NORTH YORKSHIRE COUNTY COUNCIL

YOUNG PEOPLE OVERVIEW AND SCRUTINY COMMITTEE

4 April 2014

Commissioning of the 5-19 Healthy Child Programme (HCP)

1. Purpose of the report.

To provide the Young People's Overview and Scrutiny Committee with information about the Healthy Child Programme and the commissioning arrangements.

Reference: Healthy Child Programme. From 5-19 years old.
http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_108866.pdf

2. General Information

2.1 The HCP was established by the Department of Health in October 2009 and is separated into two programmes, one focusing on pregnancy to 5 years and the other on 5 to 19 year olds. The main contract associated with the 0-5 programme relates to the Health Visitor workforce and this is contract managed by NHS England through the area team. This responsibility will transfer to Public Health in the Local Authority from October 2015. The responsibility for the 5-19 HCP transferred along with other Public Health functions to the Local Authority in April 2013.

2.2 The HCP is defined as good practice guidance for prevention and early intervention services for children and young people. Delivering the HCP is the responsibility of many partners and is not restricted to the contracted services referred to in this report. It is however important that there is effective coordination between the contracted HCP service and the range of other early intervention and prevention services that impact on health and wellbeing of children and young people.

3. Current arrangements.

3.1 The contract for the School Nursing Service which includes the delivery of the National Child Measurement Programme currently represents the contracted element of the HCP. Harrogate and Rural District NHS Trust manage this service across all of North Yorkshire except in Easingwold and Selby District. The service in these localities is delivered by York Teaching Hospital NHS Foundation Trust and Public Health in the City of York Council manage this element of the contract on behalf of North Yorkshire.

3.2 The contracted services for the delivery of the HCP were transferred under the waiver to contract procedure as referred to above and these will end on the 31st March 2015. The main reason for commissioning a new service is that the current arrangements have evolved over a number of years out of different commissioning and contractual processes. This has resulted in a fragmented delivery model which has made managing the contract difficult.

4. Progress

4.1 The commissioning timetable is on schedule and the engagement and information exchange phase has been completed and a report produced (Appendix A). The project team had been established and the scoping of the service specification has commenced.

4.2 The authorisation and accountability for the procurement process are slightly more challenging than normal due to the responsibility and budget for this work sitting within Public Health which is managed within Health and Adult Services with the commissioning process being led by CYPS. All the necessary authorisations have been received for the procurement of a new service to progress. The aim is to have this in place and ready to commence on the 1st April 2015.

5. Summary of gaps in provision and emerging priorities. (Refer to Appendix)

5.1 The most frequently mentioned areas of concern and identified gaps were:

- The importance and increasing demand for help with issues related to emotional wellbeing and mental health(section 8.1)
- Lack of provision for young people aged 16 and over (section 8.2)
- Insufficient focus on the needs of children and young people who are at higher risk of poor health outcomes and those least likely to seek help with regards to their health (section 8.3)
- Lack of clarity and publicity about what the service provides (section 8.4)
- Inconsistency of practice in the type and standard of the services being offered in different geographical areas and settings (section 8.5)
- Lack of advice and practical help after children have been weighed and measured as part of the National Child Measurement Programme (section 8.6)
- The importance of having effective screening and health checks to identify problems that may be impacting on the child's development (section 8.7)

6. Challenges that the service specification and delivery model will need to address.

6.1 Establishing a seamless 0-19 HCP

The most recent government announcement is that this responsibility for the 0-5 HCP will transfer to Local Authorities in October 2015. When defining the support pathways within the 5-19 HCP due regard has been given to the key transition points and this includes that from the pre 5 age as well as transition to adult provision. The goal of having an integrated 0-19 HCP for North Yorkshire can still be realised but within a longer timeframe than anticipated and developed as part of an incremental process.

6.2 Highlighting unmet need.

The commissioning process for the 5-19 HCP has inevitably highlighted some gaps in provision which are not within the scope of a HCP. Where these are being uncovered further discussions are being had with the respective commissioners or service areas to clarify who has responsibility for which element of care.

6.3 Opportunities for creating efficiencies.

The commissioning process provides an opportunity to create efficiencies across different aspects of the CYPS. This might be in terms of financial efficiencies and/or in terms of contributing to the reduction in pressures on other parts of the service or minimising the demand being placed on tier 3 provision. The option for increasing the capacity at tier 2 to support young people with emotional and mental health needs through the HCP service is being considered.

6.4 Provision for those living outside of North Yorkshire.
There is no easy answer to the question as to how best to provide a service for children and young people who live outside of North Yorkshire but who may receive education on a daily or residential basis in the county. The project group are addressing this and will ensure that there is clarity prior to finalising the specification for the contract. Legal advice will be sought to ensure that whatever is proposed does not contravene any discrimination legislation or contracting rules.

7. Proposed delivery model.

7.1 The proposal is to tender for a Core HCP Service, a community child and young person's weight management service and if additional resources are found, a Targeted HCP service that will include some additional support for those with emotional and mental health. These different elements of the service will be identified under the umbrella of the HCP and contribute to achieving the outcomes identified as a priority within the Children and Young People's Plan and the Health and Wellbeing Board.

8. Recommendations

8.1 The Young People's Overview and Scrutiny Committee is recommended to note the information on the Healthy Child Programme in this report

Appendices Appendix A Findings of stakeholder engagement

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21st March 2014.

APPENDIX A

Commissioning a service
to contribute to achieving the outcomes of the 5-19 Healthy Child Programme.
A report on the findings from the stakeholder engagement exercise.

1. General information about the changes to the commissioning responsibilities

1.1 The Health and Social Care Act 2012 gave new statutory responsibilities to local authorities for the health of their populations. From the 1st April 2013 North Yorkshire County Council assumed key responsibilities across the three domains of public health – health improvement, health protection and healthcare public health. The new responsibilities for public health are intended to complement the existing roles of local authorities to promote health and wellbeing and include such things as transportation, community safety, housing, education and environmental health.

1.2 Included within these responsibilities was the local co-ordination and planning to deliver elements of the Healthy Child Programme (HCP). The main contracted service delivering the HCP is that of school health service which also includes additional requirements as part of the National Child Measurement Programme. Contracts transferred under a 'lift and shift' arrangement and allowed no flexibility to amend current practice . The current contract will end on the 31st March 2015 and the aim is to commission a new service from the 1st April 2015.

2. The Healthy Child Programme

2.1 The HCP was established by the Department of Health in October 2009 and is separated into two programmes, one focusing on pregnancy to 5 years *(Healthy Child Programme. Pregnancy and the first five years of life. Dept of Health October 2009)* and the other on 5 to 19 year olds. *(Healthy Child Programme. From 5-19 years old. Dept of Health October 2009)* The main contract associated with the 0-5 programme relates to the Health Visitor workforce and this is contract managed by NHS England through the area team. This responsibility will transfer to Public Health in the Local Authority from October 2015.

2.2 The HCP is defined as good practice guidance for prevention and early intervention services for children and young people. Health and wellbeing is not restricted to physical health needs and there is frequent reference within the HCP to the importance of the emotional and mental health of children and young people. There is an expectation that there will be structured and clearly understood integrated pathways to identify and provide preventative services to those at risk of having poor health outcomes. Delivering the HCP is the responsibility of many partners and is not restricted to the contracted services referred to in this report. It is however important that there is effective coordination between the contracted HCP service and the range of other early intervention and prevention services that impact on health and wellbeing of children and young people.

3 The reasons for commissioning a new service.

3.1 The main reason for commissioning a new service is that the current arrangements have evolved over a number of years out of different commissioning and contractual processes. This has resulted in a fragmented delivery model which has made managing the contract difficult. For example the Selby district and Easingwold town (which is part of Hambleton district) receive their school nursing service from York NHS Trust with the remaining areas of North Yorkshire receiving their service from Harrogate and Rural District NHS Trust.

3.2 The contract specification had been modified in the past by NHS NYY to reflect changing commissioning priorities but this 'ad hoc' and reactive response to changing needs has produced a service which lacks coherency and integration with other provision for children and young people and their families.

3.3 The current contract has the potential to exacerbate inequalities in health because of the gaps in service that have resulted from the contractual requirements. For example the focus is on school aged children and those who attend school. As such those at risk of poorer health outcomes, for example families that are dis-engaged from mainstream services, children not in education etc. are not prioritised and may not receive any provision.

3.4 The activities delivered as part of the contract are historically based and do not reflect the changing physical development or societal and technological influences that impact on children and young people. The organisational structures, most noticeable of which is the governance and management of schools, within which the service needs to operate are now significantly different to when the original school nursing contract was established.

3.5 There are increasing financial pressures on all services therefore the need to coordinate the commissioning priorities and delivery of services is important. As the responsibility for the commissioning of children's services rests with different bodies this is made more complex but shouldn't prevent commissioners from seeking ways to integrate their plans and/or co-commission services to ensure that pathways of support are appropriate and meet the needs of children, young people and their families.

4. The commissioning timetable.

Phase	Timeframe	Activity
1	August – September 2013	Preparation, information gathering and research
2	September – October 2013	Awareness raising, information giving. Reports to Children's Trust Board, Health & Wellbeing Board, Executive members.
3	October 2013 – February 2014	Engagement and information exchange with: Stakeholders that are recipients of the service

		(children, young people, families) Stakeholders who have a vested interest in the decisions taken (schools, youth settings, children's centres, GPs) Stakeholders who will be directly affected by the decisions taken (current and potential providers, practitioners and managers) Other commissioners (CCGs, PCU, NHS England Area team) and colleagues within CYPS/NYCC
4	Feb - March 2014	Scoping of the service and production of draft specification.
5	April – May 2014	Consultation on the draft service specification. Production of final specification by end of May.
6	June 2014	Gateway 1 of procurement process Required authorisations attained from Public Health, CYPS, CTB Key decision attained from Executive
7	July 2014 – October 2014	Procurement - through relevant Gateway stages
7	By end of Nov 2014	Contract awarded
7	December 2014 – March 2015	Standstill period / appeals
8	January – March 2015	Transition and transfer arrangements of workforce (if necessary)
	1st April 2015	New contract commences.

5. Stakeholder engagement.

5.1 This report is the conclusion of phase 3. Information was exchanged and gathered from 319 individual stakeholders via questionnaires, individual conversations, group meetings and workshops and included children, young people, parents, and a wide range of other partners. A full list of acknowledgements is included in Appendix A.

5.2 One of the challenges in engaging with different stakeholders, many of whom had no previous knowledge about the HCP was to provide relevant information in sufficient detail to enable them to engage effectively.

5.3 Many people use the term 'health' broadly to encompass the many varied and different organisational structures that now exist under the health services' umbrella. For the purposes of this commissioning exercise the following descriptions and explanations were used to help participants to understand what the HCP related to.

6. Identifying age and development related needs.

6.1 The HCP uses traditional age bandings when describing the services and support that it envisages being delivered within the programme. These age bandings of 5-10 (primary school, 11-16 (secondary school) and post 16 do not reflect the age bandings that might be more appropriate in defining the commissioning priorities for the 5-19 age range.

6.2 Every child will mature physically and emotionally at a different rate and therefore it is not possible to describe exactly an age range that would receive a specific intervention it is possible to cluster features that are associated with an age range which would affect commissioning decisions. Feedback from stakeholders was useful in illuminating what these features might be and the benefits of describing the HCP in different age bandings to those described in the published document.

6.3 Features associated with the 5-8 age range

- Transition from early years and nursery settings to school.
- Decisions about health and control over health behaviours determined by parent(s).
- Parents/carers largely engaged and interested in child's education and lifestyle.

6.4 Features associated with the 9-12 age range

- Transition to secondary school.
- Physical changes and puberty.
- Increased control over decision making about certain aspects of their lifestyle and increased peer pressure.
- Greater exposure to external influences through media and peers.
- Relaxed parental control and/or influence may impact on a child's health and wellbeing.

6.5 Features associated with the 13 – 19 age range

- Increased control over decision making with regards to lifestyle and health behaviours.
- Decreased involvement of some parents in the education / development needs of their child.
- Transition from mainstream education into post 16 learning
- Transition into employment or unemployment
- Increased potential risks associated with some behaviours.
- Transfer of consent from parent to young person.

6.6 The service provided as part of the 5-19 HCP will also be applicable to those young people with additional needs up to the age of 25 and there will also be an overlap with other commissioned services that encompass teenage/young adult age range such as specialist sexual health services.

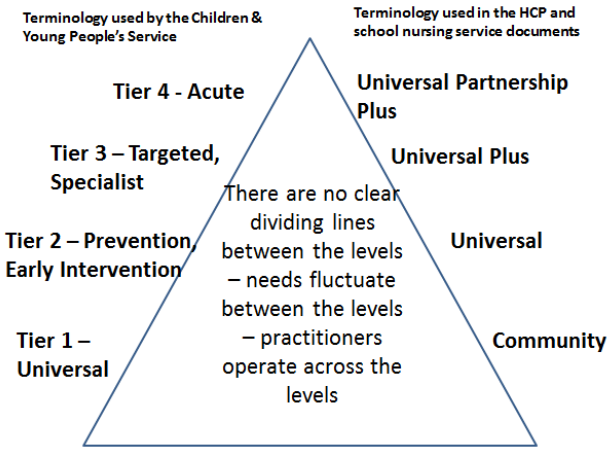
6.7 Although this programme does not directly relate to the 0-5 age range, the services delivered to that age range will have implications for the consistency of support and provision that families and children receive.

Features associated with the 0-5 age range

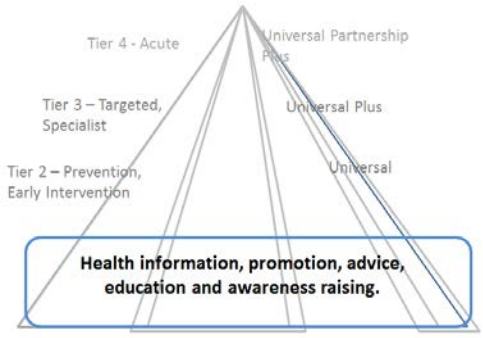
- Maternal health and social wellbeing (including maternal mental health) during pregnancy and its impact on the health of the baby
- Significant changes in brain development
- Rapid physical and sensory development
- The importance of attachment and parenting on future outcomes
- Attendance at early years and nursery settings
- A recognition that services delivered as part of the 0-5 Healthy Child Programme relate not just to mother and baby but also to paternal and family health and their involvement in the child's development.

7. Tiers of intervention.

7.1 The terminology used by children and young people's services when describing different levels of help differs slightly to that used in the HCP and other documents familiar to the school health service.

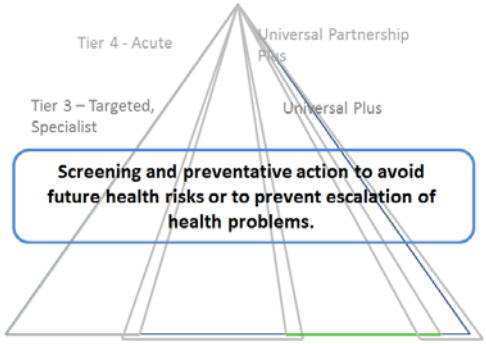


7.2 To ensure consistency throughout the engagement process the different levels were described by the type of health activity that might take place at each level.



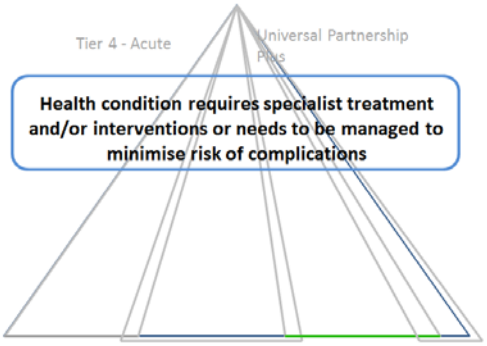
Tier 1: Children and young people receive most of the interventions at this level from parents, exposure to national health campaigns, publicity or other promotional materials, information obtained from watching TV programmes which are focusing on a health topic or through structured classes as in school based PSHE programmes or health sessions in youth settings.

The source and accuracy of the information cannot always be assured and therefore the HCP would seek to ensure that information being provided at this level was from a reliable source and accurate.

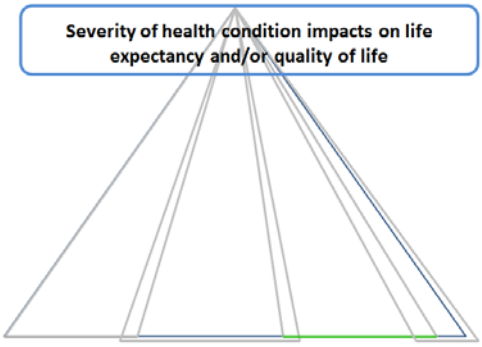


Tier 2: This will be the main focus for the commissioned HCP service. It will seek to add value and where pertinent signpost to the services provided by other health professionals who also provide some services at this tier, for example those available from GPs.

Although these are tier 2 interventions and may be focused on specific issues, individual children/ young people or families the delivery of the interventions will primarily be in tier 1 settings such as schools, homes and local communities.



Tier 3: Some elements of the HCP contracted service will operate at this level. There are currently services commissioned by the Children and Young People's Service which deliver services at this level and which contribute to the delivery of the HCP, for example with the Risk Taking Behaviour service which includes young people's drugs and alcohol treatment services.
Settings and interventions at this tier will include vulnerable children and young people, for example those subject to Child Protection orders or Looked After Children or those within the Youth Justice Service.
It will be important to have in place effective care pathways from tier 2 to enable timely and appropriate referrals to be made into specialist services.



Tier 4: The HCP will not deliver services at this tier but will be required to understand the services and referal routes that are available at this level and where necessary support children and young people with this level of need who may be being supported in a universal setting.

7.3 The discussions with stakeholders therefore focused on what they expected from a service that operated within the universal setting (homes, community, schools) but which could provide tier 2/early help and support to prevent health problems occurring or escalating.

8. Gaps in current provision and emerging priorities.

8.1 The importance and increasing demand for help with issues related to emotional wellbeing and mental health.

8.1.1 This subject was raised by all participants as a high priority. Feedback from young people always placed this as a high priority. Practitioners including school staff expressed concerns about the consequences that such things as anxiety and stress, poor body image and peer pressure are having on children and young people.

8.1.2 In the primary school age range these pressures mainly stem from tensions within the family environment. The impact is generally behaviour related which impacts on the learning of the individual child and those around them. Although problems are

usually addressed by the school directly with parents there was a sense that teachers were struggling to afford the time or give the necessary attention to individual children to help them deal with these issues. There were many references to the perceived benefits that having access to talking therapies (often referred to as counselling) would bring.

8.1.3 In the secondary school age range stress and anxiety tended to be related to educational attainment and the pressure to achieve high grades. Young people reported this as almost a constant stress throughout their secondary school life.

8.1.4 Participants felt that the incidence of self-harm and extreme dieting resulting in eating disorders such as bulimia were increasing. Practitioners working with young people described situations where they were offering support to young people with what they considered to be 'mental health' problems and some practitioners expressed frustration in the current referral pathways into Child and Adolescent Mental Health (CAMH) services. There were also examples of excellent joint working with CAMHS colleagues with support being provided to tier 2 workers and referral routes operating effectively.

8.1.5 Generally the feeling was that gaining help from a qualified mental health practitioner was challenging because of the increased demand on the tier 3 CAMHS. Not all practitioners wanted to transfer the support for cases into CAMHS but they wanted reassurance from a mental health qualified colleague that the support they were giving to a child/young person was appropriate.

8.1.6 From the responses gathered there appears to be a gap in provision at the prevention/early intervention tier of support. Because of the pressures of demand on the CAMHS some children and young people are being held at this tier by practitioners who feel ill-equipped to deal with the mental health problems that are being presented to them.

8.2 Lack of provision for young people aged 16 and over.

8.2.1 Responses from young people in this age range tended to report that they would be comfortable seeking advice from their GP for ill health problems. They would be less likely to seek advice for exploratory behaviours that may affect their health and wellbeing, for example when they are or intend to become sexually active, or for alcohol or drug use. They may not recognise the need to seek advice or may delay accessing this until they or others, encourage them to seek help.

8.2.2 Services in Further Education colleges were well organised under Student Services (or similar) but this type of service is not always replicated in school settings for Year 12/13 students. Partnership working in FE settings has evolved differently depending on the institution with evidence of some good interagency work and effective referral pathways. There is no service provision delivered to these settings under the current contract.

8.2.3 Those young people who do not access an education setting do not currently receive a service but it can be assumed that the needs of these young people would be the same as that described by the post 16 aged respondents. These requirements mainly related to emotional health and the behaviours that resulted from anxiety and stress and relationship problems. As this age range felt that they would not be proactive in seeking help until the problem had escalated further consideration needs to be given to how best to encourage earlier engagement and/or to encourage young people to heed the health information that they are already aware of.

8.3 Insufficient focus on the needs of children and young people who are at higher risk of poor health outcomes and those least likely to seek help with regards to their health.

8.3.1 Many children and young people fall into this category but the main ones referred to in the engagement process were children and young people who are poor school attenders and/or low attainers, Looked After Children, young offenders, those with additional sensory, medical or physical needs and those with special educational needs.

8.3.2 There are many more children and young people who may fall into this category, for example those who witness or experience domestic violence, those who have parents with mental health and/or alcohol or drug abuse, young carers etc.

8.3.3 For many of these children/young people there are services including those provided by health services specifically addressing their needs. It is not the remit of the HCP to deliver a dedicated service for these children/young people but to identify how it can provide early help and interventions more effectively to add value to the services that already exist.

8.3.4 Some of the young people who provided feedback had direct experience of health services and unfortunately not all of their accounts were positive. However the purpose of the information exchange was not to judge existing provision but to try to identify what might be done in the future to improve services.

8.3.5 Because of the reluctance of these young people to voluntarily engage with what they considered to be judgemental or authoritarian services the options for improving their perceptions were explored. Some interesting suggestions were generated but the main responses related to the importance of having a trusted adult, someone who was non-judgemental and the importance of continuity of support. The young people didn't just want a 'brief intervention' but wanted on-going help.

8.3.6 Whilst they acknowledged that they disliked being 'forced' to engage with services they also recognised that the voluntary nature of the engagement meant that not engaging was the easy option for them. They also did not want anything that stigmatised them because of their circumstances although they did acknowledge

that by attending, for example, a Pupil Referral Unit they were already different to their peers.

8.3.7 The health support provided to Looked After Children (LAC) appeared to be well organised and feedback was positive including that provided by the specialist LAC nurses. There were some concerns raised in relation to the statutory requirement to provide annual reviews for all LAC and the need to ensure that these are conducted on all those from 5-19.

8.3.8 Residential homes had established good working relationships with health services in their locality and residential home staff were delivering advice and guidance where pertinent. Staff identified that if additional interventions were available from the HCP those most needed would be to for the emotional and mental health needs of young people and health factors related to risk taking behaviours, in particular in relation to sexual activity and drugs and alcohol.

8.3.9 Children with additional sensory, medical and physical needs and those with learning difficulties have a wide range of needs many of which cannot be met through the HCP. Because of their additional needs maintaining positive health will be made more challenging and access to universal services may be limited. For others their stage of emotional maturity may not match their physical maturity making them vulnerable when engaging in exploratory behaviours that are normal for young people as they move into adulthood. The interventions for these young people will need to be differentiated to reflect the specific need and level of vulnerability of each child/young person.

8.3.10 Practitioners working with these children/young people were frustrated by the inconsistencies in service provision and this is something that the different commissioning bodies for health will need to address.

8.4 Lack of clarity and publicity about what the service provides.

8.4.1 These responses reflect the findings from national research into what parents, children and young people want from a school nursing service*. (Ref: School Nurses Survey Results. National Children's Bureau 2011. Our School Nurse. Young people's views on the role of the school nurse. British Youth Council 2011. Online survey of parents organised by Netmums Dept of Health 2011)* Both parents and children/young people wanted practitioners in the service to be approachable and ideally for there to be someone who is known to the family and remains constant throughout the life of the child.

8.4.2 Understanding about what the HCP service can provide will be important as there remains a lot of confusion about the different health provision that is available. Some respondents queried how the HCP service would differ from what they received from their GP and some assumed that the service would just be located within schools.

8.4.3 The message that the HCP is about providing a service for children and young people was reiterated throughout the information exchange process. This was useful when discussing with schools what the new service might look like as they were able to differentiate between what they required as a school (in relation to curriculum support or policy development) and what their children/young people might need.

8.4.5 As the majority of children and young people attend school these will be key settings through which the contracted service can access children/young people and families. Although there were no strong opinions about the name of the practitioners it was felt that calling them 'school nurses' may no longer be apt. Young people in particular felt that this title implied a requirement on the nurse to share all information with their school. For other respondents there was the suggestion that the term carried with it a historical image of what the school nurse's role was and if there was a desire to change that perception the title will need to change.

8.5 Inconsistency of practice in the type and standard of the services being offered in different geographical areas and settings.

8.5.1 Historical arrangements, local working practices and local relationships that have developed between practitioners all play a part in creating inconsistent practice. This coupled with the geography of the county has resulted in variations in service. Without listing the specific examples it was evident through the information exchange that inequalities did exist and that these need to be addressed as part of the commissioning process for a new service. The aim will be to ensure that irrespective of where in the county a child lives they will receive the same standard and level of care.

8.5.2 It will also be necessary to unpick some of the queries that were raised related to the inconsistencies that result from cross border issues such as with children who live in one Local Authority area but who attend school in another Local Authority area. Likewise for those children registered with a GP and who receive their medical care from outside of North Yorkshire but who live within the county (or visa-versa).

8.6 Lack of advice and practical help after children have been weighed and measured as part of the National Child Measurement Programme.

8.6.1 Measuring the weight and height of all children when they reach reception and year 6 of school age is a national requirement. There is no requirement regarding what to do if a child is assessed as being overweight.

8.6.2 The main feedback on the impact of this came from parents. For many the communication about what the purpose of the weight and height measurement was unsatisfactory and some parents either could not recall their child having this or

were not informed. Of greater concern is the impact that notification that a child is overweight can have on the child and the family.

8.6.3 There was little evidence of any additional advice or communication being provided to the parent to help them understand the implications of the measurement or to investigate what other factors might indirectly be affecting the child's weight gain. Some of the responses clearly indicated that parents would have welcomed the opportunity to have a discussion or meet with a nurse or better still, a nutritionist to find practical ways to improve their child's weight problem.

8.7 The importance of having effective screening and health checks to identify problems that may be impacting on the child's development (physically and academically).

8.7.1 It is difficult to persuade people of the evidence base for certain practices when it relates to topics which they may have a particular interest in or which directly affected their child. This was particularly pertinent when discussing the benefits of some population screening. .

8.7.2 One of the topics which generated several strong opinions was in relation to hearing and sight screening. There are connections between impaired hearing/sight and the speech, language and communication development of a child. This in turn can have significant impact on their social, emotional and educational development so the need to identify problems early would be advantageous. Whether this is the role of the HCP needs further consideration.

8.7.3 Advice on the management of common childhood problems such as nits still emerged as a problem that parents and schools had to deal with. Whilst there was no indication that people wanted a return to mass hair checks there was a call for better advice and consistent practice in dealing with outbreaks. Several respondents believed that having a HCP nurse who could provide more targeted advice to parents/families where there was a recurring problem would be of value.

8.7.4 There was also reference to bed wetting and the impact that this can have on a child's confidence. The need for accurate preventative advice was seen as essential as was the targeted support for problems such as bedwetting through a discrete enuresis clinic.

9. Additional considerations when scoping the service specification.

9.1 During the engagement process there were queries and issues raised that will require further consideration and clarification as part of the scoping for the service specification.

9.2 There are areas of work which the HCP would be well placed to deliver but which may be the responsibility of different commissioners including the administration of

immunisations and vaccinations and the services provided for children with additional physical, sensory or medical needs or disabilities.

9.2 There are practical arrangements in delivering the HCP contracted service which will need addressing as a result of the cross border challenges, including where these differ for residency, education, GP registration and other healthcare provision.

9.3 There are number of private schools providing residential education in North Yorkshire. It will be important to define what is or is not being made available to these children and young people whilst resident in the county and what options there are in offering a bought HCP service to these institutions.

10. Conclusion

10.1 The engagement process has highlighted the key issues which the majority of respondents felt were important. The observations and suggestions that were gathered as part of this exercise along with reference to the specific requirements that are outlined in the 5-19 Healthy Child Programme guidelines will be used to inform the scoping of the service specification.

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18th February 2014