ROCHDALE BOROUGH COUNCIL & ROCHDALE CLINICAL COMMISSIONING GROUP

APPENDIX B - SERVICE SPECIFICATION

Children and Young People's Integrated Community Health Service in the Borough of Rochdale

Chest Reference: **DN397379**
STAR Reference: **4754**

Contract Period

1st October 2019 to 30th September 2024, with the option to extend annually until 30th September 2026.

Specification Contents

SCHEDULE 2 – THE SERVICES

Service Specification	Children and Young Peoples Integrated Community Health Service
Clinical Lead	
Commissioner Lead	Karen Kenton
Provider Lead	
Period	5 Years (+2)
Date of Review	Annual

1.0 National, Greater Manchester and Local Context

1.1 National Context

In 2011, the Secretary of State commissioned a working group to look at the services for children and young people. As a result of this, the 'Report of the Children and Young People's Health Outcome's Forum (for the Secretary of State) July 2012' was produced. A key finding of this report was that:

'The NHS and social care have been designed around the system, rather than the individual. To children, young people and their families, that system feels fragmented and often means they have to tell their story repeatedly, striving unsuccessfully to be heard and get the properly joined up care they need. Designing and planning health and healthcare around the needs of the individual child or young person, taking account of their changing needs over time, will improve their experience of services and their health outcomes – not just at a point in time, but for the longer term – and improve their lives enormously'.

The NHS Long Term Plan, published in January 2019 contains a number of measures which will, if implemented, make a real difference to the health and wellbeing of children and help to achieve our vision for the NHS. By 2028 the NHS will move to a 0-25 years' service and towards service models for young people that offer person-centred and age appropriate care inclusive of mental and physical health needs.

1.2 GM Context

GMCA / GMHSCP Context

Rochdale is one of the ten localities that constitute the Greater Manchester Combined Authority and Greater Manchester Health and Social Care Partnership. The GMCA is run jointly by the leaders of the ten councils and the Mayor of Greater Manchester, Andy Burnham. A variety of Boards, Panels and Committees look specifically at areas including transport, health and social care and School Readiness.

Rochdale is also part of the GMHSCP; the GM principles around improving the population's health are reflected in our local plans. Population health means tackling the cause's poor health and providing the right help at the right time to prevent health problems developing.

In line with the GM Children's and Young Peoples Plan (2019-2022) our local ambitions focus on investing in 'Early Years' opportunities from before birth to the age of five to build firm foundations for life, including mental and physical health, social and communication skills and behaviour. One of the main priorities of our local population health plan is to support and enable all children and young people to attain a good level of development, physically, mentally, emotionally and socially; by ensuring we identify and tackle abuse, neglect, delayed development and special educational needs and/or disabilities as early as possible.

The remit of the Children's Community Health Services will be to support the final model approved through this ambitious change programme and play a significant role in ensuring that children and young people achieve good outcomes in childhood, to help avoid future ill health in adult life.

Giving every child the best start in life is crucial for securing health and reducing health inequalities across the life course. The foundations for virtually every aspect of human development - physical, intellectual and emotional are laid in early childhood. What happens during these early years, starting in the womb, has life-long effects on many aspects of health and wellbeing from; obesity, heart disease and mental health, to educational attainment and economic status.

1.3 Local Context

This commission is predicated on Rochdale's Family Services Model (FSM) see section (2), and integrated locality working for the delivery of children and young people's health services for the Local Authority, CCG and its Children. The aim of the Family Services Model (FSM) is "*to deliver a whole system approach for children, young people and families that describe an integrated delivery offer from universal / community level support to highly specialised and acute interventions". The Family Service Model was developed as part of Rochdale's Transformational agenda to respond to* the wider system need to improve outcomes for children and young people as part of the prevention agenda. The aim of the model is in reducing further future demand and providing support at the earliest opportunity, it is therefore essential that the service ensures all provision reflects the key elements and principles of the FSM.

In line with GM, Rochdale Council and HMR CCG are developing their Local Care Organisation (LCO); the case for Local care organisations is set out in the document **"Taking Charge of our Health and Social Care in Greater Manchester" (GMCA** December 2015).

The document states that;

"LCOs is a term developed at a GM level to describe how across GM, we will secure, in all parts of the conurbation, the principal features of a proactive, preventative, population health model, which delivers consistently high outcomes. It takes the best of local, national and international learning from Accountable Care Organisations and applies them to the GM context."

Whilst the scope of this commission is currently outside of the LCO there is an imperative build on the excellent partnership working with the LCO which exists in the Borough. To this end the children and young people community integrated health service is required to support the vision of the LCO which may include future alignment.

Rochdale Council and Heywood Middleton and Rochdale Clinical Commissioning Group aim to work with providers to design and implement models of care that support the integration of paediatric skills across the children's health and social care economy. Drawing upon the wider Family Services Model, our services will be age appropriate, closer to home and bring together physical and mental health together. The Family Services model will support health development by providing holistic, well-coordinated care across local authority and NHS services. This will include community, universal and specialist health services, together with primary care, in order to improve outcomes for our children and young people.

Rochdale Borough's locality plan for health and wellbeing sets out how we will co-operate across the system to improve health and wellbeing outcomes for children and young people and their families. The plan is aligned with NHSE Five Year Forward View, Rochdale Borough Joint Strategic Needs Assessment and the Council Corporate Plan. The plan sets out how we will prioritise prevention and deliver a new model of care to reduce inequalities for our children, young people and their families.

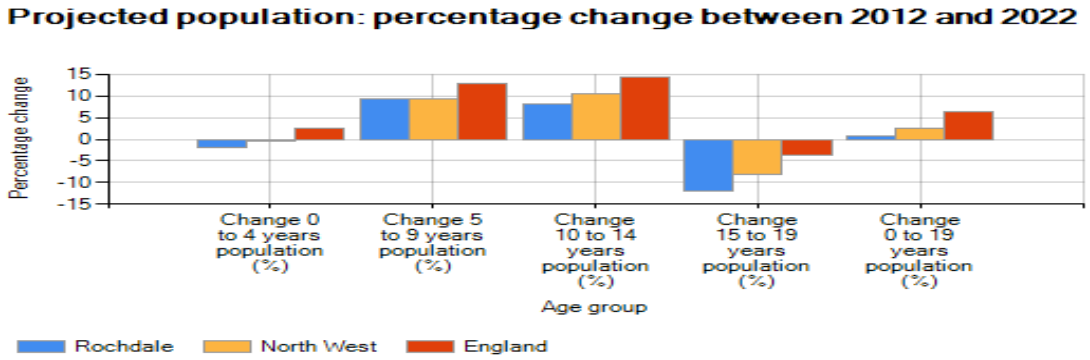
1.4 Population

The total resident population of children and young people aged 0-19 living within the Rochdale Borough is 57,261. This has increased by 2.3% since 2014 (55,905). The table below provides a breakdown of the population per 5 year age band.

	Male	Female	Total
0-4	7820	7416	15236
5-9	7870	7473	15343
10-14	7070	6678	13748
15-19	6822	6112	12934
Total	29582	27679	57261

- (ONS Mid-Year Estimates 2017. Please note figures are based upon resident-based estimates.)

The chart below shows how the resident child population in Rochdale is forecasted change between 2012 and 2022.



2.0 Children and Young People's Community Service and the Wider System

The aim of this specification is to set out the aims and functions of the Rochdale Children and Young Peoples Integrated Community Health Service. We will set out minimum standards for the service to improve health and wellbeing of Children, Young People and their families.

2.1 Family Services Model

This service is predicated on **Family Services Model** and integrated locality working for the delivery of children and young people's health services for the Local Authority, CCG and its Children.

The aim of the Family Services Model (FSM) is "*to deliver a whole system approach for children, young people and families that describe an integrated delivery offer from universal / community level support to highly specialised and acute interventions".*

The Family Service Model was developed as part of Rochdale's Transformational agenda to respond to the wider system need to improve outcomes for children and young people as part of the prevention agenda. The aim of the model is in reducing further future demand and providing support at the earliest opportunity.

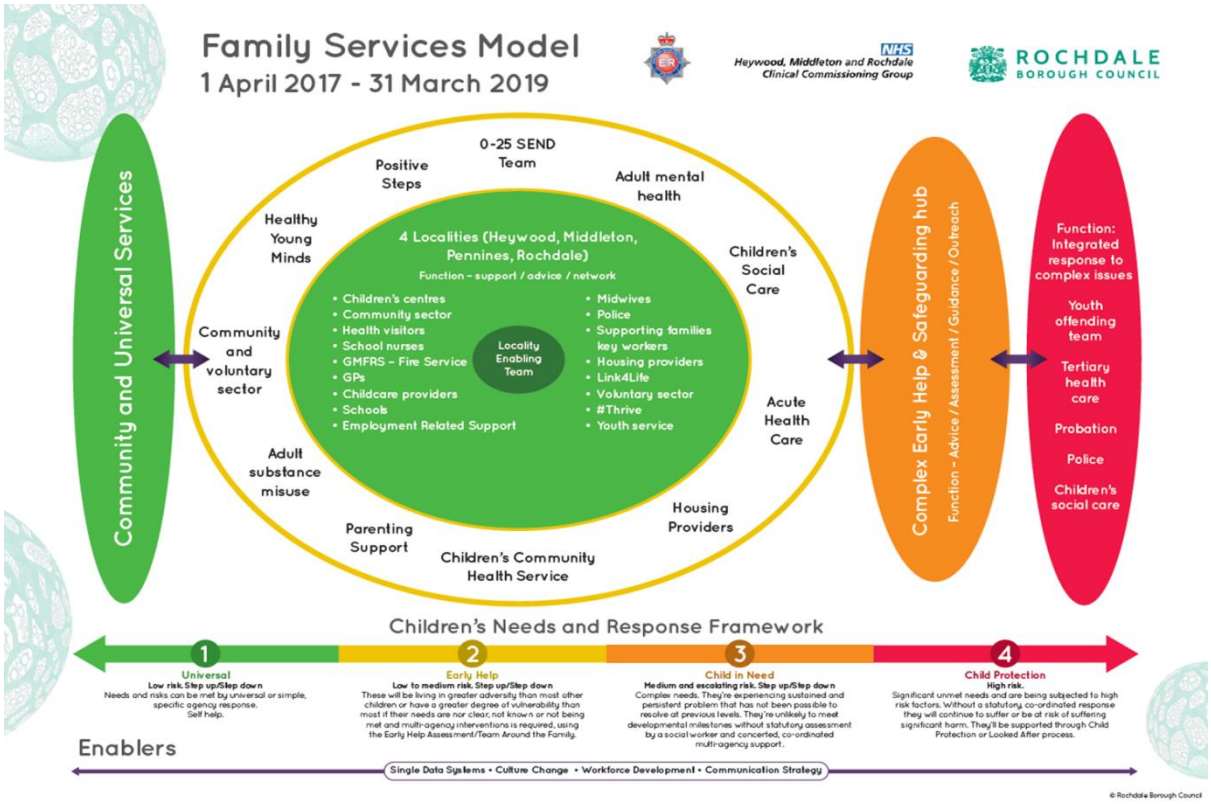
The key elements of the FSM are:

- Complex Early Help and Safeguarding Hub to triage all contacts and manage risk based on the utilisation of data and broad skill base of co-located multi-agency staff.
- Early Help Locality Teams to provide a locally co-ordinated multiagency response to need which fully utilises local knowledge, builds on community assets and scale up of early help interventions including relevant GM delivery models.
- An Integrated 'intermediate' response to more complex issues that require enhanced support to that offered through the early help locality teams, and which will prevent escalation through to very specialist services (such as social care, in patient mental health beds) - bringing together existing borough wide teams such as, core Child and Adolescent Mental Health, Special Educational Needs and Disabilities, Children's Community Nursing Team. This will include an enhancement to the CCNT to support the management of acutely ill children in the community.

This Service will be required to operate within the FSM and deliver against these principals;

- Prioritise early help and intervention in order to reduce demand on high cost specialist services specifically children in the care system and hospital admissions.
- Avoid Children, young people and families entering crisis due to a failure to recognise and respond to need at an early help level.
- Recognise that many children and young people experience adverse childhood experiences which can affect negatively health outcomes.
- Eliminate duplication of resources as a result of poor co-ordination and fragmentation with Children, Young People and their families telling their story once and receiving the right response.

- To enhance the co-ordination of an “out of hours “ response through the CEHASH
- Build families’ capacity and the confidence to self-manage
- To support a behaviour change amongst the workforce and local population
- System wide workforce development- new skill sets and approaches across the whole workforce and different disciplines
- Strengthening and scaling up responses to key issues that impact on children’s outcomes such as attachment, mental health, parenting and parental health.



2.2 Current Position / Locality Working

The FSM currently operates within four localities (see Appendix 1 Locality map) with a central Complex Early Help and Safeguarding Hub. The locality enabling teams and CEHASH currently operate from children’s centres and other venues across Rochdale Borough, these are multiagency teams made up of the following, those which are in the scope of this commission are clearly identified.

- **Health Visitors (in scope)**
- **School Nurses (in scope)**
- **Paediatric Nurse Practitioners (in scope)**
- **Children’s Community Nursing Team (in scope)**
- Early Help Assessment Team (out of scope)
- Early Years Staff (out of scope)
- Children’s Centre Staff (out of scope)
- Schools Staff (out of scope)

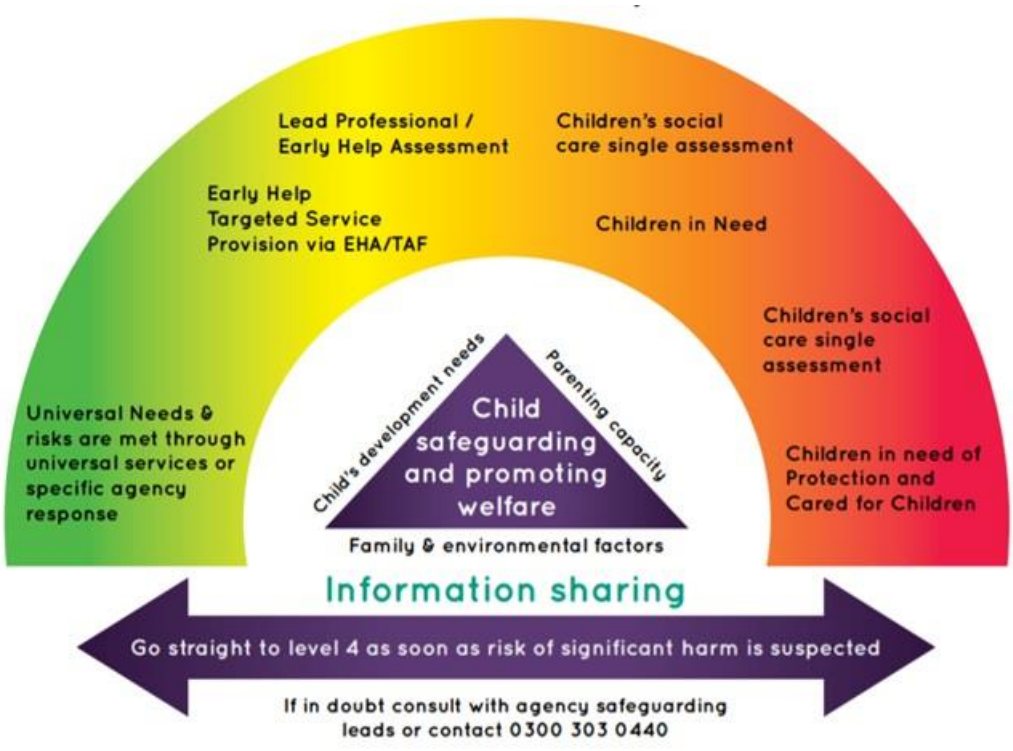
- Mental Health Practitioners (out of scope)
- Children with Disability Team (out of scope)
- Children's Social Care (out of Scope)
- Complex early help and safeguarding hub (out of scope)

These locality teams are supported through the wider FSM 'One System' and bring together the wider partnership to provide a seamless approach to supporting Children, Young People and Families. The wider partnership includes the following;

- Midwives
- Police
- GP's
- Schools
- Housing Providers
- Employment related support
- Voluntary and Community Sector
  (NB: These services are out of the scope of this commission)

The FSM operates within Rochdale's Children's Needs Response Framework with each locality being managed by a locality lead. The Rochdale Children's Needs and Response Framework applies to all children and young people from conception to the age of 18 years. It recognises that all service responses must be directed at preventing vulnerability and meeting the needs identified at the lowest level of intervention. Early recognition, intervention and prevention are essential in order to achieve this.

The diagram below shows the Rochdale Needs and Response Framework. The use of the definition of Early Help Offer covers services from community and universal level but is mainly aimed at those children and young people at Level 2 (children whose health or development may be affected) and Level 3 (children whose health and development is at increased risk of being affected).



The service must be aware of the following safeguarding priorities and work in partnership showing awareness and willingness to engage with developments in these areas and implementation of all strategies and procedures across the Rochdale Children and Young Peoples Integrated Community Health Service.

- Neglect is the most prevalent form of child abuse. It is a complex issue and there is no single cause of neglect and no single solution. Full commitment, from all partners, to urgently address child neglect is essential. It is necessary for the service to be fully aware of and committed to Rochdale's Neglect Strategy and to recognise the specific needs of children and in turn understand 'failure to meet basic needs': The tool of choice for the assessment of Neglect in the Borough is the Graded Care Profile, following initial completion of Rochdale's Neglect Screening Tool.
- Female genital mutilation of any type is an illegal practice, a form of child abuse and a violation of the human rights of girls and women. The Greater Manchester Female Genital Mutilation Multi Agency protocol and Rochdale's FGM strategy provides a framework for protecting female children under the age of 18 and adult females including those who come under the No Secrets definition of a Vulnerable Adult.
- Tackling domestic violence and abuse effectively requires a multi-agency response. In Rochdale all agencies have a vital part to play in supporting victims, bringing perpetrators to account and raising awareness, in line with Rochdale's Domestic Violence and Abuse Strategy. Effective partnership working is essential with specialist services where domestic abuse or any form of sexual violence is identified and correct referral pathways must be followed.
- Prevent Duty- services are expected to have an appropriate level of training regarding the Prevent agenda which is part of the government's counter terrorism strategy. Concerns should be reported where appropriate in line with RBSCB processes and local authority leads for PREVENT as necessary.
- Services must be conversant with Child Sexual Exploitation (CSE) and Child Criminal Exploitation (CCE), its complexities, the warning signs and children's vulnerabilities; and follow appropriate referral processes in line with RBSCB policies, procedures and Rochdale's Child Sexual Exploitation Strategy.
- Rochdale is at the forefront in the delivery of family conflict interventions with a Relationships Matter Manifesto, action plan and a range of interventions to reduce parental, family conflict and child to parent violence. The service would be expected to appropriately refer into interventions and be committed to the implementation and delivery of the Rochdale Relationships Matter Action Plan.

2.3 Children and Young People/Parent Carer Participation

Children and young people's participation is a right, not an option and children/young people report that we could do it better. The human and legal rights to participation are identified in The United Nations Convention on the Rights of the Child (Article 12) which states that "public services and governments are to provide children with the freedom and opportunities to express their views and that the service or government must consider their views in a meaningful way".

- Health and Social Care Act, 2012 CCGs have to involve children and the public in the planning and delivery of health services and to set out their plans for doing so within the public domain. Health and Wellbeing Boards must ensure that the experiences and needs of all groups within their local area are heard and taken into account within local health needs assessments.

- The Children and Families Act (2014) Young people and their parents/carers must be supported to participate as fully as possible in the planning of support for children with special educational needs and disabilities.

- Involving people in their own health care (2017) statutory NHS guidance linked to the 2010 Act for CCGs on how to involve people in their own health care e.g. through personal budgets, personalised care planning and shared-decision-making.

- Children and public participation in commissioning health and care (2017) statutory NHS guidance for CCGs on: embedding participation in governance and in commissioning; how public involvement can be reported and the service held to account around involvement.

- You're Welcome is a set of quality criteria for young people friendly health services and provides a systematic framework to help commissioners and services to improve the suitability, accessibility, quality and safety of health services for young people. The standards are supported by Public Health England, NHS England and the Department of Health. They have recently been refreshed by the British Youth Council, the Association for Young People's Health and Youth Focus North West.

As a borough we aim to integrate the views and voice of the children, families, services users and other stakeholders into the important decisions that we make in a way which is meaningful. We recognise that we have a duty to understand the needs, assets and aspirations of children and young people in order to design services that are both fit for purpose and fit for the future. Such activity ensures that services are effective, meaningful & efficient. Providers that are commissioned to deliver services will have a duty to balance the health and social care needs of children's and service users, with their need for them to have a say in their own lives. Research shows that supporting children and young people to make informed decisions about their own lives improves outcomes in terms of self-confidence, social skills and positive life choices. For children and young people who experience additional challenge, participation is of particular importance.

This should include but not be limited to:

- Children, young people and parents and carers identifying their own goal based outcomes when accessing support and their voice being embedded within care plans.
- Participating in decisions about their lives now and for the future.
- Being involved in the design of services that support that children and young people.

Where there are barriers to communication specific skills and processes should be utilised to facilitate the participation of the most vulnerable children in our services including the very young, children with neurodevelopmental disabilities or communication difficulties and children from cultural and linguistically diverse backgrounds.

3.0 Outcomes

3.1 Strategic outcome goals

The service will provide a range of universal, targeted and specialist interventions to ensure that all children are healthy and ready to succeed when they start school, and all children and young people and young adults achieve their potential.

The Public Health Outcomes Framework (PHOF) and child health profile[1] outline the key strategic outcomes for children and young people with the aim of supporting commissioners and services to improve health and wellbeing of children and tackle health inequalities.

3.2 Locally defined outcomes goals

The services will play a vital part in ensuring every child, whatever their start in life, is enabled to achieve their optimum health and wellbeing and secure a successful and healthy transition to adulthood.

The service will need to work across children and young people's health and wellbeing services in an integrated way to improve outcomes for children and young people and will work in close partnership with other children and young people's service contractors in Rochdale, including other NHS organisations, Rochdale Borough Council, and the voluntary sector. This integrated approach seeks to ensure that the contractor thinks in terms of delivering care pathways and outcomes rather than services labeled by the name of the profession providing them, and they will have the freedom to configure cross cutting teams to achieve joint outcomes.

The service will work towards specific outcomes as detailed in section 3, however the service will be required to contribute to all of the following strategic outcomes which operate across the system;

- All children feel healthy and remain in good state of health for as long as possible
- All children are protected from harm, through support in times of need and by safeguarding and protecting those who are vulnerable
- All children have good mental health and wellbeing, are resilient, enjoy life, and are able to cope with life's challenges
- All children are healthy and ready to succeed when they start school and all children and young adults achieve their potential
- All children have the opportunities they need to enable them to help themselves, their loved ones and their communities to achieve their full potential
- The borough is a place where people age well, can live with dignity and have equitable access to services and opportunities
- The borough is friendly, fair and co-operative

[1] https://fingertips.phe.org.uk/profile/child-health-profiles/data#page/9/gid/1938133228/pat/6/par/E12000002/ati/102/are/E08000005

- The borough is safe, resilient, and clean and has good quality places where people choose to live, work and invest
- The borough has thriving growing businesses and new enterprises and creates the conditions for high skill levels and high quality jobs
- The borough has sound finances and is able to provide services to meet resident's needs now and in the future

The service is expected to deliver on:

- Increasing breastfeeding rates (local 6-8 week breastfeeding target is 40%)
- Child development at age 2-2.5 years (target and stretch target)

The service is expected to be able evidence their contribution to:

- Transition to parenthood and the early weeks
- Improving healthy weight, healthy nutrition and physical activity with a particular emphasis on reducing childhood obesity.
- Managing minor illness and reducing hospital attendance and admission
- Reducing hospital admissions caused by unintentional and deliberate injuries in children (age 0-4 years)
- Support to be 'ready for school'
- Support to be ready to learn
- Improving maternal mental health
- Reducing maternal parental and smoking amongst young people
- Improving oral health
- Improving vaccination coverage
- Safe sleep

Whilst the scope of this commission is currently outside of the LCO there is an imperative build on the excellent partnership working with the LCO which exists in the Borough. To this end the children and young people community integrated health service is required to support the vision of the LCO which may include future alignment.

4.0 Scope

4.1 Aims and objectives of the service

The overarching aim of this commission is to build upon existing models in the ongoing development of a single Children and Young Peoples Integrated Community Health Services a single service with a single set of performance outcomes whereby the ultimate aim is that '*All children are healthy and ready to succeed when they start school and all children and young adults achieve their potential'.*

The service will deliver the following functions:

- **Function One:** Provide assessment and interventions for children and young people who are acutely unwell or are living with long term conditions. The clinical management of specialist long term conditions is provided within secondary care. Although secondary care services are not within the scope of this specification it is expected that the service will work with closely with secondary care providers to ensure a seamless journey with strong links and integration with acute paediatric colleagues/services. The acute preventative community elements of the model must

be maintained within the community, and the service will work closely with primary care in order to support deflection from acute sites to ensure that Children and Young People are cared for by their families, in familiar surroundings and in a way that most appropriate to their needs.

- **Function Two:** Delivery of the Healthy Child Programme (0-19 years).
- Health Visiting (HCP 0-5 years) to include all mandated functions in line with GM Early Years Delivery Model;
- School Nursing (HCP 0-19 years) to include all mandated functions
- Delivery of assessments and interventions in line with the Greater Manchester Early Years Delivery Model and associated pathways.
- Work collaboratively with partners to support implementation of Rochdale's School Readiness Strategy 2018-2020, Action Plan and the 1001 Day's Pathway.
- Delivery of early intervention responses in the context of the Health Child Programme. I.E Person-centred place-based approach, targeted support across continuum of need, Early Help and partnerships working in existing networks and communities, in an integrated manner
- **Function Three:** SEND (0-25); Clinical Statutory requirements within the context of the FSM
- HMR CCG and Rochdale Council are intending to develop a boroughwide integrated service for children and young people with special educational and disabilities – this will continue be progressed through the integrated commissioning arrangements. The acute and on-going needs service encompasses a range of provision that will fall within the scope of this work. The contractor will be expected to take a leading role in the further development, innovation and design of this service, and to take this into account in the design of the FSM in aligning with existing RBC SEND provision which falls outside of this specification.
- **Function Four:** Statutory and Mandatory Requirements. The service will take a coordinated response to ensure compliance with all statutory responsibilities, specifically in relation to public health mandated services looked after children, those with special education needs and disability and safeguarding.

4.2 The objectives of the service

The service must:

- Provide a streamlined access and co-ordinated assessment, intervention and review service to children and young people aged primarily between 0-19th birthday (or beyond for SEND/LAC 0-25) in consultation with commissioners), which is accessible and provided in an appropriate setting, taking into account the child/young person's preference - this will include in-reach (into hospital) or outreach (any location where the child/young person would reasonably be expected to need to be, e.g. school, home).

- Take holistic responsibility for developing and delivering integrated care pathways and packages of support based around the needs of children and young people (which may change over time); ensuring a seamless journey, which enables children and young people to tell their story once, and delivers the most effective use of resources by avoiding duplication.
- Develop innovative, accessible methods of engaging with children and young people who use the service to ensure that service improvements/changes are always designed with children and young people, for example, the use of prototyping to test changes to service models, before implementation.
- Take a 'team around the child/family' approach to care to achieve the desired outcomes for children and young people.
- Ensure that children and young people's, parental needs where required, emotional and mental health and social needs are considered alongside their physical health needs.
- Agree the aim and goal of interventions **with** the child/young person or parent/carer, ensuring that they are actively involved in learning about, understanding and making decisions about their health, and to support self-care, where appropriate.
- Ensure that children and young people leaving the service have an agreed and documented plan that supports self-management where possible and explains how to re access timely help (open door policy) if this becomes necessary.
- Actively support children and young people through a Transition process to ensure that this is as smooth as possible, and is driven by the needs of the child or young person rather than arbitrary cut off points according to age. This includes transition to school, from primary to secondary and into adulthood. This will include having the relevant pathways and protocols in place, which are shared and agreed with partners. For transition to adulthood, as a minimum, this will involve a joint meeting with the child/young person's lead professional/key worker and the new service that includes the child/young person and/or parent/carer and a written transition plan, followed up within 6 months to check that the transition has proceeded smoothly and appropriate interventions are in place. The service will be required to utilise specific transition tool kits such as ready, steady go and ensure operational practice is aligned to the Boroughs integrated Transition strategy.
- Take a coordinated response to ensure compliance with all statutory responsibilities, specifically in relation to looked after children, those with special education needs, Health Education and Care Planning and safeguarding.
- Provide advice, support and training where appropriate to enable professionals, families, carers and other practitioners to care for and support children and young people.
- Produce an annual school health profile for each school using local Joint Strategic Needs Assessment data, data held by the Rochdale Children and Young Peoples Integrated Community Health Service and by the school itself. The school health profile should include the pupil voice. Promoting the health and wellbeing of pupils has the potential to improve both educational outcomes and health and wellbeing outcomes. A whole school approach should be taken in the development and delivery of a health improvement action plan. Evaluation of the interventions/activities carried out is essential to delivering high quality outcomes. Each year the school

health profile will be reviewed and a refreshed the whole school health improvement action plan will be produced.

- Contribute to supporting parenting within the Borough. This includes supporting local multi-agency implementation of Incredible Years, Incredible Babies, Strengthening Families, Separated Parents Toolkit, "How to Argue Better" and Solihull Programmes. Parenting Programme delivery will continue to evolve in line with local and Greater Manchester Combined Authority requirements.
- Use the speech, language and communication needs (SLCN) assessment tool and work in line with the SLCN pathway at age 2 (both in development by Public Health England and Department for Education), to identify and support children with early SLCN.

- Ensure that every contact counts as an opportunity to promote, maintain and, where possible, improve children's and young people's holistic needs (parental needs for Health Visiting)

4.3 Pathways

The service will be required to develop relationships, pathways and collaborative plans, which will lead to wider collaboration with voluntary sector services.

In order to:

- Respond to children that are not brought to appointment
- Engage with vulnerable or harder to reach groups
- Respond to local emerging needs
- Promote population health and reduce health inequalities
- Recognise the importance and value of innovation
- Strengthen accountability in our communities in managing and delivering VCS

The Rochdale Children and Young Peoples Integrated Community Health Service will work to key pathways in place some of which will be based on a Greater Manchester approach and others will be Rochdale focused. The list below is not exhaustive.

- Antenatal
- Perinatal and infant mental health
- Neurodevelopment pathway
- Urgent Care
- Primary Care
- Substance misuse services
- Breastfeeding and Infant feeding
- Childhood obesity – (healthy weigh, healthy nutrition including physical activity)
- Oral health improvement
- Speech, language and communication needs (as defined on GM level)
- Transition

The service will be required to develop a number of Service Level Agreements to ensure the effective operation of the following;

- Tier Three Dietetic Service
- Child Health Information System (CHIS)
- IMMS

The responsibility for commissioning CHIS lies with GM Health & Social Care Partnership (NHS England). The service for children's community services in HMR will be required to work closely with CHIS. CHIS provision is currently subject to a commissioning review and is out of scope of this procurement at this time.

School aged Vaccinations and immunisations are currently commissioned by NHS England (NHSE) and funding for this goes directly to the service. There is currently agreement that this is delivered by this service as part of an integrated offer. This is, however, under review by NHSE and may be subject to change. The service must work with NHSE on any future developments.

The following pathways and processes are to be developed within the first six months of the contract;

- Childhood Obesity
- Speech, language and communications
- Integrated service pathways across all elements of the service
- Delivery of the local early years 8 stage model in line with GM & National requirements
- Provision of Emergency Hormone Contraception.

4.4 Service development

The service will work with the commissioner throughout the first year of the contract to support the implementation of key processes to ensure success. These include performance integrated working, development of the children's service Model, pathway development and performance data requirements. The service will be required to develop the following within the first year of the contract;

- An effective electronic case management system which operates across all elements of the service
- The case management system must interface with existing LA and CCG systems in line with FSM
- Single and joint assessment process across the elements of the service and the wiser system in line with the FSM
- Support development of the FSM Alliance
- Effective sharing of child level outcomes from ASQ assessments with childcare services to inform an integrated review process at 2- 2.5 years.
- Whilst the scope of this commission is currently outside of the LCO there is an imperative build on the excellent partnership working with the LCO which exists in the Borough. To this end the children and young people community integrated health service is required to support the vision of the LCO which may include future alignment.

The service will also work closely with a range of community and voluntary partners in order to engage with harder to reach or vulnerable groups and to offer a broader range of support to families and encourage coping and thriving at home. There is an expectation that the service will actively work to bring in third sector and community services over the lifetime of the contract.

4.5 Acceptance and exclusion criteria and thresholds

The service must ensure equal access for all children aged 0-19/25 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.

The service must ensure it provides appropriate staff allocation according to population need whilst maintaining the universal offer (see Cowley & Bidmead 2009).

The service should provide an equality impact assessment where changes to the existing contract are proposed.

The service will work with an objective that no referral is inappropriate instead there will be a proactive working down to support and help with reasoning to identify need, deliver education and signpost appropriately for support/treatment for the family/child/young person.

Each assessment will decide whether the child/young person will be better accepted or whether they would be better served by alternative provision. This will include an internal single step down referral to universal provision or step up to secondary care/specialist provision.

4.6 Operating Hours

The core service will operate over 7 days each week and offer evening and weekend sessions. The service will develop plans in consultation with children/young people and families, and commissioners to ensure operating hours support ease of access and flexibility in order to create minimal impact on a child/young person's educational attendance.

The Children's Community Nursing Team will operate 365 days per year, during the hours of 8am until 8pm. It is expected that these hours will be extended across the lifetime of the contract.

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

4.7 Population Covered

Provision under these services should be available to all children and young people aged 0 - 19/25 (where specified) who are registered with a HMR GP or a resident within HMR.

The service will ensure that any coverage/boundary issues that may arise will be dealt with proactively in collaboration with neighbouring services. 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.

5.0 The Service Model and Description

5.1 Service Model and Description

HMR believe in order to provide the very best care, support and advice to children, young people, families and carers, we must deliver services that are delivered across a range of need and intervention, at the right place and the right time. We are proud of the existing structures that exist within the borough and would like to maintain the progress that has

already been achieved with regards to integration. The service will ensure that the service builds upon the existing Family Services Model, Locality Team working and the present Children's Acute and On-going Needs Model of care.

The new Children's Community Health Service will enhance the current model by delivering an integrated and multi-disciplinary approach to meeting the child needs. We require that it provides care to children and young people universally, to children with short and long term health conditions and those children who have special education needs, complex needs and/or a disability, by bringing together Health Visiting, School Nursing and CAONs to offer a fully integrated model that can respond to all levels of need.

This must include:

Where a child has additional vulnerabilities the service will deliver statutory support which will include but not be limited to Statutory Assessment, Specialist Interventions for children with additional vulnerabilities (Looked after Children, Young People known to Youth Justice, Child Criminal Exploitation, Child Sexual Exploitation and Children requiring Education, Health and Care Planning). Children and Young People may move in and out of levels of need throughout their journey through the service.

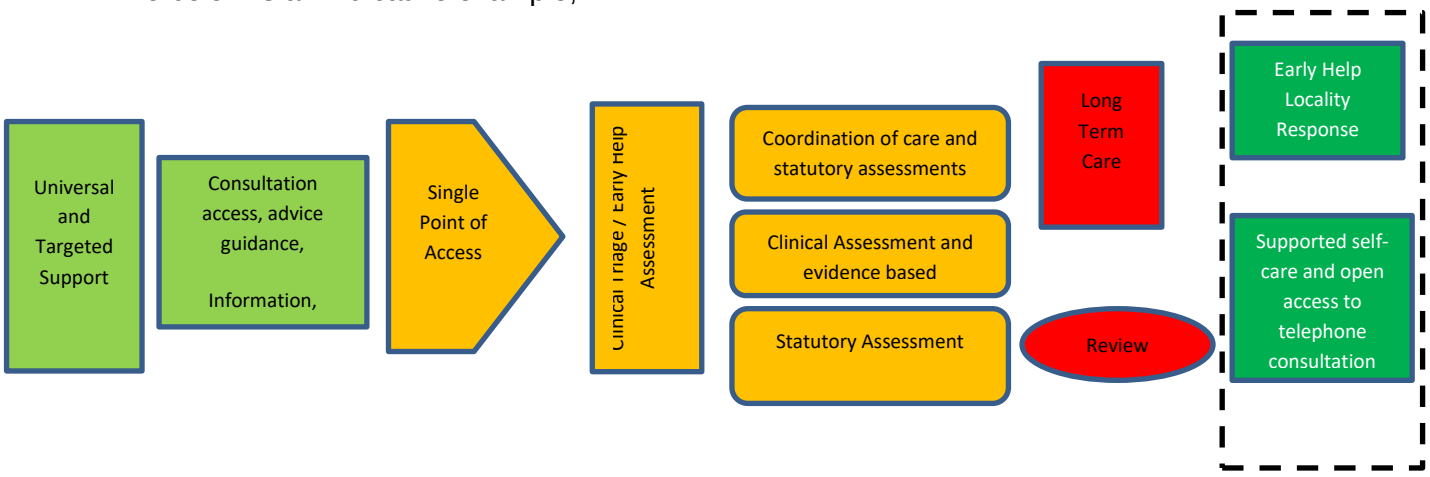
The integrated service is to include the following:

- Health Visiting Service – See technical specification (appendix 2)
- School Nursing Service – See technical specification (appendix 3)
- Children's complex and additional needs service – see technical specification (appendix 3) to include:

  - Children's Community Nurses
  - Children's Epilepsy Specialist
  - Children's Diabetes Specialist
  - Children's Occupational Therapy
  - Children's Palliative/Complex Care Specialist
  - Children's Physiotherapy
  - Children's Respiratory Specialist
  - Children's Speech and Language Therapy

- Community Paediatrics Consultants Service

The below is an indicative example;



The service will also work closely with a range of community and voluntary partners in order to engage with harder to reach or vulnerable groups and to offer a broader range of support to families and encourage coping and thriving at home.

The service will also work closely with a range of community and voluntary partners in order to engage with harder to reach or vulnerable groups and to offer a broader range of support to families and encourage coping and thriving at home.

Staged Framework delivery model sets out what families can expect from the Rochdale Children and Young Peoples Integrated Community Health Service under the following service levels and links to the Rochdale Children and Young Peoples Integrated Community Health Service Assessment and Intervention model:

- **Community & Universal (FSM Level 1) -** empower all families within the local community with children and young people, through maximising family resources and development of community resources via involvement of local agencies and community groups as appropriate and; working in partnership with children, young people and families to lead and deliver the Healthy Child Programme 0-5 and 5-19 and Rochdale's Children and Young Peoples Integrated Community Health Service (8 Stage Assessment model) working together to programme seamless transitions at key points.

- **Universal plus (FSM Level 2)** – To identify vulnerable children, young people and families, provide and co-ordinate tailored packages of support, including emotional health and wellbeing, safeguarding, children and young people at risk with poor outcomes and additional and complex needs. For 0-5 these interventions will be those prescribed in Rochdale Children and Young Peoples Integrated Community Health Service model.

- **Universal Partnership plus (FSM Level 3)** – to work in partnership with partner agencies via Rochdale's Early Help Offer and CEHASH in the provision of intensive and multi-agency targeted packages of support.

5.2 Rochdale Children and Young Peoples Integrated Community Health Service Interventions

The service will ensure high quality delivery of evidence based interventions supported by robust supervision to achieve sustained behaviour change.
A suite of evidence-based and timely interventions have been developed which are sequenced as a package of transformational support to families, with appropriate step-down support rather than 'free fall', with a strong focus on parenting programmes because of the clear link between parenting and children's behaviour and mental health.

The service will:

- Work with a range of multi-agency partners across Rochdale and will be required to liaise with them accordingly. Existing FSM and partnership arrangements will need to be explored and where appropriate maintained in order to continue and improve service delivery and ensure it is not adversely affected. As defined above in section 2.2.
- Work with children, young people and families in the design and delivery of services.
- Be expected to utilise and work with existing local voluntary organisations where appropriate in the delivery of the offer to ensure the involvement of the sector and maximise the effectiveness of its established role within the Borough.
- Services must be provided in accordance with a philosophy of integrated service delivery as described with the FSM between partners and agencies across the Borough. The service must ensure that all professional within the service are clear about their role and contribution to the FSM. This puts an onus on a cross-sector approach and effective local partnerships, particularly between the service and other agencies within the FSM, so that vulnerable families are supported with appropriate interventions that are applied in a co-ordinated way that does not duplicate and confuse those in receipt of services.

The service must place emphasis on the leadership role they will play, working with and a range of others particularly locality teams to carry out their specialist function. As described at section 2.1 the FSM is predicated on a One System approach requiring working across all stakeholder listed below:*

- Health Services
- CEHASH
- Social Care / Social Workers
- Private, Voluntary, Independent and maintained providers of children's services
- One Rochdale (Includes the Family Services Directory)
- Extended Schools / Primary Clusters
- Early Help locality team
- Parents / Carers.
- Housing Officers
- Adult Services
- Children's Centres
- The Schools and Learning Settings Performance Team
- Children with Disability Team
- Integrated Healthy lifestyles Service (including Oral Health Improvement)
- Early Break
- 0-25 SEND Team

* This list is not exhaustive and may be subject to change.

Strategic Partnership Arrangements - the service will report and contribute to the relevant boards and strategic partnerships as agreed with the commissioner and as relevant to each of the service delivery areas. This will include for example the Health and Wellbeing Board, Children and Young Peoples Partnership, the School Readiness sub-group and the Family Services Model Partnership Board and RSCB and sub groups, as well as other groups which will be discussed and agreed at the start of the contract. There will be an expectation that the service also contributes to relevant Greater Manchester partnerships and working groups.

Whilst the scope of this commission is currently outside of the LCO there is an imperative build on the excellent partnership working with the LCO which exists in the Borough. To this end the children and young people community integrated health service is required to support the vision of the LCO which may include future alignment.

5.3 Management and Organisational Requirements

The service must ensure and be able to demonstrate that the manager(s) and all staff have the experience, skills and where appropriate qualifications that are relevant to the type, scale and professional elements of services offered. This includes ensuring that staffs within the service are registered with the appropriate professional bodies and that accreditations are kept up to date.

The service must ensure that at all times there is sufficient staff to deliver the requirements of the Service Specification. The service must provide dedicated posts as referred in the safeguarding section 6.3.

The service must provide all staff with a means of identification. This should include as minimum a photograph, the name of the member of staff, and the service's logo. The service must have a system in place for ensuring that such identification cards are returned should a staff member leave.

The service must ensure effective and high quality leadership, budget management and coordination of the children's centre(s), working with and through others to design and shape flexible responsive services that meet the changing needs of children and families across the reach area of each centre.

The service must ensure that there are adequate resources and capacity to further develop the leadership and management of the Integrated Community Services Team.

5.4 Single Performance Framework

The Integrated children's community service single performance framework will operate on a service reported model.

The service is accountable for demonstrating that they are achieving the standards required and are having a sustained positive impact on the lives of families with young children living in Rochdale.

The framework is aligned to local and national statutory requirements of all services included in this specification and as such are subject to change in line with changing legislation. The principle aim of the framework is to ensure that outcomes are achieved and challenge underperformance to enable the service to have a sustained, high value, positive impact and achieve improved outcomes for children, young people and families.

Key Measures will be developed to reflect both the local and national outcomes frameworks. Details of the Performance Framework metrics can be found in the outcomes section 5.4.

The aim of the single performance framework is to maximise the use of information and streamline reporting requirements as a result of integrated delivery.

5.5 NHS England Recording and Reporting Requirements

The service is expected to report to, and when required, to attend meetings on a quarterly basis with commissioners. This will be in order to share data, performance information and discuss any issues in relation to service delivery.

It is expected that the service will submit data to the commissioner at least three weeks ahead of standard contract meetings as required. Where the service is responsible for contribution to national data submissions systems it is expected that they will work with the commissioners so these submissions are made at least three weeks ahead of any national deadline.

The service should submit the Health Visitor Activities and Outcomes return no later than the 20th of the middle month following the end of the quarter e.g. for the Q1 April to June submission, we will require the data by the 20th August or the nearest working day to that date. This allows time for scrutiny and validation of the data and meeting with the service if necessary prior to submission to PHE.

The service must ensure that all appropriate records are kept in CHIS or similar system to enable high quality data collection and reporting to NHS England.

Further information on the required record keeping, data collection systems and information sharing are outlined in the technical specifications [Appendix 2-4].

As referred to in section 4.4 the service will be required to develop one electronic integrated case management record and one reporting system, which must work towards aligning and interfacing with the LA and HMR single children's system.

The service will also be expected to continue the use of any licenced tools which are currently in or planned to be in operation. Any migration to these tools and ongoing licences will be financed from within the contractual amount.

6.0 The Service Requirements and Standards

6.1 Applicable National Standards, e.g. NICE

This service will comply with all relevant national standards and guidance including, but not limited to those listed below:

- Allen, G. (2011a) Early Intervention: The Next Steps. HM Government: London

- Allen, G. (2011b) Early Intervention: Smart Investment, Massive Savings. HM Government: London
- Department for Education (2015) Working Together to Safeguard Children
- Department of Health (2013) Getting it right for children and young people : Overcoming cultural barriers in the NHS so as to meet their needs
- Department of Health (2012) The Children and young people's Health Outcomes Strategy
- Department of Health (2011) Healthy lives, healthy people: update and way forward (DH, 2011)
- Department of Health (2011) Healthy lives, healthy people: a call to action on obesity in England
- Department of Health (2011) You're welcome: quality criteria for young people friendly health services
- Department of Health (2010) Achieving equity and excellence for children. How liberating the NHS will help us meet the needs of children and young people
- Department of Health (2010) Equity and excellence: Liberating the NHS and Liberating the NHS: Legislative framework and next steps
- Department of Health (2009) Healthy Lives Brighter Futures: The Strategy of Children and Young People's Health
- Department of Health (2004) The National Service Framework for Children, Young People and Maternity Services
- Department of Health (2013) Annual Report of the Chief medical Officer 2012. Our Children Deserve Better: Prevention Pays
- Field, F. (2010) The Foundation Years: preventing poor children becoming poor adults. HM Government: London
- Hall, D. and Elliman, D. (2006) Health for All Children (revised 4th edition). Oxford: Oxford University Press.
- HM Government (2013) Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children (HM Government,
- HM Government (2010) The Foundation Years: preventing poor children becoming poor adults. The report of the Independent review on Poverty and Life Chances
- Marmot (2010) The Marmot Review Strategic Review of Health Inequalities in England, post-2010 (Available at http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report)
- Department for Education and Department of Health (2014) Special Educational Needs and Disability (SEND) Code of Practice.
- Royal College of Paediatrics and Child Health, (2010 – revised in 2015) Facing the Future – standards for acute general paediatric services.
- Royal College of Paediatrics and Child Health, (2015) Facing the Future – Together for Child Health.
- Royal College of Paediatrics and Child Health, (2012) Standards for children and young people in emergency care settings.
- Royal College of Paediatrics and Child Health, (2012) Standards for children and young people in emergency care settings – supplement children and young people with complex medical needs.
- National Institute for Health and Care Excellence (NICE) guidance relating to children and young people's health.
- Department of Health (2009 – amended 2010) Healthy Child Programme - 5-19 years
- Department of Health (2009) Healthy Child Programme – The Two Year Review
- Royal College of GPs (2010) Child Health Strategy 2010-2015

- Care Quality Commission (2014) From the Pond into the Sea – Children's transition to adult health services.

6.2 Applicable Standards set out in guidance and/or issued by a competent body (e.g. Royal Colleges)

All practitioners are trained and will have nationally recognised qualifications and where appropriate will be registered with the recognised professional body.

6.3 Quality, Safety and Safeguarding

Quality
Quality is central to all HMR CCG and RBC commissioning activity. The CCG requires all providers of commissioned services to deliver a high quality service which provides safe, clinically effective care which is personalised and a positive experience for children and service users.

The aim of this section of the service specification is to indicate the minimum quality standards, which the Provider(s) of the Children's Integrated Community Health must provide care:

- **In the right way** (delivered by a workforce that is highly skilled, motivated and competent to deliver the care required).
- **At the right time** (through accessible services available when the child/young needs them).
- **In the right place** (providing treatment/services locally in a safe and non-threatening environment).
- **With the right outcome** (improving health, reducing variation in clinical outcomes, ensuring parity of esteem, reduction in potential years lost to conditions amendable to treatment)

Clinical Governance
The service must have a robust system of clinical governance in place and all staff must be fully familiar with the treatments employed within the Children Integrated Community Health Service and be trained and deemed competent to deliver them as per their role.

Adverse/Serious Incidents
The service must have frameworks in place for reporting, investigating and monitoring incidents, near misses and Serious Untoward Incidents with appropriate notification to the CCG and RBC in accordance with specified/agreed timescales. The service will comply with CCG and RBC policy, NHS England guidance for the management of Serious Incidents and statutory guidance on the Duty of candour.

There must be robust and effective systems in place to identify and share the learning from all children safety incidents, near misses, Serious Incidents & complaints, embedding this learning into everyday practice. The service must ensure that any serious incident that results in harm is reported to the Commissioner within a maximum of 24 hours of the occurrence. The service will also report the incident via the Strategic Executive Information System (STEIS).

The service will ensure compliance with the recommendations from audits directly relating to the service as determined in this service specification and any audits conducted following a complaint, Serious Untoward Incident report or Patient Safety Incident Report.

The service will submit reports to the CCG and RBC commissioners at agreed intervals, containing a triangulated analysis of complaints, adverse incidents and serious incidents. Breaches of the Duty of Candour must be notified to the CCG and RBC at the earliest opportunity.

Infection Prevention & Control
The service must have a robust Infection Prevention & Control framework in place which will ensure on-going compliance with current infection control guidelines and local/national infection trajectories/targets during the life time of the contract.

Safety Alerts
The service will ensure that children safety notices, alerts and other communications concerning children safety, which require action, are acted upon within required time-scales and that audits are conducted to ensure on-going compliance.

Safe Staffing
The service will ensure that staffing levels across all services are adequate to manage the delivery of care. This will include adherence to national or local guidance on safe staffing and any current or future requirement to publish staffing levels.

The service will monitor caseloads for staff to ensure safe and effective delivery of services.

Clinical Effectiveness
The service should employ models of care, interventions and treatments that are evidence based e.g. Royal College Standards, NICE guidance. Non-clinical interventions delivered in accordance with this specification such as, leisure activities, may not be evidenced based, but rather based on what the child/young person feels will be effective to meet their individual needs at that time.

The service will use technology, clinical audit, data management and analysis, service reviews, intelligence and other techniques to evaluate its effectiveness and to drive continuous service improvement.

The service will be required to participate in properly conducted quality research where possible (with appropriate ethical approval).

Safeguarding
The service must have clear protocols and policies in place to ensure that local safeguarding procedures are an integral part of the service delivery to ensure in particular the Protection of Children but also extending to Vulnerable Adults. The Rochdale Borough Children's Safeguarding Board provides help and advice if there are any concerns around the safety of

children, as well as access to the policies/protocols used locally – the web address is: https://www.rbscb.org/

The service is required to ensure that all staff are appropriately trained in local safeguarding procedures and maintain these competencies, to ensure that staff are appropriately supported to implement safeguarding procedures where concerns have been identified. All staff working with Children will have undertaken an enhanced Disclosure and Barring check.

The service is also required to ensure that protocols and policies are in place to ensure compliance with current and future National guidance and legislation (e.g. Mental Capacity Act (2005), Deprivation of Liberty Safeguards).

In order to fully comply with statutory and local requirements the service will be required to have in the place the following;

- LAC Specialist Safeguarding Nurse x1
- Named Nurse (Safeguarding) x1
- CSE/CCE Specialist Safeguarding Nurse x 1.5
- Complex Early Help and Safeguarding Health practitioners x2

6.4 Children/Young People/Family Experience

The service will have an age appropriate feedback mechanism, to ask children and young people, and their families about their experience and outcomes for any or all elements of their journey that reflects whether they:

- were involved in decisions about their management, treatment and discharge;
- received good quality care;
- had a positive experience of the service and an improvement to their health;
- involved families/carers – where appropriate; and
- Were treated with kindness and compassion, respect and dignity.

The service will be required to actively engage with children and young people to ensure that the services are always designed with children and young people in mind.

The service will also need to develop a process to measure children experience through this delivery model, which captures timely, relevant and accurate views from children and young people and their families/carers who use these services. The service will demonstrate that they actively listen to feedback and act and plan accordingly ensuring that any feedback received is reflected in any service improvement plans. All children and young people and their families/carers must be given the opportunity to provide feedback, regardless of race, ethnicity, religion and sexual orientation and the methods used to collect feedback must facilitate this.

Prevention, Self-Care & Children and Young People and Family/Carer Information
Literature, must be clear and age appropriate, and where possible designed with children and young people.

All literature must meet the required communication standards for children's literature and have systems in place which allow for appropriate recording and management and respond to children queries.

The service must have robust processes in place to ensure children's literature is relevant, clear effective and all examples of children's literature must be made available to the commissioners.

Complaints
The service must create a system that empowers children and young people to challenge services. Robust and effective processes must in place to enable children and service users to raise complaints/concerns and for investigating and responding to complaints/concerns within agreed national NHS timescales. Children and young people and their families/carers must be supported throughout any complaint investigation and the service must have a clear process for complying with the duty of candour.

The service will be required to inform the Commissioner or Commissioning Agents within 24 hours of any complaint raised by a child concerning the service's staff or any other matter relating to a child's care. All child complaints will be investigated by the service. However, any complainant has the right to complain to their respective NHS organisation.

6.5 Business Continuity, Resilience and Risk

The service will be required to have a business continuity plan which is compliant with the standards in ISO 22301:2012 Societal Security – Business Continuity Management Systems (Replacing BS25999) and these will be submitted for commissioner's approval.

The Business Continuity Plan must include:

- Staff sickness
- Major Incident Management /response
- Flu pandemic plans
- Adverse weather plans

The service will be required to work with partners to enable system flex to support unexpected variance or issues, and commissioners would encourage partners to consider having one Business Continuity and Resilience Plan to support this.

The service will ensure that the service is operational during periods of annual leave, short and long term leave, short and long term sickness and training periods.

6.6 Interdependence with other services/providers

This service is predicated on **Family Services Model** and integrated locality working for the delivery of children and young people's health services for the Local Authority, CCG and its Children. The aim of the Family Services Model (FSM) is "*to deliver a whole system approach for children, young people and families that describe an integrated delivery offer from universal / community level support to highly specialised and acute interventions".*

Whilst the scope of this commission is currently outside of the LCO there is an imperative build on the excellent partnership working with the LCO which exists in the Borough. To this end the children and young people community integrated health service is required to support the vision of the LCO which may include future alignment.

The service will be required to develop strong relationships and work in partnership across services within the children and adult partnership arrangements in order to improve outcomes for children and young people. The service will work in an integrated way with children's centres and early years services so that families receive seamless, co-ordinated assessments, interventions and support.

6.7 Provider Management Structures

A full service staffing structure (including names, posts, WTE/PTE and qualifications) is required to demonstrate service ability to deliver the described services for the integrated community health service.

The service shall ensure as a minimum the following:

- Designated Medical Officer
- Safeguarding – Named Doctor
- Designated day-to-day Operational Manager who can be contacted by health staff.
- Designated Clinical Lead
- Designated Caldicott Guardian – this is a senior member of the organisation who carries the responsibility for the appropriate use and protection of children's data.
- Identified safeguarding lead
- Identified quality and safety champion
- Contact details of the designated staff will be made available, i.e. names, titles, email addresses and telephone numbers.
- Safeguarding specific posts as referred to in section 2.2

If any of the Trust or service designated managers are absent, nominated contacts will be notified.

The service will be required to be proactive to ensure the organisation is a good place to work. This includes setting internal Key Performance Indicators and encouraging staff feedback through formal and informal feedback.

It is envisaged that the service will recruit a creative and innovative multi-disciplinary workforce that can deliver the requirements of this specification.

6.8 Service Improvement and Innovation

The service will be required to adopt a culture of continuous improvement and review. The service will:

- Continuously seek to improve the co-designed outcomes of the child/young person.
- Work with Commissioners to develop ideas and opportunities for innovation and improvement.
- Innovatively, co-design service improvements with children and young people and their families/carers.
- Optimise the use of technology in consultation with children and young people, for example, the use of social media.
- Inclusion of community third sector in the development and delivery of the service
- Development of pathways as referred to in section 4.3
- Electronic case management /record keeping system
- SLA as described in section 4.3

- Support integration of the FSM agenda

The service will be required to undertake service audits as agreed by the commissioner.

The service will be required to be flexible in order to shape the service in line with the development of the model for Integrated Children and Young People's Services.

6.9 Data Collection and Security

The service will use effective systems for collecting, collating and managing relevant information in relation to individual children and young people, as required to fulfil the requirements of this specification. Utilisation of national data collections systems/tools/support should be considered to enable standardisation.

The service will develop data systems that will ensure that activity, performance and finance information (as outlined in this specification) are readily available to commissioners. The service should collate information into quarterly, and at year end, annual reports for commissioners – in line with the monitoring arrangements detailed within this specification.

It is the responsibility of the service to ensure that information is stored securely and remains confidential in accordance with the Data Protection Act 1998 and NHS Information Governance requirements.

As described in section 4.4 it is expected that during the first year of this contract the following will be achieved;

- Development of pathways as described in section 4.3
- Development of integrated assessment in line with FSM
- Development of single outcome framework in line with FSM
- Development of single electronic case management, reporting system which is compatible with LA and CCG systems
- Support integration agenda between commissioned elements of this service and existing in house provisions in line with FSM

All data and information produced by the service model will remain the intellectual property of the Commissioners.

6.10 Medicine Optimisation

The importance of correct use of medicines in children and young people cannot be overstated. Whilst some medicines are used "off label" in younger children due to licensing, experience, use of national and local guidelines can ensure that medicines are used safely and to good effect.

Specialist knowledge is often required to ensure that the correct medicines are chosen and if required, doses are adjusted accordingly. Close monitoring of some medicines are required with increased vigilance for possible adverse effects and or / interactions with concurrent medicines.

Use of clinically effective medicines for children and young people with long term conditions in the early years of life can reduce the likelihood of complications or deterioration of good control in later life. Compliance with medication research in children is sparse and vigilance

from health professionals and parents & carers is often required to ensure that the number of missed treatments is as low as possible.

Clearly effective communication with the child's GP is essential – details of any changes made to medication made by qualified non-medical prescribers to improve treatment or reduce adverse effects must be made in a timely manner. It is also integral to enhanced professional practice that the clinician who assesses and decides that a change of treatment is required will undertake prescribing for that child and provide any additional relevant information to ensure concordance with the treatment provided. When prescribing any medicine – particularly for children – access to the information which has been developed by the Greater Manchester Medicines Management Group (GMMMG) is required, this can avoid confusion. Some medicines are CCG commissioned and other NHSE commissioned, Red classified medicines cannot be prescribed by the GP and any Amber classified therapies will require a Shared Care Protocol signed by a medical specialist

For community staff, who maintain regular contact with younger children, medication reviews which can identify problems which may be leading to over or under use of medicines. This should always be discussed with the child's GP, with advice from the CCG Medicines Optimisation Team sought if necessary.

In line with National directives any suspected or proven adverse reactions or clinical incidents related to medicines use by children or young people within HMR CCG must be reported to the National Reporting and Learning Service (NRLS) and via the Yellow Card Scheme with supplementary information provided as required.

Prescribing Budget

During year 2020/2021 the CCG will work with the service to capture all prescribing costs and ancillaries as part of the new model of delivery. The intention is then to provide an agreed budget to cover prescribing costs from 2021/2022 onwards.

6.11 Information Sharing/Governance

The service should ensure that information is shared appropriately across agencies in accordance with legislation, guidance and local information sharing protocols. Please see NHS Standard Contract General Condition (GC21 – confidentiality, data protection, freedom of information and transparency).

The service should:

- Provide appropriate tools to employees to enable them to best support the child/young person, ensuring physical resources, including the technology is appropriately protected, secure and fit for purpose.
- Ensure all employees are adequately trained and kept informed in IG related matters, consummate to their role and function.
- Ensure all services comply with all relevant information law and the required IG standards, including successful completion of the IG Toolkit on an annual basis.
- Take IG seriously and evidentially embeds IG principles and processes throughout the service and the organisation.

6.12 Integration of Care Records

The service will be required to demonstrate their ability to share access to care records. Remote access will be further developed to support mobile working and efficient working. Real-time data systems will also save time when care is transferred between professionals or teams and reduce duplication of assessments etc. for children and young people and their families.

Integrated clinical systems are already being considered though multi-agency discussion across the North East Sector footprint, Rochdale, Oldham, Bury and North Manchester including CCGs, Local Authorities, Out of Hours providers, NWAS and Pennine Acute Trust to deliver an Integrated Health and Social Care Record. The service will be involved in this work over the duration of the contract.

6.13 Electronic Referral

The CCG's Data Quality Team has developed an electronic referral form which integrates with our clinical systems to merge demographic and basic clinical data in a standardised format agreed across our organisation. The provider(s) should only be expected to receive electronic referrals from across the system; this should aim to be linked with the electronic case management system as referred to throughout. An electronic copy of the completed referral form can then be held within the children's record and be visible to integrated records systems as they become available.

Similarly, the service will be required to generate correspondence following clinical encounters with children to be transmitted electronically back to primary care clinicians for merging with their clinical records systems. HMR GP practices currently have a mixed economy of EMIS Web and InPS Vision systems across the primary care estate, and all sites have PCTI Docman ECC management systems in place behind these. The current primary care systems are capable of receiving electronic documents in .tif file format, or via DTS transmissions. There should be no use of fax machines to transfer clinical information to any other setting,

6.14 Use of data for contract monitoring and to inform the service model

The service will be required to have in place an IT system to support the collation of a Intervention Data Set (IDS) and Community Intervention Data Set to contribute to the outcomes framework and contract review process.

The service will be required to leverage this linked data to make smart interventions in order to improve outcomes and reduce costs. The commissioner will require the service to be able to analyse past data to predict / model which cohorts of children/young people are likely to be at risk of mental health problems in the future, and to be able to make smart interventions to improve outcomes and reduce costs.

6.15 Workforce Requirements – Staff Training and Development

There must be an integrated approach to the implementation of the acute and ongoing needs Team. This will require staff to have training in an agreed set of core basic behaviour

change competencies. Staff will be competent to train others in 'Every Contact Counts' and offer the local health chats programmes for interventions such as Smoking Cessation, Alcohol brief interventions, Physical Activity and Healthy Weight.

The service will take account of having an appropriate skill mix whilst maximising the use of specialist skills in the most efficient way. All staff will be required to have training in an agreed set of core competencies supported by a set of clear referral pathways to be developed and implemented by the service and partners.

Common processes:

- All staff will be trained to use common processes, e.g. Early Help Assessment and Safeguarding procedures, in line with the protocols to support integrated working and in line with the Early Help Strategy.
- Staff will complete/contribute to common assessments, child and family meetings, assuming the role of Lead Professional where appropriate and in the use of local information sharing systems.
- All staff will undertake Multi-agency Risk Assessment Conference (MARAC) training. All staff should complete a Safe lives risk assessment to determine the level of risk upon disclosure of domestic abuse and should then refer victim into the appropriate pathway depending upon the level of risk identified.

The service will ensure that it operates as part of the wider integrated children's workforce across the Rochdale Borough, and in line with the Borough's Locality Workforce Strategy. In particular, the service will ensure all staff possess the minimum core competencies and skills required of the children's workforce and undertake relevant training that supports integrated working and service delivery such as: the Integrated Children's Workforce Multi-agency Welcome Event, Early Help and Safeguarding.

6.16 Equality and Diversity

The service is required to commit to promoting equality and diversity, this means that all organisations will have due regard to the need to eliminate unlawful discrimination, harassment and victimisation prohibited by the Equality Act (2010).

The service needs to ensure that all equality groups including disabled people, vulnerable people and disadvantaged groups, are not disadvantaged in their access to services and that services offer flexibility in meeting their needs.

The service is expected to undertake an annual Equality Impact Assessment for all services provided. In addition, the service must gather and submit evidence to the CCG and RBC annually (1 November) via the latest EDHR Schedule within their contract, to evidence their equality and human rights legal compliance.

The service must assure the commissioner that all staff have completed training in equality, diversity and human rights within the 12 months post service commencement. As a minimum, the service must evidence how they meet the minimum requirements of the Equality Act 2010 including the PSED (public sector equality duty).

7.0 Applicable Quality Requirements and CQUIN Goals

7.1 Applicable Quality Requirements

CCG Quality Framework

You're welcome: quality criteria for young people friendly health services
Care Quality Commission Ofsted/Care Quality Commission Children's Joint Inspection (Safeguarding and Looked After children)

7.2 Applicable CQUIN Goals

CQUIN arrangements will be considered during the routine annual contract process.

8.0 Location of Service Premises

The Provider(s) must occupy the existing clinically safe and accessible locations (see premises list) which support the localities as identified in Appendix One.

Where possible the Provider(s) will be expected to identify opportunities within stakeholder premises to co-locate. This must include sites which have already been established within the community and existing provision (any relocation from existing sites must first be agreed with the commissioner), all premises should be considered in relation to the One Public Estate (OPE) approach in Rochdale borough.

All costs relating to premises are included within the total funding envelope.

9.0 Key Performance Indicators

9.1 Outcomes

It is expected that the service in consultation with commissioners will design tools/systems to capture the outcomes described below. The child/young person's care plan will be used to capture the majority of outcome goals and a proforma will be designed with commissioners and children and young people to ensure that it is user friendly, and reflects the outcomes that are important to children and young people and their families. It is accepted that the service may not have the infrastructure to measure the full list of outcomes in the first year of the contract. Consequently, it is proposed that the service works to deliver the outcome measures highlighted in bold during the first year of the contract, with the remaining outcome measures delivered in year 2.

In order to evidence the integration across the system the service will be expected to work towards the following system outcomes;

System Outcomes

1. **Seamless and safe access to community health and social services across the system.**

Measure

- Integrated assessments are developed and undertaken

- Eliminate service duplication, reduce waiting times and improve service user flow

2. Further development of integrated care pathways across the system and shared electronic children's and young people case management system.

Measure

- Joint care management protocols and case management electronic system across the service and the wider FSM system within the first year
- Improved access to service

3. The integrated model is proactively responsive in prevention and identifying need early.

Measure

- Reduced demand for specialist service
- Higher take up of provision in community setting, supporting self-care and increased resilience

Service Outcomes

It is expected that the service in consultation with commissioners will design tools/systems to capture the outcomes described below. The child/young person's care plan will be used to capture the majority of outcome goals and a proforma will be designed with commissioners and children and young people to ensure that it is user friendly, and reflects the outcomes that are important to children and young people and their families.

1. All Children have the opportunities they need to enable them to help themselves, their loved ones and their communities to achieve their full potential.			
Outcome Goal	**Outcome Indicator**	**Measure**	**Threshold**
Professionals and those around me actively involve me in learning about, understanding and making decisions about my health.	Proportion of CYP who said they were involved as much as they wanted to be in decisions about their care and support.	Data collection / satisfaction survey / audit sample of Care plan	**95%**
	Proportion of CYP who report that they have received advice about, and training on, how best to manage their condition.	Data collection / satisfaction survey / audit sample of Care plan	**95%**
	Proportion of CYP who have a co-designed care plan, which is SMART in structure and design, with clear review points.	Data collection / satisfaction survey / audit sample of Care plan	**95%**
	Proportion of children measured as overweight or obese who are provided with an appropriate intervention	Data collection (as reported)	**100%**
I know who to turn to when I have a concern or an emergency.	Proportion of CYP who have a named professional(s), with contact methods included in care plan.	Data collection / satisfaction survey / audit sample of Care plan	**95%**
I can get involved in designing services for people like me.	Percentage of CYP actively involved in service improvement/design.	Evidence, e.g. attendance at design meetings etc.	**25%**
I am fully aware of	Proportion of CYP who have a	Data collection /	**100%**

what to expect and can challenge services that do not meet those expectations.	detailed care plan describing their individual care needs and agreed and documented outcome goals.	satisfaction survey / audit sample of Care plan	
	Percentage of CYP who have been given information about the steps to take if they are not happy and the complaints process.	Data collection	**100%**
2. All Children are protected from harm, through support in times of need and by safeguarding and protecting those who are vulnerable.			
I am respected and listened to as a whole person.	Proportion of CYP who felt that their views, opinions and desires were taken into account in their care planning.	Data collection / satisfaction survey / audit sample of Care plan	**100%**
I am supported in an environment that is appropriate to meet my needs.	Percentage of CYP offered a range of environments to access care.	Data collection / satisfaction survey / audit sample of Care plan	**95%**
	Number of location choices offered in accordance with You're Welcome standards.	Identified service locations.	**95%**
I can trust the people who support me to be open and honest.	Proportion of CYP, who agree.	Data collection / satisfaction survey / audit sample of Care plan	**Baseline and stretch after year 1**
There is consistency of people supporting me.	Staffing Levels / staff sickness rates.	Data collection	**Baseline in year 1**
My agreed goals (short and long term) are taken into account and valued.	Percentage of CYP who have short and long term goals documented and monitored in their care plan.	Data collection / satisfaction survey / audit sample of Care plan	**100%**
3. The borough is a place where people age well, can live with dignity and have equitable access to services and opportunities.			
People in my school / community are made aware of how to identify and support people who need help.	Number of community training and awareness sessions undertaken for staff/Trusted adults.	Training programme identified and completed.	**Baseline in year 1**
	Percentage of school staff reporting increased knowledge and awareness.	Survey of schools who have received training/awareness	**95%**
I have timely access to support when I need it.	Number/Percentage of statutory assessments completed with within statutory requirements	Data collection	**95%**
	Percentage of referrals triaged within 24 hours	Data collection	**95%**
	Percentage of CYP assessed and receiving treatment within 18 weeks	Data collection	**95%**

I am able to access support from home and over the internet.	Number of CYP accessing information on their condition and self-management online	Data collection	**N/a**
I don't want to have to repeat my story.	CYP feel that their care has been coordinated, with their keyworker/lead professional acting as navigator.	Data collection / satisfaction survey / audit sample of Care plan	**95%**
	Percentage of CYP with a single shared care record	Data collection	**100%**
	Percentage of CYP with an agreed transition plan.	Data collection / satisfaction survey / audit sample of Care plan	**100%**
	Percentage of GPs are informed of referral, action taken and discharge of CYP	Data collection / satisfaction survey / audit sample of Care plan	**100%**
I have access to advice from people my age or with similar experiences	Number of CYP who have been trained to become a peer mentor.	Data collection.	**N/a Baseline and stretch after year 1**
	CYP user groups convened and facilitated to meet regularly.	Groups identified and meeting schedule	**N/a**
4. All Children have good mental wellbeing, are resilient, enjoy life, and are able to cope with life's challenges.			
I have opportunities to have fun and get involved in meaningful activities that I enjoy	Percentage of CYP referred to community activity groups.	Data collection / satisfaction survey / audit sample of Care plan	**N/a Baseline and stretch after year 1**
I can make a contribution to society	Percentage of CYP who are supported to access opportunities which will enable them contribute in a way that is meaningful to them.	Data collection / satisfaction survey / audit sample of Care plan	**Develop with CYP in year 1**
5. All children are healthy and ready to succeed when they start school and all children and young adults achieve their potential.			
I have all the information and advice I need from professionals to successfully breastfeed	Percentage of infants for whom breastfeeding status is recorded at 6-8wk check	Numerator: Number of infants where feeding status has been recorded at 6-8wk check Denominator: Total number of infants due 6-8wk check Formula: Numerator / Denominator x 100	**40% prevalence target**
I have all the information and advice I need from professionals to successfully	Percentage of infants being breastfed at 6-8wks	Numerator: Number of infants recorded as being totally and partially breastfed at 6-8wks	**40% prevalence target**

breastfeed		Denominator: Total number of infants due 6-8wk check Formula: Numerator / Denominator x 100	

Activity Requirements

The service will collect and report on a full dataset that will provide robust information relating to the Acute and Ongoing needs service and will be used to inform future service development and commissioning plans. The table below describes the initial activity reporting requirements; however, these may be updated upon agreement of the service model.

Additional activity requirements can be found at Appendix Five, full agreement on reporting relating to these elements will be finalised during the first six months of the contract.

A	**Statutory Requirements**	**Threshold**	**Period**
1	EHC assessments undertaken and reported within 6 weeks of referral receipt	Actual	**Quarterly**
2	LAC assessments undertaken and reported within 28 days of receipt of referral.	Actual	**Quarterly**
3	Annual review medicals completed within +/- 2 weeks of review date	Actual	**Quarterly**
4	LAC report	Actual	**Annual**
B	**Mandatory Requirements**	**Threshold**	**Period**
5	Number of mothers who receive a first face to face antenatal contact with a health visitor at 28 weeks or above	actual number	**Quarterly**
6	Percentage of births that receive a face to face NBV within 14 days by a health visitor using NBO	95%	**Quarterly**
7	Percentage of face to face NBV undertaken after 14 days by a health visitor.	<5%	**Quarterly**
8	Percentage of babies who receive a 6-8 week review using ASQ 3 / NBO	95%	**Quarterly**
9	Percentage of children who receive a 9- 12 month review by the time they turned 12 months old	95%	**Quarterly**
10	Percentage of children who receive a 9- 12 month review (stage 4) by the time they turned 15 months	100%	**Quarterly**
11	Percentage of children who receive a 9- 12 month review (stage 4) using ASQ 3.	95%	**Quarterly**
12	Percentage of children who received a 2-2½ year review during the quarter for whom the ASQ-3 is completed as part of	95%	**Quarterly**

	their 2-2½ year review		
13	Percentage of children who were at or above the expected level in communication skills	As reported	**Quarterly**
14	Percentage of children who were at or above the expected level in gross motor skills	As reported	**Quarterly**
15	Percentage of children who were at or above the expected level in fine motor skills	As reported	**Quarterly**
16	Percentage of children who were at or above the expected level in problem solving skills	As reported	**Quarterly**
17	Percentage of children who were at or above the expected level in personal -social skills	As reported	**Quarterly**
18	Percentage of children who were at or above the expected level in all five areas of development	As reported	**Quarterly**
C	**Child Development at 2-2.5 years Outcome**	**Threshold**	**Period**
19	Percentage of children who were at or above the expected level in all five areas of development. In future year's targets will agreed with the commissioner.	2019/20 Baseline to be collected/established	**Quarterly**
20	**Mandatory** National Child Measurement Programme (NCMP) – Responsibility of the service to coordinate and deliver NCMP in line with national guidance and specification requirements	Not to fall below 90%	**Annually via Public Health**
D	**Oral Health**		
21	Increase exposure to fluoride via the delivery of family tooth brushing packs at one year and two year assessments and signpost to a dental practice if needed.	100% of children receive pack	**Quarterly**
22	Percentage of mandated contacts where oral health pack and advice is given	100%	**Quarterly**
23	Refer families requiring specialist oral Health support to Living well Oral Health Improvement Officer	100%	**Quarterly**
24	School Nursing staff engaged in oral health training sessions delivered by Living Well Service	80%	**Annually**
25	Promote and support oral health and related public health campaigns within schools.	Healthy Child Programme Universal Offer	**Annually**
E	**Reduction in smoking prevalence**	**Threshold**	**Period**
26	Number of children and young people given smoking cessation brief interventions.	Increase	**Quarterly**

27	Number of smoking parents provided with a smoking cessation brief intervention	Increase	**Quarterly**
28	Number of smoking parents provided with a smoking cessation brief intervention who are referred to the Stop Smoking Service	Increase	**Quarterly**
F	**Contribute to increasing uptake of childhood immunisations**	**Threshold**	**Period**
29	**Childhood immunisations:** Diphtheria, tetanus, pertussis, polio, Hib and Hep B, Pneumococcal, Meningococcal Group B, Rotavirus. Hib and Men C, Measles, Mumps and Rubella	All 95% uptake	**Quarterly**
G	**Contribute to increasing uptake of school aged immunisations**	**Threshold**	**Period**
30	**School aged immunisations:** HPV (to include boys from September 2019) MenACWY School Leaver booster School flu	All 100% offer 65% uptake	**Quarterly**
H	**Promoting Good Mental Health And Wellbeing**	**Threshold**	**Period**
31	Number and proportion of young people who report an improved WEMWEBS score post intervention or equivalent	Monitor numbers	**Quarterly**
I	**Reducing Unintentional Injuries**	**Threshold**	**Period**
32	Number of A&E notifications received	Establish baseline	**Quarterly**
33	Notifications to service following an A&E attendance are followed up as per the health visiting and school nursing pathway.	100%	**Quarterly**
J	**Whole school approach to health improvement**	**Threshold**	**Period**
34	Produce an annual school health profile and school health plan for each school using local Joint Strategic Needs Assessment data, data held by the Rochdale Children and Young Peoples Integrated Community Health Service and by the school itself. Support the development of whole school approach to healthy eating and drinking and physical activity	100% coverage Work towards 100% coverage.	**Provide a narrative report quarterly to demonstrate impact on all Public Health Outcomes**

10.0 Reporting Requirements

The service is expected to report to, and when required, to attend meetings on a quarterly basis with commissioners. This will be in order to share data, performance information and discuss any issues in relation to service delivery.

It is expected that the service will submit data to the commissioner at least three weeks ahead of standard contract meetings which are held every quarter and as and when required. Where the service is responsible for contribution to national data submission systems it is expected that they will work with the commissioner so these submissions are made at least three weeks ahead of any national deadline. Where there is a requirement to provide clinical validation i.e. safeguarding or serious untoward incidents that these will be done immediately where thresholds are met or on a monthly basis.

The service should submit the Health Visitor Activities and Outcomes return no later than the 20th of the middle month following the end of the quarter e.g. for the Q1 April to June submission, we will require the data by the 20th August or the nearest working day to that date. This allows time for scrutiny and validation of the data and meeting with the service if necessary prior to submission to PHE.

INDICATIVE REPORTING SUBMISSION TIMEFRAMES

SERVICE PERFORMANCE REPORT & REVIEW MEETINGS: AND LOCAL / NATIONAL DATA RETURNS

Year 1: 2019/20

Quarter	Quarterly monitoring report to be submitted by provider to commissioner (2 weeks prior to meeting) w/c	Quarterly monitoring meeting date w/c (PHE 0 to 4 activity return due)
3 (Oct - Dec.)	27/01/20	17/02/20
4 (Jan - March)	27/04/20	18/05/20

Year 2: 2020/21

Quarter	Quarterly monitoring report to be submitted by provider to commissioner (2 weeks prior to meeting) w/c	Quarterly monitoring meeting date w/c (PHE 0 to 4 activity return due)
1(April - June)	27/07/20	17/08/20
2 (July - Sept.)	26/10/20	16/11/20
3 (Oct - Dec.)	25/01/21	15/02/21
4 (Jan - March)	26/04/21	17/05/21

11.0 Monitoring and Review

The service will be subject to an annual review, which will seek to ensure that the service is delivering the outcomes set out in this service specification. It will include an analysis of activity levels and staffing, performance against key performance indicators, and value for

money. The service will also be able to demonstrate a commitment to continuous service improvement. This review will be used to inform future commissioning intentions, and revisions to the service specification.

The service will be expected to receive announced and unannounced visits from commissioners, and also to accommodate all reasonable requests for visits from other relevant colleagues.

Standards of service provision, performance indicators and monitoring criteria are outlined in this specification and may be subject to continuing negotiation during the course of service development and delivery.

11.1 Continual Service Improvement Plan

The Service Specification has set out the standard expected based on National Guidance and direction. The outcomes will establish a baseline position which will be reviewed one year on. The Indicators will then be re-assessed to ensure that improvement is maintained year on year.

12.0 Financial Arrangements

12.1 Contract Value

Maximum funding envelope £9,682,571 per annum*

*Some functions included within the financial envelope will be subject to an annual deflation of 1%, other elements will also include QCUIN which is not inclusive of this financial envelope.

13.0 Glossary

Term:	Meaning:
Vulnerable	In need of special care, support or protection because of age, disability or risk of abuse or neglect.
Transition	Any major change point in a child/young person's life. For this specification it means transition into adult services or a step up into CAMHS Tier 3/Step 4 provision or step down into universal services. Equally children may go through many transition processes as they grow up, such as leaving primary school etc.
Trusted Adult	Can be any adult, who has built up a trust with a child/young person and is committed to keeping that child/young person safe, for example, a teacher or a community boxing coach. A trusted adult: • Respects a child/young person's right and need to express thoughts and feelings openly. • Understands a child/young person's need for safe healthy boundaries. • Believes a child when they 'disclose' a boundary violation. • Takes action by engaging other trusted adults to assist and protect the child.

Hard to Reach	Those individuals who: • have failed to attend appointments • are NEET (Not in Education, Employment or Training) • require additional support to access services, i.e. those who: have SEND (specialist Educational Needs or Disability); those who speak English as a second language; those from a BME background; those from transient communities; those from asylum seeker communities; those whose sexual orientation is classed as lesbian, gay or bisexual; those undergoing or completing gender transformation; those who do not fall under the remit of local health services; and those placed from other areas.
Safe Staffing	Safe staffing means having enough nursing staff with the right skills and knowledge, in the right place, at the right time. Without safe staffing levels in place, nursing staff are struggling to provide patients with the safe and effective care they would like to, and which patients deserve.
Duty of Candour	Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. This means that healthcare professionals must: • Tell the patient (or, where appropriate, the patient's advocate, carer or family) when something has gone wrong • Apologise to the patient (or, where appropriate, the patient's advocate, carer or family) • Offer an appropriate remedy or support to put matters right (if possible) • Explain fully to the patient (or, where appropriate, the patient's advocate, carer or family) the short and long term effects of what has happened.
Vigilance	The action or state of keeping careful watch for possible danger or difficulties.

14.0 Appendices

• **Appendix 1 – Locality Map**	Appendix 1 - Locality Plan.jpg
• **Appendix 2 – Health Visiting Specification**	Appendix 2 - GM specific HV 19 24 serv Appendix 2 - HV Specification (GM).do
• **Appendix 3 – School Nursing Specification**	Appendix 3 - School Nursing Specification.
• **Appendix 4 – CAON Technical Specification**	Appendix 4 - CAON Technical Specificatio

• **Appendix 5- Additional Activity Requirements**	Appendix 5 - Additional Activity