select one of the following options and explain why this has been chosen.** (**Remember:** we have an anticipatory duty to make reasonable adjustments so that disabled people can access services and work for us) | **Tick option chosen** |
|---|---|
| **1. No adverse impact - no major change needed to the proposal.** There is no potential for discrimination or adverse impact identified. | **x** |
| 2. **Adverse impact - adjust the proposal -** The EIA identifies potential problems or missed opportunities. We will change our proposal to reduce or remove these adverse impacts, or we will achieve our aim in another way which will not make things worse for people. | |
| **3. Adverse impact - continue the proposal -** The EIA identifies potential problems or missed opportunities. We cannot change our proposal to reduce or remove these adverse impacts, nor can we achieve our aim in another way which will not make things worse for people. (There must be compelling reasons for continuing with proposals which will have the most adverse impacts. Get advice from Legal Services) | |
| **4. Actual or potential unlawful discrimination - stop and remove the proposal –** The EIA identifies actual or potential unlawful discrimination. It must be stopped. | |

**Explanation of why option has been chosen.** (Include any advice given by Legal Services.)

Ongoing engagement with service users will support continuous points of review to ensure that no adverse impact is felt due toi protected characteristics.

The service model will be under regular review through the NYCC and HDFT partnership, and will underpin service transformation and the development of coordinated and integrated practices in 0-19 services across system.

The

**Section 11. If the proposal is to be implemented how will you find out how it is really affecting people?** (How will you monitor and review the changes?)

Ensure effective communication to be carried out with all stakeholders; staff, service users and the wider public, to enable change management and service mobilisation.

Regular review of how the new model is being delivered will be a carried out in partnership with HDFT.

Complaints and commendations.

**Section 12. Action plan.** List any actions you need to take which have been identified in this EIA, including post implementation review to find out how the outcomes have been achieved in practice and what impacts there have actually been on people with protected characteristics.

| Action | Lead | By when | Progress | Monitoring arrangements |
|---|---|---|---|---|
| Consider data and feedback on protected characteristics when reviewing / monitoring the changes | Commissioning Manager and Public Health Consultant And reported to Healthy Child Programme Board | Fortnightly | | Ongoing |
| Continue to work in partnership with local partners and community organisations to mitigate against reduction in services | NYCC and HDFT through the Healthy Child Programme Board | Ongoing | | |

**Section 13. Summary** Summarise the findings of your EIA, including impacts, recommendation in relation to addressing impacts, including any legal advice, and next steps. This summary should be used as part of the report to the decision maker.

No adverse impacts have been identified at this stage.

The programme will support the council's equality objective to reduce differences in life expectancy between communities as it will to ensure every child gets the good start they need to lay the foundations of a healthy life.

The universal reach of the Healthy Child Service provides an invaluable opportunity from early in a child's life to identify families that are in need to additional support and children who are at risk of poor outcomes. A healthy start in life gives each child an equal chance to thrive and grow into an adult who makes a positive contribution to the community. To facilitate this change, NYCC will have to work with its partners and the proposed partnership with HDFT to deliver a new Healthy Child Service model is part of the process.

All equalities priorities (Age, Disability, Gender, Gender Reassignment, Marriage or Civil Partnership, Religion or belief, Race, Sexual Orientation, Pregnancy or Maternity) have been addressed in this process.

This EIA will be regularly reviewed during the mobilisation of new service model and throughout the duration of the partnership.

**Section 14. Sign off section**

This full EIA was completed by:

**Name:**
**Job title:**
**Directorate:**
**Signature:**

**Completion date:**

**Authorised by relevant Assistant Director (signature):**
Victoria Ononeze
Consultant in Public Health

**Date: 28.07.2020**

# DRAFT – Live Document

## Communications plan
## Healthy Child Programme (universal 0-19 service) – consultation on changes to the service model, 26 Oct 2020 to 4 Jan 2021

**Aim of the communications plan**

The aim of this plan is to set out the channels that can be used to publicise the consultation on how the national Healthy Child Programme will be delivered in North Yorkshire from 2021 (when current contractual arrangements expire).

This will include the opportunity to:

- take part in online meetings
- complete an online survey, which will also be available in accessible versions (easy read, and other formats or languages on request)

There will be broadly three different groups to target:

- the public
- parents, families, children and young people (who are also stakeholders)
- a wide range of stakeholders including partners, staff, unions, and community groups

This communications plan covers digital, internal (NYCC and HDFT) and external channels that can be used to advertise the consultation – please see the communications schedule below.

This plan does not cover consultation with staff potentially affected by the changes to the service being consulted on, or engagement with Trade Unions.

There is a stakeholder map at the end of this document – some stakeholder communications will be carried out directly by the project team, and are therefore not covered in this plan.

There will be a separate communications plan for the consultation about the use/content of a section 75 agreement to deliver the service (due to start late 2020/early 2021). There will also be a separate consultation on the delivery of the targeted element of the programme re Emotional Health and Wellbeing.

This consultation runs from 26 October 2020, for 10 weeks to 4 January 2021

**Background**

North Yorkshire County Council (NYCC), in partnership with Harrogate and District NHS Foundation Trust (HDFT), is proposing a new model for Health Visiting and School Nursing Services (the Healthy Child Programme) in the County. We want to hear the views of children, families, local partners and the wider public about these proposals and how they can be implemented – this approach will include a prioritisation on the under 5s and their families and it will draw on the learning from the Covid period.

North Yorkshire County Council

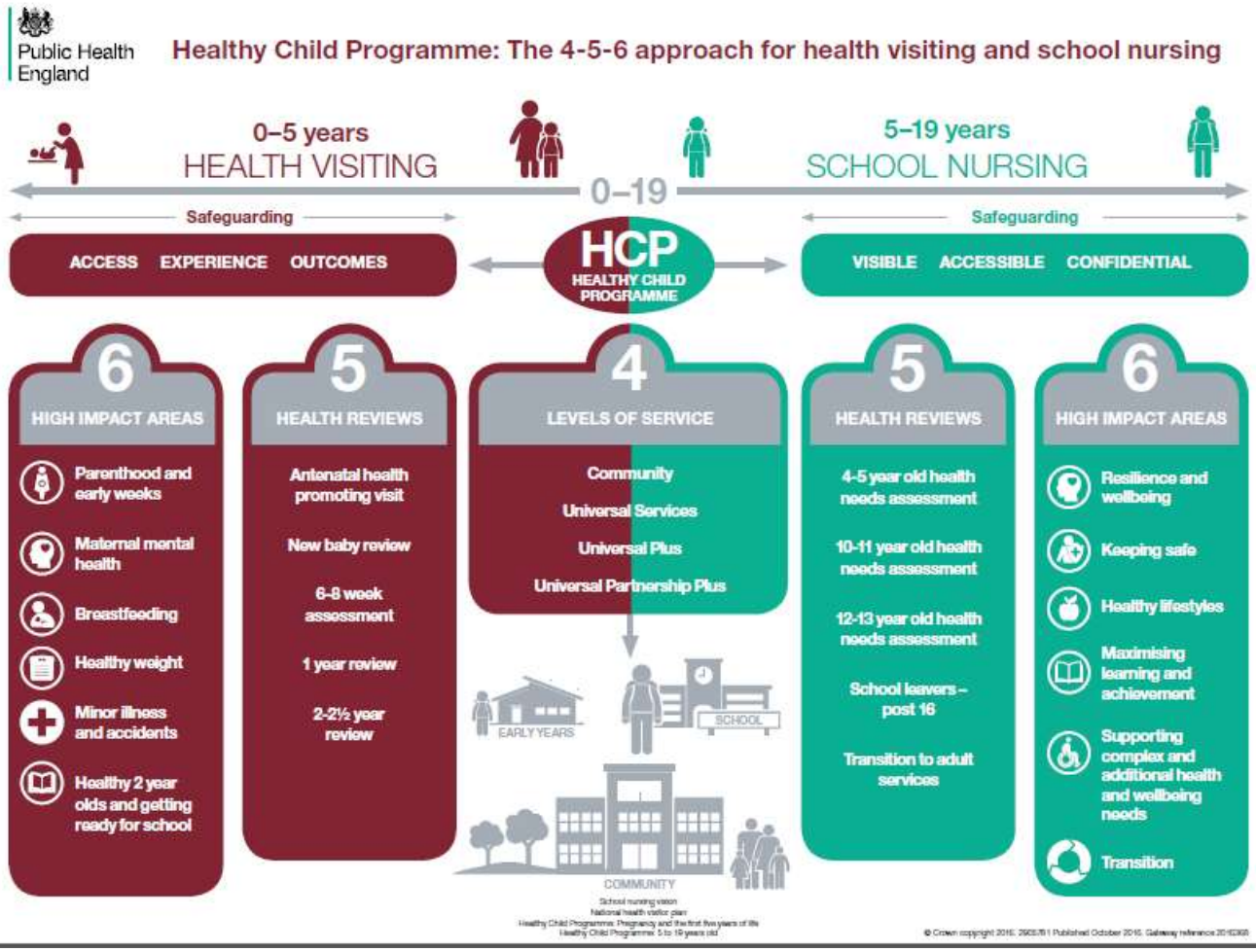
NHS Harrogate and District NHS Foundation Trust

The provision of the 0-19 healthy child programme is being reviewed ahead of entering into a section 75 agreement with HDFT when the current contract ends in 2021.

The HCP programme is a universal preventative child and family health promotion programme set up by the Department of Health and Social Care, available to all families, children and young people and aims to ensure that every child gets the good start they need to lay the foundations of a healthy life.

Local authorities are responsible for commissioning public health services for children aged 0-19. Regulation requires all families with babies to receive five health reviews before their child reaches 2 and a half years old as described in the Healthy Child Programme 0-5 years. National Child Measurement Programme at reception and year 6 is also mandated.

Please see below the current national model for the healthy child programme from Public Health England.



It is proposed that changes to this model are needed in order to manage cuts to the public health grant in North Yorkshire of up to £4 million in the coming years.

**Audiences**

General public
Parents, families, children and young people
Healthwatch NY
Community First Yorkshire
PHE
North Yorkshire MPs
NYCC and HDFT internal audiences (staff directly affected, and the wider workforce)
Wider NHS including CCGs, NHS FTs, GPs, LMC and Tees, Esk and Wear Valleys NHS Foundation Trust
VCS and community organisations
Borough and district councils

Professional partners and stakeholders include: CCGs, NHSE&I, Early years settings inc child minders, Education Improvement Partnerships, 0-5 & 5-19 HCP workforce, Prevention teams, Social care teams, GPs, Acute and Community Paediatricians, AMH/CAMHS, Therapy services, CVS/VCS organisations, Maternity Services, Partners and professional bodies including public health, HWBB, Children's Trust Board, LSCB, Local health watch OSC, Parent carer forums, Youth groups, Youth participation groups, Stay & Play, Children's Centre groups, Schools
Wider colleagues in CYPS including early years and children's centres,

**Channels**

To advertise consultation events (virtual only due to Covid restrictions) and signpost to the online survey, for the wider public we will use:

- Media releases (talking heads from NYCC and HDFT available for interview/video during consultation:
  From HDFT – clinically: Natalie Lyth and Suzanne Lamb, Executive level: Jonathan Coulter.
  From NYCC – Louise Wallace, Stuart Carlton

  All Media releases will be issued jointly by NYCC and HDFT

- NYCC and HDFT websites
- Monthly Johnston press pages (pages in free newspapers distributed throughout the county)
- NYCC and HDFT facebook and twitter accounts to signpost people to the surveys/event information on the websites at www.northyorks.gov.uk/healthychild
- Target age groups and geographical areas via paid for NYCC facebook advertising if required
- Sharing via NYCC CFS hub facebook pages, district partners etc
- Community groups/groups that access services already (to be identified via the service and Stronger communities).

- NYCC internal channels – examples include intranet, key messages, member and MP weekly bulletin (during Covid), Richard Flinton's message, early years key messages, Richard Webb blog, red bag to schools, direct emails to partners (to be managed by project team). Examples from HDFT include the weekly all staff bulletin (Wednesdays), emails to specific teams, staff Facebook group, intranet, governor briefings.

**Key messages**

**Public facing messages**
North Yorkshire County Council, in partnership with Harrogate and District NHS Foundation Trust, is proposing a new model for the Healthy Child Programme (which currently comprises health visiting and school nursing Services) in the county. We want to hear your views about our proposals and how they can be implemented.

Please read the information at www.northyorks.gov.uk/healthychild which explains our aims as follows:

- We (the council) propose intensifying our focus on children under 5, based on the evidence that supporting them has a greater impact throughout life, gives them the best start in life and prepares them to be ready to learn.
- We want to secure longer term funding and certainty for the Healthy Child Programme in North Yorkshire, within the context of the national reduction in Public Health Grant which is the main source of funding for the service.
- We propose extending and developing the partnership between North Yorkshire County Council and Harrogate and District NHS Foundation Trust (HDFT), to provide the service for a period of up to ten years, taking us to 2031.
- We want to learn from the emergency changes made to the current service during the response to Covid-19.
- We are managing a reduction of up to £4 million over the coming years in the public health grant.
- We propose implementing a new service model as a result of all of the above factors.

In putting these proposals forward, we are making clear pledges to you.

- All children and young people will receive universal and targeted services to enable them to have the best start in life, through our work in children's early help and social care, schools and community support for children and young people with additional needs.
- We will prioritise our public health grant-funded Healthy Child Programme towards children under five, to support their early development and to ensure that they are ready to learn.
- All new-born babies and their parent(s)/carer(s) will have a face to face visit from a qualified health visitor.

- We will continue to provide targeted support for 5-19 year olds, through a range of different programmes and funding streams.
- Our Healthy Child 0-19 services will combine a mix of face to face, online, individual and group work services, tailored to the personal circumstances of each family.
- We will continue to work with children and families, public and private agencies and voluntary and community groups to ensure that the right support is provided by the right person and at the right time.

**2. Case studies**

Service user case studies – parents/carers talking about virtual sessions, new parents talking about their face to face visit, young person with additional needs who has benefited from the service, professionals talking about changes to how they deliver the service during Covid and how that has informed these proposals etc.

**3. Reassurance messages**

The council are facing a significant reduction in government funding and the consequential pressures – however, spend on children and young people, including HCP, will remain as a third of total Public Health spend.

We are here to listen– we will engage with you and take on board your views. We are going to great lengths to reach the people who need this support the most and we are confident we are going about this in the most thorough and planned way.

We are going to great lengths to understand the views of the people who need our support the most - that will ensure we provide the help needed in the most effective way.

**4 Call to action**

Please tell us what you think about the prioritisation of the under 5s and the proposed changes to the 0-19 Healthy Child programme in North Yorkshire. All feedback will be considered and used to shape our final recommendations.

- **Read the information at www.northyorks.gov.uk/healthychild and fill in the online survey by 9am on 04 January 2021.**
- **Sign up for one of our virtual Q&A sessions here www.northyorks.gov.uk/healthychild**

• Printed copies of the information on the proposals and the survey can also be provided on request – please call 01609 780780
• If you can't attend an event you can email any questions to healthychild@northyorks.gov.uk • If you would like the information about the proposals or the survey questions in another language or format, or if you would like printed copies, please ask us. Tel: 01609 780 780 or email: healthychild@northyorks.gov.uk
• You can also write to '0-19 Healthy Child Service model, c/o Central Admin Team, North Yorkshire County Council, County Hall, Northallerton, DL7 8AE

N.B Any video communications will require sub-titles.

**Communications schedule**

| Audience | Channel | Messages | Who | Cost | Date |
|---|---|---|---|---|---|
| Public | Joint media releases prior and during consultation and reactive statements as and when required | 1-4<br>Plus signposting to website | NYCC and HDFT comms | n/a | Before and during consultation<br><br>See appendix 1 for 05.10.20 release and 26.10.20 release |
| | Web page | 1-4 plus<br>SNAP survey, consultation info inc FAQs, details of events/virtual sessions, accessible versions, how to request other information<br><br>Additions to FAQs to be made as and when questions are received.<br><br>Translations to be added to NYCC web page – Polish, Romanian and Arabic | NYCC with links from HDFT | £687 for translations | Oct to Jan |
| | Social Media targeted and organic (to be shared by partners) | 1-4 | NYCC and HDFT | £50 to £200 depending on campaign targets | Oct to Jan |
| | Video content as required during consultation– will need subtitle | Mitigation or response to any frequently arising theme. Re-enforcement of key messages | NYCC | £200 - £500 | TBC |
| | Virtual events – targeted to different audiences | See ppt by Mike Rudd | NYCC and HDFT representatives | | 3-6 Nov<br>18-20 Nov |

| Audience | Channel | Messages | Who | Cost | Date |
|---|---|---|---|---|---|
| | Posters - Libraries | Signpost to website | NYCC and sent to HDFT | | Distributed from 02.11.20 |
| | Any other NYCC buildings? (PRU's?)<br><br>Children's centres?<br><br>GPs? (TBC – GP waiting rooms not in use?) | Signpost to website | Service to advise | | |
| | Paid for advertising if required (depends on consultation KPIs – service to advise) | Signpost to website | Comms (service to advise) | | |
| | Partner sharing (i.e districts, NHS, CCGs etc) | Signpost to website | Service | | |
| | Community groups | 1-4 | Stronger communities? | | |
| Schools | Red bag | Asking them to share with parents/carers and also staff to fill in the survey themselves | Service | | 06.11.20 |
| All NYCC staff | Intranet, key messages, Richard Flinton's message, Early years key messages, Stuart Carlton/Lincoln Sargeant/Richard Webb blog, red bag to schools, direct emails to staff groups (to be managed by project team). Children and Families service newsletter | 1-4 and please share our messages | Comms | | Oct to Jan<br><br>Internal news, and key message live 30.10.20.<br><br>CFS newsletter 29.10.20. |
| HDFT 0-19 service staff | Establish staff engagement programme ahead of mobilisation for new contract | Messages to be advised by HDFT | Suzanne Lamb | | |

| Audience | Channel | Messages | Who | Cost | Date |
|---|---|---|---|---|---|
| | Run 2x 1 hour sessions w/c 7 September via Teams with Mobilisation Team and Exec reps – 'Staff Engagement Sessions'. To include overall summary/presentation of doc, methods of comms, social media etiquette, keeping in touch. | Messages to be advised by HDFT<br><br>Share Social Media Policy and highlight responsibilities | Ashley Iceton, Yvonne Campbell, HDFT Comms | | |
| | Additional staff engagement sessions across (initially) the 70 day period. 30 min drop-in sessions on Teams, one a week for 10 weeks | | Mobilisation and Exec Team, HDFT Comms | | |
| | Staff email communication, weekly to include cascade of FAQs. | | Mobilisation and Exec Team, HDFT Comms | | |
| | Open forum weekly sessions with Executive Team | | Suzanne Lamb, Yvonne Campbell | | |
| All HDFT staff | Weekly all staff bulletin (Wednesdays), emails to specific teams, staff Facebook group, intranet, governor email briefings. | All | HDFT Comms to lead and co-ordinate | | |
| HDFT Foundation | Part of an email bulletin | All | HDFT Comms | | |

| Audience | Channel | Messages | Who | Cost | Date |
|---|---|---|---|---|---|
| Trust members | | | | | |
| Parents/carers/stakeholders whose first language is not English | Website: Arabic, Polish and Romanian translations of full consultation information available 03.11.20 | All | Comms | | Nov |
| NYCC Members/MPs | NYCC Exec members briefing? | 1-4 | Comms<br><br>Project team | | Oct to Jan |
| Professional stakeholders - partners and professionals outlined on stakeholder map (see below), including parents/carers and young people | Direct invites to virtual events via email? | 1-4<br><br>Asking for views and asking to share messages with their audiences | EL/LS and HDFT | | Oct to Dec<br><br>NYCCG Primary care committee meeting 26.11.20 (VO attended virtual meeting) |
| | Email direct to all stakeholders | 1-4<br>Asking for views and asking to share messages with their audiences | AB | | Sent 23.10.20 – see appendix 1 |
| | Targeted work with existing forums/networks, including attending meetings they have planned during the consultation period. | Service to provide details | AB/VO/MR | | |
| | www.nypartnerships.org.uk | Signpost to info on corporate site | Comms | | Complete 02.11.20 |
| | Via schools and early years settings | Service to provide details | AB/VO/MR | | |
| | School virtual events? | Service to provide details | AB/VO/MR | | VO attended Primary Leadership Meetings |

| Audience | Channel | Messages | Who | Cost | Date |
|---|---|---|---|---|---|
| | | | | | (Deputy and Head Teachers) on the following dates 18/11/20 Craven and Harrogate 20/11/20 Hambleton and Richmondshire 25/11/20 Ryedale, Scarborough And Selby |
| | Early Years Key messages | 1-4 | Comms | | November 2020 |
| | Get a slot on the agenda at virtual professional events during the consultation – early years forums, partner events, E&S training events etc | Service to provide details | AB/VO/MR | | Foster Carers Support Group on the 17th November – VO attended |
| Young people | Children's version of survey on website<br>Schools? (Red bag)<br>Youth Council<br>NY Sport | 1-4 | Service to advise – liaising with Matthew Edwards | | Matthew Edwards to send consultation direct to his contacts (AB to confirm when done) |
| Young people with SEND and their parents/carers young people in rural communities, etc | Red bag Schools/Pupil referral units?<br>Stronger communities contacts<br>NYPACT<br>Flying High group?<br>https://www.northyorks.gov.uk/flying-high-giving-young-people-send-voice | | | | |
| Community organisations (baby groups, breastfeeding support,) | Stronger communities?<br><br>Community Anchor organisations like CAVCA on the coast. | 1-4 and please share our messages | Service to advise | | |

## Evaluation

Service/project team to advise the target number of survey completions required by the end of the ten week consultation in order to achieve a robust consultation response.

Comms team to report on campaign reach, visits to web page and surveys completed (plus demographic info).

Service/project team to evaluate volume and diversity of responses to the survey and feedback from online events to determine whether or not further paid for promotional activities need to be undertaken to meet the consultation KPIs and target under represented groups.

| Description | Target/KPI | Status |
|---|---|---|
| Number and type of survey responses:<br>Stakeholders<br>Professionals<br>Young people<br>Parents/Carers | Service to advise | |

Reach week 1 26.10.20 to 02.11.20

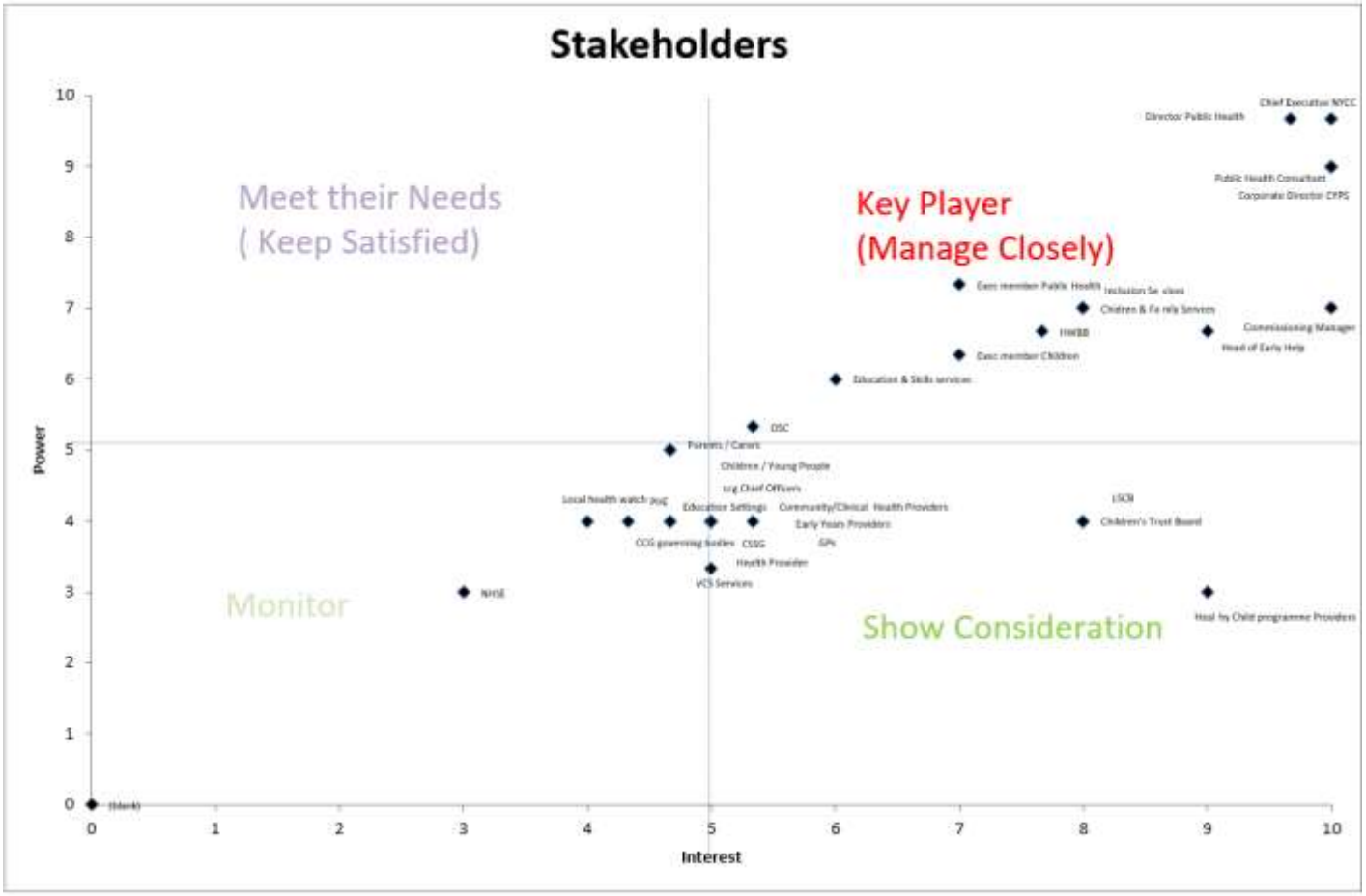
| Channel | Details | Overall reach |
|---|---|---|
| NYCC Facebook | X 3 posts | 24241 |
| NYCC Twitter | X 4 tweets | 35600 |
| NYCC Instagram | X 1 post | 2924 |
| HDFT Facebook | X 1 post | 8838 |
| Media coverage | Press coverage – Harrogate Advertiser 29.10.20 | 36000 print readership |
| | Craven Herald 29.10.20 | TBC |
| NYCC internal staff comms | Intranet news item, key message | 7141 |
| Red bag | November red bag bulletin | 800 school email addresses in North Yorks (includes academies in addition to NY maintained schools. All phases plus special and PRS.) |
| Stakeholder email | 23.10.20 | Service to advise |

**NYCC Comms Unit, October 2020**

North Yorkshire County Council

NHS Harrogate and District NHS Foundation Trust





**APPENDIX 1, PRESS RELEASES and stakeholder email**

**06.10.20**

# News

**Communications Unit**
County Hall, Northallerton, North Yorkshire, DL7 8AD
Tel: 01609 532448  01609 533109
media@northyorks.gov.uk

## Council to consult on public health programme for children, young people and families

A new way of providing a range of public health services for children and young people across North Yorkshire is to be considered for consultation.

North Yorkshire County Council's Executive will decide next week (Oct 13) whether to consult on a new model for the Healthy Child Programme. The proposals are to carry on with the universal

service for children under 5, but will focus on more tailored support for children and young people aged 5-19 and target support for families most in need.

The Healthy Child Programme is a child and family health promotion programme for children aged 0-19 years. Some of the services within it are for all children, such as health visiting, and some are targeted to those most in need, such as vulnerable families and children and young people with emotional health and drug and alcohol problems.

The Council currently commissions these services from Harrogate and District NHS Foundation Trust and is proposing a new, long-term agreement, with the Trust, to deliver these services across North Yorkshire.

Dr Lincoln Sargeant, North Yorkshire's Director of Public Health said: "We are working with Harrogate and District NHS Foundation Trust to deliver the next stage of the Healthy Child Programme, which provides health visiting, support for children of school age and other prevention services to children and families.

"As we lead on public health service commissioning, we have been funding the programme and have been working with the Trust for a number of years to provide the service. We are looking to continue that relationship for a longer term of up to 10 years. This will provide the opportunity to transform the way we provide services to children and families, and help closely align the programme with the Early Help Service run by the County Council's Children and Young People's Service, as well as other health services and community support."

The Council and partners have needed to find new ways of delivering the Healthy Child Service in the face of a national reduction in public health funding.

Dr Sargeant continued, "In particular, we must take account of the national changes in public health funding which will see a reduction across the board of around 15 per cent. For us, here in North Yorkshire, that requires a reduction in our public health spending of up to £4m in the next few years. We will protect the Healthy Child Programme as much as possible and reductions to these services will be less than the overall cut to the Public Health Grant. We will have a universal and targeted service for children and it will continue to be our biggest single area of spend in public health."

The proposals for consultation include:

- Mandatory visits to families with children under five at key child development stages will be co-ordinated by a qualified health visitor.
- At-risk under 5s and their families will continue to be prioritised, as they are now, with 100% face to face visits where needed;
- Learning from how services have operated under Covid-19 restrictions, introducing a blended approach of face to face and online contact for families, based on robust assessment of the child and family's needs;
- More integrated support from agencies across the health, education, social care and voluntary sector for children to be ready to learn and to address developmental concerns in children and young people;

- More prevention and early intervention activities to reduce childhood obesity focused on infant feeding and family diet and nutrition including breastfeeding and healthy weaning;
- A partnership approach to the prevention and management of risky adolescent behaviour including prioritising and improving emotional health and resilience
- Effective identification and management of the safeguarding of children and vulnerable parents or family members.

Dr Sargeant said: "We will continue to deliver mandatory health checks for children under five years old and will continue to support new parents with a focus on those children and families most in need. There will also be a focus on emotional resilience for young people.

"We are committed to continue delivering a safe and effective service that protects children and young people and contributes to them growing up well."

The new model will help local partners to be innovative in the way they co-ordinate the right level of support for children, young people and families.

"During the Covid-19 pandemic, we have had to make emergency changes to the way we delivered many of our face to face services for children, young people and families," said Stuart Carlton, North Yorkshire's Director of the Children and Young People's Service. "We now have really strong learning about how to provide a safe and effective personal service via digital platforms which can be taken forward for the Healthy Child programme. This is one part of a multi-agency partnership approach to ensure that the right services are provided at the right time and in the most effective way to meet diverse needs across the county.

"The proposals being brought to our Executive for consultation would allow resources to be targeted at those most in need by employing some of these innovations."

The programme will also work closely with Public Health England, clinical commissioning groups, primary care, NHS hospital trusts, voluntary organisations and community groups to ensure that children and families are supported to access alternative services, for the aspects of the current service that will no longer be delivered with the new service.

Suzanne Lamb, Head of Safeguarding (Lead Nurse for Public Health and Quality) from Harrogate and District NHS Foundation Trust, said: "While the Trust recognises that the future model will need to look very different to what is being offered now, we appreciate the opportunity to continue to work closely with North Yorkshire County Council in a longer term arrangement.

"This will ensure that effective services can continue to be delivered to children, young people and families in North Yorkshire, with wider integration of children's services; more targeted support in relation to need and new ways of working including support via digital channels.

"We appreciate that this process means a lot of change for colleagues in the North Yorkshire service, and we are working hard to support them through it."

If the Council's Executive gives the go ahead, the public consultation will commence on 26 October 2020.

**Press contact:** media@northyorks.gov.uk



**26.10.20**

# News

**Communications Unit**
County Hall, Northallerton, North Yorkshire, DL7 8AD
media@northyorks.gov.uk

## Views sought on how to deliver public health services for children and young people

A consultation is being launched on how to deliver a range of public health services for children and young people across North Yorkshire.

The Healthy Child Programme is a child and family health promotion programme for children aged 0-19 years. Some of the services, such as health visiting and school nursing, are for all children,

and some, including supporting emotional health and managing substance misuse, are targeted to those most in need.

North Yorkshire County Council currently commissions services from Harrogate and District NHS Foundation Trust, which delivers the main elements of the programme on its behalf.

The council and partners need to find new ways to deliver the Healthy Child Service in the face of a national reduction in public health funding.

Members of the public are now being invited to give their views on the proposals.

Dr Lincoln Sargeant, North Yorkshire's Director of Public Health, said: "In North Yorkshire, we are managing a reduction of up to £4m in our Public Health funding from Government over the next few years. We will protect the Healthy Child Programme as much as possible and reductions to these services will be less than the overall cut to the Public Health Grant. We will have a universal and targeted service for children and it will continue to be our biggest single area of expenditure in public health.

"The Healthy Child Programme forms one part of a number of children and young people's services commissioned and provided by the County Council, the NHS and other partners in the county. Overall, these services provide robust support to help young people in North Yorkshire have the best start in life and grow up well.

"We will continue to deliver health checks for children under five years old and will continue to support new parents with a focus on those children and families most in need. All new babies will have a face-to-face visit from a health visitor, as they do now. Depending on the family's needs, further visits will be either face-to-face or online."

The proposals for consultation include:

- Mandatory visits to families with children under five at key child development stages will be co-ordinated by a qualified health visitor.
- At-risk under-5s and their families will continue to be prioritised, as they are now, with face to face visits where needed;
- Learning from how services have operated under Covid-19 restrictions, introducing a blended approach of face-to-face and online contact for families, based on robust assessment of the child and family's needs;
- More integrated support from agencies across the health, education, social care and voluntary sector for children to be ready to learn and to address developmental concerns in children and young people;
- A partnership approach to the prevention and management of risky adolescent behaviour, including prioritising and improving emotional health and resilience;
- Effective identification and management of the safeguarding of children and vulnerable parents or family members.

Stuart Carlton, North Yorkshire's Director of the Children and Young People's Service, said: "Because we know that the foundations of a healthy life are set in the earliest stages of childhood, we're proposing to target resources on supporting children under five.

"National policy related to providing the best start in life provides further evidence that increasing investment in children aged 0-5 years can have a positive impact on emotional wellbeing and school readiness. Improvements in these areas will support lifelong positive outcomes.

"We also want to give young people the tools they need to look after their mental health and navigate their way to adulthood; that's why our proposals for a new way of delivering the service include a focus on emotional resilience for young people."

Suzanne Lamb, Head of Safeguarding (Lead Nurse for Public Health and Quality) from Harrogate and District NHS Foundation Trust, said: "Ensuring that effective services continue to be delivered to children, young people and families in North Yorkshire is our priority and we are pleased to continue delivering these in conjunction with North Yorkshire County Council.

"We know this is a challenging transitional period, with the added pressures brought by Covid-19, but we hope that the public consultation will provide an opportunity for our service users, partners, communities as well as colleagues at the Trust to share their views on the proposed service offer. We are keen to hear from as many as possible to ultimately work together to continue to ensure we provide excellent Healthy Child Services across North Yorkshire."

People can give their views on the proposals by filling in the online survey at www.northyorks.gov.uk/healthychild before the consultation closes on 4 January, 2021.

Feedback will be considered by the County Council's Executive, as well as its Scrutiny of Health Committee, and by Harrogate and District NHS Foundation Trust Board, before any final decision is made.

Subject to the outcome of this consultation and due consideration, it is proposed that the new service would begin on 1 April, 2021.

The council is hosting online events where people can hear more about the proposals and ask questions before filling in the survey. Unfortunately, face-to-face events are not possible due to Covid-19 restrictions.

The dates and times of the online events are:

| | |
|---|---|
| 3 November 2020 | 10:30 |
| 4 November 2020 | 18:00 |
| 5 November 2020 | 13:30 |
| 6 November 2020 | 10:30 |
| 17 November 2020 | 10:30 |
| 18 November 2020 | 18:00 |
| 19 November 2020 | 13:30 |
| 20 November 2020 | 10:30 |

Register for an event at www.northyorks.gov.uk/healthychild

Copies of the consultation information will also be available at your local library during the consultation and the information can be requested in a different language or format by emailing healthychild@northyorks.gov.uk

**Ends**

**26-10-20**

**Press contact:** media@northyorks.gov.uk



**Stakeholder email 26.10.20**

North Yorkshire Healthy Child Programme
Public Consultation on service changes 26/10/2020 – 04/01/2021

Dear Partner,
North Yorkshire County Council (NYCC), in partnership with Harrogate and District NHS Foundation Trust (HDFT), is proposing a new model for Health Visiting and School Nursing Services (the Healthy Child Programme) in the County, this new model is described in detail on the consultation website: www.northyorks.gov.uk/healthychild

As you may be aware, due to significant reductions in the North Yorkshire Public Health grant in recent years, it has been necessary to review all services provided through this funding stream. The Healthy Child Programme (HCP) constitutes approximately one third of all spending through the Public Health Grant.

In North Yorkshire, we are managing a reduction of up to £4m in our Public Health funding from Government over the next few years. We will protect the Healthy Child Programme as much as possible and reductions to these services will be less than the overall cut to the Public Health Grant. We will have a universal and targeted service for children and it will continue to be our biggest single area of expenditure in public health.As key stakeholders in this change we would like to hear your views on our proposals for the service.

A series of online events are planned which are open to anyone interested in the Healthy Child Programme – you can register at www.northyorks.gov.uk/healthychild

In addition we would welcome the opportunity to speak to any existing meetings or groups which you feel would add value to the consultation process.

The public consultation runs from 26th October 2020 to 4th January 2021 and the information and online survey can be accessed atwww.northyorks.gov.uk/healthychild

To arrange a bespoke briefing session please contacthealthychild@northyorks.gov.uk

Physical copies of the consultation information as well as copies in a range of other languages can be requested by emailing healthychild@northyorks.gov.uk

Kind Regards

The Healthy Child Programme Team

Appendix D

North Yorkshire County Council

# Specification for Integrated 0-19 Healthy Child Service

## Draft – Working Document

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**Supporting Children, Young People and Families at Risk of Poor Outcomes**

**Comprehensive Assessment – Vulnerable Children, Young People and Families**

**Children with Special Educational Needs and/or Disabilities (SEND)**

**Vulnerable, Exploited, Missing, Trafficked (VEMT)**

**Support for Children and Young People Attending Pupil Referral Units (PRU)**

**Looked After Children/Care Leavers**

**Transition into Adulthood/Services**

## SERVICE ACCESS AND DELIVERY ENVIRONMENT

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**Co-Location**

**Operating Hours**

**Service Environment**

**Access and Referrals**

**Interdependencies with Other Services**

**Moving Out of Area**

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**End of Contract Arrangements**

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**Information Governance**

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**Data Information, Systems and Confidentiality**

**Technical Security Requirements**

**Future Proofing**

## A TRANSFORMED WORKFORCE

## Executive Summary

One of the four North Yorkshire County Council Plan key ambitions for 2023 is that every child and young person has the best possible start in life[1]. Our measure of success in delivering this ambition is that North Yorkshire will be 'A place of opportunity where all children and young people are happy, healthy and achieving' (Children and Young People's Plan).

In order to achieve this ambition local partners are working together to transform the way we plan, design and deliver services and support children, young people and families; with a focus on the things that underpin our outcomes. These include strong attachments to parents and carers and ensuring that parents and carers have the relationships, networks and support they need to raise children. We have started to focus on prevention and early intervention by promoting resilience and focusing our resources upstream to improve outcomes for children and protect them from harm. The aim is to create positive changes that are widespread, high impact and long lasting.

The North Yorkshire Children and Young People's Plan, *Young and Yorkshire 2* sets out our system approach to meeting the health and wellbeing needs of children and young people (Figure 4). The Plan sets out the ambitious and aspirational approach embraced by partners within the County.

The Plan was informed by the voice of children and young people and their families/carers and sets not only the step-by-step improvements, but also some of the more difficult challenges that sometimes limit children's life chances - whether it be the family they are born into, school they go to or the community they grow up in. The plan acknowledges that these differences are unacceptable and we have set out our commitment to tackle them.

To help achieve our vision, we are working to bring together work programmes under a progressive transformation programme – *The Childhood Futures Programme*. These include the Healthy Child Programme, key delivery elements of North Yorkshire Children and Young People Services and Healthy School Programme. Three areas form the initial focus of the transformation of approaches of partners to improve children and young people outcomes in North Yorkshire:

- School Readiness
- Emotional and Mental Wellbeing
- Risk Taking in Adolescents

This Healthy Child Programme Service Specification will contribute to delivering this agenda. The Provider will work collaboratively with service commissioners and other service providers to innovate and find more efficient and outcome focused ways of improving the health and wellbeing of children and young people and families in North Yorkshire.

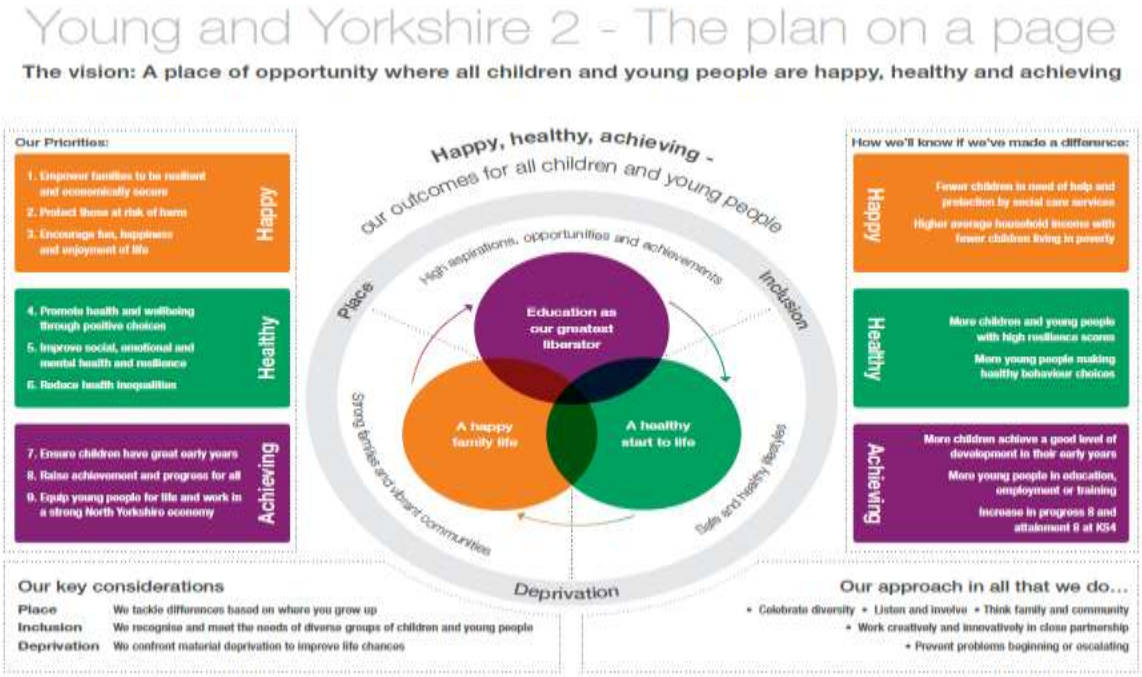
# Our system for improving the health and wellbeing of children, young people and families

[1] North Yorkshire County Council Plan for 2023

## 1. Priorities

The nine priorities within the North Yorkshire Children and Young People's Plan, Priorities and the Measures of Success are listed in Figure 1 below.

Figure 1: North Yorkshire Priorities for Children and Young People




As a system, we know that a significant proportion of children and young people do not achieve these outcomes. But we interact with children, young people and families from before birth through to staged review points and with teenagers. However, we know that often we do not meet the needs identified because our responses are disjointed and uncoordinated, and are missing the opportunities to enable families to use and widen their own networks of support.

This is why we are embarking on an ambitious programme of service transformation with the aim of achieving 'full integration', optimising integrated working practices of preventative services and other appropriate services and support for the 0-19 age group within North Yorkshire. This requires developing a shared understanding of what an integrated 0-19 services means and involves amongst all partners.

## 2. Principles

Since 2013 and the transfer of Public Health responsibilities to the Council, there has been considerable joint work between the County Council and health services, and more recently promoting integrated working practices across the system. Most notable is the collaborative working between the Healthy Child Programme (provided by Harrogate and District Foundation NHS Trust) and Prevention Service (now Early Help Service) within the County Council.

These developments have laid the foundations for a better integrated system for planning, commissioning and delivering preventative and early intervention services for children,

young people and families. We are building on these successes to deliver an integrated 0-19 service and this Service specification is central to this process.

We recognise that service integration means different things to different people. Thus, part of the transformation journey will involve defining and developing the different ways we will work effectively and efficiently together to achieve a fully integrated 0-19 service in North Yorkshire[2]. We have made a good start at describing the levels of collaboration (Figure 2 below). Our ambition is to work towards the optimum level of collaboration - shared goals and values, shared leadership and governance, integrated processes and pathways management and shared risk management:

To facilitate collaborative working, the Healthy Child Programme Service will operate under a partnership arrangement, in which the North Yorkshire County Council Children and Young People Service (CYPS) partners with an NHS Foundation Trust (NHSFT), with direct line management to CYPS and the NHSFT, using Section 75 (s75) of National Health Services Act 2006[3]. This includes establishing a Programme Board to ensure the right leadership and governance that will enable service transformation.

This new way of working will work to the following partnership principles:

- Transformational and innovative - innovation, continuous improvement and appropriate use of digital technologies to deliver services and support.
- Improving outcomes, through delivery of strong evidence based practice that promotes consistent messages and support. A strong focus given to prevention, health promotion and early identification of needs.
- Commitment to listening to children and young people and their families and the wider communities, and to involving them directly in understanding problems, designing and testing solutions and co-producing outcomes.
- Addressing inequalities and easy access -open access for all but intensive targeted work with priority population groups that is timely and consistent.
- Delivering excellent quality through strong leadership, professional and skilled workforce, effective system working and value for money.
- Collaborating in information sharing system and interoperability prioritised to help record, communicate and exchange data accurately, effectively, and consistently, and facilitate the use of information that has been exchanged.
- Collaborating with local partners, valuing each other's contributions, and working effectively together to solve problems.

## 3. The Vision for an Integrated 0-19 Service

The purpose of the Service is to provide a comprehensive range of preventative and early interventions to expectant parents, children, young people and families in North Yorkshire. This includes a range of universal interventions delivered to the whole population, as well as targeted interventions and support to those with identified need and the most vulnerable.

The vision for the Service is to deliver high quality, evidence based interventions which support children and young people and families, and identify and respond appropriately to needs across North Yorkshire to improve health and wellbeing outcomes.

It will have the following characteristics.

[2] North Yorkshire HCP & Prevention Services - Collaborative Relationship Depth and Maturity Journey

[3] Section 75 Agreement

- An integrated service offering assessment, advice and support to expectant parents, children, young people and families, working in collaboration with the Early Help and Early Years Services within the County.
- A high quality approach to ensuring the effective delivery of the Healthy Child Programme including all mandatory functions (5 mandated health visiting contacts and the National Child Measurement Programme).
- Support the delivery of an enhanced integrated service to improve school readiness.
- Support the delivery of an enhanced integrated service to improve social, emotional and mental wellbeing children and young people.
- Support the delivery of an enhanced integrated service to reduce risk taking behaviour in adolescents.
- Effective management of the safeguarding of children and vulnerable parents or family members.
- Provision of an appropriately trained and supervised workforce.
- Harness technology and the digital opportunity in service delivery and needs assessment, with robust safeguarding in place.
- Demonstrable commitment to improving outcomes for children, young people and families in North Yorkshire.
- Accessible service working into service users' homes, children's centres and appropriate community venues
- Work with Stronger Communities and voluntary and community organisations to maximise the use of community assets and networks for prevention and early intervention.
- High levels of communication and engagement with children, young people and their families including use of innovative methods of communicating, for example social media, apps, texting and websites.
- Productive relationships with other professionals supporting children, young people and their families.
- A distinctly branded and visible service which is understood by service users and stakeholders.

## 4. A Focus on Outcomes

We need a clear focus on prevention and early intervention ways of working across the system and the Service will be required to deliver the Healthy Child Programme and contribute to the delivery of an integrated 0-19 services, in partnership with other local services with measurable and indicative outcomes.

The Service will deliver on and contribute to reducing inequalities and improving the key outcomes as identified in the Public Health Outcomes Framework, the Guide to Early Years Profile, the NHS Outcomes Framework and other relevant framworks:

- Increased breast feeding at 6-8 weeks
- Reduced number of low birth weight babies
- Reduced smoking for pregnant women at delivery and hence more smoke free homes
- Improved child development at 2-2.5 years
- Improved school readiness for children in Reception Class
- Increased social and emotional development ASQ-3/ASQ-SE
- Fewer children are obese or overweight in reception aged 5-6 years and at age 10-11 years

- Improved population vaccination coverage
- Improved oral health and a reduction in oral health inequalities, with a greater percentage reduction in dental disease in the most deprived areas according to the Index of Multiple Deprivation (IMD).
- Contribute to more children being emotionally resilient and making good lifestyle choices including - reduction in self harm admissions, smoking prevalence 15 year olds and in under 18 conceptions and an increase in Chlamydia diagnosis (15-24 years old)
- Contribute to less children being admitted to hospital due to illness or accidents, including a reduction in the rates of admissions to hospital for children 0-4 years and older children (0-14 years and 15-24 years) and rates of children (0-15) killed and seriously injured on local roads.
- Contribute to reducing the number of children in care
- Contribute to reducing the number of children living in poverty

## NATIONAL CONTEXT

Getting a good start in life and throughout childhood, building resilience and getting maximum benefit from education are important markers for good health and wellbeing throughout life.

Professor Sir Michael Marmot[4] and the Chief Medical Officer[5] have highlighted the importance of giving every child the best start in life and reducing health inequalities throughout life. Both recognise 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 universal provision and targeted support. Delivering this vision is dependent upon a wide range of organisations and key stakeholders working together and embracing change.

A number of national policies are enabling actions in shaping local services to plan the design and delivering for the identified health and wellbeing needs of children and young people including (but not limited to):

- NHS Long Term Plan - Chapter 3: Further Progress in Quality and Outcomes, A strong start for children and young people. https://www.longtermplan.nhs.uk/
- Maternity Transformation Programme - Drive improvement and ensure women and babies receive excellent care wherever they live, to make care more personal and family friendly. https://www.england.nhs.uk/mat-transformation/
- The Healthy Child Programme - A universal and targeted public health services 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. https://www.gov.uk/government/publications/healthy-child-programme-0-to-19-health-visitor-and-school-nurse-commissioning
- Working Together to Safeguard Children 2018 - A guide to inter-agency working to safeguard and promote the welfare of children. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779401/Working_Together_to_Safeguard-Children.pdf

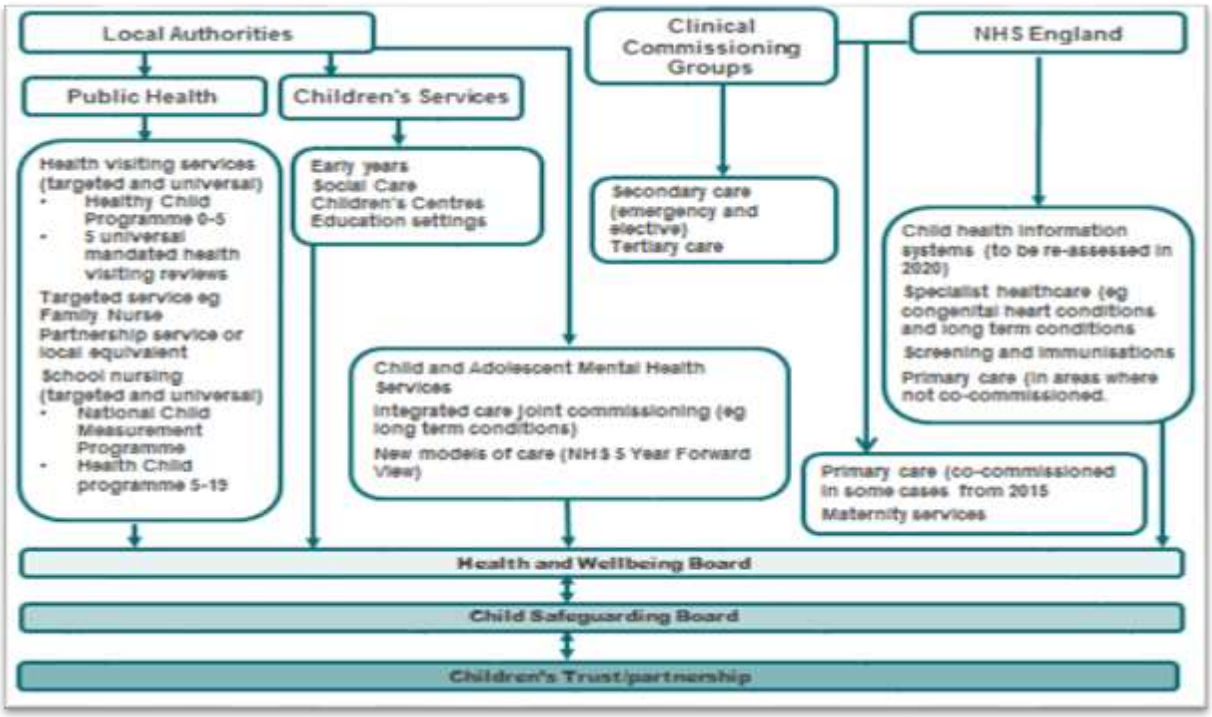
[4] www.local.gov.uk/web/guest/health/-/journal_content/56/10180/3510094/ARTICLE

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

- Social Mobility Action Plan for Education - Includes a plan for the early years with a focus on improving early language acquisition. https://www.gov.uk/government/news/plan-to-boost-social-mobility-through-education

This Service Specification is based on these national guidance, and data derived from local learning and engagement with stakeholders and children and young people and their families. The aim is to work closely with all key partners to make the best use of collective resources, using a whole systems based approach as identified in Figure 3.

Figure 3: Whole systems based approach to delivery of Public Health 0-19 children's services (PHE Guidance 2018)




# LOCAL CONTEXT

## 5. Local Data and Intelligence

North Yorkshire covers over 3000 square miles, ranging from isolated rural settlements and farms to market towns such as Thirsk and Pickering, and larger urban conurbations such as Harrogate and Scarborough. Whilst North Yorkshire is in overall terms more affluent than a typical local authority in England, there are areas of profound deprivation, including some parts of the County that are ranked within the 10% most deprived areas in England. The County is also home to a significant military presence, including the UK Army's largest Garrison at Catterick in the north of the County.

We have carried out a Children and Young People Joint Strategic Needs Assessment (JSNA) (insert link) to inform the development of an integrated 0-19 service. The following provides an overview of some of the key issues and concerns impacting on the health and wellbeing of children and young people in North Yorkshire.

### 5.1 Demographic Profile

- There are around 130,000 children and young people aged 0-19 in North Yorkshire in 2017, projected to decrease by 5.6% to 122,759 by 2035.
- There is a slightly higher proportion of males to females and more children aged 5-9 than those aged 0-4.
- About 7% of school children are from ethnic groups.

## 5.2 Armed Forces

- In 2017, there were over 9,000 serving personnel in North Yorkshire of which about 6,700 are resident in Richmondshire and 1,900 Harrogate.
- It is estimated that by 2031 there will be an increase in the adult personnel population in Catterick by around 3,000 individuals[6]. When children are added the population will be about 9,000. This will create additional demand for services which needs to be taken into in planning future services.

## 5.3 Wider determinants of health

- The 2015 Index of Multiple Deprivation (IMD) identifies 23 Lower Super Output Areas (LSOAs) of the 373 LSOAs in North Yorkshire which are amongst the 20% most deprived in England. These have a combined population of 39,000 people (6% of the population).
- A higher proportion of children claim free school meals (FSM) in primary compared with secondary schools. The proportion of FSM claimants increased slightly in North Yorkshire primary schools from 2017 to 2018, compared with a decrease nationally.
- Scarborough district has the most children eligible for FSM (25.7%) in comparison to Craven district (8.0%) with the least. This highlights a clear correlation between FSM eligibility and children in poverty, as Scarborough district has a high level of children in poverty and therefore receive FSM compared to Craven district.
- The average Attainment 8 score[7] for North Yorkshire (47.8) was higher than England (46.7) in 2017/18. Scarborough district had the lowest Attainment 8 score in 2018 (40.7) and Harrogate had the highest score (53.1).
- In 2017, the proportion of those aged 16 to 17 Not in Education Employment or Training (NEET) in North Yorkshire was 6.5%, significantly higher than England (6%), despite the slight decrease of 0.5% between 2016 and 2017

## 5.4 Health Improvement

- In 2016, the proportion of all live births with a low birth weight in North Yorkshire was 6.6%; is significantly lower than England (7.3%).
- In 2017/18 in North Yorkshire, 22.3% of the proportion of children aged 4-5 aged were classed as overweight or obese, similar to England (22.4%). 31.6%)of children in Year 6 (aged 10-11) were classed as overweight or obese, significantly lower than England (34.3%). Scarborough district has the highest and Hambleton district the lowest.

[6] It should be noted that troop movement cannot be predicted so the increases may be due to some Germany repatriation but this cannot be categorically assumed at this point so caution must be applied when interpreting the data.

[7] https://www.aqa.org.uk/about-us/what-we-do/policy/gcse-and-a-level-changes/attainment-8

- In reception Scarborough district has a significantly higher rate of children who are classed as overweight or obese, in contrast to Hambleton district which has a significantly lower rate compared to England in 2017/18
- The under 18 conception rate for North Yorkshire in 2017 was 10%, significantly better than England average o 17.8%.

## 5.5 Health Protection

- In 2017/18, slightly less than 95% (the minimum recommended coverage level) of children have received their first dose of immunisation by the age of two in North Yorkshire (92.7%). By the age of five, only 88.1% of children have received their second dose of MMR immunisation.
- The proportion of eligible children aged 5 who have received *two doses* of MMR vaccine in North Yorkshire (88.1%) is higher than England (87.2%). However, there are significant variations within the County, with less than 70% of children receiving two doses of MMR in the Catterick and Scarborough areas.
- Slightly less than 95% (the minimum recommended coverage level) of children have received their first dose of immunisation by the age of two in North Yorkshire (92.7%). By the age of five, only 88.1% of children have received their second dose of MMR immunisation.

## 5.6 Prevention of Diseases and Ill-health

- In 2017/18, North Yorkshire (48.5%) has a significantly higher rate of mother's breastfeeding at 6 to 8 weeks after birth than England (42.7%).
- In 2017/18 North Yorkshire has a significantly higher proportion of females smoking at the time of delivery than the England average. Ryedale and Scarborough districts have a significantly higher rate than England.
- The rate of children and young people being admitted to hospital due to alcohol specific conditions in North Yorkshire in 2017/18 is 43.1 admissions per 100,000 people aged under 18, compared to 32.9 per 100,000 in England; the rate in North Yorkshire is significantly higher than England.
- Harrogate and Scarborough districts have a significantly higher rate of hospital admissions due to alcohol specific conditions for those aged 18 and under compared to England in 2015/16-17/18.
- In 2017/18, North Yorkshire (122.7 per 100,000) has a significantly higher rate of hospital admissions caused by unintentional and deliberate injuries in children aged 0 to 14 years compared to England (96.4 per 100,000). With the exception of Selby district the remaining six districts all have a significantly higher rate of admissions than England.
- In 2017/18, North Yorkshire (161.6 per 10,000) has a significantly higher rate of hospital admissions caused by unintentional and deliberate injuries in children aged 15 to 24 years compared to England (132.7 per 10,000). With the exception of Selby and Ryedale districts the remaining five districts in North Yorkshire have a rate which is significantly higher than England.

## 5.7 Growing up in North Yorkshire survey (GuNY) 2018[8]

[8] http://www.safeguardingchildren.co.uk/growing-up-in-north-yorkshire-2018-survey-data

- The Growing up in North Yorkshire survey (GuNY)[9] is a two-yearly survey of local pupils that is undertaken on behalf of the Council by the Schools Health Education Unit (SHEU) based at Exeter University.
- Since 2006, pupils in schools within the County North Yorkshire have been surveyed to collect information on their learning and well-being, the most recent of which was conducted in 2018.
- Over 19,000 children participated in GuNY in 2018. This survey provides a rich data set on the experiences and perceptions of young people in the county, and helps inform the provision of Children and Young People's Services in North Yorkshire.
- Some of the key priorities identified in the summary report produced by the Schools Health Education Unit on behalf of North Yorkshire County Council include:
    - Developing resilience and emotional wellbeing
    - Promoting positive ethos and culture of the school
    - Pupil voice influencing decisions
    - Reducing risky behaviours
    - Reducing inequalities caused by deprivation
    - Promoting the adoption of healthy lifestyles
    - Preventing and reducing bullying

There are sections in the JSNA which focus specifically on some of the key questions asked of secondary school students and which are linked to the stated priorities across the districts in North Yorkshire. This is an extensive survey and not all questions are presented in this report.

## 5.8 North Yorkshire Healthy Child Programme Engagement Report 2019

North Yorkshire County Council initiated an engagement activity during August 2018 to inform the re-commissioning of the Healthy Child Programme in April 2020. The aim of engagement was to obtain the views of a variety of stakeholders in order to review the services currently offered and inform development of a new service model. The key findings are:

- Support for a 0-19 approach to service planning and delivery and regular health and wellbeing reviews as touchpoints of early identification of needs
- Vulnerable families are a priority
- School readiness, Emotional wellbeing and Adolescent risk taking as priority areas
- Autism Spectrum Disorder (ASD)/ Attention Deficit Hyperactivity Disorder (ADHD) Concern – service offer and workforce skills to respond
- Diverting activity from GP's to Early Help interventions would support 'right place right time' approach to care and support
- Information sharing systems should be improved and interoperability prioritised
- A clear offer required for children with complex health needs
- Healthy Child Safeguarding role as a valued element of the service

## 5.9 Priority Areas for Action

[9] http://www.safeguardingchildren.co.uk/growing-up-in-north-yorkshire-2018-survey-data

Detailed analysis of the three areas (School Readiness, Risk Taking in Adolescents and Emotional and Mental Wellbeing) which form the focus of transformation of approaches of local partners to improve children and young people's outcomes are found in the JSNA report. This includes a review of existing service pathways/developing new ones that will help to integrate 0-19 services across the health and social care system, and to identify, predict and manage demand for services and support.

## 6. Supporting Local Strategies

The scope of the 0-19 Service has been informed by a number of local plans and strategies in North Yorkshire. These are summarised below. The strategies are regularly updated and the Provider will work with local partners to ensure that service delivery remains consistent with the strategies for the duration of the contract. Any new or alternative strategies emerging during the life of the contract must also be considered.

### 6.1 North Yorkshire County Council Plan

The North Yorkshire Plan identifies four key ambitions for 2023:

- Every child and young person has the best possible start in life;
- Every adult has a longer, healthier and independent life;
- North Yorkshire is a place with a strong economy and a commitment to sustainable growth that enables our citizens to fulfil their ambitions and aspirations; and
- We are a modern council which puts our customers at the heart of what we do**.**

### 6.2 Health and Wellbeing Strategy

The North Yorkshire Health and Wellbeing Strategy sets out its priorities and outcomes which informs the basis of commissioning plans in the area (insert link). "Start Well" is one of the five themes, and has been further developed in the Children and Young People's Plan.

The Service Model has been developed in the context of the principles from the Health and Wellbeing Strategy:

- Recognise where things are different
- Tackle issues early
- Joining things up to make life simpler
- Make a positive contribution
- Keep people safe
- Spend money wisely

### 6.3 Children and Young People's Plan, Young and Yorkshire 2

The Service will work to support the delivery of the Children and Young People's plan in North Yorkshire, *Young and Yorkshire (see section 1 above)*.

This vision is "A place of opportunity where all children and young people are happy, healthy and achieving". The principles, priorities and outcomes are summarised on the plan on a page below.

The Director of Public Health Annual Report 2018, "Back to the Future", which reviewed progress in the health and wellbeing of children and young people in the past five years identified obesity, a healthy start in life and mental health as the top priority areas for stakeholders.

The Service Model has been developed in the context of these principles and priorities and will support the delivery of the outcomes.

### 6.4 Early Help Strategy

The Early Help Strategy aims to create a shared approach to meeting enhanced need across the health and social care system. It sets out a new direction of travel for the provision of Early Help services across North Yorkshire, a move to one agreed assessment tool and shared plan *("Continuum of Need"*).

The Service will support the delivery of the seven strategic objectives of the Early Help Strategy:

- Improve early identification and response to children in need of enhanced support, across the partnership
- To increase community capacity to support effective early help delivery in localities
- Implement 'Signs of Safety' methods across the partnership using strength based support
- Foster a strong culture of collaboration, integration and ownership for solution focussed
- interventions
- Build on the No Wrong Door methodology and contextual safeguarding – to implement a partnership approach to the management of risky adolescent behaviour.
- Improve attendance and inclusion and reduce the number of exclusions
- Explore the use of shared I.T. systems to capture early help activity and outcomes

### 6.5 Supporting Children and Young People with Social, Emotional and Mental Health (SEMH) Difficulties in School –Future in Mind Local Transformation Plan for North Yorkshire

Children and young people face many challenges in their lives, ranging from difficult home environments and trauma to stress and anxiety about exams and their future, complex long-term physical and mental health conditions.

Local policies and delivery plans have been developed based on national strategies {*Future in Mind Report (2015)*, *Five Year Forward for Mental Health (2016),* the *Green Paper 'Transforming Children and Young People's Mental Health Provision (2018)}.* They include a Whole Pathway Commissioning Group to enhance integration, build a skilled workforce, improve communications and increase prevention and early intervention. Key services include an enhanced eating disorder service, universal and targeted wellbeing service in schools, an online counselling service and mental health support teams in schools and colleges (in certain areas of the county)

### 6.6 Strategic Plan for Special Education Needs (SEND) Provision

The North Yorkshire Strategic Plan SEND Education Provision 0-25 is for all children and young people who have special education needs and disabilities, their families and all those working with them. It builds on both the Council Plan and The Young and Yorkshire 2 Children and Young People's Plan.

The strategic priorities are for all children and young people with SEND to:

- Have the best educational opportunities so that they achieve the best outcomes
- Be able to attend a school or provision locally, as close to their home as possible, where they can make friends and be part of their community
- Make progress with learning, have good social and emotional health and to prepare them for a fulfilling adult life.

# INTEGRATED 0-19 SERVICE DESCRIPTION

## 7. Scope of Service

- This Service will contribute to delivering an integrated 0-19 service in North Yorkshire for expectant parents, children, young people and families in the area that offers interventions from the antenatal stage up to the age of 19 (up to 25 for SEND).

- 0-5 years:
    - Mandated health reviews through a risk assessed and blended approach of physical and virtual support rather than the current model of all visits being face to face
    - Safeguarding support
    - Targeted support for children and families most in need and where required
    - A focus on best start in life in particular on infant feeding and family nutrition and diet
- School aged children (5-19):
    - Safeguarding support
    - Support for emotional wellbeing and resilience and in reducing risk taking in young people will be enhanced
- The above is a minimum offer for all young people and additional contacts will apply to those aged 18-25 years who have Special Education Needs/Disabilities (SEND) or are leaving care.
- The Service will deliver the Mandated National Child Measurement Programme (NCMP) and contribute in delivering measures to reduce childhood obesity
- The Service will work with other agencies to maximise resources to innovate and provide coordinated effective support through mandated touchpoints for children, young people and their families who are at risk of not achieving desired outcomes. This includes being responsive to the needs and opportunities identified, promoting access to evidenced based support around attachment, early learning, healthy development, parental capacity, social inclusion and good maternal emotional wellbeing and mental health.

## 8. High Impact areas

While 0-19 services contribute to the delivery of 0-19 healthy child programme, there are areas of health and wellbeing that health visitor and school nurse services are evidenced to have a significant impact on, these are:

- Transition to parenthood and the early weeks
- Maternal mental health
- Breastfeeding (initiation and duration)
- Healthy weight, healthy nutrition (to include physical activity)
- Managing minor illnesses and reducing hospital attendance/admissions

- Health, wellbeing and development of the child aged 2: Two year old review (integrated review) and support to be 'ready for school'
- Resilience and emotional wellbeing
- Keeping safe: Managing risk and reducing harm
- Improving lifestyles
- Maximising learning and achievement
- Supporting complex and additional health and wellbeing needs
- Seamless transition and preparation for adulthood

Early intervention, prevention and a whole family focus are embedded within effective practice that contributes to good outcomes across the 12 high impact areas

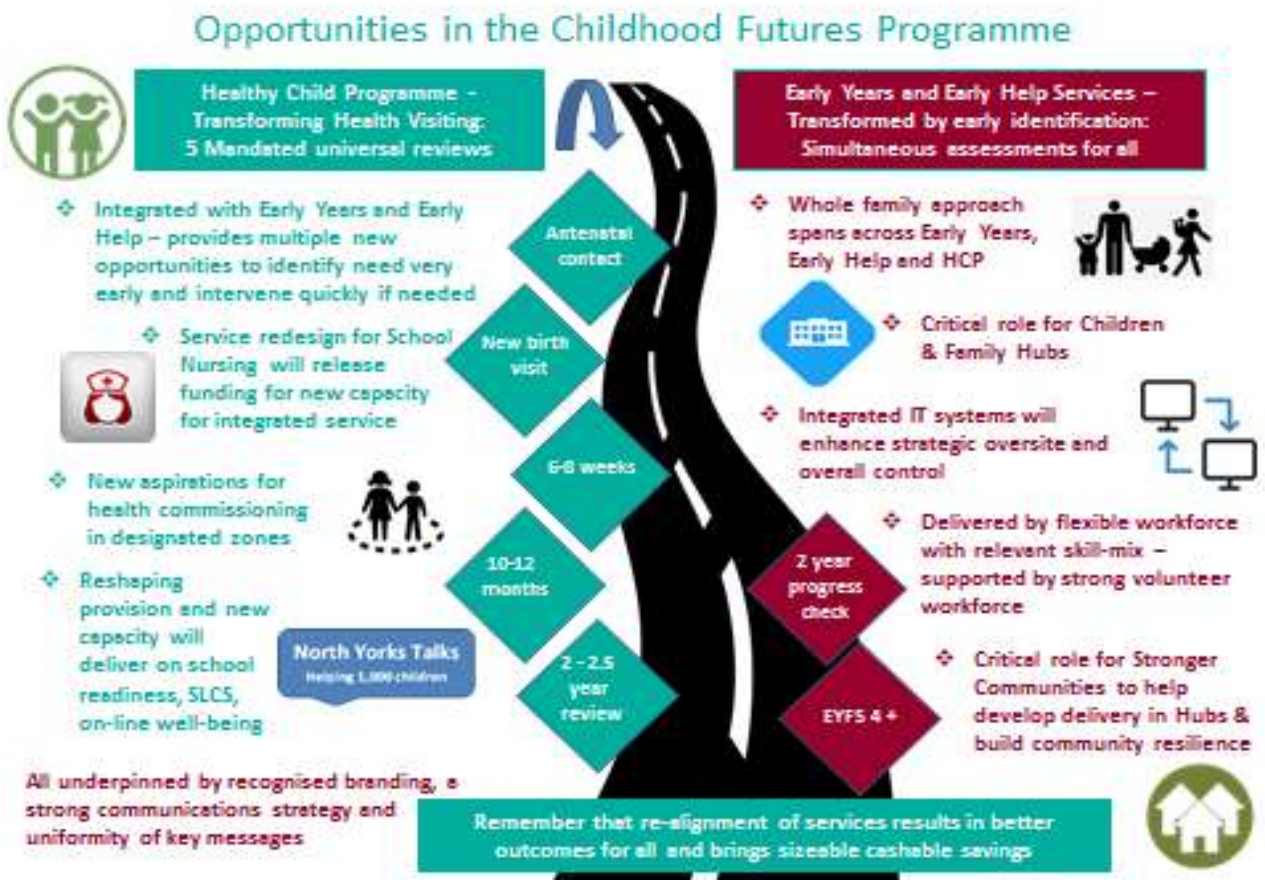
## 9. Service Transformation

Our ambition is to develop a New 0-19 Model of Service in North Yorkshire that helps to integrate the working practices of prevention and early intervention services and community support for children, young people and families - under the banner of the Childhood Futures Programme. This includes integrated working practices across the:

- Key contacts in the Healthy Child Programme
- Early Help
- Early Years
- School Readiness/ Speech and Language Service Pathway
- Key services to Improve the Physical, Social and Emotional Health and Wellbeing of parents, children and young People

The Service will contribute to this transformation programme and work has started to articulate how this might be achieved for children aged 0-5 years (Figure 5 below). For example, the Health Child Programme mandated six contacts are central to ensuring that children are ready to learn at 4-5 years, through the effective early identification and addressing of early developmental and learning needs.

Figure 5:




Over the life of the contract, the Service will be expected to work with service commissioners and other service providers to further develop these opportunities and transform them into a new service model. In a similar vein, the Service will be expected to proactively engage in work to transform services for school-aged children.

## 10. Digital Delivery

One of the strategic priorities of the North Yorkshire Health and Wellbeing Board is to implement an enhanced and appropriate use of digital technologies, to help deliver more efficient and responsive services. Harnessing technology and the digital opportunity is also important in achieving a safe, convenient and personalised health and wellbeing services and support.

This approach will underpin the transformation of 0-19 services, and the Service will actively embrace the innovative use of technology to improve service delivery and outcomes. Innovation in this area must take account of the latest research which requires appropriate safeguarding needs to be in place to stop the known harmful effects of some social media platforms. The Council will work with the provider around real and perceived risks.

As a minimum the Service will:

- Provide and operate, within the …… of operation?, an interoperable information sharing system that will communicate and exchange data accurately, effectively, and consistently, and facilitate the use of information that has been exchanged.
- Ensure that all staff are digitally enabled to work in settings or remotely.

- Provide a digital offer to children, young people and families (particularly for some universal provision). Professionals will need to be skilled and empowered to tailor their engagement to the needs of the child, young person and family, making more or less visits depending on needs, using different ways of engaging (phone, text, social media) based on what works for that child, young person and parent(s).

### 11. Enhanced Community Approaches

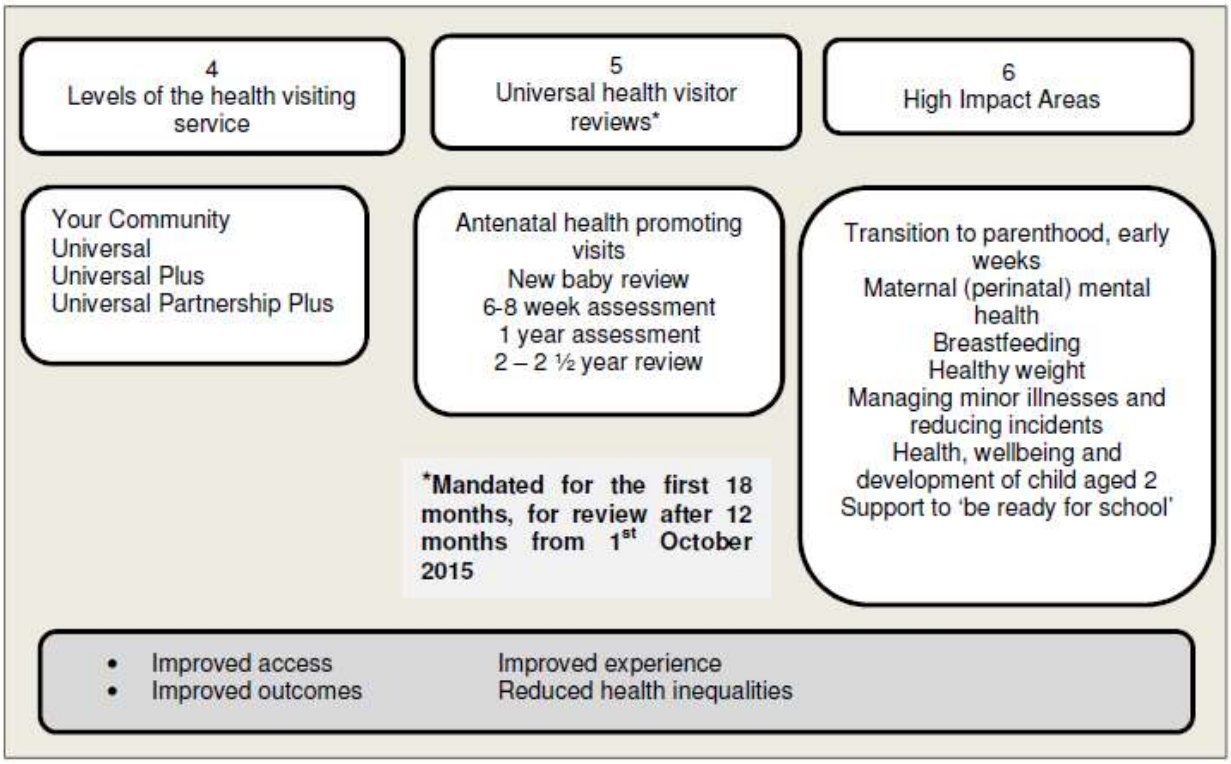
The Service will:

- Ensure the workforce delivering service has a wide knowledge of the needs in North Yorkshire through the use of available data (e.g. Joint Strategic Needs Assessment, Child Health Profile and Public Health Outcomes Framework), as well as information gathered by the service and other services in day-to-day work.
- Ensure the workforce has a high level of knowledge of community resources and assets (Children's Centres, General Practice, community groups, peer support groups etc.)
- Ensure the service is clearly visible and provides written and online advice and information to service user and the wider community, in relation to the services offered and how these can be accessed.
- Engage in relevant early help and early years, education and family support networks.
- Utilise community provision, for example, health centres or children's centres to provide additional opportunities for services users to access advice and information in relation to a range of topics including

## 0-5 HEALTH AND WELLBEING REVIEWS

An area-based geographical Healthy Child Service will be delivered and structured in line with local children's services alongside the Early Help teams, working together to deliver integrated, evidence- based services for children and their families, with a focus on prevention, promotion and early intervention.

The service will deliver services and interventions in line with the transformed model of Health Visiting: - still relevant but need to review in light of new service model!




**Please note the outcome of the national review may affect the delivery of mandated health reviews and will be updated accordingly.**

The Service will deliver the following mandated health and wellbeing reviews.

## 12.0 Developmental Visits and Assessments from Antenatal to 4/5 Years

The Service will deliver a series of visits from the antenatal period until children reach primary school age. These will form a core part of the activity of the Service and enable it to make a universal offer to all expectant parents and families with children below the age of 5.

Visits will be designed to address specific areas at each stage of development and promote good parent-child attachment. We expect the Service to comply with all national requirements for currently mandated checks and reviews, including adherence to timescales and the competency and professional background of those carrying out mandated interactions.

- Antenatal
- New Baby
- 6-8 weeks
- 1 year
- 2-2.5 years

The Service will deliver additional reviews in areas of most need and amongst families most at risk.

## 13. Levels of Delivery

### 13.1 Community level

The Service will be based a broad knowledge of community health needs and resources available e.g. health profiles, Children's Centres and self-help groups and work to develop these where there is identified need and make sure families know about them. These will include:

- Empower families within the local community, through maximising family resilience.
- Develop community resources and capacity with involvement of local agencies and community groups as appropriate.
- Collate and co-ordinate information, data and intelligence in order to ensure that the best interests of the child are met.
- Provide and develop intelligence about communities' assets in partnership with communities to support the health and wellbeing of 0-5 year olds, to inform the Joint Strategic Needs Assessment (JSNA)
- Use intelligence to carry out regular, at least once yearly, local needs assessment in order for teams to develop a service offer to respond to local need.
- Raise awareness and promote the services offered to professionals, children and young people and their families
- Work in partnership with Children's Services in the local authority and community and voluntary sector to ensure that local innovation can flourish and appropriate developments grown.
- Work with the Council's stronger Communities to identify and develop peer support groups and where appropriate support existing groups
- Use networks to improve public health; Signposting families to other services already existing locally, particularly early years Services and professional but also adult education and training.
- Utilise local media opportunities for health promotion.

### 13.2 Universal Delivery

The Service will lead delivery of the 0-5 HCP. The Service will ensure that every new mother, father and child have access to a Health Visitor and the child will receive development checks (as listed below and detailed in appendix 2) and receive consistent good evidence based information about healthy start issues such as parenting and immunisation.

At this level the Service will be expected to:

- Offer core health reviews to all families – (as set out within the current national mandate and any nationally recommended change will be negotiated with the Council) delivered in a variety of formats depending on cumulative risk assessment, except primary visit and 2 yr review which will always be face to face .
- Promote attachment
- Help families understand the short, medium and longer term consequences of their health related behaviour for themselves and others;
- Plan behaviour change in terms of easy steps over time; this will support families to plan and implement change in a realistic and manageable way

- Plan with families explicit scenario 'if/then' coping strategies to prevent relapse;
- Recognise in conjunction with families how their social context and relationships may affect their behaviour, and identify and plan for situations that might undermine changes they are trying to make;

### 13.3 Universal Plus

Families can access timely, expert advice from the team when they need it on specific issues such as postnatal depression, weaning or sleepless children.

At this level the Service will be expected to:

- Provide additional services to families that are identified as needing more support than is universally offered
- Provide early intervention to prevent problems developing or worsening.
- Include in their offer but not restricted to care packages for maternal mental health, parenting support, toilet training, complex needs, weaning and baby/toddler sleep problems

### 13.4 Universal Partnership Plus

Health Visitors to 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.

At this level the Service will be expected to:

- Provide additional on-going support to vulnerable families; this could be additional visits, co-working with other agencies including joint visits and delivery of integrated, multi-agency care packages.
- Work within the local common assessment framework and local Council processes to ensure early intervention
- Ensure appropriate safeguards and interventions are in place to reduce risks and improve health and wellbeing of children for whom there are safeguarding and/or child protection concerns (*Universal Partnership Plus Offer).* This includes maintaining accountability for babies and children for whom there are safeguarding concerns and working in partnership with other agencies to ensure the best outcomes for these children
- Share information and communicate with other health professionals as part of a statutory duty and agencies where there are safeguarding concerns and engagement of the health visiting service in multi-agency services.
- Communicate effectively with other agencies including contributing to initial and review case conferences and other safeguarding meetings as appropriate to the needs of the children - where appropriate and the child or young person is known to the Service, senior team members will attend child protection conferences or meetings when they are the most appropriate health representative and there is a specific outcome to contribute towards
- Work with the Looked After Children (LAC) nurse to contribute to and support assessments of Looked After babies and children aged 0-5 with timescales in line with national requirements and contribute to ensuring any action plans are

carried out. Ensure provision of the 0-5 HCP and additional services to meet their health needs.

- Work with agencies to deliver more intensive support - this could include but is not restricted to a range of special needs, for example families at social disadvantage, safeguarding, families with a child with a disability, young parents, adult mental health problems or substance

The following will be common to each review and the service will need to demonstrate they have been considered and covered all areas:

**Continuous assessment** - Assessment of family strengths, needs and risks; providing parents with the opportunity to discuss their concerns and aspirations; assess child growth and development, communication and language, social and emotional development; and detect abnormalities. Health Visitors should use evidence-based assessment tools and **must use** ASQ 3 for the 2 -2.5 year review.

**Promote Immunisations** – the Service should promote immunisations and check status and refer to GP if unvaccinated

**Carry out health promotion** – Make every contact with the family a health promoting one. Supporting parents to know what to do when their child is ill, and promoting appropriate use of primary and urgent care services with the view to reducing hospital attendance and admissions

**Identifying and supporting children with additional needs** – The Children and Families Act – SEND Code of Practice 2015 states *'Where a health body is of the opinion that a young child under compulsory school age has, or probably has, SEN, they must inform the child's parents and bring the child to the attention of the appropriate local authority. The health body must also give the parents the opportunity to discuss their opinion and let them know about any voluntary organisations that are likely to be able to provide advice or assistance'*.

The service will be expected to:

- Have a process in place to bring the child to the attention of the local authority.
- Work in partnership with other services in supporting the assessment of and developing the education health and care plans for children aged 0-5. This will be through sharing information about the child's and family's needs and reviewing in collaboration with other services what they can do to support the delivery of these plans.
- Provide assessment, care planning and on-going support for babies and children up to school entry with disabilities, long term conditions, sleep or behavioural concerns, other health or developmental issue in the context of the HCP.
- Actively should actively contribute to the Local Offer.

**Information sharing and active consent -** The Service will be expected to gain consent to share live birth data and agree a process with the Council to regularly transfer this information. The Service will be expected to seek to gain written or electronic consent to share information with other agencies but in particular with the Early Help Service (Section 75 Partnership Agreement Schedule ..).

## 14. High Impact Areas

The Service will:

- Provide responsive care when families have problems or need support or preventative interventions in response to predicted, assessed or expressed need (through intervention using new evidence in developmental psychology).
- Ensure a family focus and close partnership working with early intervention services including step up and step down transitions
- Have access to validated tools for assessing development and identifying health needs
- Validated tools for assessing individual health outcomes, e.g. outcomes star

The Service will be able to deliver evidence based initiatives in response to local need across the following high impact areas. It will be expected that across the county a needs led annual programme of initiatives will delivered to address all high impact areas.

## 15. Transition to parenthood, early weeks and beyond

This will be delivered at the antenatal and postnatal contacts and where possible in group based activities:

- Lead delivery of evidence based antenatal and postnatal groups to promote attachment, for example, parenting classes/groups e.g. Preparing for Pregnancy and Beyond, parent quality marked parenting classes, and evidence-based groups for parents.
- Support for parenting – One of the core functions of the HCP is to support parenting using evidence-based programmes and practitioners who can work across different agencies who are trained and supervised. Work with parents, using well evidenced, strengths-based approaches e.g. motivational interviewing, Solihull approach to promote positive lifestyle choices and support positive parenting practices to ensure the best start in life for the child.
- Lead delivery, in partnership with other agencies, of evidence-based parenting programmes for toddlers and pre-school children e.g. Incredible Years Pre-school basic programme and other evidence based programmes
- Promotion of social and emotional development – The HCP include opportunities for parents and practitioners to review a child's social and emotional development using evidence-based tools such as ASQ 3 Promote parent and infant mental health and secure attachment e.g. through use of Neonatal Behavioural Observation and Neonatal Behavioural Assessment Scale.

## 16. Maternal mental health (perinatal depression)

- Active enquiry and support for those identified at risk
- Direct support to women with mild to moderate mental health difficulties
  A bit on Listening visits!

## 17. Breastfeeding (initiation and duration) –

- On-going breastfeeding support across North Yorkshire for all families. This includes the provision of specialist support for mothers experiencing difficulties in breastfeeding.
- Achieve and maintain full accreditation of UNICEF Baby Friendly community initiative. Compliance with Unicef BFI standards and works jointly with the Council's children's centres to provide training and support to the wider workforce
- Delivery of breastfeeding support is co-ordinated across the different sectors, with the Service as the interface with key partners including maternity, primary care and early year's settings and as partners in a multi-agency approach to this important and shared public health outcome.
- The Service will lead work around breastfeeding in the community, including building community capacity to support breastfeeding by working with communities groups and children's centres to set up services where there is a need
- Training and resources are provided for the workforce to support work around breastfeeding
- The availability of healthy start vitamins is promoted to all families. Uptake amongst those eligible is monitored in order to identify where uptake needs to be improved.

## 18. Healthy weight, healthy nutrition and physical activity

The focus should be on the prevention and early identification of obesity in children, through an emphasis on, and promotion of:

- breastfeeding
- delaying the introduction of solid food to babies until at, or around, 6 months of age
- healthy eating – healthy foods, portion size, limiting snacking, etc.
- an active lifestyle
- good oral health

The Service will be required to identify weight problems early and support appropriate care planning and weight management interventions, that are quality assured and evidence based in their approach to health promotion and childhood obesity prevention.

Interventions will include a combination of healthy eating and physical activity. Where appropriate strengths based, solution focussed intervention that improves parenting

efficacy to help children and their families achieve and maintain a healthier weight will be offered.

Implement NICE guidance through a partnership approach with parents and carers. This encourages responsive parenting and a holistic family focused method of addressing excess weight in childhood should be actively employed to help the whole family change habits and achieve new goals. Supporting children, parents and carers to achieve or maintain a healthy weight through advice and help with accessing locally available services, and for adults signposting to local adult weight management opportunities will be a vital component of service delivery.

Where weight management issues are identified at 2 -2.5 year review, families will be encouraged and supported to access an appropriate evidence based intervention.

## 19. Managing minor illness and reducing hospital attendance and admission

- All health reviews should include age appropriate accident prevention messages – HEAT?
- Active follow up of A&E attendances, out of hours and admissions to hospital, if required following risk assessment .
- Prescribe medication as an independent/supplementary prescriber in accordance with current legislation. Where Health Visitors have not undertaken this module in training, it is a requirement of CPD for completion within the first 2 years of practice. For more information visit http://www.nmc-uk.org/Nurses-and-midwives/Regulation-in-practice/Medicines-management-and-prescribing/ this needs clarity in terms of capacity and also additional costs of prescribing and expectation of staff.
- Identify early signs of developmental and health needs and signpost and/or refer for investigation, diagnosis, treatment, care and support.

## 20. Health, wellbeing and development of the child age 2 – 2.5 year old review (integrated review) and support to be 'ready for school'.

To be addressed throughout all reviews but particularly at the 9-12 month and 2-2.5 year reviews.

Topics should include health promotion, encouraging a healthy weight and active lifestyle, raising awareness of and supporting families to ensure that all children are accessing routine preventive care and advice (primary dental care services, hearing and vision assessments, incontinence advice, etc). Promote injury prevention and age appropriate behaviour and boundary management messages.

Promotion of good language development and supporting parents to understand important milestones is essential whilst also identifying early any speech, language and communication difficulties.

The Service will support active identification of those families eligible for the 2 year offer and sign post appropriately.

**Model for 2-2.5 year integrated review – does it need updating?**

| Universal | Universal plus | Universal Partnership Plus |
|---|---|---|
| A separate EYFS Progress Check and HCP review will be maintained, integration will be achieved via information sharing and joined-up responses to needs | At a universal plus level it is expected that a joint review will be offered to all families | All UPP families should receive one joint review meeting |

The Service will ensure a family focus and safe transition into school aged (5-19) services, through close partnership working with services meeting the needs of children and young people aged up to 19.

## 21. Health Protection

The Service will:

- At the request of the Council, provide whatever support or assistance is reasonably required by the Council and/or Public Health England in response to a national, regional or local Public Health emergency or incidents.
- Respond to childhood communicable disease outbreaks and health protection incidents as directed by the Health Protection Team (PHE) often at short notice.
- Identify and reduce barriers to high coverage for childhood immunisations in order to prevent serious communicable disease, particularly targeted at vulnerable groups.

## 22. Antenatal and Newborn Screening

The Service will ensure:

- Delivery of the health visiting aspects of the new-born screening programmes, for example, ensuring results are recorded and acted upon in line with UK National Screening Committee Programme Standards.
- That when a child transfers into an area that the Health Visitor must check new-born blood spot status and arrange for urgent screening if necessary.
- That it develops its own local area new-born blood spot policies and pathways in partnership with local midwifery, Child Health Information Systems (CHIS) and GP colleagues
- That Health Visitor check status of, and record, all screening results including hearing, New-born Infant Physical Examination (NIPE) and Hep B schedule, immunisation status and refer immediately for any follow up necessary.

# SERVICES FOR SCHOOL AGED CHILDREN (5-19)

The Service will provide support to all children aged 5-19 in North Yorkshire in the commissioned areas of:

- safeguarding and;
- enhanced support for emotional wellbeing and resilience and in reducing risk taking in young people

The Service must provide an appropriate level of service offered throughout the calendar year to ensure all statutory and non-statutory requirements in relation to the health and wellbeing of children and young people are met.

## 23. National Child Measurement Programme (NCMP)

The Service will deliver the mandated NCMP programme aligned with local offer on universal and targeted programmes and interventions for addressing child obesity (e.g. School Zone Programme and Healthy School Award).

The Service will:

- Deliver the NCMP in line with national operating guidance and standards, including recording of accurate data and submitted using the online tool on time.
- Ensure that all children will have their height and weight measured in Reception and in Year 6.
- Provide effective communication and feedback of the results of height and weight measurements to parents in a sensitive manner, promoting healthy weight and physical activity and providing evidence-based support and interventions where appropriate.
- Support and engage with parents of children who have been identified as overweight or obese with a BMI over the 91$^{st}$ centile, or children who are under the 5$^{th}$ centile in both reception and year 6 and encourage them to join community programmes in accordance with appropriate local pathways.
- Support the reduction in childhood obesity by supporting interventions to promote healthy eating, increase physical activity and working with children who are identified as being severely obese providing further follow up and intervention. The Service will be expected to contribute to delivering the Integrated Healthy Weight Pathway.
- Refer children who present as obese, overweight or with an eating disorder to the relevant service and follow up three months later to determine outcome and to support children, young people and families with appropriate advice and intervention.
- More proactive work and focus on prevention e.g. by supporting the Healthy Schools Award and Schools Zone Programme, helping to embed healthy messages into the curriculum, supporting schools following NCMP and Growing up in North Yorkshire (GuNY) results.

## 24. Emotional Health and Wellbeing

The Service will:

- Identify children and young people at risk of poor emotional health early through the health review questionnaires, assessments and drop in sessions, including protected groups such as minority ethnic groups and LGBT children and young people.
- Provide communication and interventions which raise confidence and self-esteem for children and young people, including those aimed at prevention of poor emotional

and social well-being and personal coping mechanisms to protect against psychological ill health. This includes building resilience in and supporting those who may be experiencing emotional and mental health difficulties.

- Ensure that children and young people with mental health concerns are identified and actively engaged in prevention and early help intervention services and have access to a named School Nurse.
- Ensure that appropriately trained and/or qualified staff will assess and triage children and young people as appropriate and refer to the CAMHS and other services as appropriate.
- Work together with agencies providing emotional and mental wellbeing being support and services within schools and educational psychologists to provide support to promote the mental health and wellbeing of young people.
- Ensure all children and young people who are identified as having a non-urgent mental health concerns are contacted as soon as possible – agree timeframe and should ensure further follow up is arranged within -timeframe
- Ensure that Young Carers are accessing appropriate health services and other support which positively affects attainment, attendance and emotional health and wellbeing.
- Support, signpost and work with the CAMHS as appropriate, supporting the transformation and delivery of the Future in Mind Strategy & Action Plan and work streams.
- Support and raise awareness of bullying, exam stress, self-harm, and the impact this has on the health and wellbeing of children, young people and families, offering confidential support where possible.

## 25. Reducing Risky Behaviours and Improving Lifestyles

The Service will:

- Deliver a health promotion programme to address health inequalities and risky behaviours for school age children based on need, and which is proactive in addressing factors that negatively impact upon the health and wellbeing of children and young people.
- Proactively address preventable causes of ill health and disability e.g. infectious diseases, sexually transmitted infection (STI), smoking, poor diet, substance misuse and oral health with emphasis and priority on areas of greatest need and inequality.
- Raise awareness of the risks associated with smoking and provide advice, interventions and support to stop smoking including smoke free homes, signposting children and young people for specific support which may include the prescribing of Nicotine Replacement Therapy where necessary.
- Provide advice, support and information on the impact and prevention of substance misuse (including alcohol and legal highs) and ensure referral to appropriate services where substance misuse issues are identified.

## 26. Support for Children who are Elected Home Educated (EHE)

The Service will establish agreed procedures with colleagues within the Quality & Improvement Service in the Children and Young People's Service for identifying and communicating with the parent/carer of EHE children.

All EHE children will be offered the services within this specification including health checks and immunisations and should be provided with the necessary information to enable them to self-refer into the service.

## 27. Supporting Children, Young People and Families at Risk of Poor Outcomes

Some children and young people are at higher risk of poor health outcomes due to their situation or lifestyle. The Service will play a key role, working alongside CYPS Early Help Service in identifying those at greatest risk and intervening to offer the information, advice and support to prevent problems from escalating.

Staff should be capable of acting as a lead professional in cases that may be allocated to the Service as part of the North Yorkshire Team Around the Child (TAC) process. The Service would also be required to identify which senior staff would be trained to chair TAC meetings.

The Service will also be required to work directly with those children and young people who are known to be at risk of poor health outcomes. Staff will need to have a sound understanding about the application of the Common Assessment including the use of the North Yorkshire Early Help Assessment Tool (see section…). The Service will be expected to contribute to care pathways and early intervention programmes that have been developed to support families and children/young people including those related to Developing Stronger Families (North Yorkshire's name for Troubled Families).

## 28. Comprehensive Assessment – Vulnerable Children, Young People and Families

The Service will:

- Ensure early identification of children and young people and families where additional evidence-based preventive programmes will protect health; in an effort to reduce the risk of poor future health and wellbeing
- Undertake child and family focussed assessments using professional knowledge, skills and tools such as Early Help, Signs of Safety and Threshold of Need, and follow relevant multi-agency policies and protocols to identify vulnerability or child maltreatment. North Yorkshire Safeguarding Children procedures should be used if a child is identified to be at risk of significant harm.
- Deliver appropriate health assessment and contribute to multi-agency assessments, planning and interventions, relating to babies, children, young people and families who are at risk and need additional support, for example those identified in vulnerable groups Appendic C.
- Ensure targeted services so that the outcomes of disadvantaged or most "at risk" children and families are not compromised by poor early experiences and environment (Appendix C). Schools where necessary should also be prioritised according to need (Prioritisation List by IMD ranking – Appendix D).
- Include vulnerable groups at risk of being marginalised from the service, including those not in schools, for example:
    - Children missing education
    - Children educated at home
    - Young people not in education, employment and training (NEET)
    - Young Carers
    - Children educated on site – for example children's homes

  - Children whose parents are in prison
  - Children missing from home and/or at risk of sexual exploitation
  - Young offenders

- Support Youth Offending Teams with meeting the health needs of young people by offering information, advice and support where appropriate and an in-reach service into the PRUs where necessary.
- Operate a multi-agency approach to ensure the welfare of children and young people, for example keeping children safe from violent extremism and child sexual exploitation.

## 29. Children with Special Educational Needs and/or Disabilities (SEND)

The Service will:

- Deliver the full public health offer of the Healthy Child Programme to children and young people with SEND attending special schools and mainstream schools.
- Provide annual dental screening to all Special Schools and referral on as appropriate. The service will also provide supervised tooth brushing to Special Schools.
- Have a named Public Health nurse champion with expertise and experience of working and supporting children and young people with SEND across the County.
- Provide early identification of complex and/or additional needs through assessment and on-going support for children and their parents where appropriate to improve outcomes for children.
- Focus on early identification and assessment of health and developmental needs and signpost and / or refer for investigation, diagnosis, treatment, care and support.
- Develop care pathways that take into account the full range of needs and thresholds ensuring support and signposting for Education, Health, Care Plan (EHCP) for those children with SEND and provide support for preparation and effective hand over to the Council's Adult Services department and the transitional period.
- Contribute to the EHCP of children with SEN, who are known to the service ensuring the level of nursing intervention for school age children (5-19 years) is completed within the statutory timescales.
- Work in partnership with appropriate healthcare professionals in order to offer support, advice and training to parents/carers and others in order to meet the needs of children and young people with SEND.
- Contribute and support local CCGs and the Council to develop and implement pathways for children with SEND. This includes active involvement of parents and children, to ensure their individual needs are considered at all stages and are brought to the attention of the relevant support services.
- Work in partnership with key stakeholders and commissioners to review SEND provision within the County as and when required. Future offer in relation to SEND to be delivered in line with the agreed outcomes of any review and in line with current and future SEND pathways.

## 30. Vulnerable, Exploited, Missing, Trafficked (VEMT)

Children and young people who are sexually exploited are the victims of child sexual abuse and their needs require careful assessment.

The Service will operate a multi-agency approach to ensure the welfare of children and young people, for example keeping children safe from violent extremism and child sexual exploitation.

- Contribute to the Multi-Agency Child Exploitation (MAST) meetings on contextual safeguarding on abuse in the home but the wider circle of the child e.g. community or peers.
- Contribute to intelligence gathering on children and young people, based on issues and problems the see in their interactions with them.
- Contribute in a wider context of safeguarding, for example a drop-in at a school where there are several at risk children in one setting.
- Promote awareness of Child Sexual Exploitation (CSE) services (e.g. Children's Society Hand in Hand Project, Partners Against Child Sexual Exploitation - PACE and Trusted Relationships Project) and make referral to these services where appropriate.

## 31. Support for Children and Young People Attending Pupil Referral Units (PRU)

The Service will contribute to targeted approach to meeting the needs of children attending PRUs, working close with other agencies to ensure that children transferring between PRU and mainstream school or who are being supported through Pupil Referral Services receive a consistent service.

The Service will liaise with colleagues delivering targeted services to ensure that children attending PRUs are offered the relevant immunisations and vaccinations.

## 32. Looked After Children/Care Leavers

The Service will contribute to Review Health Assessments (RHA) for Looked After Children aged between 5 and 18 as requested by the Specialist LAC nurse team. At the final RHA the Service will help provide the care leaver with a completed health passport (as devised by the North Yorkshire CCGs) and liaise with the Leaving Care pathway team as appropriate.

The Service will conduct the reviews in accordance with the quality standards required by (but not limited to) North Yorkshire Children's Social Care , Statutory Guidance, British Association for Adoption and Fostering and the local Clinical Commissioning Groups, and will ensure that the outcome of reviews are recorded accurately and communicated to the Specialist LAC nurse team in a timely way. The Specialist LAC team will provide training and continuing professional development free of charge to the HCP workforce to ensure staff have the required skills and knowledge to complete high quality health assessments and completion of health passports for care leavers.

Where the young person is a care leaver, the Service should liaise with the Leaving Care team to provide relevant information to secure smooth transition to adult health provision where required.

## 33. Transition into Adulthood/Services - need to include work between HAS & CYPS

As young people reach the age where their service needs will transfer to adult provision they will be encouraged to familiarise themselves with adult services. Where the young person has specific barriers to engaging with adult provision the Service should provide additional reassurance and support to assist them with transition.

## SERVICE ACCESS AND DELIVERY ENVIRONMENT

### 34. Service Delivery Location(s)

The Service will:

- Be delivered within the County boundaries ensuring ease of access for children, young people and families and maximising opportunities for them to access the service.
- Be delivered and co-located in accordance with the area based footprint. The Service will ensure that community settings provide equity of access
- Offer a choice of locations and times for visits (including virtual ones) which best meet service user needss. Locations must be easily accessible for all children, young people and families who live in the local vicinity (including access by public transport and at times appropriate to the service user), child and young family friendly, suitable for multi- disciplinary delivery of services in both individual and group sessions and be conducive to flexible availability (e.g. early mornings, lunchtimes, after school, evenings and weekends).
- In collaboration with local partners and feedback from service users, agree specific locations for service delivery. Reviews will be undertaken periodically to ensure the locations are suitable to local needs.
- Carry out joint visits/contacts in partnership with other agencies where this is appropriate and reduces inconvenience for families.
- Be delivered in accessible venues and community settings and prioritisation of resources shall be according to need so priority is given to most deprived areas.

### 35. Co-location

- The Service will work in partnership with the County and District Councils and other providers to ensure that seamless and integrated service delivery is facilitated and co-located in line with the Early Help Service.
- The vision for this integrated model of delivery includes shared premises, leadership and staff resource.
- Potential locations of delivery may be:
  - Children's Centre
  - Schools
  - Health centres
  - Community venues
  - Other suitable venues as appropriate
- Where provision is made from outreach sites the Service is responsible for sourcing premises, negotiating and agreeing the terms of any leases or licences.
- The Service shall make payment for usage of both Council and non-Council premises where it is required to do so.

- The Service will provide responsive services through agile working to improve efficiency, including working at times which are most effective; better utiliisation of accommodation and planning working arrangements to best suit the needs of children, young people and families.

## 36. Operating Hours

The Service will ensure that days and hours of operation are flexible, demand led and appropriate and are monitored on a quarterly basis in order to ensure optimum access/coverage in response to need.

The Service will ensure that access to the service is provided at dates and times which meet the requirements of those accessing the service. Take into account childcare provision and parental responsibilities in order to facilitate access to the service for those with parenting and other family responsibilities.

## 37. Service Environment

The Service will:

- Be provided from an environment in which services are well maintained, easily accessible, with good public transport links, and have infection control and health and safety policies and procedures in place which meet national regulation and requirements.
- Ensure that consideration is given to the external environment of all delivery sites including the potential impact and effects on the local community and those using the service.
- Ensure compliance with all relevant CQC requirements.

## 38. Inclusion Criteria

The Service will be delivered to residents within North Yorkshire – defined by the Council's geographical boundaries. The Service must ensure equal access for all children aged 0-5 and their families regardless of disability, gender reassignment, marriage and civil partnership, sex or sexual orientation and race – this includes ethnic or national origins, colour or nationality, religion, belief or lack of belief.

## 39. Exclusion criteria

Looked after children who do not normally reside within North Yorkshire County Council's geographical boundary will not be included within the service delivery described by this contract. If the Service choose to provide a service including carrying out review health assessments to this particular population, it must ensure that this is not to the detriment of this contract and any costs incurred should be arranged with the responsible CCG commissioner.

## 40. Access and Referrals

- The Service shall make any reasonable adjustments to ensure that the Service is accessible to all eligible service users, including people whose characteristics are included within the scope of the Equality Act 2010.
- The Service must ensure equal access for all children and their families, irrespective of age, disability, gender reassignment, marriage and civil partnership and race – this

includes ethnic or national origins, colour or nationality, religion, lack of belief, sex or sexual orientation.

- Non-urgent referrals, irrespective of source, (including families transferring in from outside the County) shall receive a response to the referrer within 4 working days, with contact made with the family within 5 working days (total of 5 working days). Following the initial contact with the family the next steps will be negotiated with the family, based on the information available. Public Health Nurse will use their professional judgement as to the appropriate action to take. If no contact is made within 10 days of the original referral/notification to either the referrer or family a clear rationale as to why it has not been undertaken must be documented and reported.
- Urgent referrals, including all those with a safeguarding or child protection component, must receive a same day or next working day response to the referrer and contact with the family within two working days (it is preferable that urgent referrals are dealt with by the named Public Health Nurse for the family involved).
- The Service will ensure that any coverage/ boundary issues that may arise will be dealt with proactively in collaboration with neighbouring providers. Delivery of a service that meets the needs (including safeguarding needs) of the child or family must take precedent over any boundary discrepancies or disagreements.
- The Service will work within County/District wide pathways and processes to ensure service users can access advice, support and interventions that fall outside the scope of this Service Specification.
- The Service will proactively engage with service users to develop a thorough and up-to-date understanding of the issues and barriers service users experience in accessing generic services, and using learning will be used to further develop the service.
- The Service should be responsive to the changing needs of service users to enable innovation and development.
- The Service will ensure that advice and information is made available via a range of communication channels, including, but not limited to; written, telephone, email, internet and social media, with the emphasis on access for young people in the medium they use such as texting.
- The Service will ensure that information is made available in a range of formats and languages that take into account the diverse population across the County and includes those with impairments and disabilities.
- The Service will ensure that young people are able to make an appointment or have access to a Public Health Nurse, or the appropriately qualified/trained staff member, without having to go through a third party.

## 41. Interdependencies with Other Services

- The Service will be delivered as part of the 0-19 Early Help framework and therefore integrated and co-located with relevant services.
- The Service will work with services across the County ensuring good partnership working to offer the best support for service users.
- The Service will work in partnership with other professionals, including for example but not restricted to Midwifery Services, Schools, Youth Services, Police, VCS, GPs, dental services and other Health and Social Care Practitioners (see Fig 2).
- The Service will establish good working relationships with key local partners, including representation on the North Yorkshire Strategic Boards and developing services in line with district wide priorities as highlighted in insert.
- The Service will deliver a three locality based model structured in line with local children's services, working together to deliver integrated services for children and their families, with a focus on promotion, prevention and early intervention.

- The Service will ensure that a named public health nurse or appropriately trained staff member is linked to each appropriate setting to ensure:
    - Liaison, information sharing and joint working with GP practices where necessary;
    - Direct partnership with schools to provide improved access and delivery of the commissioned elements of HCP
    - Support for Early Help and education services in their delivery of health improvements to improve outcomes for children, young people and their families
    - Promotion of the wide range of support that children and their families are entitled to, and, as part of that process, encouraging children and young people to access the service
    - The promotion of an integrated approach to improving child and family health locally, including leading partnerships with early years settings, schools and other partner agencies including social care
- The Service should link to wider stakeholder and services (e.g. hospital and community based health services, VCS) delivering in conjunction with the key practitioners.

## 42. Moving out of Area

- Where a child moves out of area the Service must ensure that the child's health records are transferred to the appropriate receiving equivalent 0-19 Service in the new area within 2 weeks of notification.
- Procedures must be in place to trace and risk-assess missing children and those whose address is not known with systems in place to follow up and trace children who do not attend for their assessments or appointments.
- Direct contact must be made to handover all child protection cases in other areas in a timely and responsive manner.

## 43. Variation During the Life of the Contract

In order to ensure that the contract remains appropriate to the needs of children, young people and families and provides value throughout its lifecycle, the Service will work with the Council in good faith and in an open and transparent manner to agree any variations that may be required as the need arises. Rationale for variations may include (though are not be limited to):

- Changes around Public Health funding
- Emergent priorities for those aged between 0 and 19 years
- Changes in statutory requirements in Public Health delivery
- Changes in local governance structures and ways of working.

Variations will be carried out in accordance with Terms and Conditions Clause as set out in the Section 75 Agreement.

## 42. End of Contract Arrangements

- The Service must liaise with the Council during final year of the contract to ensure the Service is transferred or discontinued effectively.
- The Provider must establish a plan for the final year of the contract which details all stages, dependencies and issues. This must be shared with the Council.

- During the final year of the contract, the Provider must ensure each stage of the plan is delivered and identified risks are managed to ensure the Service is fully operational until the end of the contract.
- The end of contract arrangements will affect many existing service users and Providers must work closely with the service users, staff, new providers and the Council to minimise impact.
- During the end of contract period, the Provider must put in place management and support systems to handle redundancies or the transfer of staff, addressing any TUPE implications, working with both the Council and any new providers (where applicable).
- Ensure on notification of the end of the contract, liaison is commenced with any new providers to begin planning for the safe transfer of data at the closure of the Service.
- Ensure access to relevant staff and processes with regard to data transfer are made available to any new providers.
- Carry out any necessary migration of data to new providers at the closure of the Service and in line with legislative requirements (clause).

## COMPLIANCE AND GOVERNANCE

### 43. Clinical Governance

The Service will ensure that robust Clinical Governance systems are in place for all elements of the service delivery.

- Establish and implement the framework of clinical governance that clinical and non-clinical practitioners will be operating within.
- Undertake regular audits of clinical practice to ensure on-going service improvement is embedded into working practice.
- Undertake regular training needs assessment and provide evidence of completion of courses by staff to ensure continuing professional development is applied in support of clinical governance.
- Ensure clinicians and non-clinical practitioners are linked to an appropriate Responsible Officer for the purposes of revalidation.
- Enable analysis of staff practice using external peer review as appropriate – in particular where staff are part of small professional groups within the Service, for example, those engaged in Oral Health Promotion.
- Ensure arrangements are in place to report and manage all Serious Incidents and Never Events, in line with Council Procedures.
- Ensure there is a complaints procedure in place which is accessible to children, young people and families.
- Ensure arrangements are in place to manage the collection, storage and disposal of clinical waste.
- Ensure infection control arrangements are in place to reduce the risk of transmission of infections.

- Review quality of prescribing, where required, with the nominated Medicines Management Prescribing Adviser to North Yorkshire County Council on a regular basis and agree on action plans to address any concerns raised.
- Participate in inspections, where required, in relation to the safe and secure handling of medicines (for example, the Council, CQC, etc).

## 44. Regulatory Compliance

- The Service will:
    - Comply, where applicable, with the registration and regulatory compliance guidance and quality standards of CQC and any other applicable regulatory body
    - Provide the Council with a copy of the Provider's CQC registration
    - Respond, where applicable, to all requirements and enforcement actions issued by CQC or any other applicable regulatory body;
    - Notify the Council of service inspections relevant to the Services commissioned in this Specification and provide copies of reports and improvement or enforcement actions and the related Provider progress reports; and
    - Notify the Council of the registered Provider's CQC overall summary ratings.
- The Service will comply with the mandatory registration and revalidation requirements of the NMC for registered nurses, midwives and Public Health Nurses. The Service will comply with all standards and guidance as required by the NMC.

## 45. Child Protection and Safeguarding

Safeguarding is a core part of the Service, and runs through all levels of service delivery. The Service will provide appropriate and effective safeguarding services and will be expected to adhere to relevant national and local requirements and guidance, and implement wherever necessary.

A new safeguarding model was implemented in September 2020 which describes more clearly the role and responsibilities of the Service in safeguarding. This is to enable the effective use of resources and to avoid duplication of efforts within the system.

In summary, the Service will:

- Work in partnership with other key stakeholders to help promote the welfare and safety of children and young people.
- Work 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
- Contribute to reducing the number of children who enter the safeguarding system through preventative and early help work as part of their Community, Universal and Universal Plus role
- Support safeguarding and access and contribution to targeted family support
- Deliver accordingly in line with local inter-agency and internal safeguarding policies and procedures as determined by the North Yorkshire Children's Safeguarding Partnership
- Be aware of children with an early help assessment, child in need, child protection or Looked After Child plan. Work with designated school safeguarding leads and local authority services, providing assessments and reports as required

- Contribute to multi-agency decision-making, assessments, planning and interventions, relating to children in need, children at risk of harm and Looked After Children (LAC). This includes providing Review LAC Child health assessments (in accordance with Promoting the Health and Wellbeing of Looked After Children Statutory Guidance 2015) and reports in accordance with the local Safeguarding Children Board policies and procedures and national guidance such as Working Together to Safeguard Children (HM Government, 2015)
- Where appropriate and the child or young person is known to the Service, senior team members will attend child protection conferences or meetings when they are the *most appropriate* health representative and there is a specific outcome to contribute.
- Be responsible for all general enquiries, contributing to individual case management issues, handling or crisis and emergency situations with other partners as required, informing the Council of such activity through routine contract monitoring arrangements or directly where it relates to a crisis or an emergency that warrants this being shared as a matter of urgency
- Contribute to the completion of an annual section 11 safeguarding children's audit (Produced by the Safeguarding Children's Board).
- Have a named nurse for safeguarding children and ensure that all staff (including administrative and voluntary staff) are compliant with child protection and Children and Adult Safeguarding Policies. For example, ensure all staff employed are aware of and trained to a level appropriate to their role in accordance with the intercollegiate document and abide by national and local guidance and legislation on safeguarding (children and adults).
- Ensure staff has access to sufficient safeguarding support, supervision, advice, training and guidance.
- Ensure staff will be competent in joint working with safeguarding teams and Designated Health Professionals i.e. Designated Nurse and Designated Doctor for Child Protection/Safeguarding Children (see link http://www.safeguardingchildren.co.uk/section-2-procedures.html for further information regarding Designated Health Professionals).
- Comply with the North Yorkshire Safeguarding Adults and Safeguarding Children Board's policies and procedures These can be found at the following webpage links: North Yorkshire Safeguarding Children Partnership (www.safeguardingchildren.co.uk) and North Yorkshire Adults Safeguarding Partnership (http://www.nypartnerships.org.uk/index.aspx?articleid=17008)
- Have robust child protection and adult safeguarding policies and procedures. When working in outreach settings the Service shall ensure that all staff employed by the Service are familiar with and have due regard to the settings' child protection policy and safeguarding procedures.
- Ensure compliance with the Mental Capacity Act where clinicians employed by the Service have contact with young people aged 16-17, those with learning difficulties or where there is impairment in decision making.
- Ensure it has Policies in place to safeguard the safety of its employed staff that may be lone working.

## 46. Data Requirements

- The Service will be wholly responsible for maintaining up-to-date datasets and will implement dataset changes as required and adhere to data reporting requirements as directed by the Council.

- The Service is responsible for the submission of nationally agreed datasets adhering to reporting requirements and submission deadlines with include (subject to change in line with reporting requirements) but not limited to:[10]

    - National Child Measurement Programme (NCMP) – NHS Digital
    - Community Services Dataset (CSDS) – NHS Digital
    - Health Visiting Service Delivery Metrics – PHE

- The Service is required to generate data extracts for the datasets relevant to the service that are created during the life of the Contract (e.g. local outcome framework measures - Appendix) and specified additional reporting requirements to ensure activity and performance is quantified.
- The Service will be compliant with the requirements and data flows to the current local Child Health Information Service (CHIS)[11] to:
    - Enable data collection to support the delivery, review and performance management of services; and
    - Ensure compliance with the …..clinical system? which requires all clinical systems to be able to receipt and process a range of child health informatics and be interoperable with other service providers for the secure and timely transfer of electronic data.
- The Service will work collaboratively with commissioners and NHS England as part of the developing redesign Healthy Children: Transforming Child Health Information NHS England 2016)[12].
- The Service will be required during the mobilisation period, to develop a system which will capture data to evidence the outcomes required in this Specification and to demonstrate compliance and quality standards.
- The Service will discuss data analysis with the Council at contract management meetings to enable informed commissioning decisions relating to activity and trends.
- The Service shall contribute to health needs analysis using tools such as the Early Years Profile.
- The Council may request anonymised data extracts including local level District population and if so will be provided as soon as is reasonably possible.
- The Service will be responsible for all general enquiries, contributing to individual case management issues, handling or crisis and emergency situations with other partners as required, informing the commissioner of such activity through routine contract monitoring arrangements or directly where it relates to a crisis or an emergency that warrants this being shared as a matter of urgency.

## 47. Information Technology (IT) System

- The Service will use a government approved system identified in the NHS' GP Systems of Choice (GPSoC) framework for its Electronic Health Care Record (EHCR) which is able to fully integrate with the primary care trust's system so that:

[10] Further information is available at: http://content.digital.nhs.uk/maternityandchildren/CYPHS

[11] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/417076/Child_Health_Information_240315.pdf

[12] https://www.england.nhs.uk/wp-content/uploads/2016/11/healthy-children-transforming-childhealth-_info.pdf

  - There is a shared care record available at the point of care between this service and primary care in North Yorkshire.
  - Safeguarding is at the heart of this shared EHCR.
- SystmONE is the system used by the primary care system in the North Yorkshire and the Service should ensure that the system that it uses is compatible.
- The Personal Child Held Record (PCHR) will be completed routinely by professionals supporting parents and carers. The system needs to be able to share with midwifery and GP and Early Help, and needs to be able to allow tracking across services using identifier (NHS number). The Service will also need to share data for the purposes of improving health, care and services through research and planning.
- Appropriate records will be kept in the Child Health Information System (CHIS) or similar system to enable high-quality data collection to support the delivery, review and performance management of services in line with national service level agreements with CHIS where necessary.
- The Service will ensure that employees are trained to use the IT system effectively.
- The Service will be responsible for the provision of and on-going support, upgrades, maintenance and replacement of any IT system hardware, software and associated licenses.

## 48. Information Governance (IG)

- The Service must have in place a robust IG framework.
- The Service will ensure that all employees understand their obligations in relation to IG and training is provided where necessary.
- The Provider is required to demonstrate that they are either:
  - registered with the NHS Digital IG Toolkit achieving Level 2 for all requirements; or
  - the same standards are met through a different IG quality system of a similar standard.
- The Service will ensure the processing, transfer and storage of Service User identifiable data is secure and complies with all relevant and current legislation and guidance.
- The Service will establish a secure process to share patient identifiable data with urgent and emergency care services.
- The Service will be registered with the Information Commissioner Office (ICO) and comply with the standards set by the ICO.

## 49. Confidentiality

- The Service must demonstrate that robust confidentiality processes are in place and Caldicott Principles are adhered to in the interest of patient safety:
  - justify the purposes of using confidential information
  - only use it when absolutely necessary
  - use the minimum that is required
  - access should be on a strict need to know basis
  - everyone must understand his or her responsibilities
  - understand and comply with the Law

- the duty to share information can be as important as the duty to protect patient confidentiality

- These Caldicott Principles as well as the Data Protection Act 2018 and The Common Law Duty of Confidentiality should not be a barrier to sharing relevant, proportionate information to safeguard and protect children and young people.
- The Service must have a named Caldicott Guardian, who shall be responsible for ensuring that all employees comply with the data standards produced by the Information Standards Board for Health and Social Care.
- The Service will ensure that data is not revealed or passed on to any third party who is not authorised to receive such data.
- Where there is any doubt as to whether or not someone has legitimate access to information, checks should be made before any information is disclosed, in cases where the right to confidentiality is overruled by issues of safeguarding, the Individual concerned should be informed wherever possible if other agencies are to be involved.

. Providers should also refer to 'Record Keeping: Guidance for Nurses and Midwives', NMC, 2015.[13]

## 50. Data Information, Systems and Confidentiality

- The Terms and Conditions in ….Schedule…. set out the provisions in relation to Data Protection for the Service of those termsm clearly defining the processing which is to take place under the Contract.
- Transfer and Storage of Data:
  - The Service shall at all times adhere to requirements of the General Data Protection Regulations and Data Protection Act 2018 in the transfer and storage and processing of data specific to this contract. Where data is held on Provider IT systems, Providers should also comply with the requirements under clause 5.6 below.
- Data sharing / consent:
  - The Service shall obtain all appropriate consents prior to the sharing of any data to a third party.
- Freedom of Information:
  - The Service shall comply with all reasonable requests for information made under the Freedom of Information Act 2000 in relation to the services provided.
- Confidentiality:
  The Service will receive Confidential Information from the Council or other stakeholders and shall undertake to keep such information secret and strictly confidential and shall not disclose any such Confidential Information to any third party, without the Discloser's prior written consent, subject to the provisions outlined in Clause 30 of the Terms and Conditions specific to this contract.
- Contract closure:

  The Service must comply with obligations relating to document retention and destruction in accordance with statutory guidance and the NHS Records Management Code of Practice for Health and Social Care 2016 as referenced in the Data Schedule at Schedule ….. of the s75 .
- Data ownership / Intellectual property rights:

[13] https://www.nmc.org.uk/standards/code/record-keeping/

- Under the General Data Protection Regulations, for the purposes of this Contract, the Council is the Data Controller and the Provider is the Data Processor.
- All Intellectual Property Rights furnished to or made available to the Provider by the Council shall remain the property of the Council, along with those prepared by or for the Service for use, or intended use, in relation to the performance of its obligations under the Contract shall belong to the Council. Further information regarding Intellectual Property can be found at Clause 29 of the Terms and Conditions specific to this contract.

## 51. Technical Security Requirements

The Service will:

- Ensure that any Council data which resides on a mobile, removable or physically uncontrolled device is stored encrypted using a product which has been formally assured through a recognised certification process.
- Ensure that any Council data which it causes to be transmitted over any public network (including the Internet, mobile networks or un-protected enterprise network) or to a mobile device shall be encrypted when transmitted.
- Must operate an appropriate access control regime to ensure users and administrators are uniquely identified.
- Ensure that any device which is used to process Council data meets all of the security requirements set out in the National Cyber Security Centre (NCSC) End User Devices Platform Security Guidance.
- At their own cost and expense, procure an IT Health Check from a certified supplier and penetration test performed prior to any live data being transferred into their systems.
- Perform a technical information risk assessment on the service supplied and be able to demonstrate what controls are in place to address those risks.
- Collect audit records which relate to security events in delivery of the Service or that would support the analysis of potential and actual compromises. The retention period for audit records and event logs shall be a minimum of 6 months.
- Must be able to demonstrate they can supply a copy of all data on request or at termination, and must be able to securely erase or destroy all data and media that the Council data has been stored and processed on.
- Not, and will procure that none of its sub-contractors, process the Council's data outside the European Economic Area (EEA).
- Implement security patches to vulnerabilities in accordance with the timescales specified in the NCSC Cloud Security Principle 5.
- Ensure that the service is designed in accordance with NCSC principles, security design principles for digital services, bulk data and cloud security principle.
- Implement such additional measures as agreed with the Council from time to time in order to ensure that such information is safeguarded in accordance with the applicable legislative and regulatory obligations.

### 52. Future Proofing

The Service will:

- Keep up to date with technical developments as they become available and shall ensure that provision is made to build innovative solutions into the service model, without compromising on compliance or quality. This should be achieved so that the delivery of a high quality and responsive service is maintained.
- Review and continuously improve the Service making use of technology and computer applications where appropriate and will seek and act on Service User, and staff feedback to support continuous improvement and development.
- Ensure service and support reflects local health needs and priorities including the sustainability and transformation of services. The Service will prioritise babies, children's and young people's health. There will be an appreciation that the health and wellbeing needs of babies, children and young people are crucial to securing long-term population health and reducing the local burden of healthcare provision.

## A TRANSFORED WORKFORCE

The workforce is critical to the vision of the service for children, young people and families and transforming the workforce is the key to achieving this. We know that there are system barriers that prevent frontline practitioners from working with families in the way they know best. Over the life of the contract, the Council will work with the Service and other local partners to identify and where possible remove these barriers and create enabling working cultures and environments.

The Service will play an important role in the achieving this transformed workforce through the right leadership and workforce competency and development.

### 53. Strategic and Operational Leadership

The Service will:

- Have in place an organisational management structure (OMS) which provides a description of the key leadership roles and responsibilities, reporting relationships and accountabilities.
- The OMS will support delivery of a safe, effective and efficient service in line with the requirements of this Service Specification.
- For the purpose of delivering an integrated 0-19 service, show the links between the organisation's roles, responsibilities and accountabilities and those of all other local organisations.

### 54. Workforce Competency and Development

The Service will:

- Have in place a multi-disciplinary team of appropriately qualified Public Health Nurses and a *skill mix of staff* which is diverse and reflects the needs of the population.

- Ensure all public health nurses are registered or working towards registration with the Nursing and Midwifery Council.
- Have in place an appropriately qualified named clinical lead(s), responsible for ensuring clear and consistent governance processes are in place. The clinical lead will be accountable for the clinical quality of the Service and will work closely with the senior leads in other key partners.
- Ensure supervision arrangements are in place for all staff, in line with national guidance, and measures are in place to maintain competency standards of all Staff.
- Develop a robust workforce development plan which should demonstrate service development in response to client experience, feedback from families and staff.
- Align and prioritise delivery in line with local population needs, inequalities and outcomes.
- Ensure a focus on Building Community Capacity and collaborate in interagency approaches and training, to enable innovative and creative Public Health nursing services to meet local needs and to add to the body of research evidence for the profession.
- Ensure:
    - Robust workforce analyses and plans are developed which include: numbers of new students needed; number of apprentices/trainees; recruitment/retention plans; numbers of retirees; potential other leavers; and
    - Organisational processes and managerial support are in place to ensure that mentors and practice teachers are able to provide high quality placements for students.
- Ensure all employees, including agency/locums can demonstrate professional competency and understand all relevant policies and processes.
- Have in place individual training and development plans for all employees, including agency/locum, and will undertake annual appraisals, with peer review where appropriate, to ensure their CPD.
- Ensure all staff are up to date and competent in key public health training – e.g. stop-smoking, smoke free homes, substance misuse, sexual health, obesity, infant nutrition, immunisations, breastfeeding and it will promote and support a healthy workforce.
    - Manage strong emotions, sensitive issues and undertake courageous conversations.

# MOBILISATION

## 55. Mobilisation Plan

- There will be a Mobilisation Period in accordance with the provisions set out in the Section 75 Agreement.
- The Service will have in place a detailed mobilisation plan, which shall set out how each aspect of the Service will be mobilised, including key milestones.
- The Mobilisation Period will be from …..Dates. The Service will be expected to start provision of the service on the 1st April 2021.
- The Service and the Council will meet (timescale?) during the mobilisation period to ensure key milestones have been met and that any remedial/corrective action has been taken.

## 1.13 Client Feedback and Engagement

The Service will be able to evidence that the experience and involvement of families is regularly gathered and taken in to account to inform service delivery and improvement.

They will use established consistent tools for measuring outcomes.

Service impact will also be demonstrated through service user feedback.

The Service should also have a well-publicised feedback and complaints procedure which includes quality standards related to how complaints are dealt with and responded to.

The Service is required to have a process for dealing with and responding to Serious Incidents including those related to safeguarding and child protection.

## 1.15 Performance and Contract Management

Quarterly service review meetings will be held between the Service and the Council. The Service shall provide a quarterly report of activity data and performance against the measures identified in the Performance and Monitoring Framework. Performance reports shall be produced and sent to the Council at least one week in advance of the review meeting. The format of the performance report will be agreed between the Council and the Service.

Review meetings will be held on the Council's premises unless the parties agree otherwise. The Council will not pay for any expenses for attendance at any of these review meetings.

The Service will provide when requested exception reports where there are queries or anomalies in their performance reports and/or data. Exception reports may also be requested where there have been good outcomes to demonstrate what has been effective.

An annual contract review meeting will be held to assess performance over the previous year. At this meeting the Service shall produce an annual report. The annual review meeting will include a review of budget and performance against measures as well as agreeing any developments or new performance measures for the Service for the forthcoming year. The performance measures will be reviewed annually and may be amended to specifically address emerging needs or trends.

## Staff performance

The Service shall provide exception reports where staff performance is identified by the Council as having an adverse impact on the delivery of the Service.

## Organisational Performance

The Service and the Council will work together to demonstrate the value of this contract in delivering outcomes for children, young people and adults, for example when either organisation is subject to an inspection by a government or professional body.

The Service shall provide information for needs assessment and any other monitoring reports required by the Council, the Children's Safeguarding Partnership, the Health and Wellbeing Board or other relevant Committees or Boards.

## Auditing Impact and Outcomes

To provide assurance that frontline practice is safe and delivering its stated objectives, the Service shall carry out relevant audit exercises and use the findings to inform and improve practice. The Service will submit an annual audit/service transformation plan to be agreed with the Council.

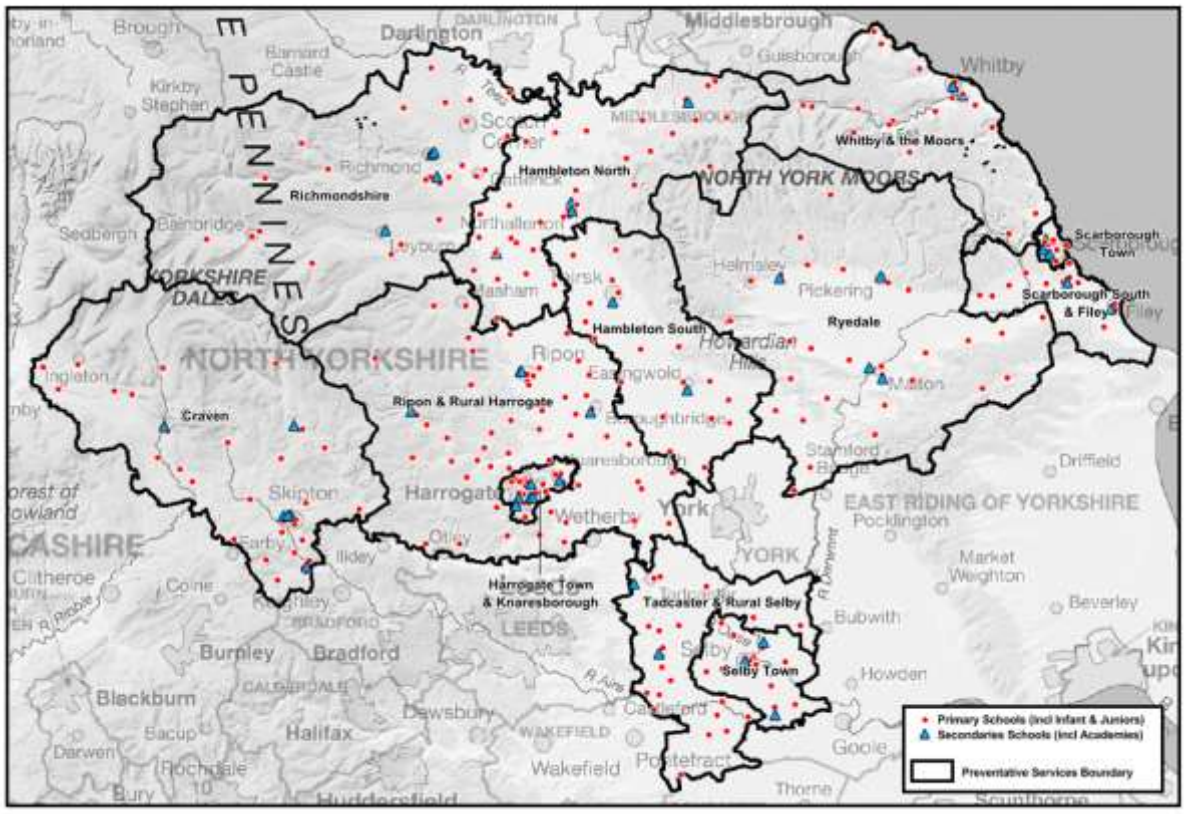
## Commissioner visits – Not relevant! – to be replaced by partnership board arrangements

To provide additional assurance the Council will conduct twice yearly visits to discuss performance and progress across the wider service. The Council will adopt a supportive approach to the visits in helping the Service raise standards and/or commit to continuous improvement where required.

**Review all appendices**

## Appendix 1

CYPS Early Help Service Areas & Primary & Secondary School Locations




The number of primary and secondary schools by prevention service area is illustrated in the following table:

| Area | Number of Primary Schools | | Number of Secondary Schools | | Independent Schools |
|---|---|---|---|---|---|
| | Maintained | Academy | Maintained | Academy | |
| Craven | 33 | 2 | 5 | 3 | 2 |
| Hambleton North | 32 | 2 | 4 | 1 | |
| Hambleton South | 20 | | 2 | | |
| Harrogate Town & Knaresborough | 18 | 5 | 4 | 4 | 2 |
| Richmondshire | 30 | | 4 | | |
| Ripon & Rural Harrogate | 55 | 1 | 4 | 1 | 4 |
| Ryedale | 33 | | 4 | 1 | 2 |
| Scarborough Town | 6 | 1 | 4 | 1 | 1 |
| Scarborough South & Filey | 14 | | 2 | 1 | |
| Selby Town | 18 | | 4 | | 1 |
| Tadcaster & Rural Selby | 21 | 1 | 2 | | 1 |

| | | | | | |
|---|---|---|---|---|---|
| Whitby & the Moors | 21 | | 2 | | |

Table Illustrating Number of Children and Young People by Proposed Prevention Service Area

| Area | Number of Children & Young People | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | 0 to 19 Pop (Mid '14 estimate) | Under 5 Pop (Mid '14 estimate) | 5 to 19 Pop (Mid '14 estimate) | Eligible for FSM (Oct 2015) | Children Subject CPP (Dec 15) | Children with an open involvement (Dec 15) | Families Identified within DSF phase 2 (Dec 15) | Persistent Absent Pupils (2013/14) | |
| Craven | 11522 | 2522 | 9000 | 471 | 30 | 106 | 402 | 80 | |
| Hambleton North | 11324 | 2702 | 8622 | 511 | 25 | 108 | 368 | 201 | |
| Hambleton South | 7436 | 1774 | 5662 | 221 | 9 | 54 | 193 | 89 | |
| Harrogate Town & Knaresborough | 20453 | 5122 | 15331 | 746 | 30 | 195 | 534 | 186 | |
| Richmondshire | 11510 | 2863 | 8647 | 367 | 17 | 126 | 312 | 208 | |
| Ripon & Rural Harrogate | 15673 | 3208 | 12465 | 385 | 14 | 110 | 348 | 105 | |
| Ryedale | 10897 | 2471 | 8426 | 477 | 24 | 91 | 291 | 142 | |
| Scarborough Town | 10058 | 2636 | 7422 | 973 | 52 | 249 | 551 | 271 | |
| Scarborough South & Filey | 6383 | 1506 | 4877 | 649 | 37 | 111 | 288 | 120 | |
| Selby Town | 9579 | 2529 | 7050 | 633 | 31 | 106 | 386 | 168 | |
| Tadcaster & Rural Selby | 9827 | 2307 | 7520 | 246 | 10 | 63 | 211 | 95 | |
| Whitby & the Moors | 5245 | 1150 | 4095 | 285 | 8 | 47 | 238 | 58 | |

FSM – Free School Meals
CPP – Child Protection Plan
CiN – Child in Need
DSF – Developing Stronger Families
TAC – Team Around Child

## Appendix 2 - National Policy, Guidance and Applicable Quality Standards

Healthy Child Programme – Pregnancy and the first five years of life (DH, 2009 amended August 2010)

Better health outcomes for children and young people Pledge

Allen, G. (2011a) Early Intervention: The Next Steps. HM Government: London

Allen, G. (2011b) Early Intervention: Smart Investment, Massive Savings. HM Government: London

NHS Outcomes Framework 2014 to 2015 (DH, 2013)

Public Health Outcomes Framework 2013 to 2016 (DH, 2014)

The Marmot Review (2010) Strategic Review of Health Inequalities in England, post-2010

Conception to Age two: The Age of Opportunity. WAVE Trust and DfE
UNICEF UK Baby Friendly Initiative

Rapid Review to Update Evidence for the Healthy Child Programme 0–5 (PHE, March 2015)

Promoting children and young people's emotional health and wellbeing: A whole school and college approach (PHE and The Children and Young People's Mental Health Coalition, March 2015)

**CQC Essential Standards of Quality and Safety 2010**

**UK National Screening Committee Standards and Guidelines**

- Newborn Bloodspot Screening
- Newborn Hearing Screening
- Newborn Infant & Physical Examination
- The Green Book- (Imms)

**Key NICE public health guidance includes:**

NICE guidance summary for public health outcome domain (PHE 2013) https://www.gov.uk/government/publications/nice-guidance-summary-for-public-health- outcome-domain

Please note: For all reference see the NICE website.

- PH3 Prevention of sexually transmitted infections and under 18 conceptions

- PH6 - Behaviour change at population, community and individual level (Oct 2007)
- PH8 Physical activity and the environment
- PH9 - Community engagement (July 2010)
- PH11 - Maternal and child nutrition
- PH12 - Social and emotional wellbeing in primary education
- PH14 Preventing the uptake of smoking by children and young people
- PH17 - Promoting physical activity for children and young people
- PH21 - Differences in uptake in immunisations
- PH24 Alcohol-use disorders: preventing harmful drinking
- PH26 - Quitting in smoking in pregnancy and following childbirth (June 2010)
- PH27 - Weight management before, during and after pregnancy (July 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 Issued (November 2010)
- PH30 Preventing unintentional injuries among the under-15s in the home
- PH31 Preventing unintentional road injuries among under-15s
- PH40 Social and emotional wellbeing – early years: NICE public health guidance 2012
- PH42- Obesity working with local communities
- PH44 Physical activity: brief advice for adults in primary care
- PH48 Smoking cessation: acute, maternity and mental health services http://www.nice.org.uk/guidance/PH48
- PH49 Behaviour change: individual approaches
- PH50 Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively. NICE public health guidance http://www.nice.org.uk/guidance/PH50
- CG43 Obesity: Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children
- CG45 - Antenatal and postnatal mental health: clinical management and service guidance (February 2007)
- CG62 - Antenatal care: routine care for the healthy pregnant woman (March 2008)
- CG89 - When to Suspect Child Maltreatment (July 2009)
- CG93- Donor milk banks: the operation of donor milk bank services
- CG110- Pregnancy and complex social factors**:** A model for service prevision for pregnant women with complex social factors
- CG170 Autism: the management and support of children and young people on the autism spectrum http://www.nice.org.uk/guidance/cg170

- QS22 Quality standards for antenatal care
- QS31 Quality standard for the health and wellbeing of looked-after children and young people
- QS37 Postnatal Care
- QS59 Antisocial behaviour and conduct disorders in children and young people http://www.nice.org.uk/guidance/QS59
- QS43 Smoking cessation: supporting people to stop smoking
- QS46 Multiple pregnancies
- QS48 Depression in children and young people
- QS51 Autism http://www.nice.org.uk/guidance/QS51
- Suite of Evidence based pathways and interventions
- Svanberg P O, Barlow J & TigbeW The Parent–Infant Interaction Observation Scale:
- reliability and validity of a screening tool. Journal of Reproductive and Infant Psychology,
- 2013: Volume 31, Issue 1, 2013
- Milford R, Oates J. Universal screening and early intervention for maternal mental health and attachment difficulties. Community Practitioner, 2009; 82(8): 30-

## Appendix 3 – Health Reviews

| Review | Description |
|---|---|
| **Universal –**<br><br>**Antenatal health promoting visits –**<br><br>**a robust referral process will need to be developed and agreed with Local maternity Services.** | Contact should be universal and include preparation for parenthood messages.<br><br>Promotional narrative listening interview.<br><br>This should be done as a face-to-face, 1-2-1 interview in a confidential setting where parents are identified as universal plus and universal partnership plus are given prirority because of additional vulnerability including:<br>• age under 20<br>• domestic abuse;<br>• poverty;<br>• homelessness.<br>• Mental health<br>• substance misuse;<br>• recent arrival as a migrant;<br>• asylum seeker or refugee status;<br>• difficulty speaking or understanding English;<br><br>https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/465344/2903819_PHE_Midwifery_accessible.pdf |

| | |
|---|---|
| **Universal-**<br>**New Baby Review** | Face-to-face review by **14 days** with mother and father to include:<br>- Initial relationship building with family following birth<br>- Infant feeding<br>- Promoting sensitive parenting<br>- Promoting development<br>- Assessing maternal mental health<br>- SIDS prevention including promoting safe sleep<br>- Keeping safe<br>- Promoting community support services<br>- Discussing consent to share information<br><br>- If parents wish or there are professional concerns:<br>1. An assessment of baby's growth<br>2. On-going review and monitoring of the baby's health<br>3. Assessment of safeguarding concerns<br>4. Promotion of secure attachment.<br>5. Include promotion of immunisations specifically:<br>a. Adherence to vaccination schedule for babies born to women who are hepatitis B positive<br>b. Assess maternal rubella status and follow up of two MMR vaccinations (to protect future pregnancies).<br>6. Checking of the status of all screening results and take prompt action to ensure appropriate referral and treatment pathways are followed in line with UK NSC Standards, specifically:<br>7. Newborn blood spot; ensuring results for all conditions are present<br>8. Results of NIPE examinations<br>9. Hearing screening outcome.<br>10. Contraception (all families): provision of post natal contraception to reduce sexually transmitted infections and subsequent unplanned pregnancies<br><br>**Additional/ complex health needs** –where a child remains in hospital this visit must still take place within the given timescale the service will play a key part of discharge planning and support. |

| | |
|---|---|
| **Universal plus /Universal partnership plus – 4 Weeks** | Build on and strengthen therapeutic relationship between practitioner and mother/father/ family<br><br>• Engage and share public health information and guidance to promote positive attachment and health and wellbeing<br>• Observe/ discuss developmental progress of infant<br>• If previously disclosed, routine enquiry related to identified vulnerability<br>• Promoting community support services<br>• Discussing consent to share information<br>• Agree plan of ongoing care |

| | |
|---|---|
| **Universal 6 – 8 Week Assessment** | Includes:<br>- On-going support with breastfeeding involving both parents<br>- **Assessing maternal mental health**<br>Assessment of the mother's mental health at six to eight weeks and three to four months, by asking appropriate questions for the identification of depression, such as those recommended by the NICE https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212906/Maternal-mental-health-pathway-090812.pdf<br>1. The baby's GP (or nominated Primary Care examiner) will have responsibility for ensuring the 6-8 week NIPE screen is completed for all registered babies<br>2. Include promotion of immunisations specifically:<br>a. Adherence to vaccination schedule for babies born to women who are hepatitis B positive<br>b. Assess maternal rubella status and follow up of two MMR vaccinations (to protect future pregnancies).<br>c. Checking of the status of all screening results and take prompt action to ensure appropriate referral and treatment pathways are followed in line with UK NSC Standards as above in initial check.<br>• Promoting community support services<br>• Discussing consent to share information<br>• Agree plan of ongoing care |

| | |
|---|---|
| **Universal plus/Universal partnership Plus**<br><br>**3 – 4 months** | **At three to four months**<br>• Supporting parenting by providing access to parenting and child health information and guidance (telephone helplines, websites, NHS Direct, etc.), and information on community support services.<br>• Checking the status of Immunisations at three months against diphtheria, tetanus, pertussis, polio, Haemophilus influenzae type B and meningococcus group C.<br>• Checking the status of Immunisations at four months against diphtheria, tetanus, pertussis, polio, Haemophilus influenzae type B, pneumococcal infection and meningococcus group C.<br>• If parents wish, or if there is or has been professional concern about a baby's growth or risk to normal growth (including obesity), an assessment should be carried out. This involves accurate measurement, interpretation and explanation of the baby's weight in relation to length, to growth potential and to any earlier growth measurements of the baby.<br>• Emphasising the importance of delayed weaning<br><br>**Assessing maternal mental health**<br>Assessment of the mother's mental health at six to eight weeks and three to four months, by asking appropriate questions for the identification of depression, such as those recommended by the NICE https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212906/Maternal-mental-health-pathway-090812.pdf |

| | |
|---|---|
| | Temperament-based anticipatory guidance – practical guidance on managing crying and healthy sleep practices.<br><br>Encouragement of parent– infant interaction using a range of media-based interventions (e.g. Baby Express newsletters).<br><br>**Promoting development**<br>Encouragement to use books, music and interactive activities to promote development and parent–baby relationship (e.g. media-based materials such as Baby Express newsletters and/or Bookstart) Promote language development;<br><br>**Keeping safe**<br>Raise awareness of accident prevention in the home and safety in cars. Be alert to risk factors and signs and symptoms of child abuse. Follow local safeguarding procedures where there is cause for concern.<br><br>https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf[1]<br><br>https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/209907/S9_Happy_Helathy_Familes_First_Community_EISCS_V121210.pdf<br><br>• Promoting community support services<br>• Discussing consent to share information<br>• Agree plan of ongoing care |

| | |
|---|---|
| **Universal**<br>**9- 12 months** | Includes:<br>• Assessment of the baby's physical, emotional and social development and needs in the context of their family using evidence based tools, for example, Ages and Stages 3 and SE questionnaires;<br>• Promote language development;<br>• Supporting parenting, provide parents with information about attachment and developmental and parenting issues;<br>• Monitoring growth;<br>• Health promotion, raise awareness of dental health and prevention (ensuring that all children are accessing primary dental care services for routine preventive care and advice), healthy eating, injury and accident prevention relating to mobility, safety in cars and skin cancer prevention;<br>• Check newborn blood spot status and arrange for urgent offer of screening if child is under 1 year;<br>• Adherence to vaccination schedule and final serology results for<br>• babies born to women who are hepatitis B positive; status of<br>• MMR vaccination for women non-immune to rubella.<br>• Promoting community support services<br>• Discussing consent to share information<br>• Agree plan of ongoing care |

| | |
|---|---|
| **Universal**<br>**By 2 – 2½ Years** | Includes:<br>• Review with parents the child's social, emotional, behavioural and language development using ASQ 3 and SE;<br>• Respond to any parental concerns about physical health, growth, development, hearing and vision;<br>• Where weight management issues are identified families will be encouraged and supported to access an appropriate evidence based intervention.<br>• Offer parents guidance on behaviour management and opportunity to share concerns;<br>• Offer parent information on what to do if worried about their child;<br>• Promote language development;<br>• Encourage and support to take up early years education;<br><br>- Give health information and guidance;<br>- Review immunisation status;<br>- Offer advice on nutrition and physical activity for the family;<br>- Raise awareness of dental care, accident prevention, sleep management, toilet training and sources of parenting advice and family information;<br><br>- This review should be integrated with the Early Years Foundation Stage two year old summary as described in the service model.<br>• Promoting community support services<br>• Discussing consent to share information<br>• Agree plan of ongoing care |
| **By 4 ½ years** | 4½ years - Formal handover to School Nursing Service timed to meet<br>the needs of the child e.g. if the Health Visitor is lead professional<br>the handover may be delayed where this will improve outcomes<br>for the child |